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FOR DISCUSSION WITH PROJECT TEAM

CURRENT AND PROPOSED FEDERAL GOVERNMENT POLICIES IN RESPECT OF WELFARE SERVICES FOR PERSONS SUFFERING FROM CANCER

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1. INTRODUCTION

1.1 The purpose of this section is to delineate the current and proposed Federal and State Government policies in respect of welfare services for persons suffering from cancer. This is not as clear or specific a task as it may seem. The major difficulty is that State and Federal Government departments do not create policies or servcies which relate to cancer patients as an isolated group, but rather, services which cater for a broader section of the population.

1.2 For the purpose of this review therefore, only those policies or services which have been identified as relevant or problematic by the project team have been discussed here.

1.3 The policies and services are those of the Commonwealth Department of Health, the Health Commission of Victoria, and the Commonwealth Department of Social Security.

2. HEALTH COMMISSION OF VICTORIA

2.1 Hospitals Division

2.1.1 The Hospitals Division sets down the charges payable for:

- inpatient accommodation and professional services
- outpatient charges
- services and patients exempt from fees (as per circular no. 17, June 22, 1982)

2.1.2 There are several distinctions made in the status of patients. These are:

- Commonwealth entitled persons (i.e. social security health benefit card holders or those entitled to a health card).
- Private inpatients (i.e. those who retain their private doctors or specialists).
- Non-insured, non-commonwealth entitled persons and persons insured with non-Victorian health funds.

2.1.3 The policies in repest of the defined patient groups are outlined below:

- Commonwealth Entitled Persons: No changes are raised against these person for 'Hospital' inpatient or outpatient services or pharmacy costs.
- Private inpatients are charged at the same accommodation rate as 'Hospital' inpatients. Financial responsibility for all medical services (including diagnostic services) is a matter between patients and their practitioners.
- Nursing Home type patients (State run) (circular no. 13 May 6, 1982). The policy here refers to those persons who are on old

age or other pensions. It spells out the percentage of the pension which is deducted towards the payment of Nursing Home or Hostel care and outlines the Commonwealth subsidies which are also available for special care, e.g. personal care subsidy $20 per week; extensive care subsidy $6 per week; and supplementary allowance $8 per week.

At present the pensioner contribution is 85.64%.

This percentage will increase in the near future to 87% in line with the percentage charged in Private (as opposed to State run) Nursing Homes.

- Non-insured, non-commonwealth entitled persons. These persons are charged for all outpatient services including pharmacy, and inpatient hospital and professional services ($60 per day)

Uninsured cancer patients may be eligable for free outpatient attendances where the uninsured patient is defined as being chronically ill.

The Health Commission circular states "NO PERSON SHOULD BE DENIED ADMISSION OR TREATMENT BY REASON ONLY OF INABILITY TO PAY".

The Health Commission of Victoria has empowered all Public Hospitals to make 'Financial Assessments' of patients who may request it. This means that any person can ask to be financially assessed in order to reduce or waive charges raised against them. This is primarily intended as a catch all for

these persons who may be of low income but are not eligible for a Commonwealth Health Card or who are otherwise in an ardious financial situation. Discretion and the form of 'financial assessment' rests with each hospital. They have the power to reduce charges, waive charges, or allow for periodic payments.

2.2 Public Health Division: Free Travel To And From A Public Hospital On State Owned Transport Scheme

2.2.1 This scheme is available to pensioners and persons of similar limited means who:

- require regular treatment at public hospitals, or
- are required by appointment to travel from outlying areas to pubic hospitals

2.2.2 If the applicant is not a pensioner there is provision on the application form for a declaration to the be made by a person holding a public position to certify that the person is of similar limited means to a pensioner.

2.2.3 Applications must be made prior to the appointment dates allowing time for weekends and postage. The scheme applies only to State owned transport anywhere within Victoria. It does not apply to privately owned bus companies.

3. COMMONWEALTH DEPARTMENT OF SOCIAL SECURITY

3.1 Sickness Benefits (as at May 1982)

3.1.1 Sickness benefit is available to people who are not able to work because of temporary sickness or injury from an accident.

Eligibility: aged between 16 and 65 (male) or 60 (female)

sickness benefit does not come into effect until a person has been off work for seven days.

The maximum benefit payable for those over 18 years and single is $74.15 per week.

The maximum benefit payable to a married couple is $123.60 per week.

The amount of the benefit payable reduces (as per scale) once any other income reaches $10 per week.

3.1.2 If the claim for sickness benefits is made within 13 weeks the benefit will be backdated to the end of the second week.

If the claim for sickness benefits is made after 13 weeks the benefit will only be paid from the date of the claim, unless there is good reason, e.g. nature of illness.

3.1.3 Payments are made on the authority of a doctor's certificate.

If the person is still too sick to work a new certificate needs to be sent to the Department of Social Security before the first is out of date.

3.2 Invalid Pensions

3.2.1 To be eligible for an invalid pension a person must be 16 years or older and either permanently blind or permanently unfit for work because of health problems.

3.2.2 The amount paid to single people is $74.15 per week and they may have other income up to $20 per week before reductions are made to the pension.
The amount paid to married people is $61.80 per week to each person if combined other weekly income does not exceed $34.50 per week (i.e. $123.60 per married couple).

3.2.3 Pension payments will begin from the first pension pay day after the claim is made.

3.3 Fringe Benefits

3.3.1 Health Benefits Card: For those receiving sickness benefits or an invalid pension a health benefits card will be issued if:

- The person is single and other income does not exceed $40 per week.
- A married couple whose combined weekly income does not exceed $68 per week.

3.3.2 Health Care Card: Eligibility for a health care card is based on gross income, including any benefit, for the four weeks prior to the date of application.

	No children	With one child	Add for each extra child
Single	$412 (av. $103 p.w.)	$688 (av. $172 p.w.)	$80 (av. $20 p.w.)
Married	$688 (av. $172 p.w.)	$768 (av. $192 p.w.)	$80 (av. $20 p.w.)

(Family allowance, orphan's pension, and handicapped child's allowance do not count as income)

4. COMMONWEALTH DEPARTMENT OF HEALTH

4.1 Domiciliary Nursing Care Benefit

4.1.1 Domiciliary Nursing Care Benefits are available to a person who is caring for a relative fulltime at home. That is, the applicant and the person being cared for must reside in the same house.

A relative is defined as:

- wife or husband of the applicant
- defacto wife or husband of the applicant
- a parent, a son or daughter, brother or sister, niece or nephew, or an aunt or uncle of the applicant
- such other person(s) as the permanent head (Com. Dept. of Health) may approve having regard to the circumstances of the particular case.

4.1.2 Eligibility criteria are:

- Patients must be 16 years of age or more
- They must have the offical certificate from their own doctor stating that because of infirmity or illness, disease, incapacity or disability, they have a continuing need for nursing care by a registered nurse.
- The applicant must provide fulltime care for the patient. Short absences only for shopping or business matters are permitted.
- The patient must be receiveing adequate care by a registered nurse. Originally this meant at least twice weekly visits. However, where the caring person is considered to be sufficiently competent by the visiting nurse, to care for the patient, the nurse need only visit once a fortnight.

4.1.3 The application form has three sections. The first to be completed by the applicant, the second to be completed by the registered nurse, the thrid to be completed by the patient's doctor.

4.1.4 The benefit of $42 per fortnight is payable only from the date the application is received by the Commonwealth Department of Health in each state.

4.1.5 The application is finally approved by a departmental officer.

4.2 Isolated Patients Travel And Accommodation Assistance Scheme

4.2.1 This scheme provided financial help to people in rural areas who need to travel more than 200 km from their homes to obtain specialist medical treatment or services.

4.2.2 Eligibility: The patient must:

- reside more than 200 km from the specialist
- reside in an isolated area (i.e. all other than metropolitan)
- be refered by a medical practitioner to the nearest suitable specialist.

4.2.3 Provision exists for reimbursement of escort/attendant if:

- the patient is under 17 years of age
- the doctor certifies that an escort/attendant is necessary for medical reasons.

4.2.4 Benefits Payable are:

- Travel: Reimbursement of travel costs of the patient (and escort/attendant where applicable) from the patient's residence to the place of treatment are reimbursable less a single contribution of $20 per referal. Travel costs are based on economy surface trave (train, bus or boat). Costs for private car or plane are only reimbursable where the referring doctor certifies that such travel is medically necessary or the department considers economy surface travel as unreasonable.

- Accommodation: An accommodation allowance up to a maximum of $20 per night per person is payable where costs for accommodation are incurred for overnight stays in transit or at the treatment centre due to the limitations of public transport schedules or, overnight stays at the place of treatment where certified as necessary for medical reasons by the specialist.

  An accommodation allowance for an escort/attendant is only payable if the patient is eligible for accommodation allowance on the same nights and the specialist certifies that it is

necessary for medical reasons for the escort/attendant to remain with the patient.

Where the patient is over 17 years no accommodation allowance is payable for the escort/attendant if the patient is hospitalized. Where the patient is under 17 years and hospitalised an accommodation allowance is not normally paid for an attendant. It is payable for an escort if the specialist certifies that it is necessary for medical reasons for the escort to remain with the patient.

However, an accommodation allowance may be payable in both instances if the cost would be less than the cost of additional trips home and back by the escort/attendant.

Claims must be made within 12 months or the benefits are not payable.

The application form has several sections and must be completed by;

- referring doctor
- patient or guardian
- specialist
- transport and accommodation details includeing receipts.

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FOR DISCUSSION WITH PROJECT TEAM

REVIEW OF ACCV WELFARE SERVICE 1977/78 TO 1981/82

Source Material

* ACCV Welfare Service Annual Report
* Welfare Statements
* Memo, Minutes and Situational Report prepared for Ad-hoc Committee on Welfare Program May/June 1978

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1. PATIENT WELFARE POLICY 1976

1.1 The ACCV Patient Welfare Policy was defined in a document prepared by the Director dated June 10, 1976. This document states:

The objective of the Anti-Cancer Council's program in Patient Welfare is to improve the social and non-medical components of the cancer patient's situation by whatever means are appropriate. Over the years a philosophy has been developed by the Committee which may be summarised:

* All available use should be made of Government resources.

* The Council should not generally do anything which the Government will do.

* It should sometimes do things which the Government can do but will not do, on a short-term basis

* It should concentrate on doing the things which the Government cannot do, e.g. to identify the needs of cancer patients/families, to make Governments aware of gaps in the statutory services.

Above all, out policy should be flexible and our administration unbureaucratic.

Because the medical system has changed substantially several times in recent years, the Council's policy has changed of necessity. Detailed policies at present are:

1. To provide direct help to cancer patients and their families where illness and medical treatment are complicated by social and emotional problems.

2. To provide consultation with hospital and community social workers and for members of other service disciplines on how to work most helpfully with cancer patients and/or their families.

3. To mobilise the wide range of welfare services available in the community.

4. To contribute to the development of social and health programs in the community.

5. To conduct research and pilot studies on social aspects of cancer care both at treatment and preventive level.

Our emphasis is always on helping cancer families grapple with their particular problem by whatever means is best suited to their particular capabilities - this can be done by sharing some of the problems the families face that cancer can cause and her broad knowledge of the many ways these problems can be alleviated.

1.2 Direct service is emphasised in this policy statement

2. PATIENT WELFARE POLICY 1978

2.1 In June 1978 an ACCV sub-committee on the future of the Welfare Program considered a Situational Report prepared by the Social Worker (May 1, 1978) and a Memo from the Director (May 28, 1978) which identified key points to be the addressed in respect of the Council's Welfare Program. The minutes of the Sub-Committee meeting (June 6, 1978) state:

"General Welfare Policy: A number of questions were considered including the basic one "should the Anti-Cancer Council be involved in any type of welfare program? There was considerable discussion, which emphasised the philosophical view that the Council, in general, should avoid routine service commitments; that our research and development role should be emphasised and that our analytical work should lead to policy developments which ought to be presented to Government in order to change the welfare scheme."

"The basic objectives of the program were spelt out as follows:

The ACCV should work towards improving welfare programs and the social management of cancer patients.

That the ACCV should maintain a significant research bias.

That a continuing emphasis should be placed upon the need to delineate problems to alert the appropriate Government agency to these and where necessary exert pressure.

The ACCV should contribute towards informing appropriate sections of the health care system, e.g. doctors, nurses, of developments within Government welfare programs. The possibility of a newsletter was raised here.

2.2 This policy statement emphasises a research and policy development role.

3. PATIENT WELFARE BUDGET 1977/78 TO 1981/82

3.1 The total expenditure on the Patient Welfare Service has increased from $157,545 in 1977/78 to $194,953 in 1981/82. The proportion of the total budget allocated from major expenditure areas has remained relatively constant over the period. The spending pattern for the years 1977/78 to 1981/82 is shown in Table 1.

TABLE 1

ACCV Welfare Services Budget Allocation To Major Expenditure Areas
1977/78 to 1981/82

Budget Allocation	1977/78 $	1978/79 $	1979/80 $	1980/81 $	1981/82 $
Individual Grant Program	81,774 (52%)	66,808 (45%)	89,247 (54%)	88,340 (54%)	103,777 (53%)
Subsidised Support Systems	21,555 (14%)	15,638 (11%)	13,625 (8%)	13,471 (8%)	22,555 (11%)
Salaries and Superannuation	36,980 (23%)	46,950 (32%)	40,555 (24.5%)	42,134 (25.5%)	41,782 (21%)
Administrative Services	17,236 (11%)	17,500 (12%)	22,455 (13.5%)	20,956 (12.5%)	26,894 (14%)
Total Expenditure	157,545	146,896	165,882	164,901	194,953

3.2 The change of policy emphasis noted in Sections 1 & 2 is not reflected in the expenditure pattern.

4. THE INDIVIDUAL GRANT PROGRAM

4.1 This program is described in the Social Worker's Annual Report 1977/78 as:

> "An innovative family support service. Its main thrust is to maintain as healthy functioning units cancer families shattered by the diagnosis or scared stiff to the point of complete immobility

by the financial chaos precipated by Cancer."

(para 4)

4.2 The concept of a 'bridging grant contract' rather than a charitable short term crisis grant was introduced in 1976/77. The Social Worker's Annual Report 1978/79 describes the "bridging contract" as follows:

> "The function of the ACCV social worker is to continually present a problem-solving rather than a bandaid approach to patients' problems. The term 'bridging contract' has been coined to describe this sphere of welfare spending. It in fact provides the bridge between two life styles - the old and the new. Many families are forced to live on one wate, having become accustomed to two wages - or are reduced from having a wage income to being dependent on statutory benefits. Financial commitments have usually been made at a time when the wages income appeared secure. These family units impressionistically appear to compose the larger segment of our client groups.
>
> Philosophically our belief is that the earlier a family unit or individual receives an appropriate infusion of financial assistance the less likely is this family (or individual) to requre further large allocations of financial assistance at a later

stage in the patient's life. Without such help many families would slide below the poverty line and thus be forced to continually turn to ACCV and other community welfare agencies for 'piecemeal' handouts.

Funds are made available, usually through an intermediary social worker who is hospital based or through other health professionals based in community health centres. We attempt to ensure that red tape is kep to a minimum and that welfare grants are offered in a manner commensurate with the individual's (or family's) sense of personal dignity."

4.3 The distribution of individual grant expenditure over areas of assistance for the years 1977/78 to 1981/82 is shown in Table 2.

TABLE 2

Distribution Of Individual Grant Expenditure Over Areas Of Assistance 1977/78 to 1981/82

Areas of Assistance	1977/78 $	1978/79 $	1979/80 $	1980/81 $	1981/82 $
Terminal Subsidies	30	112	Phased out		
Insurances	6,016 7%	2,867 4%	2,083 2%	209 0·25%	1,174 1%
Living Allowances	8,529 11%	3,404 5%	8,920 10%	7,948 9%	14,198 14%

Table 2 cont.

Housing	15,182 19%	12,447 19%	14,264 16%	13,492 15%	20,973 20%
Rates	13,677 17%	13,906 21%	23,~~704~~ 021 26%	29,704 34%	20,752 20%
Transport	11,161 14%	17,426 26%	21,058 23.5%	20,624 23.5%	26,696 26%
Hire Purchase	6,496 8%	6,660 10%	4,174 5%	2,756 3%	5,308 5%
Telephone	7,260 9%	4,399 7%	7,775 9%	6,213 7%	7,837 7%
Accommodation/ Per Diem	3,663 4%	909 1%	502 0.5%	1,190 1.5%	1,829 2%
Medical Equipment	875 1%	1,562 2%	2,348 3%	3,462 4%	1,987 2%
Funerals	6,105 7%	2,017 3%	2,995 3%	450 0.5%	Phased out
Other	2,780 3%	1,099 2%	2,152 2%	2,292 2.5%	3,023 3.%
Total Expenditure	81,774	66,808	89,247	88,340	103,777

4.4 Applications for grants are administered by ACCV staff. The distribution of the grants to patients or their families through hospitals/agencies in Victoria is shown in Table 3.

TABLE 3

Distribution Of Welfare Grants Expenditure By Hospitals/Agencies
1977/78 to 1981/82

HOSPITALS/AGENCIES	1977/78 $	1978/79 $	1979/80 $	1980/81 $	1981/82 $
Peter MacCallum Hospital	28,532 35%	22,454 34%	26,827 30%	24,253 27%	31,399 30%
Royal Children's Hospital	20,647 25%	15,858 24%	17,902 20%	20,600 23%	24,457 24%
Other Metropolitan Hospitals	23,749 29%	18,587 28%	29,142 33%	29,904 28%	31,260 30%
Country Hospitals	1,004 1%	1,367 2%	2,629 3%	1,688 2%	798 1%
Community Health Centres	3,563 4%	2,389 3%	944 1%	4,120 5%	1,844 2%
Municipal Councils	-	-	208 0.2%	1,314 1.5%	690 1%
R.D.N.S.	-	-	0 0	224 0.2%	490 0.5%
Other Agencies	2,712 3%	3,531 5%	1,401 1.5%	4,420 5%	2,576 2%
Acc. Social Worker	1,567 2%	2,622 4%	10,194 11%	6,817 8%	10,263 10%
Total Expenditure	81,774	66,808	89,247	88,340	103,777
Av. cost per patient	312	301	290	256	309

The proportion of the total expenditure allocated directly by the ACCV Social Worker increased from 2% in 1977/78 to 10% in 1981/82.

5. SUBSIDISED SUPPORT SYSTEMS

5.1 The programs supported under this Budget allocation together with this allocation of funds to those programs in the years 1977/78 to 1981/82 is shown in Table 4.

TABLE 4

Subsidised Support Systems - Budget Allocation
1977/78 to 1981/82

	1977/78	1978/79	1979/80	1980/81	1981/82
Breast Prosthesis Service	4,865 (22%)	1,323 8%	1,055 (8%)	2,066 (15%)	1,481 7%
Sessional Consultant Caritas Christi Hospice Hospice Grant Geelong	3,846 (18%)	5,715 37%	3,970 (29%)	2,605 (19%)	4,519 (42%)
Visiting Nurse Services	7,600 (35%)	7,300 47%	7,300 (54%)	7,500 (56%)	10,000 44%
R.C.H. Special Transport Grant	1,300 (6%)	1,300 8%	1,300 (9%)	1,300 (10%)	1,500 7%
Final Phase Out Terminal Care	4,124 (19%)				
Total	21,555	15,638	13,625	13,471	22,500

5.2 The Breast Prosthesis service is regularly assessed in the Annual Reports. The conclusion reached by the Sub-Committee on the Future of the Welfare Program in 1978 in respect of the breast prothesis service is supported in subsequent Annual Reports. The Minutes (June 6, 1978) states:

> **". . it was generally concluded that the service was first quality, involved a coordinating role and minimal expense and that it was appropriate for the Council to continue running the service . ."**
> (p. 1)

5.3 The Volunteer Visiting Service was established in 1980/81. A patient who has recently had a mastectomy can, if she wishes, be visited by a trained volunteer visitor, a fellow mastectomee who has been disease free for a minimum of two years and has adjusted to the change in her self image and resumed her normal life style.

In the Welfare Statement (April 1982) the Social Worker reported that 16 volunteers were no actively involved in the service. She expressed the view that the service was "a valuable adjunct to the Breast Prosthesis Service."

6. RESEARCH AND POLICY DEVELOPMENT

6.1 The General Welfare Policy adopted by the Council (June 6, 1982) states:

> ". . the Council, in general, should avoid routine service commitment; that our research and development role should be emphasised and that our analytical work should lead to policy development which ought to be presented to Government in order to change the welfare scheme."

This research on policy development emphasis is not evidenced in subsequent Annual Reports or Welfare Statements examined.

6.2 Four policy issues are noted in the Annual Reports.

6.2.1 Isolated Patients Travel and Accommodation Assistance Scheme (1979/80).

The problems associated with the 200 km distance from treatement centre criteria were raised at the Australian Cancer Society meeting (April 1980). The meeting argued that a 75-100 km distance criteria would be more realistic.

6.2.2 Sickness Benefit Claims (1979/80)

Sickness benefit requires an initial 7 days waiting period before payments commence. Each period of ill health thereafter also requires a new registration and a 7 day interlude before Sickness Benefit is forthcoming. This criteria discriminates against people with chronic or recurring diseases. A letter was sent to the Minister for Social Security (and other relevant MPs) in August 1980 which identified this problem and proposed alternative criteria.

6.2.3 Voluntary Transport Service (1980/81)

Hospital Social Work Departments provided information on problems encountered with volunteer transport services. The Social Workers Report concluded that "voluntary transport for patients in Victoria is fragmented, inflexible in the main and is not comprehensive. Each hospital does 'its own thing' and there has been a failure on the part of the hospitals to attempt to coordinate in an effort to overcome their common difficulties."

6.2.4 Program of Aids for the Disabled (1981/82).

Problems associated with the functioning of PADP were identified.

6.3 The Secretary to the Council has indicated that although some of these issues have been presented to Government that no changes to the Welfare Scheme have resulted to date.

7. EDUCATION

7.1 The educative function of the ACCV Welfare Service is noted in each Annual Report examined. Three principal activities are outlined in the Annual Reports.

7.2 The Social Worker has presented papers on community resources at Cancer Seminars conducted by the ACCV. Seminars for Welfare personal or counselling persons suffering from cancer have also been conducted.

7.3 The Social Worker has visited hospital social work departments and community agencies to provide information on changes to Medibank and the implications of these changes to persons suffering from cancer. The consultative role of the ACCV Welfare Service has also been promoted through these visits.

7.4 Enquiries from both cancer patients and their families and from welfare profressionals who deal with persons suffering from cancer are handled by staff of the Welfare Service.