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To:

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

To Committee Secretary, Mr Elton Humphery

Thank you for the opportunity to provide a supplementary submission to the to Inquiry into the funding and operation of the Commonwealth State/Territory Disability Agreement.

With Regards

Raelene West

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 State/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 people with a disability. The more predominant formal model of funding saw most people with a disability segregated and excluded from mainstream society and supported within the institutional setting. In the early 1970's, based on emerging international models of deinstitutionalisation, the Independent Living Movement and the Social Model, Australia shifted its policy response to disability away from that of segregation and institutionalisation, towards one of deinstitutionalisation and social inclusion. The *Disability Services Act 1986 (Cwlth)* was implemented as the dominant piece of legislation that would oversee this process of deinstitutionalisation and the establishment of a community based model of care for people a disability. With the realisation that a large expansion in service delivery would be required in establishing this community based a model of care, the Commonwealth State/Territory Disability Agreements (CSTDAs) were established to support the Disability Services Act. The CSTDAs aimed to clarify the funding roles and responsibilities of the State/ Territory and Federal governments in relation to disability service delivery, and create administrative efficiency between the two levels of government.

The CSTDAs however have emerged as problematic. As with much of the Australian health system, the split between the Commonwealth and State/Territory governments' roles in terms of overlapping funding parameters and jurisdictions, duplicity in administrative procedures and multiplicity in service program delivery has created fractures, lack of uniformity and a 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 the 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 in the CSTDA framework Home and Community Care (HACC) services, Commonwealth Rehabilitation Scheme (CRS) programs, insurance-based funding of

disability services (such as those received through WorkCover and Transport Accident schemes) and disability services funded privately as a result of public liability claims, have distorted the view of how disability service delivery is truly funded across Australia, and failed to provide an adequate picture as to many inequities in funding that exist across the disability sector.

In terms of the provision of health and community services programs related to disability service delivery, despite a population in Australia of only 20 million people, the Australian Institute for Health and Welfare (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, annual CSTDA national minimum data sets and increased awareness through public consultation.

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 many of the structural funding problems associated with the CSTDAs. 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.

The CSTDA framework, as it currently stands, only serves to reproduce and further fragment disability service delivery through its siloed and jurisdictional funding approach to disability service delivery. A nationalised funding 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 disability support services, significantly in providing funding to service delivery agencies at a local level that are more personalised and of increased quality

- The inclusion of insurance-based funding of disability services into the 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

- that disability data definitions are consistent with the International Classification of Functioning Disability and Health (2002), 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 - most particularly for people with a disability under 65 where HACC services are being utilised to meet the shortfall in disability service delivery. Hence, an expansion in funding for disability service delivery, allowing for the use of HACC services solely by the aged care sector and those with age related disabilities.

(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 funding 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 a 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 for people with a disability rather than a model that supported centralised and institutional control of people with a disability (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 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 and restructuring of the funding arrangements would be required to meet the outcomes of the new legislation (Ohlin and Group 1999). Funding of services appeared to be significantly

hampered by lack of clear knowledge of State and Federal responsibilities, duplication of administration, delays with processing requests and unwarranted interference across the dual levels of government (Monro 2003). It was surmised that neither the State/Territory's or Federal governments alone would be able to resolve the issues, and that to meet increasing need for services and implement a service model based on independent community living, a significant restructure in funding arrangements would be required within the existing multi-layered government framework.

(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 streamline funding associated with disability service delivery 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:

Advocacy – administered by both Commonwealth and State/Territory

Information - administered by both Commonwealth and State/Territory

Print disability services – 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

Employment Services – administered by Commonwealth*

Commonwealth Rehabilitation Service (CRS) – administered by Commonwealth*

Home and Community Care (HACC) program – administered by Commonwealth with states matching State funding; operationalised by the States*

*funding 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).

In terms of service delivery classification, 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 to obtain and/or retain paid employment through open employment or supported employment services (Productivity Commission Australian Government 2004; AIHW 2005)
- advocacy, information and print services –providing services to help people with disabilities 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

A review of the operationalisation of the first CSDA was undertaken in 1996 towards the ends of the first agreement. The review highlighted that 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). The review noted that 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). Further, the review noted that 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 employment related services that were administered by the Commonwealth, access HACC and generic community support services for daily support care needs funded by both the Commonwealth (but administered by the States/Territories) and State/Territories, access assistive aids and equipment from State services, 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 were being constructed across each State/Territory in Australia. The delivery of disability services in each State or Territory therefore came to be governed by differing arrays of legislations and guidelines and administered through differing forms of management and administrative processes.

In addition, the review highlighted significant gaps in the provision of services implemented under the first CSDA. The review highlighted 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 (Yeatman 1996). This was largely in light of difficulties associated with the lack of clear definition around eligibility and assessment criteria. These posed significant problems in that various classifications, interpretations and definitions of what constituted a disability were being used across different states and territories to determine levels of need for disability services. 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 with the 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 very boundaries of the CSDA and the 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 the 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 however 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 second 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 also included within the agreements in an effort to improve reporting mechanisms on service delivery effectiveness and accountability back to the Commonwealth (Yeatman, 1996).

Under the second agreement, Government expenditure on CSTDA services was again 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 (Productivity Commission 2004). In terms of overall CSDA funding allocations, 28.9 per cent of funding came from the Commonwealth Government, with State and Territory governments funding the remaining 71.1 per cent of services (Productivity Commission 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 2004).

In addition, it was identified that levels of outgoing funding for services at a Commonwealth level were not matching levels within State reporting. The utilisation of performance indicators in the second CSTDA designed to alleviate this problem were not 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?") also continued to be 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 2nd 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. Data collection had commenced in 1995, and on a year by year basis, and had been provided by a 'snapshot' of service usage collected over a single day. This snapshot of a day's utilisation of services had 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 daily snapshot would always be diminished.

The redevelopment of the CSTDA minimum data set in 2000 therefore sought to establish a means of data collection that would more effectively assist state based performance indicators within the CSTDA and provide a more effective basis for a review of services. The redevelopment sought to improve state-by-state breakdowns of services 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). Data collection would also utilise revised service type definitions to improve classification of 'disability' (Productivity Commission Australian Government 2004). The CSTDA minimum data set would adopt 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 CSTDA minimum data set was renamed the CSTDA NMDS (Commonwealth State/Territory Disability Agreement National Minimum Data Set) and was fully implemented nationally in October 2002. Funded agencies were now required to provide information back to the States/Territories, based on the new classifications, about all disability service usage throughout the year. The introduction of the redeveloped CSTDA NMDS was viewed as a move towards the clarification of recipient usage and improved identification of levels of disability service delivery. As quoted in the 2003-2004 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" (National Disability Administrators 2005). Although not providing a measure of 'quality' of services, the CSTDA NMDS had at least been revised to ensure that data collected reflected more accurate types of specialist disability services being delivered and relevant issues, trends and information needs associated with service usage (National Disability Administrators 2005).

The redeveloped CSTDA NMDS was also supported by newly obtained data from the Australian Bureau of Statistics (ABS) with publications such as *Disability, Ageing and Carers, Australia: Summary of Findings 1998* and information obtained from the national census related to disability and aging. Further, the release of the AIHW publications

such as *Disability and Ageing* (2000) and *Australia's Welfare (*2003; 2005) 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 NMDS, were hoped to more effectively provide a picture as to levels of efficiency, usage and overall effectiveness of service delivery at a national level.

(vii) review of 2nd CSTDA – 2002

A review of the second CSTDA Agreement was included within the Productivity Commission's *Report on Government Services 2002.* The report 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 of 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 2002).

The Productivity Commission Report supported the uptake of the CSTDA NMDS in an attempt to better meet required assessment criteria, but also to provide consistency with other major data sets, such as the HACC minimum data set (Productivity Commission 2002). The Productivity Commission supported the view that the collection of data on an ongoing basis would more effectively provide data on accessibility, appropriateness, efficiency and effectiveness of services (Productivity Commission 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 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. In particular, the inclusion of the CSTDA NMDS has appeared to provide a significant step towards improving the comparability and scope of reporting within the CSTDA framework (National Disability Administrators 2005).

Yet although providing a more detailed picture of the delivery of disability services on a state-by-state basis, limitations around the structural framework of the CSTDAs remain.

The CSTDA Annual Report 2003-04 report itself displays the array of different approaches and strategies being undertaken by each State and Territory. Under the section titled 'Progress by Jurisdictions', the Annual report, although only approximately 40 pages long, uses 20 pages to examine 'by jurisdiction' the roll-out by each State and Territory of the array of individual state services. The report demonstrates that each of the States/Territories 'jurisdictions' continue to fund disability services at different rates and with differing levels of accountability, obligations and priorities to users. Under the current CSTDA funding framework, 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 across states remaining difficult. Hence a complex framework of funding continues to fund disability services 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.

The CSTDA Annual Report 2003-2004 itself 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 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." (CSTDA Annual Report 2003-2004)

The BiLateral Arrangements underpinning the CSTDA between individual States/Territories and the Commonwealth 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 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 (CSTDA Annual Report 2003-2004).

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 of service delivery, and provide measurement of outcomes of government funded services for people with a disability. If this can be achieved given the difficulties in obtaining accurate data (and effectively contrasting this data) remains highly questionable (Productivity Commission 2004).

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 2004). The considerable levels of duplicity across each State/Territory also remain problematic with considerable administrative burdens of operationalizing each separate State/Territory disability service division.

Of further note**,** the current CSTDA funding framework for service delivery is also highly problematic for recipients requiring funded disability 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 levels of funded services if moving to another State or Territory. As anecdotally noted, one moves to the bottom of a new list if moving states. Additionally, users of insurance based disability service delivery schemes such as WorkCover and TAC, in some instances would fall onto generic state disability service systems if required to move interstate where no provisions by the listed but limited number of provider agencies could provide services. Of note, the TAC scheme documents a higher rate of charge for services able to provided interstate (TAC 2006).

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.

The ACROD CSTDA submission (2006) highlights:

The CSTDAs 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;

• 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)

(ix) CSTDA and HACC Interface

The CSTDA and HACC interface also continues to be problematic in terms of funding arrangements. The HACC program was designed to provide community care to predominantly the frail aged, in an attempt to provide services that would 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 utilise HACC services to make up the need for services they require to live independently within the community. 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, improving clarity of disability service delivery and need and providing specialised disability support services. The separation of HACC services away from disability service delivery would most particularly assist people with a disability under 65 and provide a distinction between disability services that are not age related. An expansion in funding for disability service delivery may then allow the use of HACC services by the aged care sector and potentially those with age related disabilities. The shortfall of disability services is highlighted by the Young People in Nursing Homes campaign where many people with disabilities are being forced into institutional facilities because of limited support services and where no other accommodation options are available.

In addition to a separation of HACC and specialised disability services, the expansion and strengthening of local government in providing the funding stream to support agencies would work towards improving the quality of disability support services. A nationalised funding system that provided funding directly to local governments, would create a more personalised and localised provision of services, with local governments having a closer and an improved knowledge of issues and problems specific to the local area and funding requirements (such as increased travel costs for isolated areas). A strengthened and expanded role in the provision of disability support services for local government would in

addition reduce duplicity in administration and allow closer and more effective monitoring of services provided by agencies.

(x) The CSTDA and health sector as a whole

In 2006, the issue of the funding split between the Commonwealth governments and State/Territory governments remains highly problematic for not only the disability sector, but the health sector as a whole. The split between Commonwealth and State/Territory governments is viewed by many as the dominant obstacle in achieving an effective national health system in Australia (Dwyer 2004). 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 the creation of a more efficient funding framework for the delivery of funded disability services. 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 of funded service delivery (Productivity Commission 2002).

Instead, the current delivery of funded disability services nationally therefore appears to remain fixed 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;

In relation to unmet need, it is apparent that 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 account for disability service delivery undertaken by primary carers carrying out informal and unpaid service delivery has meant significant levels of service need have not been adequately addressed for prolonged periods of time. A shortfall in funded disability support services appears to have placed may individuals and families providing informal care under strain for extended 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 data obtained within the CSTDA NMDS.

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 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 levels of unmet need on the ground in terms of provision of disability services appears substantial and appears to be unmet by the funding

resources within the CSTDA funding arrangement. This appears to be most evident in relation to levels of informal care provided by family members in the family home situation (AIHW 2003).

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

(i) alternative funding of disability support services – state based

It is also important to recognise that the State/Territory governments 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 funded disability services through the Department of Veterans Affairs, although operating at a Commonwealth levels, also sits outside of the CSTDA agreement. 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 through 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 services are truly funded (or not funded) across Australia. The failure to provide a comprehensive picture as to the multiple funding streams of disability services has inadvertently concealed many of the 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 for individuals sustaining an injury as a result of a motor vehicle accident 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 provided with what was defined as 'reasonable' and ongoing levels of disability support services as required irrespective of fault. Those who could prove fault were entitled to pursue further compensation through the courts, but all TAC clients remain entitled to ongoing funding of required support 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 scheme allowing compensation through the courts and ongoing funding of required support 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).

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).

(ii) alternative funding of disability support services – overseas examples

The complex, multi-tiered 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). The New Zealand system, irrespective of fault, provides ongoing support services to those acquiring permanent personal injury. Although with its own complexities and ongoing development, an Australian system modelled on the New Zealand system but inclusive of a capped common law system (such as provided by TAC) would serve to provide an effective model for a nationalised no-fault disability services support scheme. This scheme could incorporate the various funding sources (motor vehicle, workcover, VA) into a pool of funding and provide funding for services on a parallel pathway as generic services. A common law component could then still be maintained for acquired injuries within this framework.

Two articles listed below provide further information which serves to outline the New Zealand no-fault system and provide information as to how the nationalised scheme is effectively funded through a variety of sources.

S Todd, 'Negligence Liability for Personal Injury: A Perspective from New Zealand' (2002) 25 UNSWLJ 895.

Lichtenstein, B. (1999). "From Principle to Parsimony: A Critical Analysis of New Zealand's No-Fault Accident Compensation Scheme." Social Justice Research 12(2): 99-116.

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).

Supplementary Submission – CSTDA senate inquiry

As a supplementary submission, below is a summary list of issues highlighted at the Melbourne Evidence proceedings on September 28 2006. The serve to highlight general issues raised about the current operationalisation of disability service delivery in Victoria and across Australia.

Evidence summaries

CA 1
- Irregularity of agencies providing services due to funding constraints
- Example: Uniting Care Community Options, Australian Home Care Services, Royal District Nursing Services, St Vincent's at Home, A&E Program, CAS funding, Centrelink, local council, Bethlehem Health Care (respite),
- Heavy administration burden on clients

CA 2
- Lack of appropriate equipment (air mattress) leading to the need for hospitalisation
- Training of carers, lack of: low skilled work force
- Turnover of staff

CA 3
- Inconsistency of policy across different jurisdictions, in relation to carers work
- Lack of flexibility of support services for people with chronic progressive conditions, where needs change over time
- Interface between aged care and health funding streams
- The intersection of needed services with other sectors (eg access to built environment, transport)

CA 4
- Involvement of states in employment process for PWD
- Fragmentation in long term care and support, divided by age not need
- Questioning of 65 as beginning of aged care jurisdiction
- Significant waiting lists of people in acute need
- Sustainability of long term care and support structures?

CA 5
- No fault insurance for catastrophic injury (in Victoria, expansion of TAC across all catastrophic injuries not just transport to cater for exigencies of major health events such as asthma and stroke)
- Need to avoid increasing tax – "flagged social insurance levy"
- The difficulty of young people with high and complex needs fitting in to the current services framework
- Flagged national rehabilitation strategy – current responses reactive and *ad hoc*, a strategy that would also seek to assist people with degenerative conditions slowing the onset of symptoms of those conditions (reducing need for immediate implementation of services)

CA 6
- Pressure being placed on families to buy equipment when system is unable to provide funding for equipment, expansion of resources required
- National equipment program

CA 7
- Brokering facility of services – role and responsibility of case managers from one agency often brokering across agencies for services

CA 8
- Standardizations of individualized funding approaches (eg work based personal assistance schemes – work place assistance schemes that would assist with mobility and environmental control)
- Commonwealth administers individualized funding through the providers, so incentive is with provider outcomes not client outcomes

- Effects of Welfare to Work placing conditions on receiving of services versus flexibility of individualized support??

CA 9

- Seeking an improved consistency in the funding of disability services, blurring of disability policy and welfare policy??
- Support services with people with chronic services only seem to kick in when people fall out of work (double disadvantage of disability and unemployment): no capacity for the state to help with job retention
- Model of tagging people through the system: needed because of lack of systemic responses in place; "a more proactive system" – regular checks and reviews on maintenance of services rather than having to continually prove need to be provided with services

CA 10

- Gap upon turning 18 of services that emerges, pwd 16 in nursing homes as cannot access DSP; shortfall with parents paying differences;
- Measuring unmet need – 6500 in nursing homes; discouraged pple not putting themselves on waiting lists ; how many others require services;
- SA one entry point, one exit point (queues instead are internal)
- Education for pple to be aware of need to list services required, register

CA 11

- COAG agreement – YPINH: shifted landscape
- Waiting lists won't accept people that are prospective; it is not known – how much is enough
- States with not enough financial resources to meet need

CA 12

- Community expectations; spending money to invest in people, invest in people that need our support;
- Duplication of services; lack of general services AH means emergency services are often used at dble cost to compensate
- Prevention of backfilling of places once COAG YPINH agreement is implemented; pple with unmet using places (!); 4 states have signed bilateral agreement however it is not even enough to cover target gp under 50 and address first 2 criteria of bringing pple into alternative accommodation, or delivering services to the home. Lack of coordinated national response - vigilance; each state managing things there own way

CA14

- set of standards and obligations to need rather than multilateral agreements

CA15

- measuring outcomes not output
- the overflow of people with complex needs who could not get a service in the disability sector flowed into aged care.

CA 25

- ANOA -Accountability of FACSIA and bi-lateral agreements – lack of state reporting
- What does a state-of-the-art service system look like? At an individual level or at a state level?
- Eligibility and identification defined differently across the states e.g. alcohol brain injury is not considered an ABI but medical condition in SA
- System that allows pple to move around the country – consistent approach
- Disruptions caused by pple moving jurisdictions to seek better services
- Discussion on how accommodation places are determined in Vic – ABI strategic plan;
- Little choice, low chance of moving once in a facility

CA 27

- ABI, SCI static; MND, MS, FA degenerative
- Funding of advocacy under NADP state and fed

CA28

- Issues with rural advocacy – no specialist ABI services in rural areas; difficulty with traveling and attending specialist appointments; need for extra care hrs

CA 29

- Patient assisted transport scheme – PATS

CA 31

- Waiting lists for services
- Unrecognized role of unpaid carers

- Where children of aging unpaid carers be accommodated if primary carer dies
- States decide on the models of care/ funding

CA 32
- Lack of recognition in Fairer Victoria and in new Disability Bill legislation
- Turnover in getting home modifications completed

CA 33
- Lack of application of O,H & S guidelines for unpaid carers
- Inability to move states without starting at the bottom of applying for new services – equal right to move as any other Australian Citizen

CA 34
- Population based benchmark funding of disability as applied to aged-care i.e. disability services be funded on a number of places per 1000 of the population base. Aged Care funded at 108 places per 1000 of the population over 70 (with an incident rate of 22.5 of severe and profound disability). If applied to disability –pple under 65, that would provide 18 places/1000 pple – i.e. 238,940 places and packages. Further breakdown CA 41

CA 39
- NSW $1.2 billion over 5 years for carers

CA 40
- Liability by families/WorkCover of a home workplace – gap in Vic system
- Commonwealth assume responsibility for all accommodation and respite, HACC services, respite, support services – including facility and in-home intensive support - CAPS equivalent ; FFYA
- Supports combination of aged-care services and disability services to enable pple to age in place.
- Inflexibility of services over time in relation to changing needs - once pple placed in shared accommodation, funding is fixed. Aging and changing needs – life course perspective; "person centered" and reviewed regularly, funding matching needs
- Pple under 65 with disability with onset of age related condition (dementia, alzheimer's), can't be moved into aged care facility even though they have terminal condition
- Inability to plan for services of child with disability in future;
- Split between disability and health services
- Complex needs – Victorian Dual Disability Service
- Innovative Pool – aged care interface; Community Aged Care Packages topping up services study : Jenny Hales top-up amounts were cheaper than a RACF placement

"When you talk about equity, the point needs to be made that people living in disability accommodation, people receiving disability services, are receiving those services because they are citizens and because the aim is to equalize the opportunities and the quality of life available to those people so that they can access and participate in the rest of the community."CA48 Senate Committee Inquiry CSTDA 2006

- A structural issue about being able to provide appropriate amount of support when they are living in accommodation services and when they are not employed.
- What is lifelong disability related and what is additional age related need.

"We need to regard people with a lifelong disability who are aging as <u>citizens who have the right</u> to stay in there own homes and not in congregate care until such a time when they really need intensive nursing care, the same as other older people" CA50 Senate Committee Inquiry CSTDA 2006

- Age related disorders before 65 creates gap
- Disability services are currently tied to service provider and not the individual; service orientated rather than individual orientated
- Qld model – pple given a global package calculated by reference to their level of need; rather than segmented services for different aspects of their disability

CA 58
- Quantative measures of un-met need; accountability;
- Moving from an output based structure around data collection systems that the CSTDA does have to an outcomes measure of success or lack of success
- Are there structured agreements where the driver is an outcomes based measure of success/ outcomes based example

CA 61
- SOLUTION TO PROBLEM
- Not building further housing stock; new is replacing old but no additional

CA 62

- Role of carers in new Disability Act Vic – reference recognizing the value of carers/families; rights of carers and rights of pwd; concept of Absolute Rights; rights of last resort
- Jurisdiction of Cwealth and States – re supported accommodation;
- Aging in a state provided disability accommodation service

CA 63

- Pwd competing in public housing market bc of unmet need in public housing; missing opportunities, increased stress on carers;

CA 65

- Vic Gov – no clear measures of effectiveness in delivering improved outcomes, few or limited strategies bw jurisdictions around respective funding. 'outcome focused partnerships',
    - Dvlpt more accessible community based housing
    - Individualized flexible packages of support
    - Increased access to employment
    - Joint approach to the provision of aids and equipment
    - Support for carers

- More coordinated approach to employment opportunities for school leavers
- Increased funding allocation from CWealth – estimated $40 million shortfall over life of current CSTDA
- Rate of indexation of real costs is not matching service requirements, reducing sustainability
- Looks to HACC model for boundaries bw agreements, shared outcomes and serviced pathways.
- Vic Gov changing days program – working w pple in day programs to create more flexible day options – combinations say of day activities, programs, employ
- 100 pple moved out of shared supported accommodation by utilization of individualized support packages- those places have been back-filled. Average package range $10000 to $50000; Assessments through regional assessment panel;

CA 78

- Numbers of individuals in respite facility….w support pckgs, should CSTDA stipulate numbers allowed in one facility?
- Catastrophic injury compensation scheme; those born w disability receive nothing: concept of 'delivering a package depending on a person's disability'
- Who would Pay for a scheme?

CA79

- Those outside TAC / VWA on state services that acquire a catastrophic injury funded by an insurance scheme rather than through state budget.

CA 80

- Pool of funding for catastrophic injury, from council and doctors premiums. 'Magic Pudding' comment on not feasible to have someone else paying insurance, states paying less and pwd getting more assistance.

CA 82

- OH&S of carers in the home; VWA incident – family liable
- Current state response to same issue

CA 83

- Possibility of standards for carers workplace in home such as those for electricians, inclusion in CSTDA?
- States to indemnify carers against liability

CA 84

- Supply issue of accommodation for pwd whose primary carers are ageing and over 65, not enough places for them to move out, not enough resources; future planning

CA 87

- Aged care fairly uniform; possibility of standardization of programs across Australia for disability; allow movement from state to state; inability to carry package from region to region, let alone state to state; National agreement on portability; On standardization – nationally agreed outcomes, outlined expectations about what pple

can receive across the country; around their community participation, living, employment and other things; agreement on standard and measurable outcomes.

CA 103

- How much in percentage is advocacy work commonwealth and how much is state?? Employment advocacy commonwealth, services state, or systemic advocacy, say inability to access local cinema
- Recommendation into advocacy funding framework
- Levels of individual vs systemic advocacy that exist

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