I began to write this paper in the hills North of Canton in China. It seemed appropriate to reflect on some of the differences and similarities between Chinese health services and ours. The outstanding similarity is that they set a high value on health. An outstanding difference lies in the reason they attach so much importance to the health of individuals and of the community.

They are committed to a philosophy of productivity. The work of peasants and of industrial workers is of the utmost value to individual families, to their collective groups and to the nation as a whole. It is felt essential, therefore, to keep people as healthy as possible, to restore them to health quickly after illness, and to ensure that functional capacity is returned no matter how impossible the task may seem in any particular set of circumstances. Patriotic movements stress that "preventing and fighting diseases is a major issue concerning the whole people and the entire nation".

In the application of this philosophy, a network of medical services is being established to ensure that prevention of disease and disability is given first priority, illness is detected and treated early, hospital care is accessible to all, and restoration of function is highlighted during all phases of treatment. Of directly relevant interest is the method of treating fractures that has been developed at the Nankai Hospital in Tientsin. Shortly after reduction and immobilisation of limb fractures, and without immobilisation in the case of compression fractures of the thoracic and lumbar vertebrae, an impressive range of graduated exercises is started. Within weeks they are strenuous enough to be associated with demonstrations of astonishing muscle strength and function. The work is done in the ward by normal ward staff. There is no rehabilitation department in terms of our understanding of the concept. Yet patients are back at work appreciably faster than ours are, and in a system which provides guaranteed income maintenance while they are away from work.

I asked myself whether a special medical rehabilitation service is necessary, and I came to the conclusion that it should not be. But in Australia it is necessary. Why the contradiction?

Perhaps our problems have arisen because of too great an emphasis in medical practice on the scientific diagnosis and treatment of disease, with the consequent relative exclusion of much of the material that is relevant to the restoration of function. The best rehabilitation is that which starts early. Every general practitioner and every specialist should have the real objective of his work in the forefront of his thinking and practice. Medicine is a social function. Its target is to keep individuals adjusted to their environment as useful members of society, or re-adjust them when they have dropped out as a result of illness. To regard it otherwise is to reduce it to a technology that is practised by those who are assigned limited diagnostic and therapeutic functions. The real work of helping individuals and their families with their problems rather than their diseases must then be undertaken by personnel of a different nature.

We are already close to that situation in the most highly developed nations. Because of the failure of our usual medical services to tackle problems rather than diseases, we have seen the emergence of community mental health services, of special programmes for the intellectually handicapped, the drug dependents and alcoholics, and special geriatric and physical rehabilitation departments and services. There are, of course, certain groups of disabled people who have found that

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1 Delivered at the XIV Biennial Congress of the Australian Physiotherapy Association, Sydney, August, 1975.
common problems can best be resolved when staff and patients are mutually engaged in devising solutions.

In a situation where the so-called mainstream of medicine has bypassed so many of the problems of all these people, the emergence of medical rehabilitation as a specialty is inevitable and should be encouraged. The measure of its success, however, will be the extent to which it can work itself out of existence. It will constitute the wedge that opens up a new awareness in all health workers that they should assign the prevention and management of disability a very high priority. When all practitioners have accepted the philosophies of rehabilitation and mastered the techniques as eagerly as they have mastered those of diagnostic and surgical procedures, then only a few units of excellence may remain as training and research centres in medical rehabilitation.

Where might we begin? The selection and education of medical students, and of others entering health careers, have been in the spotlight frequently in recent years. The spotlight might well be intensified. It is not enough that it should be focussed only by our academic colleagues. The needs of society must be satisfied by those whom society chooses to educate to serve those needs. Selection and training that are exclusively motivated by academic excellence are rapidly becoming an anachronism, unwittingly bequeathed by Flexner when he rescued medical education in the early years of this century.

I would like to quote from Eric Saint’s address at the Twelfth World Congress of Rehabilitation International:

“Rehabilitation is regarded as a separate, discreet enterprise. But all our experience is indicating that it is an integral part of a broader, comprehensive activity. Every psychiatrist must be, in part, a rehabilitator; every orthopaedician must have his eye on the total, long term well being of his smashed up patient; every teacher in primary school must be trained to detect special learning difficulties in his pupils. It is a defect, in general, in tertiary professional education — which must be remedied — that awareness of and sensitivity to the need for personal and social rehabilitation is not encouraged.”

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the specific field of medical rehabilitation. Three important principles emerge from Government statements of policy. They are that:

1. the Commission's task is to promote both community health services and hospital services.
2. the services are to be planned on a regional basis.
3. there is to be co-operation with the States, and criteria for development are to be identified in conjunction with the States.

Sections 5 and 6 of the Hospitals and Health Services Commission Act detail the functions and powers of the Commission.

Briefly, the functions are:

1. to recommend on the provision of health services by the Department of Health;
2. to ascertain health care needs and to make recommendations concerning:
   (a) health care delivery systems
   (b) funds to be allocated for these systems
   (c) the education of health personnel
   (d) the accreditation of services
   (e) financial assistance to be made available to States, Territories, regions, local governments, charitable organisations and other persons;
3. with the Minister's approval, to make grants;
4. to investigate representation on organisation involved in health care; and
5. to promote and participate in planning in relation to health services.

The Commission set out as quickly as possible to devise a single programme that would facilitate a variety of solutions, each tailored to local needs, for many of the problems common to most communities. This was the genesis of the report entitled: "A Community Health Program for Australia", submitted to the Minister on 28th May, 1973. The assistance that can be given under this programme has already enabled Governments and local committees all over the country to tackle those aspects of the organisation and delivery of community health care on which a broad consensus had been reached in recent years.

The plan permits flexibility so that local administrators can vary expenditures on components of any approved scheme to suit changing circumstances, and it is hoped that it will substantially replace the present fragmented system of tightly specified and controlled grants for separate categories of services. It is based on a foundation of primary health care which the Commission regards as the key element in a system of comprehensive health services.

Grants have been made for community health centres, some with general practitioners practising on the premises, others with only consultant and support staff at the centres who work in a close relationship with neighbouring general practitioners. Other grants assist various community nursing arrangements, regional geriatric and rehabilitation services, day hospitals, and community mental health and mental retardation programmes, alcoholism and drug addiction services, handicap assessment centres, and training programmes for community and occupational nurses and rehabilitation aides. Special help has been given in what has come to be known as the Family Medicine Programme to help qualified medical graduates train themselves to deal effectively with the problems they meet in general practice. Emphasis is placed on the diagnosis and management of physical, mental and social handicaps.

A programme of Health Services Planning and Research makes available: up to $500,000 per annum on a $2 for $1 basis to States to develop and expand State health planning agencies; up to $300,000 per annum to universities and colleges for independent research and evaluation of health care systems; and up to $200,000 per annum for studies requested by the Commission. Studies of the needs of the handicapped, and of the effectiveness of rehabilitation services, are eligible for funding.

There will remain gaps in the availability of adequate data collection techniques. We have commissioned a study to elucidate the problem. There are not enough people who know how to measure and evaluate health

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care delivery, but we are completing a report on the School of Public Health and Tropical Medicine in Sydney which will recommend on expansion of research and teaching in this area.

Concurrently with the development of the programmes already described, the Commission has studied the existing situation of hospitals in Australia, and has prepared a report which is now being translated into action. The present system of financing Australia’s hospitals is highly complex and cumbersome, but we are directly involved only in the capital funding component.

We have proposed that the Australian Government should provide $760 million during the current quinquennium, leaving the States to continue capital funding at approximately the same level as the average for the past five years. Hospital-based medical rehabilitation units will be eligible for capital funding under this programme. Hospital-based rehabilitation services which are delivered outside the hospital into the community are eligible for support to the extent of 90% of running costs under the Community Health Programme.

It is my view that the best interests of the disabled will be served when there are medical rehabilitation units which are seen and felt to be within the mainstream of the medical endeavour. My Commission’s view is that it would be wrong to create a separate medical rehabilitation service in which staff are segregated in a system outside the administrative arrangements for other hospital and community health services. Such a development could perpetuate the relative neglect of rehabilitation oriented management during early phases of illness and injury, and may well delay the absorption of rehabilitation philosophies into the practice of all personnel in hospitals and community health services.

These broad statements of principle are contained in the Commission’s 1973 report on a “Medical Rehabilitation Programme for Australia”. All States have been asked to submit proposals for medical rehabilitation units in line with these principles, and a meeting will be held to discuss these matters with State officers. It is anticipated that as a result of these initiatives, an expansion of services and training programmes will start immediately, so that personnel can be trained in adequate numbers to take the next steps that will be necessary.

A problem that confronts our society, and others at similar levels of development, is the difficulty of effecting links between all the stages of service that are required by individuals, and of co-ordinating the planning and organisation of these services. At local level, there are many who hope that regional health and welfare agencies will evolve with sufficient delegated authority to plan and organise facilities and services according to local needs, and to receive block grants for the provision of such services in accordance with agreed guide-lines. This rational arrangement has been delayed by a long series of ad hoc responses to specific pressures which have resulted in a kaleidoscope of policies, principles and programmes administered by a plethora of departments and authorities. The report of the National Committee of Inquiry on “Compensation and Rehabilitation in Australia” recommended a brave solution. I believe that solution will inevitably be the one to be adopted. We are fortunate to have a person so skilled and interested as His Honour, Mr. Justice Meares, who has the task of co-ordinating the various approaches at Federal level.