THE AFTERMATH - CARING FOR ACCIDENT VICTIMS IN NEW SOUTH WALES

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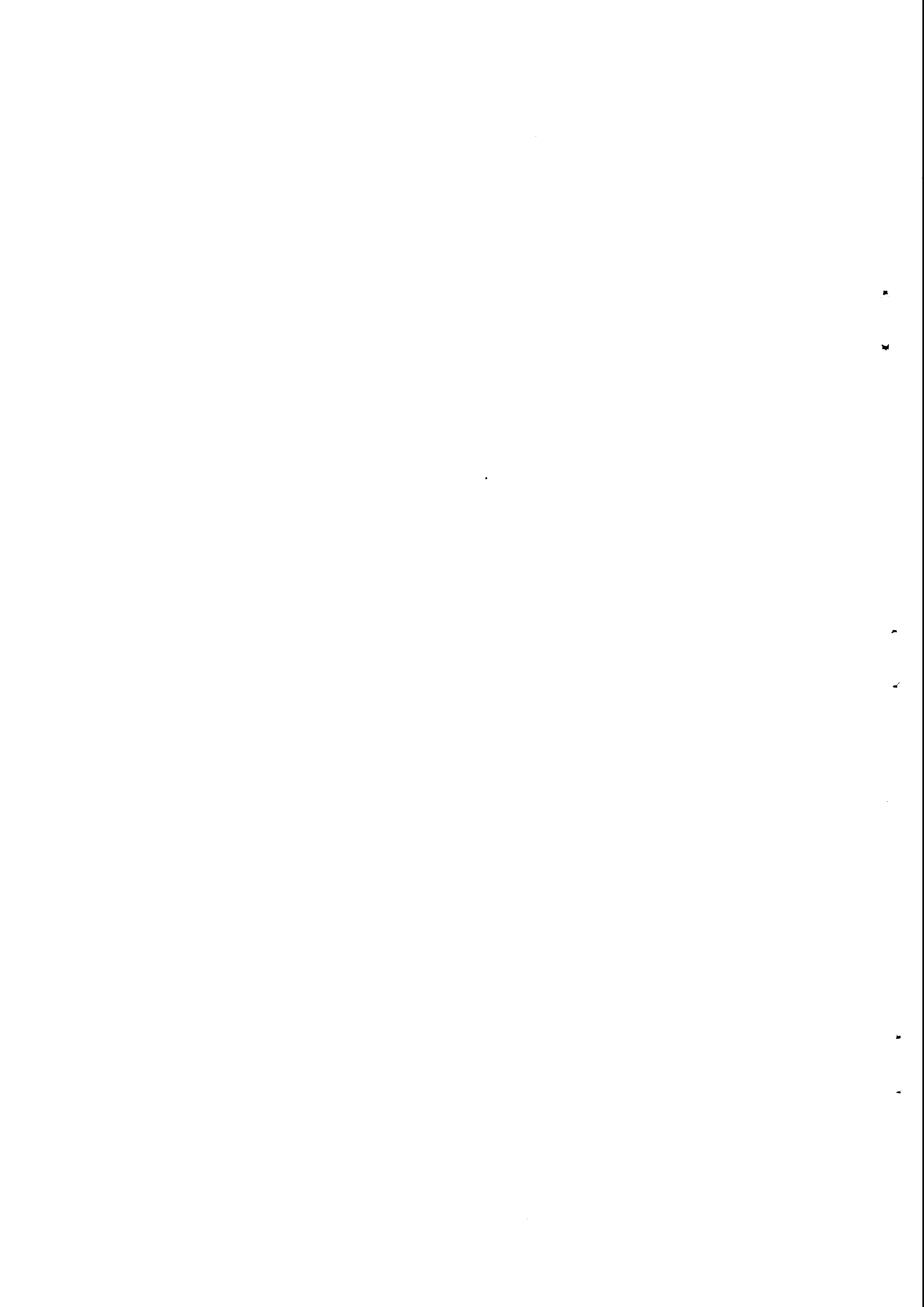

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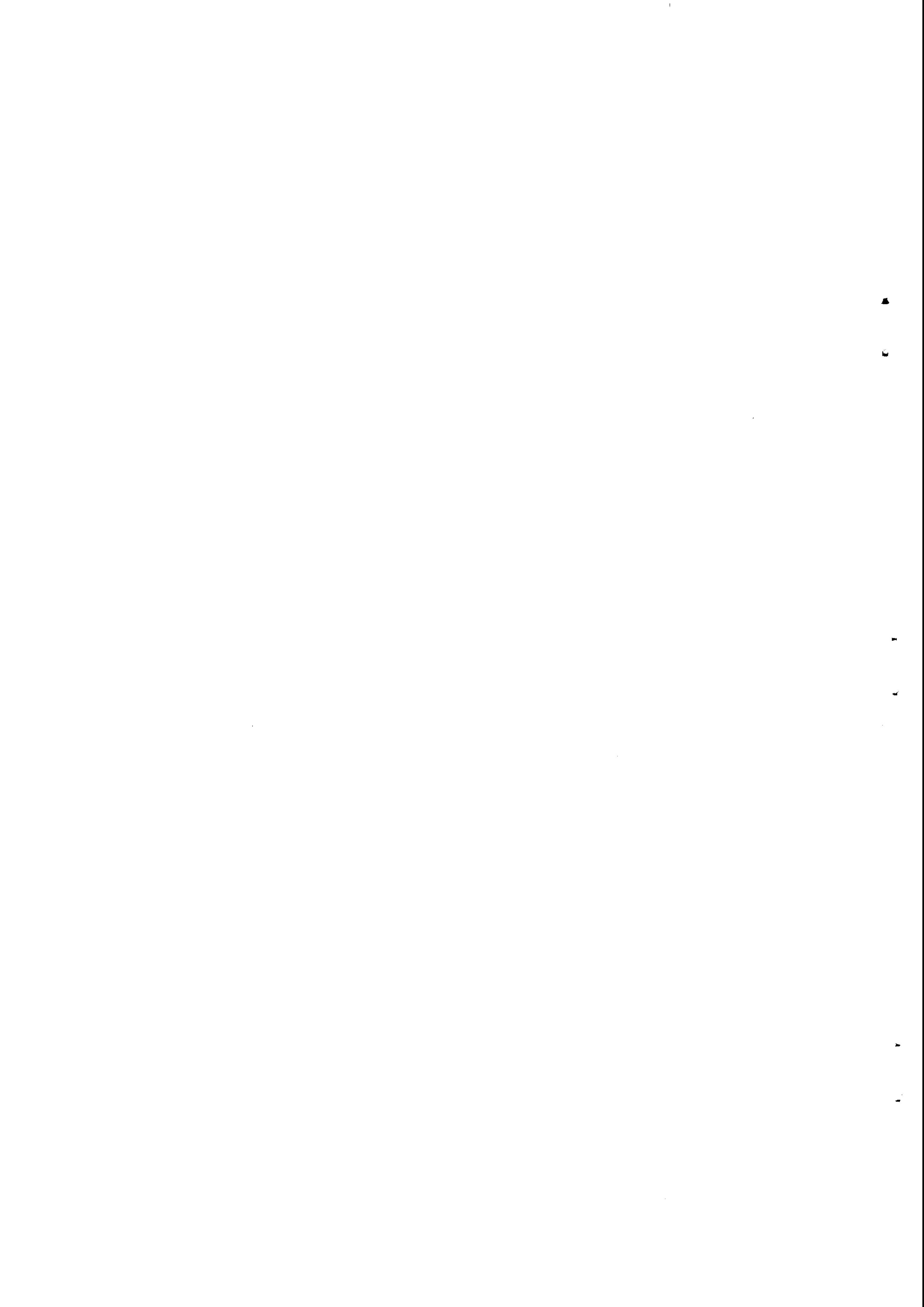


THE AFTERMATH - CARING FOR ACCIDENT VICTIMS IN NEW SOOTH WALES

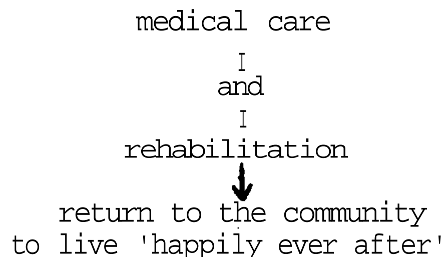
CHAPTER ONE

INTRODUCTION

1.1 Post accident care

It is a pity that the word 'rehabilitation' is so widely used in relation to the care of the injured, the sick and those suffering from some developmental disorders. A pity because while rehabilitation is an important part of the care of many persons within those groups, a substantial number within each group will need long term or lifelong support and care of various kinds, kinds which cannot really be described as rehabilitative. And another substantial number within those groups do not need, indeed cannot be given rehabilitation, because their problems started so early in life that what they do need is 'habilitation'.

For many accident victims, the sequel to their accident does not follow the pattern of



That picture fails to show that post accident problems frequently do not end when a definable 'rehabilitation' process has been completed. In fact in many cases that definable rehabilitation process is terminated, rather than completed, because the agencies which define their role as providing rehabilitation can offer either no, or no more help. But of course the

accident victim's problems do not end there, and help may be sought from one or more of a bewildering number of potential sources whose role is then not rehabilitative but supportive, providing either continuous or episodic care, perhaps for the rest of the victim's life.

In cases where the rehabilitation process is apparently completed successfully, problems which can be related back to the accident may arise - for example the emergence of late sequelae of trauma, the failure of 'lump sum' compensation to provide adequate income - and again the accident victim will need 'post-accident' care or assistance.

In our report we use the term post accident care to embrace all aspects of the care needed by, and sometimes provided to those who have suffered physical or mental trauma resulting from accident.

1.2 The post-accident **'maze'**

Whatever the cause of a serious 'accident' - a genetic aberration, physical trauma, degenerative disease - the aftermath will be a journey through a maze of services and agencies. Travelling through the maze the accident victim may be supported, helped, and sometimes hindered by a variety of professional and ancillary workers, by a formidable array of legislation, legal and administrative procedure, by family, friends and fellow victims.

Among the determinants of the path followed by the victim will be the nature of the accident; how, where and by whom it was caused; the kind and extent of injury suffered; the victim's age, sex, ethnicity and marital status; educational, occupational, socio-economic and insurance status prior to the accident; the advice given to and the decisions made by or for the victim after the accident. Some victims will find a short and speedy path through the maze/

for others the path will be more lengthy and take longer to traverse; some will never really escape the maze but will remain for the rest of their lives either deeply entrapped or less tightly bound around its periphery.

This survey attempts to describe the major elements of this maze, the commonly travelled paths within and through it, the problems which are encountered both by the traveller and those who work within it.

1.3 The needs, the providers and the programmers

1.3.1 For purposes of description, evaluation and comment it is convenient to divide the broad field of post-accident care into three major sectors

- the needs
- the providers, and
- the programmers.

1.3.2 The needs

Under this rubric are placed the wide array of post-accident needs. The major groupings of need to be considered in our review are

- income maintenance
- medical care, including medical rehabilitation
- equipment, prostheses, aids and home modification
- information and counselling
- accommodation
- daily living needs
- education
- vocational assessment, training and placement
- social and recreational activities

Not all these needs will necessarily be felt by a particular accident victim, and the constellation and relative priority ranking of that victim's needs will vary from time to time.

1.3.3 The providers

This heading covers the persons and agencies directly concerned with meeting the needs of accident victims through the provision of services, goods and money, or less directly through the provision of funding to agencies and people dealing directly with them.

The following sub headings embrace all the major provider groups

- the Federal Government
- the N.S.W. Government
- local government
- non-government, not-for-profit agencies
- non-government, for-profit agencies
- relatives and friends of accident victim
- 'self-help' agencies

1.4 The Programers

The third major heading serves to bring together a group of agencies whose activities are concerned with the identification of accident victims' needs and the development of means whereby those needs may be met. These programming activities include

- policy making
- planning
- advising
- coordinating

- advocacy
- evaluating

1.5 inter-relation of needs, provision and programming

In an ideal situation the programmers would ensure that the provision of services, goods and cash exactly matched needs. In reality this is not always so, as we shall see. And, again we shall see, an agency may be a provider and also engage in programming. Commonly, too, a provider will endeavour to meet a variety of needs; some agencies have as their objective the meeting of a range of needs so as to provide a relatively 'comprehensive' service; others are predominantly concerned with meeting one or a few relatively limited types of need but also attempt to cope with some other needs which arise incidentally.

The relationship of the three sectors described here is illustrated on page 12 in Figure 1.1.

1.6 Oar modus operandi and information sources

Our brief was to describe the rehabilitation and 'after-care' services available to victims of motor vehicle accidents in New South Wales. As we have noted, the needs of these victims are not, with a few exceptions, different from those of people who have the misfortune to suffer other types of accidental injury or misadventure. Nor, with few exceptions, have services been established to deal with the problems posed by the sequelae to motor vehicle accidents. Therefore a full examination and description would entail inquiry into a very wide range and an enormous number of agencies and activities in the health and welfare field. Merely to list the agencies is a daunting task - the Handicapped Persons' Services Directory published in 1982 by the N.S.W. Council of Social Service took 180 pages, each listing some six or seven named

agencies, to present What was acknowledged to be an incomplete catalogue(1). Most of the agencies listed could be involved in one or more aspects of the rehabilitation or after care of motor vehicle accident victims. Hundreds more, for example most public and private hospitals and nursing homes, were not listed as separate entries, although any one of them might be called upon to provide such care for these victims.

At the outset it was obvious that, given the fourteen working weeks (September-November 1983) allotted to this review, we found several important constraints, including

(a) time and distance limited the number of personal visits that could be made to agencies;

(b) assuming a readiness and ability of agency staff to complete a postal questionnaire, the conduct of a large scale mail survey was impossible because of lack of time for adequate 'reminder' follow-ups and for collation and analysis of a large mass of data;

(c) the great differences in agency size, function, organizational characteristics, location, et cetera precluded anything in the nature of probability sampling; and since the characteristics of many agencies were but sketchily documented, the drawing of a 'representative' sample posed great problems;

(d) the routine operating statistics recorded by many health and welfare agencies are rudimentary, therefore only very limited information regarding utilization of agency services by motor vehicle accident victims is available at relatively short notice, if at all;

(e) we lacked the resources to carry out anything approaching a valid evaluation study of the services available or provided; for many of them no proper evaluative criteria have yet been formulated; thus any evaluative comments we would offer would be based largely on broad criteria, impressions and anedotes.

Recognising these difficulties we decided to seek information from three sources. The first of these was a collection of published and unpublished, official and unofficial material in the form of directories; annual reports; reports on special studies; 'public awareness' booklets and pamphlets; journals, magazines and so on emanating from agencies concerned with welfare rehabilitation and aftercare; legislation; procedure manuals, et cetera. Some of this material was located through systematic searches in libraries, some from individual agencies, some from personal contacts.

The second source of information was a relatively small-scale postal questionnaire survey. A questionnaire relating to agency objectives, services provided, facilities available, administration, staffing, finances, charges to recipients of services, clientele, case load, case mix, outcome of contacts, problems and plans was prepared (see Appendix A). This was mailed with a reply paid envelope to 200 agencies selected from the NSW Council of Social Services' <u>Handicapped Persons' Services Directory</u>[2] Grounds for selection were that an agency was known to us as providing services to motor vehicle accident victims or was thought to be a likely provider of some service to them. Ninety one questionnaires were returned fully or partially completed; another eight were returned from agencies with no responses entered other than that they had no motor vehicle accident victims among their clientele - an overall return rate of nearly fifty per cent.

Our third informant source comprised individuals active in the provision or programming of services for handicapped persons. These informants were either known to us as knowledgeable figures in the field of rehabilitation and after care or were brought to our attention in the 'snowballing' process which inevitably occurs when knowledgeable people are contacted in an area of their concern. Some twenty relatively lengthy interviews were conducted, discussion being guided along the lines of the questionnaire content mentioned above; a much larger number of briefer contacts, in person or by telephone were made, but pressure of time precluded records being kept of all of these.

We did not attempt to contact two very large, very important groups of providers - the first made up of relatives and friends who carry much of the burden of caring for some accident victims, the second being constituted by private practitioners of medicine, law, accounting, physiotherapy, domicilliary nursing and other occupations relating to rehabilitation and aftercare. It was our opinion that more light would be shed upon the activities of members of these provider groups by other studies being conducted under the auspices of the N.S.W. Law Reform Commission than could be shed with our limited resources.

Nor did we contact a third, much smaller group of providers, the insurers whose role in providing money for rehabilitation and aftercare is, in many cases, a central one. it was our belief that those who commissioned this present study had inquired into the role and function of these agencies.

To obtain a proper picture, drawn in perspective, of the extent to whether particular types of agencies and services are actually used by motor traffic accident victims and to identify the strengths, weaknesses and lacunae in the system, one must review the experience and opinions of the victims themselves.

This complementary review is being conducted by other investigators on behalf of the New South Wales Law Reform Commission.

1.7 Comments on modus operandi and information sources

Although the findings of our searches for information are presented at some length in subsequent chapters of this report, it is pertinent here to comment upon some aspects of the modus operandi and information sources.

In terms of information yield, the 'literature review' is by far the most efficient approach to describing what we have dubbed 'the maze'. In addition to enabling one to build up the formal structure from official documents, the literature includes much 'unofficial' comment reflecting the views of providers and their clientele. Personal communication with provider personnel also helps to 'fill out' the framework constructed from official publications, although often the comments made and opinions expressed are to be found in written materials. However, much of the written and spoken comments and opinions reflects anecdotal, impressionistic material which would take perhaps weeks of careful investigation to substantiate or refute. For example statements such as 'the young ones and old ones like to be together' and 'the mentally handicapped shouldn't be separated from the physically handicapped' were repeated by numbers of informants but we had no opportunity to examine their validity.

The postal questionnaire survey was, as we anticipated, of limited value. Motor vehicle accident victims in need of rehabilitation and aftercare are far outnumbered by people whose similar needs arise from other causes; consequently motor vehicle accident victims make up only a small fraction, or, in many instances, none, of the case load of most agencies in this field. A survey of those agencies will reveal perhaps a lot of information about health and

welfare agencies generally, but not much that is of any specific and particular relevance to the problems of caring for motor vehicle accident victims. The survey confirmed the absence of detailed statistical records in agencies large and small, agencies' difficulties and uncertainties associated with funding, their attempts to cover a wide range of needs with inadequate resources in terms of trained personnel, finance and lack of appropriate back-up facilities. But these are shortcomings probably pervading the health and welfare services generally, and their proper description and assessment goes far beyond the bounds of our limited concern. Late in 1983 advertisements appeared in newspapers calling for submission of views regarding the effectiveness, coverage and administration of programs of special services for disabled people(3). The findings and recommendations emerging from this inquiry may be of relevance to the care of motor vehicle accident victims.

It must be borne in mind that a review of the type we have reported here may, if not used cautiously, lead in incorrect conclusions. The amount of space devoted in this report to a particular agency or group of providers of care bears no relation to their relative importance in the overall rehabilitation and aftercare of motor vehicle accident victims. The central roles played by victims' relatives, friends and by a private practitioners of several professions get but little mention in a report such as this - but in many cases they are crucial to the wellbeing or otherwise of the victim.

1.8 The format of our report

The accident victim experiences needs, turns to providers for assistance in meeting those needs, and then, perhaps finding that there are problems which are not being dealt with adequately, may focus attention on programmers' activities or lack of them.

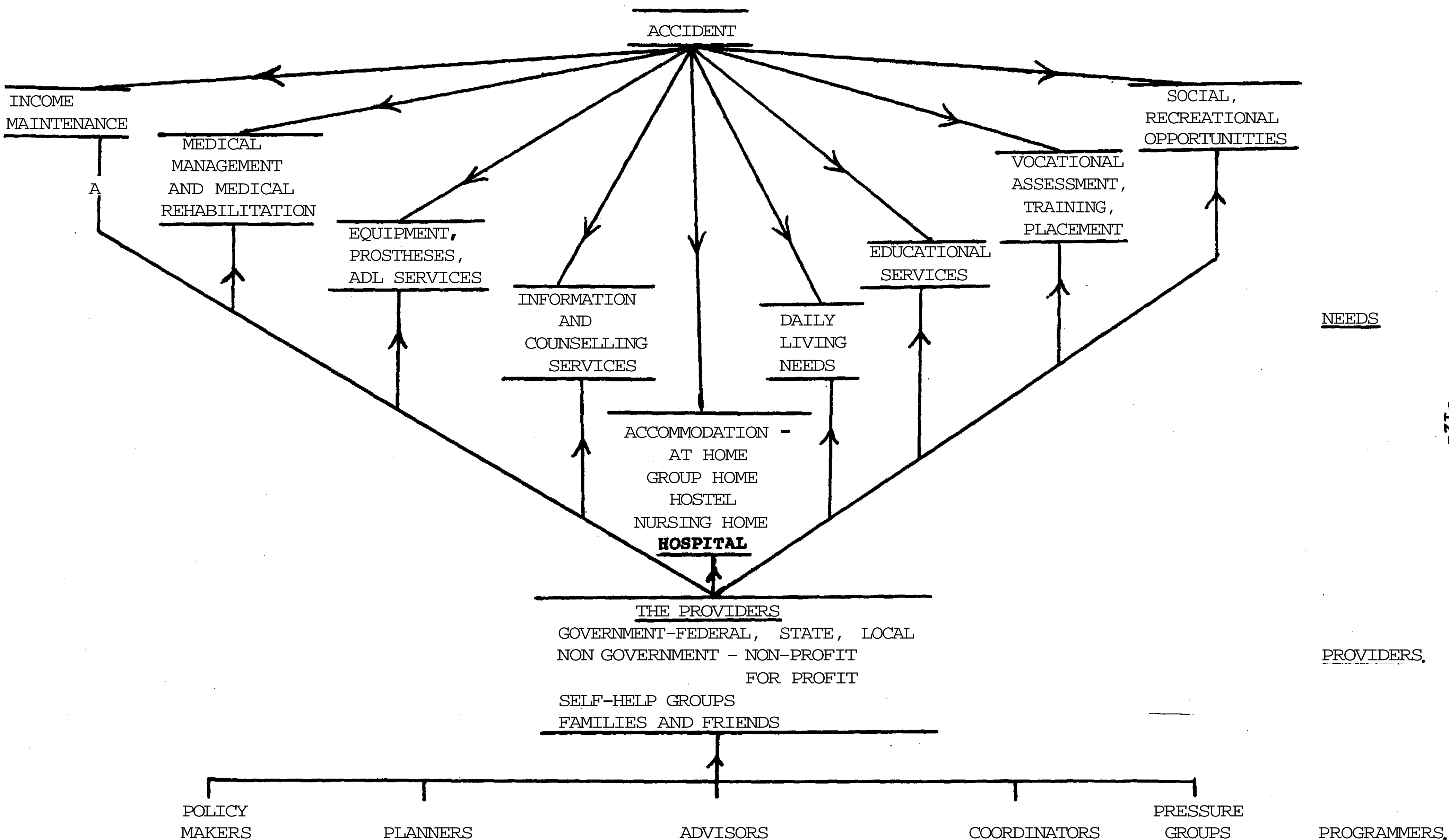
But to gain an understanding and appreciation of the complexities of providing post accident care it is perhaps best to look first at the providers. Then we devote one chapter to each of the eight categories of need listed in 1.3.2 above, give some description of the need and review the present provision to meet that need. That review includes such matters as the agencies concerned; the scope and scale of their activities; where appropriate details of organisation, staffing, finance, client eligibility criteria, case-load and case-mix; their achievements and their problems* Each chapter includes some evaluative comments. Chapter 12 is concerned with programming activities - the agencies concerned, the roles they play and the functions they perform. The final chapter presents a summary of the present situation regarding post accident care in New South Wales.

1.9 A note on terminology

For some purposes it is necessary to define strictly the concepts to be used in reference to people having some physical or mental disability. Thus the Australian Bureau of Statistics used the following definitions in its Survey of Handicapped Persons 1981([4]), based on those in the World Health Organisation's International Classification of Impairments, Disabilities and Handicaps -

> A disabled person is a person who has one or more of the following disabilities or impairments. These have to have lasted or be likely to last for 6 months of more:
>
> (a) loss of sight (even when wearing glasses or contact lenses);
>
> (b) loss of hearing;
>
> (c) speech difficulties in native language;

Figure 1.1 Needs, providers and programmers



(d) blackouts, fits, or loss of consciousness;

(e) slowness at learning or understanding;

(f) incomplete use of arms or fingers;

(g) incomplete use of feet or legs;

(h) long term treatment for nerves or an emotional condition;

(i) restriction in physical activities or in doing physical work;

(j) disfigurement or deformity;

(k) need for help or supervision because of a mental disability;

(1) long term treatment or medication (but is still restricted in sane way by the condition being treated).

A disabling condition is that condition which caused one or more of the disabilities or impairments listed above.

A handicapped person is a disabled person aged 5 years or more who is further identified as being limited to some degree in his or her ability to perform certain activities or tasks in relation to one or more of the following five areas:

(a) self care;

(b) mobility;

(c) communication;

(d) schooling;

(e) employment.

Disabled persons aged under 5 years are all regarded as being handicapped.

In this report of our review we use the terms 'disabled person' and 'handicapped person' interchangeably, without the constraints of age or duration of impairment or disability imposed in the ABS definitions. Generally we use these terms interchangeably too with the term 'accident victim' . if the terms 'accident victim' or, more specifically, 'motor vehicle accident victim' are used in a restricted sense, this should be clear from the context.

Footnotes

1. Hew South Wales Council of Social Service, Handicapped Persons' Services Directory, (Sydney, NSWCOSS, 1982).

2. Id.

3. See section 12.4 below for more details of this review.

4. Australia Bureau of Statistics, Survey of Handicapped Persons, 1981, (Canberra, AGPS, 1982).

CHAPTER TWO

THE PROVIDERS

2.0 The New South Wales Council of Social Service published, in 1982, its first Handicapped Persons' Services Directory. More than a thousand agencies concerned with meeting the needs of the handicapped were listed. For descriptive purposes these agencies may be grouped into six categories, categories which reflect such important administrative characteristics as sponsorship, legal status, management, finance and staffing. A seventh category of provider is shown in the list below, a category very different from any of the preceding six, yet immeasurably important in meeting the needs of accident victims -

- Commonwealth Government agencies
- N.S.W. State Government agencies
- Local government agencies
- Non-government, not-for-profit agencies
- Non-government, for-profit agencies
- 'Self-help' agencies
- Relatives and friends

Of the thousands of agencies within the first six categories serving the handicapped in this State, few are concerned solely with accident victims, almost none solely with motor vehicle accident victims.

In this chapter the principal roles of each major provider group are outlined; more detailed description of the activities of individual agencies is to be found in the chapters devoted to clients' needs.

2.1 Commonwealth Government agencies

The greater part of federal provision for the handicapped, and thus for accident victims, is administered through four departments -

2.1.1 Department of Social Security

2.1.2 Department of Health

2.1.3 Department of Veterans' Affairs

2.1.4 Department of Employment and Industrial Relations

Other federal departments also have readily identifiable programs directed towards meeting some needs of handicapped persons, including -

2.1.5 Department of Housing

2.1.6 National Library

2.1.7 Schools Commission

2.1.8 Department of Science and Technology

2.1.9 Taxation Office

2.1.1 Commonwealth Department of Social Services

The Department assists the handicapped through cash payments which constitute the major source of income for many, through subsidies for a variety of facilities and services and directly through the Commonwealth Rehabilitation Service. The Department also plays a part in the Commonwealth health benefits scheme as the assessing agency for issue of health benefit cards.

The Department's State Headquarters and central offices of Welfare and Rehabilitation Services are located in the City of Sydney. The 1982-83 Annual Report of the Department listed 69 regional offices covering New South Wales(1).

The Department administers the following programs which meet some of the needs of the handicapped -

2.1.1.1 Cash payments to individuals under the Social Security Act, 1974, Parts III, VII, VIIA and VIIB

These payments provide basic income support and income supplementation to meet particular needs. They include -

(i) Invalid Pension

(ii) Age Pension

(iii) Spouse Carer's Pension

(iv) Sickness Benefit

(v) Handicapped Child's Allowance

(vi) Supporting Parent's Benefit

(vii) Mother's/Guardian's Allowance

(viii) Supplementary Assistance

(ix) Rehabilitation Allowance

(x) Vocational Training - Living Away From Home Allowance

(xi) Sheltered Employment Allowance

(xii) Incentive Allowance

(xiii) Open Employment Incentive Allowance

(xiv) Mobility Allowance

Details of the first eight of these schemes are to be found in Chapter 3, and of the other six in Chapter 10 below.

2.1.1.2 Commonwealth Pensioner Fringe Benefits Scheme

The Department assesses eligibility for, and issues Pensioner Health Benefit cards and Health Care cards. Holders of these cards are entitled to a range of health related benefits and, for PHB card holders, other concessions which may

reduce their living costs. These benefits and concessions are financed from Commonwealth, State and local government sources and by private business enterprise - see Chapter 3 below.

2.1.1.3 Handicapped Persons Welfare Program

Based on the Handicapped Persons Assistance Act 1974, the program provides both capital and recurrent subsidies to voluntary non-profit or local government bodies for the provision of sheltered employment, activity therapy and training services and for residential accommodation, the program is mentioned at greater length in Chapters 4, 7, 10 and 11 below.

2.1.1.4 Residential accommodation for permanently disabled people aged 16 years and more under the Aged or Disabled Persons Homes Act 1954 and the Aged or Disabled Persons Hostels Act 1972

The program makes available capital subsidy for the provision of new facilities and extension of existing homes - see Chapter 7 below.

2.1.1.5 Personal care subsidy under the Aged or Disabled Persons Homes Act 1954

2.1.1.6 Home care subsidies to the States under the States Grants (Home Care) Act, 1969, Part II

These subsidies support respectively personal care services to hostel residents and persons living in their own homes - see Chapter 8 below.

2.1.1.7 Delivered meals subsidy under the Delivered Meals Subsidy Act 1970

Non-profit organizations and local government bodies may be granted subsidy towards the cost of providing 'meals-on-wheels' - see Chapter 8 below.

2.1.1.8 Children's service program under the Child Care Act 1972

Funds are provided to the States and Northern Territory for the support of a range of services including child day care centres, pre-schools and special services for handicapped children. All services funded under this program are expected to give priority to handicapped children (see Chapters 8 and 9 below).

2.1.1.9 Commonwealth Rehabilitation Service (CRS) under the Social Security Act 1947, Part VII

CRS is the major avenue through which the Department provides welfare services direct to disabled clients. The service places particular emphasis on meeting the individual social and vocational needs of its clients (see Chapters 4, 8, 10 and 11).

2.1.1.10 Senior citizens' centres and welfare officers subsidies under the States Grants (Home Care) Act, 1969, Part III

Capital subsidies are paid to State and local governments for the construction of senior citizens' centres; States are reimbursed one half of expenditure on salaries of welfare officers associated with these centres - see Chapter 11 below.

2.1.1.11 Print-handicapped scheme

Grants are made to publishers to assist in the production of Braille and audio books for the print-handicapped - see Chapter 8 and 11 below.

2.1.1.12 Grant-in-Aid Program

Major coordinating bodies may receive grant-in-aid funding under this program - see Chapter 12.

2.1.2 Commonwealth Department of Health

This department assists in meeting the needs of the handicapped mainly through funding programs, some of which direct finance to State governments and agencies, some to non-government agencies and some to individuals to assist them in buying care or obtain goods and services free or at less than market price.

a) Several of these programs support important areas of health care delivery to the community generally; one group within the community that obviously benefits is that composed of accident victims. These general programs include

- grants to the States for:- public hospital services
community health services

- subsidies on a 'per occupied bed day' basis to: private hospitals
nursing homes

- financing deficits of not-for-profit nursing homes

- Medicare, nursing home and pharmaceutical benefits schemes

- supervision of private health insurance arrangements

b) Programs which benefit handicapped people particularly - provided they meet eligibility requirements - include

- pensioner health benefit card and health care card arrangements providing some health benefits free or at reduced cost

- home nursing subsidy scheme

- domiciliary nursing care benefit

- provision of medical and surgical appliances and aids under the PADP scheme - this scheme is funded by the Commonwealth but detailed administration is in the hands of the State Health Department

- grants for paramedical services for aged persons

c) Other programs which are of benefit to individuals include the provision of hearing aids free of charge through the National Acoustic Laboratory and the Isolated Patient Travel and Accommodation Assistance Scheme (IPTAAS).

Fuller detail of Commonwealth Department of Health programs will be found in later chapters of this review.

2.1.3 Veterans Affairs Department

The comprehensive medical services operated by this department may be made available for the treatment of accident victims since Departmental institutions have now adopted a 'community service' role in addition to their primary concern for service-related conditions of veterans. Repatriation Artifical Limb and Appliance Centres operate a scheme to provide free prostheses and similar appliances to those who need them.

2.1.4 Commonwealth Taxation Office

A concessional rebate on income tax is available to people who contribute to the care of severely handicapped relatives.

The Office administers the scheme whereby exemption from sales tax may be granted to handicapped persons purchasing a motor vehicle or spare parts.

2.1.5 Commonwealth Schools Commission

Grants are made under the Commission's Special Education Program to assist in the provision of educational facilities and services for the disadvantaged, including handicapped people.

2.1.6 Commonwealth Department of Science and Technology

Funds are provided for specific projects to assist disabled people.

2.1.7 National Library

The National Library projects of benefit to the handicapped include

- ABLEDATA - a computer based information service on commercially available products and technical aids for disabled people
- National Union Catalogue of library material for the handicapped
- Directory of library services for the handicapped in Australia.

2 . 1 . 8 Other Commonwealth agencies

Among other agencies conducting programs of benefit specifically of benefit to the handicapped are the Department of Housing and Construction and the Commonwealth Public Service Board.

2.2 N.S.W. Government agencies

Governmental agencies concerned with the needs of accident victims include the Departments of Health and of Youth and Community Services (YACS), the Government Insurance Office and the Workers' Compensation Commission. Others having programs of benefit to victims of accident include the education departments, Urban Transport Authority, the Housing Commission, the Anti Discrimination Board and the Industrial Registrar's Office. This list is not exhaustive.

2.2.1 N.S.W. Department of Health

The Department administers legislation relating to public and private hospitals and nursing homes, and that relating to mental health. Although many public hospitals are governed by boards, the Department exercises very considerable, and increasing, control since it regulates the finances and to a considerable degree the staffing and equipment of public hospitals. Major medical rehabilitation units are generally located in public hospitals; the present policy of developing regional assessment and rehabilitation units and teams which work both inside the hospitals and in the community is closely linked with the public hospital system and with the Department's community health service development programs. Some nursing homes and the State psychiatric and mental retardation institutions which provide care for accident victims among other handicapped patients are under direct Health Department control. Private

hospitals and nursing homes, though not under the State Health Department's control as to their detailed activities, are nevertheless licensed by and subject to inspection by Health Department officers. The N.S.W. Ambulance Service administration is very closely tied to the Health Department structure. The Health Department administers the Commonwealth funded PADP scheme mentioned earlier in this chapter.

2.2.2 Department of Youth and Community Services

In 1978 the Hew South Wales Government established the Handicapped Persons' Bureau within the Department of Youth and Community Services. The Bureau's main functions are the coordination and development of state social welfare services for handicapped people, the provision of advice and assistance to community groups on developing services for handicapped people, and administering government finances and programmes to agencies providing those services. The total amount of subsidy available for allocation between the selected agencies is not large. The 1983-84 Budget provided for an estimated $2.7 million to be available for allocation in that fiscal year.(2) Among the recipients of grants are 'programming' agencies such as the Australian Council on Rehabilitation of the Disabled and the Association of Sheltered Workshops, and 'provider' agencies such as the Australian Quadraplegic Association and Technical Aid for the Disabled. Over the past few years the Bureau has been engaged in developing a scheme for licensing of residential facilities to ensure that minimum standards of 'boarding house' type accommodation for handicapped people will apply throughout the State. A similar project in cooperation with the Association of Sheltered Workshops is aimed at establishing minimum standards for sheltered workshops. The Bureau has encouraged the establishment of self help groups which provide 'respite care', that is relief care for parents of handicaped children.

Motor traffic accident victims may also benefit from other programmes of this Department. Money and other material assistance (in the form of blankets, footwear, travel concessions) may be provided to disadvantaged persons experiencing an immediate financial crisis; the 1983-84 Budget provided for $21.6 million dollars to be available for such purposes.(3) The N.S.W. Home Care Service, (described at greater length in later chapters of this report), which provides full-time or part-time assistance in the home on a temporary or continuing basis where the householder is unable to engage in normal household duties, is subsidised through this Department, the Budget allocation for subvention in 1983-84 being $23.7 million.(4)

2.2.3 Workers' Compensation Commission of N.S.W.

The activities of this agency are not dealt with in this review.

2.2.4 N.S.W. Department of Education

The Department is responsible for the operation of education services for all children of school-age throughout the State. Provision by way of special teachers, special classes and special schools is made to meet the needs of handicapped children, including accident victims.

2.2.5 N.S.W. Department of Technical and Further Education (TAFE)

TAFE offers a very wide variety of vocational and general education courses, many of which are suitable for handicapped adults.

2.2.6 The Urban Transport Authority of N.S.W.

In addition to concession fares on public transport available to some social security beneficiaries, the Authority subsidises a scheme to provide handicapped people with the service of taxis specially adapted to their needs - at reduced fares.

2.2.7 The Housing Commission of N.S.W.

The Commission has arrangements whereby the need of the handicapped for reasonably priced housing and housing modified to minimize the effects of handicap may be met. Group home projects are also sponsored by the Commission.

2.2.8 N.S.W. Anti-Discrimination Board

Legislation provides a means Whereby a handicapped person who feels that she or he has been subjected to discrimination on the grounds of handicap may seek inquiry into and appropriate redress of a complaint.

2.2.9 H.S.W. Industrial Registrar's office

This office is empowered to issue 'slow worker' permits to handicapped people seeking employment.

2.2.10 Other departments - H.S.W.

A number of other State Government agencies operate small scale programs to the benefit of handicapped people.

2.3 Local government agencies

Local government councils provide a variety of services for the handicapped and other disadvantaged people living in the areas of their jurisdiction. Some are provided directly through a welfare department or section of the council's administrative structure; others are provided indirectly by financial contributions from rate revenue. Some local government welfare activities are supported in part by federal and State subsidies.

Pensioners may be granted some relief from the payment of council rates - see Section 7.2.4 below.

2.4 Non government, not-for-profit agencies

Turn to almost any one of the 180 pages in the N.S.W. Council of Social Services 'Handicapped Persons' Services Directory' on which agencies are listed alphabetically and there will be found, among the six or seven listings, at least 3 or 4 non-government, not-for-profit agencies serving the handicapped in some way or ways. The services offered range from A to Z or rather A to Y, 'Youth, handicapped, social development' being the last heading in the Index to Services.[5]

Many of these agencies receive financial support from federal, State or local government funds - sometimes from two or all three sources. Revenue is derived also from such sources as charges to clients, charitable donations, sales of work, public appeals, street stalls and fetes, et cetera. Those receiving government funding are subject to some degree of government direction and control - often this is very light.

Although some of the larger ones now have the structure and modus operandi of

large scale business enterprise, agencies in this category represent the continuance of the spirit of philanthropy which has played, and still plays, a very important part in the provision of health and welfare services in this country.

2.5 Non-government, for-profit agencies

Under this heading we include the private practitioners of the several professions which serve the needs of the handicapped. Here too are placed the private for-profit hospitals, nursing homes, assessment and treatment centres, boarding houses, nursing and home care agencies, pharmaceutical and medical equipment suppliers, limb-makers et cetera - the list is a long one. That this private enterprise sector is essential to the present provision arrangements is reflected in the fact that a large part of the revenue of this sector is derived by way of subsidies paid by governments. Activities within this sector are to a considerable degree subject to some government control - some control being exerted directly through regulatory legislation and through financial control, some indirectly through the necessity for private enterprise to compete against government and government-subsidised not-for-profit agencies.

2.6 'Self-help' agencies

In general these agencies come within the non-government, not-for-profit category but are distinguishable because the sponsorship and direction of the agency comes from people who are themselves handicapped rather than from well-intentioned others.

The Association of Self Help Organizations and Groups (ASHOG), founded in July 1975 and formally established in July 1976, is a coalition of self help bodies covering needs of a wide range of people including those within approximately

thirty areas of disability and those in parent groups. The Association maintains a register of self help organizations in New South Wales; it operates a seven-day-a-week information referral phone service; and an after-hours crisis talk-out phone service for people with handicaps and their relatives and friends.

For the year ended 30 April 1984 the Association operated on an income less than $5,000, with $4,000 being received from the State Government's Department of Youth and Community Services.

Problems faced by the Association and its member bodies include uncertainty as to future funding; difficulties in securing tax concessions as not-for-profit 'benevolent' organizations; the inability of self help groups to afford the high cost of attendance at major conferences and thus information-sharing is restricted; being called upon by government and other planning bodies for comment, information and advice only when decisions have already been made.

The quarterly journal, ASHOG News, is incorporated in the publication Independence, published by the Self-Help Association for Multiple Sclerosis and Allied Disorders (SAMSAD).

2.7 Relatives and friends

The contribution of relatives and friends to the care of accident victims and other handicapped people is immeasurable. Much discussion of compensation to motor vehicle accident victims focusses upon the needs and problems of the persons actually involved in accidents. Much less frequently is mention made of 'compensating' the 'secondary victims' - those family members and others whose lives are disrupted, expectations drastically altered, hopes shattered as a consequence of accident involving a relative or close friend.

2.8 Problems of complex system.

Although, as stated earlier in this report, we did not attempt to undertake any detailed evaluative enquiries, there are certain questions which arise whenever one confronts a health and welfare service system composed of a multiplicity of providers operating under a variety of auspices, and aimed at meeting a wide range of personal needs. These questions relate to such matters as the availability of clear statements of policy, of objectives, of operational guidelines; the presence and adequacy of mechanisms for coordination, cooperation, and 'quality control', equity in allocation of resources; accessibility of services and benefits in terms of geographic location, financial barriers, or disincentives; eligibility rules, their application and temporal constraints; grievance handling and appeal machinery; certainty as to future funding - and so on. It came as no surprise to us to find that in our short descriptive review we encountered either examples of or mention of shortcomings in every one of the matters listed here. To investigate fully the ramifications of any shortcoming was quite beyond our limited resources.

Footnotes

1. Department of Social Security, annual Report 1982-83, (Canberra, AGPS, 1983), p.183.
2. New South Wales Parliament, Budget Estimates Classified by Program, 1983-84, (NSW Government Printer, 1983), pp.428-429.
3. Id., p.426.
4. Id., p.433.
5. New South Wales Council on Social Service, Handicapped Persons' Services Directory, (Sydney, NSWCOSS, 1982).

CHAPTER THREE

INCOME MAINTENENCE

3 . 1 The need

The literature of medical management of accident victims lays great emphasis upon the necessity to institute rehabilitative measures from the moment that the patient is admitted to care. No less urgency attaches to ensuring that an accident victim has, from the time of the accident, appropriate financial means to meet the financial demands which continue to be made throughout the period of post accident care - which as we have noted previously, will in some cases extend through the remaining years of life.

Income will be needed to meet demands which are inescapable - that part of the cost of care in all its many forms which must be met by the recipient and the cost of the bare essentials of life in a generally affluent society. In addition are the demands generated by pre-existing commitments, such as mortgage and hire-purchase payments - and the other future and continuing demands arising from the obligations and reasonable expectations generated by the life-style pursued prior to the accident.

Clearly the income needs will vary from case to case, and if the period of care to be covered is a lengthy one, will probably change over time. Consider, for example, a two-year old child who suffers severe brain-damage in a motor vehicle accident, who requires intensive hospital care for many months, whose single supporting parent is unemployed; the child later attends a special school; as the result of parental neglect she becomes a ward of the state; later she enters employment in a sheltered workshop; at the age of 25 years she

marries a developmentally-handicapped fellow employee at the workshop and then becomes the parent of two children.

An Important area of need related to income maintenance is access to sources of information and advice regarding financial matters. This topic is dealt with in Chapter 6 - information and Counselling.

3.2 Categories of income

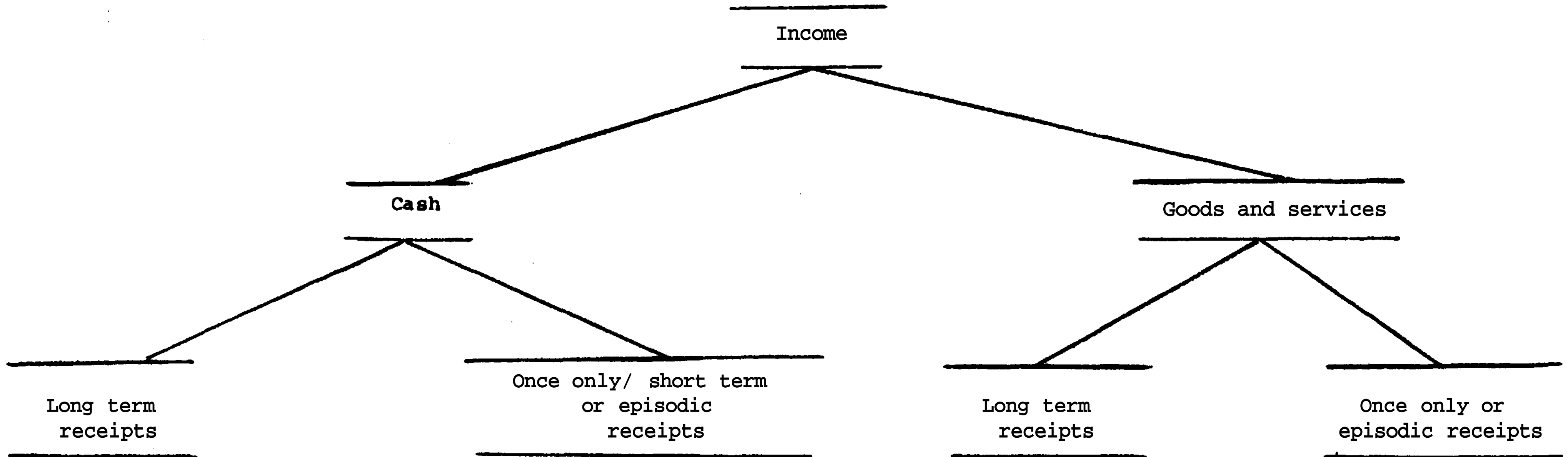
Income to meet these needs and demands may be divided into two major categories - see Figure 3.1. The first category covers cash income, the second includes income by way of goods and services. Among the sub categories common to both of these groups perhaps the most important distinction to be made is that between relatively regular relatively long term income receipts and once-only, episodic or relatively short term income. It is important to note that sometimes a once-only payment, such as the award of lump-sun compensation to an injured worker, may give rise to regular, long-term income generated from the investment of that lump-sum.

Here we will mention the more common and more important sources of income for persons whose income is not wholly derived from their own efforts or from their own resources. Thus accident victims who are able to derive an adequate income through personal effort or from investments managed by themselves or others on their behalf will not be concerned with any of the income sources mentioned below.

The regular long term income category includes

- 3.3.1 Earnings by the accident victim in permanent or casual employment.
- 3.3.2 Continuing financial support from relatives and friends.
- 3.3.3 Superannuation schemes.

Figure 3.1 Categories of income



3.3.4 Regular payments under workers' compensation arrangements.

3.3.5 Regular payments under private income-maintenance and accident insurance policies.

3.3.6 Social security and veterans' pensions and benefits.

3.3.7 Long term subsidised accommodation, including nursing home accommodation et cetera.

3.3.8 Continuing receipt of free or partially free goods and services.

Once-only, short term and episodic receipts include:

3.4.1 Short term statutory benefits and allowances.

3.4.2 Cash, goods and services received to meet a particular crisis or episode of acute need.

3.4.3 Once only supply of medical equipment, prostheses, home modification et cetera.

Host items in this second category and some of those in the first are more appropriately dealt with at length in other chapters of this report.

3.3 Long term receipts

3.3.1 Earnings from own efforts

The findings of the Australian Health Survey[1] show that a very significant part of the New South Wales workforce suffers from some form of chronic disability. But most of these disabled workers are not currently in the group of our concern - certainly not all of them are suffering from disabilities directly attributable to accidents, and of those who are, very many can not be said to be 'in care' in the sense that that phrase is used in our report, because despite their disabilities they receive the same income, have the same needs and have the same access to services as non-disabled people.

But numbers of accident victims who are currently 'in care' do participate in the workforce. The distinguishing features of those in the 'in-care' category are that their earnings are, because of their post-accident handicap, less than

those of other workers in similar employment and that those earnings are supplemented by cash payments from some source not directly related to their employment - such as an invalid pension or regular payments under workers' compensation arrangements. Within this group one may find -

(a) the self employed

(b) employees working on a part-time or casual basis

(c) employees holding 'slow worker' permits

(d) sheltered employees

The number of motor vehicle accident victims in any one of these categories is not known. Those in group (a) and (b) whose earnings are sufficiently small to enable them to qualify for part payment of the invalid pension are included but not separately identified in the invalid pensioner statistics. At 30 June 1983 there were nearly 76 thousand invalid pensioners in New South Wales, of whom about 1 in 10 received a reduced rate(2) pension. The invalid pension may be paid to persons over the age of 16 years who are totally blind or permanently incapacitated for work to the extent of not less than 85 per cent. Payment is subject to an income test for persons other than the permanently blind who are eligible irrespective of income. It is possible then for an accident victim who is an invalid pensioner to receive a small income as the result of her or his own efforts and still be eligible to receive the pension though the pension may be reduced progressively as the level of other income rises.

In late 1983 there were perhaps 40 holders of 'slow worker' permits employed in New South Wales - the number may be less[3]. At the end of June, 1983, there were 3,688 sheltered employees in the 86 workshops through which sheltered workshop allowances were paid(4). Numbers of motor vehicle accidents victims holding slow worker permits or employed in sheltered workshops are not obtainable - but the numbers are not large.

3.3.2 Continuing support from family and friends

Undoubtedly this must be an important part of the income of many handicapped people - by way of cash gifts and by way of regular gifts of goods and services.

A resident tax payer who contributes to the maintenance of an invalid relative may be entitled to a concessional rebate under section 15PJ of the Income Tax Assessment Act 1943. An invalid relative is defined as a child, step-child, adopted or illegitimate child, brother or sister of the taxpayer who is over 16 and in receipt of an invalid pension or is certified as permanently disabled.

3.3.3 Superannuation schemes

Government sponsored and private superannuation schemes may provide for pension or lump-sum payment in the event of the person covered becoming permanently unfit for employment. Schemes which provide for pensions may offer opportunities to commute the whole or part of the pension entitlement for a lump sum payment. In general, superannuation benefits in respect of permanent unfitness for employment are payable irrespective of the nature of the cause of unfitness. Superannuation pensions which are not periodically adjusted according to changes in the cost of living may prove to be of limited usefulness in maintaining an adequate income.

Investment of a lump sum in an annuity may similarly lead to an income of diminishing real value due to the effects of inflation.

3.3.4 Regular payments under workers' compensation arrangements

Details of the workers' compensation scheme are beyond the terms of reference of this review.

3-3.5 Regular payments under private income-guarantee & accident insurance policies

Private insurance companies offer a variety of policies covering loss of earning capacity arising from accidental injury. Loss of earnings policies provide income for specified periods. Many policies provide for payment of a lump sum in the event of loss of limb or sight.

3.3.6 Social security and veterans' pensions and benefits

Accident victims may be eligible to receive Commonwealth pensions and benefits payable to persons who have not suffered an accident - for example age and service pensions and unemployment benefits. Pensions and similar continuing cash benefits which are more specifically applicable to accident victims are -

(a) Invalid Pension
(b) Age Pension for aged persons who are blind
(c) Handicapped Child's Allowance

(a) Invalid Pension, as noted in 3.2.1 above, is payable to a person not less than 16 years of age, who is permanently incapacitated for work to the extent of at least 85 per cent or is permanently blind. The pension is subject to an income test (except in the case of a permanently blind person) and a residence requirement.

Invalid pensioners may also qualify for wife's pension, additional pension for children, supplementary (rental) assistance, a Pensioner Health Benefit Card or a Health Card and, in the case of a single pensioner with dependent children, Mother's/ Guardians Allowance.

The maximum rates of the invalid Pension are the same as those for the Age Pension.

In the last few years there has been controversy concerning the guidelines used in the medical assessment of invalid pension and the uniformity of their application. The guidelines were clarified in May 1981 and released for use by Commonwealth Medical Officers and for the information of the public generally. The revised guidelines recognise that permanent incapacity for work may result from a combination of medical impairment and other factors such as a claimant's education, age, sex, personal disabilities and lack of skill.

Of the 75,735 invalid pensioners in New South Wales at 30 June, 1983, some 70 per cent were male, around 40 per cent were married and over 80 per cent were assessed as having either no other income or a weekly income of less than $20 in addition to their pension. Federal expenditure on invalid pensions in NSW for the fiscal year 1982-83 amounted to $378 million or, roughly, one million dollars every day of the year(5). Motor traffic accident victims would constitute only a small fraction of all invalid pensioners in the State; figures are not available.

(b) The Age pension, as noted above, is not generally directed towards the disabled as a distinct group of the aged population, but the Social Security Act 1947 does make special provision for the blind aged. The Age Pension is payable to men aged 65 years and over and women aged 60 years and over. A claimant must in general be residing in, and physically present in, Australia on the date of claiming pension and have had ten years continuous residence in Australia at any time.

The pension is subject to an income test except in the case of the permanently blind, who are entitled to the maximum rate of pension irrespective of non-pension income.

(c) Handicapped Child's Allowance is payable to a parent or guardian of a 'severely handicapped child' (a child who has a physical or mental disability and who needs and is likely to need permanently, or for an extended period, constant care and attention by reason of that disability). An allowance is also payable, subject to an income test, in respect of a 'handicapped child' (a child with a substantial physical or mental disability who needs marginally less care and attention). The child must be under 16 years of age (under 25 years in the case of a dependent fulltime student not receiving an Invalid Pension) and living in the family home.

There is no income test in respect of the allowance for a 'severely handicapped child'. The allowance in respect of a 'handicapped child' is only paid where the income of the parents or guardians, after the deduction of expenditure which results from the child's disability, falls below specified limits. The allowance is not subject to income tax.

There were 9,049 handicapped children's allowances current in New South Wales at 30 June, 1983. Of these 8,479 were in respect of severely handicapped children and 470 in respect of substantially handicapped children. Commonwealth expenditure on these allowances during the fiscal year 1982-83 totalled, for NSW beneficiaries, $8.89 million(6).

In addition to these regular long-term payments to accident victims, the Federal Department of Social Security may provide assistance to maintain the disabled person's family through

(a) Spouse Carer's Pension

(b) Supporting Parent's Benefit

(c) Mother's/Guardian's Allowances

A spouse carer's pension is also available through the Department of Veterans' Affairs.

(a) Spouse Carer's Pension was introduced in December, 1983. The pension is paid to men:

(i) whose (legal or de facto) wives are age or invalid pensioners, or recipients of rehabilitation allowance (provided they received invalid pension immediately prior to grant of rehabilitation allowance). Veterans' Affairs is paying spouse carer's pension to men whose (legal or de facto) wives are service pensioners;

(ii) whose wives have a physical or intellectual disability or serious illness and as a result require constant care and attention, either permanently or for an extended period (at least six months); and

(iii) who permanently provide constant care and attention for their wives at home.

A man may cease to care for his wife for short periods but still be paid.

This pension is payable subject to income test, and is not taxable provided that the man is under 65 and the woman under 60 years of age.

(d) Supporting Parent's Benefit eligibility was extended in December 1983 to include any "married" person caring for a child and whose legal or de facto spouse is unable indefinitely to live at home due to illness or infirmity. Payment of this benefit is subject to income test.

(e) Mother's/Guardian's Allowance eligibility was extended in December, 1983 to a "married" person caring for a child where the couple are unable indefinitely to live together at home due to illness or infirmity of either partners. The allowance is payable subject to income test.

3.3.7 Long-term subsidised accommodation, including nursing home accommodation et cetera

This important element of income maintenance is treated at length in the chapters concerned with medical management and accommodation. However it is appropriate to mention here that the Department of Social Security makes available an income supplement to eligible pensioners and persons in receipt of Supporting Parent's Benefit and Rehabilitation Allowance to alleviate financial hardship which might otherwise arise from having to pay rent, charges for lodgings or board and lodgings, or fees for nursing home care. Some accident victims may be in one or other category of eligibility for this income supplementation.

3.3.8 Continuing receipt of free or partially free goods and services such as health care, delivered meals, housekeeping services, et cetera

Continuing income supplementation by these methods is dealt with in some detail in chapters concerned with medical care and daily living. Here it is appropriate to mention the Commonwealth pensioner fringe benefits and related concessions.

The Commonwealth Department of Social Security issues Pensioner Health Benefit (PHB) cards, Health Benefit (HB) cards and Health Care (HC) cards to eligible persons. Persons eligible for PHB cards include social security and repatriation service pensioners, and recipients of rehabilitation and sheltered

employment allowances who comply with the relevant income test - the income test levels are set at a level which precludes some pensioners and allowance recipients from receiving a PHB card. Social security sickness beneficiaries are eligible for an HB card - the income test for HB card eligibility is the sickness benefit income test, so that all sickness beneficiaries are entitled to this card. The wives and children of PHB & HB card holders may receive the same Commonwealth fringe benefits as the social security beneficiaries themselves .

The Commonwealth 'fringe benefits' available to PHB and HB card holders are -

- free optometrical consultations from participating optometrists;
- a range of free pharmaceuticals;
- free hearing aid services;
- a one-third telephone rental concession (subject also to the incomes of co-residents ;
- postal redirection for concessions; and
- a 50 per cent fare concession for travel on Australian National Railways and the Australian National Line(7).

State and local government bodies also offer fringe benefits to defined groups of disadvantaged persons. Those benefits include local government rate concessions and transport concessions for public transport services. Eligibility for those concessions may be based on possession of a PHB card(8). In New South Wales at 30 June 1983 there were, including wives, 411 thousand age pensioners, 86 thousand invalid pensioners, 3,712 sheltered employment allowances and 815 rehabilitation allowances covered by these cards(9). It is not possible to determine how many of those who eligibility for cards could be attributed wholly or in part to having been involved at some time in a motor traffic accident.

The Department also administers a Health Card scheme on behalf of the Commonwealth Department of Health. This card entitles the holder and any dependants to the same optometrical benefits as PHB card holders, and to a range of pharmaceuticals at a concessional contribution rate. Those eligible to receive a Health Care card are

(a) recipients of unemployment and special benefits who have income, excluding their benefit, below the appropriate Commonwealth pensioner fringe benefits limits;

(b) invalid pensioners or recipients of sheltered employment allowance (or recipients of rehabilitation allowance in lieu of one of these payments) who enter the workforce and lose eligibility for a pension or allowance on income grounds. The card is valid for 12 months from the date that the pension or allowance ceases, irrespective of the holder's income;

(c) other persons on low incomes who meet specific residence requirements; and

(d) migrants and refugees during the first six months of residence in Australia (free of income test)(10).

At 30 June 1983 there were in New South Wales 545,258 persons covered by Health Care cards(11).

3.4 Once only, short-term and episodic receipts

Turning to shorter term income and income supplementation, we note

3.4.1 Short term statutory benefits and allowances

Federal legislation provides for the payment of

(a) Sickness Benefit (Social Services Act)

(b) Rehabilitation Allowance (Social Services Act)

(c) Loss of Earnings Allowance (Repatriation Act)

(a) Sickness Benefit is payable to a person who is temporarily incapacitated for work because of sickness or accident and has thereby lost income. The person must be at least 16 years of age and under 65 years (male) or under 60 years (female). *The* benefit is subject to an income tet.

Sickness beneficiaries may also qualify for additional benefit for children, supplementary (rental) assistance and a Health Benefit Card. From May 1984, single beneficiaries with dependent children may also qualify for Mother's/Guardian's allowance.

In New South Wales during the fiscal year 1982-83, an estimated average of 26.4 thousand persons were on sickness benefit at the end of each week. An analysis of all those on benefit in May 1983 showed that 77 per cent were male, 62 per cent were single and over 30 per cent had been receiving the benefit for 12 months or more. The published figures did not show how many beneficiaries were motor vehicle accident victims. Sickness benefits paid in N.S.W. in fiscal 1982-83 totalled $120.55 million(12).

(b) Rehabilitation Allowance is payable to a disabled person accepted by the Commonwealth Rehabilitation Service (CRS) for a rehabilitation program provided that person is in receipt of or would be eligible to receive a social security pension, benefit or sheltered employment allowance at the time of acceptance.

The Rehabilitation Allowance replaces the former payment and is paid at the same rate and under the same conditions as the Invalid Pension. It is income tested (unless the Invalid Pension is received for blindness) but is tax free. The maximum rate incorporates any incidental payments (eg supplementary assistance) to which the person was entitled before he commenced to receive, or to which he becomes entitled during currency of, the allowance. The allowance is payable for the duration of the rehabilitation program and may be extended thereafter for a period of six months. A recipient of rehabilitation allowance may, in addition, be eligible for a training allowance, a living away from home allowance and for full or partial payment of fares and living expenses incurred in connection with a CRS program.

At 30 June 1983 in New South Wales Rehabilitation allowances were being paid to 736 persons(13).

(c) Allowance for Loss of Earnings may be paid by the Department of Veterans' Affairs to a veteran who is prevented from following his or her usual occupation which results in a loss of earnings because of absence from employment due to a non-service related disability where the veteran has been paid sick leave previously in the year because of absence due to service related conditions (subject to a maximum period of entitlement).

The maximum amount of loss of earnings allowance payment is the lesser of the actual amount of earnings lost or the Special (T. and P.I.) Rate pension less any disability pension in payment. The maximum rate will be increased where there are dependants.

During the fiscal year 1982-83, for the whole of Australia, 1,019 veterans were paid an Earnings Allowance,the total expenditure being $261,842(14).

3.4.2 Cash, goods and services received from government and non-government agencies to meet a particular crisis or episode of acute need

The low income of many accident victims and the rapidly increasing cost of living make it increasingly difficult for them to meet any marked increased demand upon their straitened financial resources. Even predictable large bills, such as those for rates and electricity, may create a very serious problem, while a sudden, unexpected demand - say the need to visit a seriously ill relative, a breakdown of a refrigerator or television set, many precipitate a major financial crisis. With no financial reserves, the impoverished accident victim needs immediate assistance by way of cash or perhaps of goods of some description.

Some of these urgent needs may be met through the N.S.W. Department of Youth and Community Services, which in fiscal 1982-83 expended $11.4 million under its Budget item C9, Cash and Other Assistance to Persons in Necessitous Circumstances. The 1983-84 Budget Estimates show an estimate of $13 million for this item(15). Some local government welfare departments, the non government welfare agencies and of course relatives and friends also play an important role as providers of aid in crisis situations.

3.4.2 Once-only supply of medical equipment, artificial limbs, hone modifications et cetera

The victim of an accident may be faced with the necessity to expend a considerable sum of money on what might be regarded as a 'capital' item necessitated by disablement - the purchase of a wheelchair, an artificial limb, a suitably adapted vehicle, or having modifications made to a dwelling. The cost of items such as these may be included in the calculation of compensation awarded through third party or workers' compensation arrangements. Also, several schemes provide financial assistance towards the cost of acquiring these essential aids.

The Commonwealth Rehabilitation Service may provide funds for aids, home and vehicle modifications needed by persons accepted as CRS beneficiaries. In the year ended 30 June 1983 in New South Wales $188.8 thousand were expended on aids and modifications(16). The Repatriation Artificial Limb and Appliance Centres (RALAC), which operate the federally funded Free Limb Scheme, described more fully in Chapter 5 below, incurred expenditure for their Australia-wide activities totalling $5.55 million in the year ended 30 June 1983(17). The federal Program of Aids for Disabled People (PADP), funded through the Commonwealth Department of Health and operated in Hew South Wales by the State Health Department - see Chapter 5 below - supplies a range of aids to disabled persons and also funds basic home modifications. In the financial year 1982-83 PADP expenditure in New South Wales totalled $1.6 million(18).

Home modifications are also carried out by a number of non government agencies •• these services may be provided free of charge - see Chapter 5.

3.5 Changing patterns of income maintenance

From this summary of the major types of income maintenance arrangements it is apparent that a multiplicity of providers are involved as primary sources of income by the direct provision of cash or less directly by providing free or below-cost goods and services to the disabled. The sources available to any one person may change as her or his circumstances change.

3.6 The proposed "Assets Test' and its implications

The Federal Government intends to introduce an 'Assets Test' , to operate from March 1985, to further restrict eligibility for age pension; invalid pension; wife's pension; widower's pension; supporting parent's benefit; spouse carer's benefit; rehabilitation allowance; sheltered employment allowance and the Department of Veterans' Affairs service pensions. Entitlement to those pensions and benefits will be assessed under two tests - an income test, which is currently applied, and the new assets test. The test which produces the lower rate (or zero) pension or benefit will be applied. This additional test is aimed at excluding from or restricting pension or benefit to persons whose assets exceed relatively modest limits. Because, as noted in preceding sections of this report, eligibility for a range of fringe benefits provided by federal, State, local and non-government agencies is tied to eligibility for the pensions and benefits to be limited by the assets test, the effects of this test extend far beyond restriction of eligibility for the pensions and benefits to which the test is applied.

It is extremely probable that some motor vehicle accident victims now entitled to statutory entitlements and other fringe benefits will lose their entitlement or find the amount and range of benefit restricted. It is impossible to estimate the number of victims who will actually be affected when the test comes into operation. The introduction of the test obviously complicates the

planning of long-term income maintenance for accident victims, particularly persons who have received or who may in the future receive lump sum compensation payments. Those who are home owners and who enter a nursing home or sheltered accommodation for prolonged periods will face additional problems in that their homes may cease to be regarded as 'allowable assets' , normally disregarded in assessing eligibility. Provisions of the test which relate specifically to handicapped persons include exemption from the assets test of 'blind* pensioners in respect of eligibility for maximum rate pension, additional pension for first child and fringe benefits, and the classification of special equipment such as wheelchairs and hearing aids as 'allowable assets'.

3.7 The broad view of income maintenance

It could be said that in this chapter a rather broad view of income maintenance has been taken - so broad in fact that virtually any provision of cash, or of goods or services to the disabled which entails no expenditure or reduced expenditure on the part of the disabled can be classed as income maintenance. This is true. That such a broad view is reasonable is supported by the publication in November 1983 of the report on income maintenance by the Federal Parliament's Public Accounts Committee(19) That report identified 10 Commonwealth departments involved during 1981-82 in schemes which contributed to the maintenance of personal incomes through the operation of 127 different programs. The PAC found that more than one third of all federal government expenditure could be classified as coming under the broad heading of income maintenance - in 1982-83 that third would amount to more than $20 billion. Of course, only a small fraction of that enormous sum would be directed to maintaining income of the disabled, and an even smaller fraction to the income maintenance of motor vehicle accident victims in Hew South Wales - nevertheless a very small fraction of twenty billion dollars may be a large sum of public money.

3.8 Income maintenance - the dim prospect

Although we have listed quite a number of ways in which the income of an accident victim may be maintained, the future for a person whose long term earning capacity has been reduced as the result of accident faces a somewhat dim future. Those who, after the imposition of the Commonwealth Government's assets test next year are entitled to long term social security pensions or benefits, and the fringe benefits linked to the PHB card[20], certainly have a considerable degree of income security, but their income will probably be maintained at a relatively low and relatively unchanging level throughout the rest of their lives; they are not likely to be able to secure the progressively increasing standard of living which is the normal expectation of many income earners.

Those who receive some form of lump sun payment intended to provide them with an income for the rest of their lives also faces a dim, indeed potentially very worrying future. Inflationary trends, the present taxation arrangements and and foreshadowed changes such as the introduction of capital gains taxes, together with uncertainties of future economic developments will make it increasingly difficult to manage a lump sum so as to secure an appropriate level of income (at the worst, this means a level of income marginally higher than that obtainable by a social security pensioner or beneficiary) and maintain the capital necessary to sustain that income level. Few accident victims themselves possess the knowledge and experience necessary to manage effectively large sums of money, and the credentials, competence and performance of persons who tender advice on financial matters perhaps warrants closer scrutiny than they currently receive - see section 6.5 below.

Footnotes

1. Australian Bureau of Statistics, Australian Health Survey, 1977-78 Chronic Conditions (Canberra, ABS, 1980), p.19.

2. Department of Social Security, Annual Report 1982-83, (Canberra, AGPS, 1983), pp.100-101.

3. Information supplied by officer of N.S.W. Department of Industrial Relations, December, 1983.

4. Department of Social Security, op. cit., 101.

5. Id., p.99-100.

6. Id., p.123.

7. Id., pp.47-48 and information from the Commonwealth Department of Health.

8. Department of Social Security, op. cit., p.48.

9. Id., p.111.

10. Id., pp.48-49.

11. Id., p.112.

12. Id., pp.116-117.

13. Id., pp.33 and 102.

14. Repatriation Commission, Annual Report 1982-83, (Canberra, AGPS, 1983, p.10).

15. New South Wales Parliament, Budget Estimates Classified by Program, 1983-84 (N.S.W. Government Printer, 1983), pp.428-429.

16. Department of Social Security, op. cit., p.140.

17. Repatriation Commission, op. cit., p.48.

18. Commonwealth Department of Health, Annual Report of the Director-General of Health 1982-1983, (Canberra, AGPS, 1983), p.179.

19. Commonwealth of Australia Parliament, Joint Committee of Public Accounts, Income Maintenance Programs, volume 1 - Discussion Paper, (Parliamentary Paper No. 308/1983, Canberra, AGPS, 1983), p.1.

CHAPTER FOUR

MEDICAL MANAGEMENT

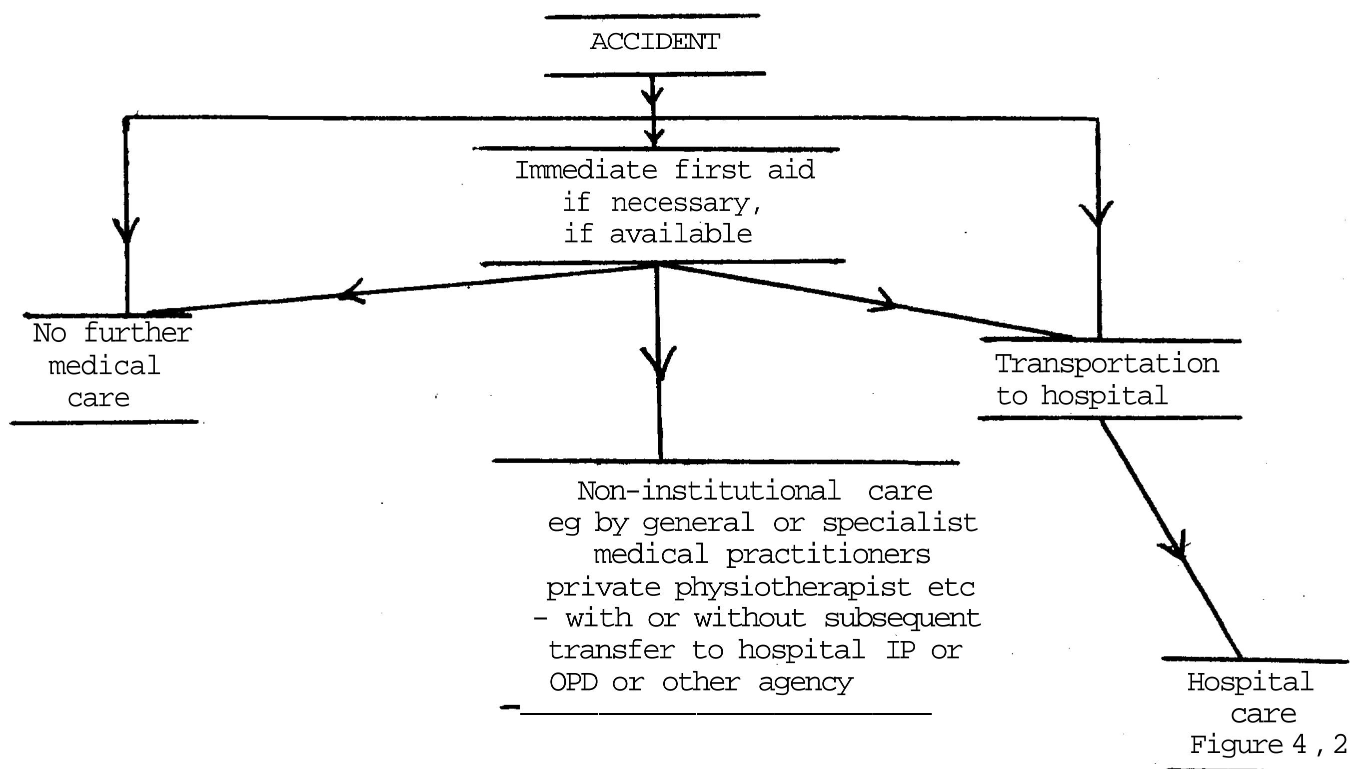
4.1 In this Chapter we are concerned with the following aspects of the medical care of the accident victims -

- **4.2** immediate post accident care
  - 4.2.1 - first aid
  - 4.2.2 - transportation
  - 4.2.3 - non hospital care
  - 4.2.4 - hospital 'emergency' care
- 4.3 longer term hospital care
  - 4.3.1 of inpatients - short stay and fast stream
    - slow stream
    - later admissions
    - readmissions and transfers
  - 4.3.2 of outpatients
- 4.4 hospital care - administrative aspects
- 4.5 longer term non hospital-based care
  - 4.5.1 institutional - nursing homes and other long stay institutions
  - 4.5.2 non-institutional - private practice
    - domiciliary care
    - training and activity centres
    - other
- 4.6 hospital rehabilitation units and rehabilitation centres
- 4.7 training in rehabilitation medicine
- 4.8 administrative and organizational issues

4.2 immediate post accident care

The needs for medical care immediately following an accident are shown in Figure 4.1

Figure 4.1 Medical care of the accident victim, I - immediate post accident care



Note: IP or OPD = inpatient or outpatient department.

4.2.1 First aid services

These may be provided by anyone who happens to be at the scene of the accident including members of the general public, police officers, ambulance officers. No charges are levied in respect of these services.

4.2.2 Patient transportation

In many cases where it appears necessary to transport an accident victim to a treatment centre private vehicles, sometimes taxis, are used. If ambulance transport is required, the cost of this service will be covered in part by State Government funding of the N.S.W. Ambulance Service. Contributors to the Ambulance Contribution Fund and specified groups of low income recipients receive free use of the service but other users are required to meet the heavy

charges levied by the Ambulance Service. Some of the health insurance funds in New South wales pay contributions to the Ambulance Contribution Fund on behalf of their members, some do not.

The Ambulance Service operates air ambulances for use when other modes of transport are inappropriate. Occasionally helicopters operated either by government or private agencies are used for the transportation of accident victims.

4.2.3 non-hospital care

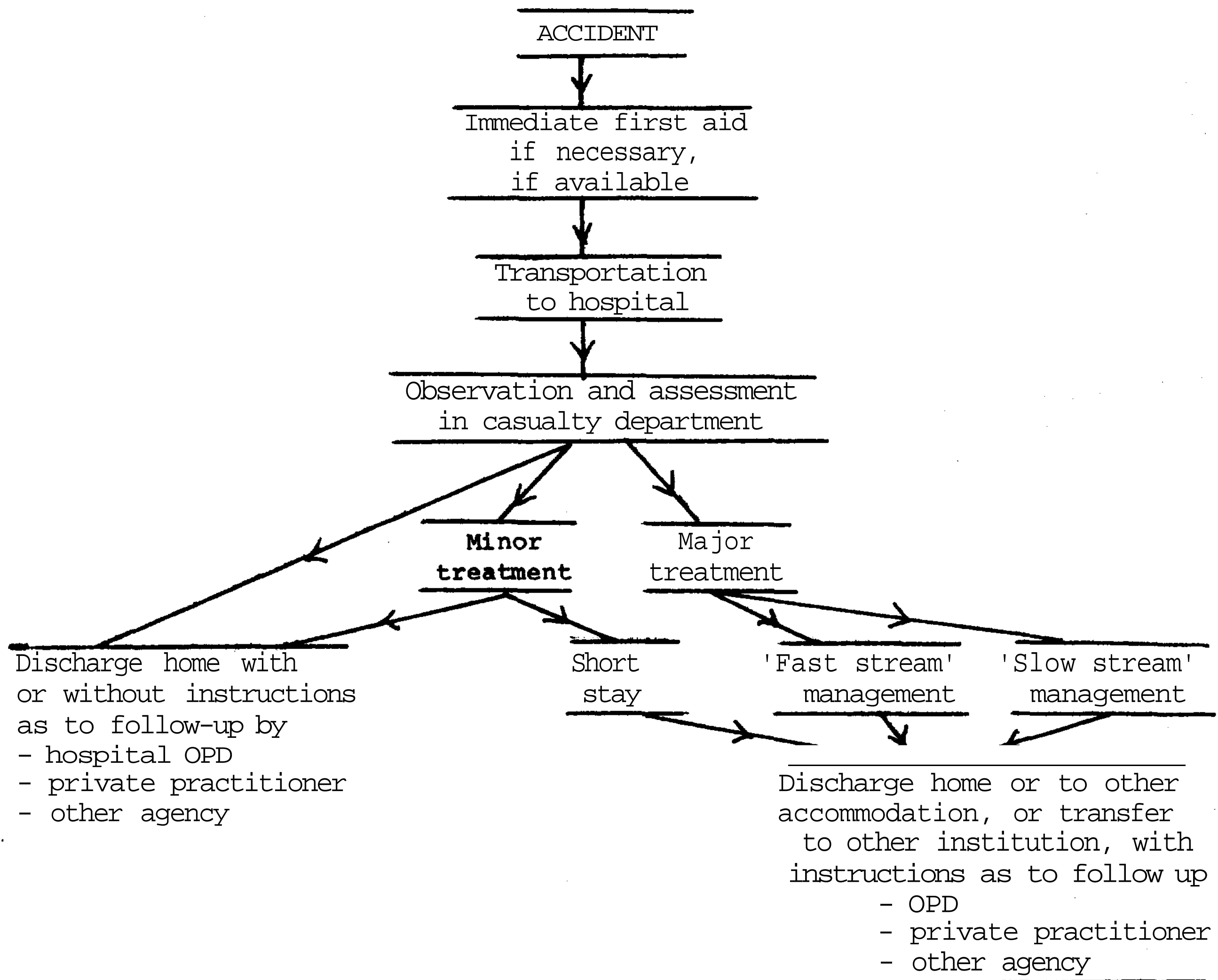
Fortunately the great majority of people involved in accidents require either no professional medical care or care only of a relatively trivial nature which does not require hospital treatment. But because the extent of injury suffered is not necessarily immediately apparent, and the possibility that what immediately after an accident appears of a minor nature may later reveal itself as a serious medical problem, very many accident victims do present to hospital.

4.2.4 Hospital 'emergency* care

As is shown in Figure 4.2, examination of an accident victim on arrival at hospital may lead to a decision to send the patient home with no treatment other than reassurance and perhaps instructions to report back to the hospital outpatient department or to visit a general practitioner for a check up in a few days time. Patients who require relatively minor treatment such as suturing of superficial lacerations or reduction and immobilization of simple fractures may be similarly discharged home with instructions regarding follow up attendances. Most of these patients do not stay at the hospital long enough to be admitted as in-patients. The state-wide hospital morbidity statistics

collection system does not gather detailed information about casualty and out-patient attendances and thus there are no readily available figures as to the numbers of motor vehicle accident victims passing through these departments.

Figure 4.2 Medical care of the accident victim, II - hospital care



Note: OPD - Out-patient department

As a general rule casualty departments and out-patient departments are found only in 'recognised' public hospitals - see Chapter 7 for details of hospital classification. Private hospitals do not have casualty departments; in some private hospitals doctors have rooms in which to attend patients on an 'out-patient' basis.

4.3 Longer term hospital care

4.3.1 A minority of people entering hospital will be assessed as requiring inpatient treatment.

4.3.1.1 Short stay patients

The average length of stay of motor vehicle accident patients in N.S.W. hospitals in 1981 was 9.4 days (see Table 4.1). Because some patients remain in hospital for long periods, the majority of patients would have been discharged before the ninth day of hospitalization. Many short stay patients require no rehabilitative care other than that which is part of their proper medical management while in hospital or which is obtainable by a relatively short period of attendance at outpatient or other physiotherapy clinics.

4.3.1.2. Fast stream rehabilitation patients

Some motor vehicle victims, and victims of other kinds of accidents may remain in hospital for a longer period of inpatient care, measured in weeks rather than days. These patients probably require more intensive and a wider range of rehabilitative activity. Because their progress towards discharge is, however, relatively rapid they are regarded as 'fast stream' patients and on discharge the majority will return to their own homes. Some will need continuing care for a long time, depending upon the nature and extent of their residual handicap. Others will place few or virtually no demands on after care services.

4.3.1.3 Slow stream rehabilitation

Those who sustain very serious damage, such as spinal injury or damage to the brain, will require a long period of inpatient care, a period measured in

months rather than weeks or days. These 'slow stream' patients are likely to require a great deal of rehabilitative effort both on their own part and on the part of the hospital staff caring for them. Upon their eventual discharge from hospital they will probably continue to need a considerable amount of assistance from various agencies and, if it is forthcoming, from relatives and friends. Among this group of patients one finds a significant proportion who do not return to home but require some form of institutional care, perhaps for the rest of their lives.

4.3.1.4 Later admissions

As noted above, the full effects of accidental injury may not become apparent until some time after the accident occurred. These later appearing sequelae may be treated in a public or private hospital, if the patient has private health insurance cover, or is likely to receive a third party or workers' compensation payment, then the treating doctor may prefer to admit the patient to a private hospital, perhaps to bypass a waiting list or to avoid uncertainty as to admission date at a public hospital.

4.3.1.5 Iteadmissions and transfers

Some patients discharged from hospital may later be readmitted for further medical care. Some patients initially admitted to, say, a public hospital may for various reasons be transferred to another public hospital, to private hospitals, to psychiatric institutions or to nursing homes.

4.3.2 Hospital **care** of outpatients

The majority of public hospitals in New South Wales offer outpatient treatment and employ some professional physical therapy staff - most commonly in

physiotherapy clinics. Public hospitals which do not have a full time specialist in rehabilitation medicine on the staff may employ one or more to visit the hospital on a monthly, weekly or more frequent basis to attend inpatients and conduct out-patient clincis. The care of many accident victims is not exclusively or, indeed, not at all in the hands of specialists in rehabilitative medicine; accident cases may be seen in general surgical, orthopaedic, neuro-surgical wards and outpatient clinics, The proper care of seriously injured people both as inpatients and outpatients may demand the attention of practitioners in a variety of specialties. 1

A public hospital having a rehabilitation unit so designated provides both inpatient and outpatient facilities for the unit's patients. These units are discussed at greater length in section 4 . 6 below.

4.4 Hospital care - administrative aspects

4.4.1 Hospitals, beds and utilization

In New South Wales at present there are some 250 public and 110 private hospitals with total bed complements of 28,000 and 6,300 respectively. Of the 28 thousand public hospital beds 872 are designated specifically as 'A & R' (assessment and rehabilitation) beds for the assessment, diagnosis, acute cars and rehabilitation of aged, chronically ill, fast or slow stream rehabilitation patients. The majority of these beds are used for the care of aged patients, a minority for motor vehicle accident victims. These A & R beds are distributed throughout all 11 Regions of the State(1). During 1981 there were on an 'average day' 504 beds in public hospitals occupied by motor vehicle accident patients - many of these would not be in designated A & R beds. Also, on an average day, 20 private hospital beds were occupied by motor vehicle accident patients. In 1981 a total of 20,433 separations of motor vehicle accident

patients from N.S.W. hospitals was reported, 19,255 being from public hospitals, 1,178 from private hospitals. (A separation is recorded when a patient leaves hospital on discharge, on transfer to another institution or upon death.) The average stay of all those patients was 9.4 days, but with some differences between public and private, metropolitan and country hospitals as shown in Table 4.1. About three quarters of motor vehicle accident inpatients were, in 1981, treated in hospitals located within the Region of their residence. More than half of all hospitalized motor vehicle accident victims were aged less than thirty years; this was so for males and for females. The nature of the injury leading to hospitalization, the percentage of patients dying in hospital and percentage of bed days attributable to particular injuries are indicated in Table 4.2. One notes that one third of all bed days are attributable to leg fractures, the other major contributions to total bed days being head injuries (fracture of skull and intracranial injury) and spinal/trunk fractures - together accounting for another one third of bed days.

Table 4.1 Motor vehicle accident patients, N.S.W. public and private hospitals, 1981

	Separations	Bed Days	Average Number of Beds Occupied per Day	Average Length of Stay (Days)
Public Hospitals				
- Metropolitan	10,136	109,593	300	10.8
- Country	9,119	74,348	204	8.2
Total Public Hospitals	19,255	183,941	504	9.6
Private Hospitals				
- Metropolitan	1,014	5,893	16	5.8
- Country	164	1,296	4	7.9
Total Private Hospitals	1,178	7,189	20	6.1
All Hospitals	20,433	191,130	524	9.4

Source; N.S.W. Health Department, 1983.

Table **4.2 Nature of injury: public and private hospital separations, deaths and bed days, N.S.W. 1981**

Nature of Injury	All separations No.	%	Deaths (in hospital) No.	%	Percentage of total bed days %
Fracture of skull	1,200	5.9	36	15.7	6.5
Fracture of spinal trunk	1,749	8.6	22	9.6	15.0
Arm fracture	1,655	8.1	5	2.2	6.5
Leg fracture	3,013	14.7	20	8.7	34.7
Dislocation	401	2.0	0		2.0
Sprain or strain	615	3.0	0		1.3
Intracranial injury	2,694	13.2	64	27.9	9.9
Internal injury of chest, abdomen or pelvis	635	3.1	33	14.4	4.1
Open wound	2,604	12.7	7	3.1	5.8
Superficial injury	558	2.7	1	0.4	0.8
Contusions	1,014	5.0	1	0.4	1.7
Injury to nerves or spinal cord	95	0.5	4	1.7	0.4
Other injury	824	4.0	6	2.6	2.3
Observation	348	1.7			0.3
*Other condition (i.e. not an injury	3,028	14.8	30	13.1	8.8
Total	20,433	100	229	100	100

* Includes readmissions for continuing treatment.

Source; N.S.W. Health Department, 1983.

4.4.2 **Charges to hospital inpatients**

Both public and private approved hospitals receive funding from the Commonwealth Government; public hospitals also receive State Government financial support. Thus fees charged to patients for hospital care represent only a fraction of a hospital's revenue - a large fraction in the case of a private hospital, a considerably smaller fraction for a public hospital.

From 1 February 1984 a patient admitted to public hospitals has been classified into one of four groups -

'third party' patient

workers' compensation patient

private patient

'hospital patient'

Patients who are thought by the hospital administration to be covered, or likely to be covered by third party or workers' compensation insurance arrangements have charges raised against them by the hospital and are treated by members of the medical staff of the hospital as their private patients - the doctors thus being entitled to charge fees in respect of these patients. Both the hospital charges and doctors' fees may be recoverable from the insurer.

Patients not thought to be covered by third party or workers' compensation arrangements may elect to be classified as private patients. They then may nominate a doctor (or doctors) to attend them from among members of the hospital staff having the right to private practice within the hospital. Their medical attendant or attendants are entitled to charge them fees for their medical care - quite separately from the fees which the hospital will levy for the accommodation and services provided by the hospital. Private health insurance may be purchased from federally registered not-for-profit health insurance funds to cover the hospital charges. The registered funds are not permitted to offer insurance against doctors' fees, but the Federal Government's 'Medicare' scheme reimburses patients to the extent of 85 per cent of the schedule fee, with a maximum payment for any service of $10.(12) However a doctor may charge any fee he wishes, and thus the patient may be called upon to pay more than the 'moiety' arising from the Medicare arrangements.

Anyone not included in one or other of the above three groups is admitted as a 'hospital patient' and receives accommodation and all necessary medical and

other services in the hospital without charge. Patients in this category are not entitled to nominate a particular doctor or doctors to be responsible for their medical care.

Most patients admitted to a public hospital immediately following a road traffic accident will come into the first category - 'third party' patient.

Private hospitals raise charges against patients for the services provided and the doctors who attend patients in private hospitals charge fees to those patients/ separately from hospital charges. Private hospital fees may be covered in whole or in part by third party, workers' compensation or private health insurance. Fees charged by doctors attending patients in private hospitals may be covered wholly or in part by third party or workers' compensation arrangements, or in part by Medicare as described above in relation to patients treated as private patients in public hospitals.

4.5 Longer term non-hospital based care

Accident victims who receive no hospital care, and some who do, may obtain medical care from other sources.

4.5.1 Long stay institutional care

Those whose handicaps either physical or mental, or both, are severe and long lasting may need continuing care in a nursing home or an Institution for the psychiatrically disturbed or intellectually handicapped, in these long stay institutions their care will be under medical supervision.

Patients in State Government long stay institutions are, in general, not very likely to face great problems in meeting any charges levied by the institution,

because charges, if any, are generally tied to some specified fraction of a social services pension, and medical attendance is provided by practitioners paid by government and not entitled to charge patients for services rendered. However patients may face problems in relation to arrangements concerning any property they may have such as a house they can no longer occupy. The institutions themselves may face financial problems arising from inadequate allocation of funds from the State authorities.

A patient in a private nursing home will be required to pay weekly charges, which, although fixed by the Commonwealth authorities, and partly covered by the Commonwealth Nursing Home Benefit, may impose a considerable burden on the patient or relatives. The federally regulated private health insurance arrangements do not cover nursing home charges. Fees charged by doctors to patients in private nursing homes may be covered wholly or in part by third party or workers' compensation insurance arrangements, or through Medicare.

4.5.2 Hon-institutional longer term care

4.5.2.1 Private practice

Medical practitioner care outside institutions is largely provided by private general practitioners and specialists working mainly in their rooms, but with general practitioners making some domiciliary visits. 'Out-of-hours' care in urban areas particularly is likely to be provided by practitioners other than the patient's usual doctor.

Compensation arrangements or Medicare may cover part or all of doctors' fees. Under the Medicare scheme, there is automatic entitlement to medical benefits of 85 per cent of the schedule fee, with a maximum payment for any service of $10.([12]) A medical practitioner may elect to 'bulk-bill' - that is, claim payment of 85 per cent of the schedule fee directly from Medicare - in which

case the patient is charged nothing. But the practitioner nay choose to charge the patient a fee higher than the schedule fee in which case the patient is required to pay more than the 15 per cent or $10 moiety payable where the schedule fee is charged. The registered health insurance organizations are not permitted to offer medical insurance to cover that moiety or other fees charged by medical practitioners. Arrangements for payment for treatment by optometrists in private practice are similar to those described for private medical practitioner treatment.

Treatment provided by private practitioners of physiotherapy and some other forms of care may be covered in whole or in part by 'third party', workers' compensation or other private insurance arrangements. The extent of cover depends upon the type of insurance cover and the insurers' rules regarding payment of benefits.

4.5.2.2 Domiciliary care

Domiciliary medical, nursing and paramedical care may be provided by private practitioners. Doctors' visits will attract medical benefits under the national health insurance arrangements. The registered health funds offer 'additional cover packages' which may meet part of the cost of home nursing and paramedical care up to some specified annual limit.

Some public hospitals and state Health Department community health centres Operate domiciliary nursing and paramedical services. These services are subsidised by the State and Commonwealth Governments.

The Commonwealth also provides a Domiciliary Nursing Care Benefit to assist people who choose to care, in their own homes, for chronically ill or infirm relatives who would require admission to a nursing home if this care in their own homes was not available. The basic criteria for this benefit are that the patient must be at least 16 years of age, be in need of continuing nursing care and be receiving regular visits from a registered nurse.

To assist in the extension of home nursing activities the Commonwealth introduced its Home Nursing Subsidy Scheme in 1957. To be eligible to receive the subsidy, an organisation must provide a home nursing service, be non-profit making, employ registered nurses and be in receipt of assistance from a State Government or a local Government body or other authority established under a State Act. The amount of subsidy paid by the Commonwealth Government is limited to the assistance received from the State and/or local government. Principal among these home nursing organisations is the N.S.W. Home Nursing Service.

Although exact figures are not obtainable, upwards of 750 nurses in N.S.W. are engaged in domiciliary work. Services are coordinated on a regional basis throughout the State. Generally operating hours are 8 a.m. to 4.30 p.m. Monday to Friday. Very limited weekend service may be provided. Patients not in receipt of a pension who receive visits from the N.S.W. Home Nursing Service are charged up to $2 a visit, depending on ability to pay(2).

4.5.2.3. Training and activity centres

These centres are principally concerned with training in living skills, the occupation of the intellectually handicapped and with social and recreational type activities. They may receive Commonwealth assistance on the same terms as sheltered workshops. At 30 June 1983 there were 68 training centres and 64 activity therapy centres operating in New South Wales with Commonwealth

subvention(3).

4.5.2.4. Community health centres and domiciliary nursing services

Responses to our questionnaire from community health centres, community rehabilitation services and domiciliary nursing operating under the aegis of the State Health Department indicated that their staffing included personnel whose training could be regarded as appropriate for the rehabilitation and after care of road traffic accident victims. But the reported case mixes of these centres and services showed that those victims constituted 0-3 per cent of their clientele. In some returns the caseload was almost exclusively in the 65 year and over age range, but even when this was not so the percentage of road traffic accident victims treated was very small. It is not possible for us to say how accurately these returns reflect the case mix of other community health centres and domiciliary nursing services.

4.5.2.5. Other non-inpatient facilities

Day hospitals and day centres provide care for people who need continuing care under medical and nursing supervision but do not need to be kept in institutions as inpatients. Many of those attending for day care require special transport arrangements, being unable to provide their own or to use public transport services. The State Health Department reported in 1983 a total of 411 day hospital places distributed among 9 of the 11 Health Regions of Mew South Wales; the number of day centres and day centre places was not stated, but some day centre facilities were reported in 10 of the Regions (4).

4.5.2.6 Other demands of non-institutional medical care

The Commonwealth Department of Health administers the federal Pharmaceutical Benefits Scheme which makes available on prescription by medical practitioners a. very wide range of drugs - benefits - either free of charge or at concessional rates. From 1 January 1983 a three-tier system of patient contribution - holders of PHB and HB cards (see section.....) and their dependants receive benefits free of charge; holders of Health Care cards, together with social security pensioners and Veteran's Affairs Service pensioners who are ineligible for free pharmaceutical benefits receive their benefits upon payment of a small charge per item patient contribution; all other persons are required to pay a contribution per item. Although the patient contributions per item are not large, patients requiring a long term medication regime, perhaps requiring several different drugs concurrently, may find the cost of this treatment burdensome. Where drugs not listed as pharmaceutical benefits are prescribed, the cost to the patient may be very considerable - but most drugs in common use are included in ths list of benefits.

4.6 Hospital rehabilitation units and rehabilitation centres

4.6.1 Hospital rehabilitation units

On the basis of facilities, staffing types of cases handled, two rehabilitation specialists (Drs. Voss and Jones) classified N.S.W. hospital rehabilitation units as follows:-

I Major - Concord (in association with Lady Davidson Hospital)
Prince Henry
Prince of Wales
Royal North Shore (in association with Coorabel, Royal Ryde)
Royal South Sydney
Westmead Centre - Parramatta

II	Large	-	Royal Newcastle Royal Prince Alfred St. George	
III	intermediate	-	Albury Base Bathurst District Gosford District Hornsby Woden Valley A.C.T. (serves surrounding N.S.W. area)	Port Kembla St. Vincent's, Lismore Tamworth Base Western Suburbs
IV	Smaller	-	Apex Rehab, unit, Orange Blue Mountains District, Katoomba Canterbury Governor Phillip, Penrith Liverpool District Lourdes Hospital, Dubbo	Manly District Monal Vale District Royal (Alexandra (Amputees only) St. Vincent's. Sydney Sutherland District Sydney Hospital
V	Not assessed	-	Arraidale Bankstown Bowral Broken Hill	Griffith Manning River District, Taree Port Macquarie Ryde District

Units which, in addition to more general rehabilitation also provide special facilities were noted as located at -

Head injuries	- Lidcombe Hospital
Spinal injuries	- Royal North Shore with Coorabel, Royal Ryde Rehabilitation Hospital - Prince Henry Hospital
Paediatric programs	- Prince of Wales Hospital - Western Suburbs Hospital
Amputee service	- Royal Prince Alfred Hospital

Although these listings are admittedly somewhat impressionistic, they give some indication of the location and status of hospital rehabilitation units(5).

4.6.2 Rehabilitation centres

The CRS Centres have been mentioned above and are described at greater length in section 12.2.1.2 below. The privately run IIlawarra Rehabilitation Centre is located in the Wollongong area. Other private clinics and agencies specialising in medical aspects of disability assessment and rehabilitation include International Rehabilitation Associates Pty. Ltd. (INTRA). Some large

enterprises which have their own occupational health departments headed by a medical officer may also provide some rehabilitative care for their employees.

4.6.3 A medical **rehabilitation hospital**

The Royal Ryde Rehabilitation Hospital provides an example of a medical rehabilitation and long term care complex. The hospital is incorporated under the Companies Act 1961 (NSW) and is recognised as a public hospital under the Public Hospitals Act 1929 (NSW). It comprises the following units.

Weemala Home - 176 beds for long-stay younger and middle aged patients suffering from incurable injuries and illnesses. The length of stay of patients is reflected in the small number of admissions and separations, about 20 per year. The average age of female residents (1982-83) was 53 and of males 47 years.

Some residents are employed in sheltered workshops in Allambie Heights and West Ryde. Groups of residents are taken weekly to Royal North Shore Hospital for hydrotherapy. A variety of social and recreational activities is organized by recreations officers and volunteers.

Coorabel Hospital is a specialised rehabilitation unit operating (in 1982-83) 74 beds, to which 607 patients (almost exactly equal numbers of males and females) were admitted during that year. The unit is particularly concerned with the care of early stage brain injured patients and will in the future be operating a Regional Brain Injuries unit. The age distribution of patients treated in the past two years has been

	1981-82	1982-83
	%	%
Less than 30 years	12	16
30-49	15	14
50-69	36	36
70+	37	34
	100	100

Patients were admitted for the most part from short stay hospital in the Inner and Northern Metropolitan Regions; about 7 per cent were admitted from home.

The destinations of patients discharged from Coorabel were

	1981-82	1982-83
	%	%
Own home	70.6	61.9
Acute hospital or other specialist care	21.4	33.1
Nursing home	7.4	4.7
Died in hospital	0.6	0.3
	100.0	100.0

Moorong Centre includes a 17-bed assessment unit, a day hospital and a day care centre, The assessment unit is operated in conjunction with an assessment clinic at Ryde District Hospital. The majority (78%) of the 152 patients admitted to the Dixson Unit in 1982-83 were aged 70 years or more, 45 per cent were admitted from home, 40 per cent from Ryde Hospital and the remainder from elsewhere. Separations were to home for 55 per cent of patients, to an acute hospital for 25 per cent, another 13 per cent were transferred to nursing homes and seven per cent died in the units.

The complex has its own physiotherapy, occupational therapy, speech pathology, clinical psychology, social work and recreation departments. Home nursing and meals-on-wheels services are based on the hospital.

The income of the complex for 1982-83 was $8.1 million, of which approximately half was by way of Commonwealth and State Government subsidy, the other half being made up of $2.2 million by way of fees paid by patients and through the registered health insurance funds, plus $1.8 million by way of Commonwealth Nursing Home Benefit. As is usual in medical institutions 80 per cent of all expenditure was by way of wages and salaries. The year's operations resulted in a deficit of $210,207.

Among the problems encountered during 1982-83 were -

- temporary closure of the Day Care Centre and Day Hospital due to lack of funds

- a waiting list of patients for admission to Coorabel Rehabilitation Hospital

- an inadequate number of assessment beds to meet the demand

- inability to meet demand for out-patient care because of limited numbers of physiotherapists

- difficulty in arranging nursing home placements(6).

This institution represents, under one administration, most of the services which go to make up comprehensive medical rehabilitation and continuing after care.

4.6.4 A public hospital rehabilitation unit

The following material was prepared by the Medical Director of one of Sydney's larger hospital rehabilitation units. It provides an informative review of the work and problems of a hospital-based unit:-

DEPARTMENT OF REHABILITATION MEDICINE, HOSPITAL X, 1983

AIMS AND FUNCTIONS

(1) To assess all referred patients in relation to their rehabilitation potential. To advise on (a) the prognosis, (b) an outline of an appropriate rehabilitation programme, and (c) the most appropriate rehabilitation unit at which to receive such rehabilitation. Or to advise, in those cases where rehabilitation is deemed to be not applicable, on appropriate placement of the patient (preference being given, where possible, to returning the patient to his home, and provision of domiciliary care from community services). The assessment includes physical, mental, social and vocational components.

(2) To provide rehabilitation medicine treatment to patients referred to the Department.

(a) In-patients; The majority of the referred in-patients are seen in a consultative role. Alternatively, the referring Specialist may transfer the patient into the care of the Specialist in Rehabilitation Medicine.

At the present time, rehabilitation beds are scattered, rather than being in one ward.

Rehabilitation medicine treatment is provided to the following categories of patients:

(i) Patients awaiting transfer to other units for long-term or medium-term rehabilitation management.

(ii) Short-term patients who will be ready for discharge within five to six weeks or less, most of whom will require continuing rehabilitation on an out-patient basis.

(iii) In-patients transferred from other hospitals, particularly peripheral and country hospitals, for specialised rehabilitation medicine management.

(b) Out-Patients: Patients are referred by:

Other departments within the hospital
General practitioners, especially from the local area, but also from other urban and country areas.
Specialists, particularly orthopaedic surgeons, from wide areas in Sydney.
Insurance company doctors.
Other hospitals, particularly from country areas.

(3) To provide physical medicine treatments in the management of acute and sub-acute musculo-skeletal strains and injuries.

The majority of these patients are referred as out-patients. Referrals come from:

Local general practitioners and specialists.
Other departments of the hospital, including the Casualty Department and Staff Health.

(4) The Department provides physical medicine and rehabilitation medicine to service the local community.

(5) A wider community is also served, as illustrated by paragraph (2) above. This is in recognition of the fact that certain diagnostic and special treatment facilities and skills in physical medicine and rehabilitation medicine are concentrated in selected hospitals and the services are provided continuously to the Region and the State.

(6) At the same time, the aim is to return the patient to his home (whether this be locally or in the country) or to a rehabilitation unit close to his home as soon as possible.

(7) To maintain multi-disciplinary teams to provide the service so that the patient can return to his normal environment and normal daily living as fully as his individual abilities will allow and to do so as quickly as possible.

(8) To provide a complete physical medicine and rehabilitation medicine treatment programme. Thus, where the patient was previously at work prior to his illness or injury, services are available to assist the patient to return to his previous work or to return to alternative work of a more appropriate nature. Facilities are available for vocational assessment and for up-grading of activity tolerance. Liaison is maintained with the Special Categories Section of the Commonwealth Employment Service. On the other hand, it is not a function of a hospital department to attempt to provide any vocational training or vocational re-training. If our vocational assessment indicates that vocational re-training is appropriate, then we place or refer the patient accordingly (for example, placed in employment with on-the-job training, placed at Technical College or other tertiary or correspondence course, or referral to a Commonwealth Vocational re-training unit).

(9) Involvement in educative and preventitive work within the hospital, through the Division of Community Medicine, directed at the staff and at the patients in the hospital. In addition, the Department runs education courses for particular groups of rehabilitation patients and their relatives; those courses which relate to particular disability conditions (e . g . stroke groups, or amputee groups) also provide the opportunity amongst relatives for mutual support.

(1 0) To attempt to gradually convey to other specialists, physicians and surgeons in the hospital the philosophy of rehabilitation medicine and the need for referral.

(1 1) To provide training in physical and rehabilitation medicine.

(1 2) To conduct research and also to encourage research activities amongst the various allied health professionals within the team.

CORE SERVICE

Full physical medicine and rehabilitation medicine service is provided on an individual basis for patients admitted to the hospital and referred to the Department.

Similar services are also provided for patients attending as out-patients. Such patients may have been referred initially as out-patients, or patients from the hospital wards may continue their rehabilitation medicine programme on an Out-patient basis after discharge from the ward if they live within the area convenient for travelling, or if they are from country areas and are having specialised treatment.

This hospital was amongst the first in Australia to establish the multi-disciplinary rehabilitation team approach.

Teaching functions include the teaching of physical and rehabilitation medicine to residents, to medical students, to therapists and to nurses, and the teaching of aspects of physical medicine at postgraduate medical courses held in the Department through the Postgraduate Medical Institute, University of Sydney.

The provision of a mobile home-visiting team, particularly for the purpose of assessment of the home conditions prior to discharge of the patient from hospital, and the provision and installation of any rails or aids as indicated.

Close liaison with other rehabilitation units, vocational re-training and employment services, and community health services, dose association with most other departments within the hospital.

Special services and clinics (some of which attract patients State-wide):

Amputees
Hand injuries
Cardiac
Respiratory
Back pain
Adult spina bifida

SOURCES OF REFERRAL

In-patients; The majority of in-patients are seen in a consultative capacity.

Requests for consultations on in-patients arises particularly from the neurology and neurosurgery units; the other main sources of requests for consultations on in-patients are from urology, general medicine and respiratory medicine units.

Requests to transfer patients into rehabilitation beds arise particularly from neurosurgery units, and to a lesser extent from neurology, general medicine and respiratory medicine units. Referrals for admission of patients from outside the hospital originate particularly from orthopaedic surgeons, and to a lesser extent from medical officers of insurance companies and from general practitioners.

Comment: The number of referrals from within the hospital is in direct proportion to the extent to which the Department is able to make its presence felt in other units and departments, such as by participation in ward rounds and/or staff conferences. Owing to the medical under-staffing, we are unable to have any regular on-going liaison with departments who have some patients who would benefit from an integrated complete rehabilitation team management e.g. oncology, orthopaedics, cardiac surgery.

Out-Patientst The sources of out-patients attending the Department are:

Continuing management of patients whose rehabilitation programme had been commenced when they were in-patients.
Patients referred from other out-patient services in the Hospital, particularly the Pain Clinic.
Referrals from other hospitals.
From general practitioners, specialists, particularly orthopaedic surgeons, and from community health centres.

LINKS WITH OTHER DEPARTMENTS

Information liaison with heads of departments and specialists, particularly in neurology, neurosurgery, the Pain Clinic, and psychiatry and psychology.

Regular once weekly case discussion by our R.M.O., on the neurosurgery ward with a registrar, and on neurology with a registrar.

These links with other departments are inadequate. We should be able to provide the service to, at least, neurology and neurosurgery of having a rehabilitation registrar or specialist at the principal weekly round of each of the neurology and neurosurgical units, as as to provide rehabilitation in-put and advice during the round. There is also a need for rehabilitation medicine resident or registrar participation in some form of regular liaison with each one of the units and department mentioned above under "Sources of Referral" (as by participation in ward rounds, or staff conferences or, at the least, a weekly patient review with the respective registrars). We do not have the medical manpower for such activities.

SUPPORT SERVICES

Medical Staff;

Director	Specialist in Physical and Rehabilitation Medicine
V.M.Os.	Specialist in Physical and Rehabilitation Medicine
	Specialist in Cardiologist
	Specialist Hand Surgeon
	Physician (co-ordinator of the Adult Spina Bifida Clinic)

Staff Specialist - Surgeon co-ordinator of the Amputee Clinic
Other specialists available for consultation - psychiatrists have attended staff conferences in the Rehabilitation Medicine Department on occasions, but there is a need for the permanent allocation of a psychiatrist part-time to the Department.
- referral of the patient, to any other specialist within the hospital as required.

Allied health professionals;

Speech pathologists - 3 . 5
Occupational therapists - 23
Physiotherapists - 40
Social Workers - 25
Dietitians Psychologists
(Interpreters)

Many of the above practise specialised skills within the rehabilitation service, for example, neuro-physiotherapy, manipulative therapy, pediatric physiotherapy, amputees, hand injuries, cardie-thoracic physiotherapy, and, within occupationnal therapy, specialised fields such as amputee and hand injury management, assessment for correct prescribing of wheelchairs, vocational assessment etc.

Nursing Staff;

Apart from the general nursing staff on the wards, two sisters have appointments (part-time) in the main treatment areas of the Rehabilitation Medicine Department, being attached to the Amputee and the Cardiac Rehabilitation Clinic.

In-patient Accommodation;

Rehabilitation beds are available. However, these are scattered and not all in one ward.

Pressure on bed availability within the hospital prevents us from keeping patients who require in-patient rehabilitation facilities for more than 2-2.5 months. Yet we continually find difficulty in trying to place patients who require long-stay rehabilitation medicine beds. There is a need for long-stay beds, under specialist rehabilitation medicine supervision, within the areas served by the hospitals. We recommend that these beds or at least some of these long stay beds be at this hospital.

Live-in for Relatives;

Live-in accommodation for relatives is available within the hospital complex.

Assessment and A.D.L. Re-training Areas;

Fully equipped areas are available for re-training in all aspects of A.D.L. (Activities of Daily Living) - such as a bathroom practice area, a furnished bedroom, a kitchen (all within one of the occupational therapy treatment areas for assessment, provision of aids and re-training) - and also the provision or some work-simulated activities, for the purposes of vocational assessment and upgrading of activity tolerance.

Outreach;

Our department maintains close liaison with:
Other hospital departments of rehabilitation medicine.
Vocational re-training centres e.g. Queen Elizabeth II Rehabilitation Centre; National Association for training the Disabled in Office Work.
Community health centres.
Home visits to patients' homes by our mobile team to assess the home environment, structural barriers, social situation and need for the provision of any A.D.L. aids.

Equipment Pool;

Fully equipped, including many facilities and equipment not available at smaller units.
The Department was the first to introduce into Australia facet joint nerve blocks, and was amongst the first in Australia to introduce the use of interferential and biofeedback training equipment.
The Department was the second in Australia to introduce a heated hydrotherapy pool.
Our Surgical Shoe unit is staffed by two surgical shoemakers and a trainee.
Our Orthotics unit is staffed by five orthotists and three trainees.

Diagnostic Services;

The full diagnostic services of this hospital are available.

Education Services;

In addition to the health education (general and specific) and the prevention education included in the overall management of the patient, other education activities include:

English, and other basic subjects as appropriate.
Education programme for relatives and patients, e.g. stroke patients, amputee patients.

Transport;

The Department was amongst the first in Australia to develop an effective transport system for out-patients coming to the rehabilitation department regularly for treatment.

However, we now have a totally inadequate service since our hospital transport services have recently been drastically cut.

As a result of the loss of our Hospital transport, we have the situation where some patients are being treated inadequately in the sense that the frequency of their treatments had to be restricted, and some patients Who need treatment are not being treated due to their inability to reach the hospital without the Provision of transport.

Teaching;

The hospital serves as a major clinical teaching centre for every one of the allied health professions listed above

The specialists in physical and rehabilitation medicine are involved in teaching aspects of the speciality to nurses and medical students and at the postgraduate level.

4.6.5 Case load and case nix of a public hospital rehabilitation centre

The Director of Medical Services and Director of Rehabilitation of another metropolitan public hospital having a rehabilitation centre also provided details of the centre's activities. The Royal South Sydney Hospital has 126 beds ranging from intensive care to an independent living ward where patients are independent in activities of daily living. The hospital's Rehabilitation Centre treats an average of 200 adult inpatients and outpatients daily. Usually outpatients attend for 1-4 weeks but 10-20 per cent attend for longer than 4 weeks with 1 per cent attending for longer than 6 months. More than 4000 patients were treated at the centre in the most recent 12 month period; waiting time for out-patient treatment is currently (November 1983) 6.5 weeks, but increasing with a present waiting list of 34 persons.

The causes of the disability of patients treated in the past twelve months were -

Trauma - occupational	33% of patients
road accident	17
other trauma	10
Congenital causes	Nil
Geriatric conditions	35
Other causes	5
	100%

Usually all occupational and road accident cases were awaiting the outcome of compensation claims; rarely is treatment given subsequent to award. The Centre has a supra-regional responsibility for workers compensation patients and amputees; it provides rehabilitation to the general population with a defined

local area surrounding the hospital.

Of the inpatients treated by rehabilitation centre staff 70 per cent return home, 30 per cent are transferred to nursing homes, hospital et cetera. At discharge from the Centre, 85 per cent of patients are totally independent, five per cent minimally and 5 per cent moderately dependent, the other five per cent being heavily to totally dependent.

4.6.6 the Ranter Regional Rehabilitation Services (HRRS)

With a Committee of Management which includes nominees from the Commonwealth Rehabilitation Service, the Royal Newcastle Hospital and the Hunter Regional Office of the State Health Department, the Hunter Regional Rehabilitation Service stands from an administrative point of view somewhere between a CRS rehabilitation centre and a public hospital based centre. The service has capacity for 80 or more clients attending on a daily basis; programmes run from 8.30 a.m. to 5 p.m. No inpatient facilities are provided but if necessary arrangements can be made for clients, who are drawn from the Hunter and adjoining regions, to stay in self care or hospital accommodation. The multi-disciplinary staff comprises 25 full time and 6 part time workers. Funding for the HRRS is provided by the CRS and the State Health Department on a 1:1 basis. Arrangements for charging recipients of service are the same as those applying to public hospital outpatients. The service received 1500 applications in the twelve months ending April 1984, of which 300 were successful. Only four percent of clients accepted into programs were outside the 15 to 64 years range. Twenty per cent of clients treated were road accident victims - in virtually all cases unsettled compensation claims were pending. Fifty per cent of clients were suffering the results of occupational trauma. Average waiting time for initial interview is 3 to 4 weeks and then 1-10 weeks wait for commencement of programme. A programme may entail

attendance for up to three days a week over five months. Of those completing programmes, an estimated 20 per cent returned to full employment, 15 per cent were on to a retraining program, 40 per cent followed an avocational lifestyle and the rest went to activity or work therapy centres et cetera.

4.6 Problems of medical rehabilitation centres

The problems reported from the Royal South Sydney Hospital Rehabilitation Centre reflect in part general shortcomings in the rehabilitation and after care system, in part particular problems of minor vehicle accident victims and in part particular problems of that institution.

Among more general problems are:-

- inadequate staffing levels
- insufficient nursing home beds for placement of patients on discharge from hospital
- lack of adequate centres for avocational interests
- lack of sufficient training establishments for development of alternate skills
- lack of suitable housing and attendant care for chronically disabled young and middle-aged adults
- lack of follow-up staff in the community and staff to carry out long-term treatment, especially of brain damaged people.

Particular problems encountered in the care of motor vehicle accident victims include:-

- delays in processing claims; there is a need for liaison personnel in third party organisations to assist in emergency situations

- difficulty in the successful resettlement in the community of brain injured young adults
- delay in final Court hearings

Among problems particular to the institution was obtaining approximately $300,000 over the next two years to establish a fully equipped regional and supra-regional rehabilitation engineering service - there was considered to be a need to augment the present rehabilitation staff of three with twelve additional personnel, and extend the facilities at the centre.

4.7 Training in rehabilitation medicine

Among the many branches of medical practice competing for space in medical school undergraduate teaching programs, rehabilitation medicine occupies a minor placing. Nor does this subject occupy much time in the immediate postgraduate years spent as a hospital intern or resident. Thus, although a large proportion of motor traffic accident victims are treated by medical practitioners at some time, not all medical practitioners have received systematic formal training in this branch of medicine.

In 1967 the Australian Association of Physical and Rehabilitation Medicine, among whose members were most of the practitioners who by long experience, and with or without formal postgraduate qualifications in this specialty, could be regarded as the leading practitioners, discussed the formation of a professional college to be responsible for the development of training and certification in the specialty. In 1976 the National Specialist Qualification Advisory Committee recognised rehabilitation medicine as a major specialty. The Australian College of Rehabilitation Medicine was finally established on 22 August, 1980. Thus the College is one of the 'youngest' of the learned medical colleges in Australia - and it is one of the smallest.

The College's training program consists of two, parts, the first requiring three years medical and surgical experience after completion of the MB,BS degree. Part II requires a minimum of three years vocational training and experience. Satisfactory completion of this program leads to the diploma of Fellow of the Australian College of Rehabilitation Medicine, F.A.C.R.M.(7) Among the present Fellows of the College a number have not completed this program, having been admitted to the College under a 'grandfather' clause of the type commonly written into the constitution of professional bodies to cover the admission of persons whose experience and training is thought to fit them to specialist status.

With an increasing number of geriatric assessment and rehabilitation units in this State, and on increasing utilisation of these units, there is likely to be an increasing demand for formally qualified specialists in this State. Some specialists based in Sydney make regular visits to units in extra metropolitan hospitals.

As stated in the College's Manual for Candidates,

> 'A specialist in Rehabilitation Medicine works in close collaboration with medical colleagues, allied health professionals and others...'

The training of these allied health professionals, such as physiotherapists and occupational therapists, psychologists, social workers and rehabilitation counsellors is conducted in universities, Colleges of Advanced Education and rehabilitation agency-based training programs.

4.8 Administrative and organizational issues

4.8.1. Given the geographic distribution of population in New South Wales it is inevitable that highly specialised medical rehabilitation activities will be centred in the Sydney metropolitan area. However, as noted in section 4.6.1

above there is a dispersion of units throughout the State and efforts are being made to strengthen these units as part of the State wide 'regionalisation' of health services.

In the course of our interview survey some comments were made about the close proximity of units located at Prince Henry Hospital, the Prince of Wales Hospital and the South Sydney Hospital - comments regarding amalgamation; some mention was made of inappropriate utilizaion of metropolitan units in that some patients travel long distances across Sydney to attend a particular unit 'bypassing' a unit closer to their place of residence; staff at the Prince Henry Hospital unit expressed uncertainty and fears as to the possible future of that unit in the present climate of 'rationalization' of hospital services; while these matters are obviously of concern in considering the details of provision of rehabilitation services, their proper investigation was beyond both our resources and, in our opinion, our brief.

Of more immediate import regarding the medical management of motor traffic accident victims are the desirability and practicability of establishing one or more units specifically and perhaps exclusively to treat these people. In Melbourne, victoria, the Bethesda Hospital administered as a not-for-profit private hospital by the Salvation Army serves this function. The Minogue Report, 1978(9) included mention of the desirability of the Government of Victoria taking up with the Commonwealth Government the question of the use of Commonwealth rehabilitation facilities whereby motor vehicle accident victims might gain more ready access to Commonwealth rehabilitation facilities, particularly those victims whose needs were not specifically vocational rehabilitation training. The Report did refer to the temporary requisition of institutions to accommodate those who could not be admitted to the existing rehabilitation hospitals. That report did not make any specific recommendations regarding the establishment of a non-government treatment facility(10). A

knowledgeable informant from Victoria expressed the opinion that the decision to locate a specialised rehabilitation unit at Bethesda was made at ministerial level, not necessarily with the support of State hospital authorities(11). it was our impression that the majority of those who, in New South Wales, expressed an opinion on the matter favoured the utilization and where appropriate the improvement of existing medical rehabilitation units. However we did not canvass opinion outside the public sector; one notes that private enterprise is increasingly active in the medically supervised rehabilitation of workers' compensation cases. More detailed consideration of the 'specialised or general rehabilitation units' and 'public v. private sector provision' is called for - we did not have time to explore these issues other than superficially, Among relevant points to be considered are the decline in the number of motor traffic accident victims requiring intensive and longterm rehabilitation, as the consequence of beneficial effects of seat-belt wearing (reported to us by respondents in interviews) and the decreasing proportion of 'reliabilities' who are motor vehicle accident victims due to the increasing number of geriatric rehabilitation case coming into active care.

Footnotes

1. New South Wales Health Department - unpublished data on geriatric and rehabilitation care facilities.

2. Information supplied by NSW Home Nursing Service.

3. Department of Social Security, Annual Report 1982-83, (Canberra, AGPS, 1983), p.146.

4. New South Wales Health Department - material referred to in Note 1 above.

5. J. Voss and R. Jones, Facilities available for rehabilitation of victims of accidents resulting from vehicular transport, unpublished notes supplied to the Secretary, New South Wales Law Reform Commission, dated 20 July, 1983.

6. Royal Ryde Rehabilitation Hospital, Annual Report, 1983.

7. Australian College of Rehabilitation Medicine; A Manual for Candidates, 3rd ed., (Sydney, ACRM, 1983), pp.1-8.

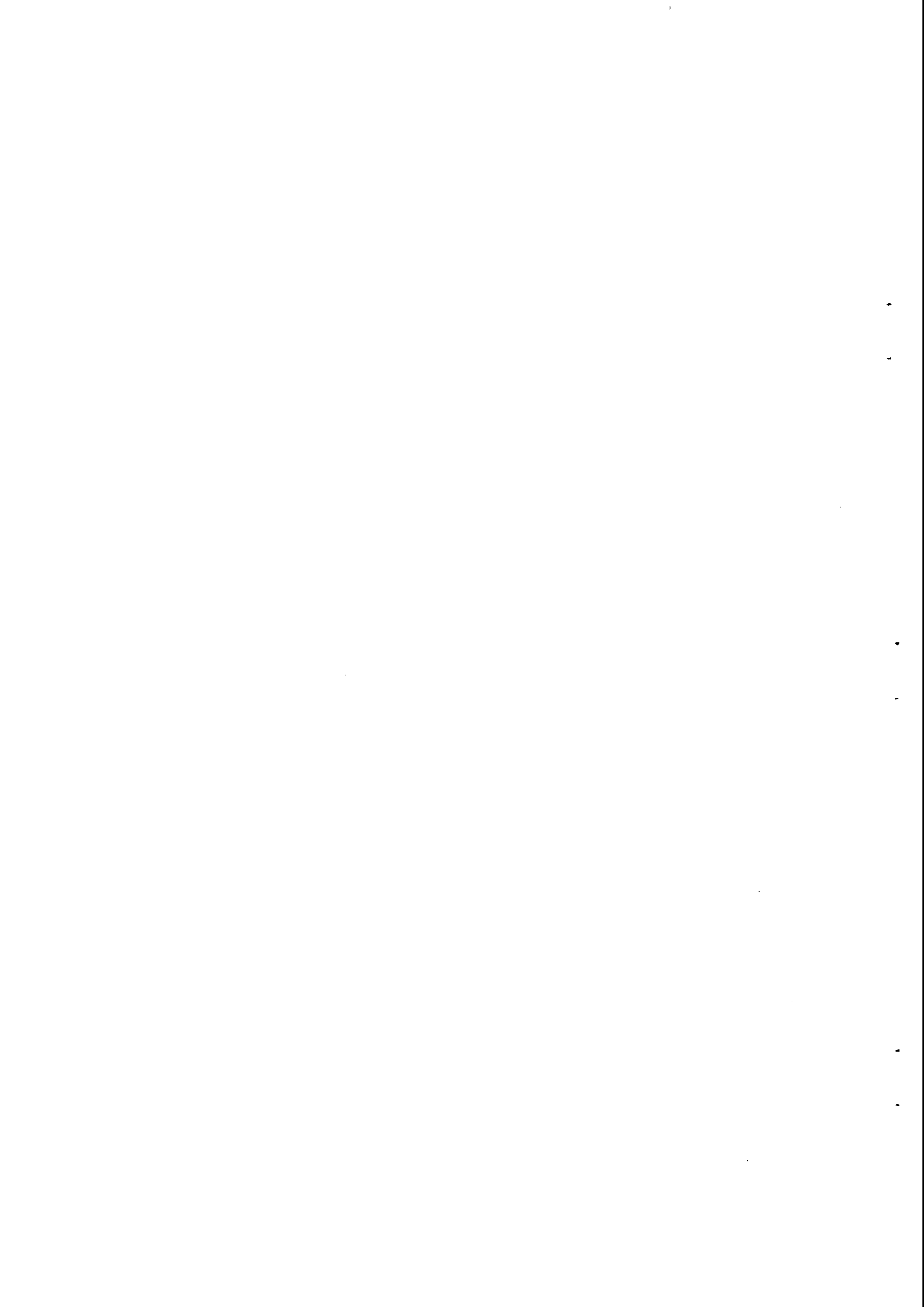
8. Id., p.7.

9. Victoria, Board of Inquiry into Motor Vehicle Accident Compensation in Victoria, Report ('Minogue Report') (Melbourne, Government Printer, 1978), Chapter 7. A copy of Chapter 7 is affended to our report - Appendix B.

10. Id., p.79.

11. Personal communication, August 1984.

12. If a patient's "gap" payments total $150 in any one year, then Medicare meets the whole of the schedule fee for subsequent medical services.



CHAPTER FIVE

EQUIPMENT, PROSTHESES, AIDS AMD HOME MODIFICATIONS

5.1 Introduction

The handicapping consequences of a physical impairment can frequently be reduced, sometimes eliminated by the use of appropriate aids, appliances or the modification of the handicapped person's surroundings.

From our discussions with rehabilitation personnel it was apparent that confusion exists even among health care professionals as to the availability of assistance and many individuals entitled to such assistance under present programs remain unaware of the help available or are utterly daunted by the 'bureaucratic red tape'.

Providers of aids and services are sometimes reluctant to advertise widely often for fear of being swamped. Service is therefore biased towards those better informed, articulate individuals who have plenty of initiative and perserverence.

5.2 Definitions

(a) Prostheses - essentially replace some part or parts of the body and may have cosmetic or funotional purposes. The supply of artificial limbs to ex-servicemen and permanent Australian residents is provided free of charge by the Department of Veterans Affairs from their Repatriation Artificial Limb and Appliance Centres (R.A.L.A.C.) which will be discussed later.

(b) Orthoses - include braces, splints, calipers, surgical corsets and surgical shoes and may be prescribed as part of the treatment of a condition (e . g . to correct a congenital dislocation of the hip) or to facilitate a function such as walking or standing. The traditional materials used are metal and leather. However there is an increasing application of plastics giving both a moulded fit together with relative lightness. Functional electrical stimulation has also been used as a treatment device, an orthosis and a research tool in understanding neuro muscular mechanisms but its application in Australian remains limited.

(c) Bionic implants - such as pacemakers and synthetic joints. These are costed as part of the surgical procedure and as such funded from the general hospital budgets as part of the overall medical cost.

5 . 3 The needs

When aids, appliances or modifications are considered, people with impairments of a similar nature will have numerous personal idiosyncracies such as height, weight, balance, skin sensitivity, patience, pain threshold and the demands of a general lifestyle, any one of which can render what might be a desirable aid for one person totally unacceptable, or at least an inappropriate solution to another. Needs can vary even in the same person and often the solution will only be found in a range of special purpose appliances (e . g . a shorter than normal prosthetic leg for golf).

Many aids will take the form of every day products such as a waterbed, a serving trolley or an electric can opener, while others will be more specifically designed to achieve a disability related purpose, for instance hand rails, a wheelchair or a motor vehicle hand control. Many aids, even where the principles have been well refined, will still require being custom made,

others will be available commercially. Whatever the case it is imperative that the user have access to the broadest possible range of products in order to meet his particular need and at the lowest possible cost to him if the aid cannot be supplied free.

Principal areas of need include

5.3.1 Home modifications - alterations and additions to housing may be needed, such as ramps, widened doorways, adjusted or changed plumbing, bathroom fixtures, furniture, window closures, electrical re-wiring for optimum height of light switches and power outlets, kitchen modifications and cement paths. The list may be extensive and clearly it can be expensive for the authority meeting the cost of the modifications. Among questions which arise are - how often can modifications be made in the client's life time? Should security of tenure with a minimum term lease or even outright ownerships be demonstrated? What happens when a client moves to another house?

5.3.2 Training and/or work aids - can be of a personal nature owned by the individual such as clamps, jigs, a trolley, or Braille typewriter or they may require modification of the employer's property - again ramps, doors, accessible toilets or special changes in machinery, a filing system or a telephone switchboard are examples.

5.3.3 Mobility aids - prostheses, ortheses, wheelchairs, hoists and crutches are the obvious ones. For a handicapped person unable to use public transport a motor vehicle may be a necessary aid - the vehicle may need modifications to enable him to enter, leave and drive that vehicle.

5.3.4 Daily living aids are often required on a regular replacement basis as for example incontinence aids. Items may be of a 'one-off nature such as a

shower chair, a telephone aid or an electric can opener; sometimes as in the case of eating utensils for people with poor hand control they may need to be custom made to the individuals needs. A vital consideration is always that the appropriate aid be supplied and not simply the closest one in stock. Also, even the 'one-off' item may not last forever and may need replacement or repair.

5 . 3 . 5 Repairs, maintenance and modifications to aids supplied

Many disabled people will be heavily reliant upon their aids; for those using respiratory aids, proper maintenance may be a matter of life and death; to others, extreme discomfort may result from defective equipment, such as when a quadriplegic's car or home air-conditioner fails. In other cases physical independence may be lost and the implications for employment can be serious. Clearly in such cases where repairs may be delayed there must be either a back up unit supplied with the original unit or readily available units for immediate loan.

Often aids and appliances are custom made or require modification to suit the individual and in these cases reliable and prompt low cost service and repairs are particularly important.

In some cases the modification of aids to suit the user is an integral part of their creation and may require knowledge of mechanics, electronics, hydraulics, and an appreciation of the interface between the problems and idiosyncracies of the user.

5 . 3 . 6 Information and advice of a 'multi-disciplinary' nature is often required if a disabled person is to obtain appropriate equipment. There is a need to be able to test as many alternatives as possible preferably side by side and without having to travel from one supplier to another. The Independent Living

Centre (see below) provides a comprehensive display and advisory service.

Traditionally the role of advising users of options in the aid/appliance/ modification area has gone to occupational therapists and to a lesser extent to physio-therapists, in consultation with specialists in rehabilitation medicine. The expertise of rehabilitation engineers is now being called upon more frequently.

5.3.7 Research and development is also needed to ensure that the design and development of aids and appliances for disabled people keep pace with burgeoning technology. It is arguable that most gains can be made by greater devotion of resources to the application and adaptation of current or even 'low-level' technology. Basic mechanical principles can be applied in making manual wheelchairs to suit an individual's height, size, weight displacement and upper arm rotation and strength thereby providing optimum utility, perhaps even obviating the need for electric chairs in some cases. Gait analysis using video equipment commercially available can provide the key to correcting problems with walking or incorrectly fitted prostheses and ortheses.

5.4 Meeting the needs

Rather than attempt to describe the means by which any one or group of aids/appliances/modifications may be supplied, it is convenient to co nsider the 'principal' operators of programs which supply these to handicapped people. There is no program or supplier concerned exclusively with meeting needs of this type among motor vehicle accident victims, some of them may meet the eligibility criteria for programs mentioned in this chapter where such criteria exist.

5.4.1 Government programs and suppliers

5.4.1.1 **Commonwealth Government**

5.4.1.1.1 **Department of Social Security**

a) Commonwealth Rehabilitation Service

Once accepted for a program of rehabilitation by the C.R.S. the rehabilitee becomes entitled to aids and appliances as assessed. These aids together with instruction on their use will be supplied free of charge. The aim is to obtain maximum independence in daily living and to enhance employment prospects so the range is extensive and may include all of the categories specified earlier i.e. home modification, training and work aids, mobility aids and repairs and maintenance to aids while still a rehabilitee under an approved program. Table 5.1 shows the types of aids and modifications provided in New South Wales, and their cost to the Department, in the fiscal year 30 June, 1983.

The two major drawbacks to the C.R.S. provisions are firstly that although comprehensive they are limited to those who are able to avail themselves of the program. We note in Chapter 10 below that in 1982-83 less than one in three persons referred for admission to the C.R.S. is accepted for entry into a rehabilitation program.

Secondly, benefits including maintenance of aids supplied are not available more than six months after the period of training has elapsed.

b) Print Handicapped Scheme

In the fiscal year 1982-3 the Department allocated $620,000 towards the publication of Braille and audio books for print-handicapped peopled).

Table 5.1. Type and cost of aids and Modification supplied by Department of Social Security, year ended 30 June 1983 in New South Hales.

	$
Ramps	1,961
New fittings	3,216
Other home modifications	13,740
Total home modifications	18,917
Work/training aids .	1,927
Protective clothing/equipment	1,629
Books/calculators etc.	15,543
Total training and/or work aids	19,099
Mobility training for blind people	47,978
Motor vehicle modifications	8,570
Prostheses/orthoses	11,140
Wheelchairs	31,315
Walking aids	954
Total mobility aids	99,957
Hoists	1,412
Medical aids	26,492
Telephone aids	-
Other daily living aids	17,557
Total daily living aids	45,461
Repairs, maintenance and modifications to aids supplied	5,394
Total	188,828

Source: Department of Social Security, Annual Report 1982-83 (Canberra, A.G.P.S., 1983) p.140.

c) The Expert Committee on Rehabilitation Engineering

A national Convention on Rehabilitation Engineering was held in August 1979 under the sponsorship of the National Advisory Council on the Handicapped (N.A.C.H.) - now the Disability Advisory Committee of Australia (D.A.C.A.). A committee was set up known as Expert Committee on Rehabilitation Engineering (E.C.Q.R.E.) with the object of providing a continuing forum for exchanging ideas. The Committee was intended to co-ordinate information on research and to establish one centre of excellence in research in each capital city.

5.4.1.1.2 Department of Veterans' Affairs

a) This Department provides a very comprehensive scheme of allowances and benefits to its ex-service clients. Of particular note is the fact that ex-service personnel may be issued with a motor car by way of gift together with an operating allowance ($708 p . a .) in certain classes of disability.

b) Repatriation Artifical Limb and Appliance Centres (R.A.L.A.C)

In the early seventies the service expanded to provide artifical limbs for all permanent residents of Australia free of charge to the user. These prostheses can be either made in R.A.L.A.C. workshop or on sub-contract to private limb makers. R.A.L.A.C. also makes orthoses including surgical shoes but due to limited capacity these are essentially only free to ex-servicemen and cases of special hardship. Thus where non-veterans require orthoses they are billed at cost. Where prostheses are provided and the client has had compensation aw.rded to cover costs of prostheses a record is kept by the Department and limbs must be paid for until the amount of the award has been reached.

5.4.1.1.3 Department of Employment and Industrial Relations

a) Commonwealth Employment Service

The C.E.S. is charged by its enabling legislation, the Commonwealth Employment Service Act 1978, "to make special arrangements and provide special facilities wherever necessary so as to assist such persons who are . . . handicapped".

As part of its effort to encourage equality of opportunity in employment the C.E.S. not only pays financial incentives to employers to take on people with a disability but currently (1983) provides up to $2,000 for work place modification (paid to employer) and up to $500 for the purchase of equipment for work (to the employee).

5.4.1.1.4 Commonwealth Department of Health

a) Provision of medical and surgical aids and appliances

In 1981 a Program of Aids for Disabled People was introduced by the Commonwealth Government to offer people with a permanent disability a range of aids without charge(2). By increasing levels of independence in the domestic situation it was hoped that a reduction in demand for institutional care might occur.

In principle the scheme was one of the most promising initiatives to arise from the International Year of Disabled Persons. The program signalled a possible rationalisation of all schemes for aids provision and ensured that funds which were thus earmarked could not be diverted to general health expenses, where so often priority goes to the demands of high technology and there is a failure to recognise the significance in quality of life terms offered by a simple

electric wheelchair or an accessible bathroom.

In practice the scheme leaves much to be desired. Its Australia wide budget for 1983-4 of $7.2 million is grossly inadequate for meeting the original objectives of the scheme.

Although originally devised to provide aids where none would have otherwise been available there is evidence that the program is merely replacing previous schemes. P.A.D.P. is administered in this state on behalf of the Commonwealth Department of Health by the N.S.W. Department of Health on a regional basis through public hospitals. Prior to P.A.D.P. aids were given under the Handicapped Persons Assistance Act 1976 (Cwlth) and under a welfare scheme operated by the N.S.W. Department of Youth and Community Services to people in financial need. The H.P.A.A. scheme has been reduced and Y.A.C.S. now will only fund spectacles and contact lenses.

Far from providing free aids et cetera to all disabled people who need them, eligibility is restricted in New South Wales to certain groups of social security beneficiaries - this restriction has been imposed by the State Health Department in an effort to make most appropriate use of the limited funds available from the Commonwealth. Some workers in the rehabilitation field reported being reasonably satisfied with the scheme's operation, others complained of administrative delays, difficulty in interpreting eligibility guidelines, inconvenience to clients, and insufficient funding. On the part of the recipients or would be recipients of benefits, allegations were made of arbitrary decisions as to eligibility, favouring of some applicants over others, inappropriate ordering of priorities (for example giving low priority to requests for home modifications although these might appear to be of very high priority to handicapped people).

In 1982 the Australia Council for Rehabilitation of the Disabled prepared a detailed discussion paper reviewing P.A.D.P. pointing out the shortcomings of the scheme and suggesting improvements(3). No doubt the scheme is receiving close examination in the course of the present federal review of services for the disabled.

b) The National Acoustic Laboratory (N.A.L.)

Free hearing assessment, hearing adds, services and batteries are provided through the N.A.L. to those with a Health Benefits card, though there is a six months waiting list.

5.4.1.1.5 Department of Science and Technology and C.S.I.R.O.

This department has from time to time been involved in the development of various aids to assist the disabled including a bionic ear implant for those with nerve deafness, and a bathing aid.

The Commonwealth Scientific and Industrial Research Organisation (CSIRO) has also been involved with developing a deaf aid for use in schools and visual aids used with microfiche material. It has also been represented on the Expert Committee on Rehabilitation Engineering.

5.4.1.1.6 Australian Taxation Office

a) Sales tax exemption on purchase of motor vehicle or replacement parts. [Sales Tax (Exemptions and Classification) Act - 1935, (C & L) First Schedule, Division XV, Item 135A].

In order to gain exemption from the imposition of sales tax on a new motor

vehicle or parts the beneficiary must have "lost use of one or both legs such that he is permanently unable to use public transport" and "must use the motor-vehicle for transport to and for gainful employment".

A claim for the exemption on a new vehicle automatically precludes the beneficiary from receiving the Department of Social Security's $10 per week mobility allowance for two years from the receipt of that exemption.

Being a benefit contingent upon employment there is a "Catch 22" operating for it may be that a car is a prerequisite to obtaining employment. Yet a purchase prior to obtaining a job precludes benefit under the Act.

Furthermore the conditions fail to recognise the non-vocational need of disabled person has for a motor vehicle. Often a car is his only possible means of transport. A handicapped non-wage earner is less likely to be able to afford a car and so needs more help than the one who is working.

5.4.1.1.7 Australian Telecommunication Commission

Telecom has a unit which is engaged in developing special phones and attachments for people with disabilities. They also have a range of products designed particularly for the hearing impaired. However aside from the one third rental rebate where the owner has a Health Benefits card these special products must be paid for or rented by the user at the usual rates.

5.4.1.1.8 Department of Industry and Commerce

At present Commonwealth customs legislation levies tariff against aids and appliances used by disabled people. Unlike sales tax, no automatic exemptions are made for such articles. This policy has been justified as supporting local

industry and employment. However, the same result could be achieved with a subsidy, thereby lightening the burden of the disabled consumer, rather than having to pay an import to keep his fellow countryman in employment while he himself may be on a pension.

A.C.R.O.D. has found that application for special exemptions involve so much red tape as to not warrant application for anything but the most expensive equipment.

5.4.1.2 N.S.W. Government

5.4.1.2.1 Department of Health

a) Second and Third Schedule hospitals supply the following aids and appliances to inpatients and non inpatients:

1. All prostheses and appliances placed internally during the operative procedures, excluding materials used for breast enlargement for cosmetic reasons only
2. Items supplied for cosmetic purposes related to congenital abnormalities
3. Cosmetic appliances supplied following removal of breast for medical reasons, for example, cancer
4. Colostomy appliances fitted at hospital
5. Braces, neck supports and calipers
6. First catheter on discharge (if patient is a registered non-inpatient; to be replaced as necessary)
7. Crutches and splints - on loan
8. First surgical stockings
9. Dentures to necessitous persons
10. Oxygen and necessary equipment o loan for short term terminal patients
11. Artificial ears, noses, etc., following operations of neoplastic diseases and trauma conditions
12. Artifical eyes
13. Artificial larynx

14. Home dialysis equipment and supplies except dialysis fluids provided under Section 100 of the National Health Act, 1953.

These aids and appliances are provided under the following conditions:

1. Where an inpatient is discharged and continues ongoing treatment as a registered non-inpatient, any of the listed aids and appliances may be provided without charge.

2. Where a person attends a hospital for treatment as a registered non-inpatient and, as part of that treatment, requires provision of any of the listed aids and appliances, they may be provided without charge.

3. Where a person has a pre-existing disability at the time of registration as a non-inpatient, aids and appliances associated with that disability should not be provided.

4. Where possible, listed aids and appliances should be provided to eligible patients by way of loan.

They do not however supply such items as artificial limbs (see R.A.L.A.C.), hearing aids (see N.A.L.) wheelchairs or orthoses free of charge. Aside from the list above patients must look to alternative funding where available. However where the aids are necessary, and the patient is ineligible for other assistance but still unable to pay the hospital can charge the cost to its maintenance funds.

In addition hospitals can where necessary loan aids to patients. The PADP scheme mentioned above is administered through nominated public hospitals.

It appears there are also informal arrangements whereby hospital staff will fit items such as grab rails to bathrooms charging only the cost of materials to

the patient.

The hospital will claim all costs where compensation becomes available, against that award.

b) Independent Living Centre

Operating from the Royal Ryde Rehabilitation Hospital Complex the centre provides a display of aids, appliances and commercially available products which may have particular use to people with disabilities. Occupational therapists provide advice in person and by phone on the suitability and availability of such products and also keep updated reference files including many overseas developments.

Where a more individually tailored product is required they will often refer to the private organisations of Technical Aid to the Disabled (T.A.D.) or Techelp - see under non-government voluntary agencies.

There is however a need for the servicing of country areas where knowledge of products by consumers and health professionals is often outdated. Thus funding for at least one comprehensive mobile display appears desirable.

5.4.1.2.2 Department of Youth and Community Services (YACS)

This department has a program to make surgical aids available to pensioners and other needy groups upon application and production of medical evidence. Since the introduction of P.A.D.P. they will now only supply spectacles and contact lens.

In regard to information on aids and equipment the Department funds the

Disabled Persons Resource Centre of N.S.W. (see below), a consumer based organization which provides information on issues and services relevant to disabled people, including information relating to aids, appliances and modifications.

5.4.1.2.3 Housing Commission of N.S.W.

The Commission has a policy of modifying homes with ramps, handrails, widened doorways et cetera to suit the needs of individual and groups of physically and mentally handicapped people. In 1981-82, 174 homes were so modified for individuals and 10 modified homes were allocated under the Special Purpose Housing Program to community groups who arranged for their occupations.

5.4.2 Non government agencies

5.4.2.1 Voluntary not-for-profit agencies

Technical Aid to the Disabled (TAD), Techelp and The Paraplegic and Quadriplegic Association of New South Wales are examples of voluntary not-for-profit organisations active in meeting the needs of disabled people for aids, appliances and modifications.

a) Technical Aid to the Disabled (TAD)(N.S.W.)

TAD groups are non-profit organizations of volunteers who aim to design, construct, adapt, install and maintain aids for people with disabilities where they are not otherwise available. Much of the organizations' effort is directed to the provision of technical information regarding design, methods and materials.

Members of TAD provide a resource pool drawn from a range of design, engineering, medical, para-medical and other profesional and technical skills. TAD members make no charge for labour. When possible the client covers the cost of materials but in case of financial difficulty TAD provides assistance or helps the client to obtain finance from other sources.

In addition TAD provides information on non-commercial aids together with advice. The organization also produces a bi-monthly journal in which the latest innovations can be illustrated and described.

The Annual Report of the N.S.W. organization for the year 1981-82 stated that about 1600 requests for assistance had been received; the 1982-83 Report stated that the number of requests had increased. Approximately one third of the organization's income is by way of government grants.

b) Techelp Cooperative Limited

This is a registered charity established by technical college students in 1978. The object is to service financially disadvantaged people as a formal part of their trade or vocational courses.

The network involves students, college staff, prisoners from Long Bay Goal who elect to serve the organization as part of their sentence, local councils and trade union and employer organizations.

They offer household repairs and modifications to add utility and safety; furniture repairs and modifications; domestic appliance repairs; and the making of simple aids for the disabled.

Eligibility guidelines are based on income equivalent to the full pension,

though this can be flexible.

At present the service operates in the City, Leichhardt, Randwick, Marrickville, Waverley and Woollahra and is partly funded by Y.A.C.S. and the local government councils in those areas.

c) The Paraplegic and Quadriplegic Association of New South Wales - more than 75 per cent of whose members are disabled - has a Welfare Department which stocks and distributes a large range of medical equipment that is essential to most members in their daily living. Members of the Association who are invalid pensioners are supplied with equipment under the P.A.D.P. scheme (see section 5.4.1.1.4. above) through the Association's Welfare Department.

5.4.2.2 Self-help agencies

Among activities undertaken by self agencies are the operation of an equipment pool and the provision of information on available products and services.

a) Equipment pool

A group called Westhelp, mainly parents of disabled, have formed an equipment pool for aids such as wheelchairs which can be borrowed. The high staffing costs together with storage costs has mitigated against government pursuing a similar program.

b) Information regarding products and services

The Handicapped Persons Alliance of N.S.W. (the State Branch of Disabled Persons International) is an organization of disabled people and has been funded by the Department of Youth and Community Services to provide an

information service to the whole of N.S.W. Through its Disabled Persons' Resource Centre this organization provides inquirers with information regarding consumers view on the products and services they use. The D.P.R.C. also acts a referral centre, directing queries on aids and appliances to appropriate agencies such as the Independent Living Centre mentioned above.

The D.P.R.C. also cooperates with two regional resource centres at Fairfield and Campbelltown which aim to cater for local needs.

5.4.3 Private profit-seeking agencies

These suppliers provide requisites to handicapped persons either through government-funded or government subsidised schemes as outlined in earlier sections of this chapter, or by direct sale. The principal suppliers will be. found listed in the Yellow Pages of the Sydney Telephone Directory under such headings as 'Invalid Aids and/or Equipment', 'Medical Supplies', 'Surgical Supplies' . Motor vehicle accident victims who have received lump sum compensation payments and other victims who do not qualify for social security benefits may face large and in many cases continuing expenditure to obtain from these sources the aids, appliances and modifications they require as the result of their accident.

5.5 Comments on meeting and not meeting needs for aids, appliances and modifications.

This brief chapter does not purport to give a detailed account of the full array of suppliers of aids, appliances and makers of modifications of houses, workplaces and so on required by the handicapped. Thus, for example, no mention has been made of the efforts of some local government bodies and hospital rehabilitation units to have home modifications carried out on behalf

of disabled people who can ill-afford the costs involved. However this review does point to the complexity and some of the inadequacies of the system whereby some of the needs are met.

It is pertinent to recall that the Australian Bureau of Statistics, in its report on a nation-wide survey of handicapped people conducted in 1981, stated that out of a total of the estimated 1.225 million handicapped people aged five years or more in Australia, over 75 per cent needed aids of some kind which they did not currently possess. The reasons given for not having required aids included -

- aids too costly/cannot afford to purchase — 31.1 per cent of cases
- don't know where to get it — 14.3 per cent of cases
- too much trouble/did not get around to it — 29.5 per cent of cases (5)

One can assume that among these many thousands of handicapped people in need of aids there were some motor accident victims - for 15.9 per cent of all handicapped persons on 'accident' was reported as being the cause of their primary disabling condition, and 36.1 of those accidents occurred on a street, road or highway(6).

The 'too costly/can't afford' responses remind one of the great difficulty faced by anyone who attempts to estimate for a particular accident victim the 'present value' of future expenditure on aids, appliances and modifications. Recognising the number and unpredictable behaviour of variables which should enter into such an estimate, we find it difficult to imagine how anyone could confidently use such an estimate in assessing 'lump sum' compensation.

The 'don't know where to get it' and 'too much trouble/did not get around to it' responses indicate again the daunting complexity of the rehabilitation and

after care maze.

Footnotes

1. Department of Social Security, Annual Report 1982-83, (Canberra, A.G.P.S., 1983), p.71

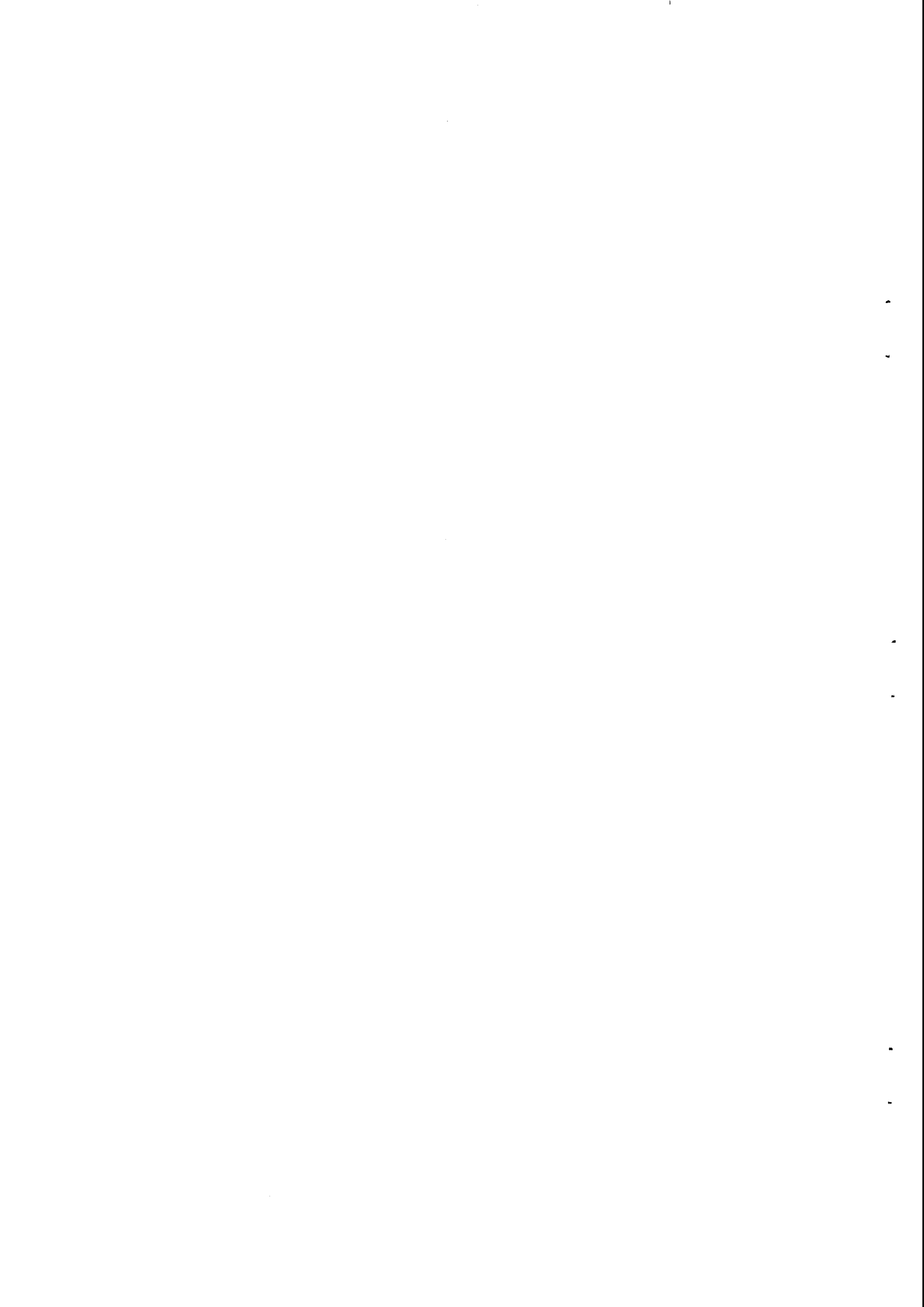
2. Commonwealth Department of Health, Guidelines for the program of Aids for Disabled People, (Circular PADP/1, July 1981).

3. Australian Council for Rehabilitation of Disabled, Review of Program of Aids for Disabled People (PADP), (December, 1982).

4. Housing Commission of New South Wales, Annual Report, 1982, (Sydney, undated, p.19.

5. Australian Bureau of Statistics, Handicapped persons, Australia 1981, (Canberra, ABS, 1982), p.43.

6. Id., pp.29-30.



CHAPTER SIX

IMFORMATION, COUNSELLING, ADVOCACY

In this chapter we turn our attention to the topics of information provision, counselling and advocacy in relation to the needs of the handicapped. In this context -

. information provision relates to the collection, dissemination of material relevant to the needs and interests of those who need or demand it:

. counselling is an interactive process in which a client and a counsellor together formulate a plan of action to cope with a problem situation - which the client may or not decide to followr

. advocacy is a means whereby attention is drawn to the interests and rights of an individual or group with a view to protecting or furthering those interests and having those rights recognised and enforced.

The second of these functions inevitably calls for information, and may lead on to advocacy. Advocacy, too, should rest upon some information base. In the care of the handicapped, social workers, rehabilitation counsellors and lawyers are among the professional personnel commonly called upon to engage in all three functions on behalf of a client.

6.2 Information types, content, users and flow

6.2.1 Information types and content

We are concerned with two broad types of information:

Type 1 - information regarding availability, scope and scale of services, benefits, facilities; rights of individuals; policies, procedure et cetera; and

Type 2 - information regarding needs, interests, demands, wishes, preferences, opinions et cetera of the disabled, of those involved in their care and of 'the community' at large.

Among the subjects upon which information is most likely to be required both by the handicapped and by those caring for them are:-

- medical care
- legal matters
- finance
- availability of and eligibility for services, benefits et cetera
- accommodation
- educational and training opportunities
- employment
- personal and social adjustment (including sexual and family matters)
- consumer information
- crisis coping

For any one of these subjects both Type 1 and Type 2 information may be required - though not necessarily available.

6.2.2 Information generators and users

Four groups of people - programmers, providers, the handicapped and 'the community' - are each both generators and users of information of relevance to members of all three other groups. Type 1 information is generated for the most part by programmers and providers; Type 2 comes mainly from the handicapped

themselves, but also of importance is information from those Who provide care, and from other members of the community, for example employers.

6 . 2 . 3 Information sources and flows

Figure 6 . 1 illustrates how information of Type 1 gets into the 'information' pool and how it flows out to the users of that type of information. Figure 6 . 2 shows the inflow and outflow of Type 2 information.

One of the problems facing those who are concerned with the care of the handicapped - or of a particular disadvantaged group such as motor accident victims - is the absence of any one repository where all the available Type 1 and Type 2 information may be found and referred to. This review of ours represents a tentative effort to bring together in a reasonably structured way some of the more important information, of both types, that can be collected from the programmer and provider groups. Our report indicates something of the immensity of the task of pooling the available information.

6.2.3.1 Providers' sources of information

Leaving aside the sources of information which programmers and providers need for formulation of policies, programs and procedures, our attention is directly here to the sources which providers have at their disposal in meeting the information needs of these to whom services and benefits may be provided. These sources may be distinguished in some degree as being formal or informal:

Figure 6.1 The flow of Type 1 information

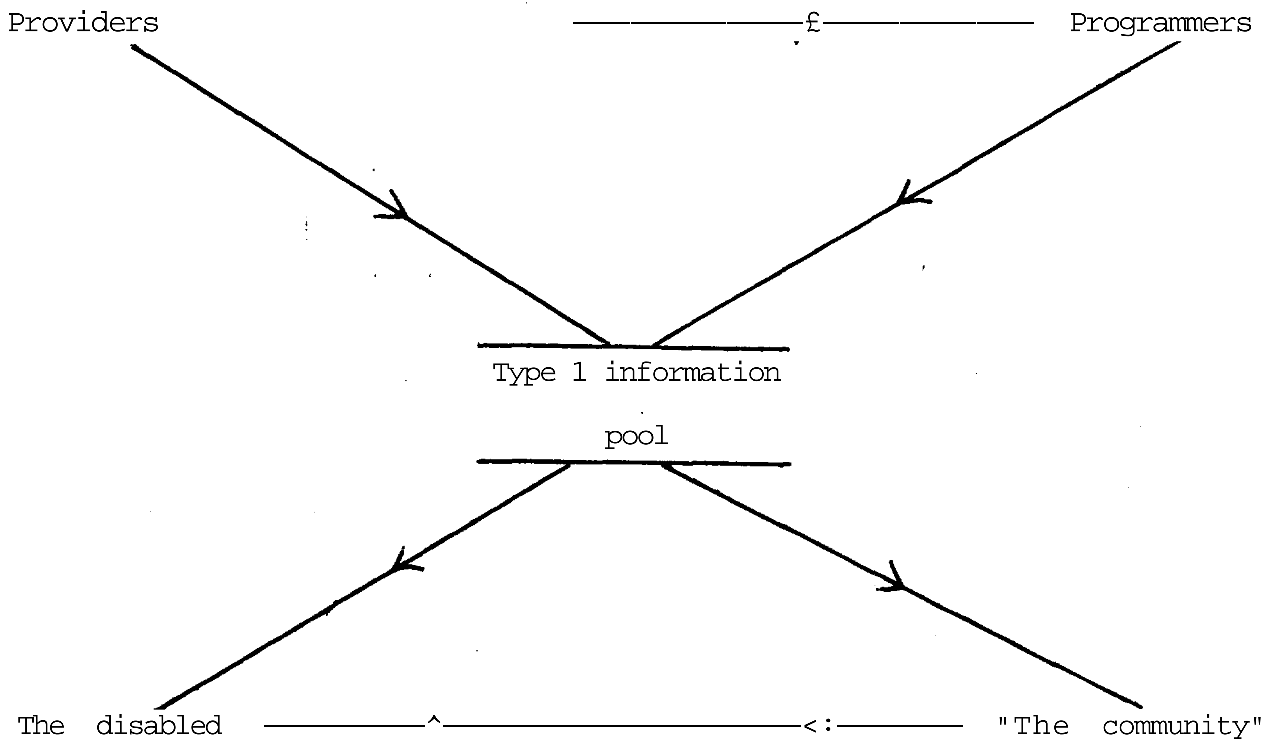
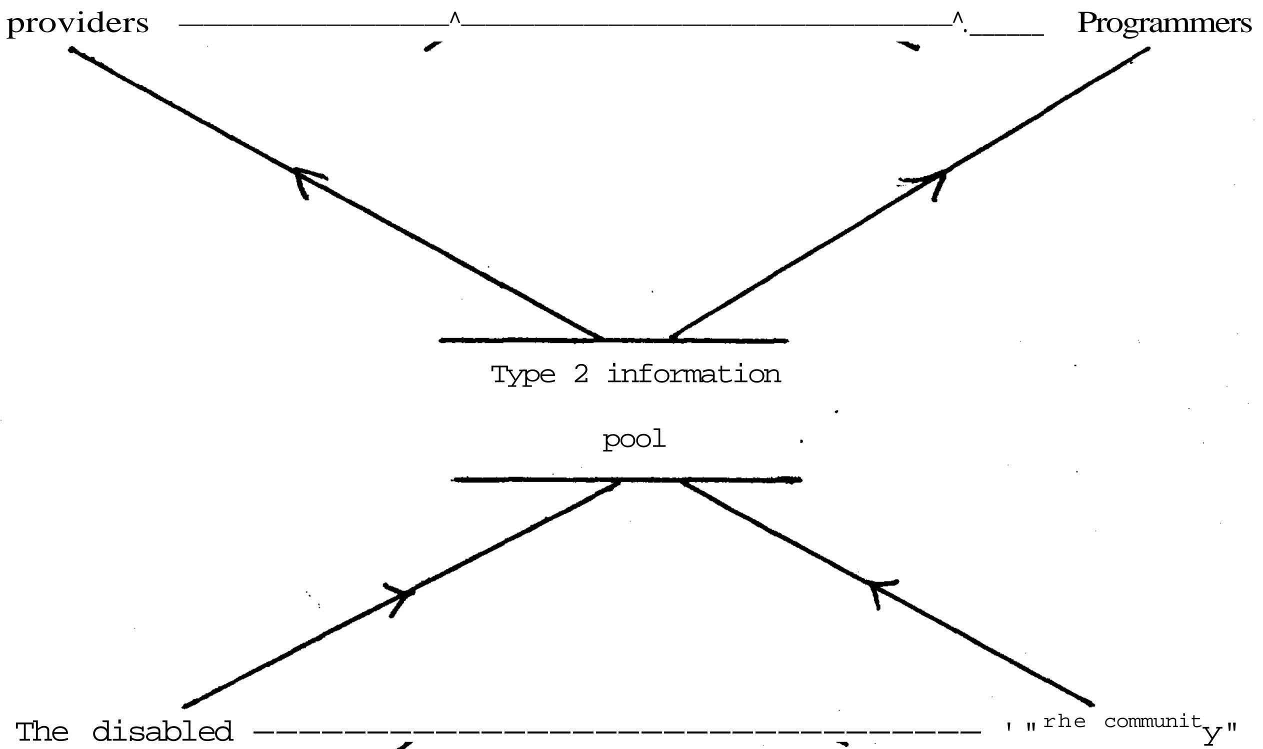


Figure 6.2 the Flow of Type 2 information



(a) formal, including published material, such as service directories

e.g. Council of Social Service of N.S.W., Handicapped Persons' Services Directory, Sydney, N.S.W. Council of Social Service, 1982

. booklets, pamphlets, newspaper advertisements etc. from government departments and other agencies

. circular letters and notices from government and other agencies, departmental and agency procedure manuals, legislation and legal resource material, annual reports

* reports of surveys, research et cetera

. and formal training courses, seminars/ in-house training programs et cetera

(b) informal, particularly the informal network of personal contacts which an individual working in the field builds up, draws upon and contributes to; these contacts are established and maintained partly through work directly related to individual patients and clients; partly through participation in formal activities such as professional conferences, seminars and the like; and partly through social interaction.

6.2.3.2 The disabled person's sources of information

Among these, important ones are:

(a) other disabled people, relatives, friends, acquaintances et cetera who constitute a sort of informal information network

(b) Information bureaux - an example is the Disabled Persons' Resource Centre in Castlereagh Street, Sydney. This centre attempts to gather a very wide range of information relevant to the needs of disabled people and provides information on a walk-in or phone-in basis to any inquirer. Subsidised by the State Department of Youth and Community Affairs, the Bureau provides its service to users without charge. Two other resource centres operate in the Sydney area.

*

The Macarthur and Districts Association for the Disabled Persons' Resource Centre, staffed by a part-time paid development officer and seventeen volunteers each contributing seven hours of unpaid work, and receiving financial assistance from the New South Wales Department of Youth and Community Services, reported a high proportion of physically handicapped people among its clients during the first year of operation. The Centre stated in its response to our questionnaire that it is working towards developing a support and information group for accident victims 'to assist them in obtaining the most efficient and appropriate service'.

The Redfern Welfare Rights Centre Limited provides assistance to clients with social security problems; lobbies for necessary changes in the social security system; and trains lawyers and welfare workers in social security advocacy. The Centre has a full-time salaried staff of six and a part-time staff of 15 volunteers, each working an average of four hours a week. The Centre is funded by the Sydney City Council and the Stte Government through its Department of Youth and Community Services. In the period 1 March to 10 November 1983 service was provided to 1165 clients.

(c) Service agency personnel -

. 'counter staff - a very important informative role is played by the 'counter staff' in government offices and other agencies throughout the State who so frequently are the personnel of ' first contact' with a disabled person seeking some form of assistance. We have no material regarding the selection, initial and continuing training, or supervision of these 'front line' workers.

. professional workers - generally speaking the information giving role of professional workers is part of a wider treatment or counselling role. This will be dealt with under the headings in this chapter relating more specifically to counselling.

. self help and mutual support agencies - agencies such as AQA & PQA have developed extensive information resources for the benefit of their members.

(d) journals, magazines and other publications

In addition to a range of directories , brochures , information leaflets and booklets published by government agencies and other providers of services to the handicapped, there are numbers of informative journals and newsletters published by self help associations.

For example the Australian Quadriplegics Association produces regulafly a journal, 'Quad Wrangle' , containing news, notice of meetings, information comment and humorous material, along with advertisements from firms which cater especially for the needs of disabled people. Thus in the 48-page issue for August 1983 one finds a 'how-to-do-it' article entitled 'How to

maximise an accident settlement'; a contribution from a financial consultant 'Wise investment means a secure future'; the report of a lengthy interview with a motor car accident victim who became editor of the journal for six years; a review of recent developments in spinal cord injury research.

On behalf of the Handicapped Persons Alliance, the Disabled Persons Resource Centre of New South Wales publishes a regular newsletter,'Linkup'. The October 1983 issue, of 28 ages, included information regarding the N.S.W. Department of Technical and Further Education provisions for disabled people; advice regarding applying for information under the Freedom of Information Act; notice of the Commonwealth Government's Handicapped Programs Review and advice regarding making submissions; views on the Community Tenancy Scheme as it operates in New South Wales; reports of meetings concerned with handicapped peoples' problems; a calendar of events and an amusingly written but highly critical review of attempts to improve access to buildings and service facilities, such as toilets, within buildings.

Among publications from the 'programming' agencies is the 'ACROD Newsletter'. the official publication of the Australian Council for Rehabilitation of the Disabled. The 20-page issue of November 1983 includes notes on parking rights for disabled people; development of accreditation standards for sheltered workshops; taxation status of voluntary agencies; the Attendant Care Pilot Project; and the effect of the proposed assets test, announced in August 1983, upon low income disabled people. There was also a roundup of items of news from the States, an article on transport safety and notices of coming events.

6.3 Counselling the disabled

A review of this nature can shed no light on the probably important part played by relatives and friends of the disabled in working out ways of coping with the various problems arising from accidental injury.

Our attention is directed towards the counselling which involves professional and other personnel working either in agencies or private practice.

6.3.1 Medical and allied health personnel - of primary concern here is counselling as to the 'medical' and 'health' aspects of the accident victim's future; this may be backed up by providing patients with self care manuals such as those prepared for each major disability group by staff of the Prince Henry Rehabilitation Centre. Inevitably counselling by medical and allied staff may touch upon many other areas of post-accident life.

6.3.2 Lawyers - as informants, counsellors and sometimes advocates, lawyers may exert very considerable influence upon the course of the accident victim's life - principally in areas related to money. The majority of accident cases requiring legal assistance are handled by solicitors in private practice, other agencies which engage in counselling the disabled on legal matters include the few community legal centres, and agencies of the Public Trustee.

Although the great bulk of legal practitioners work on a fee-for-service basis, community legal centres provide a source of free access to trained lawyers for people with low incomes. Our postal survey returns included one community legal centre, funded from Commonwealth Government and from State Government funds and staffed by a full-time salaried solicitor, a parttime paid secretary and six to twelve volunteers each of whom averages four hours a week at the centre. Over the past twelve months the centre has provided more than 2,500 people with legal advice (about 50 per cent of the centre's workload) advocacy

(40 per cent) or skilled referral (10 per cent) in legal and financial matters, and regarding accommodation, availability of and eligibility for the services. An estimated 4 per cent of clients are victims of road traffic accidents, about one in two of these having been awarded compensation before seeking the centre's assistance. The centre's major problem was reported to be insufficient funds to employ caseworkers and community solicitors to cope with an increasing demand for the centre's services.

6.3.3 Financial counsellors - although numbers of agencies we contacted - of various types - reported that they undertook the provision of financial information or counselling on financial matters - we did not find any agency solely or largely concerned with helping the disabled to cope with financial problems. A financial counsellor, so designated, is employed at the Redfern Welfare Rights Centre.

Accident victims, particularly those who receive a relatively large lump sum compensation payments, may turn for advice in financial matters to lawyers, accountants, stockbrokers or other 'investment advisers' either in private practice or employed by banks and similar institutions. It is questionable whether the victim is likely to secure the assistance of personnel sufficiently expert and experienced in managing relatively large sums of other people's money from many of these sources of advice. Certainly the management of a lump sum so as to secure an adequate income over many future years calls for a very high level of expertise - as was mentioned in Chapter 3 above.

6.3.4 Social workers - at present stratified into two levels of terms of qualifications - social workers and welfare officers - the social work profession is represented in many agencies concerned with the rehabilitation and after care of accident victims. These workers participate in counselling in hospitals, rehabilitation centres, community health centres, and a variety of other government and non-government agencies.

6.3.5. Rehabilitation counsellors - specifically trained to work with the disabled, rehabilitation counsellors are concerned with developing overall programs for the rehabilitation of individual clients, making appropriate referrals to get those programs implemented, and following the progress of their clients. They are employed in the Workers' Compensation Commission service, in rehabilitation centres and similar institutions.

6.3.6. Other trained counsellors - clinical psychologists, vocational guidance officers, marriage guidance counsellors are among the range of trained counsellors who may take part in the care of the accidentally injured, and are employed in governmental and non-government agencies.

6 . 3 . 7 Training of counsellors - the training of those who participate in counselling with the disabled was not examined in detail, but it was our impression that some of the personnel undertaking this activity were inadequately prepared for their task. In particular there appeared to be deficits in training regarding financial management and perhaps regarding the law.

6.4 Bow well are information needs met?

Because our review did not include contact with victims of motor vehicle accidents, we are in no position to assess the degree to which their demands and their needs for information are being met. The distinction between demands and needs is important - the information demanded may not necessarily be the information really needed. In other words, those seeking information may not know the 'right' questions to ask, or through ignorance, apathy or fear they may accept information which is incomplete, inappropriate or incorrect. Our postal questionnaire contained the following checklist regarding the respondent agency's information giving and related activities -

' In which areas of information provision, advice, professional counselling, skilled referral do you provide service to your clients -

None	___
Financial matters	___
Legal matters	___
Vocational matters	___
Educational & training opportunities	___
Accommodation	___
Availability of other services	___
Family matters	___
Sexual counselling	___
Social/personal adjustment	___
Eligibility for social service benefits etc	___
*Consumer advice	___
Crisis Counselling service	___
Other (specify)________________________	___

* Consumer advice - advice regarding availability, quality, price etc of equipment, appliances etc.'

It was rather surprising to find that in returned questionnaires some agencies which do not employ trained social welfare workers, for example some sheltered workshops, ticked all boxes except the first and the last. (Even more surprising, perhaps, was one returned questionnaire on which all boxes except the last were ticked!) In numbers of questionnaire forms where a more selective approach had been taken there were instances where the items 'Sexual counselling' and 'Social/personal adjustment' were ticked although the staff complement of the agency concerned did not appear to include personnel trained in these areas. Agencies which reported employing persons designated as

' social workers' and 'social welfare workers' generally ticked the items 'Financial matters' and 'Legal matters', but so did some agencies not reporting employment of such staff or other staff whose formal training includes some exposure to these topics. Of course ticking an item on the checklist saya nothing about the level or quality of service given in respect of that item. But having regard to the complexitieis relating to every one of the matters specified, one may express some doubts as to whether all clients received the information, advise, professional counselling or skilled referral required to meet their heads.

Apart from what might be seen as an over-readiness to dispense information and advice, agency personnel and professional workers such as doctors in private practice may also be misled or inadequately informed by the reference material available to them. The few directories and information handbooks available to them rapidly become out of date only recently has it been possible for 'outsiders' to have access to some government departments' policy and procedure manuals which are essential to a proper understanding of departmental activities. Where directories of services et cetera do exist, they rarely include information regarding for-profit agencies and practitioners who may be particularly appropriate in meeting a client's specific problem. While in many cases skilled referral is the appropriate response to a client's enquiry, this may well present considerable problems to the handicapped client - problems of travel, of time and of expense. Such problems are particularly likely to arise in relation to handicapped people who live in country areas where the sources of information and advice are inevitably limited in number and scope.

6.5 The advocates

The role of lawyers as advocates representing the interest of motor vehicle accident victims will not be discussed here.

Among the other agencies acting as advocates on behalf of the disabled, some are concerned with the interests of the handicapped generally - for example the Handicapped Persons' Alliance - and others are concerned with the interest of specified groups of handicapped people - for example the Australian Quadriplegic Association. Other agencies cater for disadvantaged people generally, for example the Redfern Welfare Rights Centre described in Section 6.2.3.2. above.

The necessity for and difficulties in establishing an effective advocacy agency is illustrated by the following case. It is widely acknowledged among rehabilitation workers that accident victims suffering serious brain damage present very considerable problems in treatment and after care. Facilities for the long term care needed by these people are at present inadequate. In acknowledging this deficit, a State Government officer expressed the view that one contributory factor was the absence of an effective lobby pursuing the interests of the brain-damaged. There is a body which has been established for this purpose under the name 'Cerebration'. A spokesman for Cerebration agreed that the organisation did have difficulty in serving its members adequately, but stated that it lacked financial resources. A senior official in another State Government department confirmed that applications for funding Cerebration had been refused, because the limited subsidy funds had already been committed to support already well established agencies.

6.6 Action against discrimination against the handicapped

6.6.1 Advocacy groups

Some advocacy groups of the types mentioned above have been active in attempts to focus public attention upon the needs and potentialities of the handicapped, with a view to removing discriminatory practices and prejudicial attitudes towards the handicapped.

6.6.2 Action by other bodies

A variety of bodies have been active in attempting to gain support for the United Nation's Declaration on the Rights of Disabled Persons, 1975, which reads -

> 'Disabled persons have the right to economic and social security and to a decent level of living. They have the right, according to their capabilites, to secure and retain employment or to engage in a useful, productive and remunerative occupation and to join trade unions.'

Thus in 1981 the Australian Council of Trades Unions (ACTU) and the Confederation of Australian industries (CAI) introduced and adopted their own charters for disabled people to promote equality of opportunity in employment and to provide guidance to those concerned with the employment of the disabled. In 1982 the National Labour Consultative Council followed up these initiatives with the publication of "Disabled People: Working for a Better Future: A statement of principles and guidelines" (Canberra: AGPS, 1982).

6.6.3 N.S.W. Anti-Discrimination Act

The N.S.W. Anti-Discrimination (Amendment) Act, 1981, provides disabled persons with the legal right to be treated equally with non-disabled people an important aspects of their public life. "Handicapped Person" is defined as a person who, as a result of having physical impairment to his body, and having regard to any community attitudes relating to persons having the same physical impairment as that person and to the physical environment, is limited in his opportunities to enjoy a full and active life, and "Impairment" is defined as any defect or disturbance in the normal structure and functioning of the body, whether arising from a condition subsisting at birth or from an illness or injury.

In 1981-82,, which was the first full year in which the Act included the ground of physical impairment, 91 complaints were received, but in the year 1982-83 the number dropped to 47. Ninety-two complaints were received in 1983-84, of which 58 were still under investigation at the end of the financial year. Seventeen of the 92 complaints were from women; 65 complaints alleged discrimminationin the area of employment (54 from males and 11 from females) and two thirds of these related to discrimmination in matters of recruitment or selection. Other complaints related to complaints in the area of goods and services such as public access, entertainment/recreation, insurance and transport.

The ADB Report for 1982-83 drew attention to limited effectiveness of the act which, because of wording of section 491, excluded anyone whose physical handicap has more than a minor impact on their working life. The Board's 1983-84 report proposes amendments to the Act to widen its application, in particular regarding the idea that a person should make a reasonable attempt to accommodate another person's impairment, but that this 'reasonable

accoramodation' should not. cause 'undue hardship' • The Board has set. up a Physical Impairment Consultation to obtain the views of specific groups covered by the legislation it administers. Some of the major groups represented are:

Disabled People's International (N.S.W.)

Australian Quadriplegic Association

Better Hearing Australia

N.S.W, Division of the Australian Council of the Disabled.(1)

6.7 Much material, but how much communication?

It is apparent that there are very many sources of information, advice and counselling, that much informative material is produced. But enumerating the sources and describing the material does not tell one whether needed information et cetera reaches the appropriate person at an appropriate time. It was certainly our impression that most of the people we contacted were well informed regarding needs, resources and problems. But we were contacting the 'experts' - we did not examine the extent to which appropriate and timely information is received by accident victims themselves.

Our review does point to difficulties in ensuring that counsellors and providers of information and advice are adequately trained and that they are kept up-to-date with the many changes that occur in such a wide field as rehabilitation and after care. It does draw attention to the particular difficulties which may arise when handicapped people have to be referred from one agency to another. It did not enable one to assess the frequency and magnitude of the particular problems which arise because of language and cultural differences - despite the existence of interpreter services and of efforts to sensitize personnel, patients and their relatives to the possible effects of these differences.

Footnotes

1. Anti-Discrimination Board, Annual Report, 1982-83, (Sydney, Government Printer, 1983) and personal communication from officer *of* the Board, September, 1984.

CHAPTER SEVEN

ACCOMMODATION

7.1 Many accident victims receive institutional care - perhaps a succession of institutions such as hospital-nursing home-residential training centre. But sooner or later the majority of them will live more or less permanently 'at home'. In this chapter we consider the ways on which the need for accommodation on a relatively long-term basis nay be met.

The principal categories of accommodation to be discussed are:-

- 7.2 One family homes - houses, apartments and 'self-contained units'
- 7.3 Boarding houses
- 7.4 Group homes
- 7.5 Hostels
- 7.6 Nursing homes
- 7.7 Hospitals

7.2 One family homes

No precise figures are available but it is obvious that the majority of people suffering some accidental injury return to live within a family unit - which may be a one-person family - in a house or apartment which they may own, are in the process of purchasing, or rent.

7.2.1 Home ownership

People who at the time of their accident themselves own or are part of an owner-occupier family generally face no major accommodation problem when they are fit

to return home. It may be necessary for a house or apartment to be modified in some way to meet the changed needs of the accident victim - financial and other assistance in making home modifications may be available from government and other agencies (see Chapter 5). If it becomes desirable to move to other accommodation then the property may be sold or leased to permit this move.

Recipients of lump sum payments arising from their accident may use all or part of that sum to purchase or complete the purchase of a dwelling. In view of the uncertainties of other forms of investment and the great problems of preserving capital value in times of high inflation and high taxation, this may be a very sound way in which to use the lump sum; it may have the added attraction for some disabled people of ensuring their eligibility for a social security pension with its associated fringe benefits.

People who at the time of their accident are in the process of paying off a mortgage or other loan and who do not receive sufficient compensation to either complete the purchase or maintain regular payments may face very serious difficulty in meeting their commitments. Problems may arise, too, when payment of lump-sum compensation is either long delayed or, after a lengthy delay, refused.

A handicapped person with a low income, like members of other disadvantaged groups, may benefit from preferential treatment when the N.S.W. Housing Commission makes houses available for purchase.

7.2.2 Rented homes

In general handicapped people obtain and occupy rented accommodation on the same terms as the non-handicapped, in some cases home modification schemes apply to rented premises, provided the landlord gives consent to the changes to

be made to the property.

The Housing Commission of New South Wales provides rental accommodation for people on low incomes (including pensioners). Applications to the Commission are reviewed by Housing Application Committees and are considered on the basis of 'need' compared with the applicant's ability to meet this 'need' on the private market. Successful applicants are placed on a waiting list. Sydney families with housing problems of a particularly serious or pressing nature may be assessed by a Special Allocations Committee. In country areas the task of reviewing urgent cases, which are usually associated with natural disasters such as fire or flood, remains with the local Housing Application Committee which adopts the same principles as the Sydney Committee. These cases are provided with accommodation without being put on the waiting list.

Kates of rental payable for Housing Commission accommodation are fixed at 80 per cent of the market value of rentals for equivalent accommodation in the same area in the private sector. However, a rental rebate scheme operates to ensure that tenants pay no more than approximately one fifth of the family income.

7.2.3 Self contained units - government subsidised

The Commonwealth Government makes grants under the Aged or Disabled Persons Homes Act 1954 to assist private organisations (usually religious, charitable, or benevolent organisations) and local government authorities to meet the cost of providing homes in which aged and adult disabled and incapacitated persons may live in conditions resembling ordinary domestic life as closely as possible. The grants are made, subject to subsidy limits, on the basis of $2 for each $1 (excluding government assistance and borrowed money) raised by the organisation. The accommodation provided under these arrangements may be self-

contained units, sometimes with some shared facilities such as communal diningrooms and lounges available. In the period mid-1954 to mid 1983 grants were approved for 9,597 self contained units to be provided in New South Wales. Most of these units are occupied by aged persons(1)

7.2.4 Property rate reductions

Persons holding Pensioner Health Benefit cards are entitled, on application to their local councils, to have the rates levied on the premises they occupy reduced by one half up to a specified maximum per year. The maximum reduction is $150 for general rates, and $150 for water and sewerage rates a year. Councils are recouped by the State Government for the full amount of rates written off up to the maximum specified, and they may also write off further amounts at their own cost.(2)

7.3 Boarding houses

Private for-profit boarding houses provide accommodation for a significant proportion of handicapped persons in New South Wales. A system of inspection and registration has been established by the State Department of Youth & Community Services, in cooperation with the State Health Department.(3)

A survey by the Boarding House Action Group of the N.S.W. Council of Social Services is to be published shortly.(4) Among the findings already announced is a 25 per cent reduction in numbers of boarding houses in Sydney over the past three years; the loss of some 500 household units due to closure, selling off or conversion to strata title units; charges from $20 to $45 a week for one-room accommodation.

Severely physically handicapped accident victims are unlikely to be

accommodated in boarding houses, but among boarding house residents there are undoubtedly numbers who are suffering from severe accidental brain damage.

7.4 Group **homes**

The trend over the past three decades towards de-institutionalization of residential care of disadvantaged children, the mentally-ill and the intellectually handicapped has led to the establishment of group homes. Here small groups live as a family group in, typically, a suburban house purchased or rented by a government or voluntary agency. The agency provides the residents with some assistance, such as visiting community health and welfare staff, or perhaps a housekeeper, to enable them to cope with the problems of daily living. Residents with some income contribute towards the cost of maintaining the 'family' and its home. The N.S.W Minister for Health announced in December 1983 that, as recommended in the Richmond Report(5) a considerable number of additional group homes would be made available over the next three years.

Among the small number of handicapped persons currently accommodated in group homes a small percentage may be brain damage accident victims. There is scope for developing a policy of including some physically disabled persons among group home residents. Obviously care would be needed to obtain a suitable mix of physically handicapped and mentally impaired residents in a group home.

The proper functioning of group homes demands the ready availability of appropriate backup services from welfare and health agencies.

The Minister's statement indicated that $2.5 million would be made available from State funds for the acquisition of houses over the next seven months, and $3 million would be provided to meet costs of staffing this expansion up to the

end of the 1983-84 financial year.

See sections 7.9 and 7.10 for some details of N.S.W. Housing Commission involvement in group home provision.

7.5 Hostels

The term 'hostel', in welfare workers' terminology, implies a boarding house where there is some element of 'caring' in the management of the institution, and that the hostel residents need some care or protection that would not necessarily be provided in a typical for-profit 'boarding house'. Hostel type accommodation may be particularly suitable for handicapped persons who, although having a considerable capacity for self care and independent living, require a more sheltered environment than is provided in boarding houses or can be secured by a person living alone 'at home'.

The Commonwealth had by 30 June, 1983 subsidised the provision in N.S.W. by religious, charitable and local government bodies of hostel accommodation for 6,301 persons under the Aged or Disabled Persons Homes Act 1954 and for 5,324 persons under the Aged or Disabled Persons Hostels Act 1972.(6) The N.S.W. Department of Health's survey of geriatric and rehabilitation services reported in late 1983 that of 12,127 hostel beds, 8,119 (67 per cent) were in metropolitan Regions and that some hostel beds were located in each of the non-metropolitan Regions.(7) Permanently incapacitated people over the age of 16 years may be accommodated in these hostels but the majority of places are occupied by the aged.

Personal care subsidies and hostel care subsidies are available through the Commonwealth Department of Social Services to assist hostel administrators to meet the costs of providing accommodation and care - see Chapter 8, Daily

Living Needs.

The return on capital invested in hostels is generally too low to encourage private investment in this type of accommodation.

Problems associated with the accommodation of handicapped people in hostels include:-

insufficient places available; it was reported to us that every social worker keeps a personal list of hostels which may accept the handicapped, but the contents of those lists are not willingly divulged to other workers;

inappropriate siting of hostels; it is desirable that hostels be 'on level ground, next door to a shopping centre and with a bus stop outside the front door' - these criteria are not always met;

lack of government support for private hostels; it was suggested that if assistance such as the personal care and hostel care subsidies were available to private hostels, suitably qualified people such as registered nurses would be encouraged to operate hostels for the handicapped.

7.6 Nursing homes

A small fraction of all accident victims are admitted to nursing homes - of these some will require long term nursing home care, perhaps for the rest of their lives. Because of shortages of nursing home accommodation individual homes are able to operate selective admission policies - for example some homes may give preference to bed-fast elderly patients, others may 'specialise' in caring for wheelchair cases or patients with mental impairment.

Nursing homes are operated by the State Government, by religious and other charitable organizations on a not-for-profit basis, and by private profit-seeking enterprise. Non-government nursing homes are licensed by the State Government and subject' to inspection by officers of the State Health Department - minimum standards for facilities, staffing, equipment, records and some aspects of patient care are prescribed under the Private Hospitals Act 1908 (NSW). To receive Commonwealth nursing home funding, homes must be 'approved[1] by the Federal Health Department - each approval specifies the number of beds, and thus patients, to be covered for benefit purposes. Almost all nursing homes and nursing home beds in both government and non-government nursing homes in N.S.W. have federal approval. Approved non-government, not-for-profit nursing homes may, under the Nursing Homes Assistance Act 1974 (Cth.) have their operating deficits met by the Commonwealth Government. Not all non-government not-for-profit homes have entered deficit financing agreements with the federal government. At 30 June, 1983 there were in New South Wales -

	Approved nursing homes	Approved nursing home beds
Government	33	3,391
Deficit financed	130	6,302
Other	352	18,991
Total	514	28,684

(8)

The majority of homes and beds in the 'other' category are in private ownership, operated for profit, but also included here are non-government, not-for-profit, not deficit financed homes.

Under the National Health Act 1953, the Commonwealth, through its Department of Health, pays benefits to approved homes for all 'qualified' patients.

Qualification rests upon approval of the admission by a Commonwealth medical officer - but few patients are actually examined by a Commonwealth doctor. The 'ordinary care' benefit is reviewed annually on the basis that benefits, together with the statutory minimum patient contribution, cover fees charged for 70 per cent of beds in the State in non-government nursing homes approved under the National Health Act 1953. An additional daily benefit is payable in respect of patients approved of as needing and receiving extensive nursing home care. The statutory minimum patient contribution for patients in nursing homes other than State nursing homes is set at seven-eights of the standard rate single age pension plus 100 per cent of supplementary assistance - the rationale being that pensioners in nursing homes should receive some cash income to meet the cost of items not provided by the nursing home or otherwise provided free of charge. Patients in State nursing homes are required to make a statutory minimum patient contribution set at 66.6 per cent of the single pension rate plus 80 per cent of single supplementary assistance. (9)

Nursing home fees have been controlled by the Federal Health Department since 1973. Fee increases are granted only if the applicant proprietor can show that the operating costs of the home have increased. As fees are related to cost structures, fees between homes can vary quite significantly.

Nursing homes are located throughout the State; the 1983 survey of geriatric and rehabilitation services by the State Health Department found that nursing home beds were provided in all Regions, but that 76 per cent were located in the three metropolitan regions - 63 per cent of the State' a total population live in those three regions.

In comparison with some other States the collection in New South Wales of statistics relating to nursing home patients is good, but unfortunately those statistics do not include details of the numbers of accident victims cared for

in nursing homes, nor of the types of accident which led to their admission. From the statistics available it is clear that the majority of nursing home patients are aged people, and of the whole nursing home population only a relatively small minority are victims of motor vehicle accidents.

Among problems reportedly encountered by social workers in the placement of handicapped people in nursing homes are

- low standards of accommodation and care; although government health service administrators maintain that there is an adequate (or excessive number of nursing home beds available to meet current needs, the standards attained by some homes are, in the opinion of some social workers and other professional personnel, less than adequate.

- lack of appropriate accommodation and care for some groups of handicapped people; inappropriate premises, lack of equipment and the additional benefits paid in respect of bed-fast patients are among the reasons why difficulty may be experienced in placing patients with certain types of handicap - for example those who are highly mobile in wheelchairs; some brain damaged cases.

7.7 Hospitals

Hospitals in this State are, for administrative purposes, classifiable into the following major categories

7.7.1 Public hospitals -

7.7.1.1 'recognised' public hospitals

7.7.1.2 non recognised public hospitals

7.7.2 Private hospitals -

medical

surgical

maternity

psychiatric

7.7.1 Public hospitals

The features common to all public hospitals in N.S.W. which most obviously distinguish them from private hospitals are:-

(a) they derive the largest part of their income from government sources

(b) their operation is subject to either direct or close government control, including budgetary control

(c) they are open to any member of the public who has need of the services available.

Beyond those common characteristics there are differences between public hospitals in terms of legal status, ownership, governance, administration, staffing, financing arrangements and services available. The majority of public hospitals which offer relatively short term care (including Repatriation Hospitals operated by the Department of veterans' Affairs) come within the 'recognised public hospital' sub category. From 1 February 1984 these hospitals have offered free accommodation and care to anyone who, on medical grounds, requires it; those who wish to purchase private health insurance cover may be treated in a recognised hospital by the doctor of their choice, provided that doctor is a member of the staff of that hospital.

'Non-recognised' public hospitals in Hew South Wales are not currently recognised for purposes of private health insurance payments under Commonwealth health insurance legislation. Most of the non-recognised public hospitals are Schedule V institutions, listed in the fifth schedule to the Public Hospitals Act 1929 (NSW). These are State Government psychiatric institutions, institutions for the intellectually handicapped and State nursing homes. Unlike other public hospitals, which attract both Commonwealth and State funding, Schedule V institutions receive government suport only from the State Treasury. Although patients in Schedule V institutions may be required to pay for their hospitalization, the private health insurance arrangements do not extend any cover over charges levied by Schedule V institutions.

In round numbers there are 350 recognised public hospitals with 34,000 recognised beds in New South Wales in 1984. There are some 50 non-recognised public hospitals, 10 of which are psychiatric institutions and the others cater for long stay patients in various categories.

The majority of accident victims requiring in-patient hospital treatment stay for some days or weeks in public recognised hospitals; some however will stay for months. A minority of accident victims will suffer such severe and permanent brain damage that they will spend long periods in Schedule V institutions.

7.7.2 Private hospitals

Private hospitals are licensed under the Private Hospitals Act 1908 (NSW) after inspection by officers of the State Department of Health to ensure compliance with the specific minimum standards contained in regulations promulgated under that Act. Licences state the number of beds permitted and their classification as medical, surgical, maternity or psychiatric. Some private hospitals are

operated by religious or charitable bodies, others by private investors as profit seeking enterprises.

The major part of private hospital income derives from fees charged to patients. There is no government control over these fees at present. Commonwealth subvention to private hospitals from 1 February 1984, has been scaled according to the level of accommodation and services provided - private health insurance cover to meet private hospital charges to patients in whole or part is available. The cover provided in a particular case is linked to the Health Department's rating of the hospital providing accommodation and care.

Since private hospitals are essentially short stay institutions and have generally little by way of facilities for emergency rehabilitative and after care, the fraction of all accident victims treated in the immediate post accident period in private hospitals is small. Very few accident victims receive long term accommodaton in private hospitals.

7.8:N.S.W. Housing Commission - Special Purpose Housing Committee

Requests from various community groups for Special Purpose Housing are evaluated by the Special Purpose Housing Committee, which comprises representatives from the Housing Commission, Health Commission and the Department of Youth & Community Services, and when considered appropriate Commission approval is given for the provision of accommodation either from the Commission's existing stock, by constructing accommodation, or in the private sector. Such approval generally depends on the organisation demonstrating expertise in their particular field of operation, there being an established demand for residential accommodation from those the organisation represents and there being clear evidence the organisation does not have the financial capacity to make its own arrangements to provide residential accommodation.

The tenancies granted to these organisations are established on the basis that a maximum rental is charged which is equal to 80% of the local market level. This is subject to reduction by way of rental debate if 20% of the total income of the group in residence is less than the maximum rental of the property. The maximum rental level is reviewed annually to retain its relativity to the local market situation but currently increases are restricted to $5.00 per week in any one year.

The following organisations, specifically requesting special purpose housing accommodation for the handicapped, are among those which have been offered accommodation or approved for special purpose housing:

. Aid to Retarded Persons (the Sunnyfield Association) a dwelling at St. Marys to provide housing for handicapped persons.

. Gunnedah and District Intellectually Handicapped Children's Association (Sub-Normal Children's Association) a dwelling at Gunnedah to provide accommodation for intellectually handicapped children.

. Summerland House With No Steps - accommodation at Lismore to provide accommodation for use by trainees receiving vocational rehabilitation.

. Lachlan House With No Steps - accommodation at Forbes to provide hostel accommodation for disabled people.

. Australian Association for Better Hearing - accommodation at Parramatta for use as a therapy centre.

. illawarra Society for Crippled Children-accommodation at Bellambi for use by a group of disabled persons.

. The Australian Quadraplegic Association - accommodation at Maroubra to house three or four disabled persons.

. Macquarie Hospital North Ryde Auxiliary - accommodation for use as a group home for retarded adults.

. The Hunter Regional Physically Disabled unlimited - accommodation in the Newcastle area for use as a group home for physically disabled persons.

. The Sunnyfield Association - a specially modified dwelling at Manly Vale for use by a group of intellectually handicapped persons.

7.9 Assistance for handicapped children living away from home

The Commonwealth Department of Education, through its Assistance for Isolated Children' s Scheme, provides financial assistance to families whose handicapped children must live away from home to attend a special institution. There is a basic Boarding Allowance payable free of means test and additional amounts are payable subject to means test.

7.10 N.S.W. Housing Commission - Emergency Accommodation Unit

During the latter part of 1981 the Emergency Accommodation unit was established within the Housing Commission. This Unit is responsible for providing accommodation for those people assessed as being in urgent need because of extreme housing difficulties aggravated by problems of health, low income, unemployment, etc. in many instances accommodation made available through the

Emergency Accommodation Unit is leased to various organisations established to assist these people.

Organisations which have been allocated accommodation through the Emergency Accommodation Unit specifically to assist the handicapped include:

. The Association for the Assistance of the Intellectually and Socially Handicapped - three houses at Georges Hall, Rooty Hill and Quakers Hill for the rehabilitation and training for independent living of the intellectually handicapped.

. The Blue Mountains Handicapped Centre Limited - two houses at Faulconbridge for the training for independent living of the intellectually handicapped.

. The Uniting Church - accommodation at Summer Hill for use as a half-way house, with supports to assist towards independent living.

. The Association for the Assistance of the Intellectually and Socially Handicapped - four self-contained one bedroom ground floor units at Ermington for use to teach married intellectually handicapped people independent living skills.

7.11 Disabled Persons' Accommodation project Australian Housing Research Council

A study commissioned by the Australian Housing Research Council was reported under the title "Disabled Persons' Accommodation, AHRC Project No. 119", published in 1982. The fourth Chapter of the report summarised the existing constraints on housing choice for disabled people and indicated some opportunities for policy and program changes that would begin to overcome these

constraints. The summary is based on information from the literature review, "providers" seminars in Sydney and Brisbane, and response of the "users" from the series of group discussions with disabled people.

The constraints are organised in five sets:

1 . Attitudes

The first set of constraints has to do with attitudes - societal attitudes; local community attitudes; the attitudes of many disabled individuals; the attitudes of disabled people as a minority group.

2. **Income**

The second set of constraints has to do with low incomes which constrain accommodation choice; physical housing modification; the availability of aids and appliaances; access to appropriate support services.

3. The System

The third set of constraints is in the system of service provision - its complexity; the typical problems of groups seeking government funds; the need for recurrent funding; the lack of coordination; vested interests; the quality of accommodation and services; the problems of remote areas; the inflexibility and insensitivity of the system; the need to encourage self-help initiatives; the lack of information; inappropriate grouping of disabled people.

4. Housing Supply

The fourth set of constraints has to do with problems in the supply of accommodation - gaps in the range of housing provided by organisations; the unavailability of State Housing Authority (SHA) accommodation; the inaccessibility and unsuitability of ordinary housing.

5 . Support Services

The fifth set of constraints has to do with problems relating to the supply of support services - unavailability; lack of support to families; the need for ongoing care; the need for varying levels of support over time; the need for staff.

Although not intended to do so, this list of constraints presents a summary of the constraints limiting the satisfaction of the needs of the disabled in most areas other than accommodation!

Footnotes

1. Department of Social Security, Annual Report 1982-83, (Canberra, A.G.P.S., 1983), p.143.

2. Australian Bureau of Statistics, New South Wales Year Book No. 68, 1983, (A.B.S., 1983), p.123.

3. Due to staffing problems the scheme has not been fully implemented - personal communication from officer of the Department of Youth and Community Services, August 1984.

4. The report on this survey is expected to be published about Novemberm 1984 - personal communication from N.S.W.C.O.S.S. officer, August, 1984.

5. New South Wales Department of Health, inquiry into Health Services for the Psychiatrically ill and Developmentally Disabled, (Sydney, N.S.W. D. of H, 1983), (Richmond Report).

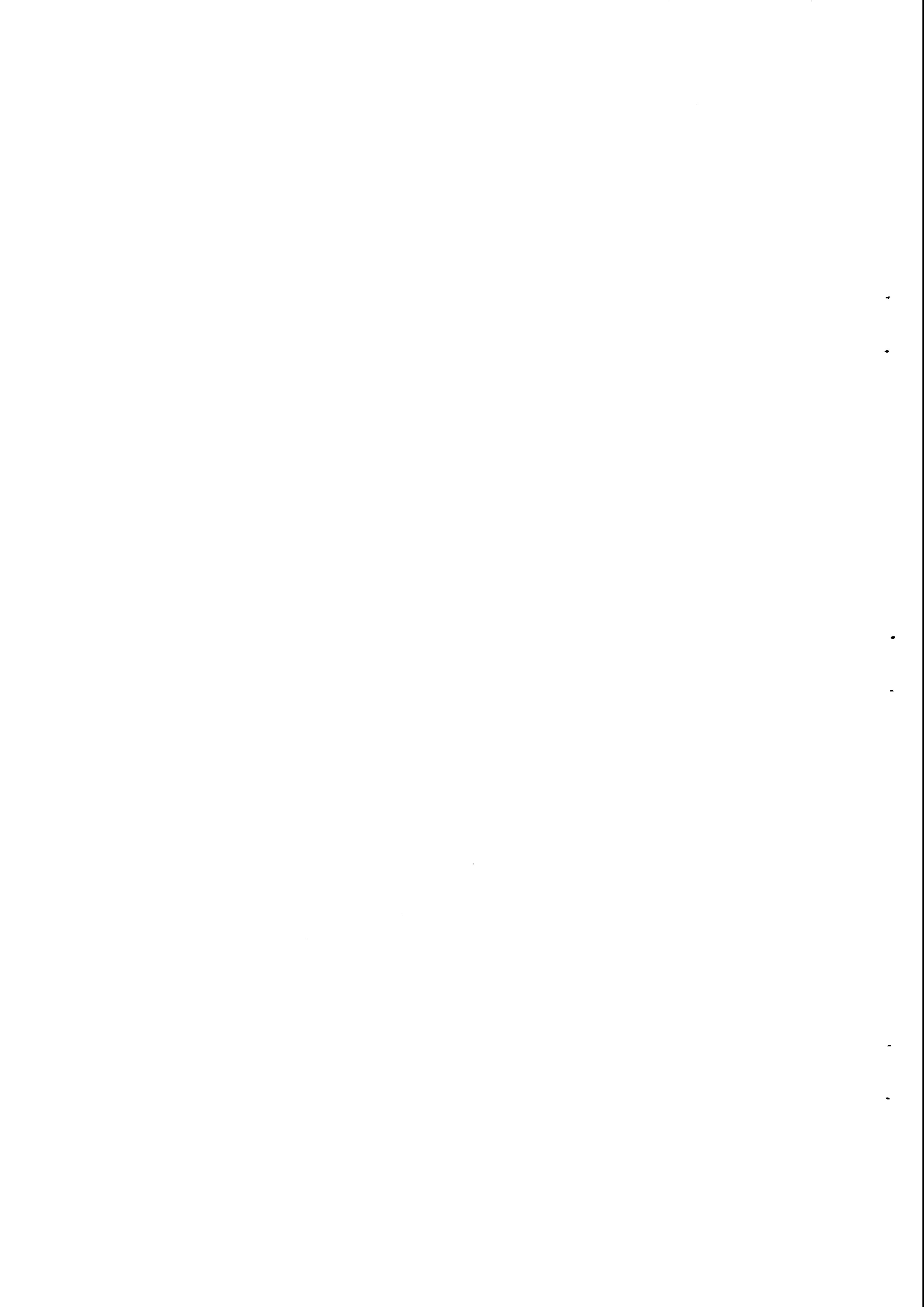
6. Department of Social Services, op. cit., pp.142-143.

7. New South Wales Health Department, Geriatrics and Rehabilitation, (1983, unpublished).

8. Commonwealth Department of Health, Annual Report of the Director-General of Health, 1982-83m (Canberra, A.G.P.S., 1983) p.188.

9. Information supplied by Health Services unit. New South Wales Health Department, August, 1984.

10. New South Wales Health Department, op. cit.



CHAPTER EIGHT

DAILY LIVING NEEDS

8.1 Handicapped people living independently or semi independently may require assistance with the routine tasks and activity of daily life, including

- personal care
- housekeeping
- provision of meals
- shopping
- transportation

Other needs of the independent and semi-independent handicapped are dealt with in other chapters of this review - see domiciliary nursing (Chapter 4); home modification, home equipment, vehicular provision and modification (Chapter 5); social and recreational opportunities (Chapter 11).

The need for those who have to provide care for handicapped people to obtain respite from their sometimes onerous responsibilities is also discussed in this chapter.

Figure 8.1 depicts the major elements of the arrangements whereby the daily living needs of the handicapped may be met.

8.2 The carers

Much of the care needed by handicapped people comes from relatives, friends and neighbours. In general this care is provided without any monetary recompense. Some financial support is available from the Commonwealth for some parents who

FUNDING

HANDICAPPED PERSON'S OWN RESOURCES

COMMONWEALTH SUBSIDY

N.S.W. GOVERNMENT FUNDS

CHARGES FOR SERVICES

OTHER FUNDING CHARITY

PROVIDER AGENCIES

COMMONWEALTH

N.S.W. YOUTH AND COMMUNITY SERVICES DEPARTMENT

N.S.W. HEALTH DEPARTMENT

LOCAL GOVERNMENT AGENCIES

NON PROFIT COMMUNITY AGENCIES

PRIVATE ENTERPRISE FOR PROFIT AGENCIES

RELATIVES, FRIENDS AND NEIGHBOURS

PROGRAMS AND SERVICES

N.S.W. HOME CARE SERVICES

MEALS ON WHEELS SERVICES

OTHER 'CARING' SERVICES

'CARERS'

PAID CARERS

VOLUNTEERS

NEEDS

DAILY LIVING NEEDS:

PERSONAL CARE

HOUSEKEEPING

HANDYMAN AND GARDENING SERVICE

DELIVERED MEALS

TRANSPORTATION

RESPITE CARE

Figure 8.1 Meeting daily living needs of the handicapped

care for handicapped children (Handicapped Children's Allowance), and for some people who care for the disabled in their own homes (Spouse Carers' Pension and Domiciliary Nursing Benefit) - see Chapter 3.

For those needing regular assistance - or episodic assistance - but who cannot call upon relatives, friends, neighbours or unpaid volunteers, care must generally be sought from 'paid' carers. If the amount of assistance required is not large, or the need is relatively infrequent then the handicapped person may be able, without great hardship, to meet the cost of obtaining the services of someone who is prepared to undertake this type of work. But if there is a continuing necessity to have assistance on a daily basis - perhaps say on several occasions during each day - the cost of obtaining this care may be very high and the problems of organising and maintaining regular care seven days a week for long periods very considerable indeed. For those who have to pay the 'market price' for care, it may be possible to reduce the problem of finding carers by having recourse to a private employment agency - such as 'Dial-an-Angel' and private nursing services. Of course such an agency requires payment for the work it does.

Governments - federal. State and local - together with voluntary agencies provide assistance to eligible handicapped people in meeting their daily living needs. Statewide schemes of assistance include -

. the Home Care Service of N.S.W.

. Meals on Wheels services

8.2.1 The Home Care Service of N.S.W.

The service is a semi-autonomous organization of which the Chairman is directly responsible to the Minister for Youth and Community Affairs. The Department

provides administrative assistance to the service. Finance is provided Ly the Commonwealth under the States Grants (Home Care) Act 1069 by way of a 1 : 1 subsidy matching State Government funds; income is also received from some recipients of service.

The Home Care Service has some 150 branches throughout the State. Each branch is managed by a local voluntary committee which enjoys considerable autonomy in the management of its services. Services provided include:

. housekeeping services such as cleaning, washing, ironing, cooking, shopping, care of children

. handyman and gardening such as changing light bulbs, moving laws et cetera

. home management such as budgetting, negotiating with government departments

. temporary live-in housekeeper service - for up to eight weeks

Anyone may request the assistance of this Service; a Home Care Assessor will then assess the need and the ability to pay for services. Fees are on a sliding scale tied to means and do not meet the actual cost of services supplied. No fees are charged to people living on low incomes.

8.2.2 Meals on Wheels services

Some 230 local services operate throughout the State under the auspices of local government and non-profit agencies. The Commonwealth Government supports these services under the Delivered Heals Subsidy Act 1970, administered by the Department of Social Security.

The service aims to deliver a midday meal on weekdays, excluding public holidays, to the sick or infirm house-bound who are unable themselves to prepare an adequate meal and have no one reasonably available to do this for them.

Heals are prepared in the kitchens of public hospitals, senior citizens clubs, service and sporting clubs and church halls. Delivery of meals is generally by volunteers working on a roster system.

In the financial year 1982-83 Commonwealth expenditure in New South Wales under the Delivered Heals Subsidy Act amounted to $1.4 million, with more than 2 million meals being delivered(1)

8.3 Attendant Care Project

Using a grant made available by the federal Department of Social Security, the Home Care Service of N.S.W. commenced recently a pilot scheme of attendant care for severely disabled people in the Sydney metropolitan area.

For the purposes of the pilot study eligibility criteria are:-

(i) severely disabled

(ii) of working age

(iii) medically stable

(iv) in need of between 2-4 hours assistance per day with personal care tasks such as bathing, toiletting, transferring and dressing

(v) at maximum level of independent functioning in their present; environment.

A small number of people able to meet these criteria will receive attendant care through the project or be given an allowance to purchase this type of care.

Findings from this study are not yet available.

8.4 Transportation

Disabled people who, as part of rehabilitative programs or of after care are required to attend hospital out-patient or other clinics, rehabilitation centres, or the like may be provided with transportation by hospital, government or public transport vehicles at no cost to themselves. But travelling in the course of daily living activities handicapped people will need to use either public or other means of transport more or less in the ways that do other members of the community. Among the schemes to assist the handicapped with transportation are -

- . fare concessions on public transport services;
- . subsidised taxi service
- . exemption from sales tax on vehicles
- . mobility allowance
- . the Federal Government's IPTAA scheme

8.4.1 Public transport fare concessions

The New South Wales Government provides subsidies and concessions towards certain transport services utilised by holders of Pensioner Health Benefit Cards. Reduced fares are payable on New South Wales Government transport, buses and ferries, and on privately-operated bus services. Rail concessions also include travel at reduced fares on certain main interstate trunk lines, and two free economy class return journeys per year between any two New South Wales stations at least one of which is outside the Sydney metropolitan area. Some travel concessions are also available to certain other groups of Commonwealth social security beneficiaries resident in New South Wales. Concessions

avatlable on Commonwealth Railways and the National Shipping Line are mentioned in Chapter 3.

8.4.2 Subsidised taxi service

In New South Wales the State Government provides subsidies through the Urban Transport Authority to enable disabled people who are unable to use buses, transport and ferries to obtain transportation in specially modified taxi cabs at half the normal taxi fare.

8.4.3 Motor vehicle sales tax exemption for handicapped persons

Purchase of a motor vehicle for the use of a handicapped person may be exempt from federal Sales Tax. As noted in Chapter 3, exemption is granted only to persons in employment and who suffer from specified disabilities.

8.4.4 Mobility allowance

From 1 April 1983 a mobility allowance of $10 a week has been payable to disabled people who are employed or in vocational training for a minimum of 20 hours a week and who because of their disability are unable to use public transport without substantial assistance. The allowance may also be payable for up to three months after the requisite employment or training has ceased. The allowance is paid free of any income test, is not subject to income tax, but is subject to an income test. At 30 June 1983 there were 3,935 people in receipt of mobility allowance(2)

8.4.5 Isolated Patients' Travel and Accommodation Assistance Scheme

The Commonwealth Department of Health administers the isolated Patients' Travel

and Accommodation Assistance Scheme which assists people in isolated areas to obtain specialist medical care. Assistance is by way of contribution to the cost of fares and accommodation for the patient and an attendant if necessary. To be eligible the patient must be referred for specialist treatment which is available only at a centre more than 200 kilometres away. In the year ended 30 June 1983 $1.9 million was expended on this scheme in New South Wales, providing assistance to 24,614 people.(3)

8.5 Development of daily living skills

To enable handicapped people to live independently or perhaps in group settings such as group homes and hostels, it may be necessary to provide training in such basic skills as looking after one's personal belongings, keeping one's room tidy, working efficiently in one's kitchen and so on. Training of this type is provided at some hospital rehabilitation units and at CRS centres.

8.6 Respite Care

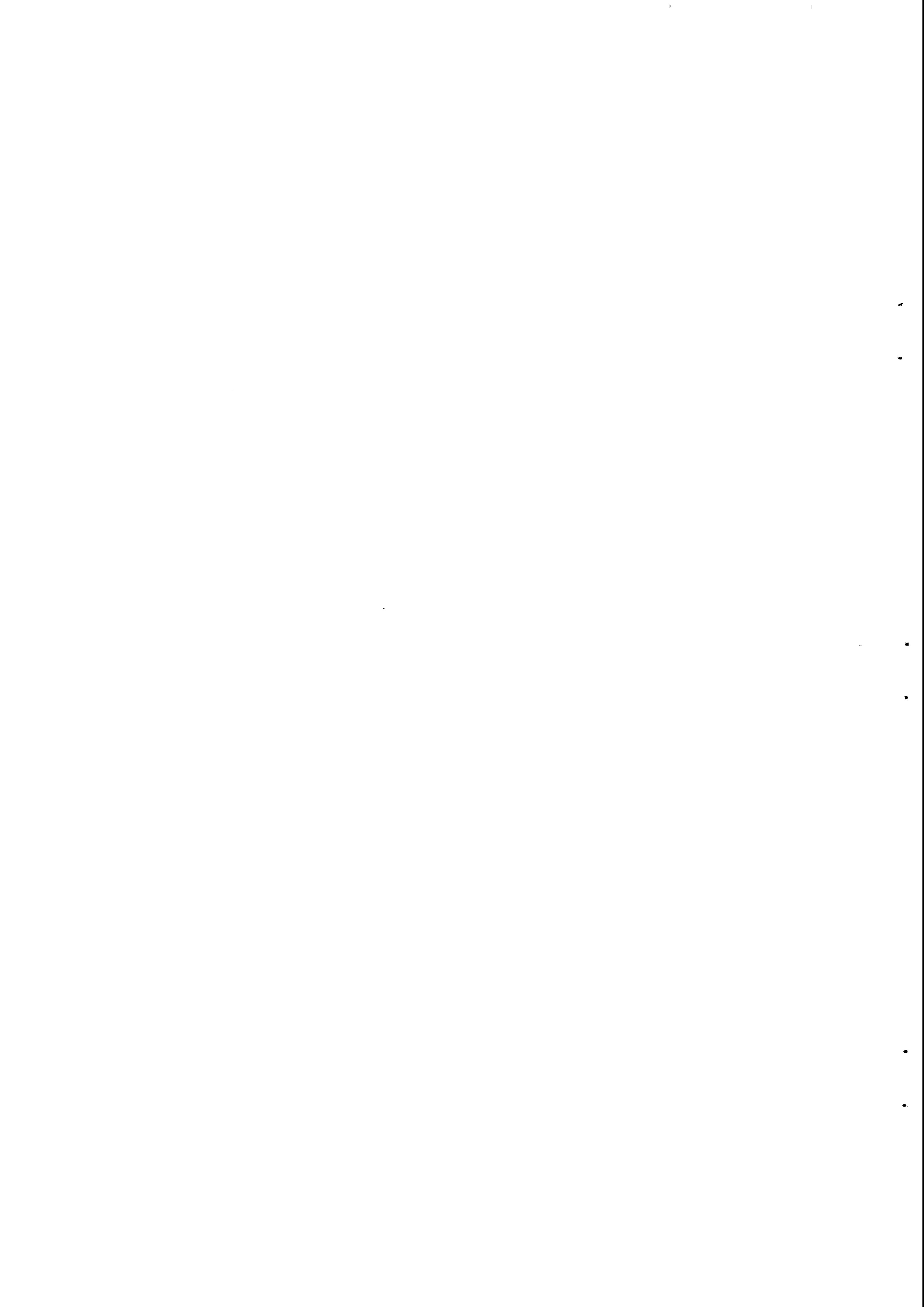
The demands made upon other members of a household in which a handicapped person lives may be very heavy in terms of physical exertion and psychological stress. The N.S.W. Department of Youth and Community Services has a scheme to provide care for some handicapped children for a short period to afford parents with some respite. Some public hospitals and some nursing homes accept, subject to availability of beds, handicapped people for a short stay as inpatients to give temporary relief to those who care for these people at home. Other families may make private arrangements for the temporary care of handicapped relatives.

Footnotes

(1) Department of Social Security, Annual Report, 1982-83, (Canberra, A.G.P.S., 1983), pp.69 and 146.

(2) Id., p.47.

(3) Commonwealth Department of Health, Annual Report of the Director-General of Health 1982-83, (Canberra, A.G.P.S., 1983), p.179.



CHAPTBR NINE

EDUCATION

9 . 1 For those suffering serious accidental injury with residual handicap early in life the educational opportunities open to them may be crucial determinants of the quality of life they will later enjoy - or suffer. Here mention will be made of educational opportunities available in the pre-school years; at the primary, secondary and post-secondary levels of formal education; and of some other special educational programs.

9.2 The pre-schoolers

The Children's Services program (CSP) of the Commonwealth Department of Social Services provides funds to State Government and to community groups for the provision of preschools and other services to children; all services funded under CSP are expected to give priority to meeting the needs of disabled children, and, in addition, the Commonwealth CSP makes available funds for services specifically serving disabled children (not necessarily only pre-schoolers).

Fees are charged at some pre schools. It is generally expected that parents will contribute to the operation of pre schools by participating in the care and training of the children or by assisting with the provision of materials, maintenance of premises et cetera. The N.S.W. Department of Youth and Community Services provides some financial support to community pre schools which enrol handicapped children.

The Department of Youth and Community Services, assisted by funding from the Commonwealth Department of Social Security Office of Child Care, operates the

Young Handicapped Children's Program. This program has an establishment of 14 field coordinators to cover the Depprtment's metropolitan, Hunter and Illawarra Regions. The Program provides advisory and referral services to families with handicapped children in the 0 - 6 years age range. The coordinators' role includes developing parent and community awareness of and participation in coping with the problems associated with meeting the needs of these young children.

A very detailed examination of educational services for handicapped children was published recently by the N.S.W. Education Department under the title "Strategies and Initiatives for Special Education in N.S.W.(1) Regarding services for the pre school age group, the report commented -

> "The youth and Community Services provisions are inequitably distributed and the Department of Education's provisions insufficient and based on chronological age rather than children's needs."

9.3 and 9.4 Primary and secondary schooling

The 'Strategies and Initiatives' report referred to in 9.2 above presents a descriptive and evaluative account of educational services for handicapped children of primary and secondary school age.

Some disabled children are enrolled in regular classes or special classes in State Schools. The Department of Education also operates special schools for handicapped children in Sydney and at a few non-metropolitan centres. Some school facilities are provided in hospitals for long stay patients.

Detailed recommendations for remedying acknowledged shortcomings in the school system are included in the report referred to above.

Table 9.1 presents estimates of the number of handicapped children aged 4-18 years in New South Wales in 1980. Only a small fraction of all these would have been motor vehicle accident victims.

9.5 Post-secondary education

9.5.1 Technical and further education (TAFE)

The N.S.W. Department of Technical and Further Education, which receives some funding from the Commonwealth Government through the Tertiary Education Commission, offers an extremely wide range of vocational and non vocational courses - over 1200 of them. Most courses are free; for some there is a small charge. Courses may be taken on a part-time or full-time basis, concurrently with employment or by external (correspondence) study. Courses may be 'tailor-made in response to the needs of particular groups of students. The variety and flexibility of TAFE programs makes them attractive to some disabled people.

Handicapped people eligible for benefits through the Commonwealth Rehabilitation Scheme may receive assistance by way of training and other allowances to enable them to pursue TAFE courses.

9.5.2 University and College of Advanced Education courses

Financed mainly by the Commonwealth Government universities and Colleges of Advanced Education (CAE's) make no charges for tuition of students pursuing diploma or degree courses. Handicapped people wishing to pursue these courses may be accepted as trainees by the Commonwealth Rehabilitation Service (CRS) which may provide a training allowance and other benefits such as living-away-from-home and mobility allowance if these are necessary, plus costs of books, student service fees et cetera. People refused assistance by CRS may apply for

TABLE 9.1 Prevalence of handicapping conditions of children 4-18 years of age, NSW, 1980.

	[illegible]	[illegible]	[illegible]					[illegible]			[illegible]		
	1%(1)	1.54%(1)	.35%(2)	.2.%(2)	.07%(2)	.003%(2)	3.2%(2)	.05%(2)	.075%(2)	.05%(2)	.,%(2)	.05%(2)	..%(2)
A Total N.S.W. population of 4 to 18 year olds 1,285,609*	12856	19798	4500	2700	900	to	41139	643	964	643	1286	643	141417
B N.S.W. school population Government and non-government 4 to 18 year olds 1,041,691	10417	16042	3645	2188	729	31	33334	521	781	521	1042	521	114586
C Non-government enrolments 240,400 Estimates unless indicated	(3) 400	(1) 3702	(2) 1000	(3) 200	(3) 100	(2) 20	(1) 7693	(4) -	(4) -	(4) -	(3) 40	(4) -	(1) 26444
Children requiring services in Government schools	10017	12340	3500	2500	800	20	25641	643	781	521	1246	643	114973

(1) Schonell Survey
(2) Departmental (Health, Youth and Community Services, Education)
(3) Estimates
(4) Not Available

Heavy outlines idenilfy nurtv.cr;, requiring special education services.

* Australian Bureau of Statistics 1978 projected figure for 1930 population **based** on 1976 Census.

:2iiH£.c~ N.S.W. Kiiuccitio;: Department. 'Strategies and Initiative;: for Special Education in N.S.W.', N.S.W. Govern-ent Printer, 1932.

Commonwealth financial assistance under the Tertiary Education Allowance Scheme (TEAS) - the scheme is open to anyone wishing to study an approved course at a university or CAE, but allowances are payable subject to means test (parents means may be examined in the case of young students living at home), and the benefits are less generous than those obtainable through the CRS.

9.6 Special types of education

9.6.1 Basic skills training

At CRS centres and some hospital rehabilitation units training in literacy, elementary numeracy, typing and similar basic skills may be provided for adolescents and adults who lack them.

6.6.2 English language skills

Instruction in English as a second language is available at CRS centres, through the State Education Department and through TAFE to assist disabled migrants acquire proficiency in the English language.

9.6.3 Vocational training through the CRS

Vocational training of disabled people is available to selected applicants through the CRS (see Chapter 10). In total number of people going through this type of training, which may be of the post secondary categories mentioned above, is not large.

For the year ended 30 June 1982, for the whole of Australia, the figures were

Number of people who	commenced vocational training	1526
	completed training	1409
	had training cancelled	62

Details of disabled people undergoing vocational training through the CRS at 30 June 1982 were

Type of course		Number in training
Full-time	classes	444
	correspondence	8
Part-time	classes	101
	correspondence	15
On-the-job		257
	Total	825 (2)

The Annual Report of the Department of Social Security for the year 1982-83 did not show any figures relating to vocational training.

Footnotes

(1) New South Wales Department of Education, Strategies and Initiatives for Special Education in N.S.W., (Sydney, Government Printer, 1982).

(2) Department of Social Security, Annual Report 1981-82, (Canberra, A.G.P.S., 1982), p.148.

CHAPTER TEN

OCCUPATIONAL ASSESSMENT, TRAINING AHD PLACEMENT

10.1 Pathways to post-accident employment

The possible outcomes for the accident victim who was in employment prior to accident are shown in Figure 10.1. For many people who suffer an accident there is no, or very little disruption of their normal routine, and even if some hospital or other medical care is required this may not cause any serious upset. Some unfortunates whose employment has been interrupted find that, although left with no residual physical or mental handicap, the job they had prior to employment is no longer open to them. These people are in the same position as other 'normal' unemployed people and have open to them the same avenues to employment; however their accident may lead to loss of income, perhaps of long duration, and thus they are a category to be considered in discussion of accident compensation schemes. We will not pursue that discussion here.

The major concern of this chapter is with accident victims who, despite medical care, including medical rehabilitation, will be left with a residual handicap which prevents their resuming their previous employment or something closely similar to it. The first step towards eventual employment is assessment of their potential which will lead to one of three prognoses -

- employable in a different capacity with no further training or retraining
- potentially trainable or retrainable for some different employment, or

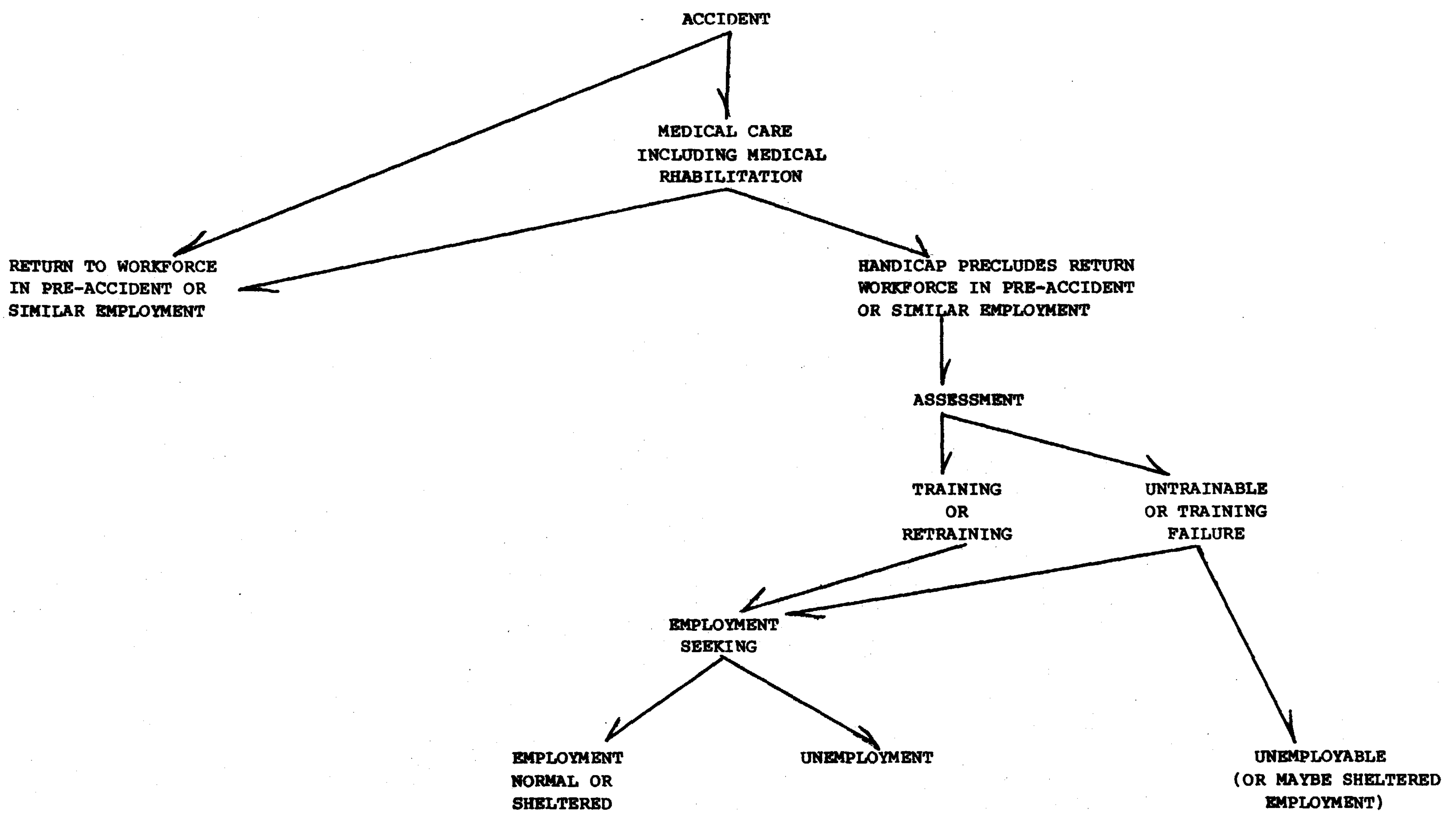


Figure 10.1 Pathways to post-accident employment or unemployment

- untrainable and handicapped to the point of unemployability or perhaps employable in sheltered conditions; also coming into this category will be those who commenced training or re-training but did not satisfactorily complete that process.

For those who require no additional training - for example an unskilled worker may be able, despite some handicap, to undertake another type of unskilled work - and for those who successfully complete some form of training, there follows the search for a job. This search may, particularly in times such as the present, prove unsuccessful; the future may hold years, perhaps a life-time of austerity on a social services pension. Those who secure employment may find themselves in normal or in sheltered employment.

There is no one agency responsible for overall assessment, training and placement of handicapped would-be workers. Assessment may be made by the Vocational Guidance Section of the State Education Department; the State Department of Youth and Community Services has a vocational guidance service for young people in its care. Hospital rehabilitation units and private rehabilitation centres may undertake assessment and offer limited opportunities for training; the largest agency in this field is the Commonwealth Rehabilitation Service. Sometimes employers provide some training or retraining of employees who have acquired an accidental handicap. Some rehabilitation units, voluntary agencies and self help groups are able to assist in finding employment but the largest agency concerned with placement of handicapped workers is the Commonwealth Employment Service.

10.2 Assessment and Training agencies

All agencies undertaking the assessment and training of injured people who may be able to return to or enter the workforce engage in similar tasks but vary

widely in the scope and scale of their activities. Here we will describe in outline the Commonwealth Rehabilitation Service of the Department of Social Security, this being the agency which covers the widest range of activities in the assessment and training field.

10.2.1 The Commonwealth Rehabilitation service (CRS)

The service was originally established to assist disabled people to enter employment, entrants to the service's programs being selected on the basis remediability of disability and likelihood of engaging in suitable employment within three years of the commencement of treatment or training, in recent years there has been a shift in CRS policy. *The* present policy is to offer services to any disabled person who can substantially benefit from the programs whether for employment, household duties or simply living at home. The following information (10.2.1.1 to 10.2.1.6) is extracted from CRS publications.

10.2.1.1 What the CRS provides

Objective assessments of a person's functioning by multi-disciplinary teams, establishment of realistic rehabilitation objectives and individually tailored programmes that will help overcome problems and attain rehabilitation goals.

. Treatment of a person's condition so that the disabling effects are minimised. Such treatment can include specialist medical, speech therapy, physio and hydrotherapy, remedial physical and psychological therapy, counselling and remedial education.

. Aids - all aids essential to a person's increased independence in ordinary activities are prescribed, supplied and training given in their use.

Equipment that is generally supplied includes mobility aids, modification to homes, aids for increasing independence in activities of daily living, devices that help in minimising pain and in improving physical comfort, and communication and work aids.

. Work assessment and training - a person's ability to perform at levels that meet the requirements of industry are assessed in a variety of work settings in the rehabilitation centres. Metal and wood workshops, automotive bays, clerical areas and printing shops provide suitable environments for disabled people to increase their knowledge of job requirements, learn and practise new work skills and upgrade their physical tolerance to levels that will enable them to return to competitive employment.

. General activities and independence at home. A goal of open employment is unrealistic for some disabled people. The rehabilitation programme provided for these people will concentrate on identifying satisfying recreational activities and ensuring that they are as independent as possible when they return to their own home. Arrangements for home support services and referrals to community support and activity groups are completed, prior to finalising the rehabilitation programme.

. Off-Centre training. Vocational training is provided to ensure that disabled people are adequately prepared to compete for positions for which they have shown potential. Training can take various forms but the two most common are on-the-job training (work therapy) and attendance at formal vocationally oriented courses at tertiary and technical training institutions. All necessary books and equipment are supplied to trainees, a training allowance is paid and trainees are covered for workers' compensation purposes by the Department of Social Security. All training is supervised by a rehabilitation

counsellor who will offer support and guidance throughout the training period.

. Employment placement. Once a person has successfully completed a rehabilitation and/or training programme, assistance in finding suitable employment is provided. A number of different means are employed to achieve placement - the C.E.S, personal contacts. Work Therapy, subsidised training schemes and direct placement are used when, and as appropriate, to the client and the circumstances.

. Follow-up on completion of a rehabilitation centre programme. Resettlement in work, community activities or at home is an integral part of the rehabilitation programme. Rehabilitation counsellors are primarily responsible for resettlement activities but they are often assisted in this work by other C.R.S. staff or community workers who are better placed geographically or who have a particular expertise that will facilitate attainment of the resettlement plan for the client.

10.2.1.2 CRS facilities

. Rehabilitation Centres

Persons entering a rehabilitation treatment programme are assessed by a team of rehabilitation practitioners and a programme is designed to assist in overcoming identified problems and to uprade a person's functioning. The rehabilitation team includes mix of professionals skilled in particular areas of human functioning e . g . medical consultants, physiotherapists, occupational therapists, speech pathologists, nurses, social workers, teachers, trades instructors and rehabilitation counsellors. A client entering a programme will be directed to any or all of these team members, according to the

presenting disability and assessed needs. Two multi-diagnostic centres are situated in Sydney - Mt. Wilga at Hornsby and the Queen Elizabeth II centre at Camperdown. In country areas, centres are conducted in conjunction with the Health Department of N.S.W. at Newcastle and Bathurst. Residential facilities are available at Bathurst and at Mt. Wilga.

. Regional Rehabilitation unit

Rehabilitation counsellors, and in some cases social workers, provide local contact for disabled persons in metropolitan and country regional rehabilitation units. These units are able to organise local treatment and training or to facilitate referral to a rehabilitation centre. Rehabilitation units are located at Albury, Orange, Canberra, Newcastle and Wollongong; and Parramatta and Liverpool in Sydney.

. Work Preparation Centres

Two specialist centres at Granville and Marrickville cater to the needs of mildly intellectually handicapped adolescents. Training in social independence, work habits and work skills is provided by a team of rehabilitation practitioners - psychologists, social workers, rehabilitation counsellors, teachers and trades instructors. The aim of the centres is to increase the independence and employment potential of developaentally disabled young adults.

. **Work** Adjustment Centre (Reset Manufacturing)

A Work Adjustment Centre located at Artarmon in Sydney, provides an opportunity for disabled people to increase work skills and work tolerance in a simulated work environment. The emphasis in this centre is on realistically

meeting the demands of a work situation, and therefore, involvement of therapeutic staff is limited. Rehabilitation counsellors and trades instructors are responsible for a person's well being and progress whilst at the Centre. On-the-job or formal vocational training or placement or employment is the usual outcome for those who complete programmes at the Work Adjustment Centre.

10.2.1.3 Rehabilitation and training allowances

When a person commences a rehabilitation programme, payment of Rehabilitation Allowance replaces their existing pension or benefit. If a person is not in receipt of a benefit, their eligibility has to be established before payment of the Rehabilitation Allowance can commence. This allowance is equivalent in rate to the Invalid Pension, attracts the same fringe benefits and is subject to the same means test. Payment can be continued for a period of 6 months following completion of a rehabilitation tretment or training programme.

For persons attending Work Preparation and Work Adjustment Centres, an Incentive Allowance is paid in addition to the Rehabilitation Allowance. The rate of Incentive Allowance varies according to a person's work productivity, time keeping and work behaviour.

Fares are refunded for attendance at all programmes and appointments connected with a rehabilitation programme.

A Training Allowance is payable to all persons undergoing formal vocational or work therapy training who are sponsored by the C.R.S. This allowance is a set weekly amount paid fortnightly with Rehabilitation Allowance and is adjusted in line with the rates payable under Manpower Training Schemes.

If a person is required to live-away-front-home in order to undertake C.R.S. sponsored training, a Living-Away-From-Home-Allowance becomes payable, this is paid in addition to and in the same manner as Training Allowances.

10.2.1.4 Eligibility criteria

As noted above, entry into CRS program is open to persons who are assessed as being likely to benefit substantially, whether for employment, household duties or simply living at home.

Entry is limited to the following age groups -

. adolescents of 14 and 15 who, without assistance, are likely to become invalid pensioners on attaining 16 years of age;

. males of 16 to 65 years of age;

. females of 16 to 60 years of age.

Commonly occurring disabilities amongst persons accepted for CRS assistance are:

. Amputations

. Back pain

. Mild intellectual handicap

. Multiple fractures

. Spinal cord injuries

. Head injuries

. Psycho-social disorders

. Arthritis

. Repetition injuries

. Cardio-vascular problems

10.2.1.5. CRS charges for service*

The services offered by the CRS are provided free of charge, but where a person has a successful claim for compensation or damages for the disability for which

rehabilitation is provided, the cost of rehabilitative treatment and training will be recovered.

10.2.1.6 Referrals to CRS

Rehabilitation counsellors located at the centre or unit closest to the person's home address will discuss a possible referral. Alternatively, if one centre appears to offer a more relevant programme, a counsellor at that centre can discuss the referral process and centre programmes in greater detail.

Following referral, assessment and admission procedures are different at each of the centres. There are always pre-acceptance interviews by rehabilitation counsellors and medical consultants (in the case of Rehabilitation Centres), psychologists and other staff in the case of Work Preparation Centres. Feedback to the referring agency as to acceptance for rehabilitation, or otherwise, is provided at this point.

Admissions to centres are organised according to the availability of the particular services required by a client. Waiting times for admission therefore vary but, in general, first preference is given to persons completing primary treatment or undergoing preliminary rehabilitation programmes to ensure continuity in management. Persons with disabilities of a more chronic nature are admitted in order of referral.

10.2.1.7. Scale of CRS activities in NSW

For Australia as a whole, there were nearly 21,582 referrals to the CRS in the year ended 30 June 1983. Of these, 6,108 commenced and 5,787 persons completed programs. In other words, less than one in three persons referred was actually accepted by the CRS(1) At 30 June 1983, again for Australia as a whole.

there were 3,658 people reported as undergoing rehabilitation in CRS and CRS related programs -

timber of people undergoing rehabilitation at 30 June 1983 (classified according to major program)

Number of people	
Through centres	
Rehabilitation centre programs	1 055
Work preparation centre programs	222
Work adjustment centre programs	90
External rehabilitation programs	115
Vocational training courses	284
On-the-job training	173
Through rehabilitation units	
Regional centre programs (a)	343
External rehabilitation programs	621
Vocational training courses	436
On-the-job training	175
Suspended	144
	3 657

(a) Treatment programs provided in conjunction with State and Territory hospitals and other facilities. (2)

For New South Wales during the **year** ended 30 June 1983 the number of people who completed rehabilitation programs and their subsequent placements were -

placed in employment	- open	327	
	- sheltered	64	
	- part time or home bound	50	
	- other employment	88	
			529
seeking employment			390
Not in employment -			
Household duties		21	
Independent or semi-independent living		384	
			405

Other placement e.g. voluntary work, activity therapy centres, return to educational studies, limited rehabilitation gain	602	
Total completions	1,926	
Cancellations, including discharge by centre, self discharge, transferred to institution, deceased	302	(3)

Obviously these statistics must be interpreted cautiously, but it seems reasonable to say that less than half of the people completing a CRS rehabilitation program in New South Wales in the year 1982-83 actually escaped from the rehabilitation/after care maze - and those who entered the programs were, as we have seen, a selected group - less than one in three of people referred.

Expenditure on these rehabilitation programs by the Department of Social Security in N.S.W. for the year 1982-83 was $11.63 million. Departmental expenditure through CRS on aids and home modifications et cetera was, for that year, in New South Wales, $188,828.[4]

10.2.18 Directions for the Commonwealth Rehabilitation Service in 1980s

The Rehabilitation Division of the Department of Social Security has published its forward plan for the triennium July 1984 to June 1987.(5) This document with its 118 pages and 96 itemised recommendations for action foreshadows a marked change in the orientation and activities of the CRS. It contains very little that bears directly upon the future role of the CRS in the retraining of injured workers to return to the workforce.

10.3 Job seeking and job placement

Handicapped people seeking jobs may secure employment through their own efforts, they may be assisted by relatives and friends, or help may be provided

by workers in a wide variety of agencies. The principal agency specialising in job finding and job placement is the Commonwealth Employment Service (CES), an arm of the Department of Employment and Industrial Affairs. Within the CES is the Special Employment Groups Section (SEGS) which is particularly concerned with promoting the employment opportunities for disadvantaged people, including those with physical or mental handicap.

CES Job Centres are distributed through the State - some 40 in the metropolitan area and about 50 elsewhere. Within each Job Centre is a designated Disadvantaged Persons Officer (DPO) whose responsibilities include service to the physically and mentally disabled.

10.4 **Job or workplace modification**

Quite commonly it is possible to modify a job so that it can be handled adequately by a disabled worker. Where changes need to be made to the workplace to accommodate a disabled employee the cost of approved modifications may be met under schemes administered by Commonwealth Government Departments -

- costs of modifications may be met for disabled people who are accepted by the Commonwealth Rehabilitation Service, or

- the Department of Employment and Industrial Relations may provide financial assistance for workplace modifications so that job training can be provided for the disabled.

10.5 Employment opportunities and employment status

Handicapped people in the workforce may be

- . self employed
- . in open employment - full time
  - part time
  - permanent
  - casual
- . in sheltered employment - in sheltered workshops
  - under 'slow worker's permit' arrangement

The Australian Bureau of Statistics reported that in February 1981, for the whole of Australia, there were 226.2 thousand handicapped persons in the workforce (67.8 per cent males). The employment status of these people was

	Hales	Females
	%	%
Self employed	23	17
Wage and salary earners	73	77
Sheltered employment	4	6
	100	100

(6)

10.5.1 Self employment

Handicapped people attempting to establish themselves in self-employment may utilise compensation or damages received as the result of an accident as capital for a business venture of some kind - or start-up finance may be obtained from other sources. In our survey of sheltered workshop sponsors it was reported that small amounts of money might be made available from the

agency funds to enable handicapped people to set up in business on their own account. People with a handicap embarking on such ventures may have recourse to the generally available private and government advisory services, such as the State Government's Small Business Agency Management Advisory Service.

10.5.2 Open employment

The majority of handicapped people in the workforce are in open employment (open as opposed to sheltered employment). Federal assistance is available to employers to make necessary modifications to the workplace (see 10.4 above). The Special Employment Groups Section of CES has produced a booklet "A Guide to Employing Disabled People"(7) to provide practical suggestions and advice to employers to help remove difficulties or doubts which might be inhibiting the employment of the handicapped.

10.5.3 Sheltered employment

'Shelter' may be provided by way of working environment specially adapted for the employment of handicapped people, or by way of slow worker permits.

10.5.3.1 Sheltered workshop*

These workshops are usually sponsored by local communities and by bodies representing particular disability groups, such as the Paraplegic and Quadraplegic Association. At least one in N.S.W. is sponsored by a commercial firm.

The majority of disabled people working in sheltered workshops suffer from mental rather than physical handicap. A knowledgeable informant estimated that about one in four of these workers is physically handicapped, and that only a

very small percentage of all people working in sheltered workshops are handicapped as the result of motor traffic accidents.

Sponsors of not-for-profit workshops may be assisted by the Commonwealth Government under the Handicapped Persons Assistance *Act.* 1974. Under this legislation, eligible organisations may apply for subsidies towards the cost of providing capital projects, maintenance and equipment. Grants are also available in respect of rental and certain salary payments.

Grants on purchases of buildings, equipment etc. take the form of a $4 subsidy for each $1 raised by an eligible organisation from non-government sources. Rent is subsidised at a rate equal to 80 per cent of the approved rental paid subject to certain conditions. Salary costs may be subsidised to an amount equal to 100 per cent of salary paid to staff employed in new ventures, but this is reduced to 50 per cent after the premises have been providing the service for 2 years or more.

As well as assisting organisations with establishment and running costs, the legislation also provides financial encouragament to sheltered workshop administrations to provide the type of training for the handicapped which will prepare them, where possible, for open employment. A training fee of $500 is paid to organisations providing approved sheltered employment for each handicapped employee who, having regeived at least 6 months training in the workshop, graduates to open employment and remains there for at least 12 months.

Sheltered employment allowance is payable to disabled people who are employed in sheltered workshops and are otherwise qualified to receive an invalid pension or would become so qualified if they ceased to be provided with sheltered employment. The allowance is subject to the same income test as

applies to invalid pension and is paid at the same rate. It is payable in the form of a supplement to the sheltered employee's wages. The allowance is not taxable unless the sheltered employee has reached age pension age.

A sheltered employee is entitled to the same additional payments as an invalid pensioner except that no supplementary assistance is payable. Instead, all people in receipt of sheltered employment allowance receive an incentive allowance of $8 per week. There is no income test on the allowance, but a person precluded by his or her income from receiving sheltered employment allowance is not entitled to incentive allowance.

Sheltered employment allowances are paid by the Department of Social Security through the workshops.

Sponsors of some sheltered workshops also provide accommodation, usually of hostel type, for people employed in the workshop. This too may attract Commonwealth capital subsidy under the Handicapped Persons Assistance Act. Charges to residents may be less than cost of providing accommodation and board - for example one hostel charges $50 per week per resident.

At 30 June 1983 there were in New South Wales 86 sheltered workshops through which federal rehabilitation allowances were being paid to a total of 3,688 allowees.[(8)]

Mentally handicapped people make up a large proportion of persons working in sheltered workshops - in some there is a mixture of physically and handicapped mentally people, in others all the employees may belong to one or other group.

Among problems reported by administrators of sheltered workshops and other people familiar with their operation -

. difficulty in obtaining sufficient and appropriate work to keep employees occupied

. competition and 'under cutting' to secure Work contracts

. the small amount paid in addition to the invalid pension rate gives little incentive to work in a sheltered workshop

. the nature of the work to be done in workshops is not considered to be appropriate by some employees

. some physically handicapped people do not wish to work in workshops where mentally handicapped workers are also employed.

10.5.3.2 Sample summary reports from sheltered workshops

The following brief summaries represent a sample of reports received from sheltered workshops in response to our postal questionnaire.

Workshop in Hunter Valley
- the workshop employs 40 handicapped people none of whom is a motor vehicle accident victim; has a salaried staff of eight - a manager, assistant manager, trainee manager, four supervisors and one clerk; hours of work are 9 to 4, five days a week; there have been three applications from handicapped persons for employment in the past twelve months but none was accepted because there were no vacant positions. The manager stated that the workshop faced no problems at present.

Workshop in south western N.S.W.
- provides up to 50 places for handicapped persons - most of those working in the workshop are mildly mentally handicapped - one is a motor vehicle accident victim; salaried staff of ten; waiting time for places in the workshop is about six months; in the past 12 months 20 applications for admission were received, and 19 were given employment; among problems stated was the difficulty experienced by motor traffic accident victims in adjusting to a work environment where the majority of fellow workers are intellectually handicapped.

Group of workshops in Sydney
- provides about 200 places for handicapped people, of whom an estimated 10 per cent are motor vehicle accident victims; salaried staff Of 24; among problems reported was the inability of people with brain injuries to concentrate and work effectively.

10.5.3.3 Accreditation of sheltered workshops - a pilot project

At the present time (August 1984) a pilot project, funded by the Federal Department of Social Services and conducted by the New South Wales Association of Sheltered Workshops in association with A.C.R.O.D. and the State Department

of Youth & Community Services, is in progress to assess the value of a system of accrediting sheltered workshops as a means of ensuring high standards of operation and of facilities. An independent evaluation of this project to be carried out by a team from Macquarie University. This pilot study may lead to the establishment of a nation-wide accreditation program supported by the Department of Social Security.

10.5.3.4 Slow workers permits

Under section 89 of the Industrial Arbitration Act 1940 (NSW) the Industrial Registrar may issue a Slow Worker's Permit relating to a person who is aged, infirm or mentally handicapped; the employer is not then bound to pay the full award rate for the job to be performed by the 'slow worker'. Permits are issued on a renewable annually basis. In 1982 thirty-nine permits were issued, in 1983 to mid December, thirty two.(10)

Footnotes

(1) Department of Social Security, Annual Report 1982-83, (Canberra, A.G.P.S., 1983), p.60.

(2) Id., p.60.

(3) Id., p.139.

(4) Id., p.140.

(5) Department of Social Security, Rehabilitation Division, Community-based Rehabilitation for People with Disabilities: Directions for the Commonwealth Rehabilitation Service in the 1980s, (Canberra, A.G.P.S., 1984).

(6) Australian Bureau of Statistics, The Labour Force, Australia, 1981, (Canberra, A.G.P.S., 1982).

(7) Commonwealth Employment Service, Special Employment Groups Section, A Guide to Employing Disabled People, (Canberra, A.G.P.S., 1983).

(8) Department of Social Security, Annual Report 1982-83, (Canberra, A.G.P.S., 1983), p.101.

(9) The Australian Disability Review, 1984, 1(2) contains a report on the Conference of New South Wales Association of Rehabilitation Facilities, Sydney, 22-24 March 1984. Several papers presented at the Conference were highly critical of the sheltered employment and activity centre industry.

(10) Personal communication from officer of the New South Wales Industrial Registrar's Office, November, 1983.

CHAPTER ELEVEN

SOCIAL AMD RECREATIONAL ACTIVITIES

11.1 The organization and provision of social and recreational activities for the disabled people in their care form part of the rehabilitative and after care programs offered by many agencies including hospital rehabilitation units, CRS centres, hospitals, nursing homes, hostels and sheltered workshops. Voluntary helpers and auxiliary groups are important participants in establishing and maintaining these activities.

Groups of people suffering from similar handicaps have established their own organizations for social and recreational purposes, for example -

- the N.S.W. Amputee Sporting Association
- the Paraplegic and Quadriplegic Sports Club of N.S.W.

Self-help, mutual support and special interest agencies are also active in providing and promoting social and recreational opportunities for the handicapped people they serve; among these are

- Disabled Unlimited
- Mount Druitt Parents Support Group for Handicapped Children
- Newcastle and District Association for Crippled Children

Activities may be organised by field workers of government departments, such as community health workers in the N.S.W. Health Department's community health centres and coordinators of the Young Handicapped Children's Program operated by the Department of Youth and Community Services.

Some agencies having broad concerns for welfare may offer, among their programs, some designed specifically for handicapped people's recreation, including

- Y.M.C.A.
- Australian Jewish Welfare Society

We have mentioned some of the social and recreational opportunities offered specifically to meet the needs of some handicapped people. Of course very many handicapped people participate in social and recreational activities which are available to their non-handicapped relatives and friends.

CHAPTER 12

THE PROGRAMMERS

12.1 Here we describe the agencies which are concerned with identifying the needs of disabled people and developing the means whereby those needs may be met. Programming activities include

- policy making
- planning
- advising
- coordinating
- advocacy and lobbying
- evaluating

Some agencies which undertake programming activities of these types are themselves also service agencies in the sense that they provide services and benefits directly to handicapped people, those mentioned in this chapter have programming as the sole or major part of their operations. We first look at government agencies - federal, State and local - and then at those in the none government sector. Towards the end of the chapter we mention ad hoc activities relating to programming in the field of rehabilitation and after-care.

We recognise the fact that there are numerous international organisations, academic bodies, professional associations and individuals having direct and indirect impact upon policies and programs which affect the manner in which the needs of disabled people are met.

In the case of international organisations their perspectives and policies

would largely be reflected in their Australian member groups who may be mentioned here as non-government national programming bodies - for example Disabled Persons International (Australia).

12.2 Government programming agencies

At government level one finds some extra departmental or supra-departmental agencies which although operating under government auspices have representation from outside government departments and services, and which take a broad view of the field such as the Disability Advisory Council of Australia (D.A.C.A.). One also finds some government departments which play important programming roles.

2.2.1 Federal Government

2*2.1.1 Extra- and supra-departmental agencies

12.2.1.1.1 Disability Advisory Council of Australia (D.A.C.A.)

This new body in 1983 replaced the National Advisory Committee for the Handicapped (N.A.C.H.) and like its predecessor will advise the Commonwealth Government on all aspects of its policies affecting disabled people. Significantly the fourteen member Council has a greater representation of disabled people than N.A.C.H., eleven in all. Its membership includes equal numbers of men and women and all states are represented. The new body reflects the Government's recognition of the need to move away from reliance on the opinion of traditional service providers, whether medical or voluntary and to listen to the views of disabled consumers.

D.A.C.A. has taken over many of the functions of N.A.C.H. such as producing "Australian Disability Review" a quarterly journal, (the journal's title was changed from 'Australian Rehabilitation Review in 1984), and a number of the Committees which operated under the auspices of N.A.C.H. including:

i) The Standing Interdepartmental Committee on Rehabilitation (S.I.D.C.O.R.).

ii) Expert Committee on Rehabilitation Engineering (E.C.O.R.E.).

In view of the reorientation of this national advisory body it may be that some of these N.A.C.H. functions will not remain under the auspices of D.A.C.A.

Activities presently being pursued by D.A.C.A. include

i) Following up on the Handicapped Programs Review (see 12.4 Ad Hoc Program Inquiries).
ii) Review of P.A.D.P. and pensions entitlement,
iii) Monitoring the success of a pilot attendant care program.

12.2.1.2 Commonwealh departmental agencies

12.2.1.2.1 Department of Social Security

a) Social Welfare Policy Secretariat: Responsible for reviewing broad policy options of the D.S.S.

b) Handicapped Persons Welfare Program: This program operates under the Handicapped Persons Assistance Act 1974 providing both capital and recurrent subsidies to voluntary, non-profit or local government bodies for prescribed services such as training, activity therapy and sheltered employment with a

small but growing component of non-institutional residential accommodation. A total of $71.2 million was spent on the Australia-wide program in 1982-83. Subsidies were allocated to 213 sheltered employment ventures, 200 activity therapy centres, 277 training services, 432 residentials and 75 ancillary services. No State figures are given. (1)

c) Accommodation and Care for Aged or Disabled People

This program operates under the -

. Aged or Disabled Persons Homes Act 1954

. Aged or Disabled Persons Hostels Act 1972

. Delivered Heals Subsidy Act 1970

. States Grants (Home Care) Act 1969

and again provides financial assistance through State Governments and directly to voluntary and charitable organisations and local government bodies.

12.2.1.2.1 Department of Health

The Department's Policy and Planning Division has a Rehabilitation and Services Section. The Department is represented on the Standing Interdepartmental Committee on Rehabilitation. Many of the policies and activities of the Department in relation to hospitals, nursing homes, community health services, et cetera have implications for the care of accident victims.

12.2.2 N.S.W. Government

12.2.2.1 Extra- and supra-departmental agencies

N.S.W. Advisory Council on the Handicapped (now defunct)

Having its statutory base in Section 7 of the Youth and Community Services Act 1973 (NSW) the Council was established with the object of providing the Minister for Y.A.C.S. and through him other appropriate ministers of the government of N.S.W. and the Inter-Departmental Standing Committees with advice on all matters affecting the well being of handicapped persons in N.S.W.

It was made up of equal numbers of government and non-government members. In 1982 it disbanded itself in protest of the failure of Y.A.C.S. to maintain adequate secretarial facilities. There is a possibility it may be re-constituted or a. similar body created once the current re-organisation of Y.A.C.S. has been completed.

12.2.2.2 N.S.W. Government departmental agencies

a) Department of Youth and Community Services (Y.A.C.S.)

The Handicapped Persons Bureau has been given the role of management, planning and coordination of current and future services for handicapped people. In addition it has to advise the Minister of Y.A.C.S. on the formulation of new initiatives for all handicapped people including intellectually handicapped people in the social welfare and community areas. It was also responsible for Ensuring adequate standards in all types of community residential facilities/ sheltered workshops and activity and day attendance centres for people who are handicapped.

Numbers of informants expressed the view that the Bureau has not achieved a very positive impact in planning and coordination of services for handicapped people. This perhaps is partly due to inadequacy of funding, problems of developing a program of regionalisation and confusion over implementing revision of community welfare legislation.

b) Public Service Board - Special Placements Officer (Disabled Persons)

Duties of the Special Placements Officer relate only to positions within the N.S.W. Public Service. The job description indicates that this officer is to " . . . develop detailed policies and procedures for the employment of disabled people, in line with positive affirmative action taken by this Board. As well as researching aspects of job design, technical aids and relevant information, this person will liaise with various departments and authorities on placement of disabled persons and apprentices".

c) N.S.W. Department of Health

The Department of Health is developing a regionalised assessment and rehabilitation service to' facilitate the appropriate care of disabled people at centres reasonably close to their homes and at home.

12.2.3 Local government

Local government councils may, and very many do, engage in the provision of welfare programs which may be utilised by handicapped people. The scope and scale of these programs vary from council to council. Some councils have established a department or sub department of welfare employing professional staff such as social workers and welfare officers.

12.3 Non-government programing agencies

Again one finds some programming agencies operating at national level, others at state level. Among the agencies at State level in New South Wales, some are branches of federal bodies. The programming agencies may be concerned with broad coverage of the handicapped population's needs, or may confine their concern to the interests of a defined group of handicapped people. Some of these agencies receive grants-in-aid from federal or State government sources.

12.3.1 National Programming Agencies

a) The Australian Council for the Rehabilitation of the Disabled (A.C.R.O.D)

A.C.R.O.D. is the national federation of voluntary organisations, hospitals, rehabilitation centres, schools, departments, institutes of learning and professional bodies providing services and facilities to disabled people or concerned with their welfare. It was established by these organisations to undertake work for handicapped people which the organisations could not achieve individually. It is the national member of Rehabilitation International.

Activities have included a review of financial and philosophical alternatives in Australia regarding income maintenance and attendant care; developing a Sheltered Workshop Accreditation program (see 10.5.3 above) and lobbying for reduction in import duty on aids and appliances.

b) Disabled Peoples International (Australia)

This is the national body of Disabled Peoples International, a world wide body with Non-Government Status recognised by the United Nations Organization with headquarters in Geneva. In essence it is disabled people speaking for themselves and arose from what was seen as the overwhelming need for disabled people to have a voice of their own in contrast to the medical and charity models which so often rule disabled peoples lives. D.P.I.(A) is constituted also at State level and in N.S.W. the State Branch is the Handicapped Persons Alliance. The Federal Government has made an initial grant in this year's budget. A full time secretariat is not yet in operation.

The issues in which the organization is particularly interested are broadly national and international in flavour, such as tariffs on aids and appliances and immigration policies as they relate to disability.

This body is gradually being accepted by government departments and private organaizations and individuals as representing the views of disabled people and this acceptance is instanced in its recognition by the Australian Bi Centennial Authority when planning the involvement of disabled people in the Centenary celebrations.

c) The Australian Council of Social Services (A.C.O.S.S.)

Established in the mid-50's, A.C.O.S.S. has a membership of more than 40 national organizations working in the field of welfare or having an active interest in its promotion.

A.C.O.S.S prepares, researches and lobbies topics relevant to national welfare issues such as family law, full employment, funding of welfare agencies,

pension trends and implications and the feasibility of national compensation programs.

Some of the member bodies are concerned directly with specific disability issues at the national level, for example the National Federation of Blind Citizens, the Australian Deafness Council and Australian Association for the Mentally Retarded. Also there are members whose primary interest is not disability but some other common denominator but they find that their members may have special difficulties related to disability e.g. the Federation of Ethnic Communities.

12.3.2 N.S.W programming agencies

12.3.2.1 General interest agencies

The main national groups A.C.R.O.D. and D.P.I, also have N.S.W. branches, the latter's being the Handicapped Persons Alliance. H.P.A. was established in late 1980, being initially funded from part of the proceeds of the Royal Gala Concert, and subsequently received government grants through the Handicapped Persons Bureau of the Department of Youth and Community Services.

The Alliance board is constituted of individual disabled people and regional group representatives. Places are reserved for representatives with intellectual impairment in recognition of their need to be involved in policy making and the difficulty they may have succeeding in open elections. A great effort is made in representing views of disabled people living in country areas who often are poorly serviced and their needs ignored by city based bureaucrats.

At the regional and local level many of the groups formed as part of the activities of the International Year of the Disabled (1981) have remained

(usually where there was strong involvement of disabled people) to form local action groups and lobby for local issues as well as the more general ones.

12.3.2.2 Special interest agencies

Numerous charitable and self-help agencies and organisations attempt to have their views accepted by policy makers and meet with varying levels of success.

12.4 Ad hoc program inquiries, reviews et cetera

At the present time a major inquiry into the provision of services for disabled people is in progress, The Federal Minister for Social Security is reviewing the Commonwealth Government's programs of special services for disabled people, particularly those administered by the Department of Social Security. The review will consider the effectiveness of programs, their coverage and administration, and the directions they should take.

The review will reflect the Commonwealth Government's stated policy of ensuring the "least restrictive alternative" for services to handicapped people (i.e. opting for that approach which, in providing support for disabled people, develops and enhances their personal freedom) and encouraging consumer participation in planning and management of these services.

Terms of Reference

To review -

(a) The effectiveness of current programs, their coverage and the broad directions they should take in order to correct any identified deficiencies in existing arrangements;

(b) the needs of disabled people which are or could be appropriately catered for by these programs;

(c) The suitability of the existing range of program and service objectives;

(d) the adequacy of financial and human resources available to continue existing and desirable additional levels of service provision;

(e) the efficacy of the measures currently employed to facilitate consumer participation in the planning and management of services and those measures aimed at .improving the accessibility of services;

(f) the specific nature of changes to existing organisational and financial arrangements and/or administrative procedures likely to enhance service efficiency and effectiveness; and

(g) the nature and effectiveness of the measures by which organisations in receipt of assistance are accountable for their operations, both to the funding source and to clients.

In the course of the review, those issues which are identified as requiring resolution in the context of other programs will be referred to the responsible authority.

Consultation

The Minister will be assisted by a secretariat of officers of his Department and will be initiating an extensive program of consultation with individuals, government agencies, voluntary welfare organisations and other interested

groups.

The Minister is hoping to receive an expression of views from a wide cross-secton of the community. The review will take account of the views of organisations and individuals directly involved in the provision of services, of other interested bodies and of disabled people, particularly clients of subsidised services and their parents or advocates (as appropriate).

12.5 Comments

Although the programming agencies are ostensibly pursuing the best interests of handicapped people, the picture they present is one of a very diverse group of departmental, sectional and personal interests. Their effectiveness is constrained to a marked degree by the overall inadequacy of available funds to meet needs, by a failure to agree on any minimum standards of provision, by competitition for a share of what funds are available.

There is no one body at either federal or State level which has the resources in terms of staff and finance to act as a central policy making body guiding and directing programs to provide a really comprehensive State-wide system of rehabilitation and after care. One has to ask whether something in the nature of an Office for the Handicapped at a very high level in either the federal or the State administrative structure is a possible means to improve the present situation.

Footnotes

1. Department of Social Security, Annual Report, 1982-83, (Canberra, A.G.P.S., 1983), p.70.

CHAPTER THIRTEEN

THE PRESENT SITUATION

13.1 Adequacy and short comings of present arrangements for care.

This review examines the major structural and some procedural features of the rehabilitation and after care arrangements in New South Wales. Such an examination can point to administrative strengths and weaknesses in these arrangements. Some of these strengths and weaknesses have clearly apparent advantages and disadvantages from the point of view of those who make and implement the arrangements and our discussions with some of those people brought out their satisfaction and dissatisfaction with the existing state of affairs. But as we remarked above, some very important groups of implementers were not consulted by us. We have had no discussions with the large numbers of private practitioners of medicine, law and some other professions who play key roles in caring for the handicapped; we have had but little contact with the lower level workers in the field of rehabilitation and after-care; nor have we had any contact with the many many thousands of relatives, friends and neighbours who provide so much of the care required by handicapped people. Thus our conclusions regarding the adequacy of present arrangements as seen from the 'supply' side are inevitably limited.

As to the extent to which the needs, demands and wishes of the handicapped themselves are presently met, again an examination of structures and processes will demonstrate some clear strengths and weaknesses of the arrangements now in operation; but because we did not contact handicapped people, we present no conclusions reflecting their opinions or actual experiences.

The following points, then, highlight some important impressions, some

conclusions, as to the adequacy and shortcomings of the present arrangements - impressions and conclusions inevitably based on an incomplete canvass of people involved in these arrangements and their workings.

13.2 Organization and responsibility - governmental levels

There are numbers of examples of countries which have, over a period of not many years, swung from having separate national ministerial departments of health and of welfare (social security et cetera) to having a dual purpose department, and then some years later reverted to a two-department structure. These moves underline the difficulty of separating the care of the individual into compartments such as health, social well-being and so on. The rehabilitation and after care of accident victims well demonstrates the multi-faceted nature of the care required by many disadvantaged and disabled people. In Australia at federal level there is division of some national responsibility for the care of, say, accident victims between the Health and Social Security Departments (and several other departments). Again at State level within New South Wales one sees a similar division of responsibility between two departments - Health and YACS - and some other departments too.

It is arguable that since handicapped people constitute a significant proportion of the total population there should be a federal 'Office for the Handicapped' with appropriately defined role, staffing and other resources. Similarly one could argue for such an 'office' being established at State level. Certainly one might question whether the present 'consultative councils' at federal and State levels are adequate in terms of 'clout', composition, and back-up staff to be really effective 'programmers' for meeting the complex needs of the handicapped.

The division of responsibility between the federal and State governments is

another central issue. We will not discuss these matters further here, but note that they should be matters of concern to the present federal 'Handicapped Programs Review'.

13.3 Regionalization of State Government activities

Theoretically regionalization of services as implemented by the NSW Department of Health should facilitate the attainment of equity in distribution of services throughout the State and make for appropriate allocation of existing resources in relation to local needs. It appears that recent moves by the Health Department towards the development of 'assessment and rehabilitation' units and after care teams on a regional basis will be of benefit to the disabled.

Our attention was drawn to the 'magnet' effect of certain highly specialised hospital rehabilitation units; these units have to serve a regional catchment area but also, because of the reputation of their medical staff and the range and standard of facilities and care they offer, they attract referrals from other areas. It was suggested that preference may be given to the admission of referred private patients, irrespective of their place of residence, over patients from within the regionally defined service area. It was also suggested that a hospital rehabilitation unit having regional responsibilities was not able to meet those responsibilities adequately because the board of the hospital required that local residents be given priority for admission to the unit. The possibility that such problems may arise calls for careful monitoring of rehabilitation admission patterns at the regional rather than at the individual hospital level.

13.4 Differential and preferential care

13.4.1 It is inevitable that where numbers of people, each one having at least to some degree a unique set of problems, have to be catered for, some inequities in provision will arise. But it is desirable that, so far as is possible, the catering system should not have inbuilt mechanisms which create and sustain inequities. Such inequities are built into the system of caring for the handicapped in this State - one needs only to reflect briefly on the post accident courses to be followed by four paraplegics whose impairment followed, respectively

- an accident at work
- a motor vehicle accident where the victim is covered by third party insurance
- a motor vehicle accident where the victim is not covered by third party insurance
- an accident at home

13.4.2 In relation to rehabilitative care and after care one could consider two people, both having the same physical disability, but one is accepted as a trainee by the Commonwealth Rehabilitation Service, the other for some good reason is among the two of every three referrals not accepted by CRS.

The one accepted by the CRS will be supported and pilotted through assessment procedures, rehabilitation counselling, training, obtaining appropriate allowances and benefits; transported daily to and from the rehabilitation centre; found, if necessary, accommodation and, if possible, employment, guided and assisted in many ways. The rejectee, having been judged as 'less likely to succeed', has to make her own way through the rehabilitation and after-care maze - certainly assistance may be available but finding it may not be easy.

13.5 Competing claims

(a) Our attention was drawn to problems faced by some groups of handicapped people in obtaining what might be regarded as a 'fair share' of available resources. It was suggested to us that some agencies which are long established and represent the interests of groups having considerable emotional appeal to the community at large are obtaining, from governments by way of subsidies, and from the public by way of appeals for charitable support, an inappropriately large fraction of the total funding within the field of care for the handicapped. Also, instances can be found where the interests of one particular group of disabled people, say quadriplegics or the blind, appear to be championed by more than one agency with some apparent overlap of roles and possible competition between them.

Determining the criteria to be used in allocating resources between competing agencies and applying them is a difficult and time consuming taks. No one body in this State is charged with that responsibility.

(b) Groups which in the past have not gained recognition for subsidy purposes may find it difficult to do so, particularly in times of financial stringency. Problems of this type may beset groups representing handicapped people who, until recently had but short life expectancy or whose management is affected by changes in policy such as the now publicly announced government closure of long-stay institutions for those with psychiatric disorders and intellectual impairment.

13.6 Short fall, gaps and unmet demands

As mentioned elsewhere in this report, our modus of operandi cannot quantify with any exactitude shortfalls and gaps in meeting the multifarious needs of

handicapped people. The report entitled 'Cold Comfort; a Regional Analysis of Distribution and Need for Services for Disabled Pewople in New South Wales' prepared by Lyn Gain, Sue Ellis and Diana Gray and dated August 1983 but not then made publicly available, presents the most recent and comprehensive review of short falls and gaps in the provision of services to meet estimated needs. But, again as we have remarked earlier, identifying needs does not necessarily reveal demands.

From the materials examined by and the information presented to us, it appeared that there is a demand coming from handicapped people which is not being adequately met, the demand to be consulted and involved in making decisions affecting their care, well-being and independence. Motor vehicle accident victims are not as yet organised as a group having specific and perhaps unique needs and demands, but it seems sensible to suggest that if any moves are made to establish some new system of meeting at least some of their needs, these victims should be given a clearly defined and effective set of roles in the formulation and operation of that system.

13.7 Carers' choice

Those who have to attend personally to handicapped people's needs may find the task unacceptable. For example it is said that a marriage in which one partner sustains serious accidental brain damage has a very high probability of breaking up; some nursing home operators do not admit certain types of handicapped patients whom they regard as difficult to manage; handicapped people living at home who require 24 hour-a-day care at home or require care intermittently for short periods throughout each day will probably have difficulty in securing such assistance from 'paid carers'.

Problems such as these reflect the legitimate choice of an individual not to

undertake tasks which they regard as too demanding. Their solution probably demands the mobilisation of more resources rather than the display of such slogans as 'Your attitude is our greatest handicap'.

13.8 Professional handicappers?

In the course of our contacts with people working in the rehabilitation and after care field one social institution and one professional group were cited on a number of occasions as exercising a particularly malign influence upon the rehabilitation and after care of some accident victims. That social institution was the law - more specifically the law relating to compensation for accidental injury and the way in which that law is implemented. Solicitors consisted the professional group; we met with no members of this group. However, these practitioners were not the only ones to be criticised.

13.9 Inter-professional criticism

Although it was not our purpose to collect such information, it became apparent in discussion with workers in a variety of agencies that some professional workers may hold somewhat negative opinions regarding other groups of workers in the rehabilitation and after care field. The most striking examples were -

. criticism of medical practitioners on the grounds that their behaviour conformed to 'the medical model' which implied that they ignored non-medical aspects of rehabilitation and after carer our encounters with doctors in this inquiry did not reveal any clear evidence of such restricted behaviour; on the contrary they appeared to favour and encourage a 'multi-disciplinary' approach to the care of the handicapped - but our contacts **were** with specialists in rehabilitation medicine;

. criticism of solicitors on the grounds that their advice to clients was sometimes ill-informed, inappropriate, not in the best interests of their clients and perhaps favoured the interests of the advising solicitor; we neither sought nor became aware of any specific evidence to support or refute this criticism;

. criticism of social workers on the grounds that they sometimes attempted to 'take over' the care of patients, usurping the roles of nurses and medical practitioners; again we neither sought nor became aware of any specific evidence for or against this assertion.

13.10 Patient mix

Some informants expressed concern that there might be a change in the present arrangements whereby rehabilitation units in hospitals accept patients irrespective of whether their disability results from accidental trauma or some other cause. It was said that the establishment of separate units to manage accident victims apart from other cases requiring rehabilitative care would lead to wasteful duplication of facilities and services. Patients enjoyed, it was said, being in an environment where there was a mixture of age groups and a range of disabilities; we did not attempt to discover whether these opinions were unanimously held by patients. There was however, an apparently generally accepted view that motor vehicle accident victims do not usually adjust well to the sheltered workshop type of environment.

13.11 Uniform data collection

It became obvious as our review proceeded that the routine data collecting systems and reporting systems of many agencies were of very limited usefulness for purposes of planning, managing and evaluating the provision of care. This

reflects the absence of any body charged with overseeing the development and provision of conprehensive rehabilitation and after care in New South Wales. Even in the absence of such a body it is desirable that agencies receiving public funding by way of subsidies be required to keep at least a prescribed set of 'minimum' operating data as a condition of receiving subvention. The minimum set should be prescribed by the funding authorities.

13.12 Closing comments

This review demonstrates the complexity of the rehabilitation and after care field in New South Wales. Some major areas of provision have been sketchily outlined, much detail omitted. As stated at the outset, our aim has been to cover the field widely, rather than in depth. It is noteworthy that with a rather small number of exceptions, our sources of information did not provide much detailed information relating specifically to the rehabilitation and after care of motor accident victims, probably because they formed but a minor part of their workload, or their problems were no different from those of other handicapped persons.

John Dewdney
Ian Irwin

September, 1983

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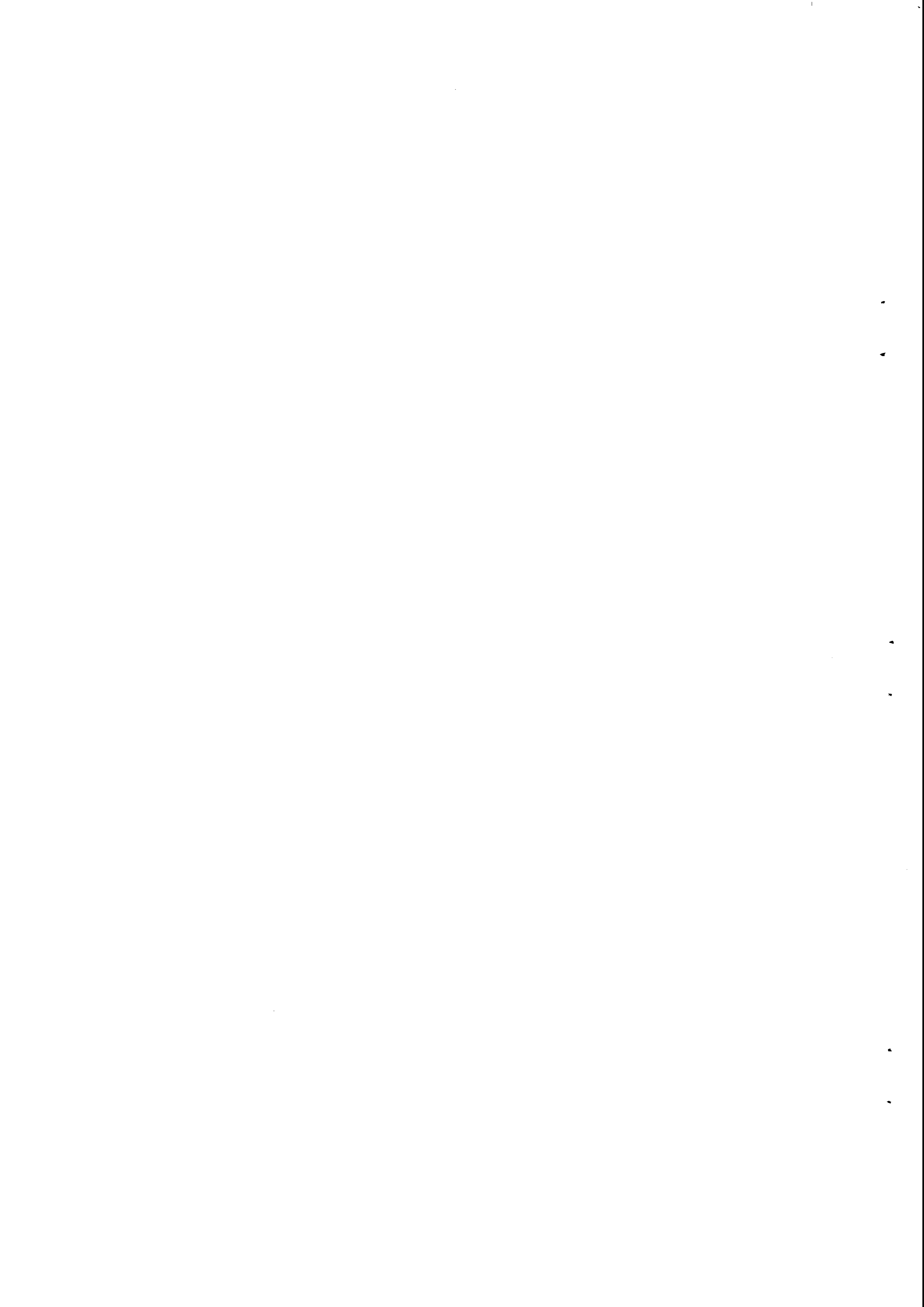
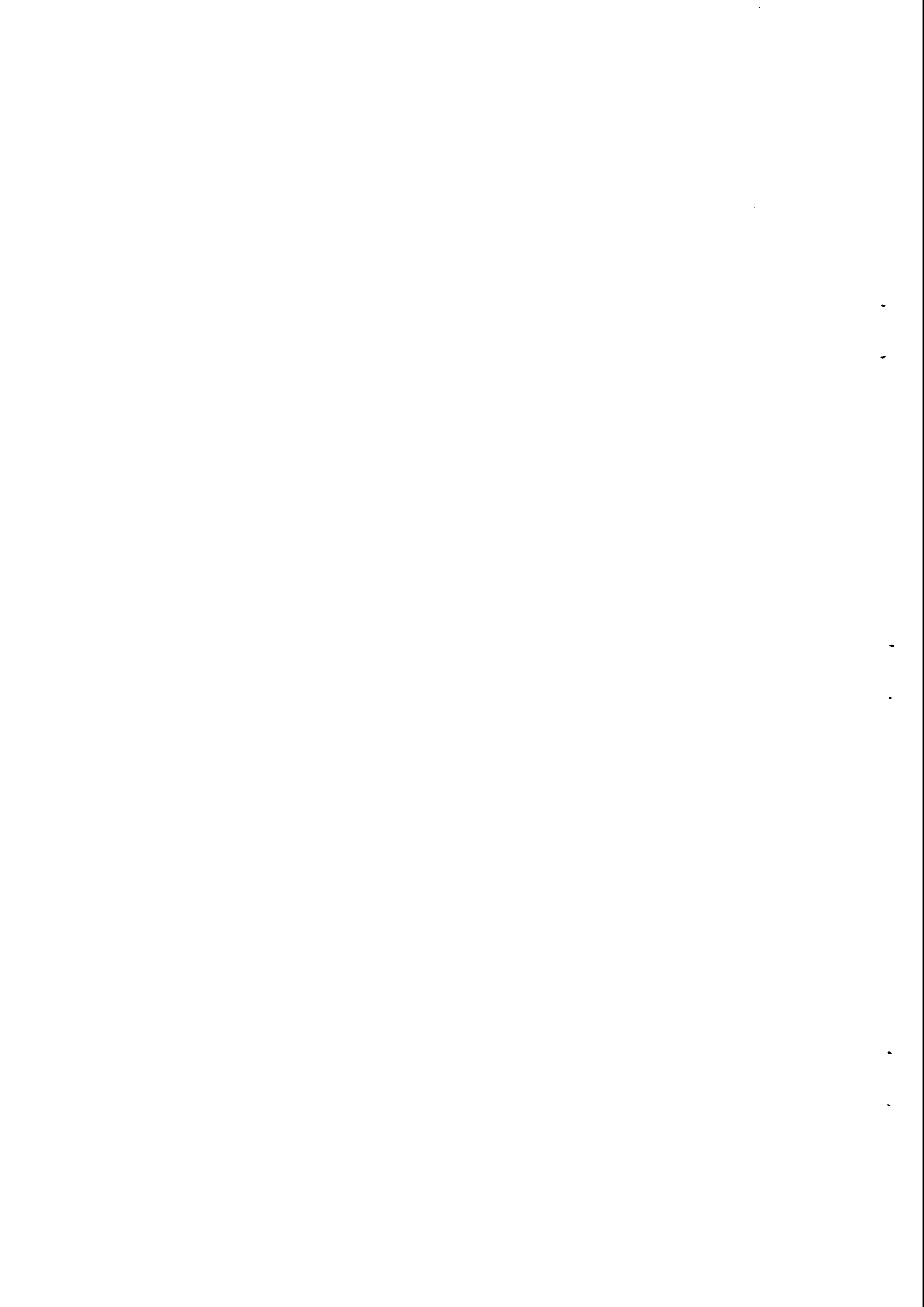


APPENDICES



QUESTIONNAIRE USED IN POSTAL SURVEY

REHABILITATION AND AFTER CARE SERVICES, 1983

Name of agency: ______________________________

Address: ______________________________

____

Telephone no: ______________________________

Name of Chief Executive Officer: ______________________________

Contact person: (Name and telephone number of person to contact regarding any queries arising from responses to this questionnaire): ______________________________

____

EXPLANATORY NOTES; Please read before proceeding to complete the questionnaire.

- This questonnaire is being sent to a wide variety of agencies
- Not all the items in it will relate to all agencies
- If any item does not relate to your agency, please write N/R against that item
- If any item does relate to your agency but the information requested is not available please write I/U against that item
- Where an item requests that numbers or percentages be given, but accurate figures are not available, please make an estimate and write EST alongside the estimate
- For several questions, examples are given of the type of answer that might be given - these examples are provided to show you how a brief but adequate answer might be written
- Some items request data covering a 12 month period - this may be the last 12 months or the last reporting year (e g 1 July 1982 to 30 June 1983) whichever is more convenient for you
- if the space provided for any response is inadequate, please attach extra pages as necessary.

OBJECTIVES OF YOUR AGENCY - please state briefly

____

____

____

____

SERVICES PROVIDED - Please tick if your agency provides the service

. Medical rehabilitation [ ]

. Domiciliary care - Nursing [ ]
Physio [ ]
O.T. [ ]
Attendant care [ ]
Housekeeping [ ]
Social visiting [ ]
Delivered meals [ ]
Shopping [ ]
Other (specify)__________ [ ]

. Accommodation - type of facility
Hospital - short stay [ ]
- long stay [ ]
Nursing home [ ]
Hostel [ ]
Group home [ ]
Respite accommodation [ ]
Other (specify)__________ [ ]

. Accommodation - type of users
Totally dependent [ ]
Partially dependent [ ]
Self care [ ]

. Home modification [ ]

. Home maintenance [ ]

. Training in activities of daily living, living skills

Vocational Rehabilitation

Assessment for Housing [ ]
Vocational guidance [ ]
Vocational training/retraining [ ]
clerical [ ]
industrial skilled [ ]
semi skilled [ ]
professional [ ]
Other (specify)__________ [ ]

Placement in employment

Assessment for placement [ ]
Job finding [ ]
Referral to other employment [ ]
agency eg CES [ ]

Provision of employment

Sheltered workshop
transitional [ ]
permanent employment [ ]
Activity therapy centre [ ]
Other (specify) __________ [ ]

Income maintenance and other financial aid

Does your agency provide clients with any continuing, regular (eg weekly) income? YES/NO

If YES, please give details :-

____

____

____

Does your agency provide clients with any lump sum or short-term financial aid to meeting immediate needs? YES/NO

If YES, please give details :-

____

____

____

Does your agency provide any other form of financial assistance not covered by the above questions? YES/MO

If YES, please give details :-

____

____

____

Transport

Does your agency operate it's own vehicles etc? YES/NO

If YES, please give details :-

____

____

____

Do you provide your clients with financial assistance to make use of other transport services? YES/NO

If YES, please give details:-

____

____

____

Do you assist your clients to obtain or maintain a vehicle for their personal use, modified if necessary to meet their special needs? YES/NO

If YES, please give details:-

____

____

____

<u>Provision of information, advice, professional counselling and referral services</u>

In which areas of information provision, advice, professional counselling, skilled referral do you provide service to your clients -

- None ☐
- Financial matters ☐
- Legal matters ☐
- Vocational matters ☐
- Educational & training opportunities ☐
- Accommodation ☐
- Availability of other services ☐
- Family matters ☐
- Sexual counselling ☐
- Social/personal adjustment ☐
- Eligibility for social service benefits etc ☐
- *Consumer advice ☐
- Crisis Counselling service ☐
- Other (specify) __________________ ☐

* Consumer advice - advice regarding availability, quality, price etc of equipment, appliances etc.

Is the provision of information/advice/counselling/referral the major activity of your agency YES/NO

Is information etc provided:

Routinely as part of the general activities of your agency? YES/NO

Only on request from clients or other inquirers? YES/NO

<u>Social and recreational activities</u>

Does your agency provide social and recreational facilities and/or activities for your clients - eg friendly visiting services, sporting facilities, organised holidays, social clubs etc? YES/NO

If YES, please give details:-

____

____

____

Coordination/planning/advocacy/lobbying group roles

Does your agency engage in

Coordination of rehabilitation/after care services	YES/NO
Planning of rehabilitation/after care services	YES/NO
Advocacy for individual cases	YES/NO
"Lobbying" activities on behalf of groups of, or all, disabled persons	YES/NO

Self-help groups and agencies

Is the promotion of mutual self-help activities among disabled persons part of the role of your agency? YES/NO

If YES, please give details:-

____

____

____

____

Any other services provided by or activities undertaken by your agency - please specify briefly;

____

____

____

____

Facilities and services available - brief description
(This section provides the opportunity to describe the services identified at the beginning of the questionnaire.)

- Description - Please give brief description of facilities and services available (eg nursing home with 24 beds, gymnasium, visiting physiotherapist; sheltered workshop with 24 places for physically handicapped persons aged 21-55, principally light assembly work, transport provided for workers, canteen on premises; home help service for up to 60 non-bedfast clients, workers may spend up to 2 hours daily in a client's home).

- Other services and facilities frequently used - please describe briefly (eg Patients taken by agency's bus to Blackville Hospital physiotherapy centre daily or as required; close cooperation with Redtown District Home Nursing Service; hospital residents are usually employed at the Greentown Disabilities Unlimited workshop).

- Comments:

ADMINISTRATION

. Does your agency produce an annual report? YES/NO

If YES, please attach a copy of the most recently published annual report to this questionnaire.

- Management structure - if the "organisation chart" of your agency is not shown in the annual report, please draw the chart on the back of this sheet. (In the case of State-wide organisations, please indicate how you service clients/members in country areas eg branch offices, field officers, regular visits to members etc.)

- STAFFING - PAID STAFF (Does not include rehabilitees, trainees, etc)

  - Professional and technical (please specify each category of staff employed, member employed and whether full-time or part-time eg physiotherapists 1F/T 2 P/T, psychologist 2 F/T 1 P/T etc).

    ____

    ____

    ____

    ____

  - Administrative and clerical

    ____

    ____

  - Domestic and ancilliary

    ____

    ____

  - TOTAL NUMBER PAID STAFF F/T |__| P/T |__|

  VOLUNTEERS

  Number of volunteers on staff |__|
  Approximate total hours worked weekly by volunteers |__|

  - If possible indicate below the types of work performed by volunteers eg driving, supervising sporting activities, counselling etc.

    ____

    ____

. Staff members having disabilities - of the staff listed above, please indicate -

Number of paid staff having disability in the area which your agency offers services (eg blind employees of an agency for the blind).

|__| If none, write 0

Number of other disabled paid staff (eg amputees working in an agency for the blind).

|__| If none, write 0

Number of volunteers having disability in the area in which your agency offers services

|__| If none, write 0

Number of other disabled volunteers

|__| If none, write 0

. Do disabled persons who are not members of the agency staff participate in management of your agency? YES/NO

If YES - to what extent and how do they participate:

____

____

• PUBLICITY - does your agency have any publicity program to inform potential users of its services? YES/NO

If YES, please give brief details:

____

____

____

FINANCE

Does your agency prepare annual financial statements? YES/NO

If YES, please attach a copy of the statement for the last financial year.

If NO, or if financial statement for last financial year is not available, please state:-

Sources of capital funds (include funds for new buildings, major equipment, extensions etc).

____

____

____

Total capital expenditure in last financial year $__________ (If none, please write NONE)

Sources of recurrent funds (includes funds for salaries, maintenance, supplies, operation of services etc) for the last twelve months or last financial year.

___

___

___

Total expenditure of recurrent nature in last financial year $________

CHARGES TO RECIPIENTS OF SERVICES

Does your agency make any charges to recipients of services? YES/NO

If YES, please give details:-

___

___

___

CLIENTELE - please state -

- Geographic area served: (eg Blackville municipality; Health Department's Western Metropolitan Region; Woodland Bay district; whole of NSW)

___

___

- Eligibility criteria - criteria may include such considerations as sex, age, financial status, nature of disability, sources of disability (occupational injury, road accident etc), social security benefit status, workers compensation or third party coverage etc, potential for independence and others.

___

___

___

- Principal source/s of referral to your agency - if possible indicate approximate percentage of referrals from each source (eg self referral 30%; Kurall Hospital 20%; Government Insurance Office 50%):

___

___

- If self referred, how do clients come to know of your agency? (eg from friends, from newspaper advertisements, from phone book etc)

___

___

OUTCOME

- Usual destination/s of your clientele - if possible indicate approximate percentage of clients going to each destination (eg to own home 60%; to nursing homes for long term nursing care 30%; to part time employment through CES 10%) :

____

____

____

- Dependency status on leaving your agency - please indicate approximate percentage in each category:-

Totally independent		%
Minimumly dependent		%
Moderately dependent		%
Heavily dependent		%
Totally dependent		%
	100	%

- 'Follow-up' arrangements - if none, please write NONE.

____

____

____

CASE LOAD

- Number of applications for your agency's services received over past 12 months __________

- Number of applicants accepted for service by your agency over the past 12 months __________

- Age and sex of clients accepted for service over the past 12 months -

	Males	Females	Total
0-14 years			
15-29 years			
30-64 years			
65 years and over			
Total			

- If any applicants were not accepted for service, please give principal reasons for non-acceptance: ______________________________

- Number of clients who, within the past 12 months, commenced rehabilitation program in your agency but withdrew from that program: __________

If none, write NONE; if any did withdraw please give principal reasons for withdrawal:

___

___

- Average frequency and duration of a client contact with your agency (eg - once admitted, patients usually stay here indefinitely;
  - rehabilitees usually attend daily for 2-4 months;
  - two or three counselling sessions each of about 45 minutes;
  - few minutes to obtain required information):

___

___

- Does your agency have a waiting list of clients? YES/NO

  If YES, how many persons are on the list today? ________

- Waiting time for admission to service - please indicate average time; if no waiting time write NONE, (eg 5-10 minutes; one to two weeks for counselling appointment; applicants are put on waiting list for inpatient admission and at present there are 200 on waiting time and average waiting time is twelve months):

___

___

- Do any particular categories of applicant receive priority in allocation of vacant places? YES/NO

  If YES, please give details:-

___

___

___

Language and culture

- Approximately what percentage of the clients utilising your agency's services in the past 12 months did not have English as their first language? ________%

- Of these, what proportion probably experienced difficulty in gaining maximum benefit from your agency's services because of language and/or cultural problems? ________

- If difficulties were encountered by these clients, what was the nature and severity of these difficulties?

___

___

___

CASE MIX

- Compensation status

Please indicate percentage of clients in each of the following categories entering your agency's service in the past 12 months:-

Workers' compensation -	awarded	
	pending	
Traffic accident compensation -	awarded	
	pending	
Other compensation (eg marine, personal injury etc)-	awarded	
	pending	
No compensation awarded or pending		
Compensation status not known		
	TOTAL	100%

- Cause of disability

Please indicate percentage of clients in each of the following categories entering your agency's service in the past 12 months:-

Trauma - occupational	
- road accident	
- other trauma	
Congenital causes	
Geriatric conditions	
Other causes	
TOTAL	100%

- Work load demand; please estimate the percentage of the resources of your agency (time, staff, finance etc) devoted to each major activity
(eg - hostel inmate care 70%, hostel maintenance 20%, transport of inmates 10%
- medical rehabilitation 60%, vocational training 30%, recreational and social activities 10%
- manufacture and fitting of prostheses 80%, patient education 20%).

____

____

____

Agency's principal achievements and problems

- Achievements - What do you regard as the principal achievements of your agency over the past 12 months?

____

____

____

____

- Problems - What, if any, major problems is your agency now facing? please be specific in your response - if possible indicate the size and urgency of the problem (eg require $5,000 immediately for urgent maintenance of vehicles; need no more rehabilitation counsellor in 1984; cannot place clients satisfactorily due to shortage of nursing home beds in this town, etc)

____

____

____

____

____

Special problems of road accident victims

- Does your agency experience any particular problems relating specifically to road accident victims? YES/NO

  If YES, please give details
  (eg particular problems relating to compensation matters and/or to specific types of disability such as spinal injuries, amputees, brain injuries, multiple injuries etc and/or to any other types of problems):

____

____

____

____

Proposals and suggestions for the future

. If your agency is currently proposing some new developments or changes in its activities, what are these proposals? (If none are currently proposed, please write DONE)

____

____

____

- Are there any other developments or changes affecting your agency which you would like to see coming into effect? (If none, please write NONE)

____

____

____

- Are there any developments or changes in the rehabilitation and after care field, apart from those directly affecting your agency, which you would like to see coming into effect? (If none, write NONE)

____

____

____

- If you have any personal comments or points you would like to make not covered by this questionnaire, please write them here:-

____

____

____

____

____

____

____

____

PLEASE ATTACH COPY OF LATEST ANNUAL REPORT AND ANY OTHER RELEVANT MATERIAL

Name and position of **person completing questionnaire**

____

____

Date ________________

THANK YOU VERY MUCH FOR YOUR COOPERATION IN THIS SURVEY

D. West. Government. Printer. New South Wales 1983

1978

APPENDIX B

VICTORIA

CHAPTER 7:

REPORT

OF THE

BOARD OF INQUIRY

INTO

MOTOR VEHICLE ACCIDENT COMPENSATION IN VICTORIA

PRESENTED TO BOTH HOUSES OF PARLIAMENT BY HIS EXCELLENCY'S COMMAND

Ordered by the Legislative Assembly to be printed, 20th April, 1978.

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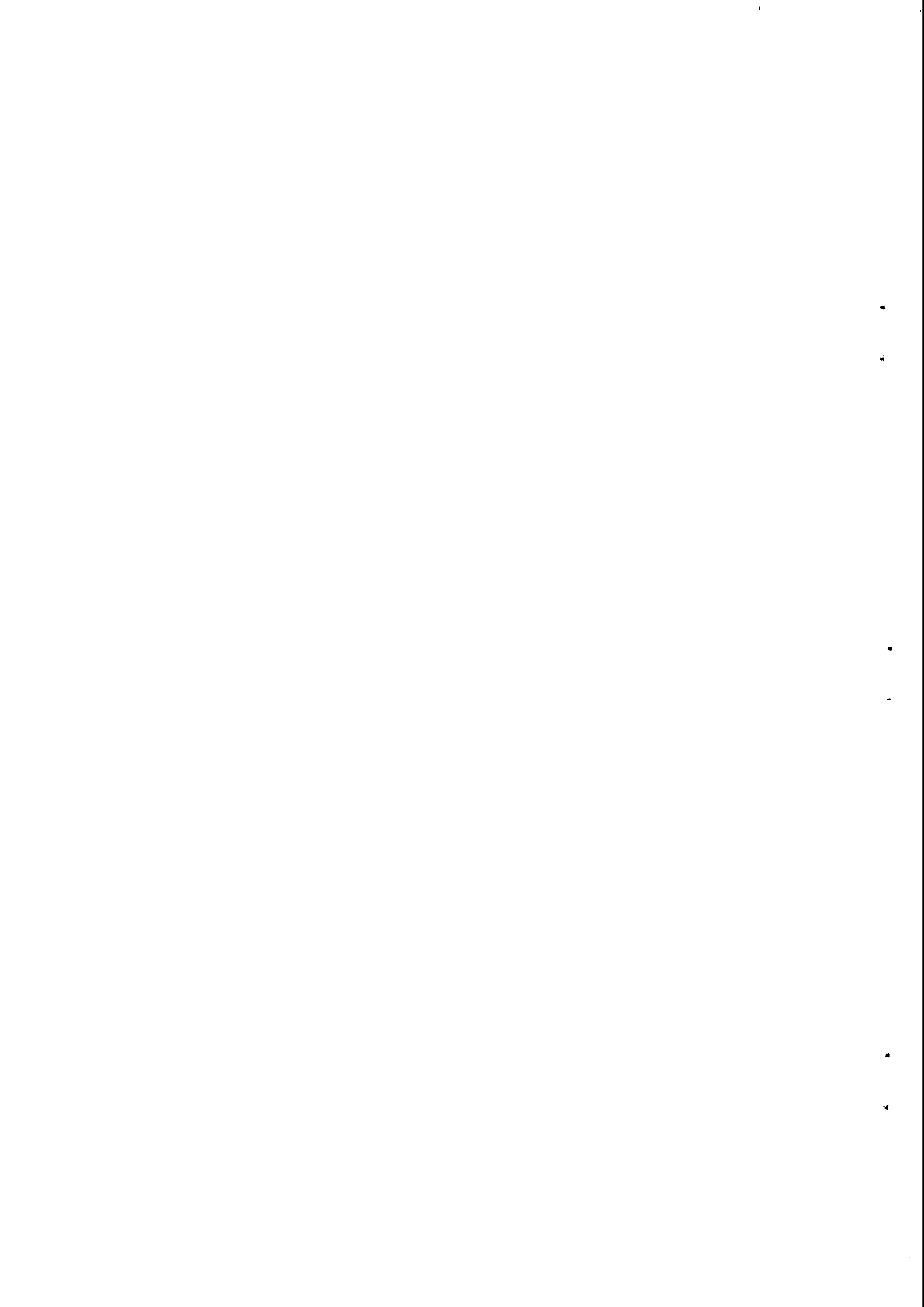

CHAPTER SEVEN

REHABILITATION

Introduction

7.01. No mention is made of rehabilitation in the Board's Terms of Reference. Nevertheless it became obvious from the beginning that this subject could not be ignored, not only because the cost of rehabilitation forms a substantial part of the compensatory process but more importantly, because the extent to which it succeeds when it has been undertaken plays a most significant part in the debate on the amount of compensation required for future losses.

7.02. As the Inquiry proceeded more and more was the Board convinced that the provision of rehabilitation facilities and the use to which they are put by victims of motor accidents claiming compensation has an importance which goes beyond their monetary significance. Anyone whose attention is drawn to the plight of the injured and handicapped in our present day society cannot escape the strong conviction that one of the most compelling needs in a suitable system of compensation is the provision of adequate rehabilitation facilities together with a co-ordinated effort on the part of all concerned to see that those who require rehabilitation care receive it.

7.03. The subject of rehabilitation care is confusing and complex, the more so as there is no moral or equitable reason to justify separate treatment of the motor accident victim from that required by the substantial body of people handicapped from other causes who are in need of rehabilitation and whose needs are not being met by society. However the Terms of Reference of this Inquiry enjoin the Board to confine itself to the system of compensation for the victims of motor car accidents. Although much of what it has to say will of necessity relate also to the needs of the handicapped generally, it is to the need and provision of rehabilitation for the motor car accident victim that it now turns.

The Need

7.04. A considerable amount has already been said on this subject by the Woodhouse Committee and the Board has profited from the breadth of investigation and views expressed in Volume 2 of its Report. No better statement exists of what the author of that Volume styles " The Challenge of Rehabilitation " than is contained in Part 2, which the Board takes the liberty of repeating. It reads :—

> " Disablement is one of the greatest personal afflictions. Yet, in the past, the handicapped have been neglected and often isolated. Society has paid far too little attention to their needs. This is all wrong. It is a widespread problem and it should be given urgent and comprehensive attention. That is the general theme of this part of the Report.
>
> Rehabilitation which implies the restoration of the disabled to their fullest physical, mental and social capacity is the principal means of lessening their burdens—and indeed of lessening that part of their burden that should be accepted by society itself. Accordingly, we firmly believe that a universal and complete range of rehabilitation services should be available to every handicapped person—regardless of geographical location or of the cause or nature of the disability—and those services should be available on an equal basis for everybody.
>
> Medical science succeeds in keeping alive more and more of the seriously injured, the sick, and those with congenital malformations. Increased industrial activity and increases in traffic are claiming an increasing number of industrial and road victims. Moreover, the number of geriatric patients continues to rise. Thus every year the numbers of the handicapped have been increasing. In the result the need for rehabilitative services has reached proportions that demand scientific and long term planning."

7.05. The Committee recognized the tremendous scope and difficulty of the work that has to be done on the problem. It commented in an Australia-wide context how fragmented, unevenly spread and inadequate are the facilities for rehabilitation. In the Victorian context and from a far less exhaustive review, the Board finds itself in complete agreement with those comments.

The Rehabilitation Process

7.06. It is pertinent at this stage to consider what is involved in the process of rehabilitation and why it is that the Board places so much importance on the subject. The latter question is easy to answer. It is because the whole emphasis of proper rehabilitation is to return the injured

to society in a condition in which they can play a useful and contented role in that society as far as human skill can ensure. According to an outstanding authority in the United States when reporting to the Department of Transportation as part of its survey in 1968, rehabilitation should be an *individualised* process in which the disabled person, professionals and others through comprehensive co-ordinated and integrated services seek to minimise the disability and its handicapping effects and to facilitate the realisation of the maximum potential of the handicapped individual. The report went on to recommend that the programme for rehabilitation should provide :—

1. early high quality medical care ;
2. comprehensive total care including scientific multi-disciplinary evaluation services ; and that
3. both the foregoing be applied in a goal directed manner recognizing and accepting the objective of returning the whole person to a useful and satisfying life.

To this end the system should deal with a person requiring rehabilitation as requiring more than medical cure alone and should treat that person as " a whole man ", i.e. a father with children and wife, a worker with a boss and colleagues, a community member with friends, with worries and aspirations, a social participating living being whose health is clearly related to his satisfaction in a changing inter-personal world.

7.07. The Law Reform Commission of Ontario, in discussing the subject of rehabilitation of motor accident victims, looked to what had been done in the field of workmen's compensation in that Province. It saw the basic premise of workmen's compensation as being rehabilitation and that almost every aspect of the Ontario system was organized to that end. Rehabilitation it said requires a positive approach in which the accident victim immediately begins to concentrate on the problem of recovering his health, freed to the maximum possible extent from worry over problems such as meeting his expenses and supporting his dependants. It saw and approved the features of workmen's compensation, conducive to that end, as being :—

1. the earliest possible treatment of the injury and the earliest possible provision of emotional support to try to prevent depression, and the development of post-traumatic neurosis or functional overlay ;
2. the guarantee of all necessary medical and hospital services and the provision of compensation for lost income during periods of disability ;
3. a hospital and rehabilitation centre staffed and equipped to deal with the problems of industrial injuries and disease from a rehabilitative point of view ;
4. the provision of socio-economic counselling, vocational evaluation, vocational training, and selective placement in employment.

Availability

7.08. The Woodhouse Committee stressed the necessity for the availability of rehabilitation services immediately disability is recognized, and the continuance of those services without interruption and on the basis of complete co-ordination until optimum recovery has been achieved.

7.09. Victoria is fortunate in that the accident victim generally speaking can rely on obtaining early high quality medical care in the acute and post-acute stages of his disability. Through the Motor Accidents Board the necessary medical and hospital services are provided free of charge to him and he receives limited compensation for lost income.

7.10. This Board has been greatly assisted by discussions with Dr. R. O. Summers, Director (Medical Services) Victoria who is the Medical Officer in charge of Commonwealth rehabilitation services in Victoria. He strongly supports the positive approach recommended in the Ontario Report. In his opinion the time to begin rehabilitation is when the patient in hospital is aware enough of his position to wonder what is going to happen to him. It is at this point that effort should be directed to his motivation to rehabilitation. In his opening address to a Seminar on Rehabilitation of the Road Accident Victim held in Sydney in November 1974 Mr. A. McSweeny had this to say :—

> " The task ahead must include co-ordination of all disciplines with allowance for overlap in fringe areas for persons suffering from combined handicaps—physical, psychological, as well as the handicaps of the special senses of hearing, of vision and of speech. Far from wishing to dominate the scene, we orthopaedic surgeons believe that each rehabilitation group needs a medical leader with expertise in his or her own field, whatever that discipline is. The objective is the ultimate rehabilitation of the individual by appropriate delegation to various therapies including, where appropriate, social, vocational and educational guidance. The potential for re-employment needs early assessment before motivation is lost and frustration begins."

7.11. It is at the point referred to by Dr. Summers that successful or any rehabilitation becomes problematical. In Victoria, apart from a small specialist unit at Mont Park, there are no facilities specifically designed for motor accident victims. They must take their place in the queue with all other handicapped persons for the use of such facilities as are available. This is not said in criticism of the system of motor accident compensation but rather to illustrate the general situation in this State.

7.12. Sir Colin Syme and Sir Lance Townsend in reporting on their inquiry into hospital and health services in Victoria seem to agree that rehabilitation of chronically handicapped people is not achieved at a satisfactory level here, that organization is to a large extent based on diagnostic groups or prognosis or other arbitrary criteria and that there is no clear focus of responsibility for planning or advocacy of needs. It appears clearly from their report how administratively fragmented and unco-ordinated are our rehabilitation services, and how communication in the system is almost exclusively at the service worker level and very little at the policy and development level.

7.13. Because of the lack of any coherent advocacy of needs, or any focus of planning responsibility, there is a dearth of statistical data concerning needs—indeed this Board has not been able to come upon any such data. It should also be stressed that as there is no directorate of, or any central body responsible for co-ordinating rehabilitative facilities in this State the Board has had to inquire as best it can from a number of individuals who are active in this area.

7.14. What then is the position of the victim of a motor car accident in Victoria in regard to rehabilitation ? First, he has to be sought out and identified as a person who needs and will benefit from rehabilitative treatment or procedures. This in part depends upon whose care he comes under. As far as the Board has been able to discover, training in, or consideration, of rehabilitation, does not form part of any medical course in this State. If the victim finds himself in a large hospital he may be lucky enough to come under the eye of a doctor who has interested himself in this branch of medicine, or a therapist or social worker who is aware of his needs and of the facilities available. If he is lucky, he may find himself in the Royal Melbourne, Alfred, Prince Henry's or St. Vincents hospitals. If at the former, he may, after he has succeeded in surmounting the acute stage, be transferred to the Mellor Ward at the Royal Talbot Rehabilitation Hospital, and if his case calls for it, eventually pass to the rehabilitation section of that hospital which indeed is its major activity.

7.15. If on the other hand, the victim finds himself in the Western General Hospital, he is in a much more unfortunate situation. Whilst that hospital has some physiotherapists, speech therapists, and social workers attached to it, it has no rehabilitation section as such, and unless there is someone who has the time to be sufficiently alert to the victim's post-hospital needs, he has to fend for himself as best he can with the help of family and friends. Mention is made of the Western General Hospital because it is a hospital serving a district in which there are situated some 350,000 people, and there is no rehabilitation unit or hospital anywhere within that area. In fact, apart from the cases wherein by reason of special negotiations victims of accidents are taken in by the Mount Royal Hospital, there are no rehabilitative facilities in the northern and western suburbs of Melbourne.

7.16. From St. Vincents Hospital after surviving the acute stage, the victim may be transferred to the After Care Hospital. In the case of the Alfred Hospital and of Prince Henry's Hospital there is a formal attachment to the Caulfield Rehabilitation Hospital and to the Hampton Hospital.

7.17. In total, Royal Talbot, Caulfield and Hampton hospitals provide approximately 272 in-patient beds and there is some provision for out-patients at these institutions. However, the principal facility for out-patients or day attendance care is at Mount Waverley and Cponac Rehabilitation centres which between them provide the capacity to deal with 150-175 out-patients ; Mount Waverley having also approximately 100 in-patient beds. It must be pointed out that the two latter institutions do not belong to this State and are part of the Commonwealth Social Service structure. Further, they are confined at present to providing rehabilitation services of a vocational nature and not general rehabilitation care.

7.18. Whilst there is obviously the best of goodwill existing at service level between the Commonwealth and State institutions, as could be expected procedures are different as are evaluation techniques and at the time of its physical investigation the Board found control exercised from Canberra tended to cause delays in admission.

7.19. The Board is not unmindful of the work being done by the National Advisory Council for the Handicapped under the chairmanship of Mr. Justice Meares of New South Wales. In its 1975-76 Report the Council has made its first recommendation one that the Commonwealth Government should take steps as soon as possible to alter the existing eligibility criteria so as to permit rehabilitation services to a wider range of handicapped persons and as a matter of urgency for the extension of facilities to housewives. The Council has also recommended high priority to the training of rehabilitation staff and the provision of State Advisory Councils. The Board commends

these recommendations but realises that their implementation depends upon a number of aspects of Commonwealth-State relations in this field which are currently under review and which it appears will be difficult of solution. It regards attention to the need for rehabilitation as urgent and for that reason it recommends the immediate action proposed later in this Chapter.

7.20. The Austin Hospital is in a special position. It contains a spinal care unit which undertakes the treatment of all spinal injury cases occurring in Victoria and Tasmania. Rehabilitation facilities exist for those cases and there is a close association between the organizers of these facilities and the hospital—to which spinal cases have to return from time to time for management.

Training

7.21. The recognition and achievement of provision of rehabilitation care for the injured seems to the Board to be a problem which goes deep into the approach to the patient which should be made by the medical profession and associated disciplines. Discussions with the Medical Directors of the two largest rehabilitation institutions in this State and with Dr. Summers, although individually held, revealed the unanimous opinion that there is an urgent need for the inclusion of some training in rehabilitative medicine in undergraduate studies in medical education. If this were only to achieve a greater capacity in the medical profession itself to recognize the need for rehabilitation care when it arises, the Board believes this would represent a profound advance and improvement. Rehabilitative Medicine is taught at the University of New South Wales and in both Sydney and Adelaide there are hospitals carrying a Director of Rehabilitation or Rehabilitative Medicine. The Board sees a general need for a body to provide organized liaison between the acute stage hospitals and the rehabilitation services. Even in the absence of such a body it envisages evaluation teams working in hospitals to evaluate the needs of patients so that rehabilitation services could begin to operate at the earliest possible moment. In its view, the existing rehabilitation services should be greatly enlarged and immediate consideration should be given to establishing rehabilitation facilities in the northern and western suburbs of Melbourne as a matter of urgency. It further suggests that rehabilitation services should be established in the major provincial cities throughout the State.

A Starting Point

7.22. Some of the foregoing suggestions would undoubtedly require large injections of capital funds—funds which are the responsibility of the community as a whole rather than of the motor vehicle owning sector to be provided as a condition of owning a vehicle. But there are ways in which a beginning can be made with motor accident victims. In small degree a beginning has already been made. The Motor Accidents Board has concerned itself with rehabilitation as in some measure it is bound to do by Section 30 of the *Motor Accidents Act.* This Section requires the Board to pay 80 per cent, of the reasonable costs of therapeutic services provided in Victoria by reason of motor accident injury, and " therapeutic services " is defined to include the provision of medical or surgical aid to rehabilitation. Already the Board has expended over $0-5m. on rehabilitation and has appointed a medical director to supervise rehabilitation of motor accident victims as far as he is able to do so. The Board is both willing and anxious to further expand its activities and this Board believes that it should be empowered and encouraged to do so. From its very nature it is the logical body to which the task of supervision of rehabilitation of motor accident victims should be entrusted.

7.23. The Accident Compensation Commission of New Zealand is directed by the legislation constituting it to take all practical steps to promote a well co-ordinated and vigorous programme for the medical and vocational rehabilitation of persons who become incapacitated as a result of personal injury by accident. The programme is to have as its objectives the restoration of victims as speedily as possible to the fullest physical, mental and social fitness of which they are capable having regard to their incapacity and where applicable their restoration to the fullest vocational and economic usefulness of which they are capable and also their reinstatement or placement in employment. Section 49 of the *New Zealand Accident Compensation Act* 1972 gives to the Commission very wide functions and powers, extending to the adaptation of home, of vehicles, financial assistance whilst training and assistance in the obtaining of and payment for training and education.

Recommendations

7.24. It is the view of the Board that similar types of powers included in the *Motor Accidents Act* would not only be of benefit to the victims of motor car accidents but to the community at large in that their provision would in the long run tend to lighten the financial burden on the community. However the Board does not envisage that the Motor Accidents Board should at once spring into full flower as a rehabilitation organization. There are many difficulties in

the way. The lack of accommodation and a trained staff are formidable obstacles. The full scope of the problem may not yet be properly understood. Nonetheless, the Board is firmly of the view that a start should be made and accordingly it makes the following recommendations :—

1. That a small rehabilitation section be raised as part of the Motor Accidents Board and that its primary and preliminary function be that of research to investigate the rehabilitative needs of motor accident victims and the ways in which those needs can best and most quickly be met.
2. That the Motor Accidents Board recruit and appoint a small number of liaison officers to function in the way in which those officers do in New Zealand—that is to seek out motor accident victims and to identify and assist them so far as they can with their problems, at the same time providing the rehabilitation section and its research component with information.
3. To provide financial assistance and encouragement to the rehabilitation hospitals i.e. Royal Talbot, Caulfield and Hampton to enable them to employ evaluation teams so that the already hard working staff at these hospitals would not have imposed upon them the necessity to engage in the evaluation of motor vehicle accident victims in the acute stage hospitals. These teams could be engaged in the work of assessing those most suitable for admission to the rehabilitation hospitals at present in existence and of devising rehabilitation plans and programmes for those unable to gain admittance to such hospitals which could be carried out in the home environment or in such other institutions as may be temporarily acquired to accommodate them.
4. The provision of a Chair of Rehabilitation Medicine at one of the universities. This has not been discussed with any of the university authorities but arises out of discussions with Dr. Ford, the Director of Rehabilitation Services for the Alfred and Caulfield Hospitals. The Board regards this matter as of prime importance because of the lack of undergraduate training in this vital field. It has been suggested that because of the existence of the two chairs of Preventative and Social Medicine and Community Medicine at Monash University this may well be the most appropriate university for the chair suggested. However, with the responsibility for rehabilitation entrusted to the Motor Accidents Board it seems to this Board that that body can best negotiate the establishment of a chair. In the view of this Board, the expenditure of moneys to fund such a chair would be a proper and desirable use of portion of the moneys levied upon the Victorian motorist.

Other Suggestions

7.25. In discussions with the Motor Accidents Board certain particular subjects have been raised. Mention has been made of the prevalence of whiplash injuries amongst motor accident victims and the need for research into and study of the treatment for this type of injury. A pilot project for what was referred to as a decanting ward was suggested. This, it was said, could be accommodation at one of the existing hospitals to be used both for in-patients and out-patients who had been discharged from acute wards in hospitals and who were fit subjects for rehabilitation. In the case of the Preston and Northcote Community Hospital, for example, the policy is to discharge patients as quickly as medically possible. Those who are motor accident victims are almost universally discharged to their homes and have very little chance of receiving rehabilitative treatment unless they are fortunate enough to somehow be " picked up " by the Commonwealth Social Services. For this type of person, such a decanting ward would no doubt be of very great value. However, the problem is so vast and far-reaching that the Board has not felt able to make any far-reaching recommendations and feels that if the Motor Accidents Board is given the power and through its rehabilitation section develops the expertise, as it should, an effective start can be made in this area of rehabilitation.

7.26. The Board makes no apology for stressing that the earlier the problem of rehabilitation is attacked the better and although it would not wish the doctor-patient relationship to be disturbed it does recommend such facilities as the availability of evaluation teams to doctors should be provided so that from the moment the patient begins to ask himself and his medical advisors what is to become of him, a ready answer and the provision of the means of achieving it can be embarked upon. In many cases it will undoubtedly be true that the best approach is that commonly in use already of keeping a person in hospital for as short a time as conveniently can be done and then discharging him home. But quite often the problem is not solved by translating a person who is worrying in hospital into one who is worrying at home, and the Board sees it as being part of the responsibility of the suggested evaluation teams at the instigation of and with the assistance of liaison officers to arrange for the provision of rehabilitation services at home.

7.27. The Board is aware of the proposal made by Judge C. W. Harris for an Accident Commission with rehabilitation responsibilities. The concept is a large and exciting one but this Board has felt it to be beyond the scope of its Terms of Reference to consider it in detail. Problems

of considerable magnitude and complexity would have to be solved and the Board would like to have the advantage of longer experience of the running of the New Zealand Accident Compensation Commission and a more extensive study of the difficulties encountered and results achieved. In the current economic climate it is difficult to foresee any large capital expenditure on the provision of rehabilitation facilities. Any finance would seem to have to come from the premiums or levies paid by motorists and premiums paid by employers. Because of this climate, the Board has concentrated on what could justifiably be termed as small beginnings and on foreseeable developments which in its view can be paid for out of the type of income currently being received into the motor vehicle accident compensation system. As has been recommended elsewhere in this Report, the system and its operation should be reviewed again in say four or five years when further advances may be planned.

7.28. Confusion in this area is further compounded by reason of the fact that the provision of rehabilitation facilities is divided between the Commonwealth and the State of Victoria. The former confines its services to those of a vocational nature and not the more general rehabilitation care with which this Board is concerned. At the service level goodwill and co-operation abound. At the higher policy level these attributes are difficult to find simply because, as the Board understands the situation, there is no identifiable rehabilitation division in Victoria at this level. The Board has consulted with and received the utmost co-operation from the Minister for Social Security and her staff concerned with the provision of rehabilitation services. It believes that as a matter of urgency the Government of Victoria should take up with the Commonwealth Government the question of the use of Commonwealth rehabilitation facilities existing in the city of Melbourne and throughout the State with a view to negotiating an agreement whereby access to Commonwealth rehabilitation facilities may be gained more readily by motor vehicle accident victims, particularly those whose needs are not specifically vocational rehabilitation training.

Rehabilitation and the Compensation System.

7.29. Much has been said in this Chapter on the role of the Motor Accidents Board in rehabilitation and nothing on the place of the fault liability system in this area. There seems little place for it in the system as it operates at present. The Ontario Law Reform Commission expressed the view that if one set out to design a system aimed at impeding the objective of rehabilitation, one could scarcely do better than invent the tort regime. It saw the features of the tort system subversive to the rehabilitation process as being—

(a) the contentious, time consuming and expensive nature of the proceedings,

(b) the uncertainty of ultimate success,

(c) the once for all assessment of compensation,

(d) the premium that attaches to non pecuniary losses.

It saw the motor vehic'e accident victim tending to be treated from a forensic rather than a clinical point of view and diagnosis, therapy and prognosis as tending to be formulated with a future claim to compensation in mind rather than with all attention focused on returning the individual to productive employment. It viewed the forensic approach to the injury and its consequences both physical and psychological as having the effect of persuading the injured person to believe the worst whereas the rehabilitation approach is based on the need to persuade the patient to believe the best. Whilst not feeling so strongly about the matter, as did the Ontario Commission, the Board feels that there are many cases which exemplify its statements. The question of lump sum and periodical payments is intimately bound up with the question of rehabilitation. It holds the opinion that there are many cases where payment of a lump sum has a definite therapeutic and consequently rehabilitatory value. However as has been pointed out, where the lump sum is delayed as it often is for a very long time in serious injury cases the net effect may be detrimental. This matter is dealt with more fully when discussing the method of making payments of compensation but the point is made here that in the making of those payments, the rehabilitation factor must be kept firmly in mind.

7.30. If effect be given to the Board's recommendation for the extension of the powers of courts to award periodical payments, it may be that those concerned with fault liability will become more involved. The Board feels unable to hazard a forecast. It is difficult to see the Bar playing any part in this process and although many solicitors assist the victims in handling their affairs and the compensation awarded them, it is difficult to envisage the solicitor in his professional capacity forming part of a rehabilitation team.

7.31. The Board sees the course of action recommended as making the first steps towards providing a clearer picture ofthe direction in which the provision of rehabilitation care could develop in the future. No precise data or solid evidence to guide this development are available at the present time. Not only would the measures advocated by the Board provide a means of easing the victim's path at present but also a source of information which would be required before the larger task which must be tackled at some stage is begun.