8A SERVICES FOR PEOPLE WITH A DISABILITY

Definitions for the descriptors and indicators in this attachment are in Section 8A.4. Unsourced information has been obtained from Commonwealth, State and Territory Governments.

8A.1 Jurisdiction comments

Commonwealth Government Comments

“The Commonwealth Government supports the inclusion of information on service provision for people with a disability in this year’s Report. This is the first attempt at publishing comparable information on service provision in this sector across commonwealth and state jurisdictions.

The performance information in this chapter should be read with caution. The majority of the data has been derived from the collection of Minimum Data Set items undertaken in late 1995. Although proving itself to be reasonably reliable at the Commonwealth level, as a data collection instrument this survey is still in its infancy. In the period under examination the survey also suffered from variable response rates across jurisdictions.

The Commonwealth notes that the scope of this Chapter is limited to specialist disability services funded under the Commonwealth/State Disability Agreement and thus it does not fully represent the jurisdiction’s contribution to supporting people with a disability. In addition to providing some $200 million for disability employment services, the Commonwealth contributes more than $300 million in transfer payments toward the provision of accommodation and other support services administered by State and Territory Governments. Combined with funding for advocacy services, national information and print disability services, the Continence Aids Assistance Scheme, the Commonwealth Rehabilitation Service, Home and Community Care for people with a disability and Australian Hearing Services, the total Commonwealth contribution in 1994–95 exceeded $835 million.

Noting the above limitations, the chapter provides a useful starting point for examining the performance of jurisdictions in the funding and administration of services for people with a disability.

The chapter also highlights the need for continued attention to be given to the further development of performance indicators for the sector. The introduction of a case based payments system for disability employment services will undoubtedly assist in providing more reliable indicators of the efficiency and effectiveness with which those programs are delivered.”

New South Wales Government Comments

“ The NSW Government welcomes the inclusion of data on disability services in this year’s Report on Government Service Provision. However, there are major limitations to the data available this year, with different services included under the CSDA in different jurisdictions and very different systems used to collect financial data.

There are also significant limitations inherent to the CSDA Minimum Data Set, which is a one-day snapshot survey, and was only applied to both NSW Government and non government services for the first time in 1995. There was a 94 per cent completion rate across both sectors, and, while this result is better than in some other jurisdictions, it is a reminder that the data available is incomplete and probably an underestimate of the actual levels of provision. For all these reasons, the NSW Government urges caution in drawing conclusions from interstate comparisons.

This chapter concentrates on specialist disability services. The data shows, for example, the relatively high proportion of people living in institutional services in NSW, reflecting historical patterns of service provision. The NSW Government is committed to an agenda of reform of these services, and created a new agency, the Ageing and Disability Department, in 1995. This has separated the responsibility for funding, policy and planning from the role of provider, which, for government services, is retained by the Department of Community Services.

NSW is also preparing a Disability Policy Framework which emphasises the role of mainstream government services (for example, public transport, health and legal aid services) in responding to the needs of people with disabilities. Increasingly specialist disability services should be seen as supporting only those with the greatest needs unable to be supported by mainstream services.

The chapter notes the difficulty we have in measuring the effectiveness of services in improving the quality of life of people with disabilities. The NSW Government agrees that this is a necessary direction for the future, but the challenge will always be to identify what it is about service provision which improves quality of life, as compared to the many other aspects of people’s lives, not least the impact of the disabilities themselves. We also need to develop measures which pick up the impact of disability services on children as well as adults. ”

Victoria Government Comments

“ The disability service system in Victoria is comprised of a diverse set of services that endeavour to provide appropriate service responses to the wide variety of needs experienced by people with a disability. As this is the first time

a chapter focusing on disability services has been included in the Report, the indicators provided do not nearly reflect this diversity.

Victoria has invested considerable energy in implementing a variety of reforms to the way the disability system operates. These include: introducing more consumer focused or consumer related funding; implementing unit cost funding; expanding the non government sector; redeveloping congregate care facilities; and introducing more effective resource allocation processes. The impact of these initiatives on the system cannot be underestimated. In many of these areas, Victoria is at the forefront of service developments within Australia.

Over recent years the Victorian Government has driven a range of measures designed to improve the effectiveness and efficiency of the disability system. Victoria has looked to improve efficiency in all areas, to assist in meeting government productivity targets and freeing funds for new and expanded services. The State has also placed priority on being clear what outputs are being purchased, ensured that these are purchased at a standard price, and insisted on accountability back to government from service providers. The range and type of service and output data that could be provided by Victoria is expansive, and is not reflected in the chapter outputs.

In terms of the data provided, the following should be noted:

- the 1995–96 unit cost figures for government provided accommodation services were inflated by the payment of significant backpay following wage increases granted to the direct care staff group in these services; and
- the data on administrative costs should be interpreted with caution due to difficulties the Working Group encountered in developing comparable methods of costing administration.

Clearly, further work needs to be undertaken to build on the results presented in this chapter. Data comparability issues have been problematic, and further work needs to be undertaken to improve outputs in this area. Coupled with this, there should be greater efforts to report on a broader range of service types within the disability system in addition to just accommodation and employment.

”

Queensland Government Comments

“ Queensland recognises the value of this chapter of the Report as a useful initial step towards nationally comparable data on disability services. there remain however, reservations in relation to the data presented. The major differences between jurisdictions as to what constitutes inclusion in the CSDA base affects the comparability and quality of the data. The CSDA Minimum Data Set provides information for Queensland from only a proportion of disability services.

Performance indicators for accommodation and employment services provide a limited picture of service provision for individuals. For many people the accommodation is only one component of a complex package of support which may include recreation, higher education and community access.

The provision and funding of services to people with disabilities in Queensland is broadly dispersed across a number of departments and agencies. Most of these were not factored into the calculation of the CSDA base and as, such, data from these services are not reflected in the Report. The Queensland Government also acknowledges the significant financial commitment provided by many non government organisations.

To address the diversity of service system, Queensland has established a Disability Directions Committee (DDC) which provides a mechanism to give effect to a whole of government approach to disability services. This committee was formed in 1992 and now has a membership of 21 State government departments and agencies. The DDC ensures that the efficiency and effectiveness of disability services administered or funded by the Queensland Government is maximised and has a focus on coordinated service systems and the development of collaborative plans.

Queensland is continuing to develop and implement more appropriate service delivery models. These include a program of service reform, with additional funding to enable people to live in community based accommodation, a focus on individuals, with funding linked to assessed ‘packages’ of support and a commitment to expanding the role of non government sector.

Recent initiatives have provided a focus on supporting families who care for a family member with a disability, ageing carers and children with complex needs who require additional support.

Queensland recognises that the publication of data on the performance of government for disability services strengthens accountability to clients. However future work needs to consider the broader range of services types and the issue of quality outcomes for an holistic picture of service provision for people with disabilities. ”

Western Australia Government Comments

“WA supports the move towards developing national performance measures and is continuing to refine and improve its own data collection methodologies. However, WA has strong reservations regarding the validity, reliability and consistency of the data which provide the basis for performance indicators contained in this Report. These concerns, combined with an appreciation of the range of factors that contribute to variation between jurisdictions, place major qualifications on any comparative analysis both across jurisdictions and with subsequent years.

WA is committed to meeting the needs of people with disabilities through a range of services. While 63.1 per cent of the State’s expenditure in 1995–96 was on accommodation, this was complemented by a strong individual and family support program. Initiatives such as Local Area Coordination and Post School Options have reduced the need for accommodation support and increased community participation.

There has been an ongoing and sustained commitment to redevelopment of accommodation services. In 1983, just 10 per cent of accommodation was community based. As indicated in this Report, 60 per cent of accommodation is now community based and plans are in place for the redevelopment of accommodation for a further 100 individuals.

The level of unmet need for disability services has been a recurring theme over the past decade at both state and national levels. The WA Government has made a commitment to fund a five year plan to resolve the current backlog in services and meet expected growth. The plan includes the provision of accommodation support for an additional 500 people.

Increasingly WA is looking to provide services through the non government sector through a program of outsourcing of government services and the direction of new funding to non government agencies or directly to consumers to purchase services. This program is complemented by a comprehensive system of safeguards for consumers, a movement towards separation of the purchaser and provider functions of government and the development and introduction of output based funding methods.

In WA specialist disability services are complemented by a comprehensive program aimed at improving access to mainstream services. WA is unique in its statutory requirements on access, with the Disability Services Act requiring all State agencies and local governments to plan and provide accessible and responsive services.”

South Australia Government Comments

“Over the past two years, the SA disability sector has been involved in a major restructure of its service system. Focus on service provision has shifted to meeting individual needs. The introduction of the Funder, Purchaser, Provider model has facilitated this move. As part of the restructuring of the disability sector, Options Coordination agencies have been established as structurally separated from the Funder (the Disability Services Office (DSO)) and Provider agencies. Options Coordinators are specialist case managers and purchasers of support services in response to the identified needs of the client. The Options Coordinators primary focus is on meeting the needs of people with a disability. Purchasing a service from a specialist disability agency occurs after community/informal networks and mainstream services have been explored. Access to a specialist disability service occurs after consideration of the relative priority of need.

This restructure has highlighted that data quality and quantity is often lacking and therefore comparability between states may be difficult to achieve. The SA government supports the inclusion of data on disability services in the Report on Government Service Provision, in recognition that further collaborative work in the area of data collection needs to be undertaken. The SA Government recognises though, that presently there are limitations in the reliability of the current data and therefore interstate comparisons should be drawn with care.

For example, there are certain limitations with the CSDA Minimum Data Set (MDS) Survey. The MDS Survey data should be treated with caution particularly as service providers have difficulty in separating their direct service delivery funding into distinct service type categories. The service type categories have some flaws as they are not mutually exclusive and are difficult to define. This can lead to states not comparing ‘apples with apples’, although the service categories may have a few similar characteristics.

Similarly, the use of ABS data is problematic given that the sample size for SA is small and the definitions of disability are much broader than those of the target client groups for disability services in SA.

In SA, further development work is being done in relation to Disability Service Standards to ensure that quality services are provided to people with disabilities. This work is a critical component in improving access, equity, efficiency and effectiveness of specialist disability support services.”

Tasmania Government Comments

“The Information provided in the chapter on Services for People with a Disability attempts to provide a preliminary analysis of the performance of services funded or provided by government under the Commonwealth/State Disability Agreement.

As this is the first time that services for people with disability have been included in the Report much of the data is still indicative but it does highlight some of the unique aspects of disability services provision in each state.

The incidence of disability and handicap is relatively high in Tasmania and no doubt reflects the high percentage of aged people in the population generally. The incidence of disability increases with age and the estimated increases of incidence of severe disability over the next 5 years (13 per cent) will have an impact on service planning and development.

The past six to eight years have seen a rapid expansion of community based disability support services in Tasmania. This is reflected in the high percentage of users of accommodation services relative to the estimated potential population. The success of the Community Integration Program in providing group homes and other supported accommodation options has been largely responsible for this outcome.

Tasmania has also been extremely successful in establishing a service system predominantly auspiced through the non government sector (Table 8.1). This reflects the commitment to localised coordinated service systems.

Tasmania has been successful in deinstitutionalising large numbers of people with disabilities. This has seen a rapid expansion of the community support sector. Downsizing however has not to date brought about significant administrative and other savings as infrastructure support levels need to be maintained until the total closure of large institutions. This has resulted in relatively high unit costs for institutional accommodation and administrative costs as a proportion of the total budget. These are issues which we are currently actively addressing.”

Australian Capital Territory Government Comments

“ The ACT is unique in a number of aspect in contrast to other jurisdictions. Therefore statistical data for the ACT must be interpreted with care and comparisons with other states must take into account a number of factors. The ACT is largely an urban jurisdiction in that all services are provided in metropolitan areas. Its size relative to other jurisdictions means that in providing a comprehensive range of services at a comparative low volume, some economies of scale are difficult to achieve.

It is important to note that the development of indicators in the area of disability services is at a relative early stage and because of this, they need to be interpreted and applied with caution.

In 1994–95 and 1995–96 significant advances were made in the development of community based accommodation support services for people with disabilities in the ACT. During this period approximately 75 per cent of institutional or large residential places were closed. These places were successfully transferred to small community based accommodation support. Changes are ongoing in service development.

ACT Community Care initiated a Strategic Directions Plan in the first quarter of 1996 which will form the basis for ongoing improvements in the Disability Program. These changes are directed towards individual needs and addressing difficulties expressed in the past by a variety of stakeholders.

These factors have significantly influenced all aspects of service delivery, including, for example the significant variation in the cost of providing an institution or large residential place over the two years covered in this Report.

From 1 July 1996 the Department of Health and Community Care has been implementing a new structure based on the purchaser/provider model. Basically the purchaser/provider model is a way of structuring organisations so that the functions of providing services, purchasing services and planning for service provision are clearly identified and the role of each work group or team in relation to these functions is clarified.

The result is to separate these functions so that work teams are able to focus on their areas of responsibility. For example for those involved in service provision (providers) the focus will now be on delivering high quality services that meet the needs of clients and are delivered on time and within budget. The purchasers meanwhile will focus on implementing purchasing strategies to ensure that we have the best mix of services for the community within the framework of government policy directions and within the available budget. ”

Northern Territory Government Comments

“The inclusion of services for people with disabilities in this Report represents a positive movement toward nationally consistent reporting and monitoring of government service provision in this area, and is welcomed by the NT Government.

As it is the first time that disability services have been included in the Report, some teething problems have been experienced. In the NT, 67 per cent of services participated in the 1995–96 CSDA Minimum Data Set Snapshot Survey and, as a consequence, the data available for that year is incomplete and probably under estimates the actual levels of service provision. The participation rate for the most recent snapshot survey in 1996–97 is much improved and the NT data available for next year's Report will be of a much higher quality.

Due to the small sample size of the NT component of the Australian Bureau of Statistics Survey of Disability, Ageing and Carers (1993), the prevalence of disability estimated in the Report (Figure 8.2) is subject to high standard errors and may over or under estimate the actual prevalence of disability in the NT. To enable more meaningful comparisons between jurisdictions, it may be useful to include age-standardised estimates of disability in future years.

With 100 per cent of accommodation services being community based, the Territory has been fortunate that it has not had to deal with the major problems of institutional reform. Nevertheless, it has faced, and continues to face, other challenges, not the least being the need to develop and deliver services to a relatively small and culturally diverse population that is dispersed across a large geographical area.

In particular, the high rate of disability amongst the NT's Aboriginal and Torres Strait Islander population, coupled with the issue of limited infrastructure development in rural and remote communities, will continue to present as a major challenge for the NT.

The NT Government looks forward to the continued development of a comprehensive national reporting framework for disability services.”

8A.2 All jurisdictions data

8A.2.1 Descriptors

Table 8A.1: People with a disability, under age 65 years, by severity of handicap, 1993 ('000)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Total with a disability	618.2	513.0	397.8	213.5	181.8	54.3	36.0	17.4	2 031.9
People with a disability but no handicap[1]	158.8	133.8	98.1	50.2	44.0	13.6	9.3	5.1	512.9
People with a handicap[1]	459.5	379.2	299.7	163.2	137.7	40.7	26.7	12.3	1 519.0
People with a severe or profound handicap[1]	119.4	92.1	72.3	34.4	30.5	9.7	7.0	2.9	368.3
People with 'other' handicaps[1,2]	340.0	287.0	227.4	128.9	107.3	30.9	19.8	9.4	1 150.7
Persons aged 5–64	4 828.9	3 609.5	2 524.7	1 378.2	1 166.6	379.0	255.8	146.6	14 289.2
Total principal carers[1]	192.4	155.8	103.2	45.7	49.6	16.6	10.8	3.4	577.5

1 High standard errors for smaller jurisdictions suggest their data should be interpreted with care.

2 'Other handicap' includes those experiencing a moderate or mild handicap, as well as all children with a disability aged up to 4 years and people who had a schooling or employment limitation only.

Source: Madden et al 1997.

Table 8A.2: Clients by type of service, 1995–96 (number)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
People using State and Territory Government funded or provided CSDA services									
Accommodation	5 594	5 593	3 043	2 251	2 083	666	251	103	19 584
Community support	3 305	2 672	1 046	na	832	286	74	15	na
Community access	2 551	5 405	1 039	na	984	308	78	21	na
Respite	543	517	465	na	177	64	50	37	na
Other/not stated	0	0	0	na	50	0	0	7	na
People using Commonwealth Government funded or provided CSDA services									
Employment services	8 962	7 501	4 718	3 104	2 373	649	154	394	27 855

na not available.

Source: Madden et al 1997.

Table 8A.3: Government expenditure on CSDA services, 1995–96

	Units	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Government Expenditure										
State and Territory	$m	450.8	409.9	159.1[1]	121.8[2]	126.3	50.5	18.2[3]	10.4[4]	1 347.0
Commonwealth	$m	na	na	na	na	na	na	na	na	523.6
Total	**$m**	**na**	**na**	**na**	**na**	**na**	**na**	**na**	**na**	**1 870.6**
Government expenditure per capita	$ per person aged 4-64	93.4	113.6	63.0	88.4	108.2	133.2	71.1	71.0	94.3[5]

na not available.

1 The Queensland figure includes four large institutions administered by Queensland Health which are linked to the CSDA funding base.

2 Expenditure by WA in relation to early intervention therapy services is excluded from total cost estimates. However, equipment purchases are not excluded as they were not able to be separately identified.

3 Due to significant changes to the administrative arrangements ACT data are incomplete.

4 NT therapy services are excluded except for those which are part of multi disciplinary assessment teams and were not able to be separately identified.

5 Based on State and Territory Government expenditure only. If Commonwealth Government expenditure is included expenditure per person aged 4-64 years increases to $99.4 per person.

8A.2.2 Effectiveness

Outcomes

Table 8A.4: Accommodation clients receiving community based care or support, 1995–96 (per cent)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Proportion receiving community based care or support	51.3	64.2	79.6	59.8	42.7	54.4	92.0	100.0	60.6

Source: Madden et al 1997.

Table 8A.5: Labour force participation and unemployed people with a disability aged 5 to 64, 1993 (per cent)[1]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Participation rate	52.8	55.1	53.7	61.2	54.0	50.4	68.3	74.7	54.9
Proportion unemployed[1]	17.5	17.9	21.4	15.1	16.7	17.2	8.3	17.0	17.8

1 Estimates for smaller jurisdictions should be interpreted with caution as the data on which they are based are subject to high standard errors.

Sources: ABS Cat. No. 4430 and Madden et al 1997

Quality

No comparable data. For non comparable data see Section 8A.3

Access

Table 8A.6: Users of accommodation and employment services relative to potential population/labour force, 1995–96 (per cent)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Proportion of estimated potential population using of accommodation services	4.4	6.0	4.4	6.0	6.8	6.7	3.9	2.2	5.2
Proportion of estimated potential labour force using of employment services	13.4	15.1	12.5	15.2	14.8	13.2	10.1	6.2	13.8

Source: Madden et al 1997.

Table 8A.7: Users of accommodation services by severe, profound or moderate to no handicap, 1995–96[1]

	Units	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Moderate to no handicap	No.	360	363	433	111	141	68	39	2	1 517
% of all handicap	%	6.5	8.1	14.2	5.8	7.3	9.9	15.5	1.9	8.4
Severe handicap	No.	2 597	2 462	1 235	818	978	361	127	39	8 617
% of all handicap	%	46.6	54.7	40.6	43.0	50.7	52.8	50.6	37.9	47.9
Profound handicap	No.	2 614	1 675	1 374	972	810	235	85	62	7 827
% of all handicap	%	46.9	37.2	45.2	51.1	42.0	37.4	33.9	60.2	43.7
All handicap	No.	5 571	4 500	3 042	1 901	1 929	664	251	103	17 961

1 Data for WA are from the 1996 MDS collection. For all other jurisdictions the 1995 MDS was used.

Source: Madden et al 1997.

Table 8A.8: Users of employment services by severe, profound or moderate to no handicap, 1995–96

	Units	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Moderate to no handicap	No.	3 704	2 427	2 122	922	814	465	67	63	10 584
% of all handicap	%	41.3	32.4	45.0	29.7	34.3	71.7	17.0	40.9	38.0
Severe handicap	No.	4 586	4 453	2 054	1 851	1 403	172	299	84	14 902
% of all handicap	%	51.2	59.4	43.5	59.6	59.1	26.5	75.9	54.6	53.5
Profound handicap	No.	672	614	541	331	156	12	28	7	2 361
% of all handicap	%	7.5	8.2	11.5	10.7	6.6	1.9	7.1	4.6	8.5
All handicap	No.	8 962	7 494	4 717	3 104	2 373	649	394	154	27 847

Source: Madden et al 1997.

Table 8A.9: Use by special needs groups, 1995–96 (per 1000 relevant population)

	Units	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
People from an Aboriginal or Torres Strait Islander background										
Proportion of indigenous people using accommodation services[1]	Per 1000 indigenous population	1.4	1.2	1.4	2.9	1.9	0.8	1.3	1.6	1.7
Proportion of indigenous people using employment services	Per 1000 indigenous population	3.1	5.0	2.4	2.9	2.7	2.0	4.2	1.2	2.7
People from a non English speaking background (NESB)										
Proportion of NESB using accommodation services[1]	Per 1000 NESB population	0.20	0.19	0.23	0.38	0.43	0.33	0.14	0.00	0.23
Proportion of NESB using employment services	Per 1000 NESB population	0.56	0.77	0.58	0.88	0.66	0.36	0.59	0.87	0.67

1 Data for WA are from the 1996 MDS collection. For all other jurisdictions the 1995 MDS was used.

Source: Madden et al 1997.

8A.2.3 Efficiency

Table 8A.10: Government costs/contributions per place, 1994–95 and 1995–96 ($)[1]

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Cost per government institutional/large residential place									
1994–95	63 645	41 891[2]	49 328[3]	58 620[5]	46 323	104 225	52 454	na[8]	53 976
1995–96	64 243	43 163[2]	50 725[3]	56 791[5]	42 055	90 330	39 245	na[8]	54 049
Cost per government community accommodation and care place									
1994–95	62 164	48 682[2]	59 818[4]	38 307[5]	49 615	51 547	87 036	na[8]	53 682
1995–96	60 372	53 143[2]	62 457[4]	37 804[5]	48 408	67 533[6]	80 060	na[8]	55 221
Government contribution per non government institutional/large residential place									
1994–95	29 407	33 327[2]	15 892	23 571[5]	20 028	20 418[6]	na[7]	na[8]	25 711
1995–96	30 761	33 464[2]	11 210	24 027[5]	20 549	21 720[6]	na[7]	na[8]	25 390
Government contribution per non government community accommodation and care place									
1994–95	40 787	27 547[2]	13 037	38 360[5]	30 544	46 724	13 566	55 140[9]	30 734
1995–96	50 603	28 330[2]	18 384	36 248[5]	32 720	49 669	13 939	54 392[9]	36 784

na not available.

1 Expenditure on government provided accommodation is net of receipts to the funding body where possible. Receipts payed to other areas of government for example Treasury's Consolidated Revenue were not excluded. No receipts were collected from client contributions charged by non government accommodation services.

2 MDS places data has not been used for Victoria due to concerns over its accuracy. Rather information from the States Annual Report has been used.

3 Includes four large institutions administered by Queensland Health which are linked to the CSDA funding base.

4 In 1995–96, 52 places within Queensland government provided villas (Intellectual Disability Operations) were reclassified from 'institution/large residential accommodation' to 'community care accommodation' in the framework as a result of a distinct shift in the model of care provided.

5 MDS places data has not been used for WA due to concerns over its accuracy. Rather 1995–96 Annual Report information has been used. Further, places identified for non government provided accommodation include both funded and non funded services.

6 Tasmanian MDS places data has been supplemented to allow for a number of services who did not respond to the original collection.

7 The ACT does not fund non government institutional/large residential places.

8 NT Health Service do not fund or provide institutional/large residential accommodation. They also do not provide community based places.

9 1995 MDS data have been supplemented to include four places not counted due to the provider not participating in the in the original collection.

Table 8A.11: Administration expenditure as a proportion of total State and Territory disability services expenditure, 1994–95 and 1995–96 (per cent)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
1994–95	4.8	6.1	3.8[2]	5.2[3]	1.1	12.8	4.7[4]	2.1[5]	5.0
1995–96	na[1]	5.2	4.1[2]	5.2[3]	1.3	11.4	5.7[4]	2.1[5]	na

na not available.

1 NSW administration costs for 1995–96 are unable to be determined given the restructuring and transfer of management responsibilities disability services in NSW from the Department of Community Services to the Ageing & Disability Department. Data will be available in 1996–97.

2 Includes four large institutions administered by Queensland Health which are linked to the CSDA funding base

3 Expenditure by WA in relation to early intervention therapy services is excluded from total cost estimates. However, expenditure in relation to equipment purchases is included due to the inability to isolate costs.

4 Due to significant changes to the administrative arrangements of services for people with a disability in the ACT data are incomplete.

5 NT Therapy services are excluded except for those therapy services provided by multi disciplinary assessment teams which are not separately identifiable.

8A.3 Single jurisdiction information

Performance monitoring against jurisdictional quality standards — Commonwealth

Q1 What are the objectives of your jurisdiction with respect to quality of services?

Disability Service Standards were introduced as a strategy to assist services funded under the disability Services Act 1986 to meet the Principles and Objectives of the Act by clearly defining what is expected of them in terms of service quality. More broadly, government also saw the role of service standards as empowering consumers by clearly defining the standards of service that they could expect when accessing services as well as providing government a means of satisfying accountability requirements.

Q2 Are there performance measures against which these objectives are measured and reported on?

The standards were set at three levels*: minimum* to be met by all services under the Act; *enhanced* for services which have made significant progress towards meeting the Principles and Objectives; and *eligibility* for services which fully meet the Principles and Objectives. The structure consists of standards and supporting standards. Each standard is a statement of the results to be achieved for each consumer from the implementation of the standards, and each supporting standard is a key practice that the service should have in place to achieve results for consumers.

Q3 What are the aspects of quality of services that are important as part of these objectives?

There are 11 standards which indicate the important aspects which are seen as contributing to quality of service provision. These are: Individual needs; Decision making and choice; Privacy; dignity and confidentiality; Participation and integration; Valued status; Complaints and disputes; Service management; Employment conditions; Employment support; Employment skills development.

Q4 What is the broad approach in your jurisdiction to the monitoring and improvement of service quality?

- *services provided by government*

The Disability Services Program funds non government agencies

- *services provided by non government organisations*

A yearly self assessment is required from each funded service to identify how well the agency is performing in meeting the needs of consumers and whether quality can be further improved. Identified improvements form the basis of an action plan which the department incorporates into the agency's funding agreement. Consumers and agency staff are involved in the assessment.

Q5 details of the processes adopted to monitor quality for government and non government providers.

- *Who in the department is responsible for these matters and whom do they report to?*

The funding contract, to which the standards action plan is attached, is agreed and signed by an officer in the relevant state office (usually the Program Manager).

If a service fails to meet applicable standards, a review will be undertaken by the Disability Standards Review Panel (established in each state or territory), which will make recommendations.

In the event of a service being determined by the Panel as failing to meet the applicable standards, the Minister may make a declaration and take appropriate action.

- *What form do reports on service quality take? Is reporting made against particular measures of quality performance?*

The assessment reports form part of the Agency's Plan for the subsequent year. The assessment of the agency is made against each of the standards.

- *What evaluation or other methods are used to obtain information on service quality? Include information on consultation with the sector and with the people and carers who use the service. Are surveys of quality undertaken?*

The process of the yearly self assessment includes a consumer report on the service agency. Consumers are given assistance by an independent training agency on the intent of the standards and assisted in reporting their experiences with the agency as part of the assessment report.

An in-depth audit of each agency in receipt of funding is undertaken every five years. This involves a detailed financial report as well as interviews with consumers, their parents and/or carers.

Q6 Are there proposed changes to this approach to quality assurance?

The government has announced that a quality assurance system for the disability services program will be pursued as part of funding reforms over the coming months. The existing standards will be reviewed. New standards benchmarks will be established which are tailored to the needs of the industry and which are simple to measure and to implement using proven mainstream industry-based mechanisms.

Performance monitoring against jurisdictional quality standards — New South Wales

Q1 What are the objectives of your jurisdiction with respect to quality of services?

Given its commitment to improving services available to people with a disability, the objectives of the NSW Government in respect of quality services includes:

- to empower consumers by clearly defining the minimum standards they should expect when accessing disability services funded or provided by the Minister;
- to provide a basis for service providers and consumers to jointly improve service quality;
- to assist existing and prospective service providers to understand what is expected of them in terms of minimum service quality under the Principles and Applications of Principles of the NSW Disability Services Act; and
- to provide rights in respect of complaints and appeals through the NSW Community Services Commission.

Q2 Are there performance measures against which these objectives are measured and reported upon?

The ten NSW Disability Service Standards are used as indicators of performance for both Government and funded non government disability services. Services are measured against these indicators through the processes of self- and independent assessment.

Q3 What are the aspects of quality of services that are important as part of these objectives?

The NSW Disability Services Standards are the essential aspects of ensuring quality of services. Each standard is a statement of the results to be achieved for each consumer. In NSW, the standards include eight National Service Standards (minus the three employment standards which apply to services funded by Commonwealth Government), plus two additional standards: (9) maintenance of family/cultural relationships and (10) human rights/freedom from abuse.

However, an effective and comprehensive quality assurance system not only protects the rights and the quality of life for people with a disability, but also drives continuous improvements towards excellence in service delivery.

Consumer involvement is considered integral to these assessment processes and the subsequent development of transition plans.

Q4 What is the broad approach in your jurisdiction to the monitoring and improvement of service quality?

The NSW Ageing and Disability Department is responsible for the monitoring of service quality in respect of both government and funded non government disability service providers.

All government and non government disability services are required to undertake the following processes:

- all services were required to self-assess against the standards;
- those services that felt they did not conform to the standards were required to prepare a transition plan outlining the outgoing strategies, indicators and time frame by which they would achieve conformity; and
- all transition plans and associated applications for transition funding are required to be independently assessed.

Q5 Please provide specific details of the processes adopted to monitor quality for government and non government providers.

- *Who in the department is responsible for these matters and whom do they report to?*

Services and independent assessors report to the Manager, Disability Services Program within the Ageing and Disability Department who is responsible for the overall monitoring and improvement of service quality issues for both government and non government funded disability services. In turn, the

Program Manager reports to the Minister through the Director, Program Policy, Policy and Operations, and the Director-General.

- *What form do reports on service quality take? Is reporting made against particular measures of quality performance?*

Based on a comprehensive process, including pre-assessment procedures, an intensive two-day assessment supported by a stringent quality review, a finding is made by the independent assessors. The resulting information is collated into a centralised database. This database details the assessment results of conforming and non-conforming standards for each service outlet.

- *What evaluation or other methods are used to obtain information on service quality? Include information on consultation with the sector and with the people and carers who use the service. Are surveys of quality undertaken?*

Consultation with consumers and their carers is integral to all service assessment processes as well as the development of transition plans.

In the development of the Independent Assessment process methodology, service providers and other stakeholders, including consumer groups, were consulted extensively by then DSA Implementation Committee.

The DSA Implementation Committee was superseded in 1996 by the Advisory Committee on Disability which was convened with broader consultative responsibilities with respect to disability programs, planning and policy.

- *Please comment on the progress made in your jurisdiction towards improvements in service quality.*

In NSW, an independent assessment process has been operational since 1994 and ensures ongoing quality assurance of disability services in accordance with the NSW Disability Services Act. Consultation and collaboration with consumers and their carers is integral to the independent assessment process. Other initiatives include:

- the *Good Practice Manual* designed to stimulate ideas and discussion for service providers in order to review their performance and continue to improve the quality of service delivery to their consumers; and

- a mentoring project which aimed to assist in building expertise, promoting inter-agency liaison and promoting ongoing improvement.

Q6 Are there any proposed changes to your approach to quality assurance?

The Ageing and Disability Department is currently the independent assessment process.

Regional service support and development teams will work more closely in areas of service development and reshaping. Monitoring will be increased for services identified as problematic.

Performance monitoring against jurisdictional quality standards — Victoria

Q1 What are the objectives of your jurisdiction with respect to quality of services?

To establish a framework for quality service provision which is founded on the National Standards for Disability Services. This framework will embrace the entire state funded and operated disability sector.

To combine the Quality Services Framework with the introduction of output performance based Funding And Service Agreements and unit costs to enable benchmarking and other forms of contestability techniques to be introduced into disability services.

To promote a coordinated approach toward quality service delivery rather than have discordant development across services and to support the emergence within the disability sector of individual attempts by service providers to incorporate formal quality concepts into their operations.

To commit $1.89 million over the next three years to implement this framework and to support a coordinated approach to the delivery of high quality services to Victorians with disabilities.

Q2 Are there performance measures against which these objectives are measured and reported upon?

The Department's funding and service agreements signed with each funded agency utilise the National Disability Service Standards as quality measures. Departmental officers conduct an annual assessment of each agency's performance in relation to its service agreement, which covers all areas of service delivery, including service output, financial accountability and quality. Work will occur within the program over 1997 to further enhance the quality measures and the assessment process.

Q3 What are the aspects of quality of services that are important as part of these objectives?

It is important that both government and non government service providers develop effective self assessment processes to measure their performance against the National Disability Standards. The Standards are as follows:

- Service Access
- Individual Needs
- Decision Making and Choice
- Privacy, Dignity and Confidentiality
- Participation and Integration
- Valued Status
- Complaints and Disputes
- Service Management

It is important to emphasise quality improvement to meet consumer needs rather than focussing just on inspection to meet standards.

The development of a strong culture of support for, and understanding of, the benefits of a quality approach to service delivery by organisations and persons receiving state funded and operated disability services is critical to the successful implementation of the draft framework in Victoria.

Q4 What is the broad approach in your jurisdiction to the monitoring and improvement of service quality?

The Department is currently restructuring its regional offices to separate the delivery and purchasing functions of service provision. This should increase accountability and provide greater opportunities for benchmarking and independent evaluation of services managed by the Department.

Q5 Please provide specific details of the processes adopted to monitor quality for government and non government providers. Please address:

- *Who in your department is responsible for these matters and who do they report to?*

Quality assurance occurs on an informal level through families, advocates, guardians and friends who are often in regular contact with consumers. On a

more formal level, existing statutory bodies play an important role in ensuring quality services by overseeing programs, promoting the rights of consumers and investigating complaints and concerns regarding services. In Victoria, these agencies include the Ombudsman, the Guardianship and Administration Board, Community Visitors, the Intellectual Disability Review Panel, the Health Services Commissioner, the Equal Opportunity Commissioner and the Office of the Public Advocate.

As stated above, Department of Human Services (DHS) regional staff monitor and review the performance of non government agencies providing services to people with disabilities, using Funding and Service Agreements as a basis for evaluating and improving agency performance. These staff report to the Regional Director in each of the nine DHS regions.

The facilitation and coordination of quality assurance in the sector is the responsibility of the Community Access Section of the Disability Services Division which reports to the Director of Disability Services.

- *What form do reports on service quality take? Is reporting made against particular measures of quality performance?*

This will be finalised in 1997. At this stage there are no formal reporting mechanisms in place.

- *What evaluation or other methods are used to obtain information on service quality? Please include information on consultation with the sector and with the people and carers who use the services. Are surveys of quality undertaken?*

In 1995, the Department of Human Services funded a comprehensive consumer satisfaction survey to assess the level of satisfaction of persons with an intellectual disability and their carers with day programs in Victoria. Individual interviews and observation were conducted with a sample of 139 consumers and 590 parents and carers were sent questionnaires. This was the first time that such a large scale study of this type had been undertaken in Victoria. Further studies of this type are planned as a component of the quality assurance strategy.

- *Please comment on the progress made in your jurisdiction towards improvements in service quality.*

While considerable attention has been given to service quality in the last twelve months, there remains a large amount of work to fully address procedures and organisational processes so that the broad directions flagged in the draft framework are embedded in the cultural and operational aspects of the disability sector in Victoria. This will occur over the next three years as is reflected in the State Plan for Intellectual Disability Services 1996 — 1999.

Q6 Are there any proposed changes to your approach to quality assurance?

There will be incremental policy changes as the framework is refined following experience gained through implementation.

Performance monitoring against jurisdictional quality standards — Queensland

Q1 What are the objectives of your jurisdiction with respect to quality of services?

This jurisdiction provides and funds services in accordance with the *Queensland Disability Services Act* 1992 (QDSA) and the National Standards for Disability Services (NSDS).

The QDSA establishes the principle that people with disabilities have the same basic human rights as other members of society and should be empowered to exercise their rights. Thus the legislation aims to provide a framework within which people with disabilities can gain access to a range of quality services and supports which allow the establishment of a quality of life valued by the general community.

Q2 Are there performance measures against which these objectives are measured and reported upon?

Currently, non government organisations funded under the Disability Program enter into annual Service Agreements which utilise the NSDS as the basis for development of performance indicators.

Services provided directly by The Department of Families Youth and Community Care (DFYCC) to people with intellectual disabilities and their families are delivered in accordance with the Intellectual Disability Operations Client Service Standards.

The Queensland Health administered residential care facilities use a range of mechanisms to ensure quality of care. These include accreditation by the Australian Council on Health Care Standards; monthly audits on individual management plans; full client reviews undertaken every three months; and environment safety audits.

Q3 What are the aspects of quality of services that are important as part of these objectives?

Important aspects of service quality included the availability of suitable grievance mechanisms for consumers of services; a capacity to provide support in a way which is flexible and responsive to individual needs at various life–stages; ongoing consideration of the special needs of consumers from Aboriginal and Torres Strait Islander and *non English* speaking backgrounds; and the development of a locally–based responses to address the needs of the people with disabilities.

Other aspects of quality services which relate specifically to direct service delivery include: consistent approaches to needs assessment and case management; minimisation of regimentation; and ensuring staff skills, knowledge and expertise are maintained and developed.

Q4 What is the broad approach in your jurisdiction to the monitoring and improvement of service quality?

- *services provided by non government organisations*

The use of Service Agreements with funded *non government* organisations allows for the development of a clear statement of the expectations of the Department in terms of service delivery. The recently distributed draft Disability Program Manual also provides broad policy parameters within which funded services are to be developed and delivered.

- *services provided by government*

Direct services are subject to Client Service Standards which are consistent with the QDSA, NSDS and the Queensland Government Financial Management Strategy. The monitoring process involves a joint assessment of service quality by service staff, consumers and their families.

Queensland Health managed facilities monitor and improve service quality through establishing Program Management Committees, developing policies on quality standards and practice, ensuring consultation with, and the participation of, consumers and families, continuous quality improvement programs and undertaking regular reviews of quality standards and performance.

Q5 Please provide specific details of the processes adopted to monitor quality for government and non government *providers*

- *services provided by non government organisations*

Regionally based staff are responsible for the ongoing monitoring and review of services and negotiating annual Service Agreements. These officers report through line management to Regional Directors.

The Service Agreement is the primary *formalised* report outlining the service quality issues of a service. Specific reports are made against particular measures of quality performance if required to do so by Regional staff. In this regard Service Agreements provide a crucial link to the implementation and monitoring of standards.

A system for the performance assessment of community organisations has been developed by the Monitoring Evaluation and Review (MER) Task force established in 1995. A range of types of performance indicators have been identified as the basis for appropriate measures of service performance.

Consultation within the sector is often more focussed on specific issues and initiatives. Many initiatives of the Disability Program seek community input through the use of reference or advisory groups.

- *services provided by government*

Comprehensive Client Service Standards have been implemented for use by the Department to ensure quality services for consumers. A formal monitoring document is completed for each service delivery team every two years which includes recommendations and agreed action plans.

The Department participated in the Price Waterhouse Urwick 1995 International Benchmarking Study and was nominated to do so on the basis of its efforts in implementing Client Service Standards.

A Consumer Grievance Procedure developed for direct services by the Department has been evaluated by Central Office in consultation with consumers, families and regional staff resulting in an improved ability to resolve grievances at the regional level.

The major accountability process for Queensland Health facilities is through line management with mechanisms such as reporting to quality improvement committees and benchmarking with similar facilities in areas such as staff/client ratios and social interaction strategies within facility care plans.

Q6. Are there any proposed changes to your approach to quality assurance?

In December 1996 the Department announced a move towards a new funding approach focusing on outputs and outcomes. This approach will build on existing MER activity and implementation is currently being worked through.

In terms of direct service delivery, a formal review of the Client Service Standards will also occur during the next 12 months and efforts will be made to increase client involvement. The restructure of Queensland Health will support improved accountability of District Health Services for the quality of services they provide through a formal system of service agreements.

Performance monitoring against jurisdictional quality standards — Western Australia

Q1 What are the objectives of your jurisdiction with respect to quality services?

The Disability Services Act 1993 (WA) requires the Disability Services Commission (DSC) to further principles in Schedule 1, and to further the services and programs provided meeting the objectives in Schedule 2.

Q2 Are there performance measures against which these objectives are measured and reported on?

The Disability Services Standards (WA) provide the performance measures.

Q3 What are the aspects of quality service that are important as part of these objectives?

Aspects of quality of service important to the objectives include:

- a clear definition of minimum service quality;
- a clear statement for consumers about what standards they should expect when accessing disability services;
- a basis from which service providers and consumers work to jointly improve service quality — increased consumer involvement and empowerment; and
- a means of satisfying government and accountability requirements for financial management, process and consumer focussed outcomes.

Q4 What is the broad approach in your jurisdiction to the monitoring and improvement of service quality?

The DSC has a number of mechanisms in place or under development to promote quality assurance which include:

- legislation which prescribes Principles and Objectives for services and Disability Service Standards which prescribe outcomes for consumers;
- a Service Standards Monitoring program which applies to both funded non government agencies and to DSC regionally provided services;
- Performance Contracts for funded agencies which specify the services to be provided, the target group for services and the legislation including standards under which these services will operate;
- consumer grievance processes are promoted and advertised;
- advocacy through direct service and organisations set up for the purpose;
- liaison with other relevant government and non government organisations to ensure that the needs of people with disabilities are included in their planning processes; and
- funded activities to promote the awareness of the Standards within agencies and the wider community.

Q5 Please provide specific details of processes adopted to monitor quality for government and non government providers.

A Standards Monitoring Unit has been established within the Community Funding Directorate. Monitoring Reports are forwarded to the Chairperson of the DSC Board.

There are several forms of report as the process of monitoring has several strands:

Annual Self Assessment conducted in an agreed month each year which enables agencies and DSC to collate information on their progress on implementing the Standards. The monitoring process validates the self assessment.

Action Plans. A specific plan arising form the Self Assessment process, detailing steps to be taken to meet particular Standards in a given period of time.

Monitoring Visits. During the period Jan 1997 — June 1998, external monitoring will be conducted by visiting teams. The team will consist of one DSC Principal Officer and at least one independent external expert contracted

for the period. Industry representatives will be involved in the recruitment and training of the independent team members.

Visits will be conducted according to a roster, with a minimum of one every four years, but dependent on circumstances, and ideally with greater frequency. Visits will be responsive to other changing factors such as new management or a change of services being provided.

Consumer participation is an important part of the review process.

After the visit, a Preliminary Report will be prepared and discussed with the service provider and consumers and a Final Report be prepared. This report, which is publicly available, indicates the level of conformity with the Standards and lists the actions necessary for improvement.

Service providers are becoming more aware of standards and quality assurance because of active promotion of the issues and changing community attitudes.

Some recent initiatives included:

- progress towards establishing Performance Agreements incorporating performance indicators for services provided directly by DSC;
- funding of Best Practice projects in 1995–96;
- Program Management Training;
- a DSC developed quality of life service questionnaire;
- the WA programs of Local Area Co-ordination and Post School Options;
- an extensive consultative network;
- extensive and active peer support networks; and
- advocacy services.

DSC also occasionally reviews agencies to address specific issues of serious or urgent concern, leading generally to significant changes and improved quality of services.

The measurement of service quality improvement is complicated by a gradual rise in expected service quality as education about the Service Standards continues.

Q6 Are there any proposed changes to your approach to quality assurance?

The processes are under continuing development and any changes will probably reflect the DSC's emphasis on self assessment and internal quality assurance.

Some services have invested in striving for third party quality assurance to International Standard ISO 9002 and the DSC is addressing ways to meet its responsibilities under the Act without unnecessary duplication.

Performance monitoring against jurisdictional quality standards — South Australia

Q1 What are the objectives of your jurisdiction with respect to quality of service?

Service quality has a threefold set of principles:

- safeguards for clients;
- maintenance of a positive quality of life; and
- accountability for funding consistent with the CSDA and the State funding provisions.

Q2 Are there performance measures against which these objectives are measured and reported on?

Performance criteria and indicators are being refined for all quality areas developed as extensions of the National Standards for Disability Services. Additional measures are being developed for residential services.

Reports on meeting criteria are a condition of funding and service agreements. In addition, issue based proactive processes will be developed by the Sector Development Unit, planned to be established early in 1997. This Unit will also be responsible for reviews of service criteria performance by exception as reported to the DSO in its funder capacity by its purchaser(s) — Options Coordination.

Q3 What are the aspects of quality of service that are important as part of these objectives?

See response to Q1.

In safeguarding and monitoring positive quality of life measures the following aspects are most important:

- an open and transparent system;
- an effective complaints/grievance policy;
- open communication systems;
- clear and effective information processes; and
- a holistic framework of assessment.

Q4 What is the broad approach in your jurisdiction to the monitoring and improvement of service quality?

All agencies and services funded through the DSO are required to abide by the provisions outlined above.

All agencies are required to demonstrate their commitment to, and ability to provide, quality services through their capability statements, and report to the DSO as part of their annual funding and service agreement negotiations. Agencies which meet such provisions will be registered as approved providers. Agencies not able to demonstrate or sustain such requirements will be required, through referral to the Sector Improvement Unit, to demonstrate corrective processes.

Disability Service Standards Monitoring and Review will be based on a partnership between: DSO (especially in its funder role), Options Coordination (especially in its purchaser role), service providers, clients and carers.

Government agencies will have to comply with additional government legislation and procedures such as the Whistle Blowers Act.

Q5 Please provide specific details of the processes to monitor quality for government and non government providers. Please address.

- *Who in your department is responsible for these matters and who do they report to?*

Senior DSO officers are required to develop and maintain a quality framework, monitor funding and service agreement performance and report on observed or suspected quality inconsistencies or non performance. Each of these senior officers report directly to the Executive Director, Disability Services Office, and through them to the Minister for Disability Services.

- *What form do reports on service quality take place? Is reporting made against particular measures of quality performance?*

Currently, reports are made in writing by the Chief Executive Officer or Manager of agencies funded through service agreements. Matters may be referred verbally and in writing on a needs basis or on reporting of non compliance by exception.

A complaints or grievance process established through Options Coordination for example, encourages clients, consumers and advocates to raise concerns with service providers. Such matters may require investigation. Guidelines have been established and in the event of no resolution or dissatisfaction with the outcome, the DSO and the Minister are subsequent points of reference for complainants.

Particular measures of quality performance are being developed for criteria and indicators of performance. These will be completed by the end of 1996 and introduced through service provider reference groups, referral of best practice and requirement of 1996–97 funding and service agreements.

- *What evaluation or other methods are used to obtain information on service quality? Please indicate information on consultation with the sector and with the people and carers who use the services. Are surveys of quality undertaken?*

Consultation with the sector has thus far included; Options Coordination (purchaser), the service providers standards development reference group (a specific task group created for standards development), and a service providers reference group (a general reference group to whom issues of service delivery are referred on a continuing basis).

Consumers are involved in developing the standards with the service providers standards development reference group. Further consultation is planned through the Disability Advisory Council (which includes service providers, consumers and carers) and its subcommittees of consumers, carers and advocacy agencies.

Surveys of quality have not been undertaken but remain valuable options for monitoring and review after completion of the quality processes.

- *Please comment on the progress made in your jurisdiction towards improvements in service quality.*

Progress to date has been on developing the overarching principles that govern the monitoring and evaluation of Disability Services Standards, involving major stakeholders identified above, defining their respective roles and agreeing to a process by which the details of Standards compliance criteria and indicators may be completed in detail and implemented as part of the funding and service agreement process.

Q6 Are there any proposed changes to your approach to quality assurance?

The current approach to quality assurance has developed through consultation with key stakeholders noted above. Implied in the quality assurance approach is that matters requiring refinement and redefinition will be addressed within a continuous improvement framework. The process identified to date will be developed and reviewed within a 3 to 5 year framework. Benchmarks and best practice will be referred to and developed throughout the sector with a view to recognising and rewarding improvements as they occur or identified.

Performance monitoring against jurisdictional quality standards — Tasmania

Q1 What are the objectives of your jurisdiction with respect to quality of services?

The objectives are set out in the Disability Services Act 1992 (Tasmania), Schedule 1.

The objectives to be furthered in respect of persons with disabilities are as follows:

(a) to enable persons with disabilities to achieve their maximum potential as members of the community;

(b) to enable persons with disabilities to;

(i) further their integration into the community and complement services available generally to persons in the community; and

(ii) enable them to achieve a better quality of life including increased independence, employment opportunities and integration in the community; and

(iii) receive services that are provided in ways that promote in the community a positive image of persons with disabilities and enhance their self-esteem;

(c) to ensure that the quality of life achieved by persons with disabilities as the result of the services provided for them is taken into account in the granting of financial assistance for the provision of those services;

(d) to encourage innovation in the provision of services for persons with disabilities: and

(e) to provide a system to administer funding in respect of disabilities that is flexible and responsive to the needs and aspirations of those persons.

Q2 Are there performance measures against which these objectives are measured and reported upon?

Yes, funded services are assessed against the *Standards for Services for People with Disabilities* at least once a year. These standards include *Standards for all Service Providers* as well as standards for specific service types (ie accommodation, day support etc.)

Q3 What are the aspects of quality of services that are important as part of these objectives?

These aspects are outlined in Schedule 3 of the Act, the more important ones being:

- services are to be designed and administered so as to achieve positive outcomes for persons with disabilities, such as increased independence, education and employment opportunities and integration into the community;
- services are to be designed and administered so as to ensure that the conditions of everyday life of persons with disabilities are the same as, or as close as possible to, the conditions of everyday life of other members of the community;
- services are to be provided as part of local coordinated service systems and be integrated with services generally available to members of the community, wherever possible;
- services are to be tailored to meet the individual needs and goals of persons with disabilities;
- programs and services are to be designed and administered so as to meet the needs of persons with disabilities who experience additional disadvantage as a result of their sex, ethnic origin, Aboriginality or geographic location;
- programs and services are to be designed and administered so as to promote recognition of the competence of, and enhance the image of, persons with disabilities;
- programs and services are to be designed and administered so as to promote the participation of persons with disabilities in the life of the local community through maximum physical and social integration in that community; and
- programs and services are to be designed and administered so as to ensure that no single organisation providing services exercises control over all or most aspects of the life of a person with disabilities.

Q4 What is the broad approach in your jurisdiction to the monitoring and improvement of service quality?

Funded organisations undergo a formal assessment process in relation to the standards at least once a year prior to re-negotiation of service agreements.

This process is conducted by regional staff. All funded organisations are currently included, however some services directly provided by the Department are currently not subject to a formal assessment. This is an issue which will need to be addressed.

Apart from the formal standards monitor process, service quality issues are also addressed by the case management system, advocacy services and the Ethics Committee which all have the capacity to raise concerns either regarding individual clients, services or service systems.

The broad approach is to use a number of safeguards to ensure quality improvement.

Q5 Please provide specific details of the processes adopted to monitor quality for government and non government providers

Responsibility for monitoring quality — Regional Case Managers, Regional Resource Development Units program officers, Corporate Office Aged and Disability Support staff all have responsibility to monitor quality. Regional staff are responsible to Regional Program Managers and Regional Directors, Corporate Office staff are responsible to State Program Coordinator, Aged and Disability Support.

Formal assessment sheets are filled out, these are based on standards and negotiated quality improvement clauses.

Consultations occur with service delivery sector, peak organisation and regional staff via planning forums.

Client satisfaction surveys are undertaken within some services on a periodical basis.

Q6 Are there any proposed changes to your approach to quality assurance?

Recent government reforms have emphasised the need for programs to focus on what is achieved for consumers rather than on inputs and processes. The introduction of a performance based funding system will reflect and be directly linked to the needs of individual consumers. It will represent an important

transition in the way accommodation, respite and day support services will be funded.

Performance monitoring against jurisdictional quality standards — ACT

Q1 What are the objectives of your jurisdiction with respect to quality of services?

The ACT uses the objectives of the ACT Disability Services Act 1991.

In addition, the ACT seeks to provide quality services that:

- are effective and efficient in meeting the needs and achieving the outcomes identified by consumers; and
- respect the human rights of consumers.

Q2 Are there performance measures against which these objectives are measured and reported on?

All disability services are required to comply with the standards defined in Schedule 2 of the ACT Disability Services Act 1991. Services are required to report on a quarterly basis, addressing these standards.

Where issues have been raised about the performance of any services, an independent review is conducted of that service.

Q3 What are the aspects of quality of services that are important as part of these objectives?

Aspects of quality of services that are important include:

- respecting the human rights and dignity of the consumer;
- consumer satisfaction;
- effectiveness in meeting needs and achieving outcomes identified by the consumer;
- access and equity; and
- price.

Q4 What is the broad approach in your jurisdiction to monitoring and improvement of service quality?

- *services provided by government*

Disability Services Advisory Committee (DSAC) — (membership: consumers, names not tabled in the Legislative Assembly) appointed at ministerial level to provide advice to the Minister on a range of issues including standards of service provision in the ACT.

HACC Advisory Committee (HACCAC) — (membership: consumers, names not tabled in Legislative Assembly) appointed at ministerial level to provide advice to the Minister on a range of issues including standards of service provision in the ACT.

HACC/Disability Services Grant Providers Network — (membership: government and non government service providers); not appointed; to liaise and exchange information.

Contractual accountability (see Q2 above).

- *services provided by non government organisations*

As for government providers.

Q5 Please provide specific details of the process adopted to monitor quality for government and non government providers? Please address:

- *who in your Department is responsible for these matters and who do they report to?*

Responsibility is shared between the contracting/purchasing area and the policy/planning area. Executive responsibility rest with the Executive Directors of Financial Management and Contracting and of health Outcomes Policy and Planning.

- *what form do reports on services quality take? Is reporting made against particular measures of quality performance?*

As noted in Q2 (above), reports on service quality take the form of quarterly reports addressing the standards described in Schedule 2 of the ACT Disability Services ACT 1991.

- *what evaluation or other methods are used to obtain information on service quality? Please include information on consultation with the sector and with the people and carers who use the service. Are surveys of quality undertaken?*

There has been no on-going mechanism for consistent evaluation of service quality in the ACT. However, in 1994, the ACT Government funded a review of intellectual disability services in the ACT. This review informed further improvement in services.

In 1996 the ACT Government funded a review of the Independent Support Packages Program and the recommendations from that review are being used as the basis for a comprehensive consultation process to provide future directions for individualised funding approaches in the ACT.

Consultation with the sector has not been undertaken on a structured basis, and has been used as a means of informing specific issues of services development from time to time.

To date, no surveys of quality have been undertaken.

- *please comment on the progress made in your jurisdiction towards improvements in service quality?*

Recent initiatives include:

- shift in policy focus from 'normalisation' to the achievement of equal citizenship for people with disabilities;
- shift in provider focus from 'services driven' to 'consumer driven' design/delivery/provision of services;
- a legislative change to enable the Commissioner for Health Complaints to investigate and resolve complaints about services for aged people and for people with disabilities;
- improvement in operating and reporting mechanisms for DSAC and HACCAC, and review of their terms of reference;
- development of a database to track consumer activity and use of services, and to aid the identification of unmet need in the disabilities sector;
- development of the capacity to predict and identify long term, on-going growth in consumer need for disability services.

Q6 Are there any proposed changes to your approach to quality assurance?

Within the Department of Health and Community Care, a framework is being developed for a comprehensive quality assurance approach to policy/planning, purchasing/contracting, and service provision in the ACT. Developing the framework will involve extensive consultation with all providers from the public and community sectors, as well as with consumers. Other agencies/organisations to be consulted will include: the Law Reform Commission, the Community Health Accreditation Standards Program, and the Australian Quality Council. A final proposal will be published by the Department during 1997.

Performance monitoring against jurisdictional quality standards — NT

Q1 What are the objectives of your jurisdictions with respect to quality of services?

The objectives the NT with respect to quality of services are:

- ongoing improvement of service quality;
- promotion of quality outcomes for the consumers of services; and
- enhanced efficiency, effectiveness and appropriateness of services.

Q2 Are there performance measures against which these objectives are measured and reported on?

Objectives are broadly measured against the Disability Services Standards (established under the Commonwealth Disability Services Act).

Q3 What are the aspects of quality of services that are important as part of these objectives?

As defined in the Disability Service Standards: service access, individual needs, decision making/choice, privacy, dignity and confidentiality, participation and integration, valued status, complaints, service management. (standards relating to employment outcomes are not applicable to NT funded services).

Q4 What is the broad approach in your jurisdiction to the monitoring and improvement of service quality?

- *services provided by government*

The NT Financial Management Act sets out broad requirements for program evaluation and review focussing on efficiency, effectiveness and appropriateness. The NT Disability Services Act sets out objectives and principles for disability services. Program goals, strategies and performance evaluation/indicators (including those relating to quality standards) are detailed in operational business plans. Under the NT Financial Management Act all functions of an agency are to be formally reviewed at least once every three years. Refer to comments below regarding monitoring processes.

- *services provided by non government organisations*

Service objectives and relevant performance indicators are detailed in service funding agreements. Two positions (Disability Liaison Officers) have been established within the Disability Program to work with providers to monitor client outcomes and to assist with maintenance of standards and development of performance indicators (these positions work with both government and non government providers). The roles of the Disability Liaison Officers are currently under review and at the wider Departmental level there is a move to self evaluation by providers against agreed criterion as set out in the service agreement.

Q5 Provide specific details of the processes adopted to monitor quality for government and non government providers

- *who in your Department is responsible for these matters and who do they report to?*

Responsibility for government provider quality assurance lies with unit/program managers and ultimately with the relevant Divisional Head. For non government providers, the Disability Liaison Officers are responsible at an operational level.

- *what form do reports on services quality take? Is reporting made against particular measures of quality performance?*

There is no uniform format for reports but it is expected that service outcomes will be reported against performance indicators outlined in the service agreement.

- *what evaluation or other methods are used to obtain information on service quality? Please include information on consultation with the sector and with the people and carers who use the service. Are surveys of quality undertaken?*

Our standards monitoring approach is currently under review but generally would be expected to include direct consultation/contact with providers and consumers as appropriate, and assessment of outcomes against agreed criteria as set out in service agreements.

Q6 Are there any proposed changes to your approach to quality assurance?

There has only been limited development of the program's capabilities in this area. The standards monitoring functions of the Disability Liaison Officers are currently under review and future approaches are, at this stage, still to be defined.

48A.4 Terms and definitions

Table 8A.12: Definition of descriptors

Descriptor	Definition
Total people with a disability (ABS)	The definition of disability adopted by this Report is: "in the context of health experience a disability is any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being (WHO 1980)." In an attempt to operationalise this definition so as to estimate the total number of people with a disability the ABS defined a person with a disability as one who experiences one or more of the following limitations, restrictions or impairments which had lasted, or were likely to last, for a period of 6 months or more: loss of sight (even when wearing glasses or contact lenses); loss of hearing; speech difficulties in native languages; blackouts fits or loss of consciousness; slowness at learning or understanding; incomplete use of arms or fingers; difficulty gripping or holding small objects; incomplete use of feet or legs; treatment of nerves or an emotional condition; restriction in physical activities or in doing physical work; disfigurement or deformity; long–term effects of head injury, stroke or any other brain damage; a mental illness requiring help or supervision; treatment or medication for a long term condition or ailment and still restricted; and any other long term condition resulting in a restriction.
People with a handicap (ABS)	Handicap is a term used by the ABS Survey of Disability Aging and Carers as a proxy for the level of support needed by respondents with a disability. For the purposes of the survey a handicap is defined as a limitation to perform certain tasks associated with daily living. The limitation must be due to a disability and in relation to one or more of the following areas: self care; mobility; verbal communication; schooling; or employment. Persons aged less than 5 years with one or more disabilities were all regarded as having a handicap but were not classified by area or severity of handicap. This was due to difficulties inherent in determining whether the needs of children aged less than 5 years were a function of their age or their disability.
People with a disability but no handicap (ABS)	Persons with a disability but not identified as having a handicap in responding to the ABS Survey of Disability Aging and Carers stated that they had one of the broad limitations, restrictions or impairments as given for disability, but then stated that they were not restricted in any of the specific tasks given to identify persons with a handicap.

cont.

Table 8A.12: Definition of descriptors (cont)

Descriptor	Definition
People with a profound handicap (ABS)	The level of severity of a person's handicap was determined based on the person's ability to perform tasks relevant to the areas of self–care, mobility, and verbal communication and on the amount and type of help required. Where a person experiences difficulty in more than one of the above areas it is the area with the highest level of severity that determines the overall level of handicap. People with a profound handicap are those people with a disability who always require help or supervision in one or more of the three categories mentioned above.
People with a severe handicap (ABS)	Those people with a disability who sometimes required help or supervision with tasks relevant to the areas of self–care, mobility, and verbal communication.
People with a moderate handicap (ABS)	Those people with a disability who did not require help or supervision with tasks relevant to the areas of self–care, mobility, and verbal communication but who had difficulty performing one or more of these tasks.
People with a mild handicap (ABS)	Those people with a disability who did not require help or supervision with tasks relevant to the areas of self–care, mobility, and verbal communication but the person uses an aid, or has a mild mobility handicap or can not easily pick up an object from the floor.
Total principal carers (ABS)	A principal carer is a person aged 15 years or more providing the most informal care for the activities of self–care, mobility or verbal communication. Principal carers are chosen (by the recipient) from the main carers nominated for the activities for the activities of self–care, mobility or verbal communication. A recipient can identify only one carer as the principle carer. Recipients include people with a disability and older people
CSDA MDS	The CSDA Minimum Data Set, which specifies data items and their definitions to be collected from all services funded or provided under the Commonwealth/State Disability Agreement. These data items were agreed and developed by all jurisdictions, working in cooperation with the Australian Institute of Health and Welfare, which collates and published national data from the collection.
People using State and Territory Government funded or provided CSDA accommodation services	People on the snapshot day agreed to as part of the CSDA MDS (except for WA where the numbers on an average day were used) using one or more services corresponding to the following CSDA MDS services types: 1.01 institutions; 1.02 hostel accommodation; 1.03 group houses; 1.04 attendant care; 1.05 outreach support/other in–home support/drop–in support; and 1.06 other accommodation.

cont.

Table 8A.12: Definition of descriptors (cont)

Descriptor	Definition
People using State and Territory Government funded or provided CSDA community support services	People on the snapshot day (except for WA where the numbers on an average day were used) using one or more services corresponding to the following CSDA MDS services types: 2.1 advocacy; 2.2 information/referral; 2.3 early childhood intervention; 2.4 recreation/ holiday programs; 2.5 therapy (PT OT ST); 2.6 family/individual case practice/management; 2.7 behaviour intervention/specialist intervention; 2.8 counselling: individual/family/group; 2.9 brokerage/direct funding; 2.10 mutual support/self help groups; 2.11 print disability; 2.12 resource teams/regional teams; and 2.13 other community support is used.
People using State and Territory Government funded or provided CSDA community access services	People on the snapshot day (except for WA where the numbers on an average day were used) using one or more services corresponding to the following CSDA MDS services types: 3.1 continuing education/independent living training/adult training centre; 3.2 post school options/social and community support/community access; 3.3 other community access and day programs.
People using State and Territory Government funded or provided CSDA respite services	People on the snapshot day (except for WA where the numbers on an average day were used) using one or more services corresponding to the following CSDA MDS services types: 4.1 own home respite; 4.2 centre based/respite house; 4.3 host family respite/peer support; and 4.4 other respite/flexible respite/combination.
Other/not stated State and Territory Government funded or provided CSDA services	People on the snapshot day (except for WA where the numbers on an average day were used) using one or more services corresponding to the following CSDA MDS services types: 6.1 service evaluation–training; 6.2 peak bodies; 6.3 research and development; and 6.4 other.
People using Commonwealth Government funded CSDA Employment services	People on the snapshot day using one or more services corresponding to the following CSDA MDS service types: 5.1 competitive employment training and placement, 5.2 individual supported job, 5.3 sheltered employment, 5.4 supported employment, 5.5 employment support — State and Territory Government funded no job placement component, and 5.6 other employment.
Total Government Expenditure	Represents all government expenditure on disability services by the central coordinating unit and the umbrella department including expenditure on both programs and administration, direct expenditures and grants to government service providers, and government grants to non government service providers. Excluded from total expenditure are provider funded contributions towards disability services. Expenditure is expressed in net terms, that is, income from fees, asset sales, and client contributions made to consolidated revenue have been subtracted. HACC, psychiatric and housing were also excluded from total disability expenditure. Therapy expenditure was excluded where possible.
Government expenditure per capita	Total expenditure by a State or Territory divided by the population aged between 4 and 64 years.

Table 8A.13: Definition of performance indicators

Indicator	Definition
Proportion receiving community care or support	The numerator for this indicator is calculated using MDS service types 1.03 group houses, 1.04 attendant care, 1.05 outreach support/other in–home support/drop–in support and 1.06 other accommodation. The denominator is derived from MDS categories 1.01 to 1.06 and therefore in addition to those categories discussed above includes 1.01 institutions and 1.02 hostel accommodation. Services for people with a psychiatric disability have been excluded. The performance indicator is calculated as the numerator divided by the denominator, multiplied by 100.
Participation rate	Total number of people with a disability in the labour force (where the labour force includes all people who are employed or unemployed), divided by the total number of people with a disability aged 15 years and over. An employed person is a person aged 15 years or more, who in his or her main job during the enumeration period: • worked one hour or more for pay, profit, commission or payment in kind in a job, business, or on a farm (includes employees, employers and self–employed persons); • worked one hour or more without pay in a family business or on a farm (excluding persons undertaking other unpaid voluntary work); or • were employers, employees, or self–employed persons or unpaid family helpers who had a job, business or farm, but were not at work. Unemployed persons are those aged 15 years or more who were not employed during the enumeration period, but were looking for work.
Potential population/labour force	The ABS concept of 'severe or profound' handicap, relating as it does to the need for assistance with everyday activities of self-care, mobility and verbal communication, has been argued to be the most relevant population figure for disability services. However, the relatively high standard errors in the prevalence rates for smaller jurisdictions, as well as the need to adjust for the Aboriginal and Torres Strait Islander population, made it necessary to prepare special estimates of the 'potential population' for disability services. These estimates, prepared by the Australian Institute of Health and Welfare (AIHW), were used in the performance indicators when population data was needed in the denominator. Briefly, the national age-sex specific rates of severe and profound handicap were applied to the 1995 age and sex structure of each jurisdiction to give an 'expected current estimate' of people with a severe or profound handicap, aged under 65 years, in that jurisdiction. People of Aboriginal or Torres Strait Islander origin were given a weighting of 2 in these estimates, in recognition of their greater prevalence rates of disability, and their relatively greater representation in CSDA services. The denominator for employment services was restricted to people aged 15–64 years and was further scaled to adjust for the overall labour force participation rate of the population. The 'potential population' is not an estimate of the population needing disability support services, but provides a consistent scale of each jurisdictions population which might require these services.

cont.

Table 8A.13: Definition of performance indicators (cont)

Indicator	Definition
Proportion unemployed	Total number of people with a disability who are in the labour force but unemployed divided by the total number of people with a disability in the labour force.
Proportion of estimated potential population using accommodation services	The denominator for this performance indicator is the expected number of Australians aged under 65 with severe or profound handicap in 1995 adjusted to reflect the greater prevalence and severity of handicaps experienced by people from an Aboriginal or Torres Strait Islander background. The numerator comes from the 1995 CSDA MDS categories 1.01 to 1.06. Services for people with a psychiatric disability have been excluded. The performance indicator is calculated as the numerator divided by the denominator, multiplied by 100.
Proportion of estimated potential labour force using employment services	The denominator for this indicator is the expected number of Australians aged 15 to 64 years with severe or profound handicap in 1995 adjusted for the greater prevalence and severity of disability among Aboriginal and Torres Strait Islander populations, multiplied by the labour force participation rate for each State and Territory as at June 1995 (ABS Cat. No. 6203.0). The numerator comes from the CSDA MDS service types 5.01 competitive employment training and placement 5.02 individual supported job, 5.03 sheltered employment, 5.04 supported employment, 5.5 employment support – State and Territory funded no job placement component and 5.06 other employment and represent the number of people receiving employment services funded by the Commonwealth under the CSDA. The performance indicator is calculated as the numerator divided by the denominator, multiplied by 100.
Users of accommodation services with a severe, profound, or moderate to no handicap	The denominator for this indicator was calculated by using service types 1.01 to 1.06 of the 1995 CSDA MDS (excluding services identified as psychiatric services). In calculating the numerator severity of handicap is derived from the 1995 MDS data item 'level of support needed — activities of daily living' (support a). This item uses the same areas of need as the ABS for determining handicap: self care, mobility and verbal communication. Moderate to no handicap is mapped from the MDS as ‘support a =1’. Severe handicap is mapped from the MDS as ‘support a = 2 or 3’. Profound handicap is mapped from the MDS as ‘support a = 4’. All handicap excludes responses from the MDS with level of 'support a' not known (76 people). Data for WA are from the 1996 MDS collection. For all other jurisdictions the 1995 MDS was used.

cont.

Table 8A.13: Definition of performance indicators (cont)

Indicator	Definition
Users of employment services with a severe, profound, or moderate to no handicap	The data for this indicator is derived from service types 5.01 to 5.06 of the 1995 CSDA MDS. In calculating the numerator severity of handicap is derived from the 1995 MDS data item 'level of support needed — activities of daily living' (support a). This item uses the same areas of need as the ABS for determining handicap namely: self care, mobility and verbal communication. Moderate to no handicap is mapped from the MDS as 'support a =1'. Severe handicap is mapped from the MDS as 'support a = 2 or 3'. Profound handicap is mapped from the MDS as 'support a = 4'. All handicap excludes responses from the MDS with level of 'support a' not known (8 people).
Proportion of people from an Aboriginal and Torres Strait Islander background using accommodation services, 1995–96, (per 1000 indigenous population)	The numerator for this indicator is Aboriginal and Torres Strait Islanders using accommodation services and is derived from accommodation type 1 services from the CSDA MDS (excluding services identified as services for people with a psychiatric disability). The denominator is the indigenous population under 65 years of age in 1991. The performance indicator is calculated as the numerator divided by the denominator, multiplied by 100. Data for WA are from the 1996 MDS collection. For all other jurisdictions the 1995 MDS was used.
Proportion of people from an Aboriginal and Torres Strait Islander background using employment services, 1995–96, (per 1000 indigenous population)	The numerator for this indicator is Aboriginal and Torres Strait Islanders using employment services (from the 1995 MDS), the denominator is Aboriginal and Torres Strait Islander population aged 15 to 64 years in 1991. The performance indicator is calculated as the numerator divided by the denominator, multiplied by 1000.
Proportion of people from a non English speaking background using accommodation services, by State and Territory and Australia, 1995–96, (per 1000 NESB population)	The numerator for this indicator is Persons of *non English* speaking background (NESB) using accommodation services with the data being derived from the 1995 MDS accommodation service type 1 (excluding services identified as services for people with a psychiatric disability). The denominator is the NESB population less than 65 in 1991 (from ABS 1991 census, expanded profile, Cat. No. 2722.0). The performance indicator is calculated as the numerator divided by the denominator, multiplied by 1000. Data for WA are from the 1996 MDS collection. For all other jurisdictions the 1995 MDS was used.
Proportion of people from a non English speaking background using employment services, by State and Territory and Australia, 1995–96, (per 1000 NESB population)	The numerator for this indicator is Persons of Non English Speaking Background (NESB) using employment services with data being drawn from the 1995 MDS. The denominator is the NESB population aged 15 to 64 years in 1991 (from ABS 1991 census, expanded profile, Cat. No. 2722.0). The performance indicator is calculated as the numerator divided by the denominator, multiplied by 1000.

cont.

Table 8A.13: Definition of performance indicators (cont)

Indicator	Definition
Cost per government institutional/large residential place	The numerator for this indicator is government expenditure on government provided institutional/large residential accommodation and care (1995 MDS categories 1.01 and 1.02 who have 6 or more clients). The denominator is the average number of places of this type available over the financial year. The indicator is calculated by dividing the numerator by the denominator.
Cost per government community accommodation and care place	The numerator for this indicator is government expenditure on government provided community accommodation and care as defined by 1995 MDS category 1.03 and who have less that 6 clients. The denominator is the average number of places of this type available over the financial year. The indicator is calculated by dividing the numerator by the denominator.
Government contribution per non government institutional/large residential place	The numerator for this indicator is government contributions to non government provided institutional/large residential accommodation and care (1995 MDS categories 1.01 and 1.02, and who have 6 clients or more). Government per place contributions to non government providers represent only a proportion of the total cost of providing a place with this proportion varying between jurisdictions. The denominator is the average number of places of this type available over the financial year. The indicator is calculated by dividing the numerator by the denominator.
Government contribution per non government community accommodation and care place	The numerator for this indicator is government expenditure on government provided community accommodation and care as defined by 1995 MDS category 1.03 and who have less that 6 clients. Government contributions to non government providers per place represent only a proportion of the total cost of providing a place with this proportion varying between jurisdictions. The denominator is the average number of places of this type available over the financial year. The indicator is calculated by dividing the numerator by the denominator.
Administration expenditure as a proportion of total expenditure	The numerator is equal to expenditure by jurisdictions on administering the system as a whole. It does not include administration expenditure on individual services. The denominator is equal to total government expenditure on providing and funding services for people with a disability and includes expenditure on both programs and administration, direct expenditures and grants to government service providers, and government grants to non government service providers. Excluded from total expenditure are provider funded contributions towards disability services. Expenditure is expressed in net terms, that is, income from fees, asset sales, and client contributions made to consolidated revenue have been subtracted. HACC, psychiatric and housing were excluded from total disability expenditure. Therapy expenditure was excluded where possible.