CHAPTER 3

APPROPRIATENESS OF JOINT FUNDING ARRANGEMENTS

Introduction

3.1 This chapter will examine the appropriateness or otherwise of the current joint funding arrangements under the CSTDA and focuses on the overall structure of the arrangements. Issues in relation to unmet need are discussed in Chapter 4.

3.2 Part 6 of the current CSTDA outlines the responsibilities of the parties to the Agreement. All parties have continuing responsibilities under the Agreement for funding specialist services for people with disabilities. While funding responsibilities are shared between the levels of government, the CSTDA divides the responsibility for funding specialist disability services from their administration. The Commonwealth has responsibility for the planning, policy setting and management of specialist disability employment services. The State and Territory Governments have responsibility for the planning, policy setting and management of specialist disability services except employment services. These services include accommodation support, community access, community support and respite care.

3.3 The Commonwealth, State and Territory Governments also share administrative responsibilities for planning, policy setting and management of advocacy services, print disability services and information services as well as participating in and funding research and development.[1] The current agreement expires on 30 June 2007; a fourth CSTDA is in the early stages of negotiation.

3.4 As part of their joint funding responsibilities under the current CSTDA governments have committed $17.1 billion over five years. There is roughly a 80/20 split between the funding contributions of the States and Territories Governments and the Commonwealth for specialist disability services other than employment services. For example in 2005-06 $3.552 billion was made available under the Agreement. This was made up of $1.056 billion from the Commonwealth and $2.496 billion from the State and Territory Governments. Of the Commonwealth's contribution, $450 million was spent on the provision of specialised disability employment services and $605 million was transferred to the States and Territory Governments for the provision of specialist disability services other than employment.

3.5 The Commonwealth makes CSTDA funding available as financial assistance to the State and Territory Governments as a Specific Purpose Payment (SPP). In the Agreement, this funding is described as the total amount required to meet the

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1 *Commonwealth State Territory Disability Agreement 2002-2007*, Part 6.

Commonwealth's responsibilities for the management and administration of all specialist disability services other than employment, 'a global amount to be allocated on the basis of need' by the State and Territory Governments.[2] The Commonwealth does not impose any requirements on the way funds are allocated, except that they are used to fund services that are eligible for funding under the CSTDA.

3.6 The Commonwealth's other contributions to people with a disability and their carers are not included in the CSTDA arrangements. These include income support payments such as the Disability Support Pension ($7.9 billion per annum), the Carer Allowance ($1.1 billion per annum), the Carer Payment ($1.1 billion per annum), the Mobility Allowance and the Disability Pension for Australian Defence Force veterans. People with a disability may also be eligible to receive Commonwealth-funded services through the Home and Community Care Program (HACC) or other services and the Commonwealth Rehabilitation Service. Both these programs are also not part of the CSTDA arrangements.

3.7 Table 3.1 is extracted from the CSTDA and provides the funding contributed by each party.

Bilateral Agreements

3.8 The Commonwealth has signed individual bilateral agreements with each of the States and Territories under the current CSTDA. Bilateral Agreements were introduced under the second CSDA. The purposes of these Bilateral Agreements are to: provide for action on strategic disability issues; provide a continuing procedure for negotiation and agreement between the Commonwealth and individual States/Territories on the transfer of responsibility for particular services from one level of government to another; and to bring into the scope of the CSTDA specialist disability services not yet included.[3]

3.9 In practice, the Bilateral Agreements provide the Commonwealth with a level of influence over the provision of State and Territory disability services. Bilateral Agreements also create a degree of flexibility to the joint funding arrangements, providing the opportunity to address specific issues such as increased access to respite care for older parents caring for their sons and daughters with a disability or the transfer of services between the levels of government.

2 *Commonwealth State/Territory Disability Agreement 2002-2007*, Part 8(6).

3 *Commonwealth State Territory Disability Agreement 2002-2007*, Recital B.

Table 3.1: CSTDA funding contributions by jurisdiction

	Contributing Government	2002-03 $	2003-04 $	2004-05 $	2005-06 $	2006-07 $	TOTAL $
NSW	State	730,358,881	810,448,778	879,370,505	736,600,000	812,100,000	3,968,878,164
	Commonwealth	165,938,584	191,956,174	186,325,495	202,232,000	206,049,000	952,501,253
	Total - NSW	896,297,465	1,002,404,952	1,065,696,00	938,832,000	1,018,149,000	4,921,379,417
VIC	State	731,758,427	791,638,205	887,559,846	774,036,000	791,065,000	3,976,057,478
	Commonwealth	120,200,973	124,074,394	129,293,354	136,221,000	139,612,000	649,401,721
	Total - VIC	851,959,400	915,712,599	1,016,853,200	910,257,000	930,677,000	4,625,459,199
QLD	State	238,548,271	276,466,893	329,269,549	422,939,000	467,832,000	1,735,055,713
	Commonwealth	102,221,729	105,386,107	107,991,451	116,090,000	118,183,000	549,872,287
	Total - QLD	340,770,000	381,853,000	437,261,000	539,029,000	586,015,000	2,284,928,000
SA	State	124,421,702	137,178,086	161,973,604	163,124,000	151,560,000	738,257,392
	Commonwealth	59,567,535	61,282,520	62,669,290	67,390,000	67,136,000	318,045,345
	Total - SA	183,989,237	198,460,606	224,642,894	230,514,000	218,696,000	1,056,302,737
WA	State	199,701,780	215,873,552	234,186,929	252,914,000	271,118,000	1,173,794,261
	Commonwealth	42,442,220	43,866,448	45,673,071	48,344,000	50,017,000	230,342,739
	Total - WA	242,144,000	259,740,000	279,860,000	301,258,000	321,135,000	1,404,137,000
TAS	State	59,432,453	63,572,851	71,897,316	77,500,000	79,900,000	352,302,620
	Commonwealth	18,543,358	19,082,812	19,520,198	20,362,000	20,754,000	98,262,368
	Total - TAS	77,975,811	82,655,663	91,417,514	97,862,000	100,654,000	450,564,988
NT	State	17,336,186	18,792,302	22,833,322	18,869,250	19,227,766	97,058,826
	Commonwealth	5,513,748	5,695,550	5,926,880	6,259,000	6,470,000	29,865,178
	Total - NT	22,849,934	24,487,852	28,760,202	25,128,250	25,697,766	126,924,004
ACT	State	39,853,753	44,580,548	49,388,663	50,165,000	51,465,000	235,452,964
	Commonwealth	7,376,247	7,623,024	7,829,812	8,503,000	8,686,000	40,018,083
	Total - ACT	47,230,000	52,203,572	57,218,475	58,668,000	60,151,000	275,471,047
CWLTH	Payments to States	521,804,394	558,967,029	565,229,551	605,400,000	616,908,000	2,868,308,974
	Employment	303,714,799	350,583,834	409,697,327	450,894,000	486,898,000	2,001,787,960
	Total	**825,519,193**	**909,550,863**	**974,926,878**	**1,056,294,000**	**1,103,806,000**	**4,870,096,934**
TOTAL	**State**	**2,141,411,453**	**2,358,551,215**	**2,636,479,734**	**2,496,147,250**	**2,644,267,766**	**12,276,857,418**
	Common-wealth	**825,519,193**	**909,550,863**	**974,926,878**	**1,056,294,000**	**1,103,806,000**	**4,870,096,934**
	Total	**2,966,930,646**	**3,268,102,078**	**3,611,406,612**	**3,552,441,250**	**3,748,073,766**	**17,146,954,352**

Source: Commonwealth State Territory Disability Agreement 2002 -2007, Schedule A1.

Joint funding arrangements

Responsibilities

3.10 The previous and current agreements have been recognised as clarifying administrative responsibilities between the Commonwealth, State and Territory Governments. However, many submissions identified problems with the joint funding arrangements of the CSTDA, in particular the lack of clarity regarding the shared funding responsibilities and accountability. The lack of clarity regarding responsibilities for funding disability services was highlighted as enabling both levels of government to shift responsibility for the inadequate funding of specialist disability services.

3.11 The CSTDA arrangements divide responsibility for the administration (the planning, policy setting and management) of disability services from responsibility for their funding. However, for the purposes of accountability for service delivery these roles are linked. The inadequate provision of disability services can result from either inadequate administration or insufficient funding. Submissions also noted concerns about where accountability rests in the division between funding and administration responsibilities in the CSTDA.

3.12 Consistently submissions and witnesses expressed frustration at the lack of clear accountability in the CSTDA arrangements.[4] Ms Di Shepard submitted:

> The current bureaucratic split between State and Commonwealth allows for endless 'argy bargy' about who is accountable. The States say they are doing their bit, but the Commonwealth is falling short. The Commonwealth says just the opposite. Frankly, I don't care about playing the 'blame game', I just want the system to work. It can't work properly until there is a fixed point of accountability.[5]

Mr Richard Deirmajer commented:

> One of the biggest issues we have also had between the states and the federal government is that, when we lobby the state government… the states seem to blame the federal government because they are not getting enough funding. So we go and see the federal government, and they blame the states.[6]

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4 *Committee Hansard* 22.11.06, p.14 (Tasmanians with Disability); *Committee Hansard* 5.10.06, p.29 (National Council on Intellectual Disability); *Committee Hansard* 5.10.06, p.68 (Ms D Croft); *Committee Hansard* 5.10.06, p.76 (CASA); *Committee Hansard* 13.10.06, p.7 (Ms S Richards); *Submission* 107, p.3 (National Ethnic Disability Alliance).

5 *Submission* 82, p.1 (Ms D Shepard).

6 *Committee Hansard* 5.10.06, p.77 (Mr R Diermajer).

Ms Deidre Croft in her submission stated:

> The States and Territories Governments have consistently maintained that the Commonwealth/States and Territories Disability Agreement was based on a commitment to joint funding of disability support services. The Australian Government, on the other hand, continues to assert that the funding of disability support services (other than employment services) is a State and Territory responsibility.[7]

3.13 However, the NSW Minister for Disability Services the Hon John Della Bosca noted the advantages of State and Territory government administration of services in allowing a level of local accountability in the provision of disability services.

> I think that in general the states—and I am speaking for New South Wales—are better placed to facilitate local planning and community engagement and to make sure there is local accountability to provide those services directly. We are the people—in the case of New South Wales—who are already running significant public services and facilitating the non-government organisations to participate in our programs.[8]

3.14 Many submissions and witnesses identified specific criticisms with individual State and Territory governments in relation to specialist disability services. Ms Brown of the National Carers Coalition commented on the 'shocking performance' of the NSW Government in provided adequate funding for disability services in the past.[9] NCOSS cited the comparable information listed in the Report on Government Services produced by the Productivity Commission to identify a number of areas where NSW has low proportions of people with disabilities using disability services.[10] The Disability Advocacy and Complaints Service of South Australia described their advocacy efforts for individuals who had severe shortages in their care hours and urgently needed aids and equipment:

> We sent 76 individual letters to the Minister, the Premier and the Treasurer of South Australia. Three years on half of the urgent needs have been picked up, the other half are still waiting.[11]

3.15 There was overwhelming evidence that there is not enough funding for disability services but some witnesses commented that they believed that there could be more effective delivery of services at the State and Territory level.

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7 *Submission* 101, p.18 (Ms D Croft).

8 *Committee Hansard* 3.10.06, p.48 (NSW Minister for Disability Services).

9 *Committee Hansard* 3.10.06, p.28 (National Carers Coalition).

10 *Submission* 95, p.4 (NCOSS).

11 *Submission* 68, p.4 (Disability Advocacy and Complaints Service of SA).

Inflexible interfaces

3.16 The nature of the division of administrative and funding responsibilities for specialist disability services to each jurisdiction and level of government has lead to different approaches to the provision of services. In some cases it has created program silos leading to inflexible interfaces between disability services at each level of government or jurisdiction. NCOSS in their submission emphasised that this frequently did not result in optimal outcomes for people with disability or their carers:

> Government funding programs stream people into designated service categories, eg disability services, residential aged care facilities, community care etc. This streaming can serve to reduce the desired flexibility of service provision thus promoting a system which is driven by the service system and not by individual needs. Clients are accepted because they "fit" the service provision, not the other way around.[12]

UnitingCare Australia commented:

> The current demarcation between jurisdictional responsibilities means that people wishing to transfer between options or undertake a mix of options are required to negotiate their way through two different service systems with differing policy and funding priorities.
>
> A need exists to simplify the system to make it easier for consumers to access and navigate. This means ensuring that improved pathways between Commonwealth and State funded services are two–way thereby enabling a smooth transition into and between programs and services according to people's changing needs at different times and life stages.
>
> Cross jurisdictional approaches to service provision need to be further developed to encourage people to experiment with new or a mix of options without risking the security of their placement.[13]

Commonwealth services - State/Territory services interface - transitions

3.17 The problems of inflexible interfaces in the current system were highlighted by Jobsupport Inc. While the cap on the Commonwealth funded Disability Employment Network can prevent those persons capable and willing to work from attempting to enter open employment, the State funded Post School Options program also discouraged people from attempting open employment by making it difficult to return after leaving the program.[14] Jobsupport stated:

> Firstly, the Commonwealth program is capped, so everyone who wants to work cannot work, even if they are capable of doing so and it would save the taxpayer money and, secondly, the state government in turn tends to want to shut the door behind people. In our view, there is an opportunity to

12 *Submission* 95, p.10 (NCOSS).

13 *Submission* 57, p.9 (UnitingCare Australia).

14 *Submission* 85, p.1 (Jobsupport Inc).

> actually save money, to let the people who want to work do so, and all we really need to get it together is a more flexible interface between the two levels of government.[15]

3.18 ACROD also noted that this interface was 'problematic' and 'fraught with risk' for people with disabilities involved in employment transitions such as supported employees seeking retirement or people moving from post-school option programs to open employment.[16]

State/Territory services interface – portability

3.19 A concern repeatedly raised with the Committee was the portability of disability services and benefits to other States or Territories. Witnesses expressed their frustration at the lack of consistency and equity in the availability of services between jurisdictions. For example Mrs Jean Tops of the Gippsland Carers Association stated:

> 'You are not a citizen of Australia. You are only a citizen of the state in which you live'…If you leave Victoria, you cannot take any of your services with you. You will have to start again on the waiting list in the place you are going to get a service back. That ties families to the state in which they live, to the region in which they live and to the services that they currently have.[17]

3.20 In July 2000 a National Disability Administrators paper 'Moving Interstate: Assistance to People with Disabilities and their Carers' in relation to the portability of funding for disability services was endorsed at a meeting of Ministers responsible for Disability Services. These recommendations provided that: individuals seeking to move interstate may access that State or Territory's service through transparent demand management processes based on relative priority of need; individuals may register their request for service prior to any planned transfer; and where the move is urgent, unplanned or due to circumstances beyond the control of the individual, the State of origin agrees to give consideration to the transfer of funds for up to 12 months.[18]

3.21 In practice these provisions do not appear to have provided a real choice for people with disability who wish to move between jurisdictions. Mr John Nehrmann of the Department of Health and Human Services in Tasmania commented:

> In terms of clients or consumers there is a huge level of uncertainty if you want to move. As I said, initially all you are getting is 12 months and then you have to hope you are getting the same level of service at the same time. The other issue is that you are not always able to get the same type of

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15 *Committee Hansard* 3.10.06, p.2 (Jobsupport Inc).

16 *Submission* 45, p.19 (ACROD).

17 *Committee Hansard* 29.9.06, p.33 (Gippsland Carers Assoc.).

18 NDA, 'Moving Interstate: Assistance to People with Disabilities and their Carers' available from www.dhs.vic.gov.au.

> service from one jurisdiction to another. You might have an individual funding program in one jurisdiction that allows you to buy certain services that include certain things and yet when you move suddenly there are different business rules and different things covered. Even though the program is roughly the same, it is not quite the same.[19]

3.22 Ms Raelene West also indicated the current CSTDA funding framework was 'highly problematic' for people wishing to move jurisdictions:

> Service recipients are often forced to renegotiate an entirely new system of programs and services, and receive differing and often only entitled to reduced levels of funded services if living in another State/Territory other than original 'jurisdiction'.[20]

3.23 However there were also links made between the level of unmet need for disability services and the lack of portability of services. Ms Lois Ford of the ACT Government commented:

> The assessment of need is based on the level of need the individual has and the resources that we have available—and I would say this is true for most states and territories—to meet that need. I guess that it is more about meeting demand and growth within disability services so that people with disability can transfer or shift from place to place like any other citizen. I would suggest that it is less about the portability of funding and more about demand for and growth of services in each area.[21]

3.24 While the problem of portability has been recognised in the past, moving between jurisdictions is still extremely difficult because of the complexities of needing to negotiate new services within a different system combined with differing limitations on resources arising from underlying levels of unmet need.

Recommendation 1

3.25 That State and Territory governments provide a specific service that assists people with disability transferring between jurisdictions to negotiate programs and services to achieve a comparable level of support.

Dual diagnosis and multiple disability

3.26 The Committee was also concerned about implications of the lack of flexible interfaces in the provision of services for people with disability requiring services in relation to other health needs. Brightwater Care Group commented:

> Dual diagnosis is a challenge whether it is somebody who has palliative issues, mental health issues or substance abuse issues—even if you are Aboriginal, basically. As soon as you have an issue that puts you with a bit

19 *Committee Hansard* 22.11.06, p.9 (Tasmanian Government).

20 *Submission* 44, p.17 (Ms R West).

21 *Committee Hansard* 13.10.06, p.66 (ACT Government).

> of a foot in both camps, you find that neither camp wants you and can find strong reasons for you to belong somewhere else. It is the need to break down those jurisdictional boundaries and get agencies and funding organisations talking to each other to see how to address the issues.[22]

3.27 However Dr Ken Baker of ACROD highlighted the problems facing service providers caring for people with disability who also had other care needs:

> People can rarely be neatly slotted into one box and not others…I think the main complaint from among disability service providers is that they are expected as disability service providers to respond to the total needs of a person, and that is not really what they are equipped to do. They would have to respond to a person's mental health or drug and alcohol issues as well as their disability rather than getting easy access to another system. In a sense, it is an institutionalised view of governments that, once you are in the disability sector, that is the institution that has to take total care of you. I think that is a flawed view, but it is also, in a way, a dangerous view because it is preventing a person from getting access to other service systems which ought to be responsive to their disability.[23]

3.28 Mr Arthur Rogers of the Victorian Government commented on the definition of disability in the *Disability Services Act 2006*:

> Certainly in our operational practice there is no impediment to people, as long as they have a disability within the meaning of the Act. So if they had a mental illness they would not get in, but if they had an intellectual disability and a mental illness we would cover them for the disability.
>
> Part of the difficulty around service provision is that where people have multiple disabilities they have complex support needs and they do not fit into some of the more generalist services. By 'generalist' I mean a house catering for people with an intellectual disability. A person with an intellectual disability and a mental health issue and maybe a physical disability has quite specific needs. You need to make sure that the service response is tailored to those needs, not just to intellectual disability. So I think the issue is the complexity of their support needs rather than the definition in the Act.[24]

3.29 There appears to be two problems emerging in relation to the recognition and support of people with dual or multiple disabilities: the first is where the interaction of multiple disabilities means that existing programs and services are ill-equipped or unable to meet the complex, higher level needs of a client; the second is the issue of 'handballing' where existing programs or services are suggesting the existence of a second disability is an excuse to pass-the-buck to another program or service and

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22 *Committee Hansard* 5.10.06, p.43 (Brightwater Care Group).

23 *Committee Hansard* 13.10.06, p.40 (ACROD).

24 *Committee Hansard* 28.9.06, p.80 (Victorian Government).

effectively deny support. There is also a clear need to provide appropriate specialised services.

Recommendation 2

3.30 That the next CSTDA clearly recognise the complex and interacting needs of, and specialist services required by, people with dual and multiple diagnosis, and people with acquired brain injury.

Complexity and overlap

3.31 The division of funding and administrative responsibilities between the Commonwealth, State and Territory Governments creates overlap and duplication in bureaucratic and administrative arrangements for the provision of disability services as well as a lack of uniformity and equity between jurisdictions. In her submission Ms West commented:

> Each of the States/Territories 'jurisdictions' continue to fund disability services at different rates and with differing levels of accountability. Each State/Territory is governed by differing legislation with differing obligations and priorities to users. This is despite a national population of only 20 million people and with only a relatively small percentage of this population utilising some form of funded disability service. Under the current form of CSTDA funding, each state continues to roll out their own gamut of programs, services, strategies and policies, creating further inequities in the system on a national level. Service delivery on the ground therefore continues to be disparate, with real mapping and contrasting of service delivery remaining difficult.[25]

3.32 The complexity in the arrangement under the current CSTDA also causes additional burdens for disability services users. Ms Teresa Hinton of Anglicare Tasmania, who had recently completed a research project on disability services, commented on difficulties with the fragmented nature of services.

> To receive personal care and support, somebody might be dealing with three or four different agencies, each with their own assessment process, different disability support workers and so on. Being able to coordinate that for individuals was very problematic and difficult for them, for individuals and also carers who might have been taking on the case management role.[26]

Cost-shifting

3.33 During the inquiry a number of issues regarding cost-shifting between the levels of government were raised. Cost-shifting may occur where funding arrangements allow responsibility for services to transfer to a program funded by another party without their agreement. The complex arrangement of the division

25 *Submission* 44, p.17 (Ms R West).

26 *Committee Hansard* 22.11.06, p.25 (Anglicare Tasmania).

between the levels of government of responsibilities in relation to areas which overlap with disability such as health, ageing, employment and education may provide opportunities and incentives to shift the costs of service delivery. Cost-shifting between governments can also contribute to problems such as accountability for disability services.

3.34 ACROD encapsulated this issue by stating in its submission that:

> For governments, funding is clearly a contentious issue. In the past, negotiations have been marred by suspicions of cost-shifting and accusations from each level of government that the other provides less than its fair share of funding for State-administered services.[27]

3.35 The Commonwealth pointed to an increased usage of services under the Home and Community Care (HACC) program by people with disability.

> People with disability are estimated to comprise over 24 per cent of the total number of HACC clients. However, they are estimated to consume 30 per cent of the funding because proportionately more people with disability access higher levels of service.
>
> The proportion of younger people (those under 65 years) accessing HACC services has increased from 18.5 per cent in 1994-95 to over 24 per cent in 2004-05. Given that the percentage of young people in the general population has declined over the same period, the growth in young people as HACC clients suggest that outside of HACC, disability services delivered by the states and territories have not grown in line with demand.
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> CSTDA data indicates that there has been significant decline in the number of service users aged 60-64 years compared to those aged 55-59 years across all CSTDA funded service types…There is a concern that this decline reflects a trend for older people with disability ending up in inappropriate aged care or hospital services due to a lack of appropriate disability services.[28]

3.36 Ms West also identified that shortfalls in State and Territory disability services had "forced" people with disability to utilise HACC program services.

> Ideally, a significant expansion and increase in funded disability services could move people requiring disability services off HACC funding and onto specific disability support programs and funding arrangements alone, increasing clarity of service need and providing specialised disability support.[29]

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27 *Submission* 45, p.9 (ACROD).

28 *Submission* 96, p.18 (Australian Government).

29 *Submission* 44, p.19 (Ms R West).

Whole of government coordination

3.37 The need for better coordination between Commonwealth, State and Territory jurisdictions and departments was also raised with the Committee. The responsibility for ensuring that Commonwealth and State/Territory programs are having a complementary impact is shared by all the parties in the current CSTDA.[30] Ms Lyndall Grimshaw of Brain Injury Australia commented:

> If we look at government policy and program development, what we see is fragmentation and program silos…There is little evidence from our perspective of interdepartmental cross-policy program collaboration, both across and between the Commonwealth and state and territory levels.[31]

3.38 The point was made that despite the interrelationships in the services covered by the CSTDA, such as health and employment, the only Commonwealth Department a party to the Agreement was the Department of Families, Community Services and Indigenous Affairs (now FaCSIA). The Department of Health and Ageing and the Department of Employment and Workplace Relations have not been parties to the CSTDAs. ADFO for example commented:

> A major barrier to the effective oversight of progress towards the achievement of the aim of the CSTDA has been that no single agency has been given the task and authority to do this. At a Commonwealth level alone, direct services to people with disability are provided by at least seven departments and most of these are not involved in the Agreement.[32]

3.39 In 2004 responsibility for administration of open employment services operating under the CSTDA moved from the Department of Family and Community Services (now known as FaCSIA) to the Department of Employment and Workplace Relations. Supported employment services for people with disability continue to be administered by FaCSIA. MS Australia commented that as a result of this change:

> FaCSIA remains the lead Agency at the Australian Government level in regard to disability services despite being the smallest and least involved agency in the delivery of disability services. This is a situation that has definitely hindered development of the sector, due to its inability to lead and champion disability issues across Australian Government portfolios including employment, education and health.
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> This problem is mirrored in the States where key areas such as infrastructure, transport and health are not directly included in the CSTDA work of the lead disability departments who are CSTDA signatories, and where the general policy response is limited.[33]

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30 *Commonwealth State Territory Disability Agreement 2002-2007*, Part 6(1)(g).

31 *Committee Hansard*, 28.9.06, p.20 (Brain Injury Australia).

32 *Submission* 90, p.8-9 (AFDO).

33 *Submission* 93, p.20 (MS Australia).

3.40 ACROD commented:

> Governments are hierarchical entities. If a whole of government approach is to be effective it needs to become a priority of central government agencies and, ultimately, requires leadership by the heads of government.[34]

3.41 The Mid North Coast Disability Committee also suggested there is potentially a greater role for local government in the delivery and co-ordination of specialist disability services.[35]

3.42 Governments are working at improving the coordination of disability services. At the July 2006 meeting of the Community and Disability Service's Ministers' Conference, Ministers agreed on three priority areas of shared concern that would likely benefit from national collaboration for a fourth CSTDA. These were service improvement, demand management and interface issues.[36]

A national approach?

3.43 The argument was made to the Committee in a number of submissions that problems associated with the CSTDA joint funding arrangements may be addressed if the Commonwealth assumed sole responsibility for funding of services in relation to disability.[37] These arguments reflect long-standing and on-going debates regarding the balance of Commonwealth, State and Territory responsibilities for Australia's health care system and the issue of cost-shifting.[38]

3.44 A Commonwealth 'take over' of disability services was seen as broadly addressing a number of perceived systemic problems with the current joint funding arrangements. These included greater accountability, a uniform approach service delivery, the more equitable allocation of disability services and improved co-ordination across service systems. Ms West elaborated on the advantages of a national approach in her submission:

> Benefits would appear to be considerably improved standardisation and uniformity in the level of funded disability service programs, increased coherency and consistency of available services and clearer expectations for clients as to available services and resources. In terms of administration, a national approach would significantly reduce as previously highlighted,

34 *Submission* 45, p.18 (ACROD).

35 *Submission* 18, p.2 (Mid North Coast Disability Committee).

36 *Submission* 112, p.8 (Queensland Government).

37 *Submission* 28, p.30 (National Carers Coalition); *Submission* 44, pp 20–21 (Ms R West); *Submission* 6, p.1 (South Gippsland Carers Group); *Submission* 8, p.17 (Gippsland Carers Association).

38 Buckmaster, L & Pratt A, 'Not on my account! Cost-shifting in the Australian health care system', *Parliamentary Library Research Note*, No. 6, 2 September 2005.

> difficulties with managerial assessment, contrasting accounting practises and data collation and analysis.[39]

3.45 Submissions, particularly from the Commonwealth, State and Territory Governments, while acknowledging problems existing in the current system, emphasised the benefits of joint funding arrangements. They noted that the CSTDAs have been successful in ensuring that all jurisdictions have specific funding available for people with disabilities and that where jurisdictions are clear on their responsibilities and sufficient funding is made available there have been significant outcomes for people with disabilities.[40] For example the Western Australian Government commented:

> The CSTDA has allowed the Commonwealth, States and Territories to maintain a focus on disability and direct resources specifically to meeting the needs of Australians with a disability to an extent that was not occurring before the existence of these agreements. While that in itself should not be held as the only argument for the continuation of the multilateral agreements, it is strong evidence in support of specific collaborative funding arrangements for disability services.[41]

3.46 Similarly the National Ethnic Disability Alliance noted that 'Commonwealth and State/Territory joint responsibilities in funding and providing disability services should be maintained for better accountability and Commonwealth/State coordination'.[42]

3.47 ACROD also noted the serious weaknesses in the CSTDA but continued to support a joint arrangement. Dr Baker commented:

> …we support governments negotiating a fourth Commonwealth State/Territory Disability Agreement. We think that the original CSTDA was an improvement on the system it replaced, and there have been some subsequent improvements. Having said that, we believe that the fourth agreement ought to be substantially reformed…[43]

Competitive federalism

3.48 An issue which was not discussed in many submissions was that of competitive federalism. The decentralisation of responsibility for disability services to the State and Territory Governments provides them with flexibility to address local issues and increased opportunities for innovation in policy. It also provides a competitive environment where the best policies once introduced and tested by one

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39 *Submission* 44, p.20 (Ms R West).

40 *Submission* 93, p.8 (MS Australia).

41 *Submission* 3a, p.5 (Western Australian Government).

42 *Submission* 107, p.6 (National Ethnic Disability Alliance).

43 *Committee Hansard* 13.10.06, p.34 (Dr K Baker, ACROD).

jurisdiction can be adopted by other jurisdictions. State and Territory Government policies in relation to disability services are comparable which creates a competitive pressure on underperforming jurisdictions to match the 'best practice'. NSW Minister for Disability Services the Hon John Della Bosca commented:

> I am a fan of competitive federalism. That might sound like a very old-fashioned idea but I think there is some merit in the idea of six different systems in a range of areas, provided there is a reasonable harmonisation…[44]

A federal dilemma

3.49 In 2005 the Productivity Commission conducted a Roundtable on 'Productive Reform of the Federal System' which focused on issues associated with the challenges of securing better policy outcomes from Australia's federal system of government and included some examination of options for systemic change in health reform.[45] Some of the discussion is readily applicable to consideration of the CSTDA joint funding arrangements.

3.50 A key feature of the current federal system in Australia is that the States have broad spending responsibilities but few revenue sources whilst the reverse is true at the Commonwealth level. The difference between the relative revenue and spending responsibilities of the Commonwealth and States is known as vertical fiscal imbalance.[46] In the CSTDA the State and Territory Governments contribute the majority of funds for specialist disability services other than employment and have administrative responsibility. However because of factors relating to vertical fiscal imbalance and recent budget surpluses the Commonwealth was perceived by some as having a greater financial capacity than the State and Territory Governments to fund specialist disability services and swiftly address unmet need.

3.51 A number of possible options for health reform were identified by Mr Andrew Podger. These options included: the States taking full responsibility for health and aged care services; the Commonwealth taking full financial responsibility for health care; the Commonwealth and States pooling their funds as regional purchasers; and a 'managed competition' model where Commonwealth and State funds are available for channelling through private health insurance funds by way of 'vouchers' which individuals may pass to the fund of their choice.[47]

3.52 Mr Podger's view was that it was feasible for the Commonwealth to take full financial responsibility and identified a number of the possible benefits of such a

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44 *Committee Hansard* 3.10.06, p.48 (Minister Della Bosca).

45 *Productivity Commission Roundtable on Productive Reform in the Federal System*, 2005.

46 Webb R, ' Public Finance and Vertical Fiscal Imbalance' *Parliamentary Research Note* no.13 2002-03 p. 1.

47 Podger A, 'Directions of health reform in Australia', *Productivity Commission Roundtable on Productive Reform in the Federal System*, 2005, p.147.

proposal. These included allowing a single Commonwealth minister and department to control the national management and delivery of services. This would increase accountability for services and operate to reduce cost-shifting and duplication. Such an approach would also address the problems created by vertical fiscal imbalance by having the revenue raiser as the primary purchaser of services. It would also reflect a trend towards increasing Commonwealth control over health care.

3.53 However, Mr Podger also noted costs and risks in a Commonwealth 'take over' of health services. It would require significant expense and a lengthy transition period for the Commonwealth to take over control of State and Territory personnel and facilities as well as to establish new administrative structures which allowed for regional and community flexibility and input. The proposal would also involve complex renegotiation of current tax revenue arrangements.

3.54 In 2006 the House of Representatives Standing Committee on Health and Ageing tabled *The Blame Game: Report on the inquiry into health funding* which also examined proposals for reforming federal arrangements in relation to health care.[48] A key recommendation from this report was that Australian governments develop and adopt a national health agenda. Part of the proposed national health agenda would be to identify policy and funding principles and initiatives to: 'rationalise the roles and responsibilities of governments, including the funding responsibilities, based on the most cost-effective service delivery arrangements irrespective of governments' historical roles and responsibilities'.[49]

Conclusion

3.55 The current and previous Agreements have demonstrated a commitment on the part of all Australian governments to ensure that resources are specifically allocated for the provision of specialist services to improve the lives of people with disability.

3.56 The Committee supports a fourth disability agreement between the Commonwealth, State and Territory Governments. The State and Territory Governments continue to have the service delivery expertise and can be more responsive to the needs of people with disability and carers within their jurisdictions.

3.57 However there is clearly a need for improvement in consistency, equity, coordination of specialist disability services as well as accountability, performance monitoring and reporting. In these areas the Commonwealth is best placed to perform a leadership role. The Commonwealth also possesses the capability through the Bilateral Agreements to achieve better results in these areas.

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48 House of Representatives Standing Committee on Health and Ageing, *The Blame Game: Report on the inquiry into health funding*, December 2006.

49 House of Representatives Standing Committee on Health and Ageing, *The Blame Game: Report on the inquiry into health funding*, December 2006, p.53.

3.58 The Committee notes that the ANAO audit of the administration of the CSTDA found evidence that the Bilateral Agreements had improved coordination with relevant State and Territory Government disability agencies and considered the Bilateral Agreements have the potential to be an effective coordination mechanism for the Commonwealth's lead agency to work with State and Territory agencies.

3.59 The Committee notes that Bilateral Agreements between the Commonwealth and State and Territory Governments for funding of disability services will often necessarily affect the provision of other disability services as well as other publicly funded services. Where possible Bilateral Agreements should not skew or distort the broader objectives of the CSTDA.

3.60 The Committee also notes that the Commonwealth may potentially have more capacity to control and co-ordinate disability services if it increased the proportion of Commonwealth funding to CSTDA services. ANAO also noted:

> The fact that the Australian Government only provides 20 per cent of the funding for services administered by the States and Territory governments limits its roles, and the amount of influence it has over the delivery of those services.[50]

3.61 The Committee recognises that the present funding arrangements assign the States and Territories the primary responsibility for funding specialist disability services and the Commonwealth responsibility for funding disability employment services, with some Commonwealth supplementation of the States and Territories' role. However these arrangements are problematic, and have generated considerable uncertainty within the disability community about where services can be found, what criteria for eligibility apply and which government bears responsibility for its proper funding. The next CSTDA must as a priority, remove this uncertainty and create transparent lines of responsibility.

3.62 Options for large-scale reform to the current CSTDA joint funding arrangements may offer more challenges than solutions. The Committee recognises that any reform is not without cost or risk and that any new arrangement or division of responsibilities will necessarily involve some service delivery problems. Any major change to the structure of joint funding arrangements under the CSTDA should be accomplished as part of a broader restructure of Commonwealth, State and Territory health and community care responsibilities.

3.63 However despite these concerns the Committee agrees the CSTDA could be utilised more broadly to improve the lives of people with disability. The Committee supports the AFDO's comment that:

> …the CSTDA is far from being a coordinated, high level strategic policy document. Despite its broad aim and the priority placed on access to

50 ANAO, *Administration of the Commonwealth States Territory Disability Agreement*, Audit Report No. 14 2005 -2006, p 30.

> generic services, the current CSTDA retains a narrow focus on service delivery, particularly disability-specific services, to people with disability aged under 65 years. The CSTDA is crisis driven, with the result that short-term, individually focussed interventions are prioritised over systemic reforms.[51]

3.64 A renewed national disability strategy could function to coordinate the objectives of the Commonwealth Disability Strategy and the disability policy frameworks which have been developed by many of the States and Territories, such as Victoria's State Disability Plan. By providing a coordinating framework for various policies, programs, legislation and standards the next CSTDA may enable effective responses to be developed to the complex issues which people with disabilities face.

Recommendation 3

3.65 That the next CSTDA should include –

- **A whole of government, whole of life approach to services for people with disabilities.**
- **A partnership between governments, service providers and the disability community to set policy priorities and improve outcomes for people with disability.**
- **A clear allocation of funding and administration responsibilities based on the most effective arrangements for the delivery of specialist disability services.**
- **A clear articulation of the services and support that people with disability will be able to access.**
- **A commitment to regular independent monitoring of the performance of governments and service providers.**
- **A transparent and clear mechanism to enable people with disability and their carers to identify and understand which level of government is responsible for the provision and funding of services.**

Recommendation 4

3.66 That in the life of the next CSTDA, signatories agree to develop a National Disability Strategy which would function as a high level strategic policy document, designed to address the complexity of needs of people with disability and their carers in all aspects of their lives.

51 *Submission* 90, p.6 (AFDO).

Assessment

Assessment and planning

3.67 The Committee was concerned at the apparent lack of connection between assessments being undertaken and the planning by governments for the needs of people with disability. Assessments would seem an appropriate method for governments and service providers to budget and plan services as well as to give people with disability and their carers a level of certainty. Mrs Franklin highlighted the approach taken by the United Kingdom to lifelong assessment and planning.

> When the child is born or diagnosed with a disability, you are assessed and they put a care package together. Then they reassess it when the child is going to school and they either take some of that care package off them or add to it, depending on the disability. Then at the end of primary school they are reassessed. Two years before they leave high school they are assessed, and what they look at there is accommodation and employment—all of that.[52]

3.68 This approach could be contrasted with the experience of many Australian families. Ms Allen commented:

> The maze to find services was an absolute nightmare and actually was the most energy-zapping situation that you can imagine. Rather than having that time to give to my child, I found myself fighting the bureaucracy almost every minute of the day. There was no plan for us and there was certainly no plan for Simon. We had to negotiate for everything that we got. We had to emphasise the negative the whole time. We had to make it sound actually as bad it was and it was very hard for people to actually realise what we were going through.[53]

Application procedures

3.69 Another assessment issue raised was the procedures involved in the applications for State and Territory disability services. While practices differ between jurisdictions these application and eligibility procedures often rely on people with disabilities or their carers filling out detailed forms setting out their circumstances and needs in order to be assessed for eligibility and access to disability services. These forms are then assessed on a competitive or criticality of needs basis to determine who has access to disability services.

3.70 These can be highly distressing for families members required to describe a loved one negatively, focusing on how caring for their needs is a burden to them.[54]

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52 *Committee Hansard* 5.10.06, p.86 (CASA).

53 *Committee Hansard* 5.10.06, p.20 (NCID).

54 *Committee Hansard* 5.10.06, p.68 (Ms D Croft).

People with disability and their families are also forced to 'compete' for the available disability services against other equally deserving families. Ms Croft commented:

> I think there are a number of consequences of having a competitive or criticality of needs basis for service provision. One is that family carers are required to portray the needs of their family member with a disability in the worst possible light, as being a burden on them and their family, and I think that has enormous implications. There is a risk of devaluing people with disabilities. I think also it requires an enormous bureaucracy to supervise who gets funding on whatever level of critical need, so providing services on the basis of pitting people's needs against each other consumes resources and has an effect even in terms of simple human dignity. I hear so many parents expressing views about having to compete against people that they recognise are also experiencing great hardship. They feel guilty about that. But also it is a matter of who can demonstrate that their crisis is worse than someone else's crisis, which is not a dignified way in which services should be provided. It also means that we have lost sight of the rights and needs of people with disabilities and instead we are focusing solely on how healthy or strong their parents or their carers are…[55]

3.71 The Committee is also concerned that some assessment procedures for access to disability services appear reliant on written applications. These procedures disadvantage people with poor literacy or communication skills, often the people in the most need of assistance. An example given by Mrs Franklin from Committed about Securing Accommodation for People with Disabilities (CASA) highlighted this concern:

> I have been helping a family—a Vietnamese lady; she has a son with severe disabilities, her husband is dying of cancer and another son has had kidney transplants. Because she cannot articulate on a piece of paper and because of her cultural background—she does not like to ask for help—she keeps getting knocked back in the funding round. If a team had gone out and assessed the child with the disability and looked at the family in general she would have got funding a long time ago.[56]

3.72 The Committee was interested in the potential benefits of utilising information technology and the internet to reduce the burden that people with disability and their carers carry in relation to communicating their needs to services providers. An Adelaide based disability organisation 'Life is for Living Inc' are currently running a project 'What I'd Like You To Know About Me!'[57] The project created a CDROM resource kit for service providers that focused on capturing holistic and positive information about people with disabilities. The information collected by the resource

55 *Committee Hansard* 5.10.06, p.68-69 (Ms D Croft).

56 *Committee Hansard* 5.10.06, p.82 (CASA).

57 *Committee Hansard* 6.10.06, p.25 (Ms M Baker).

could then be printed and shared with others such as family and friends, teachers, therapists, health professionals and community members.[58]

> For example, "Who are the members of my family?" "When I go to hospital, I need this," "This is how I like to be cared for", and "These are my favourite toys." It is written from the perspective of the person with the disability. It empowers the family and the person with the disability to put their own story forward. It can be used by health services and other service providers to talk to the child when they are in hospital, for example.[59]

A National Framework

3.73 The ANAO audit of the administration of the CSTDA noted that:

> The States and Territories, and the Australian Government, have recognised that there: "is currently no one conceptual model adopted by jurisdictions that assesses eligibility, support needs and priority for service at both a systemic and individual level".
>
> This situation has resulted in a lack of national consistency in how individuals' needs for services are identified and in determining priority. The ANAO considers that, in this circumstance, there is a significant risk that services provided under the CSTDA may not be provided to those recipients in most need across Australia.[60]

3.74 Carers Australia also highlighted the need for national consistency in assessments of eligibility, support needs and service priority.

> Carers Australia believes that the new CSTDA should include a national framework for the provision of services to meet the needs of people with disabilities in Australia. Such a framework should take a holistic approach to the needs of the person with a disability and their carer, and be based upon person-centred assessment. It should also recognise that many people have more than one disability and different services are often required to meet these different conditions.[61]

3.75 The National Disability Administrators Research and Development Program was undertaking a project *National Assessment and Resource Allocation Framework* with the purpose of developing 'a flexible, nationally-consistent system which ensures a fair, transparent, consistent and rationale-based allocation of resources that will also assist in understanding and managing demand for disability services.' The Committee understands this project has now been cancelled.

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58 www.lifeisforliving.com.au

59 *Committee Hansard* 6.10.06, p.25 (Ms M Baker).

60 ANAO, *Administration of the Commonwealth State Territory Disability Agreement*, Audit Report No. 14 2005-06 p.38.

61 *Submission* 52, p.9 (Carers Australia).

A Disability Assessment Team?

3.76 A key issue for the Committee was the importance of assessing the needs of people with disabilities. Without an accurate and comprehensive assessment of the care and support needs of each individual it seems impossible to determine which specialist disability services or other services they should be able to access. This basic information also appears crucial to a number of the other issues raised in the inquiry.

3.77 Accurate and comprehensive assessments of the needs of each individual with a disability could assist in:

- tailoring available services to meet an individual's specific needs rather than fitting people to services or programs;
- enabling governments to plan services and funding by clarifying the needs of people with disabilities in their jurisdiction;
- preventing cost-shifting between the levels of government by independently assessing the services a person should be able to access;
- informing people with disabilities about the services which they are eligible to access and facilitating access to those services;
- determining eligibility and priority through an equitable process to ensure resources are delivered to those in the most need as well as reducing the burden on family carers in making applications for services
- collecting additional data concerning unmet need in each jurisdiction as well as making governments accountable for inadequate funding or provision of specialist disability services; and
- recognising and addressing the special needs of people with dual and multiple diagnoses.

3.78 The approach of the Aged Care Assessment Teams (ACATs) involving face-to-face comprehensive functional assessments of individuals was generally supported during the inquiry. ACATs are multi-disciplinary and can include health professionals such as medical officers, social workers, nurses, occupational therapists and physiotherapists. The objective of the Aged Care Assessment Program is to 'comprehensively assess the needs of frail older people and facilitate access to available care services appropriate to their care needs.' Proposals were raised for a similar approach to assessments for people with disabilities and their access to services.

Recommendation 5

3.79 That the next CSTDA incorporate a nationally consistent assessment process to objectively and comprehensively determine the support and care needs of each person with a disability. These assessment processes should also assist people with disability by making determinations of eligibility for services and priority of need as well as facilitating access to appropriate services.

The burden of multiple assessments

3.80 The Committee was concerned to hear of the issues people with disabilities and their carers had with assessment procedures for access to disability services. A common complaint was the need to continually repeat information regarding disability care needs to service providers and care workers or to frequently attend assessments in order to access disability services. This was particularly burdensome for people with permanent lifelong disabilities and their carers. Ms Stagg explained to the Committee some of the challenges of caring for her daughter Michelle:

> All I want is a piece of paper that says, "Has anything changed?"—"No," tick, the doctor signs it and you go. That sort of stuff is frustrating all the time…Somebody who starts this from birth has to go through that again and again…I really do not know how you are going to get away from that, but there must be some way of facilitating people from day dot to help them through the system…[62]

3.81 Mrs Griffin repeated these concerns regarding assessment procedures in relation to her son Scott:

> One of the things that I find most frustrating is being sent forms continuously and having to restate that nothing has changed with Scott. The fact is that nothing is going to change. He is not going to suddenly get better. He has a genetic deletion that is there and will be there and is never going to change, so his needs are always going to be as they are, if not worse as he ages. It would be nice if some of that could be understood so that it was broader than a particular disease. It needs to be understood so that once a person is diagnosed with something like a genetic deletion that is never going to change you do not have to spend your whole time begging for equipment or begging for help. It should be on record that this child needs help ongoing, long-term, until the day he dies.[63]

3.82 This issue appeared to be the result of the complexity of the administration disability services as well as inefficient assessment procedures and information sharing by disability providers and agencies. This is an issue complicated by administrative requirements and by privacy laws designed to protect the private health information of all Australians. The Committee agrees that people with permanent lifelong disabilities and their carers should not be required to repeatedly 'prove' their disability in order to obtain disability services. Where possible they should be given the choice to consent to their assessment information being shared and utilised in the most administratively effective fashion.

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62 *Committee Hansard* 6.10.06, p.22 (Ms D Stagg).

63 *Committee Hansard* 3.10.06, p.19 (Mrs S Griffin).

Appropriate Assessment

3.83 The specialised assessment needs of people with chronic degenerative diseases such as Motor Neurone Disease and Multiple Sclerosis were also raised with the Committee. The degenerative nature of these conditions means the assessment of current and future need for disability services was problematic. Changes in their needs for disability services and equipment were often sudden and unpredictable. Long waiting periods for assessment and access to services was inappropriate for the changing nature of their conditions.

Recommendation 6

3.84 That the Commonwealth, State and Territory governments ensure that:

- **administrative burdens of assessment procedures are reduced for those with lifelong and permanent disabilities and their carers; and**
- **flexible assessment options are available to people with disabilities who have needs that may change rapidly.**

Indexation of CSTDA funding

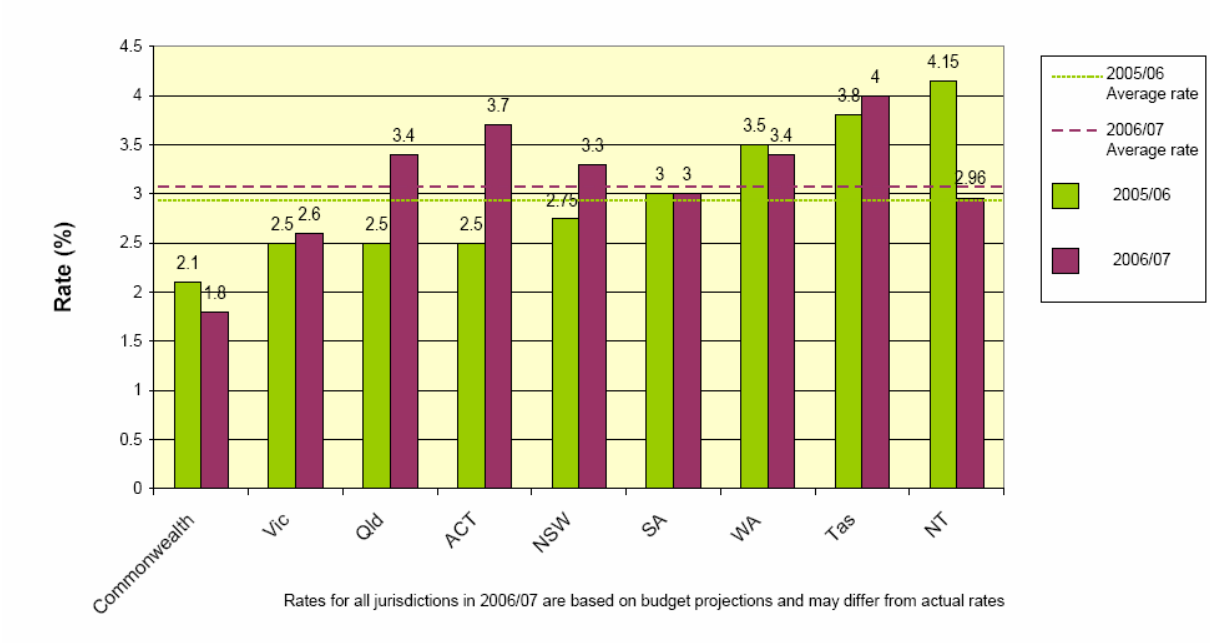
3.85 A number of submissions raised the issue of indexation of CSTDA funding, particularly in relation to Commonwealth contributions.[64] Indexation (or price adjustment) is intended to change funding to take account of changes in the cost of services over time so that providers can continue to offer the same services.

3.86 Part 8(10) of the current CSTDA provides that indexation of Commonwealth funds to be transferred to the State and Territory Government are calculated each year by reference to the Commonwealth indexation parameter Wage Cost Index 2. The Commonwealth indexation of CSTDA funding based on Wage Cost Index 2 was 2.1 per cent for 2005/06 and 1.8 per cent for 2006/07. The decision about which indexation rate is applied to Commonwealth CSTDA funding is made by the Department of Finance and Administration. The State and Territory Government indexation of their CSTDA funding varied.

3.87 Table 3.2 outlines the indexation rates applied to CSTDA funding by each jurisdiction.

64 *Submission* 3, p.17 (Western Australian Government); *Submission* 99, p.15-16 (Victorian Government); *Submission* 84, p.7 (NSW Government); *Committee Hansard*, 13.10.06, p.58 (ACT Government); *Submission* 112, p.3 (Queensland Government); *Submission* 60, p.15 (Disability Coalition WA); *Submission* 95, p.5 (NCOSS); *Submission 45*, p.7 (ACROD); *Submission* 72, p.9 (Australian Blindness Forum).

Table 3.2: CSTDA indexation rates by jurisdiction 2005/06 and 2006/07



Source: Western Australian Government, *Submission* 3, p.18.

3.88 Many submissions to the Committee argued that the Commonwealth's rate of indexation was unrealistic and insufficient to keep up with increased costs (particularly wages) in the disability sector. The consequences of indexation rates applied to CSTDA funding which did not reflect increases in costs in the provision of disability services were also highlighted. In particular an inadequate rate of indexation applied to CSTDA funding could gradually erode the real value of the base funding and affect the viability and sustainability of disability services.

3.89 NCOSS stated in their submission:

> Certainly, previous indexation rates have not compensated for increases in costs, including wages, activities and overheads, as well as external impacts such as insurance, workers compensation and fuel prices etc. This has resulted in a pattern of consistent underfunding with the net effect being diminished service capacity.[65]

3.90 Dr Baker from ACROD identified the problems that inadequate indexation of CSTDA funding could cause for disability service provider staffing:

> The cumulative effect of this gets worse and worse as time proceeds and makes it more and more difficult for disability service providers to recruit and retain staff. This has now reached quite critical levels within the sector…we need first of all to provide service providers with enough

65 *Submission* 95, p.5 (NCOSS).

> capacity to recruit, train and retain quality staff. That cannot be achieved while they are having to manage what is in effect an annual funding cut.[66]

3.91 Some State and Territory Governments argued that the level of indexation applied by the Commonwealth to CSTDA funding has operated to gradually shift the funding burden to them. The Queensland Government also highlighted the Commonwealth's application of different indexation rates in relation to other social program funding.

> The Home and Community Care Program, for example, has a range of indexation rates varying between 2.1 per cent and 3.85 per cent applied annually. The Supported Accommodation Assistance Program has an indexation rate of 2.2 per cent, while the Australian Healthcare Agreement also has varying indexation rates. Its general component is made up of two per cent wage-cost indexation and 2.84 per cent population growth. Seventy-five per cent of the general component comprises 1.7 per cent utilisation growth.[67]

3.92 However FaCSIA indicated that the Commonwealth was not merely seeking to address increased costs in the delivery of disability services in setting the indexation rate. Consideration of the Commonwealth's indexation in relation to CSTDA funding should also take into account additional funding initiatives made by government. Mr Stephen Hunter of FaCSIA commented:

> The government does not seek, through indexation, to cover all cost increases that might occur in the delivery of a service. If it were to do that there would be very few incentives to seek to contain some of the costs. What it seeks to do through indexation is to ensure that the forward estimates broadly reflect the price basis of the year in which the expense is to occur and the minimal realistic costs of delivering policy outcomes. So it does not try to compensate for actual movements in costs but rather to, in the broad, ensure that the forward estimates reflect the price basis of the units involved…I think when you look at the issue of indexation alongside the other additional funds that have been put forward in the context of the CSTDA, that is a relevant consideration. If, simply, you just compensate for all the cost increases that might occur, governments then to an extent rob themselves of the capacity to make specific initiatives which might go to achieve specific outcomes.[68]

3.93 The Department of Finance and Administration has also indicated that Wage Cost Index 2 has been used as the indexation rate for Commonwealth CSTDA funding as the relative weighting of wage and non-wage costs best reflects the balance between wage and non-wage costs in the services supplied under the CSTDA.[69]

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66 *Committee Hansard* 13.10.06, p.36 (ACROD).

67 *Committee Hansard* 17.11.06, p.2 (Queensland Government).

68 *Committee Hansard* 13.10.06, p.85 (FaCSIA).

69 Department of Finance and Administration, Additional information, 12.12.06.

3.94 However in 2002, the Social Policy Research Centre (SPRC) conducted a study for the National Disability Administrators which examined the issues of indexation and demand in relation to CSTDA funding. It suggested that Wage Cost Index 2 was not suitable for CSTDA indexation as the method of calculation was not appropriate for the disability sector:

> Wage Cost Index 2 is based primarily on the Industrial Relations Commission Safety Net Increase together with a small component based on general price inflation. This is so the index should not include any component of wage growth that is intended to be offset by efficiency gains. However, this implies assumptions about productivity growth that are not in accord with generally accepted economic principles. Economic theory suggests that wage growth in service industries and human services in particular, will run well ahead of productivity growth in that sector.[70]

3.95 This view was supported by the Queensland Government which commented:

> Indexation models adopted by the Commonwealth Government have been based upon the assumption that there will be efficiency dividends or productivity saving that result in reduced labour costs or efficiencies due to technology or telecommunications improvements. However research has found that industries such as human services are not able to make productivity gains in ways that are available to other industries. This is due to the fact that they are highly labour intensive, have limited opportunities for technology-based productivity gains, experience significant flow-on pressures for wage increases from allied sectors and are expected to meet prescribed service delivery standards.[71]

3.96 Dr Baker commented:

> There is an assumption built into the Commonwealth indexation formula which is just flawed. It may be appropriate for a manufacturing sector or a mining sector, where human resources can be replaced with technology and productivity can be achieved like that, but that is not true within the disability sector, where social interaction is the nature of the business. Disability support workers cannot be replaced by machines. The assumption within the Commonwealth indexation formula that any increase that is over and above the safety net increase can be traded off against productivity or efficiency increases is just not true.[72]

3.97 The Committee considers that the application of the efficiency dividend is generally inappropriate in relation to the indexation of funding for specialist disability services given the necessarily high proportion of total budget which must be spent on

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70 Bradbury B, *Methods to Address Requirements for Changes in Funding Disability Services Brought About By External Change*, Social Policy Research Centre, Report No. 5/02, April 2002.

71 *Submission* 112, p.5 (Queensland Government).

72 *Committee Hansard* 13.10.06, p.36 (ACROD).

staff wages in delivering personal care. Recognising that limited efficiencies can be gained in the sector, the efficiency dividend effectively acts to cut the level of funding for disability services.

Recommendation 7

3.98 Given the reality that a large proportion of costs in disability services will always be wages and salaries of care providers, the Committee strongly recommends that the Commonwealth consider removing the efficiency dividend from the indexation formula for funds allocated through the CSTDA.

3.99 The SPRC study recommended an indexation rate based on actual movement in wages that reflects a more realistic level of productivity savings in the disability sector. It proposed a wage cost index be used based on the Australian Bureau of Statistics Wage Cost Index (ABS WCI) combined with a general Consumer Price Indicator (CPI) inflator to cover costs not related to wages. It noted that over recent years the ABS WCI had grown at twice the rate of the Wage Cost 2, currently applied to Commonwealth CSTDA funding.[73] The SPRC study also noted the need for indexation of CSTDA funding to address on-costs for service providers such superannuation and workers compensation insurance.

3.100 The Committee notes the annual September quarter 2006 ABS Wage Price Index seasonally adjusted increase for all employee jobs in Australia was 3.8 per cent.

Recommendation 8

3.101 That the Commonwealth set an indexation level in line with the actual costs of delivering services. This rate should be applied as a minimum indexation rate by State and Territory Governments.

Demand funding

3.102 A number of submissions argued that the current CSTDA lacks long-term strategic planning for increasing demand for specialist disability services. In general demand adjustments to funding seek to ensure that the relationship between the supply of services and the demand for services remain the same. For example to adjust funding to account for increases in the population or in prevalence of disability in the population which would increase demand for services.[74] Ms Felicity Maddison of the National Carers Coalition commented:

> …the whole CSTDA is crisis driven as to the rollout of support. Because of the lack of the bulk of funding that is available, funding is rationed and it is

73 Bradbury B, *Methods to Address Requirements for Changes in Funding Disability Services Brought About By External Change*, Social Policy Research Centre, Report No. 5/02, April 2002, p.3.

74 Bradbury B, *Methods to Address Requirements for Changes in Funding Disability Services Brought About By External Change*, Social Policy Research Centre, Report No. 5/02, April 2002, p.1.

> coming out—it is being rolled out—on the basis of crisis intervention rather than in a well-constructed forward planning process. There is no evidence of long-term planning for the future and you are getting a lot of flavour-of-the-month-type initiatives coming through…[75]

3.103 In the current CSTDA demand adjustment and growth funding is dealt with in Part 8 (8):

> Commonwealth, States and Territories acknowledge demand management requires regular annual growth in funding levels to continually improve the level and quality of services and the efficiency of systems for specialist disability services. The States/Territories will provide annual funding growth at a level agreed between each State/Territory and the Commonwealth over the life of the Agreement for services they are directly responsible for administering under the Agreement.

3.104 The CSTDA arrangements do not require multi-year budgetary planning based on demand growth. Some submissions proposed population-based benchmark funding similar to that used for the funding of aged care services would be more appropriate for funding calculations for disability services.[76] ACROD commented:

> Aged Care uses a needs-based planning framework that seeks to achieve and maintain a national provision level of 108 residential places and Community Aged Care Packages (CACPs) for every 1,000 of the population aged 70 years and over. While there is some debate about the formula, its aim is to ensure that the growth in the number of aged care places is in line with growth in the aged population and that there is a balance of services, including services for people in rural and remote areas.
>
> The disability sector has nothing similar to guide the provision of residential and community care places to people with disability. We know that only 48 of every thousand persons in the comparable population (broadly, people under 65 years with a severe or profound core activity restriction) receive a CSTDA-funded disability accommodation support service.[77]

3.105 The Committee notes that the Disability Policy and Research Working Group (formerly the National Disability Administrators) is conducting research into Demand Management due for completion in June 2007.

Recommendation 9

3.106 That the next CSTDA incorporate appropriate benchmarks and annual targets in relation to identified unmet need for specialist disability services.

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75 *Committee Hansard* 3.10.06, p.28 (National Carers Coalition).

76 *Submission* 28, p.7 (National Carers Coalition); *Submission* 10, p.1 (Ms E Shields).

77 *Submission* 45, p.12 (ACROD).

Growth Funding

3.107 Several State and Territory submissions noted that their CSTDA funding contributions for specialist disability services were growing at a faster rate than those from the Commonwealth. The Queensland Government noted that:

> The Queensland Government has made significant additional investments in disability services in recent years representing a commitment at the State level to respond to needs of people with a disability. A commensurable effort by the Commonwealth Government has not been realised.[78]

3.108 However, a larger proportion of new Commonwealth funding has gone into the disability employment services which it directly administers. Over the course of the current agreement annual Commonwealth funding of disability employment services has increased from $303 million to $486 million while funding to the States and Territories for special disability services has increased form $521 million to $616 million.[79]

3.109 ACROD suggested the following reasons for this trend:

> This reflects the Commonwealth's view that:
>
> - implementing the ambitious raft of disability employment service reforms required additional spending on those services;
> - States are insufficiently accountable for the expenditure of funds they receive from the Commonwealth;
> - State-administered services are principally the responsibility of the States; and
> - higher-than-expected GST revenue should reduce the States' call on Commonwealth specific-purpose transfers.[80]

3.110 The State and Territory Governments also expressed concern that increases in the level of CSTDA funding were not being reflected in requirements set in the Bilateral Agreements.

> The Australian Government applies a "matched funding" requirement as a part of most bilateral agreements, but there is no structure in place to acknowledge additional funding efforts made by the States and Territories.
>
> A further shortcoming of the Commonwealth's introduction (as part of a regime of input controls) of a 'matched commitment' at the time of signing an agreement is that this does not recognise previous efforts of States and Territories. This can create a disincentive to states in making additional efforts in growth funding during an agreement as this additional effort

78 *Submission* 112, p.3 (Queensland Government).

79 *Commonwealth State Territory Disability Agreement 2002-2007, Schedule A1*.

80 *Submission* 45, p.9 (ACROD).

> becomes effectively locked-in to areas that may not be reflective of need in the State or Territory.[81]

Recommendation 10

3.111 That the next CSTDA ensure 'matched funding' commitments do not provide a disincentive for governments to provide additional funding for specialist disability services.

Equity of funding distribution

3.112 A number of State and Territory Governments argued the Commonwealth funding for specialist disability services was not distributed equally amongst the jurisdictions in relation to their proportion of people with disabilities.[82] For example the Victorian Government commented:

> Victoria receives less than its equitable share of Commonwealth funding, which results in an estimated shortfall of some $40 million over the life of the current CSTDA.[83]

3.113 The Western Australian Government provided a graph, reproduced as Table 3.3, to illustrate what it suggested was a lack of equity in the distribution of Commonwealth CSTDA funding in relation to potential population.[84] The Australian Institute of Health and Welfare (AIHW) estimates 'potential population' in each jurisdiction to broadly indicate the number of people with the potential to require specialist disability services at some time. The potential population for each jurisdiction is calculated from population disability survey estimates and is constructed for comparative purposes and to provide indications of relative need.[85]

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81 *Submission* 3a, p.20 (Western Australian Government).

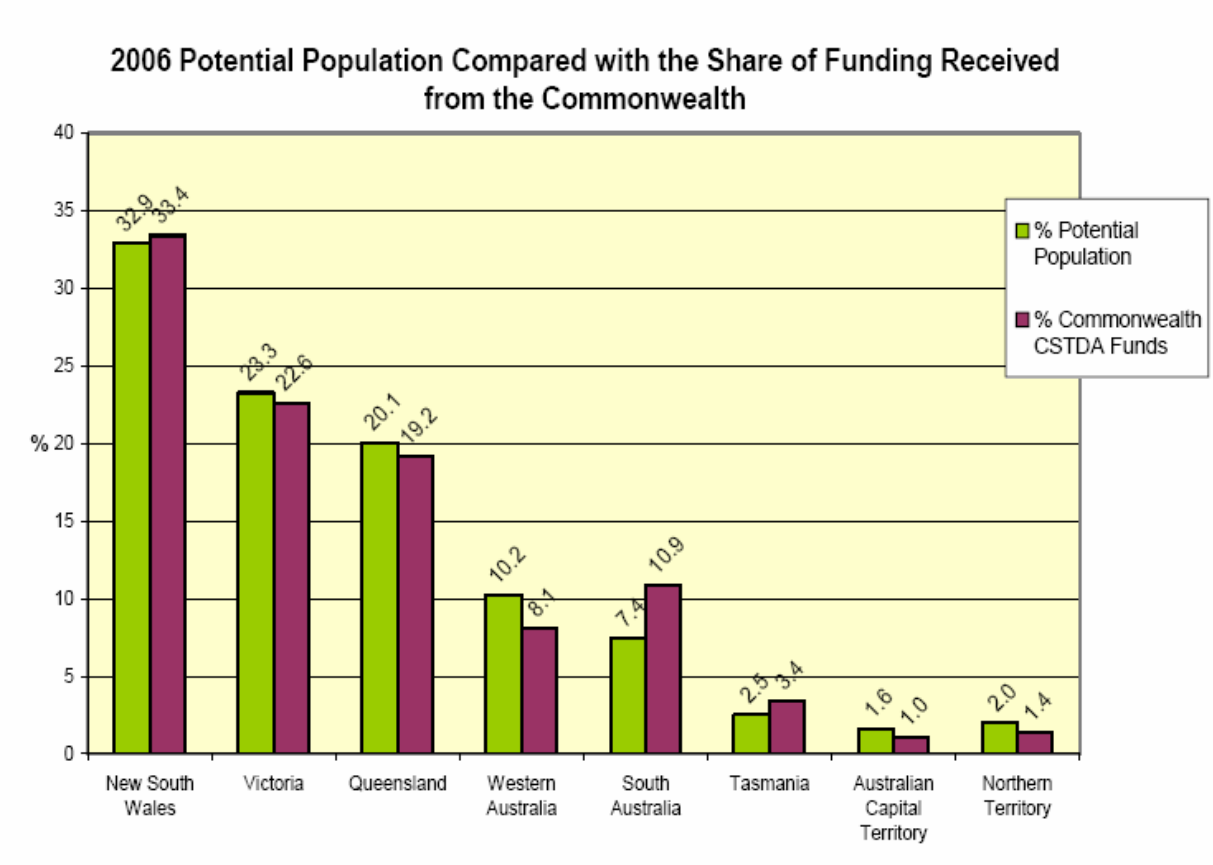
82 *Submission* 3a, p.22 (Western Australian Government); *Submission* 99, p.16 (Victorian Government); *Submission* 60, p.15 (Disability Coalition WA).

83 *Committee Hansard* 28.9.06, p.66 (Victorian Government).

84 *Submission* 3a, p.23 (Western Australian Government).

85 AIHW, *Disability and Disability Services in Australia – based on an extract of Australia's Welfare 2005*, Canberra 2006, p. 4.

Table 3.3: Funding equity in relation to potential population



Source: Western Australian Government, *Submission* 3a, p.23.

3.114 The current distribution of Commonwealth funding is based on historical arrangements present during the first CSDA. During the negotiations for the current CSTDA parties considered solutions for a more equitable distribution of Commonwealth funding. The Western Australian Government commented:

> …Ministers considered options for an accelerated equity formula. The Commonwealth Minister took the position that they would allocate their growth funds on whatever equity funding formula agreed to by States/Territories. Ultimately, agreement was not reached, and the overall distribution of funding to the States and Territories has remained inequitable. The Commonwealth was not prepared to provide additional funding to address the equity issue.[86]

3.115 The Northern Territory Government also identified funding equity issues in relation to other factors, such as the costs of service delivery:

> 29% of the Northern Territory population are Aboriginal…Australian Institute of Health of Welfare (AIHW) estimates indicate the Aboriginal people are 2.4 times as likely to have a severe or profound disability as non-Indigenous Australians…The Northern Territory also has the largest population of people living in extremely remote settings…The highly

86 *Submission* 3a, p.25 (Western Australian Government).

> dispersed nature of the population, particularly for those with the greatest need, substantially increases the cost of service delivery in the Northern Territory.[87]

Possible solutions

3.116 The Western Australian Government argued that certain principles should be adhered to in any solution to address inequity in the distribution of Commonwealth CSTDA funding:

> The core principle underlying a move towards equity must be to recognise that this is funding used to provide services to individuals and that no Australian with a disability should be disadvantaged on the sole basis of the jurisdiction they reside in.
>
> The second principle is that no state or territory should receive a lower proportion of funds than is appropriate for their population. In the case of South Australia and Tasmania this may mean that the level of funding they receive may be the level necessary and thus should not be reduced.[88]

These principles suggest a solution of the 'making the pie bigger', by providing an increased proportion new funding to States and Territories currently receiving less than the proportion indicated by their potential population. However there were also concerns raised about this approach. The Tasmanian Government noted there was a risk that jurisdictions may 'increase the number of clients that they provide a service for by simply allowing people into the system who have very low levels of support'.[89]

> We are not against anyone getting their fair share, but you can build that into future growth components and then simply try to equalise it over the next five years.[90]

3.117 An argument also discussed was that providing additional Commonwealth funding to States and Territories which are providing inadequate levels of disability services or which have historically provided inadequate funding could be perceived as rewarding underperformance. An alternative model raised also discussed which would match additional funding for disability services by State and Territory governments over a base funding level. This would reward jurisdictions which provided additional funds for specialist disability services. For example Dr Baker of ACROD commented:

> Ultimately I would not want to see any service user in any state disadvantaged by that process, but at present I think the situation is inequitable… it reinforces low performance by state governments because the Commonwealth is providing proportionately more funding to states where state government funding is low. I think the Commonwealth should

87 *Submission* 106, p.2 (Northern Territory Government).

88 *Submission* 3a, p.25 (Western Australian Government).

89 *Committee Hansard* 22.11.06, p.3 (Tasmanian Government).

90 Committee Hansard 22.11.06, p.4 (Tasmanian Government).

be doing the opposite. It should be, if anything, rewarding high-performing or high-funding states.[91]

3.118 The Committee's view is that there should be a balance in the next CSTDA between providing a base level of funding for specialist disability services and allowing governments a measure of flexibility to make agreements to provide additional funding for priority areas. The Committee is sympathetic to the principles outlined by the Western Australian Government as applied to based funding, however there should also be opportunities for governments to establish incentives for other jurisdictions to provide additional funding for specialist disability services, for example by seeking matched funding for specific initiatives of that government. Matched funding agreements have been an efficient mechanism to provide incentive for governments to commit additional funding to services.

Recommendation 11

3.119 That the Commonwealth have responsibility in the lead up to the next CSTDA for developing an equitable distribution formula of Commonwealth base funding which takes into account differences between States and Territories in terms of potential population and costs of service delivery.

Recommendation 12

3.120 That, in addition to that funding "platform", arrangements be put in place to allow specific services or programs to be initiated on the basis of cost-sharing or matched funding between the Commonwealth and particular State and Territory governments which commit additional funding for specialist disability services.

Performance monitoring and reporting

3.121 There are three main performance reporting arrangements under the CSTDA:

- the CSTDA National Minimum Data Set (NMDS) and associated data collection arrangements;
- annual reporting between governments on funding spent and progress and achievements in implementing strategies to address national policy priorities; and
- the CSTDA Annual Public Report commissioned by the National Disability Administrators listing the progress and achievements in implementing national policy priorities.[92]

91 *Committee Hansard* 13.10.06, p.41 (ACROD).

92 National Disability Administrators, *Commonwealth State Territory Disability Agreement Annual Public Report 2004-05*, August 2006.

3.122 Schedule A3 of the CSTDA provides for the form of performance reporting against the major areas of disability services being provided – accommodation support, community support, community access, respite, open employment and supported employment – see Table 3.4 for an example of the performance data required. The performance indicators are largely similar for each area of disability services and consist of efficiency measures and equity measures.

Table 3.4: Example of CSTDA performance data requirements

Service Type	Performance data
Community Support	Must include numbers of consumers vs numbers of services **average cost per unit of service** **average cost per service user** **Proportion of total community support service users by:** - **primary disability type** - **location** - **CALD** - **ATSI** - **age** **Total community support service user numbers /time by:** - **proportion per 1000 of total jurisdiction population /location** - **proportion of total jurisdictional target group population/location**

Source: Commonwealth State Territory Disability Agreement 2002-2007, Schedule A3.

3.123 In 2005 the Australian National Audit Office (ANAO) undertook a performance audit of the (then) Department of Family and Community Services' role in the CSTDA. The audit report noted that the objective of the CSTDA to 'enhance the quality of life experience by people with disabilities through assisting them to live as valued and participating members of the community' was not reflected in the performance management framework.

> …the performance information framework contained in the CSTDA includes no indicators of the quality of life of people with disabilities, their participation in the community, their value in the community, or any related parameters, despite the objective directly aimed at enhancing quality of life. Therefore, the performance information framework contained in the Multilateral CSTDA does not require the collection of data that can clearly indicate whether, or to what extent, the CSTDA is meeting its objective.[93]

3.124 This criticism was repeated in a number of submissions the Committee received. For example, the Australian Federation of Disability Organisations commented on the limitations of the current performance management model.

93 ANAO, *Administration of the Commonwealth States Territory Disability Agreement*, Audit Report No. 14 2005 -2006, p.42.

> If you think about the way that the CSTDA is currently assessed, it is a real counting exercise: how many people have you seen? It is supposed to assess the objective of the CSTDA, which is: have we made the lives of people better? There is nothing about counting how many people who have access to services that tells you anything about whether people's lives are better.[94]

3.125 The ANAO audit made five recommendations focusing on improvements in performance measures and reporting requirements all of which were accepted by FaCSIA. However FaCSIA has stated that while there has been progress in implementing the ANAO's recommendations 'because states and territories are responsible for the delivery of specialist disability services other then employment, improvements in performance reporting will require input and agreement from state and territory governments.' FaCSIA have indicated that these issues will be part of the negotiations for next agreement.[95] The ANAO Report noted long-standing problems in reconciling State and Territory commitments under the CSTDA with State and Territory Budget appropriations and reporting in annual reports.[96] The challenges in relation to obtaining performance data comparable between the jurisdictions are well recognised.[97]

Input controls

3.126 State and Territory Governments raised concerns that the structure of the CSTDA was too focused on input controls reducing the flexibility of governments and service providers to address local issues.[98]

3.127 The current CSTDA defines the specialist disability services funded under the agreement into a number of categories, such as community support services. Services with a specialist clinical focus and non-specialist services are outside of the agreement.[99] Funds made available may only be utilised for the provision of specialist disability services covered under the Agreement or a Bilateral Agreement.[100] However other specialist disability services may also be included under the agreement where the Commonwealth and States/Territories agree.

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94 *Committee Hansard* 6.10.06, p.7 (AFDO).

95 *Submission* 96, p.12 (Australian Government).

96 ANAO, *Administration of the Commonwealth State Territory Disability Agreement*, Audit Report 14 2005-2006, p.82.

97 Monro D, 'The Role of Performance Measures in a Federal-State Context: The Examples of Housing and Disability Services' 62 (1) *Australian Journal of Public Administration*, March 2003 pp.70-79.

98 *Committee Hansard* 22.11.06, p5 (Tasmanian Government); *Submission* 112, p.6 (Queensland Government); *Submission* 3, p.20 (Western Australian Government).

99 *Commonwealth State Territory Disability Agreement 2002-2007*, Part 5.

100 *Commonwealth State Territory Disability Agreement 2002-2007*, Part 8 (2).

3.128 The Queensland Government commented:

> The input control process requires the matching new funds to programs, resulting in a service system that is rigid and requires people to fit the programs instead of providing services that are needs based…Given the five-year term of the CSTDA, flexibility is needed to promote service improvement and innovation in relation to local priorities, and to promote the capacity to develop responses to emerging issues. The CSTDA was developed in such a way as to "rope" all funds into expenditure on six service types only. This is proving limiting to Queensland's ability to be more responsive and innovative.[101]

The burden of accountability

3.129 The Western Australian Government noted that performance monitoring and accountability regimes also need to appropriately balance the relative size of both parties' contributions.

> An acceptance of shared responsibilities by the States and Territories should not be taken by the Australian Government as an invitation to exercise disproportionate control over policy direction in the disability services sector. As this submission has shown, the proportion of the Australian Government contribution to the sector, particularly in Western Australia, has shrunk. Despite this, the Australian Government has sought ever higher levels of control over both administration and policy of the State's and Territory's disability services.[102]

3.130 The NSW Government highlighted that while the current CSTDA does not include incentives and targets, it does contain potential penalties for the State and Territory Governments whereby the Commonwealth Government can withhold payments if reporting requirements are not met.[103] The NSW Government commented:

> The move to include incentives, sanctions and targets in SPP Agreements needs to recognise the recommendations by the Australian Parliament's Joint Committee of Public Accounts and Audit that financial accountability requirements for SPPs should be as streamlined as possible, to improve administrative efficiency and to avoid duplication between Commonwealth and State and Territory Auditors–General.[104]

Outcomes and quality based performance framework

3.131 The current CSTDA NMDS does not include measure or indicators of individual outcomes or quality of life. The Committee noted broad support of an

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101 *Submission* 112, p.6 (Queensland Government).

102 *Submission* 3a, p.30 (Western Australian Government).

103 *Submission* 84, p.9 (New South Wales Government).

104 *Submission* 84, p.9 (New South Wales Government).

increased role of outcomes and quality based performance measures in the next CSTDA.[105] These changes appear to be a priority for governments going into the negotiations for the next agreement. FaCSIA noted that:

> …despite advances in transparency and accountability under the current CSTDA, further work is needed to augment the current input controls and output reportings with an outcomes reporting framework. An outcome reporting framework will enable us to look at performance in a meaningful way and assess what outcomes are being achieved for people with a disability.[106]

3.132 There appear to be challenges in developing a realistic outcome and quality framework which gathers meaningful performance data and does not impose administrative burdens on service providers. [107] Nonetheless ACROD commented:

> Quality monitoring has focused more on processes and systems than on quality-of-life outcomes for service users. This should change...While measuring quality of life outcomes for service users poses challenges (and invites scepticism from some commentators), there are several existing designs which claim to do it well. Measurement systems should include subjective and objective dimensions, be administratively simple for governments and service providers and closely involve service users[108]

3.133 AIHW noted the methods for collecting data on measures or indicators of individual outcomes and quality of life were the subject of extensive work during the redevelopment of the CSTDA NMDS in 1999-2000. A proposed participation module was designed to collate information collected from service providers and users into a common framework for national comparison. The AIHW commented:

> Improved information about outcomes for service users would inform the objectives of the CSTDA itself. For example, it would be possible to explore the extent to which CSTDA service users participate in a broad range of life areas such as recreation, communication with family and friends, employment or education and how they (and their carers and advocates) rate their satisfaction with this level of participation.[109]

Recommendation 13

3.134 That realistic outcomes based performance reporting requirements be added to the CSTDA.

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105 ANAO, *Administration of the Commonwealth State Territory Disability Agreement*, Audit Report 14 2005-2006, p.42.

106 *Committee Hansard* 13.10.06, p.80 (FaCSIA).

107 AIHW, *Disability and Disability Services in Australia – based on an extract of Australia's Welfare 2005*, Canberra 2006, p.46.

108 ANAO, *Administration of the Commonwealth State Territory Disability Agreement*, Audit Report 14 2005-2006, pp.15-16.

109 *Submission* 65a, p.4 (AIHW).

Recommendation 14

3.135 That the Commonwealth take the lead in developing consistent cross-jurisdictional performance monitoring and reporting of specialist disability services to promote greater coordination and accountability between jurisdictions.