KEY PERFORMANCE INDICATORS

CERTIFICATION OF KEY PERFORMANCE INDICATORS

Child and Adolescent Health Service

Certification of key performance indicators for the year ended 30 June 2026

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 2026.

Dr Neale Fong
Board Chair
Child and Adolescent Health Service
28 August 2026

Mrs Mary Anne Stephens
Chair, Finance Committee
Child and Adolescent Health Service
28 August 2026

KEY PERFORMANCE INDICATORS

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 2025 targets are based on the total child and adult population, and for each procedure is:

Surgical procedure	Target (per 1,000)
Tonsillectomy and adenoidectomy	≤79.2
Appendicectomy	≤27.8

Result

Tonsillectomy and adenoidectomy

Figure 1: Rate of unplanned hospital readmissions for patients within 28 days for tonsillectomy and adenoidectomy, 2023 to 2025

2023	2024	2025	Target
56.6	40.4	49.3	≤79.2

While the rate for tonsillectomy and adenoidectomy procedures increased compared to 2024, it remained below the 2023 result of 56.6 per 1,000 and well below the target of ≤79.2 per 1,000.

CAHS continues to take a proactive approach to patient care before, during and after surgery. Pre-operative telehealth and virtual care continue to support patient and family readiness for surgery and recovery.

Following surgery, CAHS provides comprehensive education to parents and carers at discharge, including accessible post-operative information and post-discharge telehealth consults.

Appendicectomy

Figure 2: Rate of unplanned hospital readmissions for patients within 28 days for appendicectomy, 2023 to 2025

2023	2024	2025	Target
14.8	17.5	29.5	≤27.8

The rate of unplanned readmissions for appendicectomy procedures increased to 29.5 per 1,000 in 2025, compared to 17.5 per 1,000 in 2024, and is above the target of ≤27.8 per 1,000.

Results reflect a low volume of cases, clinical complexity and a low threshold for readmission. CAHS reviews all unplanned readmissions for appendicectomy procedures to identify if there were any modifiable factors contributing to readmission. Where opportunities for improvement are identified, targeted improvements are progressed through established governance processes to strengthen care pathways and reduce avoidable readmissions.

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: 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: 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, resulting in placement of the patient 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.

Target

The 2025–26 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, 2023–24 to 2025–26

	2023–24	2024–25	2025–26	Target
Category 1	8.7%	4.6%	3.5%	0%
Category 2	26.3%	18.8%	15.5%	0%
Category 3	34.7%	26.1%	7.2%	0%

In 2025–26, CAHS continued to reduce in the percentage of patients waiting over clinically recommended timeframes across all urgency categories. While performance has improved significantly compared to prior years, results remain above the target of 0 per cent, reflecting ongoing demand for elective surgical services.

As of 30 June 2026, 3.5 per cent of Category 1 patients were not treated within 30 days, 15.5 per cent of Category 2 patients were not treated within 90 days, and 7.2 per cent of Category 3 patients were not treated within 365 days.

CAHS continues to actively manage elective surgery demand and capacity through a coordinated service-wide approach. CAHS results reflect improvements from targeted initiatives to improve theatre utilisation and scheduling efficiency, increased surgical capacity, and strengthened partnerships with the Western Australian Country Health Service to support access to care across the state.

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 (S. aureus) bloodstream infection is a serious infection that may be associated with the provision of health care. *S. 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 per cent[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 2025 target is ≤1.0 infections per 10,000 occupied bed-days.

Result

Figure 4: Healthcare-associated *Staphylococcus aureus* bloodstream infections (HA-SABSI) per 10,000 occupied bed-days, 2023 to 2025

2023	2024	2025	Target
0.70	0.55	1.08	≤1.0

The *S. aureus* bloodstream infection rate increased to 1.08 per 10,000 occupied bed-days in 2025, compared to 0.55 in 2024, and is above the WA health system target of ≤1.0 per 10,000 occupied bed-days.

CAHS participates in a statewide surveillance program and reviews all *S. aureus* bloodstream infections to identify if there were any modifiable factors that may have contributed to the infection. During 2025 CAHS identified a number of opportunities for improvement including enhanced central line care practices, introduction of new antimicrobial technologies and strengthened compliance with antimicrobial screening and decolonisation protocols. Collectively, these interventions are expected to strengthen infection prevention controls and support a return to target performance achievement.

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 per cent 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 per cent) in WA were 7.5 times more likely than non-Aboriginal patients (0.6 per cent) to discharge at own risk, compared with 5.2 times nationally (3.8 per cent and 0.7 per cent 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 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 responsive 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.

The DAMA 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 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 2025 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, 2023 to 2025

	2023	2024	2025	Target
Aboriginal patients	0.24%	0.11%	0.51%	≤2.78%
Non-Aboriginal patients	0.10%	0.06%	0.06%	≤0.99%

In 2025, CAHS recorded a DAMA rate of 0.51 per cent for Aboriginal patients, which remains 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 maintain low DAMA rates. A range of support services, including those provided by Aboriginal Liaison Officers, social workers and clinical teams, continue to support patients and families and contribute to these outcomes.

Targeted initiatives to improve culturally responsive care remain a key focus, including implementation of the CAHS Aboriginal Workforce Action Plan 2026–28, delivery of face-to-face cultural training, and the continued development of welcoming and culturally safe care environments. CAHS is committed to strengthening engagement with Aboriginal patients and families to support continued improvement in DAMA rates and broader Aboriginal health outcomes.

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 www.indigenoushpf.gov.au/measures/3-09-self-discharge-from-hospital/data#DataTablesAndResources
[9] For more information see www.pc.gov.au/ongoing/report-on-government-services/
[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 2025 target is ≤12%.

Result

Figure 6: Readmissions to acute specialised mental health inpatient services within 28 days of discharge, 2023 to 2025

2023	2024	2025	Target
24.3%	18.5%	20.1%	≤12%

The rate of total hospital readmissions increased to 20.1 per cent in 2025, compared to 18.5 per cent in 2024, and remains above the target of 12 per cent. It should be noted that this indicator does not distinguish between planned and unplanned readmissions. CAHS continues to provide clinically appropriate planned admissions for young people who would benefit from an additional inpatient stay.

During 2025, CAMHS continued to strengthen discharge planning, multidisciplinary case review processes and coordination with community mental health services to support continuity of care following discharge.

Additional initiatives, including enhanced community-based alternatives to admission and expansion of intensive outreach responses, are expected to further support young people during periods of transition and reduce avoidable readmissions. 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: www.aihw.gov.au/getmedia/d8be52c84-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 the 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 2025 target is ≥75%.

Result

Figure 7: Percentage of post-discharge community care within 7 days following discharge from acute specialised mental health inpatient services, 2023 to 2025

2023	2024	2025	Target
78.5%	83.6%	86.8%	≥75%

In 2025, 86.8 per cent of young people admitted to CAHS acute specialised mental health inpatient services were contacted by a CAHS mental health service team member within 7 days of discharge. This is above the target of 75 per cent and an improvement from 83.6 per cent in 2024.

This improvement reflects ongoing efforts to strengthen discharge planning, improve coordination between inpatient and community services, and prioritise timely post-discharge review for young people with complex mental health needs. Key initiatives have included enhanced monitoring of follow-up timeframes and continued development of community-based support options to facilitate safe transitions from inpatient care. CAHS is committed to supporting safe transitions of care from hospital to the community for our young people.

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 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 Finance, and published in the 2025–26 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 2025–26 budget allocation, it is important that efficiency of service delivery is accurately monitored and reported.

Target

The 2025–26 target is ≤ $8,183 per weighted activity unit.

Result

The average admitted cost per weighted activity unit was $9,925 in 2025–26, which is 21.3 per cent unfavourable against the target. The target was developed at a whole of WA health system level and the same target applies to all Health Service Providers.

In 2025–26 CAHS delivered considerably more admitted activity than the prior year, which was achieved at a higher cost profile in comparison to 2024–25. The higher cost profile contributing to the higher than target outcome in 2025–26 was a result of higher than expected Enterprise Bargaining Award increases from the Government's Wages Policy, and escalating costs for goods and services.

Figure 8: Average admitted cost per weighted activity unit, 2023–24 to 2025–26

2023–24 Actual	2024–25 Actual	2025–26 Actual	2025–26 Target
$9,199	$9,174	$9,925	$8,183

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.
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 and Finance, which is published in the 2025–26 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 2025–26 target is $8,094 per weighted activity unit.

Result

The average Emergency Department cost per weighted activity unit was $11,024 in 2025–26 which is 36.2 per cent above 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, CAHS supported a larger number of presentations through its Emergency Department.

Figure 9: Average Emergency Department cost per weighted activity unit, 2023–24 to 2025–26

2023–24 Actual	2024–25 Actual	2025–26 Actual	2025–26 Target
$11,388	$11,259	$11,024	$8,094

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.
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 and Finance, which is published in the 2025–26 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 2025–26 target is $8,328 per weighted activity unit.

Result

The average non-admitted cost per weighted activity unit was $10,032 in 2025-26, which is 20.5 per cent above the target. The target was developed at a whole of WA health system level and the same target applies to all Health Service Providers.

In 2025–26, 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. Compared to the prior year, CAHS has delivered significantly more non-admitted services.

Figure 10: Average non-admitted cost per weighted activity unit, 2023–24 to 2025–26

2023–24 Actual	2024–25 Actual	2025–26 Actual	2025–26 Target
$9,430	$9,334	$10,032	$8,328

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.
Data sources: Health Service financial system, Non-admitted Patient Activity and Waitlist 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 2025–26 target is ≤$3,445.

Result

In 2025–26 , the average cost per bed-day in specialised mental health inpatient services was $7,461, representing a 116.6 per cent increase above the target. This variance was driven by a combination of factors, including the continuation of additional staffing to support reforms arising from the Ministerial Taskforce into Public Mental Health Services. The higher than target cost profile includes the increase in workforce to support the commissioning, operations and licensing costs of the Nickoll Ward at the Hollywood Hospital. The Nickoll Ward continues to be used as a decant facility whilst the refurbishment of the inpatient mental health ward at the Perth Children's Hospital is completed.

Figure 11: Average cost per bed-day in specialised mental health inpatient units, 2023–24 to 2025–26

2023–24 Actual	2024–25 Actual	2025–26 Actual	2025–26 Target
$5,533	$8,021	$7,461	$3,445

Reporting period: Financial year.
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 2025-26 target is $1,117 per treatment day.

Result

In 2025–26, the average cost per treatment day for non-admitted care provided by public clinical mental health services was $1,025, which was 9 per cent higher than the prior year but 8.2 per cent below the target. The increase from 2024–25 was influenced by a range of cost pressures, including increased employment costs arising from higher than expected Enterprise Bargaining Award wage increases from the Government's Wages Policy and inflationary cost impacts. Despite these cost increases, the average cost per treatment day remained below target.

Figure 12: Average cost per treatment day of non-admitted care provided by mental health services, 2023–24 to 2025–26

2023–24 Actual	2024–25 Actual	2025–26 Actual	2025–26 Target
$876	$932	$1,025	$1,117

Note: PCH, Specialised and Community Child and Adolescent Mental Health Services have been restructured into a single integrated service for reporting. This restructure is intended to support continuity throughout the patient journey, improve coordination between services, and minimise duplication when patients transition from one service to another.
The 2025–26 KPI denominator has been calculated using a revised methodology, including the updated approach to the calculation of treatment days and the rationale for this change. This revised methodology will be applied consistently in future reporting periods.
The target and comparative figures for 2024–25 and 2023–24 have been calculated using the previous methodology and therefore remain unchanged. The impact of applying the revised methodology to the comparative figures is considered immaterial and, accordingly, no restatement of the comparative figure is required.
Reporting period: Financial year.
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 2025-26 target is $318 per person.

Result

In 2025-26, the average cost per person for delivering population health programs through Population Health Units was $345, which is 8.5 per cent unfavourable against the target. The higher cost profile which contributed to the indicator being above target was largely attributed to increased employment costs related to higher than expected Enterprise Bargaining Award increases from the Government's Wages Policy, and inflationary pressures experienced throughout the financial year.

Figure 13: Average cost per person of delivering population health programs by population health units, 2023–24 to 2025–26

2023–24 Actual	2024–25 Actual	2025–26 Actual	2025–26 Target
$281	$322	$345	$318

Reporting period: Financial year.

Data sources: Health Service financial system, Estimated Resident Populations for 2020–2024 as provided by Epidemiology Directorate, Public and Aboriginal Health Division, WA Department of Health

[13] WA Health Promotion Strategic Framework 2022-2026: www.health.wa.gov.au/Reports-and-publications/WA-Health-Promotion-Strategic-Framework