

PART 7 – SAFETY AND REHABILITATION

XXIII – THE PREVENTION OF ACCIDENTS

317. Every day 50 people are killed or injured on the roads. The number of deaths and drownings in domestic accidents of all kinds now approaches 700 each year. The annual total of casualties in industry is well over 100,000. Such figures speak graphically for themselves.

318. All this occupies the attention of many different groups in the community and considerable sums of money are allocated for the prevention of accidents. The goal, however, is as elusive and the problem as complex as the reasons which create accidents. Accordingly we regard it as a matter of prime importance that the proposed compensation system should be organised to take an active and co-ordinating part in the promotion of safety in all the different areas where accidents can occur.

319. The proposed system certainly would be in a unique position to assist the present efforts being made. It would have prompt access to the reports of every accident and it could ensure that these reports were detailed and accurate. It would have a direct interest in controlling the cost of accidents. It would be able to operate with detachment. Moreover, given trained personnel and imaginative direction it could build up a statistical picture unlikely to exist in the same detail in any other country. The information so obtained would be one of the important advantages of an integrated approach to the whole problem of personal injury and an invaluable aid to those attempting to cut down the endless lists of casualties.

THE STATISTICS

320. At present the statistical pattern is incomplete and even misleading. For example, little has been done to overcome the difficulties associated with collating and interpreting information relating to all the various domestic accidents. In the field of industrial accidents there is much more detail but their causes are often obscured by the sort of information which is currently supplied concerning them. In addition the information itself is frequently unreliable. The prospect of a court case does nothing to encourage admission of fault by the potential litigants.

321. Moreover, the recorded numbers of industrial accidents are inaccurate. The official statistics suggest that in 1965 there were 56,418 persons injured at work: and a further 35,111 who were injured but lost no more time off work than a day. But because of a consistent failure to report all accidents to the Government Statistician it is thought that the figures should be increased by about 25 percent. Effective safety programmes are not assisted by information which contains this degree of inaccuracy.

A SAFETY DEPARTMENT

322. We recommend, therefore, that the proposed authority should set up a department designed to promote all aspects of accident prevention. It should be placed under the immediate control of an experienced and energetic officer who should be left to devote his whole time to the work of the department. He should be directed to maintain an effective liaison with other organisations and the Government departments working to prevent accidents. And he should develop the statistical records in every useful direction.

323. We recommend that an annual sum of \$400,000 should be set aside by the Board for the purposes of the safety department itself and more generally for the prevention of accidents of all types. The amount should be regarded as additional to and not in substitution for any present grants for similar purposes—whether provided by the Government or from other sources except the grant by the Workers' Compensation Board mentioned in the next paragraph.

THE NATIONAL SAFETY ASSOCIATION

324. At present the Workers' Compensation Board provides substantial annual grants to support the work of the National Safety Association of New Zealand Incorporated. This Association was set up in 1954 to promote industrial safety and has an active membership of more than 1,800 firms and individuals representing all sections of industry and the trade union movement. It has a trained staff of 26 officers and operates throughout New Zealand.

325. The valuable work the Association performs must not be allowed to wither and die. We recommend, therefore, that annual grants be made to the Association by the new Board to replace those at present being made by the Workers' Compensation Board. These grants probably should be continued indefinitely, but we think the matter should be arranged between the Association and the Board after the lapse of a period long enough to enable the correct decisions to be taken.

INSPECTION AND ENFORCEMENT

326. There is a great volume of legislation aimed at protecting the health and safety of industrial workers. It is largely within the responsibility of the Department of Labour which employs an efficient and active group of inspectors and safety officers for the purpose of safety education and enforcement. In the year ended March 1967 they visited over 12,000 factories, recorded 21,000 breaches, and issued more than 14,000 requisitions.

327. We note, however, that no more than 67 prosecutions affecting safety, were taken against employers. Without question the objective of safety should never be pursued by a stereotyped policy of enforcement through the courts. But the other extreme could be equally undesirable. There certainly should be no reluctance to use the penal sections of the various Acts and regulations when (in more serious cases at least) advice and persuasion has clearly failed.

MERIT RATING

328. In paragraphs 90 and 91 we have referred to arguments that the threat of damages provides a financial incentive to exercise care and so avoid accidents. For reasons there given we regard the point as one of negligible significance. However, similar theories are advanced concerning the insurance premiums which at present must be paid by employers and by motorists. It is said that the premiums should be made to fit the accident record and so act as a spur to safety.

329. The principle is not new. It has been applied in a variety of ways in different countries. For example, under section 95 of the Workers' Compensation Act it is possible for additional charges to be imposed where the accident experience of a given employer is greater than is usual in other businesses of the same class. In North America forms of merit rating have been tried from time to time: rebates are provided where the record is a good one.

330. However, we think the arguments are decisive against attempts of this sort to rate for risk. They are quite numerous and can be found in much of the literature and in many of the reports of committees set up to consider questions relating to compensation for work accidents. We summarise the more important issues in the following paragraphs.

331. First, the process of merit or experience rating assumes that employers are able to control the incidence of accidents. Unfortunately large numbers of accidents occur by chance or because of some lapse on the part of an employee or in circumstances over which the employer has no control. A man working alone on the side of a building might know he should wear a safety belt but fails to do so although the belt is with him and his instructions are clear. An employer cannot watch over each member of his staff all through the working day. And yet such a lapse by the man could become a mishap serious enough to ruin the accident record of the employer for a year.

332. This leads to the second point. Despite the complicated administrative arrangements which such a system of rating requires, the process largely ignores the important element of the degree of culpability involved in any given accident. For this reason the principle of merit rating does not operate with equity.

333. Third, the financial incentive is insignificant for any substantial organisation and relatively unimportant for small ones. It is the cost of lost production which really counts as we mention in paragraph 90.

334. Fourth, the incentive is lacking for all the organisations which employ labour but which do not operate for profit.

335. Fifth, the basis for experience rating cuts across the important principle that there should be a general pooling of all the risks of accidents to workers. Just as the steam power station relies upon the work of the coal miner so do all industries depend directly upon one another. In the United Kingdom this principle was accepted 20 years ago.¹³¹

336. Finally, there is the effectiveness of merit rating as a method of cutting down the numbers of industrial accidents. We have found no evidence here or overseas which shows that the process has any significant effect in the interests of safety. Indeed the experience in North America suggests that it can even have a contrary effect. There has been a tendency to withhold reports of accidents or to contest claims in order to produce a low accident ratio.¹³²

¹³¹ See report of the Minister of Reconstruction, Cmd. 6551 (1944), para. 31 (ii).

¹³² Somers and Somers, *op. cit.*, pp. 180 and 229; and Report on the Workmen's Compensation Act of Ontario (1950), pp. 97-100.

337. We believe that the objective of industrial safety really lies in active co-operation between management and employee and in a wider sense between the trade unions and the employers. In this regard we were much impressed by the effective measures which have been promoted in Sweden by the Joint Industrial Safety Council. This Council of six members (three representing employers and three the unions) was set up in 1942 by the Swedish Employers' Confederation and the Confederation of Swedish Trade Unions. Both organisations have worked upon the principle that—

“ . . . not even the most elaborate safety legislation can give the desired results unless it is supported by active collaboration between employers and employees. Organised, voluntary co-operation between the firm and its employees, supported and promoted by the central organisations, fosters a sense of responsibility and interest in safety. Undertakings freely given by employees and employers have much greater moral force than legal impositions.”¹³³

338. At present the investigation of industrial accidents in New Zealand involves questions concerning the so-called *liability* of the employer; or issues as to the neglect of the injured workman. Quite properly the trade unions interest themselves in these matters on behalf of their members. They make inquiries as to the circumstances of the accident, assist in finding relevant evidence and often take steps to obtain legal assistance for the man involved. Both the common law action and the compensation system are based upon the idea of private contest and because of it the process of inquiry and assistance for the trade union member “tends to confirm the trade union in the role of adversary of the employer”.

339. We have no doubt that great advantages can flow from the sort of co-operation which has been developed in Sweden over the past 30 years between the trade unions and the employers. The two groups in Sweden have certainly promoted their mutual interests by their progressive methods as is widely known. Quite distinctly this area of accident prevention is one where the trade unions and employers in New Zealand have an important common interest. It is an area where any form of tension or dispute between them can and should be removed. The fact provides an additional and potent reason for doing away with the controversy which surrounds present methods of dealing with the losses which follow upon industrial

¹³³SAF-LO, Promoting Mutual Interests on Sweden's Labour Market, Stockholm, 1961, p. 9.

injury: and the replacement of these out-moded methods by such a non-contentious system of compensation as that proposed in this Report.

SAFETY ON THE ROADS

340. The effort being made to promote safety on the highways is well known and need not be described here. It is the prime responsibility of the Transport Department and the local authorities. In all this they are actively supported by the valuable assistance of such organisations as the automobile associations and the New Zealand Road Safety Council.

341. The effort has been developed in two general directions. First, a constant campaign is waged to prevent traffic accidents happening at all—obviously this is the ideal to be pursued and the area which demands the major expenditure of time and money. Second, attempts are made to find ways of guarding those in vehicles which might become involved in accidents. This second approach to the whole problem has received increasing attention during recent years and it is one which seems likely to produce most valuable results. It is one which should be widely encouraged.

342. We are informed that there is a mounting volume of reliable evidence concerning the essential need for safety belts in motor vehicles. The concept itself is one which for many years has been accepted and enforced in industry. Regulations require safety belts to be worn by workers in quarries, for example, when working only 6 ft above the quarry floor. The reason for the precaution is so obvious that no worker demands explanations as to whether a fall from such a height could involve him in injury.

343. When attention is transferred to the need for safety belts in moving motor vehicles the example from the quarry gains emphasis from the fact that there the obligation to wear the belts begins at the relatively short distance of 6 ft above the ground. Yet a falling man does not attain a speed of even 30 miles an hour until he has fallen about 30 ft. Put in a different way, an adult passenger in a vehicle brought to an abrupt stop from 30 miles an hour must withstand the exertion of a force upon his body of about a ton. Despite all this it seems that only 34 percent of vehicles are fitted with safety belts and usually only one in every six of the belts so fitted is actually worn.¹³⁴

¹³⁴ See results of Survey by Transport Department (Mar 1967), Appendix 12.

344. The evidence seems conclusive that the regular use of safety belts would reduce greatly the number of fatalities and serious injuries. The most recent estimate before us is that the number of deaths would be reduced by 60 percent and the number of injuries by 40 percent if all cars were fitted with belts and the belts were then worn.¹³⁵ If investigations of the Transport Department confirm the importance of safety belts then we think that the approach to the similar problem already applied and accepted in industry should be adopted for the road.

345. We do not doubt that questions would be raised as to whether such a requirement could be enforced. But most citizens require no more than a clear and unambiguous lead in most matters and given that clear lead they will then act upon it without the application of penal sanctions.

346. Nor need the cost of installing these belts be decisive against their general use. Already they must be fitted in new vehicles: other vehicles could and should be fitted with them over a period of perhaps three years. If our proposal is accepted that all victims of road accidents should be compensated for their injuries then there can be nothing unreasonable in requiring all road users to take sensible precautions for their own safety. Against the grim background of the accident statistics they could do no less.

OTHER ACCIDENTS

347. During 1966 34 persons died in tractor accidents on the farms of New Zealand and in the last eight years there have been 198 such fatalities. They are about half the total of all farm fatalities. Yet it is believed that—

“Of 198 tractor deaths in the last eight years, 127 would most probably have been prevented if safety frames had been fitted. For another 53 cases there would have been a good chance of survival.”¹³⁶

348. In Sweden it has been shown that 42 overturning tractors without safety frames resulted in 33 deaths, whereas in 27 similar accidents where frames were fitted every driver survived. These are impressive figures and they are part of a pattern which resulted in a mandatory requirement that safety frames should be fitted to all tractors in that country. There is a similar requirement in Norway.

¹³⁵ Dr Randal Elliott, 14 *New Zealand Road Safety* (1967), p. 27.

¹³⁶ Annual Report, National Safety Association of New Zealand (November 1967), p. 14.

349. Recently action of the same sort has been taken in the United Kingdom. Except in the case of some specialised industries all tractors purchased after 1 September 1970 must be fitted with safety frames and by 1977 all tractors (with a few limited exceptions) must be so fitted.

350. There is a very strong case for similar action in New Zealand where no more than 2 percent of tractors are fitted with safety frames.

351. In other areas no doubt there are neglected but important safety measures which have been recommended from time to time after careful investigation by the Government Departments concerned or by other organisations.

352. It is our view that as a corollary to the comprehensive scheme of compensation which we recommend, action should be taken to require the adoption of such precautions whenever it has been demonstrated that the need is great and the precaution itself is a valuable one. The introduction of a general scheme of compensation offers an unusual opportunity for a new approach to the whole problem of accident prevention and we recommend concurrent action accordingly.

CONCLUSION

353. In summary our recommendations are—

- (1) There should be a department set up within the new authority charged with the promotion of safety wherever accidents are likely to occur.
- (2) An annual sum of \$400,000 should be set aside for the promotion of safety.
- (3) The best statistical use should be made of the unique records which will become so readily available to the new compensation authority.
- (4) Annual grants should at present continue to be made to the National Safety Association of New Zealand (Inc.) to replace those being made by the Workers' Compensation Board.
- (5) There should be no reluctance to use penal sections of the various Acts and regulations affecting industrial safety when (in more serious cases at least) threats and persuasion have clearly failed.

- (6) The system of merit rating or experience rating is ineffective as a means of promoting safety.
- (7) The elimination of personal liability should be used to encourage increased co-operation between the trade unions and the employers in matters affecting safety in industry.
- (8) The introduction of a comprehensive system of compensation should be regarded as an unusual opportunity for requiring the general use of safeguards likely to minimise injury or avoid death such as safety belts for motor vehicles and safety frames for tractors.

XXIV—THE PROCESS OF REHABILITATION

THE OBJECTIVE

354. A widely used definition of rehabilitation in the United States is "the restoration of the handicapped to the fullest physical, mental, social, vocational, and economic usefulness of which they are capable". It is a total process which begins with the earliest treatment of the injury or disease. It does not end until everything has been done to achieve maximum social and economic independence. The aim is that this should be achieved in a minimum of time.

355. As a concept it is comparatively new because it recognises that success will depend upon an overall assessment which often may not be possible by medical evaluation alone. Over the past 20 years it has made great advances. Men who once would have been regarded as totally incapacitated have been helped and encouraged towards some constructive activity and in the course of it provided with renewed self-respect and confidence.

356. In a recent report to the Minister of Health and Social Security the National Civilian Rehabilitation Committee has referred to three patients who attended the Pukeroa Home for the Physically Disabled.¹³⁷ On arrival they were considered to be virtually beyond assistance. Nevertheless, after a period in that institution it was possible for them to move on to outside employment. The Committee describes this as "a wonderful achievement". There can be no doubt of this.

357. There are many other dramatic examples of what can be done. It is worth mentioning one more. Dr H. H. Kessler has described a victim of the war in the Pacific who was—

"so grossly wounded that he needed amputation of both arms, one leg, one testicle, and part of his jaw. He also had numerous shrapnel wounds to be repaired on various parts of his body. This man now gets about with a triple prosthesis; he is married and has a family, and is a successful business man and a Member of his State Legislature."¹³⁸

358. Even the cases far removed in gravity from this can be handled in ways which are worth while to the man himself and

¹³⁷Report (August 1962), para. 43.

¹³⁸H. H. Kessler, *Principles and Practice of Rehabilitation*, 1952.

important for the community as a whole. During a period of five years the Penrose Industrial Health Centre near Auckland has dealt with an average of 3,552 new cases each year. About 400 cases in each year were referred to hospital, and there remained about 3,150. Of these only 75 had to be put off work on compensation. All the others were treated on the spot and encouraged to return to their place of work where co-operation on the part of employers enabled them to tackle some task within their immediate capacity. In its way this too is a wonderful achievement.

359. The rehabilitation process clearly is able to provide great benefits. Independence and self-respect, an alleviation of the strain of incapacity, and some mitigation of money losses are all offered to the man himself. And apart from humanitarian considerations there is for the community the advantage of increased production and the avoidance of some of the economic costs of incapacity. It is a process which should be supported widely and made available to all who might be assisted by it: and the test for assistance should never demand that the advantage to the patient must always balance the cost to the nation.

360. Upon this principle there could be no justification for providing rehabilitation services for the victims of work accidents, for example, to the neglect of other groups of incapacitated persons. Nor would the duplication of services achieve any useful purpose in a country the size of New Zealand. Accordingly this brief survey of the subject proceeds on the basis that there should be a co-ordinated approach designed to assist disabled and incapacitated persons generally.

THE NEED

361. For the purposes of rehabilitation incapacitated people can be considered in three main groups:

- (a) There are those who will quickly recover and return to their old activities: fortunately this group constitutes by far the majority of incapacitated persons.
- (b) There are others who eventually will be able to return to their normal work or activities, but only after a period of treatment and convalescence.
- (c) There is a relatively small group who will require and deserve much assistance, and possibly retraining.

What is often described as medical rehabilitation can assist each one of these groups to achieve maximum physical condition in a minimum of time.

362. Most of those who come within the second and third groups will probably require a much longer period of rehabilitation including that form of it which can be described as vocational rehabilitation—a process aimed at conditioning a man or woman to the requirements of employment or normal social activity.

363. We have insufficient evidence to estimate the total number of persons who might come within the latter two groups. There is, however, a survey undertaken by the Social Security Department which shows that at any given time there are several thousand persons in New Zealand receiving long-term social security benefits in respect of physical disability.¹³⁹ Obviously these social security beneficiaries are only a fraction of similarly disabled persons in the whole population. All of these persons deserve some intensive form of rehabilitation.

364. Then there are the short-term cases. In the group of work-connected accidents alone the statistics show plainly that at least 95,000 short-term injuries occur each year apart altogether from several thousand others which are more serious. As the experience at Penrose has demonstrated, prompt and effective attention for these less serious cases often can reduce or even avoid wage losses and the interruption of productive work, and what is more important, provide a man with the resolve to get well quickly.

ASSESSMENT

365. The fact that rehabilitation can be of benefit to people with such a wide range of incapacities indicates the broad variety of professional skills needed to help with particular problems, and the diverse nature of the facilities which should be available. This in turn emphasises the further essential fact that as success will depend finally upon the man himself, there is a need for prompt assessment of his condition and his potential in the widest sense.

366. It has been said that “though specialists in rehabilitation, like other specialists, disagree about some things, they are unanimous about the need for early referral. A large percentage of the industrial accident cases referred to the Institute of Physical Medicine and Rehabilitation are said to require treatment *primarily because of the complications arising from injury*, such as deforming contractures, atrophy of disuse, general deconditioning, and psychological problems stemming from prolonged inactivity”.¹⁴⁰ (Our emphasis.) We do not doubt that many similar cases could be found in

¹³⁹See Report of the National Civilian Rehabilitation Committee, op. cit., paras. 11 to 13.

¹⁴⁰Walter Gellhorn and Louis Lauer, *Administration of the New York Workmen's Compensation Law* (1962), Vol. 37, N.Y. Univ. Law Review.

New Zealand and if complications of this sort can be avoided by early assessment then every effort should be made to ensure that it takes place.

367. Such an assessment will involve not merely a patient's physical condition and the likely state he will reach after appropriate medical treatment: it must extend to an appreciation of his intelligence, educational standards, mental and emotional state, general aptitudes and adaptability, motivation, resilience, and social and economic background.

368. Most people will recover quickly and successfully in the absence of this sort of assessment. But the number of severely incapacitated persons and the extent of the individual problems which they have to face shows the clear need for teams of specialist assessors in all the more populous areas of the country.

369. As yet the need has not been satisfied. Indeed in its report to the Minister the National Civilian Rehabilitation Committee felt obliged to state:

"The most striking deficiency is the need for accurate assessment of potential candidates for rehabilitation. The Committee believes that every handicapped person is entitled to a proper and accurate assessment of his potential capacity, periodic assessment according to his progress, and a final assessment which would be of value to him and to any employer with whom he might eventually be placed."¹⁴¹

We agree entirely with the opinion expressed by the Committee.

370. Although the assessment is largely medical in nature it has been increasingly recognised over recent years that the most accurate and useful answers are provided by the co-ordinated team work of a group of experts in the various fields. The more serious, and therefore the more important the case, the more likely this is to be needed. In such cases, if the man is to be provided with the best help and encouragement to overcome his problems, there must be a readiness by all concerned to work together. And this team should be wide enough to deal with all the features of many different cases: it should include surgeon, physician, psychologist, psychiatrist, social worker, placement officer, physiotherapist, and occupational therapist.

¹⁴¹Op. cit., para. 51.

371. In a paper prepared for the National Labour Market Board in Sweden the matter is mentioned in the following way:

“The total results of a teamwork will rest on the strength of each individual link. A satisfactory total result presupposes the co-operation of all the components and this depends primarily on the team members’ ability and desire to work together. No one can by himself master the medical, psychological, and social problems which may accompany the [patient’s] difficulties. These difficulties cannot as a rule be rationally solved through one-sided efforts of a representative of one speciality.”¹⁴²

The paper goes on to stress the need for each member of the team to recognise his own limitations and be ready to pass the patient over to one of his colleagues whenever the occasion requires it.

372. Much the same point is raised in a recent paper by Dr J. G. Sommerville, Director of the Medical Rehabilitation Centre, Camden Road, London. He described the past emphasis upon “personal responsibility, with the resultant isolation of the individual doctor”, and then said:

“In a complex modern society the responsibilities are too great for an individual to carry. The team approach can be defined as the capacity to appreciate the personal contribution in relation to that of others—in short, to recognise when personal responsibility can be delegated to another.”¹⁴³

373. The need for delegation of the sort referred to by Dr Sommerville has created some difficulty from time to time because it tends to cut across the normal doctor-patient relationship. In New Zealand it may have been one reason in the past for a failure to make better use of the techniques of rehabilitation.

374. If this is the case it is not unique. In 1954 two American observers described the implications of the rehabilitation movement as wide ranging because they offered a challenge to settled principles and demanded “multi-disciplined analysis and action”. They went on to say:

“The goal is no longer confined to accurate diagnosis and expert treatment of trauma or some other acute condition. The goal of rehabilitation is no less than the restoration of the whole man to a useful function in society, involving manifold skills and techniques. This implies as great a revolution in medical care

¹⁴²Seved Eriksson (Stockholm), Information Series V 1/1963 (Translation), p. 3.

¹⁴³*Physiotherapy*, Vol. 53 (1967), p. 78 at p. 82.

and medical thinking and training as it is in social insurance legislation and techniques. The revolution has been under way for some time but at a slow and hesitant pace.¹⁴⁴

375. The pace has been no less hesitant in New Zealand. Two years ago it was said of the Penrose Industrial Health Centre:

“The development of the Penrose Centre has not been simple and straightforward. There has been some controversy and inevitable delay before schemes which appeared so logical were put into practice.”¹⁴⁵

and the same point was referred to in submissions before us in the following way:

“With the passing of time there has been a reluctant acceptance of the fact that industrial medicine is a specialty and that these specialised clinics have a most important part to play not only in the implementation of the aim but also in the overall care of the patient in the broad medical sense.”

THE DOCTOR-PATIENT RELATIONSHIP

376. It was said that this “reluctant acceptance” had developed from good liaison with the rest of the profession. And that earlier opposition to the clinic had arisen from a belief that the patient was being taken from his family doctor. It is an excellent thing that these fears have been largely overcome: they certainly should be avoided in the future. The objective of rehabilitation will not be achieved without the essential support and encouragement of the medical profession as a whole.

377. The aspects of this matter were touched on by the Medical Association of New Zealand. In submissions the Association emphasised the importance of the doctor-patient relationship. We well understand the need to preserve this relationship. It is part of a system which provides a high standard of medical care throughout the country. But we think that some doctors may have been inclined to elevate the principle to an inflexible rule of practice. Adherence to the principle cannot be allowed to have large numbers of injured workers travelling miles from their place of work to seek out a busy practitioner who then would often need to put the man on compensation where the clinic would have him back at work within the hour.

¹⁴⁴Somers & Somers, op. cit., p. 263.

¹⁴⁵W. I. Glass, *The Penrose Industrial Health Centre* (1966), 65 N.Z.M.J. p. 87 at p. 92.

378. Similiar considerations should determine other questions which arise with regard to rehabilitation. There is the issue as to who is to assume general responsibility for some patients who need long-term or special attention. Care should always be taken to avoid usurping the function of a man's general doctor. But sometimes it is necessary in the patient's interests that this function should be delegated and when the occasion arises then without doubt the delegation should take place. It cannot be possible for every over-worked doctor to maintain effective liaison with the specialised teams handling cases of this sort and yet there is often a need for overall supervision.

379. Then there is the question of co-ordination of effort in a wider sense. It is a matter which needs to be considered by the medical profession if a comprehensive system of rehabilitation and compensation is to work to the best effect.

THE ONTARIO EXPERIENCE

380. In Ontario the Workmen's Compensation Act provides that—

“All questions as to the necessity, character, and sufficiency of any medical aid furnished or to be furnished and as to payment for medical aid shall be determined by the Board.”¹⁴⁶

In terms of this arrangement the Medical Director of the Board and his medical staff are constantly in touch with members of the profession throughout the whole of the province. They are able to do this because every medical report is filed promptly with the central office of the Board where it comes under the immediate attention of a skilled practising doctor and is then kept under frequent review. The impressive fact is that the profession generally gladly co-operates with the medical staff of the Board and welcomes and indeed usually requests the assistance or advice which the Board can offer.

381. This is a delicate issue in New Zealand as it is elsewhere. However there is great advantage in establishing some form of liaison between the Board we propose and the medical profession itself. There must be many general practitioners in particular who would accept with a sense of relief the opportunity of sharing their responsibility in some more complicated case. There is a need also for co-operation in regard to the matter of fees as we mention in paragraph 385. If these matters are tackled in an objective and detached fashion we believe that an acceptable formula could be devised.

¹⁴⁶Section 51 (6).

382. It is worth repeating a description of the position in Ontario given by Dr D. J. Galbraith, former Vice-Chairman of the Board there. He said:

“Briefly, our plan is this: First and foremost the profession knows that we have at our office a staff headed by senior and recognised orthopedic surgeons who are trained to consult with and advise the profession regarding the approved treatment of traumatic injuries and occupational diseases. They know that it is our policy to have our patients treated by surgeons of their own choice, at their own hospital or as near thereto as adequate skilled care can be obtained. But they also know we will accept no substitute for efficiency, no excuse for neglect. The private physicians know that it is not only their privilege but their duty to call our staff and discuss with them all serious disabilities on reverse telephone charge. They are expected to call us as freely as they would their own friends in the profession, even if we are a thousand miles away; we do not complain of telephone bills. All X-rays, both pre- and post-reduction, are sent to us promptly and examined by our expert radiologists. In serious conditions or where diagnosis is requested or is incorrect, our orthopedic surgeons, after consultation with the radiologist, telephone the attending surgeon and discuss treatment. Most cases are then left to be treated by the attending surgeon if adequate hospital facilities are available and he advises constantly of progress. Some are advised to proceed with the assistance of the more qualified specialists in their neighbourhood and of their own choice. In some cases of more complicated injuries it is suggested that the patient be transferred to a large center having more adequate facilities. The very complicated cases may be transferred to Toronto for special treatment . . . the doctors are so co-operative and know the routine so well that they not infrequently charter planes or arrange other means of transport on their own initiative and merely call us to say that the patient is coming and describe the care required.”¹⁴⁷

383. The Ontario approach to these questions has received widespread attention in the United States. It was mentioned with approval in New York for example by the Callahan Commission, set up by the State Legislature in 1957.¹⁴⁸ And recently Dr Leon Lewis of Berkeley, California, discussed these aspects of medical administration as they are beginning to interest the insurance carriers. He wrote:

¹⁴⁷D. J. Galbraith, M.D., *Proceedings of the National Conference on Workmen's Compensation and Rehabilitation*, U.S. Department of Labor, Bureau of Labor Standards, Bulletin 122, 1950, pp. 45-46.

¹⁴⁸The Callahan Commission, Second Report (December 1958), p. 18.

"The advantages of close supervision are being recognised south of the Canadian border by insurance carriers. They are beginning to employ part- or full-time medical staffs or consultants to establish liaison with treating physicians and to attempt to assure appropriate treatment. This is not easy in the United States. Traditionally the injured workman is looked upon by the doctor as 'my patient'. The intervention of an outside interest is not welcomed, and the threat of transfer of care is resisted as an attack on the prerogatives of the medical profession."¹⁴⁹

384. The difficulties referred to have been overcome in Ontario by goodwill and co-operation on both sides. We believe the same thing can and should be done here.

MEDICAL FEES

385. At present medical fees incurred by injured workers are paid on their behalf in terms of regulations made under the Workers' Compensation Act. Some criticism has been made of the scale of fees which operates in this connection. We have been invited to examine the matter and upon the point of principle involved we have reached a clear conclusion.

386. The question is one which needs to be considered in three ways. First it is a matter of national importance that every injured person should be restored to health and useful activity as soon as possible. Often this will mean specialised and expensive medical care or the attention of a general practitioner over an extended period of time. Second there is the problem of persuading a man already facing some financial strain to seek specialised attention the reasonable cost of which might considerably exceed the assistance provided by the State or the Compensation Fund. Third it could not be reasonable to expect the medical profession to meet the difference between reasonable fees and some arbitrary scale kept down for reasons of economy. If the problem of injury is accepted as a community responsibility particular sections of the community should not have to subsidise the cost.

387. Accordingly we recommend that reasonable medical fees for persons entitled to compensation under the new fund should be paid in full by the fund.

¹⁴⁹Leon Lewis, M.D., F.A.C.P., *Medical Care Under Workmen's Compensation* (Occupational Disability and Public Policy, Ed. Cheit and Gordon) 1963, at p. 138.

388. But this leads to a mixed problem of administration and equity. If the recommendation is accepted then we consider that the medical profession should recognise for its part that individual doctors could not reasonably expect to have their fees met by the fund regardless of all supervision and in the absence of a general scale of fees. The independence of the profession should be maintained and, in general, we support the attitude of the profession to this matter. We are confident nonetheless that it can be no more difficult in practice for doctors than for lawyers to accept some reasonable control of their attendances and their fees and certainly there is no difference in principle. Accordingly we recommend that just as there is a scale of legal fees which is acceptable to that profession and a procedure for settling disputed fees so should there be a scale of medical fees for the purpose of compensation claims against the fund together with suitable procedure for administering that scale of fees.

389. We think the scale should be prepared by the medical profession itself and settled in agreement with the Board. It should contain a provision for suitable increases in the fees for special or unusual cases, and the scale should be subject to automatic review at regular intervals of approximately three years. We recommend that the Medical Practitioners Disciplinary Committee (the central committee in Wellington) of The Medical Association of New Zealand should be given authority to resolve any disputed question concerning fees which might arise between the Board and individual members of the profession.

THE CHIROPRACTORS

390. At this point it is convenient to refer to submissions made by the New Zealand Chiropractors' Association (Inc.). The Association asked that chiropractic be recognised as an appropriate treatment for some types of injury, that registered chiropractors be recognised as qualified to administer such treatment and that injured persons be given the right to choose to receive treatment of this sort rather than treatment from a medical practitioner. Support was given the Association by the Chiropractic Patients' Association (Auckland). But there was much opposition from the medical profession and the physiotherapists.

391. During the course of the public hearings we indicated that we were unlikely to express any opinion upon the validity or otherwise of the treatment offered by members of the Chiropractors Association. No settled conclusion could be reached upon a technical issue of this sort without a prolonged examination of a great

deal of medical and other scientific evidence. The determination of such a technical issue is obviously irrelevant to the broad subject matter of this inquiry; and we have no doubt that if some sort of official blessing is sought in respect of the treatment as such then the matter is one for resolution by a tribunal appointed specifically for the purpose following upon a clear decision that the matter deserves or needs to be examined in this way.

392. In the circumstances it would be wrong for us to express an opinion one way or the other upon the submissions addressed to us by the Association. The basic question is the validity of the treatment and being unable to judge this issue we have no recommendation to make upon the submissions of the New Zealand Chiropractors' Association.

INCENTIVE

393. No rehabilitation programme will succeed without the interest and co-operation of those who can be assisted by it. In the past some incapacitated persons have been unaware of rehabilitation; others have refused to co-operate for economic or emotional reasons. And in general there has been a lack of central direction and co-ordination. Central to the problem is the matter of overall direction but at this point the attitude of the patient needs to be examined.

394. Those who have failed to understand or be made aware of rehabilitation have been caught up in a problem of communication. It is something which can be largely overcome by early assessment along the lines referred to in paragraph 365 and the associated steps which can then be taken. But there should be facilities for this sort of assessment at all main hospitals; and we think too that it is desirable that specialists in physical medicine should be easily available to most parts of the country.

395. Then there is the group of patients who have been reluctant to take advantage of or are disinterested in the process. Some of this group (often more serious cases) have been unwilling to face further disruption of home life when there has been the need to travel to another centre: or because of financial strain or other similar anxiety.

396. It will not be possible to provide facilities in every part of the country which might suit the needs of every type of patient although we recommend certain measures which should do much to overcome the problems which are related to the need to travel away from a home area. Accordingly we consider that in respect

of the compensation cases the Board should be authorised to make supplemental allowances to assist in special circumstances. The purpose of these allowances should be to enable a wife or husband to accompany a patient to another town where the necessary rehabilitation facilities are available. The arrangement should be for a limited or a more extended period dependent upon the circumstances. The discretion to make such allowances available should not become a matter of routine: the allowance should be made available when really needed.

397. But there will be others who are outside the support of the compensation fund. There is a clear need in our view for the provision of some type of rehabilitation benefit under the Social Security Act as suggested by the National Civilian Rehabilitation Committee.¹⁵⁰ The same proposal was made in submissions put before us by the Social Security Commission.¹⁵¹ We recommend that such a benefit should be built into the social security scheme. It should provide the incentive necessary for the individual concerned to participate in any comprehensive programme which might be available. Obviously enough the converse is of great importance; there should be an absence of any financial disincentive which might arise for example from automatic application of a means test.

398. However we are not satisfied that it is desirable or wise to attempt to promote the rehabilitation objective by coercion. The aim should be to overcome a lack of motivation by education and encouragement and we think it unlikely that any useful purpose would be achieved by the application of some sort of sanction to those who are unable to be persuaded.

THE ADVERSARY SYSTEM

399. Other injured persons have failed to accept the assistance of rehabilitation because of pending claims for damages or compensation. They have preferred to await the outcome of contested proceedings lest the prospective capital award should be diminished by their own successful effort to overcome the disability.

400. The matter is mentioned in paragraphs 123 to 125 of this Report and represents in our opinion an important reason for abandoning the adversary method of handling all claims. If the system disappears, as we recommend, then the difficulty outlined in the preceding paragraph will disappear with it.

¹⁵⁰Op. cit., paras. 74 and 87 (J).

¹⁵¹Submissions, Item 6, para. 22.

401. But it would be irrational to permit the new system to adopt principles or methods which would permit a recurrence of the old problems. For example there is a superficial attraction in arguments that compensation should be reduced once it were found that a man had managed to return to work with less than the expected income loss.

402. These are short-sighted arguments. If it was felt that energetic personal effort would result in a reduction in assessed compensation there would be a temptation to prolong the period off work or to work at less than maximum capacity. Such a situation would be bad for production, bad for the man and it would gain nothing for the compensation fund. The country cannot afford to throw away the benefits of personal initiative for the sake of delicate readjustments of compensation.

403. The matter was discussed by Somers and Somers in their work. They said—

“If workmen’s compensation is to exploit its opportunity to be something more than an income maintenance or indemnity program, however, and is to accept in practice rehabilitation as a primary objective, a strong case can be made for compensating anatomical loss as such. To stop payments to the amputee who succeeds in rehabilitating himself to his former, or even higher, earning capacity while continuing payments to one who fails to do so would increase the existing conflicts between rehabilitation and compensation. The results of rehabilitation are never entirely certain, and fear of loss of compensation rights, added to doubts about the probable success of the rehabilitation process, could prove a formidable deterrent to a worker’s receptivity to rehabilitation treatment.”¹⁵²

404. It is for reasons of this sort that we recommend¹⁵³ that upon a review of permanent compensation there should be no downward reassessment. Adoption of this principle may enable a few injured persons to secure an over-generous level of compensation. But efficient medical administration can keep the number to a minimum and in any event it is something which is worth accepting in the general public interest and for the purpose of gaining in most cases complete co-operation for the purpose of rehabilitation.

¹⁵²Op. cit., p. 278.

¹⁵³See also paras. 127, 293 (e), 305 (d).

405. We are aware that there are claims that fixed periodic compensation will encourage what is described as malingering. The word is intended to describe those who will put up a pretence that the injury is more serious than is really the case. Certainly there will be some who will attempt to take advantage of the system. But they are doing much the same in a different fashion at present. And we entirely reject the suggestion that there are substantial numbers of work-shy or dishonest people waiting for the moment of injury in order to batten on to a compensation fund for extended periods of time.

406. The matter needs to be mentioned because it troubles many reasonable people. For this reason we have examined some of the material which has been gathered together in regard to it.

407. In England the matter has been considered on several occasions over the last half century. In 1911 the report of the Departmental Committee on accidents in places under the Factory and Workshops Acts made it clear that in the opinion of the Committee injured workmen were not disposed to malingering.¹⁵⁴ Ten years later the well-known Holman Gregory Report¹⁵⁵ expressed similar conclusions having "made careful inquiries of employers and insurance companies' officials". Indeed the Committee had devoted a whole section of their questioning of witnesses to the matter. Their conclusion was that "we are satisfied that the average workman is anxious to return to his work as soon as possible".¹⁵⁶

408. In 1961, Freda Young, a perceptive student of the British Social Services, considered the question in relation to the medical and other safeguards against abuse of welfare programmes. She considered on the experience of the Ministry of Pensions and National Insurance (of persons who persistently refused to maintain themselves) that "if malingering does exist it is of tiny proportions";¹⁵⁷ and that "the medical safeguards against malingering in the welfare state are fairly comprehensive".¹⁵⁸

409. Then in 1965 the same matter was raised before Mr Justice Tysoe in British Columbia. In his report he has said—

¹⁵⁴Cmd. 5335, p. 17.

¹⁵⁵Cmd. 816 (1920).

¹⁵⁶See Wilson and Levy, *Workmen's Compensation*, Vol. 1 (1939), p. 186.

¹⁵⁷A. F. Young, *Social Security Quarterly* (1961), Vol. 35, p. 69.

¹⁵⁸Loc. cit., p. 68.

"As to malingering, I imagine there are cases of this. . . . but the number of these compensation cases must be very small indeed, and they are very hard to prove. The malingerer is a different person to the workman who honestly but wrongly believes he is not fit for work."¹⁵⁹

410. Obviously enough any scheme of the sort proposed in this Report must be administered by methods which will keep abuse to the "tiny proportions" mentioned by Freda Young. But primarily the problem, to the extent that it exists, can be controlled by an experienced and efficient medical profession. We are in no doubt that the profession in this country is well able to discharge its responsibilities in regard to the matter. And in addition there will be the central oversight and control exercisable by the Medical Department of the authority itself.

411. The short survey we have been able to make has left us satisfied that the issue of malingering is one of minimal proportions when set against the vast number of reliable citizens who may have reason, from time to time, to seek the support which the scheme is designed to afford. It is a problem with a nuisance value but this is certainly so insignificant that it would be entirely wrong to allow it to bear down upon a scheme otherwise able to produce widespread and necessary benefit for the community as a whole.

412. A complicating factor has been the confusion between "the few individual cases of dishonesty that occur under any system";¹⁶⁰ and the man who "honestly but wrongly believes he is not fit for work" (as Mr Justice Tysoe has put it). The second condition is well known to the medical profession and accepted as a type of neurosis which can arise from anxiety. It is a condition which frequently is discussed in the Courts in relation to contested claims for damages. An experienced orthopaedic surgeon in the United States has referred to the matter in the following way:

"Most of the patients whom we used to call malingerers are not that at all. They are frightened individuals. They are afraid that they are never going to be able to hold down a good job again, and hence are worrying about how they are going to support their families. To overcome this is a challenge to every doctor who has to deal with compensation injuries. Even our private patients experience a good deal of that same worry."¹⁶¹

¹⁵⁹Op. cit., p. 144.

¹⁶⁰Earl F. Cheit, *Injury and Recovery in the Course of Employment* (1961), p. 305.

¹⁶¹Edward L. Compere, IAABC Proceedings, (1955) U.S. Dept of Labor, Bureau of Labor Standards, Bulletin 186, p. 38; and see Earl F. Cheit, loc. cit., pp. 304-305.

It is wrong to put the label of "malingerer" upon people in this condition. Instead every effort should be made to keep down the incidence of the condition by adequate rehabilitation and the removal of undue financial strain.

413. It is worth adding, before we leave the topic, that we have attempted to build some incentive into the proposals we have outlined. There is a margin left for individual effort which amounts to a manageable but nonetheless realistic proportion of a man's normal earnings. There is the emphasis upon longer term incapacities and a restriction upon levels of compensation for short periods which is hardly likely to lead to any great flabbiness. And we have attempted to resolve the administrative problem associated with minor mishaps to housewives by recommending that for 14 days their families might well take the strain themselves.

414. In the final analysis, however, we hold firmly to the view expressed by Dr E. C. Steele, one of the three experienced Commissioners of the Ontario Workmen's Compensation Board. He said—

"Financial rehabilitation as provided by adequate compensation is a stimulus rather than a deterrent to speedy recovery. Prompt and regular payment of compensation during the period of incapacity is important in the rehabilitation process. Doubts and fears, unconsciously fostered by an adversary system, should be prevented if at all possible. The patient should not be allowed to be unduly disturbed about financial hardship during the course of his total disability or to have fears and forebodings for the future. Such fears accentuate the stress reaction, so ably described by Dr Selye, prolonging disability and driving reputable citizens to the only refuge they know—litigation.¹⁶² Knowledgeable rehabilitation officers attached to the staff of the administrative authority can dispel the doubts and fears of the injured workman at an early stage of treatment. They can point out to him his rights and responsibilities under the Act and influence positive thinking about rehabilitation and employment possibilities."¹⁶³

FACILITIES

415. If the prime objective of rehabilitation is to return the handicapped to useful employment or activity as soon as possible the process must be prompt, efficient, and continuous. And there will be a need for adequate facilities throughout the country.

¹⁶²Hans Selye, *Physiology and Pathology of Exposure to Stress* (Montreal: Acta Incorporated, 1950).

¹⁶³Op. cit., pp. 270-271.

Already much has been done in this direction and comparatively simple but in our view imaginative measures have been taken in certain hospitals which are bound to produce good results if applied elsewhere.

416. For example a pilot scheme in operation at the Queen Elizabeth Hospital at Rotorua enables a number of patients to be taken on to the staff of the hospital in a supernumerary capacity. They are employed in such occupations as nursing, clerical work, engineering, painting, maintenance, and gardening. An attempt is made to provide these people with work most similar to their normal occupation or most suited to their capacity. Their effort is gradually enlarged to normal hours and normal production and when they have reached work readiness they return to their usual occupation or the Labour Department endeavours to find suitable work for them.

417. At the Palmerston North Hospital a special ward is to be prepared to which patients can be transferred when they become independent of nursing procedures. In this ward they will be able to look after themselves and their day will be occupied with vigorous rehabilitation activity. In this way an early effort can be made at the hospital itself to ensure that on discharge such patients will be fit to return to work.

418. At Otara on the outskirts of Auckland there is a civilian rehabilitation unit where facilities exist for full medical rehabilitation and for a measure of industrial or vocational rehabilitation as well. It is administered by the Auckland Hospital Board under the energetic direction of the Department of Physical Medicine. It is organised in such a way that it is able to push forward the rehabilitation of severely handicapped people and at the same time take some pressure from the ordinary hospitals in the city in regard to urgently needed and expensive hospital beds.

419. We think it probable that the Queen Elizabeth experiment could be widely used in hospitals throughout the country. And wherever possible rehabilitation wards should be made available on the lines being worked out in Palmerston North. Clearly in both hospitals practical and important steps are being taken to avoid any interruption in rehabilitation which should be continuous from the moment of injury until return to normal activity.

420. In a different way the Otago unit is an example of a facility which is achieving most important results. We think a similar unit should be established in Christchurch to cater for the South Island and it is likely that another unit should be located in the Wellington district.

421. Apart from units of this sort however we think there is a basic need in all the more populous centres for a specialist in physical medicine who could organise suitable rehabilitation programmes and make use of and extend existing hospital facilities. In addition there is a need for the establishment of assessment units of the sort discussed in paragraphs 365 to 375. We believe that the matter of prompt assessment and constant review to be of such importance that the establishment of these units should not be restricted to the four main centres. In our opinion there should be 10 of these units in the North Island and five in the South Island.

ROLE OF THE STATE

422. It is well known that a number of dedicated and efficient voluntary organisations have been working in this general field for many years. The New Zealand Crippled Children's Society and Disabled Servicemen's Re-establishment League, the New Zealand Intellectually Handicapped Children's Association, the Foundation for the Blind, and the sheltered workshops in various cities are only a few examples of the help that is given on a voluntary or semi-voluntary basis.

423. But basically the responsibility is one for the State and we think that through the Health Department the State should take a leading role in laying down a general and co-ordinated programme for the whole country. There is a need for acceptance of financial responsibility in the appropriate areas. Encouragement should be given to the voluntary organisations by means of direct grants and an energetic and widespread campaign developed to assist citizens with rehabilitation wherever the process might be needed.

424. In regard to all this we remark that rehabilitation is not an area where apparent or short-term economies are likely to work well in the interests of the country; nor could they be justified in a community which rightly prides itself on the quality of its general health and medical services.

425. Finally we refer briefly to the proposal made in paragraph 310 (f) that the use of private hospitals should be encouraged if this could avoid delays in treatment and promote the general purpose of rehabilitation. We are informed by the Health Department that, with increasing annual costs of public hospitals, there may be little difference between the cost of public and private hospitals today. Indeed there is evidence which shows that in some respects the public hospital bed can be more expensive. Be that as it may, we are left in no doubt that the importance of getting people well and back to productive work far outweighs (both financially and in human terms) the ostensible economic advantage of using the public hospital bed.

426. Accordingly we recommend the use of private hospital beds whenever the occasion seems to require their use. Control should be exercised by the medical director of the new authority as we have said in paragraph 310 (g); and subject to this the cost of the beds should be met in full by the Health Department.

THE REHABILITATION AND COMPENSATION AUTHORITY

427. The proposals made in this Report for a comprehensive scheme of injury compensation are designed to promote the physical and vocational rehabilitation of all injured persons. An important part of these proposals relates to the organisation of an efficient medical branch under the leadership of an experienced doctor of high quality.

428. The compensation process should always be secondary to the goal of rehabilitation but it is not enough to pay lip service to the principle. There must be imagination, drive, and leadership which will ensure that the best use is made of facilities; the best sort of co-operation is maintained with the medical profession; and efficient medical administration is achieved in the wide area of the authority itself.

429. All this will not be easy and it is a task which must be organised from the beginning. Accordingly it would be a mistake to underestimate its importance or undervalue the position of the medical director in terms of remuneration.

430. We have been much impressed by the medical administration of the Workers' Compensation Board in Ontario. It is a feature of the Board's activities which commands widespread respect. It has been developed over a period of years by central control, the maintenance of excellent relations with the medical profession,

insistence upon the best and earliest possible care for all injured workmen, and attention to detail. Central organisation of this description is unusual in New Zealand but we think it essential if the new authority is to function satisfactorily and provide the uniform and just results upon which complete public confidence will depend.

431. Although the responsibility for rehabilitation programmes is one for the State we recommend that an annual sum of \$200,000 should be set aside by the new Board for the general purposes of rehabilitation. The amount should be used to support new programmes, encourage new ideas, provide specialised types of equipment, and ensure that at all times the country has available to it the most recent ideas and experience in this important field.

CONCLUSION

432. In summary our conclusions and recommendations are—

- (1) The process of rehabilitation should be developed and encouraged by every means possible as it has very much to offer New Zealand both in human and in economic terms.
- (2) There is a pressing need for a well co-ordinated and vigorous programme which will embrace all who might be assisted by rehabilitation and the responsibility for this financially and in all other ways should be accepted by the State through the Health Department.
- (3) In order to provide adequate coverage throughout the country we recommend that a specialist in physical medicine should be appointed by the boards of all the more important hospital districts; that the scheme at present in operation at the Queen Elizabeth Hospital at Rotorua be duplicated wherever possible; and that the type of rehabilitation ward being established at Palmerston North should be extended.
- (4) The proposed Rehabilitation and Compensation Board should set up a medical branch under the leadership of a doctor of high calibre and wide experience. The Board itself should be given sufficient authority to enable it to exercise some reasonable supervision within the field of medical administration. We recommend that the medical director should set up a small medical committee comprising a few senior members of the profession in active practice to act in a part-time capacity and provide him with assistance and advice concerning his general responsibilities.

- (5) The new authority should undertake to pay the medical fees in full for all compensation cases subject to the provision of a suitable scale of medical fees to be prepared by the Medical Association of New Zealand and agreed with the Board. There should be discretion within the scale to provide adequate payment for unusual or special cases and the scale itself should be the subject of automatic review at intervals of approximately three years.
- (6) Wherever the rehabilitation process might be speeded up by the use of private hospitals then we think these hospitals should be used and whenever such use has been authorised by the medical director of the Board then the cost of the beds should be met by the Health Department.
- (7) For the general purposes of rehabilitation the Board could set aside an annual sum of \$200,000. This amount should not be in substitution for any Health Department responsibility but should be used to urge forward the rehabilitation concept.
- (8) The industrial clinics are performing an extremely valuable function and should be encouraged. We recommend that as an experiment the new authority should provide a mobile physiotherapy van at the Penrose clinic which would enable individual physiotherapists to offer treatment to their patients at the work site in this industrial area.
- (9) A rehabilitation unit of the Otago type should be set up in the Christchurch district and consideration given to a similar establishment in the near future in the Wellington area.
- (10) There is a pressing need for specialised teams of assessors able to make prompt and continuous assessments of patients requiring rehabilitation. We believe that 10 of these teams should be located in the North Island and five teams in the South Island.
- (11) There should be much more direct and effective liaison between hospitals and other agencies concerned with rehabilitation and the employment of disabled persons and we believe the new board has much to offer in this connection. We recommend that the Director of Medical Services of the board should be invited to join the National Civilian Rehabilitation Committee.

- (12) Being of the opinion that this Royal Commission should not attempt to resolve the basic question of the validity of chiropractic treatment we have no recommendation concerning the submissions made by the Chiropractors' Association.
- (13) A special rehabilitation benefit should be defined and provided under the Social Security Act which would promote and provide incentives for rehabilitation.