POLICY, FUNDING AND MANAGEMENT STRATEGIES TO PROMOTE HEALTH, COMMUNITY BASED REHABILITATION AND REGIONAL DEVELOPMENT IN AUSTRALIA.

Abstract

People with disabilities comprise 19% of the Australian population. Normalisation, human rights, community based rehabilitation and mutual obligation policies are consistent. All require broadly conceptualised services which develop the potential and capacities of people with disabilities, to enable their self-determination and social integration. There is commitment to a national platform of standards for health and environment protection. Regionally pooled funding and separate management streams for accommodation and services for the aged would facilitate coordinated and transparent management of all accommodation, health and disability funds. Elected government representatives and universities appear well placed to assist the broad, regionally planned approach to resolving community health problems which area health service managers and others have commenced.

Context of disability management and support

Between 1990 and 1998 the self-identified disability rate in Australia climbed from 16% to 19% of the population. Seventy-five percent of disabled people experienced mobility problems. Deafness, mental disorders and respiratory conditions were also major concerns (Australian Institute of Health and Welfare 2000, p. 48-55). Musculo-skeletal problems comprised a third of all the health difficulties experienced by around 600,000 Australians receiving the Commonwealth disability pension. Around one fifth of their problems were psychological or psychiatric. The likelihood of reporting disability rises with age, and two thirds of those receiving a disability pension are between forty-five and sixty-five. People in rural areas are likely to have higher levels of disability, particularly if they are Aboriginal. In 1999 people on the disability pension comprised 21% of over 2.6 million people receiving Commonwealth support, excluding age pensioners. Thirty-one percent of the total group were unemployed, 23% were lone or partnered parents, 15% were students, 7% were partners of other pensioners and 3% were carers or on special payments (Commonwealth Department of Family and Community Services, 1999).

The Commonwealth Disability Services Act specifies the service target group is people with a disability that is attributable to an intellectual, psychiatric, sensory or physical impairment or to a combination of these. The disability must be permanent or likely to be permanent and must result in a substantially reduced capacity for communication, learning or mobility and the need for ongoing support. In stressing its permanent nature, the act suggests a broad adaptation or normalisation approach to disability and its treatment is likely to be required rather than a medical approach. Normalisation aims to help a person to live more comfortably in their chosen community (Wolfensberger, 1980). A medical approach to rehabilitation focuses on the body, and may be accompanied by high and apparently unrealistic expectations of treatment outcomes (Kenny, 2001).

The term ‘normalisation’ originated in Denmark when the 1959 Mental Retardation Act defined the aim of services as creating an existence for the mentally retarded person as close to normal living conditions as possible. This included making the client’s housing, education, working and leisure conditions as close as possible to those of the general population (Emerson 1992, p.1). In the U.S., Wolfensberger described normalisation as promoting social tolerance and support for difference, whilst assisting people with disabilities to articulate and meet their broadly defined goals of normal life. He also described normalisation as seeking socially valued ends through the process of socially valued means and wrote that the highest goals of normalisation must be the creation, support and defense of values and social roles for people who are at risk of social devaluation. Although he felt most people wish to be perceived as ‘normal’ by the communities they identify with, he also thought that society’s negative perceptions about difference should be challenged and changed (Dalley 1992, p 104).

The normalisation approach to disability management is consistent with the implementation of human rights. The relevant UN declarations state that people with disabilities should have access to opportunities available to all citizens, and share the inherent right to enjoy a life which is as full, normal and self reliant as possible. They require services to develop peoples’ potential capacities and skills to the maximum and to hasten the process of their social integration or re-integration. People with disabilities also have employment rights, according to their capabilities, and rights to protection from discrimination or abuse (Barrand, 1998, p 140).

In 1991 in Australia, the national disability reform package gave the Commonwealth responsibility for employment services and income security. State and Territory governments assumed primary responsibility for other support. In 1992 the Commonwealth Disability Discrimination Act followed earlier State discrimination legislation. The current philosophy on the provision of disability related services calls for equal rights for disabled people, and also consumer focus and consultation. Services should be provided by generic organizations used by all Australians but should be

individualized to allow people to maximize their potential for integration in every day life. There should also be involvement by people with disabilities in policy making and implementation. A broad range of Commonwealth Disability Service Standards has been established which relate to service rights and to rights at work (Ageing and Disability Department, 2000).

A national platform for developing regional community based rehabilitation

In 1991 the Council of Australian Governments (COAG) agreed to mutual recognition of State and Territory laws, and began developing national standards for health and the environment, related occupations and training, social security benefits, and labour market programs (Premiers and Chief Minister, 1991). The governance ideal has been to create a platform of national standards through the inquiry based identification of good practices. Separation of policy and accountability for service administration is required, because this is necessary for transparency, and to judge comparative outcomes of competing service provision. The Competition Policy Reform Act (1995) ideally promotes competition on a level playing field of minimum standards related to health and environment protection. Equal competition between private and public sector service providers is required unless another course of action can be shown to be in the public interest.

The number of people on the disability pension has doubled in ten years to reach 6% of the working age population. This is considered unsustainable. In 1999, the Commonwealth introduced mutual obligation policy, which requires communities to create more opportunities for people to increase their self-reliance and capacity building. The policy is based on the premise that responsibility between the community and the individual should normally flow both ways (Minister for Family and Community Services, Minister Assisting the Prime Minister for the Status of Women, 1999). The policy should be delivered according to community based rehabilitation (CBR) requirements. CBR is a strategy within community development for the rehabilitation (CBR), equalization of opportunities and social integration of all people with disabilities, implemented through the combined efforts of disabled people, their families and communities, and the appropriate health,

education, vocational and social services. (Working Group on CBR of the Regional Interagency Committee for Asia and the Pacific 2001, p 7)

The word 'community' may mean a group of people with common interests who interact with each other on a regular basis. Alternatively, it may mean a geographical, social or government administrative unit. Such definitions provide a micro and a macro perspective to assist regional planning and management. All but two of Australia's thirty-nine universities are established under State or Territory legislation and have community service functions. They potentially provide holistic planning, education, monitoring and evaluation expertise which might easily be directed to assist CBR planning and service implementation to meet identified and prioritized community need. The provision of university expertise to the community in this manner would be consistent with the legislated requirements of workplace risk management, action research, health promotion, quality management, and program budgeting. All proceed in a spiral of steps, composed of consultative planning, action, and fact finding about the results (Standards Australia 1999; Hart & Bond 1995; Johnson 1997; Eagar, Garrett & Lin, 2001).

The National Expert Advisory Group on Safety and Quality in Australian Health Care (1999) suggested Health Minister lead the way in promoting a safety and quality enhancement ethos throughout the whole health system. The Health and Medical Research Strategic Review (1997) suggested a research-planning framework which could also support CBR. It argued Australia should develop a focus on the prioritized creation and assessments of interventions and policy and stated the national research effort should take three forms, based on recommendations of the World Health Organisation. Fundamental research should generate knowledge about problems of scientific significance. Strategic research should generate knowledge about specific health needs and problems. Research for development and evaluation should create and assess products, interventions and instruments of policy that seek to improve on existing options.

Towards transparent management of regionally pooled funds

The rate of disability is rising partly because the population is aging. The aim of remaining healthy and independent in one's own home is shared by the elderly and government alike. The national strategy for an aging Australia (2000) identified a number of areas for promoting healthy aging. These include maintaining physical and mental health, engaging in physical activity, and preventing falls and other injury. Strategies to maintain wellbeing also require development of more flexible housing, employment and education options, and better coordinated provision of health and social services, including transport. Broadly coordinated services are necessary to meet the needs of people with disabilities, whatever their age. The aim should be to assist everybody to achieve independence and maintain links with recreation, education, work or community service. A consultatively planned approach to regional service provision is necessary because a submission model of funding tends to provide further advantages to comparatively privileged social groups (Brennan & O'Donnell, 1986, p 48).

The Council of Australian Governments (COAG) proposed that all Commonwealth and State funds for aged care services be pooled into a single fund to be managed by the States. The Commonwealth subsidises aged care accommodation provided by private or voluntary organisations. The resident's need for care is measured by an eight-point classification scale. The home and community care program (HACC) and aged care package assessment services have been funded jointly by government to provide home-based assistance to frail older people and those with disabilities. Kendig and Duckett (2001) have suggested that the total funding pool should be regionally managed, and should incorporate residential aged care, home and community care, community aged care packages, and relevant State-funded community health activities. They suggest that housing and aged care should be unbundled, with separate funding streams for accommodation, living costs and care needs. A regionally pooled funding approach to

accommodation appears suitable for coordinated application across all government owned or subsidised housing provision, and in other areas related to promotion of community health and rehabilitation.

Low socio-economic status, unemployment and Aboriginality are all linked to a higher risk of poor health, disability, and crime. Appropriate housing is also centrally relevant to the prevention of health problems. (Australian Institute of Health and Welfare 1996, p38-39; National Centre for Aboriginal and Torres Strait Islander Statistics, 1999; Butler, 1997; Standing Committee on Law and Justice, 2000). A regionally planned, coordinated and prioritized approach to all community health and rehabilitation issues therefore appears most appropriate. Elected government representatives and others who have a holistic role in pursuing the aspirations of their communities, appear well placed to assist an effectively coordinated, prioritized and focused approach to service delivery, and to evaluate its outcomes.

In the 2002/03 budget NSW increased the matching funds it provides for housing under the Commonwealth/State Housing Agreement. The NSW Housing Act has as its objects to ensure that housing opportunities and assistance are available to all sections of the community with housing needs, and to encourage social mix and the integration of different housing forms in existing and new communities. Social mix is an important crime prevention, transport and employment related measure. For best results it requires an effectively coordinated and planned approach to the management of development, public land and related funds. Such an approach would also facilitate transparent and therefore more effective management of other publicly or privately owned funds, including workers' compensation, motor accident and superannuation, which are also related to health.

People with disabilities are tenants in about 23% of the public housing provided by the NSW Department of Housing in cooperation with the Departments of Health, Community Services and Ageing and Disability. The Supported Accommodation Assistance Scheme aims to provide

transitional supported accommodation and related services, in order to help people who are homeless to achieve the maximum degree of self reliance and independence (Council of Social Service of NSW, 2003, p. 1). A range of other accommodation and related funds exist. For example, the NSW disability services program is spent on supported accommodation and support packages for individuals. The Aboriginal Housing Development Committee (1996) recommended the establishment of a single Aboriginal Housing Agency, with an Aboriginal board reporting directly to the Minister for Housing, to replace all current housing programs for Aboriginal people which are at present provided through the Commonwealth State Housing Agreement and the Aboriginal and Torres Strait Islander Commission, in cooperation with elected Aboriginal Land Councils.

The Aboriginal and Torres Strait Islander Commission (ATSIC) is the primary Commonwealth authority responsible for assisting Indigenous self management. It works with thirty-five elected regional councils. Local governments have made agreements with Aboriginal communities in NSW about infrastructure needs and maintenance, as well as provision of other services (Carr & Refshauge, 1997). Some communities have developed plans in which alcohol and substance abuse management and control of related breaches, especially violent offences, are priorities. Plans to support children and people with disabilities may be developed in this context. Under the ATSIC Commonwealth Development Employment Program (CDEP), Indigenous people may voluntarily forego normal entitlements to income support payments in return for increased training and work opportunities.

In 1995, following commitments to implement transparent, diagnostically related group approaches to health service provision, COAG began to fund area health service managers for three separate streams of health care. Acute care funding covers episodes of treatment, mainly in a hospital setting. General care funds are for some primary health care, allied health and community care, and community support services. Coordinated care funding is for complex and ongoing needs requiring a mix of services over an extended period, and the assistance of a care coordinator or case manager.

In NSW, area health service management authorities, in partnership with communities, other government and non government organizations, local councils and general practitioners, are now prioritizing regional public health problems to reduce them (NSW Health, 2000). Plans based on population profiles, including socio-economic indicators and information about needs of the aged are being developed. Duckett (1997) found that the taxpayer funded Medicare scheme, which is likely to be more heavily utilized as the population ages, performs comparatively well. The Medicare structure is also effectively designed to put downward pressure on private health insurance costs. Community and individual participation in decision-making at all levels of health service planning and delivery is a national health goal. An electronic health record is being created for every Australian. Coordinated management approaches to health, disability support and sustainable development are now required.

The NSW Government Disability Policy Framework (2000) calls for a planned, coordinated and flexible approach to policy and services for people with disabilities and their carers. It requires service providers to measure and report on their progress in increasing access to normal life. The separation of accommodation and service funding would facilitate this and promote transparent management of a range of Medicare services introduced in 1999. These allow primary care providers such as general practitioners to focus on preventative care for older Australians and better coordinated care for people with chronic and multidisciplinary care needs. Health assessments, multidisciplinary care plans, and case conferences are designed to achieve a case management approach to health care provision and a more flexible and efficient match between the services provided and the care recipients' needs. People receiving care in a residential aged care facility are treated separately.

A holistic, consultatively planned process of regional development is needed to drive community based rehabilitation and mutual obligation policy in a way which avoids a medicalised or adversarial approach to social problems. Elected government and related representatives have a holistic community brief and knowledge of electorate concerns. Tertiary education institutions also have

holistic community service goals and host a broad and complementary range of expertise. They appear well placed to drive management of health and disability support in cooperation with area health services, regional communities, and key service providers such as general practitioners, the Department of Social Security and other relevant organisations which have comparatively limited aims. Art, sport, tourism and trade strategies may also be pursued through a broadly applied pursuit of regional health and environment development, in line with the Principles of Multiculturalism Act (2000) which states that all individuals and institutions should respect and make provision for the culture, language and religion of others within an Australian legal and institutional framework.

Regional development of this sort could provide new, flexible, vocational education, community service or employment opportunities for students, people with disabilities and other welfare recipients. Waldrop (1992) states that effective systems for managing pooled community resources are not controlled centrally but tend to have highly dispersed control mechanisms which establish a ceaseless cycle of learning. Students would benefit from practical education in health promotion, quality management, action research and general risk management. They could develop these and other vocational skills in partnerships with individuals or communities, under supervising tertiary education institutions, hospitals, general practitioners, community health centres, nursing homes, pharmacists, schools, and a wide range of other organisations. The challenge is to achieve a broad and integrated approach to regional management of funds and delivery of services, in order to identify the most effective outcomes and treatments for consumers and their communities.

Coordination with risk management systems at work

Matching rehabilitation requirements were introduced into all State workers' compensation acts during the 1980s (Butrej and Douglas, 1995, p 64). Consultative development of rehabilitation plans and the appointment of rehabilitation coordinators in larger workplaces are also required. The NSW WorkCover insurance model was established after multiple workers' compensation insurer insolvencies, and was copied in other States. Government and industry set the benefits and

underwrite the premium pool. A dozen private sector insurers are contracted to collect and invest premium on their behalf, and to assist rehabilitation of injured workers. This competitively managed funding model retains the benefits of fully funded premium investment for industry, rather than handing it to insurers. Ideally, it also encourages insurer competition for market share through provision of risk management services, rather than premium price cutting. Better workplace risk management and better outcome data gathering are required to achieve the potential benefits of the structure (Grellman, 1997). In NSW, premium incentives for employers to establish effective workplace risk management programs have been introduced. A key requirement is that employees are involved in the development, implementation and review of return to work and occupational health and safety programs (WorkCover, 2001). This is supported by compulsory conciliation for the permanently injured, aided by independent experts whose judgments are not adversarially driven.

Sir Laurence Street (2003) writes of the 'newly evolving recognition that conflict avoidance, management and resolution are simply three closely related sequential approaches, each of which has relevance and application within the broad field of social, commercial and personal interaction', and that this is inherently the province and function of alternative dispute resolution. From 2003 the NSW Ombudsman will take on an expanded role in community services with a brief which appears broader than that of the NSW Health Care Complaints Commission. It will deal with complaints, inquire into major issues, and review the situation of groups of people in care according to the primary criteria of the best interests of the consumer and compliance with relevant legislation. It will coordinate community visitors and have standard setting, education and monitoring functions.

All communities need effective harm prevention and related education and dispute resolution to assist early identification of risk and avoidance of injury. Information on individual complaints and their solutions may also provide information to assist the resolution of related problems. For this to occur, people must have confidence they will be treated in an unbiased fashion.

Parties to a dispute should be able to bring someone to speak on their behalf. All parties who have something to say about a matter should normally be heard. Representatives of the parties in dispute may be on panels to hear disputes or make determinations on them, with the best interests of the broader community, organization and individuals firmly held in view.

Regional employers have incentives to take on social security recipients including people with disabilities through the Commonwealth funded supported wages system. People unable to work at full productivity because of disability can receive wages based on their abilities, with an additional disability wages supplement to be paid through the social security system. Employers may also receive support for necessary workplace modification. However, in the absence of a broad, effectively integrated and comparative approach to community development and rehabilitation, many employers may not be in a position to think beyond their normal business concerns, or to see how they might benefit and also contribute to their community through participation in such schemes. A regionally coordinated approach to disability support may assist in overcoming this problem. It should also assist clarification of the best means of managing a range of public and private funds in order to meet the public interest as effectively as possible.

Conclusion

CBR is a strategy within community development for the rehabilitation, equalization of opportunities and social integration of all people with disabilities, who now comprise 19% of the Australian population. This rehabilitation approach is also consistent with the self-determination and support requirements of human rights and Australian mutual obligation policy. CBR is implemented through the combined efforts of disabled people themselves, their families and communities, and the appropriate health, education, vocational and social services. Regionally pooled funding and separate funding streams for accommodation and services for the aged would facilitate effectively coordinated and transparent regional management of all accommodation, health and disability funds.

Elected government representatives and universities appear well placed to assist the planned approach to resolving community health problems which area health service managers have commenced in cooperation with others in their communities. A transparent and evidence-based approach to service provision is generally necessary, in order to facilitate the identification of those treatments which appear to be comparatively effective in meeting individual and community needs. CBR workers and others involved in the process now require appropriate education.

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PLANNING AND STRATEGIES FOR IMPROVING AUSTRALIAN REGIONAL HEALTH DEVELOPMENT, EDUCATION AND RESEARCH

Short Title: Planned, regional health, education and research

Abstract: Governments have been advised to promote economic equilibrium, health and equity by increasing competition in centrally planned or monopolistic economic sectors, and strengthening the position of communities in peripheral sectors. Quality management depends upon transparency, and requires separation of policy and administration with the former in the driver's seat and the latter proceeding in a spiral of steps composed of consultative planning, action and fact finding about the results. Regional partnerships are being developed in Australia to provide health and related community services which rely upon effective administration of funds designed to support health goals. Medicare and workers' compensation fund ownership and management models are likely to have broader application in this context. New Medicare initiatives promoting better care for disadvantaged groups appear consistent with the current policy direction. However mental health and disability problems may primarily require a holistic, community based rehabilitation approach to treatment rather than a medical one. Planned and flexible education is required to support coordinated regional development of related governance, health promotion and rehabilitation strategies. Reform of university management is also necessary to support legislated functions more effectively and to assist planning, management and identification of those initiatives which appear to meet community needs most effectively.

Key words: Australian health policy; quality management; risk management; community based rehabilitation

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A planned approach to international development

For economists with a human capital or dual market perspective, education and health are the basis of productivity. The latter group sees organisations, industries, nations and the international economy as having a central tendency towards being planned or monopolistic, and a comparatively competitive but impoverished economic periphery. There are primary and secondary labour markets related to dual development tendencies. Rural communities, subordinate cultural groups, migrants, youth, women and people with disabilities often occupy secondary labour market positions primarily because of their comparative lack of appropriate education and work opportunities (Averitt 1968; Doeringer and Piore 1971; Gordon 1972). Governments have been advised to bring dual economies into greater equilibrium by increasing competition in centrally planned or monopolistic sectors, and strengthening the position of communities in peripheral sectors (Galbraith 1973). This article discusses the regional development potential of health, education and research in this context, using the example of Australia.

Dual market economic perspectives are consistent with current international regulatory initiatives. The United Nations (UN) Declaration on Environment and Development (1992) stated that promoting human health should be the first development concern. The first meeting of the UN Commission on Sustainable Development reviewed consumption patterns and poverty. In 2000 the Commission began to focus on sustainable land management, agriculture, finance, economic growth, trade and investment. The president of the World Bank has lamented that traditional economic policies to address issues of growth have seldom been accompanied by an equal focus on governance for health, education and environment improvement (Stiglitz and Muet 1999).

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Those with a narrower economic focus, or who seek short-term profits, still appear to drive development outcomes. A broadly coordinated regional planning approach to health and education is necessary to promote standards which complement the increasing international focus on opening world markets.

Although mainstream economists (Stiglitz and Muet 1999; Sachs 2001) recognise the need for better world governance to manage public goods such as financial stability and environment protection, the World Health Organisation (WHO) has promoted the importance of a broadly coordinated approach to social administration since the Ottawa Charter in 1986. The Charter stated that the necessary supports for health include peace, shelter, food, income, a stable economic system, sustainable resources, social justice and equity. It called for development of public policy and reorientation of health services, as well as community action to support health goals. The WHO program of work aims to increase the span of healthy life for all people in such a way that the disparities between social groups are reduced. Such aims are consistent with the prescriptions of dual labour market economists like Galbraith (1973).

Achieving health and development goals requires structural change. Western systems based on the British model have traditionally valued separation of three principle governance powers. Elected politicians, government administrators, and the judiciary are ideally the central but independent pillars of governance in this model. In recent years transparency has become the critical new goal of international and national management. It is required by international trade agreements to which Australia is a signatory, such as the Uruguay Round of the General Agreement on Trade and Tariffs, and the Asia Pacific Economic Cooperation Agreement. In this governance model, the emphasis is on clear separation of policy and administration, with the

former in the driver's seat (Osborne and Gaebler 1993). This is necessary to achieve the transparency necessary for effective accountability and the identification of comparative service outcomes.

In such a model, independence is conceptualized as the responsibility to make informed decisions, which can withstand public interest based scrutiny. This emphasis on transparency is consistent with the economist's view that perfect information is necessary for perfect competition. Social administration may be envisaged as experimentation which should combine discovery and implementation in one process (Hart and Bond 1995). The general expectation of quality management is that activity should proceed in a spiral of steps composed of consultative planning, action and fact finding about the results (Johnson 1997). This iterative administration and related research process may also lead to amendment of the original regulatory or policy direction. Contemporary health planning, health promotion, workplace risk management, program budgeting and action research ideally reflect such requirements (Eagar, Garrett and Lin 2001; National Health and Medical Research Council (NHMRC) 1995; Standards Australia 1999; Wilenski 1986; Hart and Bond 1995).

Dispute resolution services have arisen in response to pursuit of the individual and public interest in fairness, the maintenance of community standards and social order. Assisting the resolution of complaints and disputes should therefore be managed as a social service, like health or education, which meets an individual and public demand. Improving social outcomes should be the goal of all such services, and dispute data gathering should support these service goals. Education and research should also support the general requirements of quality management. Related

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opportunities and problems for Australian implementation of coordinated health, education and sustainable development are addressed in this context.

Australian health management priorities

Australian health service developments reflect the internationally recognised need to promote planned approaches to encouraging service cooperation and competition which enhance the individual's quality of life and improve community standards. In 1983 the taxpayer funded Medicare system involving free hospital care, free or heavily subsidised general practitioner care, and subsidized pharmaceuticals was established for all Australians. In 1986 the Commonwealth Disability Services Act expanded community-based services for the aged and for people with disabilities. Work related rehabilitation requirements were also introduced in state workers' compensation acts to supplement injury prevention requirements of new occupational health and safety (OHS) acts. In 1988 the first national health promotion goals were established for cardiovascular disease, cancer, and injury. National programs to address mental health and the health of Aborigines were also initiated. Equitable access to services, and fostering participation of communities and individuals in decision making at all levels are also national health goals (Commonwealth Department of Human Services and Health 1994).

The health status of Australians measured as disability adjusted life expectancy is ranked second in the world, behind Japan (Leeder 2002). Nevertheless, between 1990 and 1998 the self-identified disability rate climbed from 16% to 19% of the population. Musculo-skeletal problems

comprise a third of all health difficulties experienced by around 600,000 Australians receiving the Commonwealth disability pension (Minister for Family and Community Services 1999). Around one fifth of problems they experience are psychological or psychiatric. The likelihood of reporting disability rises with age and two thirds of those receiving a disability pension are between forty-five and sixty-five. People in rural areas are likely to have higher levels of disability, particularly if they are indigenous.

Australia has begun to establish regionally coordinated management of health and development. NSW area health managers have consultatively developed population profiles and plans with an emphasis on the needs of the aged, in partnership with their communities. An electronic health record is being constructed for every individual who accesses the national health care system. Priority health care programs are being set up for people with chronic and complex conditions (NSW Health 2000). Diagnostically related group funding systems are being developed to support hospital and some community based services (Eager and Hindle 1995). The requirement for service purchaser and provider splits is consistent with the view that policy and administration must be separated to identify comparative service outcomes. Medicare services now allow primary care providers such as general practitioners to focus on preventative care for older Australians and better coordinated care. These health assessments, multidisciplinary care plans and case conferences are designed to achieve a case management approach to the services provided, and a better match between the services and the needs of recipients (Royal Australian College of General Practitioners 2000).

These initiatives have now been supplemented by Commonwealth proposals to provide training places for more general practitioners. Incentives are proposed for doctors to locate in under

serviced rural areas and to bulk bill Medicare when providing free consultations to comparatively disadvantaged people, identified primarily by their status as Commonwealth concession card holders. The government estimates these payments would mean $1 extra for the doctor per concessional service in capital cities, up to $6.30 per concessional service in rural or remote areas. Funding is proposed to assist general practices upgrade their computer links with the Health Insurance Commission, and to enable up to eight hundred practices to receive assistance in employing a nurse or other allied health care worker. Participating doctors will need to agree to provide services at no cost to patients covered by a concession card (Commonwealth Department of Health and Ageing 2003). Critics argue that the proposals will encourage doctors to charge higher fees to non-concessional patients. The government denies this, and states that no proposals are compulsory. Doctors will choose whether to access offers and whether they will continue to bulk bill all clients, without additional gap payments required.

These proposals might help address the relationship between poverty and poor health which exists in Australia as well as internationally. However, a holistic approach to treatment and rehabilitation, rather than a medical one, is often likely to be required. Many Australian families, especially those who live in comparatively disadvantaged communities, may principally require more effective child care, education, recreation or related family and vocational support to improve their mental health and reduce disabilities. For example, the physical health of Australian youth has improved in recent decades, but mental health apparently has not. Two thirds of teenage deaths are injury related. Alcohol dependence and motor vehicle accidents remain the greatest problems, although the latter have been declining. The young, troubled, poor and Indigenous experience a comparatively high risk of accidental injury, depression, anxiety,

self harm, victimization and imprisonment (Australian Institute of Health and Welfare 2000; Australian Bureau of Statistics 1997, 2001; Standing Committee on Law and Justice 2000).

In 1996 the World Health Assembly established violence prevention as a health priority. Australia now addresses interpersonal violence within the national injury prevention program (McDonald 2000). In NSW the Attorney General provides local councils with funding for crime prevention programs which are planned and implemented with communities. NSW housing policy attempts to provide subsidized housing in a manner which promotes socio-economic mix as a crime prevention and employment strategy. Debate continues about how best to develop more effectively coordinated management approaches which can improve individual and community health. The introduction in NSW of the Victims Compensation Act and the Young Offenders Act provide potential for studying the comparative effects of court diversionary practices and jail. Coordinated mental health and crime prevention strategies which focus on environment management, and on child care, education, recreation, employment and related mentoring for high risk individuals and communities are required. Planning and implementing these strategies might be undertaken through community partnerships between general practitioners, universities, elected government representatives, child care centres, schools, police, Centrelink offices, or through programs such as NSW Families First which provides support to parents. Students and others are likely to benefit from planned, community based education and service which supplement their theoretical learning.

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Towards national structures for better regional fund management

In 1989 Australian States began to review and update legislation. The Council of Australian Governments (COAG) agreed to mutual recognition of State laws, and began developing national standards for health and the environment, related occupations and training, social security benefits, and labour market programs (Premiers and Chief Ministers 1991). The governance ideal has been to create a platform of national standards through the inquiry based identification of good practices. The Competition Policy Reform Act (1995) ideally promotes competition on a level playing field of minimum standards related to health and environment protection. Equal competition between private and public sector service providers is required unless another course of action is demonstrably in the public interest (Fels 1996). Although separation of policy and administration is recognised as necessary to judge the comparative outcomes of competing service provision, state freedom of information legislation currently relates only to the public sector, and medico-legal information is exempt. This inhibits alternative dispute resolution.

Health care practitioners are increasingly encouraged to use evidence based approaches to treatment. These should not depend upon slavish application of received standards regardless of apparent particular needs. Risk management requirements of state OHS acts and professional independence are consistent. Decision makers should deviate from the relevant approved or expert recommended practice if there is good evidence that other action is likely to be safer in the specific situation under consideration. The deviation and its justification should be recorded. Large groups of relevant documented decisions and outcomes are studied. This comparative risk management and research practice ideally leads to increasingly informed evaluation of practice in

all settings, and to the general development of more informed standard setting and practices (Johnson 1997).

Duckett (1997) found that on social indicators related to access, equity and cost, the Australian Medicare system outperforms U.S. health care, which is primarily funded through employment related or family health insurance. Medicare pricing requirements put downward pressure on all private provider prices. Critics of Australian competition policy and increased government contracting (Hancock 1999; Smyth and Cass 1998) ignore the relationship these initiatives may bear to national and state regulatory processes which have progressively extended government and industry ownership of major health, workers' compensation insurance and superannuation funds over the past fifteen years. Funds are increasingly managed competitively by the private sector, according to requirements established by government in the public interest. Premium holders and those injured are the primary stakeholders in this fund management model (Heads of Workers' Compensation Authorities 1997). Such insurance schemes may be designed to extend public and industry ownership and control over funds which were formerly owned privately and commercially driven, supposedly in the interests of shareholders.

Russian and Chinese experiences suggest that stable management and competition are more important than private property for effective functioning of the market (Stiglitz and Muet 1999). The Australian insurance experience clearly shows that private sector underwriting and competition on premium price inhibits effective injury prevention, rehabilitation and fund management (NSW WorkCover Review Committee 1989; House of Representatives Standing Committee on Transport, Communications and Infrastructure 1992; Review of Professional

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Indemnity Arrangements for Health Care Professionals 1995; Australian Health Ministers Advisory Council 1996; Standing Committee on Law and Justice 1997; Industry Commission, 1997; The HIH Royal Commission 2003).

Private sector insurance practice is not transparent, and premium price competition promotes economic instability. Private underwriters require high profit margins to guard against the effects of poor investment and administration practices, competitive premium price cutting, global economic downturn, unexpected major court awards and increasing long tail claims, which lead to insurer insolvencies. When competing insurers underwrite and own the premium pool, they must not only have high profit margins to guard against insolvency, but also require costly reinsurance. On the other hand, when premiums and benefit requirements are clearly established by legislation and funds are owned by the public and industry, insurers contracted to manage the business may be encouraged to compete for market share by providing premium holders with risk management services rather than by premium price cutting. The comparative outcomes of service provider activity can be more effectively evaluated in this model, and benefits of fund investment are returned to scheme stakeholders rather than to shareholders of the insurance company.

Regional implementation of national health goals should assist development of coordinated, consultative, flexible and effective approaches to all service provision and related fund management. Kendig and Duckett (2002) have proposed that all Commonwealth and State funds for aged care services be pooled into a single regionally managed fund. They recommend that housing and aged care should be funded separately, with streams for accommodation on one hand, and for living costs and care needs on the other. Care provision based on identified personal needs should apply the current resident classification system for the elderly, irrespective

of whether services are provided in residential care or the home. A similar approach should be investigated in related service areas. Medicare and workers' compensation insurance may provide useful models for broader application (O'Donnell 2003).

Education and research to support regional development goals

The NSW disability policy framework (1998) requires a coordinated, planned and flexible approach to policy and service provision for people with disabilities and their carers. Service providers must measure and report on progress. The UN defines community-based rehabilitation (CBR) as a strategy within community development for the rehabilitation, equalization of opportunities and social integration of all people with disabilities. This should be implemented through the combined efforts of disabled people, their families and communities, and the appropriate health, education, vocational and social services. 'Community' may mean people with common interests who interact on a regular basis, or a geographical, social or government administrative unit. This perspective provides a micro and macro approach to assist regional program management in Australia. The UN CBR statement stresses that improving the capacity and skills for community involvement is important and must be coordinated to ensure optimum use of resources. CBR workers should be trained to provide client support and flexible service management to meet regional needs which are consultatively identified, prioritized and funded.

Because of their legislated functions, holistic range of expertise and independence, Australian universities potentially appear to be appropriate leaders of planned education and research programs necessary to support effective regional development. All but two of thirty-nine

universities are established under State legislation which requires they have education, research, community service and certification as their major functions. However, the review of higher education financing and policy (1997) noted universities must address the ramifications of a view of the world based on collegial decision making. A Senate references committee (2001) noted the limitations imposed on effective development by collegiate governance structures, and the need to identify alternate funding models that would better serve the needs of regional and disadvantaged students. A ministerial discussion paper (2002) quoted the views of independent auditors that the current state of cost management in most universities is not adequate to support the needs of their businesses and the changing landscape. Under-utilization of opportunities for continuing education has also been identified (Gallagher 2000).

The National Health and Medical Research Council (NHMRC 1999) stated it is difficult to find an agreed definition of research. However, the Health and Medical Research Strategic Review (1997) thought that Australia should develop a focus on the prioritized creation and assessment of interventions and policy. Adopting definitions from the WHO the report stated the national research effort should take three forms. Fundamental research should generate knowledge about problems of scientific significance. Strategic research should generate knowledge about specific health needs and problems. Research for development and evaluation should create and assess products, interventions and instruments of policy that seek to improve on existing options.

This approach appears consistent with requirements of effective regional management, and also with the Boyer (1990) model of scholarship. This seeks to integrate teaching and research activities, and distinguishes between four forms of scholarship. Discovery creates new knowledge. Integration puts it in an intellectual context. Application applies it in useful ways for

individuals, industry and institutions. Teaching facilitates student learning and developing scholars in all these areas. Consistent with these perspectives, Australian university education content, delivery and assessments should be consultatively designed to assist identification, prioritization and control of health risks at work and in communities in order to promote health and development. This should also lead to the prioritization and development of related strategic research. Such an education and research model would assist governments, industry and communities to implement regional, national and international goals and standards from in a constructive, critical and comparatively objective manner.

The National Expert Advisory Group on Safety and Quality in Australian Health Care (1999) recommended that health ministers lead the way in promoting a safety and quality enhancement ethos throughout the health system. University education and research should support this focus. From a public interest perspective, expenditure by professional and academic cultures currently lacks justification. The absence of a legislated duty of care for professionals exacerbates the problem that there is often no systematic approach to the collection of data about injuries, and no linkages between the compensation system, quality assurance processes, and programs or practices aimed at injury prevention. A consistent risk management approach should be taken, where appropriate, to the duties of care and disclosure required of employers, practitioners and researchers towards workers, clients and communities.

A legislated duty of care and duty to inform would reduce pressures on researchers to be secretive or to bend their findings to suit political, commercial or other sectional forces. It would facilitate comparison of research outcomes and promote recognition of the need for public funding to be clearly used in the public interest. However, governments currently appear unprepared to address

community needs for transparency which may come into conflict with the protection of intellectual property or with related commercial, political or legal interests as they are currently pursued. On the other hand, at a conference organized by the Medical Foundation and the College of Health Sciences of Sydney University in 2002 ‘commercialization’ was defined by the Sydney University Business Liaison Office as ‘the process of transferring research outcomes to the community in a manner which optimises the chances of their successful implementation, encourages their use, accelerates their introduction and shares the benefits among the contributing parties’. This definition integrates commercial, collegiate and government management and funding objectives more effectively in the public interest. Although it currently has no legislative or contractual backing, any organization which utilizes significant amounts of public funding might appropriately adopt it.

Conclusion

Economists draw attention to the tendency for dual market development. International and Australian policies recognise the related need to promote greater competition in centrally planned or monopolistic sectors of the economy, and to provide greater support for planned development in comparatively disadvantaged economic peripheries. A broadly coordinated and transparent approach to regional health, education and research development is necessary. NSW area health services have begun consultatively planning this. Medicare initiatives which are potentially supportive of this planning direction have also been introduced. However many mental health and disability related problems often require broadly conceived, community based rehabilitation strategies rather than a medical model of treatment. Recent proposals that all funds for aged care services should be regionally pooled may be relevant in other areas of service provision.

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Medicare and workers' compensation should also provide useful insurance models for consideration in this context. Planned and flexible education is required to support coordinated regional development. Reform of universities is also necessary to assist transparent and effective community health planning and management.

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Submission to the Senate Legal and Constitutional Committee Inquiry into the Australian Human Rights Commission Legislation Bill (2003)

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Overview and recommendations

This submission argues that assisting dispute resolution should logically be seen as a social service, similar to health or education, which meets an individual or public demand. Dispute resolution should aim for fairness, the maintenance of community standards and public order. Good dispute resolution is part of a good commercial society and its welfare state. It needs to be well managed to achieve good social outcomes. The principles of quality management and risk management are vital to the process. Prevention, rehabilitation, fairness, and related data gathering and funding need to be conceptualised in this context.

However, the Australian Human Rights Commission Legislation Bill (2003) and the commentary upon it obtain a frame of reference from the courts. Australian courts operate upon an authoritarian, pre-scientific, adversarial, confused, wilfully ignorant, uncaring, expensive and therefore socially dysfunctional paradigm. They represent a collegiate monopoly culture which has used its power to enrich itself at the expense of the society, primarily by denying information and their accountability to anybody but each other. They call this independence. They primarily justify their supreme powers of judgement by saying that they represent the social wisdom and their power over the future is entrenched in the Australian constitution.

Attempting to speak in the public interest, I don't give a damn! If the constitution actually says that only the courts can determine cases and everybody else has to conciliate them (Brandy v. HREOC, 1995) why were conciliation and arbitration tribunals set up in the early 20th century? More importantly, the men who wrote the constitution are dead. If what they thought seems really stupid now (and it does) we should ignore it.

Independence should be seen as the duty to act in the apparent public interest, on the basis of broadly conceived evidence about a matter, rather than being swayed to pursue the sectional interests of those with power, including the courts and their lawyers. A legislated duty of care to seek and tell the apparent truth might help many professionals to avoid the common pitfall of any form of advocacy. Independent inquiries, or standardised tribunals with generalist commissioners should make determinations and conciliate according to non-adversarial principles. The decisions of all should withstand public scrutiny. That is how progress is made. We educate children not to bind and silence them but so they will make their own decisions about their health and welfare better than we could. We should point this out to politicians.

Headings and related recommendations:

1. *All assisted dispute resolution or settlement should be conceptualised and treated as social service*
2. *Only recognise truly independent, standardised tribunals which make determinations upon all matters*
3. *WorkCover provides a fund management model which could assist broader risk management*
4. *Judgements should be made by informed people with a duty to seek and tell the apparent truth*

5. *The Bill aims for better management of human rights and education, but greater independence from government is needed*
6. *Rehabilitation and its relationship to compensation and prevention should be considered*
7. *No social group should be exempt from public accountability for their actions*
8. *All dysfunctional legal monopolies posing as independent should be broken*
9. *Break the lawyers' monopoly over charging*

1. All assisted dispute resolution or settlement should be conceptualised and treated as social service

If dispute resolution is not a social service, what is it? Health care and education are social services developed to meet an individual and public demand. Assisting resolution of complaints and disputes should also be conceptualised as a social service, which should be provided in response to pursuit of the individual and public interest in fairness, the maintenance of community standards, and social order. All social services should be carefully designed to obtain improving social outcomes. Consistent quality management principles should be applied to achieve this, unless another course of action appears to be in the public interest. Dispute data gathering should be designed to support such goals.

Viewed from this position, any person or organisation, which makes a submission on the Human Rights Commission Bill, should clearly explain how their views on what ought to be done meet the individual and public interest. In this context, the Competition Policy Reform Act (1995) also requires equal competition on a level playing field of national standards, unless another course of action appears to be in the public interest. In contrast with this, the propositions put about the Bill by the current Human Rights and Equal Opportunity Commission (HREOC) appear primarily based on self-interested industrial grounds, the traditional authority of the courts and the Australian constitution. This is demonstrated later.

Over the centuries the courts have entrenched their powers, but the time for all Australians to use alternative methods of decision making is long overdue. Courts operate according to an authoritarian and prescientific mode of discourse. For example, as I understand it, a high level court decision about a particular situation is commonly used as a precedent to determine judgments in future cases, and thereby to change the law, which is supposedly also the general standard. This argues from the particular to the general, on the basis of the Godlike authority of the decision maker, rather than on the basis a of broadly informed evaluation of the comparative outcome of a wide range of judgments which all supposedly reflect the application of an expected standard. The latter paradigm is scientific, the former is authoritarian.

In the scientific paradigm the professional is expected to exercise informed and independent judgment. For example, in the case of a health practitioner, the term 'independent' means she should deviate from applying the general standard of expected treatment when such a deviation appears necessary to meet the particular requirements of an individual situation, based on the evidence she has broadly gathered about the case. Careful documentation of the treatment and outcomes of a wide range of such independent professional judgments are then studied. Evaluation of the outcomes of these practices may then lead to change of the expected standard practice. Independence should rightly be conceptualised as the exercise of judgment which is justified on the evidence. It centrally involves the necessity for practices to be evidence based and to withstand public scrutiny.

State Occupational Health and Safety (OHS) acts also reflect this broadly scientific concept of independence. They require that employers and workers conduct their business safely. They are

expected to apply approved codes of practice, in order to control identified workplace risks. The worker may deviate from the approved code where she judges that, on the general evidence about a specific situation, it would be safer to do so. Evaluation of practice outcomes is then required. Existing codes of practice should be changed when it can be clearly demonstrated that there is a generally safer way of doing things.

In contrast, those who traditionally practice law show no interest in evaluating the physical or social outcomes of their judgments, either on an individual or aggregated basis. Although decisions may be changed in higher courts, this process involves a comparatively uninformed repetition of the process of judgment, carried out in another arena by men with more money and power. This is a completely different process from the one where people make different judgments in the future, because it has been found, as a result of the evaluation of past decision outcomes, that probably a different way of doing things will produce better physical or social results.

The court process is based on an adversarial method of gathering and treating evidence which is savage and bizarre. It is impossible to conceive of any intelligent parent or citizen, let alone a scientist, seeking to resolve a question using this mode of discovery. A good parent, for example, might try to gain a sympathetic understanding of the emotional motivations behind sibling conflict, in order to help the family work towards greater social harmony. In a public inquiry run by a democratically elected government the process is advertised in the newspapers and anyone may come forward with evidence and put their view to a cross-party committee which may also commission research. In contrast, the courts apply a rule bound method of gathering evidence which is determined by the narrow requirements of specific pieces of legislation. Within these confines, the lawyers on opposing sides of an issue are encouraged to secretively gather evidence which is designed to maximise their own case and demolish the other.

A basic expectation of the court appears to be that information should not generally enter the arena unless introduced by the opposing lawyers. Courts also appear to deliberate in wilful ignorance of any evidence which may have previously been received about the matter in other dispute resolution arenas. More generally, all the people engaged in the court process appear expected to blind themselves to a range of information which might educate everybody who would discuss an issue under more normal circumstances. The courts deny such information access on the basis of rules which only the legally initiated understand. To the outsider, the courts seem to equate ignorance with freedom from bias.

Are those who continue to champion such ancient expectations about the appropriate ways to develop human standards evil people? I think they must be, for the legally trained constantly assure of their brilliance. They are clearly comparatively rich, even though the jury system supposedly values judgment by one's peers. For example, the lowest grade NSW local court magistrate gets $150,000 per annum. Could you do that job? What are you making?

The concept of independent decision making by the courts or anybody else, generally means that the decision makers' duty to try to be informed, objective and honest should not be compromised by individuals or groups with vested interests who have power over them. This appears ideally to require that the way a matter is dealt with should withstand public scrutiny, to ensure that the public interest is achieved. This is generally consistent with the public interest in transparency, which is also necessary for effective data gathering to improve service outcomes. Transparency should be required in health, education and dispute resolution services, unless another course of action appears to be in the public interest. This is necessary for service outcome evaluation,

equity and cost containment. I will return to these issues later, in the light of a discussion of the Human Rights Commission Bill and the HREOC submission based upon it.

2. Only recognise independent, standardised tribunals which can make determinations upon all matters

The authoritarian and adversarial principles of the courts have come to Australia from the ancient British common law legal tradition of dispute settlement, which involves determination of a matter by a magistrate or judge. Although democracy and a welfare state increasingly developed in the 19th and 20th centuries, the courts continued to apply many of their ancient expectations to apparent breaches of the statutes enacted by elected parliaments. Work related arbitration and conciliation tribunals were established in Australia at the beginning of the 20th century. Since then governments have established an increasing range of independent tribunals to administer disputes related to particular pieces of legislation, according to rules which are considered at the time to be better than those of the traditional courts. Whether they are encouraged to remain that way is addressed later.

I assume the term 'independent' generally means a tribunal is neither required nor expected to bend to the wishes of a particular minister or his government. However, tribunal decisions may be appealed in the relevant higher courts. According to a 1995 High Court decision, the supreme decision making powers of the courts have been entrenched in the Australian constitution. Elected parliaments may enact new laws as a result of court decisions. The desire of the courts to maintain their judicial powers, and the desire of lesser judicial activists to gain access to the arena, tend to drive all related decision making practices towards those of the courts. For example, although HREOC is a tribunal, in its argument on the Human Rights Commission Bill, it compares its brief and powers to those of the higher courts and generally ignores any relationship of its operations to other tribunals which deal with similar matters, such as Commonwealth and State Industrial Commissions or Administrative Review Tribunals.

In spite of HREOC's apparent disinterest in the relationship, the appropriate treatment of industrial and discrimination related matters is highly controversial. For example, in NSW during the 1980s, when a Labor government was in power, the NSW Labor Council voiced its concern to government about the industrial ramifications of decisions and awards made in the Equal Opportunity Tribunal as a result of complaints taken under the NSW Anti-Discrimination Act. The Labor Council argued that the Industrial Commission should handle work related discrimination issues. The NSW Anti-Discrimination Board and many other organizations and individuals protested successfully against this. They argued that because only trade unions and not individuals can be represented in the Industrial Commission, those individuals who are not union members but who are discriminated against would have nowhere to go unless significant changes were made to the legislation.

In 1989 after a change of government, Professor John Niland provided a report entitled 'Transforming Industrial Relations in NSW' to the NSW Attorney General. In it he pointed out at length that his approach meshed with the direction already being taken at a Commonwealth level under a Labor government. He argued that the greatest burden borne by the Australian industrial community is that the federal parliament, as is indicated by section 51 of the constitution, shall only have power in respect to conciliation and arbitration for the prevention and settlement of industrial disputes extending beyond the limits of any one state. He deplored the effects of having many industrial tribunals and recommended that the work of 'the two mainstream tribunals' be integrated and standardised to the maximum extent allowable by

constitutional limitation and federal/state rivalries, 'thus laying down the groundwork for full integration of all State and Commonwealth tribunals in the longer run'.

In 1992, in a submission to the Commonwealth inquiry into the Workplace Relations Bill, the National Pay Equity Coalition argued that:

> The definition of equal remuneration, as specified in ILO Convention 100, should be applied, and the requirements of the Convention met, in the Workplace Relations Bill (and not applied across the Bill and Sex Discrimination Act).
>
> The equal pay provisions should be extended to ensure coverage of all employees, all components of remuneration, and include a right for everyone to take a case in the Australian Industrial Relations Commission irrespective of their employment contract.

Acceptance of this recommendation would also appear to implement the requirements of the Commonwealth Policy Reform Act (1995) that competition should occur on a level playing field of national minimum standards. This presumably includes minimum standards in regard to pay and conditions of work.

More recently, the National Alternative Dispute Resolution Advisory Council (NADRAC) which advises the Commonwealth Attorney General, has distinguished between facilitative, advisory and determinative dispute resolution processes, because there currently appears to be no clear agreement about the practices required by the terms 'mediation, conciliation and determination'. NADRAC suggests that in mediation, disputing parties should meet with the assistance of a neutral mediator, who helps them reach agreement. In conciliation, the disputing parties involved in an alleged breach of law should come together. A neutral conciliator should not make decisions, but may advise or determine the process, make suggestions for settlement terms, and actively encourage agreement. Arbitration is determinative. The arbitrator makes decisions.

Sir Laurence Street recently writes of the 'newly evolving recognition that conflict avoidance, management and resolution are simply three closely related sequential approaches, each of which has relevance and application within the broad field of social, commercial and personal interaction, and that this is inherently the province and function of alternative dispute resolution' (1). However, the HREOC submission on the current Bill indicates that in 1995 the High Court decided (Brandy v HREOC) that a court must make any binding determination of a complaint because anything else is unconstitutional. (Who else other than lawyers or idiots might care about such an argument? It appears to be the intellectual equivalent of an individual saying to his son that he should not undertake a certain action because grandfather forbade it before he died.) In this context, however, does the 1995 decision mean that there is now an expectation by some that all arbitration, which is determinative, should be undertaken in a court? If this is so, why was this problem not noticed when the Constitution and the State and Commonwealth industrial tribunals were first established?

The Attorney General says 'the Commission's function to assist in proceedings, with the leave of the relevant court, as amicus curiae is unchanged'. HREOC explains that Commissioners have the function of acting as 'amicus curiae'(friend of the court) where complaints cannot be conciliated and are referred to the Court for determination. The function is apparently to be exercised where there are special circumstances which may have an impact beyond the parties to a complaint. What exactly might this mean and why would such matters would need to be referred to the Federal Court? WorkCover inspectors or others in arbitration like positions are capable of seeing when an employer and a group of workers may be acting in collusion but

against the public interest as defined by the OHS Act. One needs the determination of matters to be undertaken with the assistance of expert advice, and with the public interested firmly help in view. This is a completely different thing from shoving a matter upstairs to be dealt with afresh by a much more expensive set of decision makers using even more dubious adversarial principles.

HREOC writes that 'a written notice of termination is an essential pre-requisite for access to the Federal Court'. It notes that Clause 46PE (1)(b) of the Bill provides that the President may terminate a complaint if 'the President is satisfied that all the affected persons want the complaint to be terminated'. Clause 46PE (3) apparently provides that the proposed President of the Commission does not issue a written 'notice' where a complaint is terminated 'at the request of the complainants'. HREOC says it would like the word 'affected person used instead of 'complainants', although it also states it is not possible to gain access to the Federal Court when a complaint is terminated on the ground that all the affected persons want the complaint to be terminated. I cannot understand any of this. It seems the lawyers' usual clever mess to me.

However, this reminds me that when I worked in the NSW WorkCover Authority those in conciliation appeared to have a poor record of settling disputes, perhaps because they seldom appeared to hold conferences, and relevant medico-legal documents were not available to them. They led a comparatively secretive life with abysmally organised administrative practices. The WorkCover CEO appeared to leave them to it. He always seemed afraid of someone. State Freedom of Information Acts exempt medico-legal documents, which are reserved for the court, even when paid for by premium holders. It is perhaps indicative of the subservient mindset of those then working in WorkCover conciliation that they recorded all those WorkCover disputes that weren't resolved, as 'proper disputes'. I have often observed that one never seems to go wrong by not upsetting a court or taking its business. In 1996 Sir Laurence Street's report on a model of conciliation for the NSW Scheme was provided to the NSW Attorney General, and conciliation services were established in the Department of Industrial Relations.

HREOC appears content with the High Court judgment in 1995 that the determination of complaints is a judicial function, and all judicial functions have to be handled by a court. However, as a health policy adviser, researcher and teacher at the University of Sydney, I resent this decision bitterly, on the public behalf. What will be its outcomes? I think all determinative processes (decision making) should be done by independent tribunals because the courts are inherently authoritarian, adversarial, unaccountable, socially dysfunctional and outrageously expensive institutions.

3. WorkCover provides a fund management model which could assist broader risk management

Because of the growing multitude of inconsistent court and tribunal processes, effective dispute data gathering is currently impossible. The community, its taxpayers and its premium holders have little idea of how the courts operate and what general outcomes they produce. They have even less data about potential inequities, unintended consequences and associated costs. That appears to be the way the lawyers like it.

However, there is a great deal of evidence collected in State workers' compensation and motor accident arenas over many years, that the traditional adversarial process severely inhibits rehabilitation of injured people by denying them early access to appropriate and effective support. In workers' compensation, a supposedly no-fault insurance scheme, the adversarial method for determining a physical level of incapacity has been particularly illogical. On the other hand, insurance provides any apparent miscreant with few economic incentives to avoid future poor

performance, because the amount of any court award, and its related costs, is borne primarily by all those organizations or individuals who are legally required to have insurance premiums in case an unforeseen claim is made upon one of their number.

Doctors and builders were insured with HIH in case their clients complained about their work. The insurance company invested and administered the premiums in a disgusting fashion. Lawyers helped them. Auditors, like most people, do not like to face anything that might upset them, especially when they are being paid large amounts of money for carrying on as usual. These problems were combined with HIH premium price cutting to attract customers, a rising cost of claims, the multiple lawyers and the courts. HIH went bankrupt. Insurance legislation appears to be supporting socially dysfunctional commercial incentives and related opaque, expensive, accounting systems, at least in this instance. It makes me want to kill, and I have never even been injured or in business, big or small.

However, workers' compensation insurance in NSW has fortunately been designed to avoid some of the key problems associated with the collapse of HIH. Government and industry underwrite the WorkCover fund. The premium holders own the fund, and also establish the appropriate level of benefits and premium prices. The scheme is fully funded. The WorkCover Authority undertakes regulatory and related operations paid for by the fund. It administers the NSW OHS Act and the NSW Workers Compensation Act. It engages twelve insurers which are paid to competitively gather premium, administer claims, collect data and invest premium on behalf of government and industry. Some large organizations may also be approved self-insurers.

The public ownership structure of the WorkCover fund and the prevention of traditional insurer competition on premium price avoid the problems which arose with HIH. WorkCover premium holders never lose control over their own money by having to give it away to an insurance company which does not appear to know or tell them what they are doing with it. WorkCover premium holders know that their fund management structure ideally promotes transparent insurer competition, and also the goals of protective legislation related to health. Furthermore, this structure is cheaper and much more stable than the system would be if private sector insurers were to underwrite it.

In the latter situation the premium pool would have to be broken up between competing insurers who would require large insolvency margins (profits). High profits mean high premium prices. This is necessary so the insurer can avoid the strong possibility they could become bankrupt as a result of competition on premium price, poor investment returns, poor management, the necessary costs of international reinsurance which result from breaking up the fund between insurers, and the growing cost of unexpectedly large, numerous or long tail claims. This unstable tendency interacts with the similarly destabilising effects of the international business and underwriting cycle. The national business system thereby becomes generally more unpredictable.

Obviously, it is vital to intimately involve independent worker experts or representatives, as appropriate, in all policy and management functions related to workers' compensation fund management. This is necessary because the fund is primarily established to provide a socially protective function rather than a commercial one. As a result of recent amendments to the NSW Workplace and Injury Management Act, premium incentives have been provided for employers to establish effective workplace risk management programs. A key requirement of these is that employees are involved in the development, implementation and review of return to work and occupational health and safety programs. This is supported by compulsory conciliation for the permanently injured, aided by independent experts whose judgments are not adversarially driven.

The seriously injured so far have access to common law if they waive other guaranteed entitlements to rehabilitation and related service support.

State workers' compensation acts are supposedly 'no-fault' legislation with workplace based rehabilitation provisions attached. Unlike third party motor accident insurance, the injured worker does not have to prove that someone else *caused* his or her injury. The insurance benefit is gained automatically as soon as the worker is injured. Permanently injured workers are also paid lump sums to compensate them for their disability and for related pain and suffering. The income support of those unable to work because of their injury is met first from workers' compensation premiums, and later by the Department of Social Security. An inquiry into the operation of the NSW Occupational Health and Safety (OHS) Act has recommended that victim impact statements be issued in conjunction with prosecutions under the OHS Act. Under the latter act, WorkCover inspectors, trade union representatives and other persons approved by the relevant Minister may undertake investigations and prosecutions. Fines from prosecutions currently add to government revenues.

Superficially, it seems equitable and efficient that consistent treatment should be available in a range of situations where workers, clients, customers, or members of the community may claim they have been injured as a result of negligent or other unforeseen treatment outcomes. However, any compensation money, as well as any rehabilitation related payments, will have to be met by others in the community somehow. Careful consideration therefore needs to be given to the design of legislation and its related administrative structures in order to get the best outcomes for everybody at the best cost.

4. Judgements should be made by informed people with a duty to seek and tell the apparent truth

Given the above context, no sensible person or organisation should go on in the same old tunnel vision way, thinking purely about their relationships with courts and lawyers. There are many people who could do the job of dispute resolution much cheaper than those with legal qualifications. They may also do it much better than a lawyer could, because they have not swallowed and upheld traditional legal principles for years on end, just so they can pick up money. A legislated duty of care to seek and tell the apparent truth might help many people to avoid the common pitfall of any form of advocacy.

All communities need effective harm prevention and related education and dispute resolution to assist early identification of risk and avoidance of injury. Information on individual complaints and their solutions may also provide information to assist the resolution of related problems. For this to occur, people must have confidence they will be treated in an unbiased fashion. Parties to a dispute should be able to bring someone to speak on their behalf. All parties who have something to say about a matter should normally be heard. Representatives of the parties in dispute may be on panels to hear disputes or make determinations on them, with the best interests of the broader community, organization and individuals firmly held in view. This appears to be consistent with relevant ILO Conventions such as Convention 121, concerning benefits in the case of employment injury.

The benefit of using relevant UN Conventions as guides for local decision making is that they reflect agreed values and principles of an ideal international, multicultural and democratic community. The application of such protective principles can be broadly evidence based and tailored to specific individual and community requirements, consistent with related risk management expectations, including implementation of quality management and relevant

professional standards. When individual judgments and treatment practices are effectively recorded and monitored, comparative analysis of the outcomes should promote effective, equitable, but diverse future practice. The process is designed to allow appropriate diversity in cultural and individual treatment, but to reduce socially dysfunctional features of any traditional decision making practices. In the absence of a universal, multicultural and democratic approach, diversity of traditional practices may lead to increased social differentiation, but also to increased intolerance, moral confusion and conflict.

5. The Bill aims for better management of human rights and education, but greater independence is needed

The Australian Human Rights Commission Legislation Bill (2003) states that:

1. A new Australian Human Rights Commission will be created to replace the Human Rights and Equal Opportunity Commission.

2. The executive structure of the new Commission will consist of a President and three Human Rights Commissioners. Each Commissioner will act on an appropriate generalist basis in handling dispute resolution, rather than as a legislative specialist.

3. Before exercising its power to seek leave to intervene in court proceedings, the Commission will be required to obtain the approval of the Attorney General for the exercise of this power, unless the President of the new Commission is a federal Judge.

4. The Attorney-General will be able to appoint part-time Complaints Commissioners to whom the President will be able to delegate complaint-handing functions.

5. The new Commission will not have power to recommend the payment of damages or compensation. However, it will have an expanded education, information dissemination and assistance role.

The aims or objects of the proposed human rights bill are not clearly explained in the bill itself. However, the bill's Explanatory Memorandum suggests that a primary aim is to replace the current legislatively specialist commissioners with generalist ones so that cases can be judged on a holistic, and therefore more broadly considered and realistic basis. For example, a situation facing a black woman with disabilities will no longer need to be decided according to the specific requirements of a single specialist jurisdiction, which may conflict with the specific requirements under another specialist jurisdiction also covered by the Commission.

As I have earlier indicated, if this hypothetical black woman experienced her disabilities as a result of an accident at work, on the road, or apparently at the hands of her husband or doctor, she might also enter another arena entirely from those presided over by the current commission. In general, the more specialist courts, tribunals and related individuals are provided specifically to administer the requirements of particular legislation, the less transparent, more unfair and more costly the process of dispute resolution invariably becomes.

Increasingly separated but fiercely independent practitioners of dispute resolution processes will generally be increasingly likely to reflect the expectations of specific pieces of relevant legislation, rather than capably dealing with the holistically lived experiences of those in dispute. To the extent that this occurs, the independent process of dispute resolution may deliver

increasingly inconsistent, unknown or unexpected outcomes. This may satisfy the lawyers best, but the process is diametrically opposed to quality management.

Although the duties of the proposed president of the new commission are not made clear in the Bill or the Explanatory Memorandum, the Attorney General stated in his Second Reading Speech that 'the existing commission's powers to investigated and conciliate complaints will be retained, and the bill will complete the task of fully consolidating the complaint handling functions with the president'. The Attorney General also says 'I will be able to appoint legally qualified persons as complaints commissioners on a part-time basis to assist the president with these functions' and 'work will be allocated to a complaints commissioner by the president'. The bill provides for three human rights commissioners to replace the existing portfolio specific commissioners.

It appears from this that the aim of creating a President, rather than another Commissioner, is to establish the managerial conditions for proper public accountability and quality management, through enabling comparison of disputes and Commissioner output. Apparently an earlier review committee recommended that the responsibility for complaint handling (other than under the Privacy Act) be combined in one office-holder. I strongly believe in the importance of having general human rights commissioners rather than specialist commissioners but have no idea why Privacy Act complaints might be treated in a separation fashion. Nobody seems to explain this. However, in the interests of clearly independent decision making, clarity, equity, cost-containment, and general quality management I would personally prefer that:

- The legislation also provides for arbitration (i.e. non-adversarial powers of determination)

- The President is appointed by an appropriate independent community mechanism such as the National Committee on Human Rights Education Incorporated. (This is an independent association dedicated to promoting and extending human rights education in all its forms. It was established with the support of government, business and community groups. The National Committee has also been designated by the Federal Government as the national focal point for the UN Decade for Human Rights Education (1995-2004).

- No more lawyers are ever appointed to the Commission by anyone.

In relation to this, it should be noted that the Attorney General states that 'where a federal court judge is appointed to the position of President, the new commission will not be required to seek approval from the Attorney-General before seeking leave to intervene'. Apart from misguided respect for the views of men who are all now dead, why should one want to bother with the higher courts at all?

More generally, the apparent aims and related changes proposed by the Bill appear consistent with common goals of quality service management. However, it also appears that an aim of the bill may currently be to reduce the independence of the Commission and to increase the powers of the Attorney General over the organisation. This could be done through specific government appointments and/or by reducing the access of the Commission in regard to its current role of providing information to influence court decisions. It would indeed be a worry if any court or tribunal began to see an Attorney General or a government as the boss, which told it what to do.

6. Rehabilitation and its relationship to compensation and prevention should be considered

The proper role of all organisational and professional independence in a democracy, requires consideration. The proper relationship of such organisational or professional independence to

legislated social goals, the courts and their related funding systems, also requires thought. In this connexion attention is again drawn to the WorkCover funding and administration model briefly discussed earlier. The proposed Commission currently has no power to recommend the payment of compensation under any circumstances. This is an important but vexed issue. The Attorney General states that 'the government believes that education is the key to a society in which human rights are respected by all'. Rehabilitation is not mentioned although 'information dissemination and assistance' are.

From the quality management perspective, to spend money on education for prevention and rehabilitation generally seems preferable than to spend money on compensation and related punishment. This is especially the case if the punishment is borne by the innocent instead of or as well as the guilty, and is also very expensive. This may happen, for example, when an insurer goes bankrupt, or when there is an increase to all premium holders as a result of major court awards. It may also happen when there is an out of court settlement to avoid the embarrassment and cost of legal suit to an innocent or guilty party. (Could there even sometimes be an element of blackmail in some suits?)

The concept of compensation is historically the product of the common law and related insurances which were formed before the development of the welfare state. Under earlier statutes and their administrative systems, compensation was traditionally made available only to those who could prove in a court they had been wronged. (The concept of no-fault compensation primarily denotes a welfare system paid for by premium holders.) However, those who run any welfare system should also see the need to promote prevention of injury and independence. In regard to the former, the excellent results which have been obtained by the Road Traffic Authorities and the police in reducing deaths on the road are very instructive. Deaths have been greatly reduced primarily through mass community education, compulsory seat belt wearing requirements, and vigorous enforcement against drink driving and speeding. (However, motor accident insurance still supports a traditional fault based system of legal suit which may be horrifyingly socially dysfunctional for many reasons which I will not go into here.)

7. No social group should be exempt from public accountability for their actions

A HREOC press release states that "the Commission does not support the bill which stands to have a detrimental impact upon the work of the Commission. HREOC believes the bill significantly undermines the Commission's independence in the exercise of its 'intervention powers'".

The first of three submissions on legal information which are provided by HREOC states that its position is based on the 'Paris Principles' established by the UN Commission of Human Rights and the UN General Assembly. According to HREOC the Principles relating to the Status of National Institutions (Paris Principles) set out international minimum standards for independent national human rights institutions internationally. HREOC further states:

> 'the essence of the Paris Principles is that a national human rights institution must have the independence and mandate essential for it to perform its functions effectively and operate in an unfettered and uncompromised manner'.

The Commission says nothing in its submission about how such publicly funded service practitioners should appropriately be held publicly accountable for expenditure of public funds. (Are these issues not addressed in the Paris principles?)

HREOC further quotes the Paris Principles:

> "In order to ensure a stable mandate for the members of the national institution, without which there can be no real independence, their appointment shall be effected by an official act which shall establish a specific duration of the mandate……."

HREOC then goes on to complain about the lack of transitional provisions for current Commissioners to transfer to the proposed new organisation. This sounds overwhelmingly like a very common industrial complaint. The Commission appears to equate independence with a *stable mandate*, which is also apparently accepted by HREOC as a fixed term appointment (of unstated length). On the other hand, the Explanatory Memorandum of the Bill refers to part-time commissioners, without discussing their expectations regarding continuing appointment. Neither does the Attorney General.

Whilst HREOC and the Bill appear to equate independence with a fixed term contract, Justice Kirby stated in 1995 that, 'it has been said that without *assured tenure* there will always be a risk that decision makers 'will bend to the will of the powerful or twist to the interests which seem to promise an advantage'. Exactly how long should a fixed term be to assure genuine independence? One year long, continuing until the age of eighty, or something in between? One assumes the lawyers would all argue that the longer the better.

In spite of what Justice Kirby says, it is hard to see why the legal profession should be treated differently from all other people who may neglect their duty to act in the public interest, simply because they fear that to do so will cost them their job or interfere with their career progression. For example, engineers, doctors and many others formerly employed in private or public sector bodies have revealed to the press instances of public safety or environmental protection being ignored, as a result of higher orders designed in the pursuit of political or economic advantage.

The provision of '*assured tenure'* for anyone, including judges, needs to avoid the problem that the privilege might be treated primarily as a personal licence to print money, whilst having a good bludge and a fine wine cellar at the public expense. On the other hand, the best way of protecting all members of the public from oppression, is likely to be to provide all professional groups with a legislated duty to seek and tell the apparent truth about matters of organisational and public importance. Then the media should be able to discuss these things as openly, honestly and with as much information as possible.

In a better system judges should publicly complain if politicians tried to influence them secretly or otherwise inappropriately, and the press should report the debate. The reason for independent decision making is ideally so that the public interest can be followed without interference by powerful sectional interests. The most obvious and democratic way of achieving this is not to promote lawyers and courts, but to champion instead the public right to service transparency and to related public scrutiny and debate across the board. Many lessons about human rights might well be taken from the Australian health and education sectors rather than from lawyers.

8. All dysfunctional legal monopolies posing as independent should be broken

The HREOC submission generally appears to seek to reduce the public accountability of the Commission rather than to increase it. For example, without presenting any evidence for its assertions, it states that 'Australia has been well served by the structure adopted to date of specialist office holders'. (How does it know?) 'As a federal body the wide jurisdiction of the

Commission requires specialist Commissioners and such specialisation complements the generalist officeholders that exist in the state and territory structures.'

It is not clear to me why HREOC implies that specialist functions are better for the Commonwealth whilst generalist ones are better for the States. I have never understood the logic specialist courts or related arenas employ when they make their decisions in the absence of information about how other, previously or differently involved adjudicators or observers have approached a matter. The practice appears to equate ignorance with objectivity. Few doctors, for example, would draw a veil over the findings of other medical examiners, preferring to conduct all their investigations without such information, and calling this practice freedom from bias.

The legally trained, on the other hand, commonly appear to find great value in equating ignorance with objectivity or freedom from bias. They often champion these concepts by building Chinese walls whenever they can, at public expense, to prevent themselves and others from what they apparently perceive to be contamination from outside. However, what may be seen by lawyers as 'objectivity' may be seen by others as a refusal to investigate holistically or to consider all readily available information and perspectives about an issue. HREOC takes the traditional lawyer's position in calling for more specialist Commissioners, and suggests they might respectively focus on rights of children, older Australians, and discrimination based sexual orientation.

Alarmingly, the position of HREOC apparently reflects the position of the UN, as contained in The Handbook on the Establishment and Strengthening of National Institutions for the Promotion and Protection of Human Rights. The Manual apparently says:

> An effective national institution will be one which is capable of acting independently of government, or party politics, ***and of all other entities and situations which may be in a position to affect its work.*** (My emphasis)

According to HREOC, the manual describes four essential characteristics of independence: independence through legal and operational autonomy; independence through financial autonomy; independence through appointment and dismissal procedures, and independence through composition. No mention of how public accountability is to be obtained. Welcome to the new mafia – the same as the old one?

On the other hand, HREOC states:

> 'the reporting to Parliament on unconciliated complaints is an important public function which should be the responsibility of the Commission rather than of an individual member. This would require and amendment to Clause 49 of the Bill substituting 'President' for 'Human Rights Commissioner'.

HREOC's concern about the importance of being independent apparently does not descend to the level of the individual. It appears to prefer that any apparently slow or stupid brethren should be able to hide within the organisational skirt.

9. Break the lawyers' monopoly over charging

HREOC's view in regard to legal costs is that the rationale for their award must be fairness first and foremost. However, HREOC also notes that this principle of fairness 'could and should be displaced if access to the legal system was unfairly prejudiced by a costs regime'. It points out that it is 'sensitive to the immediate perception that a legal costs regime disadvantages

complainants' and deters them from bringing their cases of discrimination to the Court because of the possible award of legal costs against them. On the other hand, it notes that a costs regime may have the effect of encouraging contingency fee arrangements (which it sees as beneficial).

HREOC further points out that Commonwealth discrimination acts all provide that a person other than a solicitor or council is not entitled to demand or receive any fee or award for representing a party to an inquiry. This seems to me to be in contravention of the Commonwealth Policy Reform Act (1995) which calls for equal competition on a level playing field unless another course of action can be shown to be in the public interest. HREOC seems quite happy that the lawyers' monopoly over dispute resolution should not be challenged by anybody willing to charge a lesser amount for a better product. However, it recommends that Federal Court fees 'could be waived or postponed' and that the procedures adopted by the Court be as 'user friendly' as possible. Talk about the Courts having a licence to print money. I presume the taxpayer will foot the bill for court largesse.

HREOC does not support the current bill or its management changes and writes that 'under the current legislative provisions, corporate management powers are invested in the collegiate body of HREOC as a Commission like the board of directors of a company'. I find this a strangely misleading thing to say. A company has shareholders. Does this statement suggest HREOC would like to be privatised and compete on equal terms with other conciliators in the private market or working for government? HREOC notes that Mr John Basten QC, proposed that complainants should have a right of direct access to the Federal Court, although we are not told whether he thought the playing field for all dispute resolution providers and their clients should be levelled before this happens. HREOC thought those in dispute should try conciliation first.

Reference:

(1) Street, Sir Laurence. (2002). ADR: a generic, holistic concept. *The Australian Law Journal.* Volume 76, April 2002: 213-214.