Government of **Western Australia**
Department of **Health**

Annual Report

2024–2025

Acknowledgement of Country and People

WA Health acknowledges the Aboriginal people of the many traditional lands and language groups of Western Australia (WA). It acknowledges the wisdom of Aboriginal Elders both past and present and pays respect to Aboriginal communities of today.

Using the term Aboriginal

Within WA, the term Aboriginal is used in preference to Aboriginal and Torres Strait Islander, in recognition that Aboriginal people are the original inhabitants of WA. Aboriginal and Torres Strait Islander may be referred to in the national context and Indigenous may be referred to in the international context. No disrespect is intended to our Torres Strait Islander colleagues and community.

About this report

This annual report provides an overview of the operations and performance of the Department of Health in 2024–25, to support public sector transparency and accountability to the Parliament and people of WA.

The report includes our audited financial statements and key performance indicators for the financial year ending 30 June 2025.

Copies of this and previous reports can be found online at health.wa.gov.au
Digital copies are archived in the State Library of Western Australia and the National Library of Australia, Canberra.

Department of Health

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health.wa.gov.au

Statement of compliance

For the year ended 30 June 2025

HON MEREDITH HAMMAT MLA
MINISTER FOR HEALTH; MENTAL HEALTH

HON STEPHEN DAWSON MLC
MINISTER FOR MEDICAL RESEARCH

HON JOHN CAREY MLA
MINISTER FOR HEALTH INFRASTRUCTURE

HON SABINE WINTON MLA
MINISTER FOR PREVENTATIVE HEALTH

HON SIMONE McGURK MLA
MINISTER FOR AGED CARE AND SENIORS

In accordance with section 63 of the *Financial Management Act 2006*, I hereby submit for your information and presentation to Parliament, the annual report of the Department of Health for the financial year ended 30 June 2025.

The annual report has been prepared in accordance with the provisions of the *Financial Management Act 2006*.

Dr Shirley Bowen
Director General
Department of Health
18 September 2025

Contents

From the Director General

It is with great pleasure that I present the Department of Health's 2024–25 Annual Report.

Across our vast state, healthcare is undergoing a powerful transformation in the way it is delivered, supported and sustained — guided by our commitment to person-centred care.

The past year has been a testament to the resilience and responsiveness of our health system, as we rose to meet extraordinary levels of need. We have seen an increase in emergency department attendances, admissions and elective surgeries, reflecting the growing and evolving needs of our community, and the demand placed on our services and staff.

In response, we have focused on improving access to care through innovative models and systemwide reform. The State Health Operations Centre (SHOC) is a shining example of this – our multi agency, state-of-the-art facility is designed to enhance access to emergency care through improved integration and coordination. Within the SHOC, the WA Virtual Emergency Department, delivered 5,492 consults, with 71 per cent of patients avoiding immediate attendance at an emergency department.

We streamlined patient flow and improved our systemwide responsiveness through the Demand and Capacity Optimisation Program – a dynamic initiative focused on actively managing hospital demand, ensuring that care is both accessible and efficient.

We expanded virtual care pathways and implemented the Time to Think program, freeing up hospital beds while supporting older people to transition into aged care settings.

We also implemented nurse-to-patient ratios in select hospitals, supported new graduates and expanded training and leadership programs to build capability and resilience.

I am incredibly proud of the tireless efforts of our enforcement and policy teams, whose proactive work in reducing the use of tobacco, vapes and nitrous oxide is making a meaningful and lasting impact on community health and wellbeing.

Equally, our research team continued to inspire with innovation and rigour—driving and funding evidence-based improvements and shaping the future of healthcare in WA.

Finally, I extend my sincere thanks to our workforce of more than 64,000 including nurses, doctors, allied health professionals, and corporate staff. Our ability to meet the needs of our community depends on the strength of our workforce. The release of the *WA Health Workforce Strategy 2034* provides a clear and structured path to build a capable, resilient workforce. I am proud of the commitment and compassion shown by our people, whose efforts ensure that Western Australians continue to receive safe, high-quality care.

Dr Shirley Bowen
Director General
Department of Health

About us

Who we are

Our vision

To deliver safe, quality and financially sustainable health care for all Western Australians

Our mission

To lead and steward the WA health system

Our values

Purposeful

We show pride in our work and its positive impact

Caring

We value and respect one another and support diversity and differences in our views and our people

Collaborative

We set each other up for success by aligning our effort to improve health outcomes and combining our knowledge, skills and expertise to ensure the best solution for our community

Open

We act with integrity and do what's right, and we acknowledge and address issues without blame

Outcome-focused

We simplify processes to allow our people to be effective and enable outcomes to be achieved, and we apply governance and controls that are appropriate to the risk

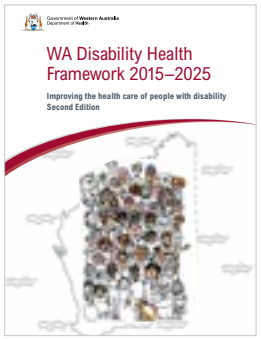
What we do

Set the strategic direction of the WA health system

Our plans and strategies drive delivery of sustainable and person-centred health care, for outcomes that matter the most to individuals and the community

Sustainable Health Review

A 10-year blueprint for transforming WA's health system focused on delivering patient-centred, innovative and financially sustainable care



WA Disability Health Framework 2015–2025

A framework to improve health care and health outcomes for people with disability

Strategy for an environmentally sustainable, low carbon and climate-resilient healthcare system 2024–2030

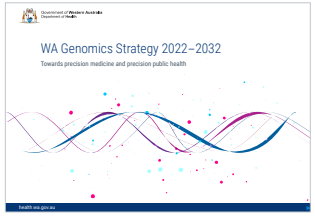
A strategy to ensure the health system operates in a sustainable, resilient and adaptive manner

WA Health and Medical Research Strategy 2023–2033

A strategy to position WA as an international leader in health and medical research and ensure that the benefits of research are felt by the community

WA Health Digital Strategy 2020–2030

A strategy to transform health service delivery for patients and staff through digital innovation and technology



WA Genomics Strategy 2022–2032

A 10-year strategy for adoption of genomic technologies to transform how we prevent, diagnose, treat and predict disease

Clinical Services Framework 2025–2035

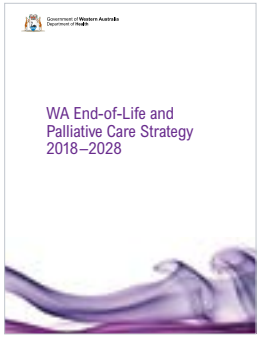
A strategic framework to support and guide clinical service planning and delivery at a systemwide and local level

Improving safety and quality in health care – a strategic plan for action in WA 2024–2026

A plan to achieve safer, high-performing and more person-centred health care

Western Australian Sexual Health and Blood-borne Virus Strategy 2024–2030

A roadmap for prevention and control of sexually transmissible infections and blood-borne viruses



WA End-of-Life and Palliative Care Strategy 2018–2028

A 10-year vision to improve the quality of life of people facing life-limiting illness and their family/carers

State Public Health Plan 2025–2030

A strategic framework to guide State Government departments and agencies, local governments, non-government organisations, communities and advocates in making decisions about public health planning

WA Clinical Trials Roadmap

A plan to guide expansion of clinical trial capacity and boost access to clinical trials for Western Australians

Western Australian Health Promotion Strategic Framework 2022–2026

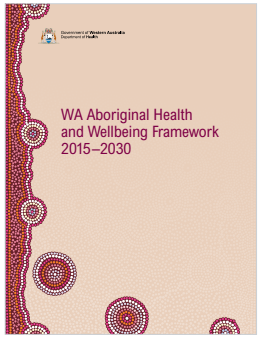
A 5-year plan to reduce preventable chronic disease and injury due to common risk factors in our communities

Western Australian Immunisation Strategy 2024–28

A roadmap to strengthen programs and partnerships that protect the health of our communities through immunisation

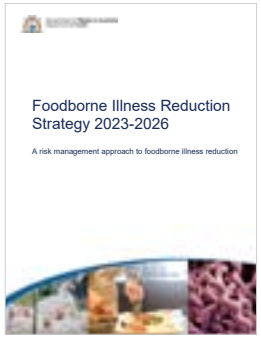
WA Health Workforce Strategy 2034

A strategy to optimise the capability and capacity of our health workforce over the next 10 years



Aboriginal Health and Wellbeing Framework 2015–2030

A 15-year strategy to guide activities to improve the health and wellbeing of Aboriginal people living in WA



Foodborne Illness Reduction Strategy 2023–2026

A 3-year strategy to reduce foodborne illness in WA

Support and manage the local health system network

We oversee the planning and performance of public health services to enable access to safe, quality health care

Our health system network

- Child and Adolescent Health Service
- North Metropolitan Health Service
- East Metropolitan Health Service
- South Metropolitan Health Service
- WA Country Health Service
- PathWest Laboratory Medicine WA
- Health Support Services
- Contracted health and community care services

64,000+

dedicated public health service staff

$12.8 billion

budget for delivery of health services

Regional

- **6** large regional hospitals
- **15** medium sized district hospitals
- **53** small rural and regional hospitals
- **41** health centres and nursing posts
- **5** dedicated mental health inpatient wards
- **18** licensed private healthcare facilities

Metropolitan

- **3** tertiary hospitals
- **8** general hospitals
- **5** specialist hospitals
- **2** contracted health entities
- **76** dedicated mental health inpatient wards
- **92** licensed private healthcare facilities

Health care at a glance

1.175 million
emergency department attendances

696,389
admissions to public hospitals

88,649
admissions for elective surgery

4.3 million
attendances at outpatient clinics

23,602
births

Hospital activity data is based on the 2024–25 time period except for publicly funded births that are for the calendar year 2024.

Prevent, detect and protect the health of the community

We promote healthy behaviours, monitor health risks and support initiatives to protect and enable community health and wellbeing

Our community's health and wellbeing at a glance

1 in 2 adults reported they had excellent or very good health

9 in 10 adults used primary health services in the past 12 months

1 in 4 adults reported having suffered an injury

1 in 4 adults reported having arthritis

1 in 5 adults reported being diagnosed with a mental health condition

1 in 10 adults reported living with diabetes

1 in 10 adults reported having asthma

1 in 13 adults reported being diagnosed with heart disease

Cases of notifiable diseases

17,020	16,005	12,789	9,246	5,645	4,820
influenza	COVID-19	chlamydial infection (genital)	respiratory syncytial virus (RSV)	varicella infection (chicken pox or shingles)	campylobacteriosis

Data sources:
1. Community lifestyle: Epidemiology Directorate, 2025. Health and wellbeing of adults in Western Australia 2023. Department of Health.
2. Cases of disease: Notifiable infectious disease dashboard, Department of Health. Based on data for the period January to December 2024, as at 31 March 2025.
3. Cases of COVID-19: Unpublished data, Department of Health. Based on data for the period January to December 2024, as at 31 March 2025.

Our community's health and wellbeing at a glance

12% used illicit drugs

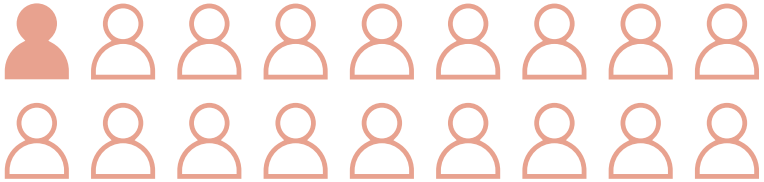
12% are current smokers

24% tried an e-cigarette

76% are above a healthy weight

35% drank alcohol at levels that put them at risk of harm

More than **1 in 3 (36%)** adults met the recommended minimum daily intake of fruit while only **1 in 18 (5%)** met the recommended minimum daily intake of vegetables



Almost **2 in 3 (66%)** adults engaged in at least **150 minutes** of moderate physical activity per week

Our responsible ministers

Hon Meredith Hammat MLA

Minister for Health;
Mental Health

Responsible for all the operational aspects of our public hospitals and ambulance services and the mental wellbeing of the community.

Hon Stephen Dawson MLC

Minister for Medical Research

Responsible for research and innovation to contribute to improving the health of the community and to support the health system.

Hon John Carey MLA

Minister for Health Infrastructure

Responsible for increasing the capacity of our health system through new hospital infrastructure, emergency department upgrades and major regional redevelopments.

Hon Sabine Winton MLA

Minister for Preventative Health

Responsible for improving the overall health and wellbeing of the community through preventative health.

Hon Simone McGurk MLA

Minister for Aged Care and Seniors

Responsible for working with the Commonwealth to deliver more aged care places and ensure older Western Australians receive the support they need.

Our accountable authority

The Director General of the department is Dr Shirley Bowen.

Under the *Health Services Act 2016*, the Director General reports to the Minister for Health and is responsible for carrying out the System Manager role for the WA health system.

The System Manager is responsible for the strategic direction, oversight, management, and performance of the WA health system, operating independently from health service delivery. The System Manager is also responsible for allocating resources for the provision of public health services in the state.

The department is part of the WA health system and supports the Director General in performing system manager functions.

Health service providers form the remainder of the WA health system. They are established as statutory authorities and governed by a board and/or chief executive. These statutory authorities are responsible and accountable for delivering public health services or health support services as prescribed through service agreements.

The Mental Health Commission purchases mental health, alcohol and drug health services from health service providers through service agreements enabled via a head agreement between the department and the Mental Health Commission, provided for within the *Health Services Act 2016*.

In performing the role of System Manager, the Director General issues binding policy frameworks to health service providers to ensure service coordination, integration, effectiveness, efficiency and accountability in the provision of health services.
The WA health system is also directed to operate under the Outcome Based Management Framework to provide a systematic approach to improving results through evidence-based decision making, improved transparency and an increased focus on accountability for performance.

Ministerial directions

In 2024–25, the department did not receive any ministerial directives relevant to the setting of desired outcomes or operational directives, the achievement of desired outcomes or operational directives, investment activities or financing activities.

Statement of Expectations

In May 2025, the State Government issued a new Statement of Expectations to the Department of Health, setting out strategic priorities and performance expectations. This document provides a clear framework to guide service delivery and strengthen accountability across the department.

Under the *Western Australian Future Health Research and Innovation Fund Act 2012*, the Director General is responsible for assisting the Minister for Medical Research in the administration of the Future Health Research and Innovation (FHRI) Account[1] and other health and medical research and innovation activities.

Effective from 19 March 2025, the Director General also reports to the Ministers for Health Infrastructure, Preventative Health, and Aged Care and Seniors.

[1]The FHRI Account is the operational account of the WA Future Health Research and Innovation Fund scheme and is managed in accordance with the *Financial Management Act 2006* (except section 20, which is disapplied by the Act).

Our executive leadership team and key responsibilities

Director General
Dr Shirley Bowen

Provides strategic leadership for the WA health system and executive management for the department

Deputy Director General
Ms Jodie South

- Delivers complex and major projects including infrastructure
- Stewards medical research and clinical innovation
- Manages departmental corporate services

Chief Health Officer / Assistant Director General Public and Aboriginal Health
Dr Andrew Robertson CSC PSM

- Leads strategic direction, planning and monitoring of public health priorities
- Oversees and leads public health regulatory activities, health protection initiatives, and prevention and control of infectious diseases
- Enables Aboriginal health growth and initiatives
- Leads, initiates and manages emergency responses

A/Assistant Director General Clinical Excellence
Dr Sheralee Tamaliunas

- Leads systemwide health service improvement through the design and implementation of reform
- Leads clinical service planning and clinical engagement on improvement opportunities
- Monitors the quality and safety of public and private health care delivery

Assistant Director General Strategy and Governance
Ms Nicole O'Keefe

- Sets systemwide objectives and plans, including health and social policy integration and community program commissioning, with key priorities including aged care, disability and digital health
- Manages intergovernmental relations, and provides governance, legal, and industrial services for the WA health system

Assistant Director General Purchasing and System Performance
Mr Rob Anderson

- Commissions and monitors health services and leads system interventions to build capacity
- Provides strategic direction, planning and leadership for procurement and contracting of whole of health, health system and community-based health services
- Leads demand and capacity modelling, system analytics, and data linkage, and manages information assets and governance
- Manages financial operations including reform and policy

Dr Shirley Bowen

BMed MM FRACP FACSHM FRACMA (Hon)

Director General

The Director General of the Department of Health, Dr Shirley Bowen is a skilled physician with extensive experience across all aspects of health service delivery. Dr Bowen is passionate about person centred care and delivering excellent health care to the people of Western Australia.

Prior to her appointment as Director General in May 2024, she served as North Metropolitan Health Service Chief Executive and CEO of St John of God Subiaco Hospital.

Throughout her career, Dr Bowen has demonstrated leadership across public and private health sectors, holding notable positions, including Chief Medical Officer of the Australian Capital Territory, Executive Director of Fremantle Hospital and Dean of the School of Medicine, University of Notre Dame Australia. In these roles, she advanced healthcare standards, fostered medical education and led innovative research and community services.

Dr Bowen holds dual Fellowships in Infectious Diseases (FRACP) and Sexual Health Medicine (FAChSHM) underscoring her extensive clinical experience. She also holds an honorary fellowship in Medical Administration (FRACMA). Her professional journey reflects a commitment to excellence in patient care, focusing on compassionate and evidence-based medicine.

As Director General, Dr Bowen ensures healthcare services are timely, accessible and grounded in the latest evidence-based practices. Additionally, she supports and empowers the health workforce in their pursuit of excellence, building a robust and resilient healthcare system for WA.

Ms Jodie South

BEc

Deputy Director General

Ms South has a personal drive to ensure equity in access to health care within WA and to support all Western Australians, no matter their background or location, to access clear and timely pathways to care.

With 33 years of extensive experience with the WA public sector, including 27 years in WA Health, Ms South is currently leading the delivery of key government priorities in major health infrastructure projects and medical research and innovation.

Previously, Ms South held leadership roles developing WA's first Clinical Services Framework, planning for the South Metropolitan Health Service (SMHS) reconfiguration to support the development of Fiona Stanley Hospital, establishing the East Metropolitan Health Service and subsequent realignment of SMHS, and guiding the mental health response during the COVID-19 pandemic.

Dr Andrew Robertson CSC PSM

MB BS, Hon DSc, MPH, MHSM, DipDHM, Grad Dip OHS, FAFPHM, FRACMA, AFACHSE, FAIM, GAICD

Chief Health Officer and Assistant Director General, Public and Aboriginal Health

Dr Robertson is passionate about providing effective public and Aboriginal health services to all Western Australians and ensuring that WA Health is prepared for and ready to respond to any major incident.

Dr Robertson has specialist qualifications in Public Health Medicine and Medical Administration, and more than 30 years' experience in disaster management, medical administration and public health service delivery with the Royal Australian Navy and the Department of Health.

Dr Robertson was appointed to his current role in 2018, and as the Chief Health Officer led the WA Health response to the COVID-19 outbreak. He continues to lead the further development of public and Aboriginal health services in WA.

Dr Sheralee Tamaliunas

BSc, Dip PM, PG Dip Clin Nsg (ICU), MCN, PhD

A/Assistant Director General, Clinical Excellence

Dr Tamaliunas has a wealth of experience in health care, health workforce, strategy and policy from 27 years' service with WA Health, including 13 years with the department. She is passionate about the delivery of health care and growing and supporting the health workforce through education, culture, and workforce planning.

Dr Tamaliunas' health workforce achievements include the development of the *WA Health Workforce Strategy 2034*, implementation of nurse and midwife to patient ratios, and international workforce recruitment and policy with the Health Workforce Taskforce.

Ms Nicole O'Keefe

BAppSci, PG Dietetics, PG Health Economics, MPH, MPA, GAICD

Assistant Director General, Strategy and Governance

Ms O'Keefe has significant experience in governance and strategy within the health sector, as well as a proven track record of developing enduring partnerships across community, public and private sectors to deliver services, including those in rural and remote areas.

Throughout her 38 years' experience across state and federal public sectors, including 6 years in her current role, Ms O'Keefe has demonstrated her commitment to public policy design and implementation.

Mr Rob Anderson

Assistant Director General,
Purchasing and System Performance

Mr Anderson has been in the role of Assistant Director General Purchasing and System Performance since 2019. Throughout his 31 years in public service, Mr Anderson has held a variety of senior positions across numerous organisations and has been involved in many large scale system projects, commissioning of health facilities and overseeing the development of contractual and purchasing reforms. These include the Fiona Stanley Hospital Commissioning Project and the Midland Health Campus Project, the Cockburn MediHotel, and Joondalup health services agreement. Also, the establishment of the Information and System Performance Directorate and associated information management and governance reforms, the Activity Based Management reform program and the Financial Sustainability program.

Preparing for organisational change

This year has been a period of review within the department and more broadly across the public sector.

As part of public sector reform, components of the Office of Major Health Infrastructure Delivery will transition to the new Department of Transport and Major Infrastructure (DTMI) from 1 July 2025. Major infrastructure projects across the health system will now form part of a new portfolio of works managed by DTMI through the Office of Major Infrastructure Delivery.

Following the commissioning of an Operational Review of the department, as well as interviews and surveys with executive and staff, we are now preparing for organisational change in 2025–26. Our focus will be to strengthen leadership and system manager functions including financial and performance management, deliver priorities supporting digital health and emergency access, and realign reporting structures and workloads to meet urgent demand needs.

Our people

Engage, develop and provide opportunities

Our people are central to everything we do and we continue to support their growth through targeted training and development opportunities.

As part of our commitment to integrity, we introduced practical training to guide managers to identify risks, understand responsibilities, and take confident, timely action. Strong participation and positive feedback reflect our shared commitment to a culture of integrity.

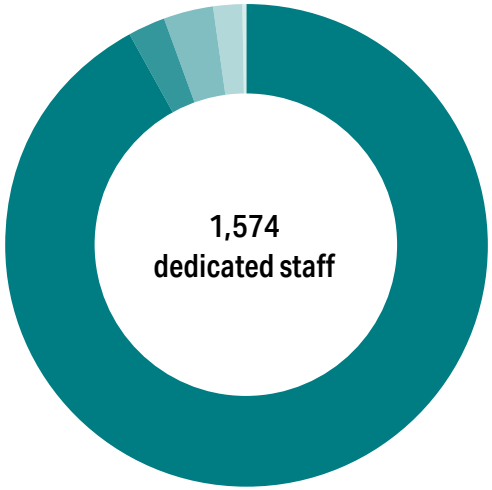
In alignment with the Public Sector Commission's Building Leadership Impact initiative, in 2024–25 we piloted programs focused on 'leading others' and 'leading leaders.'

Facilitative Leadership in Action	Compassionate Leadership	Leading Through Uncertainty
How to be the host rather than the hero, fostering empowerment, collaboration and creativity	How to create a work environment where teams feel valued, supported, and inspired	How to lead confidently and build adaptive teams when the path ahead is unclear

PRINT® profiling of leaders and teams has also increased. PRINT® profiling aims to enhance self-awareness, improving psychological safety, relationships, and leadership behaviours, and ultimately contributing to a better organisational culture.

These initiatives will inform future leadership development plans and strategies.

Our dedicated staff



92.2%	Administrative and clerical
2.4%	Medical services
3.4%	Medical support services
1.8%	Nursing services
0.2%	Other services

We continue to create meaningful pathways for young professionals. In 2025, we welcomed new school-based trainees, while previous participants progressed to corporate traineeships and transitioned to roles within the department. In addition, the WA Health Graduate Development Program offers work placements, and training and mentoring opportunities informed by the Public Sector Commission's Launch program.

More than 160 staff and leaders participated in face to face sessions or accessed online resources to support flexible work practices in line with our updated Flexible Work Policy.

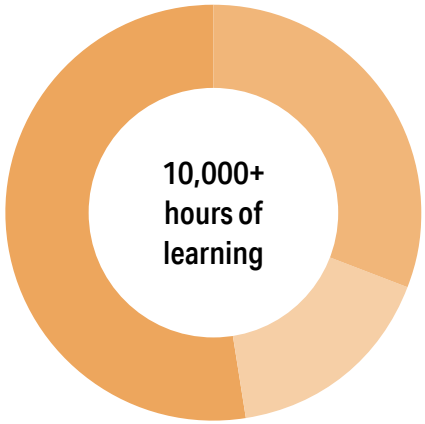
Providing opportunities for our graduates

Staff demographics

- **8 in 10** of our staff are aged **25 to 54 years**
- **3 in 4** of our staff work full time

44%	Generation Y
33%	Generation X
12%	Baby boomers
11%	Generation Z

Hours dedicated to learning and development



3,215	Mandatory eLearning
1,728	Capability building eLearning
5,447	Face-to-face training and development

My Achievement Plan

1,100

staff engaged in My Achievement Plan to support their career development and to guide learning and management activities

Learning to access and support flexible working

Welcoming our new cohort of school-based trainees

Top 5 learnings chosen by staff

- Effective Business Writing
- Mastering the Recruitment Journey
- Flexperts for Managers and Team Members
- Project Management Principles
- Facilitative Leadership in Action

Celebrating our people at the WA Health Excellence Awards

Statewide Telestroke Service team
Excellence in Rural and Remote Health Care

WA RSV Infant Immunisation Program team
Excellence in Preventative Health

Staff with Disability and Allies' Network (SDAN)
Excellence in Workplace Wellbeing and Culture

Our life-saving Telestroke service

The Statewide Telestroke Service team was recognised at the 2024 WA Health Excellence Awards for excellence in rural and remote health care.

Since it began in late 2021, WA's Telestroke Service has diagnosed and treated more than 2,900 stroke patients across more than 3,300 consults.

The service operates 24 hours per day, 7 days a week, and uses technology to remotely connect clinicians anywhere in WA with metropolitan stroke specialists who can assist in the assessment and diagnosis of patients experiencing a stroke (ischaemic or hemorrhagic) or transient ischaemic attack. This enables appropriate time critical treatment to be provided that may reduce the patient's risk of permanent brain damage resulting in disability or death.

By bridging the healthcare gap, the Telestroke Service is enabling clinicians in rural and remote areas of WA to achieve better health outcomes for their patients.

- People living in rural areas of Australia are 17 per cent more likely to suffer a stroke than those in metropolitan areas.[2]
- When a person has a stroke, brain cells can die at a rate of 1.9 million per minute.
- The FAST test is an easy way to recognise and remember the signs of stroke.

[2]Stroke Foundation (2020). 'No Postcode Untouched – Stroke in Australia 2020.'

Grow diversity and encourage inclusiveness

We remain committed to fostering a diverse and inclusive workplace where all staff feel safe, valued and supported. Guided by our Diversity and Inclusion Framework and Reference Group, we continue to drive representation and embed inclusive practices across all levels of the organisation.

In 2024–25, we launched new face to face training programs developed and co-designed by staff, focusing on workplace diversity, neurodiversity, and practical tools to support inclusion. These programs emphasised lived experience and work-based learning.

Our second Staff with Disability and Allies' Network (SDAN) Conference featured a keynote address from renowned doctor, lawyer and disability advocate Dr Dinesh Palipana about his experience as an emergency doctor in a wheelchair, and a panel discussion on hidden disability in the workplace. With more than 130 attendees, in person and online, the event encouraged reflection on workplace adjustments and inclusive practices.

We also marked key cultural days and awareness events throughout the year. For National Reconciliation Week, we hosted a screening of *Genocide in the Wildflower State* (2024), a confronting documentary that shed light on the untold history of the Stolen Generations in WA. The event prompted staff to reflect on our shared history and the ongoing journey toward reconciliation.

Other events acknowledged International Day of People with Disability, Harmony Week, International Women's Day, Wear It Purple and WA Pride Month. Activities included educational sessions and cultural experiences that deepened understanding and strengthened our inclusive culture.

SDAN Conference

PrideFEST

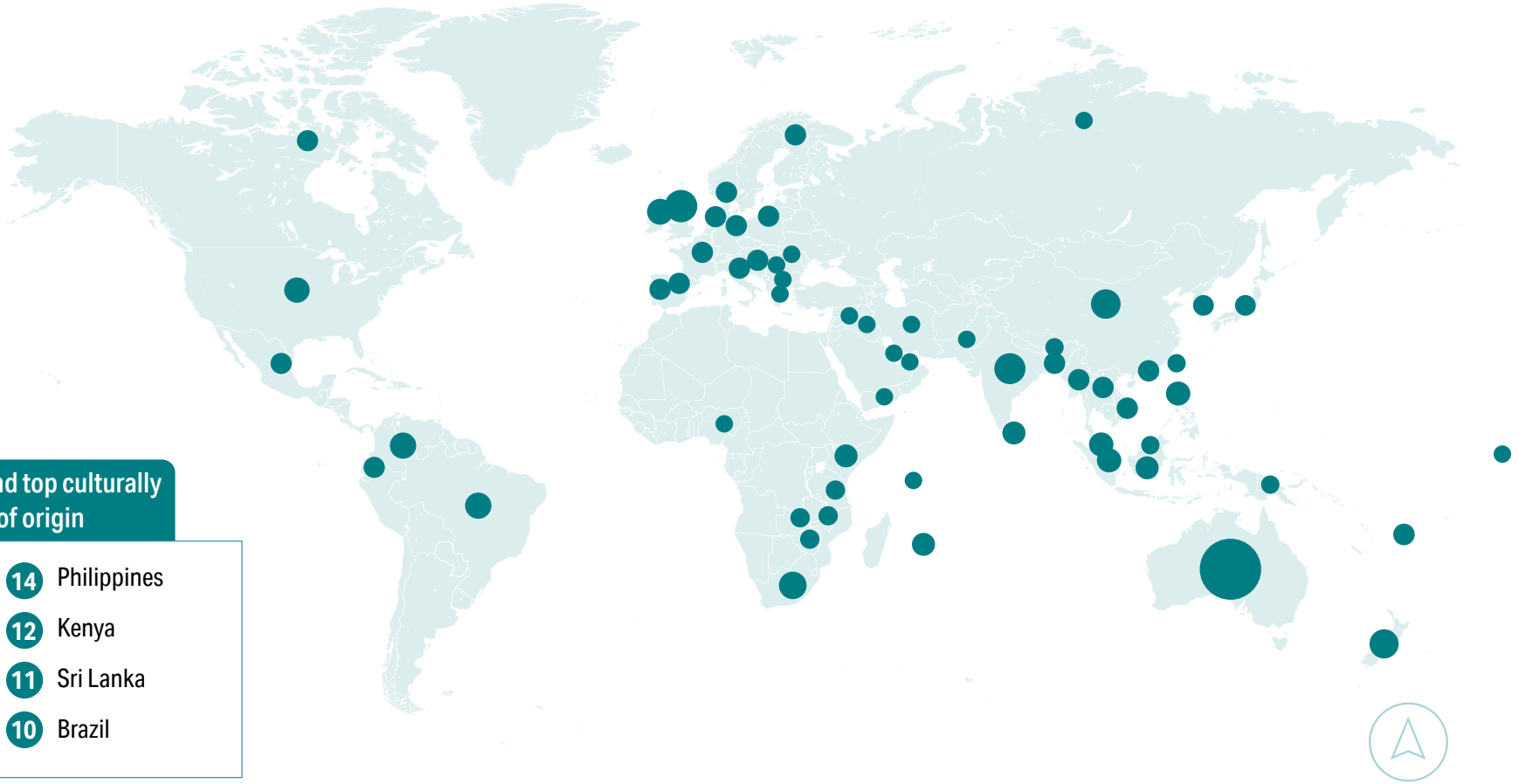
Wear it Purple

National Reconciliation Week

International Day of People with Disability

Diversity at the department

Our staff are represented from more than **66 countries** with **45 languages** other than English spoken at home.



Number of staff and top culturally diverse countries of origin

72	India	14	Philippines
31	Malaysia	12	Kenya
20	China	11	Sri Lanka
19	Singapore	10	Brazil

Aspiring to meet our diversity targets

"This International Women's Day is especially important to me, as I'm dedicated to continuously improving our efforts to achieve gender equity across the organisation.

Women bring an immensely valuable contribution to our workforce and we are starting to see a positive shift across the business landscape as more women step into leadership roles.

Three-quarters of the Department of Health's senior executive positions are held by women, and I am immensely proud to be a part of this, as the first female Director General.

While today is a great opportunity to celebrate our progress, it is also a time to reflect on the work that still needs to be done. We must continue to strive, every day, to build a community in which everyone is heard, valued and empowered to succeed."

Dr Shirley Bowen, Director General

Dr Shirley Bowen (left), with our International Women's Day panel

Women in management Tiers 2 and 3	People with disability	Youth under 25 years	Aboriginal people	People from culturally diverse backgrounds
64.3%	3.2%	2.7%	1.1%	19.0%
Target	Target	Target	Target	Target
50.0%	5.0%	5.8%	2.8%	15.5%

Ensure safety and promote health and wellbeing

In 2024, the Health and Safety Committee completed an internal risk assessment audit of our work health and safety system that identified 23 risks. In response, 19 treatment action plans were developed, all of which are on track to be addressed by the end of 2025.

The committee also initiated a buddy system, pairing new health and safety representatives with more experienced counterparts to complete workplace inspections. This enhanced the quality and consistency of inspections and provided opportunities for knowledge-sharing and mentoring.

Ergonomic workspace workshops supported staff to optimise their workstation to meet their needs and prevent injuries. The workshops addressed reducing sedentary behaviour, risk factors for musculoskeletal pain, and resources for lifestyle health management.

Treating work-related and non-work-related injuries with the same level of care and coordination is enabling staff to return to work as soon as reasonably practicable. An increase in the number of return-to-work plans being implemented is helping to manage injuries promptly and reducing the risk of delayed recovery and extended absences.

In 2024–25, we improved support for staff with caring responsibilities and attained Level 1 accreditation as a Carer Friendly Workplace, ensuring staff can more easily balance their responsibilities at home and work.

Flu vaccinations at the department

Workplace health and safety inspection at the Disaster Contingency Warehouse

Our enabling legislation

The department was established by the Governor under section 35 of the *Public Sector Management Act 1994*.

Through the administration of key legislation, the department enacts authority over the WA health system and delivers its functions. The Director General, on behalf of the Minister, is responsible for ensuring this legislation is administered appropriately.

The department is responsible for the administration of 31 Acts.

Administered legislation

- *Anatomy Act 1930*
- *Blood Donation (Limitation of Liability) Act 1985*
- *Cremation Act 1929*
- *Fluoridation of Public Water Supplies Act 1966*
- *Food Act 2008*
- *Health Legislation Administration Act 1984*
- *Health (Miscellaneous Provisions) Act 1911*
- *Health Practitioner Regulation National Law Application Act 2024*
- *Health Professionals (Special Events Exemption) Act 2000*
- *Health Services Act 2016*
- *Health Services (Quality Improvement) Act 1994*
- *Human Reproductive Technology Act 1991*
- *Human Tissue and Transplant Act 1982*
- *Medicines and Poisons Act 2014*
- *Medicines and Poisons (Validation) Act 2022*
- *National Health Funding Pool Act 2012*
- *Nuclear Waste Storage and Transportation (Prohibition) Act 1999*
- *Pharmacy Act 2010*
- *Private Hospitals and Health Services Act 1927*
- *Prostitution Act 2000* (except s.62 and Part 5, which are administered by the Department of the Attorney General)
- *Protection of Information (Entry Registration Information Relating to COVID-19 and Other Infectious Diseases) Act 2021*
- *Public Health Act 2016*
- *Radiation Safety Act 1975*
- *Royal Perth Hospital Protection Act 2016*
- *Surrogacy Act 2008*
- *Therapeutic Goods Law Application Act 2024*
- *Tobacco Products Control Act 2006*
- *University Medical School, Teaching Hospitals Act 1955*
- *Voluntary Assisted Dying Act 2019*
- *Western Australian Health Promotion Foundation Act 2016*
- *Western Australian Future Health Research and Innovation Fund Act 2012* (except Part 3 which is administered by the Department of Treasury)

Our shared responsibilities

The *Health Services Act 2016* outlines clear roles, responsibilities and accountabilities at all levels of the health system to achieve our objective to deliver safe, quality, financially sustainable and accountable health care for all Western Australians.

With shared interests and complementary strategies, policies and initiatives, we also collaborate with other public sector agencies on cross-government actions that contribute to a safe, healthy and strong community.

Public Health Act 2016 and clinical or public health management of notifiable infectious diseases

Under the *Public Health Act 2016*, the Chief Health Officer may make a test order or public health order in respect of a person, or recognise an interstate public health order, to support the clinical or public health management of notifiable infectious diseases.

A test order can ensure that any individual who may have been exposed to a notifiable infectious disease is tested. If an individual is infected, a public health order can prevent them from behaving in such a way that may transmit the disease to another person or cause a public health risk.

In 2024–25, the Chief Health Officer did not make a test order or public health order or recognise any interstate public health order.

Contributing to a safe, healthy and strong community

Department of Communities

Protecting and promoting the safety, health and wellbeing of vulnerable cohorts within our community

Department of Local Government, Sport and Cultural Industries

Supporting local public health planning as required under the *Public Health Act 2016*, and increasing physical activity across the whole community through sport and recreation

Department of Fire and Emergency Services

Preventing and responding to emergency incidents that impact on the health and safety of the community

WA Police Force

Enforcing lawful sale and use of alcohol, tobacco and other drugs, and promoting health and wellbeing and discouraging drug and alcohol use among our youth

Department of Education

Supporting the health and wellbeing of young people, including promoting eating well and being active

Department of Primary Industries and Regional Development

Managing the production of clean and safe food, water, products and services

Department of Justice

Supporting strong and safe communities and families, and the health of detainees, prisoners and offenders

Department of Water and Environmental Regulation

Providing and protecting appropriate, healthy and sustainable water supplies

Significant issues

Health system transformation

As part of our ongoing reform, we continue to build a contemporary health system that is financially sustainable. Our current focus is to have people at the centre of care, ensuring we have an integrated health sector that provides equitable access to healthcare services and supports, and enables people to stay well in their community.

Through a range of interconnected reform initiatives, we continue to streamline health services, and support improvement initiatives that directly impact hospital avoidance and inpatient length of stay as a long-term approach to increasing health care in the community. We acknowledge that to make improvements across the system we need to tackle high emergency department presentations, bed capacity, and competing pressures to reduce elective surgery and outpatient wait times.

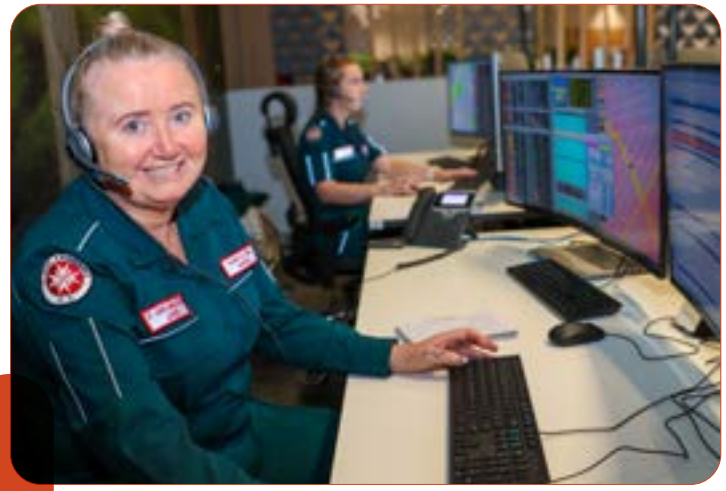
Reduce ambulance ramping

WA's Ambulance Ramping Strategy, approved by Cabinet in March 2023 has been the catalyst for system-level change over the past 2 years.

This has included the new State Health Operations Centre (SHOC) facility, opened in October 2024. The SHOC, a multi-agency state-of-the-art operations hub based in Perth, is designed to enhance emergency and medical care access across our state through improved integration and coordination of key functions.

Among the SHOC services is the WA Virtual Emergency Department (WAVED) that enables suitable patients to be seen virtually in the comfort of their own home. Regional patients continue to benefit from the Emergency Telehealth Service, also to be co-located in the SHOC. During the year WAVED increased hours of operation and implemented virtual care pathways for referrals from healthdirect, WA Police Perth Watch House, Silverchain and Derbarl Yerrigan Health Service. Further expansion of WAVED will see virtual care for children.

The expanded Time to Think, Residential Respite Pilot, and From Hospital to Home programs are improving hospital discharge timeframes and reducing the number of 'long stay' patients awaiting aged care or support through the National Disability Insurance Scheme.



State Health Operations Centre (SHOC) facility

Managing demand and capacity in our hospitals

A comprehensive and innovative Demand and Capacity Optimisation (DCO) program is helping ensure patients have timely access to care. This program, developed with partners across the healthcare landscape, including frontline clinicians and hospital teams, aims to:

1. Deliver virtual care pathways that offer virtual, high-quality, personalised care from the comfort of home or an alternative setting
2. Optimise care pathways ensuring people receive the right care, in the right place, at the right time
3. Increase system capacity enabling quality care closer to home, a 'hospital without walls' approach
4. Deliver a systemwide approach strengthening connections across the entire health ecosystem
5. Leverage data and information driving continuous improvement.

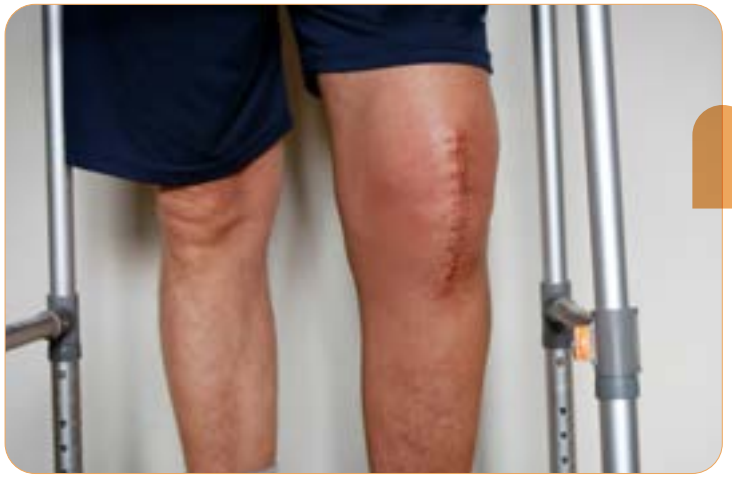
Aligned with the DCO program we launched the WA Health Winter Demand Plan in 2025, a systemwide approach to caring for our community through the colder months. This plan sets out the steps we are taking to support our patients, our workforce, and our health partners. Since actioning the plan we have seen an increase in influenza vaccination rates among staff and the community compared to 2024. In addition, we launched a statewide influenza-like illness (ILI) admissions pathway to optimise patient flow through our emergency departments.

Support and care for older people

As the number of older people in the community continues to grow, it is increasingly important to ensure access to healthcare information and services. Initiatives include:

- Expanding specialist-led virtual services: supporting older adults in care settings and at home to receive timely access to geriatric expertise to reduce hospital visits and enable timely discharge
- Implementing Older Adult Care Hubs: bringing together virtual and in-person community care, offering quicker access to services and better coordination between hospitals and the community
- Improving palliative care and end-of-life services: through in-home and community-based programs allowing more people to receive support in familiar surroundings, with fewer hospital admissions and better support for families
- Providing better dementia support: in partnership with Dementia Support Australia, supporting long stay older people with dementia to transition safely from hospital to aged care
- Expanding Hospital in the Home: providing care in the home that would otherwise need to be given during a stay in hospital
- Implementing the Time to Think program: allowing older people and families time to make decisions on their long term care options in more appropriate settings.

- **For more detail see the Sustainable health and care system section of this report.**



Maintaining financial sustainability

It is important that we are able to maintain our financial health over the long term so we can adequately finance health care in the face of growing cost pressures and need, an ageing population, new technologies and consumer expectations around healthcare coverage and quality.

The new *WA Clinical Services Framework 2025–2035* is a strategic tool to support and guide clinical service planning and delivery at a systemwide and local level. The framework supports decision making that considers all aspects of integrated planning and modelling, funding and commissioning. For the first time, the framework is hosted on an online platform, enabling regular updates to accommodate State Government priorities, key health reforms, infrastructure commitments, evolving technologies and outcomes of specialty reviews. Health service providers are required to undertake a self-assessment to determine their actual levels of service delivery compared to those levels endorsed under the framework. This regular oversight ensures hospital sites are delivering the required services safely and sustainably.

In September 2024, we also set up the WA Health Financial Sustainability Project, led by the Director General and overseen by a Financial Sustainability Taskforce. The project aims to establish a long-term sustainable funding footprint for WA Health. It will support the delivery of budget submissions in 2025–26 (stage one) and 2026–27 (stage two) and outline a financial sustainability strategy for the health system.

WA Health	Growth
Total cost of services: projected increase by 2025–26[3]	5.9%
Activity: 2022 to 2024 (post COVID)	
Emergency department attendances	7%
Admissions to public hospitals	14%
Admissions for elective surgery services	23%
Outpatient attendances	8%

Planning for health infrastructure long-term

Our State Health Infrastructure Plan (SHIP) will outline a roadmap for key infrastructure builds, redevelopments and major leases for the next 20 years to address predicted healthcare demand. The SHIP is being developed in 3 phases with completion planned by year end. Phase 1 is complete and identified new builds or redevelopments for the next 20 years based on demand modelling. Phase 2 will involve building condition audits of existing facilities to identify the key maintenance issues and new builds/redevelopments required to keep facilities fit for purpose. The last phase, informed by findings from phases 1 and 2, will be to develop a 20-year proposed pipeline of works to provide a comprehensive prioritised roadmap for the system.

[3] Adjusted for the impact of time-limited funding decisions.

Childhood vaccine coverage

WA and Australia have an aspirational childhood immunisation target for 95 per cent of children to be fully immunised at 12 months, 2 years, and 5 years of age. In 2024, this was achieved among 5-year-old Aboriginal children in the Wheatbelt, and 5-year-old non-Aboriginal children in the Kimberley. As seen nationally, overall childhood immunisation coverage in WA has declined since the COVID-19 pandemic. In 2024, 91.0 per cent of one-year-old, 88.2 per cent of 2-year-old and 92.2 per cent of 5-year-old children in WA were fully immunised.

Vaccine uptake can be impacted by reasons classified as 'attitudinal' (including vaccine hesitancy) or 'access'. Vaccine hesitancy, identified by the World Health Organization as a threat to global health, is just one reason for declining national immunisation rates.[4] Recent qualitative research undertaken in WA with select communities has also identified a range of barriers to childhood immunisation, including lack of awareness of the vaccine schedule, difficultly accessing vaccination services, workforce shortages and ineffective reminder systems.[5]

The *Western Australian Immunisation Strategy 2024–2028* seeks to increase access to vaccines for all people in WA. We aim to expand the provision of immunisation programs using mechanisms such as Structured Administration and Supply Arrangements (SASAs) to enable nurses, Aboriginal health practitioners, and pharmacists to play a larger role in vaccination delivery and increase access to vaccination.

It is our priority to also enhance the physical, informational, language and cultural accessibility of immunisation services and specialist immunisation clinics to ensure readily accessible vaccines, as well as to co-design evidence-based initiatives with communities to address barriers and leverage key enablers for immunisation.

In 2024–25, dedicated immunisation programs and information campaigns strengthened efforts to ensure more children in WA were protected against influenza and respiratory syncytial virus (RSV).

- For more detail see the Key performance indicators and the No Jab, No Play section of this report.

[4] National Centre for Immunisation Research and Surveillance. Childhood vaccination barriers in Australia – key findings summary. Available from: https://ncirs.org.au/childhood-vaccination-insights/childhood-vaccination-barriers-australia-key-findings-summary
[5] Carlson S, Tomkinson S, Hannah A and Attwell K (2024) 'What happens at two? Immunisation stakeholders' perspectives on factors influencing sub-optimal childhood vaccine uptake for toddlers in regional and remote Western Australia', BMC Health Services Research.
Puca C, Wood-Kenney P, Nelson N, Hansen J, Mathews J, van der Helder E, Kickett J, Robinson M, Attwell K, Phillips A, Swift V, Blyth CC, Carlson SJ (2025) 'Our kids are our future: Barriers and facilitators to vaccine uptake and timeliness among Aboriginal children younger than five years in Boorloo (Perth), Western Australia'. PLOS One.

ICT network security controls

Improving our ICT network security and connectivity

The Critical Health ICT Infrastructure Program (CHIIP) provides a long-term solution to replace systemwide network infrastructure, identified by the Office of the Auditor General as a significant weakness in our network security controls. As part of this program of works we completed upgrades to the May Holman building that included the laying of new fibre optic and computer cables, and enclosure refurbishments that lay the groundwork to upgrade critical network equipment, scheduled to commence in 2027.

Network access controls between major sites were implemented by limiting access to existing wide area network (macro) resources. In addition, an onsite firewall was implemented to detect critical vulnerabilities and restrict inbound cyber threats from unauthorised traffic moving through our network.

Managing cyber security threats

This year marked a significant milestone in our cyber security maturity. In alignment with whole of government requirements, the department successfully achieved Maturity Level 1 across all 8 strategies of the Australian Cyber Security Centre's (ACSC) Essential Eight framework.

The journey began with a comprehensive self-assessment of our 55 vendor systems and practices. The ICT and Security team mapped each control area ranging from patch management to user access restrictions against the ACSC's maturity model and WA Cyber Security Policy. The findings helped clearly define priorities and sequence uplift activities that would bring us in line with mandated expectations.

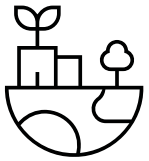
Mandatory cyber security training for staff underpinned our approach.

Report on operations

Focus for 2024–25

We continue to progress the Sustainable Health Review, our long term blueprint to transform the health system, while implementing a range of plans and strategies that provide direction to the health sector, outlined in the About us section of this report.

In 2024–25 our program of work aligned to 3 key focus areas.

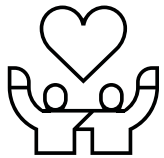


Sustainable health and care system

Activities that contribute to the sustainability of health care and the delivery of services, including innovative models of care and cross-sector partnerships, with particular focus on support and care for our most vulnerable, and initiatives to support climate resilience.

Optimal health care

Activities that support the delivery of public health services and enable access to safe, quality, person-centred health care, including workforce initiatives, infrastructure projects, use of data, and safety and quality initiatives.



Community health and wellbeing

Activities that promote healthy behaviours, monitor health risks and support initiatives to protect and enable community health including public health campaigns and partnerships, regulatory functions, disaster management and emergency response, and environmental health, with a particular focus on our Aboriginal communities.

Sustainable health and care system

98 people with disability supported through the From Hospital to Home program, freeing up 6,797 inpatient bed days

57 patients supported through the Time to Think respite care model

543 occasions of service provided through the Mobile Radiology Pilot Program

96% of WA Health staff have access to digital medical records across 135 sites

23,000+ clinicians are enrolled to use the Single Sign-On system across more than 10,400 devices

25 staff members supported to complete Carbon Literacy Training delivered by Edith Cowan University

$86.2M awarded through the Future Health Research and Innovation Fund

8 fact sheets developed to support local government to manage the effects of climate change on public health

WA Health Artificial Intelligence Policy and Standards developed

WA Clinical Trials Roadmap launched

WA Health Clinical Services Framework 2025–2035 published

Strategy for an environmentally sustainable, low carbon and climate-resilient healthcare system 2024–2030 released

Heat adaptation interventions introduced across 3 pilot communities as part of the Heat Vulnerability Project

Foot Care for People with Diabetes: Western Australia Standards released

New program introduced to support general practitioners and nurse practitioners to diagnose and manage acute and chronic liver diseases in the community

Health Navigator Pilot Program expanded to support young people facing detention

Living well through community integrated care

As part of ongoing reform to build a contemporary health system our current focus is on optimising community care.

Our overarching vision is to ensure people are at the centre of care, with access to appropriate care when it is needed, coordinated care between hospital, primary and aged care services, and support to stay well in their community.

Keeping people well in the community requires ease of access to integrated multidisciplinary care delivered via home and community-based health and social care services. Often people who cannot find or access these services may need to resort to regular emergency department presentations, require frequent hospital care due to a deterioration in their existing health condition, or have their discharge from hospital delayed.

Innovative community-based solutions present opportunities to address current challenges, shifting care away from acute hospital settings and enabling better healthcare experiences and outcomes for consumers.

Integrated community care through partnerships

Partnerships across government and with the non-government sector support the community, including those experiencing vulnerabilities and disadvantage, to access healthcare services and supports.

We are leading the State Government's Child Development Services System Reform program, in partnership with the Child and Adolescent Health Service and WA Country Health Service and supported by key government agencies, clinicians and community partners. The program is focused on ensuring that children in WA who have a developmental delay or concern, receive timely access to services including appropriate assessment, diagnosis, treatment, and support through integrated and effective service delivery.

The Health Navigator Pilot Program, delivered in collaboration with the Department of Communities and non-government organisations including Aboriginal Community Controlled Health Services, continues to address the health needs of children in out of home care by delivering timely access to health assessments, services and supports. In 2024–25, the service was expanded with the support of the Department of Justice with referrals now available through the INROADS program that provides wrap-around supports for young people aged 10 to 17 years who are facing an immediate term of detention.

Aligned with the State Government's Family and Domestic Violence (FDV) System Reform Plan, we are implementing the WA Health FDV Reform Delivery Plan, in partnership with health service providers, to improve the consistency and effectiveness of the response to FDV across WA Health. In addition, in partnership with the departments of Communities and Justice, we are developing a Sexual Violence Prevention and Response Strategy.

The Women's Legal Service WA Health Justice Partnership embeds specialist women's legal services at 2 women's health care centres: Luma in Northbridge and Goldfields Women's Health Care Centre in Kalgoorlie. Improving access to legal support for women in a culturally safe and secure environment addresses the health harming effects of unmet legal needs in parallel with health care. The partnership has supported more than 600 clients since starting in 2023, and was a finalist for the 2024 Institute of Public Administration Australia WA Achievement Awards and the 2025 Community Services Excellence Awards.

The Woodville House Pilot, established in 2025, is addressing gaps in support services for people experiencing homelessness who also have health support needs to reduce repeated engagement with the health system, particularly through frequent and lengthy hospital stays.

Thriving Families

A partnership between WA Health and Ngala is enabling at-risk families to access specialised developmental, behavioural and parenting support in the community.

Launched in late 2024, the 2-year Thriving Families pilot provides:

- a Service Navigator who works with each family to make sure they receive the support they need
- clinically led care, including consultations with healthcare professionals
- linkages and referrals to community supports
- access to community programs and group sessions
- residential stays at Ngala's parent-child residential unit, for those needing more intensive, wrap-around care.

The community-based program is an initiative through the State Government's Family and Domestic Violence (FDV) System Reform Plan. The program provides tailored services for families affected by FDV, as well as other at-risk or vulnerable parents or caregivers who would not otherwise be able to access these services due to financial barriers or lack of a referral.

Thriving Families aims to improve child and maternal health outcomes while providing families with an alternative to presenting to a hospital for support.

Families can seek support from the program directly or may be referred by health service providers, including King Edward Memorial Hospital, Perth Children's Hospital, community child health nurses, general practitioners and community-based organisations.

In its first 8 months of operation 145 families were referred to the program, with 45 per cent of these parents/caregivers having experienced FDV.

Ngala has worked with WA families for more than 130 years and is a recognised leader in parenting and child development services.

For children and young people who experience or are exposed to FDV, the harm caused can be serious and long-lasting, affecting their health, wellbeing, education, and social and emotional development[6]

"At a time in our lives where we need all the support we can get, we are eternally grateful to have had this opportunity [and] to be supported by such wonderful people here."

"I feel so safe here, I feel people care about me and my baby."

"I didn't realise until this call how much I am carrying. I feel ready to deal with it and get the supports I need."

[6] Family, domestic and sexual violence: Children and young people, Australian Institute of Health and Welfare (2025).

Support and care for older people

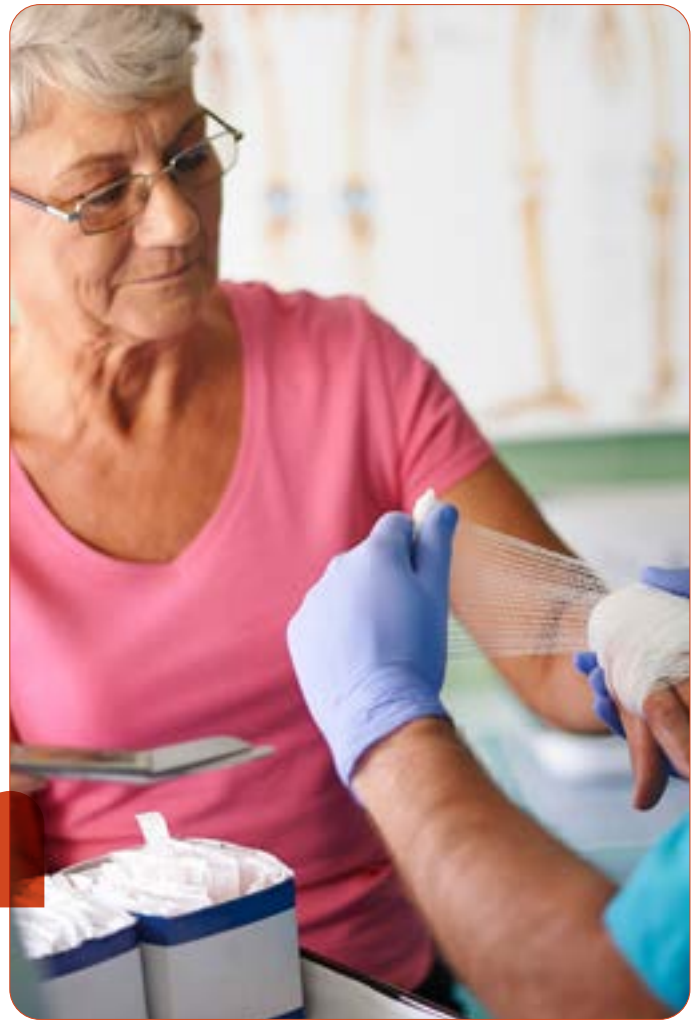
In line with recommendations from the Sustainable Health Review and actions identified in the *State Seniors Strategy 2023–2033*, we continue to implement initiatives and models of care to support older people to live independently at home and in other community settings.

Planned Community Integrated Care Hubs for older adults will bring together virtual and in-person community care to support access to a full range of health and support services for older adults with chronic and complex conditions. This will enable them to stay well in the community and avoid preventable hospitalisations.

The Transition Care Program continues to help older people recover after hospital, regain function, and delay entry into an aged care home by providing medical, therapeutic and other support services in a residential or community setting, including their own home. In 2024–25, 2,976 older patients were supported through the program.

The Time to Think program, launched in 2024–25, is supporting older patients who no longer require hospital care but are waiting on a permanent aged care bed to become available or who require more time before making decisions on their permanent care options. The program builds on the Residential Respite Pilot, a successful 6-month trial of 9 dedicated respite beds in Subiaco. Time to Think offers 42 beds across 4 licensed aged care homes, supporting older Western Australians to receive the care they need in the most appropriate setting and freeing up hospital beds for people requiring hospital care.

The Hospital to Aged Care Dementia Support Program supports older people living with dementia to successfully transition from hospital into either residential aged care, or back to their home, with aged care support. The program is being delivered in partnership with Dementia Support Australia at 2 pilot sites – Bentley Health Service commencing in June 2025, and Osborne Park Hospital from July 2025.

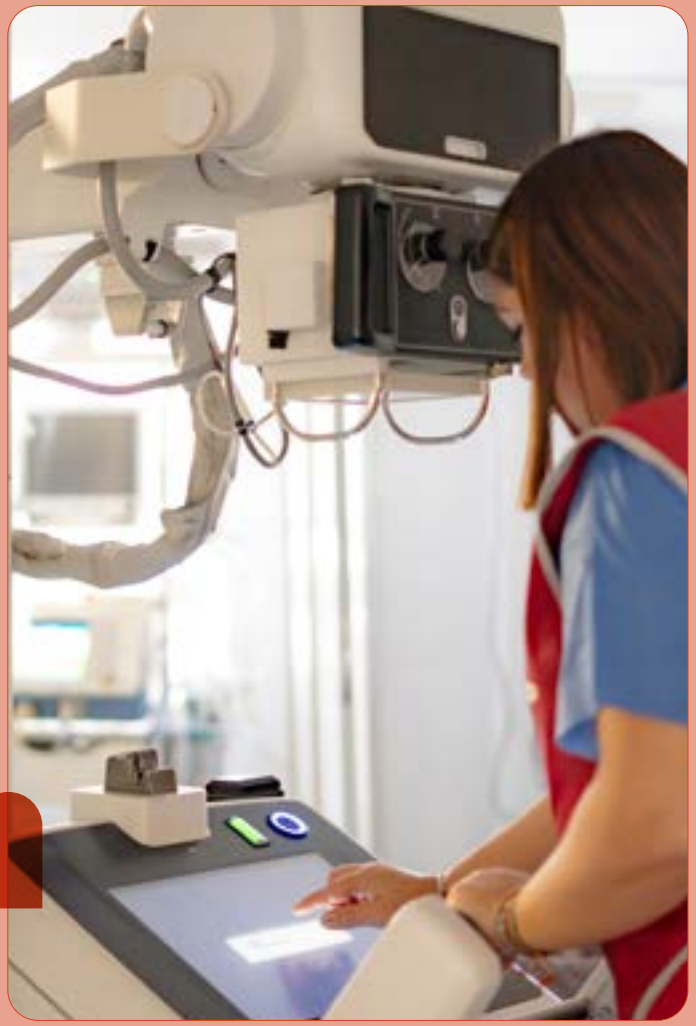


Mobile imaging improving comfort and care for older people

The new Mobile Radiology Pilot Program provides on-site x-ray and ultrasound services to residents in almost 200 aged care homes across metropolitan Perth. Since the program's launch in March 2025, 543 occasions of service have been provided to older people, avoiding the need for hospital transfers and emergency department visits.

General practitioners, nurse practitioners, and health professionals from virtual services including WA Virtual Emergency Department and Community Health in a Virtual Environment, can refer patients for mobile imaging. Accredited radiographers can perform x-ray and ultrasound examinations at the bedside, with results provided to the referring practitioner within 24 to 48 hours, or on the same day if medically urgent.

This 18-month pilot program is being delivered in partnership with the Australian Government Department of Health and Aged Care, and the WA general practice and aged care sectors.



Delivering an environmentally sustainable healthcare system

We are committed to building a climate resilient and sustainable health system, reducing emissions, energy and water use while preparing the WA health sector and community for the impacts of climate change.

The WA community is susceptible to effects of climate change including rising temperatures, droughts, coastal erosion and bushfires.

The need for many healthcare facilities to operate continuously, and the high standards of hygiene, safety and quality required to protect patients means our health system contributes to climate change. Every healthcare activity carries an environmental footprint, including the energy and water consumed in our hospitals and buildings, the vehicles used to transport patients, staff and visitors, and the products purchased to deliver patient care.

The total carbon emission footprint of WA Health in 2020 was quantified at 6,578 kilotonnes of CO_2 equivalent, or an estimated 8 per cent of the state's total emissions.[7] The State Government has made a commitment to an 80 per cent reduction in carbon emissions from 2020 levels by 2030 across all government sectors. We have an important role to play in addressing our environmental footprint in line with these targets. In addition, our health system must meet the increasing health risks and challenges posed by climate including heat-related illness, injury, and respiratory conditions.

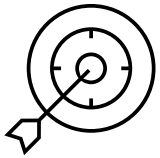
To reduce our contribution to climate change and build a resilient health system, the *Strategy for an environmentally sustainable, low carbon and climate-resilient healthcare system 2024–2030* provides a framework for achievement across 6 key areas over the next 6 years.

[7] *WA Health Climate Health Action Plan 2023*

Elements of the strategy

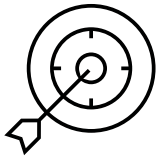
Vision

To build an environmentally sustainable, low carbon, and climate resilient health system that provides high quality health care for current and future Western Australians.



Target 1

Reduce scope 1 and 2 emissions by 80 per cent by 2030



Target 2

Achieve net zero emissions (scopes 1,2 and 3) by no later than 2040

Delivery on these targets will require collective action across our entire system.

Framework for success

Health sector

Build resilience of our health services to ensure ongoing capacity to deliver health services

Clinical care

Deliver high quality, low carbon and environmentally sustainable health care

Resources

Preference the use of environmentally and socially responsible pharmaceuticals, chemicals and consumables

Supply chains and procurement

Implement sustainable procurement processes to build the resilience of supply chains, reduce waste, and improve social, financial and environmental outcomes

Infrastructure and utilities

Support climate resilient, environmentally sustainable hospital design and function

Transport

Develop sustainable transport infrastructure and services for staff, patients and visitors

Committed to reduce, reuse and recycle

Our *Climate Action Plan 2022–24* established the foundation for our response to sustainability challenges. Our new plan is in development and will focus on the key themes of Waste and Emissions and will be accompanied by a Department of Health Waste Strategy.

In 2024–25, we began deploying new software to allow accurate and consistent monitoring of our energy generation and usage. This information will enable us to assess the effectiveness of our efforts to reduce emissions across all department sites.

In early 2025, to increase opportunities for our staff to reduce, reuse and recycle we partnered with Scouts WA for Containers for Change and EcoBatt for battery recycling. We are now investigating opportunities for centralised e-waste, office supplies and coffee pod recycling. Consideration will also be given to requirements for the sustainable use of department fleet vehicles, in line with the State Government's Electric Vehicle Strategy.

Reduce, reuse and recycle

Waste diverted from landfill

37,020kg

Recycling rate

65.4%

Batteries recycled

70kg

Health and medical research and innovation

With a vision of positioning WA as an international leader in health and medical research and innovation and guided by the *WA Health and Medical Research Strategy 2023–2033*, we provide:

- oversight of health system research and innovation activity
- support for initiatives across the health and medical research and innovation sector
- secretariat support to the Future Health Research and Innovation (FHRI) Fund.

Foundations for excellence and accountability

In 2024–25, our key focus was strengthening structures, systems and processes to enable more efficient and effective sector-wide support and administration of research and innovation funding. This included formal appointment of the Office of Medical Research and Innovation leadership team, and increased oversight of research and innovation through the WA Health Executive Committee.

We centralised the WA health system's mandatory policy for research governance and amended our intellectual property policy to align with State Government requirements. We also released our *WA Clinical Trials Roadmap* and streamlined ethical review processes for researchers through the WA Health Central Human Research Ethics Committee.

A new WA Health and Medical Research website was launched in December and a new grant management system was implemented, enabling all funding applications to be submitted online.

Roadmap charts bold path for WA clinical trials

Clinical trials provide early access to new treatments and interventions for patients and improve the overall standard of medical care provided in our hospitals.

To support the delivery of safe and high quality clinical trials for patients and consumers our *WA Clinical Trials Roadmap* sets out an ambitious vision for the future of clinical trials in WA. It outlines the key steps required to drive the quality and capacity of the state's clinical trials ecosystem that includes universities, private hospitals, medical research institutes, industry sponsors, the WA health system and consumers.

Development of the roadmap was informed by extensive consultation with the WA clinical trials sector, including consumers.

While WA already boasts a vibrant medical research and innovation sector, further harnessing the skills of our talented researchers through a strong organisational culture and supporting infrastructure and systems, will enable our clinical trials ecosystem to thrive. The community and patients will also benefit from emerging evidence-based methods and interventions that improve prevention, enable earlier diagnosis, and apply more effective, kinder treatments.

Elements of the roadmap

Vision

WA has a thriving, innovative, networked, competitive, and culturally safe clinical trials ecosystem where every Western Australian has access to world-class clinical trials that are embedded in routine clinical care.

Strategic themes and goals

Organisational culture and corporate governance

- WA has health system leaders that prioritise, value, and embed clinical trials as a core requirement of healthcare delivery

People

- WA boasts sustainable, highly skilled, and collaborative clinical trials workforce and investigators
- Consumers are empowered to access clinical trials and be involved in their design

Infrastructure and systems

- A thriving WA clinical trials ecosystem is connected by digital infrastructure and networks, underpinned by core clinical trials physical infrastructure, and streamlined through efficient operational systems

Visibility

- WA's renowned clinical trials sector, known for its expert investigators and competitive edge, attracts an increasing number of clinical trials
- Growing investment supports long-term sustainability
- Visibility and information sharing empower the ecosystem

The Clinical Trials Roadmap supports the broader *WA Health and Medical Research Strategy 2023–2033*.

Benefits of clinical trials

For researchers

- assess the effectiveness and safety of new treatments and interventions
- compare existing treatments or interventions to determine which is better
- find better ways to prevent disease
- study new tests or procedures to improve diagnosis
- find kinder treatment options with fewer side effects
- understand the causes of disease

For patients and consumers

- improve patient outcomes through access to the latest treatments/ interventions and increased delivery of evidence-based care
- increase availability of treatment options for advanced diseases, including cancer and rare diseases, where there are no standard treatments
- closer clinical surveillance and better clinician compliance for both non-trial and trial-active patients
- increase knowledge of the best treatments and availability of better options for future consumers

For the health system

- improve quality of care, efficiency of care delivery, and health policy and practice
- increase workforce skills and retain the best clinicians
- enhance health and medical research infrastructure
- reduce healthcare costs
- increase system capacity to respond to pandemics and health crises

For the economy

- generation of export revenue related to medical advances
- retention of evaluation and supply chains of locally developed treatments due to availability of trial infrastructure

Power in partnerships

Fostering close collaboration benefits researchers and the health system by unlocking partnership opportunities to drive medical research dollars further.

In a new groundbreaking initiative, the FHRI Fund is providing $15 million to co-invest with Venture Capital firms to accelerate investment in early-stage health and medical life sciences companies. The initiative is designed to drive innovation, job creation and economic activity.

Through an ongoing partnership with the Channel 7 Telethon Trust, the WA Child Research Fund was extended for a further 4 years with a joint commitment of $16 million. Since the fund began in 2012 more than $46 million has been awarded to 160 projects, including research to develop probiotics to prevent childhood pneumonia, understand the lifelong impact of paediatric burns on a child's health, and reduce the impact of climate change on the health and wellbeing of children in WA. In 2024–25, $3.6 million was awarded to 6 researchers to improve health outcomes for children and adolescents in WA.

Through the Targeted Call – Health System Solutions program, a total of $2.95 million was awarded to 6 WA innovators to develop solutions that address unmet health and medical needs within our hospital system.

Celebrating innovation in health care

Advancing healthcare through innovation was the aim of 'The Challenge', a $5 million initiative to reimagine health care in the Pilbara using technology.

The Challenge winners, Lions Outback Vision, developed Australia's first retinal camera powered by artificial intelligence (AI) that can be transported off road to reach all communities living in the region, with a focus on regional primary care, general practitioners and Aboriginal health services to maximise screening opportunities.

Diabetic retinopathy is the leading cause of blindness in adults and 98 per cent of severe eye damage is preventable through regular eye examinations and treatment. Biennial diabetes eye checks are recommended to screen for diabetic eye disease [8] but in the Pilbara only one in 5 people have had the required eye checks to detect eye disease before vision loss occurs.

It is expected that eye checks using AI will become a standard procedure in rural and remote primary health care to detect all forms of eye disease as well as other diseases that may be occurring around the body. This cutting-edge technology will continue to evolve and transform primary care across Australia.

The Challenge, supported by partners Rio Tinto and BHP, attracted a global pool of applicants and involved 12 months of planning, consultation, and program delivery in the Pilbara, where finalist teams worked to prove their concept on the ground.

The Challenge finalists in the Pilbara

The Lions Outback Vision team

Screening a patient using the AI-powered retinal camera

- Find out more about Lions Outback Vision and each of the Challenge finalists at The Challenge – Winner

[8] NHMRC Guidelines for management of diabetic retinopathy

Investing in infrastructure to support innovation

Providing infrastructure and cross-sector collaboration in biomedical research and healthcare innovation will support the development of new therapies and advance medical science. Planning has commenced to create a $50 million biomedical manufacturing hub with the aim to attract top scientists, foster industry growth, and drive innovation and commercialisation of new technologies. An additional $1.9 million has been allocated to progress the development of the UWA QEII Precinct that will support collaboration between academia, healthcare providers, and industry.

Murray Street Launchpad encouraging world-class research collaboration

Creation of a world-class facility for medical research and innovation in the heart of Perth is underway with an Indigenous business awarded the contract to revamp the former Electricity and Gas building in Murray Street into a Health Innovation Launchpad.

The heritage listed building from 1890, will be transformed into a central space for collaboration, research, and development, bringing together innovators and researchers from across the medical and health-tech sectors.

Researchers, clinicians, and students will have opportunities to engage with cutting-edge technologies and methodologies, equipping them to contribute to advancements in healthcare delivery and innovation.

Future Health Research and Innovation Fund

The FHRI Fund is accelerating medical research and innovation in WA by injecting substantial financial support into the ecosystem, with $262 million awarded to 753 grant recipients since the fund was established in 2020.

Four years on, an evaluation of the FHRI Fund and performance review of the FHRI Fund Advisory Council, expert committees, and Office of Medical Research and Innovation was undertaken in 2024–25. This independent evaluation found the fund is well regarded, has strong governance and is responsive to stakeholders. In response to recommendations made, our focus in 2025–26 will be to improve monitoring and reporting against priorities, increase the focus on innovation, and develop an investment plan for disbursements.

People, partners and platforms

In 2024–25, $86.2 million was awarded to 153 recipients through 21 programs aligned to the themes people, partners and platforms. A total of 25 programs opened for applications during the financial year, including 11 new programs approved by the Minister for Medical Research.

Translation Fellowship and addressing youth mental health

Depression is the most common mental illness worldwide and as one of the largest contributors to disease, it is a growing and important public health dilemma.

Dr Aleksandra Miljevic, a postdoctoral researcher at the Perron Institute, was awarded a 3-year fellowship through the FHRI Fund Translation Fellowships program. The research aims to build evidence for advancing non-invasive brain stimulation with genetic screening as a potential treatment model for youth under 25 years of age with depression and suicide ideation.

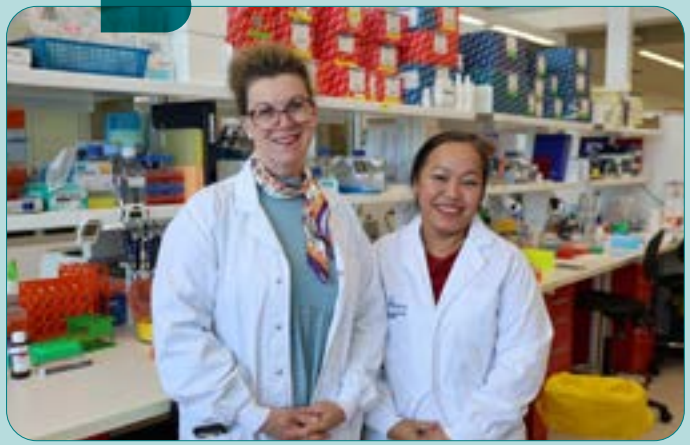
The Translation Fellowship supports early to mid-career researchers in the areas of burden of disease and/or genomics who partner with a service provider to facilitate the translation of research findings into policy and/or practice.

Dr Aleksandra Miljevic

Innovation Seed Funding and PAD

Vascular surgeon and Head of Department of Vascular and Endovascular Surgery at Sir Charles Gairdner Hospital, Professor Shirley Jansen, and Associate Professor Juliana Hamzah have found success with a new drug that could change the lives of 3.9 million Western Australians with peripheral artery disease (PAD). This is a life-threatening condition characterised by the build-up of fatty deposits in arteries. Many people don't know they have PAD until it is too late – resulting in heart attacks, strokes, and severe complications.

Atherid (ATH01), an innovative drug developed in WA, offers a groundbreaking solution by safely and effectively clearing arterial blockages in PAD patients. Supported by the FHRI Fund Innovation Seed Funding, the research team has enhanced ATH01 for human application and the next milestone is to initiate clinical trials.



Professor Shirley Jansen and Associate Professor Juliana Hamzah

Distinguished Fellows leading vital research in WA

The FHRI Fund Distinguished Fellows program aims to attract outstanding research leaders to our state to build capacity and lead high quality, globally recognised research in WA.

Distinguished Fellow, Professor Kathryn Modecki from Griffith University in Queensland, is researching the mechanisms through which early experiences and social inequalities shape children's future mental health and wellbeing.

Using WA's unique cohort studies and smartphone technology to understand how a child's developmental history influences their daily mental health experiences, will inform prevention and treatment options for young people, parents, carers and the community. Professor Modecki is also nurturing new local leaders by growing the science of child mental health research at Perth's The Kids Research Institute Australia.

Distinguished Fellow, Professor Alexey V. Terskikh, recently commenced working as Head of the Chromatin and Ageing Laboratory at the Harry Perkins Institute of Medical Research. The aim of his research is to systematically assess human ageing and provide personalised guidance to extend the healthy and productive period of peoples' lives. The key is to 'add life to our years rather than just add years to our lives'.

Professor Alexey V. Terskikh (right) with Hon Stephen Dawson, Minister for Medical Research

Professor Kathryn Modecki

Looking forward

The coming year will see a renewed focus on refining WA's health and medical research capability as we commence the second phase of the WA Health and Medical Research Strategy guided by a measurable implementation plan for 2025–2027.

We will continue to build a supportive ecosystem for innovation by progressing infrastructure initiatives and developing a model for a statewide biobank, and engagement with the Aboriginal Health Expert Committee will support development of guiding principles for research involving Aboriginal people.

A focus for the FHRI Fund will be implementation of recommendations from the evaluation and performance review, supported by the launch of a new FHRI Fund strategy.

Optimal health care

1,678

junior medical officers recruited

5,492

consults delivered via WA Virtual Emergency Department of which 71% of patients avoided immediate attendance at an emergency department

1,502

calls from triple zero (000) redirected to the Ambulance Mental Health Co-Response virtual triage team resulting in 49% of callers no longer needing a standard ambulance due to intervention provided by the service

Women and Babies

Hospital project managing contractor appointed

Central Referral Service

expanded to the Pilbara region

ScriptCheckWA

expanded to guide safe use of additional sedative and pain relief medicines

PANDA

Paediatric and Neonatal Demand and Access (PANDA) dashboard developed

Hospital falls

prevention patient education guidelines developed

Legionella risk

and audit training course developed with TAFE WA with enrolments commencing in 2026

Released:

- *WA Health Workforce Strategy 2034*
- *WA Health Allied Health Workforce Implementation Plan 2024–2034*
- Clinical Leadership Program for emerging leaders
- Safety and Quality Essentials eLearning Pathway

Our workforce in focus

To ensure we have the skills and expertise across WA Health to meet the demand for health services now and in the future, we are focusing on workforce planning, building the capacity and capability of our current staff, and training and attracting new staff, guided by the strategic priorities of the *WA Health Workforce Strategy 2034*.

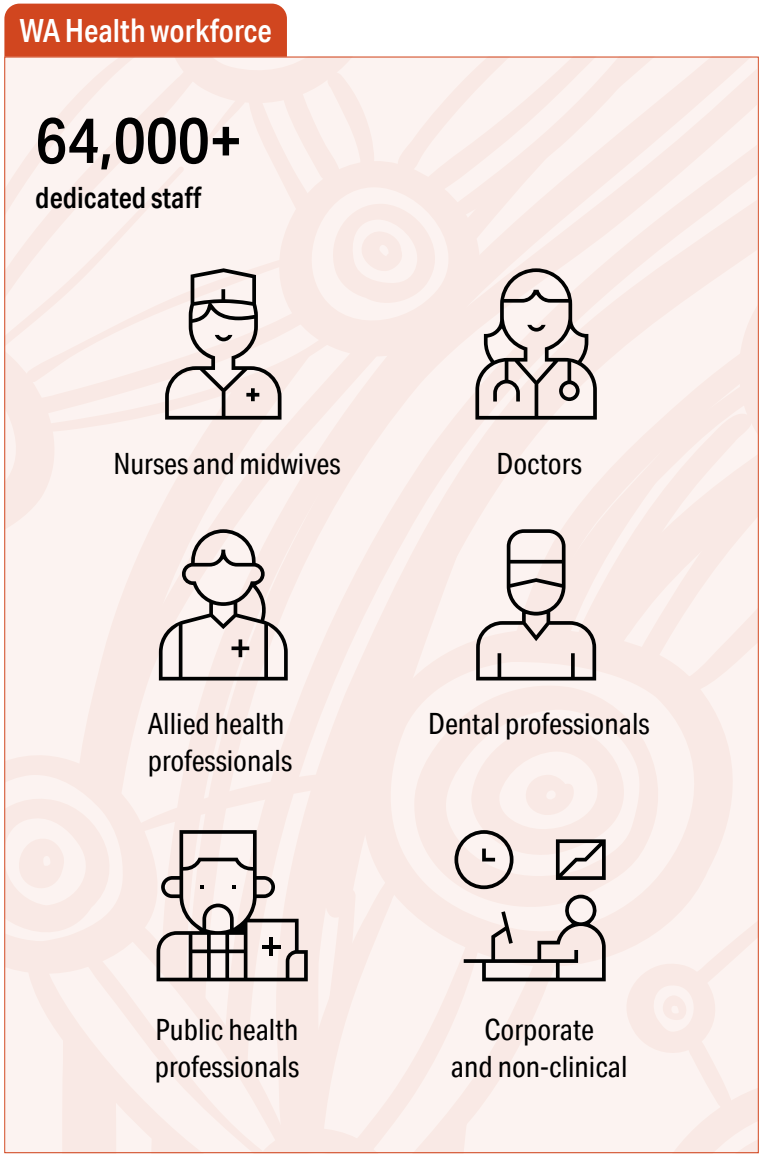
Building our workforce for the future

WA's population is projected to grow significantly over the next decade, increasing demand and pressure on our health system. This, combined with an ageing population, changing patterns in the burden of disease, and increased preference for health care closer to home, highlights the need for a sustainable workforce.

Recruitment and retention challenges and a high volume of retirements anticipated over the next 10 years adds to the complexity of building and maintaining our workforce. Health innovation and the use of digital technology will also demand new skills in future workforce requirements.

A future-focused plan has been developed through extensive consultation across the WA health system and with external stakeholders, detailed analysis of the current health workforce, and environmental and interjurisdictional scans.

The *WA Heath Workforce Strategy 2034* outlines a structured approach to optimise the capability and capacity of the health workforce while addressing workforce challenges unique to WA. The focus on 6 strategic priorities is supported by an implementation plan that details activities to drive outcomes and expected timeframes for completion. Progress will be routinely monitored and evaluated.



Supporting and growing the clinical workforce

Informed by an extensive period of collaboration and consultation with stakeholders, the *WA Nursing and Midwifery Workforce Strategy 2025–2030* strongly aligns and intersects with the WA Health strategic workforce priorities. The strategy is applicable and valuable to all settings and sectors and supports nurses and midwives throughout their career pathway, building workforce capability, capacity and leadership.

With more than 7,700 allied health professionals from more than 30 allied health professions we have commenced the first phase of the *WA Health Allied Health Workforce Implementation Plan 2024–2034*. The aim is to advance the contributions of allied health across our health system focusing on enhancing clinical practice and clinical research and developing allied health leadership. In October 2024, the inaugural WA Excellence in Allied Health Awards recognised the outstanding contributions of allied health workers across WA.

The *Mental Health Clinical Workforce Action Plan* is at the end of its term. Work has begun to align ongoing initiatives with the *WA Health Workforce Strategy 2034* to continue to drive mental health workforce planning across the system. During the life of the action plan, we increased opportunities for the mental health workforce to participate in developing leadership capabilities, achieving similar participation rates to the broader health workforce. We participated in Career Conversations events that aimed to educate secondary students on possible career pathways into the mental health industry and worked with North Metropolitan TAFE to establish a Career Taster Program for Year 9 students.

A range of initiatives is helping to ensure the sustainability of our medical and general practitioner workforce. Through a centralised systemwide recruitment approach, we facilitated the recruitment of 1,678 junior medical officers across public and private health services in 2024–25 and achieved a 75 per cent increase in applications for the 2025 mid-year recruitment cycle. The junior medical officer workforce includes residential medical officers, service medical and service surgical registrars.

To help address critical workforce shortages we continue to offer financial assistance including HECS-HELP to newly qualified registered nurses and midwives who commence work in country WA. An attraction and retention incentive program has also been implemented to address significant public dental health workforce shortages in rural and remote areas of WA.

WA Health strategic workforce priorities

- To find out more see the *WA Health Workforce Strategy 2034: Implementation Plan*

Infrastructure enabling accessible health care

In 2024–25, Project Community Advisory Groups were established to help shape future services and facilities as part of the $1.8 billion New Women and Babies Hospital (NWBH) Project. The NWBH will deliver new inpatient facilities for gynaecology and maternity patients, a neonatal unit for newborns needing specialised care, operating theatres, a family birth centre, outpatient clinics, and more than 2,000 new car bays. A contract manager was also appointed to construct the new hospital and expand maternity services at Osborne Park Hospital and neonatal services at Perth Children's Hospital.

The Perth Children's Hospital mental health inpatient unit, Ward 5A, is the statewide assessment and treatment facility for children and young people under the age of 16 with complex and acute mental health issues. To create an optimal environment that promotes mental health recovery, Ward 5A is undergoing a refurbishment aimed at providing a modern, safe, private, comfortable, welcoming, and inclusive space. The first stage of upgrades was completed in June 2025.

The Peel Health Campus redevelopment is a significant project that will deliver a modernised facility to serve the Peel and broader south-west community. A new Central Sterile Supply Department opened in December 2024 and development of the new Community Mental Health and Eating Disorders facility is soon to be completed. A significant package of forward works is in progress for the main campus development, including power supply upgrades and a new, larger central plantroom to power future facilities, plus new access roads, car parks, and a new intersection.

Expansion of the Joondalup Health Campus continued in 2024–25, with delivery of a new public ward block with 46 contemporary individual patient rooms. A further 60 beds will cater for future demand. Major transformation of the public theatre block includes a new theatre and 2 new interventional catheter laboratories for the provision of cardiac and vascular procedures.

In 2024–25, works commenced to redevelop the Sir Charles Gairdner Hospital (SCGH) emergency department (ED). Designated areas will be established to facilitate different patient needs, including a new Urgent Critical Care Toxicology Unit. Also, development of a new 10-bed intensive care Pod is to commence to expand the capacity of the existing intensive care unit. It will support both emergency and elective patients requiring intensive care including patients who have undergone cardiac and neurological surgery, and liver transplants. Both upgrades are essential to ensuring that SCGH can continue to meet the needs of a growing and ageing population.

Detailed planning has also begun for expansion of the Royal Perth Hospital and St John of God Midland Public Hospital EDs.

Planning continues for reconfiguration of the Graylands Hospital site to deliver 32 sub-acute male beds, a 5-bed child and adolescent unit and a central services hub.

In the last quarter of 2024–25, we worked with health service providers to help deliver the State Government's Public Sector Reform which will see responsibility for health infrastructure projects that are valued more than $100 million, or highly complex and/or high risk, transition to the Office of Major Infrastructure Delivery (OMID) within the new Department of Transport and Major Infrastructure. WA Health will become a client of OMID, which will build WA Health infrastructure to the requirements that best serve the needs of the WA community.

The 13 major and complex health infrastructure projects transitioning to OMID from 1 July 2025 include:

- New Women and Babies Hospital Project
- Geraldton Health Campus Redevelopment Project
- Midland Hospital Emergency Department expansion
- Royal Perth Hospital Emergency Department expansion
- reconfiguration of the Graylands Hospital site.

Regional infrastructure progress

- Bunbury Regional Hospital Redevelopment includes an expanded ED and mental health inpatient unit, new clinical tower block, helicopter handover room and helipad landing site, and additional refurbishments and upgrades. The concept design was completed, and main works have commenced.
- Geraldton Health Campus Redevelopment includes an expanded ED, new critical care unit and integrated inpatient mental health service, and essential engineering service upgrades. The structure was completed, and building fit out and operational commissioning are nearing completion.
- New Laverton Hospital will provide emergency and multidisciplinary ambulatory care facilities and outpatient services including community health, mental health, and drug and alcohol services. Forward works have been completed and main works are progressing.
- Fitzroy Crossing Renal Health Centre expansion will provide additional chairs for renal patients to receive ongoing treatment close to home and on Country. Construction is underway.
- Karratha Step Up/Step Down facility will provide adult mental health patients with short-term residential care close to family and friends. The construction contract has been awarded.
- New Mullewa Community Hospital will provide 24/7 emergency care, respite and palliation, outpatient treatment and community health programs. The contract for main works has been awarded.
- New Tom Price Hospital will include an ED, an inpatient ward, dental and pathology services, consult rooms and ambulatory care facilities, and Paraburdoo Hospital Redevelopment works include a new ED, integrated primary and community care services and space for an on-site private GP clinic. Early Contractor Involvement commenced, allowing contractors to participate in a collaborative approach to design and deliver works.

Improving access to health care

To ensure patients have timely access to appropriate care, we are prioritising delivery of a comprehensive program of work to manage total hospital capacity and demand and to optimise patient movement through the healthcare system.

The WA Virtual Emergency Department (WAVED), within the State Health Operations Centre (SHOC), enables patients to be assessed virtually by an experienced clinician (via telehealth) then connected with the care they need – at home, hospital or an alternative service – rather than waiting in an ED. Following a successful proof of concept period where virtual consults were offered to aged care residents seeking ambulance assistance, WAVED became available to all metropolitan paramedic crews in July 2024. Additional referral options to access WAVED services were also introduced from the Residential Care Line, WA Police Perth Watch House, Silverchain and Derbarl Yerrigan Health Service Clinics. Virtual Care Connect, a new ICT platform implemented in April 2025, enables adult callers to healthdirect to be offered a virtual WAVED consultation. This referral pathway marks a significant expansion of WAVED services.

The Ambulance Mental Health Co-Response service, led by the SHOC in conjunction with the Mental Health Commission, health service providers and St John WA, offers triple zero (000) callers with mental health virtual triage, assessment and urgent care. A mobile response team comprising dedicated mental health clinicians and paramedics can also be dispatched to provide specialised care for people experiencing a mental health crisis in metropolitan areas.

The Outpatient Reform Program continues to deliver improvements to outpatient services. The scope of the Central Referral Service was expanded to the Pilbara, enabling referrals to be allocated to the appropriate care site for specialist services not available in the region. New Referral Access Criteria were implemented to guide general practitioners when referring patients for respiratory and sleep medicine, hepatology, and immunology services. The Smart Referrals WA project entered the delivery phase where the enhanced and integrated referral management solution will be built, tested and deployed.

Using data wisely

Using the WA Health Data Platform, a comprehensive system designed to connect, curate, and enable the use of systemwide data, we have produced new tools that provide the WA health system with access to reliable information to manage patient throughput and the overall operations of health services:

- Paediatric and Neonatal Demand and Access (PANDA) dashboard provides real-time, systemwide emergency and inpatient paediatric demand, capacity, and acuity.
- Assertive Mental Health Patient Flow Beds Live dashboard provides an overview of mental health bed availability and occupancy across all of health, while also enabling access to ward-level information including specific availability of secure and non-secure beds.
- Patient Transport Coordination Hub (PaTCH) dashboard provides timely information to support clinical staff across the system involved in inter-hospital patient transfers.

Early use of these dashboards has highlighted the benefits of integrated demand oversight and is informing improvements to the SHOC's operational readiness and response.

In 2024–25 we also:

- implemented the Medically Cleared for Discharge Flag to enable better monitoring and reporting of patients who are experiencing discharge delays. The flag allows us to focus our efforts on removing discharge barriers especially relating to aged care and disability services.
- improved the capture of the health information of people with disability and using linked data, gained greater visibility to the type and variations in their inpatient health care.

WA Health Hackathon sparks innovation for better patient care

Artificial Intelligence (AI) and synthetic data are revolutionising the field of medical research and clinical healthcare, heralding a new era of innovation and efficiency.

Our recent WA Health Hackathon, a week-long event organised in collaboration with the WA Data Science Innovation Hub (WADSIH), brought together more than 100 problem solvers including data scientists, software developers, and enthusiastic innovators.

The Hackathon tackled 5 of the most pressing challenges in our healthcare system using technology and AI to efficiently process and analyse complex healthcare data, fostering the development of tailored, effective patient care solutions. Synthetic data prepared by our Information and Systems Performance Directorate played a crucial role, providing a secure and ethical alternative to real patient data, enabling research and innovation without compromising patient privacy.

One team, 'Waiting Around,' leveraged technology to address the challenge of how hospital emergency rooms can improve wait times and streamline the receiving, triaging and processing of patients. Their innovation included devising a simulation tool using data to predict emergency department waiting times that can be shared with patients via a mobile application.

Other innovative solutions conceived during the Hackathon are ready for further development and potential implementation in real-world healthcare settings.

The challenges

1. Planning youth mental health interventions
2. Improving end of life care
3. Simplifying and enhancing complex health information provided to patients
4. Reducing emergency department wait times
5. Optimising treatment plans for children in rehabilitation

Winning innovators 'Waiting Around'

WA Health Hackathon teams

Improving safety and quality in health care

We continue to drive systemwide improvements aligned to *Improving Safety and Quality in Health Care: A Strategic Plan for Action in WA 2024–2026*.

In 2024–25 we launched the Safety and Quality Essentials eLearning Pathway to build staff capability in healthcare safety and quality, and a new online Quality Improvement Hub provides clinicians with a suite of resources to assist in planning, implementing, monitoring and evaluating quality improvement initiatives. In parallel, our new approach to data analysis has empowered analysts and clinicians to distinguish between random variation and meaningful trends, fostering a culture of data literacy and proactive responses.

Australian Institute of Health and Welfare and Australian and New Zealand Hip Fracture Registry national benchmarking was incorporated into our Safety and Quality Indicator Set (SQuIS), enabling WA hospitals to compare performance against peer institutions, supporting more informed decision making and targeted improvement efforts.

As part of addressing the 7 High-Impact Actions identified through the WA Aboriginal Health Executive Roundtable, the Health Executive Committee completed the organisational Ending Racism Check-Up Tool via the Australian National University. In addition, the new WA Aboriginal Health Dashboard provides information to aid WA Health staff in strategic planning, implementing quality improvement initiatives, and addressing health system responsiveness for Aboriginal people in WA.

A new policy was published in 2024–25 to embed the safe and lawful use of restrictive practices in non-authorised healthcare settings. The policy promotes the use of trauma-informed care and the consideration of the patient's rights, freedoms and choices while balancing healthcare needs and staff and patient safety. We also developed clinical guidelines to assist healthcare professionals in providing care to people requesting an abortion in WA.

Nurse/Midwife to Patient Ratios

WA Health has commenced a phased implementation of Nurse/Midwife to Patient Ratios to create sustainable and safer workloads for nurses and midwives, contributing to better patient outcomes and safety.

A nurse/midwife to patient ratio is the minimum number of nurses/midwives working in a hospital ward or unit, in relation to the number of patients requiring care. The ratio is calculated based on patient acuity: the greater the level of care required, the higher the number of nurses/midwives required to provide safe care.

Following a successful pilot at Perth Children's Hospital emergency department that saw rostered staffing levels lift to one nurse for every 3 patients, ratios were trialed at Sir Charles Gairdner and Osborne Park hospitals from October 2024. Starting on select medical and surgical wards, the minimum ratios adopted are one nurse/midwife to every 4 patients, with an additional hands-free shift coordinator, for morning and afternoon shifts, and one nurse/midwife to every 7 patients for night shifts.

This new staffing model will gradually replace the Nursing Hours per Patient Day methodology.

An interim Nurse/Midwife to Patient Ratio dashboard was developed to enhance visibility of ratio compliance across selected wards, supporting safer staffing practices and improved workforce planning. This work has laid the groundwork for broader implementation of real-time workforce analytics across WA Health.

Capturing consumer feedback to inform quality care

The WA health system encourages consumer feedback as it provides valuable information to help hospitals and health services monitor and improve services.

Informed by statewide stakeholder consultation and aligned with evidence-based best practice, our recently updated Complaints Management Policy requires all health service providers to have systems and processes in place to support a consistent approach to the management of consumer feedback. This includes reporting feedback about a patient's experiences and outcomes of care that may be received from the patient, or their carer, family, representative or advocate. Review of consumer feedback, complemented by learnings from other safety and quality programs, helps to identify trends and support service improvements.

Real-time consumer feedback mechanisms continue to be established across the system. WA is the first state to have all public hospitals and health services subscribe to the nationwide Care Opinion platform. The moderated website facilitates feedback about personal experiences of care, good or bad, in a safe, public, transparent, and meaningful way, enabling consumers to engage promptly and directly, more so than with our other feedback mechanisms. We monitor Care Opinion to stay aware of the conversations and potential areas of focus for health service improvement.

In partnership with organisations such as the Health and Disability Services Complaints Office, the Health Consumers' Council and the Mental Health Advocacy Service, we support consumers to provide feedback and navigate the health system. This includes providing information, guidance and representation to resolve a problem or issue.

Overall, feedback from consumers is part of our larger quality improvement system ensuring patient safety and quality concerns are recognised, reported and reviewed to improve the care provided.

Consumer feedback on our health services 2024–25[9]

23,506
separate items of consumer feedback

13,023 compliments

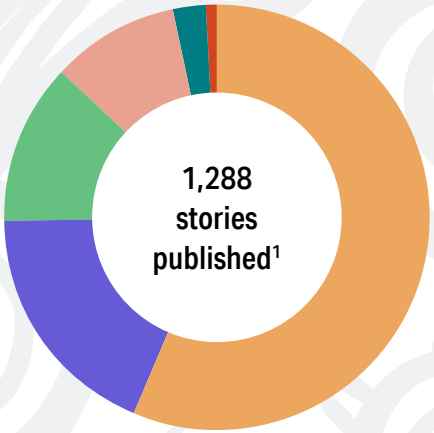
5,026 complaints

5,457 other contacts and concerns

[9]Notes:
1. Data for the period 1 July 2024 to 30 June 2025 was sourced from the WA Health Datix Consumer Feedback Module as at 9 July 2025. Data includes all WA health service providers but excludes contracted health entities.
2. Contacts and concerns include feedback where the consumer or their representative states they do not wish to lodge a formal complaint, or an issue can be resolved without going through the formal complaint management process.

Care Opinion response summary

- 1268 staff listening[2]
- 99.5% response rate[3]



737	WA Country Health Service	128	East Metropolitan Health Service
241	North Metropolitan Health Service	33	Child and Adolescent Health Service
157	South Metropolitan Health Service	9	PathWest Laboratory Medicine WA

Notes:

1. Based on story activity report for 1 January to 31 December 2024. Count of stories for each health service provider (HSP) may result in duplicate counts when more than one HSP is part of a story.
2. Number of HSP staff registered to receive story alerts from Care Opinion at 20 January 2025.
3. Percentage of stories from 1 January to 31 December 2024 that have received a response from an HSP.

- For more information see Stories posted from our WA community on their experience with our health service providers

Community health and wellbeing

RSV

Respiratory Syncytial Virus (RSV) Immunisation Program expanded to include pregnant women as well as infants and at-risk children

'Nang' regulations

introduced to protect people from the harmful effects of inhaling nitrous oxide

94%

of Western Australians now have access to fluoridated drinking water

7 health incidents

requiring activation of State Health Incident Coordination Centre

Aboriginal Health

Aboriginal Environmental Health Model of Care developed

State Hazard Plan

State Hazard Plan for Human Biosecurity updated

Released:

- *State Public Health Plan 2025–2030*
- *WA Immunisation Strategy 2024–2028*
- WA Health and Wellbeing Surveillance System trend dashboard

Launching the State Public Health Plan

Public health is about maximising the health and wellbeing of the community. It encompasses all the aspects of life that enable people to thrive. By actively planning for the best public health outcomes, we can support and drive the changes required to ensure our communities remain healthy and resilient.

The new *State Public Health Plan 2025–2030* (SPHP) outlines a roadmap for the next 5 years to promote and enable optimal health and wellbeing, while protecting against health risks, to ensure the highest quality of life for all – in routine public health management and in times of crisis.

Aboriginal health and wellbeing and equity and inclusion are fundamental objectives that permeate all other objectives and priorities of the SPHP to foster a more inclusive environment and address disparities in health outcomes.

Achieving the best public health outcomes for Western Australians requires collaboration and partnerships across multiple agencies and all levels of government. The SPHP will support individual organisations to integrate public health priorities into their strategies, plans and policies.

Overview of the SPHP

Vision

The best possible health, wellbeing and quality of life for all Western Australians – now and into the future.

Overarching objectives

Aboriginal health and wellbeing: address racism and strengthen the Cultural Determinants of health for Aboriginal people in WA.

Equity and inclusion: empower community groups who are at risk of greater inequities from the impact of social and environmental determinants of health to access health services.

Objectives

Promote: foster strong communities and healthier environments.

Prevent: reduce the burden of chronic disease, communicable disease, and injury.

Protect: protect against public and environmental health risks, effectively manage emergencies, and lessen the health impacts of climate change.

Enable: bolster public health systems and workforce, and leverage partnerships to support health and wellbeing.

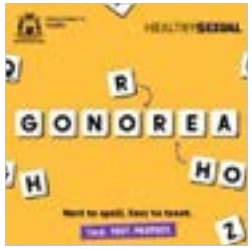
Promote and prevent: 2024–25

Raising awareness of health risks and encouraging healthy choices and behaviours through our public health campaigns

Highlighting the importance of being immunised to protect against preventable diseases.

Promoting free vaccines to prevent serious disease for students in Year 7 and Year 10.

Encouraging Western Australians, particularly high-risk groups, to get the influenza vaccine.



Raising awareness about sexual health and ways to minimise the personal and social impact of sexually transmissible infections.

Raising awareness about RSV and the importance of immunising young babies.

Raising awareness among Aboriginal people about how to prevent HIV and hepatitis C.

Maintaining public health partnerships to support the adoption of healthy behaviours in the community

Launch of the 'How to tell you' campaign that encourages smokers to quit by thinking of how a smoking-caused illness would affect their family and friends.

Launch of 'Be A Mermate' to encourage young people to speak up when their friends are engaging in unsafe behaviours in or around the water.

Also, 'Make The Right Call' targeting adults with the message 'Check the water and check yourself. Making the right call is always safer on solid ground'.

FoodChecker

Release of a new tool supporting WA schools to create canteen menus that ensure access to nutritious food and drink options and empower students to make positive, healthy choices.

Release of a guide to assist local governments and key stakeholders to consider, include and implement injury prevention activities within local level strategic plans.

Launch of the LiveLighter 'Habits' campaign, to highlight the impact of unhealthy food habits and how they can lead to poor health outcomes.

Protecting young people from harmful substances

Vapes often contain nicotine and dangerous chemicals. To limit their sale and supply, new regulations require any person wishing to purchase a vape to obtain a doctor's prescription, which can then be dispensed by a pharmacist. Acknowledging that 32 per cent of WA students reported having tried vaping, and of these students approximately 18 per cent reported vaping in the past month, we also released an online guide to help health professionals and others working with young people, to give advice on quitting vaping and managing nicotine withdrawal.[10]

With 7.4 per cent of Australian students reporting the use of an inhalant including nitrous oxide in the past month, misuse poses significant health risks including permanent brain and spinal cord damage.[11] Under new regulations, the small 10-gram cannisters referred to as 'nangs' can be sold only to registered food and beverage businesses, and educational and training institutions, making them harder to access for recreational use.

"Poor oral health does not just affect your teeth – it impacts your ability to sleep, eat, and speak, and it's linked to a range of medical conditions, including cardiovascular disease and rheumatoid arthritis."

Dr Andrew Robertson, Chief Health Officer, Department of Health

Reducing tooth decay and promoting oral health

Supported by research, water fluoridation is a safe and effective way to reduce tooth decay and promote oral health across all age groups, particularly children.

Following efforts in 2024–25 to introduce fluoridated drinking water to Bunbury, Capel, Donnybrook and Denmark, 94 per cent of the WA population now have access to fluoridated drinking water.

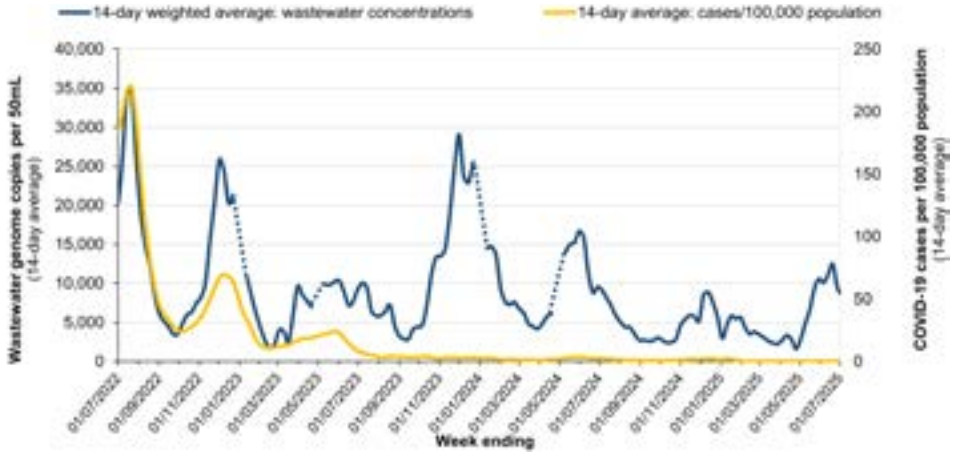
[10] Chronic Disease Prevention Directorate (2024) 'Australian Secondary Students' Alcohol and Drug Survey 2022–23: Western Australian results - tobacco and e-cigarette use'. Department of Health.
[11] Centre for Behavioural Research (2023) 'Australian secondary school students' use of alcohol and other substances 2022–23'. Cancer Council Victoria.

Surveillance and disease control in the community

Since the COVID-19 pandemic, it has become more important than ever to establish contemporary disease control data management systems, robust surveillance, and reporting to prevent and respond to disease outbreaks within the community.

SARS-CoV-2, the virus that causes COVID-19, can be detected in sewage water. This is because infected people shed virus fragments when washing and toileting. The WA Wastewater Surveillance Program tests untreated sewage for fragments of SARS-CoV-2 and contributes to the overall surveillance of the disease in the community. The program commenced in 2022 and continues to be adapted to provide the most relevant data for monitoring trends and informing public health responses.

Figure 1: SARS-CoV-2 wastewater surveillance trends and reported COVID-19 cases, 1 July 2022 to 27 June 2025[12]



Some illnesses in WA are transmitted by mosquitoes, such as Murray Valley encephalitis, Ross River and Kunjin viruses, and the recently introduced Japanese encephalitis virus (JEV). New mosquito collection and transportation methods, implemented in collaboration with local government, will enhance the surveillance of mosquito-borne viruses across northern WA. We are also providing free mosquito repellent dispensers for community groups in the high-risk Kimberley, Pilbara, and Gascoyne regions.

We routinely monitor the rate of vaccine preventable diseases in the community. A new monitoring and reporting framework has been introduced to enable examination of the implementation of the *WA Immunisation Strategy 2024–2028* that aims to reduce the incidence of, or maintain elimination status of, vaccine preventable diseases.

[12]The graph represents a weighted average of wastewater SARS-CoV-2 genome copies per sample and reported case rates in metropolitan Perth. More information about the methodology is available from the WA Wastewater Surveillance Program website.

Raising awareness using public health alerts to inform and protect the community from environmental health risks and highly infectious diseases

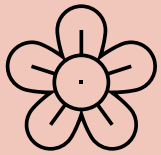
Makuru

Season of fertility

- Confirmed case of meningococcal disease

Djilba

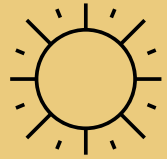
Season of conception



- Metropolitan measles alert
- Mpox warning
- Confirmed cases of meningococcal disease
- Legionnaires' disease warning for spring gardeners

Kambarang

Season of birth



- Shellfish warning for lower Swan and Canning River estuary
- Early detection of mosquito-borne virus in the Kimberley
- Confirmed cases of meningococcal disease
- School leavers urged to Talk. Test. Protect
- Confirmed JEV activity in the Kimberley
- Mpox warning
- Metropolitan and South West measles alert

Birak

Season of the young

- Health warning as heatwave conditions hit northern WA
- Be food safe over summer
- COVID-19 booster available for new strains of the virus
- Whooping cough warning as cases rise
- Mpox warning as cases increase
- Metropolitan measles alert
- Amoebic meningitis warning as water temperatures rise
- Ross River virus detected in the South West

Bunuru

Season of adolescence

- Ross River virus detected around Swan River
- Murray Valley encephalitis in the Kimberley and Pilbara
- Metropolitan measles alerts
- Confirmed cases of meningococcal disease
- Health warning due to rise in Cryptosporidiosis gastrointestinal infections
- Measles outbreak involving Hakea Prison, Bunbury Regional Prison and Bunbury Regional Hospital

Djeran

Season of adulthood

- Measles warning for Easter travellers
- Confirmed cases of meningococcal disease
- Vaccination reminder after metropolitan measles alert

Using data to guide public health policy and planning

Comprehensive data collection, collation and analysis are crucial in identifying emerging health issues and trends and to assist in planning, decision making and guiding public health interventions and services to improve the health and wellbeing of the community.

We continue to invest in linked data as an enabler of research and innovation, and to support policy development, service planning and quality improvements. In supporting the development of data linkage services through implementation of the *WA Health Data Linkage Strategy 2022–2024* we have modernised the state's linked data infrastructure and service model, while improving governance, streamlining researcher access, and enhancing data quality and timeliness.

In 2024–25, we progressed data linkage governance processes and bilateral data sharing agreements to support the linking and sharing of datasets nationally. This will enable future participation in national registries and disease control initiatives and facilitate richer longitudinal studies and population-level insights.

This year we also developed new data analytic dashboards. One brings together 21 years of health and wellbeing data gathered through the WA Health and Wellbeing Surveillance System, a statewide population-based survey of adults and children. Collating this data will support observation of longer term health and wellbeing trends. The WA Public Health Indicator Dashboard brings together 11 data collections that will provide an ongoing statewide view on a range of factors that influence the health of the WA community. It will assist us to monitor and evaluate the impact of public health prevention programs and our broader efforts to address major public health issues.

Monitoring the health of the community with the Public Health Atlas

The Public Health Atlas (the Atlas) has been developed to provide insights into the public health needs of the community.

The Atlas compiles and analyses a range of health information and uses geo-spatial technologies to produce indicators of health such as disease prevalence, incidence, lifestyle risk factors and outcomes, all presented as easy-to-use maps, graphs, tables and commentaries.

Technical improvements and new features implemented in 2024–25 have improved functionality for users and supported advanced modelling for areas in WA that are sparsely populated or have low disease counts. Detailed health profiles for local government areas are now available to assist local governments in developing their public health plans.

Public Health Atlas depiction of cancer incidence across WA health regions, 2011–2020

Providing sustainable disaster and emergency management

We are responsible for ensuring WA Health is ready to respond to significant incidents and events impacting our health system, our state and the broader international community.

The State Health Incident Coordination Centre (SHICC), a dedicated WA Health emergency operations centre, remains in a standby mode to be activated at short notice when a coordinated incident response is required from the WA health system. The SHICC was activated 7 times throughout 2024–25 for planned and unplanned events.

We manage and support the WA Medical Assistance Team (WAMAT), a multidisciplinary team comprised of healthcare professionals and Department of Fire and Emergency Services that include Urban Search and Rescue health logisticians. The WAMAT responds to major WA incidents at short notice to provide medical care and health support. The WAMAT was deployed to Leavers in 2024, providing a valuable opportunity to test new procedures, processes and equipment designed to support a self-sufficient deployment. The WAMAT was also placed on standby for Tropical Cyclone Zelia.

In support of national capability, we also manage the WA Health teams that contribute to Australian Medical Assistance Team activities, including attendance at training programs and representation at international events. In 2024–25 this included a joint training exercise with the Japanese Medical Assistance Teams, representation at Public Health Operations in Emergencies for National Strengthening in the Indo-Pacific, and one clinical staff member joining the response team to assist in Vanuatu following an earthquake.

A major focus in 2024–25 was to review and update key documentation to support disaster and emergency management. The *State Hazard Plan for Human Biosecurity* outlines emergency management arrangements for 2 key hazards: human epidemics and biological emergencies caused by actual or impending release of harmful biological substances. When such incidents exceed routine organisational capacity and become emergencies, the plan guides prevention, preparedness, response, and initial recovery activities. It also considers national and international threats and risks originating outside WA. The plan was updated and relevant sections from the *WA Government Pandemic Plan* were incorporated.

Sharing insights in emergency management in WA

The WA Health Emergency Management Forum held in October 2024 brought together experts from across the emergency management sector to share insights, network and strengthen collaboration.

Emergency management includes a range of measures taken to prevent, prepare for, respond to, and recover from, emergencies, disasters and other disruptive events.

Chief Health Officer, Dr Andrew Robertson, presented on 'AUKUS and radiation health considerations for a visiting nuclear-powered warship'. The Royal Flying Doctor Service presented on 'RFDS Horizontal Falls – A remote location emergency response' reflecting on the 2023 incident in which 28 people were injured in a boat accident at Horizontal Falls on the Kimberley coast.

The forum reinforced the critical importance of cultivating enduring relationships between organisations involved in disaster preparedness and response. Strong, pre-established partnerships foster mutual understanding of roles, capabilities, and limitations, enabling more effective coordination and decision making during complex emergencies.

WA Health Emergency Management Forum

Heatwaves hitting our most vulnerable

WA can experience long periods of higher-than-expected heat, when the maximum and minimum temperatures are much hotter than usual (heatwaves).

Heatwaves can affect any person, regardless of their fitness, and the effects of heat on the body can be fatal if symptoms are left untreated.

A recent study conducted by the department in partnership with Curtin University – *Predicting the Effects of Heatwaves and Air Quality on Emergency Department Presentations and their Spatial Variations for Children in Perth, Western Australia* – aimed to assess the effects of heatwaves on people living in Perth and their need for emergency care and treatment. This involved using emergency department (ED) patient information, daytime temperatures and air quality data collected over a 10-year period.

The study found people presenting to ED peaked on the third day of a heatwave event, with very young children and adults over 60 among the most vulnerable. ED presentations for children aged under 5 doubled during heatwaves, and patients presenting with renal failure were 1.3 times higher.

The study was also able to identify geographic areas at high risk of adverse health effects due to heatwaves, finding residents of disadvantaged areas, coastal areas, and southern areas of Perth most affected.

Overall, the findings from this study indicate the heightened monitoring of public hospital emergency activity across the WA health system will support response and recovery activities arising from the impacts and effects of a major heatwave emergency.

- To find out more see the State Hazard Plan that outlines strategies for managing a heatwave in WA.

Aboriginal health and wellbeing

Implementation of the *WA Aboriginal Health and Wellbeing Framework 2015–2030* is entering its third and final 5-year implementation cycle. In 2024–25, we commenced a review of the work progressed and achieved under the framework to refine and inform activities in the next cycle.

This year we also launched the Aboriginal Data Governance Policy to ensure the WA health system recognises the rights of Aboriginal people in WA to govern the collection, ownership and use of data about their people and communities. Policy implementation is supported by the WA Health Aboriginal Data Governance Committee and a suite of resources including the Aboriginal Data Governance Model, Aboriginal Data Governance Training, and an Aboriginal Data Use Evaluation and Declaration Form.

We have continued to steward WA Health's commitment under the *National Agreement on Closing the Gap*, working towards set socioeconomic targets for life expectancy and birthweight in partnership with representatives from across the WA health system, other state government agencies, the Aboriginal Health Council of WA, and the Ngangk Yira Institute for Change.

Service providers are being supported to transition to a new Aboriginal Environmental Health Model of Care, co-designed in collaboration with the Aboriginal Health Council of WA, Aboriginal Community Controlled Organisations, and other key stakeholders.

These initiatives support our efforts to ensure Aboriginal people receive respectful, culturally safe care and experience more equitable health outcomes throughout their lives.

Agency performance

Our performance management framework

The department operates under the WA Health Outcome Based Management (OBM) framework. This framework describes the relationship between outcomes, services and key performance indicators (KPIs) that measure how effective and efficient we are in achieving relevant overarching State Government goals.

Table 1 demonstrates the alignment between whole of government goals and our desired outcomes as per our performance management framework.

While supporting and enabling the delivery of services to achieve all 3 desired outcomes through system-led initiatives and support to health service providers, the department specifically and directly achieves outcomes 2 and 3.

Table 1: WA Health Outcome Based Management framework

State Government goals	Desired outcomes	Services
Safe, strong and fair communities Supporting our local and regional communities to thrive.	1. Public hospital based services that enable effective treatment and restorative health care for Western Australians.	1. Public hospital admitted services 2. Public hospital emergency services 3. Public hospital non-admitted services 4. Mental health services
	2. Prevention, health promotion, and aged and continuing care services that help Western Australians to live healthy and safe lives.	5. Aged care, continuing care, and end of life care services 6. Public and community health services 7. Pathology services 8. Community dental health services 9. Small rural hospital services
Strong and sustainable finances Responsible, achievable, affordable budget management.	3. Strategic leadership, planning and support services that enable a safe, high quality and sustainable WA health system.	10. Health system management – policy and corporate services 11. Health support services

The department achieves Outcome 2 through the delivery of:

Service 5:

aged care, continuing care, and end of life care services including community-based palliative care services and voluntary assisted dying services. These services include programs that assess the care needs of older people, and that provide functional interim care or support for older, frail, aged and younger people with disability to continue living independently in the community. Community-based palliative care services are delivered by private facilities under contract to the department and focus on the prevention and relief of suffering, quality of life, and the choice of care close to home for patients. Voluntary assisted dying services include provision of services to eligible patients approaching the end of their life as well as support services for anyone involved with voluntary assisted dying in WA.

Service 6:

public and community health services including services and programs delivered to increase optimal health and wellbeing, encourage healthy lifestyles, reduce the onset of disease and disability, reduce the risk of long-term illness as well as detect, protect and monitor the incidence of disease in the population.

The department achieves Outcome 3 through the delivery of:

Service 10:

health system management – policy and corporate services including the provision of strategic leadership, policy and planning services, system performance management and purchasing linked to the statewide planning, budgeting, and regulation processes. Health system policy and corporate services is inclusive of statutory financial reporting requirements, overseeing, monitoring, and promoting improvements in the safety and quality of health services, and systemwide infrastructure and asset management services.

The department reports performance towards achieving outcomes 2 and 3 through a suite of KPIs. Performance against targets for 2024–25 is summarised in the Agency performance section and described in detail in the KPI section of this report.

Changes to the WA Health OBM framework

In 2024–25 the framework was updated to clarify the provision of end of life care services, including voluntary assisted dying services.

In addition, minor amendments to the computation methodology, data source or title have occurred for 5 KPIs. Notation and further description of these amendments is provided in the KPI section of this report.

Performance summary

Summary of financial performance

Table 2 provides a summary of our financial and performance information for 2024–25.

Full details of the department's financial performance including variance explanations are provided in the Financial statements section of this report.

Table 2: Actual results versus budget targets for the Department of Health

	2024–25 Target ($'000)	2024–25 Actual ($'000)	Variation (+/-) ($'000)
Total cost of services[1]	10,639,697	11,467,888	828,191
Net cost of services	7,580,725	8,307,009	726,284
Total equity	276,857	388,588	111,731
Agreed salary expense level	200,554	230,219	29,665
Approved borrowing limit[2]	0	0	0

Note:

1. The total cost of services includes grants and subsidies to fund statutory authorities for delivery of health services.
2. Approved borrowing limit is not applicable.

Agencies are required to operate within an agreed working cash limit, defined as 5 per cent of budgeted cash payments. The approved working cash limit is the maximum level of cash required to meet commitments associated with payments for recurrent services.
In 2024–25, the cash limit target and actual for the WA health system are provided in Table 3.

Table 3: Agreed working cash limit for the WA health system

	2024–25 Target ($'000)	2024–25 Actual ($'000)	Variation (+/-) ($'000)
Agreed working cash limit (at budget)	616,714	616,714	0
Agreed working cash limit (at actuals)	671,237	672,969	1,732

Notes:

1. The working cash limit is for all WA health system entities, including health service providers.
2. The cash position for the department can be found in the notes to the financial statements.

Agencies are required to operate within an agreed executive salary expense limit.
The executive salary expense limit target and actual for the WA health system are provided in Table 4.

Table 4: Agreed executive salary expense limit for the WA health system

	2024–25 Agreed Limit ($'000)	2024–25 Actual ($'000)	Variation (+ / -) ($'000)
Agreed executive salary expense limit	12,503	11,336	-1,167

Act of grace and ex-gratia payments paid in 2024–25 are provided in Table 5.

Table 5: Department of Health act of grace and ex-gratia payments paid in 2024–25

Funding source	Payment date	Payment amount ($)	Purpose of payment
Act of grace payments			
Nil			
Ex-gratia payments			
State appropriation	Throughout the year	6,992,095	Payments to health service providers to cover the out of pocket expenses incurred by patients who chose to be treated as a private patient in a public hospital.

Summary of key performance indicators

The department reports performance towards achieving the WA health system vision through a suite of key performance indicators (KPIs).

Actual KPI results are reported against targets to help assess effectiveness of performance against desired outcomes and efficiency of service delivery. KPI actuals may vary to the target and, depending on the indicator, a positive or negative variance may represent achievement of the desired result.

To aid with understanding, the following colour coding has been applied to the results for the reporting period.

- Indicates the target was achieved
- Indicates the result is within 10 per cent of the target
- Indicates the result is greater than 10 per cent from the target

Effectiveness results are summarised in Table 6 and efficiency results are summarised in Table 7. Detailed information can also be found in the key performance indicators section of the report.

Table 6: Actual results versus key effectiveness performance indicator targets

Desired outcomes and related effectiveness indicators		2024–25 target	2024–25 actual	Variation
Outcome 2: Prevention, health promotion and aged and continuing care services that help Western Australians to live healthy and safe lives				
1	Percentage of transition care clients whose functional ability was either maintained or improved during their utilisation of the Transition Care Programme	≥82%	97%	15%
2	Percentage of people accessing specialist community-based palliative care who are supported to die at home	≥76%	68%	- 8%
3	Potential years of life lost for selected common causes of premature death			
	a. Lung cancer	1.2	1.2	- 0.2
	b. Ischaemic heart disease	2.4	2.4	0.1
	c. Malignant skin cancers	0.3	0.3	0
	d. Breast cancer	1.7	1.5	- 0.2
	e. Bowel cancer	1.1	0.8	- 0.3
4	Percentage of fully immunised children			
	a. 12 months	≥95%	91.0%	- 4.0%
	b. 2 years	≥95%	88.2%	- 6.8%
	c. 5 years	≥95%	92.2%	- 2.8%

Table 6: Actual results versus key effectiveness performance indicator targets

Desired outcomes and related effectiveness indicators		2024–25 target	2024–25 actual	Variation
5	Percentage of 15 year olds in Western Australia vaccinated for HPV			
	a. Males	≥80%	79.0%	- 1.0%
	b. Females	≥80%	80.3%	0.3%
6	Response times for emergency road-based ambulance services (Percentage of priority 1 calls attended to within 15 minutes in the metropolitan area)	≥90%	83.3%	- 6.7%
Outcome 3: Strategic leadership, planning and support services that enable a safe, high quality and sustainable WA health system				
7	Proportion of stakeholders who indicate the Department of Health to be meeting or exceeding expectations of the delivery of system manager functions	≥75%	86%	11%

Table 7: Actual results versus key efficiency performance indicator targets

Desired outcomes, services delivered and related efficiency indicators		2024–25 Target	2024–25 Actual	Variation
Outcome 2: Prevention, health promotion and aged and continuing care services that help Western Australians to live healthy and safe lives				
Service 5: Aged care, continuing care and end of life care services				
1	Average cost of a transition care day provided by contracted non-government organisations/service providers	$475	$460	- $15
2	Average cost per			
	a. home-based hospital day of care	$336	$379	$43
	b. occasion of service	$165	$163	- $2
3	Average cost per day of non-acute bed-based continuing support	$834	$908	$74
4	Average cost to support patients who suffer specific chronic illness and other clients who require continuing care	$21	$26	$5
5	Average cost per client receiving contracted palliative care services	$9,302	$10,612	$1,310

Table 7: Actual results versus key efficiency performance indicator targets

Desired outcomes, services delivered and related efficiency indicators		2024–25 Target	2024–25 Actual	Variation
Service 6: Public and community health services				
6	Cost per person of providing preventive interventions, health promotion and health protection activities that reduce the incidence of disease or injury	$58	$84	$26
7	Cost per trip for road-based patient transport services, based on the total accrued costs of these services for the total number of trips	$659	$705	$46
Outcome 3: Strategic leadership, planning and support services that enable a safe, high quality and sustainable WA health system				
Service 10: Health system management – Policy and corporate services				
8	Average cost of public health regulatory services per head of population	$8	$6	- $2
9	Average cost for the Department of Health to undertake system manager functions per health service provider full time equivalent	$4,516	$5,905	$1,389

Voluntary Assisted Dying Act review

The *Voluntary Assisted Dying Act 2019* (the Act) was developed to ensure all Western Australians have access to safe, compassionate end of life care that aligns to their preferences and values.

In November 2024, the final report on the inaugural statutory review of the Act was tabled in Parliament. The Voluntary Assisted Dying (VAD) Review Panel considered the following terms of reference for the review:

1. effectiveness and the operation of the Act, as passed by the Parliament in 2019, in providing for and regulating access to VAD.
2. extent to which current processes provided under the Act are operating to support persons eligible for VAD in WA.

Feedback was not sought on whether VAD should be precluded or whether there should be changes to the eligibility criteria for patients or practitioners involved in the VAD process. These 2 issues were discussed exhaustively during the inquiries carried out by the Joint Select Committee on End of Life Choices and the Ministerial Expert Panel on VAD. These issues were then debated in Parliament and the decisions of Parliament made clear in the terms of the Act.

Review process

The first stage of the review involved a public online survey to identify key issues related to the Act and implementation of VAD. Targeted invitations were sent to health services, aged care providers, advocacy groups and priority stakeholders to ensure broad engagement.

In the second stage, the Australian Centre for Health Law and Research conducted in-depth interviews and focus groups to explore emerging themes. The VAD Review Panel also received written submissions and held meetings with subject matter experts to inform the review.

288 survey responses received

Top 3 interest groups

1. community members with a general interest in VAD
2. people who had someone close to them access VAD as their end of life choice
3. health professionals who had supported a patient accessing VAD

Findings and recommendations

The VAD Review Panel found:

- the Act is operating as intended in providing and regulating access to VAD for eligible people
- processes provided under the Act are generally operating well in supporting all those involved in providing and accessing VAD
- the Act, as passed by Parliament in 2019, does not require legislative amendment.

The panel also made 10 recommendations for implementation.

Summary of recommendations

Improve community and health professionals' knowledge and awareness of VAD*

Improve patients' and health practitioners' understanding of how to make and respond to VAD queries and First Requests*

Minimise potential harm caused by conscientious objection to VAD*

Optimise regional access to VAD through the Regional Access Support Scheme*

Advocate for amendment to the *Criminal Code Act 1995* to improve equity of access to VAD

Ensure appropriate VAD workforce resourcing*

Advocate for the Medicare Benefit Schedule to be amended to include items for VAD

Develop best practice resources for administration, storage, transport, and disposal of the prescribed substance*

Develop a model for working with interpreters and translators in VAD*

Improve understanding about sharing patient information whilst maintaining intended safeguards*

* Actions assigned to the Department of Health

Sustainable Health Review update

The Sustainable Health Review (SHR) remains the blueprint for a sustainable healthcare system, delivering significant reforms and establishing a strong foundation for continued transformation.

The SHR aims to enhance the delivery of high-quality, patient-centred health care. The SHR outlines 30 recommendations across the 8 key enduring strategy areas, focusing on improving access to services and delivering community care models, particularly for complex conditions and frequent users of health services. It also emphasises the need for cultural and structural changes within the health system to ensure sustainability and equity in health outcomes.

SHR priority focus area achievements for 2024–25

Improving timely access to outpatient services

- ✓ Central Referral Service expanded to the Pilbara region
- ✓ Referral Access Criteria implemented for respiratory and sleep medicine, hepatology, and immunology services
- ✓ Vendor contracts awarded to enable commencement of the delivery phase of the Smart Referrals WA project

Implementing models of care in the community for people with complex health and social care needs

- ✓ Expanded hospital substitution services, including Hospital in the Home
- ✓ Developed an Older Adult Care Hub model of care

Implementing a new funding model that is focused on quality and care for patients

- ✓ Developed a new demand and capacity model for resource allocation
- ✓ Completed an evaluation report for the Emergency Department Innovation Fund

Investing in digitising the WA health system

- ✓ Completed a systemwide Digital Maturity Capability Assessment
- ✓ Developed WA Health Artificial Intelligence (AI) Policy and Standards
- ✓ Progressed the delivery of Digital Medical Record to WA Health sites
- ✓ Progressed implementation of Single Sign-On for WA Health clinicians
- ✓ Approved Electronic Medical Record (EMR) Business Case
- ✓ Evaluated expressions of interest to deliver a statewide EMR solution
- ✓ Progressed the recruitment of EMR Chief Information Officers across specialties including medical, nursing and midwifery, allied health, health information management, and pharmacy to drive statewide delivery of the EMR

Creating a workforce culture of innovation and accountability

- ✓ Established a systemwide leadership hub for self-directed learning and development

Building workforce capability to shape the skills of future health personnel

- ✓ Released the *WA Health Workforce Strategy 2034* and implementation plan
- ✓ Developed the *WA Nursing and Midwifery Workforce Strategy 2025–2030*

"I find not having to continually input my password for clinical application to be a good time-saver."

Single Sign-On user, Osborne Park Hospital

Digital Medical Record system in use at Fiona Stanley Hospital

No Jab No Play status update

Rationale

Since 2019, WA's No Jab No Play legislation has required children to be up to date with immunisations to enrol into a child care service, community kindergarten or school. A child is considered up to date if they have received all vaccinations listed on the National Immunisation Schedule for their age.

There are a limited number of circumstances in which a child may be exempt from this requirement, and services are required to report these exempt children for follow-up.

Children who are not up to date are referred to local public health units for support, with families able to request assistance through the school or child care service regardless of their child's immunisation status.

Results

Of the 607 children who did not have an up-to-date immunisation status as reported in the 2023–24 reporting period, 342 (56.3 per cent) were recorded as up to date as of 2 July 2025.

In the 2024–25 reporting period, 635 children were reported by child care services (n=42), community kindergartens (n=9) and schools (n=584) as having an immunisation status of not up to date. As of 2 July 2025, the immunisation status of 440 (69.3 per cent) of these children was considered up to date, while a further 49 children (7.7 per cent) were on a catch-up schedule.

To enhance understanding of the legislation, in 2024–25 we delivered training to staff at public health units and provided additional information resources on reporting requirements to administrative staff at schools.

Table 8: Immunisation status of children who were not fully immunised by enrolment cohort, 2023–24 and 2024–25

Enrolment cohort	Reported as not up to date at enrolment	Immunisation status as at 2 July 2025			
		Up to date	On a catch-up schedule	Not up to date	Unable to find on Australian Immunisation Register
2023–24					
Children enrolled in childcare between 1 July 2023 and 30 June 2024	36	22	0	13	1
Children enrolled in pre-kindergarten and kindergarten between 1 January and 31 March 2024	571	320	1	185	65
Total	607	342	1	198	66
2024–25					
Children enrolled in childcare between 1 July 2024 and 30 June 2025	42	26	6	9	1
Children enrolled in pre-kindergarten and kindergarten between 1 January and 31 March 2025	593	414	43	50	86
Total	635	440	49	59	87

Notes:

1. Data is based on all children enrolled at long day care, family day care, pre-kindergarten and kindergarten.
2. Child care services are directed to report a child's immunisation status at the time of enrolment, while community kindergartens and schools are directed to report a student's immunisation status by the end of term 1 each year.
3. 'Unable to find on Australian Immunisation Register' includes children whose immunisation records are not visible to third parties.
4. Due to the time lag between reporting, data cleaning and follow up activity the immunisation status of both cohorts is considered final for 2023–24 and the findings are considered preliminary for 2024–25. Any changes to immunisation status of children reported in the 2024–25 period will be provided in the 2025–26 annual report.

Data sources: WA Department of Health database, Communicable Disease Control Directorate; Student Information System (SIS) Database, WA Department of Education; Australian Immunisation Register, Services Australia.

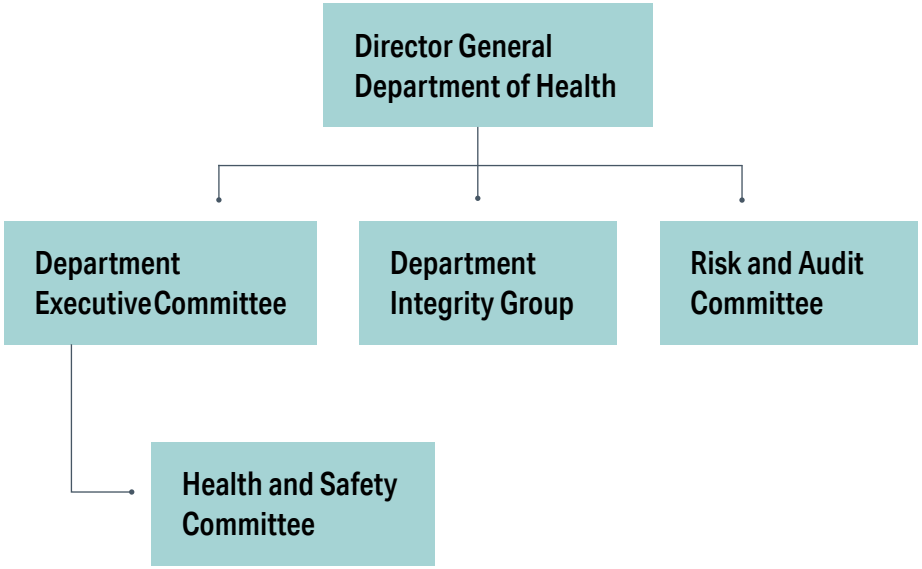
Operational disclosures

Internal governance

Governance oversight

Our governance structure ensures we execute our responsibilities in a coordinated, effective and efficient manner and assists the Director General to discharge her duties as Chief Executive Officer (CEO) of the department.

Figure 2: Department of Health internal governance structure



Department Executive Committee

The role of the Department Executive Committee (DEC) is to:

- enact strategic leadership to ensure a coordinated, effective and efficient approach to the execution of the department's responsibilities as a government agency
- assist the Director General in discharge of her responsibilities as department CEO and System Manager.

The following standalone committee reports to the DEC, as prescribed in its Terms of Reference.

Health and Safety Committee

The Health and Safety Committee facilitates cooperation between the department and staff to maintain and strengthen health, safety and wellbeing in accordance with the *Work Health and Safety Act 2020*.

In 2024–25, the committee focused on preventive health, wellbeing and safety initiatives that promote a safety culture to prevent incidents before they occur. This has included empowering our safety representatives to lead and promote proactive health and safety activities and integration of effort with our Health and Wellness Committee to ensure that health and wellness initiatives will support the department's broader Work Health and Safety strategy.

Planning for the development of a new Psychosocial Management Framework has been initiated and is being supported by the committee. This includes aligning committee activities with the framework's objectives and timelines.

Work has also been supported to improve how we conduct workplace inspections.

Department Integrity Group

The Department Integrity Group (DIG) supports the Director General, DEC and System-Wide Integrity Services to perform their functions and fulfil legislative obligations. This includes providing a coordinated and integrated approach to integrity risk management by overseeing integrity governance and capability for the department.

DIG members represent work areas or functions within the department considered of high risk to integrity, fraud and corruption and/or with responsibility for the prevention of misconduct, fraud and corruption.

In addition to monitoring reported integrity issues and trends DIG continues to provide oversight to ensure our Integrity Governance Framework is working as intended.
In 2024–25, the group:

- provided oversight of implementation of our Integrity Capability Strategic Plan
- contributed to an assessment of the maturity of our approach to integrity using the Public Sector Commission's Integrity Framework Maturity Self Assessment Tool
- contributed to a comprehensive assessment of our integrity, fraud and corruption risks.

Risk and Audit Committee

The independent Risk and Audit Committee provides systematic oversight of the department's governance, risk management and control practices.

Advice and guidance on the adequacy of governance and assurance is provided to the Director General to support achievement of strategic objectives and compliance with regulations, policies and other requirements including the expectations of customers, employees and the community.

The committee is composed of 4 external members (including the chair) and 2 senior leaders from the department. This representation ensures the committee's independence and affords broader access to the skill sets that enable the committee to effectively fulfil its role.

In 2024–25, the committee focused on monitoring the department's information security and cyber risk exposure. This included progress taken to address the Office of the Auditor General audit qualification in 2023–24 concerning our network security controls.
In addition, the committee focused on management of integrity and work health and safety risks, financial management, procurement controls, business continuity planning, and effectiveness of the department's regulatory functions.

Risk management and internal audit

We maintain an effective internal audit function, authorised by the Director General annually through our Internal Audit Charter. The charter describes how the internal audit team will operate. This includes measures to ensure their independence and objectivity, requiring adherence to Treasurer's Instructions and mandatory elements of The Institute of Internal Auditors' International Professional Practices Framework and consideration of relevant professional practice standards.

In 2024–25, 11 internal audits were conducted, focusing on financial controls relating to procurement, and regulatory oversight in areas including radiation, food, water and communicable disease control. Audit findings are reported to the Director General via the Risk and Audit Committee who provide an independent viewpoint on the department's risk management, control and governance processes. The internal audit team monitors progress of implementation of the recommendations made in internal audits.

To strengthen our risk culture, we expanded our quarterly reporting to provide a more comprehensive view of risk management activities to ensure alignment with our organisational objectives. As well as integrating strategic risks and an assurance schedule into our risk analytics dashboard, we established risk culture indicators to provide insights into risk awareness and management practices across the department.

Business Continuity Plan (BCP) tests were conducted this year, confirming critical functions, Maximum Tolerable Periods of Disruption, and continuity strategies. The testing also reinforced clarity in roles and responsibilities for BCP activation and escalation, while enhancing the Business Continuity Team's overall understanding of business continuity principles and processes.

Enquiries and complaints management

We welcome consumer enquiries and complaints as they provide opportunities to acknowledge and address issues to achieve positive outcomes.

Clear guidance is available on our website to support consumers in submitting enquiries and complaints via phone, letter, in person or online. Complaints are referred to the relevant departmental area or health service provider for a response. The Health and Disability Services Complaints Office provides an independent avenue for consumers to progress matters further if required, and advocacy services are also available to support consumers.

Complaints related to services provided by the department are managed in accordance with the WA Health Complaints Management Policy. In 2024–25, no complaints were reported for department-managed services.

Responses to enquiries and complaints received via the offices of our responsible ministers are coordinated by the department. In 2024–25, we received 315 ministerial requests referencing complaints requiring a response (see Table 9). These were received from the public, government representatives, and not-for-profit organisations.

Table 9: Ministerial complaints by allocated response area, 2022–23 to 2024–25

Response area	2022–23 (n=332)	2023–24 (n=302)	2024–25 (n=315)
Health service provider	68%	77%	74%
Department of Health	32%	23%	26%

Note: Where the ministerial is referred to more than one entity, the first referral entity is counted.

Employee disclosures

Employment profile

As at end June 2025, the department employed 1,444 full-time equivalent (FTE) employees (see Table 10). Compared to 2023–24 a 16 per cent increase in FTE was observed, primarily associated with an increase in both permanent and contract full-time employees.

Table 10: Total full-time equivalent by category, 2023–24 to 2024–25

Category	2023–24	2024–25
Full-time permanent	684	783
Full-time contract	224	312
Part-time measured as full-time equivalent	240	262
Secondment in	48	48
Secondment out	2	1
Other	46	38
Total	**1,244**	**1,444**

Notes:

1. Data extracted on 9 July 2025.
2. The total of full-time equivalent employees was calculated as the monthly average full-time equivalent employees and is the average hours worked during a period of time divided by the Award full-time hours for the same period. Hours include ordinary time, overtime, all leave categories, public holidays, time off in lieu and workers' compensation.
3. Full-time equivalent employee figures provided are based on actual (paid) month-to-date, full-time equivalent employees.
4. Excludes FTE employed under the Health Services Union award.
5. Total secondment-out FTE are to be viewed with caution due to data capture limitations in the Human Resource Data Warehouse.
6. The Other category includes casuals, agency and sessional employees.

Data Source: Human Resource Data Warehouse, Department of Health.

Industrial relations

We are responsible for managing industrial relations matters that have systemwide impact, including the maintenance and modernisation of WA Health-specific industrial instruments. This involves negotiation, monitoring and evaluation of industrial agreements and subsidiary agreements, and management of award amendments.

In 2024–25, replacement agreements covering salaried officers, medical practitioners, enrolled nurses, hospital support workers and registered nurses were finalised and registered with the WA Industrial Relations Commission. These 5 agreements cover more than 99 per cent of WA Health's workforce.

Negotiations also commenced for replacement agreements covering the 4 remaining cohorts: dental officers, dental technicians, engineering and building services, and clinical academics. These negotiations will continue into 2025–26.

Delivery of key reforms committed to during industrial negotiations is in progress, including review of industrial provisions and current practices for the delivery of telehealth services, enhancement of career pathways for medical practitioners, and initiatives to improve job security for hospital support workers.

Staff development

Details of staff learning and development activities are provided in the Our people section of this report.

Work health, safety and injury management

We are committed to ensuring the health, safety and wellbeing of our staff, and to assisting employees with work-related injuries to return to work as soon as is medically appropriate.

Details of our recent work health and safety activities, including our new approach to injury management, are provided in the Our people section of this report.

Workers' compensation

The worker's compensation scheme in WA is regulated and administered by WorkCover WA. In 2024–25, a total of 5 workers compensation claims were made, an increase from 4 in 2023–24.

Work health and safety performance

Annual public sector performance reporting in relation to work health and safety and injury management is summarised in Table 11.

Table 11: Work health and safety performance, 2022–23 to 2024–25

Measure	Target	Actual performance			Performance against target
		2022–23 (base year)	2023–24	2024–25	
Number of fatalities	0	0	0	0	Achieved
Lost time injury and disease incidence rate (LTI/D per 100 FTE)	0 or 10% reduction	0.56	0.08	0.14	Not achieved
Lost time injury and severity rate[1]	0 or 10% reduction	57	0	50	Not achieved
Percentage of injured workers returned to work:[2,3]					
(i) within 13 weeks	≥80%	66%	50%	100%	Achieved
(ii) within 26 weeks	≥80%	66%	100%	100%	Achieved
Percentage of managers trained in work health and safety and injury management[4]	≥80%	83%	72%	62%	Not achieved

Notes:

1. There were 2 lost time injuries in 2024–25, one of which was severe.
2. Injured workers returned to work are reported by calendar year (2022, 2023, 2024) to ensure complete reporting (i.e. 26 weeks have passed since injury date). There was one lost time injury in 2024 with return to work within 13 weeks.
3. Due to the small number of staff with lost time injuries per year, caution should be taken when comparing with base year performance.
4. Includes refresher training within 3 years.

Following a review of our current training program, we are transitioning from a single 5 hour session to 3 separate 2 hour modules. This change aims to improve attendance by reducing scheduling barriers, increasing compliance.

Aligned to our WA Health Work Health and Safety Management Policy and Operational Framework, we have strengthened our oversight of workplace inspections and reported hazards and incidents, including notifiable incidents reportable to WorkSafeWA. This has included the introduction of enhanced monitoring and reporting to inform our work health and safety practices (see Table 12).

Table 12: Hazard and incident measures, 2021–22 to 2024–25

Measure	2021–22 (base year)	2022–23	2023–24	2024–25
Number of hazard reports lodged	10	28	42	42
Number of incidents reported	55	55	56	35
Number of notifiable incidents reported	2	9	3	1
Percentage of workplace inspections undertaken on schedule	81%	78%	84%	83%

In 2024–25, 83 per cent of workplace inspections were undertaken on schedule, comparable with prior year results. With respect to the number of hazard reports lodged over the past 2 years we have seen a notable increase. This may be partly associated with the establishment of a workplace inspections register to record hazards and track completion of corrective actions in 2023–24.

Overall incident numbers decreased in 2024–25 in line with fewer incidents related to biological factors. However, an increase in the number of incidents related to mental stress has occurred between 2022–23 and 2024–25. In response, we have incorporated psychosocial management in our work health and safety training program and we are planning the development of a new psychosocial management framework.

Compliance reporting

Compliance with Commissioner's Instructions and Public Sector Standards

Our staff are responsible for acting ethically, ensuring their behaviour reflects the standards set by the WA Health Code of Conduct.

To ensure compliance with Commissioner's Instruction 40: Ethical Foundations, we promote understanding and compliance with expected standards of workplace behaviour by communicating with staff in a variety of ways. New staff are required to acknowledge the WA Health Code of Conduct as a part of their offer of employment, and further education is provided as part of induction and through mandatory Code of Conduct eLearning. We also require all staff complete Code of Conduct refresher training every 2 years. In 2024–25, 98 per cent of our staff had completed a form of Code of Conduct training, and 92 per cent of eligible staff were up to date with refresher training.

In addition, expectations for workplace behaviour and conduct are embedded within relevant policy documents and processes and are continuously reinforced through online and face-to-face learning, including new integrity training for managers, and through promotion on our intranet site and via scheduled news articles and emails.

A dedicated Integrity Advisory Line and email address are provided for staff queries and advice concerning integrity matters including reporting alleged non-compliant behavior. All complaints are reviewed and investigated in accordance with our Discipline Policy.

During 2024–25, 16 new misconduct matters were raised and 4 matters were carried over from 2023–24. Following internal investigation, 18 matters were finalised, of which 3 resulted in a finding of misconduct, and 2 matters are ongoing.

Assessment and monitoring of compliance with the Public Sector Code of Ethics and WA Health Code of Conduct occurs through review of training completion rates, employee declarations of conflicts of interest and offered gifts or benefits, and as a part of case management of misconduct and disciplinary matters. Integrity reporting is managed through the Department Integrity Group.

To ensure compliance with Commissioner's Instructions as they relate to the business of the department, and the wider WA health system where applicable, we rely on our strong policies, processes and procedures, as well as consultancy support from subject matter experts and dedicated business units.

We are committed to maintaining human resource practices that meet the standards of merit, equity and probity as required by the Public Sector Standards in Human Resource Management and the requirements of applicable Commissioner's Instructions. To ensure this we:

- maintain a classification policy and classification review committee to ensure appropriate classification and remuneration of positions and individuals
- facilitate regular face-to-face recruitment training and ensure a suite of templates, checklists and guidance is available on the intranet that support compliance with and navigation of the WA Health Recruitment Selection and Appointment policy
- verify executive salary expenditure and appointments on a monthly basis, supporting appropriate financial classification management and remuneration
- maintain effective policy documents and processes for performance development, grievance resolution and cessation of employment that comply with the relevant Standards
- provide consultancy support as required for the implementation of Public Sector Standards in Human Resource Management and Commissioner's Instructions.

Information about breach of standard claim processes is openly available to staff on our intranet. All breach of standards claims are reviewed and investigated with reasonable attempts made to resolve them prior to referral to the Public Sector Commission. Each claim is recorded in an internal database to allow monitoring, assessment and reporting of overall compliance with the standards.

In 2024–25, we received 4 claims related to the Employment Standard but all were withdrawn during the internal resolution period. We managed 15 claims related to the Grievance Resolution Standard, 11 new and 4 carried over from 2023–24. Of these, one was withdrawn, 12 were resolved internally, and 2 remain active, pending internal resolution.

These processes and outcomes demonstrate our high degree of compliance with the Public Sector Standards.

Compliance with public sector policy

Implementing our Multicultural Plan

Implementation of our *Multicultural Action Plan 2024–2028* has focused this year on building staff confidence to contribute to a more inclusive workplace for colleagues from culturally and linguistically diverse (CaLD) backgrounds.

Key initiatives included the roll-out of new diversity and inclusion confidence training for all staff that addresses unconscious bias and provides strategies for how to engage with different cultural and religious groups. We also expanded the content in our recruitment training for hiring managers relating to use of Commissioner's Instruction 39 to fill vacancies in accordance with provisions of the *Equal Opportunity Act 1984*.

- For more information refer to the Our People section of this report.

Our Diversity and Inclusion Reference Group also continues to focus on developing communications to staff acknowledging cultural days of significance, including:

- International Mother Language Day
- Ramadan celebrations
- Harmony Week.

We are increasing our capability to capture the voices of CaLD staff with recent modifications to our exit survey that include additional diversity metrics, including the ability to identify trends using demographic data. Additional questions have been added to more accurately measure if a person's age, ethnicity, disability, gender, or sexual identity is a source of discrimination or bias. Further refinement of our diversity and inclusion analytics dashboard now provides greater visibility of CaLD workforce trend data. Progress in relation to workforce diversification targets are regularly reported to divisions and the Department Executive Committee.

Harmony Week

Disability Access and Inclusion Plan

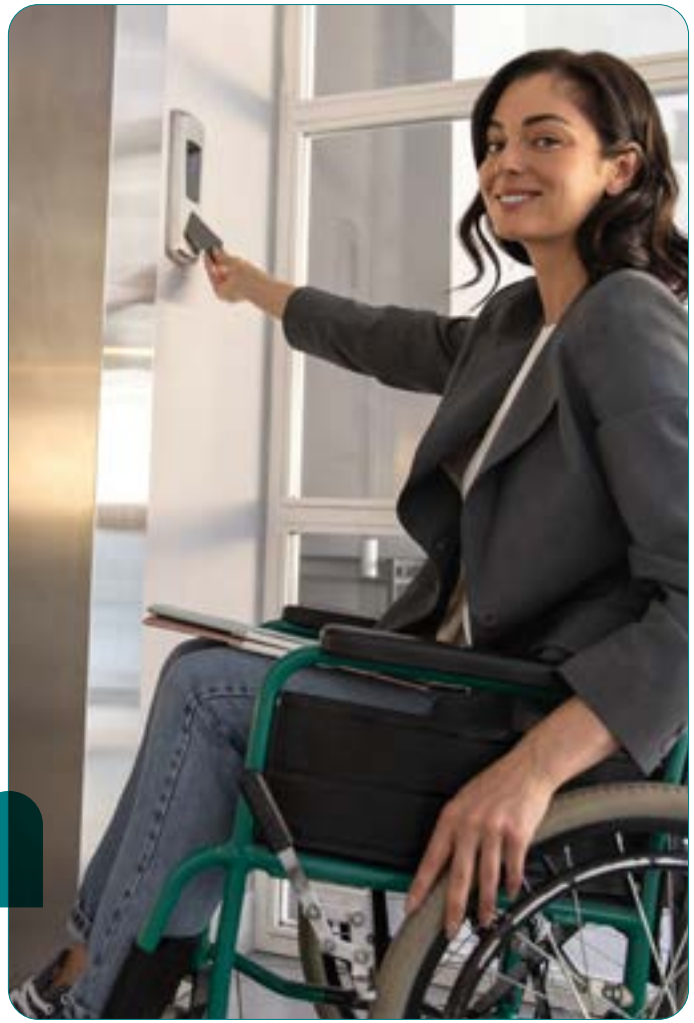
Our *Disability Access and Inclusion Plan 2020–2025* outlines the actions we will take to support people with disability to access services provided by the department in a way that promotes their independence, opportunities and participation in the workplace and community.

The annual Staff with Disability and Allies' Network Conference showcased our commitment to inclusive event design. The venue offered optimal physical accessibility, priority seating for people with vision and hearing requirements, sensory accommodations for neurodiverse staff, and a quiet room for self-regulation.

In 2024–25 we expanded our partnership with our disability employment provider to support hiring managers with recruitment advice, candidate shortlisting and screening, and promotion of vacancies. These services are integrated into recruitment training and online resources. We also promoted the Public Sector Commission Guide for Hiring People With Disability as part of a broader suite of diversity and inclusion tools promoted via our intranet.

Department-funded health programs continue to enable participation by people with disability through online platforms, Easy Read resources and visual messaging. Our public consultation platform includes immersive reader functionality and is accessible across desktop and mobile devices.

WA health service providers and non-government contracted community health service providers report achievements and progress towards disability access and inclusion outcomes on an annual basis as a requirement of their service agreements.



Substantive equality

We are committed to identifying and addressing any institutional barriers to health care that exist for different people and groups in the community, and to avoid the creation of inequalities when developing and implementing health policies, programs, and services. Specific achievements in 2024–25 that support the goal of substantive equality include:

- Commencing implementation of the Health Equity Impact Statement and Declaration Policy to provide oversight on how the health system is improving access and equity for consumers and carers from priority groups.
- Promoting our Working with Consumers and Carers Toolkit and Paid Participation in Engagement Policy through targeted information sessions and broader project management training for staff.
- Releasing the *Genetic Health WA Service Plan 2025–2030* that includes specific actions to improve provision of culturally appropriate care and equity of access to genomic services.
- Adding questions to the inpatient information system to inform care for people from CaLD backgrounds by capturing ancestry/ethnicity and main languages spoken at home.
- Testing additional questions in the MySay survey related to experiences of discrimination, including validation with Aboriginal health consumers.
- Updating the language services eModule to include information about briefing and debriefing interpreters and making the training mandatory for onboarding staff at the department, Child and Adolescent Health Service and WA Country Health Service.
- Updating the Multicultural Health Services Directory to ensure up-to-date information and improving online content for ease of access, including addition of a new section for pregnancy and childbirth
- Distributing fact sheets to Humanitarian Settlement Providers and health service providers about free health services for those who arrived in WA as displaced persons or are currently on bridging visas awaiting their claim for asylum
- Continuing to translate written information into languages other than English, including resources relating to the WA Newborn Bloodspot Screening Program, Voluntary Assistance Dying, and Advanced Care Planning.

Recordkeeping

Our recordkeeping plan outlines the records that are to be created by staff, and how they are to be kept, in accordance with State Records Commission standards.

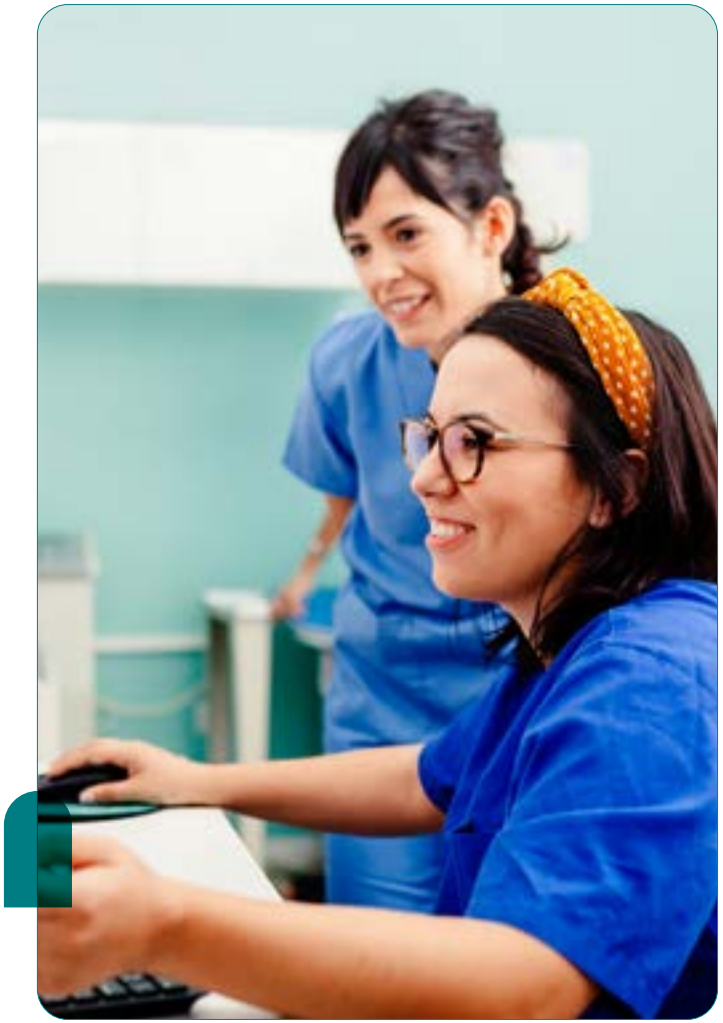
In 2024–25 our electronic document and records management system (EDRMS) was upgraded. This enhancement will strengthen protection of the confidentiality, integrity, and privacy of our information, reducing our cyber security risk profile.

To ensure staff understand their roles and responsibilities and are supported to carry these out, Recordkeeping Awareness Training (RAT) and the Content Manager (EDRMS) eLearning course are included in our mandatory induction program. Recordkeeping and use of information is also included as a stand-alone module in our code of conduct training.

To further support staff we make available:

- helpdesk support and advice
- ad-hoc training that can be tailored to suit individual needs as well as multidisciplinary, divisional, or business unit audiences
- an online suite of self-help guides
- regular communications on records management topics.

Routine monitoring, audit, and evaluation are conducted concerning record management compliance. This includes an annual staff survey to assess knowledge and practices concerning administration of records. A live dashboard also assists our records management team to monitor EDRMS usage, maintain the integrity and security of our records, and track training completion rates.



Freedom of information

The WA *Freedom of Information Act 1992* provides the public with the right to access information held by the department.

Members of the public can access various types of information from our website. Hard copy documents are available at zero or nominal cost by contacting our Freedom of Information Coordinator on (08) 9222 6411 or via email.

Requests for access to information not publicly available may be made through a Freedom of Information application. This involves lodging a written request via email, post or in person. An application form is available to support this process via the Freedom of Information page on our website. Further advice and assistance to apply for information can also be sought via our Freedom of Information Coordinator.

A WA Health freedom of information contacts list is available to provide contact points within the WA health system for requests that relate to public hospital or health service provider information and records.

Requests for information access can be granted, partially granted or may be refused in accordance with the *Freedom of Information Act 1992*. We addressed a total of 62 applications in 2024–25 of which one was transferred to another agency and 6 are in progress. This is slightly more applications than 2023–24 (n=49) but comparable to 2022–23 (n=59).

As at 30 June 2025, 55 applications were finalised (see Table 13).

Table 13: Summary of freedom of information request outcomes, 2024–25

Summary of action	Number
Applications granted – full access	21
Applications granted – partial or edited access	3
Applications withdrawn by applicant	19
Applications refused[1]	12
Total applications[2]	**55**

Notes:

1. Includes 9 matters where no records were found and 3 matters where the documents were exempt from release.
2. Includes one matter carried over from 2023–24.

Key performance indicators

Certification of key performance indicators

Department of Health

Certification of key performance indicators

For the financial year ended 30 June 25

I hereby certify that the key performance indicators are based on proper records, are relevant and appropriate for assisting users to assess the Department of Health's performance, and fairly represent the performance of the Department of Health for the financial year ended 30 June 2025.

Dr Shirley Bowen

Director General
Department of Health
Accountable Authority

18 September 2025

Key performance indicators

Key performance indicators (KPI) assist the department to assess and monitor achievement of the outcomes outlined in the Outcome Based Management Framework (see Table 14).

Table 14: Key performance indicators reported by the department

WA health system desired outcomes	Measuring effectiveness	Services	Measuring efficiency
Outcome 2 **Prevention, health promotion and aged and continuing care services that help Western Australians to live healthy and safe lives**	1. Percentage of transition care clients whose functional ability was either maintained or improved during their utilisation of the Transition Care Programme 2. Percentage of people accessing specialist community-based palliative care who are supported to die at home 3. Potential years of life lost for selected common causes of premature death:(a) Lung cancer; (b) Ischaemic heart disease; (c) Malignant skin cancers; (d) Breast cancer; (e) Bowel cancer 4. Percentage of fully immunised children: (a) 12 months; (b) 2 years; (c) 5 years 5. Percentage of 15 year olds in Western Australia vaccinated for HPV 6. Response times for emergency road-based ambulance services (Percentage of priority 1 calls attended to within 15 minutes in the metropolitan area)	**5. Aged care, continuing care and end of life care services**	Aged and continuing care services 1. Average cost of a transition care day provided by contracted non-government organisations/service providers 2. Average cost per: (a) home-based hospital day of care and (b) occasion of service 3. Average cost per day of non-acute bed-based continuing support 4. Average cost to support patients who suffer specific chronic illness and other clients who require continuing care Palliative and cancer care services 5. Average cost per client receiving contracted palliative care services

Table 14: Key performance indicators reported by the department

WA health system desired outcomes	Measuring effectiveness	Services	Measuring efficiency
Outcome 2 **Prevention, health promotion and aged and continuing care services that help Western Australians to live healthy and safe lives**		**6. Public and community health services**	Public health services 6. Cost per person of providing preventive interventions, health promotion and health protection activities that reduce the incidence of disease or injury Patient transport services 7. Cost per trip for road-based patient transport services, based on the total accrued costs of these services for the total number of trips
Outcome 3 **Strategic leadership, planning and support services that enable a safe, high quality and sustainable WA health system**	7. Proportion of stakeholders who indicate the Department of Health to be meeting or exceeding expectations of the delivery of system manager functions	**10. Health System management – policy and corporate services**	Policy services 8. Average cost of public health regulatory services per head of population 9. Average cost for the Department of Health to undertake system manager functions per health service provider full time equivalent

Actual KPI results are reported against targets to help assess the effectiveness of performance against desired outcomes and the efficiency of service delivery. KPI actuals may vary to the target and, depending on the KPI, a positive or negative variance may represent achievement of the desired result.

A result of plus or minus 10 per cent from the target indicates a material variance requiring an explanation.

To aid with understanding, the following colour coding has been applied to the results for the reporting period.

- Indicates the target was achieved
- Indicates the result is within 10 per cent of the target
- Indicates the result is greater than 10 per cent from the target

Key effectiveness performance indicators

Outcome 2

Percentage of transition care clients whose functional ability was either maintained or improved during their utilisation of the Transition Care Programme

Rationale

The Transition Care Programme[13] is a joint federal, state and territory initiative that aims to optimise the functioning and independence of eligible clients after a hospital stay and enable them to return home or allow time to make decisions on longer term care arrangements, including residential care.

The Transition Care Programme services take place in either a residential or a community setting, including a client's home. A number of care options are available, designed to be flexible in helping meet individual needs. Services may include:

- case management, including establishing community support and services, and where required, identifying residential care options
- medical services provided by a general practitioner
- low intensity therapy such as physiotherapy and occupational therapy
- emotional support and future care planning via a social worker
- nursing support
- personal care
- domestic help
- other therapies as required.

This indicator measures the effectiveness of the Transition Care Programme by measuring functional ability improvements in clients utilising the program. Monitoring the success of this indicator can enable improvements in service planning and the development of targeted strategies and interventions that focus on improving the program's effectiveness and ensuring the provision of the most appropriate care to those in need. This enhances the health and wellbeing of Western Australians.

Target

The 2024–25 target for the percentage of clients maintaining or improving functional ability is 82 per cent or above.

Improved or maintained performance is demonstrated by a result equal to or above the target.

Results

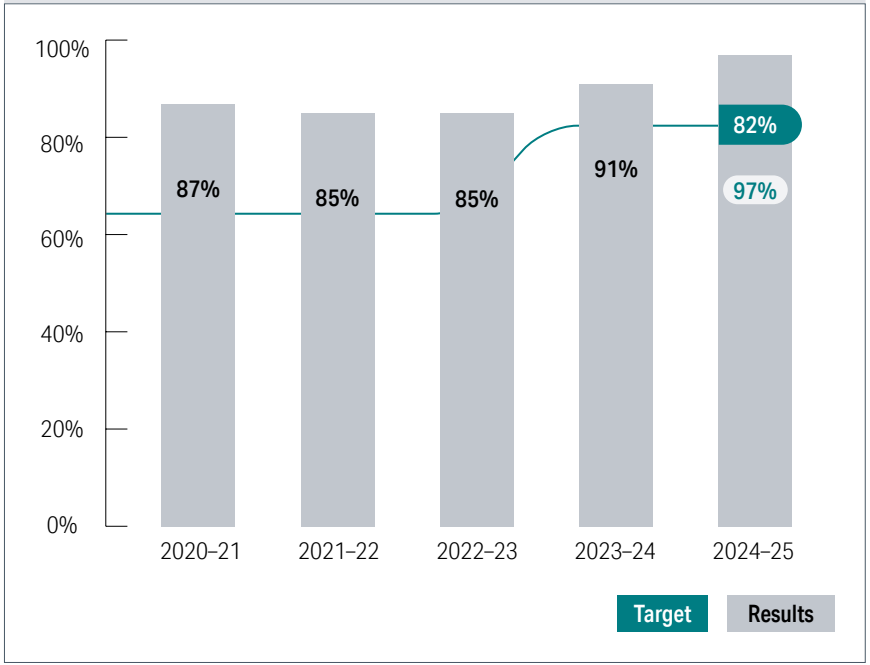
In 2024–25, the percentage of transition care clients maintaining or improving functional ability was 97 per cent, exceeding the target of 82 per cent (see Figure 3).

This year we saw an increase in clients accessing the Transition Care Programme via our new service providers as they became fully operational, with an average of 97 per cent of clients demonstrating maintained or improved functional ability at the time of discharge.

Also, through the implementation of revised contract arrangements with existing service providers client focused functionality assessment programs and more therapy hours for clients were introduced. This has resulted in a significantly greater proportion of clients demonstrating maintained or improved functional ability.

[13] https://www.health.gov.au/initiatives-and-programs/transition-care-programme

Figure 3: Percentage of transition care clients whose functional ability was either maintained or improved during their utilisation of the Transition Care Programme, 2020–21 to 2024–25



Notes:

1. The Modified Barthel Index (MBI) is widely used as a tool to assess client self-care and mobility activities of daily living. This indicator compares MBI admission and discharge results and determines the proportion of clients who demonstrate maintained or improved functional ability due to utilisation of the Transition Care Programme.
2. From 2023–24 onwards:
   a. the target was calculated on the average of prior year results from 2017–18 to 2021–22.
   b. clients with a discharge code of 'deceased' were excluded from the calculation of the KPI.

Data source: Transition Care Programme database, Department of Health.

Outcome 2

Percentage of people accessing specialist community-based palliative care who are supported to die at home

Rationale

The preference of the majority of Australians to die in their home and not in a hospital has been well documented. While between 60 and 70 per cent of people state they want to die at home, only about 14 per cent do so.[14] In addition to potential distress for patients and families, acute hospital admissions in some patients' final days of life may create avoidable pressures on the hospital system. This is likely to become an increasingly significant issue as the population ages and as an increasing proportion of people live with chronic disease.

The department contracts Silver Chain to provide specialist community-based palliative care services in the Perth metropolitan area.

This indicator aims to measure the effectiveness of these services in allowing patients to die in the comfort of their home, where it is their wish to do so. A high proportion of people realising their wish to die at home indicates that the service has appropriate strategies in place to provide in-home care appropriate to patients' needs and to avoid unplanned hospital admissions.

Target

The 2024–25 target for the percentage of people accessing community-based palliative care who opted to die at home, and who were supported to die at home, is 76 per cent or above.

Improved or maintained performance is demonstrated by a result equal to or above the target.

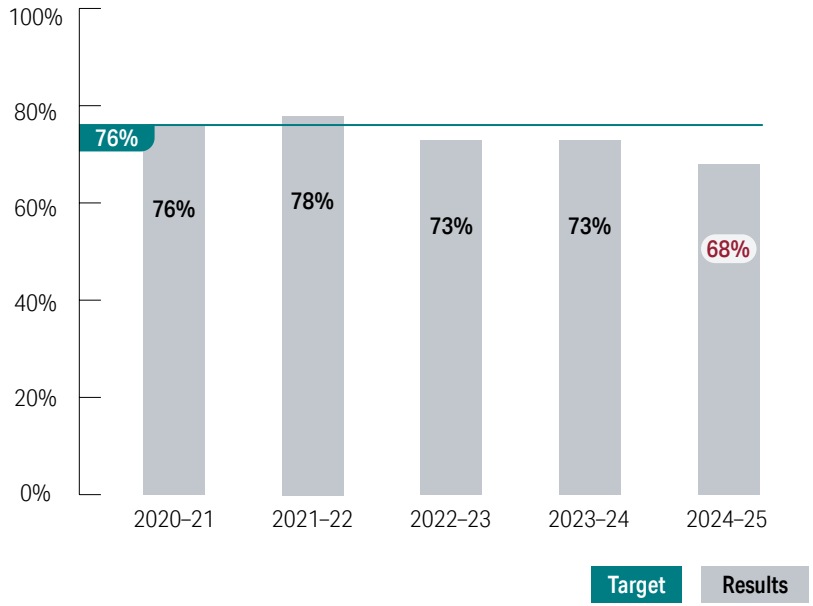
[14] Dying Well, Grattan Institute Report No. 2014-10, September 2014, 2. Available from: http://grattan.edu.au/wpcontent/uploads/2014/09/815-dying-well.pdf

Results

In 2024–25, 68 per cent of clients requiring end-of-life care who opted to die at home were supported to do so through the provision of in-home specialist palliative care (see Figure 4). This result is below the target and prior year results.

The ability to achieve the target to support clients to receive community-based palliative care so they may die at home may be impacted by the availability of specialist programs for clients with complex care requirements and the level of family/carer support. A client's care needs and/or preference may also change at any point in time during their care journey such that they may choose other options for care such as specialist palliative care in a hospital or palliative care facility.

Figure 4: Percentage of people accessing specialist community-based palliative care who opted to die at home and who were supported to die at home, 2020–21 to 2024–25



Notes:

1. There is currently no national target for this indicator. The current target is based on an average of prior year results reviewed and approved by subject matter experts in 2024–25.
2. Specialist community-based palliative care refers to palliative care that is provided by a multidisciplinary team within a private residence (i.e. 'in-home' care), but not a residential care facility.
3. The calculation of this indicator is based on:
   a. People living in the Perth metropolitan area who have an active, progressive and advanced disease, who require access to specialist palliative care services.
   b. Access to services where a medical opinion has been obtained resulting in the client being referred for specialist palliative care.
   c. People who accessed the community palliative care service provided by Silver Chain and who died at home after nominating this as their desired place of death.
4. There are some community-based palliative care services provided outside of the metropolitan area; however, this activity data is not available within the Non-Admitted Data Collection system used to source data for calculation of this KPI.
5. In 2024–25, the data source for this KPI was changed from an SAS-based dataset called the Non-Admitted Patient Activity and Wait List (NAPAAWL) to an SQL based dataset now known as the Non-Admitted Data Collection (NADC). Some small non-material differences between these datasets were identified as a result of a concurrent data quality improvement project. Therefore, comparison of the 2024–25 results to prior years is applicable.

Data source: Non-Admitted Data Collection, Department of Health.

Outcome 2

Potential years of life lost for selected common causes of premature death: (a) Lung cancer; (b) Ischaemic heart disease; (c) Malignant skin cancers; (d) Breast cancer; (e) Bowel cancer

Rationale

This indicator measures the rate of potential years of life lost for selected common causes of premature death. The WA health system aims to reduce the loss of life from health conditions that are potentially preventable and/or treatable by facilitating improvements in health behaviours and environments, and through early detection and disease management.

The rates of potential years of life lost from premature death are measured for lung cancer, ischaemic heart disease, malignant skin cancer, breast cancer (females only) and bowel cancer.

These conditions contribute significantly to the fatal burden of disease within the community. The department contributes to preventive health via early detection and health promotion and prevention activities which encourage healthy environments, communities and behaviours to reduce the risk of developing these conditions. The department also supports self-management programs to aid those living with these conditions to prevent, delay or minimise the effects and progression of the disease.

Results from this key performance indicator enable the department to monitor the effectiveness of health promotion, prevention and early intervention activities that in turn contribute to a reduction in premature deaths due to these preventable and treatable conditions.

Target

The 2023 target for each selected common cause of premature death is based on the 2022 National Person Years of Life Lost per 1,000 population.

Common causes of premature death	Target (in years)
(a) Lung cancer	**1.4**
(b) Ischaemic heart disease	**2.3**
(c) Malignant skin cancers	**0.3**
(d) Breast cancer (females only)	**1.7**
(e) Bowel cancer	**1.1**

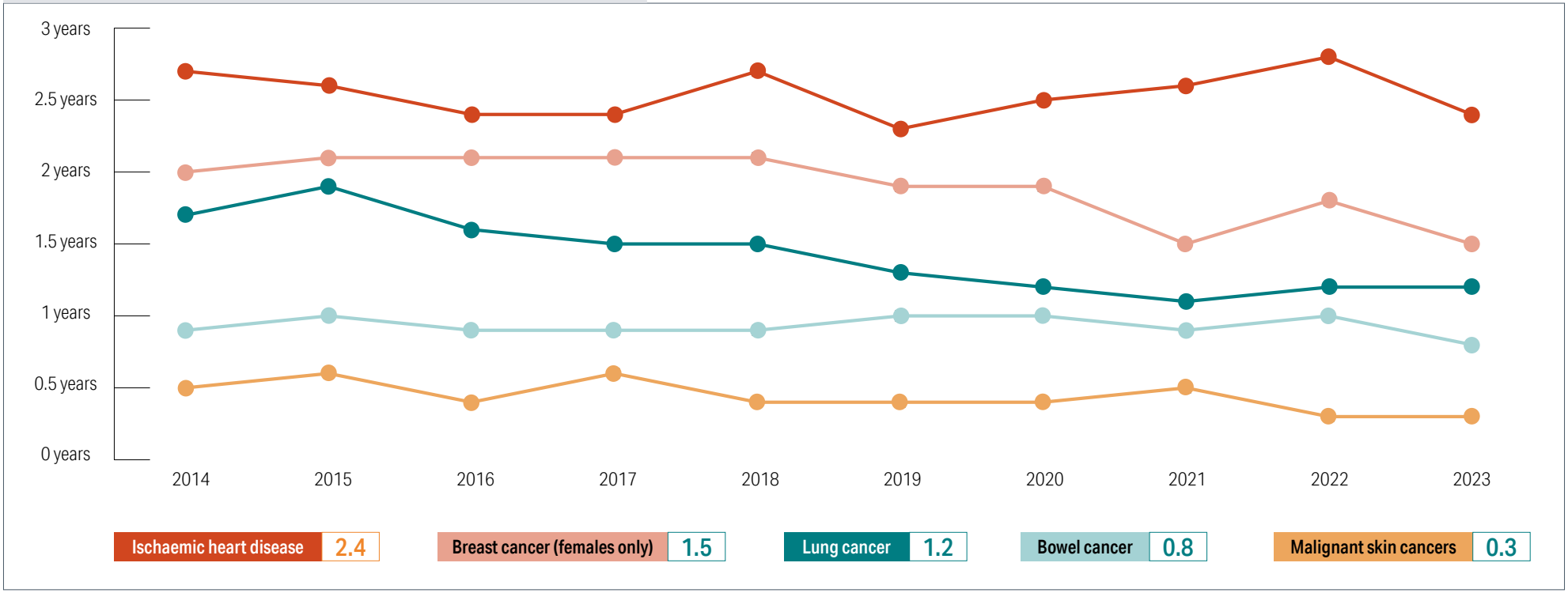
Improved or maintained performance is demonstrated by a result below or equal to the target.

Results

In 2023, the result for potential years of life lost due to cancer of the lung, breast and bowel were below set targets, and potential years of life lost due to malignant skin cancers met the target. The potential years of life lost due to ischaemic heart disease was 2.4, exceeding the target of 2.3 (see Figure 5).

Potential years of life lost due to cancer of the lung and breast have consistently been below target annually with a notable decline seen since 2019. For malignant skin cancers the target has been maintained with a slight decline noted since 2022.

Figure 5: Person years of life lost for selected common causes of premature death, 2014 to 2023



Notes:

1. Age-standardised Person Years of Life Lost (PYLL) per 1,000 population.
2. Deaths for 2014 to 2021 are final, deaths for 2022 are revised, and deaths for 2023 are preliminary.
3. The following ICD 10 codes were used:
   a. Lung cancer C33.0 to C34.9
   b. Ischaemic heart disease I20.0 to I25.9
   c. Malignant skin cancers C43.0 to C44.9
   d. Breast cancer C50.0 to C50.9 (females only)
   e. Bowel cancer C18.0 to C21.8 and C26.0.
4. Targets are based on national figures from the most recent revised National PYLL/1,000 population estimates, derived from data provided by the Australian Bureau of Statistics.
5. Minor methodological improvements and updates to death data mean that figures are not directly comparable with previous annual reports.
6. In 2024–25, the title of this key performance indicator was amended. The former title was 'Potential years of life lost for selected common causes of premature death: (a) Lung cancer; (b) Ischaemic heart disease; (c) Malignant skin cancers; (d) Breast cancer *and* (e) Bowel cancer'.

Data sources: Mortality database; Estimated resident population based on Australian Bureau of Statistics data, Epidemiology Directorate, Department of Health.

Outcome 2

Percentage of fully immunised children (a) 12 months; (b) 2 years; (c) 5 years

Rationale

In accordance with the Essential Vaccines Schedule of the Federation Funding Agreement – Health (EVS), the WA health system aims to minimise the incidence of major vaccine preventable diseases in Australia by sustaining high levels of immunisation coverage across WA, with equity of access to vaccines and immunisation services.

Immunisation is a simple, safe and effective way of protecting people against harmful diseases before they come into contact with them in the community. Immunisation not only protects individuals, but also others in the community, by reducing the spread of disease. Without access to immunisation, the consequences of illness are likely to be more disabling and more likely to contribute to a premature death.

This indicator measures the percentage of fully immunised children that have received age-appropriate immunisations in order to facilitate the effectiveness of strategies that aim to reduce the overall incidence of potentially serious disease.

Target

The target for children fully immunised at 12 months, 2 years, and 5 years of age is 95 per cent or above, based on the national aspirational immunisation coverage target.[15] Improved or maintained performance is demonstrated by a result equal to or above the target.

Results

In 2024, 90.5 per cent of children in WA had received all recommended vaccines at 12 months, 2 years, and 5 years of age (see Table 15). This is below the immunisation coverage target of 95 per cent and continues a slight downward trend from 2020.

Children at 2 years were found to have the lowest rates of immunisation (88.2 per cent) statewide. Immunisation coverage for children aged 12 months and 2 years were lower among Aboriginal children in both metropolitan and country WA. However, at 5 years vaccine coverage was comparable for both Aboriginal and non-Aboriginal children at 92.5 per cent and 92.2 per cent respectively (see Figure 6).

Our results are reflective of the national trend concerning declines in vaccination coverage in children relative to pre-pandemic peaks. Factors contributing to these ongoing declines are complex and variable but include both vaccine acceptance and access issues.

Expanding the provision of immunisation programs using mechanisms such as Structured Administration and Supply Arrangements (SASAs) will enable nurses, Aboriginal health practitioners, and pharmacists to play a larger role in vaccination delivery and increase access to vaccination.

Also, our priority is to enhance the physical, informational, language and cultural accessibility of immunisation services and specialist immunisation clinics to ensure readily accessible vaccines, as well as to co-design evidence-based initiatives with communities to address barriers and leverage key enablers for immunisation.

[15]The national aspirational immunisation coverage target has been set at 95%. Available from: https://federalfinancialrelations.gov.au/agreements/essential-vaccines. This is reflected in the National Immunisation Strategy for Australia 2025–2030.

Figure 6: Percentage of children fully immunised at 12 months, 2 years, and 5 years of age, 2024

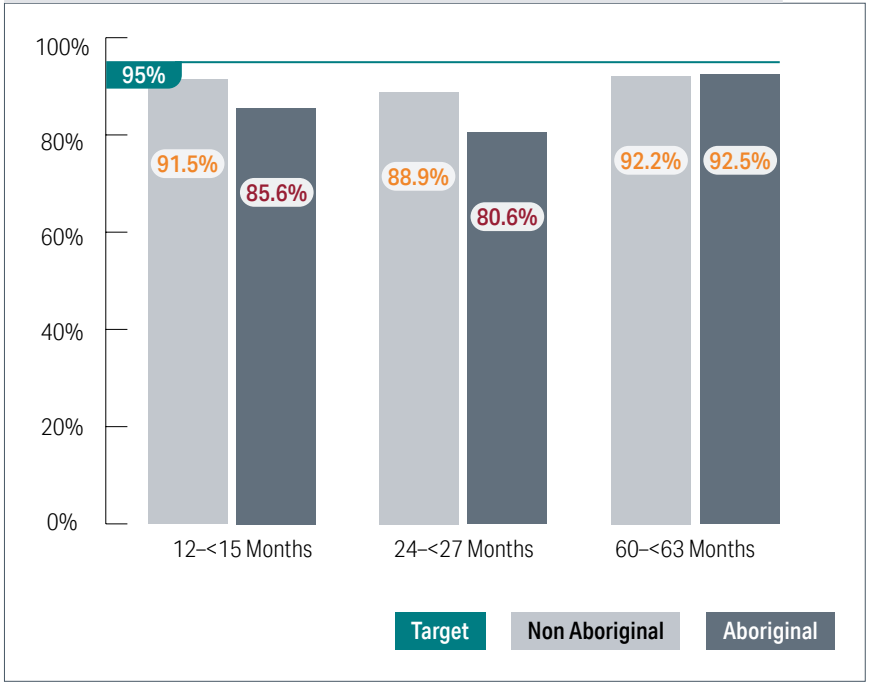


Table 15: Percentage of children fully immunised, by selected age cohort, location and Aboriginality, 2020 to 2024

Children fully immunised		2020	2021	2022	2023	2024	Target
Total of all children (12 months; 2 years; 5 years) (%)		93.5	93.1	92.4	91.5	90.5	≥95.0
12 months (%)							
					Total	91.0	≥95.0
State	Aboriginal	89.2	87.0	86.6	84.9	85.6	
	Non-Aboriginal	94.8	94.5	93.8	92.3	91.5	
Metropolitan	Aboriginal	86.5	86.8	88.0	84.7	85.8	
	Non-Aboriginal	94.9	94.8	94.0	92.8	91.9	
Country	Aboriginal	92.2	87.3	85.1	85.1	85.3	
	Non-Aboriginal	94.6	92.9	93.1	90.3	89.6	
2 years (%)							
					Total	88.2	≥95.0
State	Aboriginal	87.1	85.7	81.2	82.1	80.6	
	Non-Aboriginal	92.2	92.3	91.3	90.6	88.9	
Metropolitan	Aboriginal	86.7	84.7	82.2	83.6	81.2	
	Non-Aboriginal	92.4	92.5	91.6	90.9	89.4	
Country	Aboriginal	87.5	86.8	80.1	80.4	79.9	
	Non-Aboriginal	91.0	90.9	89.8	88.8	86.3	

Table 15: Percentage of children fully immunised, by selected age cohort, location and Aboriginality, 2020 to 2024

Children fully immunised		2020	2021	2022	2023	2024	Target
5 years (%)							
					Total	92.2	
State	Aboriginal	96.1	95.1	93.9	94.0	92.5	
	Non-Aboriginal	94.0	93.6	93.2	92.8	92.2	
Metropolitan	Aboriginal	95.4	95.1	94.4	94.0	92.3	≥95.0
	Non-Aboriginal	94.0	93.7	93.4	93.1	92.5	
Country	Aboriginal	96.7	95.1	93.3	93.9	92.8	
	Non-Aboriginal	94.1	93.1	92.1	91.3	90.4	

Notes:

1. Data is based on children aged 12 ≤ 15 months, 24 ≤ 27 months and 60 ≤ 63 months between 1 January 2024 and 31 December 2024.
2. 'Fully immunised' for children aged 4 years and under includes immunisation for hepatitis B, diphtheria, tetanus, pertussis, pneumococcus, haemophilus influenzae type B, poliomyelitis, measles, mumps, rubella, varicella (chicken pox), meningococcal ACWY and rotavirus.
3. National data for immunisation coverage for all children per age cohort can be accessed at: https://www.health.gov.au/topics/immunisation/immunisation-data/childhood-immunisation-coverage/current-coverage-data-tables-for-all-children.

Data source: Australian Immunisation Register, Communicable Disease Control Directorate, Public and Aboriginal Health Division, Department of Health.

Outcome 2

Percentage of 15 year olds in Western Australia vaccinated for HPV

Rationale

This indicator measures uptake of the human papilloma virus (HPV) vaccination among youth, which is the most effective public health intervention for reducing the risk of developing HPV-related illnesses, including cancer.

HPV is a common virus that affects both females and males and is associated with HPV-related illnesses including cancer of the cervix. HPV vaccination can significantly decrease the chances of people developing HPV-related illnesses. As HPV is primarily sexually transmitted both males and females should have the HPV vaccine, preferably before they become sexually active. Providing vaccination at 14 years and under is also known to increase antibody persistence.

The HPV vaccine is provided free in schools to all males and females in year 7 under the Western Australian school-based immunisation program. General practitioners, community health clinics and pharmacies also offer vaccination to maximise coverage of older adolescents or those who opted out of the school program.

This indicator measures the effectiveness of the WA health system's delivery of vaccination programs and health promotion strategies in maximising the proportion of adolescents who are vaccinated for HPV.

Target

The target for the percentage of 15 year old Western Australian males and females who are vaccinated for HPV is 80 per cent or above.

Improved or maintained performance is demonstrated by a result equal to or above the target.

Results

In 2024, the target of 80 per cent for vaccination of 15 year olds was achieved for females (80.3 per cent) but not for males (79.0 per cent) (see Figure 7). Vaccination among both males and females was slightly below that of 2023 except for Aboriginal males where vaccination rates remained stable.

Youth HPV coverage remains slightly lower in country WA (76.5 per cent) compared to the metropolitan area (80.4 per cent). This may be attributed to lower rates of vaccination among Aboriginal females (73.4 per cent), and Aboriginal (70.0 per cent) and non-Aboriginal (75.1 per cent) males in regional areas.

Increasing awareness and understanding of the benefits and importance of HPV immunisation remains a key focus. In 2024, we partnered with the Child and Adolescent Health Service to improve engagement with youth through targeted promotion of the school-based immunisation program including SMS reminders of upcoming vaccination opportunities. We are also collaborating with the Aboriginal Health Council of WA and WA Country Health Service to increase awareness and improve knowledge of HPV. This has included providing pop-up, walk-in HPV vaccination clinics in the South West of WA. Through the 'Don't Assume You're Immune campaign', social media videos were developed to increase HPV vaccine awareness.

Figure 7: Percentage of 15 year old Western Australians who are vaccinated for HPV, by gender, 2020 to 2024

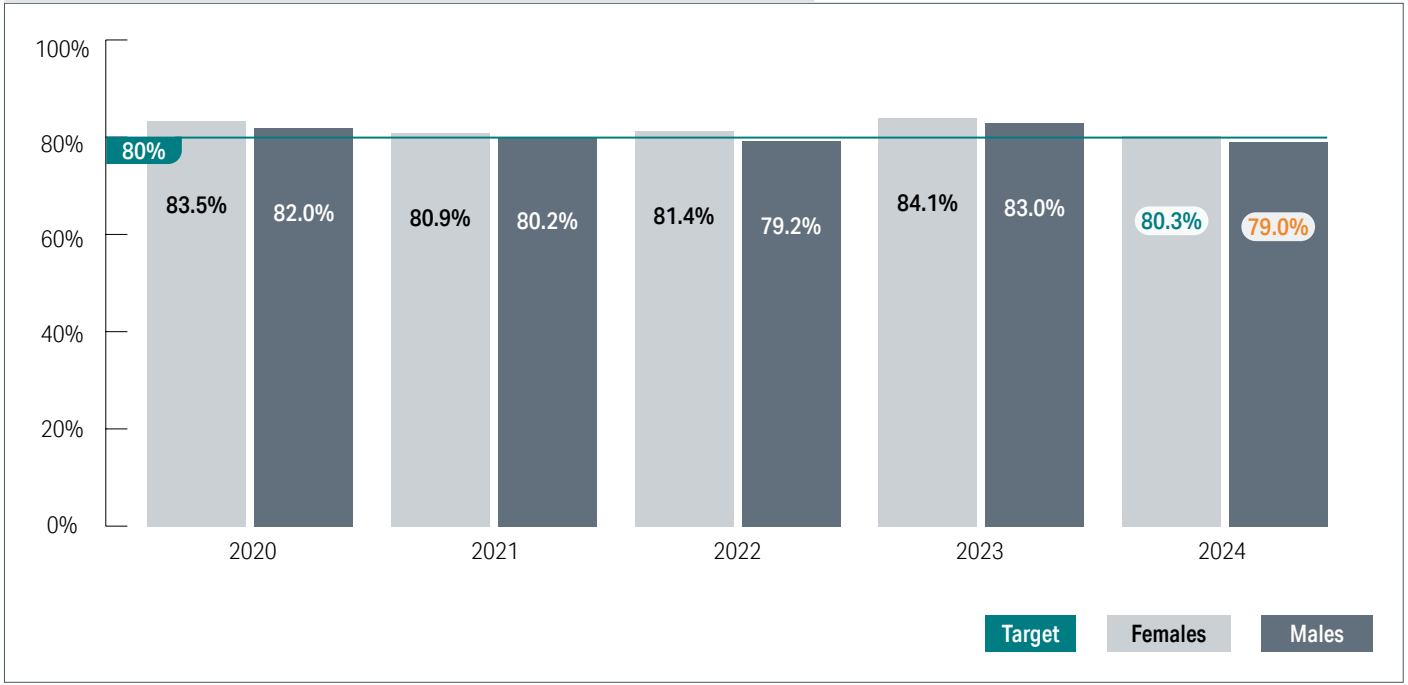


Table 16: Percentage of 15 year old Western Australians who are vaccinated for HPV, by gender, location and Aboriginal status, 2020 to 2024

Percentage of 15 year olds who are vaccinated for HPV		2020	2021	2022	2023	2024	Target
Females							
					Total	80.3	
State	Aboriginal	65.6	65.6	69.2	81.2	77.0	
	Non-Aboriginal	83.1	81.1	82.1	84.3	80.6	
Metropolitan	Aboriginal	66.7	65.4	68.8	81.7	80.7	≥80.0
	Non-Aboriginal	83.3	81.1	82.4	84.3	80.7	
Country	Aboriginal	64.5	65.8	69.6	80.7	73.4	
	Non-Aboriginal	82.1	81.1	81.1	84.1	79.9	
Males							
					Total	79.0	
State	Aboriginal	71.8	70.9	64.5	74.3	74.4	
	Non-Aboriginal	84.3	81.6	80.1	83.5	79.3	
Metropolitan	Aboriginal	70.6	71.3	63.2	74.1	78.8	≥80.0
	Non-Aboriginal	84.4	81.8	79.9	83.7	80.2	
Country	Aboriginal	73.0	70.5	65.6	74.5	70.0	
	Non-Aboriginal	83.9	80.4	80.9	82.7	75.1	

Notes:

1. This indicator is based on 15 year olds who are registered on the Australian Immunisation Register (AIR). All individuals enrolled in Medicare are automatically registered on the AIR.
2. Immunisation status is determined in the year the student turns 15 to align with national reporting by the Australian Institute of Health and Welfare and the Essential Vaccines Schedule of the Federation Funding Agreement – Health.
3. As of 6 February 2023, the routine 2 dose HPV vaccine schedule provided to young people was changed to a single dose schedule using the same Gardasil®9 vaccine. Therefore, a recipient of a single dose of the HPV vaccine is now considered fully vaccinated. As a result of this change comparing 2023 and 2024 vaccination rates with prior years is cautioned.
4. The target is based on HPV immunisation rates reported in the Australian Institute of Health and Welfare *Australia's health 2024: in brief*. Australia's health series no. 19. Canberra: AIHW.

Data source: Australian Immunisation Register, Communicable Disease Control Directorate, Public and Aboriginal Health Division, Department of Health.

Outcome 2

Response times for emergency road-based ambulance services (Percentage of priority 1 calls attended to within 15 minutes in the metropolitan area)

Rationale

To ensure Western Australians receive the care and medical transport services they need, when they need it, the department has entered into a collaborative arrangement with a service provider to deliver emergency road-based patient transport services to the Perth metropolitan area. This collaboration ensures that patients have access to an effective and rapid response ambulance service to ensure the best possible health outcomes for patients requiring urgent medical treatment.

Response times for emergency patient transport services have a direct impact on the speed with which a patient receives appropriate medical care and can provide a good indication of the effectiveness of road-based patient transport services. It is understood that adverse effects on patients and the community are reduced if response times are decreased.

This indicator measures the timeliness of attendance by a patient transport vehicle (ambulance for this priority) and crew within the Perth metropolitan area to patients with the highest need (dispatch priority 1) of emergency medical treatment. Through surveillance of this measure over time, the effectiveness of emergency road-based patient transport services can be determined. This facilitates further development of targeted strategies and improvements to operational management practices aimed at ensuring optimal restoration to health for patients in need of emergency medical care.

Target

The 2024–25 target for priority 1 calls attended to within 15 minutes in the metropolitan area by the contracted service provider is 90 per cent or above.

Improved or maintained performance is demonstrated by a result equal to or above the target.

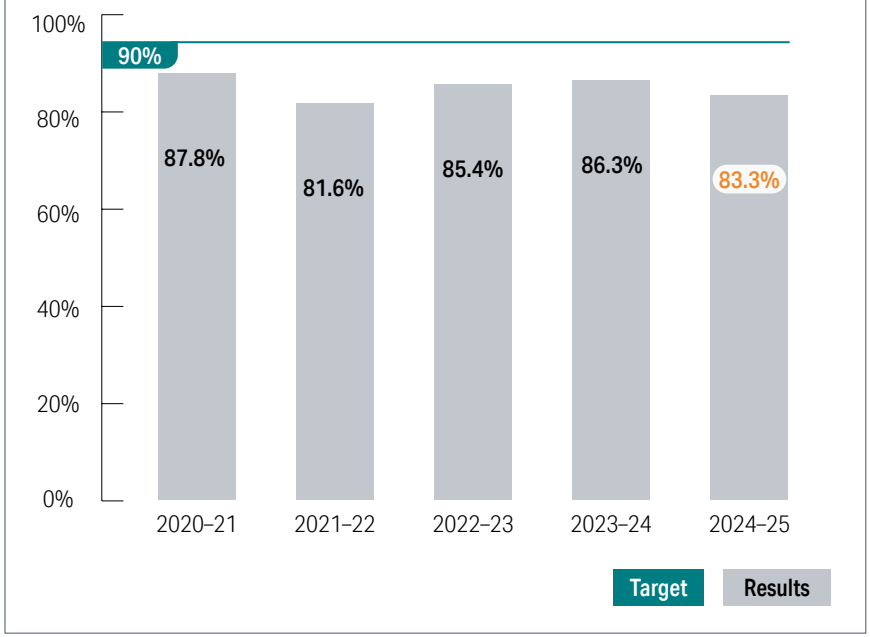
Results

In 2024–25, 83.3 per cent of all priority 1 calls in the metropolitan area were attended to within 15 minutes by emergency ambulance services (see Figure 8). This is below the target of 90 per cent.

Ambulance response times are impacted by a number of factors, including ambulance ramping, broader system capacity constraints, workforce availability, and fluctuations in demand. In 2024–25, we saw an increase in overall service demand including a 7.3 per cent increase in priority 1 cases compared to 2023–24. This coupled with high levels of Extended Transfer of Care i.e. patients arriving via ambulance waiting greater than 30 minutes before handover of their care to emergency department staff, may have attributed to the below target response times.

In 2024–25 we continued to work with key stakeholders to ensure access to high quality ambulance services during health emergencies and to progress initiatives to support improved ambulance response times. The new State Health Operations Centre (SHOC) is designed to improve systemwide oversight and visibility to enhance emergency and medical care access across the state. Operating within the SHOC, the WA Virtual Emergency Department (WAVED) has increased its hours of operation and expanded referral pathways to reduce pressure on hospital emergency departments, and a new ambulance mental health co-response service was established. In addition, in partnership with the contracted service provider we have implemented secondary triage for non-urgent triple zero calls, redirecting callers to alternate care pathways where clinically appropriate to increase the availability of ambulances for patients with the highest need.

Figure 8: Percentage of Priority 1 calls attended to within 15 minutes in the metropolitan area by the contracted service provider, 2020–21 to 2024–25



Notes:

1. KPI results are based on dispatch priority 1 patients requiring emergency attention who reside in the Perth metropolitan area.
2. Priority 1 describes an emergency incident where life is believed to be at risk, based on assessment by State Operations Centre staff via a structured call taking process.
3. In January 2023, the department entered into a new contract with the ambulance service provider. As a result, reports previously used as the source of information for this KPI are no longer provided. This has led to a revised computation methodology for this KPI using new source data that is considered more valid and reliable than previously used. As a result, data from prior years is not directly comparable to 2023–24 and 2024–25 results.

Data source: Contracted service provider's ambulance activity data extract.

Outcome 3

Proportion of stakeholders who indicate the Department of Health to be meeting or exceeding expectations of the delivery of system manager functions

Rationale

The department, in supporting a system manager function, is responsible for the strategic direction, oversight, management and performance of the WA health system. This includes the delivery of government priorities and responding to the emerging and current needs of the Western Australian community. Overall, the aim is to ensure the delivery of high quality, safe and timely health services.

This indicator measures stakeholders' perceptions of the department and its delivery of system manager functions.

Target

The 2024–25 target for the percentage of stakeholders who indicate the department to be meeting or exceeding expectations of the delivery of system manager functions is 75 per cent or above.

Improved or maintained performance is demonstrated by a result equal to or above the target.

Results

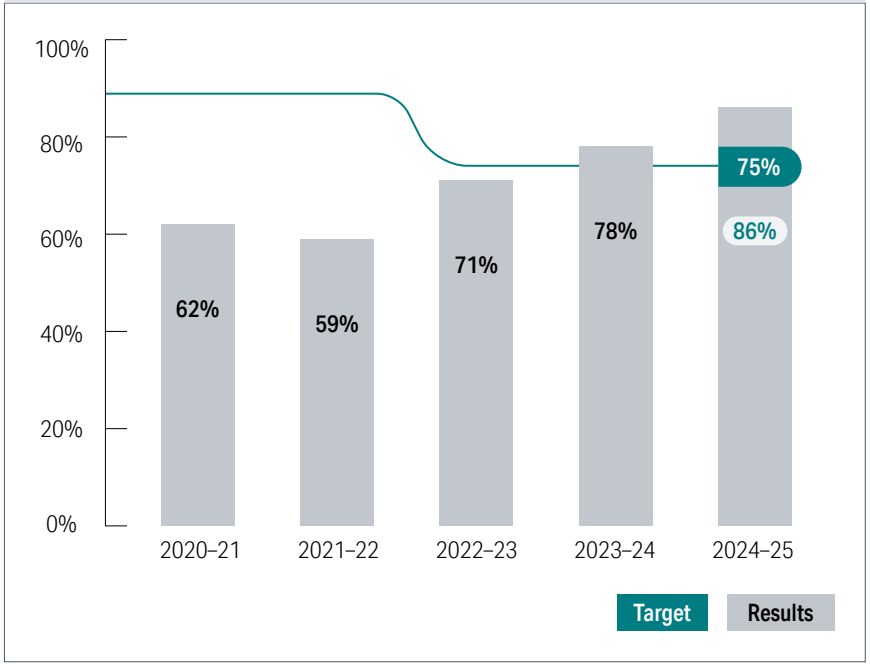
In 2024–25, 86 per cent of respondents agreed the department had met the expectations of their organisation in the delivery of the functions of the system manager (see Figure 9). This is 14.6 per cent higher than the target of 75 per cent and 13.8 per cent higher when compared to 2023–24.

These findings are based on expectations being met equal to or above the target for all functions except for 'management of performance data and analysis of performance trends and issues' (62.5 per cent).

For all respondents, expectations were met concerning 'stewardship of the WA public health system to ensure long-term sustainability and quality of public health service care' and 'regulation of the public health system'. The majority of respondents (93.8 per cent) identified the department as demonstrating strengths in 'strategic leadership and direction in relation to capital works, maintenance works and clinical commissioning of facilities for the provision of public health services' and 'management of system wide industrial relations'.

Meeting expectations related to both 'stewardship' and 'strategic leadership and direction' of the public health system were significantly above 2023–24 findings by 45.5 per cent and 85.7 per cent respectively. Advising and assisting the Minister for Health and health service providers also saw an incline in expectations being met.

Figure 9: Proportion of stakeholders who indicate the department to be meeting or exceeding expectations of the delivery of system manager functions, 2020–21 to 2024–25



Notes:

1. The number of respondents interviewed was 16 with a response rate of 100 per cent.
2. Stakeholders were identified as individuals who have contact with the department and are best positioned to accurately assess performance.
3. The survey involved inviting participants to provide their responses to prescribed questions through telephone interviewing conducted by an independent research agency.
4. Results are based on respondents providing feedback on the delivery of 12 system manager functions delivered by the department. Respondents rated the 12 system manager functions using a 5-point Likert scale from well below expectations (1) to well above expectations (5).
5. In 2024–25, prescribed system manager functions delivered by the department were updated to reflect the *Health Services Amendment Act 2023*. As a result, an additional system manager function was included. Direct comparability with prior year results and target is cautioned. However, calculating the results for 2024–25 based on the prior method, the overall finding is 85.2 per cent, a variation of 0.8 per cent from the actual reported.

Data Source: Unpublished data, Department of Health.

Key efficiency performance indicators

Outcome 2
Aged and continuing care services

Average cost of a transition care day provided by contracted non-government organisations/ service providers

Rationale

The Transition Care Programme is a joint federal, state and territory initiative that aims to optimise the functioning and independence of eligible clients after a hospital stay and enable them to return home or allow time to make decisions on longer term care arrangements, including residential care. Transition Care Programme services take place in either a residential or a community setting, including in a client's home.

The Transition Care Programme is tailored to meet the needs of the individual and aims to facilitate a continuum of care for eligible clients in a non-hospital environment.

Target

The 2024–25 target unit cost per transition care day is $475.

Improved or maintained performance is demonstrated by a result below or equal to the target.

Results

In 2024–25, the average cost per transition care day was $460, below the target of $475 (see Table 17).

Transition Care Programme service provision increased this year primarily attributable to new contract service providers becoming fully operational in 2024–25. As a result more transition care places are available in both residential and community based settings. Expenditure to activity increased comparatively in 2024–25.

Table 17: Average cost per transition care day provided by contracted non-government organisations/service providers, 2020–21 to 2024–25

	2020–21	2021–22	2022–23	2023–24	2024–25
Average cost	$329	$352	$382	$442	$460
Target	$318	$318	$334	$334	**$475**

Notes:

1. Assessment and approval by an Aged Care Assessment Team (ACAT) is necessary before a patient can enter the Transition Care Programme.
2. People may be eligible for the Transition Care Programme if they:

- are aged 65 years and over or 50 years and over for Aboriginal and Torres Strait Islander people; and
- are an inpatient in a public or private hospital; and
- would otherwise be eligible for aged residential care; and
- have completed their acute or subacute hospital care, including rehabilitation but need more time in a non-hospital environment to make a decision on their longer-term aged care options.

Data sources: Transition Care Programme database, Department of Health; Oracle 11i Financial System, Department of Health.

Outcome 2
Aged and continuing care services

Average cost per: (a) home-based hospital day of care and (b) occasion of service

Rationale

Home-based hospital services have been implemented as a means of ensuring patients have timely access to effective health care. These services aim to provide safe and effective medical care for WA patients in their homes, where they may otherwise require a hospital admission.

The department has entered into collaborative arrangements with service providers to provide home-based hospital services that may be delivered as in-home acute medical care, measured by days of care, or as post-discharge, acute or sub-acute medical and nursing intervention, delivered as occasions of service.

Target

The 2024–25 target unit cost per:

a) home-based hospital day of care is $336

b) home-based hospital occasion of service is $165.

Improved or maintained performance is demonstrated by a result below or equal to the target.

Results

In 2024–25, the average cost per home-based hospital day of care was $379, above the target of $336 and the prior year result (see Table 18).

Service delivery expenditure increased in 2024–25 attributable to contract price indexation adjustments and anticipated increase in patient care days required to meet demand.

Table 18: Average cost per home-based hospital day of care, 2020–21 to 2024–25

	2020–21	2021–22	2022–23	2023–24	2024–25
Average cost	$294	$320	$335	$366	**$379**
Target	$293	$301	$308	$322	**$336**

The average cost per home-based hospital occasion of service in 2024–25 was $163, slightly below the target of $165 (see Table 19).

Table 19: Average cost per home-based hospital occasion of service, 2020–21 to 2024–25

	2020–21	2021–22	2022–23	2023–24	2024–25
Average cost	$138	$140	$141	$158	**$163**
Target	$131	$145	$143	$149	**$165**

Notes:

1. Days of care are defined as the number of days where a patient has received one or more occasions of care, including a face-to-face visit or phone call with significant clinical content, and is recorded in the patient record.
2. In 2024–25, the title of this key performance indicator was amended. The former title was 'Average cost per home-based hospital day of care and occasion of service'.

Data sources: Unpublished data, Department of Health; Oracle 11i Financial System, Department of Health.

Outcome 2
Aged and continuing care services

Average cost per day of non-acute bed-based continuing support

Rationale

The goal of non-acute support is the prevention of deterioration in the functional and health status of individuals, such as adults with a complex disability.

Non-acute bed-based support is typically provided in specialist facilities where individuals with complex needs receive support to prepare and/or optimise their ability to enter long term supported accommodation or return to their own home.

Historically, non-acute bed-based support needed to be provided in a hospital, as no other options were available, while individuals awaited community-based supports such as supported accommodation, respite, home modification or support in their home.

The department has entered into collaborative partnerships with several service providers to deliver non-acute bed-based programs within the community.

Target

The 2024–25 target unit cost per day of non-acute bed-based continuing support is $834.

Improved or maintained performance is demonstrated by a result below or equal to the target.

Results

In 2024–25, the average cost of non-acute bed-based continuing support was $908 (see Table 20). This result is above the target of $834 but comparable to the prior year with a 2 per cent increase per unit cost observed. This year we saw an increase in From Hospital to Home disability transition support services in regional WA.

Table 20: Average cost per day of non-acute bed-based continuing support, 2020–21 to 2024–25

	2020–21	2021–22	2022–23	2023–24	2024–25
Average cost	$808	$783	$862	$888	$908
Target	$812	$799	$775	$814	**$834**

Data sources: Unpublished data, Department of Health; Oracle 11i Financial System, Department of Health.

Outcome 2
Aged and continuing care services

Average cost to support patients who suffer specific chronic illness and other clients who require continuing care

Rationale

Chronic conditions pose a significant burden on the healthcare system in WA. Chronic conditions describe a broad range of health conditions including chronic and complex health conditions and disability. Chronic conditions often require ongoing treatment, health care and can lower a person's quality of life and may affect their independence.

To support people with chronic conditions the department has entered into collaborative arrangements with service providers to provide care to optimise their quality of life and support independent living.

Target

The 2024–25 target unit cost to support patients who suffer specific chronic conditions and people who require continuing care is $21.

Improved or maintained performance is demonstrated by a result below or equal to the target.

Results

In 2024–25, the average cost to support people who experience activity limitation or have a long term health condition requiring continuing care was $26, above the target of $21 (see Table 21).

The increase in cost per person is attributable to expenditure for the delivery of the Community Aids and Equipment Program and Continence Aids Subsidy Scheme to benefit people with long term health, disability or age-related functional impairment living at home. Funding of these programs was not included at derivation of the target.

Table 21: Average cost to support patients who suffer specific chronic illness and other clients who require continuing care, 2020–21 to 2024–25

	2020–21	2021–22	2022–23	2023–24	2024–25
Average cost	$19	$19	$19	$19	**$26**
Target	$25	$25	$19	$20	**$21**

Note: Long-term health conditions were categorised for the Survey of Disability, Ageing and Carers (SDAC) based on the International Classification of Diseases: 10th Revision (ICD-10). Coding of long-term health conditions were updated for the 2022 SDAC in 2024 to improve use of condition data.

Data sources: Estimated resident population based on Australian Bureau of Statistics data, Epidemiology Directorate, Department of Health; Australian Bureau of Statistics 2022 Survey of Disability, Ageing and Carers (Cat. No. 4430.02022); Oracle 11i Financial System, Department of Health.

Outcome 2
Aged and continuing care services

Average cost per client receiving contracted palliative care services

Rationale

Palliative care is an approach that improves the quality of life of individuals, including their family/carer, facing problems associated with life-threatening illness/condition, through the prevention and relief of suffering.

Palliative care recognises the person and the importance and uniqueness of their family/carer. It serves to maximise the quality of life and considers physical, social, financial, emotional, and spiritual distress. Such distress not only influences the experience of having a life-limiting illness but also influences treatment outcomes.

In addition to palliative care services that are provided through the public health system, the department has entered into collaborative arrangements with service providers to provide palliative care services for those in need.

Target

The 2024–25 target unit cost per client receiving contracted palliative care services is $9,302.

Improved or maintained performance is demonstrated by a result below or equal to the target.

Results

In 2024–25, the average cost per client receiving contracted palliative care services was $10,612, above the target of $9,302 (see Table 22).

The increase in expenditure this year is attributable to additional funding provided to meet service delivery model adjustments associated with the provision of direct care services by general practitioners, and an unexpected increase in patients requiring oncology care in regional WA.

Table 22: Average cost per client receiving contracted palliative care services, 2020–21 to 2024–25

	2020–21	2021–22	2022–23	2023–24	2024–25
Average cost	$7,636	$8,461	$9,356	$8,608	**$10,612**
Target	$8,030	$8,487	$8,942	$9,131	**$9,302**

Notes:

1. Effective palliative care requires a broad multidisciplinary approach and may be provided in hospital or at home. The services include nursing and medical services at home, respite care, care in designated inpatient palliative care facilities, and community care and support.
2. The department currently contracts palliative care services from several providers, who comprise the total activity data for this measure. In 2024–25, one service provider changed their existing data source from an SAS-based dataset called the Non-Admitted Patient Activity and Wait List (NAPAAWL) to an SQL based dataset now known as the Non-Admitted Data Collection (NADC). Some small non-material differences between these datasets were identified as a result of a concurrent data quality improvement project. Therefore, comparison of the 2024–25 results to prior years is applicable.

Data sources: Unpublished data, Department of Health; Oracle 11i Financial System, Department of Health.

Outcome 2
Public and community health services

Cost per person of providing preventive interventions, health promotion and health protection activities that reduce the incidence of disease or injury

Rationale

In order to improve, promote and protect the health of Western Australians it is critical that the WA health system is sustainable by providing effective and efficient care that best uses allocated funds and resources.

The delivery of effective targeted preventive interventions, health promotion and health protection activities aims at reducing disease or injury within the community and fostering the ongoing health and wellbeing of Western Australians.

Target

The 2024–25 target unit cost to provide preventive interventions, health promotion and health protection activities is $58 per person.

Improved or maintained performance is demonstrated by a result below or equal to the target.

Results

In 2024–25, the average cost per person for providing preventive interventions, health promotion and health protection activities was $84 (see Table 23). This result is above the target of $58 but is 18 per cent below that of 2023–24.

Immunisation programs accounted for 37 per cent of overall expenditure in 2024–25 as we continued to support the National Immunisation Program and focused on protecting the community against influenza and respiratory syncytial virus (RSV) by implementing dedicated immunisation programs and information campaigns. A new information campaign to address vaccine hesitancy was also funded.

We also continued to support health and medical research and innovation that equates to 26 per cent of overall expenditure noting this expend was found to be above the estimated budget for 2024–25 but below that of the prior year.

Table 23: Cost per person of providing preventive interventions, health promotion and health protection activities that reduce the incidence of disease or injury, 2020–21 to 2024–25

	2020–21	2021–22	2022–23	2023–24	2024–25
Average cost	$151	$237	$90	$102	**$84**
Target	$62	$149	$174	$49	**$58**

Data sources: Estimated resident population based on Australian Bureau of Statistics data, Epidemiology Directorate, Department of Health; Unpublished data, Department of Health; Oracle 11i Financial System, Department of Health.

Outcome 2
Public and community health services

Cost per trip for road-based patient transport services, based on the total accrued costs of these services for the total number of trips

Rationale

To ensure Western Australians receive the care and ambulance and patient transport services they need, when they need them, the department has entered into collaborative arrangements with service providers to deliver road-based patient transport services in WA. This collaboration ensures that patients have access to effective ambulance and patient transport services to ensure the best possible health outcomes for patients who may require medical treatment.

This includes emergency transport via ambulance and non-emergency transport which can be carried out in patient transport vehicles (which are not ambulances but can be stretcher fitted vehicles, wheelchair accessible vehicles or standard vehicles).

Transport of non-emergency patients includes non-emergency inter-hospital patient transports, non-emergency mental health patient transports and community patient transports.

The accrued costs include all costs borne by the department for the provision of ambulance and non-emergency patient transport programs, including costs associated with the provision of operations centres responsible for ambulance/vehicle dispatch, and funding model elements associated with the provision of inter-hospital patient transports, but does not include the trip related costs which are borne by health service providers for the provision of inter-hospital patient transport.

Target

The 2024–25 target unit cost per trip for road-based patient transport services is $659.

Improved or maintained performance is demonstrated by a result below or equal to the target.

Results

In 2024–25, the cost per trip for road-based ambulance and patient transport services was $705, above the target of $659 (see Table 24).

There was a notable increase in demand this year for non-emergency transport that can be carried out in patient transport vehicles that are not ambulances but include stretcher fitted vehicles, wheelchair accessible vehicles or standard vehicles. This increased uptake of non-emergency mental health patient and community patient transports has had a direct impact on expenditure. Contract price indexation adjustments for metropolitan ambulance transport services also resulted in a higher cost per trip compared to 2023–24.

Table 24: Cost per trip for road-based patient transport services, based on the total accrued costs of these services for the total number of trips, 2020–21 to 2024–25

	2020–21	2021–22	2022–23	2023–24	2024–25
Average cost	$514	$534	$680	$655	$705
Target	$494	$523	$553	$673	**$659**

Note: In 2023-24, the department entered into a new contract with (1) St John WA resulting in revised service delivery obligations and (2) several non-emergency planned transport services. As a result, 2023–24 and 2024–25 findings are not directly comparable to prior years.

Data sources: Contracted service provider's activity data reports; Oracle 11i Financial System, Department of Health.

Outcome 3
Health system management

Average cost of public health regulatory services per head of population

Rationale

The department performs state wide regulatory functions including the regulation of food and water safety, vector control, waste water management, tobacco licensing, e-cigarette compliance, radiation safety, pesticides, asbestos, and medicines and poisons in order to promote health in the community, prevent disease before it occurs, manage risks to human health, whether natural or man-made, and collaborate with local, national and state regulatory agents and industry.

This indicator measures the department's ability to regulate these functions in an efficient manner and aligns with a key provision of the *Public Health Act 2016* to consolidate and streamline regulatory tools to regulate any given risk to public health.

Target

The 2024–25 target unit cost per head of population to provide public health regulatory services is $8.

Improved or maintained performance is demonstrated by a result below or equal to the target.

Results

In 2024–25, the cost of public health regulatory services per head of population was $6, comparable with the past 2 financial year results (see Table 25).

Table 25: Average cost of public health regulatory services per head of population, 2020–21 to 2024–25

	2020–21	2021–22	2022–23	2023–24	2024–25
Average cost	$8	$8	$6	$6	**$6**
Target	$6	$6	$7	$7	**$8**

Note: Regulatory services are defined as the delivery of functions by the Public and Aboriginal Health Division, Department of Health, in the administration, monitoring or enforcing of legislation or regulations.

Data Sources: Human Resource Data Warehouse, WA Health; Estimated resident population based on Australian Bureau of Statistics data, Epidemiology Directorate, Department of Health; Oracle 11i Financial System, Department of Health.

Outcome 3
Health system management

Average cost for the Department of Health to undertake system manager functions per health service provider full time equivalent

Rationale

The department, in supporting a system manager function, is responsible for the strategic direction, oversight, management and performance of the WA health system. This includes the delivery of government priorities and responding to the emerging and current needs of the Western Australian community. Overall, the aim is to ensure the delivery of high quality, safe and timely health services.

This indicator measures the efficiency with which the department undertakes its role in supporting the system manager.

Target

The 2024–25 target unit cost to undertake system manager functions per full time equivalent worker is $4,516.

Improved or maintained performance is demonstrated by a result below or equal to the target.

Results

In 2024–25, the cost for the department to undertake system manager functions per health service provider full time equivalent was $5,905 (see Table 26). This is above the target but comparable with 2023–24 with only a 2 per cent increase overall in unit cost.

The State Health Operations Centre facility became fully operational in 2024–25, with associated increases in capital, infrastructure and operational expenditure. We also saw an increase in expenditure this year related to workforce initiatives to optimise the capability and capacity of the health workforce while addressing workforce challenges. Progress also continued on the Electronic Medical Record Program, and data linkage and management to support research and innovation, policy development, service planning and quality improvements.

Table 26: Average cost for the department to undertake system manager functions per health service provider full time equivalent, 2020–21 to 2024–25

	2020–21	2021–22	2022–23	2023–24	2024–25
Average cost	$6,816	$7,022	$5,490	$5,778	**$5,905**
Target	$5,559	$5,337	$4,632	$4,752	**$4,516**

Notes:

1. Health service providers include North Metropolitan Health Service, South Metropolitan Health Service, East Metropolitan Health Service, Child and Adolescent Health Service, WA Country Health Service, Health Support Services, PathWest Laboratory Medicine WA, and department staff that provide a public health regulatory function.
2. Full time equivalent (FTE) figures used in the calculation of this indicator are based on actual (paid) month to date FTE.

Data sources: Human Resource Data Warehouse, WA Health; Oracle 11i Financial System, Department of Health.

Financial disclosures and compliance

Financial disclosures

Summary of board and committee remuneration

The total annual remuneration in 2024–25 for all department boards and committees was $451,996 (see Table 27). This is an increase of 16 per cent compared to board and committee remuneration in 2023–24.

The following boards and committees were paid the highest remuneration in 2024–25:

- Voluntary Assisted Dying Board ($130,761)
- Future Health Research and Innovation (FHRI) Fund Advisory Council ($72,443)
- WA Health Central Human Research Ethics Committee ($66,750)
- Department of Health Human Research Ethics Committee ($60,698).

Remuneration for the Voluntary Assisted Dying Board decreased slightly due to the resignation of one member during the year. Remuneration for the FHRI Fund Advisory Council increased by 48 per cent due to increased workload related to the development and launch of a new FHRI Fund strategy and revised remuneration arrangements for participation in subcommittees and other working groups based on updated advice from the Public Sector Commission.

The WA Health Central Human Research Ethics Committee (Central HREC) commenced operations in August 2024 and is gradually replacing 8 separate HRECs to create efficiencies across WA Health. Remuneration for the Department of Health HREC is comparable to 2023–24 and this committee will be amalgamated into the Central HREC from November 2025.

Table 27: Summary of WA State Government boards and committees remunerated by the Department of Health, 2024–25

Board/Committee name	Total remuneration ($)
Anaesthetic Mortality Committee	10,132
Department of Health Human Research Ethics Committee	60,698
Fluoridation of Public Water Supplies Advisory Committee	0
Future Health Research and Innovation Fund Advisory Council	72,443
Human Tissue Advisory Body	0
Local Health Authorities Analytical Committee	6,207
Maternal Mortality Committee	0
Perinatal and Infant Mortality Committee	42,196
Pesticides Advisory Committee	0
Postgraduate Medical Council of Western Australia	560
Radiological Council	5,871
Stimulant Assessment Panel	3,888
Voluntary Assisted Dying Board	130,761
WA Health Central Human Research Ethics Committee	66,750
Western Australian Reproductive Technology Council	48,114
Western Australian Reproductive Technology Council Preimplantation Genetic Testing Committee	4,376
Total	**451,996**

Note: The Department of Health does not remunerate members of:
- Pharmacy Registration Board of Western Australia
- Western Australian Board of the Medical Board of Australia
- Western Australian Board of the Nursing and Midwifery Board of Australia.

Pricing policy

The National Health Reform Agreement sets the policy framework for the charging of public hospital fees and charges. Under the agreement, an eligible person who receives public hospital services as a public patient in a public hospital or a publicly contracted bed in a private hospital[16] is treated 'free of charge'. This arrangement is consistent with the Medicare principles embedded in the *Health Services Act 2016*.

The majority of hospital fees and charges for public hospitals are set under Schedule 1 of the Health Services (Fees and Charges) Order 2016 and are reviewed annually. For up to date information refer to the WA Health Fees and Charges Manual.

Advertising expenditure

In 2024–25, in accordance with section 175ZE of the *Electoral Act 1907*, the department incurred a total advertising expenditure of $2,881,310[17] (see Table 28), a decrease of 44 per cent compared to last year's total of $5,155,639.

The majority of 2024–25 advertising expenditure was for media advertising services (52 per cent), followed by market research services (40 per cent).

Table 28: Summary of advertising expenditure, 2024–25

Summary of advertising	Amount ($)
Advertising agencies	229,613
Market research organisations	1,157,483
Polling organisations	0
Direct mail organisations	209
Media advertising organisations	1,494,005
Total advertising expenditure	**2,881,310**

The organisations from which advertising services were procured and the amounts paid to each organisation are detailed in Table 29.

Table 29: Advertising by class of expenditure, 2024–25

Recipient/organisations	Amount ($)
Advertising agencies	
Speirins Pty Ltd	2,075
Spotlight Cinema Advertising	5,907
303 Mullenlowe	51,803
A0 Lets Go	5,500
Kiosk Creative Services Pty Ltd	43,725
Likeable Creative	16,500
Rare Pty Ltd	74,804
Rhythm Creative Content	29,299
Total	**229,613**
Market research organisations	
Edith Cowan University	1,133,558
Painted Dog Research Pty Ltd	23,925
Total	**1,157,483**
Direct Mail Organisations	
Mailchimp	209
Total	**209**
Media advertising organisations	
Carat Australia Media Services	604,754
Facebook	521
Initiative Media Australia PTY LTD	888,729
Total	**1,494,005**
Total advertising expenditure	**2,881,310**

[16] Includes Joondalup Health Campus and St John of God Midland Public Hospital.
[17] Excludes funding allocated for the vaccine hesitancy campaign managed by the Department of the Premier and Cabinet ($3,284,528).

Major capital projects

In 2024–25, 17 major capital projects were controlled or administered by the department (see Table 30).

Table 30: Major Asset Investment Program projects completed or in progress during 2024–25

Project name	Expected year of completion	Estimated remaining cost to complete ($ '000)	Estimated total cost of project 2024–25 ($ '000)	Estimated total cost of project 2023–24 ($ '000)	Variation from previous financial year ($ '000)
Medical Equipment and Imaging Replacement Program (a)	Ongoing	103,477	705,562	633,953	71,609
Minor Building Works Program (b)	Ongoing	43,714	215,020	178,267	36,753
Statewide 24/7 Telestroke Service (c)	TBC	2,093	2,384	2,092	292
Electronic Medical Record Program (d)	2031–32	176,413	218,433	135,799	82,634
Statewide Cladding	Ongoing	0	2,206	2,126	80
Australian Standard 5369 Reprocessing of Reusable Medical Devices (c)	Ongoing	50	2,842	2,275	567
New Women and Babies Hospital Project	2029	1,764,772	1,784,755	1,786,980	- 2,225
Graylands Reconfiguration and Forensics Project (e)	TBC	183,407	184,747	218,927	- 34,180
Cyber Security (c)	Completed	0	4,299	5,371	-1,072
State Health Operations Centre (f)	Completed	0	18,529	1,025	17,504

Table 30: Major Asset Investment Program projects completed or in progress during 2024–25

Project name	Expected year of completion	Estimated remaining cost to complete ($ '000)	Estimated total cost of project 2024–25 ($ '000)	Estimated total cost of project 2023–24 ($ '000)	Variation from previous financial year ($ '000)
Outpatient Reform – Smart Referrals	2026	438	4,372	4,372	0
Anti-Ligature Remediation Program - Statewide (g)	Ongoing	27,846	27,846	0	27,846
Perth Health Innovation Hub (h)	2026	15,332	15,332	0	15,332
MHC Broome Step Up/Step Down (i)	TBC	0	10,900	0	10,900
MHC Karratha Step Up/Step Down facility (j)	2026	7,343	7,743	0	7,743
MHC South Hedland Step Up/Step Down (k)	TBC	10,159	10,159	0	10,159
MHC Youth Step Up/Step Down (l)	TBC	1,482	6,088	0	6,088

Notes:

1. The above information is based upon estimated costs from the:
   i. 2023–24 published budget papers as reported in the 2023–24 Department of Health Annual Report.
   ii. 2024–25 published budget papers.
2. Completion timeframes are based upon a combination of the approved delivery schedule, scope, and budget at the time of reporting and may be subject to change from one reporting period to the next.
3. In the 2023–24 Department of Health Annual Report the completion timeframes cited for the following capital works was 2024-25 however, they were completed in 2023–24 (see 2024–25 published budget papers for further information):

- Emergency Capital Works
- Modulars – 4x30 Bed Ward Units

4. Only capital projects that were administered by the department are reflected in the table.
5. A variance represents the difference between the estimated total cost of the project in the 2024–25 published budget papers in comparison to the estimated total cost of the project as reported in the 2023–24 Department of Health Annual Report. An explanation is provided below where a variance is greater than or equal to 10 per cent.

The footnotes that apply to individual projects are:

(a) $72.6 million in additional funding was allocated in the 2024–25 Budget to replace high-priority medical and imaging equipment nearing the end of its operational life.

(b) $40 million in additional funding was approved to continue minor building works across the WA health system, supporting patient and staff safety through ongoing maintenance and upgrades.

(c) Budgeted expense capital is excluded from the current year estimated total cost of the project to align to the published budget paper.

(d) $104.1 million was allocated to initiate preparation and procurement activities for the Electronic Medical Record Program. This staged initiative will deliver clinical decision support tools and workflow enhancements to improve patient outcomes.

(e) $218.9 million was originally approved in the 2023–24 Budget for the Graylands Reconfiguration and Forensics Project, with $32.2 million subsequently reallocated to the Bentley Secure Extended Care Unit project.

(f) $8.4 million in additional funding was approved in the 2023–24 Mid-Year Review for immediate service-related costs for the WA Virtual Emergency Department, and $9.7 million was redirected from the WA Country Health Service Expansion of Command Centre.

(g) $27.8 million was approved to address the highest risks identified in the systemwide audit of ligature risks.

(h) A new project was approved to establish the Perth Health Innovation Hub, aimed at fostering industry innovation and attracting global expertise to WA.

(i) $10.9 million was transferred to the department from the Mental Health Commission (MHC) Asset Investment Program for delivery of the Step Up/Step Down facility in Broome.

(j) $7.7 million in Royalties for Regions (RfR) funding was transferred to the department from the Department of Communities and the MHC for delivery of the Step Up/Step Down facility in Karratha.

(k) $10.1 million in RfR funding was transferred to the department from the MHC Asset Investment Program for delivery of the Step Up/Step Down facility in South Hedland.

(l) $6.1 million was transferred to the department from the MHC Asset Investment Program for delivery of the Youth Step Up/Step Down facility in the Perth Metropolitan Area.

Unauthorised use of purchasing cards

The department uses purchasing cards when purchasing low value goods and services as they achieve savings by reducing paperwork and streamlining purchasing processes.

Staff who have a justified work need and meet relevant criteria are provided purchasing cards. All cardholders are regularly reminded of their obligations pertaining to the use of their purchasing card, including goods or services that cannot be procured with purchasing cards, and the requirement that purchasing cards are not for personal use. This messaging has recently included targeted emails to approved cardholders as well as regular broader communications to all staff.

Should a cardholder use a purchasing card for a personal purpose, they must give written notice to the accountable authority within 5 working days and refund the total amount of expenditure.

We routinely monitor cardholder purchasing card compliance that includes card usage and expenditure activity through a dedicated analytics dashboard. We have also implemented a program of periodic compliance auditing of all purchasing card transactions, that includes ensuring instances of personal use of purchasing cards are investigated to identify areas of non-compliance and enable corrective action to be taken.

There were 28 instances of purchasing cards being used for personal purposes in 2024–25 (see Table 31) by 13 cardholders. The full amount of $2,391.51 was refunded before the end of the reporting period.

Table 31: Personal use expenditure by purchasing card holders, 2024–25

Credit card personal use expenditure	Amount ($)
Aggregate amount of personal use expenditure for 2024–25	**2,391.51**
Aggregate amount of personal use expenditure settled within 5 working days	1,008.81
Aggregate amount of personal use expenditure settled after 5 working days	1,382.70
Aggregate amount of personal use expenditure outstanding at the end of 2024–25	0.00

Annual estimates

The department's annual operational budget estimates are to be reported to the Minister for Health under section 40 of the *Financial Management Act 2006* and Treasurer's Instruction TI 9 Financial Statements.

The annual estimates for 2025–26 will be published on the department's website.

GOVERNMENT OF WESTERN AUSTRALIA

Auditor General

INDEPENDENT AUDITOR'S REPORT

2025

Department of Health

To the Parliament of Western Australia

Report on the audit of the financial statements

Opinion

I have audited the financial statements of the Department of Health (Department) which comprise:

- the statement of financial position as at 30 June 2025, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year then ended
- administered schedules comprising the administered assets and liabilities as at 30 June 2025 and administered income and expenses by service for the year then ended
- notes comprising a summary of material accounting policies and other explanatory information.

In my opinion, the financial statements are:

• based on proper accounts and present fairly, in all material respects, the operating results and cash flows of the Department for the year ended 30 June 2025 and the financial position as at the end of that period

- in accordance with Australian Accounting Standards, the Financial Management Act 2006 and the Treasurer's Instructions.

Basis for opinion

I conducted my audit in accordance with 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 believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Responsibilities of the Director General for the financial statements

The Director General is responsible for:

- keeping proper accounts
- preparation and fair presentation of the financial statements in accordance with Australian Accounting Standards, the *Financial Management Act 2006* and the Treasurer's Instructions
- such internal control as they determine 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 Director General is responsible for:

- assessing the entity's ability to continue as a going concern
- disclosing, as applicable, matters related to going concern
- using the going concern basis of accounting unless the Western Australian Government has made policy or funding decisions affecting the continued existence of the Department.

Auditor's responsibilities for the audit of the financial statements

As required by the *Auditor General Act 2006*, my responsibility is to express an opinion on the financial statements. The objectives of my audit are 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 Australian 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. 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.

A further description of my responsibilities for the audit of the financial statements is located on the Auditing and Assurance Standards Board website. This description forms part of my auditor's report and can be found at:
https://www.auasb.gov.au/auditors_responsibilities/ar4.pdf

Report on the audit of controls

Basis for Qualified Opinion

I identified the following weaknesses in controls:

Procurement to pay process

I identified significant weaknesses in the payment processing controls for the direct payments to third parties pathway approved and utilised by the Department as system manager for all WA Health entities to use in limited circumstances. The pathway has weaknesses in design and implementation, as editable Excel forms are being used, without any mandatory controls enforcing segregation of duties. In addition, there were insufficient controls in place to validate the information on the Excel form prior to payments being processed using this pathway. This means that officers could make incorrect or fraudulent payments without being detected.

Network security controls

I identified significant weaknesses in network security controls and controls over unauthorised connection of devices at the Department of Health. These weaknesses could compromise the confidentiality, integrity and availability of key systems and information. These weaknesses also exposed the WA Health network to increased vulnerabilities which could undermine the integrity of data across all systems, including the financial system.

Qualified Opinion

I have undertaken a reasonable assurance engagement on the design and implementation of controls exercised by the Department. The controls exercised by the Department are those policies and procedures established to ensure that the receipt, expenditure and investment of money, the acquisition and disposal of property, and the incurring of liabilities have been in accordance with the State's financial reporting framework (the overall control objectives).

In my opinion, except for the possible effects of the matters described in the Basis for Qualified Opinion section of my report, in all material respects, the controls exercised by the Department are sufficiently adequate to provide reasonable assurance that the controls within the system were suitably designed to achieve the overall control objectives identified as at 30 June 2025, and the controls were implemented as designed as at 30 June 2025.

The Director General's responsibilities

The Director General is responsible for designing, implementing and maintaining controls to ensure that the receipt, expenditure and investment of money, the acquisition and disposal of property and the incurring of liabilities are in accordance with the *Financial Management Act 2006*, the Treasurer's Instructions and other relevant written law.

Auditor General's responsibilities

As required by the *Auditor General Act 2006*, my responsibility as an assurance practitioner is to express an opinion on the suitability of the design of the controls to achieve the overall control objectives and the implementation of the controls as designed. I conducted my engagement in accordance with Standard on Assurance Engagements ASAE 3150 *Assurance Engagements on Controls* issued by the Australian Auditing and Assurance Standards Board. That standard requires that I comply with relevant ethical requirements and plan and perform my procedures to obtain reasonable assurance about whether, in all material respects, the controls are suitably designed to achieve the overall control objectives and were implemented as designed.

An assurance engagement involves performing procedures to obtain evidence about the suitability of the controls design to achieve the overall control objectives and the implementation of those controls. The procedures selected depend on my judgement, including an assessment of the risks that controls are not suitably designed or implemented as designed. My procedures included testing the implementation of those controls that I consider necessary to achieve the overall control objectives.

I believe that the evidence I have obtained is sufficient and appropriate to provide a basis for my qualified opinion.

Limitations of controls

Because of the inherent limitations of any internal control structure, it is possible that, even if the controls are suitably designed and implemented as designed, once in operation, the overall control objectives may not be achieved so that fraud, error or non-compliance with laws and regulations may occur and not be detected. Any projection of the outcome of the evaluation of the suitability of the design of controls to future periods is subject to the risk that the controls may become unsuitable because of changes in conditions.

Report on the audit of the key performance indicators

Opinion

I have undertaken a reasonable assurance engagement on the key performance indicators of the Department for the year ended 30 June 2025 reported in accordance with the *Financial Management Act 2006* and the Treasurer's Instructions (legislative requirements). The key performance indicators are the Under Treasurer-approved key effectiveness indicators and key efficiency indicators that provide performance information about achieving outcomes and delivering services.

In my opinion, in all material respects, the key performance indicators report of the Department for the year ended 30 June 2025 is in accordance with the legislative requirements, and the key performance indicators are relevant and appropriate to assist users to assess the Department's performance and fairly represent indicated performance for the year ended 30 June 2025.

The Director General's responsibilities for the key performance indicators

The Director General is responsible for the preparation and fair presentation of the key performance indicators in accordance with the F*inancial Management Act 2006* and the Treasurer's Instructions and for such internal controls as the Director General determines necessary to enable the preparation of key performance indicators that are free from material misstatement, whether due to fraud or error.

In preparing the key performance indicators, the Director General is responsible for identifying key performance indicators that are relevant and appropriate, having regard to their purpose in accordance with Treasurer's Instruction 3 Financial Sustainability – Requirement 5: Key Performance Indicators.

Auditor General's responsibilities

As required by the *Auditor General Act 2006*, my responsibility as an assurance practitioner is to express an opinion on the key performance indicators. The objectives of my engagement are to obtain reasonable assurance about whether the key performance indicators are relevant and appropriate to assist users to assess the entity's performance and whether the key performance indicators are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. I conducted my engagement in accordance with Standard on Assurance Engagements ASAE 3000 *Assurance Engagements Other than Audits or Reviews of Historical Financial Information* issued by the Australian Auditing and Assurance Standards Board. That standard requires that I comply with relevant ethical requirements relating to assurance engagements.

An assurance engagement involves performing procedures to obtain evidence about the amounts and disclosures in the key performance indicators. It also involves evaluating the relevance and appropriateness of the key performance indicators against the criteria and guidance in Treasurer's Instruction 3 Financial Sustainability - Requirement 5 for measuring the extent of outcome achievement and the efficiency of service delivery. The procedures selected depend on my judgement, including the assessment of the risks of material misstatement of the key performance indicators. In making these risk assessments, I obtain an understanding of internal control relevant to the engagement in order to design procedures that are appropriate in the circumstances.

I believe that the evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

My independence and quality management relating to the report on financial statements, controls and key performance indicators

I have complied with the independence requirements of the *Auditor General Act 2006* and the relevant ethical requirements relating to assurance engagements. In accordance with ASQM 1 *Quality Management for Firms that Perform Audits or Reviews of Financial Reports and Other Financial Information, or Other Assurance or Related Services Engagements*, the Office of the Auditor General maintains a comprehensive system of quality management including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

Other information

The Director General is responsible for the other information. The other information is the information in the entity's annual report for the year ended 30 June 2025, but not the financial statements, key performance indicators and my auditor's report.

My opinions on the financial statements, controls and key performance indicators do not cover the other information and accordingly I do not express any form of assurance conclusion thereon.

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

If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact. I did not receive the other information prior to the date of this auditor's report. When I do receive it, I will read it and if I conclude that there is a material misstatement in this information, I am required to communicate the matter to those charged with governance and request them to correct the misstated information. If the misstated information is not corrected, I may need to retract this auditor's report and re-issue an amended report.

Matters relating to the electronic publication of the audited financial statements and key performance indicators

This auditor's report relates to the financial statements and key performance indicators of the Department of Health for the year ended 30 June 2025 included in the annual report on the Department's website. The Department's management is responsible for the integrity of the Department's website. This audit does not provide assurance on the integrity of the Department's website. The auditor's report refers only to the financial statements, controls and key performance indicators described above. It does not provide an opinion on any other information which may have been hyperlinked to/from the annual report. If users of the financial statements and key performance indicators are concerned with the inherent risks arising from publication on a website, they are advised to contact the entity to confirm the information contained in the website version.

Caroline Spencer

Auditor General for Western Australia
Perth, Western Australia

19 September 2025

Certification of financial statements

Department of Health

Certification of financial statements

For the financial year ended 30 June 25

The accompanying financial statements of the Department of Health have been prepared in compliance with the provisions of the *Financial Management Act 2006* from proper accounts and records to present fairly the financial transactions for the financial year ended 30 June 2025 and the financial position as at 30 June 2025.

At the date of signing, we are not aware of any circumstances which would render the particulars included within the financial statements misleading or inaccurate.

Ms Elizabeth Amudo

Chief Finance Officer
Department of Health

18 September 2025

Dr Shirley Bowen

Director General Department of Health
Accountable Authority

18 September 2025

Financial statements - Contents

Statement of comprehensive income

For the year ended 30 June 2025

	Notes	2025 $'000	2024 $'000
COST OF SERVICES			
Expenses			
Employee benefits expenses	3.1(a)	230,219	192,361
Contracts for services	3.3	781,099	704,969
Supplies and services	3.4	92,433	88,608
Grants and subsidies	3.2	10,298,578	9,357,410
Depreciation and amortisation expenses	5.1, 5.2, 5.3	3,063	2,216
Loss on disposal of non-current assets	4.6	147	49
Finance costs	7.3	92	95
Other expenses	3.5	62,257	54,404
Total cost of services		**11,467,888**	**10,400,112**
Income			
User charges and fees	4.2	25,789	23,146
Commonwealth grants and contributions	4.3	3,123,343	2,957,662
Other grants and contributions	4.4	642	605
Other income	4.5	11,105	9,303
Total income		**3,160,879**	**2,990,716**
NET COST OF SERVICES		**8,307,009**	**7,409,396**

Statement of comprehensive income (continued)
For the year ended 30 June 2025

	Notes	2025 $'000	2024 $'000
Income from State Government			
Service appropriation	4.1	8,160,831	7,269,484
Income from other public sector entities	4.1	119,228	63,060
Resources received	4.1	716	627
Royalties for Regions Fund	4.1	14,439	18,241
Total income from State Government		**8,295,214**	**7,351,412**
SURPLUS/(DEFICIT) FOR THE PERIOD		**(11,795)**	**(57,984)**
OTHER COMPREHENSIVE INCOME			
Items not reclassified subsequently to profit or loss			
Changes in asset revaluation reserve	9.11	553	(1,163)
Total other comprehensive income		**553**	**(1,163)**
TOTAL COMPREHENSIVE INCOME FOR THE PERIOD		**(11,242)**	**(59,147)**

The Statement of comprehensive income should be read in conjunction with the accompanying notes.

Statement of financial position
As at 30 June 2025

	Notes	2025 $'000	2024 $'000
ASSETS			
Current assets			
Cash and cash equivalents	7.1	129,992	47,445
Restricted cash and cash equivalents	7.1	128,561	108,396
Inventories	6.1	27,626	43,022
Receivables	6.2	109,868	103,171
Other current assets	6.4	6,433	8,570
Total current assets		**402,480**	**310,604**
Non-current assets			
Receivables	6.2	4,481	4,481
Amounts receivable for services	6.3	88,351	97,163
Infrastructure, property, plant and equipment	5.1	78,762	41,436
Intangible assets	5.2	3,425	594
Right-of-use assets	5.3	2,065	2,316
Other non-current assets	6.4	-	335
Total non-current assets		**177,084**	**146,325**
TOTAL ASSETS		**579,564**	**456,929**
LIABILITIES			
Current liabilities			
Payables	6.5	133,818	104,936
Contract liabilities	6.6	2,157	1,657
Lease liabilities	7.2	663	588
Employee related provisions	3.1(b)	38,973	33,247
Total current liabilities		**175,611**	**140,428**

Statement of financial position (continued)
As at 30 June 2025

	Notes	2025 $'000	2024 $'000
Non-current liabilities			
Lease liabilities	7.2	1,415	1,719
Employee related provisions	3.1(b)	13,950	14,263
Total non-current liabilities		**15,365**	**15,982**
TOTAL LIABILITIES		**190,976**	**156,410**
NET ASSETS		**388,588**	**300,519**
Equity			
Contributed equity	9.11	198,796	99,485
Reserves	9.11	281,985	281,432
Accumulated surplus/(deficit)		(92,193)	(80,398)
TOTAL EQUITY		**388,588**	**300,519**

The Statement of financial position should be read in conjunction with the accompanying notes.

Statement of changes in equity
For the year ended 30 June 2025

	Notes	Contributed equity $'000	Reserves $'000	Accumulated surplus/(deficit) $'000	Total equity $'000
Balance at 1 July 2023		**58,636**	**282,595**	**(22,414)**	**318,817**
Surplus/(deficit)		-	-	(57,984)	(57,984)
Other comprehensive income		-	(1,163)	-	(1,163)
Total comprehensive income for the period		**-**	**(1,163)**	**(57,984)**	**(59,147)**
Transactions with owners in their capacity as owners:	9.11				
Capital appropriation		36,832	-	-	36,832
Other contributions by owners		4,017	-	-	4,017
Distribution to owners		-	-	-	-
Total contributed equity		**40,849**	**-**	**-**	**40,849**
Balance at 30 June 2024		**99,485**	**281,432**	**(80,398)**	**300,519**
Balance at 1 July 2024		**99,485**	**281,432**	**(80,398)**	**300,519**
Surplus/(deficit)		-	-	(11,795)	(11,795)
Other comprehensive income		-	553	-	553
Total comprehensive income for the period		**-**	**553**	**(11,795)**	**(11,242)**
Transactions with owners in their capacity as owners:	9.11				
Capital appropriation		102,854	-	-	102,854
Other contributions by owners		-	-	-	-
Distribution to owners		(3,543)			(3,543)
Total contributed equity		**99,311**	**-**	**-**	**99,311**
Balance at 30 June 2025		**198,796**	**281,985**	**(92,193)**	**388,588**

The Statement of changes in equity should be read in conjunction with the accompanying notes.

Statement of cash flows
For the year ended 30 June 2025

	Notes	2025 $'000	2024 $'000
CASH FLOWS FROM STATE GOVERNMENT			
Service appropriation		7,720,792	6,838,722
Capital appropriation		102,214	40,849
Funds from other public sector entities		115,678	63,060
Royalties for Regions Fund		14,439	18,241
Net cash provided by State Government		**7,953,123**	**6,960,872**
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Employee benefits		(224,806)	(188,208)
Supplies and services		(832,197)	(755,107)
Grants and subsidies		(9,855,033)	(8,947,273)
Finance costs		(92)	(95)
GST payments on purchases		(598,309)	(537,347)
Receipts			
User charges and fees		25,789	23,146
Commonwealth grants and contributions		3,051,118	2,885,687
GST receipts on sales		29,530	26,174
GST receipts from taxation authority		570,061	507,563
Other receipts		11,747	9,908
Net cash used in operating activities	7.1.3	**(7,822,192)**	**(6,975,552)**
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments			
Purchase of non-current assets		(27,477)	(17,125)
Net cash used in investing activities		**(27,477)**	**(17,125)**

Statement of cash flows (continued)
For the year ended 30 June 2025

	Notes	2025 $'000	2024 $'000
CASH FLOWS FROM FINANCING ACTIVITIES			
Payments			
Principal element of lease payments		(742)	(796)
Net cash used in financing activities		**(742)**	**(796)**
Net increase/(decrease) in cash and cash equivalents		102,712	(32,601)
Cash and cash equivalents at the beginning of the period		155,841	188,442
CASH AND CASH EQUIVALENTS AT THE END OF THE PERIOD	7.1.1	**258,553**	**155,841**

The Statement of cash flows should be read in conjunction with the accompanying notes.

Administered schedules

For the year ended 30 June 2025

Administered income and expenses by services

	Public Hospital Admitted Services		Public Hospital Emergency Services		Public Hospital Non-Admitted Services		Mental Health Services	
	2025 $'000	2024 $'000	2025 $'000	2024 $'000	2025 $'000	2024 $'000	2025 $'000	2024 $'000
Expenses								
Funding transferred to:								
Health service providers	212,627	226,583	56,231	49,375	52,512	50,097	48,747	50,682
State Pool Account and State Managed Fund Account administered for Mental Health Commission:								
Transfer of activity based funding to health service providers	-	-	-	-	-	-	484,846	479,736
Transfer of block funding to health service providers	-	-	-	-	-	-	639,574	508,701
Service concession arrangement depreciation expense (a)	-	-	-	-	-	-	-	-
Total administered expenses	**212,627**	**226,583**	**56,231**	**49,375**	**52,512**	**50,097**	**1,173,167**	**1,039,119**
Income								
Administered for WA health system:								
Capital appropriation	151,365	130,124	33,710	22,320	36,745	28,069	34,460	27,616
Administered appropriation	14,218	25,819	2,667	4,340	3,032	5,618	3,463	6,690
Royalties for Regions Fund	50,796	68,057	24,182	12,708	14,307	14,906	11,720	17,736
State Pool Account and State Managed Fund Account administered for Mental Health Commission:								
Commonwealth activity based funding	-	-	-	-	-	-	159,360	153,583
Commonwealth block funding	-	-	-	-	-	-	217,356	174,357
State activity based funding	-	-	-	-	-	-	325,486	326,153
State block funding	-	-	-	-	-	-	422,218	334,344
Service concession arrangement revenue (a)	-	-	-	-	-	-	-	-
Total administered income	**216,379**	**224,000**	**60,559**	**39,368**	**54,084**	**48,593**	**1,174,063**	**1,040,479**

Administered schedules (continued)

For the year ended 30 June 2025

Administered income and expenses by services (continued)

	Aged Care, Continuing Care and End of Life Care Services		Public and Community Health Services		Pathology Services		Community Dental Health Services	
	2025 $'000	2024 $'000	2025 $'000	2024 $'000	2025 $'000	2024 $'000	2025 $'000	2024 $'000
Expenses								
Funding transferred to:								
Health service providers	18,059	11,499	46,996	35,958	9,265	6,913	-	-
State Pool Account and State Managed Fund Account administered for Mental Health Commission:								
Transfer of activity based funding to health service providers	-	-	-	-	-	-	-	-
Transfer of block funding to health service providers	-	-	-	-	-	-	-	-
Service concession arrangement depreciation expense (a)	-	-	-	-	-	-	-	-
Total administered expenses	**18,059**	**11,499**	**46,996**	**35,958**	**9,265**	**6,913**	**-**	**-**
Income								
Administered for WA health system:								
Capital appropriation	8,771	2,871	24,437	9,106	11,897	2,726	-	-
Administered appropriation	387	595	1,178	2,515	-	-	-	-
Royalties for Regions Fund	11,552	2,511	27,270	8,370	-	-	-	-
State Pool Account and State Managed Fund Account administered for Mental Health Commission:								
Commonwealth activity based funding	-	-	-	-	-	-	-	-
Commonwealth block funding	-	-	-	-	-	-	-	-
State activity based funding	-	-	-	-	-	-	-	-
State block funding	-	-	-	-	-	-	-	-
Service concession arrangement revenue (a)	-	-	-	-	-	-	-	-
Total administered income	**20,710**	**5,977**	**52,885**	**19,991**	**11,897**	**2,726**	**-**	**-**

Administered schedules (continued)

For the year ended 30 June 2025

Administered income and expenses by services (continued)

	Small Rural Hospital Services		Health System Management - Policy and Corporate Services		Health Support Services		Total	
	2025 $'000	2024 $'000	2025 $'000	2024 $'000	2025 $'000	2024 $'000	2025 $'000	2024 $'000
Expenses								
Funding transferred to:								
Health service providers	30,038	19,083	115,598	9,502	129,480	79,626	719,553	539,318
State Pool Account and State Managed Fund Account administered for Mental Health Commission:								
Transfer of activity based funding to health service providers	-	-	-	-	-	-	484,846	479,736
Transfer of block funding to health service providers	-	-	-	-	-	-	639,574	508,701
Service concession arrangement depreciation expense (a)	-	-	3,646	3,469	-	-	3,646	3,469
Total administered expenses	**30,038**	**19,083**	**119,244**	**12,971**	**129,480**	**79,626**	**1,847,619**	**1,531,224**
Income								
Administered for WA health system:								
Capital appropriation	12,808	1,900	85,483	24,169	19,161	21,173	418,837	270,074
Administered appropriation	288	215	20,005	19,348	117,428	62,005	162,666	127,145
Royalties for Regions Fund	22,288	2,698	-	-	-	-	162,115	126,986
State Pool Account and State Managed Fund Account administered for Mental Health Commission:								
Commonwealth activity based funding	-	-	-	-	-	-	159,360	153,583
Commonwealth block funding	-	-	-	-	-	-	217,356	174,357
State activity based funding	-	-	-	-	-	-	325,486	326,153
State block funding	-	-	-	-	-	-	422,218	334,344
Service concession arrangement revenue (a)	-	-	5,474	5,474	-	-	5,474	5,474
Total administered income	**35,384**	**4,813**	**110,962**	**48,991**	**136,589**	**83,178**	**1,873,512**	**1,518,116**

(a) A Public Private Partnership Project Agreement between the State of Western Australia and International Parking Group (IPG) has been established for IPG to own, operate and manage the multi-deck car park at the Queen Elizabeth II Medical Centre site. In 2020-21, the project agreement was assessed as a service concession arrangement in accordance with AASB 1059 *Service Concession Arrangements: Grantors*.

Administered schedules (continued)

For the year ended 30 June 2025

Administered assets and liabilities

	2025 $'000	2024 $'000
Current assets		
Cash and cash equivalents	186,539	162,472
Total administered current assets	**186,539**	**162,472**
Non-current assets		
Service concession assets	150,360	145,835
Amounts receivable for services	6,440	6,440
Total administered non-current assets	**156,800**	**152,276**
TOTAL ADMINISTERED ASSETS	**343,339**	**314,747**
Current liabilities		
Payables	950	950
Service concession liabilities (Grant of the Right to Operate Model)	5,474	5,474
Total administered current liabilities	**6,424**	**6,424**
Non-current liabilities		
Service concession liabilities (Grant of the Right to Operate Model)	62,404	67,878
Total administered non-current liabilities	**62,404**	**67,878**
TOTAL ADMINISTERED LIABILITIES	**68,828**	**74,302**

The department administers the Capital Works Fund for the Asset Investment Program and the service concession arrangement for the multi-deck car park on the Queen Elizabeth II Medical Centre Site on behalf of State Government which is not controlled by, nor integral to the function of the department.

A service concession asset is recognised with respect to the multi-deck car park and a grant of the right to operate liability is recognised under AASB 1059 *Service Concession Arrangements: Grantors*, as the State Government does not have a contractual obligation to pay cash or another financial asset but grants the right to a private operator to earn revenue from the public use of the car park. The liability represents unearned revenue and is progressively reduced over the period of the concession by recognising revenue.

The administered assets, liabilities, income and expenses are not recognised in the principal statements of the department but are presented as 'Administered assets and liabilities' and 'Administered income and expenses by service' using the same basis as the financial statements.

Notes to the financial statements

For the year ended 30 June 2025

1 Basis of preparation

The Department of Health (department) is a government not-for-profit entity and is controlled by the State of Western Australia, which is the ultimate parent.

A description of the nature of its operations and its principal activities have been included in the About us section of this annual report, which does not form part of these financial statements.

These annual financial statements were authorised for issue by the accountable authority of the department on 18 September 2025.

Statement of compliance

The financial statements constitute general purpose financial statements that have been prepared in accordance with Australian Accounting Standards, the Framework, Statement of Accounting Concepts and other authoritative pronouncements of the Australian Accounting Standards Board (AASB) as applied by Treasurer's Instructions. Several of these are modified by Treasurer's Instructions to vary application, disclosure, format and wording.

The *Financial Management Act 2006* and Treasurer's Instructions are legislative provisions governing the preparation of financial statements and take precedence over Australian Accounting Standards, the Framework, Statement of Accounting Concepts and other authoritative pronouncements of the Australian Accounting Standards Board. Where modification is required and has had a material or significant financial effect upon the reported results, details of that modification and the resulting financial effect are disclosed in the notes to the financial statements.

Reporting entity

The reporting entity is comprised of the department and the Health Ministerial Body (a body corporate through which the Minister for Health can perform any of the Minister's functions under the *Health Services Act 2016*).

On 31 March 2022, approval was obtained from Treasury which exempts the department from the reporting requirements of Treasurer's Instructions 1101 (7)(ix) Application of Australian Accounting Standards and Other Pronouncements (superseded by Treasurer's Instruction (TI) 9 Financial Statements − Requirement 4) and 1105 (4)(iv) Consolidated Financial Statements (superseded by Treasurer's Guidance (TG) 9 Financial Statements – Chapter 6). The exemption relates to financial years 2021−22 to 2024−25.

The department is exempted from preparing consolidated financial statements with the Quadriplegic Centre. This chief executive governed health service provider prepares separate financial statements which are consolidated in the Annual Report on State Finances, that is available for public use.

Basis of preparation

These financial statements are presented in Australian dollars applying the accrual basis of accounting and using the historical cost convention. Certain balances will apply a different measurement basis (such as the fair value basis). Where this is the case, the different measurement basis is disclosed in the associated note. All values are rounded to the nearest thousand dollars ($'000).

Notes to the financial statements
For the year ended 30 June 2025

1 Basis of preparation (continued)

Judgements and estimates

Judgements, estimates and assumptions are required to be made about financial information being presented. The significant judgements and estimates made in the preparation of these financial statements are disclosed in the notes where amounts affected by those judgements and/or estimates are disclosed. Estimates and associated assumptions are based on professional judgements derived from historical experience and various other factors that are believed to be reasonable under the circumstances.

Accounting for Goods and Services Tax (GST)

Income, expenses and assets are recognised net of the amount of GST, except that the:

(a) amount of GST incurred by the department as a purchaser that is not recoverable from the Australian Taxation Office (ATO) is recognised as part of an asset's cost of acquisition or as part of an item of expense; and

(b) receivables and payables are stated with the amount of GST included.

Cash flows are included in the Statement of cash flows on a gross basis. However, the GST components of cash flows arising from investing and financing activities which are recoverable from, or payable to, the ATO are classified as operating cash flows.

Contributed equity

AASB Interpretation 1038 *Contributions by Owners Made to Wholly-Owned Public Sector Entities* requires transfers in the nature of equity contributions, other than as a result of a restructure of administrative arrangements, to be designated as contributions by owners (at the time of, or prior to, transfer) before such transfers can be recognised as equity contributions. Capital appropriations have been designated as contributions by owners by TI 8 − Requirement 8.1(i) and will be credited directly to Contributed Equity.

Administered items

The department administers, but does not control, certain activities and functions for and on behalf of the State Government that do not contribute to the department's services or objectives. It does not have discretion over how it utilises the transactions in pursuing its own objectives.

Transactions relating to the administered activities are not recognised as the department's income, expenses, assets and liabilities, but are disclosed in the accompanying schedules as 'Administered income and expenses', and 'Administered assets and liabilities'.

The accrual basis of accounting and applicable Australian Accounting Standards have been adopted.

2 Department outputs

How the department operates

This section includes information regarding the nature of funding the department receives and how this funding is utilised to achieve the department's objectives. This note also provides the distinction between controlled funding and administered funding.

Notes to the financial statements
For the year ended 30 June 2025

2.1 Department objectives

Mission

The mission of the department is to lead and steward a WA health system that delivers safe, quality, financially sustainable and accountable health care for all Western Australians.

The department is predominantly funded by State parliamentary appropriations. It also provides licencing services on a fee-for-service basis. The fees charged are determined by prevailing market forces.

Services

The department provides the following services:

1. Public Hospital Admitted Services

The provision of healthcare services to patients in metropolitan and major rural hospitals that meet the criteria for admission and receive treatment and/or care for a period of time, including public patients treated in private facilities under contract to WA Health. Admission to hospital and the treatment provided may include access to acute and/or subacute inpatient services, as well as hospital in the home services. Public Hospital Admitted Services includes teaching, training and research activities provided by the public health service to facilitate development of skills and acquisition or advancement of knowledge related to admitted services. This Service does not include any component of the Mental Health Services reported under Service 4 ‘Mental Health Services’.

2. Public Hospital Emergency Services

The provision of services for the treatment of patients in emergency departments of metropolitan and major rural hospitals, inclusive of public patients treated in private facilities under contract to WA Health. The services provided to patients are specifically designed to provide emergency care, including a range of pre-admission, post-acute and other specialist medical, allied health, nursing and ancillary services. Public Hospital Emergency Services includes teaching, training and research activities provided by the public health service to facilitate development of skills and acquisition or advancement of knowledge related to emergency services. This Service does not include any component of the Mental Health Services reported under Service 4 ‘Mental Health Services’.

3. Public Hospital Non-Admitted Services

The provision of metropolitan and major rural hospital services to patients who do not undergo a formal admission process, inclusive of public patients treated by private facilities under contract to WA Health. This Service includes services provided to patients in outpatient clinics, community-based clinics or in the home, procedures, medical consultation, allied health or treatment provided by clinical nurse specialists. Public Hospital Non-Admitted Services includes teaching, training and research activities provided by the public health service to facilitate development of skills and acquisition or advancement of knowledge related to non-admitted services. This Service does not include any component of the Mental Health Services reported under Service 4 ‘Mental Health Services’.

4. Mental Health Services

The provision of inpatient services where an admitted patient occupies a bed in a designated mental health facility or a designated mental health unit in a hospital setting; and the provision of non-admitted services inclusive of community and ambulatory specialised mental health programs such as prevention and promotion, community support services, community treatment services, community bed-based services and forensic services. This Service includes the provision of state-wide mental health services such as perinatal mental health and eating disorder outreach programs as well as the provision of assessment, treatment, management, care or rehabilitation of persons experiencing alcohol or other drug use problems or co-occurring health issues. Mental Health Services includes teaching, training and research activities provided by the public health service to facilitate development of skills and acquisition or advancement of knowledge related to mental health or alcohol and drug services. This Service includes public patients treated in private facilities under contract to WA Health.

Notes to the financial statements
For the year ended 30 June 2025

2.1 Department objectives (continued)

5. Aged Care, Continuing Care and End of Life Care Services

The provision of aged and continuing care services, community based palliative care services and voluntary assisted dying services. Aged and continuing care services include programs that assess the care needs of older people, provide functional interim care or support for older, frail, aged and younger people with disabilities to continue living independently in the community and maintain independence, inclusive of the services provided by the WA Quadriplegic Centre. Aged and continuing care services are inclusive of community based palliative care services that are delivered by private facilities under contract to WA Health, which focus on the prevention and relief of suffering, quality of life and the choice of care close to home for patients. Voluntary assisted dying includes the provision of services to eligible patients approaching the end of their life and is inclusive of services to provide support to anyone involved with voluntary assisted dying in WA.

6. Public and Community Health Services

The provision of healthcare services and programs delivered to increase optimal health and wellbeing, encourage healthy lifestyles, reduce the onset of disease and disability, reduce the risk of long-term illness as well as detect, protect and monitor the incidence of disease in the population. Public and community health services includes public health programs, Aboriginal health programs, disaster management, environmental health, the provision of grants to non-government organisations for public and community health purposes, emergency road and air ambulance services and services to assist rural based patients travel to receive care.

7. Pathology Services

The provision of state-wide external diagnostic services across the full range of pathology disciplines, inclusive of forensic biology and pathology services to other WA government agencies and services provided to the public by PathWest. This Service also includes the operational costs of PathWest in delivering services to both health service providers and the public.

8. Community Dental Health Services

Dental health services include the school dental service (providing dental health assessment and treatment for school children); the adult dental service for financially, socially and/or geographically disadvantaged people and Aboriginal people; additional and specialist dental; and oral health care provided by the Oral Health Centre of Western Australia to holders of a Health Care Card. Services are provided through government funded dental clinics, itinerant services and private dental practitioners participating in the metropolitan, country and orthodontic patient dental subsidy schemes.

9. Small Rural Hospital Services

Provides emergency care and limited acute medical/minor surgical services in locations 'close to home' for country residents/visitors, by small and rural hospitals classified as block funded. This includes providing community care services aligning to local community needs.

10. Health System Management – Policy and Corporate Services

The provision of strategic leadership, policy and planning services, system performance management and purchasing linked to the statewide planning, budgeting and regulation processes. Health system policy and corporate services includes corporate services inclusive of statutory financial reporting requirements, overseeing, monitoring and promoting improvements in the safety and quality of health services and systemwide infrastructure and asset management services.

11. Health Support Services

The provision of purchased health support services to WA Health entities inclusive of corporate recruitment and appointment, employee data management, payroll services, workers compensation calculation and payments and processing of termination and severance payments. Health Support Services includes finance and business systems services, IT and ICT services, workforce services, project management of systemwide projects and programs and the management of the supply chain and whole of health contracts.

Notes to the financial statements
For the year ended 30 June 2025

2.2 Schedule of income and expenses by service

	Public Hospital Admitted Services		Public Hospital Emergency Services		Public Hospital Non-Admitted Services		Mental Health Services	
	2025 $'000	2024 $'000	2025 $'000	2024 $'000	2025 $'000	2024 $'000	2025 $'000	2024 $'000
COST OF SERVICES								
Expenses								
Employee benefits expenses	-	-	4,616	-	-	-	-	-
Contracts for services	-	-	2,731	-	-	-	-	-
Supplies and services	-	-	5	-	-	-	-	-
Grants and subsidies	5,596,390	5,107,685	1,215,681	1,101,836	1,215,960	1,040,185	33,050	53,349
Depreciation and amortisation expenses	-	-	-	-	-	-	-	-
Loss on disposal of non-current assets	-	-	-	-	-	-	-	-
Finance costs	-	-	-	-	-	-	-	-
Other expenses	-	-	89	-	-	-	-	-
Total cost of services	**5,596,390**	**5,107,685**	**1,223,122**	**1,101,836**	**1,215,960**	**1,040,185**	**33,050**	**53,349**
Income								
User charges and fees	-	-	-	-	-	-	-	-
Commonwealth grants and contributions	1,780,437	1,756,524	387,369	350,073	463,210	386,775	68	122
Other grants and contributions	-	-	-	-	-	-	-	-
Other income	-	-	-	-	-	-	-	-
Total income other than income from State Government	**1,780,437**	**1,756,524**	**387,369**	**350,073**	**463,210**	**386,775**	**68**	**122**
NET COST OF SERVICES	**3,815,953**	**3,351,161**	**835,753**	**751,763**	**752,750**	**653,410**	**32,982**	**53,227**
Income from State Government								
Service appropriation	3,814,946	3,349,332	832,872	750,983	752,673	652,953	32,879	52,744
Income from other public sector entities	-	-	-	-	-	-	-	-
Resources received	-	-	-	-	-	-	-	-
Royalties for Regions Fund	1,007	1,829	181	780	77	457	103	483
Total income from State Government	**3,815,953**	**3,351,161**	**833,053**	**751,763**	**752,750**	**653,410**	**32,982**	**53,227**
SURPLUS/(DEFICIT) FOR THE PERIOD	**-**	**-**	**(2,700)**	**-**	**-**	**-**	**-**	**-**

The schedule of income and expenses by service should be read in conjunction with the accompanying notes.

Notes to the financial statements
For the year ended 30 June 2025

2.2 Schedule of income and expenses by service (continued)

	Aged Care, Continuing Care and End of Life Care Services		Public and Community Health Services		Pathology Services		Community Dental Health Services	
	2025 $'000	2024 $'000	2025 $'000	2024 $'000	2025 $'000	2024 $'000	2025 $'000	2024 $'000
COST OF SERVICES								
Expenses								
Employee benefits expenses	1,630	1,575	29,715	25,590	-	-	-	-
Contracts for services	229,917	205,188	452,615	410,520	-	-	16,284	14,516
Supplies and services	795	513	88,219	82,147	-	-	-	-
Grants and subsidies	197,341	198,089	928,033	868,339	195,158	180,935	109,747	101,547
Depreciation and amortisation expenses	-	-	882	866	-	-	-	-
Loss on disposal of non-current assets	-	-	33	49	-	-	-	-
Finance costs	-	-	3	50	-	-	-	-
Other expenses	226	147	19,158	8,756	-	-	-	-
Total cost of services	**429,909**	**405,512**	**1,518,658**	**1,396,317**	**195,158**	**180,935**	**126,031**	**116,063**
Income								
User charges and fees	-	-	408	17,571	-	-	-	-
Commonwealth grants and contributions	104,780	83,840	123,907	117,865	1,600	10,162	9,686	9,683
Other grants and contributions	-	-	10	-	-	-	-	-
Other income	140	140	10,536	9,114	-	-	-	-
Total income other than income from State Government	**104,920**	**83,980**	**134,861**	**144,550**	**1,600**	**10,162**	**9,686**	**9,683**
NET COST OF SERVICES	**324,989**	**321,532**	**1,383,797**	**1,251,767**	**193,558**	**170,773**	**116,345**	**106,380**
Income from State Government								
Service appropriation	344,459	353,075	991,046	861,095	193,558	170,773	103,472	96,991
Income from other public sector entities	-	1	52,711	51,812	-	-	-	-
Resources received	-	-	-	84	-	-	-	-
Royalties for Regions Fund	388	479	10,258	13,259	-	-	-	-
Total income from State Government	**344,847**	**353,555**	**1,054,015**	**926,250**	**193,558**	**170,773**	**103,472**	**96,991**
SURPLUS/(DEFICIT) FOR THE PERIOD	**19,858**	**32,023**	**(329,782)**	**(325,517)**	**-**	**-**	**(12,873)**	**(9,389)**

The schedule of income and expenses by service should be read in conjunction with the accompanying notes.

Notes to the financial statements
For the year ended 30 June 2025

2.2 Schedule of income and expenses by service (continued)

	Small Rural Hospital Services		Health System Management - Policy and Corporate Services		Health Support Services		Total	
	2025 $'000	2024 $'000	2025 $'000	2024 $'000	2025 $'000	2024 $'000	2025 $'000	2024 $'000
COST OF SERVICES								
Expenses								
Employee benefits expenses	-	-	194,258	165,196	-	-	230,219	192,361
Contracts for services	-	-	79,552	74,602	-	-	781,099	704,826
Supplies and services	-	-	3,414	6,091	-	-	92,433	88,751
Grants and subsidies	356,088	326,779	78,080	33,309	373,050	345,357	10,298,578	9,357,410
Depreciation and amortisation expenses	-	-	2,181	1,350	-	-	3,063	2,216
Loss on disposal of non-current assets	-	-	114	-	-	-	147	49
Finance costs	-	-	89	45	-	-	92	95
Other expenses	-	-	42,784	45,501	-	-	62,257	54,404
Total cost of services	**356,088**	**326,779**	**400,472**	**326,094**	**373,050**	**345,357**	**11,467,888**	**10,400,112**
Income								
User charges and fees	-	-	25,381	5,575	-	-	25,789	23,146
Commonwealth grants and contributions	132,437	125,087	119,849	117,531	-	-	3,123,343	2,957,662
Other grants and contributions	-	-	632	605	-	-	642	605
Other income	-	-	429	49	-	-	11,105	9,303
Total income other than income from State Government	**132,437**	**125,087**	**146,291**	**123,760**	**-**	**-**	**3,160,879**	**2,990,716**
NET COST OF SERVICES	**223,651**	**201,692**	**254,181**	**202,334**	**373,050**	**345,357**	**8,307,009**	**7,409,396**
Income from State Government								
Service appropriation	221,226	200,738	500,650	435,443	373,050	345,357	8,160,831	7,269,484
Income from other public sector entities	-	-	66,517	11,247	-	-	119,228	63,060
Resources received	-	-	716	543	-	-	716	627
Royalties for Regions Fund	2,425	954	-	-	-	-	14,439	18,241
Total income from State Government	**223,651**	**201,692**	**567,883**	**447,233**	**373,050**	**345,357**	**8,295,214**	**7,351,412**
SURPLUS/(DEFICIT) FOR THE PERIOD	**-**	**-**	**313,702**	**244,899**	**-**	**-**	**(11,795)**	**(57,984)**

The schedule of income and expenses by service should be read in conjunction with the accompanying notes.

Notes to the financial statements
For the year ended 30 June 2025

2.3 Schedule of assets and liabilities by service

	Public Hospital Admitted Services		Public Hospital Emergency Services		Public Hospital Non-Admitted Services		Mental Health Services	
	2025 $'000	2024 $'000	2025 $'000	2024 $'000	2025 $'000	2024 $'000	2025 $'000	2024 $'000
Assets								
Current assets	-	-	-	-	-	-	-	-
Non-current assets	-	-	-	-	-	-	-	-
TOTAL ASSETS	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Liabilities								
Current liabilities	-	-	-	-	-	-	-	-
Non-current liabilities	-	-	-	-	-	-	-	-
TOTAL LIABILITIES	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
NET ASSETS	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**

	Aged Care, Continuing Care and End of Life Care Services		Public and Community Health Services		Pathology Services		Community Dental Health Services	
	2025 $'000	2024 $'000	2025 $'000	2024 $'000	2025 $'000	2024 $'000	2025 $'000	2024 $'000
Assets								
Current assets	-	64	33,542	33,259	-	-	-	-
Non-current assets	-	-	5,516	3,092	-	-	-	-
TOTAL ASSETS	**-**	**64**	**39,058**	**36,351**	**-**	**-**	**-**	**-**
Liabilities								
Current liabilities	16,778	24,802	26,798	15,772	-	-	1,170	3,334
Non-current liabilities	-	-	437	917	-	-	-	-
TOTAL LIABILITIES	**16,778**	**24,802**	**27,235**	**16,689**	**-**	**-**	**1,170**	**3,334**
NET ASSETS	**(16,778)**	**(24,738)**	**11,823**	**19,662**	**-**	**-**	**(1,170)**	**(3,334)**

The schedule of assets and liabilities by service should be read in conjunction with the accompanying notes.

Notes to the financial statements
For the year ended 30 June 2025

2.3 Schedule of assets and liabilities by service (continued)

	Small Rural Hospital Services		Health System Management - Policy and Corporate Services		Health Support Services		Total	
	2025 $'000	2024 $'000	2025 $'000	2024 $'000	2025 $'000	2024 $'000	2025 $'000	2024 $'000
Assets								
Current assets	-	-	368,938	277,281	-	-	402,480	310,604
Non-current assets	-	-	171,568	143,233	-	-	177,084	146,325
TOTAL ASSETS	**-**	**-**	**540,506**	**420,514**	**-**	**-**	**579,564**	**456,929**
Liabilities								
Current liabilities	-	-	130,865	96,520	-	-	175,611	140,428
Non-current liabilities	-	-	14,928	15,065	-	-	15,365	15,982
TOTAL LIABILITIES	**-**	**-**	**145,793**	**111,585**	**-**	**-**	**190,976**	**156,410**
NET ASSETS	**-**	**-**	**394,713**	**308,929**	**-**	**-**	**388,588**	**300,519**

The schedule of assets and liabilities by service should be read in conjunction with the accompanying notes.

Notes to the financial statements
For the year ended 30 June 2025

3 Use of our funding

Expenses incurred in the delivery of services

This section provides additional information about how the department's funding is applied and the accounting policies that are relevant for an understanding of the items recognised in the financial statements. The primary expenses incurred by the department in achieving its objectives and the relevant notes are:

	Notes
Employee benefits expenses	3.1(a)
Employee related provisions	3.1(b)
Grants and subsidies	3.2
Contracts for services	3.3
Supplies and services	3.4
Other expenses	3.5

3.1(a) Employee benefits expenses

	2025 $'000	2024 $'000
Employee benefits	206,981	173,314
Superannuation - defined contributions plans	22,739	18,548
Termination benefits	499	499
Total employee benefits expenses	**230,219**	**192,361**
Add: AASB 16 Non-monetary benefits (not included in employee benefits expense)	205	167
Less: Employee contributions (per the Statement of comprehensive income)	(40)	(43)
Net employee benefits	**230,384**	**192,485**

Employee benefits include wages, salaries and social contributions, accrued and paid leave entitlements and paid sick leave, and non-monetary benefits recognised under accounting standards other than AASB 16 (such as medical care, housing, cars and free or subsidised goods or services) for employees.

Superannuation is the amount recognised in profit or loss of the Statement of comprehensive income comprised of employer contributions paid to the Gold State Super (concurrent contributions), the West State Super, other Government Employees Superannuation Board (GESB) schemes, or other superannuation funds.

Termination benefits are payable when employment is terminated before normal retirement date, or when an employee accepts an offer of benefits in exchange for the termination of employment. Termination benefits are recognised when the department is demonstrably committed to terminating the employment of current employees according to a detailed formal plan without possibility of withdrawal or providing termination benefits as a result of an offer made to encourage voluntary redundancy. Benefits falling due more than 12 months after the end of the reporting period are discounted to present value.

Notes to the financial statements
For the year ended 30 June 2025

3.1(a) Employee benefits expenses (continued)

AASB 16 non-monetary benefits are non-monetary employee benefits expenses, predominantly relating to the provision of vehicle and housing benefits that are recognised under AASB 16 which are excluded from the employee benefits expense.

Employee contributions are contributions made to the department by employees towards employee benefits that have been provided by the department. This includes both AASB 16 and non-AASB 16 employee contributions.

3.1(b) Employee related provisions

	2025 $'000	2024 $'000
Current employee benefits provisions		
Annual leave	22,487	19,003
Long service leave	16,330	14,099
Deferred salary scheme	156	145
Total current employee related provisions	**38,973**	**33,247**
Non-current employee benefits provisions		
Long service leave	13,950	14,263
Total non-current employee related provisions	**13,950**	**14,263**
Total employee related provisions	**52,923**	**47,510**

Provision is made for benefits accruing to employees in respect of wages and salaries, annual leave and long service leave for services rendered up to the reporting date and recorded as an expense during the period the services are delivered.

Annual leave liabilities are classified as current, as there is no right at the end of the reporting period to defer settlement for at least 12 months after the reporting period. Assessments indicate that actual settlement of the liabilities is expected to occur as follows:

	2025 $'000	2024 $'000
Within 12 months of the end of the reporting period	11,815	13,073
More than 12 months after the end of the reporting period	10,672	5,930
	22,487	**19,003**

The provision for annual leave is calculated at the present value of expected payments to be made in relation to services provided by employees up to the reporting date.

Notes to the financial statements
For the year ended 30 June 2025

3.1(b) Employee related provisions (continued)

Long service leave liabilities are unconditional long service leave provisions that are classified as current liabilities as the department does not have the right at the end of the reporting period to defer settlement of the liability for at least 12 months after the end of the reporting period.

Pre-conditional and conditional long service leave provisions are classified as non-current liabilities because the department has the right to defer the settlement of the liability until the employee has completed the requisite years of service.

Assessments indicate that actual settlement of the liabilities is expected to occur as follows:

	2025 $'000	2024 $'000
Within 12 months of the end of the reporting period	3,864	3,470
More than 12 months after the end of the reporting period	26,416	24,892
	30,280	**28,362**

The provision for long service leave is calculated at present value as the department does not expect to wholly settle the amounts within 12 months. The present value is measured taking into account the present value of expected future payments to be made in relation to services provided by employees up to the reporting date. These payments are estimated using the remuneration rate expected to apply at the time of settlement and discounted using market yields at the end of the reporting period on national government bonds with terms to maturity that match, as closely as possible, the estimated future cash outflows.

Deferred salary scheme liabilities are classified as current where there is no right at the end of the reporting period to defer settlement for at least 12 months after the reporting period. Actual settlement of the liabilities is expected to occur as follows:

	2025 $'000	2024 $'000
Within 12 months of the end of the reporting period	156	145
More than 12 months after the end of the reporting period	-	-
	156	**145**

Notes to the financial statements
For the year ended 30 June 2025

3.1(b) Employee related provisions (continued)

Key sources of estimation uncertainty – long service leave

Key estimates and assumptions concerning the future are based on historical experience and various other factors that have a significant risk of causing a material adjustment to the carrying amount of assets and liabilities within the next reporting period.

Several estimates and assumptions are used in calculating the department's long service leave provision. These include:

- expected future salary rates
- discount rates
- employee retention rates
- expected future payments.

Changes in these estimations and assumptions may impact on the carrying amount of the long service leave provision. Any gain or loss following revaluation of the present value of long service leave liabilities is recognised as employee benefits expense.

3.2 Grants and subsidies

	2025 $'000	2024 $'000
Recurrent		
Funding for the delivery of health services by statutory authorities within the WA health system (a):		
Child and Adolescent Health Service (b)	901,067	815,894
East Metropolitan Health Service (b)	1,831,998	1,619,291
North Metropolitan Health Service (b)	2,333,118	2,138,530
South Metropolitan Health Service (b)	2,186,044	1,938,221
WA Country Health Service (b)	2,360,358	2,149,711
Health Support Services (b)	373,106	345,419
PathWest Laboratory Medicine WA (b)	195,605	181,327
Queen Elizabeth II Medical Centre Trust (b)	844	799
Quadriplegic Centre (b)	4,469	5,389
Research and development grants	60,610	76,763
Podiatry subsidy scheme	29	33
Other grants and subsidies	51,330	86,033
Total grants and subsidies	**10,298,578**	**9,357,410**

Notes to the financial statements
For the year ended 30 June 2025

3.2 Grants and subsidies (continued)

(a) Includes the non-cash component of service appropriation.

(b) The *Health Services Act 2016* came into effect from 1 July 2016. Under this Act, the following statutory authorities are established: Child and Adolescent Health Service, East Metropolitan Health Service, North Metropolitan Health Service, South Metropolitan Health Service, WA Country Health Service, Health Support Services, PathWest Laboratory Medicine WA, Queen Elizabeth II Medical Centre Trust and Quadriplegic Centre. These transactions are considered to be significant related party transactions.

Transactions in which the department provides goods, services, assets (or extinguishes a liability) or labour to another party without receiving approximately equal value in return are categorised as grant or subsidy expenses. These payments or transfers are recognised at fair value at the time of the transaction and are recognised as an expense in the reporting period in which they are incurred. They include transactions such as: grants, subsidies, personal benefit payments made in cash to individuals, other transfer payments made to public sector agencies, local government, non-government organisations, and community groups.

3.3 Contracts for services

	2025 $'000	2024 $'000
Health care services provided by external organisations (a)	726,961	646,231
Shared services provided by Health Support Services (b)	16,914	19,529
Other contracts for services	37,224	39,209
Total contracts for services	**781,099**	**704,969**

(a) Included patient transport cost $326.6 million in 2024−25 ($284.6 million in 2023−24) and aged care service cost $222.2 million in 2024−25 ($199.4 million in 2023−24).

(b) Shared services provided by Health Support Services include IT, supply chain, finance, payroll and human resources.

Contracts for services mainly consist of payments to external organisations for the purchase of health care services, including Aboriginal health, blood and organs, chronic diseases, communicable diseases, environmental health, health promotion, home and community care, mental health, oral health, palliative care, patient transport, aged care, and pathology services.

Notes to the financial statements
For the year ended 30 June 2025

3.4 Supplies and services

	2025 $'000	2024 $'000
Medical supplies (a)	89,700	84,614
Communications	1,407	1,298
Other consumables	1,326	2,696
Total supplies and services	**92,433**	**88,608**

(a) Medical supplies included $77.6 million of vaccine costs for 2024–25 ($75.1 million in 2023–24).

Supplies and services are recognised as an expense in the reporting period in which they are incurred. The carrying amounts of any materials held for distribution are expensed when the materials are distributed.

Notes to the financial statements
For the year ended 30 June 2025

3.5 Other expenses

	2025 $'000	2024 $'000
Advertising	2,695	4,647
Computer related expenses	4,672	5,909
Ex-gratia payments (a)	6,992	5,670
Expected credit losses expense (b)	(2)	(22)
Freight and cartage	2,049	1,998
Insurance	396	400
Legal expenses	2,964	1,997
Other employee related expenses	2,487	3,194
Promotional expenses	181	14
Rental (c)	17,378	16,713
Repairs and maintenance (d)	948	1,753
Scholarships	3,155	3,327
Stock write down (e)	12,866	2,962
Special functions	548	729
Subscriptions	2,126	2,084
Write-off of debt	48	103
Worker's compensation insurance	1,267	317
Other	1,487	2,609
Total other expenses	**62,257**	**54,404**

(a) **Ex-gratia payments**: Under the Private Patient Scheme approved by the State Government, the department commenced the ex-gratia payments towards patient fee debts from July 2015. The total amount of ex-gratia payments was $6.9 million for 2024−25 ($1.2 million for East Metropolitan Health Service, $1.7 million for North Metropolitan Health Service, $3.4 million for South Metropolitan Health Service, $0.6 million for WA Country Health Service).

(b) **Expected credit losses expense** is recognised for movement in the allowance for impairment of trade receivables. Please refer to note 6.2.1 Movement in the allowance for impairment of trade receivables.

Notes to the financial statements
For the year ended 30 June 2025

3.5 Other expenses (continued)

(c) **Rental expenses** include:
- (i) short-term leases with a lease term of 12 months or less
- (ii) low-value leases with an underlying value of $5,000 or less
- (iii) variable lease payments, recognised in the period in which the event or condition that triggers those payments occurs
- (iv) Office rental expenses which are expensed as incurred, as Memorandum of Understanding Agreements between the department and the Department of Finance for the leasing of office accommodation contain significant substitution rights.

(d) **Repairs and maintenance costs** are recognised as expenses as incurred, except where they relate to the replacement of a significant component of an asset. In that case, the costs are capitalised and depreciated.

(e) **Stock write down expenses** are recognised when the carrying value of inventory exceeds net realisable value due to a reduction in market value, loss of service potential or obsolescence. There was $3.5 million of vaccines written down in 2024-25 ($2.4 million in 2023−24). In addition, $9.4 million of medical equipment purchased during the COVID-19 pandemic was written down in 2024-25 due to loss of service potential ($0.6 million in 2023-24).

4 Our funding sources

How we obtain our funding

This section provides additional information about how the department obtains its funding and the relevant accounting policy notes that govern the recognition and measurement of this funding. The primary income received by the department and the relevant notes are:

	Notes
Income from State Government	4.1
User fees and charges	4.2
Commonwealth grants and contributions	4.3
Other grants and contributions	4.4
Other income	4.5
Gains/(losses) on disposal	4.6

Notes to the financial statements
For the year ended 30 June 2025

4.1 Income from State Government

	2025 $'000	2024 $'000
Appropriation received during the period:		
Service appropriation	7,976,345	7,069,664
Amount authorised by other statutes:		
Salaries and Allowances Act 1975	1,314	1,272
Lotteries Commission Act 1990	183,172	198,548
Total appropriation	**8,160,831**	**7,269,484**
Income received from other public sector entities during the period:		
Department of Treasury - WA Future Health Research and Innovation Account	52,400	51,400
Department of Education - school health services for students attending public schools	11,503	10,955
Department of Water and Environmental Regulation - partnership in the development of the Health Sector Adaptation Plan	-	175
Mental Health Commission - Clinical and emergency response	6,091	-
Insurance Commission of WA - Motor injury insurance scheme	48,550	-
WA Police - provision of data services	113	159
WA health system statutory authorities - various services provided by the department	345	339
Other	226	32
Total income from other public sector entities	**119,228**	**63,060**

Notes to the financial statements
For the year ended 30 June 2025

4.1 Income from State Government (continued)

	2025 $'000	2024 $'000
Resources received from other public sector entities during the period:		
Department of Education - accommodation	1	-
Landgate - valuation services and land information	199	118
State Solicitor's Office - legal service	431	442
Department of Primary Industries and Regional Development - digital map downloads	18	-
Department of Finance - office accommodation management	67	67
Total resources received	**716**	**627**
Royalties for Regions Fund		
Regional Community Services Account:		
Regional Workers Incentives	5,165	5,564
Find Cancer Early Program	411	411
Paid Paramedics for the Regions	8,863	12,266
Total Royalties for Regions Fund	**14,439**	**18,241**
Total income from State Government	**8,295,214**	**7,351,412**

Service appropriations are recognised as income at the fair value of consideration received in the period in which the department gains control of the appropriated funds. The department gains control of appropriated funds at the time those funds are deposited in the bank account or credited to the holding account held at Treasury.

Income from other public sector entities is recognised as income when the department has satisfied its performance obligations under the funding agreement. If there is no performance obligation, income will be recognised when the department receives the funds or the funds are receivable.

Resources received from other public sector entities are recognised as income equivalent to the fair value of the assets received, or the fair value of services received that can be reliably determined and which would have been purchased if not donated.

The Regional Community Services Account is a sub-fund within the over-arching Royalties for Regions Fund. The recurrent fund is committed to projects and programs in WA regional areas and is recognised as income when the department receives the funds or the funds are receivable.

Notes to the financial statements
For the year ended 30 June 2025

4.1 Income from State Government (continued)

Summary of consolidated account appropriations

For the year ended 30 June 2025

	Budget $'000	Section 25 transfers $'000	Additional Funding* $'000	Revised Budget $'000	Actual $'000	Variance $'000
Delivery of services						
Item 57 Net amount appropriated to deliver services	7,261,614	201,844	512,887	7,976,345	7,976,345	-
Amount Authorised by Other Statutes						
- *Salaries and Allowances Act 1975*	1,314	-	-	1,314	1,314	-
- *Lotteries Commission Act 1990*	158,416	-	19,449	177,865	183,172	5,307
Total appropriations provided to deliver services	**7,421,344**	**201,844**	**532,336**	**8,155,524**	**8,160,831**	**5,307**
Capital						
Item 138 Capital appropriation	478,410	41,709	-	520,119	420,228	(99,891)
Administered transactions						
Item 42 Administered grants, subsidies and other transfer payments	27,826	(37,722)	11,659	1,763	-	(1,763)
Item 123 Administered capital appropriation	67,165	(41,709)	-	25,456	-	(25,456)
Total administered transactions	**94,991**	**(79,431)**	**11,659**	**27,219**	**-**	**(27,219)**
Total consolidated account appropriations	**7,994,745**	**164,122**	**543,995**	**8,702,862**	**8,581,059**	**(121,803)**

* Additional funding includes supplementary funding and new funding authorised under section 27 of the *Financial Management Act 2006* and amendments to standing appropriations.

Notes to the financial statements
For the year ended 30 June 2025

4.2 User charges and fees

	2025 $'000	2024 $'000
Licence and registration fees	4,569	4,424
Cross border charges	20,144	17,167
Other user charges and fees	1,076	1,555
Total user charges and fees	**25,789**	**23,146**

Revenue is recognised:

- at the transaction price when the department transfers control of the services to customers
- for the major activities as follows:
  - at a point-in-time for $25,515,161 ($22,962,747 in 2023-24).
  - over-time for $272,996 ($183,253 in 2023-24).

Net appropriation determination

The Treasurer may make a determination providing for prescribed receipts to be retained for services under the control of the department. In accordance with the determination specified in the 2024−25 Budget Statements, the department retained $371.3 million in 2024−25 ($295.1 million in 2023−24) from the following:

- proceeds from fees and charges
- sale of goods
- Commonwealth specific purpose grants
- other departmental revenue.

Notes to the financial statements
For the year ended 30 June 2025

4.3 Commonwealth grants and contributions

	2025 $'000	2024 $'000
Recurrent grants - cash		
National Health Reform Agreement (a):		
Statutory authorities within WA health system	2,827,661	2,683,935
Public health division within the department	60,972	56,303
Specific purpose grants:		
COVID-19 Response	-	252
Department of Veterans' Affairs	45,076	41,698
Aged Care Programs	61,148	48,988
Community Health and Hospitals Program	-	9,500
Disability Support for Older Australians	4,469	4,667
Public Health Outcome Funding Agreement - Vaccines	2,850	1,717
Public Dental Services for Adults	17,785	9,686
Other programs	31,157	28,941
Recurrent grants - non-cash		
Essential vaccines received free of charge	72,225	71,975
Total Commonwealth grants and contributions	**3,123,343**	**2,957,662**

(a) From 1 July 2012, activity based funding and block grant funding have been received from the Commonwealth Government under the National Health Reform Agreement (NHRA) for services, health teaching, training and research provided by local hospital networks or other organisations, and any other matter that under that agreement is to be funded through the National Health Funding Pool, the State Managed Fund (Health) Account and the State Managed Fund (Mental Health) Account. The funding arrangement established under the NHRA requires the Commonwealth to make funding payments to the State Pool Account from which distributions to the local hospital networks are made by the department and Mental Health Commission. All moneys in the State Pool Account and in the State Managed Fund (Health) Account are fully allocated to local hospital networks in each financial year (see note 9.9 Special purpose accounts). Under the NHRA, the Commonwealth Government also provides public health funding to the department.

Income from grants to acquire/construct a recognisable non-financial asset to be controlled by the department is recognised when the department satisfies its obligations under the transfer. The department satisfies the obligations under the transfer over time as the non-financial assets are being constructed. The department typically satisfies the obligations under the transfer when it achieves milestones specified in the grant agreement and amounts received in advance of obligation satisfaction are reported at note 6.6 Contract liabilities.

Notes to the financial statements
For the year ended 30 June 2025

4.4 Other grants and contributions

	2025 $'000	2024 $'000
Research grants	409	403
Other	233	202
Total other grants and contributions	**642**	**605**

4.5 Other income

	2025 $'000	2024 $'000
General public contributions and donations	6,000	2,000
Interest income	4,251	4,269
Return of unspent funding	854	3,034
Total other income	**11,105**	**9,303**

4.6 Gains/(losses) on disposal

	2025 $'000	2024 $'000
Net proceeds from disposal of non-current assets		
Infrastructure, property, plant and equipment	-	1
Non-current assets classified as assets held for sale	-	-
Carrying amount of non-current assets disposed		
Infrastructure, property, plant and equipment	(147)	(50)
Non-current assets classified as assets held for sale	-	-
Net gains/(losses) on disposal of non-current assets	**(147)**	**(49)**

Realised and unrealised gains are usually recognised on a net basis.

Gains and losses on the disposal of non-current assets are presented by deducting from the proceeds on disposal from the carrying amount of the asset and related selling expenses. Gains and losses are recognised in the Statement of comprehensive income.

Notes to the financial statements
For the year ended 30 June 2025

5 Key assets

This section includes information regarding the key assets the department utilises to gain economic benefits or provide service potential. The section sets out both the key accounting policies and financial information about the performance of these assets:

	Notes
Infrastructure, property, plant and equipment	5.1
Intangible assets	5.2
Right-of-use assets	5.3

5.1 Infrastructure, property, plant and equipment

Year ended 30 June 2025	Land $'000	Buildings $'000	Site infrastructure $'000	Leasehold improvements $'000	Computer equipment $'000	Furniture and fittings $'000	Other plant and equipment $'000	Work in progress $'000	Artworks $'000	Total $'000
1 July 2024										
Gross carrying amount	19,143	2,526	152	3,838	236	40	4,018	16,452	81	46,486
Accumulated depreciation	-	-	(32)	(2,319)	(194)	(29)	(2,476)	-	-	(5,050)
Accumulated impairment loss	-	-	-	-	-	-	-	-	-	-
Carrying amount at start of period	**19,143**	**2,526**	**120**	**1,519**	**42**	**11**	**1,542**	**16,452**	**81**	**41,436**
Additions	-	-	-	10,844	86	2	4,150	26,085	-	41,167
Cost adjustment	-	-	-	-	-	-	-	-	-	-
Disposals	(219)	(1,820)	-	-	-	-	(889)	-	-	(2,928)
Expensed	-	-	-	-	-	-	-	-	-	-
Transfers from/(to) other reporting entities (a)	640	-	-	-	-	-	-	-	-	640
Revaluation increments/(decrements)	334	170	49	-	-	-	-	-	-	553
Impairment losses	-	-	-	-	-	-	-	-	-	-
Impairment losses reversed	-	-	-	-	-	-	-	-	-	-
Depreciation	-	(71)	(16)	(1,485)	(29)	(5)	(500)	-	-	(2,106)
Carrying amount at 30 June 2025	**19,898**	**805**	**153**	**10,878**	**99**	**8**	**4,303**	**42,537**	**81**	**78,762**
Gross carrying amount	19,898	805	153	14,682	301	42	5,787	42,537	81	84,286
Accumulated depreciation	-	-	-	(3,804)	(202)	(34)	(1,484)	-	-	(5,524)
Accumulated impairment loss	-	-	-	-	-	-	-	-	-	-

(a) The Department of Planning, Lands and Heritage (DPLH) is the only department with the power to sell Crown land. The land is transferred to DPLH for sale and the agency accounts for the transfer as a distribution to owner.

Notes to the financial statements
For the year ended 30 June 2025

5.1 Infrastructure, property, plant and equipment (continued)

Year ended 30 June 2024	Land $'000	Buildings $'000	Site infrastructure $'000	Leasehold improvements $'000	Computer equipment $'000	Furniture and fittings $'000	Other plant and equipment $'000	Work in progress $'000	Artworks $'000	Total $'000
1 July 2023										
Gross carrying amount	20,717	2,271	152	3,294	221	44	3,712	23	81	30,515
Accumulated depreciation	-	-	(16)	(1,683)	(173)	(23)	(2,163)	-	-	(4,058)
Accumulated impairment loss	-	-	-	-	-	-	-	-	-	
Carrying amount at start of period	**20,717**	**2,271**	**136**	**1,611**	**48**	**21**	**1,549**	**23**	**81**	**26,457**
Additions	-	-	-	544	15	-	435	16,452	-	17,446
Cost adjustment	-	-	-	-	-	-	-	-	-	-
Disposals	-	-	-	-	-	-	(49)	-	-	(49)
Expensed	-	-	-	-	-	-	-	(23)	-	(23)
Transfers from/(to) other reporting entities	-	(64)	-	-	-	(4)	-	-	-	(68)
Revaluation increments/(decrements)	(1,574)	411	-	-	-	-	-	-	-	(1,163)
Impairment losses	-	-	-	-	-	-	-	-	-	-
Impairment losses reversed	-	-	-	-	-	-	-	-	-	-
Depreciation	-	(92)	(16)	(636)	(21)	(6)	(393)	-		(1,164)
Carrying amount at 30 June 2024	**19,143**	**2,526**	**120**	**1,519**	**42**	**11**	**1,542**	**16,452**	**81**	**41,436**
Gross carrying amount	19,143	2,526	152	3,838	236	40	4,018	16,452	81	46,486
Accumulated depreciation	-	-	(32)	(2,319)	(194)	(29)	(2,476)	-	-	(5,050)
Accumulated impairment loss	-	-	-	-	-	-	-	-	-	-

Initial recognition

Items of infrastructure, property, plant and equipment, costing $5,000 or more are measured initially at cost. Where an asset is acquired for no cost or significantly less than fair value, the cost is valued at its fair value at the date of acquisition.

Items of infrastructure, property, plant and equipment costing less than $5,000 are immediately expensed direct to the Statement of comprehensive income (other than where they form part of a group of similar items which are significant in total).

The cost of a leasehold improvement is capitalised and depreciated over the shorter of the remaining term of the lease or the estimated useful life of the leasehold improvement.

Notes to the financial statements
For the year ended 30 June 2025

5.1 Infrastructure, property, plant and equipment (continued)

Subsequent measurement

Subsequent to initial recognition of an asset, the revaluation model is used for the measurement of:

- land
- buildings
- site infrastructure.

Land is carried at fair value.

Buildings and infrastructure are carried at fair value less accumulated depreciation and accumulated impairment losses.

All other property, plant and equipment are stated at historical cost less accumulated depreciation and accumulated impairment losses.

Land and buildings are independently valued annually by the Western Australian Land Information Authority (Landgate). The effective date was at 1 July 2024, with valuations performed during the year ended 30 June 2025 and recognised at 30 June 2025.

In addition, for buildings under the current replacement cost basis, estimated professional and project management fees are included in the valuation of current use assets as required by AASB 2022-10 *Amendments to Australian Accounting Standards – Fair Value Measurement of Non-Financial Assets of Not-for-Profit Public Sector Entities.*

These valuations are undertaken annually to ensure that the carrying amount of the assets does not differ materially from their fair value at the end of the reporting period.

Site infrastructure is independently valued every 3 to 5 years by Rider Levett Bucknall WA Pty Ltd (Quantity Surveyor). These assets were independently revalued and recognised at 30 June 2025.

Site infrastructures include roads, footpaths, paved areas, at-grade car parks, boundary walls, boundary fencing, boundary gates, covered ways, landscaping and improvements, external stormwater and sewer drainage, external water, gas and electricity supply, and external communication cables.

Significant assumptions and judgements: the most significant assumptions and judgements in estimating fair value are made in assessing whether to apply the existing use basis to assets and in determining estimated economic life. Professional judgement by the valuer is required where the evidence does not provide a clear distinction between market type assets and existing use assets.

Notes to the financial statements
For the year ended 30 June 2025

5.1.1 Depreciation and impairment charge for the period

	Notes	2025 $'000	2024 $'000
Depreciation			
Buildings	5.1	71	92
Site infrastructure	5.1	16	16
Leasehold improvement	5.1	1,485	636
Computer equipment	5.1	29	21
Furniture and fittings	5.1	5	6
Other plant and equipment	5.1	500	393
Total depreciation for the period		**2,106**	**1,164**

As at 30 June 2025 there were no indications of impairment to property, plant and equipment or site infrastructure.

All surplus assets at 30 June 2025 have either been classified as assets held for sale or have been written-off.

Useful lives

All infrastructure, property, plant and equipment that have a limited useful life are systematically depreciated over their estimated useful lives in a manner that reflects the consumption of their future economic benefits. The exceptions to this rule include assets held for sale, land and investment properties.

Depreciation is generally calculated on a straight line basis at rates that allocate the asset's value, less any estimated residual value, over its estimated useful life. Typical estimated useful lives for the different asset classes for current and prior years are included in the table below:

Asset	Useful life
Buildings	50 years
Site infrastructure	50 years
Leasehold Improvements	Life of lease
Computer equipment	3 to 10 years
Furniture and fittings	5 to 15 years
Other plant and equipment	2 to 15 years

The estimated useful lives, residual values and depreciation method are reviewed at the end of each annual reporting period, and adjustments are made where appropriate.

Land and works of art, which are considered to have an indefinite life, are not depreciated. Depreciation is not recognised in respect of these assets because their service potential has not, in any material sense, been consumed during the reporting period.

Notes to the financial statements
For the year ended 30 June 2025

5.1.1 Depreciation and impairment charge for the period (continued)

Impairment

Non-financial assets, including items of plant and equipment, are tested for impairment whenever there is an indication that the asset may be impaired. Where there is an indication of impairment, the recoverable amount is estimated. Where the recoverable amount is less than the carrying amount, the asset is considered impaired and is written down to the recoverable amount and an impairment loss is recognised.

Where an asset measured at cost is written down to its recoverable amount, an impairment loss is recognised through profit or loss.

Where a previously revalued asset is written down to its recoverable amount, the loss is recognised as a revaluation decrement through other comprehensive income.

As the department is a not-for-profit agency, the recoverable amount of regularly revalued specialised assets is anticipated to be materially the same as fair value.

If there is an indication that there has been a reversal in impairment, the carrying amount shall be increased to its recoverable amount. However, this reversal should not increase the asset's carrying amount above what would have been determined, net of depreciation or amortisation, if no impairment loss had been recognised in prior years.

The risk of impairment is generally limited to circumstances where an asset's depreciation is materially understated, where the replacement cost is falling or where there is a significant change in useful life. Each relevant class of assets is reviewed annually to verify that the accumulated depreciation/amortisation reflects the level of consumption or expiration of the asset's future economic benefits and to evaluate any impairment risk from declining replacement costs.

5.2 Intangible assets

Year ended 30 June 2025	Computer software $'000	Works in progress $'000	Total $'000
1 July 2024			
Gross carrying amount	1,455	109	1,564
Accumulated amortisation	(970)	-	(970)
Carrying amount at start of period	**485**	**109**	**594**
Additions	-	3,231	3,231
Capitalised	-	-	-
Disposals	-	-	-
Expensed	-	(109)	(109)
Amortisation expense	(291)	-	(291)
Carrying amount at 30 June 2025	**194**	**3,231**	**3,425**
Gross carrying amount	1,455	3,231	4,686
Accumulated amortisation	(1,261)	-	(1,261)

Notes to the financial statements
For the year ended 30 June 2025

5.2 Intangible assets (continued)

Year ended 30 June 2024	Computer software $'000	Works in progress $'000	Total $'000
1 July 2023			
Gross carrying amount	1,455	1,549	3,004
Accumulated amortisation	(679)	-	(679)
Carrying amount at start of period	**776**	**1,549**	**2,325**
Additions	-	109	109
Capitalised	-	-	-
Disposals	-	-	-
Expensed	-	(1,549)	(1,549)
Amortisation expense	(291)	-	(291)
Carrying amount at 30 June 2024	**485**	**109**	**594**
Gross carrying amount	1,455	109	1,564
Accumulated amortisation	(970)	-	(970)

Initial recognition

Intangible assets are initially recognised at cost. For assets acquired at no cost or for nominal cost, the cost is their fair value at the date of acquisition.

Acquired and internally generated intangible assets costing $5,000 or more, which meet the recognition criteria as per AASB 138.57 *Intangible Assets* (as noted below), are capitalised.

Costs incurred:

- below these thresholds are immediately expensed directly to the Statement of comprehensive income
- in the research phase of a project are immediately expensed.

An internally generated intangible asset arising from development (or from the development phase of an internal project) is recognised if, and only if, all of the following are demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use or sale
- an intention to complete the intangible asset, and use or sell it
- the ability to use or sell the intangible asset
- the intangible asset will generate probable future economic benefit
- the availability of adequate technical, financial and other resources to complete the development and to use or sell the intangible asset
- the ability to measure reliably the expenditure attributable to the intangible asset during its development.

Notes to the financial statements
For the year ended 30 June 2025

5.2 Intangible assets (continued)

Subsequent measurement

The cost model is applied for subsequent measurement of intangible assets, requiring the asset to be carried at cost less any accumulated amortisation and accumulated impairment losses.

5.2.1 Amortisation and impairment charge for the period

	2025 $'000	2024 $'000
Computer software	291	291
Total amortisation for the period	**291**	**291**

As at 30 June 2025 there were no indications of impairment to intangible assets.

The department held no goodwill or intangible assets with an indefinite useful life during the reporting period. At the end of the reporting period there were no intangible assets not yet available for use.

Amortisation of finite life intangible assets is calculated on a straight line basis at rates that allocate the asset's value over its estimated useful life. All intangible assets controlled by the department have a finite useful life and zero residual value. Estimated useful lives are reviewed annually.

The estimated useful life for the following intangible asset class is:

Asset	Useful life
Computer software (a)	5 years

(a) Computer software that is not integral to the operation of any related hardware.

Impairment of intangible assets

Intangible assets with indefinite useful lives are tested for impairment annually or when an indication of impairment is identified.

The policy in connection with testing for impairment is outlined in note 5.1.1 Depreciation and impairment charge for the period.

Notes to the financial statements
For the year ended 30 June 2025

5.3 Right-of-use assets

Year ended 30 June 2025	Buildings $'000	Vehicles $'000	Total $'000
1 July 2024			
Gross carrying amount	3,008	752	3,760
Accumulated depreciation	(1,152)	(292)	(1,444)
Carrying amount at start of period	**1,856**	**460**	**2,316**
Additions	95	320	415
Disposals	-	-	-
Transfers	-	-	-
Depreciation	(502)	(164)	(666)
Carrying amount at 30 June 2025	**1,449**	**616**	**2,065**
Gross carrying amount	3,103	935	4,038
Accumulated depreciation	(1,654)	(319)	(1,973)

Year ended 30 June 2024	Buildings $'000	Vehicles $'000	Total $'000
1 July 2023			
Gross carrying amount	3,588	657	4,245
Accumulated depreciation	(992)	(417)	(1,409)
Carrying amount at start of period	**2,596**	**240**	**2,836**
Additions	73	369	442
Disposals	(195)	(6)	(201)
Transfers	-	-	-
Depreciation	(618)	(143)	(761)
Carrying amount at 30 June 2024	**1,856**	**460**	**2,316**
Gross carrying amount	3,008	752	3,760
Accumulated depreciation	(1,152)	(292)	(1,444)

Notes to the financial statements
For the year ended 30 June 2025

5.3 Right-of-use assets (continued)

Initial recognition

At the commencement date of the lease, the department recognises right-of-use assets that are measured at cost comprising of:

- the amount of the initial measurement of lease liability
- any lease payments made at or before the commencement date less any lease incentives received
- any initial direct costs
- restoration costs, including dismantling and removing the underlying asset.

This includes all leased assets other than investment property right-of-use assets, which are measured in accordance with AASB 140 *Investment Property*.

The corresponding lease liabilities in relation to these right-of-use assets have been disclosed in note 7.2 Lease liabilities.

The department has leases for vehicles, office accommodations and warehouse space.

The department has also entered into Memorandum of Understanding Agreements with the Department of Finance for the leasing of office accommodation. These are not recognised under AASB 16 *Leases* because of substitution rights held by the Department of Finance and are accounted for as an expense as incurred.

The department has elected not to recognise right-of-use assets and lease liabilities for short-term leases (with a lease term of 12 months or less) and low value leases (with an underlying value of $5,000 or less). Lease payments associated with these leases are expensed on a straight-line basis over the lease term.

Subsequent measurement

The cost model is applied for subsequent measurement of right-of-use assets, requiring the asset to be carried at cost less any accumulated depreciation and accumulated impairment losses and adjusted for any re-measurement of lease liability.

Depreciation and impairment of right-of-use assets

Right-of-use assets are depreciated on a straight-line basis over the shorter of the lease term and the estimated useful lives of the underlying assets.

If ownership of the leased asset transfers to the department at the end of the lease term or the cost reflects the exercise of a purchase option, depreciation is calculated using the estimated useful life of the asset.

Right-of-use assets are tested for impairment when an indication of impairment is identified. The policy in connection with testing for impairment is outlined in note 5.1.1 Depreciation and impairment charge for the period.

Notes to the financial statements
For the year ended 30 June 2025

5.3 Right-of-use assets (continued)

The following amounts relating to leases have been recognised in the Statement of comprehensive income:

	2025 $'000	2024 $'000
Depreciation expense of right-of-use assets	666	761
Lease interest expense	92	95
Expenses relating to variable lease payments not included in lease liabilities	67	127
Short-term leases	-	776
Low-value leases	23	31
Operating leases	17,286	15,778
Total amount recognised in the statement of comprehensive income	**18,134**	**17,568**

The total cash outflow for right-of-use leases in 2025 was $742,062 (2024: $796,000). As at 30 June 2025, there were no indications of impairment to right-of-use assets.

Notes to the financial statements
For the year ended 30 June 2025

6 Other assets and liabilities

This section sets out those assets and liabilities that arose from the department's controlled operations and includes other assets utilised for economic benefits and liabilities incurred during normal operations:

	Notes
Inventories	6.1
Receivables	6.2
Amounts receivable for services (Holding Account)	6.3
Other assets	6.4
Payables	6.5
Contract liabilities	6.6

6.1 Inventories

	2025 $'000	2024 $'000
Current		
Drug supplies	27,626	25,561
Medical equipment (a)	-	17,461
Total inventories	**27,626**	**43,022**

(a) Includes medical equipment purchased as part of the COVID-19 Response, to be distributed to statutory authorities within the WA health system when required.

At the reporting date, write-downs totalling $12.9 million in 2024−25 ($3.0 million in 2023−24) have been made comprising:

- drug supplies which were adjusted to reflect expired stock of $3.5 million in 2024−25 ($2.4 million in 2023−24)
- medical equipment which was adjusted to reflect the loss of service potential has resulted in a write-down of $9.4 million in 2024−25 ($0.6 million in 2023−24).

Please refer to note 3.5 Other expenses for stock write-downs.

Inventories are measured at the lower of cost and net realisable value. Costs are assigned by the method most appropriate for each class of inventory, with the majority being measured on a first in first out basis.

Notes to the financial statements
For the year ended 30 June 2025

6.2 Receivables

	2025 $'000	2024 $'000
Current		
Trade receivables (a)	1,456	1,429
Allowance for impairment of trade receivables (b)	(738)	(740)
Accrued revenue	60,920	53,677
GST receivable (c)	48,230	48,805
	109,868	**103,171**
Non-current		
Accrued salaries account (d)	4,481	4,481
Total receivables	**4,481**	**4,481**

(a) Trade receivables are initially recognised at their transaction price or, for those receivables that contain a significant financing component, at fair value. The department holds the receivables with the objective to collect the contractual cash flows and therefore trade receivables are subsequently measured at amortised cost using the effective interest method, less an allowance for impairment.

(b) The department recognises a loss allowance for expected credit losses (ECLs) on a receivable not held at fair value through profit or loss. The ECLs are based on the difference between the contractual cash flows and the cash flows that the entity expects to receive, discounted at the original effective interest rate. Individual receivables are written off when the department has no reasonable expectations of recovering the contractual cash flows.

For trade receivables, the department recognises an allowance for ECLs measured at the lifetime expected credit losses at each reporting date. The department has established a provision matrix that is based on its historical credit loss experience, adjusted for forward-looking factors specific to the debtors and the economic environment. Please refer to note 3.5 for the amount of ECLs expensed in this financial year.

(c) Accounting procedure for Goods and Services Tax

Rights to collect amounts receivable from the ATO and responsibilities to make payments for GST have been assigned to the department. This accounting procedure was a result of application of the grouping provisions of *A New Tax System (Goods and Services Tax) Act 1999* whereby the department became the Nominated Group Representative (NGR) for the GST group as from 1 July 2012. The entities in the GST group include the Department of Health, Child and Adolescent Health Service, East Metropolitan Health Service, North Metropolitan Health Service, South Metropolitan Health Service, WA Country Health Service, Health Support Services, PathWest Laboratory Medicine WA, Queen Elizabeth II Medical Centre Trust, Quadriplegic Centre, Mental Health Commission, and Health and Disability Services Complaints Office.

GST receivables on accrued expenses are recognised by the WA health system entity. Upon the receipt of tax invoices, GST receivables for the GST group are recorded in the accounts of the department. Additionally, the department recognises GST receivables on its own accrued expenses.

(d) Accrued salaries account contains amounts paid annually into the Treasurer's special purpose account. It is restricted for meeting the additional cash outflow for employee salary payments in reporting periods with 27 pay days instead of the normal 26. No interest is received on this account.

Notes to the financial statements
For the year ended 30 June 2025

6.2.1 Movement in the allowance for impairment of trade receivables

	2025 $'000	2024 $'000
Reconciliation of changes in the allowance for impairment of trade receivables		
Opening balance	740	761
Expected credit losses expense	(2)	(21)
Amounts written off during the period	-	-
Allowance for impairment at end of period	**738**	**740**

The maximum exposure to credit risk at the end of the reporting period for trade receivables is the carrying amount of the asset inclusive of any allowance for impairment as shown in the table at note 8.1(c) Financial risk management – credit risk exposure.

The department does not hold any collateral as security or other credit enhancements for trade receivables.

6.3 Amounts receivable for services (Holding Account)

	2025 $'000	2024 $'000
Current	-	-
Non-current	88,351	97,163
Total amounts receivable for services at end of period	**88,351**	**97,163**

Amounts receivable for services represent the non-cash component of service appropriations. It is restricted in that it can only be used for asset replacement or payment of leave liability.

The amounts receivable for services are financial assets at amortised cost and are not considered impaired (i.e. there is no expected credit loss of the holding accounts).

Notes to the financial statements
For the year ended 30 June 2025

6.4 Other assets

	2025 $'000	2024 $'000
Current		
Prepayments (a)	6,433	8,570
Total current assets	**6,433**	**8,570**
Non-current		
Prepayments (a)	-	335
Total non-current assets	**-**	**335**
Total other assets at end of period	**6,433**	**8,905**

(a) Other assets include prepayments which represent payments in advance of receipt of goods or services or that part of expenditure made in one accounting period covering a term extending beyond that period. $5.1 million is included in prepayments to the National Blood Authority under the National Blood Agreement in 2024–25 ($4.9 million in 2023–24).

6.5 Payables

	2025 $'000	2024 $'000
Current		
Trade payables	13,547	21,038
Accrued salaries	8,308	6,694
Accrued expenses	111,963	77,204
Total payables at end of period	**133,818**	**104,936**

Payables are recognised at the amounts payable when the department becomes obliged to make future payments as a result of a purchase of assets or services. The carrying amount is equivalent to fair value as settlement is generally within 20 days.

Accrued salaries represent the amount due to staff but unpaid at the end of the reporting period. Accrued salaries are settled within a fortnight after the reporting period. The department considers the carrying amount of accrued salaries to be equivalent to its fair value.

Notes to the financial statements
For the year ended 30 June 2025

6.6 Contract liabilities

	2025 $'000	2024 $'000
Current	2,157	1,657
Non-current	-	-
Total contract liabilities at end of period	**2,157**	**1,657**

	2025 $'000	2024 $'000
Reconciliation of changes in contract liabilities		
Opening balance	1,657	114
Additions	2,157	1,657
Revenue recognised in the reporting period	(1,657)	(114)
Total contract liabilities at end of period	**2,157**	**1,657**

Typically, a contract payment is received upfront for 12 months of continuing support services. The department's contract liabilities include licence and registration fees that had not been granted at the reporting date. The department received funding from the Commonwealth for the Aged Care Assessment program of which an amount of $1.9 million is yet to be transferred to Health Service Providers.

The department expects to satisfy the performance obligations unsatisfied at the end of the reporting period within the next 12 months.

Notes to the financial statements
For the year ended 30 June 2025

7 Financing

This section sets out the material balances and disclosures associated with the financing and cashflows of the department.

	Notes
Cash and cash equivalents	7.1
Lease liabilities	7.2
Finance costs	7.3
Commitments	7.4

7.1 Cash and cash equivalents

7.1.1 Reconciliation of cash

	2025 $'000	2024 $'000
Cash and cash equivalents	129,992	47,445
Restricted cash and cash equivalents	128,561	108,396
Total cash and cash equivalents at end of period	**258,553**	**155,841**

For the purpose of the Statement of cash flows, cash and cash equivalent (and restricted cash and cash equivalent) assets comprise cash on hand and short-term deposits with original maturities of 3 months or less that are readily convertible to a known amount of cash and which are subject to insignificant risk of changes in value.

Notes to the financial statements
For the year ended 30 June 2025

7.1.2 Restricted cash and cash equivalents

	2025 $'000	2024 $'000
Restricted cash and cash equivalents		
Capital works	34,640	13,900
Commonwealth specific purpose grants (a)	40,053	37,496
Donation - HBF Detect Snapshot	492	964
Telethon - WA Child Research Fund Account (b)	13,116	10,945
The Challenge Prize	-	2,000
WA Future Health Research and Innovation Account (c)	39,826	42,859
Other	434	232
Total restricted cash and cash equivalents	**128,561**	**108,396**

(a) Funds held for specific purposes include Essential Vaccines Schedule $5.2 million in 2024−25 ($5.2 million in 2023−24), Health Innovation Fund $2.5 million in 2024−25 ($2.5 million in 2023−24), Primary Care Pilot $1.1 million in 2024−25 ($6.9 million in 2023−24) and other initiatives and programs $31.2 million in 2024−25 ($22.9 million in 2023−24).

(b) Funds received from the Channel 7 Telethon Trust, the department and other donors to fund and promote child and adolescent health research in WA. Refer to note 9.9 Special purpose accounts.

(c) Funds received from the State Government to support future health research and innovation. Refer to note 9.9 Special purpose accounts.

Notes to the financial statements
For the year ended 30 June 2025

7.1.3 Reconciliation of net cost of services to net cash flows used in operating activities

	Notes	2025 $'000	2024 $'000
Net cost of services		(8,307,009)	(7,409,396)
Non-cash items:			
Depreciation and amortisation expense	5.1.1, 5.2.1, 5.3	3,063	2,216
Expected credit losses expense	6.2.1	(2)	(22)
Resources received free of charge	4.1	716	627
Asset transferred free of charge	5.1	640	(68)
Asset revaluation increments	5.1	(553)	1,163
Net (gain)/loss from disposal of property, plant and equipment	4.6	147	49
Finance costs	7.3	92	95
Transfer of non-cash funding to statutory authorities within WA health system	4.1	434,732	411,291
Transfer of medical equipment to statutory authorities within WA health system		4,343	79
Write down of inventory	3.5	12,866	2,962
Write-off of debt	3.5	48	103
Adjustments for other non-cash items		(25,824)	16,924
(Increase)/decrease in assets:			
Inventories	6.1	15,396	(5,747)
Receivables	6.2, 6.3	2,115	(36,404)
Other assets	6.4	2,472	(958)
Increase/(decrease) in liabilities:			
Payables	6.5	28,882	36,285
Contract liabilities	6.6	500	1,543
Lease liabilities	7.2	(229)	(447)
Employee related provisions	3.1(b)	5,413	4,153
Net cash used in operating activities		**(7,822,192)**	**(6,975,552)**

Notes to the financial statements
For the year ended 30 June 2025

7.2 Lease liabilities

	2025 $'000	2024 $'000
Current	663	588
Non-current	1,415	1,719
Total lease liabilities at end of period	**2,078**	**2,307**

Initial measurement

At the commencement date of the lease, the department recognises lease liabilities measured at the present value of lease payments to be made over the lease term. The lease payments are discounted using the interest rate implicit in the lease. If that rate cannot be readily determined, the department uses the incremental borrowing rate provided by Western Australia Treasury Corporation (WATC).

Lease payments included by the department as part of the present value calculation of lease liability include:

- fixed payments (including in-substance fixed payments), less any lease incentives receivable
- variable lease payments that depend on an index or a rate initially measured using the index or rate as at the commencement date
- amounts expected to be payable by the lessee under residual value guarantees
- the exercise price of purchase options (where these are reasonably certain to be exercised)
- payments for penalties for terminating a lease, where the lease term reflects the department exercising an option to terminate the lease.

The interest on the lease liability is recognised in profit or loss over the lease term to produce a constant periodic rate of interest on the remaining balance of the liability for each period. Lease liabilities do not include any future changes in variable lease payments (that depend on an index or rate) until they take effect, in which case the lease liability is reassessed and adjusted against the right-of-use asset.

Periods covered by extension or termination options are only included in the lease term by the department if the lease is reasonably certain to be extended (or not terminated).

Variable lease payments, not included in the measurement of lease liability, that are dependent on sales are recognised by the department in profit or loss in the period in which the condition that triggers those payments occur.

This section should be read in conjunction with note 5.3 Right-of-use assets.

Subsequent measurement

Lease liabilities are measured by increasing the carrying amount to reflect interest on the lease liabilities, reducing the carrying amount to reflect the lease payments made, and remeasuring the carrying amount at amortised cost, subject to adjustments to reflect any reassessment or lease modifications.

Notes to the financial statements
For the year ended 30 June 2025

7.3 Finance costs

	2025 $'000	2024 $'000
Lease interest expense	92	95
Finance costs expensed	**92**	**95**

Finance cost includes the interest component of lease liability repayments.

7.4 Commitments

The commitments below are inclusive of GST.

7.4.1 Capital commitments

	2025 $'000	2024 $'000
Capital expenditure commitments, being contracted capital expenditure additional to the amounts reported in the financial statements are payable as follows:		
Within 1 year	325,535	2,170
Later than 1 year and not later than 5 years	1,667,756	-
Later than 5 years	-	-
	1,993,291	**2,170**

7.4.2 Private sector contracts for the provision of health services

	2025 $'000	2024 $'000
Expenditure commitments in relation to private sector organisations contracted for at the end of the reporting period but not recognised as liabilities, are payable as follows:		
Within 1 year	650,511	593,484
Later than 1 year and not later than 5 years	736,496	888,295
Later than 5 years	142	10,393
	1,387,149	**1,492,172**

Notes to the financial statements
For the year ended 30 June 2025

7.4.3 Other expenditure commitments

	2025 $'000	2024 $'000
Other expenditure commitments contracted for at the end of the reporting period but not recognised as liabilities are payable as follows:		
Within 1 year	50,754	40,364
Later than 1 year and not later than 5 years	57,799	76,841
Later than 5 years	-	-
	108,553	**117,205**

8 Risks and contingencies

This note sets out the key risk management policies and measurement techniques of the department.

	Notes
Financial risk management	8.1
Contingent assets and liabilities	8.2
Fair value measurements	8.3

8.1 Financial risk management

Financial instruments held by the department are cash and cash equivalents, restricted cash and cash equivalents, receivables and payables. The department has limited exposure to financial risks. The department's overall risk management program focuses on managing the risks identified below.

(a) Summary of risks and risk management

Credit risk

Credit risk arises when there is the possibility of the department's receivables defaulting on their contractual obligations resulting in financial loss to the department.

Credit risk associated with the department's financial assets is minimal because the main receivable is the amounts receivable for services (holding account). For receivables other than Government, the department trades only with recognised, creditworthy third parties. The department has policies in place to ensure that sales of products and services are made to customers with an appropriate credit history. In addition, receivable balances are monitored on an ongoing basis with the result that the department's exposure to bad debts is minimal. Debt will be written off against the allowance account when it is improbable or uneconomical to recover the debt. At the end of the reporting period there were no significant concentrations of credit risk.

Notes to the financial statements
For the year ended 30 June 2025

8.1 Financial risk management (continued)

Liquidity risk

Liquidity risk arises when the department is unable to meet its financial obligations as they fall due.

The department is exposed to liquidity risk through its trading in the normal course of business.

The department has appropriate procedures to manage cash flows including drawdown of appropriations by monitoring forecast cash flows to ensure that sufficient funds are available to meet its commitments.

Market risk

Market risk is the risk that changes in market prices such as foreign exchange rates and interest rates will affect the department's income or the value of its holdings of financial instruments. The department does not trade in foreign currency and is not materially exposed to other price risks (for example, equity securities or commodity prices changes). The department's exposure to market risk for changes in interest rates relate primarily to the long-term debt obligations.

(b) Categories of financial instruments

The carrying amounts of each of the following categories of financial assets and financial liabilities at the end of the reporting period are:

	2025 $'000	2024 $'000
Financial assets		
Cash and cash equivalents	129,992	47,445
Restricted cash and cash equivalents	128,561	108,396
Financial assets at amortised cost (a)	154,470	156,010
Total financial assets	**413,023**	**311,851**
Financial liabilities		
Financial liabilities at amortised cost (b)	135,896	107,243
Total financial liabilities	**135,896**	**107,243**

(a) The amount of financial assets at amortised cost excludes GST recoverable from the ATO (statutory receivable).

(b) The amount of financial liabilities at amortised cost excludes GST payable to the ATO (statutory payable).

Notes to the financial statements
For the year ended 30 June 2025

8.1 Financial risk management (continued)

(c) Credit risk exposure

The following table details the credit risk exposure on the department's trade receivables using a provision matrix.

			Days past due			
	Total	**Current**	**<30 days**	**31-60 days**	**61-90 days**	**>91 days**
	$'000	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**
30 June 2025						
Expected credit loss rate		0.59%	3.23%	1.98%	5.26%	75.93%
Estimated total gross carrying amount at default	1,456	341	31	101	19	964
Expected credit losses	(738)	(2)	(1)	(2)	(1)	(732)
30 June 2024						
Expected credit loss rate		1.03%	0.69%	0.00%	0.00%	84.58%
Estimated total gross carrying amount at default	1,429	388	144	18	10	869
Expected credit losses	(740)	(4)	(1)	-	-	(735)

Notes to the financial statements
For the year ended 30 June 2025

8.1 Financial risk management (continued)

(d) Liquidity risk and Interest rate exposure

The following table details the department's interest rate exposure and the contractual maturity analysis of financial assets and financial liabilities. The maturity analysis section includes interest and principal cash flows. The interest rate exposure section analyses only the carrying amounts of each item.

Interest rate exposure and maturity analysis of financial assets and financial liabilities

		Interest Rate Exposure				Maturity Dates				
	Weighted average effective interest rate %	Carrying amount $'000	Fixed interest rate $'000	Variable interest rate $'000	Non-interest bearing $'000	Nominal amount $'000	Up to 1 month $'000	1 to 3 months $'000	3 months to 1 year $'000	1 to 5 years $'000	More than 5 years $'000
2025											
Financial Assets											
Cash and cash equivalents	-	129,992	-	-	129,992	129,992	129,992	-	-	-	-
Restricted cash and cash equivalents	-	128,561	-	-	128,561	128,561	128,561	-	-	-	-
Receivables (a)	-	66,119	-	-	66,119	66,119	22,254	146	39,238	4,481	-
Amounts receivable for services	-	88,351	-	-	88,351	88,351	-	-	-	-	88,351
		413,023	**-**	**-**	**413,023**	**413,023**	**280,807**	**146**	**39,238**	**4,481**	**88,351**
Financial Liabilities											
Payables	-	133,818	-	-	133,818	133,818	87,381	5,786	40,651	-	-
Lease liabilities (b)	4.42	2,078	2,078	-		2,223	19	160	540	1,452	52
		135,896	**2,078**	**-**	**133,818**	**136,041**	**87,400**	**5,946**	**41,191**	**1,452**	**52**

(a) The amount of receivables excludes the GST receivable from the ATO (statutory receivable).

(b) The amount of lease liabilities includes $1.4 million from leased buildings and $0.6 million from leased vehicles.

Notes to the financial statements
For the year ended 30 June 2025

8.1 Financial risk management (continued)

(d) Liquidity risk and Interest rate exposure (continued)

Interest rate exposure and maturity analysis of financial assets and financial liabilities

		Interest Rate Exposure				Maturity Dates					
	Weighted average effective interest rate %	Carrying amount $'000	Fixed interest rate $'000	Variable interest rate $'000	Non-interest bearing $'000	Nominal amount $'000	Up to 1 month $'000	1 to 3 months $'000	3 months to 1 year $'000	1 to 5 years $'000	More than 5 years $'000
2024											
Financial Assets											
Cash and cash equivalents	-	47,445	-	-	47,445	47,445	47,445	-	-	-	-
Restricted cash and cash equivalents	-	108,396	-	-	108,396	108,396	108,396	-	-	-	-
Receivables (a)	-	58,847	-	-	58,847	58,847	26,571	4,492	23,232	4,524	28
Amounts receivable for services	-	97,163	-	-	97,163	97,163	-	-	-	-	97,163
		311,851	**-**	**-**	**311,851**	**311,851**	**182,412**	**4,492**	**23,232**	**4,524**	**97,191**
Financial Liabilities											
Payables	-	104,936	-	-	104,936	104,936	83,696	2,573	5,098	13,569	-
Lease liabilities (b)	5.95	2,307	2,307	-	-	2,462	15	142	481	1,698	126
		107,243	**2,307**	**-**	**104,936**	**107,398**	**83,711**	**2,715**	**5,579**	**15,267**	**126**

(a) The amount of receivables excludes the GST receivable from the ATO (statutory receivable).

(b) The amount of lease liabilities includes $1.8 million from leased buildings and $0.5 million from leased vehicles.

(e) Interest rates sensitivity analysis

The department's financial assets and liabilities were not subject to interest rate sensitivity at the end of the current and previous period.

8.2 Contingent assets and liabilities

Contingent assets and contingent liabilities are not recognised in the Statement of financial position but are disclosed and, if quantifiable, are measured at the best estimate.

Contingent assets and liabilities are presented inclusive of GST receivable or payable respectively.

Notes to the financial statements
For the year ended 30 June 2025

8.2.1 Contingent assets

The following contingent assets are excluded from the assets included in the financial statements:

	2025	2024
	$'000	$'000
Cross border receipts for residents from other Australian jurisdictions treated in WA hospitals	18,753	17,443

8.2.2 Contingent liabilities

The following contingent liabilities are excluded from the liabilities included in the financial statements:

	2025	2024
	$'000	$'000
Cross border charges for WA residents treated in hospitals in other Australian jurisdictions	28,836	21,868

Litigation in progress

Pending litigation that is not recoverable from RiskCover insurance and may affect the financial position of the department. At this stage the settlements cannot be estimated.

Number of claims: 2

Casual long Service leave

Under the Long Service Leave Act 1958 (LSL Act) casual employees who have been employed for more than 10 years and meet continuous service requirements are entitled to long service leave. Whilst a provision has been allowed for casual long service leave entitlement, the Department is assessing the impact of continuity of service on casual long service leave liabilities. A reliable estimate cannot be determined at the present time as the assessment is still ongoing.

Contaminated sites

Under the *Contaminated Sites Act 2003*, the department is required to report known and suspected contaminated sites to the Department of Water and Environmental Regulation (DWER). In accordance with the Act, DWER classifies these sites on the basis of the risk to human health, the environment and environmental values. Where sites are classified as contaminated – remediation required or possibly contaminated – investigation required, the department may have a liability in respect of investigation or remediation expenses.

At the reporting date, the department did not have any suspected contaminated sites reported under the Act.

Notes to the financial statements
For the year ended 30 June 2025

8.3 Fair value measurements

Assets measured at fair value:

	Notes	Level 1 $'000	Level 2 $'000	Level 3 $'000	Total $'000
2025					
Land	5.1	-	4,430	15,468	19,898
Buildings	5.1	-	-	805	805
Site infrastructure	5.1	-	-	153	153
		-	**4,430**	**16,426**	**20,856**
2024					
Land	5.1	-	3,220	15,923	19,143
Buildings	5.1	-	280	2,246	2,526
Site infrastructure	5.1	-	-	120	120
		-	**3,500**	**18,289**	**21,789**

There were $0.8 million land transfers from Level 3 to Level 2 during the current period.

Valuation techniques and inputs

Level 2 assets

Fair values of market type land and buildings (office accommodation) are derived using the market approach. Market evidence of sales prices of comparable assets in close proximity is used to determine price per square metre.

Level 3 assets

Land assets

Fair value for restricted use land is based on comparison with market evidence for land with low level utility (high restricted use land). The relevant comparators of land with low level utility are selected by Landgate and represents the application of a significant Level 3 input in this valuation technique. The fair value measurement is sensitive to values of comparator land, with higher values of comparator land correlating with higher estimated fair values of land.

Building assets

Fair value for current use buildings is determined by reference to the cost of replacing the remaining future economic benefits embodied in the asset. Current replacement cost is generally determined by reference to the market observable replacement cost of a substitute asset of comparable utility and the gross project size specifications, adjusted for obsolescence. Obsolescence encompasses physical deterioration, functional (technological) obsolescence and economic (external) obsolescence.

Valuation using current replacement cost utilises the significant Level 3 input of obsolescence estimated by Landgate and Rider Levett Bucknall WA Pty Ltd (Quantity Surveyor). The fair value measurement is sensitive to the estimate of obsolescence, with higher values of the estimate correlating with lower estimated fair values of buildings.

In addition, professional and project management fees estimated and added to the current replacement costs provided by Landgate and Rider Levett Bucknall WA Pty Ltd (Quantity Surveyor) for current use buildings represent significant Level 3 inputs used in the valuation process. The fair value of these assets will increase with a higher level of professional and project management fees.

Notes to the financial statements
For the year ended 30 June 2025

8.3 Fair value measurements (continued)

Fair value measurements using significant unobservable inputs (Level 3)

	Land $'000	Buildings $'000	Site infrastructure $'000	Total $'000
2025				
Fair value at start of period	15,923	2,246	120	18,289
Additions	65	-	-	65
Revaluation increments/(decrements) recognised in Other comprehensive income	140	170	49	359
Reclassification of asset class	(660)	-	-	(660)
Disposals	-	(1,545)	-	(1,545)
Depreciation expense	-	(66)	(16)	(82)
Fair value at end of period	**15,468**	**805**	**153**	**16,426**
2024				
Fair value at start of period	4,810	2,188	136	7,134
Additions	-	-	-	-
Revaluation increments/(decrements) recognised in Other comprehensive income	(1,615)	214	-	(1,401)
Reclassification of asset class	12,728	-	-	12,728
Disposals	-	(66)	-	(66)
Depreciation expense	-	(90)	(16)	(106)
Fair value at end of period	**15,923**	**2,246**	**120**	**18,289**

Transfers in and out of a fair value level are recognised on the date of the event or change in circumstances that caused the transfer. Transfers are generally limited to assets newly classified as non-current assets held for sale as Treasurer's guidance deem valuations of land, buildings and site infrastructure to be categorised within Level 3 where the valuations will utilise significant Level 3 inputs on a recurring basis.

Basis of valuation

In the absence of market-based evidence, due to the specialised nature of some non-financial assets, these assets are valued at Level 3 of the fair value hierarchy on a current use basis (presumed to be the highest and best use), which recognises that restrictions or limitations have been placed on their use and disposal when they are not determined to be surplus to requirements. These restrictions are imposed by virtue of the assets being held to deliver a specific community service.

Notes to the financial statements
For the year ended 30 June 2025

9 Other disclosures

This section includes additional material disclosures required by accounting standards or other pronouncements, for the understanding of this financial report.

9.1 Events occurring after the end of the reporting period

In March 2025, the Premier announced a series of public sector reforms to align the Western Australian public service with the Government's new priorities of fostering a more resilient economy and improving infrastructure delivery. As part of this reform, effective 1 July 2025, the Department of Transport will be expanded to consolidate major project planning and delivery through the establishment of the Office of Major Infrastructure Delivery.

Under this restructure, responsibility for major capital works currently managed by the Department's Office of Major Health Infrastructure Delivery will be transitioned to the new Office. The restructure officially took effect on 1 July 2025 and is being progressively implemented.

This change is considered a non-adjusting subsequent event, as it occurred after the end of the reporting period and does not impact the Department's financial position as at 30 June 2025. The financial implications of the reform are not yet able to be reliably determined.

Notes to the financial statements
For the year ended 30 June 2025

9.2 Future impact of Australian Accounting Standards not yet operative

The department cannot early adopt an Australian Accounting Standard unless specifically permitted by TI 9 - Requirement 4 Application of Australian Accounting Standards and Other Pronouncements or by an exemption from TI 9. Where applicable, the department plans to apply the following Australian Accounting Standards from their application date.

		Operative for reporting periods beginning on/after
	Operative for reporting periods on/after 1 Jan 2025	
AASB 2023-5	*Amendments to Australia Accounting Standards – Lack of Exchangeability* This Standard amends AASB 121 and AASB 1 to require entities to apply a consistent approach to determining whether a currency is exchangeable into another currency and the sport exchange rate to use when it is not exchangeable. The Standard also amends AASB 121 to extend the exemption from complying with the disclosure requirements for entities that apply AASB 1060 to ensure Tier 2 entities are not required to comply with the new disclosure requirements in AASB 121 when preparing their Tier 2 financial statements. There is no financial impact.	**1 Jan 2025**
	Operative for reporting periods beginning on/after 1 Jan 2026	
AASB 2024-2	*Amendments to Australian Accounting Standards – Classification and Measurement of Financial Instruments* This Standard amends AASB 7 and AASB 9 as a consequence of the issuance of Amendments to the Classification and Measurement of Financial Instruments (Amendments to IFRS 9 and IFRS 7) by the International Accounting Standards Board in May 2024. The department has not assessed the impact of the Standard.	**1 Jan 2026**
AASB 2024-3	*Amendments to Australian Accounting Standards – Annual Improvements Volume 11* This Standard amends AASB 1, AASB 7, AASB 9, AASB 10 and AASB 107 as a consequence of the issuance of Annual Improvements to IFRS Standards – Volume 11 by the International Accounting Standards Board in July 2024. The department has not assessed the impact of the Standard.	**1 Jan 2026**

Notes to the financial statements
For the year ended 30 June 2025

9.2 Future impact of Australian Accounting Standards not yet operative (continued)

Operative for reporting periods beginning on/after 1 Jan 2027

AASB 18 (FP)	*Presentation and Disclosure in Financial Statements (Appendix D) [for for-profit entities]* This Standard replaces AASB 101 with respect to the presentation and disclosure requirements in financial statements applicable to for-profit entities. This Standard is a consequence of the issuance of International Financial Reporting Standard 18 Presentation and Disclosure in financial Statements by the International Accounting Standards Board in April 2024. This Standard also makes amendments to other Australian Accounting Standards set out in Appendix D of this Standard. The department has not assessed the impact of the Standard.	**1 Jan 2027**

Operative for reporting periods beginning on/after 1 Jan 2028

AASB 2014-10	*Amendments to Australian Accounting Standards – Sale or Contribution of Assets between an Investor and its Associate or Joint Venture* This Standard amends AASB 10 and AASB 128 to address an inconsistency between the requirements in AASB 10 and those in AASB 128 (August 2011), in dealing with the sale or contribution of assets between an investor and its associate or joint venture. There is no financial impact.	**1 Jan 2028**
AASB 2024-4b	*Amendments to Australian Accounting Standards – Effective Date of Amendments to AASB 10 and AASB 128 [deferred AASB 10 and AASB 128 amendments in AASB 2014-10 apply]* This Standard defers (to 1 January 2028) the amendments to AASB 10 and AASB 128 relating to the sale or contribution of assets between an investor and its associate or joint venture. The Standard also includes editorial corrections. There is no financial impact.	**1 Jan 2028**
AASB 18 (NFP /super)	*Presentation and Disclosure in Financial Statements (Appendix D) [for not-for-profit and superannuation entities]* This Standard replaces AASB 101 with respect to the presentation and disclosure requirements in financial statements applicable to not-for-profit and superannuation entities This Standard is a consequence of the issuance of IFRS 18 Presentation and Disclosure in financial Statements by the International Accounting Standards Board in April 2024. This Standard also makes amendments to other Australian Accounting Standards set out in Appendix D of this Standard. The department has not assessed the impact of the Standard.	**1 Jan 2028**

Notes to the financial statements
For the year ended 30 June 2025

9.3 Key management personnel

The department has determined key management personnel to include cabinet ministers and senior officers of the department. The department does not incur expenditure to compensate Ministers and those disclosures may be found in the *Annual Report on State Finances*.

The total fees, salaries, superannuation, non-monetary benefits and other benefits for senior officers of the department for the reporting period are presented within the following bands:

Compensation band of members of the accountable authority

	2025	2024
Compensation band ($)		
750,001 - 800,000	1	-
500,001 - 550,000	1	2
400,001 - 450,000	1	1
350,001 - 400,000	1	1
300,001 - 350,000	1	1
250,001 - 300,000	1	-
200,001 - 250,000	-	2
100,001 - 150,000	2	-
50,001 - 100,000	-	1
	8	**8**

	2025 $'000	2024 $'000
Short-term employee benefits	2,514	2,433
Post-employment benefits	276	233
Other long-term benefits	171	27
Total compensation of senior officers	**2,961**	**2,693**

Total compensation includes the superannuation expense incurred by the department with respect to senior officers.

Notes to the financial statements
For the year ended 30 June 2025

9.4 Related party transactions

The department is a wholly owned public sector entity that is controlled by the State of Western Australia. Related parties of the department include:

- all Cabinet Ministers and their close family members, and their controlled or jointly controlled entities
- all senior officers and their close family members, and their controlled or jointly controlled entities
- other departments and statutory authorities, including related bodies, that are included in the whole of government consolidated financial statements (i.e. wholly-owned public sector entities)
- associates and joint ventures of a wholly-owned public sector entity
- the Government Employees Superannuation Board (GESB)

Significant transactions with government-related entities

In conducting its activities, the department is required to transact with the State and entities related to the State. These transactions are generally based on the standard terms and conditions that apply to all agencies. Such transactions include:

- income from State Government (note 4.1)
- income from other public sector entities (note 4.1)
- services received free of charge (note 4.1)
- Royalties for Regions Fund (note 4.1)
- equity contribution (note 9.11)
- grants and subsidies to statutory authorities within WA health system (note 3.2)
- superannuation payments to GESB (note 3.1(a))
- lease payments to the Department of Finance (Government Office Accommodation and State Fleet) (note 3.5)
- insurance payments to the Insurance Commission and Riskcover fund (note 3.5)
- remuneration for services provided by the Auditor General (note 9.10)
- services provided free of charge to various State Government agencies (note 9.7).

Material transactions with other related parties

Outside of normal citizen type transactions with the department, there were no other related party transactions that involved key management personnel and/or their close family members and/or their controlled (or jointly controlled) entities.

Notes to the financial statements
For the year ended 30 June 2025

9.5 Related bodies

A related body is a body that receives more than half of its funding and resources from the department and is subject to operational control by the department.

The department had no related bodies for the reporting period.

9.6 Affiliated bodies

An affiliated body is a body that receives more than half of its funding and resources from the department but is not subject to operational control by the department.

The department had no affiliated bodies for the reporting period.

9.7 Services provided free of charge

During the reporting period the following services were provided to other WA agencies free of charge for functions outside the normal operations of the department:

	2025 $'000	2024 $'000
Transfer of COVID-19 medical equipment to statutory authorities within WA health system		
Child and Adolescent Health Service	268	-
East Metropolitan Health Service	330	-
South Metropolitan Health Service	916	-
North Metropolitan Health Service	973	68
WA Country Health Service	1,856	11
Department of Education	284	538
Department of Planning, Lands and Heritage	5	-
Others	23	6
Total services provided free of charge	**4,655**	**623**

Notes to the financial statements
For the year ended 30 June 2025

9.8 Indian Ocean Territories

	2025 $'000	2024 $'000
Balance at start of period	172	(146)
Receipts		
Commonwealth grant	4,922	5,246
Payment		
Purchase of WA Health services	(4,921)	(4,928)
Balance at end of period	**173**	**172**

Notes to the financial statements
For the year ended 30 June 2025

9.9 Special purpose accounts

State Pool Account

The purpose of the special purpose account is to hold money paid by the Commonwealth, the State or another state under the National Health Reform Agreement for funding health services.

	2025 $'000	2024 $'000
Controlled by the department		
Balance at start of period	-	-
Receipts		
Commonwealth activity based funding - health service providers	2,526,114	2,405,586
Commonwealth activity based funding - Department of Health	33,512	29,204
Commonwealth block funding - health service providers	268,035	249,144
Commonwealth public health funding - Department of Health	60,972	56,303
Commonwealth contribution under the National Partnership Agreement of COVID-19 Response	-	252
Commonwealth contribution under the National Partnership Agreement of COVID-19 Response (Final Adjustment)	-	43,171
State activity based funding - Department of Health	4,275,529	3,651,859
Cross border contribution from WA State	24,480	11,188
Cross border receipts from other States or Territories	21,327	6,086
Payments		
Commonwealth activity based funding - health service providers	(2,526,114)	(2,405,586)
Commonwealth activity based funding - Department of Health	(33,512)	(29,204)
Commonwealth block funding - State Managed Fund (Health) Account	(268,035)	(249,144)
Commonwealth public health funding - Department of Health	(60,972)	(56,303)
Commonwealth contribution under the National Partnership Agreement of COVID-19 Response	-	(252)
Commonwealth contribution under the National Partnership Agreement of COVID-19 Response (Final Adjustment)	-	(43,171)
State activity based funding - health service providers	(4,275,529)	(3,651,859)
Cross border transfer to Department of Health	(21,327)	(6,086)
Cross border payments to other States or Territories	(24,480)	(11,188)
Balance at end of period	-	-

Notes to the financial statements
For the year ended 30 June 2025

9.9 Special purpose accounts (continued)

	2025 $'000	2024 $'000
Administered by the department		
Balance at start of period	-	-
Receipts		
Mental Health Commission - Commonwealth activity based funding	159,360	153,583
Mental Health Commission - Commonwealth block funding	217,356	174,357
Mental Health Commission - State activity based funding	325,486	326,153
Payments		
Mental Health Commission - Commonwealth activity based funding to health service providers	(159,360)	(153,583)
Mental Health Commission - Commonwealth block funding to health service providers	(217,356)	(174,357)
Mental Health Commission - State activity based funding to health service providers	(325,486)	(326,153)
Balance at end of period	-	-

State Managed Fund (Health) Account

The purpose of the special purpose account is to hold money received by the department for the purposes of health funding under the National Health Reform Agreement that is required to be undertaken in the State through a State Managed Fund.

	2025 $'000	2024 $'000
Controlled by the department		
Balance at start of period	-	-
Receipts		
Commonwealth block funding - State Pool Account	268,035	249,144
State block funding - Department of Health	491,376	479,525
Royalties for Regions Fund - Department of Health	-	-
Payments		
Commonwealth block funding - health service providers	(268,035)	(249,144)
State block funding - health service providers	(491,376)	(479,525)
Balance at end of period	-	-

Notes to the financial statements
For the year ended 30 June 2025

9.9 Special purpose accounts (continued)

	2025 $'000	2024 $'000
Administered by the department		
Balance at start of period	-	-
Receipts		
Mental Health Commission - Commonwealth block funding	217,356	174,357
Mental Health Commission - State block funding	422,218	334,344
Payments		
Mental Health Commission - Commonwealth block funding to health service providers	(204,470)	(162,684)
Mental Health Commission - Commonwealth block funding to non-government organisations	(12,886)	(11,673)
Mental Health Commission - State block funding to health service providers	(422,218)	(334,344)
Balance at end of period	**-**	**-**

WA Future Health Research and Innovation Account

In June 2020, the Western Australian Future Health Research and Innovation Account (FHRI Account), an agency special purpose account under the *Financial Management Act 2006* section 16, was established by the *Western Australian Future Fund Amendment (Future Health Research and Innovation Fund) Act 2020*.

The purpose of the special purpose account is to provide a secure and long-term source of funding in support of future health research and innovation.

	2025 $'000	2024 $'000
Controlled by the department		
Balance at start of period	42,859	54,575
Receipts	56,472	54,792
Payments	(59,505)	(66,508)
Balance at end of period	**39,826**	**42,859**

Telethon - WA Child Research Fund Account

The purpose of the special purpose account is to receive funds from the Channel 7 Telethon Trust, the department and other donors to fund and promote child and adolescent health research in Western Australia.

	2025 $'000	2024 $'000
Controlled by the department		
Balance at start of period	10,945	11,680
Receipts	6,542	2,450
Payments	(4,371)	(3,185)
Balance at end of period	**13,116**	**10,945**

Notes to the financial statements
For the year ended 30 June 2025

9.10 Remuneration of auditors

Remuneration paid or payable to the Auditor General with respect to the audit for the reporting period is as follows:

	2025 $'000	2024 $'000
Auditing the accounts, controls, financial statements and key performance indicators	544	499
	544	**499**

9.11 Equity

Contributed equity	**2025 $'000**	**2024 $'000**
Balance at start of period	99,485	58,636
Contribution by owners		
Capital appropriation	102,214	36,832
Capital funding transferred from the Mental Health Commission	-	4,017
Land and buildings transferred from the State Government	640	-
Distributions to owners		
Transfer of net assets to other agencies	(3,543)	-
Total contributed equity at end of period	**198,796**	**99,485**

	2025 $'000	**2024 $'000**
Reserves		
Balance at the start of period	281,432	282,595
Changes in asset revaluation surplus		
Land	334	(1,574)
Buildings and site infrastructure	219	411
Total asset revaluation surplus at end of period	**281,985**	**281,432**

Notes to the financial statements
For the year ended 30 June 2025

9.11 Equity (continued)

	2025 $'000	2024 $'000
Accumulated surplus/(deficit)		
Balance at start of period	(80,398)	(22,414)
Result for the period	(11,795)	(57,984)
Total accumulated surplus/(deficit) at end of period	**(92,193)**	**(80,398)**
Total equity at end of period	**388,588**	**300,519**

9.12 Supplementary financial information

Write-offs

During the financial year, the department has written off debts and inventory under the authority of:

	2025 $'000	2024 $'000
The accountable authority	48	103
The Minister	-	-
The Treasurer	-	-
	48	**103**

Losses through theft, defaults and other causes

There were no losses through theft, defaults and other causes during the current and previous period.

Gifts of public property

There were no gifts of public property provided by the department during the current and previous period.

Notes to the financial statements
For the year ended 30 June 2025

10 Explanatory statements

This section explains variations in the financial performance of the department.

10.1 Explanatory statement for controlled operations

This explanatory section explains variations in the financial performance of the department undertaking transactions under its own control, as represented by the primary financial statements.

All variances between annual estimates (original budget) and actual results for 2025, and between the actual results for 2025 and 2024 are shown below. Narratives are provided for major variances which are more than 10% of comparative and which are also more than 1% of the following (as appropriate):

1. Estimate and actual results for the current year:
   - Total cost of services of the annual estimate for the Statement of comprehensive income and Statement of cash flows (i.e. 1% of $10,639,697,000)
   - Total assets of the annual estimate for the Statement of financial position (i.e. 1% of $436,802,000).
2. Actual results between the current year and the previous year:
   - Total cost of services of the previous year for the Statement of comprehensive income and Statement of cash flows (i.e. 1% of $10,400,112,000)
   - Total assets of the previous year for the Statement of financial position (i.e. 1% of $456,929,000).

Notes to the financial statements
For the year ended 30 June 2025

10.1.1 Statement of comprehensive income variances

	Variance Notes	Estimate 2025 $'000	Actual 2025 $'000	Actual 2024 $'000	Variance between actual and estimate $'000	Variance between actual results for 2025 and 2024 $'000
COST OF SERVICES						
Expenses						
Employee benefits expenses		200,554	230,219	192,361	29,665	37,858
Contracts for services		706,177	781,099	704,969	74,922	76,130
Supplies and services		86,132	92,433	88,608	6,301	3,825
Grants and subsidies	A	9,580,178	10,298,578	9,357,410	718,400	941,168
Depreciation and amortisation expenses		1,911	3,063	2,216	1,152	847
Loss on disposal of non-current assets		-	147	49	147	98
Finance costs		396	92	95	(304)	(3)
Other expenses		64,349	62,257	54,404	(2,092)	7,853
Total cost of services		**10,639,697**	**11,467,888**	**10,400,112**	**828,191**	**1,067,776**
Income						
User charges and fees		887	25,789	23,146	24,902	2,643
Commonwealth grants and contributions		3,037,626	3,123,343	2,957,662	85,717	165,681
Other grants and contributions		12,125	642	605	(11,483)	37
Other income		8,334	11,105	9,303	2,771	1,802
Total revenue		**3,058,972**	**3,160,879**	**2,990,716**	**101,907**	**170,163**
Gains						
Gain on disposal of non-current assets		-	-	-	-	-
Total gains		**-**	**-**	**-**	**-**	**-**
Total income other than income from State Government		**3,058,972**	**3,160,879**	**2,990,716**	**101,907**	**170,163**
NET COST OF SERVICES		**7,580,725**	**8,307,009**	**7,409,396**	**726,284**	**897,613**

Notes to the financial statements
For the year ended 30 June 2025

10.1.1 Statement of comprehensive income variances (continued)

	Variance Notes	Estimate 2025 $'000	Actual 2025 $'000	Actual 2024 $'000	Variance between actual and estimate $'000	Variance between actual results for 2025 and 2024 $'000
INCOME FROM STATE GOVERNMENT						
Service appropriation	B	7,449,170	8,160,831	7,269,484	711,661	891,347
Income from other public sector entities		87,798	119,228	63,060	31,430	56,168
Resources received		949	716	627	(233)	89
Royalties for Regions Fund		15,694	14,439	18,241	(1,255)	(3,802)
Total income from State Government		**7,553,611**	**8,295,214**	**7,351,412**	**741,603**	**943,802**
Surplus/(deficit) for the period		**(27,114)**	**(11,795)**	**(57,984)**	**15,319**	**46,189**
Other comprehensive income						
Items not reclassified subsequently to profit or loss						
Changes in asset revaluation reserve		-	553	(1,163)	553	1,716
Total other comprehensive income		**-**	**553**	**(1,163)**	**553**	**1,716**
Total comprehensive income for the period		**(27,114)**	**(11,242)**	**(59,147)**	**15,872**	**47,905**

These estimates are published in accordance with TI 9.3 Annual Estimates.

Notes to the financial statements
For the year ended 30 June 2025

10.1.2 Statement of financial position variances

	Variance Notes	Estimate 2025 $'000	Actual 2025 $'000	Actual 2024 $'000	Variance between actual and estimate $'000	Variance between actual results for 2025 and 2024 $'000
ASSETS						
Current assets						
Cash and cash equivalents		40,223	129,992	47,445	89,769	82,547
Restricted cash and cash equivalents		89,822	128,561	108,396	38,739	20,165
Inventories	1,C	46,474	27,626	43,022	(18,848)	(15,396)
Receivables		78,868	109,868	103,171	31,000	6,697
Other current assets		8,905	6,433	8,570	(2,472)	(2,137)
Total Current Assets		**264,292**	**402,480**	**310,604**	**138,188**	**91,876**
Non-current assets						
Receivables		4,481	4,481	4,481	-	-
Amounts receivable for services		102,669	88,351	97,163	(14,318)	(8,812)
Infrastructure, property, plant and equipment	2,D	55,324	78,762	41,436	23,438	37,326
Intangible assets		594	3,425	594	2,831	2,831
Right-of-use assets	3	9,442	2,065	2,316	(7,377)	(251)
Other non-current assets		-	-	335	-	(335)
Total non-current assets		**172,510**	**177,084**	**146,325**	**4,574**	**30,759**
TOTAL ASSETS		**436,802**	**579,564**	**456,929**	**142,762**	**122,635**
LIABILITIES						
Current liabilities						
Payables		101,138	133,818	104,936	32,680	28,882
Contract liabilities		1,657	2,157	1,657	500	500
Lease liabilities		579	663	588	84	75
Employee related provisions	4,E	33,247	38,973	33,247	5,726	5,726
Total current liabilities		**136,621**	**175,611**	**140,428**	**38,990**	**35,183**

Notes to the financial statements
For the year ended 30 June 2025

10.1.2 Statement of financial position variances (continued)

	Variance Notes	Estimate 2025 $'000	Actual 2025 $'000	Actual 2024 $'000	Variance between actual and estimate $'000	Variance between actual results for 2025 and 2024 $'000
Non-current liabilities						
Lease liabilities	5	9,062	1,415	1,719	(7,647)	(304)
Employee related provisions		14,263	13,950	14,263	(313)	(313)
Total non-current liabilities		**23,325**	**15,365**	**15,982**	**(7,960)**	**(617)**
TOTAL LIABILITIES		**159,946**	**190,976**	**156,410**	**31,030**	**34,566**
NET ASSETS		**276,856**	**388,588**	**300,519**	**111,732**	**88,069**
EQUITY						
Contributed equity		129,876	198,796	99,485	68,920	99,311
Reserves		271,546	281,985	281,432	10,439	553
Accumulated surplus/(deficit)		(124,565)	(92,193)	(80,398)	32,372	(11,795)
TOTAL EQUITY		**276,857**	**388,588**	**300,519**	**111,731**	**88,069**

These estimates are published in accordance with TI 9.3 Annual Estimates.

Notes to the financial statements
For the year ended 30 June 2025

10.1.3 Statement of cash flows variances

	Variance Notes	Estimate 2025 $'000	Actual 2025 $'000	Actual 2024 $'000	Variance between actual and estimate $'000	Variance between actual results for 2025 and 2024 $'000
CASH FLOWS FROM STATE GOVERNMENT						
Service appropriation	6,F	7,014,438	7,720,792	6,838,722	706,354	882,070
Capital appropriation		30,391	102,214	40,849	71,823	61,365
Funds from other public sector entities		87,798	115,678	63,060	27,880	52,618
Royalties for Regions Fund		15,694	14,439	18,241	(1,255)	(3,802)
Net cash provided by State Government		**7,148,321**	**7,953,123**	**6,960,872**	**804,802**	**992,251**
Utilised as follows:						
Cash flows from operating activities						
Payments						
Employee benefits		(182,554)	(224,806)	(188,208)	(42,252)	(36,598)
Supplies and services		(823,701)	(832,197)	(755,107)	(8,496)	(77,090)
Grants and subsidies	G	(9,145,446)	(9,855,033)	(8,947,273)	(709,587)	(907,760)
Finance costs		(396)	(92)	(95)	304	3
GST payments on purchases		(537,347)	(598,309)	(537,347)	(60,962)	(60,962)
Receipts						
User charges and fees		887	25,789	23,146	24,902	2,643
Commonwealth grants and contributions		2,986,692	3,051,118	2,885,687	64,426	165,431
GST receipts on sales		26,174	29,530	26,174	3,356	3,356
GST receipts from taxation authority		507,563	570,061	507,563	62,498	62,498
Other receipts		20,459	11,747	9,908	(8,712)	1,839
Net cash used in operating activities		**(7,147,669)**	**(7,822,192)**	**(6,975,552)**	**(674,523)**	**(846,640)**
CASH FLOWS FROM INVESTING ACTIVITIES						
Payments						
Purchase of non-current assets		(23,774)	(27,477)	(17,125)	(3,703)	(10,352)
Net cash used in investing activities		**(23,774)**	**(27,477)**	**(17,125)**	**(3,703)**	**(10,352)**

Notes to the financial statements
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10.1.3 Statement of cash flows variances (continued)

	Variance Notes	Estimate 2025 $'000	Actual 2025 $'000	Actual 2024 $'000	Variance between actual and estimate $'000	Variance between actual results for 2025 and 2024 $'000
CASH FLOWS FROM FINANCING ACTIVITIES						
Payments						
Principal element of lease payments		(2,674)	(742)	(796)	1,932	54
Net cash used in financing activities		**(2,674)**	**(742)**	**(796)**	**1,932**	**54**
Net increase/(decrease) in cash and cash equivalents		(25,796)	102,712	(32,601)	128,508	135,313
Cash and cash equivalents at the beginning of the year		155,841	155,841	188,442	-	(32,601)
CASH AND CASH EQUIVALENTS AT THE END OF THE PERIOD		**130,045**	**258,553**	**155,841**	**128,508**	**102,712**

These estimates are published in accordance with TI 9.3 Annual Estimates.

Notes to the financial statements
For the year ended 30 June 2025

10.1.4 Explanatory statement for controlled operations

Major estimate and actual (2025) variance narratives

		2025 Estimate $'000	2025 Actual $'000	Variance $'000
1	**Inventories** Inventories decreased by $18.8 million (-40.6%) due to transfer of medical equipment to other Health Service Providers and the recognition of the write down for the loss of service potential for equipment.	46,474	27,626	(18,848)
2	**Infrastructure, property, plant and equipment** Infrastructure, property, plant and equipment increased by $23.4 million (+42.4%) due to progress on the New Women and Babies Hospital and Step-Up and Step-Down projects advancing ahead of budget.	55,324	78,762	23,438
3	**Right-of-use assets** The estimate for right-of-use assets exceeds the actuals by $7.4 million (+78.1%) primarily due to an estimate reclassification between right-of-use assets and Government Office Accommodation leases, which are expensed.	9,442	2,065	(7,377)
4	**Employee related provisions** Employee related provisions increased by $5.7 million (+17.2%) primarily due to the employment of additional staff to support operational and capital project requirements.	33,247	38,973	5,726
5	**Lease liabilities** The decrease in lease liabilities of $7.6 million (-84.4%) is primarily due to an estimate reclassification between right-of-use assets and Government Office Accommodation leases, which are expensed.	9,062	1,415	(7,647)
6	**Service appropriation receipts** The receipt of service appropriation increased by $706.4 million (+10.1%) primarily to address wage policy and EBA increases and hospital services.	7,014,438	7,720,792	706,354

Notes to the financial statements

For the year ended 30 June 2025

Major actual (2025) and comparative (2024) variance narratives

		2025 Actual $'000	2024 Actual $'000	Variance $'000
A	**Grants and subsidies expense** Grants and subsidies expenses increased by $941.2 million (+10.1%) mainly due to increased funding provided to health service providers.	10,298,578	9,357,410	941,168
B	**Service appropriation income** Service appropriation income increased by $891.3 million (+12.3%) primarily to address enterprise bargaining agreement increases and hospital services.	8,160,831	7,269,484	891,347
C	**Inventories** Inventories decreased by $15.4 million (-35.8%) due to transfer of medical equipment to other Health Service Providers and the recognition of the write down for the loss of service potential for equipment.	27,626	43,022	(15,396)
D	**Infrastructure, property, plant and equipment** Infrastructure, property, plant and equipment increased by $37.3 million (+90.1%), primarily due to the capitalisation of the State Health Operations Centre and increases in work in progress on key projects, including the New Women and Babies Hospital, the Electronic Medical Record, and Step-Up Step-Down initiatives, compared to the prior year.	78,762	41,436	37,326
E	**Employee related provisions** Employee-related provisions increased by $5.7 million (+17.2%), primarily due to the employment of additional staff to support operational needs and capital project management.	38,973	33,247	5,726
F	**Service appropriation receipts** Service appropriation receipts increased by $882.1 million (+12.9%) primarily to address enterprise bargaining agreement increases and hospital services.	7,720,792	6,838,722	882,070
G	**Grants and subsidies payments** Grants and subsidies payments increased by $907.8 million (+10.1%) mainly due to increased funding provided to health service providers.	(9,855,033)	(8,947,273)	(907,760)

Notes to the financial statements
For the year ended 30 June 2025

10.2 Explanatory statement for administered items

This explanatory section explains variations in the financial performance of the department undertaking transactions that it does not control but has responsibility to the government for, as detailed in the administered schedules.

All variances between annual estimates and actual results for 2025, and between the actual results for 2025 and 2024 are shown below.

Narratives are provided for major variances which are more than 10% of the comparative and which are more than 1% of the total administered income in the comparative (i.e. 1% of $2,125,737,000 for the current year and 1% of $1,518,116,000 for the previous year in the table below).

10.2.1 Administered income and expenses

	Variance Notes	Estimate 2025 $'000	Actual 2025 $'000	Actual 2024 $'000	Variance between actual and estimate $'000	Variance between actual results for 2025 and 2024 $'000
COST OF SERVICES						
Expenses						
Funding transferred to:						
Health service providers	1,A	1,052,096	719,553	539,318	(332,543)	180,235
State Pool Account and State Managed Fund Account administered for Mental Health Commission (MHC):						
Transfer of activity based funding to health service providers		517,286	484,846	479,736	(32,440)	5,110
Transfer of block funding to health service providers	2,B	550,881	639,574	508,701	88,693	130,873
Service concession arrangement depreciation expense		3,383	3,646	3,469	263	177
Total administered expenses		**2,123,646**	**1,847,619**	**1,531,224**	**(276,027)**	**316,395**

Notes to the financial statements
For the year ended 30 June 2025

10.2.1 Administered income and expenses (continued)

	Variance Notes	Estimate 2025 $'000	Actual 2025 $'000	Actual 2024 $'000	Variance between actual and estimate $'000	Variance between actual results for 2025 and 2024 $'000
Income						
Administered for WA health system:						
Capital appropriation	3,C	478,410	418,837	270,074	(59,573)	148,763
Administered appropriation	4,D	406,692	162,666	127,145	(244,026)	35,521
Royalties for Regions Fund	E	166,994	162,115	126,986	(4,879)	35,129
State Pool Account and State Managed Fund Account administered for Mental Health Commission (MHC):						
Commonwealth activity based funding	5	182,713	159,360	153,583	(23,353)	5,777
Commonwealth block funding	6,F	187,196	217,356	174,357	30,160	42,999
State activity based funding		334,573	325,486	326,153	(9,087)	(667)
State block funding	7,G	363,685	422,218	334,344	58,533	87,874
Service concession arrangement revenue		5,474	5,474	5,474	-	-
Total administered income		**2,125,737**	**1,873,512**	**1,518,116**	**(252,225)**	**355,396**

Notes to the financial statements
For the year ended 30 June 2025

10.2.2 Explanatory statement for administered items

Major estimate and actual (2025) variance narratives

		2025 Estimate $'000	2025 Actual $'000	Variance $'000
1	**Funding transferred to Health Service Providers** Funding transferred to health service providers decreased by $332.5 million (-31.6%) mainly due to decreases in the funding received from the Digital Capability Fund and timing of carry overs related to the asset investment programs.	1,052,096	719,553	(332,543)
2	**Mental Health Commission block funding transferred to Health Service Providers** Mental Health Commission block funding income transferred to health service providers increased by $88.7 million (+16.1%) due to additional block funding provided by the Mental Health Commissioner for Cockburn Bethesda Facilities, Nicholl Ward and Next Steps programs.	550,881	639,574	88,693
3	**Capital appropriation income** Capital appropriation income decreased by $59.6 million (-12.5%) due to re-cashflow of programs into future years under the asset investment programs.	478,410	418,837	(59,573)
4	**Administered appropriation income** Administered appropriation income decreased by $244.0 million (-60.0%) due to reclassification of funding sources from administered to other sources and reduced funding received under the Digital Capability Fund.	406,692	162,666	(244,026)
5	**Mental Health Commission activity based funding income received from Commonwealth** Mental Health Commission activity based funding income received from Commonwealth decreased by $23.4 million (-12.8%) due to decreased activity for in-scope mental health.	182,713	159,360	(23,353)
6	**Mental Health Commission block funding income received from Commonwealth** Mental Health Commission block funding income received from Commonwealth increased by $30.2 million (+16.1%) due to increased funding for non-admitted mental health services.	187,196	217,356	30,160
7	**Mental Health Commission block funding income received from State Government** Mental Health Commission block funding income received from State Government increased by $58.5 million (+16.1%) due to increases in state funded block programs including Cockburn Bethesda Facilities and Next Steps.	363,685	422,218	58,533

Notes to the financial statements
For the year ended 30 June 2025

Major actual (2025) and comparative (2024) variance narratives

		2025 Actual $'000	2024 Actual $'000	Variance $'000
A	**Funding transferred to Health Service Providers** Funding transferred to health service providers increased by $180.2 million (+33.4%) related mainly to increased capital appropriation provided to fund ongoing asset investment programs.	719,553	539,318	180,235
B	**Mental Health Commission block funding transferred to Health Service Providers** Mental Health Commission block funding income transferred to health service providers increased by $130.9 million (+25.7%) due to increased funding provided for the Bethesda Cockburn facilities and other non-admitted services.	639,574	508,701	130,873
C	**Capital appropriation income** Capital appropriation income increased by $148.8 million (+55.1%) reflecting increased funding provided from State Government to fund ongoing capital programs.	418,837	270,074	148,763
D	**Administered appropriation income** Administered appropriation income increased by $35.5 million (+27.9%) due to increased funding for administered programs including Electronic Medical Record and HRplus.	162,666	127,145	35,521
E	**Royalties for Regions Fund** Royalties for Regions Fund increased by $35.1 million (+27.7%) due to an increase of Royalties for Regions funding for capital programs.	162,115	126,986	35,129
F	**Mental Health Commission block funding income received from Commonwealth** Mental Health Commission block funding income received from Commonwealth increased by $43.0 million (+24.7%) due to increased non-admitted mental health activity.	217,356	174,357	42,999
G	**Mental Health Commission block funding income received from State Government** Mental Health Commission block funding income received from State Government increased by $87.9 million (+26.3%) due to additional funding received for non-admitted mental health services.	422,218	334,344	87,874

Appendix

Appendix 1: Board and committee remuneration

Position	Name	Term of appointment	Period of membership 2024–25	Type of remuneration	Base salary/ sitting fees	Gross/actual remuneration
Anaesthetic Mortality Committee						
Chair	Dr Michael Soares*	4 years	12 months	Sessional	$220	$0
Member	Dr Celine Baber*	3 years	12 months	Sessional	$150	$0
Member	Dr Silke Brinkmann	3 years	12 months	Sessional	$150	$150
Member	Dr Anne Carlton	3 years	12 months	Not eligible	Not applicable	$0
Member	Dr Anna Clare	3 years	12 months	Not eligible	Not applicable	$0
Member	Dr Diana Fakes	3 years	12 months	Not eligible	Not applicable	$0
Member	Associate Prof. Dieter Gebauer	3 years	12 months	Not eligible	Not applicable	$0
Member	Dr Stephen Rodrigues	3 years	12 months	Not eligible	Not applicable	$0
Member	Dr Richard Taylor	3 years	12 months	Sessional	$150	$150
Member	Associate Prof. Andrew Toner	3 years	12 months	Not eligible	Not applicable	$0
Investigator	Dr Christine Grobler	3 years	12 months	Sessional	$546 – $572	$3,277
Investigator	Dr John Martyr	3 years	12 months	Sessional	$546 – $572	$6,555
*While eligible for remuneration, members decided to volunteer their time to the committee.					**Total**	**$10,132**

Position	Name	Term of appointment	Period of membership 2024–25	Type of remuneration	Base salary/sitting fees	Gross/actual remuneration
Department of Health Human Research Ethics Committee						
Chair	Dr Jane Deacon^	3 years	12 months	Annual	$26,147	$23,968
Member	Prof. Richard Brightwell	2 years	12 months	Sessional	$680 for meetings over 4 hours, $442 for meetings up to 4 hours	$5,348
Member	Dr Catherine Cole	3 years	12 months	Sessional	$680 for meetings over 4 hours, $442 for meetings up to 4 hours	$3,094
Member	Prof. Georgia Halkett	1 year	12 months	Sessional	$680 for meetings over 4 hours, $442 for meetings up to 4 hours	$3,536
Member	Rev. Graham Maybury	3 years	12 months	Sessional	$680 for meetings over 4 hours, $442 for meetings up to 4 hours	$3,536
Member	John McMath	3 years	12 months	Sessional	$680 for meetings over 4 hours, $442 for meetings up to 4 hours	$5,746
Member	Sonia McKeiver	3 years	12 months	Sessional	$680 for meetings over 4 hours, $442 for meetings up to 4 hours	$3,978
Member	Ali Radomiljac	3 years	12 months	Not eligible	Not applicable	$0
Member	Stephania Tomlin	3 years	12 months	Not eligible	Not applicable	$0
Member	Bret Watson	3 years	12 months	Sessional	$680 for meetings over 4 hours, $442 for meetings up to 4 hours	$5,304

Position	Name	Term of appointment	Period of membership 2024–25	Type of remuneration	Base salary/sitting fees	Gross/actual remuneration
Member	Dr Janet Woollard	3 years	12 months	Sessional	$680 for meetings over 4 hours, $442 for meetings up to 4 hours	$884
Deputy Member	Paul Beeson	3 years	12 months	Sessional	$680 for meetings over 4 hours, $442 for meetings up to 4 hours	$2,210
Deputy Member	Dr Prashant Bharadwaj	3 years	12 months	Sessional	$680 for meetings over 4 hours, $442 for meetings up to 4 hours	$884
Deputy Member	Catherine Carbonaro	3 years	12 months	Sessional	$680 for meetings over 4 hours, $442 for meetings up to 4 hours	$884
Deputy Member	Nuala Keating	3 years	12 months	Not eligible	Not applicable	$0
Deputy Member	Wil Liam Lim	3 years	12 months	Sessional	$680 for meetings over 4 hours, $442 for meetings up to 4 hours	$442
Deputy Member	Associate Prof. Lewis MacKinnon	3 years	12 months	Sessional	$680 for meetings over 4 hours, $442 for meetings up to 4 hours	$0
Deputy Member	Associate Prof. Daniel McAullay	2 years	12 months	Sessional	$680 for meetings over 4 hours, $442 for meetings up to 4 hours	$0
Deputy Member	Dr Erika Techera	3 years	6 months	Sessional	$680 for meetings over 4 hours, $442 for meetings up to 4 hours	$884
^The Chair received a lower remuneration due to reduced availability to participate in meetings during the year.					**Total**	**$60,698**

Position	Name	Term of appointment	Period of membership 2024–25	Type of remuneration	Base salary/sitting fees	Gross/actual remuneration
Fluoridation of Public Water Supplies Advisory Committee*						
A/Chair	*	Ongoing	12 months	Not eligible	Not applicable	$0
Member 1	*	Ongoing	12 months	Not eligible	Not applicable	$0
Member 2	*	Ongoing	12 months	Not eligible	Not applicable	$0
Member 3	*	3 years	12 months	Not eligible	Not applicable	$0
Member 4	*	3 years	12 months	Sessional	$165	$0
Member 5	*	3 years	12 months	Sessional	$165	$0
*Approval to withhold the names of the committee members has been granted by the Minister for Health.					**Total**	**$0**
Future Health Research and Innovation (FHRI) Fund Advisory Council						
Chair	Rebecca Tomkinson	2 years	12 months	Annual	$37,353 per annum	$37,353
Member	Kane Blackman	5 years	12 months	Sessional	$825 for meetings over 4 hours, $537 for meetings of 4 hours or less	$10,724
Member	Adjunct Prof. Dale Fisher	5 years	12 months	Sessional	$825 for meetings over 4 hours, $537 for meetings of 4 hours or less	$3,759
Member	Jennifer Lawrence	2 years	12 months	Sessional	$825 for meetings over 4 hours, $537 for meetings of 4 hours or less	$5,273

Position	Name	Term of appointment	Period of membership 2024–25	Type of remuneration	Base salary/sitting fees	Gross/actual remuneration
Member	Prof. Christina Mitchell AO	5 years	12 months	Sessional	$825 for meetings over 4 hours, $537 for meetings of 4 hours or less	$3,222
Member	Lesley Nelson	2 years	12 months	Sessional	$825 for meetings over 4 hours, $537 for meetings of 4 hours or less	$3,235
Member	Dr Marcus Tan	2 years	12 months	Sessional	$825 for meetings over 4 hours, $537 for meetings of 4 hours or less	$5,655
Member	Prof. Angus Turner	2 years	8 months	Sessional	$825 for meetings over 4 hours, $537 for meetings of 4 hours or less	$3,222
Member	Prof. Fiona Wood AO	2 years	12 months	Not eligible	Not applicable	$0
Member non-voting	Director General, Department of Health or nominee	Ongoing	12 months	Not eligible	Not applicable	$0
Member non-voting	Director General, Department of Jobs, Tourism, Science and Innovation or nominee	Ongoing	12 months	Not eligible	Not applicable	$0
#Sessional remuneration includes $110 per hour for ad hoc events to a maximum of 4 hours.					**Total**	**$72,443**

Position	Name	Term of appointment	Period of membership 2024–25	Type of remuneration	Base salary/sitting fees	Gross/actual remuneration
Human Tissue Advisory Body						
Chair and ex-officio member	Dr Simon Towler	5 years	12 months	Not eligible	Not applicable	$0
Medical Advisor for the Department of Health	Dr Karen McKenna	4 years	12 months	Not eligible	Not applicable	$0
Medical Advisor for the Department of Health	Dr Christine Pascott	5 years	12 months	Not eligible	Not applicable	$0
					Total	**$0**
Local Health Authorities Analytical Committee						
Chair	Ryan Quinn	3 years	12 months	Not eligible	Not applicable	$0
Member	Andrew Campbell	3 years	12 months	Not eligible	Not applicable	$0
Member	Lauren McLeod	3 years	12 months	Not eligible	Not applicable	$0
Member	Cr Paige McNeil	3 years	12 months	Sessional	$476 for meetings over 4 hours, $309 for meetings of 4 hours or less	$2,163
Member	Eduardo Perotti	3 years	5 months	Not eligible	Not applicable	$0
Member	Cr Chris Poulton	3 years	12 months	Sessional	$476 for meetings over 4 hours, $309 for meetings of 4 hours or less	$2,190
Member	Cr Elizabeth Re	3 years	12 months	Sessional	$476 for meetings over 4 hours, $309 for meetings of 4 hours or less	$1,854

Position	Name	Term of appointment	Period of membership 2024–25	Type of remuneration	Base salary/sitting fees	Gross/actual remuneration
Member	Nathan Russell	3 years	5 months	Not eligible	Not applicable	$0
Member	Sara Saberi	3 years	12 months	Not eligible	Not applicable	$0
Member	Sarah Upton	3 years	12 months	Not eligible	Not applicable	$0
					Total	**$6,207**
Maternal Mortality Committee						
Chair	Prof. John Newnham	3 years	12 months	Not eligible	Not applicable	$0
Member	Dr Chieh Cheng	3 years	12 months	Not eligible	Not applicable	$0
Member	Samantha Davies	3 years	12 months	Not eligible	Not applicable	$0
Member	Dr Manisha Doohan*	3 years	12 months	Sessional	$150	$0
Member	Dr Graeme Johnson	3 years	12 months	Not eligible	Not applicable	$0
Member	Dr Fiona Langdon*	3 years	12 months	Sessional	$150	$0
Member	Dr Lewis MacKinnon	3 years	12 months	Not eligible	Not applicable	$0
Member	Dr Dale Pugh*	3 years	12 months	Sessional	$150	$0
Member	Dr Nooshin Rasool	3 years	12 months	Not eligible	Not applicable	$0
Investigator	Dr Julia Barton	3 years	12 months	Sessional	$546 – $572	$0
*While eligible for remuneration, members decided to volunteer their time to the committee.					**Total**	**$0**

Position	Name	Term of appointment	Period of membership 2024–25	Type of remuneration	Base salary/sitting fees	Gross/actual remuneration
Perinatal and Infant Mortality Committee						
Chair	Dr Michael Gannon	3 years	12 months	Sessional	$220	$4,180
Member	Dr Disna Abeysuriyia	3 years	12 months	Not eligible	Not applicable	$0
Member	Zoe Islip*	3 years	12 months	Sessional	$150	$0
Member	Dr Gayatri Jape	3 years	12 months	Not eligible	Not applicable	$0
Member	Prof. Helen Leonard*	3 years	12 months	Sessional	$150	$0
Member	Dr Lauren Megaw	3 years	12 months	Not eligible	Not applicable	$0
Member	Dr Peta Ann Sadler	3 years	12 months	Sessional	$150	$300
Member	Dr Cara Sheppard	3 years	12 months	Not eligible	Not applicable	$0
Member	Dr Kavipriya Soma*	3 years	12 months	Sessional	$150	$0
Member	Dr Rebecca Thomas	3 years	12 months	Not eligible	Not applicable	$0
Member	Lisa Watkins	3 years	12 months	Not eligible	Not applicable	$0
Member	Dr Scott White	3 years	12 months	Not eligible	Not applicable	$0
Investigator	Dr Joanne Colvin	3 years	12 months	Sessional	$546 – $572	$0
Investigator	Dr Christine Marsack	3 years	12 months	Sessional	$546 – $572	$9,184
Investigator	Dr Corrado Minutillo	3 years	12 months	Sessional	$546 – $572	$16,281
Investigator	Dr Keren Witcombe	3 years	12 months	Sessional	$546 – $572	$12,251
*While eligible for remuneration, members decided to volunteer their time to the committee.					**Total**	**$42,196**

Position	Name	Term of appointment	Period of membership 2024–25	Type of remuneration	Base salary/sitting fees	Gross/actual remuneration
Pesticides Advisory Committee						
Chair	Dr Teresa Ballestas	Ongoing	12 months	Not eligible	Not applicable	$0
Secretary	Vic Andrich	Ongoing	12 months	Not eligible	Not applicable	$0
Member	Ian Dainty	Ongoing	12 months	Not eligible	Not applicable	$0
Member	Corrin Everitt	Ongoing	12 months	Not eligible	Not applicable	$0
Member	Imbrahim Jambol	Ongoing	12 months	Not eligible	Not applicable	$0
Member	Christa Loos	Ongoing	12 months	Not eligible	Not applicable	$0
Member	Ana Milosavljevic	Ongoing	12 months	Not eligible	Not applicable	$0
Member	Pierina Otness	Ongoing	12 months	Not eligible	Not applicable	$0
Member	Kellie Passeretto	Ongoing	12 months	Not eligible	Not applicable	$0
Member	Chris Sharpe	Ongoing	12 months	Not eligible	Not applicable	$0
Member	Eve Speyers	Ongoing	12 months	Not eligible	Not applicable	$0
Member	David Torr	Ongoing	12 months	Not eligible	Not applicable	$0
Member	Tu-Trinh (Amy) Tran	Ongoing	12 months	Not eligible	Not applicable	$0
					Total	**$0**

Position	Name	Term of appointment	Period of membership 2024–25	Type of remuneration	Base salary/sitting fees	Gross/actual remuneration
Pharmacy Registration Board of Western Australia						
Presiding member	Giovanna Cecchele	3 years	12 months	Sessional		
Deputy presiding member	Linda Diane Keane	3 years	12 months	Sessional		
Member	Philippa Brennan	3 years	10 months	Sessional		
Member	Gavin McKay	3 years	12 months	Sessional		
*Board members are not remunerated by the department					**Total**	**$0**
Postgraduate Medical Council of Western Australia						
Chair (outgoing)	Dr Gregory Sweetman	4 years	7 months	Not eligible	Not applicable	$0
Chair (incoming)	Dr Michael Levitt	3 years	5 months	Not eligible	Not applicable	$0
Deputy Chair	Dr Monica Gope	4 years	12 months	Not eligible	Not applicable	$0
Member	Dr Zarrin Allam	4 years	12 months	Not eligible	Not applicable	$0
Member	Dr Tim Bates	4 years	12 months	Not eligible	Not applicable	$0
Member	Dr Colleen Bradford	4 years	12 months	Not eligible	Not applicable	$0
Member	Ms Nicoletta Ciffolilli	4 years	12 months	Sessional	$280	$560
Member	Dr George Eskander	4 years	12 months	Not eligible	Not applicable	$0

Position	Name	Term of appointment	Period of membership 2024–25	Type of remuneration	Base salary/sitting fees	Gross/actual remuneration
Member	Dr Amanda Foster	4 years	12 months	Not eligible	Not applicable	$0
Member	Dr Athula Karunanayaka	4 years	12 months	Not eligible	Not applicable	$0
Member	Dr Graeme Maguire	4 years	12 months	Not eligible	Not applicable	$0
Member	Dr Clare Matthews	4 years	12 months	Not eligible	Not applicable	$0
Member	Dr Brendan McQuillan	4 years	12 months	Not eligible	Not applicable	$0
Member	Dr Simon Towler	4 years	12 months	Not eligible	Not applicable	$0
					Total	**$560**
Radiological Council						
Chair	Dr Andrew Geoffrey Robertson	3 years	12 months	Not eligible	Not applicable	$0
Deputy Chair	Dr Revle Diane Bangor-Jones	3 years	12 months	Not eligible	Not applicable	$0
Member	Associate Prof. Sharon Maresse	3 years	3 months	Not eligible	Not applicable	$0
Member	Associate Prof. Nigel Marks	3 years	12 months	Not eligible	Not applicable	$0
Member	Dr Melinda Morris	3 years	12 months	Sessional	$309	$309
Member	John Pereira*	3 years	12 months	Sessional	$0	$0
Member	Cameron Storm	3 years	12 months	Not eligible	Not applicable	$0

Position	Name	Term of appointment	Period of membership 2024–25	Type of remuneration	Base salary/sitting fees	Gross/actual remuneration
Member	Dr Elizabeth Louise Thomas	3 years	11 months	Not eligible	Not applicable	$0
Member	Dr Vidisha Vaidya*	3 years	5 months	Sessional	$0	$0
Member (Non-voting)	Dr John Burrage	3 years	12 months	Not eligible	Not applicable	$0
Member (Non-voting)	Frank Harris	3 years	12 months	Sessional	$309	$2,472
Member (Non-voting)	Nick Tsurikov	3 years	12 months	Sessional	$309	$3,090
Deputy Member	Associate Prof. Martin Ebert	3 years	12 months	Not eligible	Not applicable	$0
Deputy Member	Megan McGibbons	3 years	12 months	Not eligible	Not applicable	$0
Deputy Member	Associate Prof. Curtise Ng	3 years	12 months	Not eligible	Not applicable	$0
Deputy Member	Dr Melanie Cecilia Robert	3 years	5 months	Sessional	$309	0
Deputy Member	Dr Russel Troedson	3 years	12 months	Not eligible	Not applicable	$0
Deputy Member	Dr Vidisha Vaidya*	3 years	7 months	Sessional	$0	$0
* While eligible for remuneration, members declined payment.					**Total**	**$5,871**
Stimulant Assessment Panel						
Chair	*	3.5 years	12 months	Not eligible	Not applicable	$0
Member 1	*	3 years	12 months	Not eligible	Not applicable	$0
Member 2	*	3 years	12 months	Not eligible	Not applicable	$0

Position	Name	Term of appointment	Period of membership 2024–25	Type of remuneration	Base salary/sitting fees	Gross/actual remuneration
Member 3	*	3 years	12 months	Not eligible	Not applicable	$0
Member 4	*	3 years	12 months	Not eligible	Not applicable	$0
Member 5	*	3 years	12 months	Not eligible	Not applicable	$0
Member 6	*	3 years	12 months	Sessional	$229	$3,888
Member 7	*	3.5 years	12 months	Sessional	$229	$0
Member 8	*	3 years	12 months	Sessional	$229	$0
***Approval to withhold the names of the committee members has been granted by the Minister for Health**					**Total**	**$3,888**
Voluntary Assisted Dying Board						
Chair	Dr Scott Blackwell	3 years	12 months	Annual	$45,357	$43,473
Deputy Chair	Colin Holt	2 years	12 months	Annual	$24,946	$27,204
Member	Dr Robert Edis	2 years	6 months	Annual	$24,946	$12,264
Member	Maria Osman	3 years	12 months	Annual	$24,946	$23,910
Member	Linda Savage	3 years	12 months	Annual	$24,946	$23,910
Member	Dr Gareth Wahl	2.5 years	6 months	Not eligible	Not applicable	$0
					Total	**$130,761**

Position	Name	Term of appointment	Period of membership 2024–25	Type of remuneration	Base salary/sitting fees	Gross/actual remuneration
WA Health Central Human Research Ethics Committee						
Chair	Alison Garton	1 year	12 months	Sessional	$75 per hour for a maximum of 5 hours	$2,850
Member	Esther Adama	3 years	5 months	Not eligible	Not applicable	$0
Member	Brendan Ashdown	3 years	12 months	Sessional	$75 per hour for a maximum of 5 hours	$1,500
Member	Peter Barratt	3 years	12 months	Not eligible	Not applicable	$0
Member	Paul Beeson	3 years	12 months	Not eligible	Not applicable	$0
Member	Timothy Benson	3 years	5 months	Sessional	$75 per hour for a maximum of 5 hours	$750
Member	Jacqueline Bentel	3 years	9 months	Not eligible	Not applicable	$0
Member	Prashant Bharadwaj	3 years	12 months	Not eligible	Not applicable	$0
Member	Edmund (Edd) Black	3 years	7 months	Sessional	$75 per hour for a maximum of 5 hours	$0
Member	Richard Brightwell	3 years	12 months	Not eligible	Not applicable	$0
Member	Sam Buckberry	3 years	12 months	Sessional	$75 per hour for a maximum of 5 hours	$750
Member	Jonathon Burcham	3 years	12 months	Not eligible	Not applicable	$0
Member	Melanie Burkhardt	3 years	9 months	Not eligible	Not applicable	$0
Member	Prudance (Prue) Campbell	3 years	9 months	Sessional	$75 per hour for a maximum of 5 hours	$750
Member	Catherine Carbonaro	3 years	12 months	Sessional	$75 per hour for a maximum of 5 hours	$375

Position	Name	Term of appointment	Period of membership 2024–25	Type of remuneration	Base salary/sitting fees	Gross/actual remuneration
Member	Wendy Chan She Ping-Delfos	3 years	9 months	Not eligible	Not applicable	$0
Member	Antonios Chasouris	3 years	9 months	Not eligible	Not applicable	$0
Member	Johnathan (Gin) Chee	3 years	9 months	Not eligible	Not applicable	$0
Member	Laurence Cheung	3 years	5 months	Not eligible	Not applicable	$0
Member	Peter Christophides	3 years	5 months	Sessional	$75 per hour for a maximum of 5 hours	$0
Member	Patricia Clifford	3 years	9 months	Not eligible	Not applicable	$0
Member	Catherine Cole	3 years	12 months	Sessional	$75 per hour for a maximum of 5 hours	$375
Member	Dorothy Collins	3 years	12 months	Sessional	$75 per hour for a maximum of 5 hours	$1,500
Member	Lachlan Cooke	3 years	9 months	Sessional	$75 per hour for a maximum of 5 hours	$1,200
Member	Craig Cumming	3 years	12 months	Sessional	$75 per hour for a maximum of 5 hours	$1,875
Member	Carolyn Daggers	3 years	9 months	Not eligible	Not applicable	$0
Member	Eleanor Davies	3 years	9 months	Not eligible	Not applicable	$0
Member	Benjamin Edward Dawson	3 years	5 months	Sessional	$75 per hour for a maximum of 5 hours	$375
Member	Jane Deacon	3 years	12 months	Not eligible	Not applicable	$0
Member	Ravani Duggan	3 years	12 months	Sessional	$75 per hour for a maximum of 5 hours	$375

Position	Name	Term of appointment	Period of membership 2024–25	Type of remuneration	Base salary/sitting fees	Gross/actual remuneration
Member	Kylie Ekins	3 years	5 months	Not eligible	Not applicable	$0
Member	Ahmed Elagali	3 years	3 months	Sessional	$75 per hour for a maximum of 5 hours	$0
Member	Wayne Epton	3 years	12 months	Not eligible	Not applicable	$0
Member	Mohamed Estai	3 years	12 months	Not eligible	Not applicable	$0
Member	Paul Etheredge	3 years	9 months	Sessional	$75 per hour for a maximum of 5 hours	$1,125
Member	Mark Fear	3 years	9 months	Not eligible	Not applicable	$0
Member	Susan Feng	3 years	5 months	Not eligible	Not applicable	$0
Member	Saverio (Xavier) Fiorilla	3 years	12 months	Not eligible	Not applicable	$0
Member	Natalie Fleetwood	3 years	12 months	Sessional	$75 per hour for a maximum of 5 hours	$1,125
Member	Hannah Floquet	3 years	5 months	Sessional	$75 per hour for a maximum of 5 hours	$375
Member	Janice Fogarty	3 years	12 months	Sessional	$75 per hour for a maximum of 5 hours	$2,625
Member	Kathryn (Kathy) Fuller	3 years	12 months	Sessional	$75 per hour for a maximum of 5 hours	$1,500
Member	Olivia Gallagher	3 years	9 months	Not eligible	Not applicable	$0
Member	Pauline Glasson	3 years	9 months	Not eligible	Not applicable	$0
Member	Erin Godecke	3 years	5 months	Not eligible	Not applicable	$0
Member	Srinivasa Goteti	3 years	5 months	Not eligible	Not applicable	$0

Position	Name	Term of appointment	Period of membership 2024–25	Type of remuneration	Base salary/sitting fees	Gross/actual remuneration
Member	Alex Griffiths	3 years	9 months	Not eligible	Not applicable	$0
Member	Kerry Gunton	3 years	9 months	Not eligible	Not applicable	$0
Member	Georgia Halkett	3 years	12 months	Not eligible	Not applicable	$0
Member	Teresa Harms	3 years	12 months	Sessional	$75 per hour for a maximum of 5 hours	$3,000
Member	Kristie Harper	3 years	12 months	Not eligible	Not applicable	$0
Member	Jennifer Heart	3 years	5 months	Sessional	$75 per hour for a maximum of 5 hours	$225
Member	Jackson Herriott	3 years	5 months	Sessional	$75 per hour for a maximum of 5 hours	$1,125
Member	Michael Hertz	3 years	8 months	Not eligible	Not applicable	$0
Member	Julie Hibbert	3 years	5 months	Sessional	$75 per hour for a maximum of 5 hours	$750
Member	Elizabeth (Lizz) Hill	3 years	9 months	Not eligible	Not applicable	$0
Member	Charmaine Hugo	3 years	9 months	Sessional	$75 per hour for a maximum of 5 hours	$2,250
Member	Akaiti James	3 years	9 months	Sessional	$75 per hour for a maximum of 5 hours	$975
Member	Terri James	3 years	9 months	Not eligible	Not applicable	$0
Member	Gayatri Jape	3 years	5 months	Not eligible	Not applicable	$0
Member	Mohammed Junaid	3 years	12 months	Sessional	$75 per hour for a maximum of 5 hours	$375

Position	Name	Term of appointment	Period of membership 2024–25	Type of remuneration	Base salary/sitting fees	Gross/actual remuneration
Member	Mary Kamel	3 years	9 months	Not eligible	Not applicable	$0
Member	Pritika KC	3 years	9 months	Not eligible	Not applicable	$0
Member	Michelle Kirk	3 years	9 months	Sessional	$75 per hour for a maximum of 5 hours	$1,125
Member	Nin Kirkham	3 years	12 months	Sessional	$75 per hour for a maximum of 5 hours	$2,700
Member	Rolland Kohan	3 years	5 months	Not eligible	Not applicable	$0
Member	Pavitra Krishnan	3 years	9 months	Not eligible	Not applicable	$0
Member	Daryl Langman	3 years	9 months	Sessional	$75 per hour for a maximum of 5 hours	$1,500
Member	Daniel Rodolfo Laucirica	3 years	5 months	Sessional	$75 per hour for a maximum of 5 hours	$750
Member	Ashleigh Lawrence	3 years	5 months	Sessional	$75 per hour for a maximum of 5 hours	$375
Member	Francene Leaversuch	3 years	9 months	Not eligible	Not applicable	$0
Member	Eric Lim	3 years	5 months	Sessional	$75 per hour for a maximum of 5 hours	$375
Member	Wai Lim	3 years	5 months	Not eligible	Not applicable	$0
Member	Wil Liam Lim	3 years	12 months	Sessional	$75 per hour for a maximum of 5 hours	$750
Member	Elena Lovegrove	3 years	9 months	Sessional	$75 per hour for a maximum of 5 hours	$1,350
Member	Graham Mabury	3 years	12 months	Not eligible	Not applicable	$0

Position	Name	Term of appointment	Period of membership 2024–25	Type of remuneration	Base salary/sitting fees	Gross/actual remuneration
Member	Stephen MacDonald	3 years	6 months	Not eligible	Not applicable	$0
Member	Adriana Mannino	3 years	9 months	Not eligible	Not applicable	$0
Member	Adam Manuel	3 years	9 months	Not eligible	Not applicable	$0
Member	Phillip (Phil) Matson	3 years	5 months	Sessional	$75 per hour for a maximum of 5 hours	$0
Member	Anne Matthews	3 years	12 months	Not eligible	Not applicable	$0
Member	Anastasia Mattingley	3 years	9 months	Not eligible	Not applicable	$0
Member	Elizabeth Maynard	3 years	6 months	Sessional	$75 per hour for a maximum of 5 hours	$750
Member	Daniel McAullay	3 years	12 months	Not eligible	Not applicable	$0
Member	Sonia McKeiver	3 years	12 months	Not eligible	Not applicable	$0
Member	Helen McLeish	3 years	9 months	Not eligible	Not applicable	$0
Member	John McMath	3 years	12 months	Not eligible	Not applicable	$0
Member	Shailender Mehta	3 years	5 months	Not eligible	Not applicable	$0
Member	Meneesha Michalka	3 years	5 months	Sessional	$75 per hour for a maximum of 5 hours	$375
Member	Lesley Millar	3 years	5 months	Sessional	$75 per hour for a maximum of 5 hours	$750
Member	Hamish Milne	3 years	12 months	Sessional	$75 per hour for a maximum of 5 hours	$2,925

Position	Name	Term of appointment	Period of membership 2024–25	Type of remuneration	Base salary/sitting fees	Gross/actual remuneration
Member	Leanne Monterosso	3 years	5 months	Not eligible	Not applicable	$0
Member	Samuel Montgomery	3 years	5 months	Sessional	$75 per hour for a maximum of 5 hours	$0
Member	Kwi Moon	3 years	5 months	Not eligible	Not applicable	$0
Member	Kimberley Morrison	3 years	9 months	Sessional	$75 per hour for a maximum of 5 hours	$750
Member	Hana Morrissey	3 years	9 months	Sessional	$75 per hour for a maximum of 5 hours	$750
Member	Maria Antonia (Tonia) Naylor	3 years	9 months	Sessional	$75 per hour for a maximum of 5 hours	$1,650
Member	Hanh Ngo	3 years	9 months	Sessional	$75 per hour for a maximum of 5 hours	$0
Member	Menuka Pallebage Gamarallage	3 years	9 months	Sessional	$75 per hour for a maximum of 5 hours	$1,125
Member	Stephen Pannell	3 years	9 months	Not eligible	Not applicable	$0
Member	Kylee Parentich	3 years	5 months	Sessional	$75 per hour for a maximum of 5 hours	$0
Member	Marianne Phillips	3 years	5 months	Not eligible	Not applicable	$0
Member	Ashlee Piper	3 years	9 months	Not eligible	Not applicable	$0
Member	Michele Poepjes	3 years	12 months	Sessional	$75 per hour for a maximum of 5 hours	$1,350
Member	Dale Pugh	3 years	5 months	Not eligible	Not applicable	$0
Member	Ali Radomiljac	3 years	12 months	Not eligible	Not applicable	$0

Position	Name	Term of appointment	Period of membership 2024–25	Type of remuneration	Base salary/sitting fees	Gross/actual remuneration
Member	Krishnaraj Ragunath	3 years	9 months	Not eligible	Not applicable	$0
Member	Corinne Ralph	3 years	5 months	Not eligible	Not applicable	$0
Member	Theo Rangiah	3 years	12 months	Not eligible	Not applicable	$0
Member	Kush Rathore	3 years	9 months	Sessional	$75 per hour for a maximum of 5 hours	$1,125
Member	Aidan Ricciardo	3 years	9 months	Sessional	$75 per hour for a maximum of 5 hours	$750
Member	Eduardo Rodriguez	3 years	12 months	Sessional	$75 per hour for a maximum of 5 hours	$0
Member	Natalie Rudling	3 years	6 months	Not eligible	Not applicable	$0
Member	Tyler Selway	3 years	5 months	Not eligible	Not applicable	$0
Member	Madhavan Seshadri	3 years	9 months	Not eligible	Not applicable	$0
Member	Kirtida Shah	3 years	9 months	Not eligible	Not applicable	$0
Member	Gayatri Shirolkar	3 years	9 months	Sessional	$75 per hour for a maximum of 5 hours	$750
Member	Sahil Singh	3 years	3 months	Not eligible	Not applicable	$0
Member	Susan Slatyer	3 years	9 months	Sessional	$75 per hour for a maximum of 5 hours	$1,125
Member	Desmond Smit	3 years	5 months	Sessional	$75 per hour for a maximum of 5 hours	$2,100
Member	Tresslyn Smith	3 years	12 months	Sessional	$75 per hour for a maximum of 5 hours	$750

Position	Name	Term of appointment	Period of membership 2024–25	Type of remuneration	Base salary/sitting fees	Gross/actual remuneration
Member	Stephen Sparkes	3 years	12 months	Sessional	$75 per hour for a maximum of 5 hours	$2,250
Member	Katrina Spilsbury	3 years	12 months	Sessional	$75 per hour for a maximum of 5 hours	$2,175
Member	Marisa Taliangis	3 years	5 months	Sessional	$75 per hour for a maximum of 5 hours	$750
Member	Karen Taylor	3 years	12 months	Not eligible	Not applicable	$0
Member	Betty Thomas	3 years	12 months	Not eligible	Not applicable	$0
Member	Amy Thomasson	3 years	9 months	Sessional	$75 per hour for a maximum of 5 hours	$1,725
Member	Bethany Tippet	3 years	9 months	Sessional	$75 per hour for a maximum of 5 hours	$1,725
Member	Sayuri Tomioka	3 years	9 months	Not eligible	Not applicable	$0
Member	Stephania Tomlin	3 years	12 months	Not eligible	Not applicable	$0
Member	Santosh Valvi	3 years	5 months	Not eligible	Not applicable	$0
Member	Zlatibor Velickovic	3 years	12 months	Not eligible	Not applicable	$0
Member	Helen Walsh	3 years	6 months	Sessional	$75 per hour for a maximum of 5 hours	$1,500
Member	Bret Watson	3 years	12 months	Not eligible	Not applicable	$0
Member	Carol Watson	3 years	9 months	Not eligible	Not applicable	$0
Member	Ruth Webb-Smith	3 years	12 months	Sessional	$75 per hour for a maximum of 5 hours	$1,500
Member	Dieter Weber	3 years	12 months	Not eligible	Not applicable	$0

Position	Name	Term of appointment	Period of membership 2024–25	Type of remuneration	Base salary/sitting fees	Gross/actual remuneration
Member	Scott White	3 years	5 months	Not eligible	Not applicable	$0
Member	Tammy Wilson (nee Corica)	3 years	5 months	Sessional	$75 per hour for a maximum of 5 hours	$750
Member	Alexander Wood	3 years	5 months	Not eligible	Not applicable	$0
Member	Leanne Wood	3 years	9 months	Not eligible	Not applicable	$0
Member	Janet Woollard	3 years	12 months	Not eligible	Not applicable	$0
Expert reviewer	Matthew Albrecht	Ongoing	12 months	Sessional	$75 per hour for a maximum of 3 hours	$0
Expert reviewer	Jasmine Blennerhassett	Ongoing	9 months	Not eligible	Not applicable	$0
Expert reviewer	Jarrad Bothe	Ongoing	9 months	Not eligible	Not applicable	$0
Expert reviewer	Zoe Bradfield	Ongoing	12 months	Not eligible	Not applicable	$0
Expert reviewer	Erika Bro	Ongoing	12 months	Not eligible	Not applicable	$0
Expert reviewer	Rachel Fisk	Ongoing	12 months	Not eligible	Not applicable	$0
Expert reviewer	Angela Jacques	Ongoing	12 months	Not eligible	Not applicable	$0
Expert reviewer	Jeff Keelan	Ongoing	8 months	Sessional	$75 per hour for a maximum of 3 hours	$0
Expert reviewer	Pradeep Koppolu	Ongoing	12 months	Sessional	$75 per hour for a maximum of 3 hours	$0
Expert reviewer	Nicola Maslen	Ongoing	9 months	Sessional	$75 per hour for a maximum of 3 hours	$0
Expert reviewer	Charlie McLeod	Ongoing	6 months	Not eligible	Not applicable	$0

Position	Name	Term of appointment	Period of membership 2024–25	Type of remuneration	Base salary/sitting fees	Gross/actual remuneration
Expert reviewer	Matthew Moller	Ongoing	4 months	Not eligible	Not applicable	$0
Expert reviewer	Jennifer Nguyen	Ongoing	7 months	Not eligible	Not applicable	$0
Expert reviewer	Jing (Cherry) Ning	Ongoing	12 months	Not eligible	Not applicable	$0
Expert reviewer	William (Bill) Noffsinger	Ongoing	3 months	Not eligible	Not applicable	$0
Expert reviewer	Stephanie O'Hart	Ongoing	5 months	Not eligible	Not applicable	$0
Expert reviewer	Vincent (Wai Shun) Pang	Ongoing	12 months	Not eligible	Not applicable	$0
Expert reviewer	Erica Parker	Ongoing	12 months	Not eligible	Not applicable	$0
Expert reviewer	Gregory Price	Ongoing	12 months	Not eligible	Not applicable	$0
Expert reviewer	Polly Pui	Ongoing	9 months	Not eligible	Not applicable	$0
Expert reviewer	Wendy Simpson	Ongoing	12 months	Sessional	$75 per hour for a maximum of 3 hours	$0
Expert reviewer	Barry Thompson	Ongoing	9 months	Sessional	$75 per hour for a maximum of 3 hours	$300
Expert reviewer	Man Wai (Antonia) Wong	Ongoing	9 months	Not eligible	Not applicable	$0
*Sitting fees are for a minimum of 2 hours per meeting					**Total**	**$66,750**

Position	Name	Term of appointment	Period of membership 2024–25	Type of remuneration	Base salary/sitting fees	Gross/actual remuneration
Western Australian Board of the Medical Board of Australia						
Chair	Prof. Mark Edwards	3 years	12 months	Sessional		
Member	Dr Richelle Douglas	3 years	12 months	Sessional		
Member	Dr Alan Duncan AM	3 years	12 months	Sessional		
Member	Dr George Eskander	3 years	4 months	Sessional		
Member	Dr Melina Gooneratne	2 years	8 months	Sessional		
Member	Dr Michael Levitt	3 years	4 months	Sessional		
Member	Dr Peter Maguire	3 years	12 months	Sessional		
Member	Dr Clare Matthews	3 years	4 months	Sessional		
Member	Sonia McKeiver	3 years	4 months	Sessional		
Member	Meneesha Michalka	3 years	12 months	Sessional		
Member	Dr Katinka Morton	3 years	12 months	Sessional		
Member	Liam Roche	3 years	12 months	Sessional		
Member	Dr Divya-Jyoit Sharma	2 years	8 months	Sessional		
Member	Dr Ruth Shean	3 years	12 months	Sessional		
Member	Cr Hardeep Singh	2 years	8 months	Sessional		
Member	Dr Kylie Sterry	2 years	8 months	Sessional		
*Board members are not remunerated by the department					**Total**	**$0**

Position	Name	Term of appointment	Period of membership 2024–25	Type of remuneration	Base salary/sitting fees	Gross/actual remuneration
Western Australian Board of the Nursing and Midwifery Board of Australia						
Chair	Michelle Dillon	3 years	12 months	Sessional		
Member	Justine Burg	3 years	12 months	Sessional		
Member	David Cox	3.5 years	9 months	Sessional		
Member	Ann Dawson	3 years	12 months	Sessional		
Member	Heather Gillett	3 years	12 months	Sessional		
Member	Dr Yvonne Hauck	3 years	12 months	Sessional		
Member	Nathan Haynes	3 years	9 months	Sessional		
Member	Beverley Jowle	3 years	12 months	Sessional		
Member	John (Kim) Laurence	3 years	6 months	Sessional		
Member	Jill O'Connor	3 years	12 months	Sessional		
*Board members are not remunerated by the department					**Total**	**$0**
Western Australian Reproductive Technology Council						
Chair (retired)	Prof. Stephan Millet	3 years	9 months	Annual	$22,225	$16,669
Acting Chair / Member	Hamish Milne	3 years	12 months	Sessional	$376	$8,255
Acting Deputy Chair / Member	Dr Michelle De Souza	3 years	8 months	Sessional	$376	$3,008
Member	Michelle Arnold	3 years	12 months	Sessional	$251	$2,008
Member	Dr Andrew Harman	3 years	2 months	Not eligible	Not applicable	$0

Position	Name	Term of appointment	Period of membership 2024–25	Type of remuneration	Base salary/sitting fees	Gross/actual remuneration
Member	Dr Tamara Hunter	3 years	12 months	Sessional	$376	$4,136
Member	Dr Robyn Leake (Junckerstorff)	3 years	12 months	Sessional	$376	$4,136
Member	Sebastian Leathersich	3 years	12 months	Not eligible	Not applicable	$0
Member	Lauren MacKinnon	3 years	8 months	Not eligible	Not applicable	$0
Member	Juliettie Somerville	3 years	8 months	Sessional	$376	$3,008
Member	Associate Prof. Stella Tarrant	3 years	12 months	Sessional	$376	$4,512
Deputy Member	Dr Michael Allen	3 years	12 months	Sessional	$376	$376
Deputy Member	Felicite Black	3 years	12 months	Sessional	$376	$0
Deputy Member	Valda Duffield	3 years	12 months	Not eligible	Not applicable	$0
Deputy Member	Prof. Alison Garton	2 years	12 months	Sessional	$376	$1,504
Deputy Member	Deborah Gilchrist	3 years	12 months	Sessional	$376	$0
Deputy Member	Prof. Jeffrey Keelan	3 years	8 months	Sessional	$376	$0
Deputy Member	Dr Melissa O'Neill	3 years	12 months	Sessional	$376	$0
Deputy Member	Brieanne Rogers	3 years	8 months	Sessional	$376	$0
Deputy Member	Dianne Scarle	3 years	12 months	Not eligible	Not applicable	$0
Deputy Member	Kellie Twartz	3 years	12 months	Sessional	$251	$502
					Total	**$48,114**

Position	Name	Term of appointment	Period of membership 2024–25	Type of remuneration	Base salary/sitting fees	Gross/actual remuneration
Western Australian Reproductive Technology Council Preimplantation Genetic Testing Committee						
Chair	Dr Tamara Hunter	3 years	12 months	Sessional	$476	$1,904
Member	Sebastian Leathersich	3 years	12 months	Not eligible	Not applicable	$0
Member	Dr Katherine Sanders	3 years	12 months	Sessional	$309	$1,236
Member	Dr Sharron Townsend	3 years	12 months	Not eligible	Not applicable	$0
Member	Dr Melanie Walls	3 years	12 months	Sessional	$309	$1,236
					Total	**$4,376**

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14901-DoH Annual Report