Tasmania

MTS No.: 30694

MINISTER *for*
HEALTH *and* HUMAN SERVICES

9 AUG 2006

Senator Claire Moore
Chair
Senate Community Affairs References Committee
PO Box 6100
Parliament House
CANBERRA ACT 2600

Dear Senator Moore

Thank you for your letter of 23 May 2006 to the Premier of Tasmania, Hon Paul Lennon, MHA, inviting the Tasmanian Government to provide a written submission on issues to be covered by the Senate Community Affairs References Committee's inquiry into the funding and operation of the Commonwealth State/Territory Disability Agreement.

The Premier has requested that I respond directly to your request.

Please find attached a hard copy of the Tasmanian Government's submission. I will ensure that an electronic copy of the submission is also forwarded to the Committee as requested.

Should the Committee require further clarification or information regarding the submission I have arranged for details of a contact officer to be forwarded to the Committee Secretary, Mr Elton Humphrey.

On behalf of the Tasmanian Government I would like to thank you for the opportunity to provide comments on the issues to be examined by the Committee.

Yours sincerely

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Tasmanian Government Submission
to the

Australian Senate
Community Affairs References Committee

Inquiry into the funding and operation of the Commonwealth State/Territory Disability Agreement (CSTDA)

1) Intent and Effect of the three CSTDA's to date.

The first Commonwealth State Territory Agreement (CSDA, 1991-1997) was a significant event for people with disabilities and the disability sector. For the first time the issue of provision of specialist disability services was framed within a national context with particular emphasis on common standards of service provision and comparable performance data.

The major achievements of the first Agreement include parallel Commonwealth/State/Territory legislation and a clear delineation of Commonwealth and State/Territory government roles. The first Agreement also commenced joint planning and policy initiatives, provided a real and substantial funding increase and established National Disability Service Standards to underpin quality assurance processes.

The first Agreement did not focus on the identification of interface issues with other programs nor were there any specific planning strategies to meet growth in demand or address unmet need. Other issues which required attention concerned transparency, accountability and the lack of comparable performance data.

The second CSDA (1997-2002) built on the achievements of the first Agreement and attempted to address some of the shortcomings. The second Agreement included a national framework for disability services and a capacity for bilateral negotiations to target funding towards strategic issues in particular jurisdictions. There was also a coordinated approach to addressing unmet need with an injection of an additional $510 million nationally over the life of the Agreement. The first interstate service portability protocols were also developed at this time.

As with the first Agreement, one of the main failings of the second Agreement was the narrow focus on management and operation of specialist disability services with an absence of any broad strategic policy direction in terms of engagement and interface with other comparable programs, particularly in the health, aged care, home and community care and housing sectors.

The third CSTDA (covering 2002-2007) was the first Agreement to require a growth commitment from State/Territory governments (bilaterally agreed) as a condition of the Australian Government signing an agreement.

The Agreement was negotiated in a policy environment which included a growing focus on the importance of carers and families and the role of community; the Australian Government's Welfare Reform agenda and the introduction of a new taxation system in 2000 which provided for the distribution of GST funding to States and Territories.

Within this environment the Australian Government largely concentrated its' growth contribution to advance reforms in the disability employment sector rather than growth of the sector as a whole.

Responsibility for addressing growth in demand and unmet need in accommodation and support was now seen as primarily a State/Territory responsibility. In contrast to the second CSDA the third CSTDA did not include any commitment towards unmet need.

The third CSTDA remains primarily a funding agreement. However significant changes were attempted to broaden its focus including a preamble outlining the commitment of all governments to people with disabilities, the inclusion of five policy priorities which have informed the Work Plan of the National Disability Administrators (NDA) and the capacity for States and Territories to enter into bilateral arrangements with the Australian Government, based on locally identified initiatives.

The shortcomings of the current Agreement include the lack of long term agreed strategies to address and manage growth in demand and unmet need; the lack of a framework for achieving whole of government coordination and collaboration around access to generic services; ongoing gaps and interface issues with other program areas, particularly aged care, home and community care, housing and health and an increased lack of clarity regarding joint funding responsibilities.

2) Commonwealth/State/Territory joint funding arrangements – analysis of unmet need, particularly accommodation services and support.

Evidence from a number of sources indicates that the overall service system for people with disabilities continues to be under increasing pressure in terms of growth in demand and unmet need, impacting on service and financial viability.

A report by the Australian Institute of Health and Welfare (*Unmet Need for Disability Services: Effectiveness of existing funding to reduce unmet need (Report to NDA, 2005)*, identifies a number of factors driving growth in demand, including an expanding eligible population attributed to improvements in medical technologies and the ageing of the population. Disability Services now deals with a significant number of clients who require specialist services to meet both disability and ageing related needs. There are unresolved interface issues with the aged care, home and community care and the general health system in relation to these clients.

Demographic trends both in terms of ageing of clients and primary carers (*ABS 3222.0 – Population Projection, Australia, 2004 to 2010 – Series B*) give rise to concerns about the sustainability of informal care arrangements.

Growth in demand is also exacerbated by the effects of reforms in other service systems such as access to affordable housing and health services, changes to employment/income support, access to HACC programs. In many cases these programs have redefined their boundaries (in terms of core business and capping of service levels). This has resulted in severely limiting the capacity of people with disabilities to engage with the broader community and has lead to premature entry into more formal, out of home, support services, particularly accommodation support.

Research by the NDA also indicates that the disability sector is facing a staffing shortage over the next ten years given the estimated increase in clients in both the disability and aged care sectors.

Despite significant reforms pursued by jurisdictions, particularly around policy frameworks in areas of assessment and eligibility, there are still no clear or universally accepted parameters around core service provision, service levels and demarcation or joint protocols with related programs such as HACC, Aged Care and Housing.

The real annual level of growth funding required merely to maintain the current balance between supply and demand has been estimated at 8.35% (*Funding and External Change, Final Report - Social Policy Research Centre, University of NSW, 2002)*

Part of the growth component is indexation. There are issues around a commitment to standardised indexation levels across jurisdictions. Tasmania currently (2006/07) provides 4% indexation to funded community disability organisations across the board. The Australian Government provides indexation of 1.8% for its funding contribution ($20,754,232 or approximately 20% of total funds) under the CSTDA (Commonwealth Department of finance Wage Cost Index 2). The Tasmanian government therefore in effect subsidises the Australian Government's contribution by 2.2%.

However, even a total annual growth component of 8.35% will do nothing to address the existing unmet need. Substantial funding for unmet need was committed during the second CSTDA and this was rolled into the base of the current CSTDA. Unfortunately the current Agreement has no commitment towards addressing unmet need in terms of a viability issue for the whole sector.

The current CSTDA does provide some bilateral funding commitment around respite care for older parent carers, but it is debatable whether these efforts are properly targeted towards actual areas of greatest need.

Unmet need in accommodation services and supports should be analysed as a symptom of the inadequacy of current community support systems as a whole, and this issue is broader than just the disability sector. The failure to maintain and support people with disabilities in their own homes or local communities will inevitably result in increased demand for more formalised support services such as ongoing residential care.

The current inadequate response is not purely a result of lack of resources; it is also influenced by the lack of strategic targeting of effort in areas such as early intervention, building family and community capacity and ongoing interface issues with community equipment programs, HACC programs and community Aged Care programs.

In terms of the CSTDA there is a need to attempt to build in formalised linkages between relevant and similar programs, preferably through existing Commonwealth/State/Territory agreements such as Australian Health Care Agreement (AHCA), Home and Community Care Agreement (HACC), Supported Accommodation Assistance Program (SAAP) and the Commonwealth State Housing Agreement (CSHA).

3) Ageing/Disability interface – jurisdictional overlap and inefficiency

Current trends within States/Territories are to attempt to facilitate 'ageing in place' for people with disabilities who are ageing. This means that disability funded supported accommodation organisations have taken on responsibility to meet/coordinate the additional support needs of this client group. In fact relatively few people move from disability accommodation services to residential aged care (27 nationally in the past 2 years (*NDA – Ageing with a disability – Summary of findings – Fyffe, Bigby & McCubbery, February 2006)*).

Supporting ageing 'in place' involves organisations having to build capacity in order to vary service provision in areas of number and skill mix of staff, and often increasing staff to cover lack of day/employment programs. Other additional needs include modifications to the physical environment, additional aids and equipment, and changes to internal planning including redefining 'core role and responsibility'.

The trend for increased ageing 'in place' has been influenced by a number of internal and external factors. Disability shared accommodation services have displayed an increased willingness and capacity (in terms of knowledge and skills of staff, not necessarily in terms of resources), to cater for this group.

Another major factor has been the Aged Care Assessment Teams (ACAT) practice, within Tasmania, of not generally assessing or referring clients younger than 65, apparently based on the belief that shared accommodation services (disability) should continue to provide support and the fact that residential aged care will not accept clients who are ageing prematurely because of compatibility issues.

Ageing 'in place' has occurred on one level due to a shift in the philosophy of service provision away from residential care towards in-home or community based support, but it has also occurred due to the aged care sector limiting the options of access and the lack of appropriate aged care services available for older people with disabilities, particularly those ageing prematurely.

As a result 'ageing in place' is occurring basically within the existing resource base of disability organisations without any additional funds either from the CSTDA or any transfer or joint funding arrangements with the aged care or other related sectors such as HACC.

It is unclear to what extent ageing in place has been successful in terms of older residents having their health care needs met and to what extent the current trend of ageing in place is actually sustainable. Appropriate service levels and service response requires a conceptualisation beyond 'ageing in place' simply being a case of not moving to a residential aged care facility.

There has been no development of 'ageing in place' in terms of a conceptual service model/response. Key components such as the nature, range and scope of service provision, key service providers, partnerships or key stakeholders are all under-developed.

As already pointed out there is little movement directly from disability services to the residential aged care sector. Where movement does occur it is mainly indirectly via the acute care or rehabilitation systems, following a traumatic event such as an accident or serious illness, and the level of support, mainly nursing, cannot be sustained in the disability supported accommodation.

HACC Interface:

The NDA study (*Ageing with a disability – Summary of findings - February 2006*) found that all jurisdictions had significant difficulties in accessing HACC, and other community based aged care services, for clients in receipt of disability services, regardless of their age.

Not only is access a real difficulty but where services are provided there are issues of inconsistent service provision, differences in funding and allocation of resources, business rules and service philosophy and priority, leading to duplication in reporting and accountability frameworks, standards monitoring and data provision.

A prime example is the provision of individual support (in-home personal care/personal support) for clients in the community. Many clients will receive this kind of support in Tasmania from Disability Services and/or from the HACC program.

In Tasmania clients can receive an individualised funding package through Disability Services Individual Options Program. This will provide a guaranteed level of support (in terms of hours per week), funding that is individualised (allocated to the client not the support organisation) and portable (clients can choose their service provider and can move from one service to another).

The program has its own guidelines, assessment procedures for eligibility and support levels, standards monitoring and evaluation and business rules (i.e. banking of unused hours), data recording and reporting (Disability Services Minimum Data Set).

The HACC program also offers personal support but it is not individualised (block funding to organisations), support levels are not guaranteed, support dollars are not portable, there are different assessment criteria, different upper service levels, different reporting and data recording procedures for service providers and different business rules.

Reforms within the HACC program over the past few years have seen a real reduction in the upper limit of support hours available to high support clients. The burden of support and cost to make up the difference in hours lost by clients has fallen on disability services.

There is an obvious inefficiency and lack of coordination between the two programs providing the same type of support to people with disabilities. Cost shifting due to different business rules, duplication of reporting and data provision requirements for government and non-government service providers and inefficiency and uncertainty in attempting to build cross/program support packages for clients are all hindering optimum service provision to clients.

ACAT (Aged Care Assessment Teams) Interface:

ACATs are the gatekeepers for access to residential aged care and eligibility for community based aged care and other health and ageing specialist services. Aged care legislation stresses functional rather than chronological ageing but the vast majority of clients are aged over 70. There appears to be a clear operational preference/policy not to assess people under the age of 65-70, and not to refer younger clients to residential aged care facilities.

ACAT's apparently find it difficult to assess people with disabilities who are ageing citing lack of appropriate assessment tools, difficulty building up a case history for people with life long disabilities and lack of clinical records to assist in differentiation of disability and ageing related issues.

Residential Aged Care Providers Interface:

Residential aged care is considered appropriate for older people with disabilities (65-70) who require high levels (daily, up to 24 hours per day) nursing care. Aged care providers are however in effect the gate keepers and will often refuse access to ageing people with disabilities citing issues around compatibility. Again compatibility is mainly measured in terms of age and therefore excludes younger people with disabilities who are ageing prematurely.

Both sectors (residential aged care and disability) are concerned about the appropriateness of residential aged care for older people with disabilities, not just because of compatibility but also in regard to focus and philosophy of service provision.

Residential aged care's primary focus is on nursing care rather than a whole of life approach which is more relevant to people with disabilities who are ageing prematurely.

The interface between residential aged care and disability services does not, given the low level of client movement between the services, represent a significant response to ageing clients with a disability receiving accommodation support through CSTDA.

Initiatives around younger people with disabilities in nursing homes have highlighted the need for alternate service models and responses for this client group, which also may be relevant to older ageing clients with a disability. These include specialist nursing homes and/or specialist disability shared home accommodation with funding support from the aged care sector.

General Interface Issues:

Recent surveys (*Ageing with a disability – Summary of findings - February 2006*) show that most older residents living in shared disability supported accommodation are ageing in place within the disability sector. This is partly due to tightened access to aged care facilities and concerns about the appropriateness of placements, highlighted by the younger people in nursing homes issue.

Ageing in place as a concept or service response is occurring within existing disability services resources without additional funds through the CSTDA, the commonwealth aged care sector or other related sectors.

There is no specific national policy direction in this area, with jurisdictions and program areas mainly concerned about program boundaries and preventing cost shifting and double dipping by issues. There has been no concerted effort to establish joint partnerships instead program boundaries have been redefined to prevent access, both at a local and national level.

Current disability services policy is to promote a whole of government approach to access and support for people with disabilities but the reality is that the needs of people with disabilities, and the necessary expertise are not recognised or promoted within the health care or aged care system.

There is a need for a consistent commitment at policy level to develop cross sector partnerships, and improve the interface between disability and health care sectors. There is also an urgent need for protocols between hospitals, disability services and providers of aids and equipment to facilitate effective discharge planning and community based support packages for people with ongoing disabilities leaving hospitals.

4) Alternative funding, jurisdiction and administrative arrangements.

There have been a number of reports that have considered the operation and effectiveness of the current CSTDA. A performance audit was conducted by the Australian National Audit Office (*Administration of the Commonwealth, State, Territory Disability Agreement – Department of Family and Community Services.*) which identified a number of areas of concern including the need for a conceptual model for the assessment of eligibility, level of support needs and determination of relative priority for service provision.

The report also noted the absence of high level performance measures and the need for improvement in collection and accuracy of performance data.

There has also been some discussion around the development of a theoretical accountability framework and the belief that an outcomes/outputs framework would be preferable to the current input control model used in the CSTDA. An outcomes/outputs model assumes that safeguards and well defined measurable outputs and performance indicators can be designed and agreed upon (*Heads of Treasuries Report 2005 – Commonwealth, State and Territory SPP Working Group.*).

It may be difficult to retain a comprehensive multilateral agreement without some level of input control but that does not preclude a greater emphasis on output/outcome measures. Such a framework could enhance collaboration between jurisdictions and program areas particularly around more complex systemic issues.

There is an ongoing need to have some kind of framework or mechanism to advance whole-of government disability specific initiatives, such as the COAG commitment around younger people in nursing homes.

A focus on outcomes will also support innovation which retention of a multilateral input model may stifle to some extent, purely in terms of the ability to respond to local service delivery issues such as geographic and demographic disparities.

A comprehensive agreement does entail substantial administrative commitments and reporting requirements in order to advance national policy and planning priorities, research and data and information development.

An alternative to a comprehensive agreement could be a funding/administrative only agreement which would still specify a level of effort by jurisdictions and retain development and provision of data to support policy and planning. Such arrangement could provide greater flexibility and innovation on a local level however progression of national policy priorities may be reduced in the absence of an agreed framework.

This option may also be contrary to community expectations as nationally consistent approaches may be compromised. There would also be a diminished capacity for meaningful engagement with other critical service areas such as aged care and HACC.

A comprehensive CSTDA could also be replaced by the Australian government only entering into bilateral arrangements with jurisdictions, or other purely financial payments system which may still retain agreed roles, functions and responsibilities for the delivery of specialist disability services.

A major disadvantage of this approach would be the potential loss at a national level of collaboration around data development, strategic planning and the standing and status of disability as an issue of national concern and priority.