INQUIRY INTO THE FUNDING AND OPERATION OF THE COMMONWEALTH STATE/TERRITORY DISABILITY AGREEMENT

Terms of Reference

On 11 May 2006 the Senate agreed that the following matter be referred to the Community Affairs References Committee for inquiry and report by 7 December 2006.

An examination of the funding and operation of the Commonwealth tate/Territory Disability Agreement (CSTDA), including:

(a) an examination of the intent and effect of the three CSTDAs to date;

(b) the appropriateness or otherwise of current Commonwealth/State/Territory joint funding arrangements, including an analysis of levels of unmet needs and, in particular, the unmet need for accommodation services and support;

(c) an examination of the ageing/disability interface with respect to health, aged care and other services, including the problems of jurisdictional overlap and inefficiency; and

(d) an examination of alternative funding, jurisdiction and administrative arrangements, including relevant examples from overseas.

Executive Summary

The provision of resources to support people with a disability in Australia has traditionally been complex. Since European settlement in 1788, a mix of both formal and informal models of funding have supported 'disability' predominantly within the institutional setting. Based on emerging international models of deinstitutionalisation, the Independent living Movement and the Social model in the early 1970's, Australia shifted its policy response to disability away from that of segregation and institutionalisation towards one of deinstitutionalisation and social inclusion supported by a model of community based care. The *Disability Services Act 1986 (Cwlth)* was implemented as the dominant piece of legislation that would oversee the establishment of this model of community based care for people a disability. The Commonwealth State/Territory Disability Agreements (CSTDAs) were established to support the Disability Services Act in undertaking this role. The CSTDAs aimed at creating administrative efficiency and clarifying funding roles and responsibilities between State/Territory and Federal levels of governments given the large expansion in service delivery that would be required in establishing a model of community based care.

The CSTDAs however have emerged as problematic. As with much of the Australian health system, the split between Commonwealth and State/Territory government roles in terms of overlapping funding parameters and jurisdictions, duplicity in operationalisation and administrative procedures and multiplicity in service program delivery has created fractures, lack of uniformity and lack of equality in the delivery of disability services at a national level. Determining accurate levels of need and usage of disability services and monitoring and contrasting differing levels of service delivery across Australia are significantly hampered by the multi-level, multi-state delivery of services. In addition, the failure to include HACC services, CRS programs, insurance-based funding of disability services (such as those received trough WorkCover and Transport Accident schemes) and disability services funded privately as a result of public liability claims within the structure of the CSTDAs have distorted the view of how disability service delivery is truly funded (or

not funded) across Australia, failing to provide an adequate picture as to many inequities in funding that exist across the disability sector.

In terms of the provision health and community services programs related to disability service delivery, despite a population in Australia of only 20 million people, the AIHW has estimated that State/Territory and Commonwealth governments are responsible for more than 60 programs and services both within and outside of CSTDAs (AIHW 2003). For any one state, disability services are funded by between 4 and 8 different funding providers, inclusive of services funded under the CSTDAs, but also inclusive of Transport Accident schemes, WorkCover schemes and services received through federal funding schemes. These have evolved over many years and have evolved in an ad hoc basis in response to specific needs and demands, without any overlying consistent policy framework or philosophy (AIHW 2003).

In addition, significant levels of unmet need have failed to be included in the total sum of funding of the CSTDA since its implementation. The failure to address the need for these services and provide scope for disability service delivery for primary carers undertaking unpaid service delivery has placed may individuals and families under strain for prolonged periods of time. Evidence of long standing and significant levels of unmet need are only now becoming visible through the use of newly implemented accountability mechanisms and annual CSTDA national minimum data sets.

As with many proponents of the national health system, a move towards a nationalised funding of disability services, with an increased strengthening of local council roles and responsibilities, would ensure the removal of structural funding problems associated with the CSTDAs. Only a nationalised disability services framework would provide an adequate means of effectively assessing, monitoring and delivering the wide scope of disability services required to move towards the provision of fair and equitable levels of community based disability services in Australia. The potential mirroring of New Zealand's no-fault model of care, inclusive of common-law claims, may work towards the creation of a more equitably and sustainable model of disability service delivery at a national level.

It is clearly evident that the current CSTDA framework only serves to reproduce and further fragment disability service delivery through its siloed and jurisdictional funding approach to disability service delivery. Only a nationalised system of disability service delivery would effectively begin to address the levels of unmet need, administration inefficiencies and wide-scale duplication and variation of disability service delivery that currently exists across Australia.

Recommendations:

- A move towards a nationalised funding of disability service delivery (potentially based on the nationalised New Zealand scheme and inclusive of common-law claims), providing for reduced administrative overlap, improved monitoring of services and ease of movement between jurisdictions for service users

- Local government to provide a strengthened and expanded role in the provision of funding for disability support services, significantly in providing more personalised funding arrangements of increased quality

- The inclusion of insurance-based funding of disability services into nationalised disability services framework

- the development of national benchmarks and annual targets for the provision of disability services

- public financial and performance reporting that is transparent and detailed

- development of a planning framework for the provision of disability services across Australia that takes into account demographic changes, future service needs, the changing expectations of service users and carers, allows state-to-state movement of service users

- ensure that disability data collections are consistent with the International Classification of Functioning Disability and Health, endorsed by the World Health Organization.

- The inclusion of Commonwealth Rehabilitation Services into a nationalised disability services framework

- The separation of HACC services away from disability service delivery towards use solely for Aged Care provision

(a) an examination of the intent and effect of the three CSTDAs to date

(i) historical overview of establishment of CSDA / CSTDAs

The establishment of a Federation of States in 1901 saw the introduction of a constitutional system of government in Australia whereby nine independent governments - one at the national level, six states plus two territories - were formed (Power 2005). In specific relation to health, the roles and responsibilities for health were defined constitutionally. The Federal government was given the basic role of funder of health services, while the State and Territory governments, given their already entrenched bureaucracies and statutory authorities, received the role of management and operationalisation of the health services (Power 2005).

Funding for disability services throughout Australia consequently operated within this health funding structure. Care and accommodation for people with disabilities in Australia post settlement mirrored that of the English model and was supplied in the main, within formal institutional settings (Yeatman 1996). These institutions were funded by the states, and at a social level, served to reinforce the social response of 'disability' as something to be excluded and segregated away from main stream society (Kennedy 1982; Cass, Gibson et al. 1988; Lindsay 1996; Gleeson 1997). Individuals that remained outside of institutional settings received support informally. Shortly after Federation, a nominal amount of financial support became available for people with a disability in terms of a federally funded invalid pension (Lindsay 1996).

By the 1970's and 1980's however, influenced by international movements of deinstitutionalisation, the independent living movement and the social model of disability, a shift towards more socially integrated and community based models of accommodating people with a disability occurred (Cass, Gibson et al. 1988; Lindsay 1996; Gleeson 1997). Significantly, two national reviews conducted during the period, the Royal Commission on Human Relationships (1977) and the 'New Directions' - Handicapped Program Review

(1985) highlighted the predicament of people with disabilities in Australia and the significant levels of social exclusion associated with institutionalisation. As an outcome of these reviews, the *Disability Services Act* (Cwlth) was passed in 1986. The Disability Services Act (Cwlth) provided the dominant piece of legislation to oversee the process of deinstitutionalisation of people with a disability towards a model of independent community based living supported by funded disability service delivery (Cass, Gibson et al. 1988). The implementation of the Act sought to reduce models of service delivery that promoted a reliance on charity and welfare models of service delivery and instead sought to provide a full range of support services to assist people with a disability to live independently in the community (Parmenter, Cummins et al. 1994; Lindsay 1996). A key focus of its establishment was the individualised and consumer driven model of service delivery rather than a model that supported centralised and institutional control by the states (Parmenter, Cummins et al. 1994; Lindsay 1996).

In terms of operationalisation of this new model of service delivery, the *Disability Services Act 1986* (Cwlth) was significantly supported by the then recently established and federally funded Home and Community Care (HACC) program and Commonwealth Rehabilitation Service (CRS). The HACC program aimed to reduce inappropriate or premature admission to residential care by providing basic maintenance and support services to frail older people and people with a disability that would promote independent community living (Cass, Gibson et al. 1988:53; Productivity Commission Australian Government 2004). Although federally funded, each State/Territory to various levels, matched funding and oversaw the delivery of HACC services for people with disabilities within each state. These services included home help services and attendant care. In addition, the Commonwealth Rehabilitation Service (CRS) sought to provide assistance with employment and vocational rehabilitation for people with disabilities to further assist with independent community living (Lindsay 1996).

Following the implementation of the federal *Disability Services Act 1986* (Cwlth) and HACC program (1985) however, it quickly emerged that a significant expansion of the funding arrangements would be required to meet the outcomes of the new legislation (Ohlin and Group 1999). A lack of knowledge of State and Federal responsibilities, duplication of

administration, delays with processing requests and unwarranted interference across the dual levels of government were creating difficulty and confusion in implementing the objectives of the Act (Monro 2003). It was surmised that neither the State/Territory's or Federal governments alone would be able to meet the outcomes of the Act and that a significant restructure in funding arrangements would be required within the existing multi-layered government framework in implementing a service model based on independent community living.

(ii) implementation of first CSDA

In response to these difficulties, a new disability funding arrangement was formulated between the Federal and State governments in 1991 - The Commonwealth State Disability Agreement, CSDA. The five year funding agreement sought to reduce the overlap between the Commonwealth and State governments and clarify responsibilities between these two levels of government (Lindsay 1996; Yeatman 1996; Monro 2003). The agreement aimed to provide a new national framework for the funding of disability service delivery, to provide a streamlined framework to assist with funding of disability services and to establish a clear division between the Federal and State/Territory governments in terms of jurisdictions and responsibilities (Ohlin and Group 1999; McIntosh, Phillips et al. 2002). The CSDA also sought to clarify administrative procedures within each government, but provide the capacity for joint governmental approaches to policy and planning where needed (National Disability Administrators 2005). Under the agreement, funding jurisdictions within the CSDA were to be stratified. The Commonwealth in general were to take on an administrative role including broad policy and strategic planning, while the State/Territory's were given the roles of management and operationalisation of service delivery (Monro 2003). In simplified terms, the breakdowns of funding across the disability sector included:

Employment Services – administered by Commonwealth

Advocacy – administered by both Commonwealth and State/Territory

Information - administered by both Commonwealth and State/Territory

Research - administered by State/Territory

Accommodation support - administered by State/Territory

Community access - administered by State/Territory

Respite care - administered by State/Territory

Community support - administered by State/Territory

Print disability services – administered by both Commonwealth and State/Territory

Home and Community Care (HACC) program – administered by Commonwealth funding and funding matched and operationalised by the States*

Commonwealth Rehabilitation Service (CRS) – administered by Commonwealth*

*funding of the HACC program and Commonwealth Rehabilitation Service remain outside of the jurisdiction of CSDA

In monetary terms, the implementation of the first CSDA was also supported by a real increase in funding by the Commonwealth Government. $100 million was utilised in recognition of the significant expansion in funding that would be required to meet the goals of the Disability Services Act and to oversee the expansion of arrangements for the establishment of community based services (Yeatman 1996). The CSDA also provided the basis for associated capacity building in administration required for the delivery of these services at a State/Territory level which included the introduction of needs and performance based funding, brokerage, case-management, institutional reform, service upgrading and the implementation of quality standards (Yeatman 1996).

For recipients of disability services, the broad aims of CSDA were commendable. The implementation of CSDA fundamentally sought to provide outcomes that would ensure that people with disabilities had access to appropriate services which met their individual needs and enabled them to live as independently within the community as possible. The CSDA also sought to ensure outcomes that recognized people with disabilities as Australian citizens with rights equal to those of other Australians. The construction of a well coordinated, community-based disability service system with a single but integrated gateway for access to all services, regardless of the level of government funding, was viewed with anticipation by many recipients of service delivery within the disability sector (Yeatman 1996).

Service groups were separated into:

- accommodation support services—providing accommodation, or support to enable a person with a disability to remain in existing accommodation or move to more appropriate accommodation;
- community support services—providing the support needed for a person with a disability to live in a non-institutional setting;
- community access services—providing opportunities for people with a disability to gain social independence;
- respite services—providing a short-term and time-limited break for families and other voluntary caregivers of people with a disability; and
- employment services—providing employment assistance to people with a disability in obtaining and/or retaining paid employment through open employment or supported employment services (while still providing access to generic employment services (Productivity Commission Australian Government 2004; AIHW 2005)
- advocacy, information and print services –providing services to help people with disabilities to increase control over their lives by representing their interests and views in the community and by providing accessible information about services and equipment.

(iii) review of 1st CSDA

Despite the goal of administrative convenience and streamlining of funding for disability services between the Federal and State governments sought by the CSDA, the implementation of the first CSDA instead appeared to entrench the fragmentation of service provision for people with disabilities across Commonwealth State/Territory government divisions (Lindsay 1996; Yeatman 1996). Rather than viewing people with disabilities holistically and attempting to develop integrated and complementary services for the variety of needs and services required by people with a disability, the CSDA funding arrangement meant that an array of disability services and programs were spread across

both levels of governments and sourced through multiple entrance points (Lindsay 1996). The implementation of the CSDA instigated a compartmentalised nature of disability service delivery across Australia. For example, any one person with a disability living independently in the community and in search of employment would access HACC services for daily support care needs funded by the Commonwealth (but administered by the states), access assistive aids and equipment from State services, access employment related services that were administered by the Commonwealth and utilise accommodation services provided by the States (Lindsay 1996). In addition, the state-by-state funding of disability services through the CSTDAs meant that a wide array of differing programs and differing models of disability service delivery where constructed in each state across Australia in providing services. The delivery of disability services in each State or Territory were therefore governed by differing arrays of legislations and guidelines, administered through differing forms of management and administrative processes and utilised various forms of classifications of disability in structuring and operationalising service delivery.

A major review undertaken towards the end of the first agreement highlighted a significant number of gaps in the implementation of the first CSDA (Yeatman 1996). In relation to service delivery, gaps included inequities in service provision across differing jurisdictions, levels of unmet need, intentional and unintentional exclusion of some groups due to eligibility criteria and lack of provisions for meaningful, non-vocational activity programs. Of primary concern were difficulties associated with the lack of clear definition and eligibility and assessment criteria. These posed significant problems with varying descriptions of eligible target groups, differing interpretations of need, varying definitions of what constituted a disability and differing classification of disability types across different states and territories. The first CSDA also provided no planning for effective monitoring of service delivery and provided no baseline or benchmark calculations to assess contrasting delivery of services across differing States or Territories (Yeatman 1996). The CSDA was also problematic in that it did not provide for intergovernmental management capacities, mechanisms for coordination across the sector and did not include performance targets (Yeatman 1996).

Further, the review identified a number of overall structural difficulties with the first CSDA, associated particularly with the difficult interfaces that existed between the parameters of CSDA and the supporting but external roles of HACC services and CRS (Yeatman 1996). Although the service delivery role of the CRS was short-term and rehabilitation focused, the CRS provided significant vocational rehabilitation roles for people with disabilities. Undisputedly, the provision of HACC services also provided vital day-to-day community based service delivery. The review therefore questioned the CSDA program boundaries and the very exclusion of CRS and HACC program from the CSDA parameters given the similarities and areas of joint responsibilities of disability service provision.

In light of these gaps, the review concluded that the CSDA had not meet its objectives of providing a nationally consistent framework of disability service delivery (Yeatman 1996). Recommendations therefore included the need for greater accountability of service delivery by all governments, improved monitoring and assessment criteria of service delivery and the introduction of an improved and standardized definitions of disability and the development of a reliable data set (Yeatman 1996). The review also recommended the inclusion of the HACC program and CRS into the funding parameters of the CSDA (Yeatman 1996). As stated by Power (2005), in reviewing the implementation of the first CSDA, inefficiencies soon became evident in the duplication of bureaucracies and cost shifting resulting from the lack of agreement on appropriate roles between the Federal and State/Territory governments. Overall, it appeared difficult to see visible improvement in service delivery that the implementation of the CSDA and Disability Act had sought to achieve. Despite these numerous and considerable difficulties, the review overall howver recommended a further renegotiation of the CSDA funding arrangement.

(iv) ‘Working Solutions’ Report

During the same period as the first CSDA Review, the Commonwealth Government released the 'Working Solutions' Report (1995). The review provided a strategic review of the Commonwealth disability services program, outlining the Commonwealth Disability Strategy which would serve to establish a framework for policies, programs, practices, and procedures to improve accessibility and opportunity for people with a disability to live in

the community. Most significantly, the report outlined difficulties in achieving a coherent overall disability service for all persons with a disability and lack of outcome compliance and performance measures. The report identified inequity in service distribution between people with different disabling conditions, between people more articulate and inarticulate and between people in different regions, communities and states. The report recommended a national system of entry, referral and exit and annual assessment of service programs.

(v) renegotiation of 2nd CSDA / CSTDA

A 2nd CSDA was renegotiated between 1997 and 2002, renamed 'CSTDA' to include Territory jurisdiction. In response to recommendations from first CSDA review and 'Working Solutions' Report, the negotiation of the second agreement saw the inclusion of a number of bilateral agreements between the Commonwealth and the State/Territories and the inclusion of performance indicators associated with service delivery into the agreement (Monro 2003; Australian Government 2004. Performance indicators were negotiated into to CSTDA in an attempt to monitor the effectiveness of services based around client service delivery outcomes. Bilateral schedules between individual State/Territory governments administering services were included within the agreements in an effort to improve reporting mechanisms on service delivery effectiveness and accountability back to the Commonwealth {Yeatman, 1996 #211).

Under the second agreement, Government expenditure on CSTDA services was rapidly expanded to meet growing demand and need for disability services. By 2000-2001 a budget of $2.5 billion was allocated to services under CSTDA jurisdiction. In terms of overall CSDA funding allocations, 71.1 per cent of funding for services came from State and Territory governments with the Commonwealth Government funding the remaining 28.9 per cent (Productivity Commission Australian Government 2004). The main areas of State and Territory government expenditure for the same year included 56.5 per cent of total direct service delivery expenditure in accommodation and support services, 10.7 per cent in community support and 12.0 per cent in community access (Productivity Commission Australian Government 2004).

In addition, although significant funding allocations were being poured into disability services from a Commonwealth level, it was identified that levels of outgoing funding for services were not matching levels within State reporting. The utilisation of performance indicators in the second CSTDA designed to alleviate this problem did not appear to be satisfactorily resolving the problem of accountability of service utilisation or providing any accurate gauge as to quality of service delivery being provided (Monro 2003). Inconsistency of accurate data at all levels appeared to be hampering any coherent utilisation of performance indicators or the establishment of any effective benchmark with which to compare state by state performances (Monro 2003:76). These data discrepancies appeared to be a result of not only limited forms of data collection, but considerable difficulties in obtaining comparable data from each of the State/Territory in light of differing accounting practices between the States and varying levels of administrative efficiency (AIHW 2005). In addition, differing management systems between State/Territories created difficulties in interpreting the results that were obtained in relation to service utilization. Lack of clarity as to classifications of disability (e.g. "how were special needs defined?") was also problematic. The overall result of these complexities, as stated by Monro (2003) was not only a lack of coherency and understanding in how well services were being delivered, but a clear inability of the CSTDA funding arrangement to deliver equitable and uniform delivery of disability services nationally.

(vi) CSTDA minimum data set and NMDS

In response to problems associated with data collection inadequacies, a redevelopment of the CSTDA Minimum Data Set began in 2000. The minimum data set collection had commenced in 1995 and on a year by year basis had provided 'snapshot data' (i.e. data of service usage collected over a single day). This daily snapshot of the utilisation of services provided the mechanism to assess service utilisation and provide units of measure required for performance indicators. It was recognised however that given one person may be effectively using a number of services at any one time, measures would always be low and that the level of accuracy of the minimum data set would always be diminished. The

redevelopment of the minimum data set in 2000 sought to collect data using revised service type definitions (Productivity Commission Australian Government 2004). The new CSTDA data set would establish a means of data collection that would more effectively assist state based performance indicators within the CSTDA and consequently provide a more effective basis for a review of services. The redevelopment sought to provide improve state-by-state breakdowns of services funded through CSTDA, and provide specific usage breakdowns across the accommodation, employment and community sectors, including indigenous and non-English speaking utilisation of disability service delivery (Productivity Commission 2002; Australian Government 2002). An improved classification of 'disability' was also utilised within the redeveloped data set. The CSTDA adopted the 1990 World Health Organisation International Classification of Impairments, Disabilities, and Handicaps (ICIDH) that included categorization of disability by level (e.g. profound, severe, moderate etc). The new data set was renamed the CSTDA NMDS, with the most significant change being that funded agencies were required to provide information about all service users throughout the year (rather than just those who received a service on a snapshot day) (Productivity Commission 2002; Australian Government 2002). The redeveloped collection was fully implemented nationally in October 2002. Although not providing a measure of 'quality' of services, the introduction of the redeveloped minimum data set was at least viewed as a moved towards the clarification of recipient usage and improved identification of levels of disability service delivery. As quoted in the recent CSTDA Annual Report, the "new arrangements improve[d] the range and quality of information available about the people who receive CSTDA-funded services, the services they receive, service outlets and costs to government. The NMDS has been revised to ensure that data collected reflect the types of specialist disability services delivered today and is relevant to current issues and information needs" (National Disability Administrators Prepared by Australian Healthcare Associates 2005).

The redeveloped CSTDA minimum data set was also supported by newly obtained data from the 1998 census on disability and aging, and the Australian Institute of Health and Welfare's publication 'Disability, Aging and Carers', that included general data on recipient service delivery by usage and location, general transport usage by recipients, educational levels reached by recipients, labour force participation and levels of community

participation. Together with the CSTDA minimum data set, it was hoped these measures would more effectively provide a picture as to levels of efficiency, usage and overall effectiveness of service delivery at a state-wide level.

(vii) review of 2nd CSTDA – 2002

The Productivity Commission's Report on Government Services 2002 highlighted the continuing problematic nature of services and delivery methods that had persisted throughout the second CSTDA, particularly in relation to the collation of data. The Report highlighted the blurring of cross-state comparisons and difficulties providing figures on the proportion of total disability expenditure allocated to administrations. The report noted that data was not comparable across jurisdictions as governments employed different methods to apportion administrative costs (Productivity Commission and Australian Government 2002). Further, a 2003 Access Economics report criticized some State/Territory governments for a lack of transparency in their expenditure on disability.

The Productivity Commission Report recommended the uptake of the redeveloped CSTDA Minimum Data Set to that of a new CSTDA National Minimum Data Set in an attempt to better meet required assessment criteria and to provide consistency with other major data sets, such as the HACC minimum data set (Productivity Commission and Australian Government 2002). It was viewed that the collection of data on an ongoing basis would more effectively provide data on accessibility, appropriateness, efficiency and effectiveness of services (Productivity Commission and Australian Government 2002). Recommendations also included the expanding of reporting to cover non-CSTDA services used by people with a disability; developing an indicator on quality assurance processes; reporting current, ongoing social participation data and providing additional disaggregated Indigenous data (Productivity Commission and Australian Government 2002).

(viii) Negotiation of 3rd CSTDA and current situation

In light of these recommendations, a third CSTDA was negotiated in 2002 and is expected to run until mid 2007 (AIHW 2005). It is clear that improvements in data collection and

quality have been a continuing priority under all three CSTDA Agreements and that particularly, the inclusion of the CSTDA NMDS has provided a significant step towards improving the comparability and scope of reporting within the CSTDA framework. The collection of data on a yearly basis will enable reporting to be used as a baseline for future, cross year comparisons will allow the collection of information on informal carer arrangements. (National Disability Administrators 2005).

Although providing a more detailed national picture of services, limitations within the CSTDA funding arrangement remain. The CSTDA Annual 2003-04 report itself displays the array of different approaches and strategies being undertaken by each State and Territory under sections titled 'Progress by Jurisdictions'. Although only approximately 40 pages long, half of the Annual report are the individual assessments 'by jurisdiction' of each State/Territories roll-out of individual state services. 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 role 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. The current CSTDA funding framework for service delivery is also highly problematic for recipients of service delivery that choose to move interstate. 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'.

The Annual report 2003-2004 itself also highlights the continued problems of obtaining accurate data and information, despite the implementation of the CSTDA NMDS. As stated in the Annual Report 2003-2004's own disclaimer:

"The tables and charts presented throughout this report provide a comparative picture of CSTDA-funded disability services across Australia. The following factors should be considered when interpreting this data:

-Not all service outlets provided data for the period or submitted useable data. The number of service users reported is, therefore, likely to be understated, which means that the average cost per service user is probably lower than that reported.

-The mix or combination of services provided varies among jurisdictions. For example, some jurisdictions opt to provide more in-depth, and hence, more costly services than others.

-There are variations amongst jurisdictions in the collection of data relating to specialist psychiatric services."

The CSTDA BiLateral Arrangements are therefore considerably weakened as a result of the lack of accurate reporting mechanisms. Although the arrangements provide opportunities for coordinated planning and service delivery across governments, joint service mapping and accurate trend trajectories remain virtually impossible under the current framework. Consultation processes and service building partnerships will continue to remained siloed by State/Territory jurisdiction, with the objective of creating streamlined and equitably delivery of services at a national level, locked within these individualised bilateral funding arrangements.

In relation to Performance indicators, the framework of performance indicators is based on shared government objectives of services for people with a disability. The CSTDA Annual Report 2003 – 2004 claims that the performance indicator framework has been revised to provide information on equity, efficiency and effectiveness, and to distinguish the outputs and outcomes of government funded services for people with a disability. How this can be achieved given the difficulties in obtaining accurate data and effectively contrasting this data is highly questionable (Productivity Commission Australian Government 2004).

Further, in relation to efficiency outputs and administrative expenditure as a proportion of total expenditure, as also quoted "the proportion of total expenditure on administration is

not yet comparable across jurisdictions because different methods are used to apportion administration expenditure" (Productivity Commission Australian Government 2004). The considerable levels of duplicity across each State/Territory is also problematic with considerable administrative burdens of operationalizing each State/Territory service division.

The present CSTDA therefore continues to create fragmentation in relation to national disability service delivery. A complex and difficult maze of funding arrangements and entry points for clients continue to exist with significant problems in terms of data collation, data consistency, assessment and comparative analysis of data received across states.

As highlighted within the ACROD CSTDA submission (2006):

The CSTDA's fails to:-

• deliver the resources required to meet the substantial need for disability services across Australia;

• require multi-year budgetary planning based on demand growth and the increasing cost of service delivery;

• deliver a consistent robust approach to service quality;

• produce sufficient data to enable comprehensive and meaningful performance comparisons across jurisdictions; and

• build strong linkages and easy-to-navigate pathways between disability service systems administered by different governments (ACROD 2006);

Continuing to be problematic is the interface between the CSTDA and HACC funding arrangements. The HACC program provides community care to predominantly the frail aged in an attempt to provide services that will enable the frail aged to remain outside of institutional facilities for as long as possible. The shortfall in disability services resources however has seen many people with disabilities being forced to utilise HACC services to make up the need for services they require to live independently within the community. In many cases, as the Young People in Nursing Homes campaign has shown, many people with disabilities are being forced into institutional facilities because of limited or no other accommodation options available. The use of HACC funding to provide disability services therefore provides a messy interface between Commonwealth HACC funding and

State/Territory funded disability 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.

In 2006, the issue of the Commonwealth-State/Territory split remains highly problematic for not only the disability sector, but health sector as a whole. The split between Commonwealth State/Territory governments is viewed by many as the dominant obstacle in achieving an effective national health system in Australia. As noted by Dwyer, in assessing the effectiveness of public health policy in Australia, "the way that the Commonwealth State/Territory split of responsibility for health is enacted and managed is probably the single most significant problem in health system design" (Dwyer 2004; Rix, Alan Owen et al. 2005). As recently as 2005, the former New South Wales Premier, Bob Carr, claimed that this split in funding arrangements 'most clearly' highlighted the significant problems of cost-shifting between the Federal governments and the states. Further, the current federal minister Tony Abbott argued that the main structural problem in the health system is the inability by any one level of government (state or federal) to fund or take on overall responsibility for the health system'. Hon. Tony Abbott, Hon. cited in S. Lewis, 'Health cuts bad: Abbott', *The Australian*, 12 August 2005.

In looking towards solutions to the problems associated with the CSTDA funding arrangements, the establishment of a nationalised disability framework would appear to move towards a more effective strategy of disability service delivery. With demand for specialist disability services expected to grow, a clear and universal system of service delivery is required, allowing improved coordination across service systems and clear, transparent and equitable allocation of disability services to occur. 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, difficulties with managerial assessment, contrasting accounting practises and data collation and analysis. A national approach would also provide the basis for an improved strategic

networking and an improved systemic approach to addressing future needs (Productivity Commission and Australian Government 2002).

Instead, the current delivery of funded disability services nationally therefore appears to remain within these state silos and held together by these CSTDAs, despite significant reforms of the CSTDA structure. Little political will or significant international influence promoting holistic restructure, progressive development or nationalised reform of the disability service delivery sector however appears visible. In terms of solutions, the implementation of a nationalised disability services framework would best appear to address the complexities associated with the CSTDA in its current form. Only a nationalised disability services framework would provide the necessary platform to ensure equity and uniformity of disability service delivery across Australia.

(b) the appropriateness or otherwise of current Commonwealth State/Territory joint funding arrangements, including an analysis of levels of unmet needs and, in particular, the unmet need for accommodation services and support;

Flagged in numerous reports and commissions, significant levels of unmet need have failed to be included in the total sum of funding of the CSTDA since its implementation. The failure to address the need for these services and provide scope for disability service delivery for primary carers undertaking unpaid service delivery has placed may individuals and families under strain for prolonged periods of time. Evidence of long standing and significant levels of unmet need are only now becoming visible through the use of newly implemented accountability mechanisms and annual CSTDA national minimum data sets.

An Australian Institute of Health and Welfare (AIHW) study of access to disability services found the following estimates of unmet need in 2001:

Approximately 6000 people aged under 65 years living in residential aged care in 2001;

12 500 people needing accommodation and respite services;

8 200 places needed for community access services;

5 400 people needing employment services (AIHW 2003)

The AIHW noted that these estimates were conservative with respect to the provisions required for the ongoing support and assistance for people with disabilities. The AIHW study suggested that the overall service system for people with disabilities is under pressure. Particularly, health care needs of people with disabilities both in residential care and in the community remain a significant in relation to unmet need. Groups that appear to be particularly vulnerable include people with psychiatric disabilities, acquired brain injury and those with complex needs. The effects of unmet need on the ground in terms of provision of disability services is substantial and appear to be unmet by the funding resources within the CSTDA funding arrangement (AIHW 2003).

(d) an examination of alternative funding, jurisdiction and administrative arrangements, including relevant examples from overseas.

It is also important to recognise that the State/Territories also hold responsibility for the administration of a range of insurance and compensation schemes for people injured or disabled in traffic accidents or at work, which, although providing disability service delivery for individuals with a disability, sit outside and independent of the CSTDA agreements and operate under separate State and Territory legislation (AIHW 2005). In addition, people with disabilities receiving funding through the Department of Veterans Affairs also sit outside of the CSTDA agreement but within the commonwealth framework. Further, people with disabilities that receive damages obtained through the courts under public liability fund disability independently of any Commonwealth, State or CSTDA funding arrangements. Failure to include insurance-based funding of disability services (such as those received trough WorkCover and Transport Accident schemes) and disability services funded privately as a result of public liability claims within the structure of the CSTDAs have therefore distorted the view of how disability service delivery is truly funded (or not funded) across Australia, failing to provide an adequate picture as to many inequities in funding that exist across the entire disability sector, not just within the CSTDA arrangements.

As a case study, Disability legislation development in Victoria included the *Intellectually Disabled Persons Act 1986* and the *Disabled Services Act 1991*. These reflected the implementation of the *Commonwealth Disability Services Act 1986* at a local level and, most notably, provided the provision of preliminary community-based services and programs within a policy of deinstitutionalisation. The parameters of the legislation included provision of community based accommodation, day placement programs, home-based personal care, respite, community access programs, aids and equipment and variations of home-help services. These services were and are currently administered by the Disability Service Division within the State Government's Department of Human Services (DHS) and except for employment, are funded within the CSTDA arrangements(Victorian Government 2002).

Disability services to people who have acquired a disability as a result of a transport accident, have since 1986, been provided in Victoria under the jurisdiction of the Transport Accident Commission (TAC). The TAC was established in 1986 as a state-owned commercial insurer and funding body of services required by individuals sustaining an injury as a result of a motor vehicle or motor vehicle related accident (Transport Accident Commission 2006). The parameters of the TAC combined common law principles and no-fault benefits, so that every person obtaining an injury was covered by insurance irrespective of fault. Those who could prove fault were entitled to pursue further compensation through the courts, but all TAC clients remained entitled to ongoing funding of required services for a lifetime of care. (Transport Accident Commission 2006).

Parallel to TAC, the Victorian WorkCover Authority (VWA) under the *Accident Compensation Act (1995)* and *Occupational Health and Safety Act 1985* provides a comprehensive insurance allowing compensation through the courts and ongoing funding of required services for a lifetime of care (Purse 1996; Australian Healthcare Association 2004). **(**Of particular note, Australia lays claim to ten Workers Compensation Schemes for a labour force of 9.1 million (Purse 1996:114). Of 136 countries with workers compensation schemes, many of which are incorporated in general compensation schemes, only Australia, along with the United States and Canada, has sub-national compensation schemes (Productivity Commission 2004; Mansfield 2005).

Significantly, the establishment of the Transport Accident Commission and the Victorian WorkCover authority saw these previous commercial insurers taking-on the role of ongoing disability service providers as opposed to their previous role as solely commercial insurers. While still providing mechanisms of compensation, these newly established state-owned commercial insurance bodies now came to be operating alongside of the state government's generic disability services division as ongoing funders and providers of community-based disability services (Transport Accident Commission 2006; Victorian WorkCover Authority 2006). Further, people independently funding disability services as a result of public liability claims along with people with disabilities receiving services from Commonwealth Funding agencies sit parallel to TAC, VWA and generic State based CSTDA funded services again.

As this case study shows, for any one state, disability services are funded by between 4 and 8 different funding providers, inclusive of services funded under the CSTDAs, but also inclusive of Transport Accident schemes, WorkCover schemes and services received through federal funding schemes. For a national population of 20 million, this array of disability services provision is mirrored across each State/Territory. As quoted in the AIHW *Australia's Welfare* (2003) report, it [has] emerged that State, Territory and Commonwealth governments were [are] responsible for more than 60 separate health and community services programs both within and outside of CSTDAs. These had evolved over many years and had evolved in an ad hoc basis in response to specific needs and demands, without any overlying consistent policy framework or philosophy (AIHW 2003).

The complexity and virtual lottery of the Australian system sits in significant contrast to the existing New Zealand system, where a nationalised, no-fault disability service system has operated since 1974 (Luntz 1975; Lichtenstein 1999; Cane 2003; Luntz 2003; Drabsh 2005). In 1974, the Australian Whitlam government attempted to implement a no-fault health system within Australia, modelled on that of the New Zealand system. However, consensus was unable to be reached as to recommendations for parameters of the scheme (which sought to include illness within the scope of the no-fault scheme) (Luntz 1975; Lichtenstein 1999; Cane 2003; Luntz 2003; Drabsh 2005). The potential mirroring of New Zealand's no-fault model of care and inclusive of common-law claims, particularly in relation to disability service delivery, may work towards the creation of a more equitably and sustainable model of disability service delivery at a national level.

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