



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

Annual Report

2025-2026



Acknowledgement of Country and People

Department of 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 2025–26, 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 2026.

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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Statement of compliance

For the year ended 30 June 2026

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 2026.

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

11 September 2026

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From the Director General

It is my pleasure to present the Department of Health's 2025–26 Annual Report.

This year, I am proud to see our health system continue to evolve and strengthen in response to the needs of Western Australians. Across our state, our people have worked with determination, compassion and purpose to deliver care, improve services and respond to the needs of our communities.

The challenges facing health systems around the world are well known. Growing and ageing populations, increasing demand for services, workforce pressures and the rising impacts of chronic disease continue to test our capacity and resilience. Yet I believe these challenges also present opportunities to rethink how we deliver care, embrace new ways of working and strengthen the foundations of our health system for the future.

Throughout 2025–26, I remained focused on improving access to care and ensuring Western Australians receive the right care, in the right place, at the right time. I have been encouraged by the progress made through innovative models of care, expanded virtual health services, stronger system coordination and improved support for people transitioning between hospital, aged care and community services. These initiatives are helping to create a more responsive and connected experience for patients and families, while supporting the long-term sustainability of our health system.

This year also reinforced for me the power of collaboration. Across WA Health, government agencies, the research sector, community organisations and consumers worked together to tackle some of our most complex challenges. From improving services for vulnerable populations and strengthening preventative health initiatives, to driving reform in mental health, workforce development and digital health, I have seen first-hand what can be achieved when we work together towards a shared vision.

I am particularly proud of the work undertaken to strengthen tobacco control across Western Australia. Through landmark reforms, targeted enforcement activities and public education initiatives, we have continued to reduce the harms associated with tobacco, vaping products and nitrous oxide. By taking decisive action to address emerging public health risks, we are helping create healthier environments for future generations and supporting better health outcomes for communities across Western Australia.

I have also seen remarkable progress in research and innovation across our health system. The groundbreaking work being undertaken across our health and medical research community is improving patient outcomes today while helping shape the future of health care in Western Australia. Equally important is our commitment to innovation in service delivery, enabling us to provide more accessible, equitable and person-centred care for people wherever they live.

As Director General, I recognise our responsibility not only to today's communities but also to future generations. During the year, we advanced initiatives to strengthen climate resilience and sustainability across the health sector, ensuring we are prepared for emerging environmental challenges while continuing to protect and promote community health and wellbeing.

Above all, this year's achievements reflect the extraordinary people who make up WA Health. Every day, more than 65,000 staff bring skill, dedication and compassion to their work. Whether caring for patients on the frontline, supporting critical services behind the scenes, leading research breakthroughs or shaping policy and reform, our workforce is the heart of our health system.

I continue to be inspired by the commitment of our people and by the difference they make in the lives of Western Australians every day. Their professionalism, resilience and unwavering focus on patient care are the foundation of our success.

While there is more work ahead, I am optimistic about the future. Together, we are building a health system that is sustainable and responsive to the changing needs of our community. One that embraces opportunity, values partnership and puts people at the centre of everything we do.

I thank our staff, partners, consumers and communities for their ongoing support and contribution. I am proud of what we have achieved together during 2025–26 and look forward to continuing our work to improve the health and wellbeing of all Western Australians.

Dr Shirley Bowen

Director General, Department of Health

About us

2025-2026

Vision

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

Mission

To lead and steward the WA health system

Commitment

Health care equity and inclusion

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

Our role

- ▶ Provide strategic leadership and direction to the WA health system
- ▶ Oversee the delivery of health services and the overall performance of the local health system network
- ▶ Promote and enable the optimal health and wellbeing of the community

Our objectives

Sustainable health and care system

Enabling the sustainability of health care and the delivery of services, and building a climate resilient and sustainable health system

Optimal health care

Ensuring health care provision across the system is safe and of high quality, is coordinated and accessible, and represents best value for money

Community health and wellbeing

Promoting and enabling optimal health and wellbeing, while protecting against health risks via collaboration and partnerships



Our reform focus

Reform drivers

Ageing population



People aged 65 years and over in WA are projected to increase from approximately 500,000 in 2025 to 694,000 by 2036 ¹, representing a 39 per cent increase. This growth is expected to drive increased demand particularly in the management of chronic and complex conditions and will continue to place pressure on hospital, community and aged care services

Fragmentation of delivery and sub-optimal patient flow



Improving coordination between services, reducing barriers to care transitions and strengthening integrated models of care will help create a more connected health system and support patients to receive the right care, at the right time, in the right setting.

Increasing costs of care



The cost of delivering health services continues to rise, with the total cost of services projected to increase by 6.7 per cent in 2026–27.²

Increase in chronic disease



Chronic disease remains the dominant source of disease burden in WA. The leading contributors to disease burden in 2023, were: ³

1. mental and substance use disorders (15.8%)
2. cancer and other neoplasms (15.5%)
3. musculoskeletal disorders (13.2%)
4. cardiovascular diseases (11.4%)

Increasing demand for hospital services



2022–2025



8%

Emergency department attendance



15%

Admissions to public hospitals



25%

Admissions to elective surgery services



12%

Outpatient attendance

1 - [WA Tomorrow 12 Population Forecast – Data Tables](#). 2 - [2026-27 Budget Statements, Budget Paper No. 2 - Volume 2](#). 3 - [Western Australian Burden of Disease 2011-2023](#).



Technological advances

Emerging technologies, including digital health solutions, artificial intelligence (AI), advanced analytics and virtual modes of care are changing how services are planned, delivered and accessed. Harnessing these innovations requires continued investment in digital capability, infrastructure and workforce readiness to support modern, connected and sustainable health care.



Health workforce challenges

Health workforce challenges continue to affect both clinical and non-clinical professions, particularly in rural, regional and remote areas. An ageing workforce and anticipated retirements are contributing to a loss of experience and capability, while emerging models of care, digital transformation and evolving technologies are increasing demand for new skills. Attraction and retention strategies and strengthening sustainable workforce pipelines through education, training and partnerships with universities and training providers, remain critical to addressing these challenges.⁴



Therapeutic advances and changing clinical practice

Advances in therapeutics and evolving clinical practices continue to reshape health care delivery across WA.

Developments in areas such as genomics, innovative medicines, virtual care and contemporary models of care are improving patient outcomes and experiences, while driving the need for ongoing investment in workforce capability, digital technologies and service redesign across the WA health system.

4 - [WA Health Workforce Strategy 2034](#)

Reform system levers

Clinical Services Framework

WA Health Clinical Services Framework 2025–2035

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



Sustainable Health Review

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



WA Health Workforce Strategy 2034

A structured approach to optimise the capability and capacity of the health workforce while addressing workforce challenges unique to WA



WA Health and Medical Research Strategy 2023–2033

A comprehensive plan to advance health and medical research in WA to enhance health outcomes through targeted research, collaboration, and innovation



WA Health Digital Strategy 2020–2030

A roadmap for implementing new technologies, improving clinical information systems, and preparing for the health system for the future



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

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 major health infrastructure projects, hospital expansions and upgrades.



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 advocating to the Commonwealth for more aged care services to ensure older Western Australians receive the support they need.

Our accountable authority

The Director General of the Department of Health is Dr Shirley Bowen.

Under the *Health Services Act 2016*, the Director General is responsible for carrying out the system manager role for the WA health system and reports to the Ministers for Health; Mental Health, Medical Research, Health Infrastructure, Preventative Health, and Aged Care and Seniors.

The Director General is also the Chief Executive Officer (CEO) of the department under the *Public Sector Management Act 1994*. As CEO, the Director General is responsible for the efficient and effective management of the department and is accountable for strategic leadership, organisational performance, governance, financial management, workforce management, integrity, and the stewardship of public sector resources.

As system manager, the Director General is responsible for the strategic direction, oversight, management, and performance of the WA health system, operating at arm's length 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 that detail the scope of services, targeted levels of activity, performance requirements, and roles and responsibilities of the system manager and the health service provider.

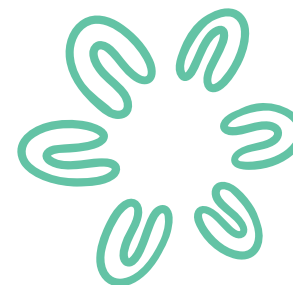
The Mental Health Commission purchases mental health, alcohol and drug health services from health service providers through service agreements enabled via a head agreement between the department and the Mental Health Commission, provided for within the *Health Services Act 2016*.

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.

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) Account⁵ and its application to health and medical research, innovation and commercialisation.

Ministerial directions

The department did not receive any formal ministerial directives in 2025–26 relevant to the setting of the department's desired outcomes.



5 - 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

Dr Clare Huppatz

Chief Health Officer and
Deputy Director General
Public and Aboriginal Health



Ms Jodie South

Deputy Director General
Infrastructure Medical Research and Innovation



Dr Lesley Bennett

Deputy Director General
Clinical Excellence



Ms Nicole O'Keefe

Deputy Director General
Strategy and Governance



Dr Shirley Bowen

Director General



Mr Adam Lloyd

Assistant Director General
Chief Digital Officer



Mr Rob Anderson

Deputy Director General
Purchasing and System Performance



Ms Pippa Beamish Burton

Assistant Director General
Financial Business Services



Notes: Dr Andy Robertson was the Deputy Director General and Chief Health Officer to 27 February 2026 and Dr Clare Huppatz was appointed to the role on 28 February 2026; Mr Philip Aylward was appointed the Deputy Director General, Chief Operating Officer Hospitals on 18 May 2026.



Dr Shirley Bowen
BMed MM FRACP FACSHM FRACMA (Hon)

Director General

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

Director General 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, and 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 person centred 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.



Mr Rob Anderson
Deputy Director General
Purchasing and System Performance

Mr Anderson has been in the role of Deputy 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.

- ▶ 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



Ms Pippa Beamish Burton
B.Bus, CPA, GAICD
Assistant Director General
Financial Business Services

Ms Beamish Burton was appointed Assistant Director General, Financial Business Services in September 2025 and serves as the department's Chief Finance Officer.

Ms Beamish Burton is committed to providing strategic financial stewardship for the WA health system, overseeing financial strategy, budget management, financial sustainability, governance and compliance.

With over 20 years of public sector experience she has held senior positions at the Department of Education, the former Department for Child Protection and Family Support, and the Department of Communities.

- ▶ Leads and stewards strategic budgeting for WA Health
- ▶ Enables and supports activity to ensure the long-term financial sustainability for WA Health



Dr Lesley Bennett
MBChB, MD, FRACP, FRCP, GAICD
Deputy Director General
Clinical Excellence

Dr Bennett is an experienced clinical and executive leader with more than 35 years in healthcare across Australia and the United Kingdom. As a specialist physician, she has held senior leadership roles including Chief Executive of East Metropolitan Health Service and Executive Director of Royal Perth Bentley Group.

Dr Bennett is committed to collaborative leadership, strong clinician engagement, and maintaining a focus on quality, safety and patient-centred care.

- ▶ 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



Dr Clare Huppatz

BMBS, MPH, MAppEpid, FAFPHM

Chief Health Officer and Deputy Director General

Public and Aboriginal Health

Dr Huppatz is a highly respected public health physician with extensive experience across communicable disease control, emergency preparedness, Aboriginal health, public health regulation, and preventative health. Appointed in 2026 as the first female Chief Health Officer, she previously served as Deputy Chief Health Officer from 2021.

During the COVID-19 pandemic, Dr Huppatz played a key role including establishing and leading the Public Health Emergency Operation Centre and providing advice on public health policy and legislation. In recognition of this work, she was awarded the Public Service Medal in 2023.

Dr Huppatz is strongly committed to improving health outcomes for all Western Australians and is deeply committed to advancing Aboriginal health and the health of disadvantaged communities.

- ▶ 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



Mr Adam Lloyd

MBA

Assistant Director General, Chief Digital Officer

Mr Lloyd is an executive digital health leader with over two decades of experience in digital strategy, portfolio governance, architecture and clinical innovation. He has a proven track record in delivering safe, high-quality and sustainable services across WA Health.

Mr Lloyd has led large-scale digital transformation initiatives, including AI-enabled virtual care, enterprise data platforms and major ICT programs. His approach is underpinned by transparent reporting, a culture of trust, and strong clinician and community engagement, supporting major initiatives such as planning for an electronic medical record.

He is committed to harnessing digital innovation to improve patient outcomes, enhance clinician experience and supporting a sustainable public health system.

- ▶ Leads systemwide digital innovation and transformation
- ▶ Oversees and supports delivery of the *WA Health Digital Strategy 2020-2030*
- ▶ Oversees core digital services across WA Health



Ms Nicole O'Keefe

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

Deputy 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 7 years in her current role, Ms O'Keefe has demonstrated her commitment to public policy design and implementation.

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



Ms Jodie South

BEC

Deputy Director General

Infrastructure Medical Research and Innovation

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 34 years of extensive experience within the WA public sector, including 28 years in WA Health, Ms South leads the delivery of key government priorities in health infrastructure projects and medical research and innovation.

- ▶ Leads development of strategies and planning of infrastructure and assets for the WA health system and provides oversight of health infrastructure projects through the Asset Investment Program
- ▶ Provides policy and funding support for health and medical research and innovation for the WA health system and wider WA medical research sector
- ▶ Manages core business functions to support the department's divisions



Honouring a distinguished public health career

In February 2026, Dr Andrew (Andy) Robertson CSC PSM retired following more than 22 years of service to WA Health, including his tenure as Chief Health Officer and Deputy Director General of Public and Aboriginal Health.

Throughout his career, Dr Robertson provided leadership during some of the State's most significant public health and emergency management events, including the COVID-19 pandemic, the Indian Ocean tsunami, the Bali bombings, the Yogyakarta and Nepal earthquakes, and the Fukushima nuclear incident.

Prior to joining WA Health in 2003, Dr Robertson served for 19 years in the Royal Australian Navy, including three tours of Iraq as a Biological Weapons Chief Inspector with the United Nations Special Commission.

His contributions over his career earned national recognition, including the Conspicuous Service Cross and the Public Service Medal.

Dr Robertson was widely respected for his calm and compassionate leadership, commitment to prevention-focused public health policy, and advocacy for improving Aboriginal health and health equity across WA.

Delivering organisational change

In 2025–26, the clinical operations and outpatient functions transitioned from the Clinical Excellence Division to 2 newly established areas, the Clinical Operations Division and the Outpatient Reform Directorate. These changes focus on system operations, patient flow and access to care, while enabling the Clinical Excellence Division to continue leading clinical engagement, workforce planning, service planning, and safety and quality functions.

The newly established Digital Health Division and Financial Business Services Division will lead WA Health's digital transformation and strengthen financial stewardship and sustainability respectively.

The executive role, Deputy Director General, Chief Operating Officer Hospitals was established in mid-May and will play a critical role in driving systemwide performance, accountability and strategic alignment across WA's public health system.

Overall, these structural changes reflect our continued commitment to strengthening system leadership, improving service delivery and responding to the evolving needs of the WA community.



Vale Emeritus Professor Bryant Stokes AO

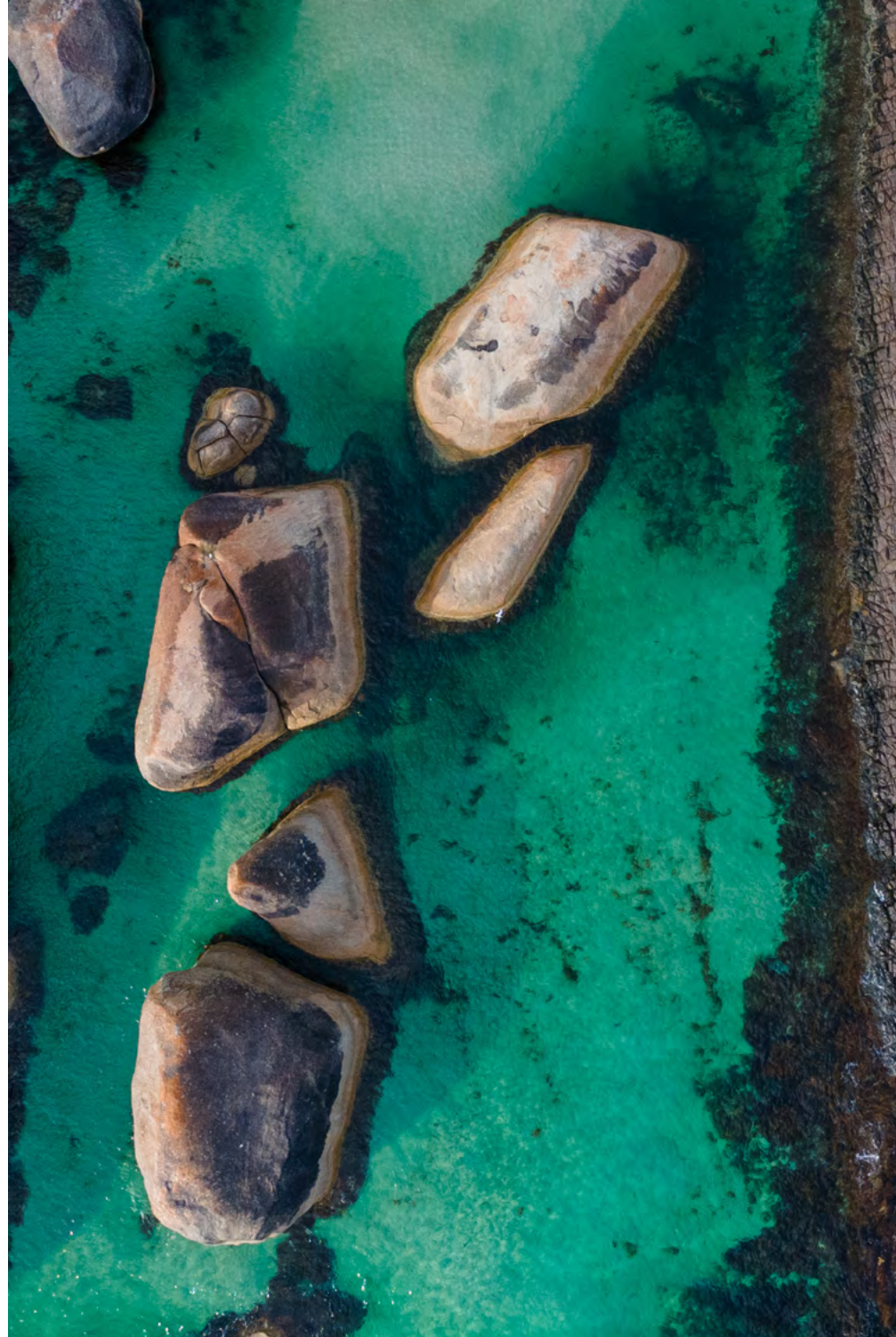
Acting Director General of the department from 2013 to 2015

WA Health farewelled one of its most respected clinical leaders and public servants with the passing of Professor Bryant Stokes AO in February 2026.

Professor Stokes dedicated more than 5 decades to advancing healthcare, medical education and public health reform in WA. A distinguished neurosurgeon, he served in several health system and academic leadership roles including as the Acting Director General of the department.

Widely recognised for his commitment to safety and quality in healthcare, Professor Stokes played a significant role in strengthening clinical governance and quality standards across the health sector. He was also a passionate advocate for medical research and education, contributing to the establishment of the Clinical Training and Evaluation Centre at the University of Western Australia and supporting neurosciences research through the Bryant Stokes Neurological Research Fund.

Professor Stokes was appointed an Officer of the Order of Australia in 2020 and his legacy continues through the many clinicians, researchers and health leaders he mentored throughout his remarkable career.



Our people



72.5% Female



27.5% Male



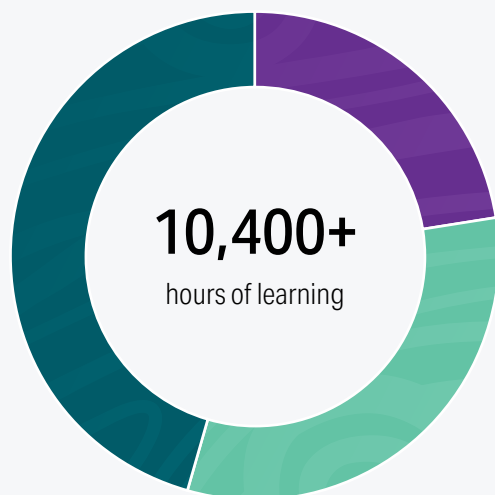
Engage, develop and provide opportunities



992

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

Hours dedicated to learning and development



- ▶ Mandatory eLearning (3,352)
- ▶ Capability building eLearning (2,361)
- ▶ Face-to-face training and development (4,688)

Top 5 learnings chosen by staff



Psychosocial Safety in the Workplace



Procurement and Contract Management in WA Health



Using AI tools in WA Health



Hidden Disabilities Sunflower Awareness Training



Aboriginal Data Governance Training

Focus on leadership and capability

In 2025–26, we focussed on strengthening leadership and interpersonal capability to enhance workplace culture, engagement and performance. Targeted investment through the Leadership Program provided a suite of programs including:

- Facilitative Leadership in Action: building capability to facilitate purposeful, collaborative conversations that promote empowerment and participation
- Compassionate Leadership: strengthening empathetic leadership approaches that support team wellbeing and performance
- Managing Workplace Behaviours: a practical, scenario-based program that builds confidence in addressing complex people issues
- The Adaptive Edge: enhancing leaders' ability to navigate uncertainty and lead in changing environments
- Systems Awareness for Leadership: development of holistic thinking to understand interdependencies, anticipate impacts and drive sustainable change.

Delivered through engaging, experiential and gamified learning approaches, these programs strengthened communication, emotional intelligence, decision making and collaboration across the department.

Building our workforce

We continue to create meaningful pathways for young professionals. In 2025–26 we welcomed a new cohort of digital government graduates and supporting corporate trainees to transition into roles within the department. These initiatives continue to build internal capability and support sustainable workforce development.

Health integrity capability

In 2025–26, we strengthened organisational integrity capability through targeted leadership engagement, integrity education and awareness activities. This included 12 Managing Integrity Risk sessions for managers, an Integrity Masterclass for senior leaders, the launch of the Integrity Starts with I campaign, and updates to Accountable and Ethical Decision-Making refresher training to align with the revised code of conduct. Together, these initiatives reinforced ethical decision-making, accountability and integrity focused leadership across the department.

Strengthening inclusive practices

Staff completed 23 equity, diversity and inclusion courses this year. We also delivered 2 face-to-face diversity confidence training sessions, building understanding of intersectionality, individual differences, privilege, cultural inclusion, unconscious bias and systemic advantage.



The Skills Academy launched in March 2026 to help public sector staff build skills and support professional development through structured learning pathways.

As of 30 June 2026, 50 per cent of staff had used the platform, with participation expected to increase as new content is added. Integration with our learning and development system provides easy access to online courses and blended learning opportunities, including workshops.

The Skills Academy reinforces our commitment to equipping staff with practical, accessible learning opportunities to help strengthen the way we design, develop and deliver health services for Western Australians.

Grow diversity and encourage inclusiveness

In 2025–26, we continued to promote inclusive leadership, equitable access to opportunities, and the creation of a workplace culture that actively celebrates diversity, promotes respect and strengthens representation across the organisation.

Strengthening inclusive and supportive environments

We launched the Hidden Disabilities Sunflower Program to raise awareness, educate and support staff with a non-visible disability. Neurodiversity in the Workplace workshops provided staff and managers with the knowledge, tools and strategies to help reduce common workplace barriers for our neurodivergent staff.

A suite of guidelines, toolkits and factsheets were produced to increase understanding of disability and support inclusive workplace practices. Additional resources simplified complex policies and industrial information, providing clear, accessible guidance on entitlements, processes and responsibilities.

We also strengthened support for flexible work and workplace adjustments through updated policies, procedures and online training, alongside enhanced remote work guidance.



Seeing the unseen: Supporting staff with hidden disability

We proudly launched the [Hidden Disabilities Sunflower Program](#) on [International Day of People with Disability](#), a powerful step towards greater inclusivity, acceptance, and understanding for people living with non-visible disability.

The global Sunflower symbol enables people living with non-visible disability to discreetly indicate that they may require additional support, understanding or assistance. Non-visible disability can include neurological, sensory and cognitive conditions, as well as chronic illness.

To support the launch, we developed a range of resources and delivered awareness training to build an understanding of the diverse experiences of people living with hidden disability. The launch event featured guest speaker Amber Anthony from the [Neurospicy Collective](#) and a staff panel sharing lived experiences, helping build understanding of the challenges and opportunities associated with creating a more inclusive workplace.



Supporting carers in the workplace



Building on our achievement of Level 1 accreditation as a Carer Friendly Workplace, we increased our focus on recognising and supporting staff with caring responsibilities. In partnership with Carers WA, this milestone was recognised during Carers Week alongside the launch of new tools and resources designed to support and assist our carers.

Enhancement to the 'Supporting Our Carers' intranet page created a central hub for information, resources and support services, further strengthening a workplace culture that values carers and their contributions.

Honouring Aboriginal culture and strengthening reconciliation



NAIDOC Week marked 50 years of honouring and elevating Indigenous voices, culture, and resilience, with this year's theme, 'The Next Generation: Strength, Vision & Legacy', reflecting both on the achievements of the past, but of the bright future ahead.

To mark NAIDOC Week we hosted a cultural workshop about local Noongar language and storytelling. This provided a meaningful opportunity for staff to engage with and deepen their understanding of Aboriginal culture and heritage.

National Reconciliation Week 2026 also provided an opportunity for staff to reflect on the theme All In and reaffirm our commitment to reconciliation. Presentations from Dr Jim Morrison, Aboriginal Health Policy and Population Health Genomics, highlighted the importance of truth-telling, shared responsibility, and ongoing efforts to improve Aboriginal health outcomes and close the gap.

Celebrating diversity and building awareness



Staff-led events provided valuable opportunities to celebrate diversity, increase awareness, and strengthen inclusion across the workforce through guest speakers, discussions and staff engagement activities.

A highlight of the year included the International Women's Day panel discussion, held under the theme Balance the

Scales, that explored gender equality and the importance for a justice system that is fair, inclusive and accessible. The panel featured inspirational women in leadership from across sectors, including mental health advocacy, elite sport, healthcare and aviation, and provided an opportunity for reflection on progress towards gender equality and the ongoing work required to support women and girls in the workplace and community.

Celebrating Youth Week 2026



[Youth Week WA](#) provides an opportunity to listen to young people, celebrate their contributions, and involve them in shaping a more inclusive and responsive workplace.

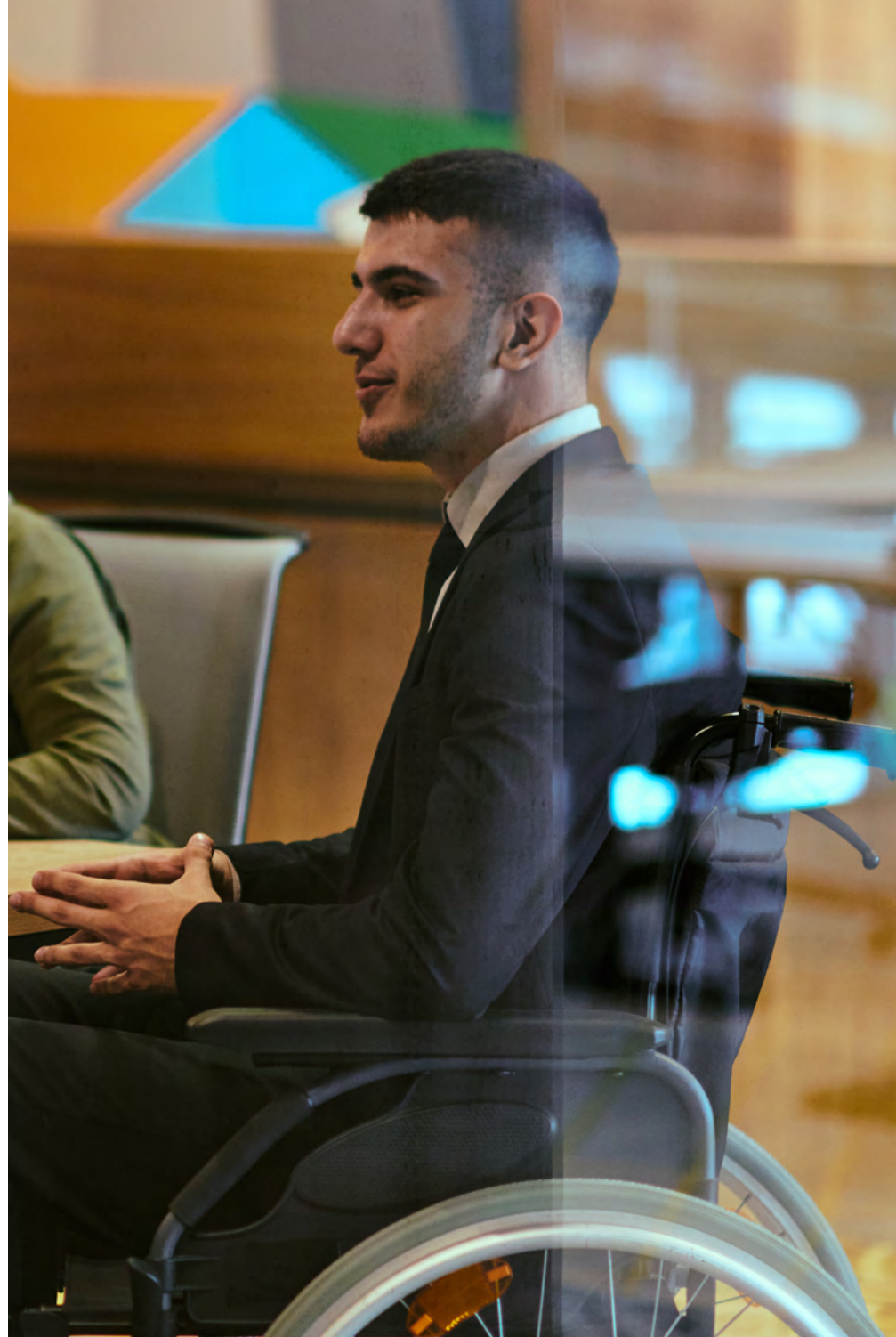
In 2025, we marked International Youth Day with a dedicated forum for our younger staff members, creating space to share ideas, discuss priorities, and explore how the department can better support and engage young people.

Workforce inclusiveness statement

We are committed to a diverse and inclusive workplace, recognising this drives higher staff satisfaction, better service outcomes, and improved performance. Employees in inclusive environments are more connected, motivated, and productive.

Insights into staff inclusivity and perceptions are gathered through the department's exit survey process. Data from 2025–26 indicates that 85 per cent of staff reported never feeling excluded or unsafe at work due to their age, ethnicity, disability, gender or sexual identity. When describing their work environment, employees most frequently used terms such as supportive, flexible, inclusive, friendly, and collaborative. Across all employee perception measures, most responses were positive or neutral, with particularly strong results reflecting that staff feel valued and supported by their teams.

These survey findings will continue to guide and strengthen our diversity and inclusion efforts over the next 12 months. Key priorities include enhancing workplace adjustment policies and processes and improving the collection of diversity data to better inform initiatives that support attraction, recruitment, and retention.



Ensure safety and promote health and wellbeing

Encouraging healthy lifestyles



979

staff influenza vaccinations administered helping protect our staff and the community



367

staff accessed discounted gym memberships supporting active lifestyles and improved health outcomes

Supporting staff wellbeing



324 health and wellbeing interactions supporting staff to proactively manage their physical and mental wellbeing



63

Roaming education and community health checks



160

FH Australia high cholesterol testing



25

Skin checks



40

RU OK Day afternoon tea



16

Active Travel Day breakfast



20

Ride2Work Day

Developing capability and resilience



- ✓ Mental health first aid officer training
- ✓ First aid officer training
- ✓ Workers' compensation and injury management, managers training
- ✓ Health and safety representative training
- ✓ Duty of care and responsibilities, managers training
- ✓ Financial wellbeing webinar – EAP
- ✓ Men's mental health webinar
- ✓ Menopause awareness training
- ✓ Sleep well, live well wellbeing webinar

Committed to workplace safety and injury management

We are committed to understanding and managing our health, safety and wellbeing risks to actively maintain staff wellbeing and prevent injuries, as well as assisting those with work-related injuries to return to work as soon as is medically appropriate (see Table 1).

During 2025–26, we strengthened our work health and safety (WHS) and injury management capability through WHS management system enhancements, policy development, workforce consultation and targeted wellbeing initiatives.

A department-wide WHS gap analysis was undertaken against the *WHS (General) Regulations 2022*. The gap analysis identified opportunities to strengthen role-specific training and induction processes, workplace design, and the management of psychosocial hazards. Key risks and controls were incorporated into the WHS risk register and escalated to the Department Executive Committee to implement governance arrangements.

Activities were undertaken to support risk mitigation and timely implementation of corrective actions for reported hazards and incidents. Workplace inspections transitioned from six-monthly to quarterly in July 2025, however implementation delays led to fewer inspections this year. Overall incident numbers were comparable with the prior year, with notable decrease in mental stress incidents, likely attributable to psychosocial management training aligned to our Psychosocial Management Framework introduced in 2024–25.

For staff with both work-related and non-work related injuries support to return to work is now coordinated between our WHS team, human resource representatives, and associated line managers to facilitate a safe and sustainable return to work. In 2025–26, 6 workers' compensation claims were made, an increase from 5 in 2024–25.

Formal mechanisms for consultation are embedded across the organisation to ensure active engagement with workers. The Health and Safety Committee remains the primary formal consultation forum with representation from management and elected health and safety representatives. The committee meets on a quarterly basis to review WHS matters, monitor injury management outcomes, and endorse key work health, safety and wellbeing initiatives.



Table 1: Our work health and safety performance, 2024–25 to 2025–26

Desired outcomes and related effectiveness indicators	Target	Results			Performance result
		2023–24 (base year)	2024–25	2025–26	
Work related injury ¹					
Number of fatalities	Zero	0	0	0	Achieved
Incidence of work related injury or illness ²	Reduce by 2% per year (and 15% by 2033 compared with 2023)	0.08	0.12	2.66	Not achieved ²
Incidence rate of serious claims with one or more weeks' lost time ²	Reduce by 2.5% per year (and 20% by 2033 compared with 2023)	0	50	0.66	Achieved
Incidence rate of claims resulting in permanent impairment ²	Reduce by 2% per year (and 15% by 2033 compared with 2023)	0	0	0.66	Not achieved ²
Incidence rate of work-related respiratory disease ²	Reduce by 2.5% per year (and 20% by 2033 compared with 2023)	0	0	0	Achieved
Hazards and incidents					
Number of hazard reports lodged	No target	42	42	37	N/A
Percentage of workplace inspections undertaken on schedule	No target	84%	83%	31%	N/A
Number of incidents reported	No target	56	35	39	N/A
Number of notifiable incidents	No target	3	1	4	N/A
Manager and supervisor training					
a) work health and safety as relevant to the agency's risk profile	Greater than or equal to 80% of cohort trained within last two (2) years	72%	62%	55%	Not achieved
b) injury management	Greater than or equal to 80% of cohort trained within last five (5) years	72%	62%	70%	Not achieved ³
Percentage of injured workers returned to work on full duties and hours ² :					
a) within 13 weeks ⁴	No target	50%	100%	100%	N/A
b) within 26 weeks ⁴	Greater than or equal to 70% returned to work within 26 weeks	100%	100%	100%	Achieved

Table 1: Our work health and safety performance, 2024–25 to 2025–26

Desired outcomes and related effectiveness indicators	Target	Results			Performance result
		2023–24 (base year)	2024–25	2025–26	
Consultative systems					
a) Number of health and safety representatives (HSRs)					
i) in total ⁵	No target	20	21	23	N/A
ii) who have attended HSR training ⁵	No target	100%	100%	91%	N/A
iii) shown as a percentage of workers ⁵	No target	1%	1%	1%	N/A
iv) shown as a ratio to the number of workplaces occupied by the agency ⁶	No target	2%	3%	3%	N/A
b) Name/s of health and safety committees and sub-committees	No target	Health, Safety and Wellbeing Committee			N/A

Notes:

- Definitions, inclusions and exclusions are provided in the explanatory notes to the DLGIRS annual reporting requirements.
- Due to the small number of staff with lost time injuries per year, caution should be taken when comparing with base year performance. In 2025–26 there was an increase in reported lost-time injuries (n=4) and an increase in permanent impairment claims (n=1).
- Injury management training was previously incorporated with work health and safety training for managers. Training on injury management was refreshed and reintroduced in the second half of 2025–26.
- Reported by calendar year (2023, 2024, 2025) to ensure complete reporting (i.e. 26 weeks have passed since injury date). Number of injured workers who returned to work to full hours and full duties (of a real job) within the specified timeframe, divided by the number of LTI/Ds reported, then multiplied by 100.
- Number of HSRs and workers is based on persons (headcount) rather than FTE.
- Number of HSRs (in terms of persons) divided by the number of workplace sites (unique addresses) occupied by the agency.

Recognise and celebrate achievements

We celebrated the achievements of our people and programs that have contributed to public health, innovation, and improved outcomes during 2025–26.

Four prestigious individual honours



Public Sector Medal

Mrs Wendy Casey *PSM*

Director Aboriginal Health Policy

Recognised for outstanding public service in Aboriginal health policy, cultural understanding and supporting improved health outcomes for Aboriginal communities.



AMA WA Hippocrates Award

Dr Simon Towler

Chief Medical Officer

Awarded for distinguished leadership and excellence in medicine as Chief Medical Officer, contributing to improved clinical standards and patient care in WA.



Churchill Fellowship

Amanda Silla

Program Manager

Recognised for her commitment to improving end-of-life care through international research and the development of compassionate, patient-centred policy approaches.



Churchill Fellowship

Henry Tan

Principal Scientific Officer

Awarded for his research into food safety and Campylobacter control in poultry production, contributing to improved public health and foodborne disease prevention.

Five major awards



2025 IPAA WA Achievement Awards for [Best Practice in Innovation](#) Gold Award

Health Justice Partnership Pilot a collaborative initiative with the Women's Legal Service WA



2025 IPAA WA Achievement Awards for [Best Practice in Innovation](#) Silver Award

2025 IPAA WA Achievement Awards for [Best Practice in Collaboration Across Government Agencies](#) (projects under \$1 million)

Western Australian Wastewater Surveillance Program



2026 WA Nursing & Midwifery Excellence Awards for Excellence in Person Centred Care – Team Award

WA Virtual Emergency Department (WAVED), State Health Operations Centre, Department of Health; St John WA



[Campaign Brief WA Creative Awards](#) - Best of Year Integrated Campaign Category Award

'Hard to Spell' campaign

Watch the award winning 'Hard to Spell' [video](#) that saw a 600 per cent increase in web traffic, demonstrating both strong engagement and impact in raising awareness of gonorrhoea prevention and testing across WA

Recognising a lifetime of medical leadership

In November 2025 our Chief Medical Officer, Dr Simon Towler received the Australian Medical Association WA Hippocrates Award. This prestigious award acknowledges a career defined by clinical excellence, leadership and commitment to improving health outcomes for the community.

Over more than three decades, Dr Towler has played a significant role in shaping healthcare in WA including the establishment of the [Clinical Senate of WA](#) and [WA Health Networks](#), leading organ and tissue donation, pioneering digital medical records, and advancing end-of-life care and voluntary assisted dying legislation.

An intensivist at Royal Perth Hospital and Fiona Stanley Hospital for a large part of his career, Dr Towler has been a strong advocate for medical workforce wellbeing, education and training. The award recognises his enduring impact on patients, clinicians and the broader health system as he approaches retirement.



30 years of data-driven research

Celebrating 30 years of the WA Data Linkage System, transforming research and policies by connecting the dots across health, education, and social data. From pioneering probabilistic linkage to launching the WA Health Linked Data Warehouse, we continue to lead data-driven innovation.



Our shared responsibilities

With shared interests and complementary strategies, policies and initiatives we collaborate with other public sector agencies on cross-government actions that contribute 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 and increasing physical activity through sport and recreation

Department of Education

Initiatives promoting immunisation, healthy eating, physical activity and student wellbeing

Department of Energy and Economic Diversification

Supporting the development, refurbishment and expansion of aged care infrastructure

Department of Fire and Emergency Services

WA Medical Assistance Teams deployment and emergency preparedness

Department of Justice

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

Department of Primary Industries and Regional Development

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

Department of Transport and Major Infrastructure

Managing major infrastructure projects supporting health service delivery

Department of Water and Environmental Regulations

Protection of healthy and sustainable water supplies

WA Police Force

Community safety initiatives relating to alcohol, tobacco, vapes and other drugs

Department of Housing and Works

Maintenance and refurbishment of key government infrastructure projects

Collaborative initiatives delivered with our partners in 2025–26

[Family and Domestic Violence – System Reform Plan 2024–29](#)

Health Navigator Pilot Program

[Low Interest Loan Scheme](#)

Memorandum of Understanding supporting the health needs of children in care

[State Seniors Strategy 2023–33](#)

[WA LGBTIQ+ Inclusion Strategy 2025–35](#)

[Women's Legal Service WA](#) Health Partnership Pilot Program

Health Asset Maintenance Fund (HAMF) program

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 32 Acts.

New legislation passed in 2025–26

- *Assisted Reproductive Technology and Surrogacy Act 2025*
- *Tobacco and Other Products Control Act 2006*

Bills in Parliament as at June 2026

- *Tobacco Products Control Amendment Bill 2026*

Administered legislation

- *Anatomy Act 1930*
- *Assisted Reproductive Technology and Surrogacy Act 2025*
- *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 and Other 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).

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 2025–26, the Chief Health Officer did not make a test order or public health order or recognise any interstate public health order.



Major milestone for reproductive healthcare

WA reached a significant milestone in reproductive healthcare reform in December 2025, with State Parliament passing the [*Assisted Reproductive Technology and Surrogacy Act 2025*](#).

The reforms represent the most substantial modernisation of WA's assisted reproductive technology (ART) and surrogacy laws ensuring the State legislative framework reflects contemporary community expectations, medical advances and evolving family structures.

Key reforms include:

- prioritising and protecting the best interests of children born through ART and surrogacy
- removing discriminatory eligibility requirements, including the requirement to demonstrate medical infertility
- improving access to fertility preservation for people undergoing medical treatments or procedures that may affect future fertility
- expanding access for donor-conceived individuals to information about their genetic and social heritage
- enhancing oversight, regulation and accountability of ART service providers, including new investigative and compliance powers for the department.

The new legislation importantly removes long-standing barriers to access, enabling same-sex couples, single people, transgender and intersex people to access ART and surrogacy services on equal grounds. Also, the legislation establishes a more contemporary and efficient regulatory framework reducing administrative burden while maintaining appropriate safeguards for people accessing ART services and children born.

The Act is scheduled to commence in mid-2027, following an 18 month implementation period. During this time, we continue to work closely with clinicians, fertility service providers and community stakeholders to operationalise the reforms.

The reforms reflect growing recognition that reproductive healthcare should be contemporary, equitable and inclusive.



Significant issues

2025-2026

Health care demand and capacity

We are always working to better streamline how we deliver health services, to help Western Australians get the care they need, when and where they need it. Some of the biggest issues facing our health system are high emergency department presentations, increased patient acuity, discharge delays, and wait times for certain types of care or treatment – and we have a host of initiatives aimed at tackling these pressures.

We continue to deliver the reforms that began with our Ambulance Ramping Strategy (2023) working to manage winter demand surges while building a broader, more enduring strategy for how we can keep on improving access to care across all health settings. We are focused on streamlining the patient journey, reducing duplication and helping the public avoid hospital presentations where clinically appropriate.

The State Health Operations Centre (SHOC) continues to enhance emergency care to maximise the effectiveness of existing hospital capacity, expanding this year to include long stay patient operations, with a dedicated team improving discharge pathways for patients with complex needs. SHOC's WA Virtual Emergency Department (WAVED) is also providing invaluable support to our physical emergency departments, by helping to address patient needs without a hospital visit, while its System Flow Centre and Patient Transport Coordination Hub work behind the scenes to help keep the system moving smoothly.

This year, we have renewed our efforts on initiatives to reduce discharge delays for patients awaiting aged care. The Time to Think program is supporting older patients to make decisions about their long-term care with comfort and dignity, providing a temporary stay in one of 146 dedicated respite beds within 9 residential aged care homes across the state. Meanwhile, we are delivering the Hospital to Aged Care Dementia Support Program (HACDSP) in partnership with the Australian Government at Bentley Health Service, Osborne Park Hospital, and Rockingham General Hospital – supporting people with dementia who are at risk of delayed hospital discharge to transition safely from hospital to an aged care home.

With the growing demand for residential aged care, we continue to partner with the sector through the Ministerial Advisory Panel on Aged Care, chaired by the Minister for Aged Care and Seniors. In May 2026, we published an independent analysis of WA's residential aged care market, informed by consultation with providers. It provides valuable insights into the availability of this care across the State and highlights the challenges of meeting future demand. These findings will inform our future policy development, planning, and advocacy activities as we aim to better support a sustainable and responsive residential aged care sector in WA.

We are also continuing to make improvements to outpatient services through the Outpatient Reform Program. The Central Referral Service is now live for 4 out of 7 regions and is on track to achieve statewide coverage by the end of 2027, bringing valuable consistency and reliability to all of WA.



Managing ageing assets

We oversee and manage a large asset portfolio worth nearly \$8 billion and over half of those assets are more than 30 years old.

We invest significantly to maintain and manage our health infrastructure, with around \$1.6 billion committed over the next four years for maintenance, asset replacement, medical equipment and other capital works programs.

In late 2025, the Health Asset Maintenance Fund (HAMF) program was launched to deliver priority maintenance and capital projects at three of our older hospitals; Sir Charles Gairdner Hospital, Royal Perth Hospital and Armadale Health Service. The HAMF in partnership with Department of Housing and Works (DHW), with 40 projects for completion across the three hospitals, with over a dozen completed as at 30 June 2026, and works well underway on the remainder.

We also continue to address the recommendations from the independent review into ongoing health maintenance, which is being delivered in partnership with the Department of Premier and Cabinet, Department of Treasury and Finance, DHW, the Department of Training and Workforce Development, and health service providers.



Tackling illicit tobacco and vapes

Tobacco use contributes to a range of health-related harms, including cancer and chronic lung conditions, while vaping has been linked to lung disease and other serious health risks.

There has been a long-term commitment to addressing the harms associated with tobacco smoking through a range of public health measures such as taxation on tobacco products, restrictions on advertising, and the prohibition of smoking in certain locations.

In WA, vapes can only be legally supplied by a registered pharmacy with a prescription from a registered medical practitioner. It is against the law for shops like tobacconists, vape stores, online shops and convenience stores to sell or supply vapes.

Despite our current public health measures, and in recognition of illegal tobacco and vape supply networks operating across Australia, we have implemented a range of new reform measures to support stronger public health protections for Western Australians.

In 2025–26, significant amendments to the [Tobacco and Other Products Control Act 2006](#) were passed in Parliament. The changes allow for expanded enforcement powers and has introduced tougher penalties aimed at disrupting illegal operators and deterring organised criminal activity linked to illicit tobacco distribution. This complements the expansion of our Tobacco and Vape Compliance Unit, strengthening the State's ability to investigate unlawful activity, undertake targeted enforcement operations and reduce the supply of illicit products within the community.^{6,7,8}



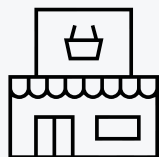
- ▶ The Illicit Tobacco and E-cigarette report estimates that the illicit tobacco market accounted for 50–60% of the total tobacco market in 2024–25, with a value of \$4.1–\$6.9 billion

6 - [Alcohol, tobacco & other drugs in Australia, Tobacco - Australian Institute of Health and Welfare](#). 7 - [18.3 Prevalence of e-cigarette use - Tobacco in Australia](#). 8 - [Closure order details at June 2026](#)

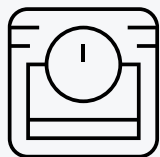
In May 2026, compliance actions have seen:



5 million+ illegal cigarettes seized



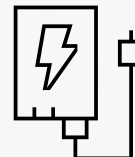
50 stores issued closure orders following compliance operations



1,218 kilograms of loose tobacco removed



49,982 illegal vapes taken off the market



621 vaping accessories seized



WA syphilis response

In 2025, syphilis was declared a Communicable Disease Incident of National Significance.

A statewide syphilis outbreak was declared in 2020 with the number of infectious syphilis notifications increasing from 93 in 2014 to a peak of 842 in 2021. While numbers decreased to 603 in 2024, they again increased to 790 in 2025.

Syphilis is a serious infection that can cause long-term health impacts if left untreated and can unknowingly be transmitted in pregnancy. Congenital syphilis, is a significant public health concern, and can result in infant disability or death. WA reported 21 congenital syphilis cases from 2018 to 2025, and 7 resulted in stillbirth.

WA's response to the increase in syphilis notifications is led by the WA Syphilis Outbreak Response Group, co-governed by the Aboriginal Health Council of WA and our Communicable Disease Control Directorate. It comprises government and non-government organisations, who meet six-monthly to discuss the epidemiology and implement initiatives to reduce syphilis transmission.

In the 2025–26, \$3.6 million was provided to support public health units, community based organisations and Aboriginal community-controlled health services to provide culturally appropriate outreach education, community based testing, and engagement with people who face barriers to mainstream health services.

A statewide syphilis advertising campaign ran from October to December 2025 to raise awareness of preventable sexually transmitted infections such as syphilis. Campaign communication channels included public transport, community settings, regional radio, digital audio and Snapchat. The campaign was viewed more than 20 million times, and online material had a click-through-rate of 0.9 per cent, compared to an average click-through-rate benchmark of 0.7 per cent. The Australian Study of Health and Relationships found WA residents' knowledge of syphilis is above the national average.⁹

Consultation is currently underway for the next WA Syphilis Action Plan, covering the period 2026–28.

Coordinated response to the diphtheria outbreak

In 2025–26, WA Health responded to a significant outbreak of diphtheria affecting predominantly Aboriginal people in regional WA, including the Kimberley, Pilbara and Goldfields regions with evidence of transmission also identified in the Midwest. The response required a coordinated statewide public health response encompassing case management, contact tracing, laboratory testing, vaccination and community engagement.

To support the response, the Public Health Emergency Operations Centre (PHEOC) was activated, providing centralised coordination, planning and operational oversight. PHEOC worked closely with WA Country Health Service, including regional public health units, Aboriginal Community Controlled Health Services, PathWest and Commonwealth agencies to support a unified response across WA.

Between 20 December 2025 and 30 June 2026, a total of 167 cases of diphtheria were notified in WA, including 102 cutaneous and 65 respiratory infections. The index case confirmed in December 2025, was the first case of respiratory diphtheria reported in WA in more than 50 years.

A key focus of the response was protecting communities at greatest risk of exposure and severe disease through expanded access to diphtheria-containing vaccines. This included close collaboration with Aboriginal health partners and regional stakeholders to support culturally appropriate engagement and the delivery of vaccination services in affected communities.

The response highlighted the importance of strong partnerships across government, health services and the Aboriginal health sector. Through coordinated action and shared commitment, WA Health and its partners strengthened the State's capacity to respond to communicable disease threats and protect the health of Western Australians.

9 - Australian Study of Health and Relationships, STI clinical services review: unpublished.

Report on operations

2025-2026

Sustainable health and care system

	340+	referrals received by the Thriving Families partnership with Ngala since 2024
	\$140M	investment portfolio for the 2026 Winter Strategy, enabling delivery of strategic priorities, operational resilience, and improved customer outcomes
	130	referrals were received, with 64 people living with dementia successfully supported to transition to aged care placement
	5	hospitals decommissioned nitrous oxide (N ₂ O) infrastructure to progress emissions reduction efforts
	\$25M	awarded to transform the approach to rheumatic heart disease in WA through the Spotlight 2025–26 program

	3 hospitals sharing real-time views of emergency department demand and capacity to improve patient flow		Hospital in the Home expanded providing 265 beds, supporting over 4,700 patients and delivering over 31,800 bed days
	Introduced WA Health Artificial Intelligence Transparency Statement to support safe, secure, and responsible use of emerging technologies across the health system		Non-Admitted Data Collection and Emergency Department Data Collection reforms were implemented to support re-design of data use practices
	\$115M released from Commonwealth to expand aged care beds for WA		New WA Health Policy Frameworks webpage launched

Living well through community integrated care

We are continuing to modernise the WA health system aiming to put people at the centre of their care to ensure they can get the right help when they need it, that hospitals, primary and aged care services work together to provide coordinated care, and that people are supported to stay well in their community.

To keep people well in the community, they need ease of access to continuity of care from different health and social care professionals, delivered in their homes or local community. When people cannot get this support, they often end up in the emergency department, need hospital care more often due to a deterioration in their existing health condition, or have their discharge from hospital delayed.

New and innovative community-based services can help fix these problems by shifting care away from hospitals and giving people better, more coordinated health experiences and outcomes.



Expanding access to care through community pharmacy

We are improving access to primary healthcare through the Enhanced Access Community Pharmacy Pilot (EACPP). This initiative is designed to enable appropriately trained pharmacists to diagnose and provide treatment for a defined range of common health conditions in the community.

The pilot represents a significant shift in the role of community pharmacy within the primary care system, supporting more timely access to care while maintaining appropriate clinical governance, referral pathways and patient safety standards. Pharmacists participating in the pilot are required to complete accredited graduate certificate training delivered by leading training providers. The training focuses on strengthening their clinical knowledge, diagnostic skills, and prescribing practices, aligned with the National Prescribing Competencies Framework. The pilot emphasises a multidisciplinary approach to patient care, ensuring that pharmacist consultations are communicated with the patient's general practitioner or medical centre, with the patient's consent.

During 2025–26, 80 community pharmacists were allocated training subsidies and commenced training with a further 200 training subsidies to be made available across the life of the pilot. Pharmacists practising in rural and remote communities, where access to primary care services can be more limited, are being supported through increased subsidies to enable ease of access to the training.

The pilot is designed to enable timely access to care, particularly in regional areas, while helping reduce pressure on general practitioners and emergency departments. Service delivery is expected to commence by 2027 following completion of training and regulatory amendments. The pilot is anticipated to continue until 2028.

Improved access to ADHD care

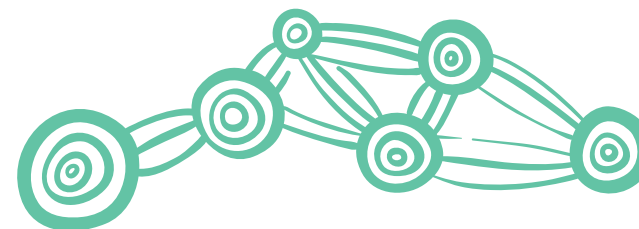
Access to care for attention deficit hyperactivity disorder (ADHD) is being made easier through a new general practitioner (GP) ADHD Training Program designed to support early diagnosis and treatment in the community.

ADHD is a neurodevelopmental condition that can cause inattention, hyperactivity and impulsiveness in a person that may negatively affect their learning, relationships, employment and overall wellbeing. While ADHD is commonly identified in childhood, symptoms can continue into adolescence and adulthood. Timely assessment and access to treatment can significantly improve educational, social and health outcomes for children and young people.

In WA, ADHD assessment and treatment initiation is provided by paediatricians and psychiatrists. Increasing demand to access a trained ADHD specialist has resulted in long wait times being experienced by patients particularly in rural and remote areas. The new training program aims to improve access to safe and timely ADHD care through trained GPs who can diagnose, treat and manage ADHD patients aged 10 years and older.

Commencing October 2025, participating GPs undertook specialised training delivered through online training modules, peer learning and mentorship from psychiatrists and paediatricians. More than 400 GPs have expressed interest in the program, highlighting the strong demand for enhanced ADHD care across WA.

Additional ADHD support resources have also been developed to assist families and carers, including information on counselling, peer support, coaching, and guidance on non-medication treatment options. These resources aim to help families better understand non-complex ADHD and navigate ongoing care and support services.





Supporting those experiencing vulnerabilities or disadvantage

We deliver a range of programs in partnership with government and the non-government sector to support people experiencing vulnerabilities or disadvantage by improving access to essential services and early intervention. These partnerships emphasise collaboration across health, legal, and community sectors to provide coordinated, culturally safe, and trauma-informed care ultimately improving safety, wellbeing, and long-term outcomes.

Aligned with the [State Government's Strengthening Responses to Family and Domestic Violence System Reform Plan 2024–2029 \(FDV System Reform Plan\)](#), we are implementing the WA Health FDV Reform Delivery Plan, in partnership with health service providers, to improve the consistency and effectiveness of health's response to FDV. In 2025–26, we coordinated and facilitated input from across WA health to develop a FDV Workforce Capability Framework and the Common Risk Assessment and Risk Management Framework.

The Women's Legal Service WA Health Justice Partnership pilot embeds specialist legal practitioners within 2 women's health centres in Northbridge and Kalgoorlie, ensuring women can receive timely and free legal assistance in a trusted, culturally safe healthcare environment. The partnership integrates legal assistance into routine healthcare pathways to address the health-harming impacts of unresolved legal issues, including family law, family and domestic violence and child protection. Approaching early legal intervention holistically prevents issues from escalating, reduces harm, and improves safety, stability, and long-term wellbeing outcomes. This partnership has supported more than 1,234 clients since 2023. [An evaluation of the program](#) found women who may not otherwise accessed legal help are engaging with the program due to its trusted setting.

Our partnership with Ngala on the Thriving Families pilot program continues to support at-risk families to access specialist developmental, behavioural and parenting support in the community. Since 2024, the program has received more than 385 referrals.

The community-based program is an initiative through the State Government's [FDV System Reform Plan](#) and provides tailored services for families affected by family and domestic violence, 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.

In collaboration with the Department of Communities and non-government organisations including Aboriginal Community Controlled Health Services, we continue to address the health needs of children in out of home care by delivering timely access to health assessments, services and supports. In 2025–26, enhancements to the Health Navigator Pilot Program (HNPP) improved pathways for access to health services and processes to support health information access. The HNPP also contributed to improved health literacy among carers, families and case workers, supporting coordinated management of children's health needs and improved engagement with health services.

The HNPP continued to support the INROADS therapeutic court program, that provides community-based support for young people who would otherwise be detained at Banksia Hill Detention Centre. Young people are supported to access timely health assessments and referrals, including developmental paediatrician assessments, dental health and optometry services allowing for the diagnosis and treatment of health conditions. From February 2025, more than 40 young people have been accepted into the health navigation stream, with 22 participants successfully completing the program during 2025–26. In 2026, counselling services and healing through culture commenced through the Wungening Aboriginal Corporation.

In addition, the HNPP commenced the On Track to Thrive program supporting at-risk children aged 5 to 9 years whose behaviour would have constituted a criminal offence if they had been above the minimum age of criminal responsibility. This program is being piloted at sites in Armadale and Geraldton partnering with the Child and Adolescent Health Service, WA Country Health Services and Geraldton Regional Aboriginal Medical Service.

The Woodville House Pilot 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. The Pilot combines medium-term accommodation with low barrier trauma-informed support. Since commencing operations in 2025, the service has been operating at or near capacity and with over 40 per cent of exited clients transitioning to longer-term housing.

Strengthening women's health services

The Community Women's Health Services Strategic Commissioning Program aims to strengthen the delivery of contemporary, accessible and high quality community women's health care and wellbeing services, including sexual assault support and unplanned pregnancy counselling services, across WA.

A comprehensive review is underway of existing WA health contracted community based services currently providing health care and support to women. This includes understanding the existing ecosystem of government funded services, identifying gaps in access and outcomes, and assessing future demand across metropolitan, regional and remote WA.

Delivered in partnership with sector, community and government stakeholders the program aims to strengthen equitable access to care for all women. The program is also examining opportunities to strengthen partnerships between primary care, specialist services and community-based supports, enabling more integrated, person-centred models of care.

The program aligns with key health, social and justice reforms as well as relevant State and national frameworks including the [National Women's Health Strategy 2020-2030](#). Together, these frameworks help ensure women across WA can access responsive, high-quality and culturally safe health services, regardless of geography or circumstance.



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.

The Transition Care Program (TCP) continues to help older people recover after hospital, regain function, and delay entry into aged care by providing medical, therapeutic and other support services in a residential or community setting, including their own home. In 2025–26, the [Transition Care Program](#) enhancement, TCP@Home+, went live providing enhanced safety through wearable technology, 24/7 alert monitoring, daily wellbeing checks, and rapid response pathways. This is an exciting step forward in how we use the latest virtual technology to assist older patients as they return home.

We continue to partner with Dementia Support Australia in the delivery of Hospital to Aged Care Dementia Support Program (HACDSP). This program supports older people with dementia who are at risk of delayed hospital discharge to transition safely from hospital to aged care. The HACDSP operates from Bentley Health Service and Osborne Park Hospital with a recent expansion to a third site at Rockingham General Hospital. As at May 2026, approximately 130 referrals were received, with 64 people living with dementia successfully supported to transition to aged care.

The Time to Think program is supporting older patients who no longer require hospital care but are waiting on a Commonwealth funded aged care bed to become available. The program provides a temporary stay in one of 146 dedicated respite beds within nine aged care homes across the state. Between May 2025 to June 2026, the program has supported the discharge of over 530 patients from hospital, freeing up over 19,500 hospital bed days. This program is helping meet the growing demand for aged care services and provides a supportive environment for decision-making for older people and their families.

Older Adult Health Hubs

WA's first Older Adult Health Hub opened in Cockburn in 2025–26, introducing a new model of community-based care designed to support older people to live well at home and in their communities. The Cockburn hub is the first of 3 hubs that will help older adults living in the Perth metropolitan area whose health needs are becoming more complex or who may benefit from short-term extra support and care coordination.

Each hub is staffed by a multidisciplinary team including geriatricians, nurses, allied health professionals and care navigators, working together to deliver coordinated, person-centred care. Services provided in person, at home or by telehealth include comprehensive geriatric assessments, physiotherapy, nursing care, medication management, dietetics, memory and cognition support, and assistance navigating health and social services.

Working closely with GPs and other providers, the hubs offer timely, specialised support to help older adults stay healthy, independent, and living in their community for as long as possible.

Driving investment in aged care infrastructure

The Aged Care Low Interest Loan Scheme (Loan Scheme) aims to address the growing demand for residential aged care across WA and support the development of modern, fit-for-purpose infrastructure capable of delivering additional concessional/supported aged care beds for residents with low-means who are unable to fully contribute to accommodation costs.

Delivered in partnership with Department of Energy and Economic Diversification, the Loan Scheme provides concessional finance to eligible aged care providers, to help accelerate investment in residential aged care infrastructure.

Under the Loan Scheme, eligible providers may apply for loans that can support:

- construction of new residential aged care homes
- refurbishment or expansion of existing aged care homes
- infrastructure upgrades to meet contemporary clinical and building standards
- integrated models supporting hospital discharge, transitional care and step-down care pathways.

The Loan Scheme prioritises projects that improve access and equity for vulnerable and underserved populations, including:

- older Aboriginal people
- people at risk of homelessness
- residents requiring complex care, including bariatric, dementia, or palliative care
- communities experiencing geographic undersupply, particularly in regional or remote WA.

The initiative is designed to stimulate broader industry growth and modernisation by improving project viability and encouraging innovation in aged care design and service delivery, resulting in increased residential bed capacity.

In 2025–26, capital project applications were received from providers across the State. Following a robust cross-agency evaluation process the Departments' of Energy and Economic Diversification and Health progressed recommended applications for consideration by the Minister for State Development.

Connected and digitally enabled health system

The [WA Health Digital Strategy 2020–2030](#) sets out how digital technologies will transform healthcare delivery for Western Australians to make care more personalised, connected and accessible. As patients increasingly use digital tools to manage their own health and expect services to fit seamlessly into their daily lives, the strategy provides a clear direction to harness innovation, use data more effectively, and modernise the health system.

Our Digital Strategy Roadmap (Roadmap) is an evolving document that adapts to the rapidly changing business, technology, and consumer landscape in health. The refreshed Roadmap for 2025–2030 provides a clear, evidence-based view of digital investment needs and strengthens governance across the health system.

Electronic Medical Record Program

The Electronic Medical Record (EMR) Program is a state-wide digital transformation project delivered in partnership with all WA health service providers connecting patient clinical information across all health sites. In addition to providing a digital version of a patient's medical chart the EMR provides the ability for healthcare providers to connect patient history, test results, and treatment while securely storing and managing comprehensive patient health information. Centralising information enables health professionals to make faster, better-informed decisions and deliver safer, more connected, patient-centred care across WA.

The program has recently delivered the Digital Medical Record (DMR) and Single Sign On (SSO) systems that will support a fully functional EMR. In progress are the Virtual Desktop Infrastructure and the Intensive Care Unit (ICU) EMR projects. In May 2026, the ICU EMR solution went live at Sir Charles Gairdner Hospital and is expected to go live at the Perth Children's Hospital by the end of 2026. These projects will support the foundation for the roll out of the full scale EMR.

The program continues to progress procurement activities and the associated readiness projects required to enable the implementation of the EMR.

To support this progress lived experience perspectives across EMR decision making, procurement and design activities are being established through engagement with consumers including via the Health Consumers Council.

Major milestone for Stage 1 of EMR Program

Through extensive collaboration between the EMR Program, the department, Health Support Services, health service providers and hospital project teams across WA, two foundational components of the EMR Program, the DMR and SSO systems, are now live across all WA public health sites. This major milestone is a significant achievement in WA Health's digital transformation journey and enhances the digital infrastructure for care delivery.

The DMR replaces traditional paper based medical records with a secure, digital solution, providing clinicians with timely access to medical records and supporting safer, more coordinated care. The SSO simplifies access to clinical applications, enabling staff to log on and off computers with the tap of their access card. This reduces time spent signing in to multiple systems, improves clinician mobility and allows more time to be focused on patient care.

The achievement reflects the collective effort of clinicians, health service staff, technical teams and project personnel across WA Health, who have worked together to establish the foundations for the State's future EMR capabilities.

Digital Medical Record

More than 44 million documents digitised

Accessed by over 77,000 staff each weekday

Single Sign On

Used by more than 30,000 clinicians

Supports approximately 348,000 logins each week

Provides streamlined access to more than 80 clinical applications

► For more information visit: [Electronic Medical Record](#)

ICT network and security controls

In collaboration with Health Support Services we continue to implement the Critical Health ICT Infrastructure Program (CHIIP) to provide a long-term solution to replace systemwide network infrastructure. CHIIP directly supports the [National Digital Health Strategy 2023–2028](#) in reducing systemwide infrastructure risks.

We also continue to strengthen the policy foundations for safe, responsible and secure digital health service delivery with the WA Health Artificial Intelligence Policy and the Information Security Policy. Together, these policy instruments provide a clear baseline for responsible digital technology use, consistent security controls and improved protection of WA health information assets and digital systems while aligning with the [2024 WA Government Cyber Security Policy](#).



Health and medical research and innovation

The Office of Medical Research and Innovation (OMRI) leads the development, coordination and delivery of health and medical research and innovation policy, strategy and investment in WA. In 2025–26, activities were guided by the [WA Health and Medical Research Strategy 2023–2033](#), which sets the long-term direction for a more connected, capable and impactful research and innovation system.

A central focus of OMRI's work is the administration of the Future Health Research and Innovation (FHRI) Fund scheme, the State's flagship funding program that supports research excellence, builds system capability and accelerates the translation of innovation into practice improving clinical and community outcomes. In 2025–26, \$81 million was awarded to 136 recipients supporting the State's ability to attract, deliver and embed higher value research and innovation within the health system. Complementary efforts include strengthening partnerships across government, health services, research organisations and industry, progressing research governance and ethics reform, and advancing initiatives that support clinical trials, commercialisation and sector engagement.

In 2025–26, significant progress in strengthening the foundations of health and medical research and innovation were achieved including the development of the WA health and medical innovation ecosystem. This work supports stronger alignment between government investment, health service priorities, industry capability and research translation, delivered through the proposed Murray Street Launchpad (early-stage ideation), progress of the QEII Health and Biomedical Precinct, and the Floreat Biomedical Manufacturing Hub. Providing infrastructure and cross-sector collaboration in biomedical research and innovation will support the development of new therapies and advance medical science.

Development of a new WA Grant Success Framework commenced to identify priority actions that lift success rates for national competitive grant applications. The framework will build capability, alignment and consistency across WA, complementing support provided by FHRI Fund investments, and will be informed by best-practice approaches and engagement with WA research and innovation leaders.

What's next

In 2026–27, OMRI will focus on driving impact across the health and medical research and innovation system, supported by over \$80 million in FHRI Fund investment. Key priorities include building traction across all three pillars of the WA health and medical innovation ecosystem and improving access and coordination of clinical trials.

OMRI will progress collaboration through the FHRI Fund's Programs and Initiatives, strengthening partnerships to address complex health and wellbeing challenges. Additional focus will be placed on intellectual property, commercialisation pathways and better integration of innovation into practice, ensuring investments translate into sustained health and economic outcomes.

Future Health Research and Innovation Fund

The FHRI Fund has awarded almost \$342 million to 887 recipients since its establishment in 2020, supporting partnerships that drive impact. On 1 July 2025, the [FHRI Fund Strategy 2025–2030](#), was launched outlining 3 strategic themes:

1. Connect and collaborate: fostering partnerships across health, research, and innovation communities
2. Accelerate and translate: boosting innovation and commercialisation in WA
3. Foundational confidence: strengthening the sector's competitiveness through sustained support.

These themes guide the design and delivery of FHRI Fund programs and initiatives. The Spotlight Program is the flagship initiative under the connect and collaborate theme and will see the FHRI Fund commit to one major, uniquely Western Australian issue each year supporting it over five years with targeted funding and support.

The Spotlight Program encourages researchers, innovators, and consumers to co-design solutions that build capacity and translate research and innovation into improved health outcomes.

The inaugural Spotlight topic announced in 2025–26 is Rheumatic Heart Disease (RHD) providing a statewide platform to strengthen collaboration, accelerate research and innovation, and reduce the significant burden of this preventable disease on WA communities.



Accelerate and translate: researching lung cancer early detection and diagnosis

Clinical Professor Rajesh Thomas at Sir Charles Gairdner Hospital (SCGH) is transforming lung cancer diagnosis in WA through the introduction of the state's first robotic bronchoscopy program.

Funded through the FHRI Fund Enabling Scheme, the project supports the establishment of an integrated clinical, research and training program in robotic bronchoscopy to improve early detection of lung cancer. The \$1.25 million investment is enabling access to advanced robotic bronchoscopy technology that allows minimally invasive biopsy of the small, hard to reach nodules in the peripheral lung, where more than 70 per cent of cancerous nodules occur. The technology improves diagnostic accuracy while reducing complications, supporting faster diagnosis and earlier access to treatment for patients.

Integrating robotic bronchoscopy into routine clinical practice is currently only offered at SCGH, and a few hospitals nationally. The program aligns with the commencement of the National Lung Cancer Screening Program, strengthening the pathway from early detection to accurate diagnosis and treatment.

This project demonstrates how strategic investment in research infrastructure through the FHRI Fund accelerates translation of innovation into real world clinical care, delivering tangible benefits for patients and the WA health system.



Connect and collaborate: Investigating wearable technology to combat vertigo

WA based innovator Dr Kate Lewkowski, co-founder and CEO of Neurotologix, is leading a team developing a novel digital health solution to improve the diagnosis and management of dizziness and vertigo.

Vertigo and dizziness can place significant demand on outpatient services and can lead to lengthy delays in diagnosing the cause of these conditions. Neurotologix's ROMI system provides patients with a take-home portable device that will capture clinical data during dizziness episodes that is integrated with a cloud-based platform enabling analysis by a clinician. This approach helps clinicians access information that is often not available in traditional clinic-based assessments.

The project has received support through the FHRI Fund Innovation Seed Fund, enabling clinical and real world evaluation, including health economics analysis, in collaboration with the Audiology Department at Fiona Stanley Hospital.

This work highlights the FHRI Fund's role in connecting innovators, clinicians, and health services to support the translation of WA-developed ideas into practical healthcare solutions.



Delivering a climate resilient health system

Since the launch of the [Strategy for an Environmentally Sustainable and Climate Resilient Health System 2024–2030](#) in January 2025, we have developed an implementation plan to establish governance, reporting and performance measures. At the same time activities are underway focused on raising health workforce awareness, establishing knowledge-sharing processes for sustainability across the system, and developing models for delivering healthcare in the home, community, or closer to home.

In 2025–26, the following were achieved against the 6 key areas identified for action in the Strategy:

Health sector

Development of a Climate Change and Health eLearning module has progressed, aimed at improving staff understanding of carbon emissions, climate change and health impacts, due to be released in the later part of 2026. The Carbon Literacy Training offered as a Sustainability in Health Scholarship was expanded beyond the department, with 3 health service providers offering the training this year, strengthening leadership and climate capability across the system.

Clinical care

The Australian Commission on Safety and Quality in Health Care Environmental Sustainability and Climate Resilience Healthcare Module was piloted in WA public hospitals and findings have informed refinements to support broader implementation. The module is scheduled to become mandatory embedding sustainability considerations into routine clinical governance and care delivery and strengthening system wide alignment with national accreditation requirements.

Resources

Guidance on nitrous oxide usage in healthcare facilities in WA was developed to support reductions in nitrous oxide (N₂O) emissions across WA Health. The guidance promotes efficient clinical use, minimisation of system losses, and transition away from piped infrastructure in low use areas, where appropriate. Emissions reduction efforts progressed through the decommissioning of N₂O infrastructure at several health facilities.

Infrastructure and utilities

WA Health progressed system wide onboarding to Envizi, that allows the tracking of energy consumption and greenhouse gas emissions. Envizi will enable consistent, auditable reporting and improved performance tracking enabling enhanced decision making to achieve our sustainable goals.

Transport

The department continued to align with the State Government target for at least 50 per cent of new vehicle purchases in eligible categories to be electric vehicles. Progress to date has been supported through the Senior Officer Vehicle Scheme, with uptake currently reliant on access to home charging arrangements.

Supply chains and procurement

Health Support Services progressed work to embed environmental sustainability considerations within supply chain and procurement activities. This work contributes to reducing environmental impacts across the health supply chain while maintaining clinical safety and supply continuity.

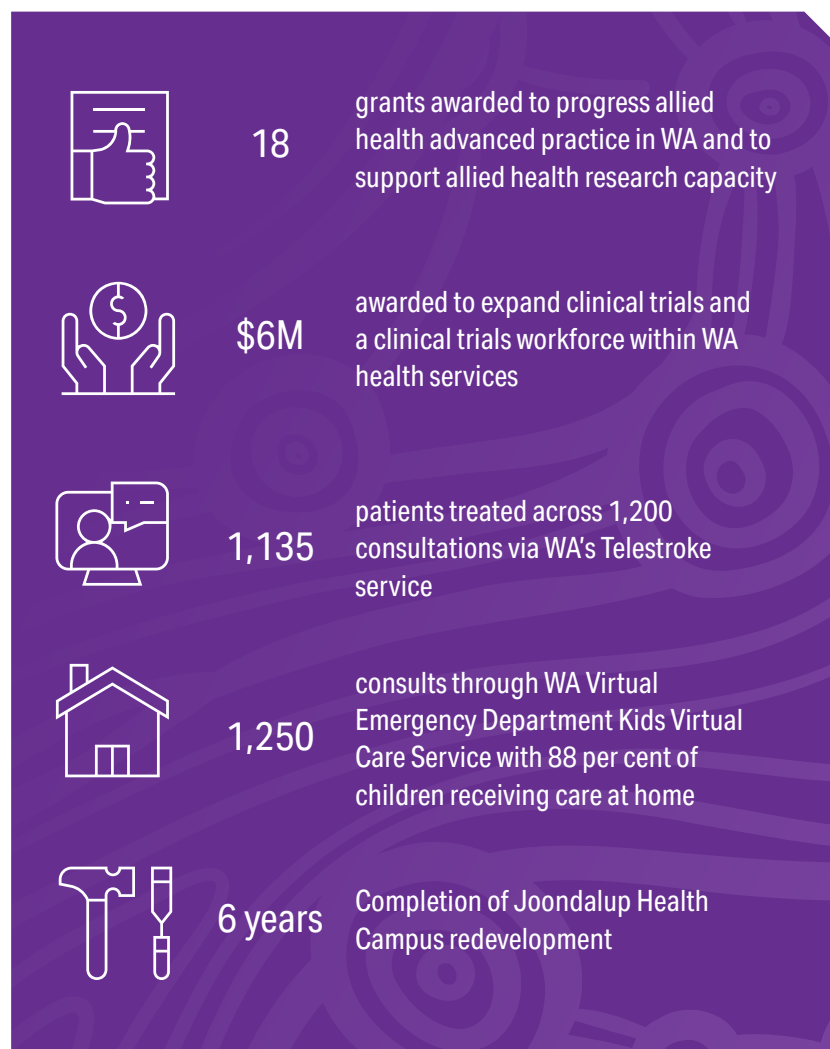
WA Health climate risk assessment

Climate change is already affecting health care delivery in WA, with impacts set to intensify over coming decades. To better understand these challenges, we completed a first pass Climate Risk Assessment, drawing on engagement across WA Health.

The assessment identified significant system level risks affecting the key areas of service delivery, Aboriginal people and priority populations, workforce, finance, and leadership. Overall, current risks are assessed as high and are expected to escalate by 2050. As a key action under the Strategy, the assessment provides the foundation for embedding climate risk into health system planning and decision making.



Optimal health care



Paediatric Sepsis Pathway and training rolled out across the health system

[Fraud, Corruption Control System 2026–2028](#) published

The Dental Workplan developed to help build a sustainable public dental workforce

WA Health dental assistants authorised to apply fluoride varnish to help prevent decay and strengthen enamel

[Pathways into Nursing and Midwifery](#) developed to inform on entry points, education pathways and career advancement opportunities

What Matters to You? launched to embed person-centred conversations in clinical practice

Improving access to health care

WA Health has continued to focus on improving timely access to appropriate care by managing hospital capacity and demand, and optimising patient flow across the health system. The 2026 Winter Strategy, including the Access Health campaign, built on lessons learned from the 2025 winter response and interjurisdictional review to support a more integrated, coordinated and resilient winter response across the health system.

The State Health Operations Centre (SHOC) continues to enhance emergency care across our state, optimising the use of existing hospital capacity. In 2025–26, SHOC expanded its scope to include long-stay patient operations, with a dedicated team improving discharge pathways and funding arrangements for patients with complex needs. This work is improving patients transition experience as they leave hospital.

The WA Virtual Emergency Department (WAVED) continues to deliver rapid virtual care and has strengthened paediatric clinical support with the launch of WAVEDKids in August 2025. WAVEDKids is delivered through the SHOC and allows families/carers who call 1800 MEDICARE or the Healthdirect helpline to access a virtual consultation, where clinically appropriate, as an alternative to attending a hospital emergency department (ED). Care is delivered by the same experienced clinicians who work in our EDs, ensuring expert advice and support. The service was expanded from 3 to 7 days a week in May 2026. Since launching more than 1,250 consults have taken place, with 88 per cent of children receiving care at home.

Improvements to outpatient services continue to be delivered through the Outpatient Reform Program. The Central Referral Service (CRS) successfully expanded into the Midwest region and the Goldfields region in early 2026. With 4 of 7 regions now live and expansion to the additional regions planned, the CRS is on track to achieve statewide coverage by the end of 2027.

Smart Referrals WA will digitise and improve outpatient referral workflows to enable ease of access to public specialist appointments while aiming to remove the inefficiencies of fax and paper outpatient referrals.



Our commitment to winter safety

In February, we launched our [Winter Strategy 2026](#), aimed at keeping Western Australians healthy and safe during the winter season. 2025 was one of the toughest winters for our health system, with more severe flu-like illnesses and greater demand for hospital and community care services.

In collaboration with health service providers, St John WA, the Mental Health Commission, aged care providers and community partners, the strategy focuses on:

- preparing our health system early and working together
- reducing the impact of seasonal illness
- supporting people to stay well and recover at home
- keeping patients moving through our hospitals
- supporting our hospital staff
- educating people to know where to go when they're sick, so they can get the right care first time
- helping people to understand their care options
- promoting vaccination as the most powerful step we can take together.

To help the community protect against respiratory illness, our 2026 Winter Immunisation Strategy aimed to reduce influenza and respiratory syncytial virus (RSV) associated hospitalisations by delivering free vaccinations to children, older adults and health staff at accessible sites across the community. Meanwhile, our Access Health campaign worked to strengthen the available advice and guidance on when and where to seek care, helping people make informed choices based on their needs, time and cost.

To support patient flow and bed capacity in our health services, we implemented a range of initiatives, including:

- providing clear escalation pathways during periods of peak activity to improve patient flow and facilitate timely discharges
- deploying Winter Care Teams across major hospitals to provide additional clinical support, and support patients to receive timely care and earlier discharge where appropriate
- establishing Bed Turnaround Teams to increase bed availability and reduce delays in patient transfer and admission
- elevating the 24/7 service of the State Health Operations Centre (SHOC) with live data to track bed availability, patient numbers and optimise ambulance allocation
- growing virtual healthcare through the WA Virtual Emergency Department (WAVED), to see more complex cases and link with other services such as healthdirect
- using rapid respiratory testing technology to diagnose flu-like illness
- supporting weekend and same day discharges, so patients can go home as soon as they are ready.



'Where to go When'

A new long-term public-facing health campaign has been launched to ensure the community can continue to access safe, timely, and appropriate health care during periods of high-demand for our public hospitals and health services.

The Access Health WA website and public information campaign are designed to increase awareness and understanding of the care options available to Western Australians, helping people access appropriate services for various health conditions.

The website provides information on a range of health care options including:

- emergency departments
- urgent care clinics
- general practitioners
- pharmacists
- 1800MEDICARE
- WA Virtual Emergency Department.

The website provides information on the various health conditions that can be treated at each service, from everyday health needs through to urgent medical care, as well as the cost, opening hours, and wait times. Designed to help Western Australians to confidently navigate the health sector, Access Health WA empowers people to make the right healthcare choices, understand alternatives to the emergency department, and promote early and appropriate care seeking. This approach reflects community needs and will allow the public to search for credible information from trusted and reliable sources that will support them to make informed decisions.

The campaign highlights a significant commitment to the health and wellbeing of Western Australians and plays an essential role in delivering quality health care across the state. Over time, Access Health WA aims to standardise and simplify guidance for the community.



► For more information visit
[Access Health WA](https://access.health.wa.gov.au)

Supporting and growing the clinical workforce

To ensure WA Health has the skills and expertise to meet current and future demand, we are strengthening workforce planning, building the capacity and capability of our current staff, and training and attracting new staff guided by the [WA Health Workforce Strategy 2034](#).

The strategy underpins the implementation of the Junior Medical Officer Strategic Action Plan and the forthcoming WA Nursing and Midwifery Workforce Strategy, and aligns with related initiatives, including the Dental Workplan and the *WA Health Allied Health Workforce Implementation Plan 2024–2027*.

In 2025–26, we continued to strengthen workforce supply and attract high quality talent. The WA Health Centralised Recruitment Program received more than 5,300 for Resident Medical Officers and Service Medical Registrar positions, a 40 per cent increase on 2024–25.

The Neurology Advanced Training project provides in-depth specialty training in the diagnosis and management of diseases affecting the nervous system and muscles. Four trainees completed the course and have secured consultant positions in WA including providing outreach services to the rural sector.

Psychiatry training reform is ongoing to modernise training, strengthen governance, and expand the psychiatry workforce and enhance service delivery across the mental health sector and community.

The Aboriginal Health Practitioner (AHP) project continues to embed AHPs across the health system and the Aboriginal Career Pathways is helping to progress coordinated, systemwide workforce initiatives focusing on improving health outcomes for Aboriginal people.

Progress also continued towards sustainable and safer workloads for nurses and midwives. Phase 2 of the nurse and midwife to patient ratios project was implemented in metropolitan critical care areas on 23 February 2026, with phase 3, extending ratios across all metropolitan hospital clinical areas planned for 2026–27.

Shaping our workforce through responsive and agile modelling and planning is gaining momentum. In 2025–26, a Workforce Agile Modelling Business User Group was established to drive the development of a new workforce dashboard and modelling tools. Implementation of the Renal Workforce Strategic Modelling project and Renal Aboriginal Health Practitioner and Nursing Pipeline project also commenced.



WA health staff engagement, development and support

We encourage professional development opportunities for all staff and systemwide support of career pathways. The aim is to uplift, upskill and develop our workforce capability to operate in an agile and evolving workplace that supports a patient's journey across the care continuum.

'See Me Hear Me Respect Me'

In 2025–26, 'See Me Hear Me Respect Me' campaign¹⁰ resources were distributed to WA Health sites and teams to support disability awareness through enhanced internal communications, education opportunities and meaningful conversations that promote improved healthcare experiences for people with disability in WA.

Consumer and community engagement capability

A new self-paced eLearning module was launched to strengthen staff capability in meaningful consumer, family, carer and community engagement. Based on the Working with Consumers and Carers Toolkit, the module provides practical tools and guidance to support partnership-based approaches. More than 120 staff completed the training within the first 3 months of launch.

Elevating consumer voices

In April 2026, Care Opinion Australia in partnership with Health Consumers' Council WA and the department, hosted the WA Care Opinion Forum. The forum brought together consumers, carers, community representatives, leaders and health system stakeholders to reaffirm our shared commitment to accessible, person-centred healthcare. Discussions highlighted the importance of consumer and carer voices shaping healthcare delivery.

Developing health leadership

The Clinical Leadership Program supports leadership capability development across 3 key areas; engaging self, leading others and shaping systems. The program continues to receive strong participant feedback, with additional cohorts commencing in 2026.

New leadership programs, modules and learning resources are also being offered to support consistent leadership development opportunities across the health system, including leadership excellence, shaping health systems and tailored learning opportunities to meet emerging needs.

Launched in September 2025, the Next Gen Program supports the development of senior executive leaders across WA Health, focusing on authentic, adaptive, digital, and strategic leadership. Delivered in partnership with academic and industry experts, the program provides an immersive leadership experience, with participants highlighting practical application, expert guest speakers and peer learning opportunities as key strengths.

The Institute of Health Leadership continued work to establish culturally secure leadership pathways for Aboriginal staff across WA Health. The initiative will support emerging and senior Aboriginal leaders through structured development opportunities, including senior leadership, emerging leader and targeted leadership modules, with programs expected to commence from 2027.

Supporting Aboriginal career pathways

In March 2026, a project commenced to modernise resources supporting the Aboriginal Career Pathways program, which aims to strengthen career opportunities for Aboriginal people and build a culturally safe, representative health workforce. An interactive digital resource was developed to help current and aspiring Aboriginal employees to map their healthcare careers, explore education and training options, and discover the range and types of clinical and non-clinical roles. A digital landing page and mapped education pathways for clinical roles are in development. Targeted resources were also developed to support attraction and retention of Aboriginal employees, including materials promoting Aboriginal Health Practitioner roles and Aboriginal graduate and cadet programs, and guidance on the appropriate application of Section 51 to support culturally informed recruitment.

¹⁰ - Provided with permission from Queensland Health.

Industrial relations

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

In 2025–26, replacement agreements covering dental technicians, engineering and building services and clinical academics were finalised and registered with the WA Industrial Relations Commission.

Negotiations for a replacement dental officers' agreement will continue into 2026–27.

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 by medical practitioners, enhancement of career pathways for allied health professionals, and initiatives to improve job security for hospital support workers. The next bargaining round will commence in January 2027, including negotiations for replacement agreements covering allied health professionals and salaried officers, followed by medical practitioners, enrolled nurses, hospital support workers, and registered nurses.



Investing in health infrastructure

A \$5.5 billion health infrastructure pipeline is in action to build capacity, support hospital upgrades and to complete major infrastructure projects.

Building capacity

St John of God Mount Lawley Hospital is transitioning into a public hospital managed by East Metropolitan Health Service. The hospital will add 118 public beds, eight operating theatres and two procedure rooms into the public health system, supplementing existing contracted beds already in use.

Completion of a new 40-bed mental health facility at Fremantle Hospital in May 2026 significantly expands mental health care options for patients in the south metropolitan area. The development includes 20 secure adult mental health beds, 10 open adult beds, 10 older adult beds, and a 24-hour mental health crisis centre. A neurostimulation service will provide access to treatments such as electroconvulsive therapy and transcranial magnetic stimulation.

The Step Up/Step Down program delivers sub-acute short-term residential mental health care in a home-like setting, supporting consumers and helping people stay connected to their community and supports. In Karratha, a six bed facility reached practical completion in January 2026, and another six bed facility in Broome is in the construction phase with practical completion estimated next year. Two further facilities are planned, with 10 beds for South Hedland and the first youth focused facility for 16 to 24 year olds for the Perth metropolitan area.

Designs for the new radiation oncology unit at Geraldton Health Campus are finalised and works are now underway. The purpose-built facility will include clinical treatment spaces and a linear accelerator (LINAC) machine, the first of its kind for the region, allowing patients with cancer to access critical care close to home.

Construction continues on the Byford Health Hub, a two-storey multi-use health and social

care hub in the Serpentine-Jarrahdale region. The hub will provide access to a range of primary care, community and other specialist health services including outpatient services, pathology and child health services.

The Fitzroy Crossing renal health centre was opened in November 2025 providing access to renal services close to home and on Country.



Supporting hospital upgrades and redevelopment

Sir Charles Gairdner Hospital upgrades continue to progress including:

- Emergency department (ED) redevelopment with the establishment of designated areas to meet the needs of all patients including a clinical toxicology unit, redesigned ED waiting, triage and observation areas, and re-location of the ED Fast Track.
- A new 10-bed intensive care unit (ICU) pod is currently under construction designed to operate independently from the main ICU and will enable a dedicated isolation area if required to treat patients with highly infectious diseases.
- Refurbishment works in the Neurological Intervention and Imaging Service of WA (NIISwa) commenced in April 2026. NIISwa will be the statewide, cross-campus provider of neurointerventional and advanced neuroimaging service in WA.
- The medical imaging department, including enhancements to reception and waiting areas are in progress and will include installation of a third computed tomography (CT) scanner.

The major \$307.9 million expansion of the Joondalup Health Campus, in partnership with the Commonwealth, was completed in May 2026 and delivered a newly constructed 106 bed public ward block. This includes 60 newly fitted out beds and 46 modern single patient rooms, comprising of a 30 bed surgical/medical ward and a 16 bed cardiac care unit. Plus, a new public theatre and two new interventional catheterisation laboratories for cardiac and vascular procedures.

The new Laverton Hospital will consist of emergency and contemporary multidisciplinary ambulatory care facilities, specialist facilities for visiting clinicians, as well as outpatient services for community health, mental health, and space for an onsite private GP clinic. The project is progressing ahead of schedule with practical completion now anticipated for late 2026.

Construction of the new Mullewa Community Hospital commenced in July 2025 and will include a 24/7 emergency department, contemporary consult facilities for primary care, outpatient and population health services and an ambulance bay.



Major infrastructure projects

From 1 July 2025, 13 metropolitan and regional health infrastructure projects transitioned from the department to the Office of Major Infrastructure Delivery.

This included the landmark \$1.8 billion new Women and Babies Hospital Project set to expand services and choice for women, newborns and families across WA, replacing the century-old King Edward Memorial Hospital.

The project will deliver contemporary healthcare facilities including:

- ▶ a fully electric 12-storey, 274-bed Women and Babies Hospital at Fiona Stanley Hospital precinct, Murdoch. The new hospital is under construction and expected to open in 2029.
- ▶ new multi-deck car parks in and around the Fiona Stanley Hospital precinct. The first car park is under construction, will provide around 1,500 bays over six levels and is scheduled for completion in mid-2027.
- ▶ a major expansion of Osborne Park Hospital that will deliver 79 beds and is comprised of a six-storey main clinical block and a four-storey support services block. Construction is underway and the facilities are expected to open in 2029.
- ▶ Expanded neonate services at Perth Children's Hospital.

Other health infrastructure projects under construction or completed as at 30 June 2026 include:

- Royal Perth Hospital emergency department (ED) expansion currently under construction and set to include a new six-storey building with two levels dedicated to the new ED to meet operational and emerging healthcare needs.
- Peel Community Mental Health Service and Kara Maar Specialist Community Eating Disorder Service that opened in March 2026. The clinic provides outpatient, day and community-based treatment, including services for older adults and outreach services for eating disorders.
- Bunbury Hospital redevelopment with construction underway delivering a new seven storey clinical tower along with upgrades and improvements to the existing hospital.
- Geraldton Health Campus redevelopment that reached practical completion in June 2026, delivering a modernised, fit-for-purpose facility for the Geraldton and Mid West community.
- New Tom Price Hospital being delivered in partnership between the State Government and Rio Tinto. Early works for flood mitigation and site preparation were completed in April 2026 and a second package of early works is underway.



Aboriginal Health

The [WA Aboriginal Health and Wellbeing Framework 2015–2030](#) continues to guide strategic action across WA Health, with a systemwide review of its second phase (2021–2025) conducted to inform future Aboriginal health priorities. The review reinforces a focus on embedding the National Agreement on Closing the Gap Priority Reforms, advancing the WA Aboriginal Health Executive Roundtable 7 High-Impact Actions, and strengthening cultural governance. It also highlights the importance of ongoing collaboration and shared learnings and celebrates achievements across WA Health to support the vision of Aboriginal people living long, well and healthy lives.

In 2025–26, the WA Aboriginal Health Executive Roundtable 7 High-Impact Actions progressed. This included completion of the Ending Racism Check Up tool by all executive leaders, delivery of an anti-racism collaboration with Kurongkurl Katitjin, Edith Cowan University and the Australian Indigenous HealthInfoNet, and the enhancement of cultural governance across executive committees.

The mandatory WA Health Aboriginal Health Impact Statement and Declaration policy were updated, supported by a new educational video, to embed Aboriginal health considerations into health initiatives, improve cultural safety and achieve equitable outcomes for Aboriginal people.

The Strategic Aboriginal Health Group (SAHG) was also established and brings together all Aboriginal Health Directors to support the WA health system to:

- reduce inequity in both health outcomes and access to care for Aboriginal people
- elevate the cultural determinants of health
- eliminate all forms of racism within WA health that impact people.



Patient safety and service quality improvement

A WA LGBTIQ+ Health Delivery Plan is being developed to align with the new statewide [LGBTIQ+ Inclusion Strategy 2025–2035](#). The strategy aims for a WA where LGBTIQ+ people are valued, safe and supported to lead empowered, proud and connected lives. Health and wellbeing, including safe access to health services, were raised as important issues for LGBTIQ+ people during consultation, which attracted 2,400 responses. The delivery plan will include health-focused actions for an equitable, accessible, culturally safe and inclusive WA health system and health services that are responsive to the health and wellbeing needs of the LGBTIQ+ community. Progress is underway to advance inclusive data, workforce learning and improving healthcare access.

The Child Safeguarding Program (CSP) was established in 2022 to support the implementation of relevant recommendations of the 2017 final report of the Royal Commission into Institutional Responses to Child Sexual Abuse, and the 10 National Principles for Child Safe Organisations (National Principles). In 2025–26, the CSP made progress in supporting health service providers with:

- establishment of a baseline maturity status against the National Principles, setting the foundation and a framework for ongoing quarterly reporting
- coordination and support for the development of child safety and wellbeing policies
- contribution to initiatives and projects including Phase Two Working With Children Check reforms and Statewide and National Frameworks to guide clinicians and operational staff in their responses to children exhibiting harmful sexual behaviours
- coordination of the review and update of WA health system guidance resources, including the November 2025 interim update of the *Guidelines for Protecting Children 2020*, and other supporting documents.

The WA Sepsis Pathway Project, is a statewide initiative led by the department in collaboration with WA clinicians and expert working groups, aimed at standardising sepsis care. Sepsis is a life-threatening and time critical condition and the project aims to develop pathways and support hospitals in meeting the [Sepsis Clinical Care Standard](#). The WA Paediatric Sepsis Pathway was completed in May 2026, with online training made available across all health service providers. The Adult Sepsis Pathway is currently being developed.

The Legislative Governance Quality Improvement Project progressed in 2025–26, to improve governance, regulatory capability, operational efficiency and decision making concerning the licensing of private health care facilities in WA. As the state regulator responsible for the accreditation of private hospitals and private day hospitals we ensure the safety and quality of care provided to Western Australians is in line with national safety and quality standards. Future improvements will focus on enhancing service delivery and consistency through enhanced compliance systems, cross training opportunities, updated policies and procedures and modernised information systems to improve data quality, accessibility and operational efficiency.

Safe healthcare facilities

New reporting requirements for health service providers to monitor and manage water borne microbiological and chemical contaminants in health facility heating, ventilation, air conditioning and water distribution systems commenced in 2025–26. In accordance with a direction from the Minister for Health, the Chief Health Officer is required to report monthly to the Director General on any water testing exceedances at WA public hospitals that present a risk to patients, staff or any other person.

The Legionella Control in Health Care Facilities Program was also established in 2025–26, with monthly routine reporting provided to the Chief Health Officer and Director General.

Systems thinking and clinical innovation set to improve patient safety and service quality

The [Clinical Senate of Western Australia](#) is the peak advisory body in the WA health system, bringing together frontline clinicians, managers, leaders, consumers, and subject matter experts to provide strategic, evidence-based advice on systemwide issues concerning clinical care, patient safety and service quality. The Senate comprises up to 80 members from diverse disciplines across WA. Operating under the authority of the Director General, the Clinical Senate provides advice to the WA Health Executive Committee.

In 2025–26, the Clinical Senate explored practical ways to break down silos and barriers for delivering integrated care in a complex adaptive system. Systems thinking was highlighted as a key, foundational skill required to deliver truly integrated, person-centred care. A set of recommendations have been developed to encourage and support the workforce to build capability in systems thinking, including promoting a culture where this skill is always applied when approaching their work, for problem solving, and seeking input from across the health system ensuring collaboration and active partnerships.

Practical solutions were also identified to ensure evidence-based clinical innovations translate into sustainable programs and services that continue to drive improvements in health outcomes. A roadmap of practical steps was developed that outlines five necessary components to address operational hurdles, funding constraints, and fragmented information that may pose barriers to sustaining innovative solutions.

In addition, the Clinical Senate focused on identifying four priority areas to enable the hospital-based workforce to contribute effectively towards prevention, protection and early intervention for improved population health and wellbeing. These areas reflect the Senate's strong desire to embed preventative health into routine clinical care. The priority areas will be considered further in development of the WA Preventative Health Strategy alongside other consultation activities underway.



End-of-life and palliative care

The WA End-of-Life and Palliative Care Strategy (2018-2028) [*Implementation Plan Two 2026-2028*](#) (IP2) was published in May 2026. End-of-life and palliative care aims to improve the quality of life of people facing life-limiting illness, their families and carers.

The IP2 provides WA health service providers, specialist palliative care services and associated non-government organisations, aged care and community providers with an outline to guide the planning, delivery and evaluation of end-of-life and palliative care. Policy makers are also encouraged to use the IP2 to inform, complement and support related statewide service models and frameworks.

IP2 reaffirms that delivering high quality, best practice end-of-life and palliative care requires collaboration between all sectors of the WA health system to ensure people receive individualised, coordinated and integrated care, and are supported to participate in decision making about their care. The IP2 also builds on the recommended actions and outcomes from earlier years and recognises the significant changes that have taken place since the strategy was released including the implementation of voluntary assisted dying legislation.



Number of Western Australians who have accessed palliative care, 2023–24



9,512 Palliative care-related hospitalisations



131,821 Service events for non-admitted primary palliative care patients

Where Western Australians received end-of life care, 2025

Place of death for patients receiving palliative care



60.2% Hospital or hospice



20.2% Home



16.5% Residential aged care home



3.1% Not stated

Top diagnoses for people accessing palliative care in WA, 2025



Malignant conditions

- 1 Lung
- 2 Gastrointestinal tract
- 3 Colorectal / Pancreas
- 4 Prostate
- 5 Breast



Non-malignant conditions

- 1 Non-malignancy (other)
- 2 Respiratory failure
- 3 Dementia (other)
- 4 Cardiovascular disease
- 5 Alzheimer's dementia

Voluntary Assisted Dying (VAD) in WA July 2021 to June 2025



2,816 First requests to access VAD



1,219 VAD deaths

Community health and wellbeing



50,000+

children aged 2 to 11 years received protection against influenza using the intranasal FluMist® vaccine



15,542

doses of the Beyfortus® RSV vaccine were provided to newborn babies through the 2025 WA Infant RSV Immunisation Program



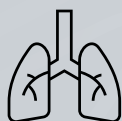
20,569

doses of maternal RSV vaccine Abrysvo® were administered to pregnant women to provide babies with protection for the first few months of life



\$3.5M

Awareness advertising campaign and \$3.5M provided to continue to respond to a syphilis outbreak



7,300+

Western Australians received a scan to detect early lung cancer

RSV-related hospitalisations dropped by 61 per cent for newborns, 54 per cent for young babies aged 3 to 5 months, and 52 per cent for older babies aged 6 to 11 months after the launch of the RSV Immunisation Program



Launched the ['Be Wise. Immunise'](#) Winter Illness Immunisation campaign

Launched the [Access Health](#) campaign to improve community awareness and understanding of health care options when unwell

Facilitated prevention focused roundtables with over 250 stakeholders to inform the WA Preventative Health Strategy

\$3.7M was dedicated to delivering a new Aboriginal Environmental Health Model of Care co-designed by Aboriginal community controlled sector

Ensuring communities remain healthy and resilient

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. Guided by the [State Public Health Plan 2025–2030](#) (SPHP), which outlines a roadmap to promote and enable optimal health and wellbeing while protecting against health risks, we continue to focus on our key 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

Shining a light on preventative health

The first *WA Preventative Health Strategy* is being developed to guide public health initiatives designed to maintain health and prevent illness, injury, or chronic disease within the WA community.

To inform the strategy, we coordinated and participated in 9 roundtable discussions between January and May 2026, hosted by the Minister for Preventative Health, Hon Sabine Winton MLA, in partnership with the Mental Health Commission and Healthway.

More than 250 senior representatives from government and non-government organisations, community groups, universities and research institutes participated. Discussions focused on a range of priority areas, including mental health and wellbeing, immunisation, cancer and genomics screening, sexual health, healthy active living, and healthy ageing. Cross-government collaboration was also discussed, as well as preventative health among priority populations and in regional and remote WA.

Insights gathered through this collaborative process will inform the next phase of work, including public consultation to ensure Western Australians can contribute to the development of the strategy.

Raising awareness and of health risks and encouraging healthy choices and behaviours



Educating and empowering young people and priority populations to take control of their sexual health while reducing stigma.



Increasing community awareness of blood-borne viruses like hepatitis B, hepatitis C and HIV and promoting prevention strategies.



Promoting access to free vaccines and awareness around serious vaccine preventable diseases to Year 7 and Year 10 students.



Providing practical information to help the community understand and manage the risks associated with extreme heat.



Improving access to free HIV preventative medication for Medicare-ineligible people living in WA.



Encouraging Western Australians, particularly those at higher risk, to protect themselves against serious illness through influenza and RSV vaccination.



Promoting access to timely and suitable care in order to improve health outcomes and support a more sustainable health system.



Promoting falls prevention strategies in hospitals and residential aged care settings.

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



Encouraging a smoke-free lifestyle to reduce tobacco-related harm and improve health outcomes.



Encouraging safe food handling and appropriate storage and preparation practices to reduce the incidence of foodborne illness in the community.



Highlighting the health risks associated with vaping and encouraging informed decision making.

First national Lung Cancer Screening Program launches

Eligible Western Australians aged 50 to 70 years can now access free, bulk-billed low-dose computed tomography (LDCT) scans to support early detection of lung cancer via the Australian Government's National Lung Cancer Screen Program (NLCSP).

The first population-based cancer screening program in Australia for almost 20 years, and the only targeted cancer screening program, the NLCSP has provided LDCT scans for 7,300 Western Australians since 1 July 2025.

Screening high-risk individuals using LDCT supports healthcare professionals to detect abnormalities or small nodules in the lungs, enabling approximately 70 per cent of lung cancers to be detected at the early stages of the disease¹¹ and reducing lung cancer mortality by 20 per cent.

Mobile screening services delivered by Heart of Australia have also provided access to over 500 people living in the Kimberley, Pilbara and Midwest regions. Planning is underway to expand mobile screening routes to improve accessibility and ensure long-term benefits for the community.

► Want to learn more about how screening works and next steps go to [Lung cancer screening explained](#)

11- [Key evidence for the lung cancer screening program](#).

Preventing rheumatic heart disease

Rheumatic heart disease (RHD) is a preventable condition that disproportionately affects Aboriginal and Torres Strait Islander Australians.

RHD develops following acute rheumatic fever (ARF), an abnormal immune response to infections caused by Group A Streptococcus (Strep A) bacteria. The most common infections caused by Strep A are sore throat and skin infections, but without treatment, the infection can cause irreparable damage to the major heart valves leading to permanent damage.

We have been at the forefront of efforts to monitor and manage the disease through the WA RHD Register, which commenced in 2009. Since 2015, notification of all known ARF and RHD cases has been mandatory, supporting early detection, improved monitoring and better coordination of care.

In 2025–26, we progressed the development of the *WA Rheumatic Heart Disease Strategic Framework*, which provides a shared roadmap to prevent and eliminate ARF and RHD in WA by 2036.

Community consultation formed a key part of this work given the framework promotes an Aboriginal-led approach focused on prevention, equitable access to care and collaboration.

Once finalised, the framework will guide researchers, clinicians and community leaders towards a common goal of reducing the burden of disease and improving health outcomes for Aboriginal people and communities in Western Australia.

Improving confidence in immunisation

The [Western Australian Immunisation Strategy 2024-2028](#) provides a clear roadmap to strengthen immunisation across the State.

The strategy aims to reduce the incidence of vaccine preventable diseases by improving immunisation access and acceptance, increasing demand and uptake, and enhancing the systems that provide and support immunisation service delivery.

A community stakeholder workshop on immunisation was held in September 2025 to support implementation and understand community perspectives. Representatives from

10 community-based organisations came together to identify barriers to vaccination and generate practical solutions to improve access and confidence in immunisation.

The workshop marked an important step in strengthening partnerships with the community and will become an annual forum for the immunisation program.

Advancing sexual health and blood-borne virus prevention

The [WA Sexual Health and Blood-borne Virus Strategy 2024–2030](#) guides the prevention and control of sexually transmissible infections (STI) and blood-borne viruses (BBV), while reducing the stigma and discrimination experienced by affected populations. The strategy focuses on improving prevention, testing, treatment, education and support.

Key initiatives delivered during 2025–26 included the new human immunodeficiency virus (HIV) pre-exposure prophylaxis (PrEP) program to improve access for Medicare-ineligible people living in WA. To support the program, a statewide awareness campaign was launched in March 2026, promoting the availability of free HIV PrEP medicine through sexual health clinics.

A dedicated online workforce development [hub](#) was also launched, providing access to professional networks, training opportunities, conferences and seminars, volunteering opportunities, scholarships and workforce resources. The initiative helps strengthen clinical capability and supports the development of a skilled workforce able to respond to emerging sexual health and BBV priorities.

Progress against the strategy continues to be monitored through the [WA Sexual Health and BBV Strategy Monitoring Framework](#).

Needle-free influenza vaccine for children

Western Australian children aged 2 to 11 years were able to access a needle-free FluMist® influenza vaccine for the first time in 2026 as part of the WA Influenza Nasal Spray Vaccination Program. From April, FluMist® became available to 12 to 17 year olds.

Administered as a quick and gentle nasal spray, FluMist® provides the same level of protection as the traditional injectable influenza vaccine without the pain and fear often associated with immunisation.

FluMist® was available through immunisation providers such as general practitioners, community health clinics, Aboriginal medical services, and pharmacies.

The introduction of FluMist® aimed to increase influenza vaccine uptake in this age group, which not only protects young children from a life-threatening vaccine-preventable disease, but also reduces community transmission and alleviates pressure on hospitals during the winter season.

- ▶ In 2025, WA recorded 10,914 influenza notifications for infants and children aged 0 to 11 years, and 1,017 hospitalisations in the same cohort, accounting for 9 per cent of total hospital admissions due to influenza in 2025.¹²

As of 30 June 2026, 18.3 per cent of children aged 2 to 11 years were vaccinated against influenza – 4 percentage points higher than the same time in 2025.¹³

By 30 June, over 50,000 WA children in this age bracket received influenza protection using the FluMist® nasal spray vaccine.



- ▶ To learn more about FluMist® [click here](#)

12 - [Australian Immunisation Register - Services Australia](#). 13 - [Notifiable infectious disease dashboard](#)

Protect

Staying safe during extreme heat

As heatwaves become more frequent and intense across WA, we continue to support communities to prepare and respond to extreme heat events.

During summer 2025–26, the statewide 'Be Prepared for Extreme Heat' campaign provided clear and accessible information to help people understand the risks of extreme heat and take simple steps to stay safe. Delivered through radio, social media and supporting community resources, the campaign encouraged Western Australians to stay hydrated, keep cool, recognise the signs of heat-related illnesses, and check on family members, neighbours and friends who may be vulnerable.

The campaign also promoted TeleRedi, a free new service delivered in partnership with the Australian Red Cross that provides regular welfare check-in calls to people at higher risk during heatwaves.

Combining public awareness, practical health advice and targeted support for vulnerable groups ensures Western Australians stay safe during periods of extreme heat.



► [Click here](#) to learn how TeleRedi can help you.

Heatwatch: using data to stay ahead of heatwaves

Heatwatch is an innovative syndromic surveillance system being developed to better understand and respond to the health impacts of extreme heat.

Led by the Disaster Preparedness and Management Directorate in partnership with the Epidemiology Directorate, Heatwatch will use advanced machine learning to analyse hospital clinical records and real time weather data. The system will identify emerging heat-related health impacts as they occur, enabling intervention, improved situational awareness and targeted public health responses during heatwave events.

This initiative brings together epidemiologists, analysts, research officers, emergency management officers, subject matter experts and data custodians from health service providers and demonstrates the value of collaboration in strengthening community resilience.

Advancing knowledge of water recycling schemes in WA

Water recycling is a sustainable and beneficial option to manage our scarce and valuable water resources. Recycled water and biosolids (sewage sludge) contain many microbial contaminants that can affect human health. For this reason, they must be treated to a level that is fit for the intended end-use, and a continual sampling program is required to monitor compliance with safety guidelines.

In 2025–26, an evaluation of the water quality monitoring program was conducted in partnership with The University of Western Australia. The project involved the review and analysis of historical monitoring data (2010–2024) to support a greater understanding of water quality outcomes and monitoring practices across recycling schemes and provided valuable insights to inform ongoing water recycling approaches.

Improving our emergency management capability

During 2025–26, significant progress was made to enhance emergency management capability across WA Health, including the upgrade of WebEOC, the department's system crisis information management platform. The uplift transitioned the platform to a contemporary cloud hosted environment, enabling improved real time information sharing, enhanced coordination, and a clearer common operating picture during incidents, emergencies and system-wide outages. Implementation activities progressed through development of internal governance documentation, workflows and engagement with priority user groups.

The [WA Health System Emergency Management Arrangements](#) were also reviewed and updated. The arrangements provide a strategic and operational framework for managing emergencies and disasters that impact health service delivery. Consultation with stakeholders informed the revised arrangements that were endorsed by the Health Emergency Management Committee.

To further strengthen preparedness and response capability, the Health Emergency Management Spatial Viewer (HEMSV) continued to be enhanced as a critical decision support tool. The HEMSV integrates real time meteorological data with information relating to communities, infrastructure, the environment and health facilities. This aims to support improved situational awareness and informed decision-making during emergencies.

A new training record database and event management system was also developed to modernise and streamline the administration of emergency management and health-related training activities. The platform replaced manual processes and improves course management, participant records, reporting capability and visibility of workforce preparedness and capability data.

Together, these initiatives strengthen our resilience and ensure teams are better equipped to respond to emergencies affecting the WA community.



► [WA Health System Emergency Management Arrangements](#)

Enable

Public health planning for healthier communities

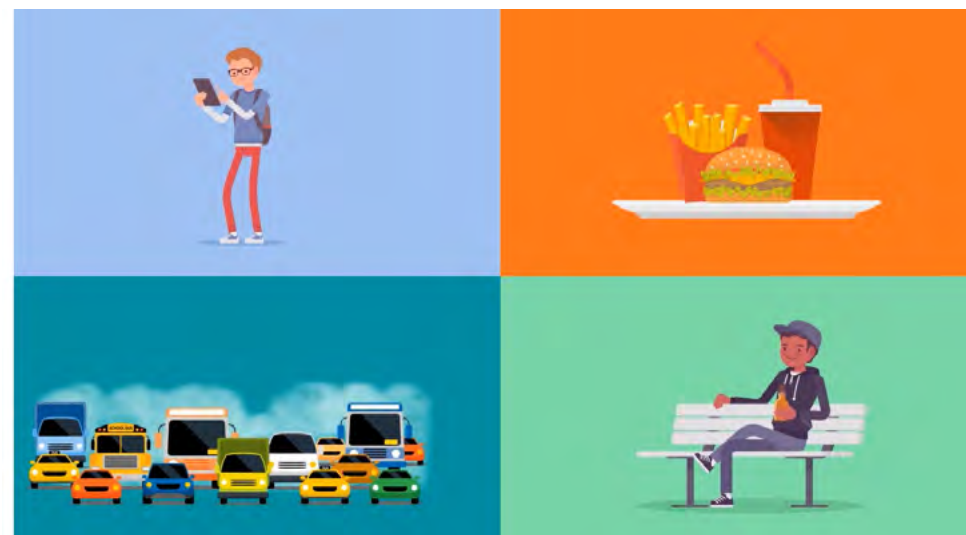
Healthy communities are built through strong partnerships and coordinated action, and ongoing support from local government is key to strengthening public health planning and responding to the unique needs of their communities.

To support this work, a Public Health Planning Guide for Local Government and dedicated suite of useful resources have been developed and made available through the Public Health Planning [website](#). These resources provide practical guidance on developing public health plans that reflect local priorities and emerging challenges.

Targeted fact sheets have also been developed addressing climate change, environmental health, communicable diseases, and Aboriginal health and wellbeing. These resources support local governments to consider diverse factors that influence community health and strengthen planning approaches.

A centralised library of public health planning resources has also been established, providing a continually updated hub of information. This resource library provides a strong foundation to guide the development of local public health initiatives.

- [Western Australian Burden of Disease 2011–2023](#) has been launched and provides an overview of disease burden by age group and gender. This information assists with public health planning and supports collaborative efforts improving health outcomes for Western Australians.



- To find out how local government fit into the picture of health today [click here](#).

Linking data, improving community outcomes

The launch of the [WA Health Data Linkage Strategy 2025–2030](#) in September 2025 marked a significant step towards positioning WA as the national leader in secure, trusted and transformative data linkage.

The strategy provides a clear roadmap for strengthening data linkage across the health system to support evidence-based policy and program design, research, service planning and evaluation.

The strategy is underpinned by four key themes:

Theme 1: accelerate access and maximise impact

Theme 2: lead trusted, ethical data innovation

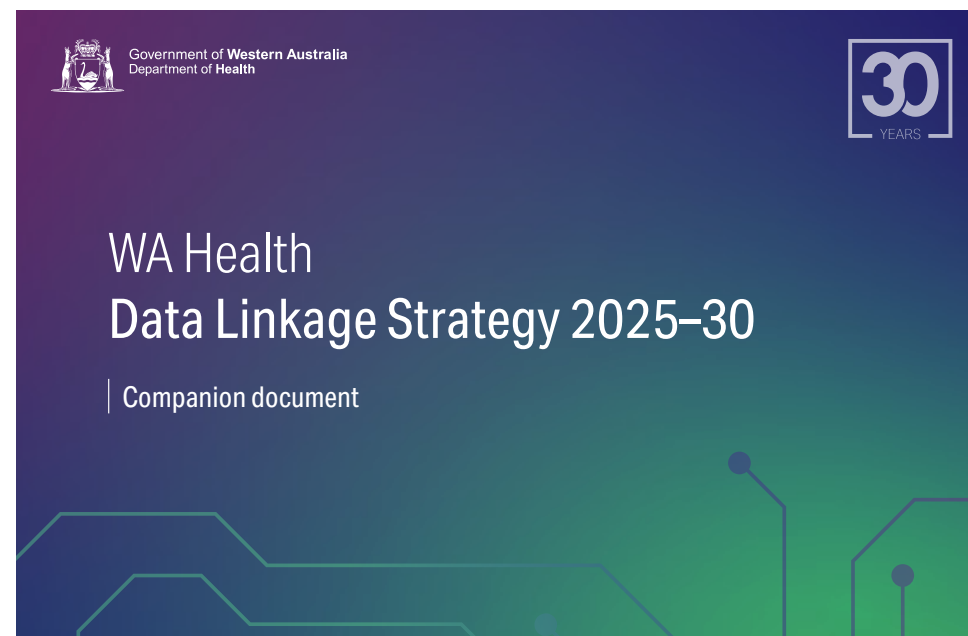
Theme 3: strengthen national and cross-sectional partnerships

Theme 4: build future-ready data capability.

Implementation will occur across three horizons, commencing 2025–26 through to 2029–30, with each building on the progress of the last. A 3-tier measurement framework will make sure achievement against goals is meaningfully measured and communicated.

The strategy builds on the success of the previous 3 years, when a broad program of reform projects was delivered to transform how linked data is accessed, governed, and used across the WA health system. In 2025–26, this included data linkage services being relocated to the WA Health website to improve accessibility, discoverability and integration for users seeking linked data information, tools and services.

By safely connecting information relating to the same person, family, place, or event, data linkage creates powerful insights that would not be possible from individual data sets alone. Leveraging these valuable data resources safely, together with strong governance and partnerships, will contribute to the delivery of safe, high quality, and sustainable services across the continuum of care now and into the future.



Agency performance

2025-2026

Our performance management framework

The department operates within the WA Health Outcome Based Management (OBM) framework, which outlines how outcomes, services, and key performance indicators (KPIs) work together to measure the effectiveness and efficiency of progress toward broader state government goals.

Table 2 outlines the alignment between the whole of government goal and the department's desired outcomes as defined in the performance management framework.

While the department supports the delivery of services that contribute to all 3 desired outcomes through systemwide initiatives and assistance to health service providers, it directly and specifically delivers outcomes 2 and 3.

Table 2: WA Health Outcome Based Management framework

State government goal	Desired outcomes	Services
Ensuring every Western Australian can access the health care we need, when we need it	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 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
	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 delivers outcome 2 through 2 key service areas:

- Service 5: aged care, continuing care, and end of life care services, including community based palliative care and voluntary assisted dying. These programs assess the needs of older people and provide interim functional care or support to enable older, frail individuals and younger people with disability to continue living independently. Community based palliative care is delivered by contracted private providers and focuses on preventing and relieving suffering, supporting quality of life, and offering care close to home. Voluntary assisted dying services include care for eligible patients nearing the end of life, as well as support for all individuals involved in voluntary assisted dying in WA.
- Service 6: public and community health services designed to promote optimal health and wellbeing, encourage healthy lifestyles, reduce disease onset and disability, minimise long term illness risk, and detect, protect, and monitor disease across the population.

The department delivers outcome 3 through:

- Service 10: health system management – policy and corporate services, which encompasses strategic leadership, policy and planning, system performance management, and purchasing aligned with statewide planning, budgeting, and regulatory processes. This service also includes statutory financial reporting, oversight of safety and quality improvements, and systemwide infrastructure and asset management.

Performance toward outcomes 2 and 3 is measured through a suite of key performance indicators. Results for 2025–26 are summarised in the agency performance section and detailed in the KPI section of this report.

Changes to the WA Health OBM Framework

The State Government updated priorities for 2025–2029 to one goal for the delivery of health care services; ensuring every Western Australian can access the healthcare we need, when we need it.

The effectiveness KPIs for response times for emergency road-based ambulance services (percentage of priority 1 calls attended to within 15 minutes in the metropolitan area) was expanded to include targets for response times for priority 2 and priority 3 calls.



Performance summary

Summary of financial performance

Table 3 provides a summary of our financial and performance information for 2025–26.

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

Table 3: Actual results versus budget targets for the Department of Health

State government goal	2025–26 Target (\$'000)	2025–26 Actual (\$'000)	Variation (+/-) (\$'000)
Total cost of services ¹	11,805,933	12,324,985	519,052
Net cost of services	8,289,436	8,867,182	577,746
Total equity	504,854	656,733	151,879
Agreed salary expense level	207,430	249,332	41,902 ²
Approved borrowing limit ³	0	0	0

Notes:

1. The total cost of services includes grants and subsidies to fund statutory authorities for delivery of health services.
2. The target does not reflect salary expense increases approved as part of the 2025–26 mid-year review and 2026–27 budget process.
3. Approved borrowing limit is not applicable.

All agencies are required to operate within an agreed working cash limit of 5 per cent of budgeted cash payments. The working cash limit is the maximum level of cash required to meet committed payments for recurrent services. In 2025–26, the cash limit target and actual for the WA health system are provided in Table 4.

Table 4: Agreed working cash limit for the WA health system

	2025–26 Target (\$'000)	2025–26 Actual (\$'000)	Variation (+/-) (\$'000)
Agreed working cash limit (at budget)	685,465	685,465	0
Agreed working cash limit (at actuals)	730,573	729,193	-1380

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 all 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 5.

Table 5: Agreed executive salary expense limit for the WA health system

	2025–26 Target (\$'000)	2025–26 Actual (\$'000)	Variation (+/-) (\$'000)
Agreed executive salary expense limit	11,921	12,034	113

No act of grace payments were paid in 2025–26. Ex-gratia payments are provided in Table 6.

Table 6: Department of Health ex-gratia payments paid in 2025–26

Funding source	Payment date	Payment amount (\$)	Purpose of payment
Ex-gratia payments			
State appropriation	Throughout the year	8,267,117	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

We measure our progress toward the WA health system vision through a suite of key performance indicators (KPIs).

Actual KPI results are assessed against established targets to evaluate both the effectiveness of outcomes and the efficiency of service delivery. Variations between actual results and targets are expected, and depending on the specific indicator, either a positive or negative variance may reflect achievement of the desired performance.

To support clear interpretation, the KPI results for this reporting period are presented using the following colour coding system.

- 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 7 and efficiency results are summarised in Table 8. Detailed information can also be found in the Key performance indicators section of the report.



Table 7: Actual results versus key effectiveness performance indicator targets

Desired outcomes and related effectiveness indicators		2025–26 target	2025–26 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	≥88%	97%	9%
2	Percentage of people accessing specialist community-based palliative care who are supported to die at home	≥76%	73%	-3%
3	Potential years of life lost for selected common causes of premature death			
	a. Lung cancer	1.4	1.2	-0.2
	b. Ischaemic heart disease	2.0	2.1	-0.1
	c. Malignant skin cancers	0.3	0.3	0.0
	d. Breast cancer	1.6	1.5	-0.1
	e. Bowel cancer	1.1	1.0	0.0
4	Percentage of fully immunised children			
	a. 12 months	≥95%	89.6%	-5.4%
	b. 2 years	≥95%	87.4%	-7.6%
	c. 5 years	≥95%	91.8%	-3.2%
5	Percentage of 15 year olds in Western Australia vaccinated for HPV			
	a. Males	≥80%	76.4%	-3.6%
	b. Females	≥80%	78.9%	-1.1%
6	Response times for road-based ambulance services in the metropolitan area			
	a. Percentage of priority 1 calls attended to within 15 minutes	≥90%	84.7%	-5.3%
	b. Percentage of priority 2 calls attended to within 25 minutes	≥90%	74.4%	-15.6%
	c. Percentage of priority 3 calls attended to within 60 minutes	≥90%	76.1%	-13.9%
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%	78%	3%

Table 8: Actual results versus key efficiency performance indicator targets

Desired outcomes, services delivered and related efficiency indicators		2025–26 target	2025–26 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	\$519	\$449	-\$70
2	Average cost per			
	a. home-based hospital day of care	\$350	\$375	\$25
	b. occasion of service	\$166	\$167	\$1
3	Average cost per day of non-acute bed-based continuing support	\$787	\$918	\$131
4	Average cost to support patients who suffer specific chronic illness and other clients who require continuing care	\$19	\$25	\$6
5	Average cost per client receiving contracted palliative care services	\$11,773	\$10,925	-\$848
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	\$70	\$88	\$18
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	\$685	\$26
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	\$5	\$7	\$2
9	Average cost for the Department of Health to undertake system manager functions per health service provider full time equivalent	\$5,061	\$5,540	\$479

Closing the Gap

The National Health Agreement on Closing the Gap (CTG) Priority Reform areas are central to guiding government action in partnership with Aboriginal voices. Partnerships with the Aboriginal community-controlled sector and shared decision-making with Aboriginal people is critical. The National Agreement contains [four priority reform areas](#) and 17 [socio-economic targets](#) to focus efforts to improve Aboriginal and Torres Strait Islander outcomes.

The department is the lead agency with responsibility for delivering on:

- socioeconomic target 1: close the gap in life expectancy within a generation, by 2031.
- socioeconomic target 2: by 2031, increase the proportion of Aboriginal and Torres Strait Islander babies with a healthy birthweight to 91 per cent.

The [WA 2026-2028 Closing the Gap Implementation Plan](#) was developed in consultation with the Aboriginal Community Controlled Sector and WA Government agencies. The plan guides delivery of the 4 priority reform areas:

1. formal partnerships and shared decision-making
2. building the community-controlled sector
3. transforming government organisations
4. shared access to data and information at a regional level.

In partnership with the Aboriginal Community Controlled Health Services sector, we are implementing several initiatives in strong alignment with the priority reforms and targets. Recent achievements to address target 1 include:

- developing the Aboriginal Data Governance Policy
- refreshing the Aboriginal Health Impact Statement and Declaration Policy
- developing an Aboriginal Anti-Racism Toolkit in collaboration with Kurungkurl Katitjin, Edith Cowan University.
- advancing the Aboriginal Health dashboard that provides data for systemwide monitoring of Aboriginal health-related measures to inform quality health care improvements.

For target 2, we are continuing to prioritise programs of work that focus on improving culturally safe antenatal care for Aboriginal women and babies. This involves exploring options to expand implementation of the culturally safe Baby Coming You Ready? antenatal screening and assessment tool. In addition, the Aboriginal health practitioner workforce continues to grow through culturally safe recruitment, tailored onboarding, and strong career pathways.



► [Click here](#) to find out more about the Implementation Plan.

Improving safety and quality in health care – a strategic plan for action 3 years on

[*Improving Safety and Quality in Health Care: A Strategic Plan for Action in WA 2024–2026*](#)

is a 3-year blueprint for improving safety and quality across WA Health, focusing on person-centred care, cultural safety, and equity for all patients, carers, and families.

Implementation of the plan from 2024–2026 has involved working collaboratively with health service providers on key achievements to support change.

Achievement highlights: 2024–2026

Goal 1 - safe care for patients, supported by a workforce with a strong safety culture:

- developed a prioritisation process for delivery of statewide clinical improvement initiatives, including guidelines, an application form and scoring sheet
- developed a working proof-of-concept for the WA Improvement Exchange to reduce duplication, improve visibility and support systemwide learning and collaboration concerning improvement projects
- hosted the first annual statewide health care improvement summit as part of the Festival of Innovation and Improvement
- progressed a standardised approach to patient safety culture measurement across WA Health
- endorsed the Patient Safety and Clinical Quality Directorate's Quality Series as the foundation for an initial WA Health learning network, recognising it as a scalable, evidence-informed monthly forum connecting staff with local, national and international expertise.

Goal 2 - high performing to create a sustainable systemwide focus on quality planning, improvement and control:

- progressed the design and establishment of a dedicated safety and quality centre within the department, embedding the function within existing structures and drawing on contemporary interstate models to support the delivery of evidence-based, high-quality care for Western Australians
- delivered the Quality Improvement Hub, establishing a centralised source of quality improvement resources to support staff and provide consistent information to effectively plan, implement and evaluate quality improvement initiatives
- established the Clinical Analytics Group focusing on improving sharing, reproducibility and standardisation of analytical tools and methods to support clinical outcomes and variations in care.

Goal 3 - person-centred through partnerships with consumers and clinicians, responding to evolving community needs:

- completed systemwide mapping of consumer engagement structures, roles and activities across WA Health to inform future improvement and consistency
- commenced early co-design of a consumer leadership capability framework in partnership with the Health Consumers' Council and Carers WA, designed to support more consistent consumer leadership and capability across the health system
- standardised the collection and reporting of patient-reported experience measures and patient-reported outcome measures
- developed and endorsed statewide minimum standards and implementation resources for the 'What Matters to You?' initiative designed to embed person-centred conversations in clinical practice.

The 'What Matters to You' initiative encourages healthcare staff to ask patients, their families, and carers a simple but powerful question about their care.

This approach aims to place patients at the centre of their healthcare journey, ensuring that care is tailored to their individual needs, values, and priorities.

Vision statement

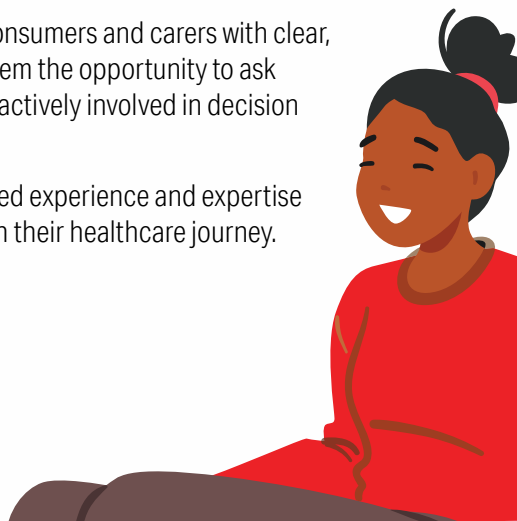
To create a movement across WA Health that builds connection between staff and consumers to ensure every voice is heard, and care is aligned with what truly matters.

Principles

Person centred - we acknowledge our consumers as individuals with unique preferences, values and goals and work to ensure these are heard and included in their care plan.

Supportive - we provide our consumers and carers with clear, timely information and give them the opportunity to ask questions so that they can be actively involved in decision making about their care.

Respectful - we respect the lived experience and expertise of our consumers and carers in their healthcare journey.



Healthcare Safety and Quality Capabilities Framework

The introduction of the [Healthcare Safety and Quality Capability Framework](#) in December 2025 is building a strong foundation for shared understanding, consistent practice and a strong learning culture across WA Health.

The new framework contains 6 capabilities that will enable our health workforce to further develop their knowledge, skills and behaviours at each level of the organisation, including:

1. contributing to becoming a high reliability organisation
2. managing clinical incidents and risk effectively
3. understanding and managing individual factors that influence how we perform our work
4. upholding a safety culture
5. utilising improvement methodologies to identify better, safer ways to deliver health care
6. utilising a system thinking approach to our work to contribute to change.

To help our workforce translate safety and quality principles into everyday practice, the capabilities have been embedded into workforce inclusion initiatives and supported by a suite of resources, including an eLearning pathway.



Government of Western Australia
Department of Health

Healthcare Safety and Quality Capabilities Framework

An Occupation-Specific Set for Healthcare Workers in WA Health



Classification: Official
health.wa.gov.au

'No Jab No Play' status update

What is 'No Jab No Play'?

The 'No Jab No Play' legislation introduced in 2019 has required children to receive the vaccinations for their age as listed on the National Immunisation Schedule before enrolling in a childcare service, community kindergarten or school.

There are a limited number of circumstances in which a child may be exempt from this requirement. Childcare services, community kindergartens, and schools are required to report children with incomplete vaccination records to the department, and they are referred to their local public health unit who supports families to access local immunisation services. Families may also request immunisation support through the school or childcare service, regardless of their child's immunisation status.

What is the immunisation status of children?

Of the 611 children who did not have an up-to-date immunisation status in 2024–25, 131 (21.4 per cent) were recorded as up-to-date by 14 July 2026 (see Table 9).

In 2025–26, 765 children were reported by childcare services (n=83), pre-kindergartens, and kindergartens (n=682) as having an immunisation status of not up-to-date. At 14 July 2026, the immunisation status of two (0.3 per cent) of these children was considered up to date, while a further 55 children on a catch-up schedule.

How are we supporting schools and public health units?

To support understanding and responsibilities of the legislation, a quiz was created and sent to school staff at non-government schools. As of 30 June 2026, over 100 responses had been collated, and respondents rated it 4/5 for 'usefulness'. These responses will form a baseline knowledge indicator that will be used for future targeted messaging.

Training for public health unit staff took place in June 2026 to support the provision of efficient follow-ups for exempt children.



Table 9: Immunisation status of children who were not fully immunised by enrolment cohort, 2024–25 and 2025–26

Enrolment cohort	Reported as not up to date at enrolment	Immunisation status as at 14 July 2026			
		Up to date	On a catch-up schedule	Not up to date	Unable to find on Australian Immunisation Register
2024–25					
Children enrolled in childcare between 1 July 2024 and 30 June 2025	32	8	2	22	0
Children enrolled in pre-kindergarten and kindergarten between 1 January and 31 March 2025	579	123	1	385	70
Total	611	131	3	407	70
2025–26					
Children enrolled in childcare between 1 July 2025 and 30 June 2026	83	0	14	60	9
Children enrolled in pre-kindergarten and kindergarten between 1 January and 31 March 2026	682	2	41	574	65
Total	765	2	54	634	74

Notes:

1. Data is based on all children enrolled at long day care, family day care (collectively referred to as childcare services), pre-kindergarten and kindergarten.
2. Childcare services are directed to report a child's immunisation status at the time of enrolment (all year long). Pre-kindergartens and kindergartens are directed to report a student's immunisation status by the end of term 1 of each school year (majority intake in Term 1). The different timings of enrolment have resulted in two reporting cohorts. The data includes children in WA on a temporary basis who meet these criteria
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 2024–25 and the findings are considered preliminary for 2025–26. Any changes to immunisation status of children reported in the 2025–26 period will be provided in the 2026–27 annual report.

Data source: 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

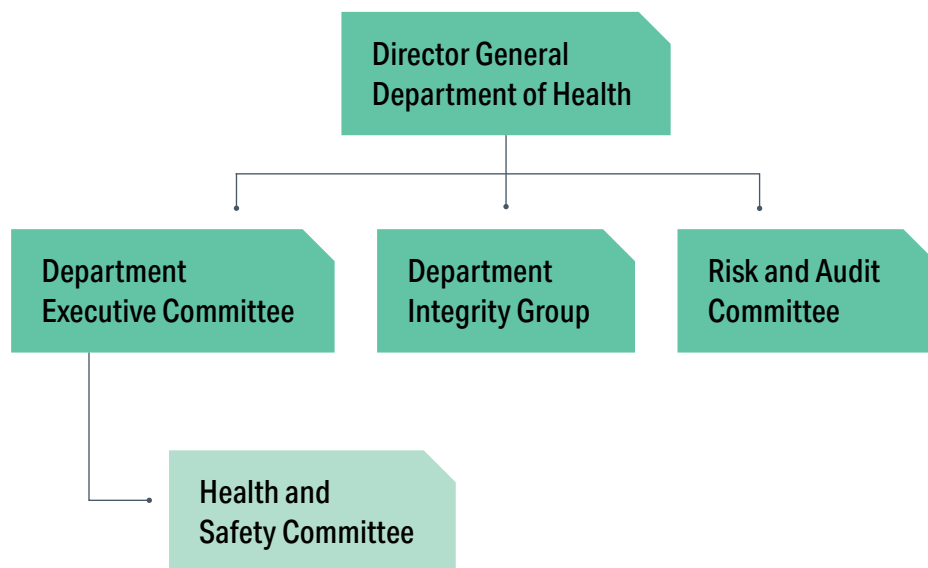
2025-2026

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 1: Department of Health internal governance structure



Department Executive Committee

The Department Executive Committee (DEC) provides strategic leadership to ensure our responsibilities as a government agency are delivered in a coordinated, effective and efficient manner. The DEC also supports the Director General in fulfilling her responsibilities as our Chief Executive Officer (CEO) and System Manager.

The following standalone committee reports to the DEC in accordance with 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 2025–26, the committee focused on empowering safety representatives to lead and promote proactive health and safety activities and wellness initiatives to support our broader health and safety framework.

Following the committee's endorsement of the *Psychosocial Management Framework* in December 2025, awareness training was delivered to leaders and workers on psychosocial risks, as well as activities related to mental health that are aligned with the framework's objectives.

The committee continued to contribute to and monitor risks that are incorporated into our work health and safety risk register. Work has also been supported to improve how we conduct workplace inspections, with inspection frequency increasing from biannual to quarterly.

Department Integrity Group

The Department Integrity Group (DIG) supports the Director General, Department Executive Committee (DEC) and System-Wide Integrity Services to perform their functions and fulfil legislative obligations. The DIG is made up of areas or functions with an increased integrity, fraud or corruption risk profile and/or specific responsibilities for misconduct, fraud and corruption prevention.

The DIG continued to participate in the Public Sector Commission Integrity Framework Maturity Assessment, which evaluates agency maturity across 13 integrity framework elements. In 2025–26, we successfully raised our integrity maturity level within the framework, moving from 'developing' to 'embedded' by developing an action plan. We published the revised *Fraud, Corruption and Control System and Integrity Governance Framework*, strengthening our approach to preventing, detecting and responding to integrity, fraud and corruption risks.

Building on these findings, we commenced improvement activities to strengthen capability, governance practices and organisational awareness across all assessment elements. The aim is to progress towards 'embedding high levels of maturity' across the integrity framework.

Risk and Audit Committee

The independent Risk and Audit Committee (RAC) provides systematic oversight of governance, risk management and control practices.

The RAC provides advice and guidance 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 of our senior leaders. This representation ensures the committee's independence and affords broader access to the skill sets that enable the committee to effectively fulfil its role. The committee met 4 times in 2025–26.

The key focus areas in 2025–26 included:

- refreshing the strategic risk register to align with our strategic and ministerial priorities
- strengthening financial management, internal controls and oversight to address Office of Auditor General audit findings
- monitoring progress of open audit recommendations
- introducing thematic deep-dive strategic risk discussions at RAC meetings concerning key initiatives and the financial management of key strategic contracts and programs.

The RAC also focused on the growing number of open audit recommendations, including those reported as overdue.

Risk management and internal audit

To strengthen our shared understanding and approach to risk, the *Risk Appetite Statement* and *Department of Health Strategic Risk Register* was refreshed to align with strategic and ministerial priorities.

Throughout 2025–26, we delivered 26 internal risk workshops and advisory engagements with staff on reform programs and major initiatives. We provided subject matter expertise to develop the *WA Health Climate Risk Register*, and a learning academy course on risk management in collaboration with the Public Sector Commission.

With a focus on auditing, we developed an *Integrated Assurance Strategy* that will enhance our approach to planning and delivering assurance activities. This will ensure consistent standards, risk management, and stakeholder confidence across the department. It will also optimise the quality of reporting on the outcomes of all assurance activities to DEC, the Director General and the RAC.

We are addressing internal control weaknesses in WA Health's processes for direct payments to third parties as identified by the Office of the Auditor General in 2025, as well as providing advice and guidance services to various business areas.

The *Business Continuity Plan* (BCP) was activated in October 2025. The plan addressed an onsite incident that resulted in valuable assurance that continuity processes could be mobilised effectively during an operational disruption, including after-hours. A post-incident review identified opportunities to strengthen BCP arrangements, including improvements to infrastructure and minor updates to after-hours communication.

Effective internal auditing in 2025–26



11 internal audits conducted



81% of audit recommendations closed within the due date



88.3% of the internal audit plan completed



96% stakeholder satisfaction

Compliance reporting

Compliance with Commissioner's Instructions and Public Sector Standards

In 2025–26, we continued to support employees to act in alignment with the *WA Health Code of Conduct* and the *Public Sector Commissioner's Instruction 40: Ethical Foundations*. The department promotes understanding of expected workplace behaviour and conduct through a range of communication, training and integrity awareness initiatives.

All new employees are required to acknowledge the Code of Conduct as a part of the offer of employment, and further education is received during their induction. Expectations regarding ethical behaviour are reinforced through policies and procedures, eLearning and face-to-face learning, intranet resources, regular communications and targeted integrity capability development for managers and senior leaders.

Significant actions to promote compliance with the Code of Conduct included targeted training for managers and revisions to the *Fraud and Corruption Control System*, *Integrity Governance Framework* and the *Gifts, Benefits and Hospitality Policy*.

A dedicated Integrity Advisory Line and email service continued to provide staff with guidance regarding integrity matters, including reporting pathways for suspected non-compliant behaviors. All reported integrity concerns were assessed through the department's Triage and Operations Committee for consistent triage, risk assessment and recommendations for management actions.

Ongoing monitoring of compliance with the *Public Sector Code of Ethics* and *WA Health Code of Conduct* provided oversight of training completion rates, conflicts of interest declarations, gifts and benefits, and case management through the DIG. For complaints alleging non-compliance in 2025–26, 7 new conduct matters were raised and 4 matters were carried over from 2024–25. Of these 11 matters, all were investigated internally, and 2 resulted in a finding of misconduct. There are 2 matters ongoing as of 30 June 2026.

We are committed to upholding the requirements of the *Public Sector Standards for Human Resource Management* and applicable Commissioner's Instructions. To support compliance, training and education on the new Commissioner's Instructions were offered, including the importance of managing conflicts of interest to ensure decision making is reviewable. The promotion of structured and consistent change management activities across the department has also been a focus, along with continued policy review and the creation of guidance material for a range of human resource management activities.

Any breach of standard claims from employees, or prospective employees at recruitment, are captured, reviewed and investigated. A broad overview of each claim is recorded in an internal database that enables the review and extraction of data as required for reporting purposes. In 2025–26, 7 claims were lodged, with 5 managed internally (either resolved or withdrawn) and 2 claims referred to the Public Sector Commission. The referred claims were not upheld.

97% of new staff completed Code of Conduct training

94% of staff completed refresher training

Compliance with public sector policy

Implementing our Multicultural Plan

In 2025–26, implementation of the *Multicultural Action Plan 2024–2028* involved promoting social cohesion and mutual respect and supporting equitable participation by culturally and linguistically diverse (CaLD) communities. Cultural diversity was recognised and celebrated by 23 diversity and inclusion communication and engagement activities throughout the year, promoting awareness of Aboriginal and multicultural initiatives, cultural celebrations, training opportunities and inclusion programs.

Workforce diversity considerations continue to be integrated into workforce and business planning. An environmental scan was undertaken to inform future workforce initiatives and the development of a broader workforce and diversity plan. Refinements to our diversity and inclusion dashboard reporting have improved visibility of workforce trends, including country-of-origin data. In addition, feedback from CaLD employees is gathered through exit surveys, training registration processes and the staff-led Diversity and Inclusion Reference Group.

A range of online equity, diversity and inclusion (EDI) training is available for staff to build cultural awareness and strengthen inclusive practices. During 2025–26, staff completed 23 EDI courses, adding to the 442 courses completed since 2022. Two face-to-face diversity confidence training sessions were delivered exploring key concepts, including intersectionality, individual differences, privilege, cultural inclusion, unconscious bias and systemic advantage.

↑ **20.6% of our staff are from CaLD backgrounds**
17.2% in 2022–23; target 15.5%

Unconscious bias continues to form part of recruitment training for hiring managers, with 61 managers and panel members completing the training in 2025–26. Updated training resources and online learning modules are in development. We also promoted the Public Sector Commission's *Hiring Manager Toolkit* and reviewed manager induction processes to strengthen awareness of equal opportunity, diversity and inclusion responsibilities. Cultural diversity questions remain embedded within registration processes for online learning to support collection of representative feedback and inform future training development.

For more information refer to the Our People section.



Disability Access and Inclusion Plan

In the final year of our current *Disability Access and Inclusion Plan* (DAIP), we focused on consolidating outcomes and reflecting on progress across the full reporting period (2020–2025) to inform development of the next DAIP.

Part of this involved an evaluation of progress across the 7 DAIP outcome areas, drawing on previous annual reporting evidence, delivered outcomes, and qualitative assessment of impact. Our evaluation shows we have made some progress in advancing disability access and inclusion, particularly in digital accessibility, inclusive recruitment practices, and disability inclusion training and awareness building. Opportunities to strengthen the next DAIP were also identified that will build on existing foundations and achieve more measurable improvements in access and inclusion across the department.

↓ **2.9% of our staff have a disability**
3.3% in 2022–23; target 5.0%

Strengthening substantive equality

We remain committed to identifying and removing barriers that affect different people and groups in the community, ensuring our policies, programs and services do not create or reinforce inequality. In 2025–26, several key achievements advanced this goal of substantive equality, strengthening fair access and equitable outcomes across WA Health, including:

- Continuing implementation of the Health Equity Impact Statement with 27 submissions received from across the health system indicating that the needs of consumers and carers from low socioeconomic backgrounds and those from CaLD backgrounds, were considered in the development and implementation of significant health initiatives.

- Reviewing and updating the Aboriginal Health Impact Statement and Declaration policy to support a whole-of-organisation approach and commitment to address systemic and institutional racism.
- Commencing a new program of work in response to the [Parliamentary Inquiry Report No. 9 Pathways to Thriving: Enhancing support for humanitarian children and young people in Western Australia](#) that is exploring care models and areas for improvement with a focus on health, mental health, education, access, and broader social determinants of health.
- Leading the WA Health LGBTIQ+SB Strategic Partnership Group with representatives from health service providers to provide support of shared priorities and maintained responsiveness to our LGBTIQ+SB workforce and community needs.
- Supporting the finalisation and passage of the [Assisted Reproductive Technology \(ART\) and Surrogacy Bill 2025](#) that removes long-standing barriers to access, enabling same-sex couples, single people, transgender and intersex people to access ART and surrogacy services on equal grounds.
- Embedding consumer and carer engagement into policy development, service design and community engagement including the Electronic Medical Record Program to support identification of diverse user needs, including accessibility, digital inclusion and continuity of care across different population groups. Also, the development of key initiatives including the State Dementia Action Plan, Voluntary Assisted Dying guidelines and interpreter resources for the CaLD community.
- Improving the collection and use of cultural diversity data with work commenced to improve ancestry and ethnicity data capture to improve utilisation of cultural diversity information to inform health service planning and delivery.
- Improving access to culturally appropriate information and resources for CaLD health consumers related to healthy lifestyles, sexual health, sepsis awareness, lung cancer screening and consumer-centred care.

Recordkeeping

We maintain a comprehensive and integrated recordkeeping framework that underpins effective service delivery and transparent public administration. This framework aligns with the *State Records Act 2000* (the Act), the State Records Commission Standards, and the department's Recordkeeping Plan (RKP).

Ongoing efforts continue to strengthen our information governance maturity to ensure records remain accurate, accessible, and secure across a complex health environment. During 2025–26, we reviewed and updated key components of the RKP to reflect evolving digital health practices, legislative changes, and the effectiveness of our information management processes. Machinery of Government changes prompted further updates to the RKP, approved by the State Records Office in May 2026. Associated policies and procedures were also reviewed for consistent recordkeeping practices.

Significant progress was achieved in modernising our digital recordkeeping capability. We implemented an upgrade to the electronic document and records management system (EDRMS) resulting in improved metadata quality, enhanced security, better search functionality, and strengthened lifecycle management. All our help guides were updated to reflect the new EDRMS and the records team delivered additional training. Identified areas for improvement led to the development of further guidance materials to support consistent practices. These improvements have supported a more robust approach to information risk management.

Building staff capability remained a priority. The mandatory induction program includes a recordkeeping component outlining employee responsibilities under the RKP and the Act. New staff receive guidance on record creation, capture, and management, the appropriate use of the EDRMS, and expectations regarding information security and retention. In 2025–26, more than 94 per cent of employees completed EDRMS training and 98 per cent completed the Recordkeeping Awareness Training module, that covers information security, retention and disposal, and digital recordkeeping processes. An information governance and EDRMS training consultant was recently appointed to further expand our recordkeeping capability and redevelopment of eLearning materials.

We continue to manage significant volumes of information ready for disposal. A quarterly dashboard captures key statistics, including more than 740,000 corporate administrative records added to the EDRMS during 2025–26, used to drive continuous improvement. The Health Sector Retention and Disposal Schedule is under review and a new initiative has been developed to enhance current corporate administrative record disposal practices for selected record types, enabling more timely disposal activities and delivering improved efficiency and cost savings.

Looking ahead, we will continue to expand our digital health capabilities, including targeted training sessions planned for the next reporting period. Further evaluations will assess the impact of recent improvements and ensure we continue to meet statutory obligations and operational needs while embedding consistent, high quality recordkeeping practices across the department.



Freedom of information

The WA *Freedom of Information Act 1992* (the Act) 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 Act. We dealt with 104 applications in 2025–26, an increase of 68 per cent compared to 2024–25 (n=62). As at 30 June 2026, 95 applications were finalised.

In preparation for the new *Privacy and Responsible Information Sharing Act 2024* commencing on 1 July 2026, FOI processes have been updated to reflect new obligations under the General Retention and Disposal Authority (GRDA) 2023-004, issued pursuant to the *State Records Act 2000*.

Summary of action	Number
Applications granted – full access	21
Applications granted – partial or edited access	18
Applications withdrawn by applicant ¹	19
Applications refused ²	37
Applications in progress	2
Applications fully transferred to another agency	7
Total³	104

Notes:

1. Includes one matter dealt with outside the *Freedom of Information Act 1992*.
2. Includes 28 matters where no records were found and 9 matters where the documents were exempt from release.
3. Includes 4 matters carried over from 2024–25 and 2 matters partially transferred to another agency.

Commitment to reduce, reuse and recycle

Following the evaluation of our *Climate Action Plan 2022–2024*, we progressed the development of the draft *Sustainability Action Plan 2026–2027*, which is due to be published in the later part of 2026. The draft plan reflects our maturation since 2022 and will cover a broader range of actions, increasing our alignment with whole of health sustainability practices and targets. As we closed out our current Plan the following activities were completed against our sustainability priorities.

Collective leadership: Promoting staff healthy habit initiatives such as Ride2Work Day and ways for staff members to reduce their use of plastics.

Waste disposal and management: Providing staff with multiple options for waste disposal to increase waste diversion and recycling. In 2025–26 our average diversion of waste from landfill was 69 per cent. This includes our recycling partnerships with Scouts WA for Containers for Change and EcoBatt for battery recycling. This is an improvement from the previous year's average of 65 per cent.

Emissions: Participating in a whole of government project to onboard the 'Envizi' platform, an emissions reporting software tool with an anticipated delivery by the end of 2026.

Transportation: Complying with the State Government's State Electric Vehicle Strategy, in which 1 in every 2 new vehicles is battery electric. This includes planning for purchasing and installing electric vehicle chargers for 189 Royal Street to ensure practicality of the department's fleet.

46,822 kg of waste diverted from landfill



30,972 kg of secure paper for shredding



5,049 kg of organics



4,226 kg of recyclable material such as glass and plastic bottles



6,382 kg paper, cardboard and paper towel



192 kg of recycled batteries

Key performance indicators

2025-2026

Certification of key performance indicators

For the year ended 30 June 2026

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 2026.

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
14 September 2026

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 10).

Table 10: 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 road-based ambulance services in the metropolitan area: a) Percentage of priority 1 calls attended to within 15 minutes; b) Percentage of priority 2 calls attended to within 25 minutes; c) Percentage of priority 3 calls attended to within 60 minutes	5. Aged care, continuing care and end of life care services 6. Public and community health 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 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

Table 10: Key performance indicators reported by the department

WA health system desired outcomes	Measuring effectiveness	Services	Measuring efficiency
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.

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

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

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 Programme¹⁴ 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 2025–26 target for the percentage of clients maintaining or improving functional ability is 88 per cent or above.

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

Results

Implementation of revised contract arrangements with existing service providers and the onboarding of new contracted services was completed this year with all providers fully operational. This has introduced client focused functionality assessment programs and increased therapy hours. Also, client functional outcomes are now monitored regularly to assess progress toward treatment goals. This enables therapists to make timely adjustments to treatment plans when client progress is not on track and supports reduced length of stay in the programme.

Overall, the TCP is resulting in maintained or improved Modified Barthel Index scores enabling a person to remain at home or enter residential aged care at an optimum level of physical and cognitive functioning.

14 - [Transition Care Program, Department of Health, Disability and Ageing](#)

Table 11: Percentage of transition care clients whose functional ability was either maintained or improved during their utilisation of the Transition Care Programme, 2021–22 to 2025–26

Transition care clients maintained or improved independence	2021–22	2022–23	2023–24	2024–25	2025–26
Results	85%	85%	91%	97%	97%
Target	65%	77%	82%	82%	88%

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. The target is reviewed annually taking into consideration historical data and discussion with stakeholders and subject matter experts.
3. Rounding has been applied to the overall per cent of MBI clients who maintained or improved their functional ability.

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.¹⁵ 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.

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 2025–26 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.

Results

In 2025–26, 73 per cent of clients who wished to die at home were supported to do so through the provision of in-home specialist palliative care (see Table 12). This was an improvement on the 2024–25 result of 68 per cent but comparable with findings from 2022–23 and 2023–24 at 73 per cent respectively.

Achievement of the target may be influenced by changes in an individual's care needs and personal preferences, as well as the level of family and carer support available to facilitate end-of-life care at home. For some clients their care needs and/or preference may change during their care journey such that they may choose other options such as specialist palliative care in a hospital or palliative care facility.

Table 12: Percentage of people accessing specialist community-based palliative care who opted to die at home and who were supported to die at home, 2021–22 to 2025–26

Patients supported to die in the comfort of their home	2021–22	2022–23	2023–24	2024–25	2025–26
Results	78%	73%	73%	68%	73%
Target	76%	76%	76%	76%	76%

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.
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 who died at home after nominating this as their desired place of death.
4. There are 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 part of a concurrent data quality improvement project; however, these do not materially affect comparability with prior years.

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

15 - 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>

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 2024 target for each selected common cause of premature death is based on the 2023 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	2.0
(c) Malignant skin cancers	0.3
(d) Breast cancer (females only)	1.6
(e) Bowel cancer	1.1

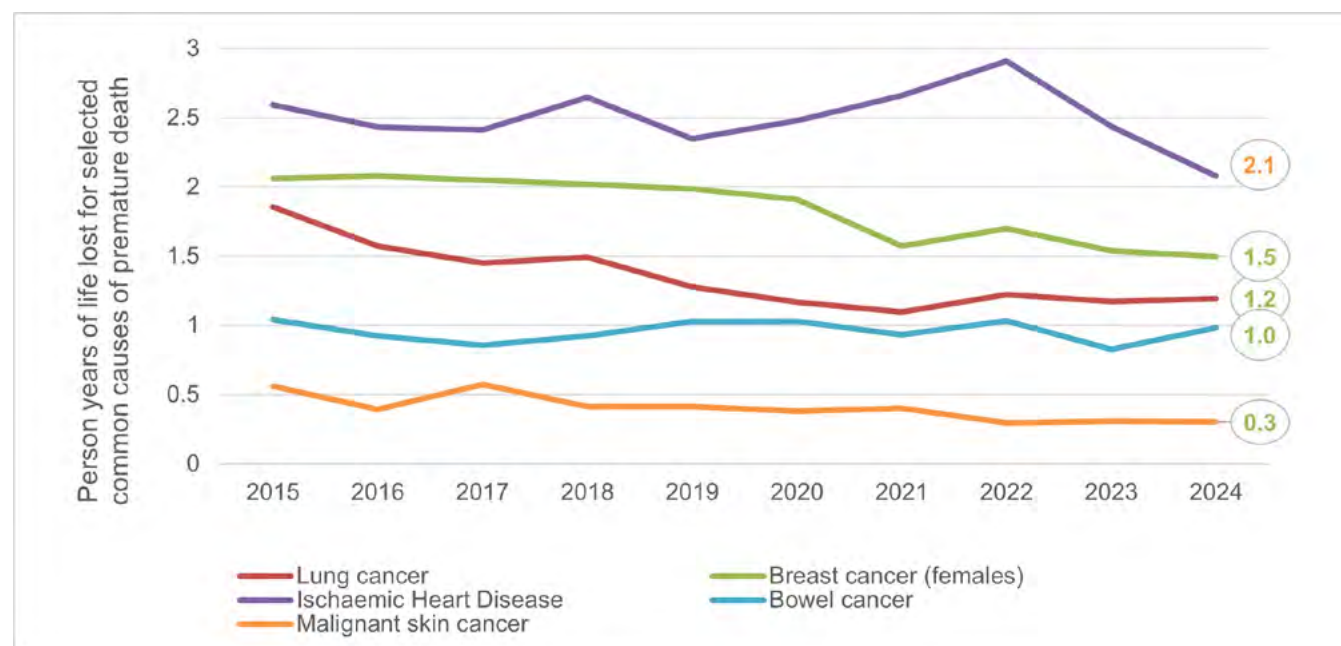
Improved or maintained performance is demonstrated by a result below or equal to the target.

Results

In 2024, the results 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 2.1, exceeding the target of 2.0 (see Figure 2).

Potential years of life lost due to cancer of the lung has remained below target since 2019, while breast cancer stabilised from 2023. Potential years of life lost due to malignant skin cancers has been maintained since 2022 and for bowel cancer it has remained below target annually.

Figure 2: Person years of life lost for selected common causes of premature death, 2015 to 2024



Notes:

1. Age-standardised Person Years of Life Lost (PYLL) per 1,000 population.
2. Deaths for 2015 to 2022 are final, deaths for 2023 are revised, and deaths for 2024 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.

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.

Improved or maintained performance is demonstrated by a result equal to or above the target.¹⁶

Results

In 2025, 89.7 per cent of children in WA received all recommended vaccines at 12 months, 2 years, and 5 years of age (see Table 13). This remains below the immunisation coverage target of 95 per cent and continues the gradual downward trend observed since 2021.

Children at 2 years of age continued to have the lowest rates of immunisation (87.4 per cent) statewide. Immunisation coverage for children aged 12 months and 2 years remained lower among Aboriginal children compared to non-Aboriginal children across both metropolitan and country WA. However, at 5 years of age, catch-up coverage for Aboriginal and non-Aboriginal children were comparable at approximately 92 per cent (see Table 13).

Our results reflect the continued national trend of reduced vaccination coverage in children relative to pre-pandemic levels. Factors contributing to these ongoing declines are complex and multifaceted, including both vaccine acceptance and access issues.

The [Western Australian Immunisation Strategy 2024–2028](#) provides a clear roadmap to strengthen immunisation across the State. The strategy aims to reduce the incidence of vaccine preventable diseases by improving immunisation access, acceptance, and increase demand and uptake, while enhancing the systems that provide and support immunisation service delivery.

This includes enhancing the physical, informational, language and cultural accessibility of immunisation services and specialist clinics to ensure vaccines are readily accessible. Collaboration with communities to co-design evidence-based initiatives continues to be critical to addressing barriers and improving vaccination uptake.

In September 2025, representatives from 10 community-based organisations came together to identify barriers to vaccinations and generate practical solutions to improve access and confidence in immunisation. Participants proposed 71 solutions to address identified barriers providing valuable insights to help shape future initiatives. This marked an important step in strengthening partnerships with the community and will become an annual forum for the immunisation program.

¹⁶ - The national aspirational immunisation coverage target has been set at 95 per cent (Department of Health and Aged Care: [Essential Vaccines Schedule - Variation to June 2025 - Signed .pdf](#)), based on national best practice recommendations under the Immunise Australia Program.

Table 13: Percentage of children fully immunised, by selected age cohort, location and Aboriginality, 2021 to 2025

Children fully immunised		2021	2022	2023	2024	2025	Target
Total of all children (12 months; 2 years; 5 years) (%)		93.1	92.4	91.5	90.5	89.7	≥95.0
12 months (%)							
Total						89.6%	≥95.0
State	Aboriginal	87.0	86.6	84.9	85.6	85.5	
	Non-Aboriginal	94.5	93.8	92.3	91.5	90.0	
Metropolitan	Aboriginal	86.8	88.0	84.7	85.8	86.5	
	Non-Aboriginal	94.8	94.0	92.8	91.9	90.6	
Country	Aboriginal	87.3	85.1	85.1	85.3	84.4	
	Non-Aboriginal	92.9	93.1	90.3	89.6	87.0	
2 years (%)							
Total						87.4%	≥95.0
State	Aboriginal	85.7	81.2	82.1	80.6	82.3	
	Non-Aboriginal	92.3	91.3	90.6	88.9	87.9	
Metropolitan	Aboriginal	84.7	82.2	83.6	81.2	83.3	
	Non-Aboriginal	92.5	91.6	90.9	89.4	88.5	
Country	Aboriginal	86.8	80.1	80.4	79.9	81.1	
	Non-Aboriginal	90.9	89.8	88.8	86.3	85.2	

Table 13: Percentage of children fully immunised, by selected age cohort, location and Aboriginality, 2021 to 2025

Children fully immunised		2021	2022	2023	2024	2025	Target
5 years (%)							
					Total	91.8%	≥95.0
State	Aboriginal	95.1	93.9	94.0	92.5	92.3	
	Non-Aboriginal	93.6	93.2	92.8	92.2	91.8	
Metropolitan	Aboriginal	95.1	94.4	94.0	92.3	91.5	
	Non-Aboriginal	93.7	93.4	93.1	92.5	92.1	
Country	Aboriginal	95.1	93.3	93.9	92.8	93.2	
	Non-Aboriginal	93.1	92.1	91.3	90.4	90.2	

Notes:

1. Data is based on children aged $12 \leq 15$ months, $24 \leq 27$ months and $60 \leq 63$ months between 1 January 2025 and 31 December 2025.
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: [Childhood immunisation 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 2025, HPV vaccination coverage among 15 year olds in WA remained below the 80 per cent target, with coverage of 78.9 per cent for females and 76.4 per cent for males (see Table 14). Overall, coverage was lower across all subgroups compared to 2024 with most notable declines for both Aboriginal males (64.4 per cent vs. 74.4 per cent) and females (70.6 per cent vs. 77.0 per cent).

Vaccination coverage remained generally lower in country WA compared to the metropolitan area again more notable for Aboriginal young people.

Our results continue to reflect broader national patterns of reduced vaccination coverage relative to pre-pandemic levels. Factors contributing to these trends are complex and multifaceted, including both access to vaccination services and vaccine acceptance among young people.

To improve overall HPV vaccination coverage, the department continues to implement initiatives under the [Western Australian Immunisation Strategy 2024–2028](#) and the recently approved *School-based Immunisation Program (SBIP) Action Plan*.

Ongoing collaboration with health service providers and partner organisations supports targeted engagement with young people to increase uptake of youth immunisation through school-based and catch-up vaccination programs. Additional activities to improve parent/carer consent processes have been implemented this year across both public and independent schools.

In collaboration with Aboriginal and Islander Education Officers (AIEOs), culturally appropriate resources are to be co-designed for school AIEO's with the aim to support informed consent, address vaccine hesitancy and improve vaccine uptake among Aboriginal youth.

Table 14: Percentage of 15 year old Western Australians who are vaccinated for HPV, by gender, 2021 to 2025

Vaccinated for HPV	2021	2022	2023	2024	2025
Females	80.9%	81.4%	84.1%	80.3%	78.9%
Males	80.2%	79.2%	83.0%	79.0%	76.4%
Target	80%	80%	80%	80%	80%

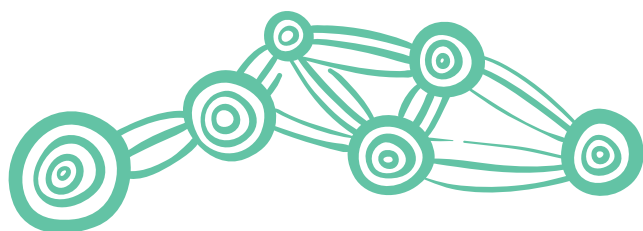


Table 15: Percentage of 15 year old Western Australians who are vaccinated for HPV, by gender, location and Aboriginal status, 2021 to 2025

Percentage of 15 year olds who are vaccinated for HPV		2021	2022	2023	2024	2025	Target
Females							
					Total	78.9	≥80.0
State	Aboriginal	65.6	69.2	81.2	77.0	70.6	
	Non-Aboriginal	81.1	82.1	84.3	80.6	79.5	
Metropolitan	Aboriginal	65.4	68.8	81.7	80.7	71.9	
	Non-Aboriginal	81.1	82.4	84.3	80.7	80.5	
Country	Aboriginal	65.8	69.6	80.7	73.4	69.3	
	Non-Aboriginal	81.1	81.1	84.1	79.9	74.7	
Males							
					Total	76.4	≥80.0
State	Aboriginal	70.9	64.5	74.3	74.4	64.4	
	Non-Aboriginal	81.6	80.1	83.5	79.3	77.2	
Metropolitan	Aboriginal	71.3	63.2	74.1	78.8	67.0	
	Non-Aboriginal	81.8	79.9	83.7	80.2	78.4	
Country	Aboriginal	70.5	65.6	74.5	70.0	62.0	
	Non-Aboriginal	80.4	80.9	82.7	75.1	71.7	

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, comparisons of vaccination rates from 2023 onwards with prior years should be interpreted with caution.
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 road-based ambulance services in the metropolitan area: a) Percentage of priority 1 calls attended to within 15 minutes; b) Percentage of priority 2 calls attended to within 25 minutes; c) Percentage of priority 3 calls attended to within 60 minutes

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. This collaboration ensures that patients have access to an effective and rapid response ambulance service, supporting the best possible health outcomes for those requiring urgent medical treatment.

Response times for emergency ambulance 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 ambulance 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 an ambulance service vehicle and crew for the following priority calls in the metropolitan area of WA:

- attend to 90 per cent of priority 1 (emergency) calls within 15 minutes
- attend to 90 per cent of priority 2 (urgent) calls within 25 minutes
- attend to 90 per cent of priority 3 (non-urgent) calls within 60 minutes.

Through surveillance of this measure over time, the effectiveness of emergency road-based ambulance services can be monitored. 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 targets for ambulance response times in the metropolitan area are:

- Priority 1 (emergency) calls attended to within 15 minutes: 90 per cent or above
- Priority 2 (urgent) calls attended to within 25 minutes: 90 per cent or above
- Priority 3 (non-urgent) calls attended to within 60 minutes: 90 per cent or above

Improved or maintained performance is demonstrated by achieving results at or above the target for each priority category.

Results

In 2025–26, 84.7 per cent of priority 1 (emergency) calls in the metropolitan area were attended to within 15 minutes, 74.4 per cent of priority 2 (urgent) calls were attended to within 25 minutes, and 76.1 per cent of priority 3 (non-urgent) calls were attended to within 60 minutes (see Table 16). Performance across all priority categories is below the target of 90 per cent.

Ambulance response times are influenced by a range of factors, including demand for emergency ambulance services, ambulance availability, hospital capacity pressures and extended transfer of care times at emergency departments. These factors can reduce ambulance availability and impact response performance across all priority categories.

In 2025–26, we saw an increase in overall service demand including a 6.4 per cent increase in priority 1 cases and 4.7 per cent in priority 2 cases, when compared to 2024–25. Despite this increase priority 1 calls attended on time was 1.7 per cent higher than last year (83.3 per cent) while priority 2 and 3 response times attended on time remained constant. 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, were observed and may have attributed to the below target response times.

Work continued during 2025–26 to improve access to timely ambulance services and support system-wide patient flow. Initiatives included the expansion of the State Health Operations Centre to include long-stay patient operations with a dedicated team improving discharge pathways and funding arrangements for patients with complex needs. The WA Virtual Emergency Department (WAVED) also continues to deliver rapid virtual care and has strengthened paediatric clinical support with the launch of WAVEDKids in November 2025.

These initiatives aim to improve access to emergency care and increase ambulance availability for patients requiring an urgent clinical response.

Table 16: Response times for road-based ambulance services in the metropolitan area, by priority 2025–26

Priority call attendance and response times	2025–26	Target
Priority 1 (emergency) within 15 minutes	84.7%	90%
Priority 2 (urgent) within 25 minutes	74.4%	90%
Priority 3 (non-urgent) within 60 minutes	76.1%	90%

Notes:

1. KPI results are based on ambulance response times for patients in the Perth metropolitan area.
2. From 2025–26, the KPI definition has been revised to include priority 1 (emergency), priority 2 (urgent) and priority 3 (non-urgent) incidents, with separate response time targets for each category. This revision reflects a shift towards a more comprehensive evaluation of ambulance service performance across multiple levels of clinical urgency.
3. Historical results presented in this table are based on the previous KPI definition (Priority 1 only) and are provided for reference purposes only.

Priority 1 calls	2021–22	2022–23	2023–24	2024–25
Results	81.6%	85.4%	86.3%	83.3%
Target	90%	90%	90%	90%

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 2025–26 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 2025–26, 78 per cent of respondents agreed the department had met the expectations of their organisation in the delivery of the twelve functions of the system manager (see Table 17). This represents a decrease of 9.6 per cent compared to 2024–25, although results remain above the target of 75 per cent.

For the majority of respondents expectations were met for 'stewardship of the WA public health system to ensure long-term sustainability and quality of public health service care' (93.3 per cent), and 'advising and assisting the Minister for Health in the development and implementation of system-wide planning' (93.8 per cent).

The department also demonstrated strengths in the 'management of system wide industrial relations' (87.5 per cent) and 'strategic leadership and direction in relation to capital works' (86.7). For just over eight in 10 respondent's expectations were met with the issuing of policy frameworks to set standards and ensure a consistent approach in health service provision (81.3 per cent), and budget and resource allocation to support the delivery of health services (81.3 per cent).

Areas identified for increased focus related to strengthening strategic leadership, improved engagement with health service providers, and management of performance data and analysis of trends and issues.

Table 17: Proportion of stakeholders indicating the department meets or exceeds expectations for system manager functions, 2021–22 to 2025–26

Met stakeholder expectations	2021–22	2022–23	2023–24	2024–25	2025–26
Results	59%	71%	78%	86%	78%
Target	85%	75%	75%	75%	75%

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 able to provide informed feedback on its 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 2025–26, one respondent cited not applicable to three system manager functions, while another cited not applicable to one system manager function. These responses are not included in the overall calculation of the applicable functions and comparability to prior years is cautioned.
6. 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.

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 2025–26 target unit cost per transition care day is \$519.

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

Results

In 2025–26, the average cost per transition care day was \$449, below the target of \$519 (see Table 18).

Transition Care Programme service delivery increased again this year primarily attributable to the increased availability of residential and community places in both metropolitan and rural areas, plus a higher number of referrals to the program across multiple sites. Expenditure to activity increased comparatively. Additional funding was also provided for the new Transition Care Program at Home Plus that provides enhanced supports for patients such as a wearable device and daily virtual wellbeing checks for added safety.

Table 18: Average cost of a transition care day provided by contracted non-government organisations/service providers, 2021–22 to 2025–26

	2021–22	2022–23	2023–24	2024–25	2025–26
Average cost	\$352	\$382	\$442	\$460	\$449
Target	\$318	\$334	\$334	\$475	\$519

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 2025–26 target unit cost per:

- a) home-based hospital day of care is \$350
- b) home-based hospital occasion of service is \$166.

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

Results

In 2025–26, the average cost per home-based hospital day of care was \$375, above the target of \$350 but comparable with the prior year result (see Table 19). The Hospital in the Home service is designed to provide acute care for patients in their home that would otherwise be provided at a public hospital. In the past year, the increased number of referrals from public hospitals resulted in a 10.8 per cent increase in days of care, well above contracted activity levels. Associated expenditure also increased.

Table 19: Average cost per home-based hospital day of care, 2021–22 to 2025–26

	2021–22	2022–23	2023–24	2024–25	2025–26
Average cost	\$320	\$335	\$366	\$379	\$375
Target	\$301	\$308	\$322	\$336	\$350

In 2025–26, the average cost per home-based hospital occasion of service was \$167, slightly above the target of \$166 (see Table 20). Compared to 2024–25, demand increased for complex nursing services (11 per cent) and the Hospital Discharge Support program (34 per cent) associated with higher than expected referrals from general practitioners, community-based medical practitioners and major metropolitan hospitals. Associated expenditure increased to support the delivery of these services.

Table 20: Average cost per home-based hospital occasion of service, 2021–22 to 2025–26

	2021–22	2022–23	2023–24	2024–25	2025–26
Average cost	\$140	\$141	\$158	\$163	\$167
Target	\$145	\$143	\$149	\$165	\$166

Notes:

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.

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 2025–26 target unit cost per day of non-acute bed-based continuing support is \$787.

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

Results

The 2025–26 actual cost per activity was \$918, above the target of \$787 (see Table 21).

The number of clients with complex disability supported this year was comparable with 2024–25 with less than 2 per cent increase per unit cost observed. The results reflect established and fully operational services supporting individuals with disability to transition from hospital to home following commencement of the program in 2022–23.

Implementation and expansion of From Hospital to Home disability transition support services was not included at derivation of the target. This combined with anticipated funding and activity adjustments to prior year contractual arrangements for rehabilitation services for young people with complex care needs resulted in a target set well below expected expenditure.

Table 21: Average cost per day of non-acute bed-based continuing support, 2021–22 to 2025–26

	2021–22	2022–23	2023–24	2024–25	2025–26
Average cost	\$783	\$862	\$888	\$908	\$918
Target	\$799	\$775	\$814	\$834	\$787

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 2025–26 target unit cost to support patients who suffer specific chronic conditions and people who require continuing care is \$19.

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

Results

In 2025-26, the average cost to support people who experience activity limitation or have a long-term health condition requiring continuing care was \$25, above the target of \$19 but comparable with last year (see Table 22). The provision of community aids and equipment, and home modifications continue to benefit people with long term health, disability or age-related functional impairment living at home. Funding of the Community Aids and Equipment Program was not included at derivation of the target.

Table 22: Average cost to support patients who suffer specific chronic illness and other clients who require continuing care, 2021–22 to 2025–26

	2021–22	2022–23	2023–24	2024–25	2025–26
Average cost	\$19	\$19	\$19	\$26	\$25
Target	\$25	\$19	\$20	\$21	\$19

Notes:

Long-term health conditions are categorised according to the International Classification of Diseases, 10th Revision (ICD-10), for the Survey of Disability, Ageing and Carers (SDAC). In 2024, the coding of long-term health conditions was updated and applied retrospectively to the 2022 SDAC data to improve the 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 2025–26 target unit cost per client receiving contracted palliative care services is \$11,773.

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

Results

In 2025–26, the average cost per per client receiving contracted palliative care services was \$10,925, below the target of \$11,773 but comparable to the prior year (see Table 23). Increased demand for palliative care services was seen across the majority of service providers with a notable increase in the number of clients supported. This was partly attributable to efforts taken to reduce the number of long stay hospital patients improving patient throughput and reducing overall patient care costs.

Table 23: Average cost per client receiving contracted palliative care services, 2021–22 to 2025–26

	2021–22	2022–23	2023–24	2024–25	2025–26
Average cost	\$8,461	\$9,356	\$8,608	\$10,612	\$10,925
Target	\$8,487	\$8,942	\$9,131	\$9,302	\$11,773

Notes:

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.

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 2025–26 target unit cost to provide preventive interventions, health promotion and health protection activities is \$70 per person.

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

Results

In 2025–26, the average cost per person for providing preventive interventions, health promotion and health protection activities was \$88 (see Table 24). This result is above the target of \$70 but comparable with last year.

Immunisation programs accounted for 36 per cent of overall expenditure 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 including the 'Be Wise. Immunise' campaign.

Increased expenditure this year was seen in response to a significant outbreak of diphtheria requiring case management, contact tracing, laboratory testing, vaccination and

community engagement. Also, with syphilis declared a Communicable Disease Incident of National Significance, funding was provided to support public health units, community based organisations and Aboriginal community-controlled health services to provide culturally appropriate outreach education, community based testing, and engagement with people who face barriers to mainstream health services. A statewide syphilis advertising campaign ran from October to December 2025 to raise awareness of this preventable sexually transmitted infection.

We continued to support health and medical research and innovation that equates to 25 per cent of overall expenditure.

Table 24: Cost per person of providing preventive interventions, health promotion and health protection activities that reduce the incidence of disease or injury, 2021–22 to 2025–26

	2021–22	2022–23	2023–24	2024–25	2025–26
Average cost	\$237	\$90	\$102	\$84	\$88
Target	\$149	\$174	\$49	\$58	\$70

Data sources: 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 2025–26 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 2025–26, the cost per trip for road-based ambulance and patient transport services was \$685, above the target of \$659 (see Table 25).

The increase in demand for non-emergency transport (31 per cent) and mental health patient transfer (14 per cent) continued to increase when compared to 2024–25. These changes in demand are aligned with increased market presence and consumer awareness.

Additional expenditure this year was associated with the co-location of St John WA within the State Health Operations Centre. Also, new initiatives including the Aboriginal and Torres Strait Islander Patient Transport Trial, Extended Care Paramedic Trial and Clinical Hub Expansion.

Table 25: Cost per trip for road-based patient transport services, based on the total accrued costs of these services for the total number of trips, 2021–22 to 2025–26

	2021–22	2022–23	2023–24	2024–25	2025–26
Cost per trip	\$534	\$680	\$655	\$705	\$685
Target	\$523	\$553	\$673	\$659	\$659

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 2025–26 target unit cost per head of population to provide public health regulatory services is \$5.

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

Results

In 2025–26 the cost of public health regulatory services per head of population was \$7. This is above the target of \$5 and that of prior year expenditure from 2022–23 (Table 26).

The increase is primarily attributable to the uplift and increase in regulatory functions in relation to tobacco and vape compliance including storage and destruction of contraband. These changes are aligned with the recent amendments to the [Tobacco and Other Products Control Act 2006](#) that allows for expanded enforcement powers and tougher penalties aimed at disrupting illegal operators and deterring organised criminal activity linked to illicit tobacco and e-cigarette distribution. Cost increases are inclusive of the expansion

of our Tobacco and Vape Compliance Unit strengthening the State's ability to investigate unlawful activity, undertake targeted enforcement operations and reduce the supply of illicit products within the community.

Table 26: Average cost of public health regulatory services per head of population, 2021–22 to 2025–26

	2021–22	2022–23	2023–24	2024–25	2025–26
Cost per trip	\$8	\$6	\$6	\$6	\$7
Target	\$6	\$7	\$7	\$8	\$5

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. In 2025–26, illicit tobacco compliance regulatory functions were introduced.

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 2025–26 target unit cost to undertake system manager functions per full time equivalent worker is \$5,061.

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

Results

In 2025–26, the cost for the department to undertake system manager functions per health service provider full time equivalent was \$5,540 (see Table 27). This is above the target but comparable with expenditure over the past 2 years noting a slight decrease of 2 per cent from 2024–25.

Through a range of interconnected reform initiatives, we continue to streamline how we deliver health services, tackling high emergency department presentations, bed capacity, discharge delays, and elective surgery and outpatient wait times.

The Emergency Access Reform initiative continues to support system-level improvements including the operation of the State Health Operations Centre (SHOC). Expansion of SHOC

services this year is associated with increases in infrastructure and operational expenditure.

We also focused on improving access to primary healthcare through the Sexual Health Quarters Day Procedure Centre at Cockburn and expansion of the Advanced Practice Pharmacy program enabling appropriately trained pharmacists to diagnose and provide treatment for a defined range of common health conditions in the community.

Table 27: Average cost for the department to undertake system manager functions per health service provider full time equivalent, 2021–22 to 2025–26

	2021–22	2022–23	2023–24	2024–25	2025–26
Average cost	\$7,022	\$5,490	\$5,778	\$5,905	\$5,540
Target	\$5,337	\$4,632	\$4,752	\$4,516	\$5,061

Note:

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

2025-2026

Financial disclosures

Summary of board and committee remuneration

The total annual remuneration in 2025–26 for all department boards and committees was \$528,808 (see Table 28). This is an increase of approximately 17 per cent compared to board and committee remuneration in 2024–25.

The WA Health Central Human Research Ethics Committee (\$194,916) and Voluntary Assisted Dying Board (\$135,980) were paid the highest remuneration in 2025–26. Remuneration for the WA Health Central Human Research Ethics Committee increased significantly with the expansion of the committee's responsibilities following the consolidation of functions performed by the Department of Health Human Research Ethics Committee and six Health Service Provider Human Research Ethics Committees into a single central committee, creating efficiencies and a more streamlined approach to research ethics review across WA Health.

Remuneration for the Western Australian Reproductive Technology Council is comparable to 2024–25.

The Western Australian Future Health Research and Innovation Fund Advisory Council remuneration decreased by 19 per cent compared to 2024–25 due to fewer additional meetings required following the completion of the FHRI Fund Strategy.

Table 28: Summary of WA State Government boards and committees remunerated by the Department of Health, 2025–26

Board/Committee name	Total remuneration (\$)
Anaesthetic Mortality Committee	13,097
Department of Health Human Research Ethics Committee	5,304
Fluoridation of Public Water Supplies Advisory Committee	927
Human Tissue Advisory Body	0
Local Health Authorities Analytical Committee	3,708
Maternal Mortality Committee	0
Perinatal and Infant Mortality Committee	46,024
Pesticides Advisory Committee	0
Postgraduate Medical Council of Western Australia	618
Radiological Council	13,287
Stimulant Assessment Panel	2,287
Voluntary Assisted Dying Board	135,980
WA Health Central Human Research Ethics Committee	194,916
Western Australian Future Health Research and Innovation Fund Advisory Council	58,750
Western Australian Reproductive Technology Council	48,298
Western Australian Reproductive Technology Council Preimplantation Genetic Testing Committee	5,612
Total	528,808

Note: The department 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.

Consultant expenditure for strategic advice

In 2025–26, the department incurred a total of \$902,520 to obtain strategic advice provided by a contractor on a fee for service basis.

The engagement of consultants and associated expenditure of:

1. Less than \$50,000 included 6 consultants with expenditure totalling \$160,476 including GST.
2. Greater than \$50,000 included 4 consultants with expenditure totalling \$742,044 including GST (see Table 29).

Table 29: Strategic consultant expenditure greater than \$50,000, 2025–26

Consultant	Title of project	Amount
Churchill Capital Consulting Pty Ltd (Trading as Sia Partners)	Development of the <i>Future Health Research and Innovation (FHRI) Fund Strategy 2025–2030</i>	\$96,643
Deloitte Touche Tohmatsu	Evaluation of the Nurse Practitioner and Team Based Primary Care Pilot	\$249,346
FTI Consulting	Priority Strategic Social Health Policy Program initiatives	\$224,455
Paxon Consulting Group	Economic evaluation, cost analysis and demand modelling for priority Strategic Social Health Policy Program Initiatives	\$171,600
Total consultancy expenditure		\$742,044

Note:

1. Strategic advice is defined as advice that has the potential to influence State Government policy or decisions provided under a contractual engagement on a fee for service basis. It is intended for government to action, not just for the agency's internal use.
2. Contracted services may extend across more than one reporting period with an end date that may be beyond the date of final delivery of the service, to allow for administrative matters to be completed. Contract deliverables completed prior to 2025–26 but where the final expiry date of the contract was reached within the reporting period (and no payments were made), have not been included. Expenditure reported is for payments that occurred in 2025–26 based on agreed contractual terms.

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 is treated 'free of charge'. This arrangement is consistent with the Medicare principles embedded in the *Health Services Act 2016*.

Most 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 2025–26, in accordance with section 175ZE of the *Electoral Act 1907*, the department incurred a total advertising expenditure of \$3,622,425 (see Table 30). This is an increase of 26 per cent compared to last year's total of \$2,881,310.

The majority of 2025–26 advertising was for media advertising services (47 per cent) and market research services (41 per cent). Advertising expenditure was primarily related to community immunisation including for influenza and respiratory syncytial virus, sexual health, and activity aligned to the winter strategy and the 'Where to go When' campaign.

Table 30: Summary of advertising expenditure, 2025–26

Summary of advertising	Amount (\$)
Advertising agencies	434,166
Market research organisations	1,483,327
Polling organisations	0
Direct mail organisations	3,955
Media advertising organisations	1,700,977
Total advertising expenditure	3,622,425

Table 31: Advertising by class of expenditure, 2025–26

Recipient/organisations	Amount (\$)
Advertising agencies	
Wildings Creative	101,398
Bonfire Digital Pty Ltd	13,167
Cooch Creative Pty Ltd	14,322
Kiosk Creative Services Pty Ltd	32,072
The Better Health Company	7,700
Spotlight Cinema Advertising	14,097
Rare Creative Thinking	251,410
Total	434,166
Market research organisations	
Edith Cowan University	1,184,253
University of New South Wales	66,741
CoreData WA Pty Ltd	129,820
Metrix Consulting Pty Ltd	54,956
Ccentric International Pty Ltd	14,667
Painted Dog Research Pty Ltd	32,890
Total	1,483,327
Direct mail organisations	
Essendex Australia Pty Ltd	3,914
Quickmail	41
Total	3,955
Media advertising organisations	
Carat Australia Media Services Pty Ltd	1,585,934
Facebook	2,662
JBCC Enterprises Pty Ltd	5,686
Initiative Media Australia Pty Ltd	106,695
Total	1,700,977
Total advertising expenditure	3,622,425

Major capital projects

In 2025–26, the department administered 28 major capital projects (see Table 32 and 33). Of these projects, 16 were managed by the department and 12 were managed by the Office of Major Infrastructure Delivery on behalf of WA Health. The budgets for the projects managed by the Office of Major Infrastructure Delivery were centrally administered by the department and provisioned to health service providers.

Table 32: Major capital works in progress during 2025–26

Project name	Expected year of completion	Estimated remaining cost to complete (\$'000)	Estimated total cost of project 2025–26 (\$'000)	Estimated total cost of project 2024–25 (\$'000)	Variation from previous financial year* (\$'000)
Medical Equipment and Imaging Replacement Program	Ongoing	93,002	748,818	705,562	43,256
Minor Building Works Program	Ongoing	23,486	205,119	215,020	-9,901
Statewide 24/7 Telestroke Service	TBC	2,200	2,352	2,384	-32
Electronic Medical Record (EMR)	TBC	121,519	221,780	218,433	3,347
Statewide Cladding (a)	Ongoing	28,130	28,130	2,206	25,924
Australian Standard 5369 Reprocessing of Reusable Medical Devices (b)	Ongoing	5,050	7,584	2,842	4,742
Outpatient Reform (Smart Referrals)	2026–27	4,086	4,372	4,372	0
State Health Operations Centre (c)	2025–26	4,300	22,046	18,529	3,517

Table 32: Major capital works in progress during 2025–26

Project name	Expected year of completion	Estimated remaining cost to complete (\$'000)	Estimated total cost of project 2025–26 (\$'000)	Estimated total cost of project 2024–25 (\$'000)	Variation from previous financial year* (\$'000)
Mental Health Commission (MHC) Karratha Step Up/Step Down facility (d)	2025–26	14,802	19,674	7,743	11,931
Anti-Ligature Remediation Program – Statewide	2026–27	26,305	27,549	27,846	-297
Perth Health Innovation Hub	2026–27	12,246	14,556	15,332	-776
MHC Broome Step Up/Step Up Down facility (e)	2026–27	9,000	10,890	10,900	-10
MHC South Hedland Step Up/Step Down facility	2027–28	5,079	10,159	10,159	0
MHC Youth Step Up/Step Down facility	2027–28	5,288	6,088	6,088	0
QEII Medical Centre Access and Transport Planning (f)	Ongoing	8,950	8,950	N/A	8,950
Sexual Health Quarters Day Procedure Centre at Cockburn (g)	N/A	1,305	1,305	N/A	1,305

Table 33: Office of Major Infrastructure Delivery (OMID) managed projects

Project name	Expected year of completion	Estimated remaining cost to complete (\$'000)	Estimated total cost of project 2025–26 (\$'000)	Estimated total cost of project 2024–25 (\$'000)	Variation from previous financial year* (\$'000)
New Women and Babies Hospital Project	2028–29	994,485	1,781,937	1,784,755	-2,818
Graylands Campus Project	In planning	186,212	186,212	184,717	1,465
Claremont Therapeutic Riding Centre (h)	2027–28	10,629	10,629	N/A	10,629
Bunbury Hospital Redevelopment Project	2028–29	404,176	471,487	451,147	20,340
Geraldton Health Campus Redevelopment Project (i)	2025–26	112,487	190,199	166,069	24,130
Meekatharra Hospital Redevelopment	2027–28	47,624	48,987	48,987	0
Tom Price Hospital Redevelopment	2027–28	32,371	32,745	32,822	-77
Albany Health Campus Expansion (j)	2026–27	1,000	1,000	N/A	1,000
Peel Health Campus Transformation Program	2028–29	117,017	142,948	142,697	251
Bentley Health Service Surgicentre	2028–29	164,802	166,684	167,002	-318
Royal Perth Hospital (RPH) Emergency Department (ED) Expansion (k)	2028–29	5,000	5,000	N/A	5,000
St John of God Midland Hospital ED Expansion (l)	In planning	5,000	5,000	N/A	5,000

Note:

- The above information is based upon the:
 - 2024–25 published budget papers as reported in the 2024–25 Department of Health (DOH) Annual Report
 - 2025–26 published budget papers.
- Completion timeframes are based upon a combination of approved delivery schedule, scope and budget at the time of reporting and may be subject to change from one reporting period to the next. Reporting on the expected year of completion of projects is based on practical completion noting the defects liability period may be included in the estimated costs.
- Only capital projects that were controlled or administered by the department are reflected in both tables.
- Budgeted expense capital (BEC) has been excluded from the current year's estimated total project cost to ensure alignment with the published budget papers.
- A variance represents the difference between the estimated total cost of the project in the 2025–26 published budget papers in comparison to the estimated total cost of the project as reported in the

2024–25 Department of Health Annual Report. An explanation is provided below where a variance is greater than or equal to 10 per cent.

- (a) Additional \$25.9 million was approved as part of the 2025–26 Budget for cladding works at the Perth Children's Hospital. The department amount is for resourcing and other cladding related costs.
- (b) Additional \$5 million was approved as part of the 2025–26 Budget for planning and key infrastructure works, with the remaining variance due to adjustment to BEC.
- (c) Additional \$4 million was approved as part of the 2024–25 Mid-Year Review, with the remaining variance due to adjustment to BEC. SHOC reached the end of the defects liability period in December 2025, however the project cannot be closed until a residual funding reprioritization process is undertaken.
- (d) Additional \$11.9 million was approved as part of the 2024–25 Mid-Year Review. Practical completion achieved in January 2026. Final project completion and closeout will be progressed following the expiration of the defects liability period (1 year).
- (e) No budget allocated in the 2025–26 Budget for 2026–27, however a re-cash-flow of budget will be actioned to meet anticipated practical completion in 2027.

- (f) New project approved as part of the 2025–26 Budget for car parking initiatives at QEII.
- (g) New project approved as part of the 2025–26 Budget to establish the Women's Reproductive Health Day Procedure Centre at Cockburn Health. This funding has subsequently been transferred to recurrent funding and not part of the Capital Works program.
- (h) New project approved as part of the 2025–26 Budget for the relocation and new build of the Claremont Therapeutic Riding Centre.
- (i) Additional \$22.6 million was approved as part of the 2024–25 Mid-Year Review. A further \$1.6 million was approved as part of the 2025–26 Budget to commence planning for services and critical workforce commissioning.
- (j) New project approved as part of the 2025–26 Budget.
- (k) New project approved as part of the 2025–26 Budget.
- (l) New project approved as part of the 2025–26 Budget.

Unauthorised use of purchasing cards

Purchasing cards are used for low value purchases of goods and services enabling efficiencies in purchasing and review processes.

Staff are issued purchasing cards subject to the meeting of certain criteria and appropriate justification. Obligations of cardholders are regularly communicated. This includes the type of goods and services that cannot be procured using purchasing cards and the prohibition of purchasing cards for personal purchases.

Cardholders who do use a purchasing card for a personal purpose must give written notice to the accountable authority within 5 working days and refund the total amount of expenditure. There were 9 instances of purchasing cards being used for personal purposes in 2025–26 by 9 cardholders, amounting to \$351 (see Table 34).

To ensure purchasing card transactions are approved in a timely manner new processes have been implemented to improve compliance by cardholders. This includes daily automated email reminders and notification post closure of the purchasing card period to both cardholders and accountable authority's of outstanding transactions. Ongoing non-compliance is now escalated and reported monthly to senior executive.

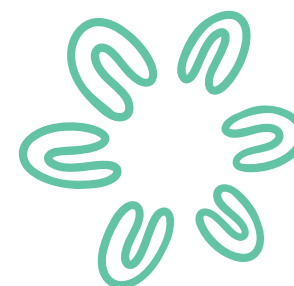
Table 34: Personal use expenditure by purchasing card holders, 2025–26

Credit card personal expenditure	Amount (\$)
Aggregate amount of personal use expenditure for 2025–26	350.73
Aggregate amount of personal use expenditure settled within 5 working days	77.42
Aggregate amount of personal use expenditure settled after 5 working days	273.31
Aggregate amount of personal use expenditure outstanding at the end of 2025–26	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](#).



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Auditor General

INDEPENDENT AUDITOR'S REPORT

2026

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 2026, 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 2026 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 2026 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 it determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

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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

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, 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 2026, and the controls were implemented as designed as at 30 June 2026.

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.

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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 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 2026 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 2026 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 2026.

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 *Financial 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.

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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 Department'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 - 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 2026, 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.

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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 for the year ended 30 June 2026 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 Department to confirm the information contained in the website version.



Aloha Morrissey
Acting Auditor General for Western Australia
Perth, Western Australia
14 September 2026

Certification of financial statements

Department of Health

Certification of financial statements

For the financial year ended 30 June 2026

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 2026 and the financial position as at 30 June 2026.

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 Pippa Beamish Burton
Chief Finance Officer
Department of Health

14 September 2026



Dr Shirley Bowen
Director General
Department of Health
Accountable Authority

14 September 2026

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Statement of comprehensive income

For the year ended 30 June 2026

	Notes	2026 \$'000	2025 \$'000
COST OF SERVICES			
Expenses			
Employee benefits expenses	3.1(a)	249,249	230,219
Contracts for services	3.3	844,455	781,099
Supplies and services	3.4	92,668	92,433
Grants and subsidies	3.2	11,079,992	10,298,578
Depreciation and amortisation expenses	5.1, 5.2, 5.3	3,544	3,063
Loss on disposal of non-current assets	4.6	10	147
Finance costs	7.3	85	92
Other expenses	3.5	54,982	62,257
Total cost of services		12,324,985	11,467,888
Income			
User charges and fees	4.2	30,413	25,789
Commonwealth grants and contributions	4.3	3,406,509	3,123,343
Other grants and contributions	4.4	10,646	642
Other income	4.5	10,235	11,105
Total income		3,457,803	3,160,879
NET COST OF SERVICES		8,867,182	8,307,009

Statement of comprehensive income (continued)

For the year ended 30 June 2026

	Notes	2026 \$'000	2025 \$'000
Income from State Government			
Service appropriation	4.1	8,703,700	8,160,831
Income from other public sector entities	4.1	104,935	119,228
Resources received	4.1	871	716
Royalties for Regions Fund	4.1	13,569	14,439
Total income from State Government		8,823,075	8,295,214
SURPLUS/(DEFICIT) FOR THE PERIOD		(44,107)	(11,795)
OTHER COMPREHENSIVE INCOME			
Items not reclassified subsequently to profit or loss			
Changes in asset revaluation reserve	9.11	640	553
Total other comprehensive income		640	553
TOTAL COMPREHENSIVE INCOME FOR THE PERIOD		(43,467)	(11,242)

The Statement of comprehensive income should be read in conjunction with the accompanying notes.

Statement of financial position

As at 30 June 2026

	Notes	2026 \$'000	2025 \$'000
ASSETS			
Current assets			
Cash and cash equivalents	7.1	77,984	129,992
Restricted cash and cash equivalents	7.1	111,768	128,561
Inventories	6.1	26,988	27,626
Receivables	6.2	119,782	109,868
Other current assets	6.4	46,473	6,433
Total current assets		382,995	402,480
Non-current assets			
Receivables	6.2	4,481	4,481
Amounts receivable for services	6.3	81,610	88,351
Infrastructure, property, plant and equipment	5.1	341,511	78,762
Intangible assets	5.2	22,849	3,425
Right-of-use assets	5.3	1,489	2,065
Other non-current assets	6.4	-	-
Total non-current assets		451,940	177,084
TOTAL ASSETS		834,935	579,564
LIABILITIES			
Current liabilities			
Payables	6.5	116,804	133,818
Contract liabilities	6.6	272	2,157
Lease liabilities	7.2	714	663
Employee related provisions	3.1(b)	45,010	38,973
Total current liabilities		162,800	175,611

Statement of financial position (continued)

As at 30 June 2026

	Notes	2026 \$'000	2025 \$'000
Non-current liabilities			
Lease liabilities	7.2	789	1,415
Employee related provisions	3.1(b)	14,613	13,950
Total non-current liabilities		15,402	15,365
TOTAL LIABILITIES		178,202	190,976
NET ASSETS		656,733	388,588
Equity			
Contributed equity	9.11	510,408	198,796
Reserves	9.11	282,625	281,985
Accumulated surplus/(deficit)	9.11	(136,300)	(92,193)
TOTAL EQUITY		656,733	388,588

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 2026

Notes	Contributed equity \$'000	Reserves \$'000	Accumulated surplus/(deficit) \$'000	Total equity \$'000
Balance at 1 July 2024	99,485	281,432	(80,398)	300,519
<i>Changes in accounting policy or correction of prior period errors</i>	-	-	-	-
Restated 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
Balance at 1 July 2025	198,796	281,985	(92,193)	388,588
<i>Changes in accounting policy or correction of prior period errors</i>	-	-	-	-
Restated balance at 1 July 2025	198,796	281,985	(92,193)	388,588
Surplus/(deficit)	-	-	(44,107)	(44,107)
Other comprehensive income	-	640	-	640
Total comprehensive income for the period	-	640	(44,107)	(43,467)
Transactions with owners in their capacity as owners:	9.11			
Capital appropriation	326,199	-	-	326,199
Other contributions by owners	-	-	-	-
Distribution to owners	(14,587)	-	-	(14,587)
<i>Restructure of administrative arrangements:</i>				
Net asset received	-	-	-	-
Net asset transferred out	-	-	-	-
Total contributed equity	311,612	-	-	311,612
Balance at 30 June 2026	510,408	282,625	(136,300)	656,733

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 2026

	Notes	2026 \$'000	2025 \$'000
CASH FLOWS FROM STATE GOVERNMENT			
Service appropriation		8,254,288	7,720,792
Capital appropriation		326,199	102,214
Funds from other public sector entities		104,935	115,678
Royalties for Regions Fund		13,569	14,439
Net cash provided by State Government		8,698,991	7,953,123
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Employee benefits		(242,549)	(224,806)
Supplies and services		(995,258)	(832,197)
Grants and subsidies		(10,623,306)	(9,855,033)
Finance costs		(85)	(92)
GST payments on purchases		(693,887)	(598,309)
Receipts			
User charges and fees		30,413	25,789
Commonwealth grants and contributions		3,339,113	3,051,118
GST receipts on sales		30,825	29,530
GST receipts from taxation authority		651,199	570,061
Other receipts		20,881	11,747
Net cash used in operating activities	7.1.3	(8,482,654)	(7,822,192)
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments			
Purchase of non-current assets		(284,396)	(27,477)
Net cash used in investing activities		(284,396)	(27,477)

Statement of cash flows (continued)

For the year ended 30 June 2026

	Notes	2026 \$'000	2025 \$'000
CASH FLOWS FROM FINANCING ACTIVITIES			
Payments			
Principal element of lease payments		(742)	(742)
Net cash used in financing activities		(742)	(742)
Net increase/(decrease) in cash and cash equivalents		(68,801)	102,712
Cash and cash equivalents at the beginning of the period		258,553	155,841
CASH AND CASH EQUIVALENTS AT THE END OF THE PERIOD	7.1.1	189,752	258,553

The Statement of cash flows should be read in conjunction with the accompanying notes.

Administered schedules

For the year ended 30 June 2026

Administered income and expenses by services

	Public Hospital Admitted Services		Public Hospital Emergency Services		Public Hospital Non-Admitted Services		Mental Health Services	
	2026 \$'000	2025 \$'000	2026 \$'000	2025 \$'000	2026 \$'000	2025 \$'000	2026 \$'000	2025 \$'000
Expenses								
Funding transferred to:								
Health service providers	362,748	212,627	106,915	56,231	93,896	52,512	82,589	48,747
State Pool Account and State Managed Fund Account administered for Mental Health Commission:								
Transfer of activity based funding to health service providers	-	-	-	-	-	-	899,876	484,846
Transfer of block funding to health service providers	-	-	-	-	-	-	292,253	639,574
Service concession arrangement depreciation expense (a)	-	-	-	-	-	-	-	-
Total administered expenses	362,748	212,627	106,915	56,231	93,896	52,512	1,274,718	1,173,167
Income								
Administered for WA health system:								
Capital appropriation	293,978	151,365	75,533	33,710	72,670	36,745	65,158	34,460
Administered appropriation	10,435	14,218	1,592	2,667	3,097	3,032	2,574	3,463
Royalties for Regions Fund	25,840	50,796	12,301	24,182	7,278	14,307	5,962	11,720
Commonwealth grants and contributions	-	-	-	-	-	-	-	-
Contribution from Department of Health	-	-	-	-	-	-	-	-
State Pool Account and State Managed Fund Account administered for Mental Health Commission:								
Commonwealth activity based funding	-	-	-	-	-	-	334,519	159,360
Commonwealth block funding	-	-	-	-	-	-	121,319	217,356
State activity based funding	-	-	-	-	-	-	565,357	325,486
State block funding	-	-	-	-	-	-	170,934	422,218
Service concession arrangement revenue (a)	-	-	-	-	-	-	-	-
Total administered income	330,253	216,379	89,426	60,559	83,045	54,084	1,265,823	1,174,063

Administered schedules (continued)

For the year ended 30 June 2026

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	
	2026 \$'000	2025 \$'000	2026 \$'000	2025 \$'000	2026 \$'000	2025 \$'000	2026 \$'000	2025 \$'000
Expenses								
Funding transferred to:								
Health service providers	37,099	18,059	111,494	46,996	2,004	9,265	-	-
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	37,099	18,059	111,494	46,996	2,004	9,265	-	-
Income								
Administered for WA health system:								
Capital appropriation	22,766	8,771	71,579	24,437	2,004	11,897	-	-
Administered appropriation	51	387	4,713	1,178	-	-	-	-
Royalties for Regions Fund	5,876	11,552	13,872	27,270	-	-	-	-
Commonwealth grants and contributions	-	-	-	-	-	-	-	-
Contribution from Department of Health	-	-	-	-	-	-	-	-
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	28,693	20,710	90,164	52,885	2,004	11,897	-	-

Administered schedules (continued)

For the year ended 30 June 2026

Administered income and expenses by services (continued)

	Small Rural Hospital Services		Health System Management - Policy and Corporate Services		Health Support Services		Total	
	2026 \$'000	2025 \$'000	2026 \$'000	2025 \$'000	2026 \$'000	2025 \$'000	2026 \$'000	2025 \$'000
Expenses								
Funding transferred to:								
Health service providers	66,237	30,038	325,209	115,598	122,779	129,480	1,310,970	719,553
State Pool Account and State Managed Fund Account administered for Mental Health Commission:								
Transfer of activity based funding to health service providers	-	-	-	-	-	-	899,876	484,846
Transfer of block funding to health service providers	-	-	-	-	-	-	292,253	639,574
Service concession arrangement depreciation expense (a)	-	-	3,759	3,646	-	-	3,759	3,646
Total administered expenses	66,237	30,038	328,968	119,244	122,779	129,480	2,506,858	1,847,619
Income								
Administered for WA health system:								
Capital appropriation	38,699	12,808	383,701	85,483	82,629	19,161	1,108,717	418,837
Administered appropriation	-	288	314	20,005	33,271	117,428	56,047	162,666
Royalties for Regions Fund	11,338	22,288	106,597	-	-	-	189,064	162,115
Commonwealth grants and contributions	-	-	-	-	-	-	-	-
Contribution from Department of Health	-	-	-	-	-	-	-	-
State Pool Account and State Managed Fund Account administered for Mental Health Commission:								
Commonwealth activity based funding	-	-	-	-	-	-	334,519	159,360
Commonwealth block funding	-	-	-	-	-	-	121,319	217,356
State activity based funding	-	-	-	-	-	-	565,357	325,486
State block funding	-	-	-	-	-	-	170,934	422,218
Service concession arrangement revenue (a)	-	-	5,474	5,474	-	-	5,474	5,474
Total administered income	50,037	35,384	496,086	110,962	115,900	136,589	2,551,431	1,873,512

Administered schedules (continued)

For the year ended 30 June 2026

- (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 assets and liabilities

	2026 \$'000	2025 \$'000
Current assets		
Cash and cash equivalents	229,397	186,539
Total administered current assets	229,397	186,539
Non-current assets		
Service concession assets	171,242	150,360
Amounts receivable for services	6,440	6,440
Total administered non-current assets	177,682	156,800
TOTAL ADMINISTERED ASSETS	407,079	343,339
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)	56,930	62,404
Total administered non-current liabilities	56,930	62,404
TOTAL ADMINISTERED LIABILITIES	63,354	68,828

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 2026

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 has 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 14 September 2026.

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*).

The department is exempt 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.

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, the Department of Transport was renamed the Department of Transport and Major Infrastructure, with its role expanded to consolidate major project planning and delivery across the public sector through the establishment of the State's Office of Major Infrastructure Delivery (OMID). Effective 1 July 2025, the project planning and delivery functions, together with the associated staff, of the Department of Health's Office of Major Health Infrastructure Delivery were transferred to OMID. The value of leave provisions transferred to OMID from the department totalled \$777,555.

Through this reform, a new partnership delivery model has been established under which OMID is responsible for the planning and delivery of major health capital works projects, while the Department of Health retains accountability for health service planning and operational and service delivery requirements.

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 2026

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
Department objectives	2.1
Schedule of income and expenses by service	2.2
Schedule of assets and liabilities by service	2.3

Notes to the financial statements

For the year ended 30 June 2026

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 2026

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 include 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 include 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 2026

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	
	2026	2025	2026	2025	2026	2025	2026	2025
	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000
COST OF SERVICES								
Expenses								
Employee benefits expenses	-	-	8,298	4,616	-	-	-	-
Contracts for services	-	-	2,835	2,731	-	-	-	-
Supplies and services	-	-	58	5	-	-	-	-
Grants and subsidies	6,045,057	5,596,390	1,313,214	1,215,681	1,317,398	1,215,960	35,076	33,050
Depreciation and amortisation expenses	-	-	-	-	-	-	-	-
Loss on disposal of non-current assets	-	-	-	-	-	-	-	-
Finance costs	-	-	-	-	-	-	-	-
Other expenses	-	-	187	89	-	-	-	-
Total cost of services	6,045,057	5,596,390	1,324,592	1,223,122	1,317,398	1,215,960	35,076	33,050
Income								
User charges and fees	-	-	-	-	-	-	-	-
Commonwealth grants and contributions	1,901,182	1,780,437	462,731	387,369	553,326	463,210	82	68
Other grants and contributions	-	-	-	-	-	-	-	-
Other income	-	-	-	-	-	-	-	-
Gains								
Gain on disposal of non-current assets	-	-	-	-	-	-	-	-
Total income other than income from State Government	1,901,182	1,780,437	462,731	387,369	553,326	463,210	82	68
NET COST OF SERVICES	4,143,875	3,815,953	861,861	835,753	764,072	752,750	34,994	32,982
Income from State Government								
Service appropriation	4,128,684	3,814,946	858,724	832,872	761,360	752,673	34,909	32,879
Income from other public sector entities	-	-	-	-	-	-	-	-
Resources received	-	-	-	-	-	-	-	-
Royalties for Regions Fund	827	1,007	148	181	64	77	85	103
Total income from State Government	4,129,511	3,815,953	858,872	833,053	761,424	752,750	34,994	32,982
SURPLUS/(DEFICIT) FOR THE PERIOD	(14,364)	-	(2,989)	(2,700)	(2,648)	-	-	-

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 2026

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	
	2026	2025	2026	2025	2026	2025	2026	2025
	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000
COST OF SERVICES								
Expenses								
Employee benefits expenses	2,182	1,630	33,038	29,715	-	-	-	-
Contracts for services	244,479	229,917	531,829	452,615	-	-	17,148	16,284
Supplies and services	1,856	795	87,627	88,219	-	-	-	-
Grants and subsidies	188,498	197,341	912,184	928,033	207,829	195,158	117,310	109,747
Depreciation and amortisation expenses	-	-	1,046	882	-	-	-	-
Loss on disposal of non-current assets	-	-	-	33	-	-	-	-
Finance costs	-	-	22	3	-	-	-	-
Other expenses	546	226	6,416	19,158	-	-	-	-
Total cost of services	437,561	429,909	1,572,162	1,518,658	207,829	195,158	134,458	126,031
Income								
User charges and fees	-	-	24,011	20,144	-	-	-	-
Commonwealth grants and contributions	132,081	104,780	59,787	123,907	1,911	1,600	11,570	9,686
Other grants and contributions	-	-	-	10	-	-	-	-
Other income	1,799	140	7,940	10,536	-	-	-	-
Gains								
Gain on disposal of non-current assets	-	-	-	-	-	-	-	-
Total income other than income from State Government	133,880	104,920	91,738	154,597	1,911	1,600	11,570	9,686
NET COST OF SERVICES	303,681	324,989	1,480,424	1,364,061	205,918	193,558	122,888	116,345
Income from State Government								
Service appropriation	349,308	344,459	1,383,041	991,046	185,918	193,558	121,962	103,472
Income from other public sector entities	-	-	49,584	52,711	-	-	-	-
Resources received	-	-	-	-	-	-	-	-
Royalties for Regions Fund	318	388	10,135	10,258	-	-	-	-
Total income from State Government	349,626	344,847	1,442,760	1,054,015	185,918	193,558	121,962	103,472
SURPLUS/(DEFICIT) FOR THE PERIOD	45,945	19,858	(37,664)	(310,046)	(20,000)	-	(926)	(12,873)

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 2026

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	
	2026	2025	2026	2025	2026	2025	2026	2025
	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000
COST OF SERVICES								
Expenses								
Employee benefits expenses	-	-	205,731	194,258	-	-	249,249	230,219
Contracts for services	-	-	48,164	79,552	-	-	844,455	781,099
Supplies and services	-	-	3,127	3,414	-	-	92,668	92,433
Grants and subsidies	383,076	356,088	163,232	78,080	397,118	373,050	11,079,992	10,298,578
Depreciation and amortisation expenses	-	-	2,498	2,181	-	-	3,544	3,063
Loss on disposal of non-current assets	-	-	10	114	-	-	10	147
Finance costs	-	-	63	89	-	-	85	92
Other expenses	-	-	47,833	42,784	-	-	54,982	62,257
Total cost of services	383,076	356,088	470,658	400,472	397,118	373,050	12,324,985	11,467,888
Income								
User charges and fees	-	-	6,402	5,645	-	-	30,413	25,789
Commonwealth grants and contributions	158,202	132,437	125,635	119,849	-	-	3,406,507	3,123,343
Other grants and contributions	-	-	10,650	632	-	-	10,650	642
Other income	-	-	494	429	-	-	10,233	11,105
Gains								
Gain on disposal of non-current assets	-	-	-	-	-	-	-	-
Total income other than income from State Government	158,202	132,437	143,181	126,555	-	-	3,457,803	3,160,879
NET COST OF SERVICES	224,874	223,651	327,477	273,917	397,118	373,050	8,867,182	8,307,009
Income from State Government								
Service appropriation	222,882	221,226	259,794	500,650	397,118	373,050	8,703,700	8,160,831
Income from other public sector entities	-	-	55,351	66,517	-	-	104,935	119,228
Resources received	-	-	871	716	-	-	871	716
Royalties for Regions Fund	1,992	2,425	-	-	-	-	13,569	14,439
Total income from State Government	224,874	223,651	316,016	567,883	397,118	373,050	8,823,075	8,295,214
SURPLUS/(DEFICIT) FOR THE PERIOD	-	-	(11,461)	293,966	-	-	(44,107)	(11,795)

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 2026

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	
	2026	2025	2026	2025	2026	2025	2026	2025
	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000
Assets								
Current assets	-	-	-	-	-	-	-	-
Non-current assets	-	-	-	-	-	-	-	-
TOTAL ASSETS	-	-	-	-	-	-	-	-
Liabilities								
Current liabilities	642	-	-	-	-	-	-	-
Non-current liabilities	-	-	-	-	-	-	-	-
TOTAL LIABILITIES	642	-	-	-	-	-	-	-
NET ASSETS	(642)	-	-	-	-	-	-	-

	Aged Care, Continuing Care and End of Life Care Services		Public and Community Health Services		Pathology Services		Community Dental Health Services	
	2026	2025	2026	2025	2026	2025	2026	2025
	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000
Assets								
Current assets	-	-	83,704	33,542	-	-	-	-
Non-current assets	-	-	5,114	5,516	-	-	-	-
TOTAL ASSETS	-	-	88,818	39,058	-	-	-	-
Liabilities								
Current liabilities	6,707	16,778	55,621	26,798	-	-	3,147	1,170
Non-current liabilities	-	-	487	437	-	-	-	-
TOTAL LIABILITIES	6,707	16,778	56,108	27,235	-	-	3,147	1,170
NET ASSETS	(6,707)	(16,778)	32,710	11,823	-	-	(3,147)	(1,170)

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 2026

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	
	2026 \$'000	2025 \$'000	2026 \$'000	2025 \$'000	2026 \$'000	2025 \$'000	2026 \$'000	2025 \$'000
Assets								
Current assets	-	-	299,291	368,938	-	-	382,995	402,480
Non-current assets	-	-	446,826	171,568	-	-	451,940	177,084
TOTAL ASSETS	-	-	746,117	540,506	-	-	834,935	579,564
Liabilities								
Current liabilities	-	-	96,684	130,865	-	-	162,801	175,611
Non-current liabilities	-	-	14,914	14,928	-	-	15,401	15,365
TOTAL LIABILITIES	-	-	111,598	145,793	-	-	178,202	190,976
NET ASSETS	-	-	634,519	394,713	-	-	656,733	388,588

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 2026

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

	2026 \$'000	2025 \$'000
Employee benefits	223,424	206,981
Superannuation - defined contributions plans	25,811	22,739
Termination benefits	14	499
Total employee benefits expenses	249,249	230,219
Add: AASB 16 Non-monetary benefits (not included in employee benefits expense)	216	205
Less: Employee contributions (per the Statement of comprehensive income)	(45)	(40)
Net employee benefits	249,420	230,384

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.

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.

Notes to the financial statements

For the year ended 30 June 2026

3.1(b) Employee related provisions

	2026 \$'000	2025 \$'000
Current employee benefits provisions		
Annual leave	25,540	22,487
Long service leave	19,307	16,330
Deferred salary scheme	163	156
Total current employee related provisions	45,010	38,973
Non-current employee benefits provisions		
Long service leave	14,613	13,950
Total non-current employee related provisions	14,613	13,950
Total employee related provisions	59,623	52,923

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:

	2026 \$'000	2025 \$'000
Within 12 months of the end of the reporting period	13,406	11,815
More than 12 months after the end of the reporting period	12,134	10,672
	25,540	22,487

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.

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.

Notes to the financial statements

For the year ended 30 June 2026

3.1(b) Employee related provisions (continued)

Assessments indicate that actual settlement of the liabilities is expected to occur as follows:

	2026 \$'000	2025 \$'000
Within 12 months of the end of the reporting period	4,435	3,864
More than 12 months after the end of the reporting period	29,485	26,416
	33,920	30,280

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:

	2026 \$'000	2025 \$'000
Within 12 months of the end of the reporting period	163	156
More than 12 months after the end of the reporting period	-	-
	163	156

Employment on-costs

The settlement of annual and long service leave liabilities gives rise to the payment of employment on-costs including workers' compensation insurance. Employment on-costs, including workers' compensation insurance, are not employee benefits and are recognised separately as liabilities and expenses when the employment to which they relate has occurred. Employment on-costs are included as part of Note 3.5 'Other expenses' and are not included as part of the Department's 'employee benefits expense'.

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.

Notes to the financial statements

For the year ended 30 June 2026

3.2 Grants and subsidies

	2026 \$'000	2025 \$'000
Recurrent		
Funding for the delivery of health services by statutory authorities within the WA health system (a):		
Child and Adolescent Health Service (b)	990,726	901,067
East Metropolitan Health Service (b)	2,001,585	1,831,998
North Metropolitan Health Service (b)	2,502,559	2,333,118
South Metropolitan Health Service (b)	2,406,469	2,186,044
WA Country Health Service (b)	2,451,810	2,360,358
Health Support Services (b)	387,991	373,106
PathWest Laboratory Medicine WA (b)	211,853	195,605
Queen Elizabeth II Medical Centre Trust (b)	1,238	844
Quadriplegic Centre (b)	4,199	4,469
Research and development grants	58,810	60,610
Podiatry subsidy scheme	19	29
Other grants and subsidies	62,733	51,330
Total grants and subsidies	11,079,992	10,298,578

(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.

Notes to the financial statements

For the year ended 30 June 2026

3.3 Contracts for services

	2026 \$'000	2025 \$'000
Health care services provided by external organisations (a)	788,681	726,961
Shared services provided by Health Support Services (b)	18,918	16,914
Other contracts for services	36,856	37,224
Total contracts for services	844,455	781,099

(a) Included patient transport cost \$359.0 million in 2025–26 (\$326.6 million in 2024–25) and aged care service cost \$237.4 million in 2025–26 (\$222.2 million in 2024–25).

(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.

3.4 Supplies and services

	2026 \$'000	2025 \$'000
Medical supplies (a)	89,472	89,700
Communications	1,404	1,407
Other consumables	1,792	1,326
Total supplies and services	92,668	92,433

(a) Medical supplies included \$82.7 million of vaccine costs for 2025–26 (\$77.6 million in 2024–25).

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 2026

3.5 Other expenses

	2026 \$'000	2025 \$'000
Advertising	1,903	2,695
Computer related expenses	6,667	4,672
Ex-gratia payments (a)	8,267	6,992
Expected credit losses expense (b)	53	(2)
Freight and cartage	2,146	2,049
Insurance	113	396
Legal expenses (c)	3,458	2,964
Other employee related expenses (d)	4,216	3,754
Promotional expenses	262	181
Rental (e)	18,877	17,378
Repairs and maintenance (f)	1,024	948
Scholarships	2,583	3,155
Stock write down (g)	1,106	12,866
Special functions	685	548
Subscriptions	2,138	2,126
Write-off of debt	2	48
Other	1,482	1,487
Total other expenses	54,982	62,257

- (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 \$8.3 million for 2025–26 (\$1.4 million for East Metropolitan Health Service, \$2.1 million for North Metropolitan Health Service, \$3.9 million for South Metropolitan Health Service and \$0.9 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.
- (c) **Legal expenses** in the current reporting period contain a provision for developments in legal proceedings as result of management reassessing the likelihood of an outflow of economic benefits based on legal advice and available evidence. Refer to note 8.2.2 Contingent liabilities.
- (d) **Other employee related expenses** include workers' compensation insurance and other employment on costs. The oncosts liability associated with the recognition of annual and long service leave liabilities is included at note 3.1(b) Employee related provisions. Superannuation contributions accrued as part of the provision for leave are employee benefits and are not included in employment on-costs.
- (e) **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

Notes to the financial statements

For the year ended 30 June 2026

- (iv) Office rental expenses which are expensed as incurred, as Memorandum of Understanding Agreements between the department and the Department of Housing and Works for the leasing of office accommodation contain significant substitution rights.

Notes to the financial statements
For the year ended 30 June 2026

3.5 Other expenses (continued)

- (f) **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.
- (g) **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 \$1.1 million of vaccines written down in 2025–26 (\$3.5 million in 2024–25). In addition, \$nil million (\$9.4 million in 2024–25) of medical equipment purchased during the COVID-19 pandemic was written down due to loss of service potential.

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 2026

4.1 Income from State Government

Appropriation received during the period:

Service appropriation

2026 \$'000	2025 \$'000
8,516,497	7,976,345

Amount authorised by other statutes:

Salaries and Allowances Act 1975

Lotteries Commission Act 1990

1,350	1,314
185,853	183,172

Total appropriation

8,703,700	8,160,831
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Income received from other public sector entities during the period:

Department of Treasury and Finance - WA Future Health Research and Innovation Account

Department of Education - school health services for students attending public schools

Mental Health Commission - Clinical and emergency response

Insurance Commission of WA - Motor injury insurance scheme

WA Police - provision of data services

WA health system statutory authorities - various services provided by the department

Other

49,300	52,400
12,078	11,503
1,751	6,091
41,258	48,550
213	113
335	345
-	226

Total income from other public sector entities

104,935	119,228
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Notes to the financial statements

For the year ended 30 June 2026

4.1 Income from State Government (continued)

	2026 \$'000	2025 \$'000
Resources received from other public sector entities during the period:		
Department of Education - accommodation	-	1
Landgate - valuation services and land information	95	199
State Solicitor's Office - legal service	645	431
Department of Primary Industries and Regional Development - digital map downloads	50	18
Department of Housing and Works - office accommodation management	-	67
Western Australia Police Force - staff secondment	81	-
Total resources received	871	716
Royalties for Regions Fund		
Regional Community Services Account:		
Regional Workers Incentives	4,169	5,165
Find Cancer Early Program	410	411
Paid Paramedics for the Regions	8,990	8,863
Total Royalties for Regions Fund	13,569	14,439
Total income from State Government	8,823,075	8,295,214

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 2026

4.1 Income from State Government (continued)

Summary of consolidated account appropriations

For the year ended 30 June 2026

	Budget \$'000	Section 25 transfers \$'000	Additional Funding* \$'000	Revised Budget \$'000	Actual \$'000	Variance \$'000
Delivery of services						
Item 58 Net amount appropriated to deliver services	7,971,775	12,912	531,810	8,516,497	8,516,497	-
Amount Authorised by Other Statutes						
- <i>Salaries and Allowances Act 1975</i>	1,350	-	-	1,350	1,350	-
- <i>Lotteries Commission Act 1990</i>	169,446	-	28,933	198,379	198,379	-
Total appropriations provided to deliver services	8,142,571	12,912	560,743	8,716,226	8,716,226	-
Capital						
Item 135 Capital appropriation	553,737	110,253	76,335	740,325	729,973	(10,352)
Administered transactions on behalf of the Department of Treasury and Finance						
Item 38 Administered grants, subsidies and other transfer payments	12,266	(11,135)	57,992	59,123	-	(59,123)
Item 122 Administered capital appropriation	144,348	(99,901)	-	44,447	-	(44,447)
Total administered transactions on behalf of the Department of Treasury and Finance	156,614	(111,036)	57,992	103,570	-	(103,570)
Total consolidated account appropriations	8,852,922	12,129	695,070	9,560,121	9,446,199	(113,922)

* 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 2026

4.2 User charges and fees

	2026 \$'000	2025 \$'000
Licence and registration fees	5,213	4,569
Cross border charges	23,743	20,144
Other user charges and fees	1,457	1,076
Total user charges and fees	30,413	25,789

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 \$30,052,375 (\$25,515,161 in 2024-25).
 - over-time for \$360,302 (\$272,996 in 2024-25).

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 2025–26 Budget Statements, the department retained \$527.2 million in 2025–26 (\$371.3 million in 2024–25) from the following:

- proceeds from fees and charges
- sale of goods
- Commonwealth specific purpose grants, including a one-off NHRA payment
- other departmental revenue.

Notes to the financial statements

For the year ended 30 June 2026

4.3 Commonwealth grants and contributions

	2026 \$'000	2025 \$'000
Recurrent grants - cash		
National Health Reform Agreement (a):		
Statutory authorities within WA health system	2,946,166	2,827,661
Public health division within the department	65,668	60,972
Specific purpose grants:		
NHRA one off payment received via State Treasury	158,134	-
Department of Veterans' Affairs	52,559	45,076
Aged Care Programs	61,635	61,148
Community Health and Hospitals Program	6,278	-
Disability Support for Older Australians	4,341	4,469
Public Health Outcome Funding Agreement - Vaccines	3,366	2,850
Public Dental Services for Adults	9,686	17,785
Other programs	31,280	31,157
Recurrent grants - non-cash		
Essential vaccines received free of charge	67,396	72,225
Total Commonwealth grants and contributions	3,406,509	3,123,343

- (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 2026

4.4 Other grants and contributions

	2026 \$'000	2025 \$'000
Research grants	474	409
Contributions - Health programs WA are participating	10,000	-
Other	172	233
Total other grants and contributions	10,646	642

4.5 Other income

	2026 \$'000	2025 \$'000
General public contributions and donations	4,000	6,000
Interest income	3,407	4,251
Return of unspent funding	2,827	854
Total other income	10,235	11,105

4.6 Gains/(losses) on disposal

	2026 \$'000	2025 \$'000
Net proceeds from disposal of non-current assets		
Infrastructure, property, plant and equipment	-	-
Non-current assets classified as assets held for sale	-	-
Carrying amount of non-current assets disposed		
Infrastructure, property, plant and equipment	(10)	(147)
Non-current assets classified as assets held for sale	-	-
Net gains/(losses) on disposal of non-current assets	(10)	(147)

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 2026

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 2026	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 2025										
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	-	-	-	-	-	-	-	-	-	-
Carrying amount at start of period	19,898	805	153	10,878	99	8	4,303	42,537	81	78,762
Additions	-	-	-	35	44	8	478	278,799	-	279,364
Cost adjustment	-	-	-	-	-	-	-	-	-	-
Disposals	-	-	-	-	(10)	-	-	-	-	(10)
Expensed	-	-	-	-	-	-	-	-	-	-
Transfers from/(to) other reporting entities (a)(b)	(9,305)	-	-	-	-	-	-	(5,281)	-	(14,586)
Revaluation increments/(decrements)	518	109	12	-	-	-	-	-	-	639
Impairment losses	-	-	-	-	-	-	-	-	-	-
Impairment losses reversed	-	-	-	-	-	-	-	-	-	-
Depreciation	-	(65)	(12)	(1,895)	(32)	(2)	(652)	-	-	(2,658)
Carrying amount at 30 June 2026	11,111	849	153	9,018	101	14	4,129	316,055	81	341,511
Gross carrying amount	11,111	849	153	14,716	252	49	6,266	316,055	81	349,532
Accumulated depreciation	-	-	-	(5,698)	(151)	(35)	(2,137)	-	-	(8,021)
Accumulated impairment loss	-	-	-	-	-	-	-	-	-	-

(a) The transfer of a Land parcel to Department of Planning, Lands and Heritage (\$8.950m) and the transfer of land parcels to WA Country Health Service (\$0.355m)

(b) Temporary Carparks constructed as part of the New Women and Babies Hospital transferred to South Metropolitan Health Service (\$5.281m)

Notes to the financial statements

For the year ended 30 June 2026

5.1 Infrastructure, property, plant and equipment (continued)

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	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	-	-	-	-	-	-	-	-	-	-

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 2026

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 2025, with valuations performed during the year ended 30 June 2026 and recognised at 30 June 2026.

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.

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 2026

5.1.1 Depreciation and impairment charge for the period

	Notes	2026 \$'000	2025 \$'000
Depreciation			
Buildings	5.1	65	71
Site infrastructure	5.1	12	16
Leasehold improvement	5.1	1,895	1,485
Computer equipment	5.1	32	29
Furniture and fittings	5.1	2	5
Other plant and equipment	5.1	652	500
Total depreciation for the period		2,658	2,106

As at 30 June 2026 there were no indications of impairment to property, plant and equipment or site infrastructure.

All surplus assets at 30 June 2026 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 2026

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 2026

1 July 2025

Gross carrying amount

Accumulated amortisation

Carrying amount at start of period

Additions

Capitalised

Disposals

Expensed

Amortisation expense

Carrying amount at 30 June 2026

Gross carrying amount

Accumulated amortisation

	Computer software \$'000	Works in progress \$'000	Total \$'000
	1,455	3,231	4,686
	(1,261)	-	(1,261)
	194	3,231	3,425
Additions	-	19,618	19,618
Capitalised	-	-	-
Disposals	-	-	-
Expensed	-	-	-
Amortisation expense	(194)	-	(194)
	-	22,849	22,849
Gross carrying amount	1,454	22,849	24,303
Accumulated amortisation	(1,454)	-	(1,454)

Notes to the financial statements

For the year ended 30 June 2026

5.2 Intangible assets (continued)

Year ended 30 June 2025

1 July 2024

Gross carrying amount

Accumulated amortisation

Carrying amount at start of period

Additions

Capitalised

Disposals

Expensed

Amortisation expense

Carrying amount at 30 June 2025

Gross carrying amount

Accumulated amortisation

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.

Computer software \$'000	Works in progress \$'000	Total \$'000
1,455	109	1,564
(970)	-	(970)
485	109	594
-	3,231	3,231
-	-	-
-	-	-
-	(109)	(109)
(291)	-	(291)
194	3,231	3,425
1,455	3,231	4,686
(1,261)	-	(1,261)

Notes to the financial statements

For the year ended 30 June 2026

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

	2026 \$'000	2025 \$'000
Computer software	194	291
Total amortisation for the period	194	291

As at 30 June 2026 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 2026

5.3 Right-of-use assets

Year ended 30 June 2026

1 July 2025

Gross carrying amount

Accumulated depreciation

Carrying amount at start of period

Additions

Disposals

Transfers

Depreciation

Carrying amount at 30 June 2026

Gross carrying amount

Accumulated depreciation

Year ended 30 June 2025

1 July 2024

Gross carrying amount

Accumulated depreciation

Carrying amount at start of period

Additions

Disposals

Transfers

Depreciation

Carrying amount at 30 June 2025

Gross carrying amount

Accumulated depreciation

Buildings	Vehicles	Total
\$'000	\$'000	\$'000
3,103	935	4,038
(1,654)	(319)	(1,973)
1,449	616	2,065
46	70	116
-	-	-
-	-	-
(522)	(170)	(692)
973	516	1,489
3,149	894	4,043
(2,176)	(378)	(2,554)
Buildings	Vehicles	Total
\$'000	\$'000	\$'000
3,008	752	3,760
(1,152)	(292)	(1,444)
1,856	460	2,316
95	320	415
-	-	-
-	-	-
(502)	(164)	(666)
1,449	616	2,065
3,103	935	4,038
(1,654)	(319)	(1,973)

Notes to the financial statements

For the year ended 30 June 2026

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 Housing and Works for the leasing of office accommodation. These are not recognised under AASB 16 *Leases* because of substitution rights held by the Department of Housing and Works 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 2026

5.3 Right-of-use assets (continued)

The following amounts relating to leases have been recognised in the Statement of comprehensive income:

	2026 \$'000	2025 \$'000
Depreciation expense of right-of-use assets	692	666
Lease interest expense	85	92
Expenses relating to variable lease payments not included in lease liabilities	54	67
Low-value leases	18	23
Operating leases	18,806	17,286
Total amount recognised in the statement of comprehensive income	19,655	18,134

The total cash outflow for right-of-use leases in 2026 was \$742,062 (2025: \$742,062). As at 30 June 2026, there were no indications of impairment to right-of-use assets.

Notes to the financial statements

For the year ended 30 June 2026

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

	2026 \$'000	2025 \$'000
Current		
Drug supplies	26,988	27,626
Total inventories	26,988	27,626

At the reporting date, write-downs totalling \$1.1 million in 2025–26 (\$12.9 million in 2024–25) have been made comprising:

- drug supplies which were adjusted to reflect expired stock of \$1.1 million in 2025–26 (\$3.5 million in 2024–25)

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 2026

6.2 Receivables

	2026 \$'000	2025 \$'000
Current		
Trade receivables (a)	12,446	1,456
Allowance for impairment of trade receivables (b)	(791)	(738)
Accrued revenue	49,862	60,920
GST receivable (c)	58,265	48,230
	119,782	109,868
Non-current		
Accrued salaries account (d)	4,481	4,481
	4,481	4,481
Total receivables	124,263	114,349

(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 Other expenses 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 2026

6.2.1 Movement in the allowance for impairment of trade receivables

	2026 \$'000	2025 \$'000
Reconciliation of changes in the allowance for impairment of trade receivables		
Opening balance	738	740
Expected credit losses expense	53	(2)
Amounts written off during the period	-	-
Allowance for impairment at end of period	791	738

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)

	2026 \$'000	2025 \$'000
Current	-	-
Non-current	81,610	88,351
Total amounts receivable for services at end of period	81,610	88,351

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).

6.4 Other assets

	2026 \$'000	2025 \$'000
Current		
Prepayments (a)(b)	41,436	6,433
Investments (c)	5,037	-
Total current assets	46,473	6,433
Non-current		
Prepayments (a)	-	-
Total non-current assets	-	-
Total other assets at end of period	46,473	6,433

(a) Increases in prepayments are attributable to the new partnership delivery model that has been established under which OMID is prepaid for the planning and delivery of major health capital works projects for Department of Health, notably the New Women and Babies Hospital and Graylands Campus Project. OMID retains accountability for health service planning and operational and service delivery requirements.

Notes to the financial statements

For the year ended 30 June 2026

- (b) 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. No prepayments to the National Blood Authority under the National Blood Agreement in 2025–26 were paid (\$5.1 million in 2024–25).
- (c) The department made investments in medical research organisations to support the objectives of the Future Health Research and Innovation Fund (FHRI Fund).

6.5 Payables

	2026 \$'000	2025 \$'000
Current		
Trade payables	15,741	13,547
Accrued salaries	10,532	8,308
Accrued expenses	90,531	111,963
Total payables at end of period	116,804	133,818

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.

6.6 Contract liabilities

	2026 \$'000	2025 \$'000
Current	272	2,157
Non-current	-	-
Total contract liabilities at end of period	272	2,157

	2026 \$'000	2025 \$'000
Reconciliation of changes in contract liabilities		
Opening balance	2,157	1,657
Additions	272	2,157
Revenue recognised in the reporting period	(2,157)	(1,657)
Total contract liabilities at end of period	272	2,157

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 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 2026

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

	2026 \$'000	2025 \$'000
Cash and cash equivalents	77,984	129,992
Restricted cash and cash equivalents	111,768	128,561
Total cash and cash equivalents at end of period	189,752	258,553

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.

7.1.2 Restricted cash and cash equivalents

	2026 \$'000	2025 \$'000
Restricted cash and cash equivalents		
Capital works	20,946	34,640
Commonwealth specific purpose grants (a)	47,049	40,053
Donation - HBF Detect Snapshot	15	492
Telethon - WA Child Research Fund Account (b)	13,873	13,116
WA Future Health Research and Innovation Account (c)	29,793	39,826
Other	92	434
Total restricted cash and cash equivalents	111,768	128,561

- (a) Funds held for specific purposes include Aged Care Programs \$19.1 million in 2025–26 (\$15.9 million in 2024–25), DVA \$7.9 million in 2025–26 (\$3.4 million in 2024–25), Essential Vaccines Schedule \$6.9 million in 2025–26 (\$5.2 million in 2024–25) and other initiatives and programs \$13.1 million in 2025–26 (\$15.6 million in 2024–25).
- (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 2026

7.1.3 Reconciliation of net cost of services to net cash flows used in operating activities

	Notes	2026 \$'000	2025 \$'000
Net cost of services		(8,867,182)	(8,307,009)
Non-cash items:			
Depreciation and amortisation expense	5.1.1, 5.2.1, 5.3	3,544	3,063
Expected credit losses expense	6.2.1	53	(2)
Resources received free of charge	4.1	871	716
Asset transferred free of charge	5.1	(14,586)	640
Asset revaluation (increments)/decrements	5.1	(639)	(553)
Net (gain)/loss from disposal of property, plant and equipment	4.6	10	147
Finance costs	7.3	85	92
Transfer of non-cash funding to statutory authorities within WA health system	4.1	449,412	434,732
Transfer of medical equipment to statutory authorities within WA health system		-	4,343
Write down of inventory	3.5	1,106	12,866
Write-off of debt	3.5	2	48
Adjustments for other non-cash items		19	(25,824)
(Increase)/decrease in assets:			
Inventories	6.1	638	15,396
Receivables	6.2, 6.3	(3,173)	2,115
Other assets	6.4	(40,040)	2,472
Increase/(decrease) in liabilities:			
Payables	6.5	(17,014)	28,882
Contract liabilities	6.6	(1,885)	500
Lease liabilities	7.2	(575)	(229)
Employee related provisions	3.1(b)	6,700	5,413
Net cash used in operating activities		(8,482,654)	(7,822,192)

Notes to the financial statements

For the year ended 30 June 2026

7.2 Lease liabilities

	2026 \$'000	2025 \$'000
Current	714	663
Non-current	789	1,415
Total lease liabilities at end of period	1,503	2,078

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 2026

7.3 Finance costs

Lease interest expense

Finance costs expensed

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

Capital expenditure commitments, being contracted capital expenditure additional to the amounts reported in the financial statements are payable as follows:

Within 1 year

Later than 1 year and not later than 5 years

Later than 5 years

7.4.2 Private sector contracts for the provision of health services

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

Later than 1 year and not later than 5 years

Later than 5 years

2026 \$'000	2025 \$'000
85	92
85	92

2026 \$'000	2025 \$'000
831,946	325,535
888,687	1,667,756
-	-
1,720,633	1,993,291

2026 \$'000	2025 \$'000
578,614	650,511
532,962	736,496
-	142
1,111,576	1,387,149

Notes to the financial statements

For the year ended 30 June 2026

7.4.3 Other expenditure commitments

	2026 \$'000	2025 \$'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	129,079	50,754
Later than 1 year and not later than 5 years	133,189	57,799
Later than 5 years	194	-
	262,462	108,553

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 2026

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:

	2026 \$'000	2025 \$'000
Financial assets		
Cash and cash equivalents	77,984	129,992
Restricted cash and cash equivalents	111,768	128,561
Financial assets at amortised cost (a)	147,608	154,470
Total financial assets	337,360	413,023
Financial liabilities		
Financial liabilities at amortised cost (b)	118,307	135,896
Total financial liabilities	118,307	135,896

(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 2026

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.

	Total \$'000	Current \$'000	<30 days \$'000	Days past due 31-60 days \$'000	61-90 days \$'000	>91 days \$'000
30 June 2026						
Expected credit loss rate		1.69%	0.00%	4.55%	2.94%	96.39%
Estimated total gross carrying amount at default	12,446	473	10,960	176	34	803
Expected credit losses	(791)	(8)	-	(8)	(1)	(774)
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)

Notes to the financial statements

For the year ended 30 June 2026

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

	Weighted average effective interest rate %	Interest Rate Exposure				Maturity Dates					
		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
2026											
Financial Assets											
Cash and cash equivalents	-	77,984	-	-	77,984	77,984	77,984	-	-	-	-
Restricted cash and cash equivalents	-	111,768	-	-	111,768	111,768	111,768	-	-	-	-
Receivables (a)	-	65,998	-	-	65,998	65,998	30,067	14,065	14,836	6,996	34
Amounts receivable for services	-	81,610	-	-	81,610	81,610	-	-	-	81,610	-
		337,360	-	-	337,360	337,360	219,819	14,065	14,836	88,606	34
Financial Liabilities											
Payables	-	116,805	-	-	116,805	116,805	102,355	123	14,327	-	-
Lease liabilities (b)	4.77	1,503	1,503	-	-	1,503	21	167	569	746	-
		118,308	1,503	-	116,805	118,308	102,376	290	14,896	746	

(a) The amount of receivables excludes the GST receivable from the ATO (statutory receivable).

(b) The amount of lease liabilities includes \$1 million from leased buildings and \$0.5 million from leased vehicles.

Notes to the financial statements

For the year ended 30 June 2026

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

	Weighted average effective interest rate %	Interest Rate Exposure				Maturity Dates					
		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	-	-	2,078	19	160	540	1,307	52
		135,896	2,078	-	133,818	135,896	87,400	5,946	41,191	1,307	52

(c) The amount of receivables excludes the GST receivable from the ATO (statutory receivable).

(d) The amount of lease liabilities includes \$1.4 million from leased buildings and \$0.6 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.

Notes to the financial statements

For the year ended 30 June 2026

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.

8.2.1 Contingent assets

The following contingent assets are excluded from the assets included in the financial statements:

	2026 \$'000	2025 \$'000
Cross border receipts for residents from other Australian jurisdictions treated in WA hospitals	24,338	18,753

8.2.2 Contingent liabilities

The following contingent liabilities are excluded from the liabilities included in the financial statements:

	2026 \$'000	2025 \$'000
Cross border charges for WA residents treated in hospitals in other Australian jurisdictions	29,488	28,836

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 that cannot be estimated are for 4 claims. Management has assessed 2 claims that maybe be probable of settling and are provisioned for. Refer to note 3.5(c) Other expenses.

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 2026

8.3 Fair value measurements

Assets measured at fair value:

	Notes	Level 1 \$'000	Level 2 \$'000	Level 3 \$'000	Total \$'000
2026					
Land	5.1	-	4,543	6,568	11,111
Buildings	5.1	-	-	849	849
Site infrastructure	5.1	-	-	153	153
		-	4,543	7,570	12,113
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

There were no 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 2026

8.3 Fair value measurements (continued)

Fair value measurements using significant unobservable inputs (Level 3)

	Land \$'000	Buildings \$'000	Site infrastructure \$'000	Total \$'000
2026				
Fair value at start of period	15,468	805	153	16,426
Additions	-	-	-	-
Revaluation increments/(decrements) recognised in Other comprehensive income	405	109	12	526
Reclassification of asset class	-	-	-	-
Transfers from/(to) other reporting entities	(9,305)	-	-	(9,305)
Depreciation expense	-	(65)	(12)	(77)
Fair value at end of period	6,568	849	153	7,570
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

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 2026

9 Other disclosures

This section includes additional material disclosures required by accounting standards or other pronouncements, for the understanding of this financial report.

	Notes
Events occurring after the end of the reporting period	9.1
Future impact of Australian Accounting Standards not yet operative	9.2
Key management personnel	9.3
Related party transactions	9.4
Related bodies	9.5
Affiliated bodies	9.6
Services provided free of charge	9.7
Indian Ocean Territories	9.8
Special purpose accounts	9.9
Remuneration of auditor	9.10
Equity	9.11
Supplementary financial information	9.12

9.1 Events occurring after the end of the reporting period

There is no significant event occurring after the end of the reporting period that would have a material financial effect on the financial statements of the Department of Health.

Notes to the financial statements

For the year ended 30 June 2026

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 beginning on/after 1 Jan 2026	
AASB 2024-2	<i>Amendments to Australian Accounting Standards – Classification and Measurement of Financial Instruments</i> 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	<i>Amendments to Australian Accounting Standards – Annual Improvements Volume 11</i> 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
AASB 2025-1	<i>Amendments to Australian Accounting Standards – Contracts Referencing Nature-dependent Electricity</i> This Standard amends AASB 7 and AASB 9 as a consequence of the issuance of IFRS Contracts Referencing Nature-dependent Electricity (Amendments to IFRS 9 and IFRS 7) by the International Accounting Standards Board in December 2024. There is no financial impact.	1 Jan 2026

Notes to the financial statements

For the year ended 30 June 2026

9.2 Future impact of Australian Accounting Standards not yet operative (continued)

Operative for reporting periods beginning on/after 1 Jan 2028

<i>AASB 2014-10</i>	<i>Amendments to Australian Accounting Standards – Sale or Contribution of Assets between an Investor and its Associate or Joint Venture</i> 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
<i>AASB 2024-4b</i>	<i>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]</i> 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
<i>AASB 18 (NFP /super)</i>	<i>Presentation and Disclosure in Financial Statements [for not-for-profit and superannuation entities]</i> 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 2026

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

	2026	2025
Compensation band (\$)		
750,001 - 800,000	1	1
600,001 - 650,000	1	-
550,001 - 600,000	1	-
500,001 - 550,000	-	1
450,001 - 500,000	1	-
400,001 - 450,000	1	1
350,001 - 400,000	2	1
300,001 - 350,000	1	1
250,001 - 300,000	1	1
200,001 - 250,000	2	-
100,001 - 150,000	1	2
	12	8
	2026	2025
	\$'000	\$'000
Short-term employee benefits	3,851	2,514
Post-employment benefits	445	276
Other long-term benefits	431	171
Total compensation of senior officers	4,727	2,961

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 2026

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 Housing and Works (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 2026

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 nature of assistance provided in the form of grants and subsidies to affiliated bodies is outlined below:

	2026 \$'000	2025 \$'000
Research and development	438	-
Public health	6,481	-
	6,919	-

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:

	2026 \$'000	2025 \$'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
WA Country Health Service	-	1,856
Department of Education	136	284
Department of Planning, Lands and Heritage	-	5
Others	2	23
Total services provided free of charge	138	4,655

9.8 Indian Ocean Territories

	2026 \$'000	2025 \$'000
Balance at start of period	173	172
Receipts		
Commonwealth grant	5,565	4,922

Notes to the financial statements
For the year ended 30 June 2026

Payment

Purchase of WA Health services

Balance at end of period

(4,230)	(4,921)
1,508	173

Notes to the financial statements

For the year ended 30 June 2026

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.

	2026 \$'000	2025 \$'000
Controlled by the department		
Balance at start of period	-	-
Receipts		
Commonwealth activity based funding - health service providers	2,617,380	2,526,114
Commonwealth activity based funding - Department of Health	32,981	33,512
Commonwealth block funding - health service providers	295,805	268,035
Commonwealth public health funding - Department of Health	65,668	60,972
State activity based funding - Department of Health	4,939,256	4,275,529
NHRA one off payment received via State Treasury	158,134	-
Interest earned on State Pool Account	4	-
Cross border contribution from WA State	26,423	24,480
Cross border receipts from other States or Territories	16,757	21,327
Payments		
Commonwealth activity based funding - health service providers	(2,617,380)	(2,526,114)
Commonwealth activity based funding - Department of Health	(32,981)	(33,512)
Commonwealth block funding - State Managed Fund (Health) Account	(295,805)	(268,035)
Commonwealth public health funding - Department of Health	(65,668)	(60,972)
State activity based funding - health service providers	(4,939,256)	(4,275,529)
NHRA one off payment received via State Treasury	(158,134)	-
Interest transferred to Treasury Consolidated Account	(4)	-
Cross border transfer to Department of Health	(26,423)	(21,327)
Cross border payments to other States or Territories	(16,757)	(24,480)
Balance at end of period	-	-

Notes to the financial statements

For the year ended 30 June 2026

9.9 Special purpose accounts (continued)

	2026 \$'000	2025 \$'000
Administered by the department		
Balance at start of period	-	-
Receipts		
Mental Health Commission - Commonwealth activity based funding	334,519	159,360
Mental Health Commission - Commonwealth block funding	121,319	217,356
Mental Health Commission - State activity based funding	565,357	325,486
Payments		
Mental Health Commission - Commonwealth activity based funding to health service providers	(334,519)	(159,360)
Mental Health Commission - Commonwealth block funding to health service providers	(121,319)	(217,356)
Mental Health Commission - State activity based funding to health service providers	(565,357)	(325,486)
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.

	2026 \$'000	2025 \$'000
Controlled by the department		
Balance at start of period	-	-
Receipts		
Commonwealth block funding - State Pool Account	295,805	268,035
State block funding - Department of Health	468,193	491,376
Royalties for Regions Fund - Department of Health	-	-
Payments		
Commonwealth block funding - health service providers	(295,805)	(268,035)
State block funding - health service providers	(468,193)	(491,376)
Balance at end of period	-	-

Notes to the financial statements

For the year ended 30 June 2026

9.9 Special purpose accounts (continued)

	2026 \$'000	2025 \$'000
Administered by the department		
Balance at start of period	-	-
Receipts		
Mental Health Commission - Commonwealth block funding	121,319	217,356
Mental Health Commission - State block funding	170,934	422,218
Payments		
Mental Health Commission - Commonwealth block funding to health service providers	(113,471)	(204,470)
Mental Health Commission - Commonwealth block funding to non-government organisations	(7,848)	(12,886)
Mental Health Commission - State block funding to health service providers	(170,934)	(422,218)
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.

	2026 \$'000	2025 \$'000
Controlled by the department		
Balance at start of period	39,826	42,859
Receipts	52,771	56,472
Payments	(62,804)	(59,505)
Balance at end of period	29,793	39,826

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.

	2026 \$'000	2025 \$'000
Controlled by the department		
Balance at start of period	13,116	10,945
Receipts	4,621	6,542
Payments	(3,864)	(4,371)
Balance at end of period	13,873	13,116

Notes to the financial statements

For the year ended 30 June 2026

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:

	2026 \$'000	2025 \$'000
Auditing the accounts, controls, financial statements and key performance indicators	591	544
	591	544

9.11 Equity

Contributed equity

Balance at start of period

Contribution by owners

Capital appropriation

Capital funding transferred from the Mental Health Commission

Land and buildings transferred from the State Government

Distributions to owners

Transfer of net assets to other agencies (a)

Total contributed equity at end of period

Reserves

Balance at the start of period

Changes in asset revaluation surplus

Land

Buildings and site infrastructure

Total asset revaluation surplus at end of period

Accumulated surplus/(deficit)

Balance at start of period

Result for the period

Total accumulated surplus/(deficit) at end of period

Total equity at end of period

	2026 \$'000	2025 \$'000
Balance at start of period	198,796	99,485
Capital appropriation	326,199	102,214
Capital funding transferred from the Mental Health Commission	-	-
Land and buildings transferred from the State Government	-	640
Transfer of net assets to other agencies (a)	(14,587)	(3,543)
Total contributed equity at end of period	510,408	198,796
	2026 \$'000	2025 \$'000
Balance at the start of period	281,985	281,432
Changes in asset revaluation surplus	519	334
Land	121	219
Buildings and site infrastructure	121	219
Total asset revaluation surplus at end of period	282,625	281,985
	2026 \$'000	2025 \$'000
Balance at start of period	(92,193)	(80,398)
Result for the period	(44,107)	(11,795)
Total accumulated surplus/(deficit) at end of period	(136,300)	(92,193)
Total equity at end of period	656,733	388,588

(a) Refer to note 5.1 Infrastructure, property, plant and equipment.

Notes to the financial statements
For the year ended 30 June 2026

9.12 **Supplementary financial information**

Write-offs

During the financial year, the department has written off debts and inventory under the authority of:

	2026 \$'000	2025 \$'000
The accountable authority	2	48
The Minister	-	-
The Treasurer	-	-
	2	48

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 2026

10 Explanatory statements

This section explains variations in the financial performance of the department.

Notes

Explanatory statement for controlled operations	10.1
Explanatory statement for administered items	10.2

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 2026, and between the actual results for 2026 and 2025 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 \$11,805,933)
 - Total assets of the annual estimate for the Statement of financial position (i.e. 1% of \$694,638).
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 \$11,467,888)
 - Total assets of the previous year for the Statement of financial position (i.e. 1% of \$579,564).

Notes to the financial statements

For the year ended 30 June 2026

10.1.1 Statement of comprehensive income variances

	Variance Notes	Estimate 2026 \$'000	Actual 2026 \$'000	Actual 2025 \$'000	Variance between actual and estimate \$'000	Variance between actual results for 2026 and 2025 \$'000
COST OF SERVICES						
Expenses						
Employee benefits expenses		207,430	249,249	230,219	41,819	19,030
Contracts for services		761,837	844,455	781,099	82,618	63,356
Supplies and services		81,400	92,668	92,433	11,268	235
Grants and subsidies		10,677,877	11,079,992	10,298,578	402,115	781,414
Depreciation and amortisation expenses		4,418	3,544	3,063	(874)	481
Loss on disposal of non-current assets		-	10	147	10	(137)
Finance costs		107	85	92	(22)	(7)
Other expenses		72,864	54,982	62,257	(17,882)	(7,275)
Total cost of services		11,805,933	12,324,985	11,467,888	519,052	857,097
Income						
User charges and fees		445	30,413	25,789	29,968	4,624
Commonwealth grants and contributions		3,501,845	3,406,509	3,123,343	(95,336)	283,166
Other grants and contributions		292	10,646	642	10,354	10,004
Other income		13,915	10,235	11,105	(3,680)	(870)
Total revenue		3,516,497	3,457,803	3,160,879	(58,694)	296,924
Gains						
Gain on disposal of non-current assets		-	-	-	-	-
Total gains		-	-	-	-	-
Total income other than income from State Government		3,516,497	3,457,803	3,160,879	(58,694)	296,924
NET COST OF SERVICES		8,289,436	8,867,182	8,307,009	577,746	560,173

Notes to the financial statements

For the year ended 30 June 2026

10.1.1 Statement of comprehensive income variances (continued)

	Variance Notes	Estimate 2026 \$'000	Actual 2026 \$'000	Actual 2025 \$'000	Variance between actual and estimate \$'000	Variance between actual results for 2026 and 2025 \$'000
INCOME FROM STATE GOVERNMENT						
Service appropriation		8,154,837	8,703,700	8,160,831	548,863	542,869
Income from other public sector entities		120,384	104,935	119,228	(15,449)	(14,293)
Resources received		949	871	716	(78)	155
Royalties for Regions Fund		15,820	13,569	14,439	(2,251)	(870)
Total income from State Government		8,291,990	8,823,075	8,295,214	531,085	527,861
Surplus/(deficit) for the period		2,554	(44,107)	(11,795)	(46,661)	(32,312)
Other comprehensive income						
Items not reclassified subsequently to profit or loss						
Changes in asset revaluation reserve		-	640	553	640	87
Total other comprehensive income		-	640	553	640	87
Total comprehensive income for the period		2,554	(43,467)	(11,242)	(46,021)	(32,225)

These estimates are published in accordance with TI 9.3 Annual Estimates.

Notes to the financial statements

For the year ended 30 June 2026

10.1.2 Statement of financial position variances

	Variance Notes	Estimate 2026 \$'000	Actual 2026 \$'000	Actual 2025 \$'000	Variance between actual and estimate \$'000	Variance between actual results for 2026 and 2025 \$'000
ASSETS						
Current assets						
Cash and cash equivalents		124,521	77,984	129,992	(46,537)	(52,008)
Restricted cash and cash equivalents		136,585	111,768	128,561	(24,817)	(16,793)
Inventories		27,626	26,988	27,626	(638)	(638)
Receivables		109,868	119,782	109,868	9,914	9,914
Other current assets	1,A	6,433	46,473	6,433	40,040	40,040
Total Current Assets		405,033	382,995	402,480	(22,038)	(19,485)
Non-current assets						
Receivables		4,481	4,481	4,481	-	-
Amounts receivable for services		92,767	81,610	88,351	(11,157)	(6,741)
Infrastructure, property, plant and equipment	2,B	186,867	341,511	78,762	154,644	262,749
Intangible assets	3,C	3,425	22,849	3,425	19,424	19,424
Right-of-use assets		2,065	1,489	2,065	(576)	(576)
Other non-current assets		-	-	-	-	-
Total non-current assets		289,605	451,940	177,084	162,335	274,856
TOTAL ASSETS		694,638	834,935	579,564	140,297	255,371
LIABILITIES						
Current liabilities						
Payables		132,617	116,804	133,818	(15,813)	(17,014)
Contract liabilities		2,157	272	2,157	(1,885)	(1,885)
Lease liabilities		663	714	663	51	51
Employee related provisions	D	38,982	45,010	38,973	6,037	6,037
Total current liabilities		174,419	162,800	175,611	(11,619)	(12,811)

Notes to the financial statements

For the year ended 30 June 2026

10.1.2 Statement of financial position variances (continued)

	Variance Notes	Estimate 2026 \$'000	Actual 2026 \$'000	Actual 2025 \$'000	Variance between actual and estimate \$'000	Variance between actual results for 2026 and 2025 \$'000
Non-current liabilities						
Lease liabilities		1,415	789	1,415	(626)	(626)
Employee related provisions		13,950	14,613	13,950	663	663
Total non-current liabilities		15,365	15,402	15,365	37	37
TOTAL LIABILITIES		189,784	178,202	190,976	(11,582)	(12,774)
NET ASSETS		504,854	656,733	388,588	151,879	268,145
EQUITY						
Contributed equity		312,499	510,408	198,796	197,909	311,612
Reserves		281,985	282,625	281,985	640	640
Accumulated surplus/(deficit)		(89,630)	(136,300)	(92,193)	(46,670)	(44,107)
TOTAL EQUITY		504,854	656,733	388,588	151,879	268,145

These estimates are published in accordance with TI 9.3 Annual Estimates.

Notes to the financial statements

For the year ended 30 June 2026

10.1.3 Statement of cash flows variances

	Variance Notes	Estimate 2026 \$'000	Actual 2026 \$'000	Actual 2025 \$'000	Variance between actual and estimate \$'000	Variance between actual results for 2026 and 2025 \$'000
CASH FLOWS FROM STATE GOVERNMENT						
Service appropriation		7,701,223	8,254,288	7,720,792	553,065	533,496
Capital appropriation	4,E	113,768	326,199	102,214	212,431	223,985
Funds from other public sector entities		60,384	104,935	115,678	44,551	(10,743)
Royalties for Regions Fund		15,820	13,569	14,439	(2,251)	(870)
Net cash provided by State Government		7,891,195	8,698,991	7,953,123	807,796	745,868
Utilised as follows:						
Cash flows from operating activities						
Payments						
Employee benefits		(207,430)	(242,549)	(224,806)	(35,119)	(17,743)
Supplies and services	5,F	(853,314)	(995,258)	(832,197)	(141,944)	(163,061)
Grants and subsidies		(10,164,263)	(10,623,306)	(9,855,033)	(459,043)	(768,273)
Finance costs		(107)	(85)	(92)	22	7
GST payments on purchases	6	(282,117)	(693,887)	(598,309)	(411,770)	(95,578)
Receipts						
User charges and fees		445	30,413	25,789	29,968	4,624
Commonwealth grants and contributions		3,436,332	3,339,113	3,051,118	(97,219)	287,995
GST receipts on sales		19,435	30,825	29,530	11,390	1,295
GST receipts from taxation authority	7	262,682	651,199	570,061	388,517	81,138
Other receipts		14,207	20,881	11,747	6,674	9,134
Net cash used in operating activities		(7,774,130)	(8,482,654)	(7,822,192)	(708,524)	(660,462)
CASH FLOWS FROM INVESTING ACTIVITIES						
Payments						
Purchase of non-current assets	8,G	(113,768)	(284,396)	(27,477)	(170,628)	(256,919)
Net cash used in investing activities		(113,768)	(284,396)	(27,477)	(170,628)	(256,919)

Notes to the financial statements

For the year ended 30 June 2026

10.1.3 Statement of cash flows variances (continued)

	Variance Notes	Estimate 2026 \$'000	Actual 2026 \$'000	Actual 2025 \$'000	Variance between actual and estimate \$'000	Variance between actual results for 2026 and 2025 \$'000
CASH FLOWS FROM FINANCING ACTIVITIES						
Payments						
Principal element of lease payments		(742)	(742)	(742)	-	-
Net cash used in financing activities		(742)	(742)	(742)	-	-
Net increase/(decrease) in cash and cash equivalents	H	2,555	(68,801)	102,712	(71,356)	(171,513)
Cash and cash equivalents at the beginning of the year		258,553	258,553	155,841	-	102,712
CASH AND CASH EQUIVALENTS AT THE END OF THE PERIOD		261,108	189,752	258,553	(71,356)	(68,801)

These estimates are published in accordance with TI 9.3 Annual Estimates.

Notes to the financial statements

For the year ended 30 June 2026

10.1.4 Explanatory statement for controlled operations

Major estimate and actual (2026) variance narratives

		2026 Estimate \$'000	2026 Actual \$'000	Variance \$'000
1	Other current assets Other current assets were \$40.0 million (+622.4%) higher than the Estimate due to additional capital project prepayments made under the agreed billing arrangement with OMID. This arrangement was established during 2025-26 as a part of the partnership delivery model formed following the 2025 Public Sector Reform.	6,433	46,473	40,040
2	Infrastructure, property, plant and equipment Infrastructure, property, plant and equipment was \$154.6 million (+82.8%) higher than the Estimate, primarily due to the additional investment in key projects approved during 2025-26, including the New Women and Babies Hospital and Step-Up Step-Down initiatives.	186,867	341,511	154,644
3	Intangible assets Intangible assets were \$19.4 million (+567.1%) higher than the Estimate, due to the revised Electronic Medical Record project schedule approved during 2025-26.	3,425	22,849	19,424
4	Capital appropriation receipts Capital appropriation receipts were \$212.4 million (+186.7%) higher than the Estimate due to the approved Asset Investment Program changes made during 2025-26, as outlined in the 2026-27 Budget Papers.	113,768	326,199	212,431
5	Supplies and services Supplies and services were \$141.9 million (+16.6%) higher than the Estimate primarily due to the capital project funding arrangements established post Public Sector Reform implementation in 2025-26.	(853,314)	(995,258)	(141,944)
6	GST payments on purchases GST payments on purchases were \$411.8 million (+146%) higher than the Estimate, primarily due to the GST obligations associated with the additional investment approved during 2025-26.	(282,117)	(693,887)	(411,770)
7	GST receipts from taxation authority GST receipts from the taxation authority were \$388.5 million (+147.9%) higher than the Estimate, primarily due to the extra GST paid during 2025-26 for additional expenditure approved during the year.	262,682	651,199	388,517
8	Purchase of non-current assets payments Purchase of non-current assets payments was \$170.6 million (+150.0%) higher than the Estimate, primarily due to the additional investment in key projects during 2025-26, including the New Women and Babies Hospital, Electronic Medical Record, and Step-Up Step-Down initiatives.	(113,768)	(284,396)	(170,628)

Notes to the financial statements

For the year ended 30 June 2026

10.1.4 Explanatory statement for controlled operations (continued)

Major actual (2026) and comparative (2025) variance narratives

	2026 Actual \$'000	2025 Actual \$'000	Variance \$'000
A Other current assets Other current assets increased by \$40.0 million (+622.4%), due to additional capital project prepayments made under the agreed billing arrangement with OMID. This arrangement was established during 2025-26 as a part of the partnership delivery model formed following the 2025 Public Sector Reform.	46,473	6,433	40,040
B Infrastructure, property, plant and equipment Infrastructure, property, plant and equipment increased by \$262.7 million (+333.6%), primarily due to additional investment in work in progress on key projects, including the New Women and Babies Hospital and Step-Up Step-Down initiatives, compared to the prior year.	341,511	78,762	262,749
C Intangible assets Intangible assets increased by \$19.4 million (+567.1%), due to additional approved work in progress on the Electronic Medical Record project.	22,849	3,425	19,424
D Employee related provisions Employee related provisions increased by \$6.0 million (+15.5%), primarily due to the employment of additional staff to support operational needs and capital project management.	45,010	38,973	6,037
E Capital appropriation receipts Capital appropriation receipts increased by \$224.0 million (+219.1%) recognising the additional capital investment approved for 2025-26, including the New Women and Babies Hospital, Electronic Medical Record and Step-Up Step-Down initiatives.	326,199	102,214	223,985
F Supplies and services Supplies and services increased by \$163.1 million (+19.6%), primarily due to changes to capital project funding arrangements implemented post 2025 Public Sector Reform.	(995,258)	(832,197)	(163,061)
G Purchase of non-current assets payments Purchase of non-current assets payments increased by \$256.9 million (+935.0%), primarily due to cash paid for work in progress on key projects, including the New Women and Babies Hospital, Electronic Medical Record, and Step-Up Step-Down initiatives.	(284,396)	(27,477)	(256,919)
H Net increase/(decrease) in cash and cash equivalents Net increase/(decrease) in cash and cash equivalents decreased by \$171.5 million (-167.0%), due to the timing of cash receipts and payments during the year and approved revisions to capital project schedules.	(68,801)	102,712	(171,513)

Notes to the financial statements

For the year ended 30 June 2026

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 2026, and between the actual results for 2026 and 2025 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 \$2,375,570 for the current year and 1% of \$ 1,873,512 for the previous year in the table below).

10.2.1 Administered income and expenses

	Variance Notes	Estimate 2026 \$'000	Actual 2026 \$'000	Actual 2025 \$'000	Variance between actual and estimate \$'000	Variance between actual results for 2026 and 2025 \$'000
COST OF SERVICES						
Expenses						
Funding transferred to:						
Health service providers	1,A	1,149,070	1,310,970	719,553	161,900	591,417
State Pool Account and State Managed Fund Account administered for Mental Health Commission (MHC):						
Transfer of activity based funding to health service providers	4,E	880,317	899,876	484,846	19,559	415,030
Transfer of block funding to health service providers	2,C	340,709	292,253	639,574	(48,456)	(347,321)
		-				
Service concession arrangement depreciation expense		3,556	3,759	3,646	203	113
Total administered expenses		2,373,652	2,506,858	1,847,619	133,206	659,239

Notes to the financial statements

For the year ended 30 June 2026

10.2.1 Administered income and expenses (continued)

	Variance Notes	Estimate 2026 \$'000	Actual 2026 \$'000	Actual 2025 \$'000	Variance between actual and estimate \$'000	Variance between actual results for 2026 and 2025 \$'000
Income						
Administered for WA health system:						
Capital appropriation	3,D	553,737	1,108,717	418,837	554,980	689,880
Administered appropriation	E	410,129	56,047	162,666	(354,082)	(106,619)
Royalties for Regions Fund	F	185,204	189,064	162,115	3,860	26,949
State Pool Account and State Managed Fund Account administered for Mental Health Commission (MHC):						
Commonwealth activity based funding	5,G	299,586	334,519	159,360	34,933	175,159
Commonwealth block funding	H	133,747	121,319	217,356	(12,428)	(96,037)
State activity based funding	I	580,731	565,357	325,486	(15,374)	239,871
State block funding	6,J	206,962	170,934	422,218	(36,028)	(251,284)
		-				
Service concession arrangement revenue		5,474	5,474	5,474	-	-
Total administered income		2,375,570	2,551,431	1,873,512	175,861	677,919

Notes to the financial statements

For the year ended 30 June 2026

10.2.2 Explanatory statement for controlled operations

Major estimate and actual (2026) variance narratives

		2026 Estimate \$'000	2026 Actual \$'000	Variance \$'000
1	Funding transferred to Health Service Providers Funding transferred to health service providers was \$161.9 million (+14.1%) higher than the Estimate due to additional funding allocated for capital projects during the year.	1,149,070	1,310,970	161,900
2	Mental Health Commission block funding transferred to Health Service Providers Mental Health Commission block funding income transferred to health service providers decreased by \$48.5 million (-14.2%) reflecting the transition of a significant portion of block funding to activity based funding.	340,709	292,253	(48,456)
3	Capital appropriation income Capital appropriation income was \$555.0 million (+100.2%) higher than the Estimate due to additional capital appropriation approved during 2025-26, including the New Women and Babies Hospital.	553,737	1,108,717	554,980
4	Administered appropriation income Administered appropriation income decreased by \$354.1 million (-86.3%) due to reclassification of funding sources from administered to capital funding.	410,129	56,047	(354,082)
5	Mental Health Commission activity based funding income received from Commonwealth Mental Health Commission activity based funding income received from Commonwealth was \$34.9 million (+11.7%) higher than the Estimate due to the revision of activity estimates for in-scope mental health during 2025-26 and the transition of a significant portion of block funding to activity based funding.	299,586	334,519	34,933
6	Mental Health Commission block funding income received from State Government Mental Health Commission block funding income received from State Government was \$36.0 million (-17.4%) lower than the Estimate due to lower than expected activity for non-admitted mental health and the transition of a significant portion of block funding to activity based funding.	206,962	170,934	(36,028)

Notes to the financial statements

For the year ended 30 June 2026

10.2.2 Explanatory statement for controlled operations (continued)

Major actual (2026) and comparative (2025) variance narratives

		2026 Actual \$'000	2025 Actual \$'000	Variance \$'000
A	Funding transferred to Health Service Providers Funding transferred to health service providers increased by \$591.4 million (+82.2%) related mainly to increased capital appropriation provided to fund ongoing asset investment programs.	1,310,970	719,553	591,417
B	Mental Health Commission activity based funding transferred to Health Service Providers Mental Health Commission activity based funding income transferred to health service providers increased by \$415.0 million (+85.6%) reflecting the transition of a significant portion of block funding to activity based funding.	899,876	484,846	415,030
C	Mental Health Commission block funding transferred to Health Service Providers Mental Health Commission block funding income transferred to health service providers decreased by \$347.3 million (-54.3%) due to the transition of a significant portion of block funding to activity based funding.	292,253	639,574	(347,321)
D	Capital appropriation income Capital appropriation income increased by \$689.9 million (+164.7%) reflecting increased funding provided from State Government to fund ongoing capital programs.	1,108,717	418,837	689,880
E	Administered appropriation income Administered appropriation income decreased by \$106.6 million (-65.5%) due to reclassification of funding sources from administered to capital funding.	56,047	162,666	(106,619)
F	Royalties for Regions Fund Royalties for Regions Fund increased by \$27.0 million (16.6%) due to an increase in capital funding for regional initiatives.	189,064	162,115	26,949
G	Mental Health Commission activity based funding income received from Commonwealth Mental Health Commission activity based funding income received from Commonwealth increased by \$175.2 million (+109.9%) due to additional in-scope mental health activity and the transition of a significant portion of block funding to activity based funding.	334,519	159,360	175,159
H	Mental Health Commission block funding income received from Commonwealth Mental Health Commission block funding income received from Commonwealth decreased by \$96.0 million (-44.2%) reflecting the transition of a significant portion of block funding to activity based funding.	121,319	217,356	(96,037)

Notes to the financial statements

For the year ended 30 June 2026

I	Mental Health Commission activity based funding income received from State Government Mental Health Commission activity based funding income received from State Government increased by \$239.9 million (+73.7%) primarily due to the transition of a significant portion of block funding to activity based funding.	565,357	325,486	239,871
J	Mental Health Commission block funding income received from State Government Mental Health Commission block funding income received from State Government decreased by \$251.3 million (-59.5%) reflecting the transition of a significant portion of block funding to activity based funding.	170,934	422,218	(251,284)

Appendix



Appendix 1: Board and committee remuneration

Position	Name	Term of appointment	Period of membership 2025–26	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 (4 hours or less)	\$0
Member	Dr Silke Brinkmann	3 years	12 months	Sessional	\$150 (4 hours or less)	\$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 (Deputy)	Dr Erin Horsley	3 years	12 months	Sessional	\$150 (4 hours or less)	\$150
Member	Dr Stephen Rodrigues	3 years	12 months	Not eligible	Not applicable	\$0
Member	Dr Richard Taylor	3 years	12 months	Not eligible	Not applicable	\$0
Member	Associate Prof. Andrew Toner	3 years	12 months	Not eligible	Not applicable	\$0

Position	Name	Term of appointment	Period of membership 2025–26	Type of remuneration	Base salary/sitting fees	Gross/actual remuneration
Investigator	Dr Christine Gobler	3 years	3 months	Sessional	\$546 - \$572	\$4,265
Investigator	Dr Irina Kurowski	3 years	9 months	Sessional	\$594	\$0
Investigator	Dr John Martyr	3 years	3 months	Sessional	\$546 - \$572	\$8,531
*While eligible for remuneration, members decided to volunteer their time to the Committee					Total	\$13,096

Position	Name	Term of appointment	Period of membership 2025–26	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	\$0
Member	Prof. Richard Brightwell	2 years	12 months	Sessional	\$680 for meetings over 4 hours, \$442 for meetings up to 4 hours	\$0
Member	Dr Catherine Cole	3 years	12 months	Sessional	\$680 for meetings over 4 hours, \$442 for meetings up to 4 hours	\$0
Member	Prof. Georgia Halkett	1 year	12 months	Sessional	\$680 for meetings over 4 hours, \$442 for meetings up to 4 hours	\$884
Member	Rev. Graham Maybury	3 years	12 months	Sessional	\$680 for meetings over 4 hours, \$442 for meetings up to 4 hours	\$884
Member	John McMath	3 years	12 months	Sessional	\$680 for meetings over 4 hours, \$442 for meetings up to 4 hours	\$1,768
Member	Sonia McKeiver	3 years	12 months	Sessional	\$680 for meetings over 4 hours, \$442 for meetings up to 4 hours	\$884
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	\$0

Position	Name	Term of appointment	Period of membership 2025–26	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	\$0
Deputy Member	Paul Beeson	3 years	12 months	Sessional	\$680 for meetings over 4 hours, \$442 for meetings up to 4 hours	\$884
Deputy Member	Dr Prashant Bharadwaj	3 years	12 months	Sessional	\$680 for meetings over 4 hours, \$442 for meetings up to 4 hours	\$0
Deputy Member	Catherine Carbonaro	3 years	12 months	Sessional	\$680 for meetings over 4 hours, \$442 for meetings up to 4 hours	\$0
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	\$0
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	\$0
					Total	\$5,304

Position	Name	Term of appointment	Period of membership 2025–26	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	\$309	\$618
Member 5	*	3 years	12 months	Sessional	\$309	\$309
*Approval to withhold the names of the committee members has been granted by the Minister for Health					Total	\$927

Position	Name	Term of appointment	Period of membership 2025–26	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

Position	Name	Term of appointment	Period of membership 2025–26	Type of remuneration	Base salary/ sitting fees	Gross/actual remuneration
Local Health Authorities Analytical Committee						
Chair	Ryan Quinn	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	\$1,545
Member	Shane McRedmond	3 years	12 months	Not eligible	Not applicable	\$0
Member	Edward Perotti	3 years	12 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	\$927
Member	Cr Elizabeth Re	3 years	12 months	Sessional	\$476 for meetings over 4 hours, \$309 for meetings of 4 hours or less	\$1,236
Member	Nathan Russell	3 years	12 months	Not eligible	Not applicable	\$0
Member	Sarah Upton	3 years	12 months	Not eligible	Not applicable	\$0
Member	Craig Watts	3 years	12 months	Not eligible	Not applicable	\$0
					Total	\$3,708

Position	Name	Term of appointment	Period of membership 2025–26	Type of remuneration	Base salary/ sitting fees	Gross/actual remuneration
Maternal Mortality Committee						
Chair	Prof. John Newnham	3 years	12 months	Not eligible	Not applicable	\$0
Member	Dr Chieh Cheng	3 years	3 months	Not eligible	Not applicable	\$0
Member	Dr Verelle Roocke	3 years	9 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 (4 hours or less)	\$0
Member	Dr Graeme Johnson	3 years	12 months	Not eligible	Not applicable	\$0
Member	Dr Fiona Langdon	3 years	9 months	Sessional	\$150 (4 hours or less)	\$0
Member	Dr Lewis MacKinnon	3 years	12 months	Not eligible	Not applicable	\$0
Member	Dr Dale Pugh	3 years	12 months	Sessional	\$150 (4 hours or less)	\$0
Member	Dr Nooshin Rasool	3 years	12 months	Not eligible	Not applicable	\$0
Investigator	Dr Julia Barton	3 years	12 months	Sessional	\$546 - \$594	\$0
Member (Deputy)	Dr Winston Andrew Almeida	3 years	12 months	Not eligible	Not applicable	\$0
Member (Deputy)	Dr Michael Bryant Gannon	3 years	12 months	Sessional	\$150 (4 hours or less)	\$0
Member (Deputy)	Dr Heather Mary Coventry	3 years	12 months	Sessional	\$150 (4 hours or less)	\$0
Members eligible for remuneration decided to volunteer their time to the Committee					Total	\$0

Position	Name	Term of appointment	Period of membership 2025–26	Type of remuneration	Base salary/ sitting fees	Gross/actual remuneration
Perinatal and Infant Mortality Committee						
Chair (outgoing)	Dr Michael Gannon	3 years	9 months	Sessional	\$220 (4 hours or less)	\$1,980
Chair (incoming)	Dr Scott White	3 years	12 months	Not eligible	Not applicable	\$0
Member	Dr Disna Abeysuriya	3 years	12 months	Not eligible	Not applicable	\$0
Member	Zoe Islip	3 years	12 months	Sessional	\$150 (4 hours or less)	\$0
Member	Dr Gayatri Jape	3 years	12 months	Not eligible	Not applicable	\$0
Member	Prof. Helen Leonard	3 years	12 months	Sessional	\$150 (4 hours or less)	\$0
Member	Dr Lauren Megaw	3 years	12 months	Not eligible	Not applicable	\$0
Member	Dr Melissa O'Neill	3 years	3 months	Sessional	\$150 (4 hours or less)	\$0
Member	Dr Nooshin Rasool	3 years	7 months	Not eligible	Not applicable	\$0
Member	Dr Peta Ann Sadler	3 years	12 months	Sessional	\$150 (4 hours or less)	\$300
Member	Dr Kavipriya Soma	3 years	12 months	Sessional	\$150 (4 hours or less)	\$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
Investigator	Dr Bronwyn Bennett	3 years	3 months	Sessional	\$546 - \$594	\$13,732
Investigator	Dr Joanne Colvin	3 years	12 months	Sessional	\$546 - \$594	\$0

Position	Name	Term of appointment	Period of membership 2025–26	Type of remuneration	Base salary/sitting fees	Gross/actual remuneration
Investigator	Dr Kate Hammond	3 years	6 months	Sessional	\$546 - \$594	\$6,282
Investigator	Dr Christine Marsack	3 years	6 months	Sessional	\$546 - \$594	\$5,342
Investigator	Dr Corrado Minutillo	3 years	12 months	Sessional	\$546 - \$594	\$14,329
Investigator	Dr Keren Whitcombe	3 years	9 months	Sessional	\$546 - \$594	\$4,059
					Total	\$46,024

Position	Name	Term of appointment	Period of membership 2025–26	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 2025–26	Type of remuneration	Base salary/ sitting fees	Gross/actual remuneration
Pharmacy Registration Board of Western Australia						
Presiding member (outgoing)	Giovanni Cechele	3 years	3 months	Sessional		
Presiding member (incoming)	Gavin McKay	3 years	9 months	Sessional		
Deputy presiding member	Linda Keane	3 years	12 months	Sessional		
Member	Jane Barker	3 years	12 months	Sessional		
Member	Giovanna Cecchele	3 years	9 months	Sessional		
Member	Gavin McKay	3 years	3 months	Sessional		
Board members are not remunerated by the department					Total	\$0

Position	Name	Term of appointment	Period of membership 2025–26	Type of remuneration	Base salary/ sitting fees	Gross/actual remuneration
Postgraduate Medical Council of Western Australia						
Chair	Dr Michael Levitt	3 years	12 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	Clinical Associate Prof. Timothy 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	\$309	\$618
Member	Prof. Mark Edwards	4 years	12 months	Not eligible	Not applicable	\$0
Member	Associate Prof. George Eskander	4 years	12 months	Not eligible	Not applicable	\$0
Member	Dr Athula Karunanayaka	4 years	12 months	Not eligible	Not applicable	\$0
Member	Prof. Graeme Maguire	4 years	12 months	Not eligible	Not applicable	\$0
Member	Dr Anand Trivedi	4 years	12 months	Not eligible	Not applicable	\$0
Member	Dr Helen Wilcox	4 years	12 months	Not eligible	Not applicable	\$0
Member	Dr Chris Wilson	4 years	12 months	Not eligible	Not applicable	\$0
Member (incoming)	Prof. Rebecca Anglin	4 years	6 months	Not eligible	Not applicable	\$0
Member (incoming)	Dr Aresh Anwar	4 years	2 months	Not eligible	Not applicable	\$0

Position	Name	Term of appointment	Period of membership 2025–26	Type of remuneration	Base salary/ sitting fees	Gross/actual remuneration
Member (incoming)	Dr Alexandra Cowan	4 years	6 months	Not eligible	Not applicable	\$0
Member (incoming)	Dr Caroline Rhodes	4 years	6 months	Not eligible	Not applicable	\$0
Member (incoming)	Dr Owen Taylor-Williams	4 years	6 months	Not eligible	Not applicable	\$0
Member (incoming)	Dr Andrew Toffoli	4 years	6 months	Not eligible	Not applicable	\$0
Member (incoming)	Dr Caitlyn White	4 years	6 months	Not eligible	Not applicable	\$0
					Total	\$618

Position	Name	Term of appointment	Period of membership 2025–26	Type of remuneration	Base salary/ sitting fees	Gross/actual remuneration
Radiological Council						
Chair	Dr Andrew Robertson	3 years	12 months	Not eligible	Not applicable	\$0
Deputy Chair	Dr Revle Bangor-Jones	3 years	12 months	Not eligible	Not applicable	\$0
Member	Dr Mikaela Dell'Oro	3 years	12 months	Sessional	\$309	\$309
Member	Dr Andrew Hohnen*	3 years	12 months	Sessional	\$309	\$0
Member	Associate Prof. Nigel Marks	3 years	12 months	Sessional	\$309	\$3,090
Member	Mr John Pereira*	3 years	12 months	Sessional	\$309	\$0
Member	Mr Cameron Storm	3 years	12 months	Sessional	\$309	\$3,090
Member	Dr Vidisha Vaidya*	3 years	12 months	Sessional	\$309	\$0
Member (Non-voting)	Dr John Burrage	3 years	12 months	Not eligible	Not applicable	\$0
Member (Non-voting)	Mr Frank Harris	3 years	12 months	Sessional	\$309	\$3,090
Member (Non-voting)	Mr Nick Tsurikov	3 years	12 months	Sessional	\$309	\$2,472
Deputy Member	Dr Jeff Davis	3 years	8 months	Not eligible	Not applicable	\$0
Deputy Member	Mr Robert Day	3 years	12 months	Not eligible	Not applicable	\$0
Deputy Member	Adjunct Prof. Martin Ebert	3 years	12 months	Not eligible	Not applicable	\$0
Deputy Member	Ms Megan McGibbons	3 years	4 months	Not eligible	Not applicable	\$0

Position	Name	Term of appointment	Period of membership 2025–26	Type of remuneration	Base salary/ sitting fees	Gross/actual remuneration
Deputy Member	Mrs Robyn Mitchell	3 years	8 months	Sessional	\$309	\$0
Deputy Member	Associate Prof. Curtise Ng	3 years	4 months	Sessional	\$309	\$1,236
Deputy Member	Dr Melanie Robert	3 years	12 months	Sessional	\$309	\$0
Deputy Member	Dr Russell Troedson	3 years	12 months	Sessional	\$309	\$0
* Members decided to volunteer their time to the Committee					Total	\$13,287

Position	Name	Term of appointment	Period of membership 2025–26	Type of remuneration	Base salary/ sitting fees	Gross/actual remuneration
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
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	\$2,287
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	\$2,287

Position	Name	Term of appointment	Period of membership 2025–26	Type of remuneration	Base salary/ sitting fees	Gross/actual remuneration
Voluntary Assisted Dying Board						
Chair	Dr Scott Blackwell	3 years	12 months	Annual	\$45,357	\$50,638
Deputy Chair	Colin Holt	3 years	12 months	Annual	\$24,946	\$29,642
Member	Maria Osman	2 years	12 months	Annual	\$24,946	\$27,850
Member	Linda Savage	3 years	12 months	Annual	\$24,946	\$27,850
Member	Dr Gareth Wahl	2.5 years	12 months	Not eligible	Not applicable	\$0
					Total	\$135,980

Position	Name	Term of appointment	Period of membership 2025–26	Type of remuneration	Base salary/ sitting fees	Gross/actual remuneration
WA Board of the Medical Board of Australia						
Chair	Prof. Mark Edwards	3 years	12 months	Sessional		
Member	Dr Richelle Douglas	3 years	12 months	Not eligible		
Member	Dr Alan Duncan AM	3 years	12 months	Sessional		
Member	Dr Melina Gooneratne	2 years	12 months	Sessional		
Member	Dr Peter Maguire	3 years	12 months	Sessional		
Member	Meneesha Michalka	3 years	12 months	Sessional		
Member	Dr Katinka Morton	3 years	12 months	Not eligible		
Member	Liam Roche	3 years	12 months	Sessional		
Member	Dr Divya-Jyoti Sharma	2 years	12 months	Sessional		
Member	Dr Ruth Shean	3 years	12 months	Sessional		
Member	Cr Hardeep Singh	2 years	12 months	Sessional		
Member	Dr Kylie Sterry	2 years	12 months	Sessional		
*Board members are not remunerated by the department					Total	\$0

Position	Name	Term of appointment	Period of membership 2025–26	Type of remuneration	Base salary/ sitting fees	Gross/actual remuneration
WA Board of the Nursing and Midwifery Board of Australia						
Chair	Michelle Dilllon	3 years	12 months	Sessional		
Member	Justine Burg	3 years	12 months	Sessional		
Member	David Cox	3.5 years	12 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	Beverley Jowle	3 years	12 months	Sessional		
Member	Jill O'Connor	3 years	12 months	Not eligible		
Member	Penny Webb	3 years	9 months	Sessional		
*Board members are not remunerated by the department					Total	\$0

Position	Name	Term of appointment	Period of membership 2025–26	Type of remuneration	Base salary/ sitting fees	Gross/actual remuneration
WA Health Central Human Research Ethics Committee						
Chair	Alison Garton	3 years	12 months	Sessional	\$75 per hour	\$11,625
Member	Esther Adama	3 years	12 months	Not eligible	Not applicable	\$0
Member	Brendan Ashdown	3 years	12 months	Sessional	\$75 per hour	\$750
Member	Peter Barratt	3 years	12 months	Not eligible	Not applicable	\$0
Member	Paul Beeson	3 years	12 months	Sessional	\$75 per hour	\$2,250
Member	Timothy Benson	3 years	12 months	Sessional	\$75 per hour	\$4,875
Member	Jacqueline Bental	3 years	12 months	Not eligible	Not applicable	\$0
Member	Prashant Bharadwaj	3 years	12 months	Sessional	\$75 per hour	\$3,225
Member	Richard Brightwell	3 years	12 months	Not eligible	Not applicable	\$0
Member	Sam Buckberry	3 years	12 months	Sessional	\$75 per hour	\$1,500
Member	Jonathon Burcham	3 years	12 months	Not eligible	Not applicable	\$0
Member	Melanie Burkhardt	3 years	12 months	Not eligible	Not applicable	\$0
Member	Prudence (Prue) Campbell	3 years	12 months	Sessional	\$75 per hour	\$2,250
Member	Catherine Carbonaro	3 years	12 months	Sessional	\$75 per hour	\$3,750
Member	Wendy Chan She Ping-Delfos	3 years	12 months	Sessional	\$75 per hour	\$2,250

Position	Name	Term of appointment	Period of membership 2025–26	Type of remuneration	Base salary/ sitting fees	Gross/actual remuneration
Member	Antonios Chasouris	3 years	12 months	Not eligible	Not applicable	\$0
Member	Jonathon (Gin) Chee	3 years	12 months	Not eligible	Not applicable	\$0
Member	Laurence Cheung	3 years	12 months	Not eligible	Not applicable	\$0
Member	Peter Christophides	3 years	12 months	Sessional	\$75 per hour	\$5,250
Member	Patricia Clifford	3 years	12 months	Not eligible	Not applicable	\$0
Member	Catherine Cole	3 years	12 months	Sessional	\$75 per hour	\$1,125
Member	Dorothy Collins	3 years	12 months	Sessional	\$75 per hour	\$1,500
Member	Lachlan Cooke	3 years	12 months	Sessional	\$75 per hour	\$1,875
Member	Craig Cumming	3 years	12 months	Sessional	\$75 per hour	\$3,375
Member	Carolyn Daggers	3 years	12 months	Not eligible	Not applicable	\$0
Member	Eleanor Davies	3 years	12 months	Not eligible	Not applicable	\$0
Member	Benjamin Dawson	3 years	12 months	Sessional	\$75 per hour	\$0
Member	Jane Deacon	3 years	12 months	Not eligible	Not applicable	\$0
Member	Ravani Duggan	3 years	12 months	Sessional	\$75 per hour	\$1,725
Member	Kylie Ekins	3 years	12 months	Not eligible	Not applicable	\$0
Member	Wayne Epton	3 years	12 months	Not eligible	Not applicable	\$0

Position	Name	Term of appointment	Period of membership 2025–26	Type of remuneration	Base salary/ sitting fees	Gross/actual remuneration
Member	Mohamed Estai	3 years	12 months	Not eligible	Not applicable	\$0
Member	Paul Etheredge	3 years	12 months	Sessional	\$75 per hour	\$2,250
Member	Mark Fear	3 years	12 months	Not eligible	Not applicable	\$0
Member	Susan Feng	3 years	12 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	\$375
Member	Hannah Floquet	3 years	12 months	Sessional	\$75 per hour	\$2,475
Member	Janice Fogarty	3 years	12 months	Sessional	\$75 per hour	\$6,750
Member	Kathryn (Kathy) Fuller	3 years	12 months	Sessional	\$75 per hour	\$2,475
Member	Olivia Gallagher	3 years	12 months	Not eligible	Not applicable	\$0
Member	Pauline Glasson	3 years	12 months	Not eligible	Not applicable	\$0
Member	Erin Godecke	3 years	12 months	Not eligible	Not applicable	\$0
Member	Srinivasa Goteti	3 years	12 months	Not eligible	Not applicable	\$0
Member	Alex Griffiths	3 years	12 months	Not eligible	Not applicable	\$0
Member	Kerry Gunton	3 years	12 months	Not eligible	Not applicable	\$0
Member	Georgia Halkett	3 years	12 months	Sessional	\$75 per hour	\$3,000

Position	Name	Term of appointment	Period of membership 2025–26	Type of remuneration	Base salary/ sitting fees	Gross/actual remuneration
Member	Teresa Harms	3 years	12 months	Sessional	\$75 per hour	\$7,125
Member	Kristie Harper	3 years	12 months	Not eligible	Not applicable	\$0
Member	Jennifer Heart	3 years	12 months	Sessional	\$75 per hour	\$3,600
Member	Jackson Herriott	3 years	12 months	Sessional	\$75 per hour	\$3,375
Member	Julie Hibbert	3 years	12 months	Sessional	\$75 per hour	\$5,100
Member	Elizabeth (Lizz) Hill	3 years	12 months	Not eligible	Not applicable	\$0
Member	Charmaine Hugo	3 years	12 months	Sessional	\$75 per hour	\$2,250
Member	Akaiti James	3 years	12 months	Sessional	\$75 per hour	\$750
Member	Terri James	3 years	12 months	Not eligible	Not applicable	\$0
Member	Gayatri Jape	3 years	12 months	Not eligible	Not applicable	\$0
Member	Mohammed Junaid	3 years	12 months	Sessional	\$75 per hour	\$2,625
Member	Mary Kamel	3 years	12 months	Not eligible	Not applicable	\$0
Member	Pritika KC	3 years	12 months	Not eligible	Not applicable	\$0
Member	Michelle Kirk	3 years	12 months	Sessional	\$75 per hour	\$1,875
Member	Nin Kirkham	3 years	12 months	Sessional	\$75 per hour	\$9,150
Member	Roland Kohan	3 years	12 months	Not eligible	Not applicable	\$0

Position	Name	Term of appointment	Period of membership 2025–26	Type of remuneration	Base salary/ sitting fees	Gross/actual remuneration
Member	Pavitra Krishnan	3 years	12 months	Not eligible	Not applicable	\$0
Member	Daryl Langman	3 years	12 months	Sessional	\$75 per hour	\$3,750
Member	Daniel Laucirica	3 years	12 months	Sessional	\$75 per hour	\$2,850
Member	Ashleigh Lawrence	3 years	12 months	Sessional	\$75 per hour	\$2,625
Member	Francene Leaversuch	3 years	12 months	Not eligible	Not applicable	\$0
Member	Eric Lim	3 years	12 months	Sessional	\$75 per hour	\$3,002
Member	Wai Lim	3 years	12 months	Not eligible	Not applicable	\$0
Member	Wil Liam Lim	3 years	12 months	Sessional	\$75 per hour	\$3,675
Member	Elena Lovegrove	3 years	12 months	Sessional	\$75 per hour	\$2,250
Member	Graham Mabury	3 years	12 months	Sessional	\$75 per hour	\$3,067
Member	Adriana Mannino	3 years	12 months	Not eligible	Not applicable	\$0
Member	Adam Manuel	3 years	12 months	Not eligible	Not applicable	\$0
Member	Phillip (Phil) Matson	3 years	12 months	Sessional	\$75 per hour	\$0
Member	Anne Matthews	3 years	12 months	Not eligible	Not applicable	\$0
Member	Anastasia Mattingley	3 years	12 months	Not eligible	Not applicable	\$0
Member	Dainel McAullay	3 years	12 months	Sessional	\$75 per hour	\$375

Position	Name	Term of appointment	Period of membership 2025–26	Type of remuneration	Base salary/ sitting fees	Gross/actual remuneration
Member	Sonia McKeiver	3 years	12 months	Sessional	\$75 per hour	\$1,942
Member	Helen McLeish	3 years	12 months	Not eligible	Not applicable	\$0
Member	John McMath	3 years	12 months	Sessional	\$75 per hour	\$6,817
Member	Shailender Mehta	3 years	12 months	Not eligible	Not applicable	\$0
Member	Meneesha Michalka	3 years	12 months	Sessional	\$75 per hour	\$375
Member	Lesley Millar	3 years	12 months	Sessional	\$75 per hour	\$1,500
Member	Hamish Milne	3 years	12 months	Sessional	\$75 per hour	\$3,450
Member	Leanne Monterosso	3 years	12 months	Sessional	\$75 per hour	\$1,125
Member	Samuel Montgomery	3 years	12 months	Sessional	\$75 per hour	\$1,125
Member	Kwi Moon	3 years	12 months	Not eligible	Not applicable	\$0
Member	Kimberley Morrison	3 years	12 months	Sessional	\$75 per hour	\$1,500
Member	Hana Morrissey	3 years	12 months	Sessional	\$75 per hour	\$2,625
Member	Hanh Ngo	3 years	12 months	Sessional	\$75 per hour	\$0
Member	Menuka Gamarallage	3 years	12 months	Sessional	\$75 per hour	\$2,250
Member	Stephen Pannell	3 years	12 months	Not eligible	Not applicable	\$0
Member	Kylee Parentich	3 years	12 months	Sessional	\$75 per hour	\$5,250

Position	Name	Term of appointment	Period of membership 2025–26	Type of remuneration	Base salary/ sitting fees	Gross/actual remuneration
Member	Marianne Phillips	3 years	12 months	Not eligible	Not applicable	\$0
Member	Ashlee Piper	3 years	12 months	Not eligible	Not applicable	\$0
Member	Michele Poepjes	3 years	12 months	Sessional	\$75 per hour	\$2,625
Member	Dale Pugh	3 years	12 months	Sessional	\$75 per hour	\$975
Member	Ali Radomiljac	3 years	12 months	Not eligible	Not applicable	\$0
Member	Krishnaraj Ragunath	3 years	12 months	Not eligible	Not applicable	\$0
Member	Corinne Ralph	3 years	12 months	Not eligible	Not applicable	\$0
Member	Theo Rangiah	3 years	12 months	Not eligible	Not applicable	\$0
Member	Kush Rathore	3 years	12 months	Sessional	\$75 per hour	\$4,825
Member	Aidan Ricciardo	3 years	12 months	Sessional	\$75 per hour	\$2,700
Member	Eduardo Rodriguez	3 years	12 months	Sessional	\$75 per hour	\$0
Member	Tyler Selway	3 years	12 months	Not eligible	Not applicable	\$0
Member	Madhavan Seshadri	3 years	12 months	Not eligible	Not applicable	\$0
Member	Kirtida Shah	3 years	12 months	Not eligible	Not applicable	\$0
Member	Gayatri Shirolkar	3 years	12 months	Sessional	\$75 per hour	\$3,775
Member	Susan Slatyer	3 years	12 months	Sessional	\$75 per hour	\$2,625

Position	Name	Term of appointment	Period of membership 2025–26	Type of remuneration	Base salary/ sitting fees	Gross/actual remuneration
Member	Desmond Smit	3 years	12 months	Sessional	\$75 per hour	\$3,450
Member	Tresslyn Smith	3 years	12 months	Sessional	\$75 per hour	\$975
Member	Stephen Sparkes	3 years	12 months	Sessional	\$75 per hour	\$3,375
Member	Katrina Spilsbury	3 years	12 months	Sessional	\$75 per hour	\$2,663
Member	Marisa Taliangis	3 years	12 months	Sessional	\$75 per hour	\$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	12 months	Sessional	\$75 per hour	\$3,525
Member	Bethany Tippet	3 years	12 months	Sessional	\$75 per hour	\$7,125
Member	Sayuri Tomioka	3 years	12 months	Not eligible	Not applicable	\$0
Member	Stephania Tomlin	3 years	12 months	Not eligible	Not applicable	\$0
Member	Santosh Valvi	3 years	12 months	Not eligible	Not applicable	\$0
Member	Zlatibor Velickovic	3 years	12 months	Not eligible	Not applicable	\$0
Member	Bret Watson	3 years	12 months	Not eligible	Not applicable	\$0
Member	Carol Watson	3 years	12 months	Not eligible	Not applicable	\$0
Member	Ruth Webb-Smith	3 years	12 months	Sessional	\$75 per hour	\$3,975

Position	Name	Term of appointment	Period of membership 2025–26	Type of remuneration	Base salary/ sitting fees	Gross/actual remuneration
Member	Dieter Weber	3 years	12 months	Not eligible	Not applicable	\$0
Member	Scott White	3 years	12 months	Not eligible	Not applicable	\$0
Member	Tammy Wilson (nee Corica)	3 years	12 months	Sessional	\$75 per hour	\$1,500
Member	Alexander Wood	3 years	12 months	Not eligible	Not applicable	\$0
Member	Leanne Wood	3 years	12 months	Not eligible	Not applicable	\$0
Expert reviewer	Matthew Albrecht	Ongoing	12 months	Sessional	\$75 per hour	\$0
Expert reviewer	Jasmine Blennerhassett	Ongoing	12 months	Not eligible	Not applicable	\$0
Expert reviewer	Jarrad Bothe	Ongoing	12 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	12 months	Sessional	\$75 per hour	\$0
Expert reviewer	Pradeep Kopppolu	Ongoing	12 months	Sessional	\$75 per hour	\$0
Expert reviewer	Nicola Maslen	Ongoing	12 months	Sessional	\$75 per hour	\$0
Expert reviewer	Charlie McLeod	Ongoing	12 months	Not eligible	Not applicable	\$0

Position	Name	Term of appointment	Period of membership 2025–26	Type of remuneration	Base salary/ sitting fees	Gross/actual remuneration
Expert reviewer	Matthew Moller	Ongoing	12 months	Not eligible	Not applicable	\$0
Expert reviewer	Jennifer Nguyen	Ongoing	12 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	12 months	Not eligible	Not applicable	\$0
Expert reviewer	Stephanie O'Hart	Ongoing	12 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	12 months	Not eligible	Not applicable	\$0
Expert reviewer	Wendy Simpson	Ongoing	12 months	Sessional	\$75 per hour	\$0
Expert reviewer	Barry Thompson	Ongoing	12 months	Sessional	\$75 per hour	\$0
Expert reviewer	Man Wai (Antonia) Wong	Ongoing	12 months	Not eligible	Not applicable	\$0
*Sitting fees are for a minimum of 2 hours per meeting					Total	\$194,916

Position	Name	Term of appointment	Period of membership 2025–26	Type of remuneration	Base salary/ sitting fees	Gross/actual remuneration
Western Australian Future Health Research and Innovation Fund Advisory Council						
Chair (outgoing)	Rebecca Tomkinson	2 years	2 months	Annual	\$37,353 per annum	\$5,833
Chair (incoming)	John Van Der Wielen	8 years	10 months	Annual	\$37,353 per annum	\$29,576
Member	Kane Blackman	7 years	12 months	Sessional	\$825 for meetings over 4 hours, \$537 for meetings of 4 hours or less	\$4,144
Member	Adjunct Prof. Dale Fisher	7 years	12 months	Sessional	\$825 for meetings over 4 hours, \$537 for meetings of 4 hours or less	\$3,598
Member	Jennifer Lawrence	4 years	10 months	Sessional	\$825 for meetings over 4 hours, \$537 for meetings of 4 hours or less	\$1,776
Member	Prof. Dan McAullay	2 years	3 months	Sessional	\$825 for meetings over 4 hours, \$537 for meetings of 4 hours or less	\$1,886
Member	Prof. Christina Mitchell AO	7 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	4 months	Sessional	\$825 for meetings over 4 hours, \$537 for meetings of 4 hours or less	\$0
Member	Mary (Marie) Smyth	2 years	3 months	Sessional	\$825 for meetings over 4 hours, \$537 for meetings of 4 hours or less	\$1,349
Member	Dr Marcus Tan	2 years	12 months	Sessional	\$825 for meetings over 4 hours, \$537 for meetings of 4 hours or less	\$4,144

Position	Name	Term of appointment	Period of membership 2025–26	Type of remuneration	Base salary/sitting fees	Gross/actual remuneration
Member	Prof. Angus Turner	2 years	12 months	Sessional	\$825 for meetings over 4 hours, \$537 for meetings of 4 hours or less	\$3,222
Member	Prof. Fiona Wood	2 years	3 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	\$58,750

Position	Name	Term of appointment	Period of membership 2025–26	Type of remuneration	Base salary/ sitting fees	Gross/actual remuneration
Western Australian Reproductive Technology Council						
Chair	Hamish Milne	3 years	12 months	Annual	\$22,225	\$22,225
Deputy Chair/Member	Dr Michelle De Souza	3 years	12 months	Sessional	\$376	\$4,136
Member	Petrina Burnett	3 years	12 months	Sessional	\$251	\$2,008
Member	Dr Tamara Hunter	3 years	12 months	Sessional	\$376	\$3,008
Member	Dr Demelza Ireland	3 years	6 months	Sessional	\$376	\$1,128
Member	Dr Robyn Leake (Junckerstorff)	3 years	1 month	Sessional	\$376	\$376
Member	Sebastian Leathersich	3 years	12 months	Sessional	\$376	\$2,632
Member	Lauren MacKinnon	3 years	12 months	Not eligible	Not applicable	\$0
Member	Juliettie Somerville	3 years	12 months	Sessional	\$376	\$4,136
Member	Associate Prof. Stella Tarrant	3 years	12 months	Sessional	\$376	\$3,008
Deputy Member	Dr Michael Allen	3 years	12 months	Sessional	\$376	\$752
Deputy Member	Felicite Black	3 years	5 months	Sessional	\$376	\$752
Deputy Member	Valda Duffield	3 years	12 months	Not eligible	Not applicable	\$0
Deputy Member	Prof. Alison Garton	2 years	11 months	Sessional	\$376	\$0
Deputy Member	Deborah Gilchrist	3 years	12 months	Sessional	\$376	\$376

Position	Name	Term of appointment	Period of membership 2025–26	Type of remuneration	Base salary/ sitting fees	Gross/actual remuneration
Deputy Member	Prof. Jeffrey Keelan	3 years	12 months	Sessional	\$376	\$3,008
Deputy Member	Selina Metternick-Jones	3 years	6 months	Not eligible	Not applicable	\$0
Deputy Member	Dr Melissa O'Neill	3 years	12 months	Sessional	\$376	\$0
Deputy Member	Brieanne Rogers	3 years	12 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	\$753
					Total	\$48,298

Position	Name	Term of appointment	Period of membership 2025–26	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	Sessional	\$309	\$1,236
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	\$5,612

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