

DISABILITY AND COMMUNITY BASED REHABILITATION

AIM: To discuss some key definitions of disability. To describe disability levels in Australia and to discuss historical and recent efforts made to meet the needs of people with disabilities. To explain the value of the community based rehabilitation approach.

DISABILITY IS A BROAD PROBLEM REQUIRING BROAD SOLUTIONS

In popular speech, the term disability seems primarily a physical concept, related to lack of ability to perform, which invites a related intervention. The term rehabilitation seems to mean returning someone or something to physical normality. This may be too narrow an approach if it brings about repeated professional servicing without any apparent reduction in client suffering.

Terminology is important because it usually establishes the legislative approach taken to a particular problem. This usually also entails a statement of the kind of taxpayer-funded services which are to be made available to meet the sufferer's need. Such definitions also tend to establish the parameters within which management and measurement systems should logically operate.

In Australian society almost 19% of the population now refer to themselves as having a disability of some kind. Addressing this apparently broad and diverse problem and population seems to require equally broad and diverse solutions. One would not, for example, want to see only a very narrow range of treatments or remedies available for use, especially if they appeared to constitute a comparatively expensive yet ineffective use of taxpayers' funds. In this lecture I want you to think about how your professional response to disability and rehabilitation should be managed, so as to promote an appropriately broad yet evidence based approach to service delivery to meet individual need. The lecture provides you with information about policy guidelines to assist this task. An evidence-based approach is one which facilitates the identification of those treatments which are comparatively effective in relation to the achievement of established goals. Duckett (2004) argues that the measurement of quality of care should incorporate at least two distinct elements: technical quality (cure quality) and satisfaction (care quality).

WHO DEFINITIONS OF IMPAIRMENT, DISABILITY AND HANDICAP

It is important to take World Health Organization (WHO) definitions as our starting point because adoption of them, where considered appropriate, should facilitate international comparison of health, disability and treatment efficacy. This process is called international benchmarking. The WHO International Classification of Impairments, Disabilities and Handicaps (ICIDH) makes the following distinctions.

Impairment: Any loss or abnormality of psychological, physiological or anatomical structure or function

Disability: Any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being

Handicap: A disadvantage for a given individual, resulting from an impairment or a disability, that limits or prevents the fulfilment of a role that is normal (depending on age, sex, and social and cultural factors) for that individual (WHO 1980)

The ICIDH definitions have often been considered too medically and individually focused, without accounting adequately for environmental factors which are crucial to determining the

extent of any disability or handicap. Personally, I get application of these definitions of disability and handicap mixed up. Can you clearly distinguish between them? If not, this is a bad sign.

AUSTRALIAN BUREAU OF STATISTICS SURVEYS ON DISABILITY

The Australian Bureau of Statistics undertakes regular surveys on levels of disability in the population. In the 1998 Survey of Disability, Ageing and Carers, a person with a disability was defined as a person who had one or more of the following **disabilities or impairments** which had lasted or were likely to last for six months or more:

- Loss of sight (not corrected by wearing glasses or contact lenses)
- Loss of hearing, with difficulty communicating or use of aids
- Loss of speech
- Chronic or recurring pain that restricts everyday activities
- Shortness of breath or breathing difficulties that restrict everyday activities
- Blackouts, fits or loss of consciousness
- Difficulty in learning or understanding
- Incomplete use of arms or fingers
- Difficulty gripping or holding things
- Incomplete use of feet or legs
- A nervous or emotional condition that restricts everyday activities
- Restriction in physical activities or in doing physical work
- Disfigurement or deformity
- Head injury, stroke or other brain damage with long term effects that restrict everyday activities
- Needing help or supervision because of a mental illness or condition
- Long term treatment or medication (but was still restricted in some way by the condition being treated)
- Any other long-term condition that restricts everyday activities

You should note that in 1998 there no longer seems to be a clear distinction being made by the ABS between a disability and impairment, whereas there was in earlier surveys. In 1998 the ABS defined a person with a handicap as ‘a disabled person aged five years or over who was further identified as being limited to some degree in his/her ability to perform tasks in relation to one or more of the following five areas: **self care, mobility, verbal communication, schooling and/or employment.**’ Severity of core activity restriction was classified into four levels: mild (no difficulty performing a core activity but using aids or equipment); moderate (not needing assistance, but having difficulty); severe (sometimes needing assistance to perform a core activity) and profound (unable to perform a core activity or always needing assistance.)

Such definitions are part of a necessary framework for establishing consistent management and related funding decisions to support individually tailored assistance to help disabled people to lead more normal or satisfying lives. The breadth of potential disabilities and their causes suggests that the services available for their treatment also need to be extremely broadly defined and flexibly delivered. However, management of what should ideally be broad and flexible service provision needs to be undertaken in a way which also allows the establishment and comparison of personal goals, treatments and outcomes. Without this, the taxpayers’ money might reasonably be seen as primarily providing support to the service providers, not their clients.

LEVELS OF DISABILITY IN THE AUSTRALIAN POPULATION

In the 1998 ABS survey almost 19% of the population reported a disability or handicap. This had increased from almost 16% of the population in 1990. The most common types of disability were musculoskeletal conditions. Deafness, mental disorders and respiratory diseases were also major problems. Mobility was the most common area of difficulty, and was reported to be a problem for 77% of the total population of disabled people. (Of the 600,000 people receiving the Commonwealth Disability Pension during 2000 the two most common conditions were musculo-skeletal problems, which comprised around a third of all situations, and psychological/psychiatric problems, which comprised around one fifth.)

The likelihood of reporting disability rises with age. Overall reported rates are the same for both sexes, but both the age distribution and the pattern of severity reported is different for females and males. Males in all age groups apart from the oldest (65+) are more likely to report handicap than females. These differences are particularly marked in the 60-64 age groups. However, females more commonly report a severe problem than males. This is true for all age groups.

The Australian Institute of Health and Welfare suggested that the higher male rates of disability in the 0-14 years of age group might be related to higher incidence among males of congenital impairment and developmental disability. It also suggested the higher rates of handicap for males of most ages may relate to higher industrial and road accident rates. However, the ABS found more chronic and recent illnesses and higher rates of hospitalisation were reported for working age females in other data sources. It suggested that women might report more severe handicap because the survey question equates this to reporting the need for help with any three areas of activity. This infers that women may be more likely to ask for help and to access it than men are, rather than that they are more severely disabled. The Australian Institute of Health and Welfare suggests that different life expectancies are likely to be responsible for the difference between females and males in the oldest age group.

All people in rural areas appear to be at risk of suffering from higher levels of disability, as a result of their isolation from a wide range of preventive work and welfare services. However, Aboriginal people are 70% more likely than the general population to report a disability. They are likely to die up to 20 years earlier than the general population and, especially in remote areas, are much more likely to suffer from problems such as blindness through trachoma, hearing loss due to middle ear infection, diabetes and cardiovascular disease.

In general, the ABS surveys shows that people with a disability are a very diverse population. They range from people with profound intellectual disability, to people with severe and multiple physical disabilities. The group also encompasses people who may have a significant disability but who have, for various reasons, achieved a significant diminution in the resultant handicap.

COMMONWEALTH DISABILITY SERVICES ACT TARGET GROUP

The Commonwealth Disability Services Act specifies the target group for disability services as people with a disability that:

- (a) Is attributable to an intellectual, psychiatric, sensory or physical impairment or a combination of such impairments
- (b) Is permanent or likely to be permanent
- (c) Results in a substantially reduced capacity of the person for communication, learning or mobility; and the need for ongoing support services.

In stressing the chronic nature of disability, the above Act suggests a broader adaptation or normalisation approach to apparent disability is necessary, rather than a medical rehabilitation focus which seeks to bring about physical wellness, against all the odds. However, it often appears difficult to conceptualise and apply the requirements of this latter, broad approach effectively. This may be because this is a comparatively recent aspect of welfare state development in an area which has traditionally been dominated by a medico-legal framework.

Reported disability levels have been rising rapidly in Australia in recent times. This is partly due to the ageing of the population and to advances in technology and health treatments. It is also due to the wider availability of the Disability Support pension since the 1980s. The fact that the Australian Bureau of Statistics has added questions to its periodic surveys about self reported disability levels has also increased the numbers of people who come into this category.

It is possible that the increasingly high performance expectations which people in Western societies are generally taught to have, may mean that many feel increasingly incapacitated by the narrowly defined but apparently overabundant group of role models which may be held up to them for emulation. For example, a commonplace perception of young people with eating disorders is that their problem primarily relates to the distorted desire to live up to some media driven ideal of female beauty. Why is this kind of social explanation, which is so eagerly embraced in relation to anorexia and bulimia, not extended to a much wider range of disorders? For example, could cultural and media obsession with career or sports related success symbols be driving an unknown proportion of the population into a variety of forms of physical and mental disability or despair? Personal observation suggests that this warrants more investigation. Do very high but very narrowly defined social expectations about personal success drive a proportion of the population towards physical and mental breakdown, rather than satisfying achievement?

ADAPTATION, NORMALISATION AND COMMUNITY BASED REHABILITATION

Any community needs to think carefully about the appropriate approach to income support for people with disabilities and for other groups currently on welfare benefits. A major challenge is the large and growing number of people on Disability Support Pension which is now provided by the Commonwealth Department of Social Security through Centrelink offices. In 1999 there were nearly 600,000 people, or about 6% of the working age population on the disability pension. This number has doubled in ten years. Two thirds of the disability pension population is made up of people aged between 45 and 65. Around one fifth of Disability Support pensioners have been on the payment for more than ten years. The majority of recipients remain on the pension for life and only 8% have income from earnings. For some people at least, access to the disability pension is seen as a better alternative to unemployment benefits and the activity test that goes with it. At the same time, most people probably want to feel pain free, useful, interesting, and respected in their community.

The principle of normalisation in regard to disability service provision emerged in the 1960s. In the 1980s Wolfensberger defined it as **‘the use of culturally valued means, in order to enable people to lead culturally valued lives’**. This definition is useful in thinking about how plans for regionally based community development should proceed, with reference to assisting disabled people on the one hand, and in order to promote a diverse, rich and multi-cultural society on the other. The combination of ageing and economic restructuring has forced many older workers from downsized manufacturing industries out of the workforce. Their employment prospects may be few, especially if they have an illness or disability. However, they may have vital trade related and other knowledge, which they could pass on to younger people. There are many other

people with comparatively little Australian formal education, whose knowledge and skills have never been effectively tapped by the dominant society. The real problem is a denial of opportunity appropriate to needs of welfare recipients and their communities, not the payment of a benefit. Many people, especially the young, could benefit from the knowledge, skills and experience of a wide range of community based teachers, if broader and more effective management structures were established to meet identified individual and community needs.

The aims of **normalisation** contrast interestingly with the aims of **rehabilitation**. As outlined by Hagedorn, the latter appear more related to a dominant Western and medical paradigm. This narrower and more demanding approach may ignore the realities of life for large sections of the population, whether they are service clients or those delivering service. For example, Hagedorn describes the aims of rehabilitation as:

- To enable the individual to achieve independence in the areas of work and self care
- To restore the individual's functional ability to the previously attained level, or as close to this as possible
- To maximise and maintain the potential of retrained, undamaged, abilities
- To compensate for residual disability by means of aids, appliances, orthosis or environmental adaptation

The primary assumptions of the normalisation focus are that:

- Therapy should promote personal independence and should restore function to normal or near normal
- Restoration of function can be achieved by graded practice of the damaged ability
- Retraining should be carried out under realistic conditions with a view to the eventual resettlement location, social situation or work of the client
- Where residual disability persists, this may be compensated for by teaching the patient new skills or through the provision of aids, appliances, environmental adaptation or assistance from someone else

Both these approaches appear to be brought together and usefully extended in the concept of **community based rehabilitation (CBR)** which has been advocated by the WHO, ILO and UNESCO. Community based rehabilitation is defined as a strategy within community development for the rehabilitation, equalisation of opportunity, and social integration of all people with disabilities. CBR is implemented through the combined efforts of disabled people themselves, their families and communities, and the appropriate health, education, vocational and social services.

Twible (1995) states that CBR has a problem solving focus and seeks to develop empowerment and control by the community and the individual. Intervention takes place in the client's normal community, using local resources, and focuses on solving the daily living problems of the client and community. CBR pays attention to client and community assets and believes all people are able to contribute to community improvement. It values individual differences and contributions and also educates the client, family and community about disabilities. A regionally based approach to this will be discussed later.

THE EARLY HISTORY OF DISABILITY SUPPORT SERVICES IN AUSTRALIA

In the current environment, the services for people with disabilities should potentially embrace all the welfare and related services available to the whole Australian population, as well as specialised support services. A brief history of disability services provides an indication of what services have traditionally been called for in regard to disability support. The situations of the elderly and of those injured at work are discussed in other lectures.

Specific disability service provision began with Federation and the Commonwealth government introduced invalid and aged pensions in 1908. These were the first non-contributory pensions in the world. Private disability insurance arrangements also emerged. By 1910 there were approximately 4150 Friendly Societies, providing insurance schemes for disability and sickness for about one third of the population. The slow workers permit, introduced in 1904 with the passage of the Conciliation and Arbitration Act, enabled exceptions to be made to award wages in the case of 'aged, slow, or infirm workers', and with the agreement of State departments of labour.

World War I created a need to repatriate large numbers of returned soldiers. The Repatriation Commission emerged in 1919 as a Commonwealth funded organization providing funds and other forms of support to veterans. Through the Commission, ex-servicemen with disabilities were included in vocational training schemes which operated in conjunction with treatment in army hospitals. Self help organizations for the blind and deaf were established in the 1920s. In the 1930s the Crippled Children's Association was formed. In 1941 the organization later to be called the Commonwealth Rehabilitation Service was established to facilitate vocational rehabilitation for people with an acquired disability. This occurred primarily as a response to the rehabilitation needs of newly returned soldiers and invalid pensioners. A system of unemployment and sickness benefits was enacted in 1944. These were payable to any person between sixteen and sixty-five who was temporarily incapacitated for work because of sickness or accident.

In order to meet the increasing pressure from community based self-help and voluntary organizations, the Commonwealth passed the Disabled Person's Accommodation Act in 1963. It gave financial assistance towards the capital costs of accommodation provided by eligible organizations for people with disabilities who were employed or who were seeking employment in a sheltered workshop. This was replaced by the Sheltered Employment (Assistance) Act in 1967, where the Commonwealth provided grants to charitable, religious, and other non-profit organizations, to assist in the establishment of both sheltered employment and accommodation. In 1970 the Act was amended to provide a salary subsidy to enable agencies to provide accommodation for clients in open employment. This assistance saw a rapid growth in work-based disability services and in the facilities associated with them.

The Handicapped Children's (Assistance) Act was introduced in 1970 to allow subsidies to be provided to eligible organizations to offset the costs of facilities that provided training and accommodation for children with a disability. In 1974 the Handicapped Persons Assistance Act provided an increase and extension to subsidies for approved training, therapy and rehabilitation centres. It also provided for building, equipment and rental subsidies. At the same time, the Commonwealth introduced the Handicapped Child's Allowance for a parent or guardian caring for a child likely to need constant care and attention for an extended period. The expansion of sheltered employment, related accommodation and other services funded under the Handicapped Persons Assistance Act continued until 1984.

In the late 1950s a national advocacy body for people with intellectual disabilities was started by groups of parents. It later became the National Council for Intellectual Disability, whose membership includes consumers, family members, service providers and other individuals. In 1961 the Australian Council for the Rehabilitation of the Disabled was established and became the major national peak body for disability service providers. In the 1960s and 1970s State governments moved into the area of special education, taking over the administration of a number of schools set up by charitable groups. Until then, State government had left the responsibility for managing disability concerns largely to charitable organizations such as the Institute for the Deaf and Blind, the Society for Crippled Children and the Subnormal Children's Welfare Association (now Challenge Foundation.)

THE EMERGENCE OF REQUIREMENTS FOR NORMALISATION

In 1971 Australia became a signatory to the UN Declaration on the Rights of Mentally Disabled Persons and in 1975 to the UN Declaration of the rights of Disabled Persons. These Declarations emphasised that people with disabilities should have:

Access to opportunities that are available to all citizens. They should also share the inherent **right to human dignity, and to enjoy a decent life, which is as full and normal as possible.** Measures should be designed to enable disabled people to **become as self-reliant as possible,** and services should enable them to **develop their capacities and skills to the maximum** and hasten the process of their **social integration and re-integration.** In addition, people with disabilities have the right, according to their capabilities, to **secure and retain employment or to engage in a useful, productive and remunerative occupation.** They also have the right to **protection** against all exploitation, all regulations and all treatment of a discriminatory, abusive or degrading nature.

(In the contemporary environment such statements may provide a useful framework for the community-based implementation of the Commonwealth government's 'mutual obligation' policy. This is addressed later, and is based on the premise that responsibility between the community and the individual flows both ways.)

The decade of the 1980s began with the International Year of Disabled Persons. During this time there were significant changes in the field of disability services, and a new emphasis was placed on community based rather than institutional care. In 1983 in NSW the Richmond Report recommended that priority be given to community-based care for people with an intellectual or psychiatric disability, with a distinction to be made between the two. In 1985 the Commonwealth established the Home and Community Care Program (HACC) as a joint State/Commonwealth funded program which provides home-based assistance to frail older people and to people with disabilities. Assistance through HACC is provided to help people live independently in their own homes and may include home help, personal care, delivered meals, visiting health services and in-home and centre-based respite care. Early childhood intervention programs provided in the community also experienced growth in funds during this period.

In 1986 the Commonwealth Disability Services Act brought together a range of Commonwealth disability programs which promoted community based care and downscaling of large institutions. Definition of services according to a set of principles and objectives were established which stressed the need for consumer driven services and an increase in the range of services available. The HACC budget was doubled and Aged Care Assessment Teams were also introduced.

The Disability Reform Package of 1991 sought to integrate people with disabilities into the labour market more effectively. The Commonwealth and all State and Territory Governments signed the Commonwealth/State Disability Agreement. It gave the Commonwealth responsibility for employment services in recognition of its national responsibility for employment and income security, while State and Territory governments assumed primary responsibility for other support. The Disability Support Pension replaced a range of earlier benefits. Recipients of this could be offered vocational training, rehabilitation and employment placement services by panels whose members came from the relevant Commonwealth government departments.

In 1992 the Commonwealth Disability Discrimination Act was passed. This makes it unlawful to discriminate in service provision against people with disabilities, their relatives or associates. Under the NSW Disability Services Act of 1993 all government bodies were required to prepare plans to make their services better able to meet the needs of people with disabilities. Independent mechanisms for complaints, monitoring and appeals related to all services were to be provided or funded by the Department of Community Services. The introduction of a supported wages system was announced in the 1993/94 federal budget. Under this system, people who are 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 can receive help with the cost of workplace modification and a start-up payment.

THE CONTEMPORARY PHILOSOPHY ON DISABILITY SERVICES

By the 1990s the government philosophy on the provision of disability related services encompassed the requirements for:

- Consumer focus and consultation
- Equal rights for disabled people
- Services provided by generic organizations used by all Australians
- Services individualised to allow people to maximise their potential for integration in every day life
- Involvement by people with disabilities in policy making and implementation

Commonwealth Disability Service Standards are available to provide guidance about:

- Service access
- Individual needs
- Decision making and choice
- Privacy, dignity and confidentiality
- Participation and integration
- Valued status
- Complaints and disputes
- Service management
- Employment conditions
- Employment support
- Employment skills development

Service performance may be judged against these standards.

THE INTRODUCTION OF MUTUAL OBLIGATION REQUIREMENTS

In 1999 the Minister for Family and Community Services introduced the government's concept of mutual obligation and spoke of the related necessity to create greater opportunities for people to increase self-reliance and capacity building, rather than merely providing a passive safety net. She pointed out that the number of people on Disability Support Pension had doubled in ten years to reach 6% of the working age population. She noted that this was unsustainable and that it was necessary to redirect the focus from incapacity and inability to capacity and ability.

To be eligible for the Disability Support Pension a person must:

- Be permanently blind or have a permanent impairment of at least 20 points under the impairment table
- Be unable to work, or be re-skilled for work, for the next two years; or
- Be participating in the Supported Wage Scheme

The impairment tables assign impairment ratings in proportion to the severity of the impact of a condition on normal function as it relates to work performance. An impairment rating of 20 points is considered to be the level at which a person's impairment has a significant effect on their ability to work. To be considered unable to work for the next two years, a person's impairment alone must prevent them from working for at least 30 hours per week at award wages in any work that is available in Australia that they are capable of performing without the need for retraining. The work ability tables are used as a guideline to this.

In 1999 people on the DSP comprised 21% of over 2.6 million people, excluding age pensioners, who received government support in 1998. Of this total group of welfare recipients:

- 31% were unemployed
- 15% were students
- 14% were lone parents
- 9% were partnered parents
- 7% were partners of age and disability support or other pensioners
- 3% were widows, carers, veterans or on Special Benefit or Disaster Relief Payment

Regional employers now have economic support to take on Centrelink recipients, including people with disabilities. This includes a wage subsidy scheme which provided financial assistance for up to 13 weeks, and a workplace modification scheme which provides up to \$5000 per person to modify a workplace or to provide special or adaptive equipment. There is also a supported wage system available which provides a pro-rata wage for people who cannot get work on full wages due to the effect of their disability on their productivity. Funds are also used to make assessments and provide on the job support. Special employment placement officers are also employed to assist industry to increase the employment of people with disabilities. However, in the absence of a regionally based approach to planning, many individual employers may not be in a position to think more broadly than their normal business concerns, or to see how they might benefit from and contribute to their community by participation in this scheme. Health and welfare workers need to consult broadly and work creatively to assist the development of effective education, work and recreation placement systems to improve the situation of people with disabilities of any kind.

THE NSW GOVERNMENT DISABILITY FRAMEWORK AND SUSTAINABLE DEVELOPMENT

The current NSW Government Disability Policy Framework calls for a planned, coordinated and flexible approach to policy and service provision in NSW for people with disabilities and their carers. It requires the creation and promotion of related opportunities, services and facilities. It also calls for the provision of ways for service providers to measure and report on their progress in increasing access to normal life for people with disabilities.

The NSW framework states that in all situations it will be necessary to incorporate initiatives to address specific needs related to gender, culture, language, religion, sexuality, geographic location and socio-economic circumstances in the planning process. Appropriate accommodation and transport, as well as work and education related support, are key aspects of the proposed development. To effectively implement these requirements and also those of mutual obligation, a much more effectively coordinated process of regional and community based planning, development and funding is needed than currently exists.

The vision for public health in NSW is that each area health service, in partnership with its community, other government and non government organizations, local council and general practitioners will develop a three year plan for public health that identifies regional public health issues and prioritises responses to those issues. A similarly coordinated and regionally based approach should also be taken to Australia's national strategy for ecologically sustainable development (ESD) which was first established in 1992. This would also assist the tasks of implementing regional sustainable development and the NSW disability framework.

The objectives of ESD are clearly compatible with a coordinated approach to health and employment management in regional contexts, and should be supported by a pooled regional funding model. The goal of ESD is development that improves the total quality of life, both now and in the future, in a way that maintains the ecological processes on which life depends. The core objectives are:

- To enhance individual and community well-being and welfare by following a path of economic development that safeguards the welfare of future generations
- To provide for equity within and between generations
- To protect biological diversity and maintain essential ecological processes and support systems

The strategy addresses agriculture, fisheries and ecosystem management, forest resource use and management, manufacturing, mining, urban and transport planning and tourism. It also addresses a range of intersectoral issues such as biological diversity and nature conservation systems, including native vegetation. Designing and coordinating appropriate systems which meet the needs of communities and people with disabilities, in order to improve the lives of all, is now the major challenge.

CONCLUSION

In a 1998 ABS survey almost 19% of the population reported a disability or handicap. This had increased from 16% of the population in 1990. The most common types of disability are musculoskeletal conditions. Mobility is the most common area of difficulty, and is reported to be a problem for around 77% of the total population of disabled people. Disability income support and services grew slowly throughout the century. The principle of normalisation first emerged in

the 1960s. It can be defined as ‘the use of culturally valued means, in order to enable people to lead culturally valued lives’. This can also be seen as a precursor to the current international support for community based rehabilitation, which is defined as a strategy within community development for the rehabilitation, equalisation of opportunity, and social integration of all people with disabilities. During the 1980s the Commonwealth Disability Services Act promoted the downscaling of large institutions and put a renewed emphasis on funding home and community care and related services. Carer’s pensions were also introduced. In 1999 the Minister for Family and Community Services introduced the government’s concept of mutual obligation and spoke of the related necessity for the community to create greater opportunities for people to increase self-reliance and capacity building, rather than merely providing a passive safety net. This requires a coordinated, regionally based approach to the management and funding of community health and ecologically sustainable development related services which is also tailored to meet the needs of people with disabilities.

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