KEY PERFORMANCE INDICATORS

CERTIFICATION OF KEY PERFORMANCE INDICATORS

CHILD AND ADOLESCENT HEALTH SERVICE

Certification of key performance indicators for the year ended 30 June 2025

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

Ms Pamela Michael
CHAIR, CAHS BOARD
Child and Adolescent Health Service
23 September 2025

Dr Alexius Julian
CHAIR, CAHS FINANCE COMMITTEE
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23 September 2025

EFFECTIVENESS KPIs

Effectiveness KPI – Outcome 1

Unplanned hospital readmissions for patients within 28 days for selected surgical procedures

Rationale

Unplanned hospital readmissions may reflect less than optimal patient management and ineffective care pre-discharge, post-discharge and/or during the transition between acute and community-based care.[1] These readmissions necessitate patients spending additional periods of time in hospital as well as utilising additional hospital resources.

Readmission reduction is a common focus of health systems worldwide as they seek to improve the quality and efficiency of healthcare delivery, in the face of rising healthcare costs and increasing prevalence of chronic disease.[2]

Readmission rate is considered a global performance measure, as it potentially points to deficiencies in the functioning of the overall healthcare system. Along with providing appropriate interventions, good discharge planning can help decrease the likelihood of unplanned hospital readmissions by providing patients with the care instructions they need after a hospital stay and helping patients recognise symptoms that may require medical attention.

The surgeries selected for this indicator are based on those in the current National Healthcare Agreement Unplanned Readmission performance indicator (NHA PI 23).[3]

Target

The 2024 targets are based on the total child and adult population, and for each procedure is:

Surgical Procedure	Target (per 1,000)
Tonsillectomy & Adenoidectomy	≤84.4
Appendicectomy	≤29.7

Result

Tonsillectomy & Adenoidectomy

Figure 1: Rate of unplanned hospital readmissions for patients within 28 days for tonsillectomy and adenoidectomy, 2022 to 2024

2022	2023	**2024**	Target
50.6	56.6	**40.4**	≤84.4

CAHS has continued to reduce readmission rates for tonsillectomy and adenotonsillectomy procedures. The rate of unplanned readmission was 40.4 per 1,000, which is below the target of 84.4 per 1,000.

This achievement reflects CAHS' proactive approach to patient care, before, during and after surgery. Pre-operative telehealth and virtual care helps prepare patients and families for surgery and the recovery process. This has proven effective in alleviating pre-surgery anxiety and setting clear expectations for post-operative care.

Following surgery, CAHS provides comprehensive education to parents and carers at the time of discharge. This includes post-operative information accessible in multiple languages.

Additionally, CAHS proactively contacts parents and carers to offer support for post-operative pain management and address any concerns during the recovery period.

Appendicectomy

Figure 2: Rate of unplanned hospital readmissions for patients within 28 days for appendicectomy, 2022 to 2024

2022	2023	**2024**	Target
15.0	14.8	**17.5**	≤29.7

The rate of unplanned readmissions was 17.5 per 1,000, significantly below the target of 29.7 per 1,000. CAHS' ongoing commitment to timely access to emergency surgery, has helped to reduce the risk of complications and shortened hospital stays. Other factors include providing comprehensive education and information to parents and carers, before and after surgery. Our Acute Pain Service provides effective pain relief for children, supporting successful discharge home and enhancing patient comfort.

Reporting period: Calendar year, to account for lags in reporting due to time difference between index episode discharge date and clinical coding completion of readmission episode

Data source: Hospital Morbidity Data Collection; WA Data Linkage System

[1] Australian Institute of Health and Welfare (2009). Towards national indicators of safety and quality in health care. Cat. no. HSE 75. Canberra: AIHW. Available at: https://www.aihw.gov.au/reports/health-care-quality-performance/towards-national-indicators-of-safety-and-quality/summary

[2] Australian Commission on Safety and Quality in Health Care. Avoidable Hospital Readmissions: Report on Australian and International indicators, their use and the efficacy of interventions to reduce readmissions. Sydney: ACSQHC; 2019. Available at: https://www.safetyandquality.gov.au/publications-and-resources/resource-library/avoidable-hospital-readmission-literature-review-australian-and-international-indicators

[3] https://meteor.aihw.gov.au/content/742756

Effectiveness KPI – Outcome 1

Percentage of elective wait list patients waiting over boundary for reportable procedures

Rationale

Elective surgery refers to planned surgery that can be booked in advance following specialist assessment that results in placement on an elective surgery waiting list.

Elective surgical services delivered in the WA health system are those deemed to be clinically necessary. Excessive waiting times for these services can lead to deterioration of the patient's condition and/or quality of life, or even death.[4] Waiting lists must be actively managed by hospitals to ensure fair and equitable access to limited services, and that all patients are treated within clinically appropriate timeframes.

Patients are prioritised based on their assigned clinical urgency category:

- Category 1 – procedures that are clinically indicated within 30 days
- Category 2 – procedures that are clinically indicated within 90 days
- Category 3 – procedures that are clinically indicated within 365 days.

On 1 April 2016, the WA health system introduced a new statewide performance target for the provision of elective services. For reportable procedures, the target requires that no patients (0%) on the elective waiting lists wait longer than the clinically recommended time for their procedure, according to their urgency category.

Target

The 2024–25 target is 0% for each urgency category. Performance is demonstrated by a result that is equal to the target.

Result

Figure 3: Percentage of elective wait list patients waiting over boundary for reportable procedures, by urgency category, 2022–23 to 2024–25

	2022–23	2023–24	**2024–25**	Target
Category 1	9.9%	8.7%	**4.6%**	0%
Category 2	28.7%	26.3%	**18.8%**	0%
Category 3	39.6%	34.7%	**26.1%**	0%

In the 2024–2025 year, there has been a decrease in the percentage of reportable patients over boundary on the surgical wait list across all categories.

As of 30 June 2025, 4.6 per cent of Category 1 patients were not treated within 30 days, 18.8 per cent of Category 2 patients were not treated within 90 days, and 26.1 per cent of Category 3 patients were not treated within 365 days. CAHS remains committed to improving service delivery and clinical management to ensure patients with the most critical clinical need are prioritised and treated as soon as possible.

CAHS has implemented a range of initiatives to improve access to elective surgery and reduce wait lists. A key development was the opening of an additional operating theatre in December 2024 which has added surgical capacity. We continued to partner with the Western Australian Country Health Service, to deliver dental surgery in the South West and Great Southern regions.

We have maintained a strong focus on theatre management, efficiency and performance monitoring. For example, an improved approach to low complexity procedures in identified specialities has helped to maximise theatre efficiency.

Note: The result is based on an average of weekly census data for the financial year.

Reporting period: Financial year.
Data source: Elective Services Wait List Data Collection.

[4] Derrett, S., Paul, C., Morris, J.M. (1999). Waiting for Elective Surgery: Effects on Health-Related Quality of Life, International Journal of Quality in Health Care, Vol 11 No. 1, 47-57.

Effectiveness KPI – Outcome 1

Healthcare-associated *Staphylococcus aureus* bloodstream infections (HA-SABSI) per 10,000 occupied bed-days

Rationale

Staphylococcus aureus bloodstream infection is a serious infection that may be associated with the provision of health care. *Staphylococcus aureus* is a highly pathogenic organism and even with advanced medical care, infection is associated with prolonged hospital stays, increased healthcare costs and a marked increase in morbidity and mortality (SABSI mortality rates are estimated at 20–25%[5]).

HA-SABSI is generally considered to be a preventable adverse event associated with the provision of health care. Therefore, this KPI is a robust measure of the safety and quality of care provided by WA public hospitals.

A low or decreasing HA-SABSI rate is desirable, and the WA target reflects the nationally agreed benchmark.

Target

The 2024 target is ≤1.0 infections per 10,000 occupied bed-days and is the agreed benchmark utilised for National Health Performance Reporting.

Result

Figure 4: Healthcare associated *Staphylococcus aureus* bloodstream infections (HA-SABSI) per 10,000 occupied bed-days, 2022 to 2024

2022	2023	**2024**	Target
0.92	0.70	**0.55**	≤1.0

CAHS reduced the *Staphylococcus aureus* (*S. aureus*) bloodstream infection rate in 2024 to 0.55 per 10,000 occupied bed-days, which is below the WA health system target of 1.0 per 10,000 bed-days. This reflects initiatives such as *S. aureus* decolonisation of all children undergoing high-risk procedures, a strong focus on hand hygiene and aseptic technique compliance, and the role of the dedicated central venous access device insertion and management service.

Reporting period: Calendar year, to account for lag in reporting in clinical coding completion.

Data source: Healthcare Infection Surveillance Western Australia Data Collection.

[5] van Hal, S. J., Jensen, S. O., Vaska, V. L., Espedido, B. A., Paterson, D. L., & Gosbell, I. B. (2012). Predictors of mortality in Staphylococcus aureus Bacteremia. Clinical microbiology reviews, 25(2), 362–386. doi:10.1128/CMR.05022-11

Effectiveness KPI – Outcome 1

Percentage of admitted patients who discharged against medical advice: a) Aboriginal patients; and b) Non-Aboriginal patients

Rationale

Discharged against medical advice (DAMA) refers to patients leaving hospital against the advice of their treating medical team or without advising hospital staff (e.g. take own leave, left without notice, missing and not found, or discharge at own risk). Patients who do so have a higher risk of readmission and mortality[6] and have been found to cost the health system 50% more than patients who are discharged by their physician.[7]

The national Aboriginal and Torres Strait Islander Health Performance Framework reports discharge at own risk under the heading 'Self-discharge from hospital'. Between July 2019 and June 2021 Aboriginal patients (4.4%) in WA were 7.5 times more likely than non-Aboriginal patients (0.6%) to discharge at own risk, compared with 5.2 times nationally (3.8% and 0.7% respectively).[8] This statistic indicates a need for improved responses by the health system to the needs of Aboriginal patients. This indicator is also being reported in the Report on Government Services 2024 under the performance of governments in providing acute care services in public hospitals.[9]

This indicator provides a measure of the safety and quality of inpatient care. Reporting the results by Aboriginal status measures the effectiveness of initiatives within the WA health system to deliver culturally secure services to Aboriginal people. While the aim is to achieve equitable treatment outcomes, the targets reflect the need for a long-term approach to progressively closing the gap between Aboriginal and non-Aboriginal patient cohorts.

Discharge against medical advice performance measure is also one of the key contextual indicators of Outcome 1 "Aboriginal and Torres Strait Islander people enjoy long and healthy lives" under the new National Agreement on Closing the Gap, which was agreed to by the Coalition of Aboriginal and Torres Strait Islander Peak Organisations and all Australian Governments in July 2020.[10]

Target

The 2024 targets are based on the total child and adult population:

	Target
a) Aboriginal patients	≤2.78%
b) Non-Aboriginal patients	≤0.99%

Result

Figure 5: Percentage of admitted patients who discharged against medical advice, 2022 to 2024

	2022	2023	**2024**	Target
Aboriginal patients	0.25%	0.24%	**0.11%**	≤2.78%
Non-Aboriginal patients	0.05%	0.10%	**0.06%**	≤0.99%

In 2024, CAHS recorded a DAMA rate of 0.11 per cent for Aboriginal patients, which is below the target of 2.78 per cent. For non-Aboriginal patients, the rate was 0.06 per cent, which is also below the target of 0.99 per cent.

CAHS continues to consistently achieve low DAMA rates. A range of support services including those provided by Aboriginal Liaison Officers, social workers and clinical teams have contributed to the lower DAMA rates.

We continue to work towards creating more culturally safe and inclusive spaces for Aboriginal families who access our services. We educate staff on how to deliver culturally safe clinical care and are committed to meaningful engagement with Aboriginal families to build and maintain trust in the health services.

Reporting period: Calendar year, to account for lag in reporting due to clinical coding completion.

Data source: Hospital Morbidity Data Collection

[6] Yong et al. Characteristics and outcomes of discharges against medical advice among hospitalised patients. Internal medicine journal 2013:43(7):798–802.

[7] Aliyu ZY. Discharge against medical advice: sociodemographic, clinical and financial perspectives. International journal of clinical practice 2002;56(5):325–27.

[8] See Table D3.09.3 https://www.indigenoushpf.gov.au/measures/3-09-self-discharge-from-hospital/data#DataTablesAndResources

[9] For more information see 12 Public hospitals - Report on Government Services 2024 – Productivity Commission (pc.gov.au)

[10] www.closingthegap.gov.au/national-agreement

Effectiveness KPI – Outcome 1

Readmissions to acute specialised mental health inpatient services within 28 days of discharge

Rationale

Readmission rate is considered to be a global performance measure as it potentially points to deficiencies in the functioning of the overall mental healthcare system.

While multiple hospital admissions over a lifetime may be necessary for someone with ongoing illness, a high proportion of readmissions shortly after discharge may indicate that inpatient treatment was either incomplete or ineffective, or that follow-up care was not adequate to maintain the patient's recovery out of hospital.[11] Rapid readmissions place pressure on finite beds and may reduce access to care for other consumers in need.

These readmissions mean that patients spend additional time in hospital and utilise additional resources. A low readmission rate suggests that good clinical practice is in operation. Readmissions are attributed to the facility at which the initial separation (discharge) occurred rather than the facility to which the patient was readmitted.

By monitoring this indicator, key areas for improvement can be identified. This can facilitate the development and delivery of targeted care pathways and interventions aimed at improving the mental health and quality of life of Western Australians.

Target

The 2024 target is ≤12%.

Result

Figure 6: Readmissions to acute specialised mental health inpatient services within 28 days of discharge, 2022 to 2024

2022	2023	**2024**	Target
24.9%	24.3%	**18.5%**	≤12%

The rate of total hospital readmissions for 2024 is above the target of 12 per cent. It should be noted that this indicator does not distinguish between planned and unplanned readmissions. CAHS provides clinically appropriate planned admissions for young people who would benefit from an additional inpatient stay.

CAHS is working to better understand unplanned readmissions to identify opportunities to make improvements. CAHS is considering the impact that overnight leave may have on the success of transition from inpatient to community-based services and continues to focus on improving the mental health care provided in the community. CAHS will always prioritise the safety of young people and their families through admission to an inpatient mental health service when required.

Reporting period: Calendar year, to account for lag in reporting due to time difference between index episode discharge date and clinical coding completion of readmission episode.

Data source: Hospital Morbidity Data Collection (Inpatient Separations).

[11] Australian Health Ministers Advisory Council Mental Health Standing Committee (2011). Fourth National Mental Health Plan Measurement Strategy. Available at: https://www.aihw.gov.au/getmedia/d8e52c84-a53f-4eef-a7e6-f81a5af94764/Fourth-national-mental-health-plan-measurement-strategy-2011.pdf.aspx

Effectiveness KPI – Outcome 1

Percentage of post-discharge community care within 7 days following discharge from acute specialised mental health inpatient services

Rationale

In 2022, one in four (6.6 million) Australians reported having a mental or behavioural condition.[12] Therefore, it is crucial to ensure effective and appropriate care is provided not only in a hospital setting but also in the community.

Discharge from hospital is a critical transition point in the delivery of mental health care. People leaving hospital after an admission for an episode of mental illness have increased vulnerability and, without adequate follow up, may relapse or be readmitted.

The standard underlying this measure is that continuity of care requires prompt community follow-up in the period following discharge from hospital. A responsive community support system for persons who have experienced a psychiatric episode requiring hospitalisation is essential to maintain their clinical and functional stability and to minimise the need for hospital readmissions. Patients leaving hospital after a psychiatric admission with a formal discharge plan that includes links with public community-based services and support are less likely to need avoidable hospital readmissions.

Target

The 2024 target is ≥75%.

Result

Figure 7: Percentage of post-discharge community care within 7 days following discharge from acute specialised mental health inpatient services, 2022 to 2024

2022	2023	**2024**	Target
78.8%	78.5%	**83.6%**	≥75%

In 2024, 83.6 per cent of young people who were admitted to the CAHS acute specialised mental health inpatient services were contacted by a CAHS mental health service team member within 7 days of discharge, which is above the target of 75 per cent. CAHS reviews all cases where a follow-up did not occur within 7 days of discharge to identify opportunities for improvement. CAHS is committed to supporting safe transitions of care from hospital to the community for our young people and will consider additional strategies to support this improving trend.

Reporting period: Calendar year, to account for reporting delays caused by time difference between episode discharge date and clinical coding completion of non-admitted post-discharge episode.

Data source: Mental Health Information Data Collection, Hospital Morbidity Data Collection (Inpatient separations).

[12] National Health Survey, 2022 | Australian Bureau of Statistics

EFFICIENCY KPIs

Efficiency KPI – Outcome 1

Service 1: Public hospital admitted services

Average admitted cost per weighted activity unit

Rationale

This indicator is a measure of the cost per weighted activity unit compared with the State target, as approved by the Department of Treasury, and published in the 2024–25 Budget Paper No. 2, Volume 1.

The measure ensures a consistent methodology is applied to calculating and reporting the cost of delivering inpatient activity against the State's funding allocation. As admitted services received nearly half of the overall 2024–25 budget allocation, it is important that efficiency of service delivery is accurately monitored and reported.

Target

The 2024–25 target is ≤$7,899 per weighted activity unit.

Result

The average admitted cost per weighted activity unit was $9,174 in 2024–25, which is a 16.1 per cent unfavourable outcome relative to target. The target was developed at a whole of WA health system level and the same target applies to all Health Service Providers.

In 2024–25 CAHS delivered considerably more admitted activity than the prior year, which was achieved at a higher cost profile in comparison to 2023–24. This indicator shows an improvement from the prior year outcome. The higher cost profile that contributed to the higher than target outcome in 2024–25 was as a result of the higher-than-expected Enterprise Bargaining Award increases from the Government's Wages Policy, and escalating costs for goods and services.

In addition, admitted service provision has increased due to the opening of the new theatre in response to clinical demand.

Figure 8: Average admitted cost per weighted activity unit, 2022–23 to 2024–25

2022–23 Actual	2023–24 Actual	**2024–25 Actual**	2024–25 Target
$8,297	$9,199	**$9,174**	$7,899

Note: Weighted activity units adjust raw activity data to reflect the complexity of services provided to treat various conditions. WA health system hospitals utilise the Australian Refined Diagnosis Related Groups classifications to assign cost weights to each diagnostic group.

Reporting period: Financial year.

Comparative data for 2022–23 and 2023–24 have been restated due to a change in methodology for some cost distribution.

Data sources: Health Service financial system, Hospital Morbidity Data Collection.

Efficiency KPI – Outcome 1

Service 2: Public hospital emergency services

Average Emergency Department cost per weighted activity unit

Rationale

This indicator is a measure of the cost per weighted activity unit compared with the State target as approved by the Department of Treasury, which is published in the 2024–25 Budget Paper No. 2, Volume 1.

The measure ensures that a consistent methodology is applied to calculating and reporting the cost of delivering Emergency Department activity against the State's funding allocation. With the increasing demand on Emergency Departments and health services, it is important that Emergency Department service provision is monitored to ensure the efficient delivery of safe and high-quality care.

Target

The 2024–25 target is ≤$7,777 per weighted activity unit.

Result

The average Emergency Department cost per weighted activity unit was $11,259 in 2024–25 which is 44.8 per cent higher than the target. The target was developed at a whole of WA health system level and the same target applies to all Health Service Providers.

The higher cost profile, which caused the indicator to exceed the target, is primarily due to specialist paediatric services, increased staffing costs due to higher than expected Enterprise Bargaining Award increases from the Government's Wages Policy, and an increase in staffing. The staffing cost profile includes nurse-to-patient ratios and the dedicated resuscitation team in the Emergency Department. Notwithstanding the expenditure profile, the Child and Adolescent Health Service supported a larger number of presentations through its Emergency Department, which improved the 2024–25 Actual outcome.

Figure 9: Average Emergency Department cost per weighted activity unit, 2022–23 to 2024–25

2022–23 Actual	2023–24 Actual	**2024–25 Actual**	2024–25 Target
$9,768	$11,388	**$11,259**	$7,777

Note: Weighted activity units adjust raw activity data to reflect the complexity of services provided to treat various conditions. WA health system hospitals utilise the Australian Refined Diagnosis Related Groups classifications to assign cost weights to each diagnostic group.

Reporting period: Financial Year.

Comparative data for 2022–23 and 2023–24 have been restated due to a change in methodology for some cost distribution.

Data sources: Health Service financial system, Emergency Department Data Collection.

Efficiency KPI – Outcome 1

Service 3: Public hospital non-admitted services

Average non-admitted cost per weighted activity unit

Rationale

This indicator is a measure of the cost per weighted activity unit compared with the State (aggregated) target, as approved by the Department of Treasury, which is published in the 2024–25 Budget Paper No. 2, Volume 1.

The measure ensures that a consistent methodology is applied to calculating and reporting the cost of delivering non-admitted activity against the State's funding allocation. Non-admitted services play a pivotal role within the spectrum of care provided to the WA public. Therefore, it is important that non-admitted service provision is monitored to ensure the efficient delivery of safe and high-quality care.

Target

The 2024–25 target is ≤$7,903 per weighted activity unit.

Result

The average non-admitted cost per weighted activity unit was $9,334 in 2024–25, which is 18.1 per cent above target. The target was developed at a whole of WA health system level and the same target applies to all Health Service Providers.

In 2024–25, the higher cost profile for non-admitted services is due to the higher than expected Enterprise Bargaining Award increases from the Government's Wages Policy and inflationary cost pressures. The increased target has also contributed to this indicator reducing the unfavourable outcome. Compared to the prior year, the Child and Adolescent Health Service has delivered significantly more non-admitted services, which improved the 2024–25 Actual.

Figure 10: Average non-admitted cost per weighted activity unit

2022–23 Actual	2023–24 Actual	**2024–25 Actual**	2024–25 Target
$8,820	$9,430	**$9,334**	$7,903

Note: Weighted activity units adjust raw activity data to reflect the complexity of services provided to treat various conditions. WA health system hospitals utilise the Australian Refined Diagnosis Related Groups classifications to assign cost weights to each diagnostic group.

Reporting period: Financial year.

Comparative data for 2022–23 and 2023–24 have been restated due to a change in methodology for some cost distribution.

Data sources: Health Service financial system, non-admitted Patient Activity and Wait List Data Collection.

Efficiency KPI – Outcome 1

Service 4: Mental health services

Average cost per bed-day in specialised mental health inpatient services

Rationale

Specialised mental health inpatient services provide patient care in authorised hospitals. To ensure quality of care and cost-effectiveness, it is important to monitor the unit cost of admitted patient care in specialised mental health inpatient services. The efficient use of hospital resources can help minimise the overall costs of providing mental health care and enable the reallocation of funds to appropriate alternative non-admitted care.

Target

The 2024–25 target is ≤$2,553 per bed-day.

Result

In 2024–25, the average cost per bed-day in specialised mental health inpatient services rose significantly to $8,021, representing a 214.2 per cent increase above the target. This variance was driven by a combination of factors, including the allocation of additional staffing to support reforms arising from the Ministerial Taskforce into Public Mental Health Services and a reduction in the target in 2024–25.

The significant increase in cost profile includes the temporary increase in workforce to support the commissioning, and operations and licensing costs of the Nickoll Ward at the Hollywood Hospital. The Nickoll Ward is being used as a decant facility whilst the inpatient mental health ward at the Perth Children's Hospital undergoes refurbishment.

Figure 11: Average cost per bed-day in specialised mental health inpatient units, 2022–23 to 2024–25

2022–23 Actual	2023–24 Actual	**2024–25 Actual**	2024–25 Target
$4,740	$5,533	**$8,021**	$2,553

Reporting period: Financial year.

Comparative data for 2022–23 and 2023–24 have been restated due to a change in methodology for some cost distribution.

Data sources: Health Service financial system, BedState.

Efficiency KPI – Outcome 1

Service 4: Mental health services

Average cost per treatment day of non-admitted care provided by mental health services

Rationale

Public community mental health services consist of a range of community-based services such as emergency assessment and treatment, case management, day programs, rehabilitation, psychosocial, residential services, and continuing care. The aim of these services is to provide the best health outcomes for the individual through the provision of accessible and appropriate community mental health care.

Public community-based mental health services are generally targeted towards people in the acute phase of a mental illness who are receiving post-acute care.

Efficient functioning of public community mental health services is essential to ensure that finite funds are used effectively to deliver maximum community benefit. This indicator provides a measure of the cost-effectiveness of treatment for public psychiatric patients under public community mental health care (non-admitted/ambulatory patients).

Target

The 2024–25 target is ≤$868 per treatment day.

Result

In 2024–25, the average cost per treatment day for non-admitted care provided by public clinical mental health services increased to $932, exceeding the target by 7.4 per cent. This outcome was influenced by a range of cost pressures, including increased employment costs arising from higher than expected Enterprise Bargaining Award increases from the Government's Wages Policy, and inflationary cost impacts.

Figure 12: Average cost per treatment day of non-admitted care provided by mental health services, 2022–23 to 2024–25

2022–23 Actual	2023–24 Actual	**2024–25 Actual**	2024–25 Target
$848	$876	**$932**	$868

Reporting period: Financial year.

Comparative data for 2022–23 and 2023–24 have been restated due to a change in methodology for some cost distribution.

Data sources: Health Service financial system, Mental Health Information Data Collection.

Efficiency KPI – Outcome 2

Service 6: Public and community health services

Average cost per person of delivering population health programs by population health units

Rationale

Population health units support individuals, families, and communities to increase control over and improve their health.

Population health aims to improve health by integrating all activities of the health sector and linking them with broader social and economic services and resources as described in the WA Health Promotion Strategic Framework 2022–2026.[13] This is based on the growing understanding of the social, cultural and economic factors that contribute to a person's health status.

Target

The 2024–25 target is ≤$314 per person.

Result

In 2024–25, the average cost per person for delivering population health programs through Population Health Units was $322, which is 2.5 per cent unfavourable against the target. The higher cost profile which contributed to the indicator being above target is attributed to increased employment costs related to higher than expected Enterprise Bargaining Award increases from the Government's Wages Policy, and inflationary pressures.

Figure 13: Average cost per person of delivering population health programs by population health units 2022–23 to 2024–25

2022–23 Actual	2023–24 Actual	**2024–25 Actual**	2024–25 Target
$263	$281	**$322**	$314

Reporting period: Financial year.

Comparative data for 2022–23 and 2023–24 have been restated due to a change in methodology for some cost distribution.

Data sources: Health Service financial system, Estimated Resident Populations for 2019–2023 as provided by Epidemiology Directorate, Public and Aboriginal Health Division, WA Department of Health

[13] WA Health Promotion Strategic Framework 2022–2026
WA Health Promotion Strategic Framework