
# Key performance indicators

# Certification of key performance indicators

## Child and Adolescent Health Service

Certification of key performance indicators for the year ended 30 June 2024

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 (CAHS) for the reporting period ended 30 June 2024.

**Dr Rosanna Capolingua AM**
Board Chair
Child and Adolescent Health Service
9 September 2024

**Ms Pamela Michael**
Deputy Board Chair
Child and Adolescent Health Service
9 September 2024

# 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 predischarge, 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).

## Target

The 2023 targets are based on the total child and adult population, and for each procedure is:

| Surgical Procedure | Target (per 1,000) |
|---|---|
| Tonsillectomy & Adenoidectomy | ≤77.3 |
| Appendicectomy | ≤23.9 |

## Result

### Tonsillectomy & Adenoidectomy

**Figure 1: Rate of unplanned hospital readmissions for patients within 28 days for tonsillectomy and adenoidectomy, 2021 to 2023**

| 2021 | 2022 | 2023 | Target |
|---|---|---|---|
| 49.1 | 50.6 | 56.6 | ≤77.3 |

The rate of unplanned readmission for tonsillectomy and adenoidectomy was 56.6 per 1,000, which is below the target of 77.3 per 1,000. CAHS has a comprehensive approach in place for managing tonsillectomy and adenotonsillectomy procedures, which encompasses pre-operative and post-operative initiatives to improve patient care and decrease readmission rates.

Before surgery, CAHS provides a pre-operative telehealth clinic appointment to prepare patients and their families for surgery and the subsequent recovery process. Following surgery, CAHS provides comprehensive education to parents and carers at the time of discharge, provides post-operative information that is accessible in different languages to assist families in managing care, and contacts parents and carers to provide support for post-operative pain management and address any concerns that may arise during the recovery period.

### Appendicectomy

**Figure 2: Rate of unplanned hospital readmissions for patients within 28 days for appendicectomy, 2021 to 2023**

| 2021 | 2022 | 2023 | Target |
|---|---|---|---|
| 11.0 | 15.0 | 14.8 | ≤23.9 |

The rate of unplanned readmissions for appendicectomy was 14.8 per 1,000, which is below the target of 23.9 per 1,000. CAHS' constant attention to timely access to the theatre for appendicectomy has contributed to this outcome, resulting in a decrease in the risk of complications and reduced length of hospital stay. Following surgery, CAHS provides comprehensive education and information to parents and carers at the time of discharge.

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.

[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/healthcare-quality-performance/towards-national-indicators-of-safety-and-quality/contents/table-of-content

[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-hospitalreadmission-literature-review-australian-and-international-indicators

## 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[3]. 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 2023–24 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, 2021–22 to 2023–24**

| | 2021–22 | 2022–23 | 2023–24 | Target |
|---|---|---|---|---|
| **Category 1** | 4.7% | 9.9% | **8.7%** | 0% |
| **Category 2** | 28.1% | 28.7% | **26.3%** | 0% |
| **Category 3** | 26.8% | 39.6% | **34.7%** | 0% |

In the 2023–2024 year, there has been a steady improvement in the percentage of patients over boundary on the surgical waitlist. An average of 8.7 per cent of Category 1 patients were not treated within 30 days, 26.3 per cent of Category 2 patients were not treated within 90 days, and 34.7 per cent of Category 3 patients were not treated within 365 days.

CAHS is dedicated 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 continually strives to improve access to elective surgery for patients and added additional capacity for the 2023–2024 financial year.

The impact of the restrictions placed on elective surgery during the COVID-19 pandemic, coupled with ongoing high demand for surgical care, continue to impact the results of these indicators.

CAHS has implemented initiatives to manage the elective surgery waitlist including:

- the commencement of one additional operating theatre session per week in 2023–2024.
- the commencement of commissioning and fit-out of an additional operating theatre due for completion in 2024.
- partnering with the Western Australian Country Health Service (WACHS) to deliver dental surgery in the South West and Great Southern regions.
- continuing weekly surgical capacity planning meetings to ensure that all elective theatre sessions are booked to maximum capacity.

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.

[3] 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.

## 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%[4]).

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 2023 target is ≤1.0 infections per 10,000 occupied bed-days.

### Result

CAHS maintained its *S. aureus* bloodstream infection rate in 2023 at 0.70 per 10,000 occupied bed-days, which is below the WA health system target of 1.0 per 10,000 bed-days. The favourable result is due to initiatives that CAHS has in place to prevent *S. aureus* infection, particularly *S. aureus* decolonisation of all children undergoing high-risk procedures, including where a new central venous access device (CVAD) is inserted, a strong focus on hand hygiene and aseptic technique compliance, and the dedicated CVAD 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.

**Figure 4: Healthcare associated *Staphylococcus aureus* bloodstream infections (HA-SABSI) per 10,000 occupied bed-days, 2021 to 2023**

| 2021 | 2022 | 2023 | Target |
|---|---|---|---|
| 0.88 | 0.92 | 0.70 | ≤1.0 |

[4] 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

## 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, or missing and not found). Patients who do so have a higher risk of readmission and mortality[5] and have been found to cost the health system 50% more than patients who are discharged by their physician.[6]

Between July 2019 and June 2021 Aboriginal patients (4.7%) in WA were over 10 times more likely than non-Aboriginal patients (0.5%) to discharge against medical advice, compared with 6.6 times nationally (4.0% and 0.6% respectively)[7]. 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 2023 under the performance of governments in providing acute care services in public hospitals.[8]

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.[8]

### Target

The 2023 targets are based on the total child and adult population:

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

### Result

In 2023, CAHS recorded a DAMA rate of 0.24 per cent for Aboriginal patients, which is below the target of 2.78 per cent. For non-Aboriginal patients, the rate was 0.10 per cent, which is also well below the target of 0.99 per cent. Contributing to the continued favourable result, comparative to target, for Aboriginal patients is the Koorliny Moort (Walking with Families) program, which engages with Aboriginal people through the patient's journey. While these results demonstrate that CAHS continues to meet its targets for DAMA, CAHS continues to work towards reducing these rates even further.

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

Data source: Hospital Morbidity Data Collection.

**Figure 5: Percentage of admitted patients who discharged against medical advice, 2021 to 2023**

| | 2021 | 2022 | 2023 | Target |
|---|---|---|---|---|
| **Aboriginal Patients** | 0.33% | 0.25% | **0.24%** | ≤2.78% |
| **Non-Aboriginal Patients** | 0.04% | 0.05% | **0.10%** | ≤0.99% |

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

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

[7] Australian Institute of Health and Welfare 2024. Aboriginal and Torres Strait Islander Health Performance Framework 2020 summary report. Cat. no. IHPF 2. Canberra: AIHW. Available at: www.indigenoushpf.gov.au/measures/3-09-self-discharge-from-hospital/data#DataTablesAndResources

[8] For more information see 12 Public hospitals - Report on Government Services 2023 – Productivity Commission (pc.gov.au)

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

## 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.[10]

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 2023 target is ≤12%.

### Result

The rate of total hospital readmissions for 2023 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. While CAHS continues to strive to understand and reduce the number of unplanned readmissions through care provided in community mental health services, 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).

**Figure 6: Readmissions to acute specialised mental health inpatient services within 28 days of discharge, 2021 to 2023**

| 2021 | 2022 | 2023 | Target |
|---|---|---|---|
| 13.6% | 24.9% | 24.3% | ≤12.0% |

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

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

### Rationale

In 2017–18, one in five (4.8 million) Australians reported having a mental or behavioural condition[11]. 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 2023 target is ≥75%.

### Result

In 2023, 78.5 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 is committed to supporting safe transitions of care from hospital to the community for our young people and will consider strategies to address the declining 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).

**Figure 7: Percentage of post-discharge community care within seven days following discharge from acute specialised mental health inpatient services, 2021 to 2023**

| 2021 | 2022 | 2023 | Target |
|---|---|---|---|
| 87.2% | 78.8% | 78.5% | ≥75% |

[11] National Health Survey: First results, 2017-18 financial year | Australian Bureau of Statistics (abs.gov.au)

## 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 2023–24 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 2023–24 budget allocation, it is important that efficiency of service delivery is accurately monitored and reported.

### Target

The 2023–24 target is ≤$7,461 per weighted activity unit.

### Result

The average admitted cost per weighted activity unit was $9,335 in 2023–24, which is 25.1 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 2023–24 the combination of the higher cost profile, particularly through Government's Wages Policy, cost escalation for goods and services, and the lower-than-normal activity generated and below activity target performance contributed to this indicator being above target. Increases were noted in employment costs to address the continuing pressures in clinical areas.

In addition, the hospital workforce capacity increased to ensure adequate staffing levels to maintain safety and quality measures, and cost pressures were also seen within surgical and consumables, pharmaceutical supplies, and utility charges.

**Figure 8: Average admitted cost per weighted activity unit, 2021–22 to 2023–24**

| 2021–22 Actual | 2022–23 Actual | 2023–24 Actual | 2023–24 Target |
|---|---|---|---|
| $7,816 | $8,418 | **$9,335** | $7,461 |

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 have been restated due to a change in methodology for some cost distribution.

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

## 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 2023–24 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 2023–24 target is ≤$7,243 per weighted activity unit.

### Result

The average Emergency Department cost per weighted activity unit was $11,474 in 2023–24 which is 58.4 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 staff costs from the Government's Wages Policy, and the expanded workforce capacity in the Emergency Department to maintain appropriate safety and quality measures.

Additional efforts were also undertaken to enhance nurse-to-patient ratios and implement a dedicated resuscitation team at the PCH Emergency Department under the Emergency Department Reform and System Capacity and Demand Responses. Additionally, the average cost increased due to lower presentations in the Emergency Department compared to the previous year.

**Figure 9: Average Emergency Department cost per weighted activity unit, 2021–22 to 2023–24**

| 2021–22 Actual | 2022–23 Actual | 2023–24 Actual | 2023–24 Target |
|---|---|---|---|
| $9,200 | $9,839 | **$11,474** | $7,243 |

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 have been restated due to a change in methodology for some cost distribution.

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

## 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 2023–24 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 2023–24 target is ≤$7,325 per weighted activity unit.

### Result

The average non-admitted cost per weighted activity unit was $9,547 in 2023–24, which is 30.3 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 2023–24 the combination of the higher cost profile due to the Government's Wages Policy, inflationary cost pressures and the lower-than-target activity contributed to this indicator being above target. In addition, the hospital workforce capacity increased to ensure adequate staffing levels to maintain safety and quality measures.

**Figure 10: Average non-admitted cost per weighted activity unit, 2021–22 to 2023–24**

| 2021–22 Actual | 2022–23 Actual | 2023–24 Actual | 2023–24 Target |
|---|---|---|---|
| $7,207 | $8,931 | **$9,547** | $7,325 |

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 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.

## 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 2023–24 target is ≤$2,937 per bed-day.

### Result

The average non-admitted cost per weighted activity unit was $9,547 in 2023–24, which is 30.3 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 average cost per bed-day in specialised mental health inpatient services increased significantly in 2023–24 to $5,555 which is 89.1 per cent above the target. In 2023–24 the costs of delivering mental health inpatient services have increased due to additional staffing was dedicated to support the reform from the outcomes under the Ministerial Taskforce into Public Mental Health Services. The higher cost profile was also driven by the Government's Wages Policy, inflationary pressures, higher security service costs and an elevated RiskCover premium.

**Figure 11: Average cost per bed-day in specialised mental health inpatient units, 2021–22 to 2023–24**

| 2021–22 Actual | 2022–23 Actual | 2023–24 Actual | 2023–24 Target |
|---|---|---|---|
| $3,374 | $4,779 | **$5,555** | $2,937 |

Reporting period: Financial year.

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

Data sources: Health Service financial system, BedState.

## 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. Efficient functioning of public community mental health services is essential to ensure that finite funds are used effectively to deliver maximum community benefit.

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.

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 2023–24 target is ≤ $723 per treatment day.

### Result

The average cost per treatment day of non-admitted care provided by public clinical mental health services rose in 2023–24 to $877, which is 21.3 per cent above the target. The financial performance in 2023–24 is attributable to a combination of higher operating costs including the impact of Government's Wages Policy, as well as inflationary cost pressures seen in 2023–24 and lower treatment days in community mental health settings.

**Figure 12: Average cost per treatment day of non-admitted care provided by mental health services, 2021–22 to 2023–24**

| 2021–22 Actual | 2022–23 Actual | 2023–24 Actual | 2023–24 Target |
|---|---|---|---|
| $653 | $850 | **$877** | $723 |

Reporting period: Financial year.

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

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

## 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.[12] This is based on the growing understanding of the social, cultural and economic factors that contribute to a person's health status.

### Target

The 2023–24 target is ≤ $247 per person.

### Result

The average cost per person of delivering population health programs by population health units in 2023–24 was $282, which is 14.2 per cent above the target.
The higher cost profile which contributed to the indicator being above target is mainly because of increase in staff costs due to the Government's Wages Policy, as well as inflationary cost pressures seen in 2023–24 and a lower target set for 2023–24.

**Figure 13: Average cost per person of delivering population health programs by population health units, 2021–22 to 2023–24**

| 2021–22 Actual | 2022–23 Actual | 2023–24 Actual | 2023–24 Target |
|---|---|---|---|
| $242 | $264 | **$282** | $247 |

Reporting period: Financial year.

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

Data sources: Health Service financial system, Australian Bureau of Statistics.

[12] A copy of the WA Health Promotion Strategic Framework 2022-2026 can be located on www.health.wa.gov.au/~/media/Corp/Documents/Reports-and-publications/HPSF/Health-Promotion-Strategic-Framework-2022-2026.pdf