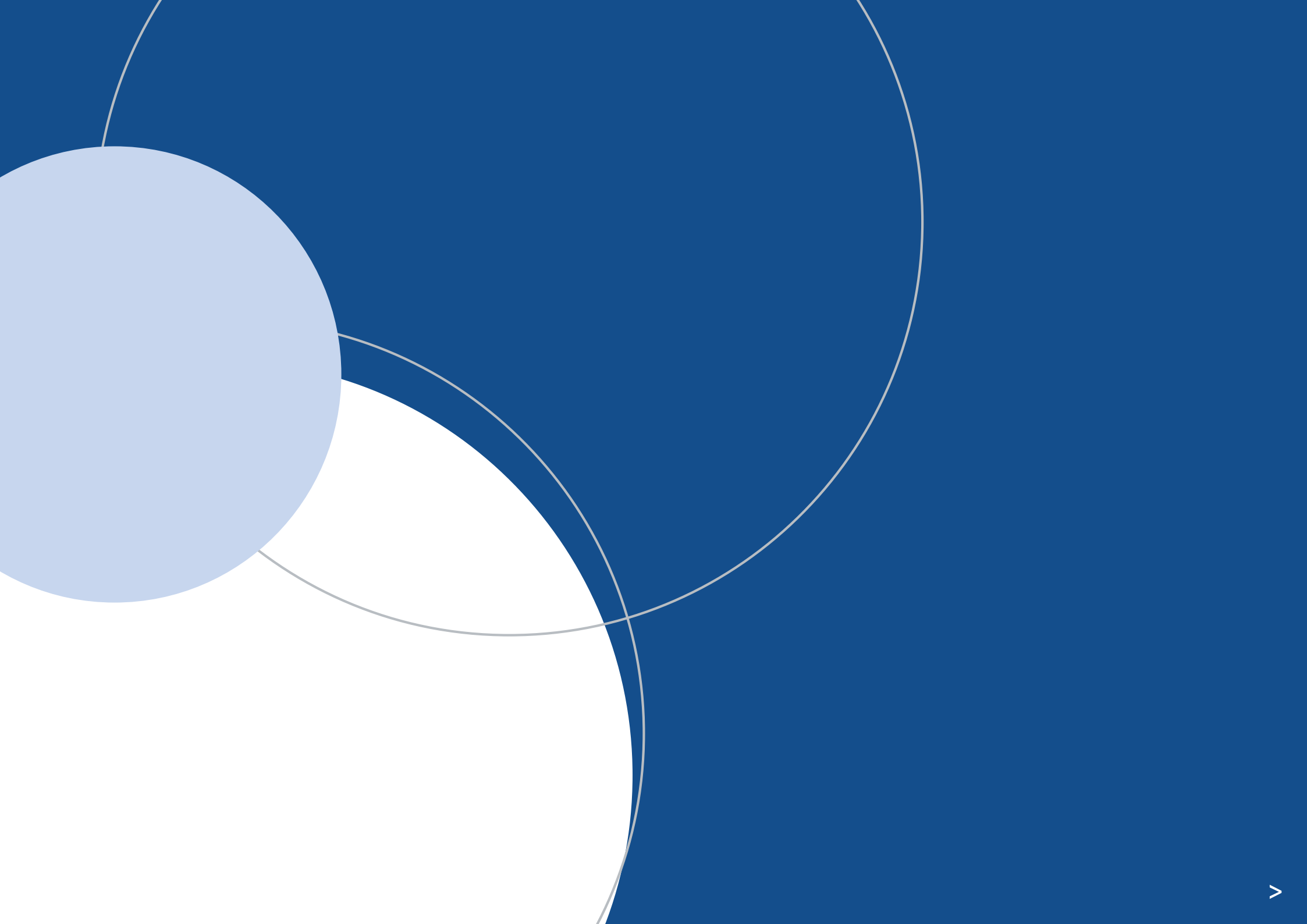




Government of **Western Australia**
Department of **Health**

Annual Report 2021–22







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

Annual Report 2021–22

This annual report provides an overview of the Department of Health operations for the financial year ended 30 June 2022.

Department of Health

189 Royal Street, East Perth, Western Australia 6004
PO Box 8172, Perth Business Centre
Perth, Western Australia 6849
Telephone: 08 9222 4222
enquiries@health.wa.gov.au
www.health.wa.gov.au

Statement of compliance

For the year ended 30 June 2022

**HON AMBER-JADE SANDERSON MLA
MINISTER FOR HEALTH; MENTAL HEALTH**

**HON STEPHEN DAWSON MLC
MINISTER FOR EMERGENCY SERVICES; INNOVATION AND ICT;
MEDICAL RESEARCH; VOLUNTEERING**

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 reporting period ending 30 June 2022.

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



Dr D J Russell-Weisz
DIRECTOR GENERAL
DEPARTMENT OF HEALTH

19 September 2022

Contents

From the Director General	vi	Staff learning and growth	13
Our key achievements 2021–22	viii	Health and wellbeing highlights	13
About us	1	Feeling proud at Pride	14
Our responsible Ministers	2	Celebrating National Reconciliation Week	14
Our accountable authority	2	Significant issues	15
Our enabling legislation	2	Public health leadership	16
Our system manager function	3	Increasing WA's hospital capacity	16
Our strategic directions	4	Multi-pronged health workforce attraction and retention strategy	17
Our organisational structure	5	Independent Inquiry into Perth Children's Hospital	17
Our executive leadership	6	A digitally enabled WA health system	17
Office of the Director General	6	Report on operations	19
Office of the Deputy Director General	6	Transition to living with COVID-19	20
Public and Aboriginal Health Division	7	Governance	20
Clinical Excellence Division	7	Outbreak management, preparation and prevention	20
Clinical Strategy and Planning Division	8	Community transmission and eased borders	20
Strategy and Governance Division	8	COVID-19 caseload peak	21
Purchasing and System Performance Division	9	Hotel quarantine	21
State Health Incident Coordination Centre	9	COVID-19 testing	21
Our people	11	Protecting Aboriginal communities	21
Who we are	11	Supporting aged care	22
Strengthening our diverse workforce	11	COVID-19 medications	22
Our values	12	COVID-19 vaccination and ease of access	22
What our staff are saying	12	Our Corporate Plan 2020–22	23

Lead and innovate	24
COVID-19 modelling	26
Sustainable Health Review progress	27
Health and medical research and innovation	30
WA Child Research Fund	31
Steward and assure	32
Health service provider service agreements	33
Protect and enable	34
The Public Health Atlas: a tool for policy and planning	35
Youth vaping	36
Climate health	37
Assessing the health effects of landscape fire smoke	38
Inspire and empower	39
Spotlight on leadership development	39
Queen's Birthday Honours 2022	40
Award-winning COVID-19 dashboards	41
Our partnerships	42
Celebrating enduring partnerships	42
Collective development of a model of care	44
Reducing inequity in health outcomes and access to care	44
Agency performance	45
Our performance management framework	46

Performance summary	47
Summary of financial performance	47
Summary of key performance indicators	48
No Jab, No Play	50
End-of-Life care in Western Australia	52
Sexually Transmissible Infections Strategy: progress report	53
Operational disclosures	57
Ministerial directives	58
Employee disclosures	58
Employment profile	58
Industrial relations	59
Staff development	59
Work health, safety and injury management	60
Internal governance	62
Governance oversight	62
Risk, compliance and internal audit	62
Risk and Audit Committee Chair 2021–22 appraisal	63
Enquiries and complaints management	64
Managing enquiries and complaints during a pandemic	64
Compliance reporting	65
Compliance with public sector standards	65
Compliance with public sector policy	65

Key performance indicators	69		
Certification of key performance indicators	70	Average cost to support patients who suffer specific chronic illness and other clients who require continuing care	87
Key performance indicators	71	Average cost per client receiving contracted palliative care services	88
Key effectiveness performance indicators	72	Cost per person of providing preventative interventions, health promotion and health protection activities that reduce the incidence of disease or injury	89
Percentage of transition care clients whose functional ability was either maintained or improved during their utilisation of the Transition Care Program	72	Cost per trip for road-based ambulance services, based on the total accrued costs of these services for the total number of trips	90
Percentage of people accessing specialist community-based palliative care who are supported to die at home	73	Average cost of public health regulatory services per head of population	91
Loss of life from premature death due to identifiable causes of preventable disease or injury: (a) Lung cancer; (b) Ischaemic heart disease; (c) Falls; (d) Melanoma; (e) Breast cancer	74	Average cost for the Department of Health to undertake system manager functions per health service provider full time equivalent	92
Percentage of fully immunised children: (a) 12 months; (b) 2 years; (c) 5 years	76	Financial disclosures and compliance	93
Percentage of 15 year olds in Western Australia that complete their HPV vaccination series	78	Financial disclosures	94
Response times for emergency road-based ambulance services (Percentage of priority 1 calls attended to within 15 minutes in the metropolitan area)	80	Summary of board and committee remuneration	94
Proportion of stakeholders who indicate the Department of Health to be meeting or exceeding expectations of the delivery of system manager functions	82	Pricing policy	95
Key efficiency performance indicators	84	Advertising expenditure	95
Average cost of a transition care day provided by contracted non-government organisations/service providers	84	Major capital projects	96
Average cost per home-based hospital day of care and occasion of service	85	Unauthorised use of purchasing cards	97
Average cost per day of care for non-acute admitted continuing care	86	Annual estimates	97
		Audit opinion	98
		Certification of financial statements	102
		Financial statements	103
		Appendix	195
		Appendix 1: Board and committee remuneration	196

From the Director General

Each year in health brings new challenges and opportunities. The past 12 months have proven to be no exception, as we marked the peak of COVID-19 cases in May 2022 and moved towards living with COVID-19.

Our achievements extend well past the successful response to COVID-19 and include the delivery of a broad range of programs to improve the health and wellbeing of Western Australians. Likewise, the pressures on our health system were not restricted to COVID-19, as demand for emergency and general care continues to increase.

Around the country, WA remains the highest-performing jurisdiction for 6 of the last 7 financial years in terms of patient access to emergency services, and in 2020–21 was the highest of all jurisdictions. Over the past year, the WA health system managed more than 1.1 million emergency department attendances, performed 70,000 elective surgeries and delivered 33,500 babies.

I am incredibly proud of how staff in our department have risen to meet these challenges, as we continue to lead and steward the WA health system to enable the delivery of world-class health care to our community.

The department has adapted to the needs of the system throughout the year. The Clinical Strategy and Planning Division was created to focus on the COVID-19 clinical response, and the Office of the Deputy Director General was established to provide support and oversight to ongoing strategic activities.

This year, the COVID-19 response comprised a significant part of the department's activities, from outbreak preparedness to management. The delivery of the hotel quarantine program held the front line against the virus in hotels, rather than in hospitals. The successful rollout of the Western Australian COVID-19 Vaccination Program was a huge undertaking, and a key factor in our low hospitalisation rates from the virus.

Supporting the response was modelling of the anticipated Omicron wave and the establishment of the Patient Flow Command Centre, and the COVID Care at Home program. These initiatives enabled the department to manage and alleviate system demand and ensure at-risk patients received the care they needed.

The publishing of over 30 legislative Directions ensured the Chief Health Officer had the capacity to deliver the public health social measures that were critical in reducing the impact of COVID-19 on our community.

To future-proof the WA health system, the department is leading a project to deliver 120 beds via 4, 30-bed modular wards, strategically placed across the system with commissioning activities underway. These form part of the 530 new hospital beds planned to be open by October 2022, with more than 420 of these already available.

The department has also played a key role in progressing the Women and Newborn Service Relocation Project, with a focus on delivering the business case, refining project governance and quality assuring the project, including the site selection process, and all associated infrastructure needs for the new hospital.

As the department's COVID-19 response transitions to a 'living with COVID-19' strategy, focus has returned to the Sustainable Health Review (SHR). Delivering the SHR will see the health system provide person-centred care, that is innovative and financially sustainable, so Western Australians can receive excellent health services, closer to home, now and for future generations.

Developing a culture and workforce to support new models of care is at the forefront of our work. A multi-pronged workforce attraction and retention strategy was launched in 2021–22 and included the multimedia Belong recruitment campaign and planning for additional Curtin Medical School graduates to bolster the system's medical workforce.

Achieving respectful and appropriate end-of-life care and choices has been a guiding recommendation of the SHR and informed the implementation of the *Voluntary Assisted Dying Act 2019*. This landmark legislation gives terminally ill people the ability to choose the manner and timing of their death. The End of Life Care program has implemented initiatives to empower the dedicated people working and volunteering in the palliative care sector to provide the best possible care.

We also marked a significant milestone of the Electronic Medical Record (EMR) Program with the commencement of digital medical record projects at Armadale Health Service and Kalamunda Hospital, Rockingham General Hospital, King Edward Memorial Hospital, Perth Children's Hospital, Great Southern and Goldfields regions. Preparation and development for the full EMR business case has also commenced.

Progress towards delivering the Outpatient Reform Program continues to gain momentum with the expansion of the Manage My Care app, which enables users to track outpatient appointments and referrals at all WA public hospital facilities. Work to standardise the referral process for public outpatient services is also underway through the development of Referral Access Criteria, with nephrology, neurology and ear, nose and throat specialities already complete.

The Future Health Research and Innovation (FHRI) Fund marked its second year of operation, implementing programs and initiatives totalling \$32 million in grants. From July 2022 the new Office of Medical Research and Innovation at the department will support the Minister for Medical Research and work closely with the FHRI Advisory Council and the medical research and innovation sector to deliver on priority initiatives.

The department has undertaken programs across the state to improve public health in Western Australia, above and beyond the COVID-19 response. This includes improving Aboriginal immunisation rates through inter-agency collaboration, progressing the implementation of the WA Syphilis Action Plan to combat regional outbreaks, and the delivery of statewide influenza, sexual health and food safety campaigns.

The department maintained its comprehensive whole-of-population approach to obesity prevention by investing in a new family-based early intervention program. This includes an intervention program to support children who are above a healthy weight and their families, and implementation of a whole-of-school healthy eating initiative to support healthy eating policies and food literacy across the state.

Closing the gap in health outcomes between Aboriginal and non-Aboriginal Western Australians remains a priority. An evaluation of the first 5 years of the *WA Aboriginal Health and Wellbeing Framework 2015–2030* was delivered to assess our progress, and 11 priorities were set for the next 5-year implementation cycle of the framework.

A Transition Care Program pilot also commenced in partnership with Aboriginal Medical Services and WA Country Health Service; the first ever transition aged care service specifically designed for Aboriginal people in Western Australia.

Through the establishment of a cross-agency long stay patient program, the department has provided complex case input or consultation for more than 220 patients experiencing delayed discharge, including developing 38 bespoke solutions to address barriers to discharge, to facilitate their return to community living. WA's first 12 bed disability transition care unit has also been established to safely and sustainably transition individuals from hospital to supported community living.

The first phase of the expanded Statewide Telestroke Service began in September 2021, enabling clinicians in rural, remote and outer metropolitan areas to seek expert advice from leading stroke experts at the state's tertiary hospitals. The service has already provided over 220 initial and follow-up consultations to stroke patients around Western Australia.

Providing staff with the opportunity to develop their skills and career will continue to be a priority for the department's leadership team, as we strive to make the Department of Health a safe, healthy and contemporary workplace. This year also marked the second cohort of the Introduction to Leadership Program, which builds the leadership capacity of our staff well into the future.

I would like to take this opportunity to thank all department staff, and those throughout the WA health system, for their ongoing dedication and professionalism in supporting the health and wellbeing of all Western Australians.

I look forward to continuing our work together in the year ahead, as we respond to new challenges and take new opportunities in the ever-changing healthcare sector.



Dr D J Russell-Weisz
Director General



Our key achievements 2021–22

Introduced the
**first aged care
transition service
in WA designed for
Aboriginal people**

located in the Kimberley,
South West and
Midwest regions



Released the
**WA Nursing and Midwifery
Digital Health Strategy: fit
for a digital future, every
nurse's and midwife's
business**



Awarded the
**Asia Pacific
Spatial Excellence
(National) Award**

for Community Impact
for interactive COVID-19
dashboards

**New mentoring
program, Moordidjadbiny**

(becoming strong), introduced at our tertiary
hospitals to improve support and retention of
Aboriginal nurses and midwives

WA was designated a
Fast-Track city
on 1 December 2021,
World AIDS Day



Introduction of
Mako SmartRobotics

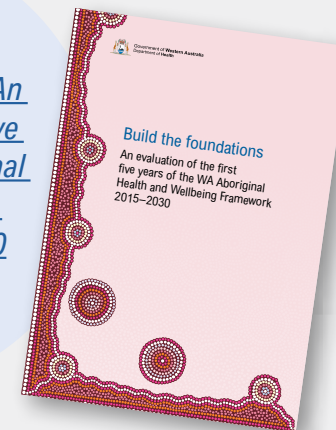
for robotic arm assisted surgery
at Fremantle Hospital, the first
publicly funded system of
its kind in WA's public
hospital system





Over **220**
Telestroke consultations
with patients occurred
across Western Australia,
with **54%** of these patients
receiving treatment and
care close to home

Published
*Build the Foundations: An
evaluation of the first five
years of the WA Aboriginal
Health and Wellbeing
Framework 2015-2030*



Provision of a new

12
bed disability unit to accommodate
persons aged 30 to 65 years
transitioning from hospital to
community living

Awarded the
**Office of Digital
Government Award for
Best Practice in Digital
Transformation**
for the Vaccine
Management System

Managed

250
patient referrals to emergency care
for medium and high risk COVID-19
patients isolating at home

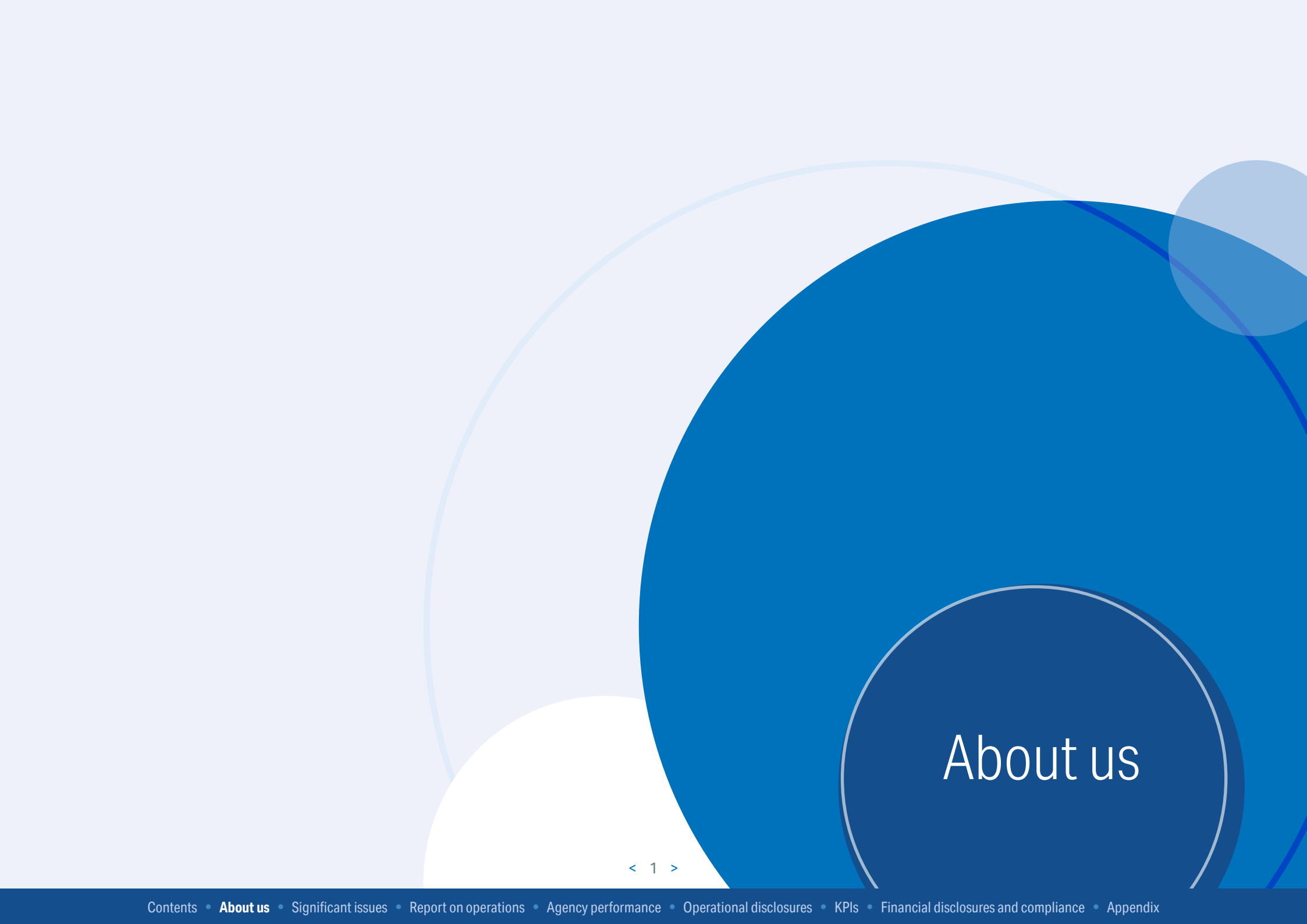
More than
10,000
illegal e-cigarettes seized up to
the end of June 2022 as part of
increased compliance activities
in relation to the illegal sale of
e-cigarettes and nicotine



482
community pharmacies are
now on the state vaccination
distribution system



This page has been left blank intentionally



About us

< 1 >

Our responsible Ministers

The Department of Health is primarily responsible to the Honourable Amber-Jade Sanderson MLA, Minister for Health; Mental Health.



The Department of Health is also responsible for health and medical research funding and strategy, which fall under the portfolio of the Honourable Stephen Dawson MLC, Minister for Emergency Services; Innovation and ICT; Medical Research; Volunteering.



Our accountable authority

The Director General of the Department of Health is Dr D J Russell-Weisz.

In accordance with the *Health Services Act 2016*, the Director General is established as the system manager for the WA health system and is responsible for the strategic direction, oversight, management and performance of the WA health system. Under this Act, the Director General reports to the Minister for Health.

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) Account¹ and its application to health and medical research, innovation and commercialisation. The Director General is also accountable to the Minister for Medical Research for other health and medical research and innovation activities.

The department supports the Director General in the performance of all legislative functions, including his functions as system manager.

Our enabling legislation

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

Through the administration of key legislation, the Department of Health 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 29 Acts. In 2021, the following new legislation passed:

- *Public Health Amendment (Safe Access Zones) Act 2021*
- *Protection of Information (Entry Registration Information Relating to COVID-19 and Other Infectious Diseases) Act 2021*.

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

Our system manager function

The Chief Executive Officer of the Department of Health (the Director General) is established as the system manager for the WA health system under the *Health Services Act 2016*. The system manager operates at arm's length from health service delivery and is responsible for the strategic direction, oversight and management of the WA health system. The Department of Health is part of the WA health system and supports the Director General in performing the system manager functions.

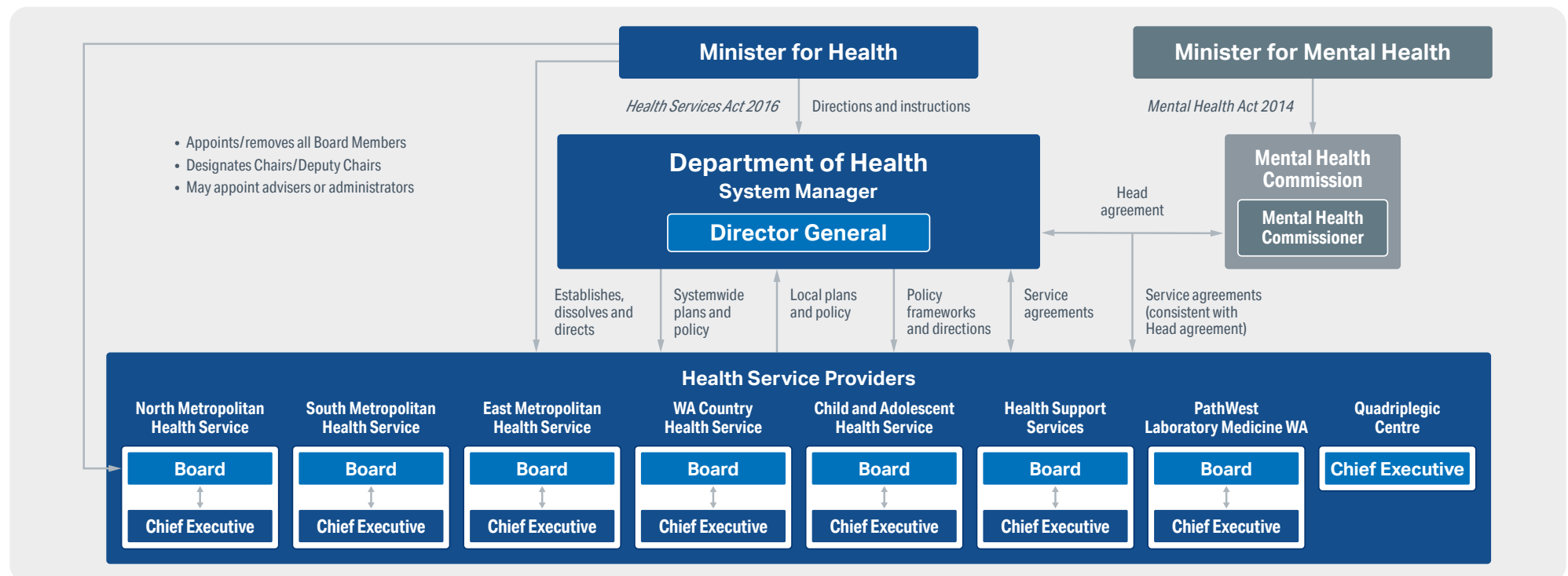
Health service providers form the remainder of the WA health system. They are established as statutory authorities and are each governed by a board and/or chief executive. These statutory authorities are responsible and accountable for delivering public health services or health support services as prescribed through service agreements between the Director General and each health service provider. The service agreements define and detail the scope of services, targeted levels of activity, performance requirements, and roles and responsibilities of the system manager and the health service providers.

Mental health, alcohol and drug health services are purchased from health service providers by the Mental Health Commission through service agreements. These agreements are enabled via a head agreement between the Department of Health and the Mental Health Commission, provided for within the *Health Services Act 2016*.

As the system manager, the Director General also 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.

Figure 1 depicts the governance relationships between the system manager, the Department of Health, health service providers and the Mental Health Commission.

Figure1: WA health system governance structure

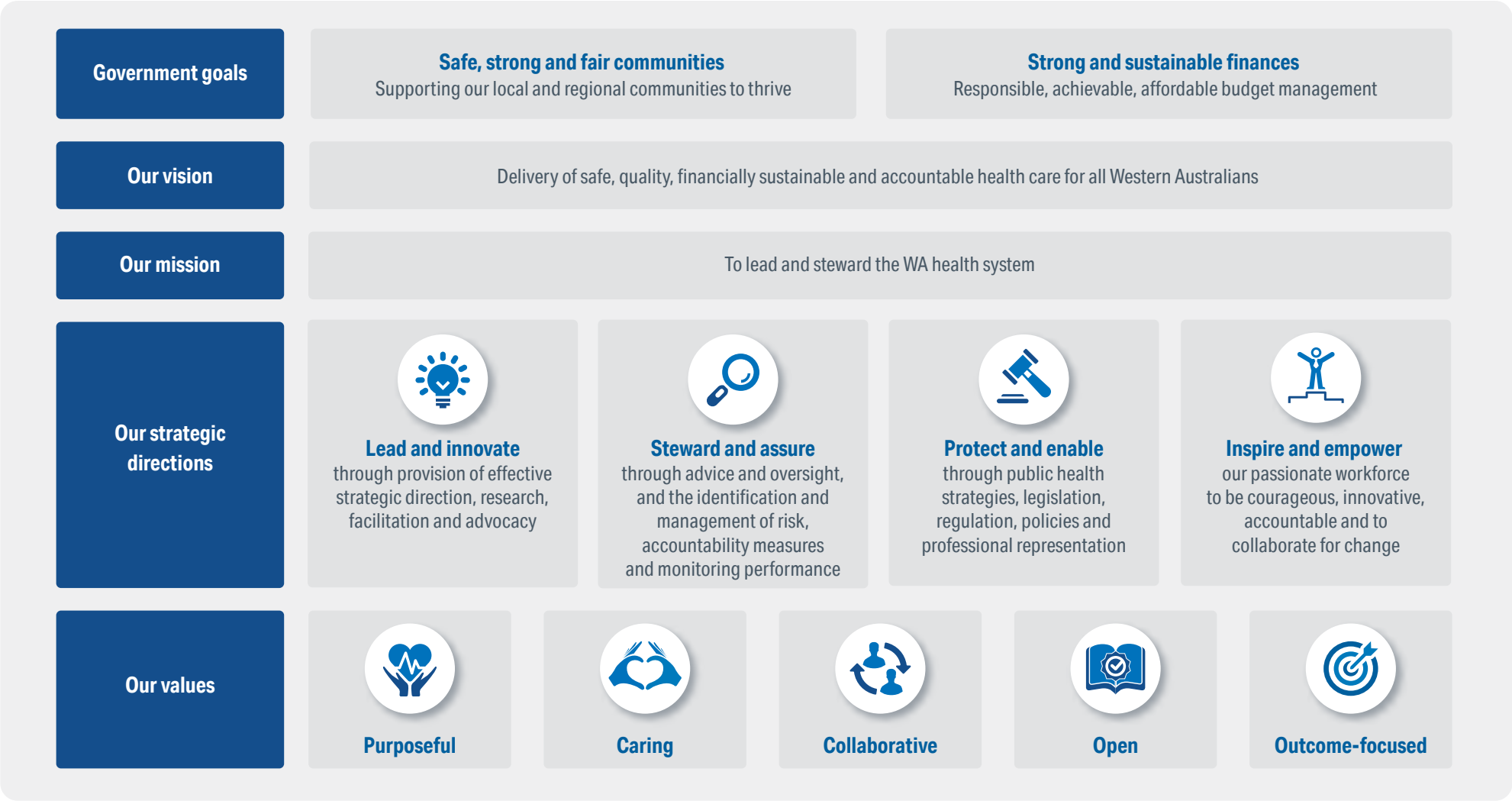


Our strategic directions

The Department of Health’s strategic directions outline a roadmap towards achieving the overarching health system vision for delivery of safe, quality, financially sustainable and accountable health care for all Western Australians.

Our strategic directions reinforce our mission to lead and steward the WA health system to support the State Government’s goals of safe, strong and fair communities and strong and sustainable finances, and our values guide us in all we do.

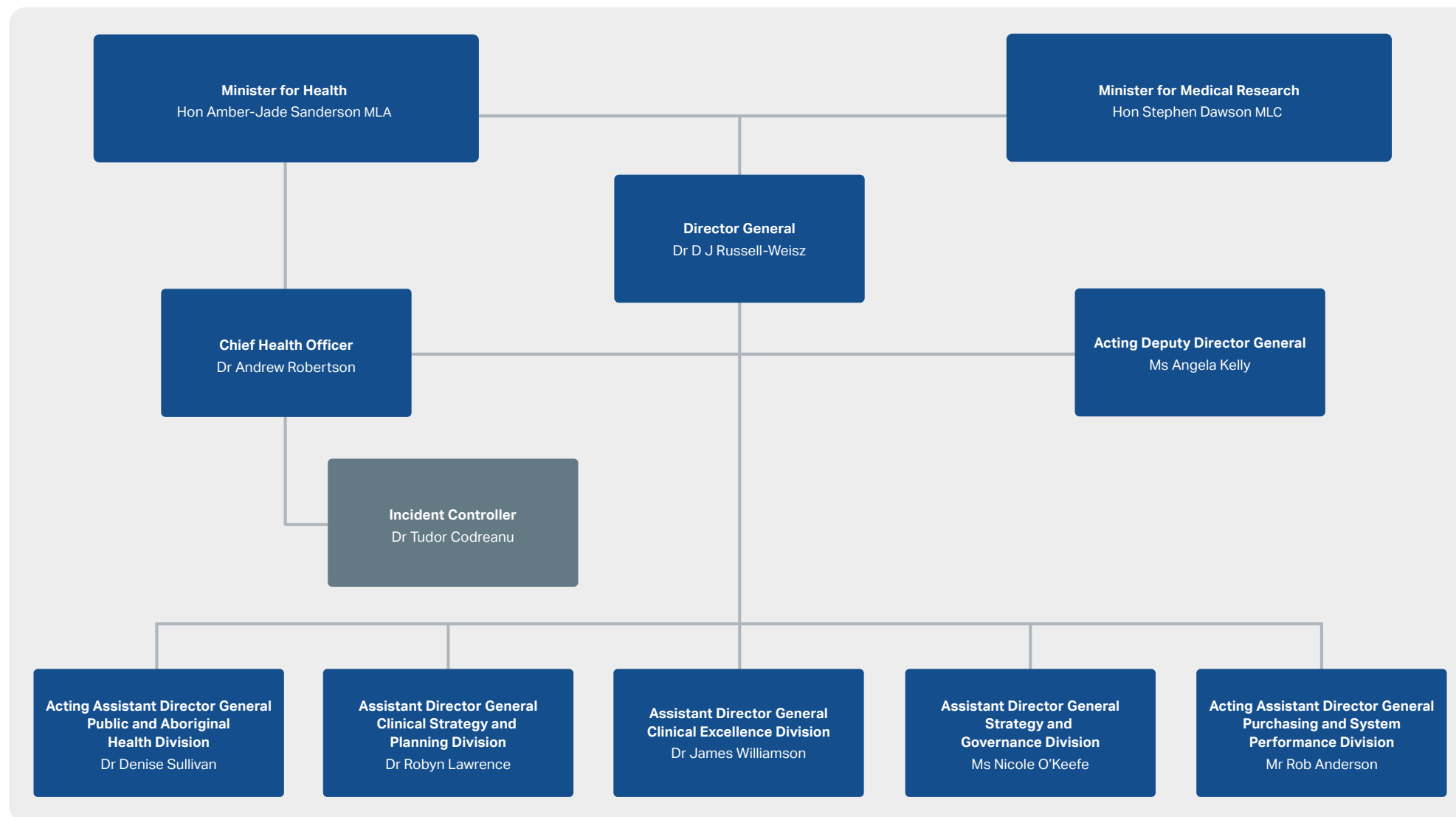
Figure 2: Department of Health vision, mission and directions



Our organisational structure

In the operation of the Department of Health, the Director General is supported by the Deputy Director General, Chief Health Officer and 5 Assistant Directors General (see Figure 3).

Figure 3: Department of Health organisational and senior management structure, 2021–22



Our executive leadership

In 2021–22, the Department of Health delivered services through the following offices and divisions:

- Office of the Director General
- Office of the Deputy Director General
- Public and Aboriginal Health Division
- Clinical Excellence Division
- Clinical Strategy and Planning Division
- Strategy and Governance Division
- Purchasing and System Performance Division
- State Health Incident Coordination Centre

Office of the Director General

The Office of the Director General provides strategic leadership and planning to the WA health system, an executive management function to the Department of Health and health service providers, the facilitation of departmental and systemwide responses to external stakeholders, and administrative and operational support to the Director General. The Office of the Director General comprises 3 areas, including Communications, Ministerial Liaison and the Office of the Director General.

Dr D J Russell-Weisz Director General

Dr Russell-Weisz has guided the WA health system's response to the COVID-19 pandemic, ensuring continuous quality of care for patients and progression of strategic projects. Since his appointment in August 2015, Dr Russell-Weisz has overseen the major reform to devolved governance, and the establishment of health service provider boards under the *Health Services Act 2016*. Along with the Department of Health, health service providers and key external partners, Dr Russell-Weisz is responsible for delivering the recommendations of the *Sustainable Health Review: Final Report to the Western Australian Government 2019*.



Before his appointment as Director General of the Department of Health, Dr Russell-Weisz oversaw the commissioning of the Perth Children's Hospital, led the commissioning of the state's flagship \$2 billion Fiona Stanley Hospital, and served as the Chief Executive of the North Metropolitan Health Service where he led the \$1 billion redevelopment of the QEII Medical Centre, and oversaw 3 tertiary and 3 outer metropolitan hospitals.

Office of the Deputy Director General

The Office of the Deputy Director General provides strategic direction and coordination on key matters for the Department of Health and supports the Director General in the leadership and management of the department and the delivery of key government priorities. The Office of the Deputy Director General comprises 3 areas: Corporate Services, Major Health Projects and Infrastructure, and Mental Health Projects. In addition, the Office of Medical Research and Innovation will move into this area from 1 July 2022.

Ms Angela Kelly PSM Acting Deputy Director General

In 2021, as part of the department's response to COVID-19 and in preparation for the transition to a post-pandemic environment, Ms Angela Kelly was appointed to act in the role of Deputy Director General. Since then, Ms Kelly has played a key role in enabling the department and the Director General to deliver upon key strategic outcomes during disruptions caused by the COVID-19 pandemic.



Ms Kelly holds an economics qualification from the University of Western Australia and has more than 25 years' experience in the public health system, from system performance and financial management to strategic planning and corporate governance. She has also led numerous projects and teams to deliver systemwide reforms.

Prior to performing the Deputy Director General role, Ms Kelly was seconded to the role of Deputy Director General, Recovery Implementation and State Services at the Department of the Premier and Cabinet. Ms Kelly has held several senior executive positions within the Department of Health, including Assistant Director General Purchasing and System Performance, Executive Director Resourcing and Performance and Director of Health Infrastructure.

In 2022, Ms Kelly was recognised in the Queen's Birthday Honours List, awarded the Public Service Medal (PSM) for her outstanding service to the Western Australian health system.

Public and Aboriginal Health Division

The Public and Aboriginal Health Division provides strategic and operational direction for public health services in the WA health system. The division is responsible for fulfilling the legislative responsibilities of the *Public Health Act 2016*, *Food Act 2008* and related Acts. These responsibilities include the regulation of food and tobacco products, public buildings, chemical hazards, personal services, water and radiation safety, regulation of medicines and poisons, vector control, waste-water management, immunisation, infectious disease surveillance, outbreak investigation and disaster management.

The Public and Aboriginal Health Division performs functions that encourage and enable healthy lifestyles and Aboriginal health and wellbeing. The division also collects and analyses statewide health information to survey and monitor the population's health status and aid planning and design of programs and health responses to protect and promote the health of Western Australians.

Dr Andrew Robertson CSC PSM Chief Health Officer

Dr Andrew Robertson provides expert leadership and advice to the Director General and Minister for Health on public and Aboriginal health matters and emerging issues. In his capacity as Chief Health Officer, Dr Robertson is a member of the State Emergency Management Committee and the Australian Health Protection Principal Committee and has played a critical role in guiding the Western Australian and national response to the COVID-19 pandemic.

Dr Robertson has specialist qualifications in public health medicine and medical administration. He served with the Royal Australian Navy (RAN) from 1984 until 2003 and remains in the RAN's Active Reserve.

As Chief Health Officer, Dr Robertson played an integral role in the state's COVID-19 pandemic response including representing the state at national public health forums, developing public health advice/measures to inform the State Emergency Committee and leading the department's COVID-19 response.



Dr Denise Sullivan Acting Assistant Director General

Appointed by the Department of Health in 2010, Dr Denise Sullivan was the founding Director of the Chronic Disease Prevention Directorate, where she led the development of state chronic disease and injury prevention policy and planning frameworks, and contributed to the shaping of the national preventive health policy agenda.

Dr Sullivan holds a Master and a Doctor of Philosophy in Public Health, is a graduate of the Australian Institute of Company Directors and the Leadership WA Signature Program, and an Associate Fellow of the Australian Institute of Management and the Australian College of Health Service Managers.

Dr Sullivan stepped into the role of Assistant Director General in March 2020 while Dr Robertson led the public health response to COVID-19.



Clinical Excellence Division

The Clinical Excellence Division provides clinical advice to the WA health system. It is the focal point for clinical policy development and engagement with the clinical workforce and represents the interests of the professions nationally in addressing specific workforce issues.

The Clinical Excellence Division implements systems to support the safety and quality of health care and oversees the licensing of over 6,100 beds in 122 private healthcare facilities, as well as licensing reproductive technologies. It also administers state-funded research and innovation programs and contributes to national research and innovation directions.

Dr James Williamson Assistant Director General

Dr James Williamson is the Assistant Director General leading the Clinical Excellence Division. He is a general physician and rheumatologist with a PhD and post-doctoral experience in immunology, stem cell biology, gene targeting and scleroderma.

Dr Williamson has held clinical and executive positions in the North Metropolitan Health Service and has previously led the eHealth program and Musculoskeletal Health Network.



Clinical Strategy and Planning Division

In December 2021, the Clinical Strategy and Planning Division was established to reflect the department's need to focus on the COVID-19 clinical response both internally and externally to the WA health system, in addition to ongoing and robust clinical planning and strategic oversight for the future. The division led key systemwide and transformational clinical planning and strategy, and related programs including those aligned to major health infrastructure projects.

Following the department's successful response to Western Australia's Omicron variant outbreak in 2022, the Clinical Strategy and Planning Division will be realigned into the broader Clinical Excellence Division from 1 July 2022.

Dr Robyn Lawrence Assistant Director General

Dr Robyn Lawrence commenced as Assistant Director General of the Clinical Strategy and Planning Division in December 2021.

Dr Lawrence is a highly experienced leader and change agent with a strong emphasis on dynamic and adaptable leadership in rapidly evolving environments.

In her current role, Dr Lawrence has overseen the Department of Health's transition to 'living with COVID-19' in addition to providing ongoing and robust clinical planning and strategic oversight for the future.

Dr Lawrence has a Bachelor of Science, Bachelor of Surgery (MBBS), Master of Business Administration, Fellowship of the Royal Australasian College of Medical Administrators and is a Graduate of the Australian Institute of Company Directors.



Strategy and Governance Division

The Strategy and Governance Division is responsible for the systemwide governance, strategy, policy and planning functions.

The division has 2 directorates. The Governance and System Support directorate is responsible for workforce and employment services, industrial relations, integrity, governance and assurance, and policy frameworks for the WA health system. It provides legal and legislative services to the Department of Health.

The Strategy, Policy and Planning directorate leads advocacy on federal/state matters and supports negotiations with the Australian Government, including on agreements across disability, primary health, aged care and mental health portfolios. It also leads the system planning function for the WA health system, oversees aged care services and provides governance and assurance across information, communication and technology governance bodies.

Key deliverables for the Strategy and Governance Division include supporting the implementation of the Sustainable Health Review, coordinating and reporting against the Election Commitments and Recovery Program portfolios, overseeing the delivery of the *WA Health Digital Strategy 2020–2030*, and delivery of the statewide Electronic Medical Record Program.

Ms Nicole O'Keefe Assistant Director General

Ms Nicole O'Keefe commenced as Assistant Director General, Strategy and Governance in September 2019. 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.

Ms O'Keefe joined the Department of Health from her position as State Manager WA of the National Disability and Insurance Agency (NDIA). Before joining the NDIA in February 2016, Ms O'Keefe held various senior positions across state and federal portfolios.



Purchasing and System Performance Division

The Purchasing and System Performance Division comprises 3 areas: Information and System Performance, System Resourcing and System Procurement.

This division is the primary point of liaison between the Department of Health and Department of Treasury and is responsible for the strategic management of resource allocation. It also monitors, manages and analyses the performance of the WA health system in accordance with the *Health Services Act 2016*, with the underlying objective to ensure the continued provision of safe and quality public health care to all Western Australians.

The Purchasing and System Performance Division undertakes demand and capacity modelling, system analytics, and data integrity and linkage. It oversees system performance and is responsible for the strategic management of financial operations, including financial reform and policy, and delivers national and public reporting for the department. The division also manages key community sector contracts for statewide services and undertakes budgeting and purchasing functions. This includes issuing of service agreements with health service providers and stewarding the head agreement with the Mental Health Commission.

Mr Rob Anderson Acting Assistant Director General

Mr Rob Anderson was appointed to act in the role of Acting Assistant Director General of the Purchasing and System Performance Division in September 2020 following the secondment of Ms Angela Kelly to the Department of the Premier and Cabinet as Deputy Director General. Before this, Mr Anderson had been the Executive Director of Information and System Performance Directorate, formerly System Performance, since July 2016.

Throughout his 28 years in public service, Mr Anderson has held a variety of senior portfolios, including the Director of Activity Based Management (ABM) Reform and was involved in both the Fiona Stanley Hospital Commissioning Project and the Midland Health Campus Project.



State Health Incident Coordination Centre

As the mandated Hazard Management Agency for the Human Epidemic, the department's health response to the COVID-19 pandemic was coordinated by the State Health Incident Coordination Centre (SHICC) under the direction of the Chief Health Officer.

The pandemic response was guided by the emergency management elements of prevention, preparedness, response and recovery, based on national and state priorities.

The SHICC responded to the pandemic through the strategic coordination of Western Australia's health response and operations, including the management of hospital, clinical health service and non-public health sector COVID-19 responses, as well as that of many other industries and sectors.

The SHICC worked with health service providers to provide oversight to WA's systemwide health surge capacity, including sourcing ventilators and personal protective equipment, intensive care unit beds, coordinating safe transport of COVID-19 hospital patients, and supporting workforce planning from a state perspective.

The SHICC managed WA's hotel quarantine program and the WA health system's contact tracing function, as well as providing community information and education for a range of industries, settings and communities, as well as the general public.

Dr Tudor Codreanu Incident Controller

Dr Tudor Codreanu is a physician with extensive experience in emergency medicine and disaster medicine, in Australia and abroad. A WA Medical Assistance Team Divisional Commander and an Australian Medical Assistance Team lead, Dr Codreanu has international qualifications in disaster medicine and is a faculty member of the European Master in Disaster Medicine. He obtained his PhD in disaster medicine from the University of Western Australia.

Dr Codreanu was appointed SHICC Incident Controller in June 2021.





Front (L to R): Dr Andrew Robertson, Dr D J Russell-Weisz, Ms Angela Kelly. Back (L to R): Ms Nicole O'Keefe, Dr Robyn Lawrence, Mr Rob Anderson, Dr Denise Sullivan and Dr James Williamson.

Our people

Who are we

As at 30 June 2022 the department employed **1,204** full time equivalent (FTE) including:

238 FTE to respond to COVID-19

283 new starters

16 graduates

Our staff include:

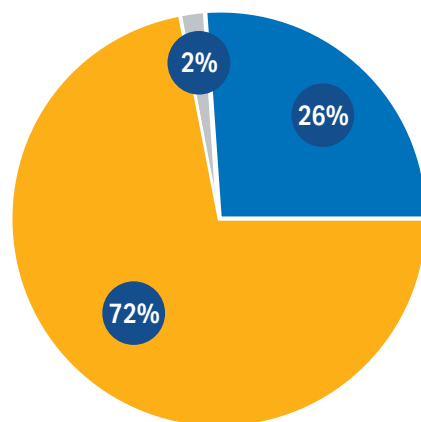
92% Administrative and clerical

3% Medical services

3% Medical support services

2% Nursing services

Employment type



■ Full time
■ Part time
■ Other

Strengthening our diverse workforce

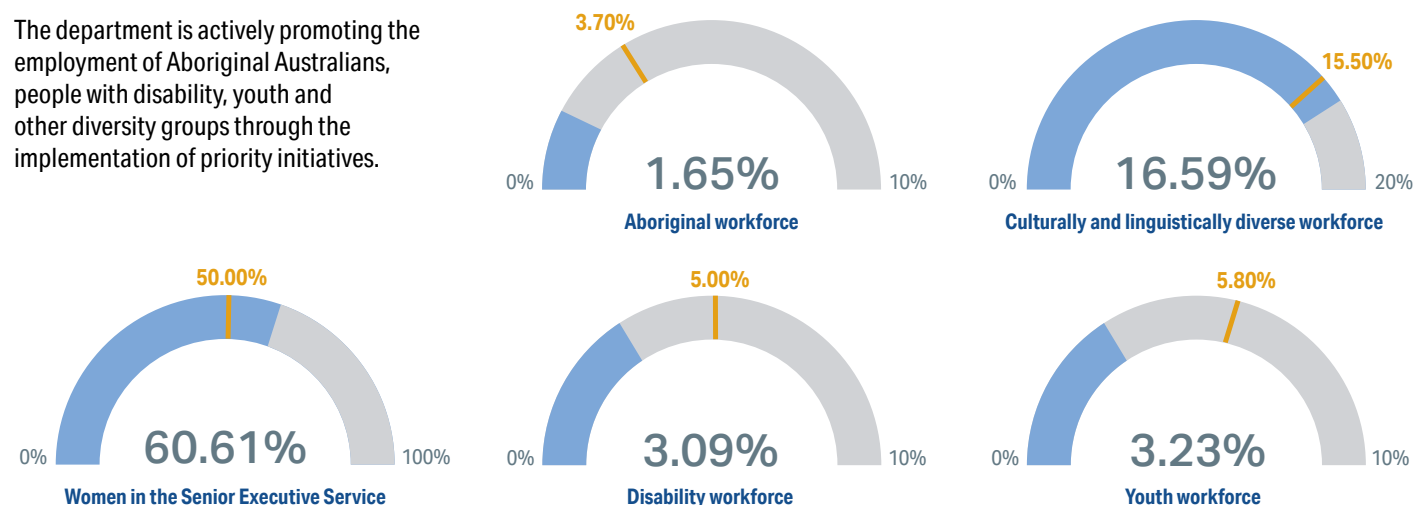
The department is committed to increasing the representation of people from different backgrounds at all levels across our sector. We recognise that a diverse and inclusive workforce brings a better understanding of community needs and expectations and thus service delivery that is responsive to change and appropriate to the community we serve.

Our employees have come from all across the world and bring with them diverse experiences and perspectives.



Department of Health workforce diversity compared to Public Sector Commission targets

The department is actively promoting the employment of Aboriginal Australians, people with disability, youth and other diversity groups through the implementation of priority initiatives.



Our values

Proudly working together for a healthier Western Australia



Purposeful "we show pride in our work and its positive impact"

- We ensure there is a clear purpose for all actions we take
- We are proud and passionate about working for the Department of Health
- We promote and reinforce the benefits and value of our work



Caring "we value and respect one another"

- We support and respect each other
- We seek to be an example of a healthy workforce
- We support diversity and differences in views



Collaborative "we set each other up for success"

- We work together towards the shared purpose
- We align our effort to improve health outcomes
- We combine our expertise to ensure the best solution



Open "we act with integrity and do what's right"

- We share information openly and responsibly to create the best outcomes
- We acknowledge and address issues without blame
- We act with integrity



Outcome focused "we enable outcomes to be achieved"

- We find better ways to achieve positive outcomes
- We simplify processes to allow our people to be effective
- We apply governance and controls appropriate to the risk

What our staff are saying

2021 Minister for Health Survey



Highest positive scoring questions	% positive
Q20. The people in my team behave in an accepting manner towards people from diverse backgrounds	88%
Q15. I believe that one of my responsibilities is to continually look for new ways to improve the way we work	87%
Q17. The people in my team cooperate to get the work done	87%
Q3. I feel committed to my organisation's goals	85%
Q8. I believe in the purpose and objectives of my organisation	85%

Staff learning and growth

- **2,500 hours** of eLearning
- **3,200 hours** of face-to-face training and development
- **36 cadets** recruited to the Aboriginal Cadetship Program
- **38 participants** involved in the First Step Aboriginal Leaders program
- **14 participants** completed the Public Health Training Program
- Over **40 managers** attended all Level 8 senior leadership presentations and over **25 leadership alumni members** engaged with either the formal or informal development opportunities
- **15 aspiring leaders** are currently completing the 2022 Introduction to Leadership Program



Introduction to Leadership Program participants with Dr D J Russell-Weisz, Director General

Health and wellbeing highlights

In 2021–22, departmental staff took advantage of the varied health and wellbeing initiatives on offer throughout the year.

- Free skin checks were held offering participants a 15-minute full body assessment by a qualified nurse, summary report and if required, a guideline for referral to a general practitioner.
- Prior to R U OK Day, the department hosted a wellbeing seminar which emphasised the importance of maintaining connections with others and how to start a conversation that could change a life, how to talk with others to encourage wellbeing, and to identify where and when to access support.
- In Mental Health Week staff were invited to live webinars to raise awareness of mental health issues and increase efforts in support of mental health. This was an opportunity for staff to talk about their work, and what more needs to be done to make mental health care a reality for people inside and outside the workplace.
- 76 employees participated in 30 Days of Health, a month of challenges and events covering the themes of nutrition, physical activity, sleep and mental health. Employees participated in step challenges and divisional activity battles in addition to attending seminars such as Healthy Habits for Busy People.
- The department delivered the annual staff flu vaccination program which enabled 591 employees to receive their vaccination through a convenient on-site clinic.
- The department also promoted Lifeblood, the branch of the Australian Red Cross responsible for collection and distribution of blood, with the goal to encourage more volunteers to donate.



Feeling proud at Pride

The Department of Health was proud to have joined this year's PrideFest parade (Pride), demonstrating our strong commitment to 'embracing diversity in health' and our value and respect to one another.

It was the department's first year marching in Pride and we joined with our colleagues at WA Country Health Service to form a 40-strong contingent including staff, friends and family. Staff from East Metropolitan Health Service, North Metropolitan Health Service and South Metropolitan Health Service rounded out representation from the WA health system.

PrideFest was opened with Noongar elders and Indigenous community members, allies and the dancers of Corroboree for Life, followed by the much-anticipated parade. The then Minister for Mental Health, the Honourable Stephen Dawson was in attendance and came by to meet and greet the department and WA Country Health Service participants.

Involvement in the parade was a culmination of several months of planning and organising and was much appreciated by everyone who took part.



Celebrating National Reconciliation Week

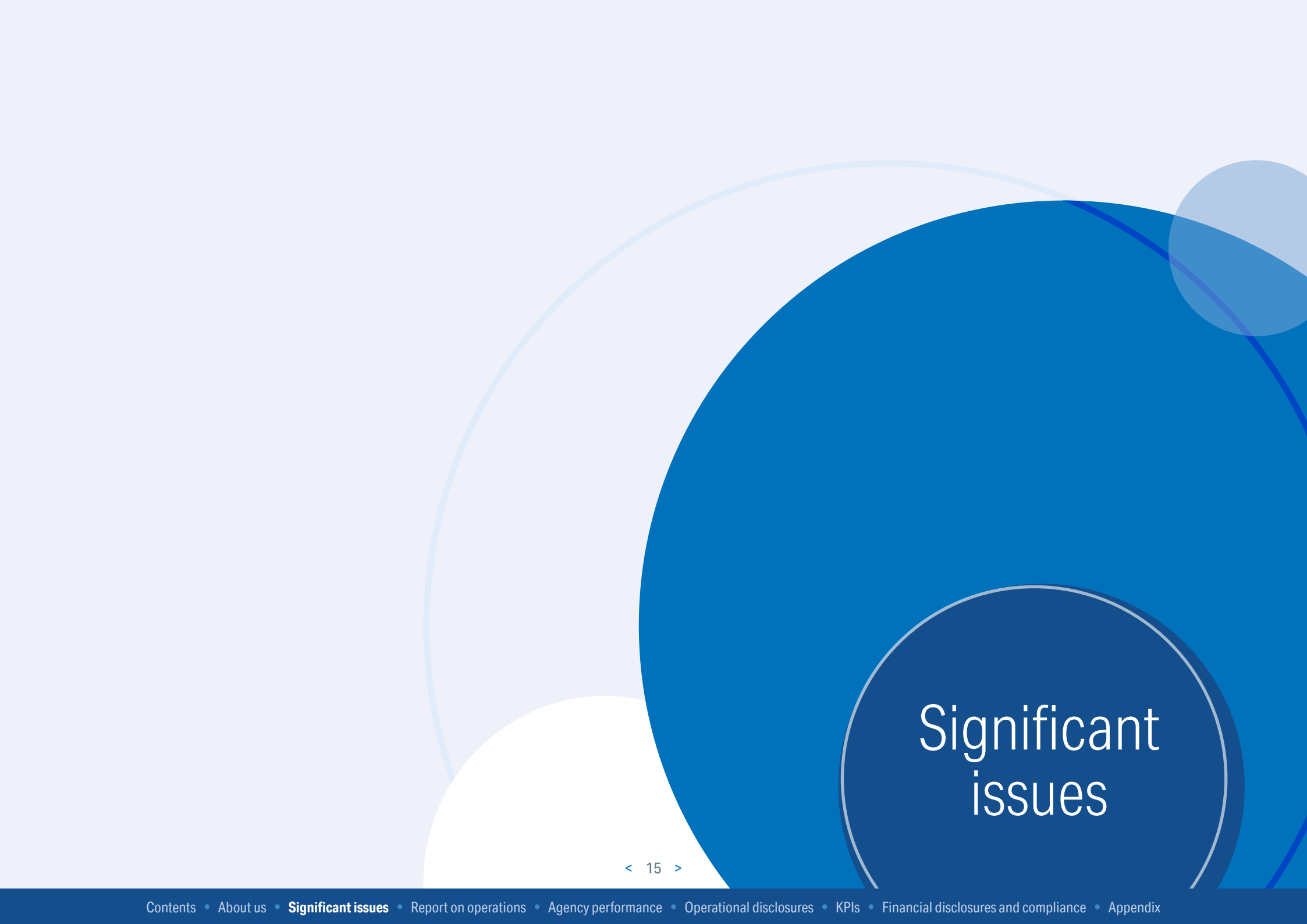
For the Department of Health, National Reconciliation Week began with a Welcome to Country and Smoking Ceremony in the May Holman Building Courtyard on Whadjuk Noongar Boodja, led by Noongar Elder Neville Collard, and continued with workshops presented by members of the Aboriginal community.

Sharon Gregory, a Noongar language teacher, provided an immersive learning experience on Noongar language, taking participants on an engaging journey, and sharing the history of her country, language and family. Participants had the opportunity to listen to Sharon speak Noongar, learn animal and place names, pronunciation, sentence structure and cultural context, as well as write their own short picture books in Noongar.

Noongar Elder Neville Collard led a discussion on Noongar culture and the significance of the 6 seasons. With a wealth of knowledge, and a knack for storytelling, Neville provided incredible insight into hunting and gathering food according to the seasons.

The department was also privileged to welcome Nerolie Bynder as artist in residence for the week. Nerolie created an inspiring artwork to display in the department. Staff were invited to watch Nerolie paint and contribute to the mural by adding their fingerprints.





Significant issues

Significant issues

Public health leadership

The Public Health State of Emergency remained in place during 2021–22, requiring significant leadership and resources from the department.

The Chief Health Officer regularly provided public health advice to the Premier, Minister and State Emergency Coordinator regarding limiting the transmission and impact of COVID-19. The advice included recommendations to implement public health and social measures including testing, tracing, isolation and quarantine strategies, mask wearing, vaccination requirements and border controls. These COVID-19 mitigation strategies were constantly being reviewed and tailored to ensure proportionality to conditions at the time. The public health advice was also pivotal in providing guidance for transitioning out of the pandemic and learning to live with COVID-19.

The measures in place to limit the spread of COVID-19 had effects on other communicable diseases, including contribution to the decline in influenza notifications across Western Australia for 2020 and 2021. For 2021, to 30 June (week 26) there were only 21 influenza notifications while the same time period in 2022 saw 4,948 notifications, a 22 per cent increase compared to the past 5-year average. In anticipation of this spike, and with the reduction in mitigation strategies and the opening of borders, the department commenced the 'Free influenza vaccination during June and July' campaign. From 1 June to 31 July 2022, free influenza vaccinations were made available to all Western Australians aged 6 months and above via general practitioners, community pharmacies and other immunisation providers. More than 190,000 Western Australians received a free influenza vaccination in the first month of the campaign.

In these unprecedented times the department also responded to new communicable diseases typically not reported in Western Australia. In February 2022, the department monitored the unfolding situation of human cases of Japanese encephalitis virus (JEV) detected for the first time in the eastern states. Part of the response involved developing the Japanese Encephalitis Virus Joint WA Surveillance Sub-plan and working with the Department of Primary Industries and Regional Development to enhance mosquito and animal surveillance efforts. Infectious disease clinicians at WA hospitals were also asked to be alert to the possibility of JEV in people presenting with encephalitis. Federal funding of \$1.25 million was secured to respond to and enable vaccination of priority risk groups.

Since May 2022, the department has also been responsible for leading WA's response to monkeypox, a rare zoonotic viral infection that usually occurs in West and Central Africa. To 30 June 2022, 5,253 cases had been reported globally including 12 cases in Australia. Western Australia's preparedness includes the department working closely with public health units, pathology laboratories, non-government organisations, general practitioners and sexual health clinics across the state to ensure we can rapidly identify cases and contacts to implement prevention and control activities.

Further information on the Department of Health's response to COVID-19 is provided in the Report on operations section of this annual report.

Increasing WA's hospital capacity

The WA health system is addressing the significant challenges of demand and capacity pressures through integrated investment in initiatives targeting emergency access, hospital avoidance, improved patient flow and reducing overall pressures across all health services. Approximately \$252 million has been allocated for 2022–23 towards an Emergency Department Package, supported by a Ministerial Oversight Committee, which incorporates strategic and operational solutions to streamline patient flow, address the root causes of ambulance ramping, and implement alternative models of care to support treatment of patients in the most appropriate setting. Funding has also been allocated to reduce avoidable hospital presentation and admissions for people with complex needs via access to multidisciplinary teams in the community and, where required, more timely and convenient access to physical and mental health consultations. Options for discharging patients who remain in hospital longer than clinically required are also being addressed.

Multi-pronged health workforce attraction and retention strategy

Due to COVID-19, there has been a global race for healthcare workers. In August 2021, a multi-pronged workforce attraction and retention strategy was launched. This included the multimedia [Belong recruitment campaign](#) featuring a range of healthcare workers in various facilities and settings to capture the multidisciplinary, collaborative, dynamic working environment of the WA health system. The 'Make a Difference in Mental Health' campaign was also launched, aimed at increasing the number of people entering the mental health workforce. A dedicated refresher program was implemented to support enrolled nurses, registered nurses and midwives requiring recency of practice to return to the workforce.

Other strategies included adding 9 nursing occupations to the State Nominated Migration Program in WA which enables visa holders already in Australia to fill jobs not being met by local workers. New graduate nursing and midwifery positions were also created to increase available staff across the sector.

Independent Inquiry into Perth Children's Hospital

On 9 November 2021, the Department of Health released the [Report of the Independent Inquiry into Perth Children's Hospital, along with a response from the Child and Adolescent Health Service Board](#). The Department of Health and the Child and Adolescent Health Service accepted the report's 30 recommendations, which covered key areas such as sepsis identification, parent escalation, consumer engagement (particularly with culturally and linguistically diverse families), clinical governance, workforce planning and supply, and organisational culture.

The department is also collaborating with health service providers to address recommendations to be adopted across applicable WA hospitals, including roll out of the Call and Respond Early (CARE) Call system and providing a clearer more cohesive policy framework for managing complaints and concerns about clinicians. In addition, continued investment in safety and quality improvements to align with contemporary standards of care, including but not limited to changes in emergency department staffing models (care-call initiative) has formed part of the 2022–23 budget.

A digitally enabled WA health system

Investment in contemporary digital infrastructure, network capability and clinical digital technologies underpins safe, high-quality health care in an increasingly digital world. The [WA Health Digital Strategy 2020–2030](#) provides a vision of how a digitally-enabled journey of health care for patients, carers and staff will drive better health outcomes for all Western Australians.

The development of an Electronic Medical Record system, the keystone of digital transformation of clinical care, is progressing and will provide the foundation for high-quality enabled healthcare. Further, Health Support Services is leading the replacement of the Human Resource Management Information System to provide contemporary support for payroll and human resource services across the health system. Funding has also been allocated for 2022–23 to ensure agile and responsive management of system pressures through development of real time data solutions that will monitor and inform management of demand and patient flow across all WA health system sites. Expansion of the use of virtual technology to triage patients in ambulances to reduce patient wait times at emergency departments is also planned.

While digital innovation is important, so too is ensuring that health network infrastructure and systems are maintained and fit for purpose. The Department of Health is working with Health Support Services to investigate the progressive uplift and refresh of the WA health system's ageing network infrastructure to resolve a qualified audit opinion from 2020–21. The planned works will improve digital security and provide a stable, supportable network platform to all WA health system sites. Migration of HealthPoint, the WA health system's corporate intranet, is also being planned to enable system updates and reduce the risk of data breaches.

This page has been left blank intentionally



Report on operations

Transition to living with COVID-19

The COVID-19 pandemic continued to dominate the 2021–22 year, but unlike other states and territories where major outbreaks took hold, Western Australia was protected from widespread community transmission of COVID-19 for most of the year.

The department's public health response to the pandemic was coordinated by the Incident Management Team situated in the State Health Incident Coordination Centre (SHICC) under the direction of the Chief Health Officer.

In late 2021, the SHICC strengthened capacity by merging with the department's Public Health Emergency Operations Centre, including its contact tracing (Public Health Operations) teams.

Governance

As prescribed by the *Emergency Management Act 2005* the Chief Executive Officer of the Department of Health, as the Hazard Management Agency (HMA), continued to implement emergency management activities in 2021–22 in response to COVID-19. Under the *Public Health Act 2016*, and as the delegated HMA, the Chief Health Officer initiated 31 Directions to enable a legal platform to implement public health and safety measures (including mandatory vaccination requirements) and testing, tracing, isolation and quarantine requirements.

Outbreak management, preparation and prevention

With the hard border in place throughout the latter half of 2021, WA's hotel quarantine program, contact tracing and infection prevention and control teams provided the first line of defence against the spread of infection from returning travellers.

During this phase, the COVID-19 response included managing cases and contacts in hotel quarantine, vaccination preparation planning and delivery, public information, stakeholder engagement functions, and outbreak management, most notably on 82 assessed maritime vessels.

Short duration lockdowns sparked by infectious cases in the community and the risk of further community transmission in WA saw the SHICC's response expand the focus on testing, contact tracing, isolation and quarantine, and communications to contain the spread of COVID-19. Statewide clinical working groups representing 11 high-risk settings and/or patient cohorts were established to support safe, consistent and equitable care. WA's surge contact tracing teams also provided critical aid and additional surge capacity to interstate contact tracing efforts.



The COVID Care and Assistance team was stood up to provide specialised case management and support for consumers and patients isolating in the community and in hotel quarantine facilities. A total of quarantine facilities, 4,798 clients were supported.

As conditions evolved in the COVID-19 response, the department was able to call on internal expertise to address emerging issues concerning public health and biosecurity, ventilation, wastewater, and public gatherings.

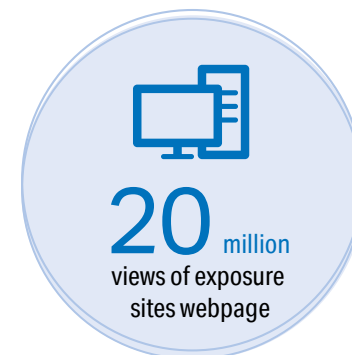
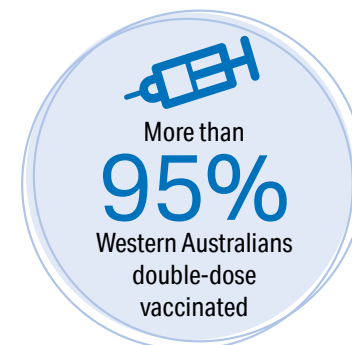
By the time WA borders had reopened on 5 March 2022, WA had achieved one of the highest COVID-19 vaccination rates in Australia, with a double-dose rate of more than 95 per cent of the population aged 16 years and older, and a triple dose rate of more than 82 per cent.

Community transmission and eased borders

As arrivals from other states and territories entering home quarantine and community cases increased over the Christmas–New Year period, the state was well prepared to respond to the expected spread of infection.

On Christmas Eve 2021, a COVID positive case was identified in a backpackers facility. The Public Health Operations team was quick to respond and successfully managed the outbreak which included 23 cases infected with the Delta subvariant, tracing more than 800 close contacts and in excess of 2,000 casual contacts. This was crucial in preventing widespread community transmission of the Delta subvariant, especially ahead of the planned border opening.

When WA border restrictions were eased in early March 2022, high vaccination rates, contact tracing, and public health and social measures were integral to slowing and tracking the expected increasing spread of COVID-19. There was a shift from intense individual case management, contact tracing and quarantine surveillance to management focused on outbreaks in high risk settings, such as aged care facilities and remote Aboriginal communities.



COVID-19 caseload peak

Western Australia's world-leading vaccination rates and strong public health and safety measures were significant in keeping hospitalisations below predicted levels.

As COVID-19 cases peaked during May 2022, protection from the virus was strengthened in healthcare settings through the implementation of additional safety measures, including mandatory personal protective equipment for clinicians and patients, visitor restrictions and modified triaging processes.

More than 200 site visits were undertaken to provide infection prevention and control education and training to industries outside the healthcare setting to support their COVID-19 preparedness efforts.

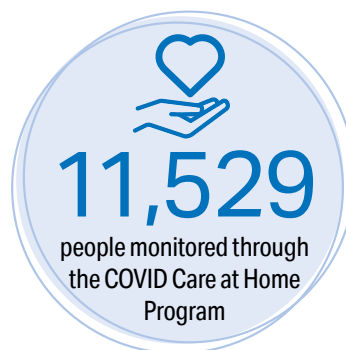
WA's COVID Care at Home program, launched in January 2022, provided home monitoring care to 11,529 people at greater risk of hospitalisation. This relieved the pressure of COVID-19 cases on our health system by supporting people who could be safely managed at home.

Public information focused on helping people understand what to do if they became a COVID-19 close contact or tested positive was critical in building trust and compliance with mandatory public health and social measures.

Hotel quarantine

As the state's first line of defence, WA's hotel quarantine program hosted Australians returning from overseas, interstate travellers, families, maritime and offshore industry workers, local community cases and Afghan humanitarian refugees. Over the life of the program, more than 68,000 people were cared for through 1,901 rooms across 6 metropolitan hotels used as quarantine facilities.

Management of passengers from the point of arrival at both domestic and international airports was also an integral part of the hotel quarantine program. The SHICC worked collaboratively with Perth Airport, and federal and state agencies, in establishing COVID-19 testing services and with air marshals, supporting rapid antigen test (RAT) distribution at the airport.



In early June 2022, Western Australia's fully opened border and reduced supervised quarantine requirements for unvaccinated travellers saw the final guest exit hotel quarantine on 2 June.

COVID-19 testing

Public access to clinic-based polymerase chain reaction (PCR) testing at public and private COVID clinics and rapid turnaround times for results were critical in detecting cases and containing the spread of infection. A new data system captured all tests performed at public and private providers in real time.

From January 2022, RATs enhanced rapid and convenient access to testing and reduced demand on pathology systems.

Mandatory registration of positive RAT results on the HealthyWA website enabled early identification of cases and facilitated their access to the COVID Care at Home program.

Operating hours at COVID clinics were agile, increasing at short notice where required and supported by contracted private pathology providers who quickly stood up drive-through testing clinics.

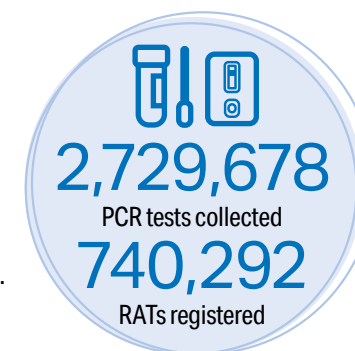
Protecting Aboriginal communities

The Chief Health Officer chaired the multi-agency forum of senior officers from state, federal and non-government agencies from November 2021 to January 2022 to collectively address enhanced COVID-19 preparedness in remote Aboriginal communities.

The forum reviewed regional accommodation, culturally appropriate communications and messaging, and incorporated lessons learned from New South Wales and the Northern Territory.

The WA Aboriginal Advisory Group for COVID-19 was critical to ensuring a culturally safe response for Aboriginal communities across the state. The COVID Care Assist Team successfully supported almost 4,000 Aboriginal people and families with complex needs throughout the pandemic.

Once interstate borders opened in March 2022, COVID-19 outbreaks in remote Aboriginal communities were successfully managed in a partnership between the SHICC team and key stakeholders, including local regional response teams and Aboriginal Community Controlled Health Services. This is a testament to the significant preparedness and planning work undertaken for Aboriginal communities.



Supporting aged care

In March 2022, the Department of Health led a multi-agency Aged Care Response Centre team with input from the Australian Government Department of Health and the Australian Defence Force, to manage COVID-19 outbreaks in WA's residential aged care facilities.

The department regularly communicated with residential aged care facilities to provide public health and infection prevention and control advice when high-risk outbreaks were identified.

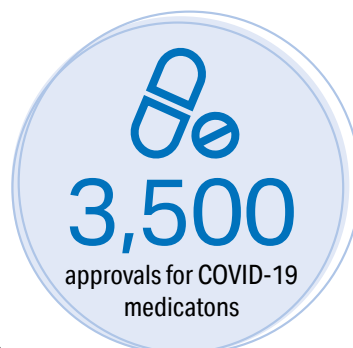
More than 60 facilities were supported through Outbreak Management Team meetings to mitigate the risk of experiencing impacts from COVID-19.

The initiative, which involved the Aged Care Safety and Quality Commission, responded to 375 COVID-19 outbreaks in residential aged care facilities in 2021–22. The department supported affected aged care facilities to close more than 330 of the outbreaks by the end of the 2021–22 financial year, enabling them to return to business as usual and continue to provide quality care to older Western Australians.



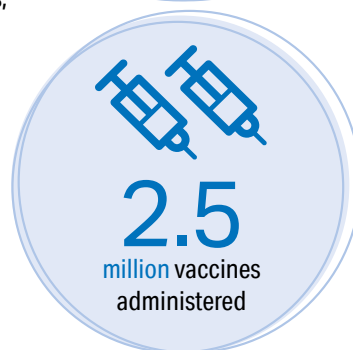
COVID-19 medications

As new COVID medications became available through the National Medical Stockpile, a COVID Treatments Cell was established to facilitate receipt, storage, distribution and reporting in relation to the various medications. To 30 June 2022, almost 3,500 approvals for medications to treat COVID-19 had been granted in addition to the prepositioning of medications at aged care facilities, Aboriginal Controlled Community Health Organisations, hospitals and health services, and correctional facilities.



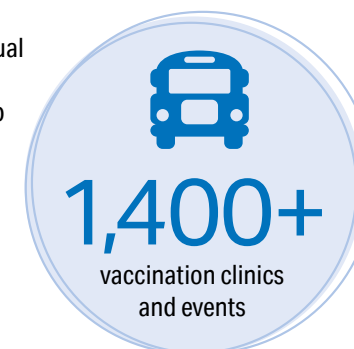
COVID-19 vaccination and ease of access

Throughout the year the team worked collaboratively with government and the private sector to deliver more than 2.5 million COVID-19 vaccinations. In early 2022, WA achieved the highest vaccination rate in the country and this has had an immeasurably positive impact on how WA has navigated the COVID-19 pandemic. The Department of Health continues to implement the WA COVID-19 vaccination program and has quickly, safely and effectively rolled out COVID-19 vaccines across the state and ensured equitable access.



The department developed a Vaccine Management System to manage the state's COVID-19 vaccine inventory. The system was required to engage with the public to access vaccination services at scale and operate a growing network of temporary vaccine clinics. The system was awarded the Office of Digital Government Award for Best Practice in Digital Transformation by the Institute of Public Administration Australia.

In 2021–22, the program delivered more than 1,400 individual events or vaccination clinics to ensure Western Australians had access to a COVID-19 vaccine. Services included pop-up vaccination clinics in hostels, parks and other locations attended by people experiencing homelessness, and in-home vaccination for individuals who are house bound or unable to attend a vaccination service.



The vaccination program also found innovative ways to provide vaccine access to all Western Australians including:

- the Maxi Vaxi bus and other mobile units established to deliver vaccinations to rural and remote communities
- pop-up vaccination clinics at locations such as cultural festivals, mosques and other places of worship
- providing sensory clinics to support people who require a low sensory environment or who may need other additional support to receive their vaccination
- establishment of a sedation clinic that provided free vaccination under sedation for people with disability, neurodiversity, or severe needle phobia aged 5 years and older.



Our Corporate Plan 2020–22

In 2021–22, the Department of Health continued to implement the Corporate Plan 2020–22 which outlines our key priorities and associated deliverables aligned to our strategic directions.

Table 1: Department of Health directions and key priorities for 2020 to 2022

Lead and innovate  Key priorities 1.1 Implement Sustainable Health Review (SHR) recommendations 1.2 Deliver person-centred, equitable, seamless access to health care 1.3 Deliver great beginnings and a dignified end of life 1.4 Innovate for sustainability 1.5 Deliver sustainable funding outcomes 1.6 Develop a culture and workforce to support new models of care	Steward and assure  Key priorities 2.1 Implement government priorities 2.2 Conduct system manager governance and assurance 2.3 Invest in digital healthcare 2.4 Use data wisely 2.5 Conduct system planning and health services commissioning
Protect and enable  Key priorities 3.1 Implement legislative priorities 3.2 Implement strategies to address major public health issues 3.3 Prevent and reduce violent incidents in our hospitals 3.4 Implement WA health system policies and frameworks 3.5 Negotiate the 2019–20 WA health system industrial agreements	Inspire and empower  Key priorities 4.1 Establish a modern work environment 4.2 Implement the Organisational Development Program 2020–24 4.3 Continue to integrate and embed risk management as an integral component of core business delivery

Implementation of the *Corporate Plan 2020–22* over the past 2 years has been challenging as the department led the state's management of the COVID-19 pandemic. Due to the complexity and need to respond to the ever-changing situation of the pandemic the department remained agile and committed to meeting the ongoing demands it presented, while ensuring continuation of business as usual and delivering on our priorities.

As the COVID-19 landscape continued to change, achievement of Corporate Plan deliverables was made even more challenging as the department was impacted by staff shortages. In 2021–22, employees of the Department of Health were absent for 2,477 COVID-19 leave days with 90 per cent occurring between March and June 2022 when cumulative case numbers in Western Australia were approximately 900,000 by June end. COVID-19 leave was predominantly used for illness (84.1 per cent).

In addition to COVID-19 leave, employees were absent for 9,808 personal leave days in 2021–22. This is an increase of 47.9 per cent compared to the previous year. The extent of employee absences is reflected in an increase of overtime and on-call hours by 62.8 per cent and an increase in the number of employees with excess leave by 42.1 per cent, compared to 2020–21.

Despite the disruption caused by the COVID-19 pandemic, the Department of Health continued to implement many key priorities in support of our strategic directions and a total of 21 deliverables from the Corporate Plan were achieved in 2021–22.

Lead and innovate

Lead and innovate through effective strategic direction, research, facilitation and advocacy.

In 2021–22, the Department of Health progressed significant initiatives to future-proof the WA health system and support the state's strategy for living with COVID-19.

The department is supporting health service providers in the delivery of over 100 infrastructure projects across the WA health system, including establishment of a new women and newborn hospital, redevelopment of Joondalup Health Campus, upgrade of the Bunbury Regional Hospital and redevelopment and expansion of the Peel Health Campus.

These projects are at various stages of planning and delivery and once complete will provide:

- expanded emergency departments
- additional beds including critical care, mental health and inpatients beds
- increased operating theatre capacity
- new clinical equipment and digital capability
- new teaching and research facilities
- additional parking bays for staff and visitors.

Significant collaboration between the Department of Health, health service providers and other key stakeholders is ensuring fast-tracked delivery of fully compliant and integrated inpatient hospital beds to increase bed capacity across the WA health system. A total of 120 beds via 4, 30-bed modular wards will be strategically placed at Osborne Park Hospital, Rockingham General Hospital, Bentley Hospital and Bunbury Health Campus.

The Outpatient Reform Program continued to deliver initiatives to improve the outpatient experience. The Manage My Care outpatient appointment app is now available statewide. A new workforce and service delivery model was developed for the Central Referral Service that coordinates the management of outpatient referrals across the health system. Planning also progressed for a pilot to bring the first WA Country Health Service region into scope for referral management. Referral access criteria to guide general practitioners when referring patients to speciality outpatient services including nephrology, ear, nose and throat and neurology have been implemented. Plastics and ophthalmology speciality access criteria are progressing. As part of the Digital Outpatients project, over 30 interviews were conducted across the WA health system to determine the digital maturity of outpatients, identify barriers to virtual care delivery, and opportunities for uplift across the system. This has enabled 3 proof of concept pilots to support virtual outpatient services to be progressed.

Following a pause to prioritise the COVID-19 response, the Emergency Access Response program recommenced in 2022 with a new governance structure, including a Ministerial Taskforce chaired by the Minister for Health. Funding of \$2.4 million has been secured for 2022–23 to plan and commence a statewide redesign program with a focus on identifying and implementing effective, data-driven and sustainable solutions for improving emergency access at a system level.

The Department of Health also led the establishment of a Long Stay Patient Program, working with the Mental Health Commission and Department of Communities to drive cross-agency solutions to support the discharge of patients who have been in hospital for extended periods but do not need hospital care.

Since 1 July 2021, this cross-agency collaboration has provided complex case input or consultation for more than 220 patients experiencing delayed discharge, including developing 38 bespoke solutions to address barriers to discharge, to facilitate their return to community living.

In November 2021, the department launched the From Hospital to Home (FH2H) Disability Support Transition Pilot. The 12-bed unit accommodates eligible people aged 30 to 65 for up to 18 weeks while National Disability Insurance Scheme and other long-term community supports are secured. As at 30 June 2022, the pilot had supported the discharge of 23 long stay patients from hospital into the pilot, and 10 participants had transferred from the pilot into safe, long-term accommodation.

Under the Ready to Go Home project, site-specific solutions are being designed and implemented to improve the hospital and discharge experience for people with disability in trial sites at Rockingham, Albany and Joondalup hospitals. A co-design group including people with disability and carers is developing resources including information booklets. Additional resources developed by the project include tools for collaborative discharge planning meetings and patient-centred communication.



The Department of Health has continued to support the transition to the National Disability Insurance Scheme, ensuring key clinical issues such as clinical governance and disability-related health supports are considered by lead agencies in bilateral negotiations. The department has strengthened engagement with the National Disability Insurance Agency, including the new Hospital Interface Branch, with regular operational and state-focused meetings to communicate and address individual patient and policy issues. The department also continues to support clients and service providers through the Continuity of Support Program, previously the WA Home and Community Care Program; transitioning eligible clients to the Commonwealth Home Support Programme and National Disability Insurance Scheme.

In 2021–22, the department partnered with 3 regional Aboriginal Medical Services to establish a pilot Transition Care Program for Aboriginal people aged over 50. This post-acute hospital service provides older Aboriginal people with access to services that include physiotherapy, occupational therapy, social work and nursing support, either in a residential facility or in their homes. This service aims to improve the physical, cognitive and psychosocial functioning of Aboriginal people leading to improved capacity in activities of daily living. Longer term this will minimise premature admission of older Aboriginal people to residential care and reduce rates of readmission to hospital.

Work to respond to the Royal Commission into Aged Care continued in 2021–22. To meet workforce related recommendations, the department partnered with metropolitan and regional residential aged care facilities, Edith Cowan University, Curtin University and Wollongong University in supporting graduate nurses to transition to practice in aged care, and in the development of a mid-career and advanced practice nursing workforce.



In 2021–22, the Department of Health completed the project planning phase for development of a 10-year health and social care workforce strategy and commenced stakeholder consultation following an evidence-based approach informed by a multifaceted interjurisdictional review. The first phase of the consultation process is focused on confirming the case for change and understanding social care within the parameters of the WA health system and aims to instil a bold vision for the future workforce through understanding the operational nature of the workforce and the interface of the health and social care systems.

The department progressed several initiatives in 2021–22 to improve the supply and the skills of the health workforce.

A multi-pronged health workforce attraction and retention strategy committing \$71.6 million to employ more doctors, nurses and midwives across the WA health system was announced in August 2021. This included a \$2 million boost to the existing local, national and international recruitment campaign to lure health professionals to work and live in WA, and the relaunch of refresher courses for experienced nurses and midwives in WA.

Planning for additional Curtin Medical School graduates entering the WA medical workforce is ongoing and the Postgraduate Medical Council of WA have identified and accredited an additional 10 medical internships. A review of the Advanced Skill Enrolled Nurses competency workbook was completed and an enrolled nurse survey was conducted to inform contemporary standards for the classification of Advanced Skill Enrolled Nurses.

As part of investigations into alternative work roles to support the allied health and health science workforce, the department arranged for an evaluation of WA allied health advanced practice roles to support the development, expansion and establishment of these roles in the future. In considering expansion of established allied health-led hospital and emergency avoidance or supported discharge services, the department has committed to expand the Complex Needs Coordination Team. This team identifies patients who are at risk of further hospitalisation and supports them to manage their health care at home through chronic condition self-management support, linkage to appropriate services and coordination of complex care needs.



COVID-19 modelling

In 2021–22, the Department of Health used modelling to reflect the emergence of COVID-19 in the community. Modelling is a process in which real-life situations or scenarios are translated into mathematical language. In this case the department analysed several pandemic scenarios to project the impact on the WA community and health system due to an anticipated increase in caseload.

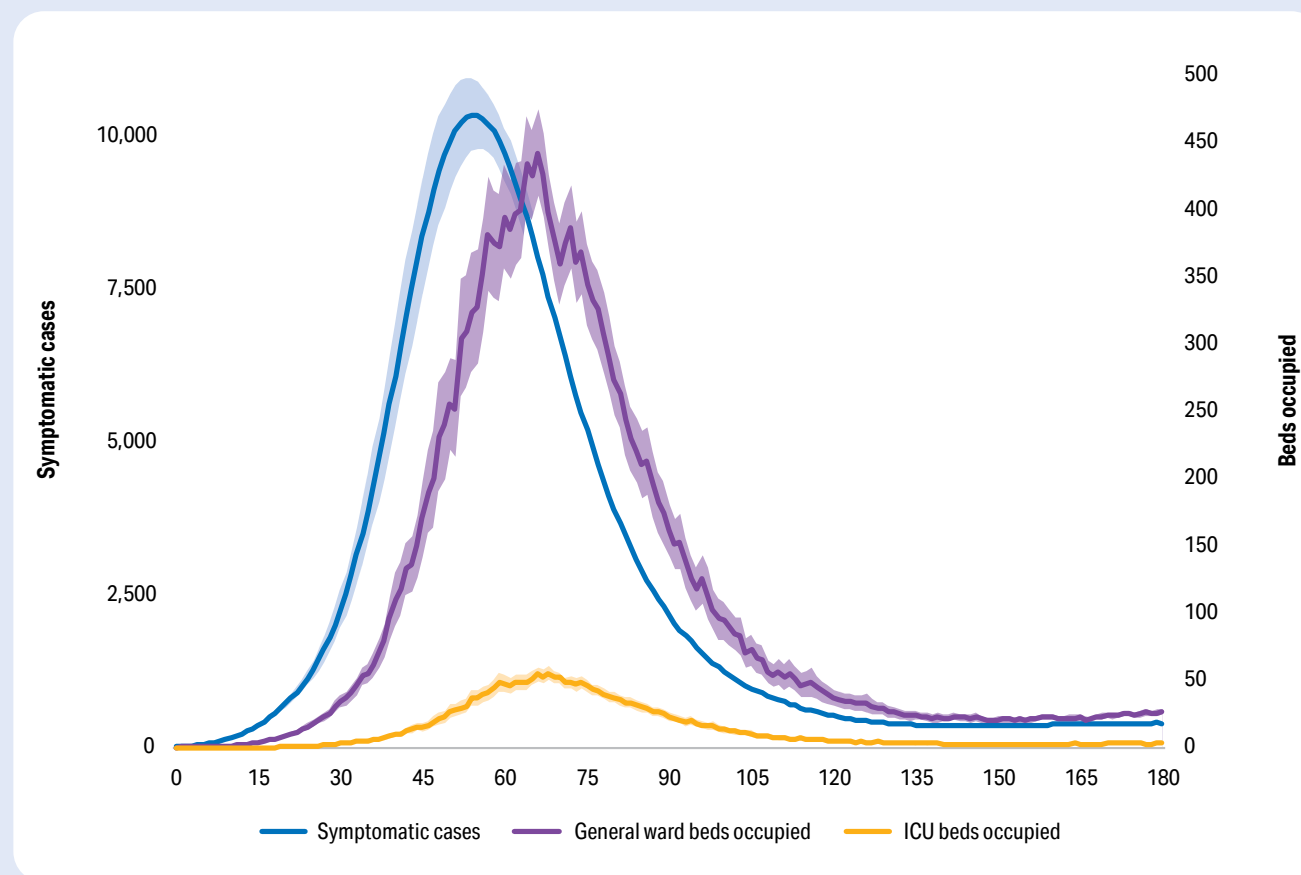
This modelling was used to inform government decisions on lockdowns, the opening of state borders, public safety measures in WA, and more recently to guide planning for the transition to living with COVID-19.

The model was originally based on the Delta strain and then revised in February 2022 with the emergence of the Omicron strain. The [Omicron COVID-19 modelling](#) projected the number of symptomatic cases, hospitalisations, intensive care unit admissions, deaths, days where the health system has more than 200 beds occupied by COVID-19 patients, and the effect of applying different levels of public health and social measures on differing caseloads (see Figure 4).

Important considerations which impacted the modelling included the:

- very different nature of Omicron which evidence has shown to be substantially less severe than the Delta strain, albeit far more transmissible
- levels of immunity within the Western Australian population because of high levels of vaccination and the significant booster uptake
- trajectory of the current outbreak and how it impacts the risk assessment of opening our borders.

Figure 4: Modelling of symptomatic cases and bed occupancy



Sustainable Health Review progress

Throughout 2021–22, the Department of Health continued to progress recommendations from the [Sustainable Health Review Final Report](#). This included setting the program up for success by the establishment of a robust governance structure that incorporates independent oversight, program management frameworks, and program management support.

Significantly, May 2022 saw the publication of [Moving towards measuring what matters – Sustainable health review fast track outcome measures](#). This report identified 10 initial 'fast-track' outcome measures that can be used to evaluate the impact of the Sustainable Health Review Program on the WA health system. The measures relate to improving public health and mental health, supporting the health workforce, and increasing health service responsiveness.

Delivery of the Sustainable Health Review Program involves collaboration across the WA health system and key stakeholders to deliver hundreds of projects and activities. Selected highlights for 2021–22 are provided below.



Enduring Strategy 1: Commit and collaborate to address major public health issues

The Sustainable Health Review recommended a commitment to new approaches to support citizen and community partnerships in the design, delivery and evaluation of sustainable health and social care services and reported outcomes.

In 2021–22, a new steering group was established to ensure person-centred perspectives are included in decision making. The steering group includes a co-lead from the community sector and 3 members with lived experience of mental ill health and/or alcohol and other drug issues (including family and carer roles). They met quarterly to progress work to inform the strategic intent of the commitment to new approaches.

In October 2021, in partnership with the Health Consumers' Council, a health and community sector forum entitled 'Engage, Share, Connect' was held to build the momentum of this work and begin to embed engagement and partnerships in everyday practice across the WA health system. More than 100 people from a broad cross-section of the health and social services sectors participated in the forum and people with lived experiences represented one quarter of attendees.

During the forum, groups identified the following as being most important to developing successful engagement and partnerships:

- being authentic and valuing diverse experiences
- building trust, being open and transparent
- time and resources
- sharing power and decision-making
- good communication
- capacity building
- acknowledging trauma.

Good communication, flexibility and building relationships were the most common themes identified to overcome barriers that might arise in engagement activities.



Enduring Strategy 2: Improve mental health outcomes

In 2021–22, the Department of Health partnered with the Mental Health Commission to deliver the following key priorities to support young people experiencing mental health issues.

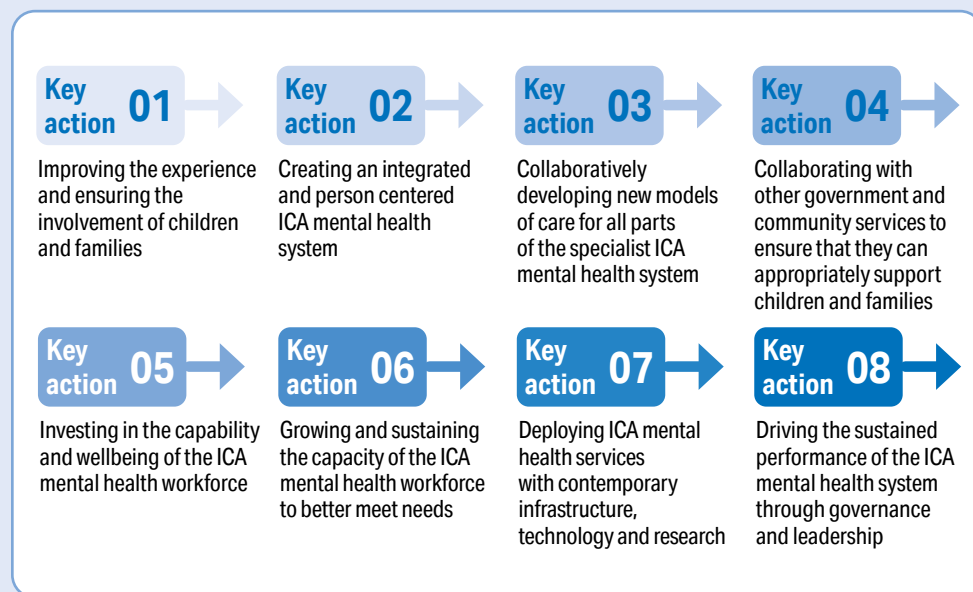
In March 2022, a new interim youth mental health and alcohol and other drug and homelessness service opened in Queens Park. The 8-bed facility provides transitional, supported accommodation for young people aged 16 to 24 who show signs and symptoms of mental ill-health, with or without a co-occurring alcohol or other drug issue, and who are experiencing or are at risk of experiencing homelessness. The goal of the service is to assist young people in their recovery and help them find stable accommodation. This service is led by non-government organisations with support from the Mental Health Commission and East Metropolitan Health Service.

Extensive community consultation shaped the creation of the facility, resulting in an age and culturally appropriate service. In addition, peer workers form a key element of the service, harnessing their lived experience of mental ill-health and recovery to support the young people and foster hope.

March 2022 also saw the publication of the [Final Report – Ministerial Taskforce into Public Mental Health Services for Infant, Children and Adolescents aged 0–18 years in Western Australia](#). The report outlines 8 key actions for change, including 32 specific recommendations to guide implementation of future services. The Mental Health Commission was the lead agency for this report and is leading the implementation of recommendations.

The needs-based modelling conducted to inform the report was a significant project completed over 4 months and is the first time that needs-based modelling had been undertaken for the mental health needs of infants, children and adolescents. This foundational work is critical in moving towards needs-based modelling, which is a major direction outlined within the Sustainable Health Review.

Figure 5: Key actions for reform of the infant, child and adolescent (ICA) mental health system



In 2022–23, the Department of Health and the Mental Health Commission will continue to work together to identify the most immediate challenges and prioritise the next steps to implement the 32 recommendations set out in the report.



Enduring Strategy 3: Great beginnings and a dignified end of life

In 2021–22, multiple initiatives were progressed across the WA health system to support children and families in getting the best start in life and to become physically and mentally healthy adults. This included investments in person-centred models of care and new technology to help parents.

Following the successful launch of the 'My Baby WA' app by the Health Consumers' Council for pregnancy-tracking, birth, and baby information, scoping has been completed by the Child and Adolescent Health Service for a digital version of the Purple Book. This will help parents keep a record of their child's health and development from birth to school entry in an easy and accessible way.

The End-of-Life Care Program also continues to support Western Australians to receive high quality end-of-life care. For more information see End of Life Care in Western Australia in the Agency performance section of this report.



Enduring Strategy 4: Person-centred, equitable, seamless access

The expansion of telehealth services using high-definition video conferencing technology continues to link doctors and nurses in regional, rural and remote sites to specialist clinicians who can assist with the diagnosis and treatment of their patients. This service provides a greater level of medical support to regional areas and helps build the knowledge and expertise of all regional clinical staff by supporting their professional development and reducing their professional isolation.

In September 2021, the Department of Health commenced operation of an expanded WA Statewide Telestroke Service, including access to a dedicated Stroke Consultant, Monday to Friday, 8am to 6pm. The clinician to clinician service facilitates time-critical diagnosis and treatment for patients with acute stroke. Since its launch the expanded service has provided more than 220 initial and follow-up consultations to stroke patients across Western Australia through the provision of specialist stroke consultant advice.

Planning is underway for future phases of service expansion, including investigation of the current and future technological capability needs to enable a 24/7 telestroke service.



Enduring Strategy 5: Drive safety, quality and value through transparency, funding and planning

In 2021–22, significant progress was made towards planning for a new women and newborn hospital. The Department of Health led the formation of a bespoke project governance structure for the planning phase.

A major achievement included the decision on the site location for the new hospital. A team of technical experts undertook stakeholder engagement and a range of detailed studies and investigations for each possible location including design analysis, engineering investigations, and constructability reviews. The site selection process utilised a robust multi-criteria methodology which has been applied on other large and complex projects nationally. The process is tailored to complex site selections and is consistent with Infrastructure Australia's Assessment Framework.

Following the comprehensive site analysis and evaluation process, a site north of Sir Charles Gairdner Hospital G block was recommended as a preferred location. A key factor in the decision to build in the selected location is its advantage in future-proofing the Queen Elizabeth II Medical Centre over a 40-year period, including future redevelopments of the Perth Children's Hospital, Sir Charles Gairdner Hospital, PathWest and teaching and research facilities.

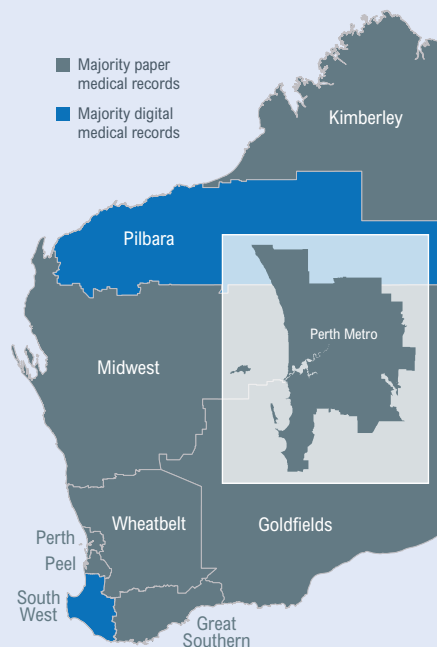


Enduring Strategy 6: Invest in digital healthcare and use data wisely

Implementation of digital medical records is the first step towards a statewide Electronic Medical Record system connecting people and information to improve the delivery of quality, person-centred health care and an improved patient experience.

Digital medical records allow clinicians real time access to patient information all in one place. Clinicians can enter information electronically, scan forms, as well as view a variety of clinical notes, assessments, medical histories, diagnostic test results, and other patient information, which will assist them to make safe and informed clinical decisions.

Digital medical records are already in place at Fiona Stanley Hospital, Fremantle Hospital, and regional sites in the South West and Pilbara. In 2021–22, planning commenced to implement digital medical records at Armadale Health Service, Kalamunda Hospital, Rockingham General Hospital, King Edward Memorial Hospital, Perth Children's Hospital, Great Southern and Goldfields regions.



Aboriginal Health Practitioners have the potential to positively impact the Aboriginal patient journey and Aboriginal workforce participation within the WA health system. Establishment of the role in an industrial instrument within the WA health (public) sector is key to bringing WA in line with other jurisdictions across Australia.

By using purposeful sampling, the consultation process engaged interested parties with an involvement and interest in Aboriginal health to inform the establishment of the role and guide implementation planning. More than 60 submissions were received across the 2-phase process and the feedback was instrumental in informing the industrial classification and negotiation process as well as the longer-term objectives to successfully implement the profession.

A key outcome of the consultation process was identification of the clinical settings in highest need of Aboriginal Health Practitioners including emergency departments, and services offering maternal and child health, chronic disease management and mental health care.

An industrial negotiation process is underway and it is anticipated that the first Aboriginal Health Practitioners will join the WA health system in 2023.



Enduring Strategy 8: Innovate for sustainability

The Sustainable Health Review recommended establishing a systemwide network of innovation units in partnership with clinicians, consumers and a wide range of partners to quickly develop, test and spread initiatives delivering better patient care. A priority is establishing a WA health system central unit to provide advice and guidance on innovation.

The Department of Health organises monthly meetings for innovation groups established across the WA health system to share innovation knowledge and experiences through its central Research and Innovation Office.

In addition, the department has partnered with Edith Cowan University to co-fund an Industry Engagement PhD Scholarship and through the Research and Innovation Office is co-supervising a research thesis on 'Diagnosing Innovation: A Human-Centred Design Approach to Cultivating Innovation in the Western Australian Public Health System'.

The objectives of this research include mapping existing innovation strategies across the WA health system, developing an innovation framework, roadmap and tools, and recommendations for the implementation of a human-centred design approach to strengthen a long-term innovative culture.



Enduring Strategy 7: Culture and workforce to support new models of care

In 2021–22, the Department of Health completed a robust consultation process regarding integration of the new role of Aboriginal Health Practitioner into the WA health system.

The profession of Aboriginal Health Practitioner is nationally accredited and registered to provide high quality care to both Aboriginal and non-Aboriginal people and makes a valuable contribution to addressing Aboriginal health outcomes within the current healthcare environment. The role is a step forward in addressing the systemic issues that have limited Aboriginal Western Australian's engagement in their own health care and the health of their families and communities.

Health and medical research and innovation

Health and medical research and innovation can contribute to improving the health of individuals and the wider population, help the health system to be more effective and efficient, while creating jobs and new industries, and bringing broader economic benefits to the state.

The Future Health Research and Innovation (FHRI) Fund scheme was established in July 2020, enabled by the [Western Australian Future Health Research and Innovation Fund Act 2012](#) (the Act). The aim of the fund is to provide a secure source of funding to drive health and medical research, innovation and commercialisation to improve the health and wellbeing of Western Australians, the sustainability of the health system, the prosperity of the state, and advancing WA as a leader in research and innovation.

The Minister for Medical Research is responsible for the FHRI Fund Scheme, including administering the FHRI Account² and applying it to support health and medical research and innovation, approving the FHRI Fund strategy, priorities, programs and initiatives and appointing the independent FHRI Fund Advisory Council. The Department of Health is principally responsible for assisting the Minister for Medical Research in administering the FHRI Account. The Department of Health is also the agency responsible for managing and supporting the decision-makers and advisers of the FHRI Fund scheme and developing programs and initiatives that support the fund's priorities.

The [FHRI Fund Advisory Council](#) is responsible for developing the strategic direction and key priorities of the FHRI Fund and recommending to the Minister for Medical Research whether programs and initiatives contributing to the achievement of one or more priorities should be approved.

In 2021–22, \$31.7 million was awarded to 2021–22 programs and initiatives aligned to the priorities to support and enhance research and innovation capabilities, provide seed funding, and build mental health research and innovation capacity (see Table 2). Grants were also awarded in 2021–22 for relevant 2020–21 programs and initiatives, in addition to the 197 grants reported in the 2020–21 Department of Health Annual Report. Further grants associated with programs and initiatives implemented in 2021–22 will be awarded in 2022–23.

² 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 disappplied by the Act).

Table 2: FHRI Fund approved grants awarded in 2021–22

FHRI Fund programs and initiatives	Number of grants awarded	Value of grants awarded
Implemented in 2020–21		
Biobank Interim Support Program	16	\$1,524,875
Clinician Research Fellowships	1	\$950,000
Implementation Science Fellowships (Aboriginal and Regional Health)	4	\$2,360,368
Research Translation Projects	8	\$2,127,961
Translation Fellowships (Aboriginal and Regional Health)	4	\$2,208,734
Total	33	\$9,171,938
Implemented in 2021–22		
Australian Clinical Entrepreneur Program Pilot	1	\$200,000
Clinician Research Fellowships	1	\$2,850,000
Early-phase clinical trial facility – Linear Clinical Research	1	\$2,250,000
Innovation Challenge – Mental Health – Stage 1	11	\$547,502
Innovation Fellowships	5	\$622,351
Innovation Seed Fund	17	\$8,060,194
Research Excellence Awards 2022	51	\$10,010,000
Translation Fellowships – Mental Health	2	\$1,198,842
WA Near-miss Awards – Emerging Leaders 2021	20	\$3,580,888
WA Near-miss Awards – Ideas Grants 2021	25	\$2,402,000
Total	134	\$31,721,777

The FHRI Fund has been a catalyst for driving co-investment in WA by other parties, and to support and enhance research and innovation capacity. In 2021–22, funding supported the Clinician Research Fellowships Program in partnership with the Raine Medical Research Foundation, contributed to the establishment of a new early-phase clinical trials centre by Linear Clinical Research, helped individual researchers to enhance their competitiveness in securing highly competitive national grants, and provided support to high-performing researchers to improve their research programs and to build human capability in health and medical-related innovation.

Stage 1 of the Innovation Challenge in Mental Health funded 6-month feasibility projects to find new ways to meet the needs of children and young people experiencing poor mental health. Three year fellowships to support researchers to conduct projects that facilitate the translation of research findings into policy and/or practice in mental health were supported through the Translation Fellowships (Mental Health) Program.

In addition to the grants awarded in 2021–22, there was substantial engagement with the WA research and innovation sectors. This included a major consultation to determine how to increase clinical trial quality and capacity, an event to celebrate the early successes of the FHRI Fund, consultation with the FHRI Fund Innovation Expert Committee, and contributions from WA researchers, innovators and consumers to the peer review selection processes that determined funding recipients.

In addition to funding associated with FHRI Fund programs and initiatives, the Department of Health provided funding to directly support health and medical research and innovation activities. Of note is funding provided in 2021–22 to support:

- five WA Independent Medical Research Institutes who received \$6,500,000 in grants through the Research Institute Support (RIS) program for the indirect costs of research
- the WA Child Research Fund that was awarded \$4,320,439 to implement 18 projects to support research of direct significance to the health of WA children and adolescents.

The department also commenced significant reforms to simplify and streamline research approvals across the WA health system. Implementation of these reforms is expected to commence in the latter part of 2022.



WA Child Research Fund

The Department of Health, in partnership with the Channel 7 Telethon Trust, supports medical research that focuses on the health of children and adolescents through the WA Child Research Fund program (WACRF). The WACRF aims to:

- fund research of direct significance to the health of WA children and adolescents
- promote the translation of research findings into evidence-based health policy and practice which will ultimately provide better health outcomes
- contribute to integrating research capability across universities, research institutes and health services by encouraging the development of research-policy-practice clusters.

One example of important work supported by this program is a grant awarded to Professor Megan Galbally, from Murdoch University, to research the differences in early life risk factors for childhood emotional disorders in metropolitan and rural children in Western Australia.

In childhood, emotional disorders (anxiety and depression) are the most common mental health disorders and when the first onset is in early childhood, emotional disorders typically persist into adolescence and adulthood. These mental disorders are associated with a range of poor longer term social and educational outcomes for children. While for other mental disorders the focus has been on adolescence and young adulthood, the key to the development of effective prevention and early intervention for emotional disorders is to understand the developmental pathways across early life. As such, pregnancy, infancy, and early childhood are crucial periods for investigations to identify both critical factors in the development of child emotional disorders and the optimal timing during development when prevention and early intervention can offer the greatest benefit.

This study will collect data on 402 Western Australian children and their parents at 4 to 5 years of age including 196 mothers and their children from Perth and 206 from the Midwest, South West and Goldfields regions.

Findings from this study will enable examination of the predictors for childhood emotional disorders from conception onwards, explain differences between metropolitan and rural children's risk and protective factors for emotional disorders, and identify optimal intervention points from pregnancy to 4 to 5 years of age to prevent the onset of childhood emotional disorders.

Steward and assure

Steward and assure through advice and oversight, and the identification and management of risk, accountability measures and monitoring performance.

An independent governance review of the *Health Services Act 2016* commenced in January 2022. An expert panel has been appointed to make recommendations to the Minister for Health on opportunities to strengthen governance, including any improvements to the Act. The panel consulted broadly, in over 70 individual sessions, to hear different perspectives from industrial partners, professional bodies, health service provider boards and chief executives, consumer groups and staff. The panel also received 58 responses to a high-level survey and 30 more detailed submissions for consideration. The panel is due to report their findings to the Minister by September 2022.

In 2021–22, the Department of Health also progressed key initiatives to inform the development of a completely revised and comprehensively updated clinical services planning framework. For the WA health system, responding to the challenges faced by our hospitals and community services during COVID-19 further emphasised the criticality of a contemporary clinical planning document informed by the current environment, and aligned to the WA health system's priorities to ensure health services are well placed for the ongoing and changing needs of the community. A focus has also been on providing clinical planning and modelling advice to inform infrastructure projects including the Bunbury Redevelopment Project, Women and Newborns Service Relocation Project, St John of God Midland Expansion Project, and Peel Hospital Redevelopment.

In December 2021, the department released [*Ambulance services Western Australia: A framework for statewide ambulance service operations*](#). The department has also commenced preparation for negotiation of a new service agreement with St John Ambulance for emergency road-based ambulance services, including establishing project governance, collaborating with key stakeholders and analysing interjurisdictional ambulance services throughout Australia. To supplement the emergency transport services provided by St John Ambulance, a new contract was established in May 2022 for the supply of non-emergency planned patient transport services throughout the Perth metropolitan area. The department has procured a panel of 5 suitably qualified, skilled, and experienced contractors. The price is set for all transportations under this contract arrangement to create a more competitive and sustainable patient transport service for the community of Western Australia. As a result, health service providers will have greater choice in relation to patient transport movement, increased transparency, and improved patient outcomes and experience.



In 2021–22, as a first step towards implementation of a single system for key financial information across the WA health system, the department reviewed the chart of accounts structure and proposed a new structure for stakeholder consideration.

Throughout 2021–22, the Department of Health continued to provide oversight, performance monitoring and regular reporting on the performance of the WA health system. This included monthly WA health service performance reporting, reporting on delivery of the Health Recovery Program, and quarterly updates to the Department of Treasury through the Whole-of-Government Report. New measures of safety and quality through the Safety and Quality Indicator Set (SQUIS) were also introduced. SQUIS brings together information from various sources into a single platform to identify trends, which in turn assist with practice improvement and the prevention of harm.



The Department of Health has continued to promote and leverage the use of business intelligence tools, training and governance structures to assist the WA health system in value-based decision making. In 2021–22, the PowerBI Governance framework was released to guide and support users to use and publish data safely, with appropriate oversight and governance. Customised for the WA health system, online training courses have been deployed via the Learning Management System to allow users to undertake self-paced learning of PowerBI so subject matter experts can develop relevant tools and dashboards to inform and improve decision making.



Power BI Centre of Excellence

Health service provider service agreements

A health service provider's main function is to provide health services as stated in formal service agreements between the Director General and each health service provider.

In 2021–22, the department implemented reforms to improve health service provider agreements and completed an audit on the adequacy of health service delivery performance management processes and controls.

Service agreements are used to define and detail the scope of services and targeted levels of activity which the system manager will purchase from health service providers in a financial year, consistent with the State Government's policy objectives and funding allocations. Service agreements are the principal budget accountability tool that defines the roles and responsibilities of the system manager and each health service provider. Through execution of the service agreements, health service providers agree to meet the service obligations and performance requirements detailed in the service agreement.

In 2021–22, the annual health service agreement process incorporated reforms recommended by the Redesign of the Service Agreement Framework Report. These changes include a new format with a greater focus on alignment with strategic priorities and clarified responsibilities, and a new non-hospital services resource allocation model to improve alignment between government approved budgets and health service provider service delivery responsibilities. Targeted funding was also introduced for several specific initiatives to build system capacity and resilience.

The audit of service agreement performance management processes was also conducted through collaboration between internal audit staff and specialist contractors. The findings confirmed that the department has a well-established process to establish, collect, validate and report key performance indicators used to manage the performance of health service providers, and has solid internal controls to manage associated risks. Recommendations were identified to further improve oversight and management of health service delivery through making changes to service agreements that included clarity on expectations concerning patient safety and clinical quality in health care and introducing additional key performance indicators for Health Support Services and PathWest. The department is actively working to implement these recommendations.



Protect and enable

Protect and enable through public health strategies, legislation, regulation, policies and professional representation.

In 2021–22, the Department of Health completed a number of significant pieces of work to inform and guide public health strategies to protect and preserve the health of Western Australians.

Notably, the department released further findings from the WA Burden of Disease Study 2015 concerning healthcare costs associated with risk factors and the burden of disease. The study found an estimated \$2 billion of health expenditure was attributable to 18 modifiable risk factors, with the greatest financial burden associated with overweight and obesity (\$510 million), followed by high blood plasma glucose (\$336 million) and high blood pressure (\$324 million). Tobacco use (\$306 million) and dietary risks (\$286 million) also made a large contribution to the financial burden. This work provides evidence to support action in primary health prevention to reduce the risk of developing disease and injury.

The *Health Promotion Strategic Framework 2022–2026* was released for public consultation in December 2021 and attracted responses from more than 60 organisations and individuals. This framework is the fourth in a series, first launched in 2007, and is due for release in late 2022. The framework aims to empower and enable Western Australians to lead healthier lives by supporting equitable and sustainable improvements in health behaviours and environments. It focuses on the main lifestyle risk factors which contribute most to the burden of chronic disease and injury in the state: being above a healthy weight, poor nutrition, insufficient physical activity, smoking and harmful levels of drinking. It also includes priorities for injury prevention. The framework includes a map of complementary policy areas that support the health and wellbeing of Western Australians and will provide a renewed focus on partnerships with other government departments and agencies, and the non-government health sector.

The department maintained its comprehensive whole-of-population approach to obesity prevention by investing in 2 new programs. Following an open competitive tender process, 2 new contracts have been awarded for the delivery of:

1. a multi-component family-based early intervention program for children aged 2 to 12 years, who are above a healthy weight, and their families
2. a whole-of-school healthy eating program to make healthy eating part of everyday school life, by integrating it into the curriculum, developing a supportive culture and environment, and engaging the whole school community.

Collectively, these contracts are valued at more than \$8.7 million over the next 5 years.

In addition, the WELL (Weight Education and Lifestyle Leadership) Collaborative was launched in November 2021. This partnership between the Department of Health, health service providers, WA Primary Health Alliance and Health Consumers' Council WA, established under the [WA Healthy Weight Action Plan 2019–2024](#), aims to address the complex issues involved in minimising the health impacts of overweight and obesity. The [WELL Collaborative website](#) shares evidence-based, scientifically sound, and consumer informed resources for consumers and health professionals, policy makers and program developers.

The *WA Aboriginal Health and Wellbeing Framework 2015–2030* is WA Health's principal Aboriginal health strategic policy. Through its 6 strategic directions and priority areas, the framework leads health and wellbeing stakeholders across Western Australia in a shared agenda to achieve its vision – Aboriginal people living long, well and healthy lives. The framework's implementation is conceptualised as 3 5-year cycles:

1. Build the foundations
2. Embed what works
3. Inform future directions.

In 2021–22, *Build the Foundations: An evaluation of the first five years of the WA Aboriginal Health and Wellbeing Framework 2015–2030* was released. Eleven priorities were identified to progress the next 5-year implementation cycle of the framework: embed what works. The evaluation supports the department to have policies and strategic initiatives in place to ensure that the health system is working to a shared agenda.

In response to recommendations from the Royal Commission into Institutional Responses to Child Sexual Abuse, the Department of Health developed a System Manager Implementation Plan based on the [National Principles for Child Safe Organisations](#), progressed a refreshed Memorandum of Understanding with the Department of Communities, and collaborated on the development of the roadmap to implement all remaining recommendations of the Royal Commission final report. The department also finalised a review of the WA health system Working with Children Check Policy and identified recommendations to facilitate further improvement and ensure ongoing compliance with the *Working with Children (Criminal Record Checking) Act 2004*.

A comprehensive community needs assessment in Western Australia identified that support with navigating services and systems was a major gap for people and families living with a rare or undiagnosed disease. In response, the Department of Health has organised for a pilot system navigation program to be developed for people living with genetic, rare, or undiagnosed neuromuscular diseases. The findings from this pilot program will inform future system navigation support for the broader cohort of Western Australians living with genetic, rare and undiagnosed diseases.

In 2021–22 the Department of Health contributed to national initiatives for early identification of significant health issues. The department led a national working group to determine the appropriateness of adding severe combined immunodeficiency (a group of inherited immune system disorders) to the Australian Newborn Bloodspot Screening Programs. The working group comprised members with varied related expertise in bioethics, population screening, paediatrics and immunology. Australia's Chief Medical Officer endorsed the recommendation to add this condition to Australian Programs. WA will adopt this decision and will progress the required developmental phase prior to commencing statewide screening. Early diagnosis of severe combined immunodeficiency through newborn bloodspot screening will allow for treatment to be undertaken before infections cause complications.

The Department of Health also continued to partner with local government authorities to protect the WA community against preventable illnesses. The department provided \$336,000 in direct funding to support 19 local government mosquito management programs across the state through the Contiguous Local Authorities Group Scheme. Funding supports 50 per cent of the cost of a range of integrated mosquito management activities undertaken by local government, including the purchase of chemicals, with local government contributing the remaining half. Additionally, the department contributed \$672,930 to cover the cost of the helicopter used to undertake broadscale mosquito management from Mandurah to Capel, where the risk of mosquito-borne disease is high. This is a critical public health prevention strategy used to reduce the incidence of Ross River and Barmah Forest viruses in the South West every year.

In 2021–22, the Department of Health progressed the following legislative priorities for the WA health system:

- The smoking exemption for Crown Perth's International Room gaming facility, previously allowed under the *Tobacco Products Control Act 2006*, was removed from 31 December 2021. This is in line with the smoke-free requirement that applies to all enclosed hospitality premises across the state.
- The *Public Health Amendment (Safe Access Zones) Act 2021* legislated the right for women seeking an abortion to have safe and private access to health services without fear of harassment or intimidation.
- The Minister for Health appointed a Ministerial Expert Panel to provide recommendations that will frame new assisted reproductive technology and surrogacy legislation.
- All policy instructions for proposed environmental health regulations under Stage 5 of the *Public Health Act 2016* were finalised in preparation for drafting by the Parliamentary Counsel's Office.

The Public Health Atlas: a tool for policy and planning

Geo-spatial technologies have enormous potential to support policy and planning decisions in health. By displaying the data spatially, they can inform health services in the delivery of programs and care to those who need it most.

This year marked the initial development of the Public Health Atlas, an ambitious tool that will enable both policy making and the planning of public health interventions and services by presenting all available public health data collected across the state. This information is crucial in measuring the health status of various populations and assessing the effectiveness of public health programs.

Through easy-to-use maps, graphs, tables and commentaries, the Public Health Atlas creates an interface that is both powerful and accessible. It can be used to highlight variations by geographical area in public health indicators such as disease prevalence, incidence, risk factors and outcomes in different populations across the state. This will enable public health practitioners, clinicians, health managers and policy makers to determine where improvements are most needed.

The first version of the Public Health Atlas was developed with a focus on potentially preventable hospitalisations and included the functionality to compare indicators, download factsheets and produce dynamic reports on specific areas. Work is underway to implement new features, with other key datasets already identified as a priority, alongside enhancing the user experience.



The Epidemiology Directorate, responsible for development of the Public Health Atlas

Youth vaping

In 2021–22, there were growing reports of young people accessing electronic cigarettes, often referred to as e-cigarettes or vapes. In the last Australian [survey of school students in 2017](#), around 13 per cent of students aged 12 to 17 years had used an e-cigarette (32 per cent of these in the past month). Almost half (48 per cent) of students who vaped had never smoked tobacco before trying an e-cigarette. A quarter (25 per cent) of these students who had used e-cigarettes before ever smoking, reported later trying tobacco cigarettes.

E-cigarettes can contain water, flavours, solvents and nicotine. Chemicals found in e-cigarettes, e-liquids, and the aerosol or “vapour” that they generate are known to include harmful substances that are toxic, including chemicals that can cause cancer.

In Western Australia, products that resemble tobacco products, including e-cigarette devices whether or not they contain nicotine, cannot be sold by tobacco or general retailers under the *Tobacco Products Control Act 2006*. It is illegal to sell, supply or possess an e-cigarette or any liquid that contains nicotine in Australia without a doctor's prescription.

In response to the growing usage of these products, the Department of Health and Department of Education have joined together to tackle vaping among WA teenagers and school-aged students. This has included educating students, families and school staff through various communication mediums on the significant health risks and impact of these products.

The 'Do you know what you're vaping?' campaign aims to raise awareness about the health risks of vaping and address the misperceptions about vaping among young people and their parents and/or guardians. It is supported by a WA Schools Anti-Vaping Toolkit which contains resources for school staff, students, parents and guardians to educate them on the health impacts of vaping.

The Department of Health has also increased compliance activities in relation to the illegal sale of e-cigarettes and nicotine, including expanding surveillance to prevent the sale of these products to youth and the public in general.



Climate health

The Department of Health is committed to building a climate resilient and sustainable health system for Western Australia by reducing emissions, energy, and water use while preparing the WA health system and the community for the impact of climate change.

The [*Climate Health WA Inquiry Final Report*](#), endorsed by Parliament in December 2020, identified 10 findings of significance and made 10 recommendations to plan and respond to the health impacts of climate change. Overall, the report sets a blueprint for the next 10 years to guide the WA health system to adapt to climate change, better protect the health of the community, and for health services to do more to reduce emissions and waste without compromising the quality of patient care.

In 2021–22, the following milestones and key pieces of work were achieved.

Aboriginal-led climate health initiatives for communities

The department is working with the Aboriginal Health Council of WA to develop climate health adaptation planning initiatives for Aboriginal communities.

The aim is to gain evidence-based information of climate health risks impacting the local community and co-designing adaptive strategies to address the risks identified.

The first phase of activities is underway and involves community engagement and consultation. Stories, local knowledge and expertise will help formulate an understanding of the health impacts of extreme weather events such as excess heat on local communities, that will then inform adaptation planning.

Once the information collection phase is complete, an Aboriginal Climate Health Adaptation Planning Toolkit and locally led co-designed Climate Change and Health Action Plan will be developed.



Leading in environmental sustainability

The department became a member of the Global Green and Healthy Hospitals Network that has over 1,500 members in 76 countries who represent the interests of over 60,000 hospitals and health centres. The network's shared goal is to reduce the environmental footprint of the health sector and contribute to improved public and environmental health.

The department also established the Sustainable Development Unit to lead and coordinate a systemwide response on climate action and sustainability. The unit will engage closely with health service providers, the public health sector and broader stakeholders to prepare the health system for the risks associated with climate change.

Reviewing and reducing emissions

As WA moves toward net zero emissions and a more sustainable future, the health sector will need to play a key role in addressing the contribution it has on our carbon footprint.

For the first time, the department has undertaken research to quantify the environmental impacts of the WA health system. The findings will show where the largest contributions to greenhouse gas emissions are from so policies and interventions can be developed for areas with the biggest potential for emission reductions.

In 2021–22, the department also held 2 workshops with healthcare professionals across the WA health system to identify carbon or waste intensive clinical practices in their workplaces that could be made more sustainable. Over 80 changes were identified and will be summarised in a final report to guide future initiatives.



Plan for plastics

In preparation for the State Government's single-use plastic ban starting 1 July 2022, the department has been phasing out plastic plates, bowls, cups and cutlery. These product swaps will result in 44,400 fewer plastic items going to landfill each year.



Heatwave hazard

The department commenced a review into changes to the State Hazard Plan for Heatwave. The changes will see the adoption of the National Heatwave Framework which includes 2 initiatives, the adoption of the Excess Heat Factor measurement of heatwaves and adopting the Australian Warning System. The new measurement method, which compares forecasted temperatures with the long-term climate record for a specific location, is more robust and will cover towns and cities all over Western Australia. The contemporary heatwave messaging aligns to the 3 community warning levels in the Australian Warning System.



Assessing the health effects of landscape fire smoke

Smoke resulting from landscape fires can be a key source of short-term air pollution, especially when it impacts high density residential and populated areas. In 2021, the Department of Health concluded a detailed study that utilised satellite imagery to gather information on the effects of acute exposure to landscape fire smoke in the Perth metropolitan area.

Plumes of smoke were mapped and analysed using satellite observation, and the information was linked with data on air quality and climate measures. It was also compared to health service statistics (which includes hospital admissions, emergency department attendance and ambulance callouts) to understand the relationship between landscape fires and health.

Smoke-related particles were significantly associated with both landscape fires (controlled burns and wildfires), and emergency attendances and hospital admission for respiratory and cardiovascular conditions, which could peak on the same day as the fire events, or up to 3 days after exposure to the fire smoke.

Several recommendations were made in the final report of the study, with implications for health policy and partnerships. Health professionals and policy makers are encouraged to improve education programs about the harms associated with landscape fire and the available means of protection, and emphasise the medical conditions involved with delayed smoke effects.

The study also recommended that regular real time fire data continue to be collected, in order to best determine the populations and geographical areas at risk. The groundwork laid by the project will be a major asset in enabling the continuation of monitoring landscape fires to better protect vulnerable groups into the future.



Inspire and empower

Inspire and empower our passionate workforce to be courageous, innovative, accountable and to collaborate for change.

In 2021–22, the Department of Health focused on building workforce capability to deliver better health outcomes for the community. People are at the heart of everything we do and are a key enabler to achieving our mission to lead and steward the WA health system.

In pursuing a values-aligned and system-focused vision for health leadership, the department implemented a suite of leadership development opportunities targeted at developing our talent pipeline to lead with confidence. Guided by the [Health Leadership Strategic Intent](#), the newly-formed Leadership Alumni Network and the Level 8 Peer Group Network have been established to drive collaboration and provide peer support. In 2021–22, over 40 managers attended all Level 8 senior leadership presentations and over 25 alumni members engaged with either the formal or informal development opportunities available through the network. In addition to these networks, 15 aspiring leaders are currently completing the 2022 Introduction to Leadership Program, an intensive and interactive program that introduces the fundamentals of leadership.

Spotlight on leadership development

Launched in 2021, the Introduction to Leadership Program (I2LP) supports staff to take the next step in their leadership journey.

I2LP focuses on enabling its participants to learn about themselves, to identify their individual roadmap for success, and build a solid foundation of leadership skills. During a 6-month course, the program combines a personalised career development plan with structured peer learning and support workshops. It also includes practical advice and mentoring.

The cohort of aspiring leaders were matched with experienced mentors who shared their valuable insights and encouraged a journey of personal and professional growth. Over the duration of the course, participants explored their own values and the concepts fundamental to success in leading both themselves and others.

The program modules are delivered in partnership with consultants and complemented by leadership practitioners. They focus on interactive discussion and participation, with flexible topics to meet the needs of the participants. Through ongoing development and reflection, the program is the first step for staff looking to build a career in leadership.

The Department of Health is also committed to inspiring and empowering its people. Learning and growth opportunities are facilitated to support this purpose, guided by the Department of Health's Learning and Development Plan. These opportunities enable our workforce to build foundational skills, grow a lifelong learning and growth mindset and support our employees' aspirations for further and future development. We continue to respond to the training needs of our workforce through the provision of face-to-face training, online learning, tailored facilitation and on the job learning opportunities. For more detail see the Staff development section of this annual report.

In 2021–22, a new Equity, Diversity and Inclusion eLearning package was launched to coincide with World Cultural Diversity Day and was made available to all staff across the WA health system. Development of the package was a collaborative effort between the department, health service providers, subject matter experts, consumers and other key stakeholders from across the WA health system. The package covers topics including age, cultural and linguistic diversity, gender equality, LGBTIQ+, disability inclusion and Aboriginal recruitment. The package reflects the ongoing needs of our workforce and challenges us all to embed inclusive behaviours in our workplaces every day to help make our work environment vibrant, respectful and inclusive.

We recognise that a diverse and inclusive workforce brings a better understanding of community needs and expectations and thus service delivery that is responsive to change and appropriate to the community we serve. The WA health system actively promotes the employment of Aboriginal Australians, people with disability, youth and other diversity groups. In 2021–22, the Department of Health established 2 new staff groups, made up of employees with diverse backgrounds and lived experiences, to help foster a culture of diversity and inclusion across the department and to lead the implementation of priority initiatives.

COVID-19 and innovative work practices

The COVID-19 pandemic caused a rapid shift in the way the Department of Health worked. Teams were challenged to maintain services while dealing with staff absences and movements. To enable resources to be allocated to priority areas during peak workforce demands, a deployment register was used to match skills profiles to essential functions and facilitate opportunities for staff to collaborate with new people and learn new skills.

New ways of collaboration and communication were implemented in terms of document sharing, task management and video-conferencing. Digital tools were essential to plan and allocate work, and daily check-in meetings, online or face-to-face, helped to quickly identify any issues and to foster an open environment.

For the 2022 WA Health Graduate Development Program, the department made adjustments to recruitment activities to encourage a more diverse pool of applicants. Sections 51 and 66 of the *Equal Opportunity Act 1984* were applied to all positions to afford equal opportunity to people of various racial and religious backgrounds. In addition, a range of measures were used to better attract and support people with disability including targeted marketing, inclusive advertising and expanding support mechanisms. As a result, 6 applicants identified as having a disability – the highest number for the Graduate Development Program. These applicants were provided with appropriate support through the recruitment process and were offered ongoing support in the workplace. Following a 2-phase process including group assessment and panel interview, 2 applicants with a disability were offered a position.

In 2021, the department completed the Graduate Pathways, Recruitment and Retention consultation across the WA health system to identify recommendations to expand the Aboriginal workforce. The report will be finalised and actions implemented in 2022–23.

The Aboriginal Cadetship Program is a key workforce initiative aimed at attracting Aboriginal university students into the WA health system and building a highly-skilled, tertiary-qualified Aboriginal workforce. The program is designed to provide Aboriginal students with an opportunity to gain an income and improve their work-readiness while studying full-time for an undergraduate degree. As of June 2022, the program has recruited and appointed 36 cadets across the WA health system. The department has worked collaboratively with a regional Aboriginal Community Controlled Health Service to host 2 cadet places, which is an initiative of the Aboriginal Workforce Partnership Working Group between the department and the sector.

In partnership with the Australian Institute for Management and health service providers, the department continued to deliver culturally tailored leadership development programs and build the leadership capacity of the WA health system. The Aboriginal Leadership Excellence and Development program which aims to fast-track high potential Aboriginal staff into senior management and executive positions has 15 participants enrolled in 2022, and the First Step Aboriginal Leaders program for mid-tier Aboriginal staff interested in career progression had a total of 38 participants in 2021–22 (18 participants in 2021 and 20 participants in 2022).

Queen's Birthday Honours 2022

The following past and current departmental staff were recognised on the 2022 Queen's Birthday Honours list.

Officer of the Order of Australia

- Mr Alan Bansemer AO, former Commissioner for WA Health (1995 to 2001), for distinguished service to public administration.

Member of the Order of Australia

- Adjunct Professor Tarun Weeramanthri AM, former Chief Health Officer and inaugural Department of Health Assistant Director General, Public and Aboriginal Health Division (2017 to 2018), for significant service to public health administration.

Public Service Medal

- Ms Angela Kelly PSM, Deputy Director General, Department of Health, for outstanding service to the Western Australian health system, particularly during the COVID-19 pandemic.

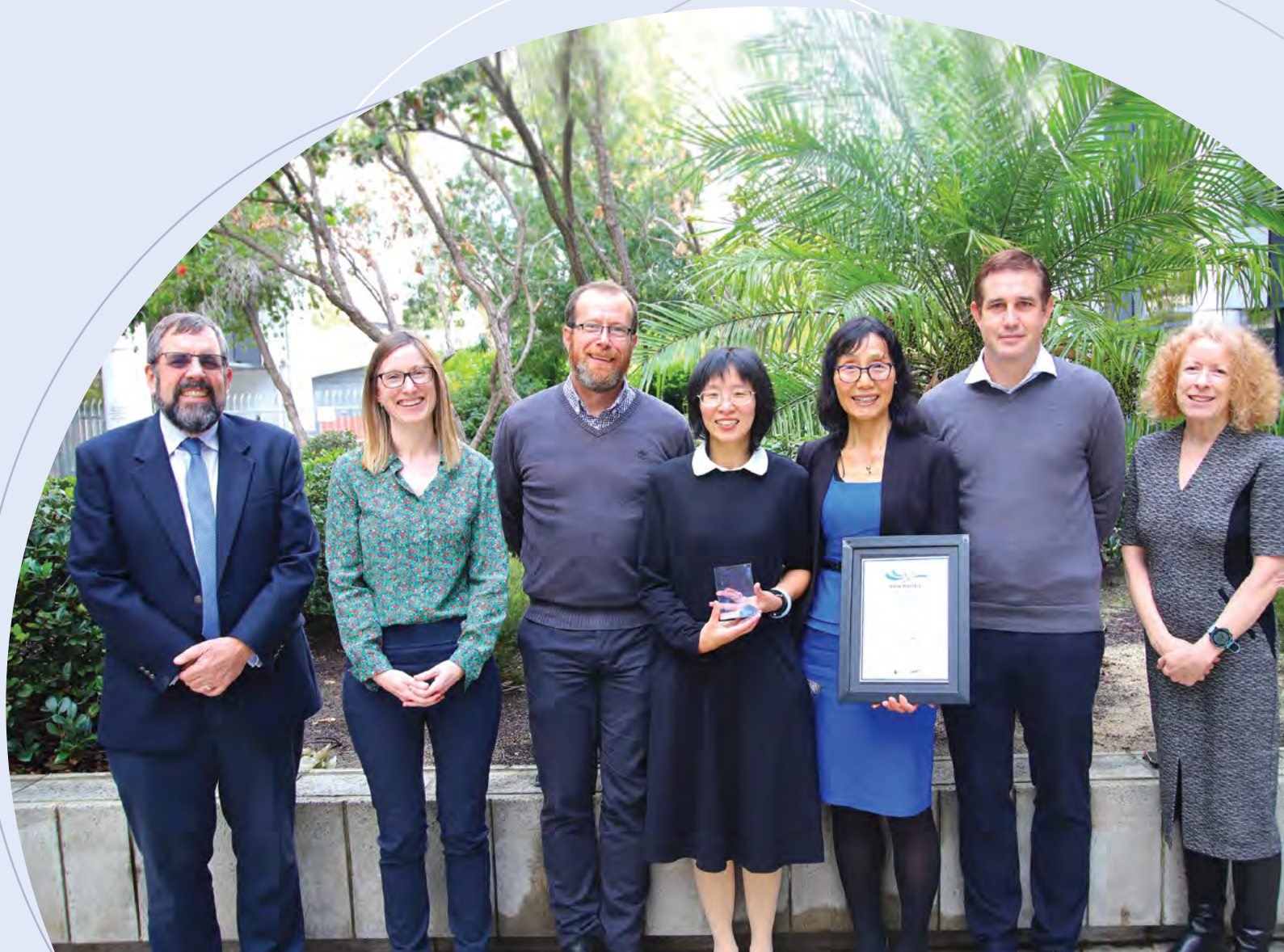


Award-winning COVID-19 dashboards

In response to an unprecedented demand for information during the COVID-19 pandemic, the Department of Health responded swiftly by developing 2 interactive [dashboards](#) to help understand the impact of the pandemic and share information with the community. Both dashboards are modern, interactive web-based GIS tools which display relevant COVID-19 information for WA. The dashboards have been widely used across the community, seeing more than 4 million hits up to 30 June 2022.

The team responsible for the development of the dashboards received national recognition for their work, receiving the prestigious Asia Pacific Spatial Excellence (National) Award for Community Impact. The judges commented the dashboards showed an excellent use of spatial technologies to both support and inform a local community health response. They remarked that the initiative gave the public accessible and up to date information, which was valuable in fighting the pandemic.

Systems and Innovation Team with
Dr Andrew Robertson, Chief Health Officer,
and Dr Denise Sullivan, Acting Assistant
Director General, Public and Aboriginal
Health Division



Our partnerships

Celebrating enduring partnerships

In 2021–22, the Department of Health celebrated milestone partnerships supporting public health and safety through community education and targeted programs.

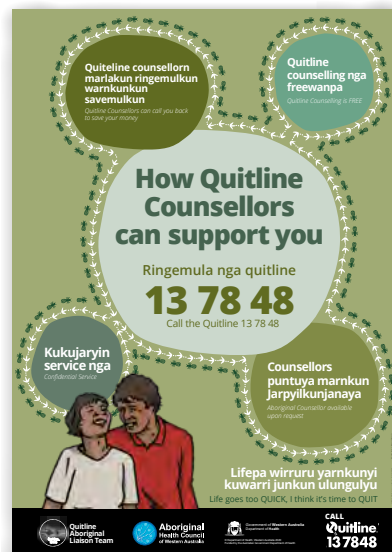
Health promotion and prevention continues to be a priority and the Department of Health's 10-year blueprint for action, the Sustainable Health Review, emphasised the importance of a cross sector, partnership approach to tackling the complex underlying factors that lead to preventable chronic disease and injury. The following long-term partnerships continue to focus on reducing tobacco use, halting the rise in overweight and obesity, preventing injury and promoting safer communities.

Make Smoking History: Cancer Council WA

Tobacco use is the leading risk factor for disease, disability and death in WA, contributing to 9 per cent of total years of life lost prematurely. Tobacco use causes 39 separate diseases, including 19 cancers, 7 kinds of cardiovascular disease, chronic obstructive pulmonary disease (emphysema), musculoskeletal conditions, and asthma.

The Make Smoking History campaign, established in 2000, takes a comprehensive approach to reducing the prevalence of tobacco use in Western Australia via statewide, television-led public education campaigns. These campaigns urge people who smoke to quit, and also play an important role in preventing people from starting smoking in the first place, and helping people stay smoke-free. Other key strategy areas of Make Smoking History include:

- support and advocacy for evidence-based tobacco control policy and legislation
- support and implementation of tailored cessation services, particularly for those groups with high smoking rates
- resource development
- dissemination and ongoing research and evaluation.



Since its inception Make Smoking History has delivered 55 waves of campaign activity. The campaigns have featured a variety of themes and creative executions, including health effects and graphic imagery, emotive narratives, testimonials, social costs and tobacco industry or policy-related messages. In 2022, a new statewide mass media campaign 'Worried about you' was launched to prompt people who smoke to think about how their smoking affects their loved ones and urge them to quit.



Evaluation of the Make Smoking History campaign demonstrates a positive impact on awareness, attitudes and behavioural intentions concerning smoking.

LiveLighter®: Cancer Council WA



The year 2022 marks **10 years** since the launch of the LiveLighter® healthy lifestyle promotion and education program delivered by Cancer Council WA and supported by the Department of Health. LiveLighter® aims to raise awareness of the serious health effects of being above a healthy weight and motivates and supports adults to make positive changes to achieve a healthier diet and more active lifestyle. The program consists of a mass media campaign and a supporting interactive website.

LiveLighter® is informed by robust evidence and is recognised internationally as an exemplar for public health mass media campaigns.

An independent [economic evaluation](#) to estimate the impact of the LiveLighter® campaign on dietary behaviours, weight, incidence of obesity-related diseases and healthcare cost-savings in WA adults found that the campaign significantly reduced consumption of sugary drinks and sweet foods (such as chocolates, cakes, and biscuits), resulting in significant healthcare cost-savings. This provides evidence that the LiveLighter® mass media campaign represents good value for money as a key obesity prevention initiative in Western Australia.

Since 2012, the LiveLighter® campaign has been adopted under license in several other Australian states and territories.

Stay On Your Feet®: Injury Matters

A partnership between the Department of Health and Injury Matters to keep older Western Australians on their feet has celebrated its **20th anniversary**. The Department of Health-funded Stay On Your Feet® program aims to reduce falls and falls-related injuries among older Western Australians and has played a crucial role in addressing the burden of falls and falls-related injuries on the WA community and the health care system.

Stay On Your Feet® uses the 'Move Improve Remove' campaign messages which focus on three simple steps: move your body, improve your health, and remove hazards. Move your body focuses on strategies to improve strength and balance, improve your health is about the importance of maintaining overall health and wellbeing, and remove hazards reminds people to remove things in and around the home that might cause slips, trips and falls.



Falls and falls-related injuries place a significant burden on the WA community and healthcare system. The 2021 WA Falls Report shows that every 12 minutes, a Western Australian goes to the emergency department because of a fall. Someone is hospitalised every 17 minutes, and every day someone dies from a fall.

Fortunately, falls are preventable. Over the past 20 years Stay On Your Feet® has supported the WA community through a range of activities, including TV campaigns, community education, workforce training, and grants to support community groups to deliver falls prevention programs to their communities.

Through the ongoing support of the Department of Health, key partnerships and the broader WA falls prevention sector, the program has evolved based on emerging falls prevention evidence and with the needs of our ageing Western Australian community.

Keep Watch: Royal Life Saving Society WA

November 2021 marks **20 years** since the introduction of legislation requiring fencing around new backyard pools – a huge step towards promoting a culture of water safety and protecting children from drowning. The laws were implemented following decades of unacceptably high swimming pool drownings involving toddlers and young children. Before 2001, on average 9 children under the age of 5 drowned each year. In the 20 years since, toddler drownings in home swimming pools has dropped to fewer than 4 per year. This is still 4 deaths too many.

Pool fencing is a critical safety measure because young children most commonly drown at times when parents aren't expecting them to be around water. It can take only a few minutes for a curious child to find their way to water while adults are distracted.

Royal Life Saving WA's Keep Watch public awareness and education campaign has been running for more than 25 years. Keep Watch is funded by the Department of Health. The campaign recommends the following safety tips to keep children safe around water:

- Actively supervise children around water.
- Restrict children's access to water.
- Teach children water safety skills.
- Learn how to respond in the case of an emergency.

Royal Life Saving WA recently released the 2020–21 WA Drowning Report which highlights key drowning trends and identifies those most at risk. The report provides an overview of drowning trends over the past 10 years in each of WA's regions, in children aged 0 to 4 years and in young people aged 15 to 24 years.



Collective development of a model of care

With the oversight of the Graylands Reconfiguration and Forensic Taskforce (GRAFT), the department has been supporting the development of a contemporary model of care for forensic services in Western Australia to inform the design of the future forensic mental health facility on the Graylands Hospital site.

The work is being led by the State Forensic Mental Health Service, North Metropolitan Health Service (NMHS) as the health service provider that will continue to be responsible and accountable for the operational delivery of forensic mental health services. Working together towards a shared purpose with NMHS and a lived experience co-chair, the department has established a large working group with diverse representation that will develop the model of care collectively.

The intent of this working group is to reflect the principles of co-design, involving consumers and users in the development approach. This means each member of the working group, regardless of role, position or experience, are equals in the development process from the very beginning. So far, the meetings have been well received with many members sharing their appreciation for being able to be a part of the process, as well as enthusiasm and optimism that this approach will produce a good outcome – everyone is learning together and growing their awareness of others' experiences, skills and knowledge.

While the co-design process is a new way of working, the department believes there is much to learn by bringing different perspectives together, particularly from those who have lived experience as users of mental health services. However, the co-design process does need to be designed in a way that is safe and respectful for all. In this particular case alternative ways to harness the needs of Aboriginal people, people who identify as LGBTIQ+, those who are ethnoculturally and linguistically diverse, young people and people with a diagnosis of neurodiversity are being sought. By investing in this approach, the model of care creates a future forensic service that is contemporary, truly reflects the individual needs of all users, and supports the achievement of good mental health and wellbeing outcomes.

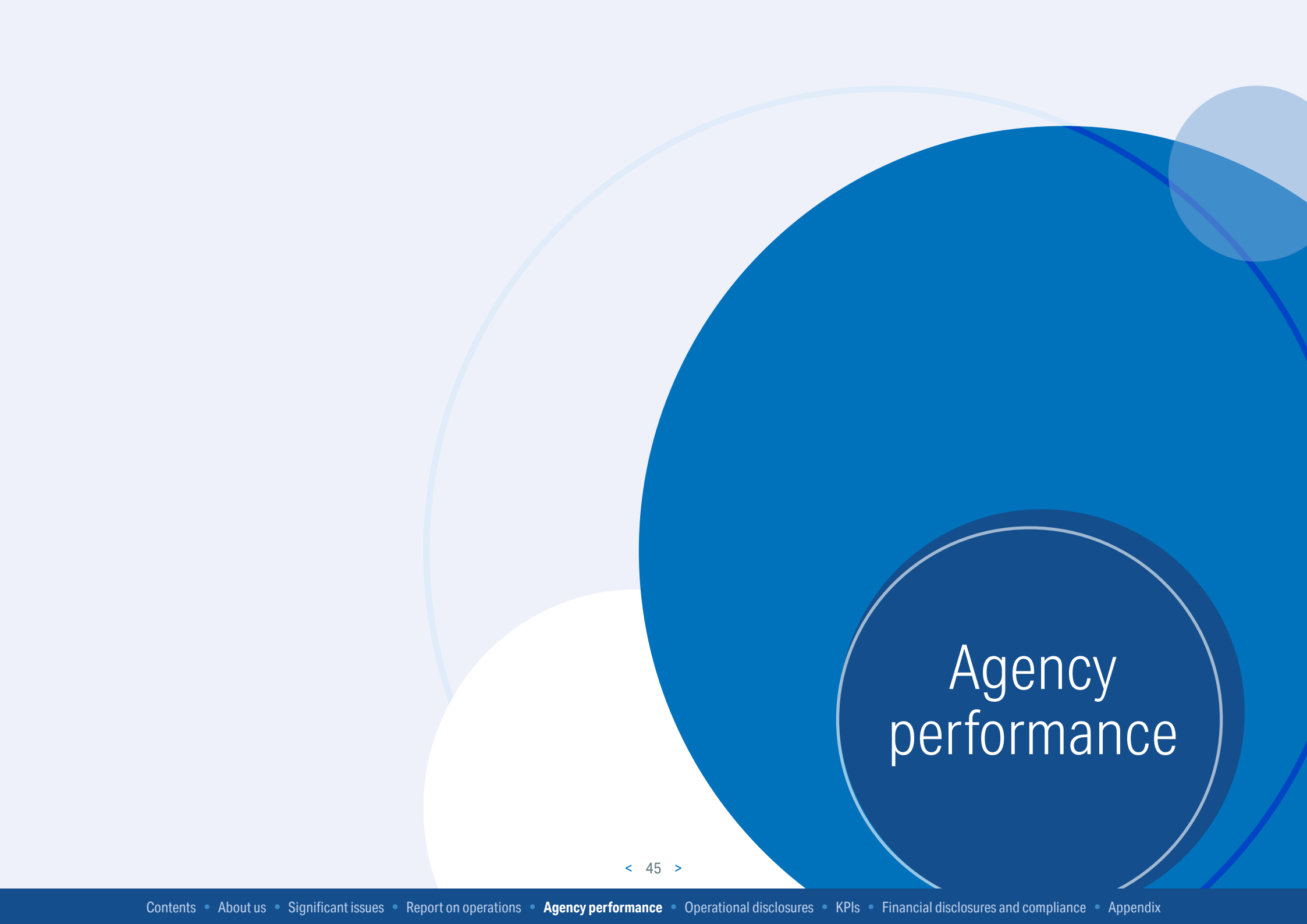


Reducing inequity in health outcomes and access to care

The Department of Health has collaborated with local government, the community and the social services sector to progress implementation of the Sustainable Health Review recommendation to reduce inequity in health outcomes, and access to care for culturally and linguistically diverse people.



The department has produced the Mirrabooka Service Mapping Report that captures and promotes collaborative approaches to providing support to the culturally and linguistically diverse community across several local government areas in metropolitan Perth. The approaches documented in this project provide a valuable guide for local governments and organisations working with culturally and linguistically diverse people.



Agency performance

Our performance management framework

The Department of Health operates under the WA health system Outcome Based Management Framework. This framework describes the relationship between outcomes, services and key performance indicators that measure how effective and efficient the organisation is in achieving relevant overarching State Government goals.

Table 3 demonstrates the alignment between whole of government goals and the WA health system Outcome Based Management Framework. The outcomes and services related to the Department of Health are marked in blue.

Table 3: Outcome Based Management Framework for the WA health system

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

The Department of Health achieves Outcome 2 through the delivery of:

- **aged and continuing care services** that 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. Aged and continuing care services is inclusive of community-based palliative care services that are delivered by private facilities under contract to the WA health system, which focus on the prevention and relief of suffering, quality of life and the choice of care close to home for patients.
- **public and community health services** that include the provision of healthcare services and programs delivered to increase optimal health and wellbeing, encourage healthy lifestyles, reduce the onset of disease and disability, reduce the risk of long-term illness as well as detect, protect and monitor the incidence of disease in the population. Public and community health services includes public health programs, Aboriginal health programs, disaster management, environmental health, the provision of grants to non-government organisations for public and community health purposes, and emergency road ambulance services.

Outcome 3 is achieved through **health system management – policy and corporate services**. This is the provision of strategic leadership, policy and planning services, system performance management and purchasing linked to the statewide planning, budgeting and regulation processes. Health system policy and corporate services is inclusive of statutory financial reporting requirements, overseeing, monitoring and promoting improvements in the safety and quality of health services, and systemwide infrastructure and asset management services.

The Department of Health reports performance towards achieving the WA health system vision through a suite of key performance indicators that form part of the WA health system Outcome Based Management Framework. Performance against targets for 2021–22 is summarised in the Agency performance section and described in detail in the key performance indicators section of this report.

Efficiency key performance indicators – change in calculation methodology

In 2021–22, financial products such as depreciation expenses, financial expenses and lease expenses were removed from the calculation of all efficiency key performance indicators. This change will improve transparency by providing a view of service efficiency that reflects the actual cost of service delivery and reduce the risk of allocating expenditure in a way that may impact on reported performance.

Performance summary

Summary of financial performance

Table 4 provides the financial and performance information of the Department of Health for 2021–22. In summary the variation to target for the total cost of services is attributable to higher than budgeted expenses associated with the response and incident management of COVID-19.

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

Table 4: Actual results versus budget targets for the Department of Health

	2021–22 Target (\$'000)	2021–22 Actual (\$'000)	2021–22 (+ / -) (\$'000)
Total cost of services	8,502,522	9,830,867	1,328,345
Net cost of services	5,768,960	6,517,766	748,806
Total equity	266,009	413,771	147,762
Net increase/decrease in cash held	2,375	115,947	113,572
Approved salary expense level	167,510	173,743	6,233
Approved borrowing limit	0	0	0

Agencies are required to operate within an agreed working cash limit, defined as 5 per cent of budgeted cash payments. The approved working cash limit is the maximum level of cash required to meet commitments associated with payments for recurrent services. In 2021–22, the cash limit target and actual for the WA health system are provided in Table 5.

Table 5: Agreed working cash limit for the WA health system

	2021–22 Agreed Limit (\$'000)	2021–22 Target / Actual (\$'000)	2021–22 (+ / -) (\$'000)
Agreed working cash limit (at budget)	496,355	496,355	0
Agreed working cash limit (at actuals)	547,291	440,240	–107,681

Notes:

1. The working cash limit is for all WA health system entities, including health service providers.
2. The cash position for the Department of Health can be found in the notes to the Financial Statements.

Act of grace payments and ex-gratia payments paid in 2021–22 are provided in Table 6.

Table 6: Department of Health act of grace and ex-gratia payments paid in 2021–22

Funding source	Payment date	Payment amount (\$)	Purpose of payment
Act of grace payment			
State appropriation	5 July 2021	72,710	Payment to Commonwealth for Medicare claims.
Ex-gratia payments			
State appropriation	Throughout the year	4,561,615	Payment to health service providers to cover out-of-pocket expenses incurred by patients who chose to be treated as a private patient in a public hospital.

Summary of key performance indicators

The Department of Health reports performance towards achieving the WA health system vision through a suite of key performance indicators. Actual results are reported against targets to help assess effectiveness of performance against desired outcomes and efficiency of service delivery.

Effectiveness results are summarised in Table 7 and efficiency results are summarised in Table 8.



Table 7: Actual results versus key effectiveness performance indicator targets

Page	Desired outcomes and related effectiveness indicators	2021-22 Target	2021-22 Actual	Variation (actual minus target)
Prevention, health promotion and aged and continuing care services that help Western Australians to live healthy and safe lives				
72	1. Percentage of transition care clients whose functional ability was either maintained or improved during their utilisation of the Transition Care Program	≥65%	85%	20%
73	2. Percentage of people accessing specialist community-based palliative care who are supported to die at home	≥76%	78%	2%
74	3. Loss of life from premature death due to identifiable causes of preventable disease or injury			
	a. Lung cancer	1.5	1.2	-0.3
	b. Breast cancer	2.0	1.9	-0.1
	c. Ischaemic heart disease	2.1	1.8	-0.3
	d. Falls	0.3	0.5	0.2
	e. Melanoma	0.3	0.3	0.0
76	4. Percentage of fully immunised children			
	a. 12 months	≥95%	94%	-1%
	b. 2 years	≥95%	92%	-3%
78	c. 5 years	≥95%	94%	-1%
	5. Percentage of 15 year olds in Western Australia that complete their HPV vaccination series			
	a. Males	≥80%	80%	0%
80	b. Females	≥80%	81%	1%
	6. Response times for emergency road-based ambulance services (Percentage of priority 1 calls attended to within 15 minutes in the metropolitan area)	≥90%	82%	-8%
Strategic leadership, planning and support services that enable a safe, high quality and sustainable WA health system				
82	7. Proportion of stakeholders who indicate the Department of Health to be meeting or exceeding expectations of the delivery of System Manager functions	≥85%	59%	-26%

Table 8: Actual results versus key efficiency performance indicator targets

Page	Services delivered and related efficiency indicators	2021-22 Target	2021-22 Actual	Variation (actual minus target)
Aged and continuing care services				
84	1. Average cost of a transition care day provided by contracted non-government organisations/service providers	\$318	\$352	\$34
85	2. Average cost per home-based			
	a. hospital day of care	\$301	\$320	\$19
	b. occasion of service	\$145	\$140	-\$5
86	3. Average cost per day of care for non-acute admitted continuing care	\$799	\$783	-\$16
87	4. Average cost to support patients who suffer specific chronic illness and other clients who require continuing care	\$25	\$19	-\$6
Palliative and cancer care services				
88	5. Average cost per client receiving contracted palliative care services	\$8,487	\$8,461	-\$26
Public health services				
89	6. Cost per person of providing preventative interventions, health promotion and health protection activities that reduce the incidence of disease or injury	\$149	\$237	\$88
Patient transport services				
90	7. Cost per trip for road-based ambulance services, based on the total accrued costs of these services for the total number of trips	\$523	\$534	\$11
Health system management – Policy and corporate services				
91	8. Average cost of public health regulatory services per head of population	\$6	\$8	\$2
92	9. Average cost for the Department of Health to undertake system manager functions per health service provider full time equivalent	\$5,337	\$7,022	\$1,685

No Jab, No Play

Rationale

In 2019, changes to the *Public Health Act 2016* and *School Education Act 1999* required a child's immunisation status to be up-to-date to enrol into long day care, family day care, pre-kindergarten, and/or kindergarten. These legislative changes, referred to as 'No Jab No Play', were effective from 22 July 2019.

There are a limited number of circumstances in which a child may be exempt from this requirement. Child care services and schools were directed to report these exempt children for follow-up.

Child care services were directed to report a child's immunisation status at the time of enrolment, while schools were directed to report a student's immunisation status by the end of Term 1 each year. The different reporting requirements of child care services and schools has resulted in 2 reporting cohorts. These are:

- children enrolled in child care services during a full financial year (i.e. between 1 July and 30 June) that are not up-to-date with their immunisations
- children enrolled in schools in Term 1 of a calendar year (i.e. between 1 January and 31 March) that are not up-to-date with their immunisations.

The immunisation records of the children reported as not up-to-date by child care services and schools are confirmed by comparing to the Australian Immunisation Register. Children that are not up-to-date are referred to public health staff to provide immunisation support to the families to get their children 'up to date'.

Parents are also able to request support through the school or child care service regardless of their child's immunisation status.

Results

Of the 586 children who were not fully immunised and reported in the 2020–21 financial year, 196 (33.5 per cent) became up-to-date and 2 children were on a catch-up schedule as of 2 July 2022.

For the 2021–22 financial year, 584 children were reported as not fully immunised at enrolment into child care services (n=23) and schools (n=561). Overall, 147 (25.2 per cent) of these children became up-to-date as of 2 July 2022 while 21 children (3.6 per cent) were on a catch-up schedule.

Follow up of children reported in 2022 is ongoing. An evaluation into the impact of this legislation on immunisation rates is currently underway, with results anticipated in 2023.



Table 9: Immunisation status of children who were not fully immunised by enrolment cohort, 2020–2021 and 2021–2022

Enrolment cohort	Reported as not up-to-date at enrolment	Immunisation status as at 30 June 2022			
		Up-to-date	On a catch-up schedule	Not up-to-date	Unable to find on Australian Immunisation Register
2020-21					
Children enrolled in child care between 1 July 2020 and 30 June 2021	57	18	0	31	8
Children enrolled in school between 1 January and 31 March 2021	529	178	2	273	76
Total	586	196	2	304	84
2021-22					
Children enrolled in child care between 1 July 2021 and 30 June 2022	23	3	3	14	3
Children enrolled in school between 1 January and 31 March 2022	561	144	18	319	80
Total	584	147	21	333	83

Notes:

1. Data is based on children enrolled at long day care, family day care, pre-kindergarten, and/or kindergarten including children in WA on a temporary basis, who are not registered with Medicare but have a record on the Australian Immunisation Register (AIR), and whose immunisation status was unknown as their registration on AIR was pending at the time of reporting.
2. 'Unable to find on Australian Immunisation Register' denotes children whose immunisation records may not be visible to third parties.
3. Due to the time lag between reporting, data cleaning, and follow up activity the immunisation status of both cohorts as at 2020–21 is considered final and for 2021–22 the findings are considered preliminary. Updated 2021–22 results on changes in immunisation status will be provided in the 2022–23 Annual Report.

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

End-of-Life care in Western Australia

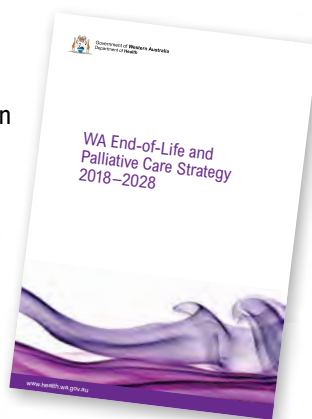
The Department of Health is committed to ensuring the highest quality end-of-life and palliative care for all Western Australians. With an ever-growing and ageing population, a renewed focus on these issues is vital so that people with life-limiting or terminal illness can live their lives fully and as comfortably as possible.

End-of-Life Care Program

The End-of-Life Care Program provides statewide strategic direction for the implementation of initiatives related to:

- end-of-life and palliative care
- advance care planning
- the *Voluntary Assisted Dying Act 2019*.

The End-of-Life Care Program is informed by the [WA End-of-Life and Palliative Care Strategy 2018–2028](#). Also, through implementing recommendations of the [Report of the Joint Select Committee on End-of-Life Choices, My Life, My Choice](#), [Final Report of the Joint Select Committee on Palliative Care in Western Australia](#), the [Ministerial Expert Panel on Advance Health Directives Final Report](#) and the Sustainable Health Review recommendation regarding respectful and appropriate end-of-life care and choices.



Report on progress in 2021–22

In 2021–22, the Department of Health undertook the following End-of-Life Care Program activities:

- Established the statewide Voluntary Assisted Dying Care Navigator Service to support people seeking access to voluntary assisted dying.
- Launched the End-of-Life and Palliative Care Education and Training Framework to provide a resource for all health professionals, staff and organisations that care for people with end of life and palliative care needs.
- Initiated and continued funding of multiple initiatives under the National Partnership Agreement on Comprehensive Palliative Care in Aged Care.
- Consulted extensively with the sector to develop targeted resources for health professionals to support their role in advance care planning.
- Released the *End-of-life and Palliative Care for People with Dementia Framework*.
- Conducted a forum to provide information on the first 6 months of the implementation of voluntary assisted dying in Western Australia with presentations from the Voluntary Assisted Dying Board, Statewide Care Navigator Service, Statewide Pharmacy Service, the Community of Practice and family members.

- Worked with a broad range of stakeholders and the Department of Justice to finalise a revised Advance Health Directive form that better meets the needs of consumers and clinicians.

Adequate funding of community based palliative care services to meet growing demand was recommended in the Joint Select Committee on Palliative Care in Western Australia report. An estimated \$110.8 million has been allocated to hospital and community based palliative care for 2022–23, slightly above funding provided in 2021–22. This includes community-based services in metropolitan and regional Western Australia, and funding for palliative care, voluntary assisted dying and advance care planning project implementation.

Also, in partnership with the Perth Children's Hospital Foundation, the State and Australian governments are supporting the establishment of a new children's hospice, which will provide holistic and compassionate care for children with life-limiting conditions from the time of diagnosis, including end-of-life support and bereavement care.

Communicating progress of implementation of the recommendations of the Joint Select Committee on End-of-Life Choices Report

- Regular Palliative Care and Advance Care Planning Health Service Provider meetings
- End-of-Life Palliative Care Advisory Committee meeting that convenes quarterly and includes representatives from across palliative care service providers in Western Australia
- Biannual End of Life Care Program update via webinar through Palliative and Supportive Care Education (PaSCE)
- Voluntary Assisted Dying communiques every 8 weeks
- Health Networks bulletins emailed every 6 weeks
- Tri-annual advance care planning updates to stakeholders identified in the Ministerial Expert Panel on Advance Health Directives and via consultation with the sector
- Advance care planning project updates via video presentation as part of the PaSCE program for health professionals
- End-of-Life Care Program Update newsletter distributed quarterly to over 1,500 stakeholders in the palliative care sector

Sexually Transmissible Infections Strategy: progress report

The [*Western Australian Sexually Transmissible Infections Strategy 2019–2023*](#) is one of 5 sexual health and blood-borne virus strategies developed by the Department of Health and endorsed by the Western Australian Sexual Health and Blood-borne Virus Advisory Committee. The strategies provide an agreed framework for a comprehensive and coordinated response to prevention and control of blood-borne viruses and sexually transmissible infections in WA. The WA Sexual Health and Blood-borne Viruses Advisory Committee continues to monitor and review progress against the WA Sexual Health and Blood-borne Virus Strategies 2019–2023.

The *WA Sexually Transmissible Infections Strategy 2019–2023* outlines the guiding principles, goals, targets and priority areas needed for an effective, coordinated and comprehensive state-wide response to minimise the impact of sexually transmissible infections on vulnerable target populations in WA.

Sexually transmissible infections represent a significant burden of disease in Western Australia, with young people and Aboriginal people disproportionately affected.

Human papilloma virus (HPV) is a common sexually transmitted 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. In 2021, 80.2 per cent of 15 year old males and 80.9 per cent of 15 year old females had completed their HPV vaccination series, above the target of 80 per cent.

In 2021–22, notifiable sexually transmissible infection testing rates were maintained despite the health system's focus on the COVID-19 response and associated competing priorities. For syphilis, testing rates increased in both the metropolitan and non-metropolitan area.



Sexually Transmissible Infections (STI) Strategy at a glance

Goals

1. Reduce transmission of sexually transmissible infections (STIs) among priority populations in Western Australia.
2. Reduce morbidity and mortality associated with STIs.
3. Minimise the personal and social impact of STIs.
4. Eliminate the negative impact of stigma, discrimination, and legal and human rights issues on people's sexual health.

Targets

1. Achieve and maintain human papillomavirus (HPV) adolescent vaccination coverage of 80 per cent or more.
2. Increase STI testing coverage of priority populations.
3. Reduce the incidence and prevalence of gonorrhoea, chlamydia and infectious syphilis.
4. Maintain virtual elimination of congenital syphilis.
5. Eliminate the reported experience and expression of stigma among priority populations affected by STIs.

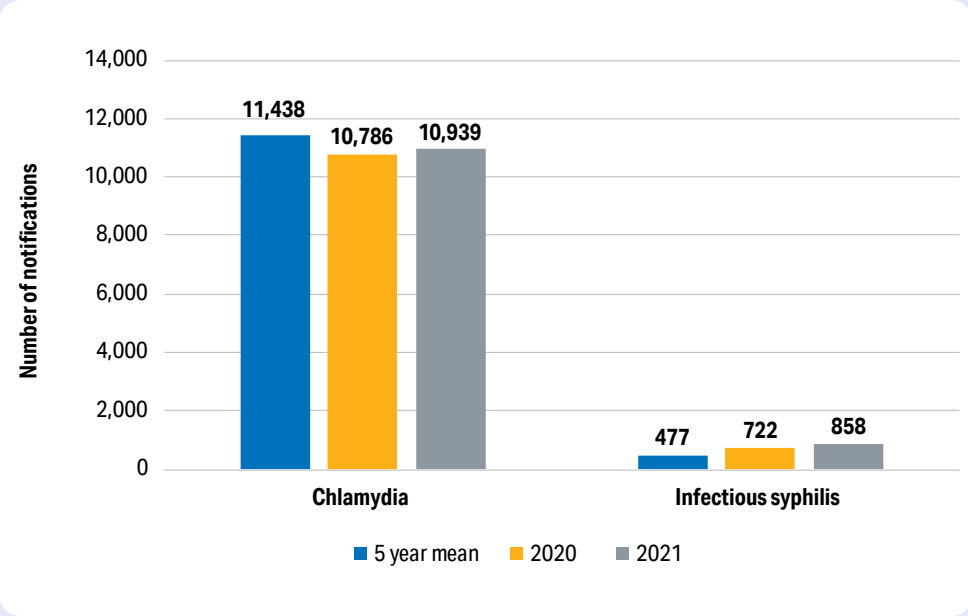
Key action areas

1. Prevention and education
2. Testing and diagnosis
3. Disease management and clinical care
4. Workforce development
5. Enabling environment
6. Data collection, research and evaluation

Syphilis notifications continue to rise across the state (858 notifications in 2021, compared to the 5-year average of 477 cases) as shown in Figure 6. In 2021, WA had 4 cases of congenital syphilis, 2 of which resulted in stillbirth. Controlling the increase in infectious syphilis remains a public health priority, including the testing and treatment of syphilis in pregnant and post-partum women to reduce the risk of negative outcomes in both the mother and neonate.

Additional funding to WA Country Health Service, non-government organisations and Aboriginal community-controlled health organisations has supported increased community engagement, testing, treatment and contact tracing for increasing numbers of syphilis and other sexually transmissible infections in rural and remote regions. Approximately \$3.5 million has been committed to the Syphilis Outbreak Response for 2022–23, that will be focused on public health programs for rural, remote and metropolitan at-risk populations.

Figure 6: Number of infectious syphilis and chlamydia notifications in WA, by time period



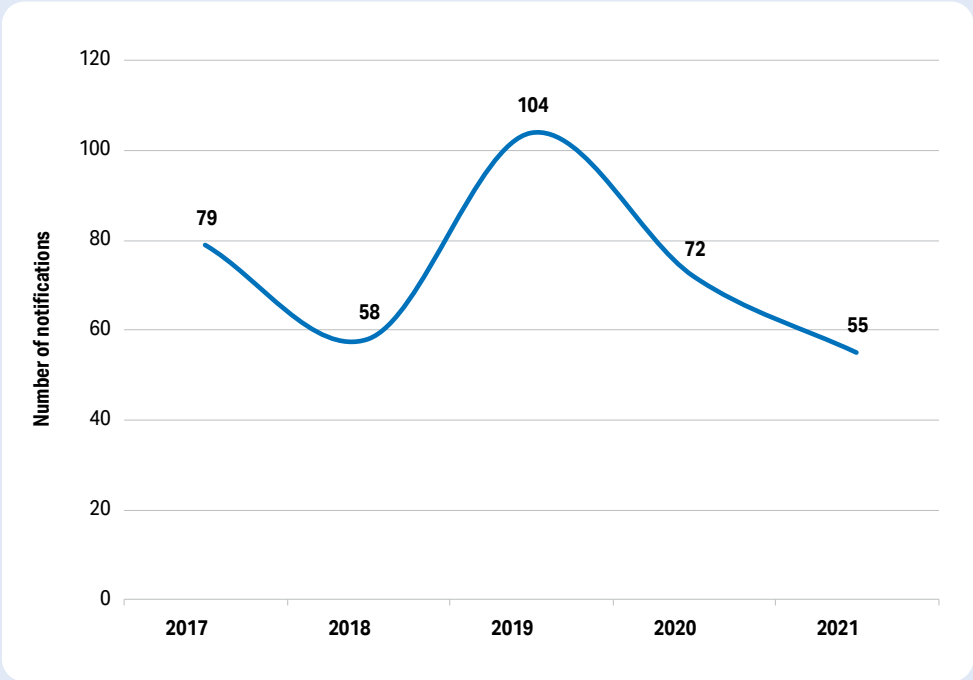
The WA Syphilis Outbreak Response Group continues to direct and monitor actions under the WA Syphilis Outbreak Response Action Plan, which aims to control the outbreak of syphilis among Aboriginal communities in Western Australia.

The group advocated for improved collaboration with public health funded pathology service PathWest to decrease the time to receive notification of positive syphilis infections and implementation of ICT systems to create efficiencies for health services, public health units and PathWest.

Chlamydia is the most common sexually transmitted infection in Australia, particularly among young people aged 15 and 25 years. In 2021, chlamydia notifications in Western Australia increased 1.4 per cent compared to 2020, however notifications are 4.4 per cent lower than the 5-year average of 11,438 cases as shown in Figure 6.

In 2021, WA had the lowest number of HIV notifications (55) since 2004 (49) (see Figure 7). This is promising progress towards the United Nations target of virtual elimination in 2030. The reduction in rates can likely be attributed to pre-exposure prophylaxis and the effectiveness of treatment that achieves undetectable viral loads.

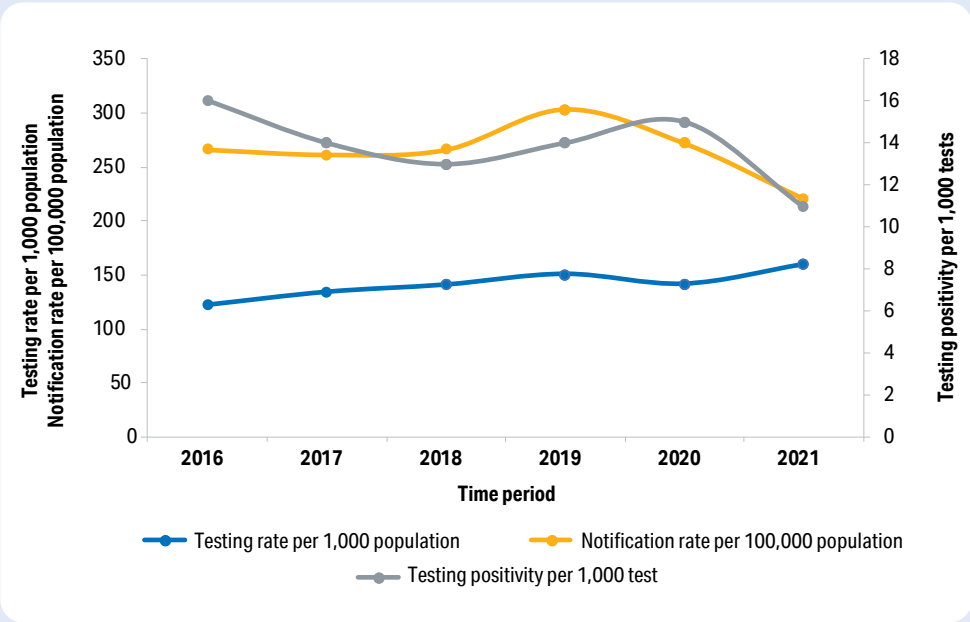
Figure 7: Number of HIV notifications in WA from 2017 to 2021



Gonorrhoea has experienced a 19 per cent decrease in notifications between 2016 to 2021, despite a marginal increase in testing rates, suggesting a true decrease in community transmission and prevalence (see Figure 8).

With borders now open and increased travel to countries with higher sexually transmissible infection prevalence, WA will require continued targeting of prevention and education campaigns.

Figure 8: Gonorrhoea testing rate, notification rate and test positivity rate in WA by time period



While there has been increased testing coverage and an overall decline in the incidence and prevalence of sexually transmitted infections, a comprehensive approach to the prevention, testing, treatment and control of these diseases must continue to be implemented. This includes the ongoing investment in:

- multi-media, social marketing campaigns such as *Healthy Sexual* and *Look After Your Blood*
- comprehensive school curriculum materials for teachers and training for undergraduate and in-service teachers in relationship and sexual health education
- funding community-based prevention and education programs and clinical services for at-risk populations
- statewide needle and syringe program
- providing accessible clinical guidelines for clinicians and general practitioners
- workforce development for Aboriginal health workers, nurses and general practitioners.



This page has been left blank intentionally



Operational disclosures

Ministerial directives

The Department of Health did not receive any Ministerial directives relevant to the setting of desired outcomes or operational directives, the achievement of desired outcomes or operational directives, investment activities, or financing activities.

Employee disclosures

Employment profile

As at 30 June 2022, the Department of Health employed the equivalent of 966 full-time employees (FTE). The Department of Health also employed 238 FTE to support the State Health Incident Coordination Centre (SHICC) to respond to COVID-19. There are 24 permanent Department of Health FTE currently working full time for the SHICC while the remainder are contracted or seconded-in employees.

A summary of the number of full-time equivalent employees, by category, for 2021–22 compared with 2020–21 is shown in Table 10.

Table 10: Total full-time employees by category

Category	Department of Health		SHICC	
	2020–21	2021–22	2020–21	2021–22
Full-time permanent	569	543	29	24
Full-time contract	170	207	83	128
Part-time measured as full-time equivalent	156	167	32	22
Secondment in	23	22	11	25
Secondment out	1	2	0	0
Other	8	25	60	39
Total	927	966	215	238

Notes:

1. The total of full-time equivalent employees was calculated as the monthly average of full-time equivalent employees and is the average hours worked during a period of time divided by the Award full-time hours for the same period. Hours include ordinary time, overtime, all leave categories, public holidays, time off in lieu and workers' compensation.
2. Full-time equivalent employee figures provided are based on actual (paid) month-to-date, full-time equivalent employees.
3. Excludes staff employed under the Health Services Union award.
4. Secondment out figures may not accurately represent actual secondments out due to data capture limitations in the Human Resource Data Warehouse.
5. The Other category includes casuals, agency and sessional employees.

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

Industrial relations

The Department of Health supports the system manager in the management of industrial relations across the WA health system, including negotiation, registration, modernisation, monitoring and evaluation of specific industrial agreements and subsidiary agreements.

In 2021–22, the following agreement was renegotiated and registered with the WA Industrial Relations Commission:

- Dental Health Services – Dental Officers – CSA Industrial Agreement 2021.

Negotiations continued regarding the following industrial agreements:

- WA Health System – Medical Practitioners – AMA Industrial Agreement 2016
- WA Health System – Medical Practitioners (Clinical Academics) – AMA Industrial Agreement 2016.

The department is also currently planning and preparing for the negotiation, registration and implementation of the following WA health system industrial agreements:

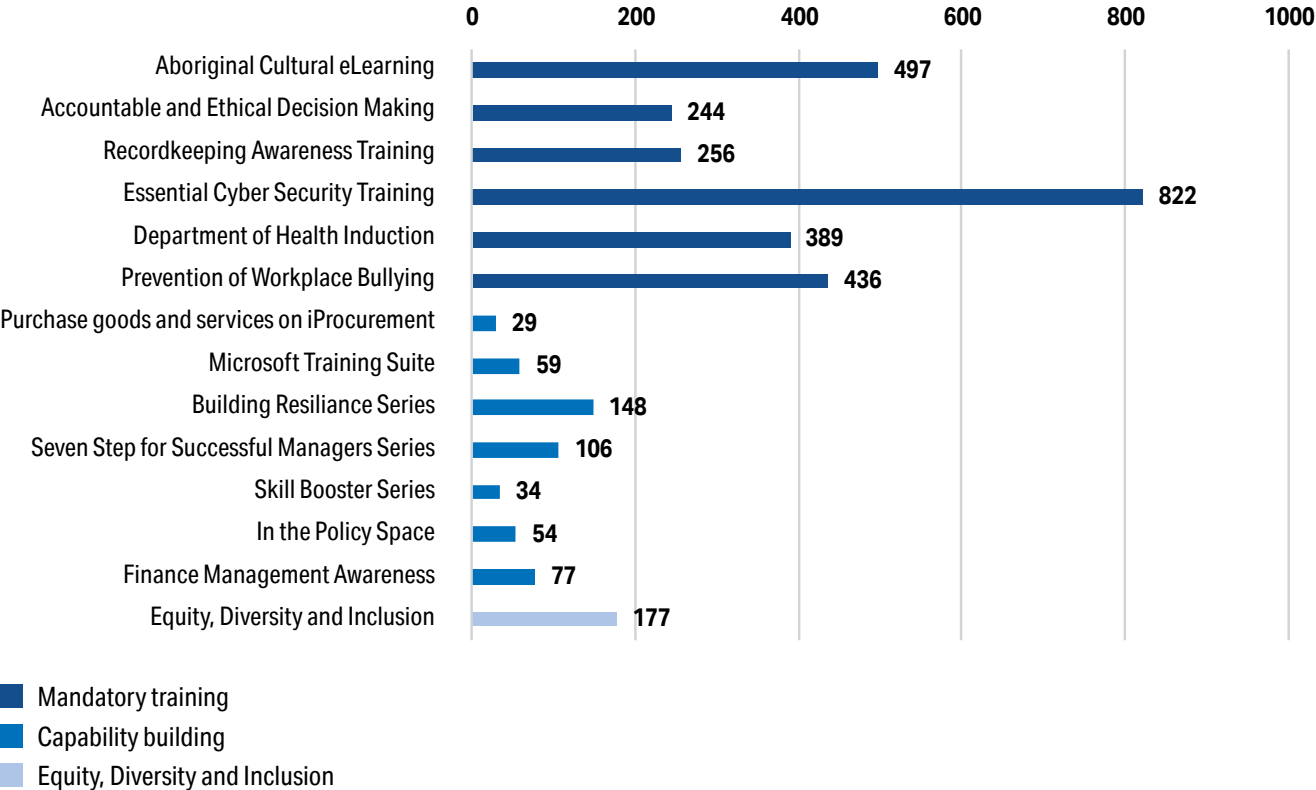
- WA Health System – Australian Nursing Federation – Registered Nurses, Midwives, Enrolled (Mental Health) and Enrolled (Mothercraft) Nurses – Industrial Agreement 2020
- WA Health System – United Workers Union (WA) – Enrolled Nurses, Assistants in Nursing, Aboriginal and Ethnic Health Workers Industrial Agreement 2020
- WA Health System – United Workers Union (WA) – Hospital Support Workers Industrial Agreement 2020
- WA Health System – Engineering and Building Services Industrial Agreement 2021
- WA Health System – HSWUWA – PACTS Industrial Agreement 2020
- CAHS – HSUWA – Multisystemic Therapy Program Agreement 2021
- Dental Health Services – Dental Technicians – CSA Industrial Agreement 2020.

Staff development

The Department of Health is committed to enabling our workforce to build foundational skills and supporting their aspirations for further and future development. We continue to respond to the training needs of our workforce through the provision of face-to-face training, online learning, tailored facilitation and on-the-job learning opportunities.

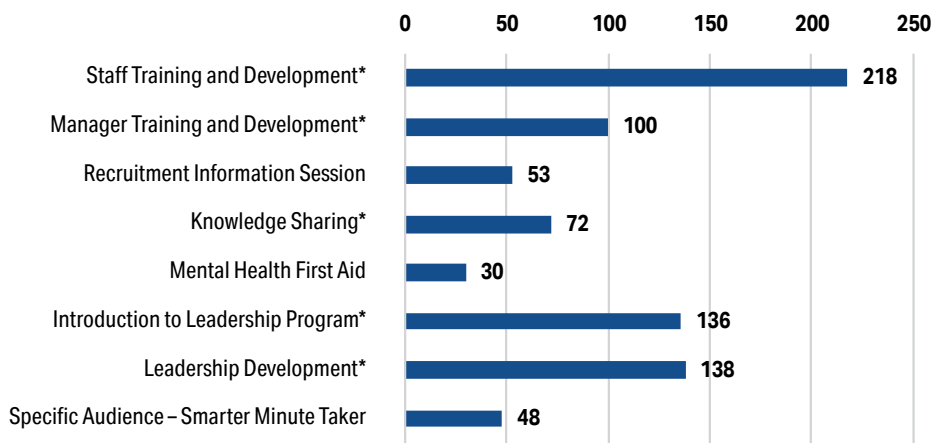
In 2021–22, Department of Health employees completed more than 2,500 hours of eLearning including courses mandated across the WA public sector and within the department, capability building programs, and the new Equity, Diversity and Inclusion package. An overview of the courses completed is provided in Figure 9.

Figure 9: Staff completion of eLearning modules by training subject, 2021–22



Department of Health employees also completed more than 3,200 hours of face-to-face training and development in 2021–22 (see Figure 10).

Figure 10: Attendees at face-to-face programs by training type, 2021–22



* Denotes categories where an individual employee may attend more than one development session

Work health, safety and injury management

Commitment to workplace health and safety

The Department of Health is committed to workplace health and safety in accordance with the new *Work Health and Safety Act 2020*.

The Work Health and Safety (WHS) Policy was revised to ensure alignment with the introduction of new work health and safety legislation that came into effect on 31 March 2022. A review of the department's WHS management system is also underway and all procedures relating to work health and safety will be updated in line with the 12-month transition window for employers to implement the WHS Act.

The Department of Health continues to improve the effectiveness and performance of the WHS management system by establishing measurable objectives and targets and consulting with staff and elected health and safety representatives on matters relating to work, health or safety.

The Safety and Health Committee is responsible for ongoing monitoring and review of WHS management requirements, strategic initiatives and action plans for the department. Members of the committee include elected health and safety representatives and divisional business management representatives.

All employees have ease of access to health and safety representatives for assistance and advice and can keep abreast of the Safety and Health Committee activity via minutes of meetings made available online. New staff receive an overview of the WHS management system as part of their induction, including information on the role of the department's health and safety representatives and the Safety and Health Committee.

In 2021–22 the following activities were implemented to support employee health and safety:

- Launch of the Family and Domestic Violence Procedure and supporting resources, including a Guide for Managers to coincide with the 16 Days in WA campaign. The documents ensure staff experiencing family and domestic violence can access appropriate support and leave from the department.
- Provision of information and support to employees throughout the COVID-19 pandemic on how to reduce the spread of COVID-19 and maintain a safe workplace through the Providing A Safe Workplace intranet page, including guides such as the COVID-19 Workplace Safety Plan and an action plan for managers when a staff member tests positive.
- Update of the WHS training for managers program to align with the new WHS legislation and enhancement of monitoring processes to improve compliance.
- The People and Culture team and health and safety representatives attended Mental Health First Aid training in October 2021 to provide staff with the skills to consider the impact on mental health when approaching people-related matters and to encourage access to support services.

Management of workplace health and safety

Injury management and return to work

Employees who have work-related injuries are assisted to return to work as soon as medically appropriate, as described in the Department of Health Injury Management System and in accordance with the *Workers' Compensation and Injury Management Act 1981*.

Management supports the injury management process and recognises that success relies on the active participation and cooperation of the injured worker. Whenever possible, suitable duties are arranged internally through a return to work program, having regard for the injured worker's medical restrictions.

Workers' compensation

The workers' compensation scheme in Western Australia is regulated and administered by WorkCover WA under the *Workers' Compensation and Injury Management Act 1981*. In 2021–22, a total of 4 workers' compensation claims were made, compared to 7 claims made in 2020–21.

Compliance

The annual performance for the Department of Health in relation to work health and safety and injury management is summarised in Table 11. Of the 4 workers' compensation claims made in 2021–22, 2 claims resulted in lost time with one unable to return to work within 26 weeks. The department has recently created a new Safety and Health Officer position to improve our support for staff returning to work.

The proportion of managers trained in work health and safety continues to increase, however was below target for 2021–22. To support ongoing training managers now have access to live staff training numbers and a notification system of overdue training to enable them to actively ensure timely staff attendance.

Table 11: Work health and safety performance, 2019–20 to 2021–22

Measure	Actual results			Results against targets	
	2019–20 (Base year)	2020–21	2021–22	Target	Comments
Fatalities (number of deaths)	0	0	0	0	Achieved
Lost time injury/diseases (LTI/D) incidence rate (per 100)	0.36	0.38	0.14	0 or 10% reduction	Achieved
Lost time injury severity rate (per 100)	25.00	40.00	0.00	0 or 10% reduction	Achieved
Percentage of injured workers returned to work ¹ :					
(i) within 13 weeks	75%	67%	50%	N/A	N/A
(ii) within 26 weeks	100%	67%	50%	Greater than or equal to 80%	Not achieved
Percentage of managers trained in occupational safety, health and injury management responsibilities	67.3%	76.0%	79.2%	Greater than or equal to 80%	Not achieved

¹ Includes injured workers with a claim and known return to work status within the reporting period (1 July 2021 to 30 June 2022)

Internal governance

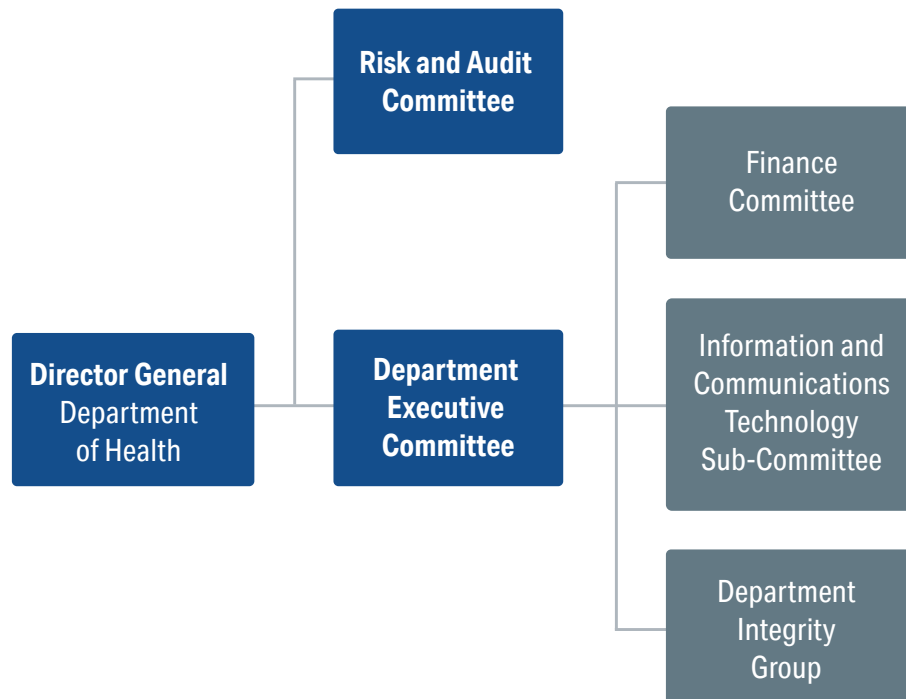
Governance oversight

The Department of Health has a clear governance structure to ensure the department's responsibilities are executed in a coordinated, effective and efficient manner, and to assist the Director General to discharge his duties as department Chief Executive Officer and system manager.

For this purpose, overarching strategic leadership is provided by the Department Executive Committee with support from 3 sub-groups which provide additional advice, recommendations and assurance: the Finance Committee, the Information and Communications Technology Sub-Committee, and the Department Integrity Group which focuses on good governance, integrity and ethics and the prevention and management of fraud and corruption.

In addition, the Risk and Audit Committee provides independent advice and assurance to the Director General and reviews the department's management of risk and internal controls to ensure compliance with legislation, regulations, policies and other requirements.

Figure 11: Department of Health internal governance structure



Risk, compliance and internal audit

The Department of Health Risk and Audit Committee includes 4 external members, including the Chair, and 2 senior leaders from the department. This representation ensures the committee's independence as well as the combination of skills that enable the committee to effectively fulfil its role.

Risk and Audit Committee members



Kaylene Gulich PSM (Chair)

Chief Executive Officer, Western Australian Treasury Corporation



Jay Peckitt

Deputy Director General, Education Business Services, Department of Education



Kathleen Oliver

Assistant Director General, Business and Corporate Services, Department of Planning, Lands and Heritage



Beata Bealozor-Kurtis

General Manager Health Customer Team, Department of Finance



Dr James Williamson

Assistant Director General, Clinical Excellence Division, Department of Health



Dr Denise Sullivan

A/Assistant Director General, Public and Aboriginal Health Division, Department of Health

The Department of Health has a dedicated Risk and Audit team that facilitates the identification, recording and evaluation of risks, and evaluates the department's internal controls to assess whether operations are efficient, effective, economical and ethical.

In 2021–22, the primary focus of the internal audits conducted was effective governance (41 per cent). The remaining focus areas were related to internal processes/controls concerning financial (36 per cent) and data management (23 per cent). A summary of internal audit activity is provided in Table 12.

Table 12: Internal audit activity summary, 2021–22

Summary of internal audit activity	Number
Number of audits conducted by department auditors	3
Number of audits conducted by contracted auditors	8
Total number of audits undertaken in 2021–22	11
Number of audit recommendations carried over from 2020–21	62
Number of audit recommendations opened in 2021–22	43
Total number of active audit recommendations in 2021–22	105
Number of audit recommendations closed in 2021–22	57
Number of audit recommendations to be carried over to 2022–23	48

Risk and Audit Committee Chair 2021–22 appraisal

The Risk and Audit Committee continues to mature the department's risk and audit oversight. A particular focus during 2021–22 has been the continued evolution of the department's risk management practices, including the capture and recognition of systemwide risks. This has supported improved identification and management of risks pertaining to the department's function as a system manager. A focus has continued on contemporary issues like information technology and cyber security risks, while new risks in areas such as climate change have focused on the department's role in recognising and managing the impact of climate change on public health.



Significant progress has been made on the 2021–22 and 2022–23 Internal Audit Plans, with efforts across the whole department in providing input, feedback and implementation of a large number of audits and audit recommendations. This whole-of-agency approach, including monthly updates to the Department Executive Committee, has ensured an ongoing focus on the department's highest risk areas and risks pertaining to the system manager functions. Of note during the year was the focus on practical and pragmatic solutions to manage risk identified in the audit reports, resulting in a notable (22.6 per cent) reduction in the total number of outstanding audit recommendations at the end of 2021–22 despite an increase in the total number of internal audit reports finalised during the year.

In August 2021 the Risk and Audit Committee undertook a self-assessment as recommended under the Office of the Auditor General best practice guide and confirmed that the committee's operations are fit-for-purpose and that the committee members' mix of skills and competencies is appropriate to fulfil the committee's responsibilities. Improvements out of this assessment saw the introduction of internal audit performance benchmarks and provided insight into the independent quality assurance review of the department's internal audit function.

Kaylene Gulich PSM
Chair, Risk and Audit Committee

Enquiries and complaints management

Enquiries and complaints can be received by phone, email, letter or in person and are referred to the appropriate business area within the Department of Health or to a health service provider for a response.

Health service providers manage patient complaints in accordance with the WA Health Complaints Management Policy. Where patients are not satisfied with the response, they may progress the matter with the Health and Disability Services Complaints Office, an independent statutory authority that provides a free and impartial resolution service for complaints relating to health, disability and mental health services in Western Australia. This process is outlined on the Department of Health website.

Additionally, the Ministerial Liaison Unit coordinates all correspondence received from the public via the Office of the Minister for Health, including complaints. From 1 July 2021 to 30 June 2022 the Ministerial Liaison Unit received 869 ministerial requests referencing a complaint or issue of concern requiring a response. Complaints were forwarded to the appropriate area for resolution, as detailed in Table 13. Complaints were received from a variety of different sources, including members of the general public, local government members, business organisations, church groups and professionals.

Table 13: Summary of responsibility for correspondence referencing a complaint received by the Ministerial Liaison Unit, 1 July 2021 to 30 June 2022

Proportion of correspondence that referenced a complaint or issue of concern requiring a response by:	(n=869)
Health service provider	37%
Department of Health	41%
State Health Incident Coordination Centre	22%

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

Managing enquiries and complaints during a pandemic

COVID-19 has been challenging for the WA health system, affecting all aspects of health care delivery. This includes the efforts made to inform, advise and respond to enquiries, complaints, and requests from the WA government sector, health service providers and the WA community in general.

Below is a snapshot of how the department in 2021–22 managed the large volume of enquiries related to COVID-19 as well as provision of information across a range of mediums to communicate key messages and in doing so reduce enquires and requests for information.

The [State Health Incident Coordination Centre \(SHICC\)](#) communication team responded to general enquiries and complaints through multiple phone lines and email inboxes, including a dedicated SHICC email.

[WA COVID-19 Vaccination Program](#) enquiries and complaints were received through a dedicated email inbox, 13 COVID phone number, Department of Health and Department of Premier and Cabinet social media accounts, and ministerial processes. A dedicated stakeholder engagement team coordinated responses to consumer feedback received by email and through ministerial processes.

Direct enquiries and complaints to the [Chief Health Officer \(CHO\)](#) were predominantly received by email. A team of officers coordinated the CHO-approved responses to all correspondence that included ministerial correspondence, general enquires and enquires concerning compliance and vaccination exemptions.

Enquiries and complaints relating to hotel quarantine were lodged directly to hotel reception or via an online form that was monitored by a [Guest Engagement Officer](#).

The Office of the CHO also worked with staff from the Department of the Premier and Cabinet to ensure appropriate material was published to reflect the latest public health advice. Direct advice and support to other government agencies, non-government agencies and other key stakeholders was also provided to assist in implementing policies and relevant Directions. This included weekly Public Health Bulletins and Clinician Alerts to all WA health system staff, sent directly to more than [1,200 key stakeholders](#). The public were also informed via various mass media mediums. The Public Information team created significant website content in 2021–22 to inform and help prepare the WA community for 'living with COVID-19'. This is in addition to content on vaccinations and outbreak locations.

Compliance reporting

Compliance with public sector standards

All employees of the department are responsible for ensuring their behaviour reflects standards of conduct embodied in the WA Health Code of Conduct. This code complies with principles of appropriate behaviour outlined in the Public Sector Commission's Code of Ethics and is reinforced by policies and policy frameworks which relate to Public Sector Standards.

To encourage understanding and compliance with the principles of workplace behaviour and conduct, Department of Health employees are inducted, informed and educated through various online communications, eLearning and face-to-face programs. Mandatory Accountable and Ethical Decision Making training is delivered online to all new employees and forms an integral part of employee training in this area. The majority (91 per cent) of all department employees have completed the course.

In December 2021, the department developed a strategy outlining integrity promotion and communication priorities and activities. This strategy includes regular integrity messaging to employees on a range of integrity topics including the use of 'Speak up: if you see something say something' branding, encouraging employees to report inappropriate behaviour.

Employee compliance with the Code of Conduct is assessed by:

- monitoring Accountable and Ethical Decision Making course completion rates
- reviewing and monitoring employee declaration of conflicts of interest and gifts accepted
- case management of misconduct and disciplinary cases
- integrity reporting through the Department Integrity Group.

The Department of Health is required to review and investigate all complaints alleging non-compliance with the Code of Ethics or Code of Conduct. Of the 15 misconduct matters raised during 2021–22, 4 did not result in a finding of misconduct, 6 matters found that misconduct had occurred and resulted in disciplinary or improvement action, and 5 matters are ongoing.

The department maintains compliance with the principles of the Public Sector Commission's Standards in Human Resource Management through education, support and quality assurance.

In 2021–22, the department conducted Recruitment Training for Manager sessions to provide managers with an overview of the Public Sector Standards and provide practical guidance to navigate advertising, assessment and appointment processes, with 53 employees attending across 6 sessions.

The human resources team provides direct support to managers when conducting a recruitment and selection process. This support is designed to improve recruitment outcomes, further educate managers, and ensure compliance with the Employment and Redeployment Standards. As a final checkpoint, the human resources team quality assures all recruitment processes prior to approval by the relevant delegated authority.

The department is required to review and investigate all breach of Standard claims and refer unresolved claims to the Public Sector Commission for assessment, if necessary. Of the 4 breach of Standard claims received during 2021–22, 3 related to recruitment, selection and appointment and one related to termination. All matters were referred to the Public Sector Commission and it has been determined that no breach occurred.

Compliance with public sector policy

Diversity and inclusion

The Department of Health Diversity and Inclusion Framework brings together 6 government-led diversity and inclusion initiatives into a single approach, including:

- Department of Health *Multicultural Plan 2021–2023*
- Department of Health *Equal Employment Opportunity Management Plan 2020–2024*
- Department of Health *Disability Access and Inclusion Plan 2020–2025*
- *WA Aboriginal Health and Wellbeing Framework 2015–2030*
- [*Stronger Together: WA's Plan for Gender Equity*](#)
- Public Sector Commission [*Workforce Diversification and Inclusion Strategy 2020–2025*](#).

The framework brings together 212 action items from across the action plans and groups them into 27 enabling initiatives across 4 themes:

- account and celebrate – value and celebrate diversity within our workforce
- attract and develop – recruit and retain a diverse workforce
- lead and build – monitor, measure and review our results to build an inclusive workplace
- educate and empower – build knowledge and understanding of diversity groups and cultural awareness.

In 2021–22 the department established the Diversity and Inclusion Working Group and the Diversity and Inclusion Reference Group consisting of employees with diverse backgrounds and lived experiences, to help foster a culture of diversity and inclusion across the department and to lead the implementation of priority initiatives from the Diversity and Inclusion Framework.

Multicultural Plan

In alignment with the department's Multicultural Plan, priority areas progressed in 2022 and included showcasing internal diversity profiles and external role models, implementing quality improvement activities for diversity data, and bringing a diversity and inclusion lens to recruitment practices. Activities to build staff cultural competencies also occurred through webinars and a seminar 'Cultural Conversations', that aimed to raise staff skills in working with culturally and linguistically diverse people around multicultural mental health. In addition, a new Equity, Diversity and Inclusion eLearning package was launched for staff to encourage inclusive and respectful behaviour towards others. Details on this eLearning package are provided in the Inspire and empower section of this report.

Disability Access and Inclusion Plan

Through the Disability Access and Inclusion Plan the department aims to ensure that people with disability can access services provided by the department, in a way that promotes their independence, opportunities and participation in the workplace and community. In 2021–22 a wide range of activities were undertaken reflecting this commitment:

- Facilitating the hotel quarantine process including transportation, accommodation, delivery of accessibility equipment, and provision of information ensuring service delivery was accessible for travellers with a variety of physical and mental health needs.
- Driving innovative cross-agency solutions to support timely and safe discharge for people with a disability who have no medical reason to remain in hospital, including development of bespoke solutions to support a return to community living.

- Hosting a variety of events enabling ease of venue access for people with disability and the provision of video conferencing facilities and broadcasting via MS Teams, which includes the option for predictive text for viewers, for those unable to attend in person. Also, providing presentations translated in AUSLAN by professional translators. Key events included:
 - an International Day for People with Disability event in partnership with South Metropolitan Health Service, where invited speakers shared their personal stories about living with disability
 - a Sustainable Health Review Citizen and Community Partnerships Forum
 - an online COVID-19 Information Forum specifically for people with disability.
- Actively consulting with people with disability, their carers and relevant community organisations on development of:
 - the WA Health Promotion Strategic Framework 2022–2026
 - guidelines for people with disability accessing the WA health system including an updated Hospital Stay Guideline and Ready To Go Home project flyers
 - the Guide to Making an Advance Health Directive in WA.
- Actively supporting department employees with disability in the workplace through frequent reviews of the work environment and adjustments and improvements undertaken, as necessary.
- Increasing participation of people with disability in the 2022 Graduate Development Program recruitment process through targeted marketing, inclusive advertising and expanding support mechanisms.
- Ensuring all contracted health service providers submit an annual report on compliance with the new disability access and inclusion plan.

Substantive equality

The Department of Health is also committed to meeting the diverse needs of the Western Australian community through health policies, programs and services and in 2021–22 contributed to substantive equality in the following ways:

- Completed the Mirrabooka Service Mapping Project which details and links more than 40 different health, mental health, education, employment, family support, housing, legal and settlement services that support the culturally and linguistically diverse community.
- Established a LGBTIQ+ data working group to progress improvements in healthcare data collection systems to be more inclusive of all sexualities, genders and sex characteristics identified as a priority area in the *Western Australian Lesbian, Gay, Bisexual, Transgender, Intersex Health Strategy 2019-2024*.
- Developed COVID-19 resources in more than 20 languages to support culturally and linguistically diverse communities to stay safe during COVID-19 outbreaks.
- Established the Culturally and Linguistically Diverse COVID-19 Communications Advisory Group, including representatives from the State Health Incident Coordination Centre, Department of the Premier and Cabinet, Office of Multicultural Interests, and stakeholder groups, to provide advice and feedback on communications and stakeholder engagement conducted by the WA health system and Department of the Premier and Cabinet.
- Ensured ongoing engagement and bespoke COVID-19 vaccination opportunities to ensure equity of access for priority populations including culturally and linguistically diverse communities, Aboriginal people and people experiencing homelessness.

- Revised the Aboriginal Health and Wellbeing Policy and the Aboriginal Workforce Policy aimed to achieve diversity and inclusion for Aboriginal people in the health sector.
- Enhancing online information and access to The Better Health Program, proving popular for families with children who have special needs, and the Food Sensations adult food literacy program designed for people with lower literacy levels, which may include people with disability.

An update on the **WA Aboriginal Health and Wellbeing Framework 2015–2030** is provided in the Protect and enable section of this annual report.

Recordkeeping plans

The Department of Health *Recordkeeping Plan 2019* documents the department's recordkeeping program and associated policies, procedures and employee responsibilities.

The recordkeeping plan was developed in accordance with the *State Records Act 2000* (the Act) and the standards and principles set by the State Records Commission. The plan is updated with new information as required and is due for formal review in 2024.

In 2021–22, more than 1.7 million corporate records were created compared to approximately 800,000 in 2020–21. This 117 per cent increase is mainly attributable to the capture of records created in response to the COVID-19 pandemic.

In 2021–22, 96 per cent of Department of Health employees had completed mandatory online Recordkeeping Awareness Training and 305 employees were trained in the use of the electronic records and document management system (EDRMS).

A recent internal audit of records management practices was conducted to ensure compliance with the Act and that effective controls exist to manage departmental records. The audit concluded that overall, the recordkeeping policy, plan and procedures were generally compliant with the Act. Recommendations were made regarding improving EDRMS usage and access management practices by department employees. Action plans have been developed to address the recommendations and increase overall usage of EDRMS across the department.

In addition, records administrators access a records management dashboard to assist them to monitor usage of the EDRMS and manage the integrity of records, including ensuring appropriate access to information within the department.

The records management team have completed additional records retention training and EDRMS administrator training to increase their skills and expertise to enable them to provide technical support to employees. The records management team has also been working with business units to improve their understanding of recordkeeping.

Recordkeeping information is available to all employees via the department's intranet. The site has been recently updated and includes the recordkeeping plan, associated policies and procedures, quick help guides and links to the State Records Commission Standards.

Freedom of information

The Western Australian *Freedom of Information Act 1992* gives all Western Australians a right of access to information held by the Department of Health.

The types of information held by the Department of Health include:

- reports on health programs and projects
- Minister for Health and executive staff briefings
- health circulars, policies, standards and guidelines
- health articles and discussion papers
- departmental magazines, bulletins and pamphlets
- health research and evaluation reports
- epidemiological, survey and statistical data/information
- publications relating to health planning and management
- committee meeting minutes
- general administrative correspondence
- financial and budget reports
- staff personnel records.

Members of the public can access some of the above information from the Department of Health [website](#). Hard copy documents are also available at zero or nominal cost by calling (08) 9222 6411.

Requests for information access may be made through a Freedom of Information application. This involves lodging a written request via email, post or in person. Contact details to obtain information or send an application can be sourced via the [WA Health freedom of information contacts](#) list.

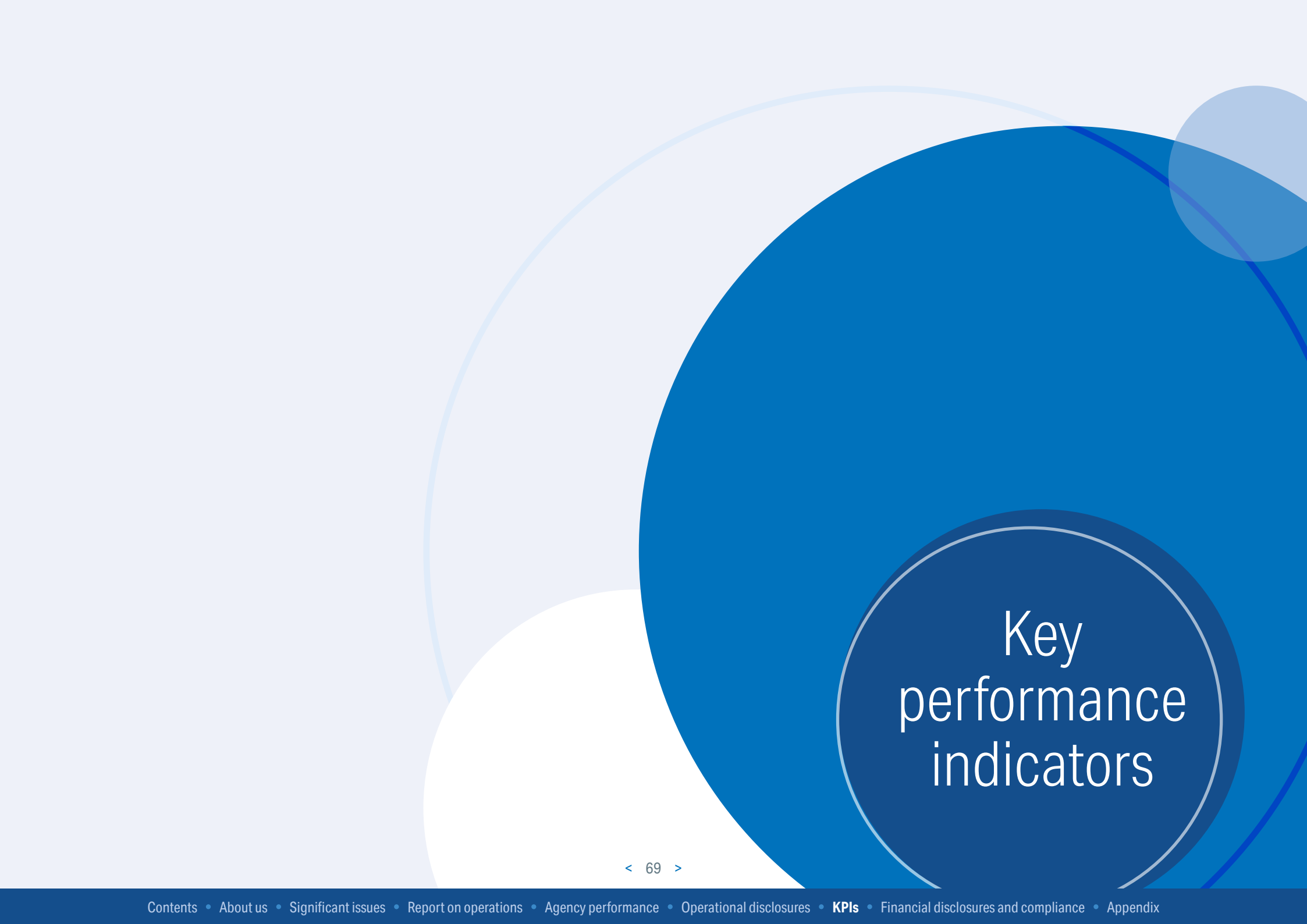
All requests for information can be granted, partially granted or may be refused in accordance with the *Freedom of Information Act 1992*. For the year ended 30 June 2022, the Department of Health dealt with 92 applications for information, of which 58 applications were granted full or partial access and 19 applications were denied access (see Table 14).

Table 14: Freedom of Information applications dealt with by the Department of Health in 2021–22

Summary of number of applications	Number
Applications carried over from 2020–21	9
Applications received 2021–22 ¹	83
Total number of applications active in 2021–22	92
Applications granted – full access	33
Applications granted – partial or edited access	25
Applications withdrawn by applicant ²	8
Applications refused ³	19
Applications in progress	4
Other applications ⁴	3
Total number of applications dealt with in 2021–22	92

Notes

1. Includes 5 matters partially transferred to another agency.
2. Includes 1 matter dealt with outside of the *Freedom of Information Act 1992* (WA).
3. Includes 12 matters where no records were found, 4 matters where the documents were exempt from release and 3 matters where the documents were found to be publicly available.
4. Includes 3 matters fully transferred to another agency for actioning.



Key performance indicators

Certification of key performance indicators

DEPARTMENT OF HEALTH

CERTIFICATION OF KEY PERFORMANCE INDICATORS FOR THE YEAR ENDED 30 JUNE 2022

I hereby certify that the key performance indicators are based on proper records, are relevant and appropriate for assisting users to assess the Department of Health's performance, and fairly represent the performance of the Department of Health for the financial year ended 30 June 2022.



Dr D J Russell-Weisz
DIRECTOR GENERAL
DEPARTMENT OF HEALTH
ACCOUNTABLE AUTHORITY

19 September 2022

Key performance indicators

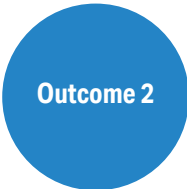
Key performance indicators assist the Department of Health to assess and monitor achievement of the outcomes outlined in the Outcome Based Management Framework (see Table 15).

Table 15: Key performance indicators reported by the Department of Health

WA health system desired outcomes	Measuring effectiveness Key performance indicators	Services	Measuring efficiency Key performance indicators
Outcome 2 Prevention, health promotion and aged and continuing care services that help Western Australians to live healthy and safe lives	- Percentage of transition care clients whose functional ability was either maintained or improved during their utilisation of the Transition Care Program - Percentage of people accessing community-based palliative care who are supported to die at home - Loss of life from premature death due to identifiable causes of preventable disease or injury: (a) Lung cancer; (b) Ischaemic heart disease; (c) Falls; (d) Melanoma; (e) Breast cancer - Percentage of fully immunised children: (a) 12 months; (b) 2 years; (c) 5 years - Percentage of 15 year olds in Western Australia that complete their HPV vaccination series - Response times for emergency road-based ambulance services (Percentage of priority 1 calls attended to within 15 minutes in the metropolitan area)	5. Aged and continuing care services	Aged and continuing services - Average cost of a transition care day provided by contracted non-government organisations/service providers - Average cost per home-based hospital day of care and occasion of service - Average cost per day of care for non-acute admitted continuing care - Average cost to support patients who suffer specific chronic illness and other clients who require continuing care Palliative and cancer care services - Average cost per client receiving contracted palliative care services
		6. Public and community health services	Public health services - Cost per person of providing preventative interventions, health promotion and health protection activities that reduce the incidence of disease or injury Patient transport services - Cost per trip for road-based ambulance services, based on the total accrued costs of these services for the total number of trips
Outcome 3 Strategic leadership, planning and support services that enable a safe, high quality and sustainable WA health system	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 - Average cost of public health regulatory services per head of population - Average cost for the Department of Health to undertake system manager functions per health service provider full time equivalent

Key effectiveness performance indicators

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



Rationale

The Transition Care Program 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 Program 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 Program by measuring improvements in client's functional ability. 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

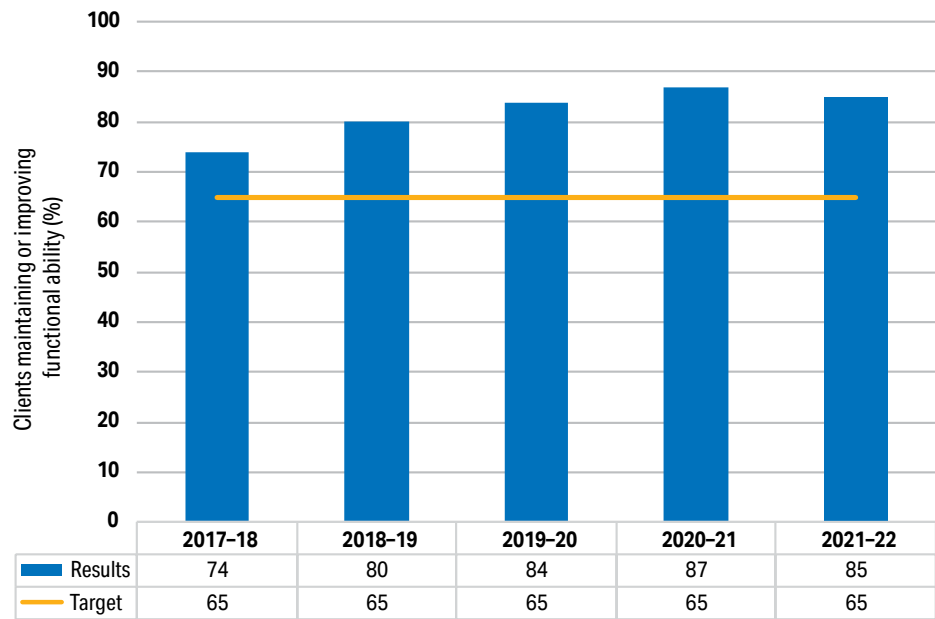
The 2021–22 target for the percentage of clients maintaining or improving functional ability is 65 per cent or above.

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

Results

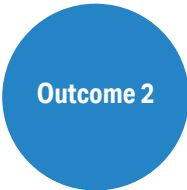
In 2021–22, the percentage of transition care clients maintaining or improving functional ability was 85 per cent, exceeding the target of 65 per cent (see Figure 12).

Figure 12: Percentage of transition care clients whose functional ability was either maintained or improved during their utilisation of the Transition Care Program, 2017–18 to 2021–22



Data source: Unpublished data, Department of Health.

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 so¹. In addition to potential distress for patients and families, acute hospital admissions in some patients' final days of life may create avoidable pressures on the hospital system. This is likely to become an increasingly significant issue as the population ages and as an increasing proportion of people live with chronic disease.

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

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

Target

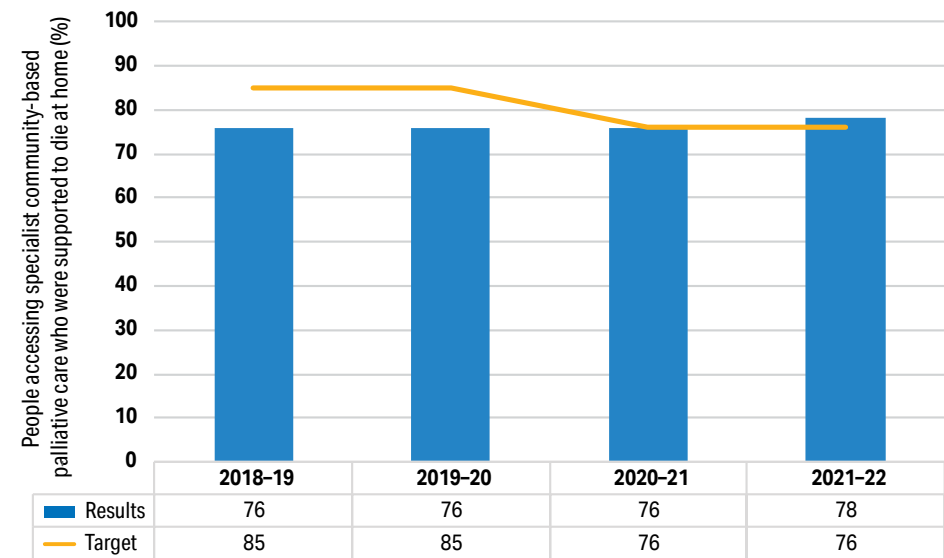
The 2021–22 target for the percentage of people accessing community based palliative care who opted to die at home and who were supported to die at home is 76 per cent or above.

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

Results

In 2021–22, 78 per cent of clients requiring end-of-life care who opted to die at home were supported to do so through the provision of in-home specialist palliative care (see Figure 13). This result is slightly above the specified target of 76 per cent.

Figure 13: Percentage of people accessing specialist community-based palliative care who opted to die at home and who were supported to die at home, 2018–19 to 2021–22



Notes:

1. There is currently no national target for this indicator. The 2021–22 target is based on an average of prior year data results.
2. Specialist community-based palliative care refers to palliative care that is provided by a multidisciplinary team within a private residence (i.e. 'in-home' care), but not a residential care facility.
3. The calculation of this indicator is based on:
 - a. People living in the Perth metropolitan area who have an active, progressive and advanced disease, who require access to specialist palliative care services.
 - b. Access to services where a medical opinion has been obtained resulting in the client being referred for specialist palliative care.
 - c. People who accessed the community palliative care service provided by Silver Chain and who died at home after nominating this as their desired place of death.
4. There are some community-based palliative care services provided outside of the metropolitan area; however, this activity data is not available within the Non-Admitted Patient Data Collection system used to source data for calculation of this KPI.

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

1 Dying Well, Grattan Institute Report No. 2014–10, September 2014, 2.
Available from: <https://grattan.edu.au/wp-content/uploads/2014/09/815-dying-well.pdf>

Loss of life from premature death due to identifiable causes of preventable disease or injury: (a) Lung cancer; (b) Ischaemic heart disease; (c) Falls; (d) Melanoma; (e) Breast cancer

Outcome 2

Rationale

This indicator measures the potential years of life lost for the most common causes of premature deaths, which is one of the most important means of monitoring and evaluating the effectiveness, quality and productivity of health systems. The WA health system aims to reduce the loss of life from preventable disease or injury, through the delivery of public health and medical interventions.

The rates of potential years of life lost from premature death are measured for lung cancer, ischaemic heart disease, falls, melanoma and breast cancer. These conditions contribute significantly to the burden of disease and injury within the community and are conditions for which the Department of Health believes premature death should be largely preventable and for which screening or health promotion programs are in place. The data obtained from this indicator assists health system managers to best determine effective and quality targeted promotion and prevention initiatives, which in turn contribute to a reduction in the loss of life from these preventable conditions.

Target

The 2020 target per preventable condition is based on the 2019 National Person Years of Life Lost per 1,000 population:

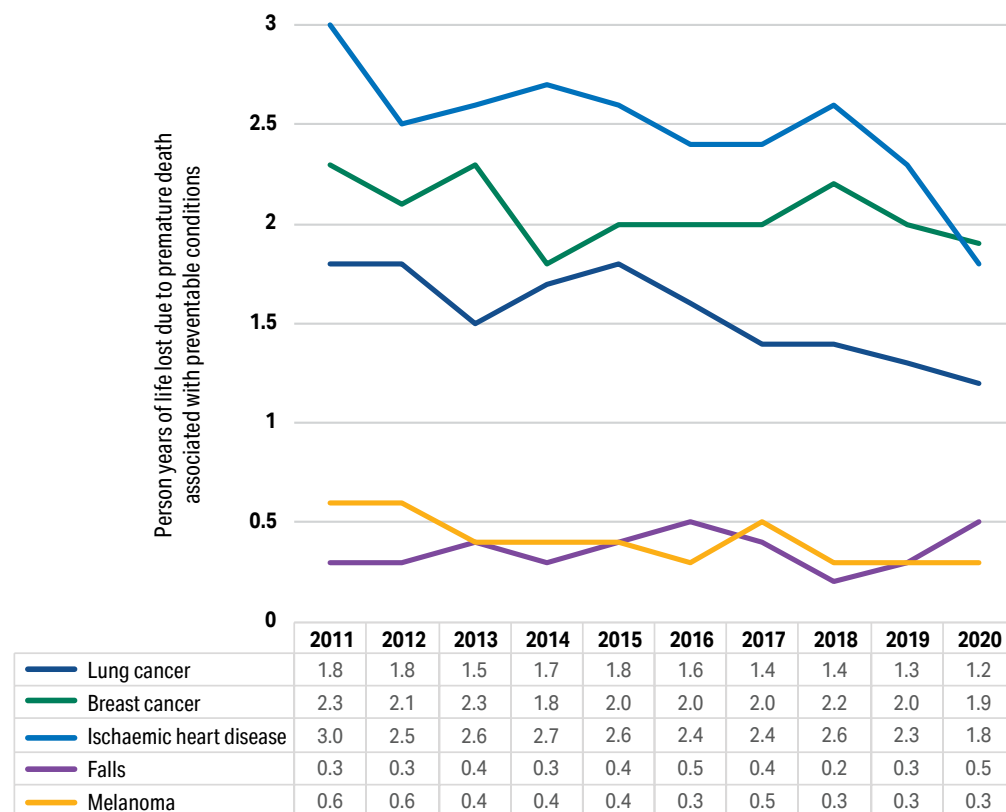
Preventable condition	Target (in years)
a. Lung cancer	1.5
b. Breast Cancer	2.0
c. Ischaemic heart disease	2.1
d. Falls	0.3
e. Melanoma	0.3

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

Results

In 2020, the result for potential years of life lost due to lung cancer was 1.2, breast cancer 1.9 and ischaemic heart disease 1.8, all below set targets (see Figure 14). The years of life lost from premature death due to melanoma were 0.3, equal to the target. The years of life lost from premature death due to falls were 0.5, exceeding the target of 0.3.

Figure 14: Person years of life lost due to premature death associated with preventable conditions, 2011 to 2020



Notes:

1. Age-standardised Person Years of Life Lost (PYLL) per 1,000 population.
2. 2011–2018 deaths are final, 2019 deaths are revised, and 2020 deaths are preliminary.
3. The following ICD 10 Codes were used:
 - a. Lung cancer C33.0 to C34.9
 - b. Breast cancer C50.0 – C50.9 (females only)
 - c. Ischaemic heart disease I20.0 to I25.9
 - d. Falls W00.0 to W19.9 or X59.0 to X59.9 (with any multiple cause codes of S02 or S12 or S22 or S32 or S42 or S52 or S62 or S72 or S82 or S92 or T02 or T08 or T10 or T12 or T14.2)
 - e. Melanoma C43.0 to C43.9
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 reports.

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

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

Outcome 2

Rationale

In accordance with the National Partnership Agreement on Essential Vaccines, the WA Health system aims to minimise the incidence of major vaccine preventable diseases in Australia by sustaining high levels of immunisation coverage across Western Australia, 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 of 95 per cent².

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

Results

In 2021, 93.1 per cent of children in Western Australia had received all recommended vaccines at 12 months, 2 years, and 5 years of age (see Table 16). This is below the immunisation coverage target of 95 per cent but comparable with 2020 results.

In 2021, the proportion of vaccinated children at 12 months and 2 years were lower among Aboriginal children when compared to non-Aboriginal children. However, 95.1 per cent of Aboriginal children across Western Australia were fully immunised at 5 years, slightly exceeding the target.

In 2021–22, research was conducted to establish the reason for sub-optimal immunisation coverage at 24 months in regional and remote WA. The study identified key barriers to immunisation uptake as perceived by practitioners and these findings will be validated by consumers in the next phase of this work. Region-specific drivers will be explored, and the structural and system changes required to improve coverage will be identified.

² The national aspirational immunisation coverage target has been set at 95%.
Available from: <https://www.health.gov.au/health-topics/immunisation/childhood-immunisation-coverage> and
https://federalfinancialrelations.gov.au/sites/federalfinancialrelations.gov.au/files/2021-07/Essential_Vaccines_NP.pdf

Table 16: Percentage of children fully immunised, by selected age cohort, by Aboriginality, 2017 to 2021

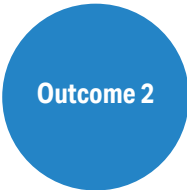
Children fully immunised		2017	2018	2019	2020	2021	Target
Total of all children (12 months, 2 years, and 5 years) (%)		91.7	92.3	92.4	93.5	93.1	≥95%
12 months (%)							
Total						93.9	≥95%
State	Aboriginal	87.7	89.0	89.1	89.2	87.0	
	Non-Aboriginal	93.9	93.8	94.3	94.8	94.5	
Metropolitan	Aboriginal	84.4	87.9	87.2	86.5	86.8	
	Non-Aboriginal	93.9	93.9	94.5	94.9	94.8	
Country	Aboriginal	90.3	90.0	90.9	92.2	87.3	
	Non-Aboriginal	94.0	93.2	93.3	94.6	92.9	
2 years (%)							
Total						91.8	≥95%
State	Aboriginal	82.6	82.2	84.6	87.1	85.7	
	Non-Aboriginal	89.5	90.7	90.2	92.2	92.3	
Metropolitan	Aboriginal	81.0	80.8	83.0	86.7	84.7	
	Non-Aboriginal	89.3	90.8	90.3	92.4	92.5	
Country	Aboriginal	83.8	83.4	86.2	87.5	86.8	
	Non-Aboriginal	90.7	90.5	89.6	91.0	90.9	
5 years (%)							
Total						93.7	≥95%
State	Aboriginal	95.9	95.1	95.5	96.1	95.1	
	Non-Aboriginal	92.3	93.3	93.4	94.0	93.6	
Metropolitan	Aboriginal	95.1	93.9	94.0	95.4	95.1	
	Non-Aboriginal	92.0	93.2	93.2	94.0	93.7	
Country	Aboriginal	96.5	96.3	96.9	96.7	95.1	
	Non-Aboriginal	93.4	93.8	94.1	94.1	93.1	

Notes:

1. Data is based on children aged 12 ≤ 15 months, 24 ≤ 27 months and 60 ≤ 63 months between 1 January 2021 – 31 December 2021.
2. 'Fully immunised' for children aged 4 years and under includes immunisation for hepatitis B, diphtheria, tetanus, pertussis, pneumococcus, haemophilus influenzae type B, poliomyelitis, measles, mumps, rubella, varicella (chicken pox) meningococcal ACWY and rotavirus.
3. National data for immunisation coverage for all children per age cohort can be accessed at: <https://www.health.gov.au/health-topics/immunisation/childhood-immunisation-coverage/immunisation-coverage-rates-for-all-children>.

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

Percentage of 15 year olds in Western Australia that complete their HPV vaccination series



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 cervical 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 years 7 and 8 under the Western Australian school-based immunisation program. General practitioners, community health clinics and central immunisation clinics 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 Western Australian health system's delivery of vaccination programs and health promotion strategies in maximising the proportion of adolescents who have completed the HPV series.

Target

The target for 2021 for the percentage of 15 year old Western Australian male and females that completed their HPV vaccination series is 80 per cent or above.

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

Results

In 2021, 80.2 per cent of 15 year old males and 80.9 per cent of 15 year old females had completed their HPV vaccination series, slightly exceeding the target of 80 per cent (see Figure 15 and Table 17).

The HPV vaccine coverage rate in Aboriginal youth aged 15 years (68.2 per cent) remains below the target and low in comparison to non-aboriginal youth at 81.3 per cent coverage. In 2021, the school immunisation catch-up program aimed at increasing overall HPV vaccination rates among students with a key focus on Aboriginal students was impacted by COVID-19, specifically staff shortages and a focus on COVID-19 vaccinations. Plans are underway to offer targeted vaccination for Aboriginal adolescents outside of the school environment as school absenteeism is a major contributor to reduced vaccine uptake.

Figure 15: Percentage of 15 year old Western Australians that completed their HPV vaccination series, by gender, 2018 to 2021

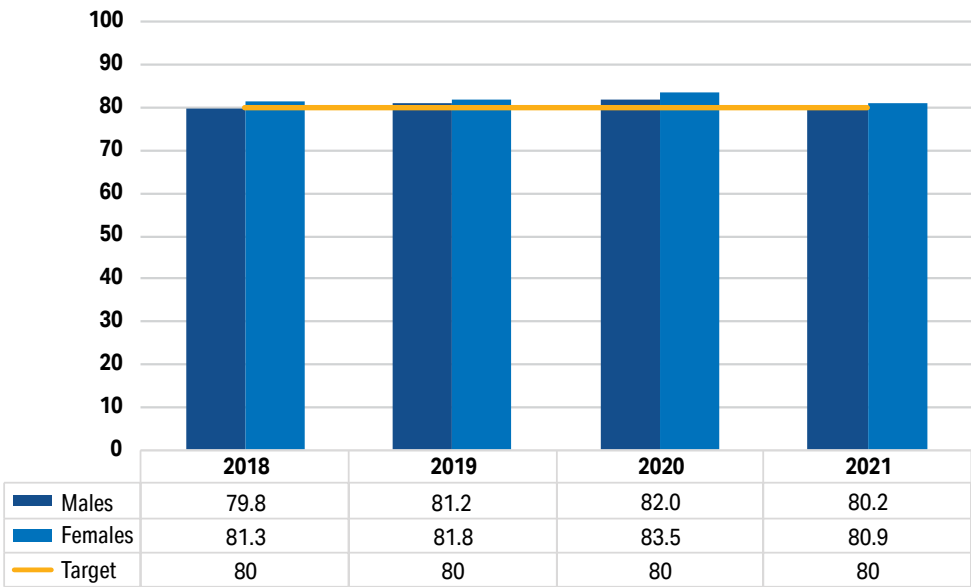


Table 17: Percentage of 15 year old Western Australians that completed their HPV vaccination series, by gender, location and Aboriginal status, 2018 to 2021

Percentage of 15 year olds who completed their HPV vaccination series		2018	2019	2020	2021	Target
Males						≥80.0
State	Aboriginal	65.0	63.5	65.6	65.6	
	Non-Aboriginal	80.6	82.2	83.1	81.1	
Metropolitan	Aboriginal	62.0	63.6	66.7	65.4	
	Non-Aboriginal	80.7	82.4	83.3	81.1	
Country	Aboriginal	67.0	63.4	64.5	65.8	
	Non-Aboriginal	80.0	81.3	82.1	81.1	
Females						≥80.0
State	Aboriginal	70.6	66.0	71.8	70.9	
	Non-Aboriginal	82.0	82.8	84.3	81.6	
Metropolitan	Aboriginal	70.9	65.4	70.6	71.3	
	Non-Aboriginal	81.6	82.9	84.4	81.8	
Country	Aboriginal	70.3	66.5	73.0	70.5	
	Non-Aboriginal	83.4	82.4	83.9	80.4	

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. Fully immunised 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 National Partnership on Essential Vaccines.
3. The target is based on HPV immunisation rates reported in the Australian Institute of Health and Welfare *Australia's health 2020*. Australia's health series no. 17. Canberra: AIHW.

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

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

Outcome 2

Rationale

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

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

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

Target

The target for 2021–22 is 90 per cent or above of priority 1 calls attended to within 15 minutes in the metropolitan area by the contracted health entity.

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

Results

In 2021–22, 81.6 per cent of all priority 1 calls in the metropolitan area were attended to within 15 minutes by emergency patient transport services (see Figure 16), below the target of 90 per cent.

The variance to target is associated with unprecedented pressure on emergency departments and ambulance services due to increased demand and staff furlough pressures caused by the COVID-19 pandemic. Hospitals aim to receive a patient being transported to an emergency department by ambulance within 30 minutes. In 2021–22, the increase in wait times for the transfer of care of patients to an emergency department has resulted in reduced ambulance response capacity and increased response times.

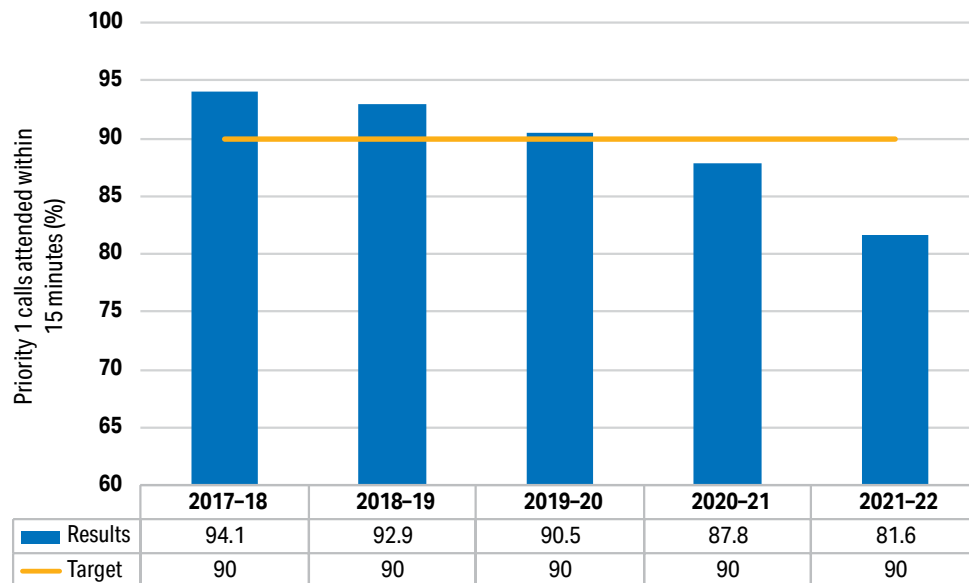
The COVID-19 pandemic and its associated impacts have highlighted areas where health and emergency management systems require further integration and strengthening. The Department of Health has commenced preparation of a new service agreement with St John Ambulance WA for the provision of emergency road-based ambulance services and is looking to make several amendments to the existing agreement to improve the provision of ambulance services throughout Western Australia.

The new service agreement will be strongly informed by the recommendations of the [Public Administration Committee inquiry into the delivery of ambulance services in Western Australia](#), and the [Government's response](#) to the inquiry report.

It is expected that through negotiation and collaboration with St John Ambulance WA, the new services agreement will:

- improve access to hospital emergency services, and more closely align the provision of ambulance services with the recently developed framework [Ambulance services Western Australia: A framework for statewide ambulance service operations](#).
- improve access and equity to ambulance services for vulnerable members of the community and people living in country WA.
- strengthen governance, transparency and accountability in the provision of ambulance services.

Figure 16: Percentage of Priority 1 calls attended to within 15 minutes in the metropolitan area by the contracted service provider, 2017–18 to 2021–22



Note: KPI results are based on dispatch priority 1 patients requiring emergency attention who reside in Metropolitan Perth.

Data source: Unpublished data, Department of Health.

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

Outcome 3

Rationale

The Department of Health, in supporting a system manager function, sets the vision and direction for the WA health system, as well as providing executive oversight of strategic decision making, identifying health system priorities, and guiding, overseeing and managing the statewide 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 of Health and its delivery of services as a system manager.

Target

The 2021–22 target for the percentage of stakeholders who indicate that the Department of Health to be meeting or exceeding expectations of the delivery of system manager functions is 85 per cent or above.

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

Results

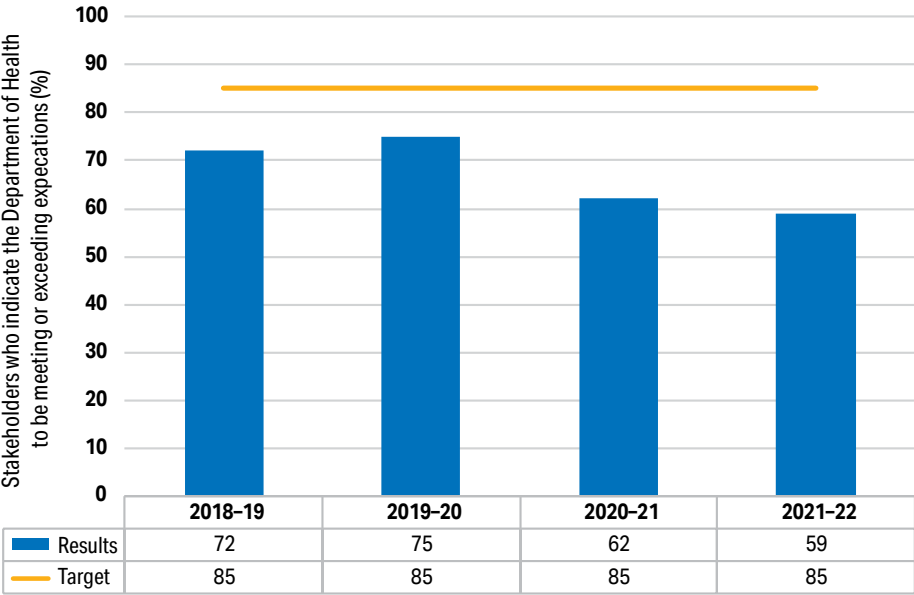
In 2021–22, 59 per cent of respondents agreed the Department of Health had met the expectations of their organisation in the delivery of the functions of the system manager (see Figure 17). This is below the target and prior year results.

The majority of respondents identified the department as demonstrating strengths in regulation of the WA health system (81 per cent) and managing performance in line with service agreement requirements (80 per cent) and associated use of data analytics (75 per cent) to inform and support decision making.

In response to the extent to which the Department of Health had met expectations in the management of the WA health system's response to COVID-19 the majority (94 per cent) stated expectations had been met with approximately 2 in 5 citing that expectations had been exceeded (somewhat above/well above expectations).

When respondents were asked to provide suggestions on how the department could improve on the delivery of services, the primary response was that the department needed to develop clear systemwide plans and actions to achieve a forward focussed strategy for the WA health system. This was substantiated by 60 per cent of respondents citing expectations were not being met (somewhat below/well below expectations) with respect to the provision of strategic direction and leadership on behalf of the WA health system, and in the development and implementation of systemwide planning (64 per cent). Respondents also identified a need to clarify the role of the system manager and the relationship with health service providers and boards. This is expected to be addressed through the current independent governance review of the *Health Services Act 2016*.

Figure 17: Department of Health stakeholders who indicate the Department of Health to be meeting or exceeding expectations of the delivery of system manager functions, 2018–19 to 2021–22



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 of Health and are best positioned to accurately assess performance.
3. The survey involved inviting participants to provide their responses to prescribed questions through telephone interviewing conducted by an independent research agency.
4. Results are based on respondents providing feedback on the delivery of 11 system manager functions delivered by the Department of Health. Respondents rated the 11 system manager functions using a 5 point Likert scale from well below expectations (1) to well above expectations (5).
5. In 2021–22, respondents were also asked to rate, using the 5 point Likert scale, the extent to which the Department of Health had met expectations in the management of the WA health system’s response to COVID-19. These results are excluded from the overall results.
6. The target is considered aspirational and was developed based on a jurisdictional review of targets and performance results of agencies with similar or comparative effectiveness survey KPIs.

Data source: Unpublished data, Department of Health.

Key efficiency performance indicators

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

Outcome 2
Aged and continuing care services

Rationale

The Transition Care Program 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 Program services take place in either a residential or a community setting, including in a client's home.

The Transition Care Program 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 2021–22 target unit cost is \$318 per transition care day.

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

Results

In 2021–22, the average cost per transition care day was \$352, above the target of \$318 (see Table 18). The variance to target is associated with new Transition Care Program services being provided in country WA from January 2022.

Table 18: Average cost per transition care day provided by contracted non-government organisations/service providers, 2019–20 to 2021–22

	2019–20	2020–21	2021–22
Average cost	\$347	\$329	\$352
Target	–	\$318	\$318

Notes:

1. To reflect approved changes to WA Health's Outcome Based Management framework, financial products have been removed from the calculation of efficiency indicators for 2021–22. To account for this change prior year results have been recalculated and the 2020–21 and 2021–22 budget targets have been recast to allow for comparability with current year findings.
2. Previously reported results for this indicator are as follows:

	2019–20	2020–21
Average cost	\$328	\$329
Target	\$321	\$346

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

Average cost per home-based hospital day of care and occasion of service

Outcome 2 Aged and continuing care services

Rationale

Home-based hospital services have been implemented as a means of ensuring patients have timely access to effective healthcare. 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 of Health 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 2021–22 target unit costs for:

- home-based hospital day of care is \$301
- home-based hospital occasion of service is \$145.

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

Results

The average cost per home-based hospital day of care in 2021–22 was \$320 (see Table 19).

Table 19: Average cost per home-based hospital day of care, 2019–20 to 2021–22

	2019–20	2020–21	2021–22
Average cost	\$295	\$294	\$320
Target	–	\$293	\$301

The average cost per home-based hospital occasion of service in 2021–22 was \$140 (see Table 20).

Table 20: Average cost per home-based hospital occasion of service, 2019–20 to 2021–22

	2019–20	2020–21	2021–22
Average cost	\$137	\$138	\$140
Target	–	\$131	\$145

Notes:

- Days of care are defined as the number of days where a patient has received one or more occasions of care that includes a face-to-face visit or phone call with significant clinical content and is recorded in the patient record.
- To reflect approved changes to WA Health's Outcome Based Management framework, financial products have been removed from the calculation of efficiency indicators for 2021–22. To account for this change prior year results have been recalculated and the 2020–21 and 2021–22 budget targets have been recast to allow for comparability with current year findings.
- Previously reported results for cost per home-based hospital day of care are as follows:

	2019–20	2020–21
Average cost	\$293	\$294
Target	\$321	\$293

- Previously reported results for cost per home-based hospital occasion of service are as follows:

	2019–20	2020–21
Average cost	\$137	\$138
Target	\$129	\$131

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

Average cost per day of care for non-acute admitted continuing care

Outcome 2 Aged and continuing care services

Rationale

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

Non-acute care is usually provided in a hospital while patients are awaiting placement into residential care, waiting for the services they will need at home to be organised or for vital modifications to be made to their homes, or when requiring respite care.

Non-acute care is also provided in purpose-built facilities where patients with complex care needs receive support to optimise their physical and psychological functioning in order to maximise their ability to enter long term supported accommodation or return to their own home.

Target

The 2021–22 target unit cost is \$799 per day of care for non-acute admitted continuing care.

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

Results

The average cost per day of care for non-acute admitted continuing care was \$783 (see Table 21).

Table 21: Average cost per day of care for non-acute admitted continuing care, 2019–20 to 2021–22

	2019–20	2020–21	2021–22
Average cost	\$759	\$808	\$783
Target	–	\$812	\$799

Notes:

1. To reflect approved changes to WA Health's Outcome Based Management framework, financial products have been removed from the calculation of efficiency indicators for 2021–22. To account for this change prior year results have been recalculated and the 2020–21 and 2021–22 budget targets have been recast to allow for comparability with current year findings.
2. Previously reported results for this indicator are as follows:

	2019–20	2020–21
Average cost	\$759	\$808
Target	\$666	\$804

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

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

Outcome 2
Aged and continuing care services

Rationale

Chronic conditions pose a significant burden on the healthcare system in Western Australia. Most chronic conditions do not resolve spontaneously and require ongoing treatment, health care and support. As such, the Government has identified several chronic conditions that require health service support to people with long term chronic conditions to optimise their quality of life (refer to National Strategic Framework for Chronic Conditions³).

In addition, ongoing care and support is also required for those who have a complex disability, which aims to improve their health and wellbeing. To achieve this, the Department of Health has entered into collaborative arrangements with service providers to deliver residential, community and respite care.

Target

The 2021–22 target unit cost is \$25 to support patients who suffer specific chronic conditions and people who require continuing care.

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

Results

The average cost to support patients who suffer specific chronic illness and other clients who require continuing care in 2021–22 was \$19, below the target of \$25 (see Table 22). The lower expenditure to target is primarily attributable to an overestimation of expenditure when deriving the 2021–22 budget target.

Table 22: Average cost to support patients who suffer specific chronic illness and other clients who require continuing care, 2019–20 to 2021–22

	2019–20	2020–21	2021–22
Average cost	\$21	\$19	\$19
Target	–	\$25	\$25

Notes:

1. To reflect approved changes to WA Health's Outcome Based Management framework, financial products have been removed from the calculation of efficiency indicators for 2021–22. To account for this change prior year results have been recalculated and the 2020–21 and 2021–22 budget targets have been recast to allow for comparability with current year findings.
2. Previously reported results for this indicator are as follows:

	2019–20	2020–21
Average cost	\$21	\$19
Target	\$27	\$25

Data sources: Unpublished data, Department of Health; Australian Bureau of Statistics 2018 Survey of Disability, Ageing and Carers (Cat. No. 4430.02018); Oracle 11i Financial System, Department of Health.

³ Available at: <https://www.health.gov.au/resources/publications/national-strategic-framework-for-chronic-conditions>

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 of Health has entered into collaborative arrangements with service providers to provide palliative care services for those in need.

Target

The 2021–22 target unit cost is \$8,487 per client receiving contracted palliative care services.

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

Outcome 2
Aged and
continuing care
services

Results

In 2021–22, the average cost per client receiving contracted palliative care services was \$8,461 (see Table 23). The result is below the target value of \$8,487.

Both the budget and expenditure increase compared to 2020–21 is primarily attributable to funding provided for the delivery of services aligned with the response and incident management of COVID-19.

Table 23: Average cost per client receiving contracted palliative care services, 2019–20 to 2021–22

	2019–20	2020–21	2021–22
Average cost	\$7,671	\$7,636	\$8,461
Target	–	\$8,030	\$8,487

Notes:

1. Effective palliative care requires a broad multidisciplinary approach and may be provided in hospital or at home. The services include nursing and medical services at home, respite care, care in designated inpatient palliative care facilities, and community care and support.
2. To reflect approved changes to WA Health's Outcome Based Management framework, financial products have been removed from the calculation of efficiency indicators for 2021–22. To account for this change prior year results have been recalculated and the 2020–21 and 2021–22 budget targets have been recast to allow for comparability with current year findings.
3. Previously reported results for this indicator are as follows:

	2019–20	2020–21
Average cost	\$7,787	\$7,636
Target	\$5,900	\$6,590

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

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

Outcome 2
Public and
community
health services

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 preventative 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 target unit cost for 2021–22 is \$149 per person to provide preventative interventions, health promotion and health protection activities.

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

Results

In 2021–22, the average cost per person providing preventative interventions, health promotion and health protection activities was \$237 (see Table 24). Approximately, 75 per cent of total expenditure was associated with the response and incident management of COVID-19, including implementation of the vaccination program, hotel quarantine, pathology testing and the COVID-19 home monitoring program. The variance to target is attributable to the differing methodological approach used to derive the budget target versus calculation of expenditure.

Table 24: Cost per person of providing preventative interventions, health promotion and health protection activities that reduce the incidence of disease or injury, 2019–20 to 2021–22

	2019–20	2020–21	2021–22
Average cost	\$66	\$151	\$237
Target	–	\$62	\$149

Notes:

1. To reflect approved changes to WA Health's Outcome Based Management framework, financial products have been removed from the calculation of efficiency indicators for 2021–22. To account for this change prior year results have been recalculated and the 2020–21 and 2021–22 budget targets have been recast to allow for comparability with current year findings.
2. Previously reported results for this indicator are as follows:

	2019–20	2020–21
Average cost	\$66	\$158
Target	–	\$62

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.

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

Outcome 2
Public and
community
health services

Rationale

To ensure Western Australians receive the care and ambulance services they need, when they need it, the Department of Health 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 and rapid response ambulance services to ensure the best possible health outcomes for patients requiring medical treatment.

Target

The target unit cost for 2021–22 is \$523 per trip for road-based patient transport services in the Perth metropolitan area.

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

Results

In 2021–22, the cost per trip for road-based ambulance services was \$534 (see Table 25). Expenditure includes costs associated with the delivery of services aligned with the response and incident management of COVID-19.

Table 25: Cost per trip for road-based ambulance services, based on the total accrued costs of these services for the total number of trips, 2019–20 to 2021–22

	2019–20	2020–21	2021–22
Cost per trip	\$469	\$514	\$534
Target	–	\$494	\$523

Notes:

1. Road-based ambulance services include emergency and non-emergency patient transport services.
2. To reflect approved changes to WA Health's Outcome Based Management framework, financial products have been removed from the calculation of efficiency indicators for 2021–22. To account for this change prior year results have been recalculated and the 2020–21 and 2021–22 budget targets have been recast to allow for comparability with current year findings.
3. Previously reported results for this indicator are as follows:

	2019–20	2020–21
Average cost	\$469	\$508
Target	\$494	\$494

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

Average cost of public health regulatory services per head of population

Rationale

The Department of Health performs systemwide regulatory functions including the regulation of food safety, vector control, waste water management, tobacco licensing, radiation safety and medicines and poisons in order to promote health in the community; prevent disease before it occurs; and manage risks to human health, whether natural or man-made.

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 target unit cost for 2021–22 is \$6 per head of population to provide public regulatory services.

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

Results

In 2020–21, the cost of public health regulatory services per head of population was \$8 (see Table 26). The variance to target is attributable to expenditure associated with COVID-19 vaccine distribution via community pharmacies.

Outcome 3
Health system
management –
Policy and corporate
services

Table 26: Average cost of public health regulatory services per head of population, 2019–20 to 2021–22

	2019–20	2020–21	2021–22
Average cost	\$8	\$8	\$8
Target	–	\$6	\$6

Notes:

1. 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.
2. To reflect approved changes to WA Health's Outcome Based Management framework, financial products have been removed from the calculation of efficiency indicators for 2021–22. To account for this change prior year results have been recalculated and the 2020–21 and 2021–22 budget targets have been recast to allow for comparability with current year findings.
3. Previously reported results for this indicator are as follows:

	2019–20	2020–21
Average cost	\$7	\$8
Target	–	\$6

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

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

Outcome 3
Health system
management –
Policy and corporate
services

Rationale

The Department of Health, in supporting the system manager, sets the vision and direction for the WA health system. It also provides executive oversight of strategic decision making, identifies health system priorities, and guides, oversees and manages the statewide 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 of Health undertakes its role in supporting the system manager.

Target

The target unit cost for 2021–22 is \$5,337 per full time equivalent worker to undertake the system manager functions.

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

Results

In 2021–22, the cost of the Department of Health to undertake system manager functions per health service provider full time equivalent was \$7,022 (see Table 27). The expenditure increase compared to 2020–21 is primarily attributable to funding outpatient reform and workforce strategy.

Table 27: Average cost for the Department of Health to undertake system manager functions per health service provider full time equivalent, 2019–20 to 2021–22

	2019–20	2020–21	2021–22
Average cost	\$5,182	\$6,816	\$7,022
Target	–	\$5,559	\$5,337

Notes:

1. Health service providers include North Metropolitan Health Service, South Metropolitan Health Service, East Metropolitan Health Service, Child and Adolescent Health Service, WA Country Health Service, Health Support Services, PathWest Laboratory Medicine WA and Department of Health staff that provide a public health regulatory function.
2. Full Time Equivalent figures (FTE) used in the calculation of this indicator are based on Actual (Paid) month to date FTE.
3. To reflect approved changes to WA Health's Outcome Based Management framework, financial products have been removed from the calculation of efficiency indicators for 2021–22. To account for this change prior year results have been recalculated and the 2020–21 and 2021–22 budget targets have been recast to allow for comparability with current year findings.
4. Previously reported results for this indicator are as follows:

	2019–20	2020–21
Average cost	\$6,167	\$6,899
Target	–	\$5,632

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



Financial disclosures and compliance

Financial disclosures

Summary of board and committee remuneration

The total annual remuneration in 2021–22 for all Department of Health boards and committees was \$428,993 (see Table 28), an increase of almost 15 per cent compared to 2020–21.

Significant changes to remuneration in 2021–22 compared to 2020–21 include:

- closure of the Implementation Leadership Team – Voluntary Assisted Dying and creation of the Voluntary Assisted Dying Board, with reduced remuneration of approximately \$30,000
- an increase for the Graylands Reconfiguration and Forensic Taskforce of approximately \$48,000, explained by the Taskforce operating for the full 12 months compared to 5 months last year
- an increase of approximately \$55,000 in remuneration for the Western Australian Reproductive Technology Council, resulting from an increase in sitting fees for members recommended by the Public Sector Commission that took into account the changed function and increased workload of members and the date of the last review of the Council, completed in 2000.

For details of individual board and committee members refer to Appendix 1.

Table 28: Summary of WA State Government boards and committees within the Department of Health, 2021–22

Board / Committee name	Total remuneration
Anaesthetic Mortality Committee	\$8,424
Department of Health WA Human Research Ethics Committee	\$44,060
Fluoridation of Public Water Supplies Advisory Committee	\$0
Graylands Reconfiguration and Forensic Taskforce	\$68,017
Local Health Authorities Analytical Committee	\$474
Maternal Mortality Committee	\$0
Perinatal and Infant Mortality Committee	\$51,475
Pesticides Advisory Committee	\$0
Pharmacy Registration Board of Western Australia	\$19,540
Postgraduate Medical Council of Western Australia	\$560
Radiological Council	\$6,100
Stimulant Assessment Panel	\$1,832
Sustainable Health Independent Oversight Committee	\$14,040
Voluntary Assisted Dying Board	\$123,073
Western Australian Future Health Research and Innovation Fund Advisory Council	\$15,637
WA Reproductive Technology Council	\$74,809
WA Reproductive Technology Council Preimplantation Genetic Diagnosis Technical Advisory Committee	\$952
Total	\$428,993

Notes:

1. Ministerial Expert Panel on Voluntary Assisted Dying ceased in 2019.
2. Department of Health does not remunerate members of:
 - Western Australian Board of the Medical Board of Australia
 - Western Australian Board of the Nursing and Midwifery Board of Australia
 - Northern Territory, South Australia and Western Australia Board of the Psychology Board of Australia.

Pricing policy

The National Health Reform Agreement sets the policy framework for the charging of public hospital fees and charges. Under the Agreement, an eligible person who receives public hospital services as a public patient in a public hospital or a publicly contracted bed in a private hospital is treated 'free of charge'. This arrangement is consistent with the Medicare principles which are embedded in the *Health Services Act 2016* (WA).

The majority of hospital fees and charges for public hospitals are set under Schedule 1 of the *Health Services (Fees and Charges) Order 2016* and are reviewed annually. For up to date information refer to the [WA Health Fees and Charges Manual](#).

Advertising expenditure

In 2021–22, in accordance with section 175ZE of the *Electoral Act 1907*, the Department of Health incurred a total advertising expenditure of \$3,878,453 (see Table 29), a reduction of almost 6 per cent compared to last year's total of \$4,108,133. The majority of 2021–22 advertising expenditure was for media advertising services (53 per cent), market research (28 per cent) and advertising agencies (19 per cent). Procured services were for advertising related to workforce recruitment, sexual health, immunisation and COVID-19. Workforce recruitment strategies accounted for 41 per cent of advertising expenditure.

Table 29: Summary of Department of Health advertising in 2021–22

Summary of advertising	Amount (\$)
Advertising agencies	735,213
Market research organisations	1,094,842
Direct mail organisations	1,835
Media advertising organisations	2,046,563
Total advertising expenditure	3,878,453

The organisations from which advertising services were procured and the amounts paid to each organisation are detailed in Table 30.

Table 30: Department of Health advertising, by class of expenditure, 2021–22

Recipient/organisations	Amount (\$)
Advertising agencies	
303 MullenLowe	592,616
Actors Now	1,815
Cooch Creative PTY LTD	36,630
Francine Eades	1,650
Josie Kate Dickinson	4,356
Media on Mars	5,000
Medical Forum	4,400
Rhythm Creative Content	17,462
Facebook	54,274
Hancock Creative PTY LTD	300
Canva PTY LTD	18
iStock	14
Austockphoto	515
Australian Flag Makers	279
The Immunisation Foundation of Australia	15,884
Total	735,213

Recipient/organisations	Amount (\$)
Market research organisations	
Kantar Australia	49,500
Survey Research Centre, Edith Cowan University	1,045,342
Total	1,094,842
Direct Mail Organisations	
Mailchimp	1,835
Total	1,835
Media advertising organisations	
Initiative Media Australia PTY LTD	2,041,914
Your Membership	147
Seek	313
Australasian Epidemiological Association	200
WANMEA	250
HAYS Specialist Recruitment (Australia)	3,739
Total	2,046,563
Total advertising expenditure	3,878,453

Major capital projects

Table 31 shows the projects that were completed in 2021–22.

Table 31: Major Asset Investment Program projects completed in 2021–22

Project name	Total cost of project (\$'000)
Replacement of the Monitoring of Drugs of Dependence System ^(a)	1,437
Stop the Violence ^(b)	2,992
COVID-19 Medical Equipment	47,437

Table 32 shows the projects currently in progress administered by the Department of Health.

Table 32: Major Asset Investment Program projects in progress during 2021–2022

Project name	Expected year of completion	Estimated remaining cost to complete (\$ '000)	Estimated total cost of project 2021–22 (\$ '000)	Estimated total cost of project 2020–21 (\$'000)	Variance from previous financial year (\$'000)
Medical Equipment Replacement Program	Ongoing	82,998	547,841	523,036	24,805
Minor Building and Emergency Capital Works ^(c)	Ongoing	30,885	179,279	217,372	-38,093
COVID-19 Vaccination System and Equipment ^(d)	2022–23	6,234	13,559	N/A	13,559
Statewide 24/7 Telestroke Service	2022–23	2,452	2,452	2,500	-48

Notes

- The above information is based upon the:
 - 2020–21 published budget papers
 - 2021–22 published budget papers
- Completion timeframes are based upon a combination of known dates at the time of reporting.
- Only capital projects that were administered by the Department of Health are reflected in the table.
- Variance represents the difference between the estimated total cost of the project in the 2021–22 published budget papers in comparison to the total cost or estimated total cost of the project as reported in the [2020–21 Department of Health Annual Report](#). An explanation is provided below where a variance is greater than or equal to 10 per cent.
- The footnotes that apply to individual projects are:
 - Variation was due to accounting reclassification of budgeted expense capital to capital cost.
 - This is a new project to procure security equipment and duress alarm systems as part of initiatives in response to the rising rates of violence and aggression towards front-line health staff.
 - Budgeted expense capital is excluded from the current year estimated total cost of project to align to the published budget paper. In addition, an amount of \$5.3 million was re-directed to other WA Health Asset Investment Program priorities.
 - This is a new initiative for rolling out the COVID-19 vaccination program, procurement of critical equipment and development of a vaccine management software solution.

Unauthorised use of purchasing cards

The Department of Health uses purchasing cards when purchasing low value goods and services as they achieve savings by reducing paperwork and streamlining purchasing processes.

The department only issues purchasing cards to employees who have a justified work need and meet relevant criteria. All cardholders are made aware of their obligations pertaining to the use of their purchasing card, including the requirement that purchasing cards are not for personal use by the cardholder.

Should a cardholder use a purchasing card for a personal purpose, they must give written notice to the accountable authority within 5 working days and refund the total amount of expenditure.

There were 5 instances of purchasing cards being used for personal purposes in 2021–22 (see Table 33). The full amount of \$272.84 was refunded before the end of the reporting period.

Table 33: Personal use expenditure by Department of Health purchasing card holders, 2021–22

Credit Card personal use expenditure	Amount (\$)
Aggregate amount of personal use expenditure for the reporting period	272.84
Aggregate amount of personal use expenditure settled by the due date (within 5 working days)	240.40
Aggregate amount of personal use expenditure settled after the period (after 5 working days)	32.44
Aggregate amount of personal use expenditure outstanding at the end of the reporting period	0

Annual estimates

The Department of Health 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 953*.

The annual estimates for 2022–23 will be published on the Department of Health website.



Auditor General

INDEPENDENT AUDITOR'S REPORT 2022 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 at 30 June 2022, and the Statement of Comprehensive Income, Statement of Changes in Equity, Statement of Cash Flows, Schedule of Income and Expenses by Service, Schedule of Assets and Liabilities by Service and Summary of Consolidated Account Appropriations for the year then ended
- Notes comprising a summary of significant accounting policies and other explanatory information, including administered transactions and balances.

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 of Health for the year ended 30 June 2022 and the financial position 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.

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 www.auasb.gov.au/auditors_responsibilities/ar4.pdf.

Report on the audit of controls

Basis for Qualified Opinion

I identified significant weaknesses in network security controls and controls over unauthorised connection of devices at the Department of Health. These weaknesses could result in a potential security exposure to the network to increased vulnerabilities which could undermine the integrity of data across all systems, including the financial system.

Qualified Opinion

I have undertaken a reasonable assurance engagement on the design and implementation of controls exercised by the Department of Health. The controls exercised by the Director General 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 legislative provisions (the overall control objectives).

My opinion has been formed on the basis of the matters outlined in this report.

In my opinion, except for the possible effects of the matters described in the Basis for Qualified Opinion paragraph, in all material respects, the controls exercised by the Department of Health are sufficiently adequate to provide reasonable assurance that the receipt, expenditure and investment of money, the acquisition and disposal of property and the incurring of liabilities have been in accordance with legislative provisions during the year ended 30 June 2022.

The Director General's responsibilities

The Director General is responsible for designing, implementing and maintaining controls to ensure that the receipt, expenditure and investment of money, the acquisition and disposal of property and the incurring of liabilities are in accordance with the *Financial Management Act 2006*, the Treasurer's Instructions and other relevant written law.

Auditor General's responsibilities

As required by the *Auditor General Act 2006*, my responsibility as an assurance practitioner is to express an opinion on the suitability of the design of the controls to achieve the overall control objectives and the implementation of the controls as designed. I conducted my engagement in accordance with Standard on Assurance Engagements ASAE 3150 *Assurance Engagements on Controls* issued by the Australian Auditing and Assurance Standards Board. That standard requires that I comply with relevant ethical requirements and plan and perform my procedures to obtain reasonable assurance about whether, in all material respects, the controls are suitably designed to achieve the overall control objectives and were implemented as designed.

An assurance engagement involves performing procedures to obtain evidence about the suitability of the controls design to achieve the overall control objectives and the implementation of those controls. The procedures selected depend on my judgement, including an assessment of the risks that controls are not suitably designed or implemented as designed. My procedures included testing the implementation of those controls that I consider necessary to achieve the overall control objectives.

I believe that the evidence I have obtained is sufficient and appropriate to provide a basis for my 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 of Health for the year ended 30 June 2022. 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 of the Department of Health are relevant and appropriate to assist users to assess the Department's performance and fairly represent indicated performance for the year ended 30 June 2022.

The Department'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 control as the Director General determines necessary to enable the preparation of key performance indicators that are free from material misstatement, whether due to fraud or error.

In preparing the key performance indicators, the Department is responsible for identifying key performance indicators that are relevant and appropriate, having regard to their purpose in accordance with Treasurer's Instruction 904 *Key Performance Indicators*.

Auditor General's responsibilities

As required by the *Auditor General Act 2006*, my responsibility as an assurance practitioner is to express an opinion on the key performance indicators. The objectives of my engagement are to obtain reasonable assurance about whether the key performance indicators are relevant and appropriate to assist users to assess the entity's performance and whether the key performance indicators are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. I conducted my engagement in accordance with Standard on Assurance Engagements ASAE 3000 *Assurance Engagements Other than Audits or Reviews of Historical Financial Information* issued by the Australian Auditing and Assurance Standards Board. That standard requires that I comply with relevant ethical requirements relating to assurance engagements.

An assurance engagement involves performing procedures to obtain evidence about the amounts and disclosures in the key performance indicators. It also involves evaluating the relevance and appropriateness of the key performance indicators against the criteria and guidance in Treasurer's Instruction 904 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 control relating to the reports on 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 ASQC 1 *Quality Control for Firms that Perform Audits and Reviews of Financial Reports and Other Financial Information, and Other Assurance Engagements*, the Office of the Auditor General maintains a comprehensive system of quality control 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 2022, but not the financial statements, key performance indicators and my auditor's report.

My opinions on the financial statements, controls and key performance indicators do not cover the other information and, accordingly, I do not express any form of assurance conclusion thereon.

In connection with our 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 our knowledge obtained in the audit or otherwise appears to be materially misstated.

If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact. I did not receive the other information prior to the date of this auditor's report. When I do receive it, I will read it and if I conclude that there is a material misstatement in this information, I am required to communicate the matter to those charged with governance and request them to correct the misstated information. If the misstated information is not corrected, I may need to retract this auditor's report and re-issue an amended report.

Matters relating to the electronic publication of the audited financial statements and key performance indicators

This auditor's report relates to the financial statements and key performance indicators of the Department of Health for the year ended 30 June 2022 included in the annual report on the Department's website. The Department's management is responsible for the integrity of the Department's website. This audit does not provide assurance on the integrity of the Department's website. The auditor's report refers only to the financial statements, controls and key performance indicators described above. It does not provide an opinion on any other information which may have been hyperlinked to/from the annual report. If users of the financial statements and key performance indicators are concerned with the inherent risks arising from publication on a website, they are advised to contact the entity to confirm the information contained in the website version.



Caroline Spencer
Auditor General for Western Australia
Perth, Western Australia
20 September 2022

Certification of financial statements

DEPARTMENT OF HEALTH

CERTIFICATION OF FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2022

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 ending 30 June 2022 and financial position as at 30 June 2022.

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.



Mr Andrew Frontino
CHIEF FINANCE OFFICER
DEPARTMENT OF HEALTH

19 September 2022



Dr D J Russell-Weisz
DIRECTOR GENERAL
DEPARTMENT OF HEALTH
ACCOUNTABLE AUTHORITY

19 September 2022

Financial statements – Contents

Financial statements						8 Risks and Contingencies			158					
Statement of comprehensive income		104	4.2		User charges and fees			135	8.1		Financial risk management	158		
Statement of financial position		106	4.3		Commonwealth grants and contributions			136	8.2		Contingent assets and liabilities	162		
Statement of changes in equity		108	4.4		Other grants and contributions			137	8.3		Fair value measurements	164		
Statement of cash flows		109	4.5		Other income			137	9 Other disclosures		166			
Administered schedules		111	4.6		Gains/(losses) on disposal			137	9.1		Events occurring after the end of the reporting period	166		
Notes to the financial statements			5 Key assets				138	9.2		Future impact of Australian Accounting Standards not yet operative	167			
1 Basis of preparation		115	5.1		Infrastructure, property, plant and equipment			138	9.3		Key management personnel	170		
2 Department outputs		117	5.2		Intangible assets			142	9.4		Related party transactions	171		
2.1 Department objectives		117	5.3		Right-of-use assets			145	9.5		Related bodies	172		
2.2 Schedule of income and expenses by service		120	6 Other assets and liabilities				148	9.6		Affiliated bodies	172			
2.3 Schedule of assets and liabilities by service		123	6.1		Inventories			148	9.7		Services provided free of charge	173		
3 Use of our funding		125	6.2		Receivables			149	9.8		Indian Ocean Territories	173		
3.1 (a) Employee benefits expenses		125	6.3		Amounts receivable for services (Holding Account)			150	9.9		Special purpose accounts	174		
3.1 (b) Employee related provisions		126	6.4		Other assets			151	9.10		Remuneration of auditors	177		
3.2 Grants and subsidies		128	6.5		Payables			151	9.11		Equity	177		
3.3 Contribution to Capital Works Fund		129	6.6		Contract liabilities			152	9.12		Supplementary financial information	179		
3.4 Contracts for services		129	7 Financing				153	10 Explanatory statements		180				
3.5 Supplies and services		130	7.1		Cash and cash equivalents			153	10.1		Explanatory statement for controlled operations	180		
3.6 Other expenses		130	7.2		Lease liabilities			156	10.2		Explanatory statement for administered items	191		
4 Our funding sources		132	7.3		Finance costs			157						
4.1 Income from State Government		132	7.4		Commitments			157						

Statement of comprehensive income

For the year ended 30 June 2022

	Notes	2022 \$'000	2021 \$'000
COST OF SERVICES			
Expenses			
Employee benefits expenses	3.1(a)	173,743	161,804
Contracts for services	3.4	599,637	526,513
Supplies and services	3.5	400,084	268,926
Grants and subsidies	3.2	8,605,148	7,439,955
Depreciation and amortisation expenses	5.1, 5.2, 5.3	2,062	964
Loss on disposal of non-current assets	4.6	8	-
Finance costs	7.3	44	17
Contribution to Capital Works Fund	3.3	-	13,313
Other expenses	3.6	50,141	67,284
Total cost of services		9,830,867	8,478,776
Income			
User charges and fees	4.2	13,373	19,970
Commonwealth grants and contributions	4.3	3,256,004	2,506,804
Other grants and contributions	4.4	1,595	872
Other income	4.5	42,129	80,761
Total income		3,313,101	2,608,407
Gains			
Gain on disposal of non-current assets	4.6	-	16
Total gains		-	16
Total income other than income from State Government		3,313,101	2,608,423
NET COST OF SERVICES		6,517,766	5,870,353

Statement of comprehensive income (continued)

For the year ended 30 June 2022

	Notes	2022 \$'000	2021 \$'000
Income from State Government			
Service appropriation	4.1	6,515,785	5,610,273
Income from other public sector entities	4.1	42,536	43,561
Liabilities assumed	4.1	-	(872)
Resources received	4.1	3,857	1,883
Royalties for Regions Fund	4.1	8,439	7,679
Total income from State Government		6,570,617	5,662,524
SURPLUS/(DEFICIT) FOR THE PERIOD		52,851	(207,829)
OTHER COMPREHENSIVE INCOME			
Items not reclassified subsequently to profit or loss			
Changes in asset revaluation reserve	9.11	1,095	379
Total other comprehensive income		1,095	379
TOTAL COMPREHENSIVE INCOME FOR THE PERIOD		53,946	(207,450)

The Statement of Comprehensive Income should be read in conjunction with the accompanying notes.

See also the 'Schedule of income and expenses by service'.

Statement of financial position

As at 30 June 2022

	Notes	2022 \$'000	2021 \$'000
ASSETS			
Current Assets			
Cash and cash equivalents	7.1	128,508	80,638
Restricted cash and cash equivalents	7.1	119,138	51,061
Inventories	6.1	45,022	47,437
Receivables	6.2	99,718	88,266
Other current assets	6.4	7,351	5,994
Total Current Assets		399,737	273,396
Non-Current Assets			
Restricted cash and cash equivalents	7.1	4,481	4,481
Amounts receivable for services	6.3	93,690	81,479
Infrastructure, property, plant and equipment	5.1	104,693	25,518
Intangible assets	5.2	1,100	1,543
Right-of-use assets	5.3	2,464	673
Other non-current assets	6.4	25	-
Total Non-Current Assets		206,453	113,694
TOTAL ASSETS		606,190	387,090
LIABILITIES			
Current Liabilities			
Payables	6.5	149,578	85,280
Contract liabilities	6.6	74	67
Lease liabilities	7.2	510	472
Employee related provisions	3.1(b)	30,517	27,968
Total Current Liabilities		180,679	113,787

Statement of financial position (continued)

As at 30 June 2022

	Notes	2022 \$'000	2021 \$'000
Non-Current Liabilities			
Lease liabilities	7.2	1,807	318
Employee related provisions	3.1(b)	9,933	10,181
Total Non-Current Liabilities		11,740	10,499
TOTAL LIABILITIES		192,419	124,286
NET ASSETS		413,771	262,804
EQUITY			
Contributed equity	9.11	142,415	45,394
Reserves	9.11	281,350	280,255
Accumulated surplus/(deficit)		(9,994)	(62,845)
TOTAL EQUITY		413,771	262,804

The Statement of Financial Position should be read in conjunction with the accompanying notes.

See also the 'Schedule of assets and liabilities by service'.

Statement of changes in equity

For the year ended 30 June 2022

	Notes	Contributed equity \$'000	Reserves \$'000	Accumulated surplus/(deficit) \$'000	Total equity \$'000
Balance at 1 July 2020		41,889	279,876	144,912	466,677
Initial application of accounting standards		-	-	72	72
Restated balance at 1 July 2020		41,889	279,876	144,984	466,749
Surplus/(deficit)		-	-	(207,829)	(207,829)
Other comprehensive income		-	379	-	379
Total comprehensive income for the period		-	379	(207,829)	(207,450)
Transactions with owners in their capacity as owners:	9.11				
Capital appropriation		3,567	-	-	3,567
Distribution to owners		(62)	-	-	(62)
Total contributed equity		3,505	-	-	3,505
Balance at 30 June 2021		45,394	280,255	(62,845)	262,804
Balance at 1 July 2021		45,394	280,255	(62,845)	262,804
Surplus/(deficit)		-	-	52,851	52,851
Other comprehensive income		-	1,095	-	1,095
Total comprehensive income for the period		-	1,095	52,851	53,946
Transactions with owners in their capacity as owners:	9.11				
Capital appropriation		97,021	-	-	97,021
Distribution to owners		-	-	-	-
Total contributed equity		97,021	-	-	97,021
Balance at 30 June 2022		142,415	281,350	(9,994)	413,771

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 2022

	Notes	2022 \$'000	2021 \$'000
CASH FLOWS FROM STATE GOVERNMENT			
Service appropriation		6,104,124	5,189,528
Capital appropriation		97,021	3,536
Funds from other public sector entities		42,536	43,561
Royalties for Regions Fund		8,439	7,679
Net cash provided by State Government		6,252,120	5,244,304
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Employee benefits		(171,442)	(156,511)
Supplies and services		(944,910)	(828,948)
Grants and subsidies		(8,205,698)	(7,036,228)
Finance costs		(44)	(17)
Contribution to Capital Works Fund		-	(13,313)
GST payments on purchases		(548,652)	(444,638)
Receipts			
User charges and fees		6,530	9,048
Commonwealth grants and contributions		3,214,318	2,464,299
GST receipts on sales		23,485	26,276
GST receipts from taxation authority		517,898	409,800
Other receipts		54,816	81,633
Net cash used in operating activities	7.1.3	(6,053,699)	(5,488,599)
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments			
Payment for purchase of non-current assets		(81,787)	(4,782)
Net cash used in investing activities		(81,787)	(4,782)

Statement of cash flows (continued)

For the year ended 30 June 2022

	Notes	2022 \$'000	2021 \$'000
CASH FLOWS FROM FINANCING ACTIVITIES			
Payments			
Payments for principal element of lease		(687)	(412)
Net cash used in financing activities		(687)	(412)
Net increase/(decrease) in cash and cash equivalents		115,947	(249,489)
Cash and cash equivalents at the beginning of the period		136,180	385,669
CASH AND CASH EQUIVALENTS AT THE END OF THE PERIOD	7.1.1	252,127	136,180

The Statement of Cash Flows should be read in conjunction with the accompanying notes.

Administered schedules

For the year ended 30 June 2022

Administered income and expenses by service

	Public Hospital Admitted Services		Public Hospital Emergency Services		Public Hospital Non-Admitted Services		Mental Health Services	
	2022	2021	2022	2021	2022	2021	2022	2021
	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000
Expenses								
Funding for Capital Works Fund transferred to:								
Health Service Providers	228,831	129,263	43,487	23,945	48,325	26,827	45,994	22,240
State Pool Account and State Managed Fund Account administered for Mental Health Commission								
Transfer of activity based funding to Health Service Providers	-	-	-	-	-	-	399,978	345,564
Transfer of block funding to Health Service Providers	-	-	-	-	-	-	423,594	383,874
Service concession arrangement depreciation expense (a)	-	-	-	-	-	-	-	-
Total administered expenses	228,831	129,263	43,487	23,945	48,325	26,827	869,566	751,678
Income								
Administered for Capital Works Fund:								
Capital appropriation	222,197	135,825	37,602	23,407	46,963	28,142	44,688	23,431
Administered appropriation	4,972	-	790	-	1,068	-	1,182	-
Royalties for Regions Fund	24,340	13,703	9,265	4,923	4,568	2,400	4,807	2,350
Commonwealth grants and contributions	-	(1,705)	-	(269)	-	(359)	-	(359)
Contribution from Department of Health	-	-	-	-	-	-	-	-
State Pool Account and State Managed Fund Account administered for Mental Health Commission (MHC)								
Commonwealth activity based funding for MHC	-	-	-	-	-	-	161,700	138,214
Commonwealth block funding for MHC	-	-	-	-	-	-	136,869	114,369
State activity based funding from MHC	-	-	-	-	-	-	238,278	207,350
State block funding from MHC	-	-	-	-	-	-	286,725	269,505
Service concession arrangement revenue (a)	-	-	-	-	-	-	-	-
Total administered income	251,509	147,823	47,657	28,061	52,599	30,183	874,249	754,860

Administered schedules (continued)

For the year ended 30 June 2022

Administered income and expenses by services (continued)

	Aged and Continuing Care Services		Public and Community Health Services		Pathology Services		Community Dental Health Services	
	2022	2021	2022	2021	2022	2021	2022	2021
	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000
Expenses								
Funding for Capital Works Fund transferred to: Health Service Providers	7,822	3,206	26,558	13,544	3,980	12,022	-	3,321
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	7,822	3,206	26,558	13,544	3,980	12,022	-	3,321
Income								
Administered for Capital Works Fund:								
Capital appropriation	4,223	2,242	16,399	9,613	6,203	6,088	-	3,967
Administered appropriation	75	-	330	-	-	-	-	-
Royalties for Regions Fund	4,404	1,896	11,355	5,953	-	-	-	-
Commonwealth grants and contributions	-	(30)	-	(120)	-	-	-	(150)
Contribution from Department of Health	-	-	-	-	-	-	-	-
State Pool Account and State Managed Fund Account administered for Mental Health Commission (MHC)								
Commonwealth activity based funding for MHC	-	-	-	-	-	-	-	-
Commonwealth block funding for MHC	-	-	-	-	-	-	-	-
State activity based funding from MHC	-	-	-	-	-	-	-	-
State block funding from MHC	-	-	-	-	-	-	-	-
Service concession arrangement revenue (a)	-	-	-	-	-	-	-	-
Total administered income	8,702	4,108	28,084	15,446	6,203	6,088	-	3,817

Administered schedules (continued)

For the year ended 30 June 2022

Administered income and expenses by services (continued)

	Small Rural Hospital Services		Health System Management - Policy and Corporate Services		Health Support Services		Total	
	2022	2021	2022	2021	2022	2021	2022	2021
	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000
Expenses								
Funding for Capital Works Fund transferred to:								
Health Service Providers	10,392	5,132	15,324	3,398	46,664	34,261	477,377	277,159
State Pool Account and State Managed Fund Account administered for Mental Health Commission								
Transfer of activity based funding to Health Service Providers	-	-	-	-	-	-	399,978	345,564
Transfer of block funding to Health Service Providers	-	-	-	-	-	-	423,594	383,874
Service concession arrangement depreciation expense (a)	-	-	2,617	2,617	-	-	2,617	2,617
Total administered expenses	10,392	5,132	17,941	6,015	46,664	34,261	1,303,566	1,009,214
Income								
Administered for Capital Works Fund:								
Capital appropriation	2,577	1,605	6,319	11,563	40,059	42,656	427,230	288,539
Administered appropriation	3	-	-	-	-	-	8,420	-
Royalties for Regions Fund	9,034	5,584	-	-	-	-	67,773	36,809
Commonwealth grants and contributions	-	-	-	3,008	-	-	-	16
Contribution from Department of Health	-	-	-	-	-	-	-	-
State Pool Account and State Managed Fund Account administered for Mental Health Commission (MHC)								
Commonwealth activity based funding for MHC	-	-	-	-	-	-	161,700	138,214
Commonwealth block funding for MHC	-	-	-	-	-	-	136,869	114,369
State activity based funding from MHC	-	-	-	-	-	-	238,278	207,350
State block funding from MHC	-	-	-	-	-	-	286,725	269,505
Service concession arrangement revenue (a)	-	-	5,474	5,474	-	-	5,474	5,474
Total administered income	11,614	7,189	11,793	20,045	40,059	42,656	1,332,469	1,060,276

Administered schedules (continued)

For the year ended 30 June 2022

- (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. Under AASB 1059, a grant of the right to operate liability is raised as the State does not have a contractual obligation to pay cash or another financial asset but grants the right to the operator to earn revenue from the public use of the asset. This liability represents unearned revenue and is progressively reduced over the period of the concession by recognising revenue each year. The Department administers the service concession arrangement for the multi-deck car park on behalf of State Government which is not controlled by, nor integral to the function of the Department.

Administered assets and liabilities

	2022 \$'000	2021 \$'000
Assets		
Cash and cash equivalents	203,564	178,216
Receivables	10,774	5,490
Service concession assets	131,870	122,980
Total administered assets	346,208	306,686
Liabilities		
Payables	(6,340)	(4,023)
Service concession liabilities (Grant of the Right to Operate Model)	(84,301)	(89,775)
Total administered liabilities	(90,641)	(93,798)

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 are not controlled by, nor integral to the function of the Department. A service concession asset is recognised in respect of the multi-deck car park and a grant of the right to operate liability is recognised as the State 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 2022

1 Basis of preparation

The Department of Health (The Department) is a WA Government entity and is controlled by the State of Western Australia, which is the ultimate parent.

The Department is a not-for-profit entity (as profit is not its principal objective).

A description of the nature of its operations and its principal activities have been included in the '**Overview**' 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 19 September 2022.

Statement of compliance

These general purpose financial statements are prepared in accordance with:

- 1) The *Financial Management Act 2006* (**FMA**)
- 2) The Treasurer's Instructions (**TIs**)
- 3) Australian Accounting Standards (**AASs**) including applicable interpretations
- 4) Where appropriate, those **AAS** paragraphs applicable for not-for-profit entities have been applied.

The FMA and the TIs take precedence over AASs. Several AASs are modified by the TIs to vary application, disclosure format and wording. 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 comprises of the Department of Health and the Health Ministerial Body (a body corporate through which the Minister for Health can perform any of the Minister's functions under the Health Services Act 2016).

On 31 March 2022, approval was obtained from Treasury which exempts the Department from the reporting requirements of Treasurer's Instructions 1101 (7)(ix) Application of Australian Accounting Standards and Other Pronouncements and 1105 (4)(iv) Consolidated Financial Statements. The exemption relates to financial years 2021-22 to 2024-25.

The Department is exempted from preparing consolidated financial statements with Quadriplegic Centre. This chief executive governed Health Service Provider prepares separate financial statements which is consolidated in the Annual Report on State Finances, that is available for public use.

Notes to the financial statements

For the year ended 30 June 2022

1 Basis of preparation (continued)

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).

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 goods and services tax (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 appropriation has been designated as contributions by owners by TI 955 *Contributions by Owners made to Wholly Owned Public Sector Entities* and has been credited directly to Contributed Equity.

Administered items

The Department administers, but does not control, certain activities and functions for and on behalf of 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 AASs have been adopted.

Notes to the financial statements

For the year ended 30 June 2022

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

2.1 Department objectives

Mission

The mission of the Department is to lead and steward a WA health system that delivers safe, high quality and sustainable services that support and improve the health of all Western Australians. The Department is predominantly funded by Parliamentary appropriations.

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 four "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 four "Mental Health Services".

Notes to the financial statements

For the year ended 30 June 2022

2.1 Department objectives (continued)

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 four "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.

5. Aged and Continuing Care Services

The provision of aged and continuing care services and community based palliative care 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 is 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.

6. Public and Community Health Services

The provision of healthcare services and programs delivered to increase optimal health and wellbeing, encourage healthy lifestyles, reduce the onset of disease and disability, reduce the risk of long-term illness as well as detect, protect and monitor the incidence of disease in the population. Public and Community Health Services includes public health programs, Aboriginal health programs, disaster management, environmental health, the provision of grants to non-government organisations for public and community health purposes, emergency road and air ambulance services and services to assist rural based patients travel to receive care.

7. Pathology Services

The provision of state-wide external diagnostic services across the full range of pathology disciplines, inclusive of forensic biology and pathology services to other WA Government Agencies and services provided to the public by PathWest. This Service also includes the operational costs of PathWest in delivering services to both Health Service Providers and the public.

Notes to the financial statements

For the year ended 30 June 2022

2.1 Department objectives (continued)

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 & limited acute medical/minor surgical services in locations 'close to home' for country residents/visitors, by small & rural hospitals classified as block funded. Include 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 state-wide planning, budgeting and regulation processes. Health System Policy and Corporate Services includes corporate services inclusive of statutory financial reporting requirements, overseeing, monitoring and promoting improvements in the safety and quality of health services and system wide 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 system wide 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 2022

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	
	2022	2021	2022	2021	2022	2021	2022	2021
	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000
COST OF SERVICES								
Expenses								
Employee benefits expenses	-	-	-	-	-	-	-	-
Contracts for services	-	-	-	-	-	-	-	-
Supplies and services	-	-	-	-	-	-	-	-
Grants and subsidies	4,313,100	4,037,858	930,843	846,562	899,920	873,153	24,434	28,091
Depreciation and amortisation expenses	-	-	-	-	-	-	-	-
Loss on disposal of non-current assets	-	-	-	-	-	-	-	-
Finance costs	-	-	-	-	-	-	-	-
Contribution to Capital Works Fund	-	-	-	-	-	-	-	-
Other expenses	-	-	-	-	-	-	-	-
Total cost of services	4,313,100	4,037,858	930,843	846,562	899,920	873,153	24,434	28,091
Income								
User charges and fees	-	-	-	-	-	-	-	-
Commonwealth grants and contributions	1,563,757	1,390,145	325,881	302,921	343,008	330,271	1,679	7,330
Other grants and contributions	-	-	-	-	-	-	-	-
Other income	-	-	-	-	-	-	-	-
Gains								
Gain on disposal of non-current assets	-	-	-	-	-	-	-	-
Total income other than income from State Government	1,563,757	1,390,145	325,881	302,921	343,008	330,271	1,679	7,330
NET COST OF SERVICES	2,749,343	2,647,713	604,962	543,641	556,912	542,882	22,755	20,761
Income from State Government								
Service appropriation	2,748,982	2,647,355	604,099	542,726	556,494	542,411	22,755	20,761
Income from other public sector entities	-	-	-	-	-	-	-	-
Liabilities assumed	-	-	-	-	-	-	-	-
Resources received	-	-	-	-	-	-	-	-
Royalties for Regions Fund	361	358	863	915	418	471	-	-
Total income from State Government	2,749,343	2,647,713	604,962	543,641	556,912	542,882	22,755	20,761
SURPLUS/(DEFICIT) FOR THE PERIOD	-	-	-	-	-	-	-	-

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 2022

2.2 Schedule of income and expenses by service (continued)

	Aged and Continuing Care Services		Public and Community Health Services		Pathology Services		Community Dental Health Services	
	2022	2021	2022	2021	2022	2021	2022	2021
	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000
COST OF SERVICES								
Expenses								
Employee benefits expenses	1,922	1,336	50,556	45,417	-	-	-	-
Contracts for services	171,586	170,482	353,886	272,027	-	-	14,967	14,540
Supplies and services	82	270	396,673	266,480	-	-	-	-
Grants and subsidies	151,605	136,744	773,720	639,186	173,209	153,304	89,063	89,439
Depreciation and amortisation expenses	-	-	731	377	-	-	-	-
Loss on disposal of non-current assets	-	-	-	-	-	-	-	-
Finance costs	-	-	35	5	-	-	-	-
Contribution to Capital Works Fund	-	-	-	-	-	-	-	-
Other expenses	125	50	22,790	9,699	-	-	-	-
Total cost of services	325,320	308,882	1,598,391	1,233,191	173,209	153,304	104,030	103,979
Income								
User charges and fees	-	4,548	2,075	130	-	-	-	-
Commonwealth grants and contributions	94,116	22,300	323,705	65,952	16,699	12,368	9,617	11,332
Other grants and contributions	-	-	-	-	-	-	-	-
Other income	-	-	42,129	58,666	-	-	-	-
Gains								
Gain on disposal of non-current assets	-	-	-	-	-	-	-	-
Total income other than income from State Government	94,116	26,848	367,909	124,748	16,699	12,368	9,617	11,332
NET COST OF SERVICES	231,204	282,034	1,230,482	1,108,443	156,510	140,936	94,413	92,647
Income from State Government								
Service appropriation	190,450	208,065	1,174,927	892,882	156,510	140,936	79,446	86,023
Income from other public sector entities	-	-	-	33,900	-	-	32,632	-
Liabilities assumed	-	3	-	(875)	-	-	-	-
Resources received	-	-	-	-	-	-	1,849	-
Royalties for Regions Fund	101	100	3,720	3,760	-	-	-	-
Total income from State Government	190,551	208,168	1,178,647	929,667	156,510	140,936	113,927	86,023
SURPLUS/(DEFICIT) FOR THE PERIOD	(40,653)	(73,866)	(51,835)	(178,776)	-	-	19,514	(6,624)

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 2022

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	
	2022	2021	2022	2021	2022	2021	2022	2021
	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000
COST OF SERVICES								
Expenses								
Employee benefits expenses	-	-	121,265	115,051	-	-	173,743	161,804
Contracts for services	-	-	59,198	69,464	-	-	599,637	526,513
Supplies and services	-	-	3,329	2,176	-	-	400,084	268,926
Grants and subsidies	241,257	196,499	206,243	129,350	801,754	309,769	8,605,148	7,439,955
Depreciation and amortisation expenses	-	-	1,331	587	-	-	2,062	964
Loss on disposal of non-current assets	-	-	8	-	-	-	8	-
Finance costs	-	-	9	12	-	-	44	17
Contribution to Capital Works Fund	-	-	-	13,313	-	-	-	13,313
Other expenses	-	-	27,226	57,535	-	-	50,141	67,284
Total cost of services	241,257	196,499	418,609	387,488	801,754	309,769	9,830,867	8,478,776
Income								
User charges and fees	-	-	11,298	15,292	-	-	13,373	19,970
Commonwealth grants and contributions	122,826	110,063	181,849	239,203	272,867	14,919	3,256,004	2,506,804
Other grants and contributions	-	-	1,595	872	-	-	1,595	872
Other income	-	-	-	22,095	-	-	42,129	80,761
Gains								
Gain on disposal of non-current assets	-	-	-	16	-	-	-	16
Total income other than income from State Government	122,826	110,063	194,742	277,478	272,867	14,919	3,313,101	2,608,423
NET COST OF SERVICES	118,431	86,436	223,867	110,010	528,887	294,850	6,517,766	5,870,353
Income from State Government								
Service appropriation	115,455	84,361	337,780	149,903	528,887	294,850	6,515,785	5,610,273
Income from other public sector entities	-	-	9,904	9,661	-	-	42,536	43,561
Liabilities assumed	-	-	-	-	-	-	-	(872)
Resources received	-	-	2,008	1,883	-	-	3,857	1,883
Royalties for Regions Fund	2,976	2,075	-	-	-	-	8,439	7,679
Total income from State Government	118,431	86,436	349,692	161,447	528,887	294,850	6,570,617	5,662,524
SURPLUS/(DEFICIT) FOR THE PERIOD	-	-	125,825	51,437	-	-	52,851	(207,829)

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 2022

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	
	2022	2021	2022	2021	2022	2021	2022	2021
	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000
Assets								
Current assets	-	-	-	-	-	-	-	-
Non-current assets	-	-	-	-	-	-	-	-
TOTAL ASSETS	-	-	-	-	-	-	-	-
Liabilities								
Current liabilities	-	-	-	-	-	-	-	-
Non-current liabilities	-	-	-	-	-	-	-	-
TOTAL LIABILITIES	-	-	-	-	-	-	-	-
NET ASSETS	-	-	-	-	-	-	-	-

	Aged and Continuing Care Services		Public and Community Health Services		Pathology Services		Community Dental Health Services	
	2022	2021	2022	2021	2022	2021	2022	2021
	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000
Assets								
Current assets	315	769	53,681	14,693	-	-	-	-
Non-current assets	-	-	3,099	1,208	-	-	-	-
TOTAL ASSETS	315	769	56,780	15,901	-	-	-	-
Liabilities								
Current liabilities	8,125	12,934	74,171	27,122	-	-	6,259	2,614
Non-current liabilities	-	-	1,480	123	-	-	-	-
TOTAL LIABILITIES	8,125	12,934	75,651	27,245	-	-	6,259	2,614
NET ASSETS	(7,810)	(12,165)	(18,871)	(11,344)	-	-	(6,259)	(2,614)

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 2022

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	
	2022 \$'000	2021 \$'000	2022 \$'000	2021 \$'000	2022 \$'000	2021 \$'000	2022 \$'000	2021 \$'000
Assets								
Current assets	-	-	345,741	257,934	-	-	399,737	273,396
Non-current assets	-	-	203,354	112,486	-	-	206,453	113,694
TOTAL ASSETS	-	-	549,095	370,420	-	-	606,190	387,090
Liabilities								
Current liabilities	-	-	92,124	71,117	-	-	180,679	113,787
Non-current liabilities	-	-	10,260	10,376	-	-	11,740	10,499
TOTAL LIABILITIES	-	-	102,384	81,493	-	-	192,419	124,286
NET ASSETS	-	-	446,711	288,927	-	-	413,771	262,804

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 2022

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
Contribution to Capital Works Fund	3.3
Contracts for services	3.4
Supplies and services	3.5
Other expenses	3.6

3.1(a) Employee benefits expenses

	2022 \$'000	2021 \$'000
Employee benefits	158,417	148,430
Superannuation - defined contributions plans	14,640	13,094
Termination benefits	686	280
Total employee benefits expenses	173,743	161,804
Add: AASB 16 Non-monetary benefits (not included in employee benefits expense)	160	187
Less: Employee contributions (per the statement of comprehensive income)	(41)	(56)
Net employee benefits	173,862	161,935

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: the amount recognised in profit or loss of the Statement of Comprehensive Income comprises employer contributions paid to the GSS (concurrent contributions), WSS, GESB, or other superannuation funds.

Termination benefits: payable when employment is terminated before normal retirement date, or when an employee accepts an offer of benefits in exchange for the termination of employment. Termination benefits are recognised when the Department is demonstrably committed to terminating the employment of current employees according to a detailed formal plan without possibility of withdrawal or providing termination benefits as a result of an offer made to encourage voluntary redundancy. Benefits falling due more than 12 months after the end of the reporting period are discounted to present value.

Notes to the financial statements

For the year ended 30 June 2022

3.1(a) Employee benefits expenses (continued)

AASB 16 Non-monetary benefits: non-monetary employee benefits expenses, predominantly relating to the provision of vehicle and housing benefits that are recognised under AASB 16 which are excluded from the employee benefits expense.

Employee contributions: are contributions made to the Department by employees towards employee benefits that have been provided by the Department. This includes both AASB 16 and non-AASB 16 employee contributions.

3.1(b) Employee related provisions

	2022 \$'000	2021 \$'000
Current employee benefits provisions		
Annual leave	17,183	15,812
Long service leave	13,079	11,919
Deferred salary scheme	255	237
Total current employee related provisions	30,517	27,968
Non-current employee benefits provisions		
Long service leave	9,933	10,181
Total non-current employee related provisions	9,933	10,181
Total employee related provisions	40,450	38,149

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: classified as current, as there is no unconditional right to defer settlement for at least 12 months after the end of the reporting period. Assessments indicate that actual settlement of the liabilities is expected to occur as follows:

	2022 \$'000	2021 \$'000
Within 12 months of the end of the reporting period	11,953	11,061
More than 12 months after the end of the reporting period	5,230	4,751
	17,183	15,812

The provision for annual leave is calculated at the present value of expected payments to be made in relation to services provided by employees up to the reporting date.

Notes to the financial statements

For the year ended 30 June 2022

3.1(b) Employee related provisions (continued)

Long service leave liabilities: unconditional long service leave provisions are classified as current liabilities as the Department does not have an unconditional right 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 an unconditional right to defer the settlement of the liability until the employee has completed the requisite years of service. Assessments indicate that actual settlement of the liabilities is expected to occur as follows:

	2022 \$'000	2021 \$'000
Within 12 months of the end of the reporting period	3,415	2,926
More than 12 months after the end of the reporting period	19,597	19,174
	23,012	22,100

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.

Under the *Long Service Leave Act 1958* (LSL Act) casual employees who have been employed for more than 10 years and meet continuous service requirements are entitled to long service leave. A provision for casual employees who are currently still employed by WA Health as well as those casual employees who are no longer employed by WA Health, and who meet the criteria has been recognised in the financial statements.

Deferred salary scheme liabilities: classified as current where there is no unconditional right to defer settlement for at least 12 months after the end of the reporting period. Actual settlement of the liabilities is expected to occur as follows:

	2022 \$'000	2021 \$'000
Within 12 months of the end of the reporting period	-	-
More than 12 months after the end of the reporting period	255	237
Carrying amount at end of period	255	237

Notes to the financial statements

For the year ended 30 June 2022

3.1(b) Employee related provisions (continued)

Key sources of estimation uncertainty – long service leave

Key estimates and assumptions concerning the future are based on historical experience and various other factors that have a significant risk of causing a material adjustment to the carrying amount of assets and liabilities within the next financial year.

Several estimates and assumptions are used in calculating the Department's long service leave provision. These include:

- Expected future salary rates
- Discount rates
- Employee retention rates
- Expected future payments

Changes in these estimations and assumptions may impact on the carrying amount of the long service leave provision. Any gain or loss following revaluation of the present value of long service leave liabilities is recognised as employee benefits expense.

3.2 Grants and subsidies

	2022 \$'000	2021 \$'000
Recurrent		
Funding for the delivery of health services by statutory authorities within WA health (a):		
Child and Adolescent Health Service (b)	714,873	652,599
East Metropolitan Health Service (b)	1,406,899	1,311,895
North Metropolitan Health Service (b)	1,848,060	1,712,085
South Metropolitan Health Service (b)	1,679,744	1,583,107
WA Country Health Service (b)	1,794,979	1,590,429
Health Support Services (b)	801,754	309,769
PathWest Laboratory Medicine WA (b)	173,679	153,304
Queen Elizabeth II Medical Centre Trust (b)	745	745
Quadriplegic Centre (b)	6,115	6,032
Funding to other State Government agencies on COVID-19 Response (c)	118,890	78,504
Research and development grants	38,665	28,711
Spectacle subsidy scheme	33	36
Other grants and subsidies	20,712	12,739
Total grants and subsidies	8,605,148	7,439,955

Notes to the financial statements

For the year ended 30 June 2022

3.2 Grants and subsidies (continued)

- a) Includes the non-cash component of service appropriation.
- b) The *Health Services Act 2016* came into effect from 1 July 2016. Under this Act, several statutory authorities are established, they are the 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 a significant related party transactions.
- c) Under the National Partnership on COVID-19 Response Agreement, there is a provision for funds to be transferred from the State Health Department to other State Government agencies that have been requested to assist in the control of, and to help with, the COVID-19 Response. In 2021-22, the Department has transferred \$118.9 million to other State Government agencies via Department of Treasury (\$78.5 million in 2020-21).

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 schools, and community groups.

3.3 Contribution to Capital Works Fund

	2022 \$'000	2021 \$'000
Contribution to Capital Works Fund (a)	-	13,313
	-	13,313

- a) Includes \$13.3 million paid to the Capital Works fund in 2020-21 (Nil in 2021-22), an administered trust account of the Department, to fund the Capital Works programs to statutory authorities within WA health.

3.4 Contracts for services

	2022 \$'000	2021 \$'000
Health care services provided by external organisations (a)	511,161	479,018
Shared services provided by Health Support Services	32,324	21,481
Other contracts for services	56,152	26,014
Total contracts for services	599,637	526,513

- a) Includes \$11.1 million private hospital viability payment for COVID-19 Response in 2021-22 (\$2.4 million in 2020-21) under the National Partnership Agreement on the COVID-19 Response with the Commonwealth.

Contracts for services mainly consist of payments to external organisations for the purchase of health care services, including aboriginal health, blood and organs, chronic diseases, communicable diseases, environmental health, health promotion, home and community care, mental health, oral health, palliative care, patient transport, aged care, and pathology services.

Notes to the financial statements

For the year ended 30 June 2022

3.5 Supplies and services

	2022 \$'000	2021 \$'000
Medical supplies (a)	168,607	56,756
Communications	1,487	1,333
Hotel quarantine related expenses (b)	226,574	209,018
Other consumables	3,416	1,819
Total supplies and services	400,084	268,926

a) Includes \$100.3 million Pathology services provided to Community for COVID-19 testing (\$5.8 million in 2020-21).

b) Includes \$119.2 million hotel cost and \$107.3 million security cost for COVID-19 Response in 2021-22 (\$113.3 million and \$95.7 million respectively in 2020-21).

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.

3.6 Other expenses

	2022 \$'000	2021 \$'000
Act of grace payments (a)	73	-
Advertising	2,603	2,835
Computer related expenses	3,874	2,675
Ex-gratia payments (b)	4,562	5,455
Expected credit losses expense (c)	(8,377)	17,821
Freight and cartage	1,799	1,744
Insurance	203	195
Legal expenses	1,467	1,157
Other employee related expenses	2,133	4,082
Promotional expenses	141	10
Rental (d)	23,242	15,115
Repairs and maintenance (e)	7,283	1,547
Scholarships	1,283	1,184
Special functions	166	355
Subscriptions	1,826	1,860
Write-off of debt and waiver (f)	4,008	8,168
Worker's compensation insurance	(388)	226
Other	4,243	2,855
Total other expenses	50,141	67,284

Notes to the financial statements

For the year ended 30 June 2022

3.6 Other expenses (continued)

- a) **Act of grace payments:** in July 2021, the Department made a net payment of \$72,710 to the Commonwealth for Medicare claims unintentionally made at the incorrect rate.
- b) **Ex-gratia payments** under the Private Patient Scheme approved by the State Government, the Department commenced the ex-gratia payments towards patient fee debts since July 2015. The total amount of ex-gratia payments was \$4.6 million for 2021-22 (\$0.1 million for Child and Adolescent Health Service, \$0.8 million for East Metropolitan Health Service, \$1.4 million for North Metropolitan Health Service, \$1.8 million for South Metropolitan Health Service, \$0.5 million for WA Country Health Service).
- c) **Expected credit losses expense** is recognised for movement in allowance for impairment of trade receivables. Please refer to note 6.2.1 'Movement in the allowance for impairment of trade receivables'.
- d) **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; and
 - iv) Office rental is expensed as incurred as Memorandum of Understanding Agreements between the Department and the Department of Finance for the leasing of office accommodation contain significant substitution rights. In 2021-22 \$7.0 million has been incurred for short term leases for payment to vaccination clinics.
- e) **Repairs and maintenance costs** are recognised as expenses as incurred. Repair costs include \$5.5 million of repairs relating to quarantine hotels.
- f) **Write-off of debt and waivers:** *the Public Health Amendment (COVID-19 Response) Act 2020* provides the Chief Health Officer with the authority to waive the whole or part of the fee payable by hotel-quarantined persons under section 202(j), on the grounds of financial hardship or other circumstances where appropriate. The Chief Health Officer has waived a total of \$4.0 million in 2021-22 (\$8.1 million in 2020-21).

Notes to the financial statements

For the year ended 30 June 2022

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:

4.1 Income from State Government

	2022 \$'000	2021 \$'000
Appropriation received for the period:		
Service appropriation	5,482,082	5,186,754
COVID-19 appropriation	847,224	278,153
Fiona Stanley Hospital Transition appropriation	-	150
Amount authorised by other statutes		
<i>Salaries and Allowances Act 1975</i>	1,182	716
<i>Lotteries Commission Act 1990</i>	185,297	144,500
Total appropriation received	6,515,785	5,610,273
Income received from other public sector entities during the period:		
Department of Treasury - WA Future Health Research and Innovation Account	32,400	33,900
Department of Education - school health services for students attending public schools	9,937	9,464
WA Police - provide data service	148	147
Other	51	50
Total income received	42,536	43,561

Notes to the financial statements

For the year ended 30 June 2022

4.1 Income from State Government (continued)

	2022 \$'000	2021 \$'000
Liabilities assumed by the Treasurer or other public sector entities during the period:		
Transfer of COVID-19 medical equipment to statutory authorities within WA health	-	(872)
Total liabilities assumed	-	(872)
Resources received from other public sector entities during the period:		
Health Support Services - provide Rapid Antigen Testing Kits	1,849	-
Department of Education - accommodation	1,020	1,007
Landgate - valuation services and land information	149	148
State Solicitor's Office - legal service	781	690
Department of Finance - office accommodation management	57	36
Main Roads Western Australia	1	2
Total resources received	3,857	1,883
Royalties for Regions Fund		
Regional Community Services Account:		
Regional Workers Incentives	7,631	7,679
Find Cancer Early Program	808	-
Total Royalties for Regions Fund	8,439	7,679
Total income from State Government	6,570,617	5,662,524

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 are 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 receive the funds.

Liabilities assumed by the Treasurer or other public sector entities are recognised as income for an amount equivalent to the liability assumed when the liability is assumed.

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 Infrastructure and Headworks Account, and Regional Community Services Accounts are sub-funds within the over-arching 'Royalties for Regions Fund'. The recurrent funds are committed to projects and programs in WA regional areas and are recognised as income when the Department receives the funds.

Notes to the financial statements

For the year ended 30 June 2022

4.1 Income from State Government (continued)

Summary of consolidated account appropriations

For the year ended 30 June 2022

	2022 Budget estimate \$'000	2022 Supplementary funding \$'000	2022 Revised budget \$'000	2022 Actual \$'000	2022 Variance \$'000
Delivery of services					
Item 52 Net amount appropriated to deliver services	5,580,807	-	5,580,807	6,329,306	748,499
Section 25 Transfer of service appropriation	-	-	-	-	-
Amount Authroised by Other Statutes					
- <i>Salaries and Allowances Act 1975</i>	1,182	-	1,182	1,182	-
- <i>Lotteries Commission Act 1990</i>	135,699	-	135,699	185,297	49,598
Total appropriations provided to deliver services	5,717,688	-	5,717,688	6,515,785	798,097
Capital					
Item 124 Capital appropriation	257,894	-	257,894	379,255	121,361
Administered transactions					
Item 36 Administered grants, subsidies and other transfer payments	11,985	-	11,985	8,420	(3,565)
Item 109 Administered capital appropriation	26,960	-	26,960	22,325	(4,635)
Item 113 Digital Capability	-	-	-	25,225	25,225
Total administered transactions	38,945	-	38,945	55,970	17,025
GRAND TOTAL	6,014,527	-	6,014,527	6,951,010	936,483

Notes to the financial statements

For the year ended 30 June 2022

4.2 User charges and fees

	2022 \$'000	2021 \$'000
Licence and registration fees	3,742	3,718
Cross border charges	6,843	10,921
Other use charges and fees	2,788	5,331
Total user charges and fees	13,373	19,970

Revenue is recognised at the transaction price when the Department transfers control of the services to customers. Revenue is recognised for the major activities as follows:

Revenue is recognised at a point-in-time for \$13,299,593.

Revenue is recognised over-time for \$73,797.

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 2020-21 Budget Statements, the Department retained \$259.8 million in 2021-22 (\$256.9 million in 2020-21) from the following:

- Proceeds from fees and charges
- Sale of goods
- Commonwealth specific purpose grants
- Other departmental revenue

Notes to the financial statements

For the year ended 30 June 2022

4.3 Commonwealth grants and contributions

	2022 \$'000	2021 \$'000
Recurrent grants - cash		
National Health Reform Agreement (NHRA) (a):		
Sututory authorities within WA health	2,319,207	2,116,975
Public health division within the Department	47,842	46,115
Specific purpose grants:		
COVID-19 Response (b)	698,584	188,377
Department of Veterans' Affairs	62,755	41,750
Aged Care Programs	44,425	45,776
Public Health Outcome Funding Agreement - Vaccines	1,984	1,672
Dental	9,748	9,624
Other programs	29,773	14,010
Recurrent grants - non-cash		
Essential vaccines received free of charge	41,686	42,505
Total Commonwealth grants and contributions	3,256,004	2,506,804

- a) As 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 new funding arrangement established under the Agreement 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 of Health 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 National Health Reform Agreement, the Commonwealth Government also provides public health funding to the Department of Health.
- b) As part of the National Partnership Agreement, the Commonwealth contributed \$698.6 million in 2021-22 (\$188.4 million in 2020-21) to the Department in response to COVID-19.

Recurrent grants are recognised as income when the grants are receivable.

Capital grants are recognised as income when the Department achieves milestones specified in the grant agreement.

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 to construct assets 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 2022

4.4 Other grants and contributions

	2022 \$'000	2021 \$'000
Research grants	687	402
Contributions - Health programs WA are participating	-	470
Other	908	-
Total other grants and contributions	1,595	872

4.5 Other income

	2022 \$'000	2021 \$'000
Hotel quarantine recovery (a)	37,826	76,095
General public contributions and donations	4,000	4,000
Other income	303	666
Total other income	42,129	80,761

a) *The Public Health Amendment (COVID-19 Response) Act 2020* provides the Chief Health Officer with the authority to recover a prescribed fee from hotel-quarantined persons under section 202(g), and also allows the Chief Health Officer to recover reasonable costs and expenses for legally-required cleaning and disinfecting of premises or vehicles under section 202(m).

4.6 Gains/(losses) on disposal

	2022 \$'000	2021 \$'000
Net proceeds from disposal of non-current assets		
Property, plant and equipment	-	10
Non-current assets classified as assets held for sale	-	115
Carrying amount of non-current assets		
Property, plant and equipment	(8)	-
Non-current assets classified as assets held for sale	-	(109)
Net gains/(losses)	(8)	16

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 the carrying amount of the asset and related selling expenses. Gains and losses are recognised in profit or loss in the statement of comprehensive income.

Notes to the financial statements

For the year ended 30 June 2022

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 2022	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 2021										
Gross carrying amount	18,988	1,946	133	3,761	261	94	2,538	-	75	27,796
Accumulated depreciation	-	(79)	(16)	(298)	(203)	(57)	(1,625)	-	-	(2,278)
Accumulated impairment loss	-	-	-	-	-	-	-	-	-	-
Carrying amount at start of period	18,988	1,867	117	3,463	58	37	913	-	75	25,518
Additions	-	-	1	-	25	-	197	78,951	-	79,174
Disposals	-	-	-	-	-	-	(7)	(2)	-	(9)
Expensed	-	-	-	-	-	-	(5)	-	-	(5)
Transfers from/(to) other reporting entities (a)	-	-	-	-	-	-	-	-	-	-
Revaluation increments/(decrements)	819	226	50	-	-	-	-	-	-	1,095
Impairment losses	-	-	-	-	-	-	-	-	-	-
Impairment losses reversed	-	-	-	-	-	-	-	-	-	-
Depreciation	-	(75)	(16)	(752)	(17)	(8)	(212)	-	-	(1,080)
Carrying amount at 30 June 2022	19,807	2,018	152	2,711	66	29	886	78,949	75	104,693
Gross carrying amount	19,807	2,172	184	3,761	286	94	2,723	78,949	75	108,051
Accumulated depreciation	-	(154)	(32)	(1,050)	(220)	(65)	(1,837)	-	-	(3,358)
Accumulated impairment loss	-	-	-	-	-	-	-	-	-	-

Notes to the financial statements

For the year ended 30 June 2022

5.1 Infrastructure, property, plant and equipment (continued)

Year ended 30 June 2021	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 2020										
Gross carrying amount	18,681	1,833	133	611	235	73	2,034	426	75	24,101
Accumulated depreciation	-	-	-	(123)	(183)	(52)	(1,437)	-	-	(1,795)
Accumulated impairment loss	-	-	-	-	-	-	-	-	-	-
Carrying amount at start of year	18,681	1,833	133	488	52	21	597	426	75	22,306
Additions	-	97	-	3,150	26	21	5,340	19	-	8,653
Disposals	(31)	(25)	-	-	-	-	(4,164)	-	-	(4,220)
Transfers from/(to) other reporting entities (a)	-	-	-	-	-	-	(672)	(19)	-	(691)
Revaluation increments/(decrements)	338	41	-	-	-	-	-	-	-	379
Expensed	-	-	-	-	-	-	-	(426)	-	(426)
Depreciation	-	(79)	(16)	(175)	(20)	(5)	(188)	-	-	(483)
Carrying amount at 30 June 2021	18,988	1,867	117	3,463	58	37	913	-	75	25,518
Gross carrying amount	18,988	1,946	133	3,761	261	94	2,538	-	75	27,796
Accumulated depreciation	-	(79)	(16)	(298)	(203)	(57)	(1,625)	-	-	(2,278)
Accumulated impairment loss	-	-	-	-	-	-	-	-	-	-

- a) The Department of Planning, Lands and Heritage (DPLH) is the only Department with the power to sell Crown land. The land is transferred to DPLH for sale and the Department accounts for the transfer as a distribution to owner.

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 2022

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; and
- 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) and recognised annually to ensure that the carrying amount does not differ materially from the asset's fair value at the end of the reporting period.

Land and buildings were revalued as at 1 July 2021 by Landgate. The valuations were performed during the year ended 30 June 2022 and recognised at 30 June 2022. In undertaking the revaluation, fair value was determined by reference to market values for land: \$3,155,000 (2021: \$2,994,000) and buildings \$74,000 (2021: \$64,000). For the remaining balance, fair value of buildings was determined on the basis of current replacement cost and fair value of land was determined on the basis of comparison with market evidence for land with low level utility (high restricted use land).

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 2022.

Site infrastructure 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 2022

5.1.1 Depreciation and impairment charge for the period

	Notes	2022 \$'000	2021 \$'000
Depreciation			
Buildings	5.1	75	79
Site infrastructure	5.1	16	16
Leasehold improvement	5.1	752	175
Computer equipment	5.1	17	20
Furniture and fittings	5.1	8	5
Other plant and equipment	5.1	212	188
Total depreciation for the period		1,080	483

As at 30 June 2022 there were no indications of impairment to property, plant and equipment or site infrastructure.

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	4 to 5 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 should be 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 2022

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 2022

1 July 2021

Gross carrying amount

Accumulated amortisation

Carrying amount at start of period

Additions

Disposals

Expensed

Amortisation expense

Carrying amount at 30 June 2022

Gross carrying amount

Accumulated amortisation

	Computer software \$'000	Works in progress \$'000	Total \$'000
	1,454	186	1,640
	(97)	-	(97)
	1,357	186	1,543
	-	131	131
	-	-	-
	-	(283)	(283)
	(291)	-	(291)
	1,066	34	1,100
	1,454	34	1,488
	(388)	-	(388)

Notes to the financial statements

For the year ended 30 June 2022

5.2 Intangible assets (continued)

	Computer software \$'000	Works in progress \$'000	Total \$'000
Year ended 30 June 2021			
1 July 2020			
Gross carrying amount	-	938	938
Accumulated amortisation	-	-	-
Carrying amount at start of period	-	938	938
Additions	1,454	702	2,156
Capitalised	-	(1,454)	(1,454)
Amortisation expense	(97)	-	(97)
Carrying amount at 30 June 2021	1,357	186	1,543
Gross carrying amount	1,454	186	1,640
Accumulated amortisation	(97)	-	(97)

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.

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, and
- the ability to measure reliably the expenditure attributable to the intangible asset during its development.

Acquisitions of intangible assets costing \$5,000 or more and internally generated intangible assets costing \$50,000 or more that comply with the recognition criteria as per AASB 138.57 (as noted below), are capitalised.

Costs incurred below these thresholds are immediately expensed directly to the Statement of Comprehensive Income.

Costs incurred in the research phase of a project are immediately expensed.

Notes to the financial statements

For the year ended 30 June 2022

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

	2022 \$'000	2021 \$'000
Computer software	291	97
Total amortisation for the period	291	97

As at 30 June 2022 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:

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 2022

5.3 Right-of-use assets

Year ended 30 June 2022

1 July 2021

Gross carrying amount

Accumulated depreciation

Carrying amount at start of period

Additions

Disposals

Transfers

Depreciation

Carrying amount at 30 June 2022

Gross carrying amount

Accumulated depreciation

Year ended 30 June 2021

1 July 2020

Gross carrying amount

Accumulated depreciation

Carrying amount at start of period

Additions

Disposals

Derecognition

Depreciation

Carrying amount at 30 June 2021

Gross carrying amount

Accumulated depreciation

	Buildings \$'000	Vehicles \$'000	Total \$'000
1 July 2021			
Gross carrying amount	629	652	1,281
Accumulated depreciation	(295)	(313)	(608)
Carrying amount at start of period	334	339	673
Additions	2,474	8	2,482
Disposals	-	-	-
Transfers	-	-	-
Depreciation	(540)	(151)	(691)
Carrying amount at 30 June 2022	2,268	196	2,464
Gross carrying amount	3,042	573	3,615
Accumulated depreciation	(774)	(377)	(1,151)
Year ended 30 June 2021			
1 July 2020			
Gross carrying amount	426	647	1,073
Accumulated depreciation	(89)	(196)	(285)
Carrying amount at start of period	337	451	788
Additions	203	6	209
Disposals	-	(1)	(1)
Derecognition	-	-	-
Depreciation	(206)	(117)	(323)
Carrying amount at 30 June 2021	334	339	673
Gross carrying amount	629	652	1,281
Accumulated depreciation	(295)	(313)	(608)

Notes to the financial statements

For the year ended 30 June 2022

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 including the following:

- 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, and
- restoration costs, including dismantling and removing the underlying asset

This includes all leased assets other than investment property ROU 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 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 2022

5.3 Right-of-use assets (continued)

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

	2022 \$'000	2021 \$'000
Depreciation expense of right-of-use assets	691	382
Lease interest expense	44	17
Expenses relating to variable lease payments not included in lease liabilities	47	287
Short-term leases	7,029	570
Low-value leases	74	78
Operating leases	15,017	14,180
Total amount recognised in the statement of comprehensive income	22,902	15,514

The total cash outflow for right-of-use leases in 2022 was \$687,081 (2021: \$412,113).

Department's leasing activities and how these are accounted for:

- The Department has leases for vehicles and warehouses.
- The Department has also entered into a Memorandum of Understanding Agreements (MOU) with the Department of Finance for the leasing of office accommodation. These are not recognised under AASB 16 because of substitution rights held by the Department of Finance and are accounted for as an expense as incurred.
- The Department recognises leases as right-of-use assets and associated lease liabilities in the Statement of Financial Position.
- The corresponding lease liabilities in relation to these right-of-use assets have been disclosed in note 7.2 'Lease liabilities'.

Notes to the financial statements

For the year ended 30 June 2022

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

	2022 \$'000	2021 \$'000
Current		
Drug supplies (at cost)	10,968	10,695
Medical equipment (at cost) (a)	34,054	36,742
Total inventories	45,022	47,437

a) Includes medical equipment purchased as part of the COVID-19 Response, to be distributed to statutory authorities within WA health when required.

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.

Inventories held for distribution are measured at cost unless they are no longer required, in which case they are measured at net realisable value.

Notes to the financial statements

For the year ended 30 June 2022

6.2 Receivables

	2022 \$'000	2021 \$'000
Current		
Trade receivables (a)	17,599	31,733
Allowance for impairment of trade receivables (b)	(9,722)	(18,099)
Accrued revenue	34,901	29,186
GST receivable (c)	56,940	45,446
Total current receivables	99,718	88,266

- a) Trade receivables included \$16.1 million receivables from hotel-quarantined persons in 2021-22 (\$29.6 million in 2020-21).
- b) Allowance for impairment of trade receivables included a \$9.2 million provision that relates to hotel-quarantined persons (\$17.7 million in 2020-21).
- c) Accounting procedure for Goods and Services Tax

Rights to collect amounts receivable from the Australian Taxation Office and responsibilities to make payments for GST have been assigned to the Department of Health. 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 of Health 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 Health Service. Upon the receipt of tax invoices, GST receivables for the GST group are recorded in the accounts of the Department of Health. Additionally, the Department recognises GST receivables on its own accrued expenses.

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 subsequently measured at amortised cost using the effective interest method, less an allowance for impairment.

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 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 3.6 for the amount of ECLs expensed in this financial year.

Notes to the financial statements

For the year ended 30 June 2022

6.2.1 Movement in the allowance for impairment of trade receivables

	2022 \$'000	2021 \$'000
Reconciliation of changes in the allowance for impairment of trade receivables		
Opening balance	18,099	278
Expected credit losses expense	(8,397)	17,821
Amounts written off during the period	20	-
Balance at end of period	9,722	18,099

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 instruments disclosures'.

The Department does not hold any collateral as security or other credit enhancements for trade receivables.

6.3 Amounts receivable for services (Holding Account)

	2022 \$'000	2021 \$'000
Current	-	-
Non-current	93,690	81,479
Balance at end of period	93,690	81,479

Amounts receivable for services represent the non-cash component of service appropriation. 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 considered not impaired (i.e. there is no expected credit loss of the holding accounts).

Notes to the financial statements

For the year ended 30 June 2022

6.4 Other assets

	2022 \$'000	2021 \$'000
Current		
Prepayments (a)	7,351	5,994
Total current assets	7,351	5,994
Non-current		
Prepayments (a)	25	-
Total non-current assets	25	-
Total other assets at end of period	7,376	5,994

- a) Other assets include prepayments which represent payments in advance of receipt of goods or services or that part of expenditure made in one accounting period covering a term extending beyond that period. \$5.5 million is included in prepayments to the National Blood Authority under the National Blood Agreement (\$3.1 million in 2020-21)

6.5 Payables

	2022 \$'000	2021 \$'000
Current		
Trade payables	16,773	8,883
Accrued salaries	4,215	3,752
Accrued expenses	128,590	72,645
Total payables at end of period	149,578	85,280

Payables are recognised at the amounts payable when the Department becomes obliged to make future payments as a result of a purchase of assets or services. The carrying amount is equivalent to fair value as settlement is generally within 20 days.

Accrued salaries represent the amount due to staff but unpaid at the end of the reporting period. Accrued salaries are settled within a fortnight after the reporting period. The Department considers the carrying amount of accrued salaries to be equivalent to its fair value.

Notes to the financial statements

For the year ended 30 June 2022

6.6 Contract liabilities

	2022 \$'000	2021 \$'000
Current	74	67
Non-current	-	-
Total contract liabilities at end of period	74	67

	2022 \$'000	2021 \$'000
Reconciliation of changes in contract liabilities		
Opening balance	67	88
Additions	74	67
Revenue recognised in the reporting period	(67)	(88)
Total contract liabilities at end of period	74	67

The Department's contract liabilities relate to licence and registration fees yet to be performed at the end of the reporting period. Typically, a contract payment is received upfront for 12 months of continuing support services.

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 2022

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

	2022 \$'000	2021 \$'000
Cash and cash equivalents	128,508	80,638
Restricted cash and cash equivalents	123,619	55,542
Total cash and cash equivalents at end of period	252,127	136,180

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

The accrued salaries suspense account (see note 7.1.2 'Restricted cash and cash equivalents') consists of amounts paid, from Department appropriations for salaries expense, into a Treasury suspense account to meet the additional cash outflow for employee salary payments in reporting period with 27 pays instead of the normal 26. No interest is received on this account.

Notes to the financial statements

For the year ended 30 June 2022

7.1.2 Restricted cash and cash equivalents

	2022 \$'000	2021 \$'000
Restricted cash and cash equivalents		
Current		
Commonwealth specific purpose grants (a)	82,157	24,050
Donation - HBF Detect Snapshot	1,159	1,158
Grants - WA Detect Schools COVID-19 Project	2	2
Telethon - WA Child Research Fund Account (c)	11,356	10,702
WA Future Health Research and Innovation Account (b)	24,464	15,149
Total current	119,138	51,061
Non-current		
Accrued salaries suspense account (d)	4,481	4,481
Total non-current	4,481	4,481
Total restricted cash and cash equivalents	123,619	55,542

- a) Funds held for specific purposes include COVID-19 Response (\$51.2 million), NPA - Essential Vaccines (\$6.7 million), Health Innovation Fund (\$4.7 million), WA Childrens Hospice (\$7.5 million) and other initiatives and programs (\$12.0 million).
- b) Funds received from the State, to support future health research and innovation. Refer to note 9.9 'Special purpose accounts'.
- c) Funds received from the Channel 7 Telethon Trust, the Department and other donors to fund and promote child and adolescent health research in Western Australia. Refer to note 9.9 'Special purpose accounts'.
- d) Funds held in the suspense account for the purpose of meeting the 27th pay in a reporting period that occurs every 11th year. This account is classified as non-current for 10 out of 11 years.

Notes to the financial statements

For the year ended 30 June 2022

7.1.3 Reconciliation of net cost of services to net cash flows used in operating activities

	Notes	2022 \$'000	2021 \$'000
Net cost of services		(6,517,766)	(5,870,353)
Non-cash items:			
Depreciation and amortisation expense	5.1.1, 5.2.1, 5.3.1	2,062	964
Expected credit losses expense	6.2.1	(8,397)	17,821
Resources received	4.1	3,857	1,883
Net (gain)/loss from disposal of property, plant and equipment	4.6	8	(16)
Finance costs	7.3	44	17
Transfer of non-cash funding to statutory authorities within WA health	4.1	411,661	403,727
Write down of inventory	3.6	435	-
Write-off of debt and waiver	3.6	4,008	8,168
Adjustments for other non-cash items		4,886	(8,786)
(Increase)/decrease in assets:			
Inventories	6.1	2,415	(26,948)
Receivables	6.2, 6.3	(23,663)	(7,984)
Other assets	6.4	(1,382)	(269)
Increase/(decrease) in liabilities:			
Payables	6.5	64,298	(12,020)
Contract liabilities	6.6	7	(21)
Lease liabilities	7.2	1,527	(77)
Employee related provisions	3.1(b)	2,301	5,295
Net cash used in operating activities		(6,053,699)	(5,488,599)

Notes to the financial statements

For the year ended 30 June 2022

7.2 Lease liabilities

	2022 \$'000	2021 \$'000
Current	510	472
Non-current	1,807	318
Total lease liabilities at end of period	2,317	790

Initial measurement

The Department measures a lease liability, at the commencement date, at the present value of the lease payments that are not paid at that date. 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.

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 so as 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 2022

7.3 Finance costs

	2022 \$'000	2021 \$'000
Lease interest expense	44	17
Finance costs expensed	44	17

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

	2022 \$'000	2021 \$'000
Capital expenditure commitments, being contracted capital expenditure additional to the amounts reported in the financial statements are payable as follows:		
Within 1 year	55,260	-
Later than 1 year and not later than 5 years	55	-
Later than 5 years	-	-
	55,315	-

7.4.2 Private sector contracts for the provision of health services

	2022 \$'000	2021 \$'000
Expenditure commitments in relation to private sector organisations contracted for at the end of the reporting period but not recognised as liabilities, are payable as follows:		
Within 1 year	497,950	403,765
Later than 1 year and not later than 5 years	53,649	220,947
Later than 5 years	429	4,432
	552,028	629,144

Notes to the financial statements

For the year ended 30 June 2022

7.4.3 Other expenditure commitments

	2022 \$'000	2021 \$'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	69,912	2,284
Later than 1 year and not later than 5 years	68,790	976
Later than 5 years	-	-
	138,702	3,260

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, finance leases, 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.

During 2020-21 financial year, a significant credit risk arose with the hotel-quarantined programme due to the COVID-19 pandemic. To protect the peoples of Australia, hotel quarantine was introduced for international arrivals and people from high risk areas. From 19 July 2020, people entering Western Australia were to be charged a contribution fee towards the cost of hotel quarantine with the further decision that the Department will administer this process. All quarantined persons may apply for a waiver to the fees due to financial hardship or other consideration that is appropriate in the circumstances. The Public Health Amendment (COVID-19 Response) Act 2020 allows the Chief Health Officer to assess the fee waiver request and approve the whole or part of the fee waive to the person. With invoices for quarantine issued after departure of the person with payment terms of 30 days, the credit risk is increased.

Notes to the financial statements

For the year ended 30 June 2022

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.

All borrowings are due to the WATC and are repayable at fixed rates with varying maturities. Other than as detailed in the interest rate sensitivity analysis table at note 8.1(e) 'Interest rate sensitivity analysis', the Department is not exposed to interest rate risk because the majority of cash and cash equivalents and restricted cash are non-interest bearing and it has no borrowings other than the Treasurer's advance (non-interest bearing), WATC borrowings and finance leases (fixed interest rate).

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:

	2022 \$'000	2021 \$'000
Financial assets		
Cash and cash equivalents	128,508	80,638
Restricted cash and cash equivalents	123,619	55,542
Financial assets at amortised cost (a)	136,468	124,299
Total financial assets	388,595	260,479
Financial liabilities		
Financial liabilities at amortised cost (b)	151,895	86,070
Total financial liabilities	151,895	86,070

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 2022

8.1 Financial risk management (continued)

c) Credit risk exposure

The following table details the credit risk exposure on the Department's trade receivables using a provision matrix.

			Days past due				181-360 days	>361 days
	Total \$'000	Current \$'000	<30 days \$'000	31-60 days \$'000	61-90 days \$'000	91-180 days \$'000	days \$'000	\$'000
30 June 2022								
Expected credit loss rate		0.57%	4.46%	4.72%	36.43%	47.37%	63.23%	68.48%
Estimated total gross carrying amount at default	17,599	871	448	339	1,054	2,776	5,931	6,180
Expected credit losses	(9,722)	(5)	(20)	(16)	(384)	(1,315)	(3,750)	(4,232)
			Days past due				181-360 days	>361 days
	Total \$'000	Current \$'000	<30 days \$'000	31-60 days \$'000	61-90 days \$'000	91-180 days \$'000	days \$'000	\$'000
30 June 2021								
Expected credit loss rate		46.00%	67.40%	76.50%	62.30%	73.00%	39.90%	21.80%
Estimated total gross carrying amount at default	31,733	14,215	5,121	4,129	4,103	2,827	223	1,115
Expected credit losses	(18,099)	(6,537)	(3,454)	(3,157)	(2,556)	(2,063)	(89)	(243)

Notes to the financial statements

For the year ended 30 June 2022

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
2022											
Financial Assets											
Cash and cash equivalents	-	128,508	-	-	128,508	128,508	128,508	-	-	-	-
Restricted cash and cash equivalents	-	123,619	-	-	123,619	123,619	123,619	-	-	-	-
Receivables (a)	-	42,778	-	-	42,778	42,778	22,113	1,422	17,294	1,949	-
Amounts receivable for services	-	93,690	-	-	93,690	93,690	-	-	-	-	93,690
		388,595	-	-	388,595	388,595	274,240	1,422	17,294	1,949	93,690
Financial Liabilities											
Payables	-	149,578	-	-	149,578	149,578	126,794	3,968	18,363	453	-
Lease liabilities (b)	2.50	2,317	2,317	-	-	2,317	15	51	444	1,702	105
		151,895	2,317	-	149,578	151,895	126,809	4,019	18,807	2,155	105

(a) The amount of receivables excludes the GST receivable from the ATO (statutory receivable).

(b) The amount of lease liabilities includes \$2.1 million from leased buildings and \$0.2 million from leased vehicles.

Notes to the financial statements

For the year ended 30 June 2022

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
2021											
Financial Assets											
Cash and cash equivalents	-	80,638	-	-	80,638	80,638	80,638	-	-	-	-
Restricted cash and cash equivalents	-	55,542	-	-	55,542	55,542	55,542	-	-	-	-
Receivables (a)	-	42,820	-	-	42,820	42,820	20,538	7,435	2,141	12,706	-
Amounts receivable for services	-	81,479	-	-	81,479	81,479	-	-	-	-	81,479
		260,479	-	-	260,479	260,479	156,718	7,435	2,141	12,706	81,479
Financial Liabilities											
Payables	-	85,280	-	-	85,280	85,280	83,436	238	384	1,222	-
Lease liabilities (b)	2.10	790	790	-	-	790	142	18	313	312	5
		86,070	790	-	85,280	86,070	83,578	256	697	1,534	5

(a) The amount of receivables excludes the GST receivable from the ATO (statutory receivable).

(b) The amount of lease liabilities includes \$2.1 million from leased buildings and \$0.2 million from leased vehicles.

e) Interest rates sensitivity analysis

The Department's financial assets and liabilities were not subject to interest rate sensitivity at the end of the current and previous period.

8.2 Contingent assets and liabilities

Contingent assets and contingent liabilities are not recognised in the statement of financial position but are disclosed and, if quantifiable, are measured at the best estimate.

Contingent assets and liabilities are presented inclusive of GST receivable or payable respectively.

Notes to the financial statements

For the year ended 30 June 2022

8.2.1 Contingent assets

The following contingent assets are excluded from the assets included in the financial statements:

	2022 \$'000	2021 \$'000
Cross border receipts for residents from other Australian jurisdictions treated in WA hospitals	7,098	12,071

8.2.2 Contingent liabilities

The following contingent liabilities are excluded from the liabilities included in the financial statements:

	2022 \$'000	2021 \$'000
Cross border charges for WA residents treated in hospitals in other Australian jurisdictions	12,792	22,221

Hotel quarantine compensation payments

The *Public Health Act 2016* sets out an entitlement to compensation where a person has suffered loss or damaged because of the exercise or purported exercise of a power under section 157(1)(h), 182 or 190(1)(f) or (g) of the Act. There are a few applications for compensation under consideration. The value is yet to be determined.

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 2022

8.3 Fair value measurements

Assets measured at fair value:

	Notes	Level 1 \$'000	Level 2 \$'000	Level 3 \$'000	Total \$'000
2022					
Land	5.1				
Vacant land		-	15,376	-	15,376
Specialised		-	-	4,431	4,431
Buildings	5.1				
Vacant building		-	74	-	74
Specialised		-	-	1,944	1,944
Site infrastructure	5.1	-	-	152	152
		-	15,450	6,527	21,977
	Notes	Level 1 \$'000	Level 2 \$'000	Level 3 \$'000	Total \$'000
2021					
Land	5.1				
Vacant land		-	14,617	-	14,617
Specialised		-	-	4,371	4,371
Buildings	5.1				
Vacant building		-	64	-	64
Specialised		-	-	1,803	1,803
Site infrastructure	5.1	-	-	117	117
		-	14,681	6,291	20,972

There were no transfers between levels 1, 2 or 3 during the current and previous period.

Valuation techniques used to derive Level 2 fair values

Level 2 fair values of non-current assets held for sale, land and buildings (office accommodation) are derived using the market approach. Market evidence of sales prices of comparable land and buildings (office accommodation) in close proximity is used to determine price per square metre.

Non-current assets held for sale have been written down to fair value less costs to sell. Fair value has been determined by reference to market evidence of sales prices of comparable assets.

Notes to the financial statements

For the year ended 30 June 2022

8.3 Fair value measurements (continued)

Fair value measurements using significant unobservable inputs (Level 3)

	Land \$'000	Buildings \$'000	Site infrastructure \$'000	Total \$'000
2022				
Fair value at start of period	4,371	1,803	117	6,291
Additions	-	-	-	-
Revaluation increments/(decrements) recognised in Other Comprehensive Income	60	215	51	326
Disposals	-	-	-	-
Depreciation expense	-	(74)	(16)	(90)
Fair value at end of period	4,431	1,944	152	6,527
2021				
Fair value at start of period	4,188	1,775	133	6,096
Additions	-	97	-	97
Revaluation increments/(decrements) recognised in Other Comprehensive Income	213	-	-	213
Disposals	(30)	(69)	-	(99)
Depreciation expense	-	-	(16)	(16)
Fair value at end of period	4,371	1,803	117	6,291

Valuation processes

There were no changes in valuation techniques during the period. However, the valuation processes have been significantly impacted by the COVID-19 pandemic.

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 instructions require 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.

Land (Level 3 fair values)

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 is selected by Landgate and represents the application of a significant Level 3 input in this valuation methodology. 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.

Notes to the financial statements

For the year ended 30 June 2022

8.3 Fair value measurements (continued)

Buildings and infrastructure (Level 3 fair values)

Fair value for existing use specialised buildings and infrastructure assets is determined by reference to the cost of replacing the remaining future economic benefits embodied in the asset, i.e. the current replacement cost. 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, consumed economic benefit/obsolescence of asset which is estimated by the Western Australian Land Information Authority (Valuations and Property Analytics). The fair value measurement is sensitive to the estimate of consumption/obsolescence, with higher values of the estimate correlating with lower estimated fair values of buildings and infrastructure.

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 an existing use basis. The existing use basis recognises that restrictions or limitations have been placed on their use and disposal when they are not determined to be surplus to requirement. These restrictions are imposed by virtue of the assets being held to deliver a specific community service.

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 were no events occurring after the reporting period which had significant financial effects on these financial statements.

Notes to the financial statements

For the year ended 30 June 2022

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 1101 *Application of Australian Accounting Standards and Other Pronouncements* or by an exemption from TI 1101. Where applicable, the Department plans to apply the following Australian Accounting Standards from their application date.

		Operative for reporting periods beginning on/after
AASB 17	Insurance Contracts This Standard establishes principles for the recognition, measurement, presentation and disclosure of insurance contracts. The Department has not assessed the impact of the Standard.	1 Jan 2023
AASB 2020-1	Amendments to Australian Accounting Standards – Classification of Liabilities as Current or Non-current This Standard amends AASB 101 to clarify requirements for the presentation of liabilities in the statement of financial position as current or non-current. There is no financial impact.	1 Jan 2023
AASB 2020-3	Amendments to Australian Accounting Standards – Annual Improvements 2018–2020 and Other Amendments This Standard amends: (a) AASB 1 to simplify the application of AASB 1; (b) AASB 3 to update a reference to the Conceptual Framework for Financial Reporting; (c) AASB 9 to clarify the fees an entity includes when assessing whether the terms of a new or modified financial liability are substantially different from the terms of the original financial liability; (d) AASB 116 to require an entity to recognise the sales proceeds from selling items produced while preparing property, plant and equipment for its intended use and the related cost in profit or loss, instead of deducting the amounts received from the cost of the asset; (e) AASB 137 to specify the costs that an entity includes when assessing whether a contract will be loss-making; and (f) AASB 141 to remove the requirement to exclude cash flows from taxation when measuring fair value. There is no financial impact.	1 Jan 2022

Notes to the financial statements

For the year ended 30 June 2022

9.2 Future impact of Australian Accounting Standards not yet operative (continued)

Operative for
reporting periods
beginning on/after

AASB 2020-6 *Amendments to Australian Accounting Standards – Classification of Liabilities as Current or Non-current – Deferral of Effective Date*

This Standard amends AASB 101 to defer requirements for the presentation of liabilities in the statement of financial position as current or non-current that were added to AASB 101 in AASB 2020-1. 1 Jan 2022

There is no financial impact.

AASB 2021-2 *Amendments to Australian Accounting Standards – Disclosure of Accounting Policies and Definition of Accounting Estimates*

This Standard amends: (a) AASB 7, to clarify that information about measurement bases for financial instruments is expected to be material to an entity's financial statements; (b) AASB 101, to require entities to disclose their material accounting policy information rather than their significant accounting policies; (c) AASB 108, to clarify how entities should distinguish changes in accounting policies and changes in accounting estimates; (d) AASB 134, to identify material accounting policy information as a component of a complete set of financial statements; and (e) AASB Practice Statement 2, to provide guidance on how to apply the concept of materiality to accounting policy disclosures. 1 Jan 2023

There is no financial impact.

AASB 2021-6 *Amendments to Australian Accounting Standards – Disclosure of Accounting Policies: Tier 2 and Other Australian Accounting Standards*

This standard amends This standard amends: (a) AASB 1049, to require entities to disclose their material accounting policy information rather than their significant accounting policies; (b) AASB 1054 to reflect the updated accounting policy terminology used in AASB 101 Presentation of Financial Statements; and (c) AASB 1060 to required entities to disclose their material accounting policy information rather than their significant accounting policy and to clarify that information about measurement bases for financial instruments is expected to be material to an entity's financial statements. 1 Jan 2023

There is no financial impact.

Notes to the financial statements

For the year ended 30 June 2022

9.2 Future impact of Australian Accounting Standards not yet operative (continued)

		Operative for reporting periods beginning on/after
AASB 2021-7	<i>Amendments to Australian Accounting Standards – Effective Date of Amendments to AASB 10 and AASB 128 and Editorial Corrections</i> This standard further defers (to 1 January 2025) the amendments to AASB 10 and AASB 128 relating to the sale or contribution of assets between an investor and its associated or joint venture. The standard also includes editorial corrections. There is no financial impact.	1 Jan 2022

Notes to the financial statements

For the year ended 30 June 2022

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 expenditures 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

	2022	2021
Compensation band (\$)		
640,001 - 650,000	-	1
630,001 - 640,000	1	-
610,001 - 620,000	-	1
550,001 - 560,000	1	-
540,001 - 550,000	-	1
510,001 - 520,000	1	1
370,001 - 380,000	1	1
320,001 - 330,000	1	-
310,001 - 320,000	-	1
290,001 - 300,000	1	-
250,001 - 260,000	1	1
150,001 - 160,000	1	-
140,001 - 150,000	-	1
	8	8
	2022	2021
	\$'000	\$'000
Short-term employee benefits	2,942	2,982
Post-employment benefits	288	278
Other long-term benefits	(118)	130
Total compensation of senior officers	3,112	3,390

Total compensation includes the superannuation expense incurred by the Department in respect of senior officers.

Notes to the financial statements

For the year ended 30 June 2022

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; and
- 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)
- Assets transferred to other government agencies (note 4.1)
- Equity contribution (note 9.11)
- Grants and subsidies to statutory authorities within WA health (note 3.2)
- Superannuation payments to GESB (note 3.1(a))
- Lease payments to the Department of Finance (Government Office Accommodation and State Fleet) (note 3.6)
- Insurance payments to the Insurance Commission and Riskcover fund (note 3.6)
- Remuneration for services provided by the Auditor General (note 9.10)
- Services provided free of charge to various State Government agencies (note 9.7)

Notes to the financial statements

For the year ended 30 June 2022

9.4 Related party transactions (continued)

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.

9.5 Related bodies

A related body is a body that receives more than half 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 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 all non-government agencies (whether affiliated or not) during the year are outlined below:

	2022 \$'000	2021 \$'000
Research and development	2,056	8,520
Public health	1,824	1,793
	3,880	10,313

Notes to the financial statements

For the year ended 30 June 2022

9.7 Services provided free of charge

During the period the following services were provided to other WA agencies free of charge for functions outside the normal operations of the Department:

	2022 \$'000	2021 \$'000
Transfer of COVID-19 medical equipment to statutory authorities within WA health		
East Metropolitan Health Service	4,783	-
South Metropolitan Health Service	700	-
North Metropolitan Health Service	256	-
WA Country Health Service	137	-
Quadriplegic Centre	11	-
Contiguous Local Authorities Group	710	670
Department of Communities	52	52
Department of Education	474	474
Department of Planning, Lands and Heritage	330	327
Department of Water and Environmental Regulation	198	195
Water Corporation	174	173
WA Police	205	139
Others	154	124
Total services provided free of charge	8,184	2,154

9.8 Indian Ocean Territories

	2022 \$'000	2021 \$'000
Balance at start of period	544	(719)
Receipts		
Commonwealth grant	2,431	3,895
Payment		
Purchase of WA Health Services	(2,937)	(2,632)
Balance at end of period	38	544

Notes to the financial statements

For the year ended 30 June 2022

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.

	2022 \$'000	2021 \$'000
Controlled by the Department		
Balance at start of period	-	14,819
Receipts		
Commonwealth activity based funding for Health Service Providers	2,058,316	1,869,889
Commonwealth activity based funding for Department of Health	21,132	27,549
Commonwealth block funding for Health Service Providers	239,759	219,537
Commonwealth public health funding for Department of Health	47,842	46,115
Commonwealth contribution under the National Partnership Agreement of COVID-19 Response	698,584	175,557
State activity based funding from Department of Health	3,386,699	3,182,937
State contribution under the National Partnership Agreement of COVID-19 Response	553,248	168,075
Interest earned on State Pool Account	-	6
Cross border deposits from interstate	30,768	54,105
Payments		
Commonwealth activity based funding to Health Service Providers	(2,058,316)	(1,869,889)
Commonwealth activity based funding to Department of Health	(21,132)	(27,549)
Commonwealth block funding to State Managed Fund (Health) Account	(239,759)	(219,537)
Commonwealth public health funding to Department of Health	(47,842)	(46,115)
Commonwealth contribution under the National Partnership Agreement of COVID-19 Response	(698,584)	(190,376)
State activity based funding to Health Service Providers	(3,386,699)	(3,182,937)
State contribution under the National Partnership Agreement of COVID-19 Response	(553,248)	(168,075)
Interest transferred to Treasury Consolidated Account	-	(6)
Cross border payment to interstate	(30,768)	(54,105)
Balance at end of period	-	-

Notes to the financial statements

For the year ended 30 June 2022

9.9 Special purpose accounts (continued)

	2022 \$'000	2021 \$'000
Administered by the Department		
Balance at start of period	-	-
Receipts		
Commonwealth activity based funding for Mental Health Commission (MHC)	161,700	138,214
Commonwealth block funding for Mental Health Commission	136,869	114,369
State activity based funding from Mental Health Commission	238,278	207,350
Payments		
MHC Commonwealth activity based funding to Health Service Providers	(161,700)	(138,214)
MHC Commonwealth activity based funding to non-government organisation (NGO)	-	-
Commonwealth block funding to Mental Health Commission to Health Service Providers	(136,869)	(114,369)
Commonwealth block funding to Mental Health Commission to non-government organisation	-	-
MHC State activity based funding to Health Service Providers	(238,278)	(207,350)
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 of Health 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.

	2022 \$'000	2021 \$'000
Controlled by the Department		
Balance at start of period	-	-
Receipts		
Commonwealth block funding from State Pool Account	239,759	219,537
State block funding from Department of Health	380,178	322,915
Royalties for Regions Fund from Department of Health	-	-
Payments		
Commonwealth block funding to Health Service Providers	(239,759)	(219,537)
State block funding to Health Service Providers	(380,178)	(322,915)
Balance at end of period	-	-

Notes to the financial statements

For the year ended 30 June 2022

9.9 Special purpose accounts (continued)

	2022 \$'000	2021 \$'000
Administered by the Department		
Balance at start of period	-	-
Receipts		
Mental Health Commission - Commonwealth block funding	126,576	114,369
Mental Health Commission - State block funding	286,725	269,505
Payments		
Mental Health Commission - Commonwealth block funding to Health Service Providers	(126,576)	(106,218)
Mental Health Commission - Commonwealth block funding to non-government organisations	-	(8,151)
Mental Health Commission - State block funding to Health Service Providers	(286,725)	(269,505)
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.

	2022 \$'000	2021 \$'000
Controlled by the Department		
Balance at start of period	15,149	-
Receipts	32,547	33,980
Payments	(23,232)	(18,831)
Balance at end of period	24,464	15,149

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.

	2022 \$'000	2021 \$'000
Controlled by the Department		
Balance at start of period	10,702	9,605
Receipts	4,135	4,040
Payments	(3,482)	(2,943)
Balance at end of period	11,355	10,702

Notes to the financial statements

For the year ended 30 June 2022

9.10 Remuneration of auditors

Remuneration paid or payable to the Auditor General in respect of the audit is as follows:

	2022 \$'000	2021 \$'000
Auditing the accounts, controls, financial statements and key performance indicators	387	370
	387	370

9.11 Equity

Contributed equity

Balance at start of period

Contribution by owners

Capital appropriation (a)

Transfer of net assets from other agencies (b)

Land and buildings transferred from the WA Country Health Service (c)

Land and buildings transferred from the State Government (c)

Distributions to owners

Transfer of net assets to other agencies (b)

Land and buildings for sale transferred to the Department of Planning, Lands and Heritage (c)

Land and buildings transferred to the State Government (c)

Total contributed equity at end of period

	2022 \$'000	2021 \$'000
Balance at start of period	45,394	41,889
Capital appropriation (a)	97,021	3,535
Transfer of net assets from other agencies (b)	-	32
Land and buildings transferred from the WA Country Health Service (c)	-	-
Transfer of net assets to other agencies (b)	-	(32)
Land and buildings for sale transferred to the Department of Planning, Lands and Heritage (c)	-	(30)
Land and buildings transferred to the State Government (c)	-	(30)
Total contributed equity at end of period	142,415	45,394

a) Treasurer's Instruction 955 '*Contributions by Owners Made to Wholly Owned Public Sector Entities*' designates capital appropriations as contributions by owners in accordance with AASB Interpretation 1038 '*Contributions by Owners Made to Wholly-Owned Public Sector Entities*'.

b) AASB 1004 '*Contributions*' requires transfers of net assets as a result of a restructure of administrative arrangements to be accounted for as contributions by owners and distributions to owners.

Under Treasurer's Instruction 955 non-discretionary and non-reciprocal transfers of net assets between state government agencies have been designated as contributions by owners in accordance with AASB Interpretation 1038. Where the transferee agency accounts for a non- discretionary and non-reciprocal transfer of net assets as a contribution by owners, the transferor agency accounts for the transfer as a distribution to owners.

c) On 1 July 2016, the Health Ministerial Body (HMB) entered into joint arrangements with each Health Service Provider for the management and control of land and buildings, where ownership is with the HMB, but management and control are with the Health Service Providers. The joint arrangements are reflected in the Memoranda of Understanding (Memoranda) between the HMB and the Health Service Providers. As only the HMB can dispose land and buildings that vest within it (as legal owner), pursuant to s13(2), management and control of the land and buildings outlined in the Memoranda are to be transferred from the Health Service Provider to the HMB, prior to disposal.

Notes to the financial statements

For the year ended 30 June 2022

9.11 Equity (continued)

	2022 \$'000	2021 \$'000
Asset revaluation reserve		
Balance at the start of period	280,255	279,876
Net revaluation increments/(decrements):		
Land	819	338
Buildings	276	41
Total asset revaluation surplus at end of period	281,350	280,255
	2022 \$'000	2021 \$'000
Accumulated surplus/(deficit)		
Balance at start of period	(62,845)	144,912
Result for the period	52,851	(207,829)
Changes in accounting policy	-	72
Total accumulated surplus/(deficit) at end of period	(9,994)	(62,845)

Notes to the financial statements

For the year ended 30 June 2022

9.12 Supplementary financial information

Write-offs

During the financial year, the Department has written off debts and inventory under the authority of:

	2022 \$'000	2021 \$'000
The accountable authority	20	-
The Minister	-	-
	20	-

Losses through theft, defaults and other causes

There were no losses through theft, defaults and other causes during the current and previous period.

Forgiveness of debts

	2022 \$'000	2021 \$'000
Waiver of debts by Chief Health Officer under "Public Health Act 2016" (a)	4,008	8,168
	4,008	8,168

The *Public Health Amendment (COVID-19 Response) Act 2020* provides the Chief Health Officer with the authority to waive the whole or part of the fee payable by hotel-quarantined persons under s202J.

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 2022

10 Explanatory statements

This section explains variances 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 2022, and between the actual results for 2022 and 2021 are shown below. Narratives are provided for key major variances which vary more than 10% from their comparative and that the variation is more than 1% of the dollar aggregate of:

- Total Cost of Services for the Statements of comprehensive income and Statement of cash flows (i.e. 1% of \$8,478,776,000 in the example below), and
- Total Assets for the Statement of financial position (i.e. 1% of \$387,090,000 in the example below).

Notes to the financial statements

For the year ended 30 June 2022

10.1.1 Statement of Comprehensive Income Variances

	Variance Notes	Estimate 2022 \$'000	Actual 2022 \$'000	Actual 2021 \$'000	Variance between actual and estimate \$'000	Variance between actual results for 2022 and 2021 \$'000
COST OF SERVICES						
Expenses						
Employee benefits expenses		167,510	173,743	161,804	6,233	11,939
Contracts for services	1,A	528,339	599,637	526,513	71,298	73,124
Supplies and services	2,B	206,460	400,084	268,926	193,624	131,158
Grants and subsidies	3,C	7,536,278	8,605,148	7,439,955	1,068,870	1,165,193
Depreciation and amortisation expenses		1,855	2,062	964	207	1,098
Loss on disposal of non-current assets		-	8	-	8	8
Finance costs		15	44	17	29	27
Contribution to Capital Works Fund		-	-	13,313	-	(13,313)
Other expenses		62,065	50,141	67,284	(11,924)	(17,143)
Total cost of services		8,502,522	9,830,867	8,478,776	1,328,345	1,352,091
Income						
User charges and fees		17,455	13,373	19,970	(4,082)	(6,597)
Commonwealth grants and contributions	4,D	2,685,453	3,256,004	2,506,804	570,551	749,200
Other grants and contributions		-	1,595	872	1,595	723
Other income		30,654	42,129	80,761	11,475	(38,632)
Total revenue		2,733,562	3,313,101	2,608,407	579,539	704,694
Gains						
Gain on disposal of non-current assets		-	-	16	-	(16)
Total gains		-	-	16	-	(16)
Total income other than income from State Government		2,733,562	3,313,101	2,608,423	579,539	704,678
NET COST OF SERVICES		5,768,960	6,517,766	5,870,353	748,806	647,413

Notes to the financial statements

For the year ended 30 June 2022

10.1.1 Statement of Comprehensive Income Variances (continued)

	Variance Notes	Estimate 2022 \$'000	Actual 2022 \$'000	Actual 2021 \$'000	Variance between actual and estimate \$'000	Variance between actual results for 2022 and 2021 \$'000
INCOME FROM STATE GOVERNMENT						
Service appropriation	5,E	5,729,674	6,515,785	5,610,273	786,111	905,512
Income from other public sector entities		32,400	42,536	43,561	10,136	(1,025)
Liabilities assumed		-	-	(872)	-	872
Resources received		903	3,857	1,883	2,954	1,974
Royalties for Regions Fund		8,747	8,439	7,679	(308)	760
Total income from State Government		5,771,724	6,570,617	5,662,524	798,893	908,093
Surplus/(deficit) for the period		2,764	52,851	(207,829)	50,087	260,680
Other comprehensive income						
Items not reclassified subsequently to profit or loss						
Changes in asset revaluation reserve		-	1,095	379	1,095	716
Total other comprehensive income		-	1,095	379	1,095	716
Total comprehensive income for the period		2,764	53,946	(207,450)	51,182	261,396

Notes to the financial statements

For the year ended 30 June 2022

10.1.2 Statement of Financial Position Variances

	Variance Notes	Estimate 2022 \$'000	Actual 2022 \$'000	Actual 2021 \$'000	Variance between actual and estimate \$'000	Variance between actual results for 2022 and 2021 \$'000
ASSETS						
Current assets						
Cash and cash equivalents		73,721	128,508	80,638	54,787	47,870
Restricted cash and cash equivalents		60,353	119,138	51,061	58,785	68,077
Inventories		47,437	45,022	47,437	(2,415)	(2,415)
Receivables		88,266	99,718	88,266	11,452	11,452
Other current assets		5,994	7,351	5,994	1,357	1,357
Total Current Assets		275,771	399,737	273,396	123,966	126,341
Non-current assets						
Restricted cash and cash equivalents		4,481	4,481	4,481	-	-
Amounts receivable for services		83,334	93,690	81,479	10,356	12,211
Infrastructure, property, plant and equipment	6,F	24,604	104,693	25,518	80,089	79,175
Intangible assets		1,255	1,100	1,543	(155)	(443)
Right-of-use assets		424	2,464	673	2,040	1,791
Other non-current assets		-	25	-	25	25
Total non-current assets		114,098	206,453	113,694	92,355	92,759
TOTAL ASSETS		389,869	606,190	387,090	216,321	219,100
LIABILITIES						
Current liabilities						
Payables		85,280	149,578	85,280	64,298	64,298
Contract liabilities		-	74	67	74	7
Lease liabilities		431	510	472	79	38
Employee related provisions		27,968	30,517	27,968	2,549	2,549
Total current liabilities		113,679	180,679	113,787	67,000	66,892

Notes to the financial statements

For the year ended 30 June 2022

10.1.2 Statement of Financial Position Variances (continued)

	Variance Notes	Estimate 2022 \$'000	Actual 2022 \$'000	Actual 2021 \$'000	Variance between actual and estimate \$'000	Variance between actual results for 2022 and 2021 \$'000
Non-current liabilities						
Lease liabilities		-	1,807	318	1,807	1,489
Employee related provisions		10,181	9,933	10,181	(248)	(248)
Total non-current liabilities		10,181	11,740	10,499	1,559	1,241
TOTAL LIABILITIES		123,860	192,419	124,286	68,559	68,133
NET ASSETS		266,009	413,771	262,804	147,762	150,967
EQUITY						
Contributed equity		45,835	142,415	45,394	96,580	97,021
Reserves		280,255	281,350	280,255	1,095	1,095
Accumulated surplus/(deficit)		(60,081)	(9,994)	(62,845)	50,087	52,851
TOTAL EQUITY		266,009	413,771	262,804	147,762	150,967

Notes to the financial statements

For the year ended 30 June 2022

10.1.3 Statement of Cash Flows Variances

	Variance Notes	Estimate 2022 \$'000	Actual 2022 \$'000	Actual 2021 \$'000	Variance between estimate and actual \$'000	Variance between actual results for 2022 and 2021 \$'000
CASH FLOWS FROM STATE GOVERNMENT						
Service appropriation	7,G	5,304,552	6,104,124	5,189,528	799,572	914,596
Capital appropriation	8,H	441	97,021	3,536	96,580	93,485
Funds from other public sector entities		32,400	42,536	43,561	10,136	(1,025)
Royalties for Regions Fund		8,747	8,439	7,679	(308)	760
Net cash provided by State Government		5,346,140	6,252,120	5,244,304	905,980	1,007,816

Utilised as follows:

CASH FLOWS FROM OPERATING ACTIVITIES

Payments

Employee benefits		(167,510)	(171,442)	(156,511)	(3,932)	(14,931)
Supplies and services	9,I	(796,865)	(944,910)	(828,948)	(148,045)	(115,962)
Grants and subsidies	10,J	(7,111,155)	(8,205,698)	(7,036,228)	(1,094,543)	(1,169,470)
Finance costs		(15)	(44)	(17)	(29)	(27)
Contribution to Capital Works Fund		-	-	(13,313)	-	13,313
GST payments on purchases	11,K	(282,117)	(548,652)	(444,638)	(266,535)	(104,014)

Receipts

User charges and fees		17,455	6,530	9,048	(10,925)	(2,518)
Commonwealth grants and contributions	12,L	2,685,453	3,214,318	2,464,299	528,865	750,019
GST receipts on sales		19,436	23,485	26,276	4,049	(2,791)
GST receipts from taxation authority	13,M	262,682	517,898	409,800	255,216	108,098
Other receipts		29,312	54,816	81,633	25,504	(26,817)
Net cash used in operating activities		(5,343,324)	(6,053,699)	(5,488,599)	(710,375)	(565,100)

CASH FLOWS FROM INVESTING ACTIVITIES

Payments

Payment for purchase of non-current assets	14,N	-	(81,787)	(4,782)	(81,787)	(77,005)
Net cash used in investing activities		-	(81,787)	(4,782)	(81,787)	(77,005)

Notes to the financial statements

For the year ended 30 June 2022

10.1.3 Statement of Cash Flows Variances (continued)

	Variance Notes	Estimate 2022 \$'000	Actual 2022 \$'000	Actual 2021 \$'000	Variance between estimate and actual \$'000	Variance between actual results for 2022 and 2021 \$'000
CASH FLOWS FROM FINANCING ACTIVITIES						
Payments						
Payments for principal element of lease		(441)	(687)	(412)	(246)	(275)
Net cash used in financing activities		(441)	(687)	(412)	(246)	(275)
Net increase/(decrease) in cash and cash equivalents		2,375	115,947	(249,489)	113,572	365,436
Cash and cash equivalents at the beginning of the year		136,180	136,180	385,669	-	(249,489)
CASH AND CASH EQUIVALENTS AT THE END OF THE PERIOD		138,555	252,127	136,180	113,572	115,947

Notes to the financial statements

For the year ended 30 June 2022

10.1 Explanatory statement for controlled operations (continued)

Major Estimate and Actual (2022) Variance Narratives

		2022 Estimate \$'000	2022 Actual \$'000	Variance \$'000
1	Contracts for services expenses Contracts for services expenses increased by \$71.3 million (13.5%) due to higher contributions to Government programmes in order to meet the increased service deliverables.	528,339	599,637	71,298
2	Supplies and services expenses Supplies and services increased by \$193.6 million (93.8%) due to higher than budgeted pathology services provided to the public for COVID-19 testing, clinical services to hotel quarantine guests, hotel cost and security.	206,460	400,084	193,624
3	Grants and subsidies expenses Grants and subsidies increased by \$1.07 billion (14.2%) due to more funding provided to health services within WA Health to meet the increased service deliverables and continued response to the COVID-19 pandemic.	7,536,278	8,605,148	1,068,870
4	Commonwealth grants and contributions income Commonwealth grants and contributions increased by \$570.5 million (21.2%) due to additional funding received from the National Partnership Agreement for the COVID-19 Response.	2,685,453	3,256,004	570,551
5	Service appropriation income Service appropriation increased by \$786.1 million (13.7%) due to additional funding to the Department of Health for the COVID-19 Response including pathology services provided to the public for COVID-19 testing, funding for Rapid Antigen Test kits and other hospital services within WA Health.	5,729,674	6,515,785	786,111
6	Infrastructure, property, plant and equipment (Non-current Assets) Infrastructure, property, plant and equipment increased by \$80.0 million (325.5%) due to the construction of inpatient surge facilities in order to increase bed capacity as part of the living with COVID-19 strategy.	24,604	104,693	80,089
7	Service appropriation receipts Service appropriation increased by \$799.5 million (15.1%) due to additional funding to the Department of Health for the COVID-19 Response including pathology services provided to the public for COVID-19 testing, funding for Rapid Antigen Test kits and the hospital service within WA Health.	5,304,552	6,104,124	799,572
8	Capital appropriation receipts Capital appropriation increased by \$96.5 million due to additional capital funding for the construction of inpatient surge facilities in order to increase bed capacity as part of the living with COVID-19 strategy.	441	97,021	96,580

Notes to the financial statements

For the year ended 30 June 2022

10.1 Explanatory statement for controlled operations (continued)

Major Estimate and Actual (2022) Variance Narratives

		2022 Estimate \$'000	2022 Actual \$'000	Variance \$'000
9	Supplies and services payments Supplies and services payments increased by \$148.0 million (18.6%) due to higher than budgeted pathology services provided to the public for COVID-19 testing, clinical services to hotel quarantine guests, hotel cost and security.	(796,865)	(944,910)	(148,045)
10	Grants and subsidies payments Grants and subsidies payments increased by \$1.094 billion (15.4%) due to more funding provided to health services within WA Health to meet the increased service deliverables and continued response to the COVID-19 pandemic.	(7,111,155)	(8,205,698)	(1,094,543)
11	GST payments on purchases payments GST payments on purchases increased by \$266.5 million (94.5%) due to increased expenses incurred from the COVID-19 Response.	(282,117)	(548,652)	(266,535)
12	Commonwealth grants and contributions receipts Commonwealth grants and contributions receipts increased by \$528.8 million (19.7%) due to additional funding received from the National Partnership Agreement for the COVID-19 Response.	2,685,453	3,214,318	528,865
13	GST receipts from taxation authority receipts GST receipts from taxation authority increased by \$255.2 million (97.2%) due to increased purchasing activity in 2021-22.	262,682	517,898	255,216
14	Payment for purchase of non-current assets Payment for purchase of non-current assets increased by \$81.7 million (100.0%) due to the construction of inpatient surge facilities in order to increase bed capacity as part of living with COVID-19 strategy.	-	(81,787)	(81,787)

Notes to the financial statements

For the year ended 30 June 2022

10.1 Explanatory statement for controlled operations (continued)

Major Actual (2022) and Comparative (2021) Variance Narratives

		2022 Actual \$'000	2021 Actual \$'000	Variance \$'000
A	Contracts for services expenses Contracts for services expenses increased by \$73.1 million (13.9%) due to higher contributions to Government programmes in order to meet the increased service deliverables.	599,637	526,513	73,124
B	Supplies and services expenses Supplies and services expenses increased by \$131.1 million (48.8%) due to higher than budgeted pathology services provided to the public for COVID-19 testing, clinical services to hotel quarantine guests, hotel cost and security.	400,084	268,926	131,158
C	Grants and subsidies expenses Grants and subsidies expenses increased by \$1,165.1 million (15.7%) due to more funding provided to health services within WA Health to meet the increased service deliverables and continued response to the COVID-19 pandemic.	8,605,148	7,439,955	1,165,193
D	Commonwealth grants and contributions income Commonwealth grants and contributions increased by \$749.2 million (29.9%) due to additional funding received from the National Partnership Agreement for the COVID-19 Response.	3,256,004	2,506,804	749,200
E	Service appropriation income Service appropriation increased by \$905.5 million (16.1%) due to increased state funding to COVID-19 Response including pathology services provided to the public for COVID-19 testing, funding for Rapid Antigen Test kits and other hospital services to the State.	6,515,785	5,610,273	905,512
F	Infrastructure, property, plant and equipment (Non-current Assets) Infrastructure, property, plant and equipment increased by \$79.1 million (310.3%) due to the construction of inpatient surge facilities to increase bed capacity as part of the living with COVID-19 strategy.	104,693	25,518	79,175
G	Service appropriation receipts Service appropriation increased by \$914.5 million (17.6%) due additional funding to the Department of Health for the COVID-19 Response pathology services provided to the public for COVID-19 testing, funding for Rapid Antigen Test kits and the hospital service within WA Health.	6,104,124	5,189,528	914,596
H	Capital appropriation receipts Capital appropriation increased by \$93.4 million due to additional capital funding for the construction of inpatient surge facilities in order to increase bed capacity as part of the living with COVID-19 strategy.	97,021	3,536	93,485

Notes to the financial statements

For the year ended 30 June 2022

10.1 Explanatory statement for controlled operations (continued)

Major Actual (2022) and Comparative (2021) Variance Narratives

		2022 Actual \$'000	2021 Actual \$'000	Variance \$'000
I	Supplies and services payments Supplies and services payments increased by \$115.9 million (14.0%) due to higher than budgeted pathology services provided to the public for COVID-19 testing, clinical services to hotel quarantine guests, hotel cost and security.	(944,910)	(828,948)	(115,962)
J	Grants and subsidies payments Grants and subsidies payments increased by \$1,169.4 million (16.6%) due to more funding provided to health services within WA Health to meet the increased service deliverables and continued response to the COVID-19 pandemic.	(8,205,698)	(7,036,228)	(1,169,470)
K	GST payments on purchases GST payments on purchases increased by \$104.0 million (23.4%) due to increased expenses incurred from the COVID-19 Response.	(548,652)	(444,638)	(104,014)
L	Commonwealth grants and contributions receipts Commonwealth grants and contributions receipts increased by \$750.0 million (30.4%) due to additional funding received from the National Partnership Agreement for the COVID-19 Response.	3,214,318	2,464,299	750,019
M	GST receipts from taxation authority receipts GST receipts from taxation authority increased by \$108.0 million (26.4%) due to increased purchasing activity in 2021-22.	517,898	409,800	108,098
N	Payment for purchase of non-current assets Payment for purchase of non-current assets increased by \$77.0 million due to the construction of inpatient surge facilities in order to increase bed capacity as part of living with COVID-19 strategy.	(81,787)	(4,782)	(77,005)

Notes to the financial statements

For the year ended 30 June 2022

10.2 Explanatory statement for administered items

This explanatory section explains variations in the financial performance of the Department undertaking transactions as an agent of the government, as detailed in the administered schedules.

All variances between annual estimates and actual results for 2022, and between the actual results for 2022 and 2021 are shown below. Narratives are provided for key major variances which vary by more than 10% from their comparative and that the variation is more than 1% of the dollar aggregate of Total Administered Income (i.e. 1% of \$1,060,276,000).

	Variance Notes	Estimate 2022 \$'000	Actual 2022 \$'000	Actual 2021 \$'000	Variance between actual and estimate \$'000	Variance between actual results for 2022 and 2021 \$'000
COST OF SERVICES						
Expenses						
Funding for Capital Works Fund transferred to:						
Health Service Providers	1,A	311,537	477,377	277,159	165,840	200,218
State Pool Account and State Managed Fund Account administered for Mental Health Commission						
Transfer of activity based funding to Health Service Providers	2,B	343,748	399,978	345,564	56,230	54,414
Transfer of block funding to Health Service Providers	3,C	408,869	423,594	383,874	14,725	39,720
Service concession arrangement depreciation expense		2,083	2,617	2,617	534	-
Total administered expenses		1,066,237	1,303,566	1,009,214	237,329	294,352

Notes to the financial statements

For the year ended 30 June 2022

10.2 Explanatory statement for administered items (continued)

	Variance Notes	Estimate 2022 \$'000	Actual 2022 \$'000	Actual 2021 \$'000	Variance between actual and estimate \$'000	Variance between actual results for 2022 and 2021 \$'000
Income						
Administered transactions:						
Capital appropriation	4,D	257,894	427,230	288,539	169,336	138,691
Administered appropriation		-	8,420	-	8,420	8,420
Royalties for Regions Fund	5,E	53,643	67,773	36,809	14,130	30,964
Commonwealth grants and contributions		-	-	16	-	(16)
Contribution from Department of Health		-	-	-	-	-
State Pool Account and State Managed Fund Account administered for Mental Health Commission (MHC)						
Commonwealth activity based funding for MHC	6,F	142,032	161,700	138,214	19,668	23,486
Commonwealth block funding for MHC	7,G	120,514	136,869	114,369	16,355	22,500
State activity based funding from MHC	8,H	201,716	238,278	207,350	36,562	30,928
State block funding from MHC		288,355	286,725	269,505	(1,630)	17,220
Service concession arrangement revenue		3,870	5,474	5,474	1,604	-
Total administed income		1,068,024	1,332,469	1,060,276	264,445	272,193

Notes to the financial statements

For the year ended 30 June 2022

10.2 Explanatory statement for administered items (continued)

Major Estimate and Actual (2022) Variance Narratives

		2022 Estimate \$'000	2022 Actual \$'000	Variance \$'000
1	Capital Works Funding transferred to Health Service Providers Capital Works Funding transferred to Health Service Providers increased by \$165.8 million (53.2%) due to additional funding provided to purchase hospital beds as part of living with COVID-19 strategy, and increased capital expenditure for ongoing projects.	311,537	477,377	165,840
2	Mental Health Commission activity based funding transferred to Health Service Providers Mental Health Commission activity based funding transferred to Health Service Providers increased by \$56.2 million (16.4%) due to increased activity for admitted mental health.	343,748	399,978	56,230
3	Mental Health Commission block funding transferred to Health Service Providers Mental Health Commission block funding transferred to Health Service Providers increased by \$14.7 million (3.6%) due to increase in non-admitted mental health activity.	408,869	423,594	14,725
4	Capital appropriation income Capital appropriation income increased by \$169.3 million (65.7%) due to additional funding provided to purchase modular hospital beds as part of living with COVID-19 strategy, and increased capital expenditure for ongoing projects.	257,894	427,230	169,336
5	Royalties for Regions Fund income Royalties for Regions Fund income increased by \$14.1 million (26.3%) due to higher funding received for projects including Patient Assisted Travel, District Medical workforce, Digital Innovation and Royal Flying Doctor.	53,643	67,773	14,130
6	Mental Health Commission activity based funding provided by Commonwealth Mental Health Commission activity based funding provided by Commonwealth increased by \$19.7 million (13.8%) due to increased activity for admitted mental health.	142,032	161,700	19,668
7	Mental Health Commission block funding provided by Commonwealth Mental Health Commission block funding provided by Commonwealth increased by \$16.3 million (13.6%) due to increased activity for non-admitted mental health.	120,514	136,869	16,355
8	Mental Health Commission activity based funding provided by State Mental Health Commission activity based funding provided by State increased by \$36.6 million (18.1%) due to increased activity for admitted mental health.	201,716	238,278	36,562

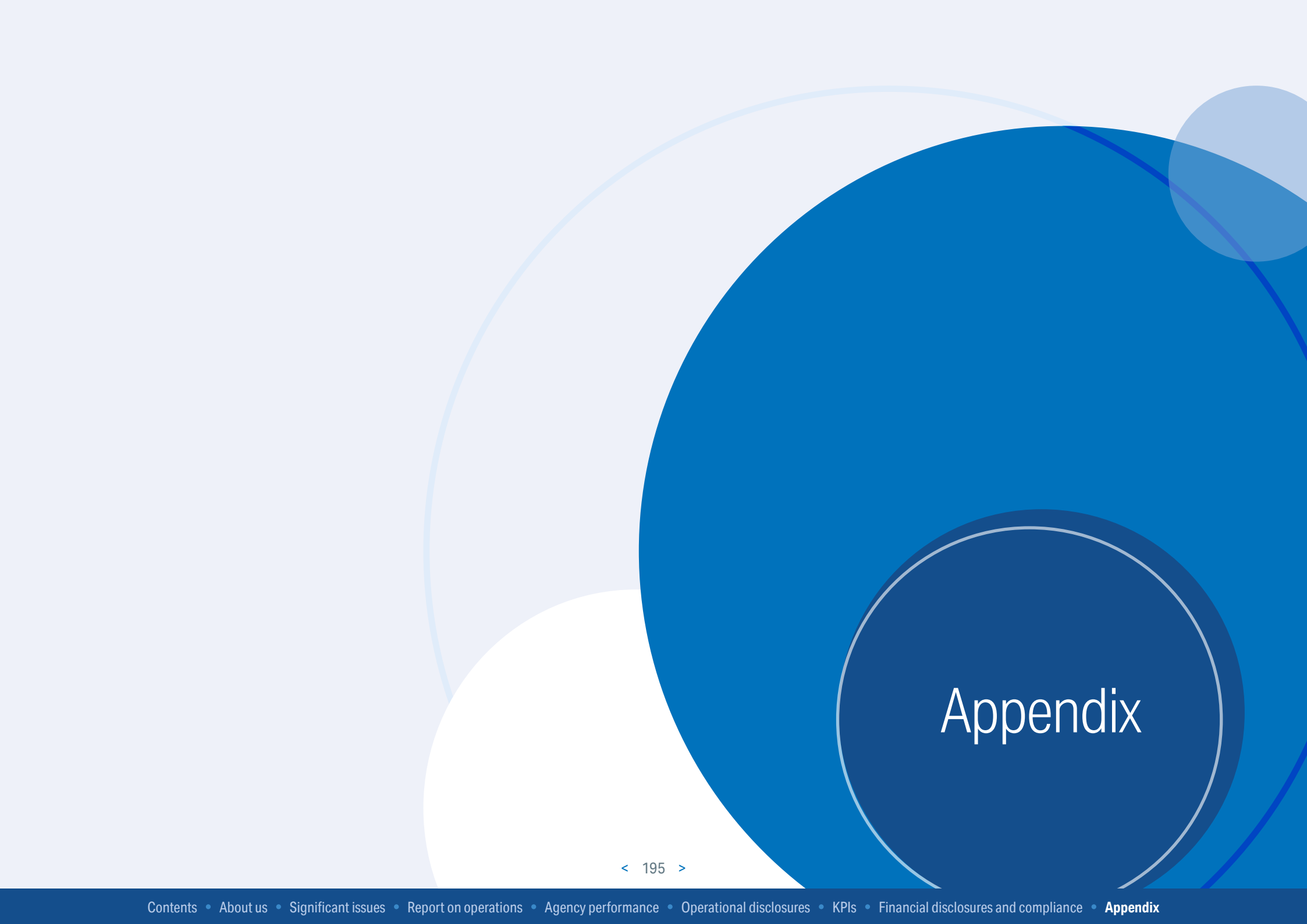
Notes to the financial statements

For the year ended 30 June 2022

10.2 Explanatory statement for administered items (continued)

Major Actual (2022) and Comparative (2021) Variance Narratives (continued)

		2022 Actual \$'000	2021 Actual \$'000	Variance \$'000
A	Capital Works Funding transferred to Health Service Providers Capital Works Funding transferred to Health Service Providers increased by \$200.2 million (72.2%) due to additional funding provided to purchase hospital beds as part of living with COVID-19 strategy, and increased capital expenditure for ongoing projects.	477,377	277,159	200,218
B	Mental Health Commission activity based funding transferred to Health Service Providers Mental Health Commission activity based funding transferred to Health Service Providers increased by \$54.4 million (15.7%) due to increased activity for admitted mental health in FY2021-22.	399,978	345,564	54,414
C	Mental Health Commission block funding transferred to Health Service Providers Mental Health Commission block funding transferred to Health Service Providers increased by \$39.7 million (10.3%) due to increase in non-admitted mental health funding.	423,594	383,874	39,720
D	Capital appropriation income Capital appropriation income increased by \$138.7 million (48.1%) due to additional funding provided to purchase hospital beds as part of living with COVID-19 strategy, and increased capital expenditure for ongoing projects.	427,230	288,539	138,691
E	Royalties for Regions Fund income Royalties for Regions Fund income increased by \$31.0 million (84.1%) due to higher funding received for projects including Patient Assisted Travel, District Medical workforce, Digital Innovation and Royal Flying Doctor.	67,773	36,809	30,964
F	Mental Health Commission activity based funding provided by Commonwealth Mental Health Commission activity based funding provided by Commonwealth increased by \$23.5 million (17.0%) due to increased activity for admitted mental health.	161,700	138,214	23,486
G	Mental Health Commission block funding provided by Commonwealth Mental Health Commission block funding provided by Commonwealth increased by \$22.5 million (19.7%) due to increased activity for non-admitted mental health.	136,869	114,369	22,500
H	Mental Health Commission activity based funding provided by State Mental Health Commission activity based funding provided by State increased by \$30.9 million (14.9%) due to increased activity for admitted mental health.	238,278	207,350	30,928



Appendix

Appendix 1: Board and committee remuneration

Position	Name	Term of appointment	Period of membership 2021-22	Type of remuneration	Base salary/sitting fees (\$)	Gross/actual remuneration (\$)
Anaesthetic Mortality Committee						
Chair	Dr Jennifer Bruce	3 years	12 months	Not eligible	Not applicable	\$0
Member	Dr Anna Clare	3 years	3 months	Not eligible	Not applicable	\$0
Member	Dr Katherine Collister	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	9 months	Not eligible	Not applicable	\$0
Member	Prof. Thomas Ledowski	3 years	12 months	Not eligible	Not applicable	\$0
Member	Dr Diane Mohen	3 years	6 months	Not eligible	Not applicable	\$0
Member	Dr Mark Newman	3 years	9 months	Not eligible	Not applicable	\$0
Member	Dr Michael Soares	3 years	12 months	Not eligible	Not applicable	\$0
Member	Dr Jason Wells	3 years	12 months	Not eligible	Not applicable	\$0
Member	Dr Kenneth Williams	3 years	9 months	Not eligible	Not applicable	\$0
Investigator	Dr Christine Grobler	3 years	8 months	Sessional	\$526	\$0
Investigator	Dr Simon Maclaurin	3 years	4 months	Sessional	\$526	\$8,424
Investigator	Dr John Martyr	3 years	8 months	Sessional	\$526	\$0
					Total	\$8,424
Department of Health WA Human Research Ethics Committee						
Chair	Dr Peter Bentley	3 years	12 months	Annual	\$19,100	\$19,100
Member	Natalie Fleetwood	3 years	12 months	Sessional	\$330	\$3,300
Member	Shane Gallagher	3 years (completed)	2 months	Not eligible	Not applicable	\$0

Position	Name	Term of appointment	Period of membership 2021-22	Type of remuneration	Base salary/sitting fees (\$)	Gross/actual remuneration (\$)
Member	Associate Prof. Angela Ives	3 years (completed)	6 months	Sessional	\$330	\$1,980
Member	Suzanne Hillier	3 years	12 months	Not eligible	Not applicable	\$0
Member	Kathryn Kirk	3 years	12 months	Sessional	\$330	\$3,630
Member	Rev. Graham Mabury	3 years	12 months	Sessional	\$330	\$3,300
Member	Associate Prof. Daniel McAullay	3 years	6 months	Sessional	\$330	\$330
Member	Ali Radomiljac	3 years	12 months	Not eligible	Not applicable	\$0
Member	Associate Prof. Alison Reid	3 years	12 months	Sessional	\$330	\$3,300
Member	Bret Watson	3 years	12 months	Sessional	\$330	\$2,520
Member	Stephania Tomlin	3 years	6 months	Not eligible	Not applicable	\$0
Deputy Member	Prof. Richard Brightwell	3 years	12 months	Sessional	\$330	\$660
Deputy Member	Prof. Satvinder Dhaliwal	3 years	12 months	Sessional	\$330	\$0
Deputy Member	Dr Garth Eichhorn	3 years	12 months	Sessional	\$330	\$660
Deputy Member	Associate Prof. Georgia Halkett	3 years	6 months	Sessional	\$330	\$660
Deputy Member	Wil Liam Lim	3 years	6 months	Sessional	\$330	\$330
Deputy Member	Clinical Associate Prof. Ann McDonald	3 years	12 months	Sessional	\$330	\$660
Deputy Member	Sonia McKeiver	3 years	12 months	Sessional	\$330	\$0
Deputy Member	John McMath	3 years	12 months	Sessional	\$330	\$3,300
Deputy Member	Dr Erika Techera	3 years	6 months	Sessional	\$330	\$330
					Total	\$44,060

Position	Name	Term of appointment	Period of membership 2021-22	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	7 months	Sessional	\$150	\$0
Member 5	*	3 years	7 months	Sessional	\$150	\$0
*Approval to withhold the names of the committee members has been granted by the Minister for Health					Total	\$0
Graylands Reconfiguration and Forensic Taskforce						
Chair	Hon Jim McGinty	2 years	12 months	Annual	\$64,795 pa	\$64,795
Member	Michael Andrews	2 years	12 months	Not eligible	Not applicable	\$0
Member	Debora Colvin	2 years	12 months	Sessional	\$825 for meetings over 4 hours, \$537 for meetings of 4 hours or less	\$3,222
Member	Rachael Green	2 years	12 months	Not eligible	Not applicable	\$0
Member	Angela Kelly	2 years	12 months	Not eligible	Not applicable	\$0
Member	Jennifer McGrath	2 years	12 months	Not eligible	Not applicable	\$0
Member	Dr David Russell-Weisz	2 years	12 months	Not eligible	Not applicable	\$0
Member	Dr Adam Tomison	2 years	12 months	Not eligible	Not applicable	\$0
					Total	\$68,017

Position	Name	Term of appointment	Period of membership 2021-22	Type of remuneration	Base salary/sitting fees (\$)	Gross/actual remuneration (\$)
Local Health Authorities Analytical Committee						
Chair	David Wilson	3 years	12 months	Not eligible	Not applicable	\$0
Member	Freya Ayliffe	3 years	9 months	Not eligible	Not applicable	\$0
Member	Catherine Barlow	3 years	12 months	Sessional	\$231 for meetings over 4 hours, \$158 for meetings of 4 hours or less	\$474
Member	Andrew Campbell	3 years	12 months	Not eligible	Not applicable	\$0
Member	Tsyr Chiat Chew	3 years	12 months	Not eligible	Not applicable	\$0
Member	Emily Dunn	3 years	12 months	Not eligible	Not applicable	\$0
Member	Kim Frost	3 years	12 months	Not eligible	Not applicable	\$0
Member	Ryan Quinn	3 years	12 months	Not eligible	Not applicable	\$0
Member	Ellie Robinson	3 years	12 months	Not eligible	Not applicable	\$0
Member	Hannah Robinson	3 years	12 months	Not eligible	Not applicable	\$0
Member	Sarah Upton	3 years	12 months	Not eligible	Not applicable	\$0
					Total	\$474
Maternal Mortality Committee						
Chair	Prof. John Newnham	3 years	12 months	Not eligible	Not applicable	\$0
Member	Dr Chieh Cheng	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	3 months	Not eligible	Not applicable	\$0

Position	Name	Term of appointment	Period of membership 2021-22	Type of remuneration	Base salary/sitting fees (\$)	Gross/actual remuneration (\$)
Member	Dr Louise Farrell	3 years	3 months	Not eligible	Not applicable	\$0
Member	Dr Graeme Johnson	3 years	9 months	Not eligible	Not applicable	\$0
Member	Dr Peter Kell	3 years	4 months	Not eligible	Not applicable	\$0
Member	Dr Fiona Langdon	3 years	9 months	Not eligible	Not applicable	\$0
Member	Dr Lewis MacKinnon	3 years	9 months	Not eligible	Not applicable	\$0
Member	Dr Christopher Nichols	3 years	3 months	Not eligible	Not applicable	\$0
Member	Dr Dale Pugh	3 years	12 months	Not eligible	Not applicable	\$0
Member	Dr Nooshin Rasool	3 years	8 months	Not eligible	Not applicable	\$0
Member	Dr Kylie Sterry	3 years	3 months	Not eligible	Not applicable	\$0
Investigator	Dr Julia Barton	3 years	12 months	Sessional	\$526	\$0
					Total	\$0
Northern Territory, South Australia and Western Australia Board of the Psychology Board of Australia						
Acting Chair	Neil McLean	1 year, 8 months	12 months	Sessional		
Member	Carolyn Bright	3 years	12 months	Sessional		
Member	Elizabeth Pritchard	3 years	12 months	Sessional		
Member	Adam Santa Maria	3 years	5 months	Sessional		
Member	Rachel Zombor	3 years	1 month	Sessional		
*Board members are not remunerated by the Department of Health.					Total	\$0

Position	Name	Term of appointment	Period of membership 2021-22	Type of remuneration	Base salary/sitting fees (\$)	Gross/actual remuneration (\$)
Perinatal and Infant Mortality Committee						
Chair	Prof. John Newnham	3 years	12 months	Not eligible	Not applicable	\$0
Member	Dr Disna Abeysuriya	3 years	12 months	Not eligible	Not applicable	\$0
Member	Dr Michael Gannon	3 years	12 months	Not eligible	Not applicable	\$0
Member	Dr Gayatri Jape	3 years	12 months	Not eligible	Not applicable	\$0
Member	Louise Keyes	3 years	12 months	Not eligible	Not applicable	\$0
Member	Dr Han-Shin Lee	3 years	6 months	Not eligible	Not applicable	\$0
Member	Prof. Helen Leonard	3 years	12 months	Not eligible	Not applicable	\$0
Member	Dr Robert Perry	3 years	9 months	Not eligible	Not applicable	\$0
Member	Dr Stephen Resnick	3 years	12 months	Not eligible	Not applicable	\$0
Member	Dr Peta Ann Sadler	3 years	12 months	Not eligible	Not applicable	\$0
Member	Dr Warren Thyer	3 years	12 months	Not eligible	Not applicable	\$0
Member	Dr Scott White	3 years	12 months	Not eligible	Not applicable	\$0
Member	Lisa Watkins	3 years	3 months	Not eligible	Not applicable	\$0
Investigator	Dr Noel French	3 years	12 months	Sessional	\$526	\$15,578
Investigator	Dr Christine Marsack	3 years	12 months	Sessional	\$526	\$10,365
Investigator	Dr Corrado Minutillo	3 years	6 months	Sessional	\$526	\$16,846
Investigator	Dr Keren Witcombe	3 years	12 months	Sessional	\$526	\$8,686
					Total	\$51,475

Position	Name	Term of appointment	Period of membership 2021–22	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	Willow Warren	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	Kellie Passeretto	Ongoing	12 months	Not eligible	Not applicable	\$0
Member	Ken Raine	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
					Total	\$0
Pharmacy Registration Board of Western Australia						
Presiding member	Giovanna Cecchele	3 years	12 months	Sessional	\$540 per full day meeting/ \$350 per half day meeting	\$6,830
Deputy presiding member	Dean Schulze	3 years	12 months	Sessional	\$350 per full day meeting/ \$230 per half day meeting	\$4,430
Member	Linda Diane Keane	3 years	12 months	Sessional	\$350 per full day meeting/ \$230 per half day meeting	\$4,200
Member	Debra Letica	3 years	12 months	Sessional	\$350 per full day meeting/ \$230 per half day meeting	\$4,080
					Total	\$19,540

Position	Name	Term of appointment	Period of membership 2021-22	Type of remuneration	Base salary/sitting fees (\$)	Gross/actual remuneration (\$)
Postgraduate Medical Council of Western Australia						
Chair (outgoing)	Dr Margaret Sturdy	4 years	6 months	Not eligible	Not applicable	\$0
Chair (incoming)	Dr Gregory Sweetman	4 years	6 months	Not eligible	Not applicable	\$0
Deputy Chair	Prof. Alison Jones	4 years	7 months	Not eligible	Not applicable	\$0
Deputy Chair	Dr Michael Levitt	4 years	5 months	Not eligible	Not applicable	\$0
Member	Dr Tim Bates	4 years	12 months	Not eligible	Not applicable	\$0
Member	Dr Megge Beacroft	4 years	12 months	Not eligible	Not applicable	\$0
Member	Dr Shirley Bowen	4 years	12 months	Not eligible	Not applicable	\$0
Member	Dr Colleen Bradfiord	4 years	12 months	Not eligible	Not applicable	\$0
Member	Dr Dean Choong	4 years	10 months	Not eligible	Not applicable	\$0
Member	Nicoletta Ciffoliili	4 years	12 months	Sessional	\$280	\$560
Member	Dr Monica Gope	4 years	12 months	Not eligible	Not applicable	\$0
Member	Prof. Jeffrey Hamdorf	4 years	12 months	Not eligible	Not applicable	\$0
Member	Dr Clare Matthews	4 years	10 months	Not eligible	Not applicable	\$0
Member	Dr Brendan McQuillan	4 years	10 months	Not eligible	Not applicable	\$0
Member	Dr Agitha Nair	4 years	12 months	Not eligible	Not applicable	\$0
Member	Dr David Oldham	4 years	12 months	Not eligible	Not applicable	\$0
Member	Dr Gregory Sweetman	4 years	6 months	Not eligible	Not applicable	\$0
					Total	\$560

Position	Name	Term of appointment	Period of membership 2021-22	Type of remuneration	Base salary/sitting fees (\$)	Gross/actual remuneration (\$)
Radiological Council						
Chair	Dr Andrew Geoffrey Robertson	3 years	12 months	Not eligible	Not applicable	\$0
Deputy Chair	Dr Revle Diane Bangor-Jones	3 years	12 months	Not eligible	Not applicable	\$0
Member	Associate Prof. Ros Francis	3 years	12 months	Not eligible	Not applicable	\$0
Member	Dr Chandra Padmini Hewavitharana	3 years	12 months	Not eligible	Not applicable	\$0
Member	Darius Kwiatkowski	3 years	7 months	Not eligible	Not applicable	\$0
Member	Dr Melinda Morris	3 years	5 months	Sessional	\$160	\$480
Member	Joh Pereira	3 years	5 months	Sessional	\$160	\$800
Member	Dr Roger Ian Price	3 years	12 months	Sessional	\$160	\$1,440
Member	Dr Elizabeth Louise Thomas	3 years	12 months	Not eligible	Not applicable	\$0
Member	Christopher John Whennan	3 years	12 months	Not eligible	Not applicable	\$0
Member (Non-voting)	Frank Harris	3 years	12 months	Sessional	\$160	\$660
Member (Non-voting)	Nick Tsurikov	3 years	12 months	Sessional	\$160	\$1,440
Deputy Member	Dr Deepthi Dissanayake	3 years	12 months	Not eligible	Not applicable	\$0
Deputy Member	Prof. Paul Parizel	3 years	12 months	Not eligible	Not applicable	\$0
Deputy Member	Helen Parry	3 years	12 months	Not eligible	Not applicable	\$0
Deputy Member	Cameron Storm	3 years	12 months	Sessional	\$160	\$1,280
Deputy Member	Dr Russel Troedson	3 years	6 months	Not eligible	Not applicable	\$0
Deputy Member	Dr Vidisha Vaidya	3 years	5 months	Not eligible	Not applicable	\$0
					Total	\$6,100

Position	Name	Term of appointment	Period of membership 2021-22	Type of remuneration	Base salary/sitting fees (\$)	Gross/actual remuneration (\$)
Stimulant Assessment Panel						
Chair (outgoing)	*	3 years	6 months	Not eligible	Not applicable	\$0
Chair (incoming)	*	3.5 years	3 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	\$1,832
Member 7 (outgoing)	*	3 years	4 months	Sessional	\$229	\$0
Member 7 (incoming)	*	3.5 years	3 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	\$1,832
Sustainable Health Independent Oversight Committee						
Chair	Tim Marney	2 years	12 months	Sessional	\$1270 per full day meeting/ \$825 per half day meeting	\$3,300
Member	Dr Richard Choong	2 years	12 months	Sessional	\$825 per full day meeting/ \$537 per half day meeting	\$2,148
Member	Margaret Doherty	2 years	12 months	Sessional	\$825 per full day meeting/ \$537 per half day meeting	\$2,148

Position	Name	Term of appointment	Period of membership 2021-22	Type of remuneration	Base salary/sitting fees (\$)	Gross/actual remuneration (\$)
Member	Janine Freeman	2 years	12 months	Sessional	\$825 per full day meeting/ \$537 per half day meeting	\$2,148
Member	Lesley Nelson	2 years	12 months	Sessional	\$825 per full day meeting/ \$537 per half day meeting	\$2,148
Member	Elizabeth Prime	2 years	12 months	Sessional	\$825 per full day meeting/ \$537 per half day meeting	\$2,148
Member	Prof. Fiona Wood	2 years	12 months	Not eligible	Not applicable	\$0
Member	Director General, Department of the Premier and Cabinet	2 years	12 months	Not eligible	Not applicable	\$0
Member	Under Treasurer of Western Australia	2 years	12 months	Not eligible	Not applicable	\$0
					Total	\$14,040
Voluntary Assisted Dying Board						
Chair	Dr Scott Blackwell	3 years	12 months	Annual	\$45,357	\$45,357
Deputy Chair	Colin Holt	2 years	11 months	Not eligible	Not applicable	\$0
			1 month	Annual	\$24,946	\$2,878
Member	Dr Robert Edis	2 years	12 months	Annual	\$24,946	\$24,946
Member	Maria Osman	3 years	12 months	Annual	\$24,946	\$24,946
Member	Linda Savage	2 years	12 months	Annual	\$24,946	\$24,946
					Total	\$123,073

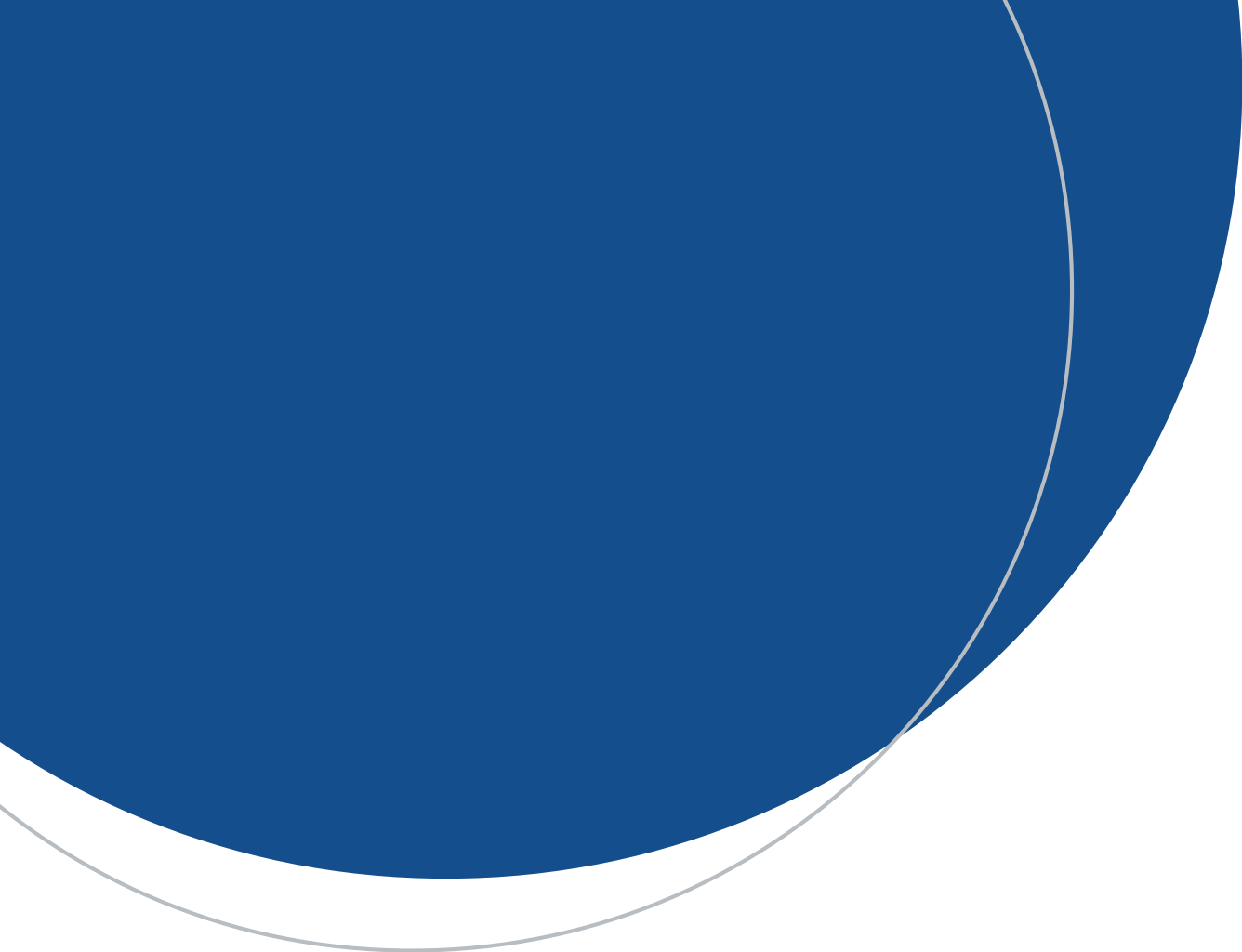
Position	Name	Term of appointment	Period of membership 2021-22	Type of remuneration	Base salary/sitting fees (\$)	Gross/actual remuneration (\$)
Western Australian Board of the Medical Board of Australia						
Chair	Prof. Mark Edwards	3 years	12 months	Sessional		
Member	Dr Richelle Douglas	3 years	12 months	Sessional		
Member	Dr Alan Duncan	3 years	12 months	Sessional		
Member	Dr Pathma (Patty) Edge	3 years	4 months	Sessional		
Member	Dr George Eskander	3 years	12 months	Sessional		
Member	Dr Michael Levitt	2 years	12 months	Sessional		
Member	Dr Clare Matthews	3 years	12 months	Sessional		
Member	Sonia McKeiver	3 years	12 months	Sessional		
Member	Prof. Constantine (Con) Michael	2 years	4 months	Sessional		
Member	Meneesha Michalka	3 years	12 months	Sessional		
Member	Dr Katinka Morton	3 years	9 months	Sessional		
Member	Liam Roche	3 years	12 months	Sessional		
Member	Dr Ruth Shean	3 years	11 months	Sessional		
*Board members are not remunerated by the Department of Health					Total	\$0
Western Australian Board of the Nursing and Midwifery Board of Australia						
Chair (outgoing)	Marie-Louise MacDonald	2 years	9 months	Sessional		
Chair (incoming)	Michelle Dillon	3 years	12 months	Sessional		
Member	Justine Burg	3 years	12 months	Sessional		

Position	Name	Term of appointment	Period of membership 2021-22	Type of remuneration	Base salary/sitting fees (\$)	Gross/actual remuneration (\$)
Member	Heather Gillett	3 years	4 months	Sessional		
Member	Adj. Associate Prof. Karen Gullick	3 years	6 months	Sessional		
Member	Linda Hadfield	3 years	12 months	Sessional		
Member	Dr Yvonne Hauck	3 years	2 months	Sessional		
Member	Nathan Haynes	3 years	4 months	Sessional		
Member	John (Kim) Laurence	3 years	12 months	Sessional		
Member	Margaret Lundy	3 years	12 months	Sessional		
Member	Kathryn Pedler	3 years	12 months	Sessional		
Board members are not remunerated by the Department of Health					Total	\$0
Western Australian Future Health Research and Innovation Fund Advisory Council						
Chair	John Van Der Wielen	3 years	12 months	Sessional	\$1270 for meetings over 4 hours, \$825 for meetings of 4 hours or less	\$4,570
Member	Dr Glenn Begley	3 years	12 months	Sessional	\$825 for meetings over 4 hours, \$537 for meetings of 4 hours or less	\$1,899
Member	Kane Blackman	5 years	7 months	Not eligible	Not applicable	\$0
			5 months	Sessional	\$825 for meetings over 4 hours, \$537 for meetings of 4 hours or less	\$1,362
Member	Prof. Sandra Eades AC	5 years	12 months	Sessional	\$825 for meetings over 4 hours, \$537 for meetings of 4 hours or less	\$1,074
Member	Associate Prof. Dale Fisher	3 years	12 months	Sessional	\$825 for meetings over 4 hours, \$537 for meetings of 4 hours or less	\$2,973

Position	Name	Term of appointment	Period of membership 2021–22	Type of remuneration	Base salary/sitting fees (\$)	Gross/actual remuneration (\$)
Member	Prof. Christina Mitchell AO	5 years	12 months	Sessional	\$825 for meetings over 4 hours, \$537 for meetings of 4 hours or less	\$2,148
Member	Vicki O'Donnell	2 years	12 months	Sessional	\$825 for meetings over 4 hours, \$537 for meetings of 4 hours or less	\$1,611
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
					Total	\$15,637
Western Australian Reproductive Technology Council						
Chair	Prof. Stephan Millet	3 years	12 months	Annual*	\$22,225	\$29,458
Member	Michelle Arnold	3 years	7 months	Sessional	\$376	\$1,506
Member	Antonia Clissa	3 years	6 months	Sessional	\$376	\$4,362
Member	Dr Angela Cooney	3 years	11 months	Sessional	\$376	\$6,826
Member	Dr Veronica Edwards	3 years	6 months	Not eligible	Not applicable	\$0
Member	Dr Andrew Harman	3 years	12 months	Sessional	\$376	\$5,619
Member	Prof. Roger Hart	3 years	11 months	Sessional	\$376	\$4,086
Member	Anjali Krautmann	3 years	6 months	Not eligible	Not applicable	\$0
Member	Hamish Milne	3 years	6 months	Sessional	\$376	\$2,256
Member	Dr Dale Pugh	3 years	11 months	Not eligible	Not applicable	\$0

Position	Name	Term of appointment	Period of membership 2021-22	Type of remuneration	Base salary/sitting fees (\$)	Gross/actual remuneration (\$)
Member	Associate Prof. Peter Roberts	3 years	6 months	Sessional	\$376	\$5,122
Member	Associate Prof. Stella Tarrant	3 years	6 months	Sessional	\$376	\$1,504
Member	Dr Lucy Williams	3 years	12 months	Sessional	\$376	\$5,072
Deputy Member	Dr John Beilby	3 years	12 months	Sessional	\$376	\$0
Deputy Member	Dr Megan Byrnes	3 years	12 months	Sessional	\$376	\$234
Deputy Member	Dr Louise Farrell	3 years	12 months	Sessional	\$376	\$1,909
Deputy Member	Renee Fox	3 years	12 months	Not eligible	Not applicable	\$0
Deputy Member	Prof. Alison Garton	2 years	12 months	Sessional	\$376	\$3,455
Deputy Member	Dr Michele Hansen	3 years	12 months	Sessional	\$376	\$363
Deputy Member	Dr Andrew Lu AM	2 years	12 months	Sessional	\$376	\$1,688
Deputy Member	Rachel Oakeley	3 years	11 months	Sessional	\$376	\$1,349
Deputy Member	Dianne Scarle	3 years	12 months	Not eligible	Not applicable	\$0
*Remuneration for Prof. Stephan Millet changed from sessional to annual and includes backpay from January to June 2021					Total	\$74,809
Western Australian Reproductive Technology Council Preimplantation Genetic Diagnosis Technical Advisory Committee						
Chair	Dr John Beilby	3 years	12 months	Sessional	\$476	\$952
Member	Dr Angela Cooney	3 years	11 months	Sessional	\$309	\$0
Member	Dr Katherine Sanders	3 years	12 months	Sessional	\$309	\$0
Member	Dr Sharron Townshend	3 years	12 months	Not eligible	Not applicable	\$0
					Total	\$952



A large blue circle is partially visible on the left side of the page, with a smaller blue circle overlapping its right edge. A thin grey arc is also visible below the larger circle.

This document can be made available in alternative formats on request for a person with disability.

© Department of Health 2022

Copyright to this material is vested in the State of Western Australia unless otherwise indicated. Apart from any fair dealing for the purposes of private study, research, criticism or review, as permitted under the provisions of the *Copyright Act 1968*, no part may be reproduced or re-used for any purposes whatsoever without written permission of the State of Western Australia.