8 SERVICES FOR PEOPLE WITH A DISABILITY

8.1 Introduction

The focus of this chapter is disability support services. Governments provide support through a variety of avenues, including disability support services, income support and by inclusion in the target groups of services available to the general community. Governments strive to enhance the quality of life experienced by people with a disability by providing support to assist them to live as valued and participating members of the community.

Disability support services range from accommodation and home support to therapy, equipment and employment services. Given that this is the first time that services for people with a disability have been included in the Report, a complete coverage of the available services was not attempted. Rather, this chapter provides a preliminary assessment of the performance of government funded or provided services which fall under the auspice of the Commonwealth/State Disability Agreement (CSDA).[1] Broadly speaking CSDA services target people who develop a disability before the age of 65 and who require on going support.

This Report is the first time performance monitoring of services for people with a disability has been undertaken on a national level and, as such, a number of difficulties have been encountered in obtaining data that is comparable across jurisdictions. Consequently, some indicator results should be interpreted with caution.

8.2 Profile of the sector

A wide range of support types and service providers have emerged in an effort to meet the varied needs of people with a disability. Many people with a disability participate fully in the community without accessing government services. Others receive an extensive amount of support throughout their lives.

[1] The services covered by the CSDA vary between jurisdictions. The ability of jurisdictions to report on service types also varies. To achieve consistency, therapy services were excluded from efficiency data where possible; and services for people with a psychiatric disability were included in effectiveness results for Commonwealth Government funded services only.

8.2.1 Disabilities in Australia

What is a disability?

The most widely accepted definition of 'disability' is provided by the *International Classification of Impairments, Disabilities and Handicaps* (ICIDH):

> 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 p.143).

By this definition, a disability arises from one or more physiological or psychological impairments and results in an inability to perform certain functions at a 'normal' level. In 1993, approximately five million people in Australia experienced an impairment of some kind. Three million of these people also experienced a disability.

In 1993, based on the most recent Australian Bureau of Statistics (ABS) data, it was estimated that the major source of disability was physical impairment which was reported by around 57 per cent of those reporting a disability.[2] The physical impairment in approximately one third of these cases was one of a number of impairments contributing to a disability (Figure 8.1).

In many cases it is the combination of a disability and the environment that limit a person's quality of life. The term 'handicap' has been used in the past to indicate the level of support a person required to undertake everyday tasks. The following is the ICIDH definition:

> In the context of health experience, a handicap is a disadvantage for a given individual, resulting from an impairment or a disability, that limits or prevents the fulfilment of a role that is normal (depending on age, sex, and cultural factors) for that individual. (WHO 1980 p.183)

The two terms differ in that disability refers to an inability to perform an activity at a certain level, whereas handicap refers to the impact of this inability on the person's everyday life. Approximately 79 per cent of people with a disability in 1993 also reported a handicap, and in almost one-third of these cases it was classified as severe or profound (ABS Cat. No. 4430.0).

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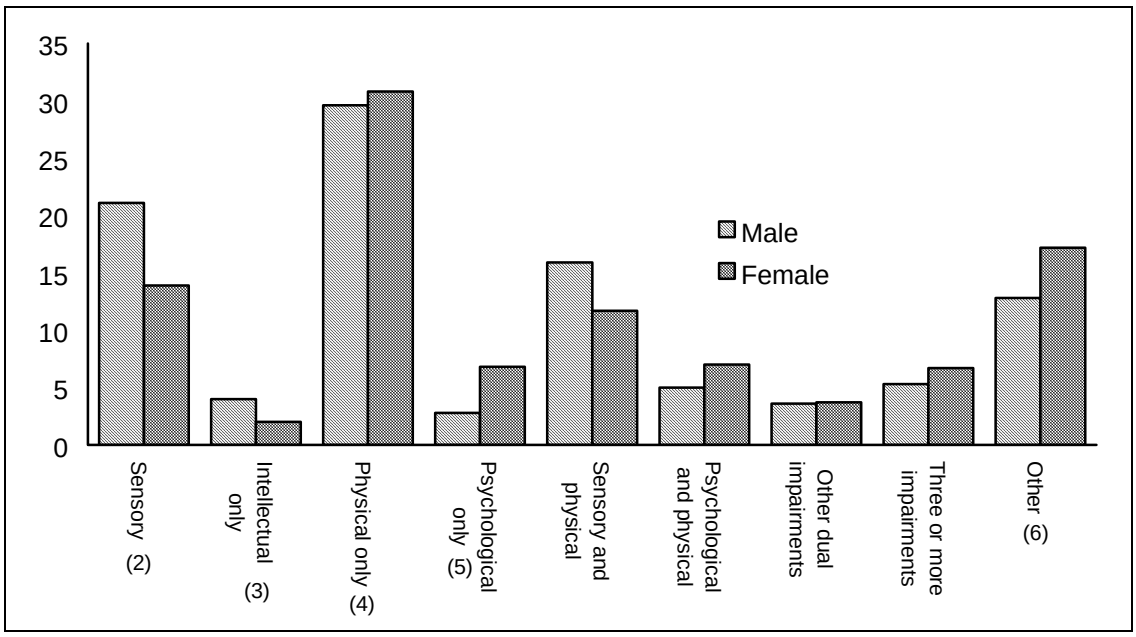
[2] Much of the population information on people with a disability was derived from the ABS survey of Disability Aging and Carers (ABS Cat. No. 4430.0) which is conducted every eight years. It was last conducted in 1993.

Figure 8.1: Impairments of people with a disability, 1993 (per cent)[1]



1 People were in one group only.

2 'Sensory' referred to loss of sight or hearing.

3 'Intellectual' covered 'slow learning or understanding'.

4 'Physical' included incomplete use of limbs, restrictions in physical activity, difficulty with gripping, brain damage or a deformity where the person did not indicate another impairment type.

5 'Psychological' included nervous or emotional conditions, treatment for mental illness and fits or loss of consciousness.

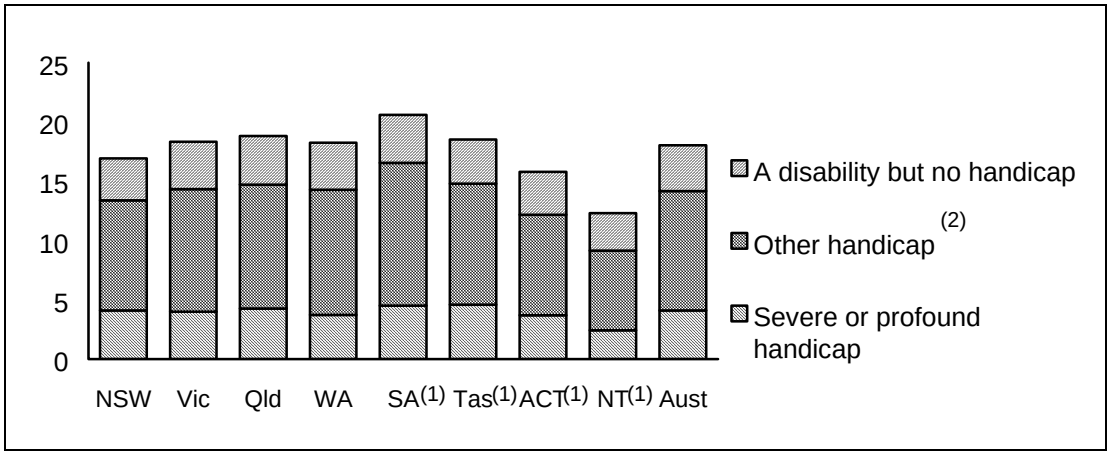
6 'Other' included those with a speech loss only.

Source: ABS Cat. No. 4433.0.

Prevalence of disability

Approximately 18 per cent of Australians experienced a disability in 1993, with around 14 per cent being handicapped in some way by their disability. There was some variation across jurisdictions in both the prevalence of severe or profound handicap and the overall prevalence of disability. The proportion of the total population with a severe or profound handicap ranged from 2.5 per cent in the NT to around 4.5 per cent in SA and Tasmania. The NT and SA were also at the extremes in the prevalence of disability (Figure 8.2). However, high standard errors in the data collected for small population states and territories mean that these results should be interpreted with care.

Figure 8.2: Population prevalence of handicap by disability status, 1993, (per cent)



1 Estimates for jurisdictions with smaller populations should be interpreted with caution because the data on which they are based are subject to high standard errors as a result of small sample sizes.

2 'Other handicap' included 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

Sources: ABS Cat. No. 4430, ABS Cat. No. 3201.0.

The prevalence of disability increases with age. For example, approximately 12 per cent of those aged 25 to 44 years reported a disability in 1993, compared with an estimated 26 per cent of people aged 45 to 64 years, and 56 per cent of those older than 65 years (ABS Cat. No. 4430.0). The proportion of aged people in the population is expected to increase in future years, so the prevalence of disability is also forecast to increase (Madden, Wen, Black, Malam, and Mallise 1996).

8.2.2 Support for people with a disability

While Government and non government organisations make an important contribution to support for people with a disability, most care is provided by informal carers. In 1993, more than 577 000 people over the age of 15 years served as the principal source of care for a person with a disability. Of the 425 200 principal carers providing support to a person with whom they co-resided, just over 25 per cent were over the age of 65 (ABS Cat. No. 4430.0).

Commonwealth/State Disability Agreement

A primary objective of the CSDA, which was signed in 1991, was to achieve greater coordination and integration among the services funded or provided by governments (Box 8.1). However, the coverage of the CSDA was not

comprehensive, excluding some important aspects of government support such as the Home and Community Care (HACC) program, equipment services and the Commonwealth Rehabilitation Service (CRS).

Box 8.1: Services included in the Commonwealth/State Disability Agreement

The disability support services provided under the CSDA include services provided individually and jointly by Commonwealth, State and Territory Governments.

Services for which the Commonwealth Government is responsible:

• *competitive employment, training and placement services* assist persons to obtain and retain paid employment in the work force; and

• *supported employment services* assist people with a disability, for whom competitive employment at or above award wages is unlikely, to obtain and retain paid employment.

Services for which State and Territory Governments are responsible:

• *accommodation support services* provide accommodation (for example, group homes, hostels, large institutions) and support to maintain accommodation (for example, attendant care);

• *community access services* assist people with a disability to develop or maintain the personal skills and self-confidence necessary to enhance their independence and self-reliance in the community;

• *respite care services* relieve or support (for limited periods) people with a disability living in the community, and their families and carers; and

• *community support* assist people with a disability to integrate and participate in the community; by funding and providing, for example, information/referral services, recreation services, case management, brokerage, individual/family/group counselling, advocacy, early intervention therapy, print disability services, mutual support/self help groups, behaviour intervention/specialist intervention, resource teams/regional teams, and other therapy services excluded from growth funding.

Services for which responsibility is shared:

• advocacy services; and

• research and development.

The CSDA specified the target group of disability services as people with disabilities that:

- are attributable to an intellectual, psychiatric, sensory or physical impairment or a combination of such impairments; and
- are permanent or likely to be permanent and result in;

  – a substantially reduced capacity of the person or persons for communication, learning or mobility; and

  – the need for ongoing support services.

The target group includes people with a disability of a chronic or episodic nature.

Based on one 'snapshot' day, services falling under the CSDA provided support to more than 65 000 clients.[3] The majority of clients were aged between 5 and 64 years because the needs of people who were older than 65 years were usually addressed through aged care services and those of children under 5 years were generally addressed through other community or health services.

The Commonwealth Government does not provide CSDA services directly, rather it provides funding to support non government service providers and to a small number of state and territory and local government service providers. State and Territory Governments also vary in their use of government and non government providers (Table 8.1).

Funding arrangements

Total government expenditure for support to people with a disability was more than $10 billion in 1994–95 with income support accounting for most of this figure (AIHW 1995, Yeatman 1996). Expenditure on services specifically for people with a disability covered by the CSDA totalled $1.2 billion in 1994–95, an increase of 14 per cent in real terms on the 1989–90 figure (Yeatman 1996).

[3] This excludes clients of services under the auspice of the WA government for which comparable data were not available. It may have included some double counting where people received more than one service on the snapshot day but high non response rates in some jurisdictions have reduced the estimate.

Table 8.1: Clients of government and non government CSDA services, 1995–96 (number)[1]

	NSW	*Vic*	*Qld*	*WA*[2]	*SA*	*Tas*	*ACT*	*NT*	*Aust*[2]
State and Territory responsibility									
Government	6 814	6 271	2 116	na	1 318	335	212	15	na
Non government	5 179	7 916	3 603	na	2 808	989	241	161	na
Not stated	0	0	0	na	0	0	0	7	na
Total	**11 993**	**14 187**	**5 719**	**na**	**4 126**	**1 324**	**453**	**183**	**na**
Commonwealth responsibility									
Government	408	833	551	309	412	376	126	59	3 074
Non government	8 554	6 668	4 167	2 795	1 961	273	268	95	24 781
Total	**8 962**	**7 501**	**4 718**	**3104**	**2 373**	**649**	**394**	**154**	**27 855**

na not available.

1 Services included under State and Territory Government responsibility were accommodation, respite and other services. Services included under Commonwealth Government responsibility were employment and other services. Clients may have received more than one service on the snapshot day or may be under-estimated due to high non response rates in some jurisdictions.

2 1995 snapshot data for WA were not available. However, an estimated 20 287 people used services for which the WA government had responsibility over the 12 months to 30 June 1996. Of this number 8872 used government provided services and 11 415 used non government services. Clients may be counted across more than one service type.

Source: Madden et al 1997.

The non government sector also contributed significantly to the support provided for people with a disability. For example, it was estimated that in 1993–94 organisations providing services specifically for people with a disability received 40 per cent of their income from non government sources (IC 1995).

The majority of CSDA funding is provided by States and Territory Governments. In 1994–95, they accounted for 62 per cent of total CSDA funding.

The Commonwealth Government also contributes significantly to the funding of CSDA services. In addition to assuming primary responsibility for employment services and contributing around $200 million towards their provision, the Commonwealth Government also provided funding of around $267 million for accommodation and other support services in 1994–95.

8.3 Recent developments

8.3.1 Changing nature of service provision

Increased attention has been paid over the past two decades to the rights of people with a disability. In addition to legislation designed to remove discrimination against people on the basis of their disability, recent developments have focused on achieving a service network that is more responsive to client needs.

There has been a general push towards progressively developing and implementing output based funding methods and introducing performance monitoring. Most government funding bodies now employ some form of service agreement with service providers which links funding to the achievement of specified outcomes for clients. Attention to client needs has also been heightened through increased emphasis on the use of case management models. Case management, through providing a package of services individually tailored to the client, aims to achieve a better match between support needs and the services received.

The recent trend towards providing community based rather than institutional care and support aims to enable people with a disability to better integrate into the community. This trend has seen the closure of a significant number of large institutions and the expansion of community based support.

Governments have also endeavoured to improve their accountability and transparency and the outcomes achieved. In particular, there has been an increase in the use of purchaser provider arrangements and competitive tendering. Changes in the sector associated with this trend include:

- a clearer distinction between the funding, purchasing and providing functions of government agencies;
- decreasing government involvement in direct service provision; and
- the emergence of for-profit providers.

8.4 Framework of performance indicators

The indicators in this Report are based on the objectives and guiding principles developed by the Steering Committee (Box 8.2).

Box 8.2: Objectives for government services for people with a disability

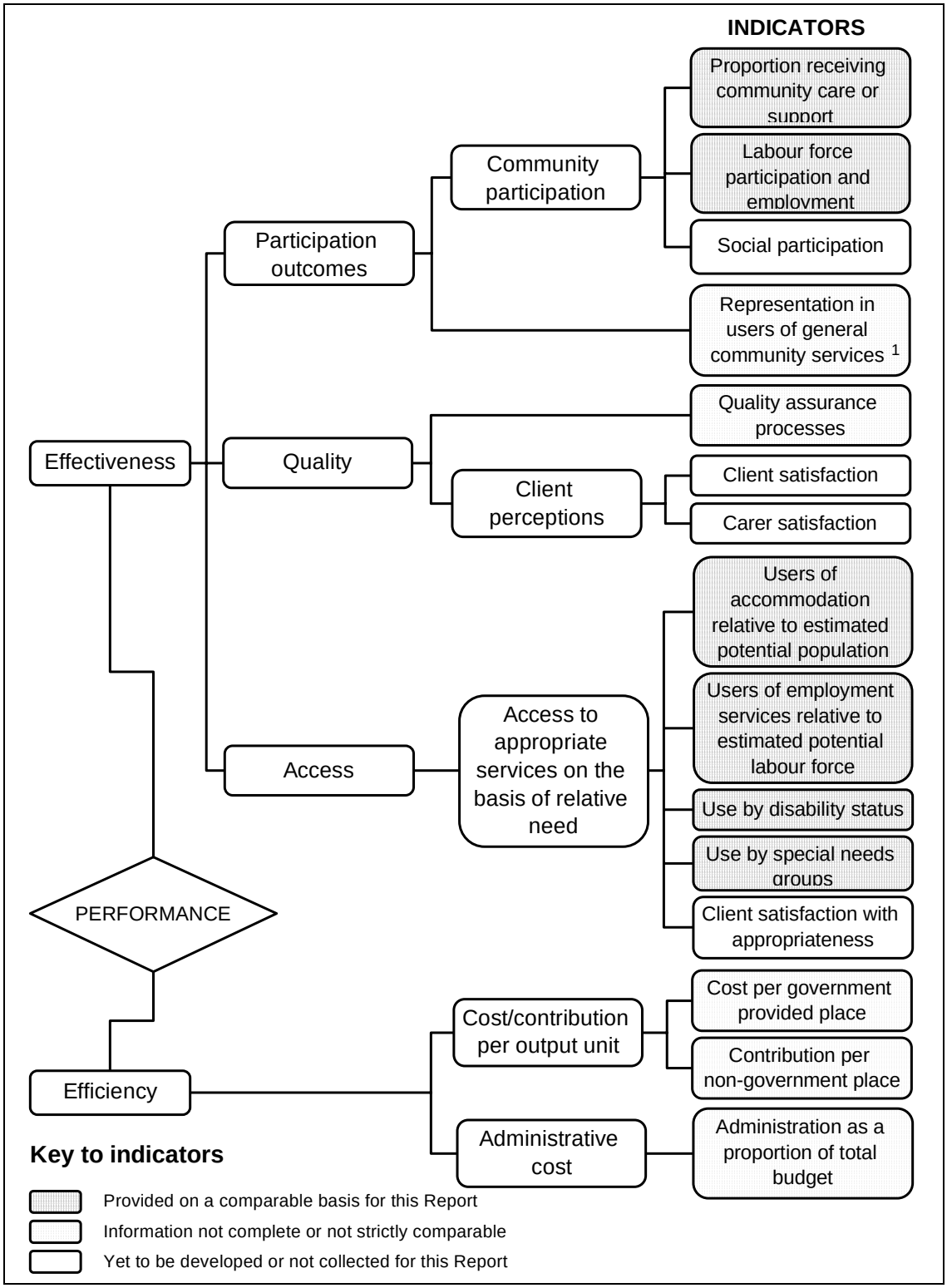
Governments strive to enhance the quality of life experienced by people with a disability through assisting them to live as valued and participating members of the community.

Guiding principles for government achieving this objective in working towards this objective are to:

- provide access to specialist government funded or provided disability services on the basis of relative need and available resources, and promote access to general community services and facilities;
- fund or provide quality services in an efficient and effective way, and be accountable to those using or funding services;
- ensure that clients and carers are consulted about the type and mix of services made available to meet their individual needs and goals; and
- promote the rights of people with a disability as members of the community, and empower them to exercise these rights.

The indicator framework aims to provide information on the efficiency and effectiveness of government services (Figure 8.3). *Effectiveness* indicators focus on outcomes as well as appropriateness and access. *Efficiency* indicators provide information on unit costs and administrative costs. It is important that performance indicators are viewed collectively to gain an overall picture of governments' performance, rather than considered in isolation. A description of all indicators is provided in Attachment 8A.

Figure 8.3: Framework of performance indicators for disability services



1 Indicators for the participation of people with a disability in other service areas were included in the indicator frameworks for those service areas.

8.5 Future directions

The Steering Committee has concentrated on developing a comprehensive set of indicators and acquiring robust results for a subset of the performance indicators appearing in the framework. Data quality will improve in future years as will the number of indicators for which results are available. An expansion of the range of service types covered by the Report is also anticipated.

Priority will be given in preparing next year's Report to achieving greater comparability across jurisdictions for the performance indicators on which data are available. Effectiveness indicator results were derived from the 1995 CSDA Minimum Data Set (MDS), the first MDS data collection attempted at a national level. Future MDS collections are expected to provide data which are more comparable and of a higher quality.

Greater difficulties were experienced in collecting comparable efficiency data. Future Reports will move towards providing unit costs in terms of hours of care rather than total clients. It is also anticipated that expenditure data will be collected on an accrual rather than cash basis in the future.

There were no quantitative indicators of service quality. The possibility of undertaking a client satisfaction survey providing comparable information on client perceptions of both the quality and appropriateness of services will be investigated for the next Report.

The service types covered in this chapter represent only a small proportion of the total range of government funded or provided services available to people with a disability. It is hoped that the coverage of the chapter will be expanded in later editions of the Report, although it is recognised that there are considerable difficulties in identifying HACC services delivered to younger people with a disability. Developments such as the renegotiation of the CSDA and the HACC Agreement and other outcomes of the health and community services reform process may also affect future reporting.

8.6 Key performance results

The 1997 Report is the first time that performance monitoring of services for people with a disability has been attempted at a national level. Data collection processes for many indicators are still at an early stage, particularly those for efficiency indicators.

There are a number of limitations of the main data sources for the effectiveness indicators — the 1995 CSDA MDS collection and the most recent ABS survey of Disability, Ageing and Carers (ABS Cat. No. 4433.0). For example, response

rates to the MDS survey were often low — 33 per cent of NT service providers did not respond to the survey in 1995.

In an effort to update and improve the accuracy of prevalence rates for individual jurisdictions provided by the ABS survey, additional information from the ABS and the Grants Commission was used to produce estimates of the potential population. Nevertheless, data limitations reduce the capacity to make valid comparisons of performance across jurisdictions.

8.6.1 Outcomes for people with a disability

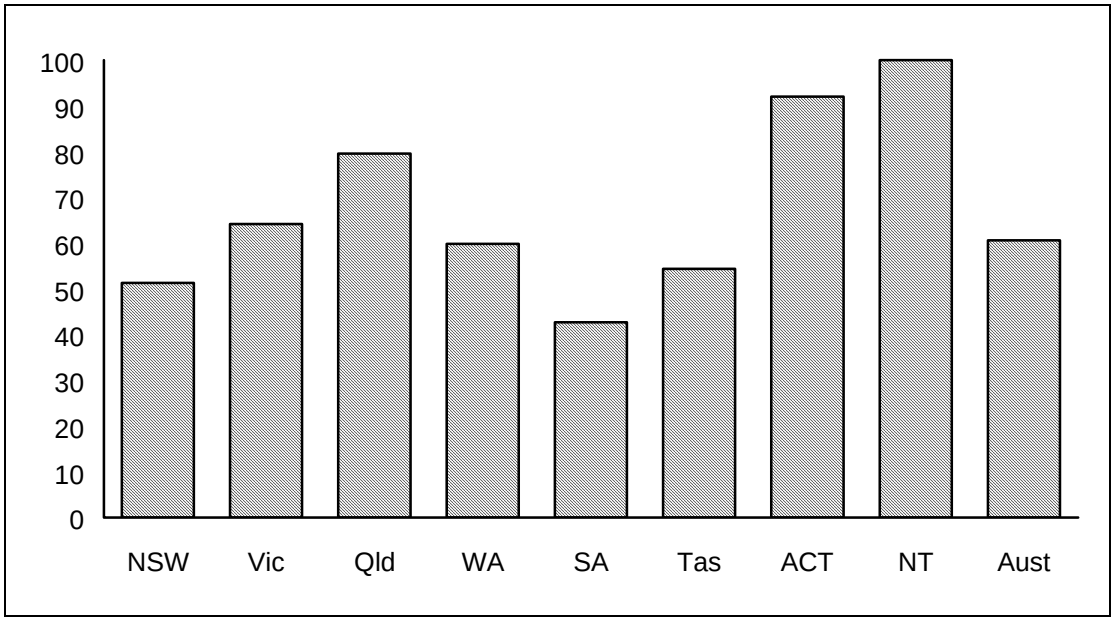
In addition to examining specific aspects of service delivery such as quality and access, a number of performance indicators have been included in the framework to provide information on the outcomes for people with a disability. In particular, the following three sets of indicators provide information on the degree to which people with a disability are able to live and work as valued participating members of the community.

Proportion of accommodation clients receiving community based care or support

Community based accommodation and support such as group houses, attendant care and outreach support has been viewed as a means of enabling people with a disability to better integrate and participate more fully in the community. Most states and territories have been moving towards a greater emphasis on community based care and support, but the degree to which this has taken place varies significantly across jurisdictions. Factors affecting the utilisation of community based care and support include the prevailing models of support, the nature of client populations and access to support services not falling under the CSDA.

In 1995–96, 100 per cent of accommodation clients in the NT and 92 per cent of clients in the ACT received community based care or support whereas only around 43 per cent of clients in SA and 51 per cent of NSW clients received this type of care (Figure 8.4). It should be noted, however, that changes over time in the proportion of people receiving community based assistance or the starting point of this process in each jurisdiction were not examined.

Figure 8.4: Accommodation clients receiving community based care or support, 1995–96 (per cent)



Source: Table 8A.4.

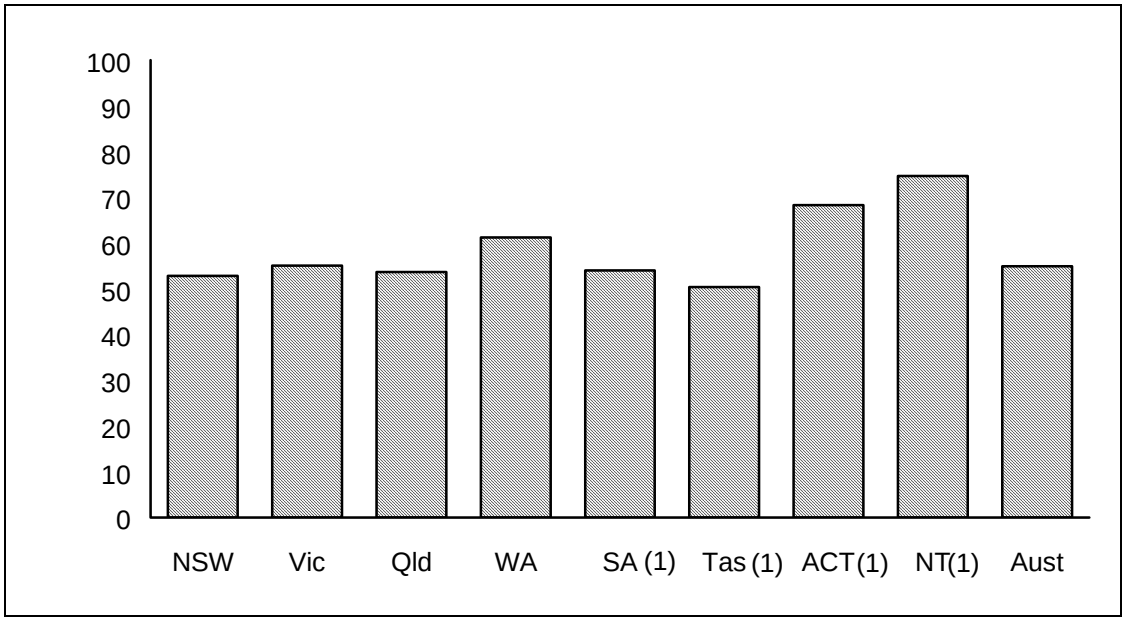
People with a disability in the work force and proportion employed

This indicator aims to provide an indication of the degree to which people with a disability are able to participate in the labour force. As such, differences across jurisdictions reflect a broad range of influences impacting on the degree to which people with a disability are empowered and have the opportunity to participate in the labour force. Employment services are but one of these influences.

Approximately 55 per cent of people with a disability were participants in the Australian labour force in 1993, compared with a participation rate of around 74 per cent for the broader community (ABS Cat. No. 4430.0). The highest participation rates of people with a disability were in the NT (75 per cent) and the ACT (68 per cent). These jurisdictions also had the highest participation rates for the community as a whole (Figure 8.5).[4]

[4] Participation rates for the broader community include both people with and without a disability. The participation rates reported for the broader community in ABS Cat. No. 4430.0 differ from those of the ABS Labour force survey (ABS Cat. No. 6203) due to differences in survey methods and sample sizes.

Figure 8.5: Labour force participation by people with a disability aged 15 to 64, 1993 (per cent)



1 Estimates for jurisdictions with smaller populations should be interpreted with caution because the data on which they are based are subject to high standard errors as a result of small sample sizes.
Source: ABS Cat. No. 4430.0.

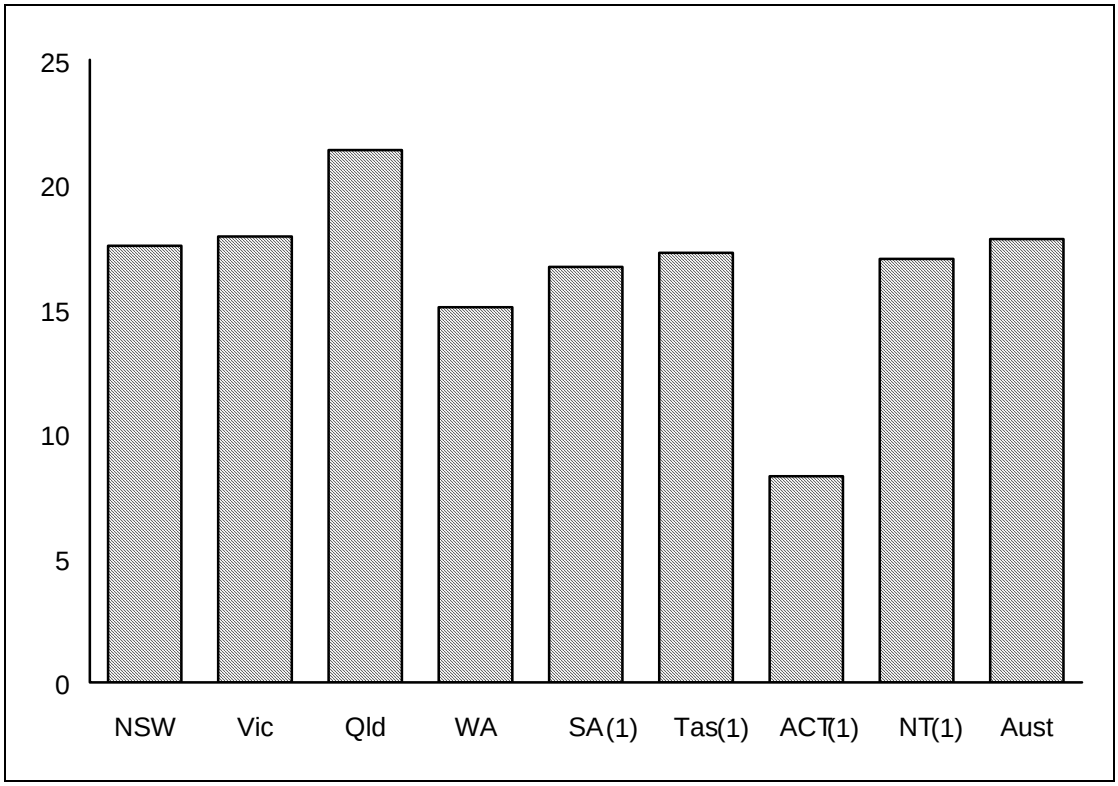
Approximately 18 per cent of those people with a disability who were in the labour force were unemployed. The proportion unemployed for most jurisdictions was within four percentage points of the national rate. The exception was in the ACT where approximately 8 per cent were unemployed (Figure 8.6). These results need to be interpreted in the context of employment conditions for the broader community in each jurisdiction.

8.6.2 Service quality

Comparable data on the quality of services were not available. As an alternative, a brief questionnaire was circulated to jurisdictions requesting information on the priorities and processes adopted to promote service quality (Section 8A.3).

The National Disability Services Standards (NDSS), initiated in the 1991 CSDA, specify objectives to be pursued by services and play an important part in the overall quality assurance processes adopted by all jurisdictions. The standards are reflected in legislation enacted within each jurisdiction and have resulted in a high degree of similarity in the objectives and principles adopted by jurisdictions as part of efforts to provide high quality services.

Figure 8.6: Unemployment rates for people with a disability in the labour force, 1993 (per cent)



1 Estimates for jurisdictions with smaller populations should be interpreted with caution because the data on which they are based are subject to high standard errors as a result of small sample sizes.
Source: ABS Cat. No. 4430.

Most jurisdictions enter into service agreements with providers and link funding to the attainment of specified quality objectives closely related to the NDSS. Providers in jurisdictions adopting this approach self-assess their performance each year against these objectives and identify avenues for improvement where necessary. In some jurisdictions — for example, SA, NSW, WA and the Commonwealth — consultation with consumers and carers forms part of the assessment process.

8.6.3 Access to services

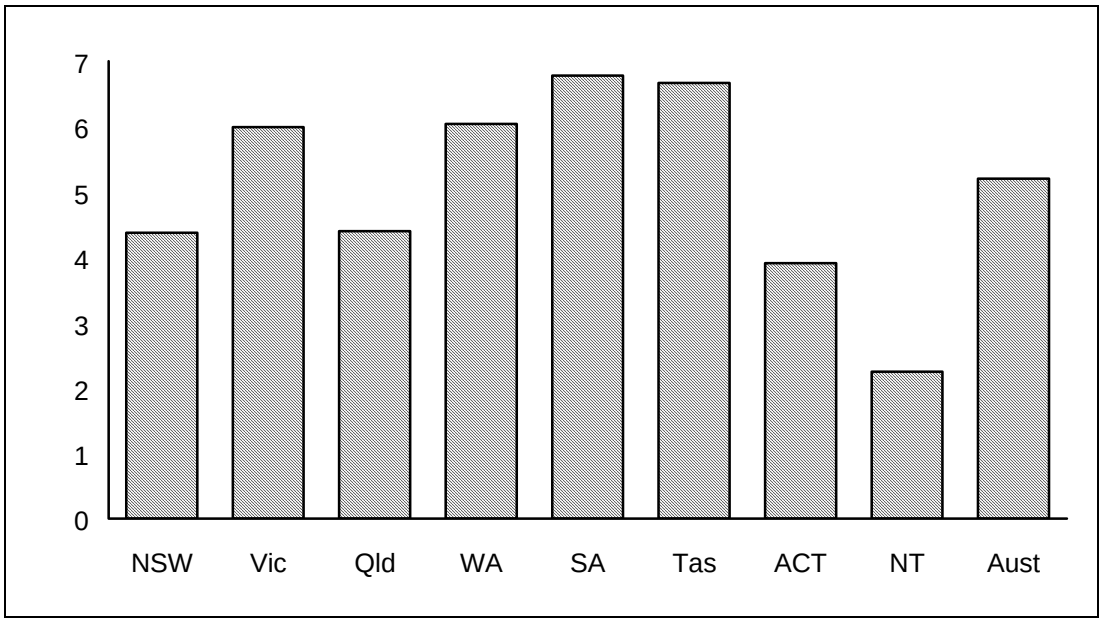
The available access indicators focus mainly on the ability of those needing support to gain access to a service. It is anticipated that a client survey planned for future years will provide information on the appropriateness of services, that is, the degree to which the services are perceived by clients to match their needs.

Accommodation and in home support

The proportion of the estimated potential population for accommodation services which is using government funded or provided services is an indicator of access to accommodation and in home support services. It is important to note that it does not measure the level of unmet demand for services, such an indicator would have to account for the differences in the availability of alternative forms of formal support and informal support across jurisdictions and relative needs.[5]

In general, in 1995–96, government funded and provided services were delivered to a relatively small proportion of the estimated potential users of accommodation services. Services were accessed by around 7 per cent of the estimated potential population in both SA and Tasmania, and by approximately 6 per cent in WA and Victoria. The national figure was 5 per cent (Figure 8.7).

Figure 8.7: Users of accommodation services relative to estimated potential population, 1995–96 (per cent)



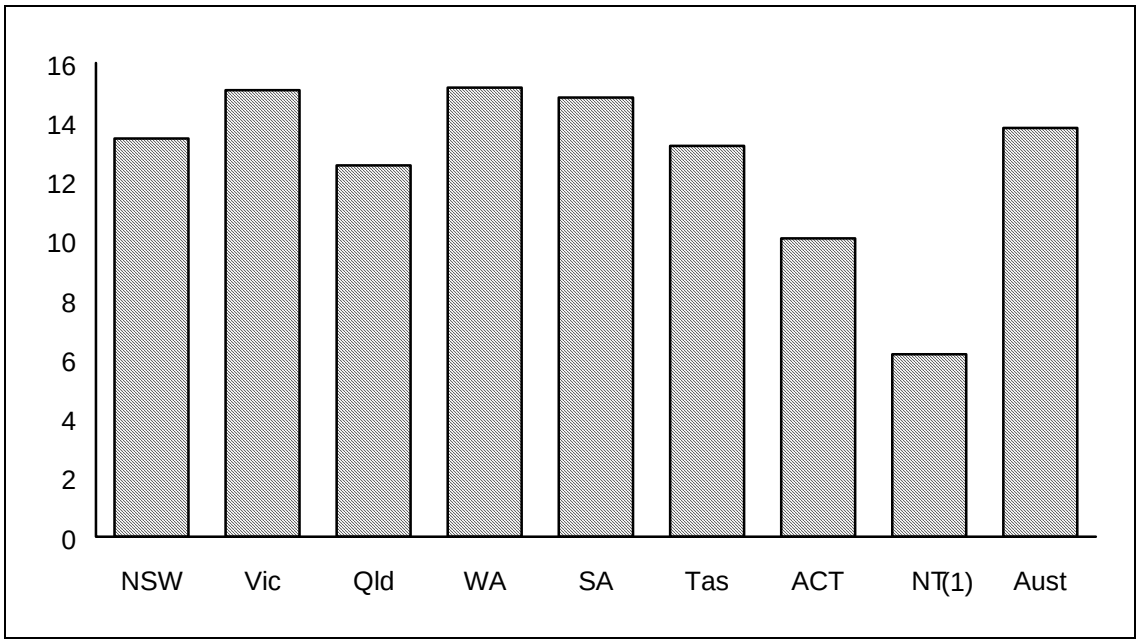
Source: Table 8A.6.

[5] Other types of formal care include other CSDA services (such as respite care), accommodation services not receiving government funding, and services provided by other government programs (such as aged care).

Employment services

The indicator of access to employment services is the number of people with a disability who use employment services compared to the estimated potential labour force of people. At the national level, approximately 14 per cent of the estimated potential population for employment services accessed Commonwealth Government funded employment services in 1995–96. As with the accommodation services Victoria, WA and SA appeared to have relatively higher proportions of their estimated potential populations using funded services (Figure 8.8).

Figure 8.8: Users of employment services relative to estimated potential labour force, 1995–96 (per cent)



1 NT data should be interpreted with caution as only 67 per cent of NT service providers responded to the 1995–96 CSDA collection.

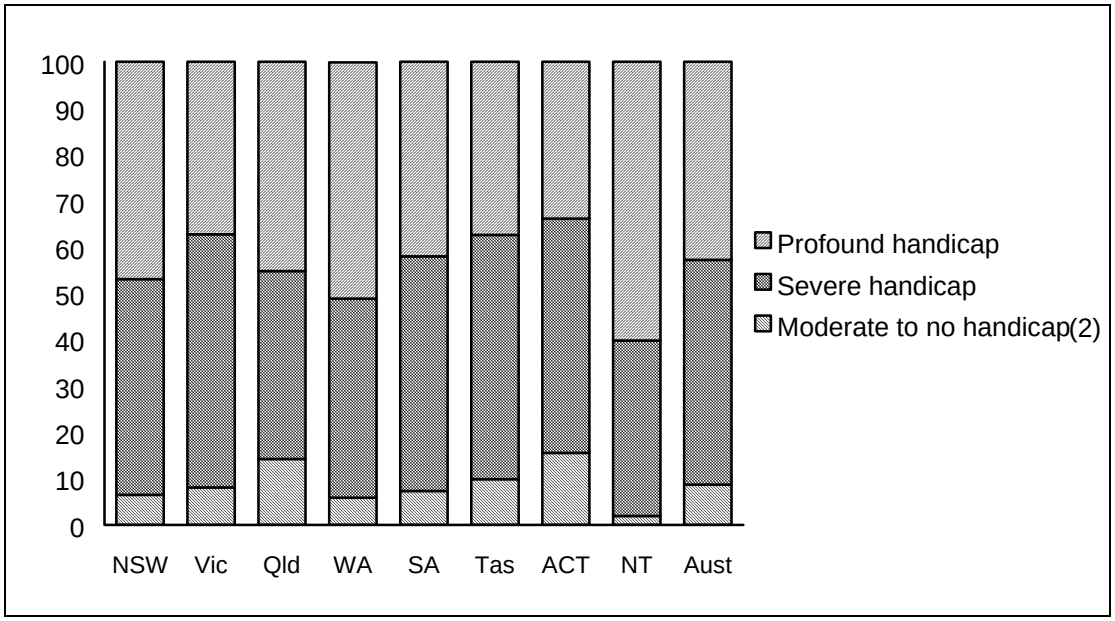
Source: Table 8A.6.

Access by level of handicap and disability status

In addition to examining the overall level of service use, the framework includes indicators of the utilisation of services by people with high support needs or who come from a non English speaking or Aboriginal or Torres Strait Islander background.

Over 90 per cent of total accommodation service clients experienced a severe or profound handicap (in ABS terms) in 1995–96. The ACT and Queensland were below the national figure, with 85 per cent and 86 per cent respectively reporting a severe or profound handicap (Figure 8.9).

Figure 8.9: Users of accommodation services with a severe, profound or moderate to no handicap, 1995–96 (per cent)[1]



1 Data for WA are for 1996 due to 1995 data being unavailable. For all other jurisdictions the 1995 data were used. In calculating WA estimates the variables of self-care, mobility and communication were aggregated into one category to allow comparisons with the 1995 collection.

2 'Moderate to no handicap' includes those with a mild handicap in ABS terms.

Source: Table 8A.7.

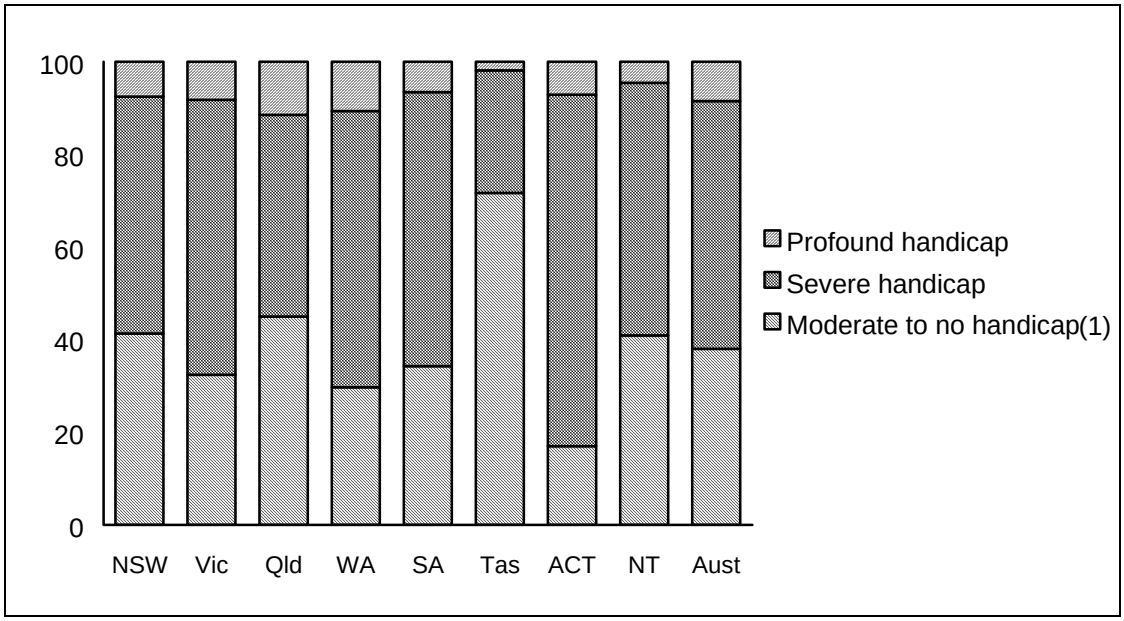
Employment services had a significantly lower proportion of users with a profound handicap than accommodation services (around 9 per cent of total clients). Service use by people with a severe handicap ranged from 27 per cent in Tasmania to 76 per cent in the ACT. In Tasmania, almost 72 per cent of those with a disability using employment services were classified as having moderate to no handicap compared with a national average of 38 per cent (Figure 8.10).

Access by special needs groups

The framework addresses variations in the access achieved by people who face disadvantages in addition to those associated with their disability.

Only a small proportion of Aboriginal or Torres Strait Islander people used accommodation services — from almost three per thousand in WA to less than one per thousand indigenous population in Tasmania (Figure 8.11).

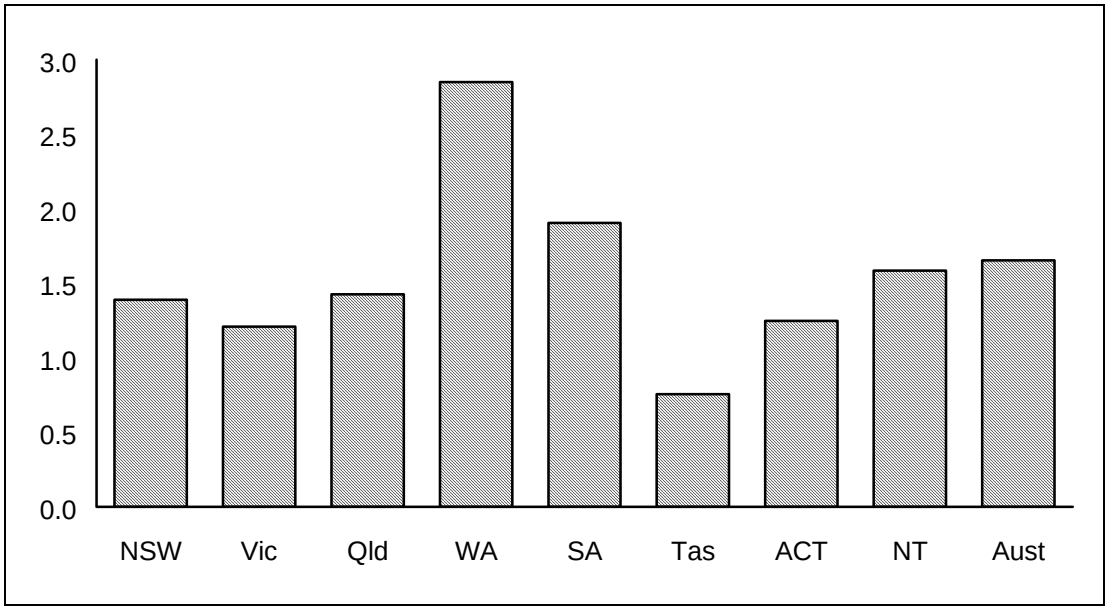
Figure 8.10: Users of employment services with a severe, profound or moderate to no handicap, 1995–96 (per cent)



1 'Moderate to no handicap' includes those with a mild handicap in ABS terms.

Source: Table 8A.8.

Figure 8.11: Aboriginal or Torres Strait Islander background use of accommodation services, 1995–96 (per 1000 indigenous people)[1]

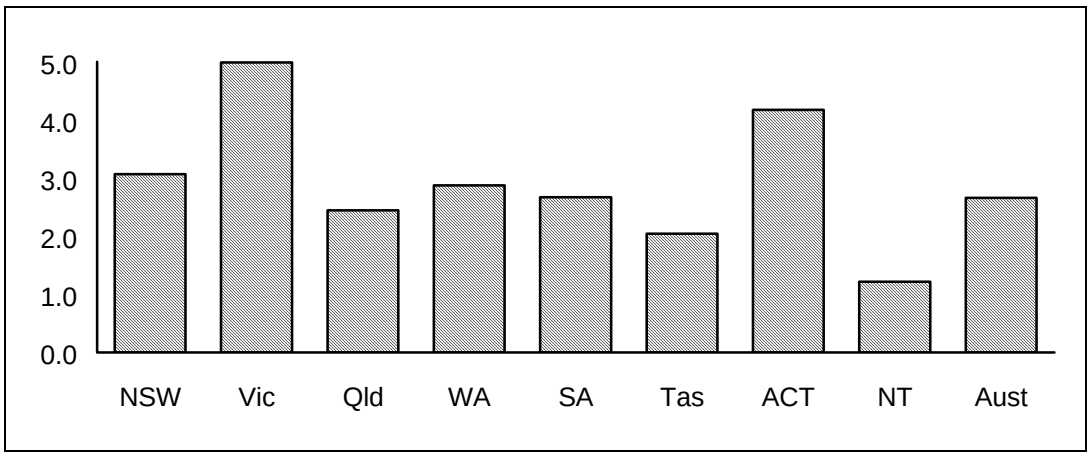


1 Data for WA are for 1996 as 1995 data were unavailable. For all other jurisdictions the 1995 data were used.

Source: Table 8A.9.

Generally, a larger proportion of indigenous people with a disability used employment services than used accommodation services. The proportion was highest in Victoria at five per 1000 and lowest in the NT at 1.2 per 1000 indigenous people (Figure 8.12).

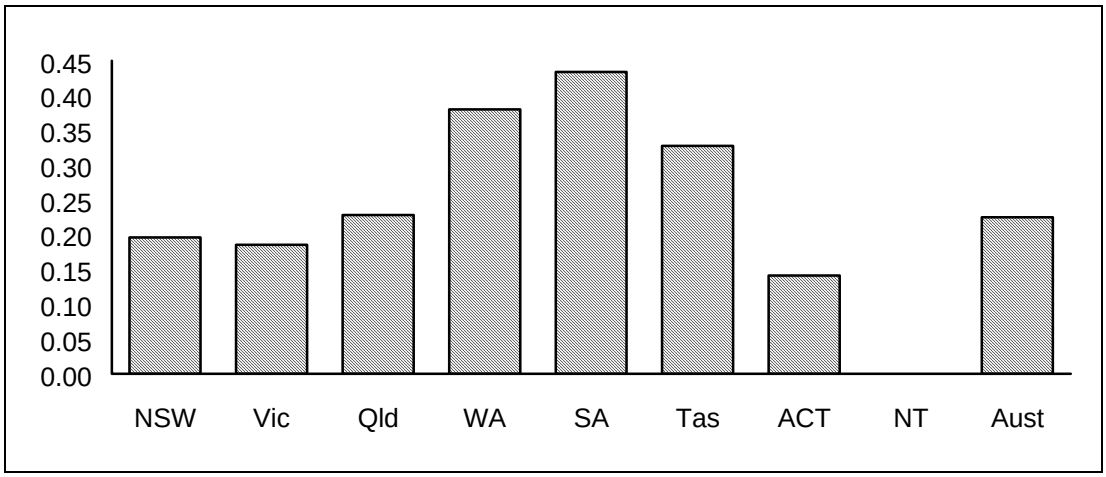
Figure 8.12: Aboriginal or Torres Strait Islander background use of employment services, 1995–96 (per 1000 indigenous people)



Source: Table 8A.9.

At the national level, only 0.2 people per 1000 people of non English speaking background used accommodation services in 1995–96. The results varied widely amongst jurisdictions — for example, the rate in SA was more than twice that in several other jurisdictions (Figure 8.13).

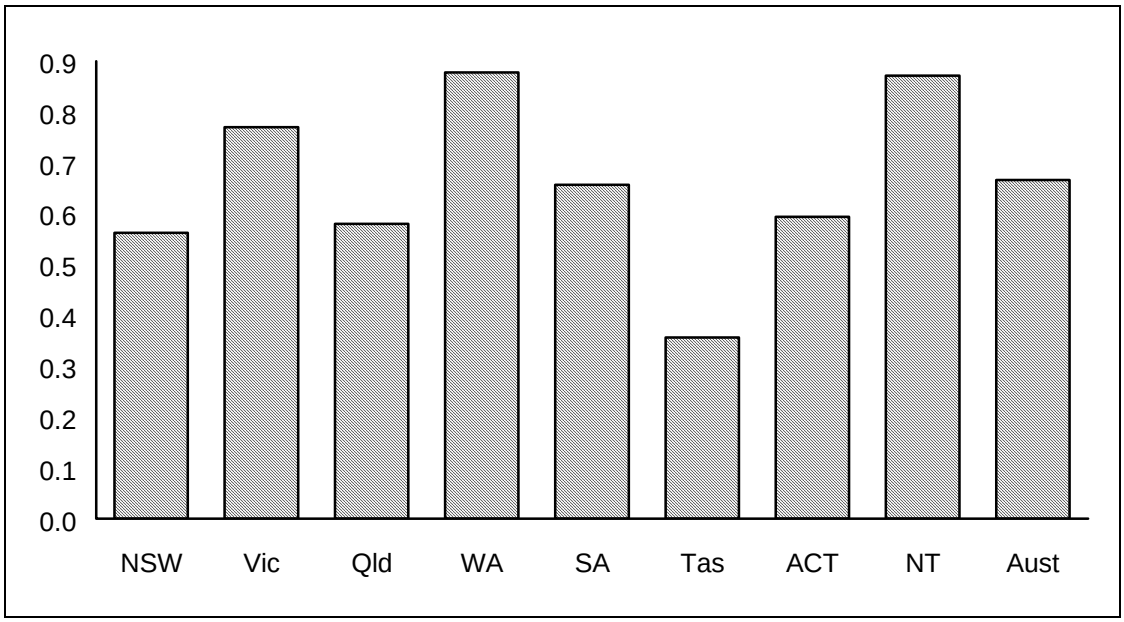
Figure 8.13: Non English speaking background use of accommodation services, 1995–96 (per 1000 people of non English speaking background)[1]



1 Data for WA are for 1996 as 1995 data were unavailable. For all other jurisdictions the 1995 data were used.
Source: Table 8A.9.

In all jurisdictions, less than one person per 1000 people of non English speaking background used employment services on the day on which data were collected. The NT and WA had the highest proportion of service use (0.9 per 1000 people of non English speaking background) and Tasmania had the lowest (0.4 per 1000 people of non English speaking background) (Figure 8.14).

Figure 8.14: Non English speaking background users of employment services, 1995–96, (per 1000 people of non English speaking background)



Source: Table 8A.9.

8.6.4 Efficiency of services delivery

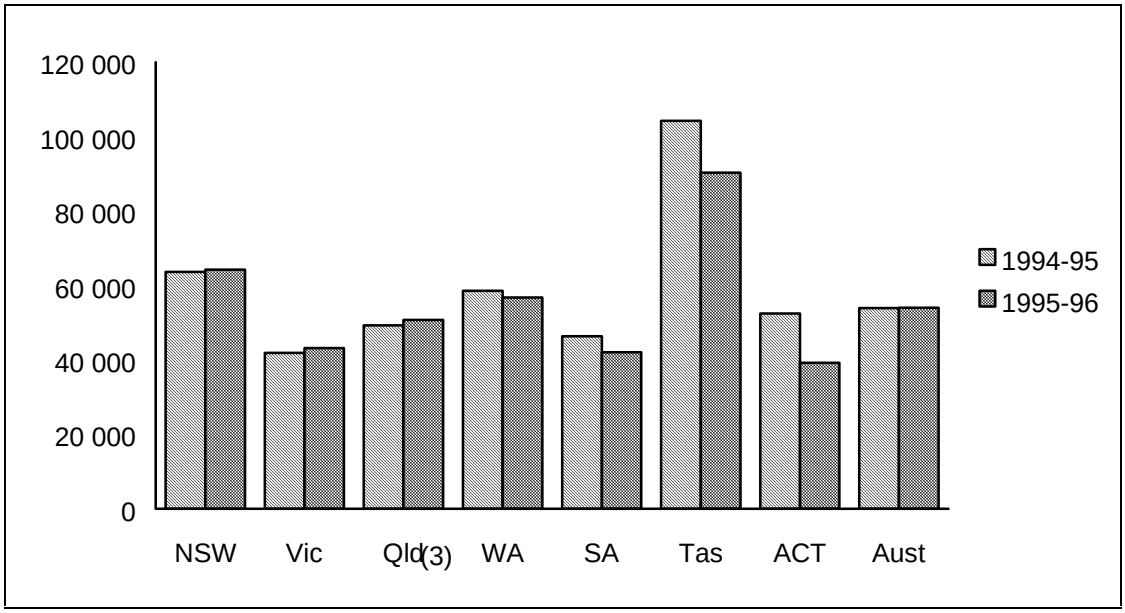
The results presented below represent a first attempt at analysing the efficiency of services for people with a disability and should be treated as indicative only. It is anticipated that more comparable efficiency indicator results will be available for future Reports.

Unit costs

The cost of providing an institutional or large residential place varied significantly across jurisdictions. In 1995–96, the highest expenditure per place was around $90 000 per year for Tasmania while the lowest was around $39 000 in the ACT. This result suggests that economies of scale may not be a major factor in explaining variations among jurisdictions.

Both Tasmania and the ACT showed a significant decrease in expenditure from 1994–95 to 1995–96. There was a fall of 25 per cent in real terms in the unit cost for the ACT and a fall of around 13 per cent for Tasmania (Figure 8.15).[6]

Figure 8.15: Cost per government provided institutional/large residential place (at 1995-96 prices), 1994–95 and 1995–96, ($)[1, 2]



1 Expenditure on government provided accommodation is net of receipts to the funding body where possible. Receipts paid to other areas of government (such as Treasury's Consolidated Revenue) were excluded. No receipts were collected from client contributions charged by non government accommodation services.

2 There were no institutional/large residential services in the NT.

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

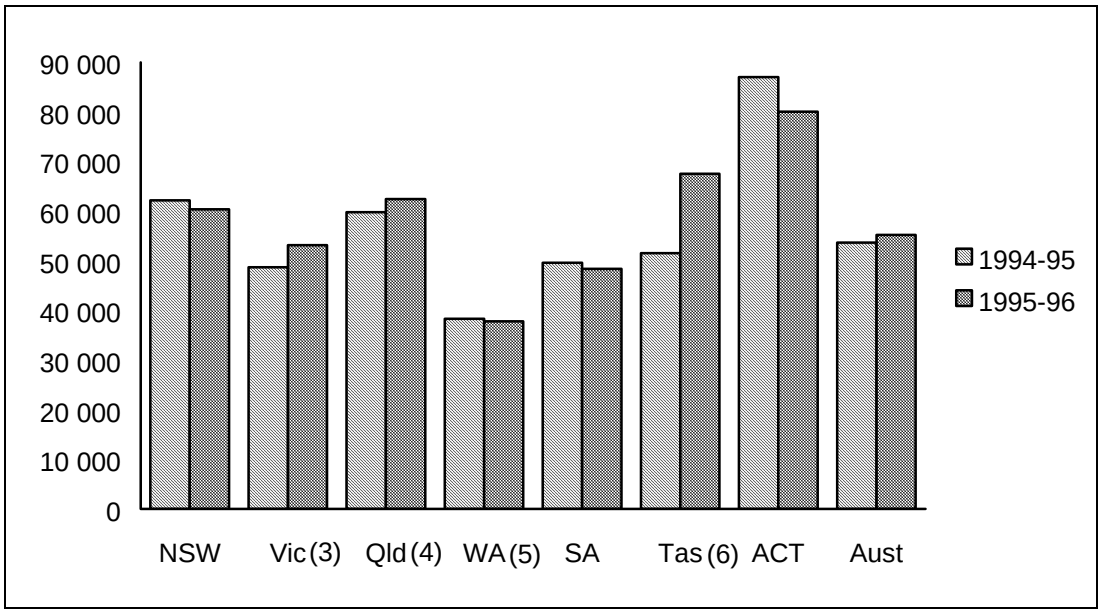
Source: Table 8A.10.

6 A significant factor in the fall in ACT expenditure was the closure of a residential service in 1995–96 that provided approximately 70 per cent of institutional care in the ACT.

For most jurisdictions, the cost to the government of providing a community accommodation and care place was greater than that of providing an institutional or large residential place. For example, a community place cost around $40 000 more than an institutional or large residential place in the ACT in 1995–96.

The cost per place of government provided community accommodation and care ranged from $38 000 in WA to over $80 000 in the ACT (Figure 8.16). There was no consistent change in the real cost per place between 1994–95 and 1995–96.

Figure 8.16: Cost per government provided community accommodation and care place, 1994–95 and 1995–96 ($)[1,2]



1 Expenditure on government provided accommodation was net of receipts to the funding body where possible. Receipts paid to other areas of government (such as Treasury's Consolidated Revenue) were excluded. No receipts were collected from client contributions charged by non government accommodation services.

2 The NT government did not directly provide community accommodation support places. All services were provided through funded non government agencies.

3 As a result of concerns over the accuracy of MDS places data for Victoria, Department of Human Services 1995–96 Annual Report data was combined with unpublished information to estimate total places.

4 In 1995–96, 52 Queensland places within 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.

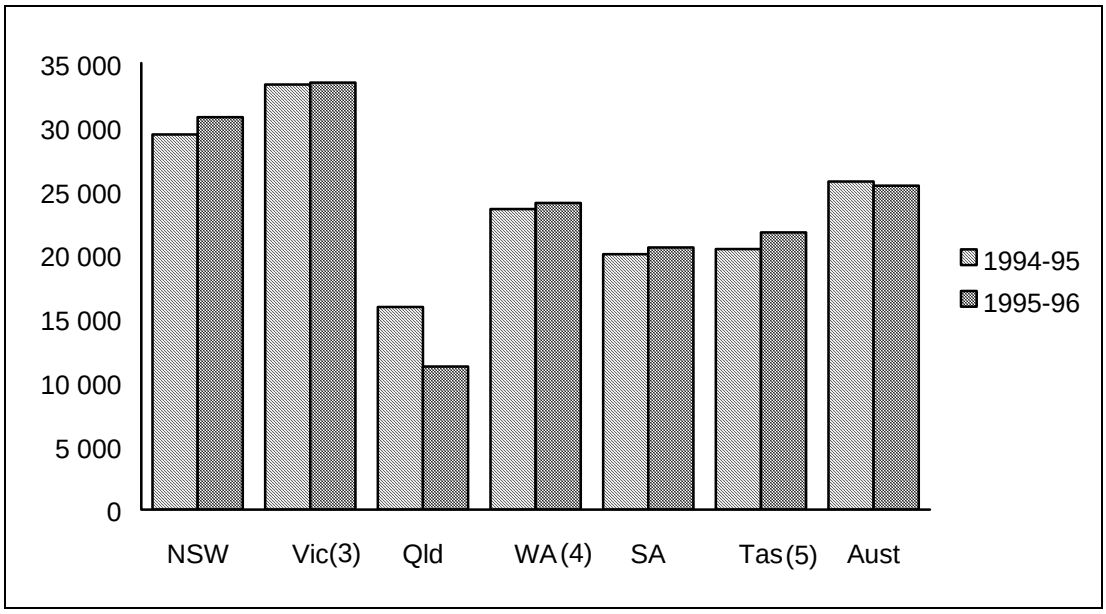
5 1994 MDS places data was not used for WA. Rather 1995 MDS figures was used as reported in the WA Disability Services Commission Annual Report.

6 MDS places data for Tasmanian was supplemented to adjust for services that did not respond to the original collection.

Source: Table 8A.10.

On average, governments contributed around $25 000 towards the total cost of providing a non government institutional/large residential place in both 1994–95 and 1995–96 (Figure 8.17). State and Territory Governments contribute a varying proportion of the total cost of providing a non government place.

Figure 8.17: Government contribution per non government institutional/large residential place (at 1995-96 prices), 1994–95 and 1995–96 ($)[1,2]



1 Expenditure on government provided accommodation was net of receipts to the funding body where possible. Receipts paid to other areas of government (such as Treasury's Consolidated Revenue) were excluded. No receipts were collected from client contributions charged by non government accommodation services.

2 The ACT and the NT did not fund non government institutional/large residential places.

3 As a result of concerns over the accuracy of MDS places data for Victoria, Department of Human Services 1995–96 Annual Report data was combined with unpublished information to estimate total places.

4 1994 MDS places data was not used for WA. Rather 1995 MDS figures were used as reported in the WA Disability Services Commission Annual Report. Places identified for non government provided accommodation include both funded and non funded services.

5 MDS places data for Tasmania were supplemented to adjust for services that did not respond to the original collection.

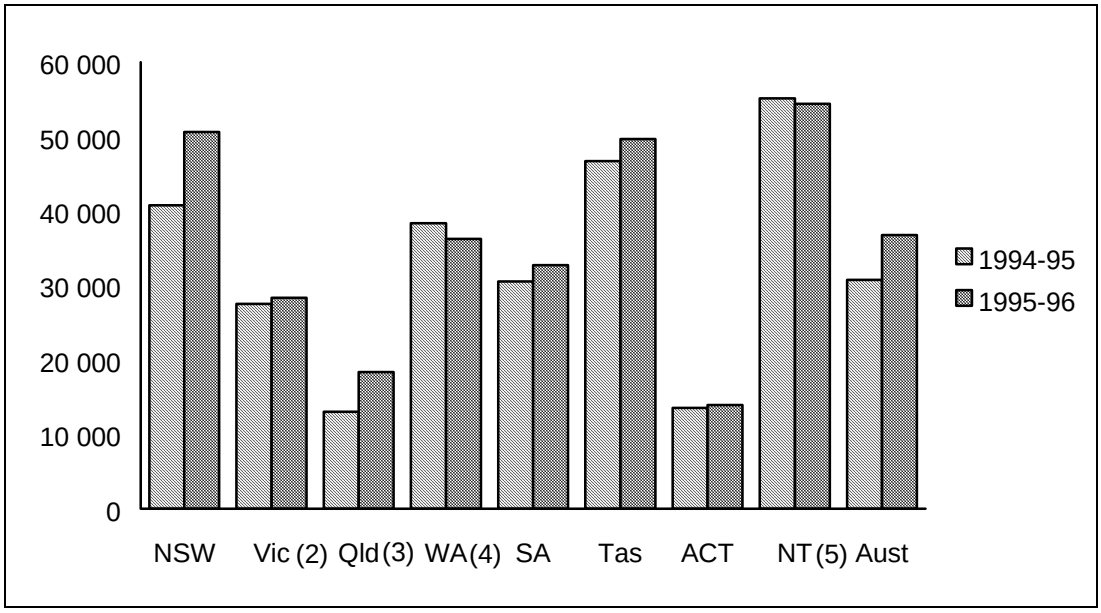
Source: Table 8A.10.

For all jurisdictions, the government per place contribution was greater for community accommodation and care places than for institutional or large residential places. Tasmania had the largest difference in 1995–96, with a contribution per community accommodation and care place of almost $28 000 greater than its contribution per residential or large institution place.

Across Australia, governments contributed around $36 000 per community accommodation and care place, but the contributions of jurisdictions varied

considerably (Figure 8.18). Most jurisdictions recorded a rise in their contribution per community accommodation and care place from 1994–95 to 1995–96. Queensland recorded the largest increase — around 40 per cent in real terms.

Figure 8.18: Government contribution per non government community accommodation and care place (at 1995-96 prices), 1994–95 and 1995–96, ($)



1 Expenditure on government provided accommodation was net of receipts to the funding body where possible. Receipts paid to other areas of government (such as Treasury's Consolidated Revenue) were excluded. No receipts were collected from client contributions charged by non government accommodation services.

2 As a result of concerns over the accuracy of MDS places data for Victoria, Department of Human Services 1995–96 Annual Report data was combined with unpublished information to estimate total places.

3 Places and funding amounts for Queensland excludes one large service provider that was unable to participate in the 1995 MDS.

4 1994 MDS places data were not used for WA. Rather 1995 figures published by the WA Disability Services Commission were used . Places identified for non government provided accommodation included both funded and non funded services.

5 Included four NT places not counted in the original MDS collection.

Source: Table 8A.10.

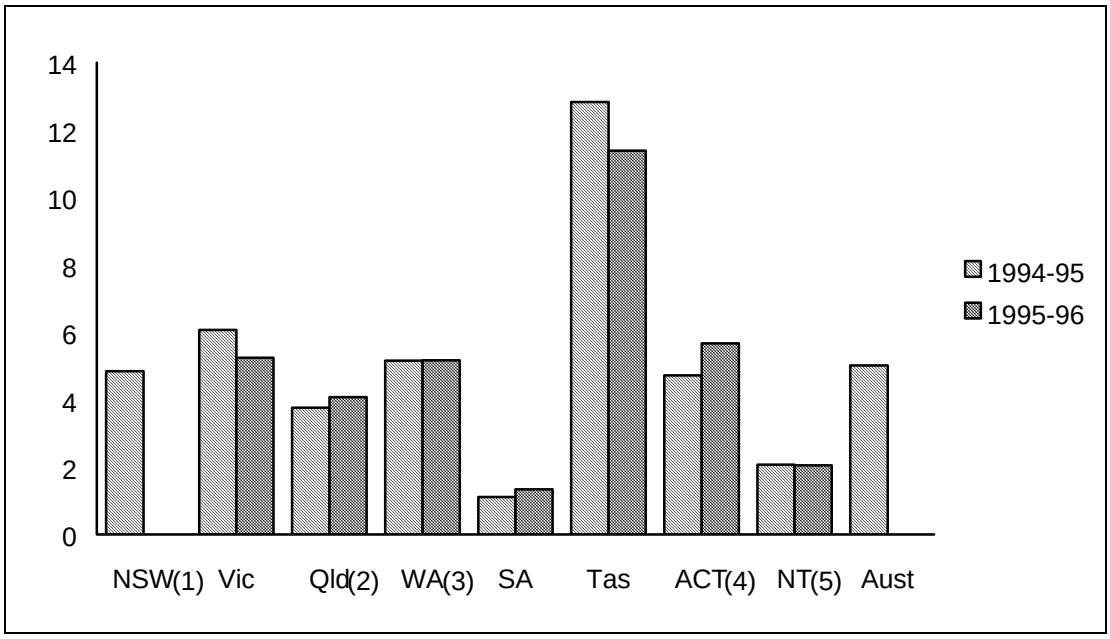
In addition to accommodation services, unit contributions were also collected for Commonwealth Government employment programs. The Commonwealth contributed, in real terms, around $6400 per employment place in 1994–95. Data for 1995–96 were not available.

Administrative efficiency

The proportion of total expenditure spent to administer the system in Queensland, SA and the NT was less than 5 per cent of total expenditure in 1995–1996. These results were significantly lower than the 11.4 per cent recorded for Tasmania. The varying results for the smaller population states and territories suggest that scale economies may not be a significant factor in explaining variations among jurisdictions.

While the share of total cost expended on administration was high in Tasmania relative to those of other states and territories, the decrease in this share over the two years for which data are available was surpassed only by Victoria. Administration's share of total cost increased for Queensland, WA, SA, and the ACT over the same period but from a lower base (Figure 8.19). Again, scale economies were not a major influence on the proportion of total expenditure accounted for by administration costs.

Figure 8.19: Administration expenditure as a percentage of total expenditure, 1994–95 and 1995–96, (per cent)[1]



1 NSW administration costs for 1995–96 were not available due to a departmental restructure.

2 Included four large institutions administered by Queensland Health but linked to the CSDA funding base.

3 Expenditure by WA excluded expenditure in relation to early intervention therapy services but equipment purchases were included.

4 ACT data were incomplete due to significant changes to departmental administrative arrangements.

5 NT multi-disciplinary assessment teams were included as they provided a mix of therapy, training and other services which were not separately identifiable.

Source: Table 8A.11.

The share of total Commonwealth Government expenditure expended on administration was approximately 2.8 per cent in 1995–96 — up slightly from the 2.6 per cent in 1994–95. Results for the Commonwealth Government have not been compared with those for the State and Territory Governments on this indicator because the two tiers of government perform different functions.