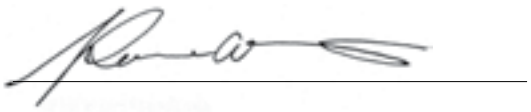
Key performance indicators

Certification of key performance indicators

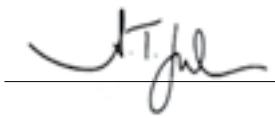
CHILD AND ADOLESCENT HEALTH SERVICE

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

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 reporting period ended 30 June 2022.



Dr Rosanna Capolingua
Board Chair
Child and Adolescent Health Service
1 September 2022



Dr Alexius Julian
Board Member
Child and Adolescent Health Service
1 September 2022

The relationship between the following key performance indicators and the Government goal, outcomes and services is described in the Performance Management Framework section commencing on page 83.

The latest available data has been used to report performance, which in some instances means results are for the 2021 calendar year.

KPIs measuring Outcome 1:

KPIs measuring Outcome 2:

Effectiveness KPI – Outcome 1
Public hospital-based services that enable effective treatment and restorative health care for Western Australians

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 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 Health Agreement Unplanned Readmission performance indicator (NHA PI 23).

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/contents/table-of-contents

Target

The 2021 targets are based on the total child and adult population, and for each procedure is:

Surgical Procedure	Target (per 1,000)
Tonsillectomy & Adenoidectomy	≤81.8
Appendicectomy	≤25.7

Results

Tonsillectomy & Adenoidectomy

The rate of unplanned readmission for tonsillectomy and adenoidectomy was 49.1 per 1,000, which is lower than previous years and below the target of 81.8 per 1,000 (Figure 1).

Appendicectomy

The rate of unplanned readmissions for appendicectomy was 11.0 per 1,000, which is lower than previous years and below the target of 25.7 per 1,000 (Figure 2).

Figure 1: Rate of unplanned hospital readmissions for patients within 28 days for tonsillectomy and adenoidectomy, 2019 to 2021

Actual 2019	Actual 2020	Actual 2021	Target
77.9	65.5	49.1	81.8

Figure 2: Rate of unplanned hospital readmissions for patients within 28 days for appendicectomy, 2019 to 2021

Actual 2019	Actual 2020	Actual 2021	Target
19.3	16.5	11.0	25.7

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

Effectiveness KPI – Outcome 1
Public hospital-based services that enable effective treatment and restorative health care for Western Australians

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[2]. 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.

2 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.

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

Target

The 2021–22 target is zero per cent for each urgency category. Performance is demonstrated by a result that is equal to the target.

Results

Figure 3 shows an average of 4.7 per cent of Category 1 patients were not treated within 30 days, 28.1 per cent of Category 2 patients were not treated within 90 days, and 26.8 per cent of Category 3 patients were not treated within 365 days.

CAHS is dedicated to ongoing improvement in service delivery and clinical management to ensure patients with the most critical clinical need are prioritised and treated as soon as possible. CAHS considers the performance reported unacceptable and continues to work toward improved access to elective surgery for patients.

Declines in performance were impacted due to the COVID-19 pandemic with patients not being fit for surgery, reduced booking of cases and increased cancellations. Continued impact of furloughed staff due to COVID-19 has also reduced the capacity of surgical cases and reduction in elective surgery to manage WA health service demand.

This included the scaling back of elective surgeries in September 2021 due to hospital capacity issues state-wide, and again from March 2022 when the COVID-19 Framework for System Alert and Response (SAR) moved to a phase 'red' alert, which reduced the amount of Category 2 and 3 surgical activity to support a coordinated risk management approach to the pandemic.

Figure 3: Percentage of elective wait list patients waiting over boundary for reportable procedures, by urgency category, 2019–20 to 2021–22

	Actual 2019-20	Actual 2020-21	Actual 2021-22	Target
Category 1	4.7%	1.7%	4.7%	0%
Category 2	15.1%	29.2%	28.1%	0%
Category 3	13.1%	21.5%	26.8%	0%

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.

Effectiveness KPI – Outcome 1
Public hospital-based services that enable effective treatment and restorative health care for Western Australians

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 healthcare. *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 per cent[3] in adults and five per cent in children).

HA-SABSI is generally considered to be a preventable adverse event associated with the provision of healthcare, 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 2021 target is ≤1.0 infections per 10,000 occupied bed-days.

Result

CAHS provides a range of specialised services, including neonatal and paediatric intensive care, cardiothoracic surgery and oncology. Many patients are therefore at higher risk of Staphylococcus aureus (S. aureus) infection than those at hospitals providing less specialised services. Despite this, CAHS maintained its S. aureus bloodstream infection rate in 2021 to 0.88 per 10,000 occupied bed-days, which is below the WA health system target of 1.0 per 10,000 bed-days (Figure 4). The favourable result is due to a number of initiatives that CAHS has in place to prevent S. aureus infection, particularly S. aureus decolonisation of all children 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.

Figure 4: Healthcare associated Staphylococcus aureus bloodstream infections (HA-SABSI) per 10,000 occupied bed-days, 2019 to 2021

Actual 2019	Actual 2020	Actual 2021	Target
0.89	0.48	0.88	1.0

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

Data source: Healthcare Infection Surveillance Western Australia Data Collection.

3 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


ULTRASOUND

Effectiveness KPI – Outcome 1
Public hospital-based services that enable effective treatment and restorative health care for Western Australians

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

Rationale

Discharge against medical advice (DAMA) refers to patients leaving hospital against the advice of their treating medical team or without advising hospital staff (e.g. absconding or missing and not found). Patients who do so have a higher risk of readmission and mortality[4] and have been found to cost the health system 50 per cent more than patients who are discharged by their physician.[5]

Between July 2015 and June 2017 Aboriginal patients (3.4 per cent) in WA were over 11 times more likely than non-Aboriginal patients (0.3 per cent) to discharge against medical advice, compared with 6.2 times nationally (3.1 per cent and 0.5 per cent respectively) 6. This statistic indicates a need for improved responses by the health system to the needs of Aboriginal patients.

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.

Target

The 2021 targets are based on the total child and adult population:

	Target
Aboriginal patients	≤2.78%
Non-Aboriginal patients	≤0.99%

Results

In 2021, CAHS recorded a rate of discharge against medical advice of 0.33 per cent for Aboriginal patients, which is well below the target of 2.78 per cent. For non-Aboriginal patients, the rate was 0.04 per cent, which is also well below the target of 0.99 per cent (Figure 5). 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.

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

Figure 5: Percentage of admitted patients who discharged against medical advice, 2019 to 2021

	Actual 2019	Actual 2020	Actual 2021	Target
Aboriginal Patients	0.13%	0.14%	0.33%	2.78%
Non-Aboriginal Patients	0.10%	0.06%	0.04%	0.99%

Reporting period: Calendar year, to account for lag in reporting due to clinical coding completion.
Data source: Hospital Morbidity Data Collection.

Effectiveness KPI – Outcome 1
Public hospital-based services that enable effective treatment and restorative health care for Western Australians

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[6].

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 2021 target is ≤12 per cent.

Result

Although above the target of 12 per cent, the rate of total hospital readmissions within 28 days to an acute designated mental health inpatient unit in 2021 has improved over the years to 13.6 per cent (Figure 6). The reduction is in part due to the continuation of the Emergency Telehealth Service to provide mental health assessments within the home. It should be noted that this indicator does not distinguish between planned and unplanned readmissions. Child and Adolescent Mental Health Services provide planned admissions for those who require frequent inpatient admissions and non-acute interventions as part of their care.

Figure 6: Readmissions to acute specialised mental health inpatient services within 28 days of discharge, 2019 to 2021

Actual 2019	Actual 2020	Actual 2021	Target
26.6%	23.3%	13.6%	12.0%

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)

6 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-a53f4eef-a7e6-f81a5af94764/Fourth-national-mental-health-plan-measurement-strategy-2011.pdf.aspx

Effectiveness KPI – Outcome 1
Public hospital-based services that enable effective treatment and restorative health care for Western Australians

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.[7] 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 2021 target is ≥75 per cent.

Result

In 2021, 87.2 per cent of young people who were admitted to CAHS acute specialised mental health inpatient services were contacted by a community-based public mental health non-admitted health service within seven days of discharge, which is well above the target of 75 per cent (Figure 7). This included contacts with their carers. The continuation of the Emergency Telehealth Service in 2021 contributed to this performance by establishing a formal process of follow up for those young people discharged to private and not-for-profit care providers.

Figure 7: Percentage of post-discharge community care within seven days following discharge from acute specialised mental health inpatient services, 2019 to 2021

Actual 2019	Actual 2020	Actual 2021	Target
89.1%	94.1%	87.2%	75.0%

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).

7 National Health Survey 2017-18

Effectiveness KPI – Outcome 1
Public hospital-based services that enable effective treatment and restorative health care for Western Australians

Average admitted cost per weighted activity unit

Rationale

This indicator is a measure of the cost per WAU compared with the State target, as approved by the Department of Treasury and published in the 2021-22 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 2021-22 budget allocation, it is important that efficiency of service delivery is accurately monitored and reported.

Target

The 2021–22 target is ≤$6,907 per weighted activity unit.

Result

The average admitted cost per weighted activity unit was $7,816 in 2021–22, which is 13.2 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. In 2021-22 admitted activity slowed as a result of the COVID-19 pandemic, and the combination of the higher cost profile and lower activity contributed to the indicator being above target. Increases were noted in employment costs to address continuing pressures in clinical areas, largely associated with Government's announcement of opening additional beds on the wards and Emergency Department. In addition, staffing levels were uplifted to enhance safety and quality measures and increase hospital workforce capacity to ensure preparedness for COVID-19 management and response.

Figure 8: Average admitted cost per weighted activity unit, 2019–20 to 2021–22

2019-20 Actual[(a)]	2020-21 Actual[(a)]	2021-22 Actual	2021-22 Target
$ 7,327	$ 6,866	$7,816	$6,907

[(a)] The Under Treasurer has approved the changes to the calculation methodology of the 2021-22 efficiency indicators by removing financial products, such as depreciation and amortisation expense, to allow for better comparison of performance across the Health Service Providers. CAHS has restated the 2019-20 and 2020-21 results for comparability.

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 a ssign 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, which is published in the 2021-22 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 2021–22 target is ≤$6,847 per weighted activity unit.

Result

The average Emergency Department cost per weighted activity unit rose significantly to $9,200 in 2021–22, which is 34.4 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. Activity in Emergency Department continues to increase and remains above the recorded level in the prior year. The higher cost profile which contributed to the indicator being above target is mainly as a result of staff uplift to increase Emergency Department workforce capacity and to ensure preparedness for COVID-19 management and response.

Figure 9: Average Emergency Department cost per weighted activity unit, 2019–20 to 2021–22

2019-20 Actual[(a)]	2020-21 Actual[(a)]	2021-22 Actual	Target 2021-22
$ 7,565	$7,056	$9,200	$6,847

(a) The Under Treasurer has approved the changes to the calculation methodology of the 2021-22 efficiency indicators by removing financial products, such as depreciation and amortisation expense, to allow for better comparison of performance across the Health Service Providers. CAHS has restated the 2019-20 and 2020-21 results for comparability.

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 target, as approved by the Department of Treasury, which is published in the 2021-22 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 2021–22 target is ≤$6,864 per weighted activity unit.

Result

The average non-admitted cost per weighted activity unit rose significantly to $7,207 in 2021–22, which is 5.0 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 contributed to the indicator being above target is mainly as a result of staff uplift to increase hospital workforce capacity and to ensure preparedness for COVID-19 management and response.

Figure 10: Average non-admitted cost per weighted activity unit, 2019–20 to 2021–22

2019-20 Actual[(a)]	2020-21 Actual[(a)]	2021-22 Actual	2021-22 Target
$7,271	$6,318	$7,207	$6,864

(a) The Under Treasurer has approved the changes to the calculation methodology of the 2021-22 efficiency indicators by removing financial products, such as depreciation and amortisation expense, to allow for better comparison of performance across the Health Service Providers. CAHS has restated the 2019-20 and 2020-21 results for comparability.

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 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 2021–22 target is ≤ $3,209 per bed-day.

Result

The average cost per bed-day in specialised mental health inpatient services rose to $3,374 in 2021-22, which is 5.1 per cent above the target. The decline in financial performance in 2021-22 is attributable to fewer bed days due to staffing shortages and the impact of furloughed staff as a result of COVID-19.

Figure 11: Average cost per bed-day in specialised mental health inpatient units, 2019–20 to 2021–22

2019-20 Actual[(a)]	2020-21 Actual[(a)]	2021-22 Actual	2021-22 Target
$3,425	$2,750	$3,374	$3,209

(a) The Under Treasurer has approved the changes to the calculation methodology of the 2021-22 efficiency indicators by removing financial products, such as depreciation and amortisation expense, to allow for better comparison of performance across the Health Service Providers. CAHS has restated the 2019-20 and 2020-21 results for comparability.

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. 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 healthcare (non-admitted/ambulatory patients).

Target

The 2021–22 target is ≤ $609 per treatment day.

Result

The average cost per treatment day of non-admitted care provided by public clinical mental health services rose to $653 in 2021-22, which is 7.2 per cent above the target. The decline in financial performance in 2021-22 is attributable to a combination of higher operating costs and lower treatment days due to the impact of COVID-19 on staffing and patient attendance.

Figure 12: Average cost per treatment day of non-admitted care provided by mental health services, 2019–20 to 2021–22

2019-20 Actual[(a)]	2020-21 Actual[(a)]	2021-22 Actual	2021-22 Target
$575	$581	$653	$609

(a) The Under Treasurer has approved the changes to the calculation methodology of the 2021-22 efficiency indicators by removing financial products, such as depreciation and amortisation expense, to allow for better comparison of performance across the Health Service Providers. CAHS has restated the 2019-20 and 2020-21 results for comparability.

Reporting period: Financial Year

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

KPIs measuring 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 2017–2021. This is based on the growing understanding of the social, cultural and economic factors that contribute to a person's health status.

Target

The 2021–22 target is ≤ $235 per person.

Result

The average cost per person of delivering population health programs by population health units is fairly constant at $242 in 2021-22, which is 3.0 per cent above the target.

Figure 13: Average cost per person of delivering population health programs by population health units, 2019–20 to 2021–22

2019-20 Actual[(a)]	2020-21 Actual[(a)]	2021-22 Actual	2021-22 Target
$236	$239	$242	$235

(a) The Under Treasurer has approved the changes to the calculation methodology of the 2021-22 efficiency indicators by removing financial products, such as depreciation and amortisation expense, to allow for better comparison of performance across the Health Service Providers. CAHS has restated the 2019-20 and 2020-21 results for comparability.

Reporting period: Financial Year

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