

**High on Aspiration,
Low on Implementation:
The development and implementation
of the
New Zealand Disability Strategy**

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Table of Contents

Acronyms	iii
Abstract	iv
Acknowledgements	v
Introduction and Methodology	1
Chapter One: New Zealand Government Disability Policy – from medical model to social model	12
Chapter Two: The Development of the New Zealand Disability Strategy by Central Government (1995-2000)	30
Chapter Three: The Implementation of the New Zealand Disability Strategy by Central Government (2001-2011)	44
Chapter Four: Background – New Zealand’s Public Health and Disability System and Case Study One: Capital and Coast District Health Board	79
Chapter Five: Case Study Two: Otago District Health Board	103
Chapter Six: The New Zealand Disability Strategy: Are we living the vision of an inclusive society?.....	125
Bibliography	141
Appendices	153

Acronyms

CCDHB	Capital and Coast District Health Board
CPHAC/DSAC	Community Public Health Advisory Committee / Disability Support Advisory Committee
DHB	District Health Board
DPA	Disabled Persons Assembly
DSAC	Disability Support Advisory Committee
DSRG	Disability Sector Reference Group
NZDS	New Zealand Disability Strategy
ODHB	Otago District Health Board
ODI	Office for Disability Issues
PBF	Population Based Funding
SDHB	Southern District Health Board

*The most frequently used acronyms in this research are listed here.

Abstract

In 2001 the New Zealand Government launched the *New Zealand Disability Strategy*. This thesis examines the historical background behind the Strategy's formulation, the rationale for it, and implementation within government. The Strategy's implementation met numerous obstacles within the state sector during the first ten years of its existence. These obstacles are evaluated at the micro-organisational level within two case studies, namely the Otago and Capital Coast District Health Boards.

This thesis found that the Strategy initially met an enthusiastic reception across government and from within the disability sector. However, implementation slowed down significantly within sections of the public sector while it continued apace within others. The reasons for the two-speed nature of Strategy implementation are analysed within the two studies. The lack of progress on the Strategy (as viewed from a disability perspective) comes down to a variety of factors including a lack of funding and a national plan of action for implementation from central government, as well as the impact of managerialist theory and minimal understanding of disability issues on the part of some officials.

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otherwise during my childhood. Credit must go to my former partner Jacinta Latta for pushing me on while writing the bulk of this thesis in late 2010/early 2011.

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Introduction and Methodology

On the late afternoon of April 30 2001, members of the disability community in Dunedin gathered to witness an historic occasion for disabled New Zealanders at the Cargill's Hotel complex in the northern end of the city – the launch of the *New Zealand Disability Strategy*.¹ Those gathered had waited for this day for almost two years since the election of the Labour-Alliance Government in 1999. Indeed, for most, they had waited a lifetime. While Disability Issues Minister, Lianne Dalziel, officially launched the New Zealand Disability Strategy (NZDS) at the Beehive in Wellington, internet and audio links allowed members of the New Zealand disability sector from around the country to participate in the event.

Through the link I heard numerous speeches and waiata including what seemed a very emotional address from Disabled Persons Assembly DPA Chief Executive, Gary Williams. He described the new strategy as being the disability sector's equivalent of the Treaty of Waitangi. Some found the reference perplexing given that the Crown had historically violated the Treaty both through commissions and omissions, but he meant that the NZDS was a relationship/partnership building document which might bring government to redress the various inequities that disabled people faced. One interviewee closely linked to the disability sector noted that while the two documents are different, with one being the national founding document and the other a strategic one, she felt that '...why [disabled] people described it as their treaty, I think, is because it was the first time that this [the social model of disability] has been physically documented.'²

On that mid-autumn day in 2001 the New Zealand Government recognised for the first time the political importance of disability. The Government recognised the need to remove the multifarious barriers that confronted disabled people in their daily lives. These barriers had been centuries in the making, and many were structural, leading through their

¹ Minister for Disability Issues, *The New Zealand Disability Strategy: Making a World of Difference: Whakanui Oranga*. (Wellington: Ministry of Health, 2001), i-viii, 1-30.

² Anonymous interviewee closely linked to disability sector. Telephone interview by author, April 19, 2010.

interaction with one another, to the attitudinal issues that confronted people with impairments.

Statistics New Zealand conducted the first independent disability survey following the 1996 Census. Approximately 636,000 identified as having a disability in 1996, a number that had increased to 743,800 by 2001. Compared to the overall population, the ratio of one in five (or 20 percent) of the population living with disability had remained unchanged between the two surveys.³

Both the 2001 and subsequent 2006 disability surveys, and other research, tended to confirm both the anecdotal and empirical observations that impaired people were at the bottom of the societal heap in this country (as they are internationally) when it came to the key measurements which indicated social well-being. The *Making a World of Difference: Whakanui Oranga* discussion document produced in 2000, indicated that disabled people are less likely to possess formal educational qualifications; are more susceptible to experiencing labour market disadvantage; are far more likely to live on lower incomes; and have unmet needs for support or other types of assistance. Complaints on the grounds of disability were amongst the highest number received by the Human Rights Commission and resulted from poor attitudes amongst the general population towards disabled people.⁴

These injustices inspired an un-named submitter to the Disability Strategy consultation to write the following:

*Disability is in society, not in me...I have the right to dignity, to develop my potential, to use my qualities and skills.*⁵

The drafters of the Disability Strategy chose these words to introduce the document as they eloquently summed up the basic principle of the modern disability rights movement that

³ "Household Disability Survey 1996," Statistics New Zealand, accessed March 27 2009, <http://www.stats.govt.nz/products-and-services/Articles/household-disab-survey-1996.htm>.

⁴ Hon. Ruth Dyson, *Making a World of Difference: Whakanui Oranga: The New Zealand Disability Strategy Discussion Document.* (Wellington: Ministry of Health, 2000),1-2.

⁵ Minister for Disability Issues, *The New Zealand Disability Strategy*, 3.

disability is a social construct whereby society puts in place attitudinal, environmental, and social barriers to the inclusion of people with impairments. These barriers transcend the traditional socio-political cleavages of class, ethnicity, gender, sexual orientation, and religion as impairment occurs across all strata of society.

Therefore, the NZDS notes ‘...that we live in a disabling society. The New Zealand Disability Strategy presents a plan for changing this.’⁶ For me as a disabled person, as much as for others who live with impairment and experience disability, this is easier said than done. But the journey has to begin somewhere and the NZDS, within the local context, provides the best starting point against which progress can be measured at the governmental level towards eliminating barriers to participation for disabled people.

This thesis examines the process by which the NZDS came into being and its varying implementation across government as illustrated by a case of study of its application in two District Health Boards (DHBs), namely Otago (ODHB), and Capital and Coast (CCDHB). My argument is that the NZDS promised much to the disability community in terms of objectives and actions that would, if fully implemented, improve the lives of disabled people. However, as of 2011, the Strategy has never been fully implemented due to the lack of disability awareness and political will that has existed within sections of the bureaucracy. I will demonstrate that the Fifth Labour Government’s decision to weaken the proposed draft Strategy, from being a directive document to simply an aspirational one, limited its potential ability to effect radical change in the lives of disabled people. I will also argue that the Strategy has been under-resourced in funding terms by both Labour and National Governments and has suffered from not having a national implementation plan.

The Labour-Alliance Government sought to improve the status of disabled people through the drawing up of the Disability Strategy following its election to office in 1999. Since the mid-1970s, New Zealand Government disability policy had been gradually transitioning from a medical model of disability to a social model of disability. The Fourth National Government’s decision to transfer disability support funding from the social welfare sector into the health sector effectively halted this transition in the early 1990s. In the view of disability activists the National Government’s move in this regard represented a regression

⁶ Ibid, 3.

back to the medical model of disability. Labour pledged to modify National's disability policy in that while they pledged to retain disability support funding within a centrally based health and Disability Support Services (DSS) framework, their manifesto promised that within its first term it would develop, in partnership with the disability sector, a comprehensive disability strategy.⁷ The appointment of a Minister for Disability Issues at cabinet level formed a key component of this policy.⁸

Concurrently the Labour-Alliance Government under Minister of Health, Annette King, sought to carry out another coalition promise: to restructure the health sector in order to administer it within a more public service-oriented ethos. This necessitated the passage of the New Zealand Public Health and Disability Act 2000 under which were established 21 Crown entities known as District Health Boards. These DHBs were legally responsible (with oversight from the Ministry of Health) for the funding of primary health care services and the direct provision of secondary and tertiary health services within their regions. This legislation also mandated the drawing up of a *New Zealand Disability Strategy* and annual progress reports upon it to Parliament. The Public Health and Disability Act stipulated that the strategy sit alongside the *New Zealand Health Strategy* and other relevant health and disability strategies.⁹

Chapter One sets the historical context of the NZDS within the contrasting medical and social models of disability and explains why the social model was preferred. The chapter

⁷ Robin Gauld, *Revolving Doors: New Zealand's Health Reforms* (Wellington: Institute of Policy Studies, Victoria University, 2001), 179-80. The National-New Zealand First Coalition Government of 1996-98 had abolished the four Regional Health Authorities and amalgamated them into a central Health Funding Authority [HFA] structure in 1998.

⁸ Paul Saucier *Promoting A National Vision for People with Disabilities: Successful Policies and Enduring Barriers*, (Wellington: Ian Axford (New Zealand) Fellowship in Public Policy Report, 2002), 18.

⁹ *New Zealand Public Health and Disability Act 2000*, s 8(2) of the New Zealand Public Health and Disability Act 2000 states that "The Minister of the Crown who is responsible for disability issues must determine a strategy for disability support services called the New Zealand disability strategy, to provide the framework for the Government's overall direction of the disability sector in providing disability support services; and may amend or replace that strategy at any time."

explains how the social model has definitively influenced the NZDS in both its development and implementation.

Chapter Two looks at the development of the Disability Strategy and, specifically, the institutions and individuals who promoted it. The chapter analyses the processes involved and the issues that surrounded its development by the NZDS reference group and other bureaucratic and political actors. I will also describe in this chapter the reasons why the Strategy became less directive and more aspirational in character.

In Chapter Three I look at how the NZDS was implemented across government with reference to annual implementation reports. I assess the perspectives of both the government and disability sectors on the successes and problems involved in Strategy implementation with special reference to the positives and negatives of Strategy implementation under both Labour and National governments.

Chapter Four outlines the functions and roles of district health boards and, in particular, the legal responsibilities that DHBs have towards disabled people. It then proceeds to the first case study of a DHB and its implementation of the NZDS, namely the CCDHB (Wellington). Chapter Five contains the next case study of the ODHB's implementation of the Strategy. Both case study chapters will consider these questions: have these DHBs sought to meet the relevant health service access and other objectives of the NZDS? What progress have they made on implementing the Strategy? Have these DHBs developed disability strategy implementation plans with clearly defined outcomes? What barriers have been encountered in terms of implementing the NZDS? Have disabled people, their families/whanau and support agencies been adequately consulted about the NZDS at DHB level? And, overall, how successful has Strategy implementation been at the DHB level? Have service quality and health outcomes for disabled people improved? Are disabled people treated within the health system on the basis of the social model of disability, where the person and their holistic health needs are primarily respected while medical/rehabilitation treatment or assessments are undertaken? Given the Strategy's call for the collation of additional statistics on disability by government agencies are these factors measurable?

Chapter Six will look at the lessons learnt from implementing the NZDS across the public sector and how these lessons and any best practice can be applied to future developments. The progress made in implementing the NZDS within health boards has been symptomatic of its wider implementation across the state sector – erratic at best. The chapter provides a series of short recommendations on improvements to the Strategy and its implementation across government and acknowledges both positive and negative developments. Finally the chapter speculates as to what the future might hold for the NZDS following New Zealand’s adoption of the *UN Convention on the Rights of Persons with Disabilities* in 2008.¹⁰

A note on the terminology used in this thesis. The term ‘disabled person’ as adopted for use in the NZDS, reflects a further sea change in how disabled people view themselves and their place in the world. In fact arguments about terminology/language pervaded the discussions of the NZDS reference group. Previously the American-derived term ‘people with disabilities’ was used to describe disability in this country. This terminology emphasised that the person came first before their impairment. However, the term ‘disabled people’ became the preferred official terminology within the New Zealand Disability Strategy context. New Zealand social and disability policy specialist, Martin Sullivan, agrees with the need for this:

I would characterise the ‘disabled people’ camp as representing those with a materialist or structural analysis that unequivocally locates disability in mainstream social structures. Disability, therefore, is a social phenomenon, it is a form of social oppression, it is socially created, it does not reside in individuals.¹¹

Furthermore, this thesis covers the spectrum of disability and includes age-related impairment within its reference as well. One potential pitfall, though, is that people in some impairment-based groups reject the term disability when applied to them. People from the Deaf community do recognise that they face barriers through the hearing world’s

¹⁰ “United Nations Convention on the Rights of Persons with Disabilities,” United Nations, accessed September 25 2010, <http://www.un.org/disabilities/convention/conventionfull.shtml>.

¹¹ Martin Sullivan, "Does It Say What It Means, Does It Mean What It Says, Do We Know What We Are Saying? Problematizing the Way Disability Is Conceptualised, Written and Spoken About," *New Zealand Journal of Disability Studies*, no. 8 (2000): 39.

non-recognition of their cultural identity and right to participate within society.¹² Similarly, people with experience of mental illness see themselves, predominantly, as having a mental health condition, but they tend to experience disability in terms of the stigmatisation and prejudice that surrounds them in the community.¹³ While recognising and respecting these varying perspectives, this thesis argues that disability is about how society imposes barriers against ALL people with impairments and the NZDS recognises this.

Methodology

Research Strategy

I wanted to find out about the views and perceptions of those involved in the formation and implementation of the Strategy. Therefore, I decided to take a qualitative approach through conducting in-depth interviews with various Strategy stakeholders to elicit this information. I extensively consulted primary source documentation, in the form of government discussion papers, strategy documents and meeting minutes, particularly for the DHB case studies. I also consulted literature, in terms of books and journal articles pertaining to disability theory and those relating to health and disability policy, to theoretically underpin my case study findings.

Selection of Participants for Case Studies

Overall, I conducted twenty-three in-depth interviews with twenty-one subjects from December 2009 to May 2010. My aim was to speak with disability sector and government actors involved in the Strategy's formulation and implementation. Case study participant selection occurred on the following basis: I selected six interviewees owing to my personal involvement with them during my time as an ODHB employee, or the fact that I personally knew them through disability community connections. Snowball sampling (people recommended to me by others owing to their known involvement with the NZDS)

¹² Rachel Noble, telephone interview by author, May 26, 2010.

¹³ Mary O'Hagan, telephone interview by author, June 4, 2010.

accounted for three interviews. Purposive sampling (people whom I personally knew to be involved with the NZDS) accounted for the remaining fourteen interviews. I conducted face-to-face interviews with seven participants with the remaining sixteen by phone.

The number of interviews exceeded the number of interviewees for three reasons. First, two interviewees played multiple roles in the Strategy's formulation, namely, Paul Gibson (as former DPA president, disability sector reference group member and Capital and Coast DHB disability advisor) and Jan Scown (as disability sector reference group co-chair and Office for Disability Issues director). Second, I interviewed Jan Scown and Paul Martin twice. I interviewed Scown twice (the first time face-to-face and the second via phone) owing to time constraints on our first interview, and Martin given that he had additional information that I believed would be useful. Third, I interviewed Paul Gibson jointly with Maurice Priestley in their district health board roles.

I also interviewed seven former disability sector reference group (DSRG) members. I identified the group members through reference to the NZDS document as it contained their names. This group provided advice to the Ministry of Health and the Minister for Disability Issues on strategy content. All former members gave an idea of the internal group debates that transpired during the Strategy's formulation. For the DPA perspective, I interviewed two former leaders on the organisation's role in helping push the Strategy forward.

On the government side, I interviewed two former Ministers for Disability Issues, the Hon. Ruth Dyson and the Hon. Lianne Dalziel. Interviewing Ruth Dyson proved invaluable as, being the first Minister for Disability Issues, she provided a candid account of her role in the Strategy's development. Conversely Lianne Dalziel gave only limited information as she served temporarily in the Disability Issues portfolio from late 2000 to early 2001. For a bureaucratic perspective I interviewed senior officials in the Ministry of Health and Office for Disability Issues. I also invited the National-led government's Minister for Disability Issues, the Hon. Tariana Turia, and her associate, the Hon. Pansy Wong, for interviews. Both ministers declined their invitations.

For the DHB case study chapters, I interviewed eight individuals with the intention of covering both governance and management perspectives. Accordingly four interview

subjects had management experience and three had governance experience within the DHB system. In terms of regional balance, six DHB interviewees came from the ODHB and two from the CCDHB. I also interviewed a former Labour Government Minister of Health, the Hon. Pete Hodgson, about the legal powers that he possessed in DHB matters.

Data Analysis

All interviews were recorded and later transcribed. Interview duration lasted from 25 minutes minimum to 60 minutes maximum with 45 minutes being the average length. In terms of being able to replicate the study, I have identified all my interviewees except two. Those two requested anonymity owing to the sensitive nature of their current or past roles. Only two interviewees requested a copy of the questions in advance (the two former ministers Dalziel and Dyson, whose question transcripts are included in the Appendices). However, in all cases, I gave each subject a general indication of the interview questions.

All interviewees faced ten pre-set questions and then any clarifying questions. I put many of my pre-set questions to interviewees, while others emerged as follow-ups from comments they made that were of interest. Other questions were not asked at all owing to their having been answered within an earlier question. I also faced issues in contacting at least three potential interviewees who initially agreed to be interviewed. After numerous attempts were made to re-contact them, I abandoned my efforts. Notably I interviewed Otago DHB management and governance actors but at Capital and Coast only management actors. This came about owing again, to proximity issues. I was located in Otago and had time and financial resource constraints (especially those involved in travelling to Wellington). Moreover, the information supplied to me by Paul Gibson and Maurice Priestley at Capital and Coast enabled me to establish the reasons why NZDS implementation had been more effective within their DHB. Otherwise, I encountered few problems with them apart from some interviewees finding it difficult to recollect events.

During my analysis of the interview transcript data, I used the techniques of American academics Gerry W. Ryan and H. Russell Bernard around identifying common themes.¹⁴ I looked for any repetition of topics and ideas that came up during each interview. Cumulatively these analyses assisted in building up the key themes and theories that came to underpin my findings. I also focused upon looking for similarities and differences, especially when it came to the DHB case study interviews. These enabled me to establish the comparisons and contrasts between DHB implementation at the Otago and at the Capital and Coast boards.

Criterion for Selection of District Health Boards

I opted to study District Health Boards for my case studies for two reasons. Firstly, disabled people face considerable barriers in accessing health care both nationally and internationally.¹⁵ Secondly, I have been an employee of a DHB, namely the Otago DHB. In terms of specific DHB selection, I chose the Otago, and Capital and Coast District Health Boards as case study examples for the following reasons: I chose Otago as the Board servicing my home region. I am also a former employee of the Otago DHB's planning and funding section and this personal connection assisted in my securing interviews with governance and management stakeholders who had participated in NZDS implementation. I also wanted to objectively seek answers to questions raised by the local disability community about the Otago DHB's commitment to the Strategy both prior to my employment with the board and during it. Why was the Otago board so tardy in its implementation of the Strategy? Was this owing to Otago Board staff and governance players having poor attitudes towards disability issues in general? Was this due to financial constraints? Was it a combination of both? Coming into this thesis, I had the impression that the Otago DHB was, in colloquial terms, 'the odd man out' being one of the few public sector agencies that had not fully advanced the Strategy. I came from the

¹⁴ Gerry W. Ryan and H. Russell Bernard, "Techniques to Identify Themes", *Field Methods* 15, no.1 (2003): 87-94.

¹⁵ Disability Rights International, *Disability Rights in Aotearoa New Zealand 2010: A report on the Human Rights of Disabled People in Aotearoa New Zealand* (Wellington: Crown Copyright, 2010), 49-50.

expectation that nearly all government agencies would have implemented the Strategy but my research shows this not to be the case.

My discovery that the ODHB was simply representative of widespread public sector antipathy towards the Strategy prompted my search for a DHB that had successfully engaged with the NZDS. I received suggestions from disability sector contacts about DHB regions that had developed NZDS-related plans but, in the end, the CCDHB stood out as an example of good NZDS implementation practice. This was after I analysed a number of the CCDHB's Disability Strategy related documents and plans. Through choosing the CCDHB as a comparator organisation, I could answer the following questions: First, how should a government agency actually go about implementing the Strategy in terms of securing stakeholder buy-in? Secondly, how can a government agency, like the CCDHB, implement a comprehensive strategy like the NZDS while operating within severe financial constraints?

Overall, I will use the ODHB and CCDHB examples to demonstrate, from a micro-organisational level, as to why the Strategy was high on aspiration but low on implementation throughout government.

Chapter One

New Zealand Government Disability Policy - from medical model to social model

This chapter documents the popular and political influence of both the medical model of disability and the social model of disability in New Zealand. An overview of both these models is important in understanding the intellectual context that informed the New Zealand Disability Strategy. The Strategy responded to the disability community's desire that government policy should no longer recognise the medical model of disability in its entirety and instead premise itself upon the social model of disability. Indeed, it is important to recognise the intellectual and political influence of the global disability rights movement on the New Zealand disability rights movement given that, traditionally, the medical model of disability has influenced the public view of disability both in New Zealand and globally.¹⁶ This chapter will outline, using the medical and social models of disability, the key historical and political events for disabled people both in New Zealand and overseas between 1911 and 1999. This chapter will also introduce the theory of managerialism that later came to impact upon NZDS implementation within the public sector.

Medical versus social model of disability

American disability theorist, Mary J. Johnson, defines the medical model of disability as 'a personal, medical problem requiring but an individualised medical solution.'¹⁷ Indeed, the

¹⁶ Chris Ford, "Good-bye to Tiny Tim: An introduction to the politics of disability," *New Zealand Political Review*, Summer 2004, 10-19.

¹⁷ Mary J. Johnson in Bradley A. Areheart "When Disability Just Isn't Right: The Entrenchment of the Medical Model of Disability and the Goldilocks Dilemma," *Indiana Law Journal*, 83, no.181 (2008):186.

model locates disability inside the individual rather than within society itself.¹⁸ Because of its adoption of an individualised disability focus, the medical model encompasses a view of impaired people ‘as having individual attributes of incapacity and dependence.’¹⁹ To address these deficits, the medical profession traditionally resorted to rehabilitation or medical cures in an attempt to eradicate impairment altogether.²⁰ Owing to the popular view of disability being influenced by the medical paradigm, disability rights, in the view of American legal theorist, Bradley A. Areheart, have been seen as ‘special’ and accordingly dispensed as a ‘form of charity for biological losers.’²¹ Therefore, the medical model has no regard for the human rights of disabled people and even their right to exist has been questioned at intervals during the last three centuries.

The proponents of eugenics, in particular, questioned the right of disabled people to exist. Eugenic philosophy, first expounded by British scientist, Francis Galton, in the late nineteenth century, sought to control the reproductive and other rights of those deemed undesirable including beggars, alcoholics, and people who had a wide range of physical, intellectual, sensory and other impairments and those with experience of mental illness.²²

Galton’s work expanded on that of his famous half-cousin, the naturalist, Charles Darwin. Darwin scorned the need for society to support and include disabled people and those with mental illness. He wrote in *The Descent of Man and Selection in Relation to Sex*:

*We civilised men, on the other hand, do our utmost to check the process of elimination; we build asylums for the imbecile, the maimed and the sick; we institute poor laws; and our medical men exert their utmost to save the life of everyone to the last moment.....Thus the weak members of society propagate their kind. No one who has attended to the breeding of domestic animals will doubt that this is highly injurious to the race of man.*²³

¹⁸ Ibid.

¹⁹ Ibid.

²⁰ Ibid.

²¹ Ibid.

²² Francis Galton, *Inquiries into Human Faculty and Its Development* (London: J.M. Dent, 1883), accessed October 23, 2010, <http://www.galton.org/books/human-faculty/pdf/part1.pdf>.

²³ Charles Darwin, *The Descent of Man in Relation to Sex* (New York: Appleton, 1922), 136.

In the wake of Galtonian eugenics, from the mid-1880s onwards, the medical control of disabled people's lives became greater in the interests of preventing not just impairment itself, but the feared genetic spread of it through the wider population. Of course, the wider societal view of impairment had been inconsistent up to this juncture. American disability theorist, Patrick J. Develiger, argues that the religious/moral theory of disability predominated popular thinking in the pre-medical model era. Religious/moral theory surmised, for example, that people had their disability either conferred by God as a special gift or as punishment for past sin.²⁴

As medicine evolved so did the authoritarian and coercive power of its practitioners. The French theoretician, Foucault, in Sullivan's words, created 'a history of the modes by which human beings are objectified and transformed into subjects.'²⁵ Sullivan further summarises this process with respect to disability:

*In contemporary society, the hospital is an important node in the carceral where 'dividing practises' objectivise the subject as either sick or healthy, curable or incurable, complete or incomplete, normal or abnormal. The medical-judges, the priests and priestesses of secular society, having assumed the right to either absolve or condemn, exercise immense power over people's bodies, their health and their lives.*²⁶

The medical profession subjected disabled people more to their control, deeming them as largely unproductive. Medical institutions arose to cater for the rising number of these people. This had negative socio-economic ramifications for disabled people as Western society severely restricted the role of people judged incapable of fully contributing to society.

²⁴ Patrick J. Develiger, "Generating a Cultural Model of Disability" (paper presented at the 19th Congress of the European Federation of Associations of Teachers of the Deaf (FEAPDA), Geneva, Switzerland, October 14-16, 2005), 7-8.

²⁵ Martin Sullivan, "Subjected Bodies: Paraplegia, rehabilitation and the politics of movement" in *Foucault and the Government of Disability*, ed. Shelley Tremain (Ann Arbor, Michigan: Michigan University Press, 2005), 28.

²⁶ *Ibid*, 30. Martin Sullivan undertakes his critique from the perspective of a person who has undergone rehabilitation in a spinal unit environment after becoming paralysed in an accident in the early 1980s.

Large-scale medical model-inspired institutionalisation marked the role defined for the disabled in New Zealand as it did overseas.²⁷ Legislation acted as a political tool to reinforce this forcible segregation (almost expulsion) of disabled people from society. As Sullivan notes, successive New Zealand governments passed repressive legislation such as the Immigration Restriction Act 1899, preventing people with mental illness and intellectual disabilities from entering the country. The Mental Defectives Act 1911 extended this immigration ban to cover people with physical impairments, and the Education Amendment Act 1907 established a segregated education system.²⁸

For this reason American disability activist, James I. Charlton, argues that disabled people:

*...at least as a group, may have been the first to join the ranks of the underclass. Since feudalism and even earlier, they have lived outside the economy and political process. It should be noted, of course, that few people with physical disabilities survived for very long in pre-capitalist economies.*²⁹

Although writers such as Finkelstein have contested this idea of pre-industrial economic exclusion, the overall treatment of disabled people has largely remained negative throughout the ages.³⁰ Charlton writes that this has had cumulative negative impacts on the socio-economic and political status of disabled people:

²⁷ Martin Sullivan, "Regulating the Anomalous Body in Aotearoa/New Zealand," *New Zealand Journal of Disability Studies* 1(1995): 20-21.

²⁸ Peter Beatson, *The Disability Revolution in New Zealand*, (Palmerston North: Massey University Press, 1998), 248-9.

²⁹ James I. Charlton, *Nothing About Us Without Us: Disability Oppression and Empowerment*, (Berkeley and Los Angeles: University of California Press, 1998), 24.

³⁰ Colin Barnes, "The Social Model of Disability: A Sociological Phenomenon Ignored by Sociologists?" in *The Disability Reader: Social Science Perspectives*, ed. Tom Shakespeare (London: Continuum, 1998), 73-74. Vic Finkelstein, a psychologist and person with lived experience of disability, takes a Marxist perspective on disability theory. He assisted in the development of the social model of disability, alongside Oliver. A white exile from apartheid South Africa, who had been active in the underground Communist Party of South Africa, Finkelstein saw the links between racial segregation and oppression in his homeland and that of disabled people internationally. Barnes relates that Finkelstein, through the employment of a Marxist materialist analysis in his book, *Attitudes and Disabled People* (1980), hypothesised that disabled people

*The vast majority of people with disabilities have always been poor, powerless and degraded. Some aspects of disability oppression are remnants of ancient regimes of politics and economics, customs and beliefs, and others can be traced to more recent developments.*³¹

With greater numbers of people acquiring impairment through work related accidents and illness, and with more disabled ex-soldiers coming home to New Zealand in the wake of World War One, more consideration was given to the welfare needs of disabled people. The government made its first moves towards a welfare state in this country with the passage of the Old Age Pensions Act in 1898 with many older disabled people amongst the early beneficiaries of this Seddon Liberal Government policy.³² During the First World War and interwar years, successive Liberal, Reform and Coalition administrations granted pensions to miners and blind people and introduced workers' compensation schemes.³³ After 1935, the First Labour Government introduced a means tested Invalids Benefit and Sickness Benefit (plus other relevant benefits) for those who were deemed unable to work due to long-term impairment or serious illness.³⁴ The introduction of means tested benefits provided an independent income for many disabled people for the first time. However, the downside remained that any entitlement to government assistance remained judged on a person's ability to work.

This long-term state of medical model-determined societal exclusion continued during the Second World War and into the post-war period when the Keynesian Social Democratic

had not been included within pre-industrial society as the modes and relations of production in existence then did not necessarily exclude impaired people from being a part of the production process. When the Industrial Revolution arrived, this changed as with the rise of mechanisation and other more technology-based production modes, disabled people were deemed surplus labour and began to be separated, thereby making the process of medicalisation and segregation much easier to achieve.

³¹ Charlton, *Nothing About Us*, 21.

³² Beatson, *The Disability Revolution in New Zealand*, 248.

³³ Ford, "Good-bye to Tiny Tim", 13.

³⁴ New Zealand Social Security Department, *The Growth and Development of Social Security in New Zealand* (Wellington: Department of Social Security and Department of Health, 1950), 71-73, 78-86, 89, 97-100.

Disabled people and those with various health conditions were entitled (via means testing) to apply for Invalids, Sickness, Emergency or (if impaired through war) War Veterans Benefits under the terms of the first Labour Government's Social Security Act of 1938.

policy consensus produced the long economic boom that lasted until the 1970s. During this time, as Sullivan notes, the control of what he calls the ‘anomalous’ body continued under the auspices of the Welfare State as polio outbreaks and the return of disabled veterans from another global conflict further increased the number of disabled people within the New Zealand population.³⁵

At the same time, rehabilitation practice changed as increasing numbers of professional occupational therapists, speech therapists and physiotherapists emerged within the health system. For those disabled people categorised as being able to participate in some form of work, sheltered workshops began to increase in number throughout the country. The rise in these workshops where disabled workers had few, if any, statutory employment protections effectively barred disabled people from competing with their able-bodied counterparts for well-paid employment during the long boom. Legislation passed by the Second Labour Government (1957-1960) reinforced the undervaluing of disabled workers’ labour and made these practices legal in the euphemistically titled Disabled Persons Employment Promotion Act 1960.³⁶

Through the long boom of 1945-1973 and into the crisis years that followed, more disabled people began to integrate into New Zealand society. The spectre of the medical model still hovered over New Zealand and other Western societies, however, as the welfare system expanded. Medical control reinforced the charitable model of disability and, in the New Zealand environment, this politically, economically and socially disempowered disabled people.

Many disabled people considered themselves to be repressed and that belief would grow into a wider political consciousness and give birth to a new type of social movement – the Disability Rights Movement (DRM). The DRM emerged in the late 1960s stressing a new social model of disability that sought to overthrow the oppressive medical model of disability. Influences on the DRM included the African-American civil rights movement in the United States, third wave feminism, the anti-Vietnam war movement,

³⁵ Sullivan, "Regulating the anomalous body", 1995, 16-17.

³⁶ Ford, "Good-bye to Tiny Tim", 14.

environmentalism and the first moves towards gay, lesbian, bisexual and transgendered rights. The rise of this movement, both in New Zealand and globally, slowly saw the legislative acknowledgement of disabled people's human rights.

The modern disability rights movement was born in the ferment of these times when, as the slogan went, 'the personal is political.'³⁷ These new social movements of which the disability rights movement was a part, focused 'on the individual's – rather than the collective's – subjective experience of life under contemporary capitalism.'³⁸ In the United States, Ed Roberts, a paralysed young man who was a student during the 1960s at that great crucible of student activism, the University of Southern California at Berkeley, founded the first Centre for Independent Living. This centre, founded in the early 1970s, was the first in a movement to provide support services *by* disabled people and *for* disabled people with an emphasis on promoting community-based, integrated, independent living.³⁹ Meanwhile, the UK saw the foundation of the Disability Income Group (DIG) in 1966 that advocated for the State to provide a universal income to recognise the costs of disability. In the DIG, people from across the impairment spectrum formed the first political group led by disabled people. A decade later, another mass disability movement, the Union of Physically Impaired Against Segregation (UPIAS), was co-founded in the UK by two men who are now among the most eminent academic disability theorists in the world, Vic Finkelstein and Michael Oliver.⁴⁰

Oliver wrote UPIAS's main philosophical document, *The Fundamental Principles of Disability* in 1976. In this document, he explained the social model of disability this way:

³⁷ Ibid, 15.

³⁸ Ibid,15

³⁹ Charlton, *Nothing About Us*,131.

⁴⁰ Ibid.

*In our view it is society which disables physically impaired people. Disability is something imposed on top of our impairments by the way we are unnecessarily isolated and excluded from full participation in society.*⁴¹

Thus, in Oliver's view, the level of a person's impairment was not the main cause of their social exclusion. The way that society treated them in terms of erecting attitudinal, social and environmental barriers to their participation, was. The social model of disability offered a move away from the un-democratic patronising control of able-bodied professionals within the medical sector towards a world where disabled people would determine their own future. Disabled people, like other liberation movements that had come before, would struggle for emancipation through political change.

Therefore, disability finally arrived as a political construct alongside ethnicity, gender, class and sexual orientation, but the disability rights movement was the last major liberation movement to emerge on the scene.⁴² The DRM also arrived more quietly than the other aforementioned movements, meaning that it made a slower start in penetrating the public consciousness than had the others.⁴³

The medical and social models of disability and the right to access health care

Before continuing with a fuller discussion of the disability rights movement and its activism in the New Zealand context, there is a need to analyse the distinction between the medical model of disability and the right of disabled people to access health care utilising

⁴¹ Michael Oliver. "The Social Model in Action: if I had a hammer" in *Implementing the Social Model of Disability: Theory and Research*, ed. Geoff Barnes and Colin Mercer, (Leeds: The Disability Press, 2004), 19.

⁴² Ford, "Goodbye to Tiny Tim", 16. I wrote in this respect that 'But while the black civil rights, gay and lesbian, and women's movements each had a Montgomery, a Stonewall, and a Female Eunuch to define and inspire them; the message about disability rights at first spread only slowly and un-sensationally. The disabled community's initial task was to convince itself, before penetrating (through the mass media and protest) the wider public consciousness.

⁴³ Ibid.

the social model. This is an important issue given that the implementation of the NZDS at District Health Board level constitutes the case study element of this thesis.

The joint World Health Organisation (WHO) and World Bank *World Report on Disability 2011* found that, globally, disabled people face innumerable barriers to accessing health care within their communities.⁴⁴ Historically, as British disability theorist Simon Brisenden has pointed out this has been due to the negative impact that the medical model of disability has had on the attitudes of the medical profession itself:

*The medical definition of disability bears very directly on the outlook of the medical profession, which has exhibited an unwillingness to revise the very way that it views people with disabilities. This definition has portrayed disability entirely as a medical problem and it has led to a situation where doctors and others are trapped in their responses by a definition of their own making. They are stuck within the medical model of disability.*⁴⁵

Brisenden holds that the medical model constricts medical practitioners from seeing disabled people as being capable of leading full lives irrespective of their impairment.⁴⁶ Furthermore, British academic Nasa Begum found in her study of disabled women seeking regular general practitioner assistance for health issues that most tend to treat illness and impairment as completely separate issues.⁴⁷ However, as Brisenden stated above, the medical fraternity have failed to make the same distinction and in doing so have marginalised disabled people within their practice. This has had negative consequences for disabled people who need to access health care for any reason.

Within the New Zealand context, a report *Disability Rights in Aotearoa New Zealand* produced by Disability Rights Promotion International in 2010 as part of this country's UN Convention reporting requirements (of which more will be said in Chapter Three)

⁴⁴ World Health Organisation and World Bank, *World Report on Disability* (Geneva, Switzerland: World Health Organisation and World Bank, 2011), 55-83.

⁴⁵ Simon Brisenden, "Independent Living and the Medical Model of Disability" in *The Disability Reader: Social Science Perspectives*, ed. Tom Shakespeare (London,: Continuum, 1998), 24.

⁴⁶ Nasa Begum, "General Practitioners' Role in Shaping Disabled Women's Lives" in *Exploring the Divide: Illness and Disability*, ed. Geoff Barnes and Colin Mercer, (Leeds: The Disability Press, 1996), 165-66.

⁴⁷ *Ibid*, 165.

submitted that ‘negative experiences with regard to [seeking] health [care] emerged as the second most significant theme’ for disabled people.⁴⁸ The report also noted ‘the fact that health [care for disabled people] is an issue is not surprising given that disability politics grew out of a critique of the medical model’.⁴⁹ It cites an example of where a health service receptionist advised a Deaf person that she would tell their sign language interpreter the message she wanted to convey to the client first, thus denying the Deaf person their right to receive the receptionist’s message simultaneously via sign language interpretation. The authors cited the medicalised context in which the incident took place as proof of the medical model’s ‘paternalism and tendency to categorise people according to impairment.’⁵⁰ Consequently, the Disability Rights report found that:

The results of the monitoring project clearly demonstrate that health continues to be an issue with experiences of negative dignity, disrespect for difference, lack of autonomy, discrimination and inequality and segregation and isolation featuring far more strongly...⁵¹

The reality is that disabled people want to have their health care needs met holistically. Hence, disabled people want all medical sector employees to understand that their impairments may or may not contribute to the health issues they may face at any given time. Therefore, disabled people have a right to access health care on the same basis as non-disabled people. To facilitate this desired attitude change towards more equitable health service access for disabled people, policy interventions are required at the government and health sector level. Begum points out the positives, for example, of making general practitioners more aware of the social model of disability:

As far as many disabled women are concerned a GP’s ability to adapt a broader approach to their work and acknowledge how attitudinal, environmental and institutional barriers will affect them, does not negate the medical practitioner’s role in managing their impairment, but rather enhances it.⁵²

⁴⁸ Disability Rights International, *Disability Rights in Aotearoa New Zealand*, 49.

⁴⁹ *Ibid.*

⁵⁰ *Ibid.*, 48-49.

⁵¹ *Ibid.*, 50.

⁵² Begum, “General Practitioners’ Role”, 171.

Chapters Four and Five will examine how well the ODHB and CCDHB have responded to the opportunity afforded by the NZDS to improve access to health services for disabled people.

Disability rights activism in New Zealand (1945-1990)

Disability rights activism in New Zealand has a long history. In 1945 the blind and vision impaired members of what was then the Royal New Zealand Foundation for the Blind came together to form the Dominion Association of the Blind (now known as the Association of Blind Citizens of New Zealand).⁵³ A twenty-seven year gap followed before the next major development in forging a disability consciousness in New Zealand occurred. This came in 1972, when coordinating councils for the disabled formed in the four main centres of Auckland, Wellington, Christchurch, and Dunedin. In these councils, representatives from both service providers and disabled people united to work on issues pertaining to education and access, amongst others.⁵⁴ A national coordinating council followed in 1978.⁵⁵

The passage of the Accident Compensation Corporation (ACC) Act by the Second National Government in 1972 and the Disabled Persons Community Welfare Act 1975 by the Third Labour Government brought the social model into greater play within a legislative framework. Another significant milestone was the Third Labour Government's appointment of a Royal Commission on Services for the Intellectually Handicapped in 1973. The Royal Commission's final report recommended that people with intellectual

⁵³ Beatson, *The Disability Revolution*, 258-59.

⁵⁴ Martin Sullivan, "Disabled People and the Politics of Partnership in New Zealand," in *Disability, Politics and the Struggle for Change* ed. Len Barton (London: David Fulton, 2001), 97.

⁵⁵ *Ibid.*

disabilities be removed from large mental hospitals into community-based residential accommodation.⁵⁶

During the period 1975 to 1983, further dramatic developments outside New Zealand occurred which influenced events here. These developments saw disabled people assert a greater political role for themselves in the policymaking process. The most dramatic such event occurred in 1980, when a revolt led by disabled delegates at the Rehabilitation International (RI) Congress in Winnipeg, Canada shook the international disability sector. This revolt took the form of a walk-out and wheel-out of most of the disabled delegates present. The bolters protested RI's continued refusal to incorporate disabled people into the decision making process which representatives from the medical and rehabilitation fraternity, following the medical model, still dominated.⁵⁷

The action of the RI bolters became the seminal moment in the arrival of a disability political consciousness, and with it the social model, on both the national and international scenes. The following year 1981, saw the rise of the first disability international, the Disabled Persons International, and a New Zealand branch formed at around this time.⁵⁸ Also in 1981, the world observed the United Nations' International Year of Disabled Persons, which saw disability and the issues surrounding it gain a greater foothold in both the public and political consciousness.

Spurred on by these events, the grassroots New Zealand disability movement came together finally (despite tensions between able-bodied dominated service providers and disabled people) in 1983 with the formation of DPA.⁵⁹ The founding organisations of the DPA included the New Zealand Coordinating Council for the Disabled, the New Zealand

⁵⁶ Peter Beatson, *The Disability Revolution in New Zealand: A Social Model*, (Palmerston North: Massey University Press, 2004), vi-vii.

⁵⁷ Quentin Angus, "DPA: The Beginning," DPA New Zealand, accessed March 23 2009, <http://www.dpa.org.nz/about/index.html>.

⁵⁸ Ibid.

⁵⁹ Sullivan, "Disabled People and the Politics of Partnership", 2001, 97. He rightly observes that: 'This should have served as an early warning of the entrenched and hostile attitudes of traditional organisations towards their 'children' when they start talking and organising for themselves'.

branch of Disabled Persons International and the New Zealand branch of Rehabilitation International.⁶⁰ The DPA played a pivotal role in many of the major legislative and policy triumphs for disabled people in New Zealand over the next 20 years. DPA is therefore intrinsic to the story of how the Disability Strategy developed. This group was the first umbrella organisation of disabled people from across the impairment spectrum, incorporating representation from groups representing the physically, intellectually, sensory, and psychiatric and psychologically impaired, enhancing the lobbying efforts of the disability rights movement in this country.

Disability policy advances under the Fourth Labour Government (1984-1990)

Key changes made in the 1980s included the right of parents of disabled children to enrol their child in the nearest state primary and secondary schools under the Education Act 1989.⁶¹ Another significant achievement addressed employment opportunities for disabled people in the Fourth Labour Government's State Sector Act 1988 (a law which would otherwise adversely impact upon NZDS-related decision making as will be related further on).⁶² Following international trends and in a belated effort to implement the 1973 Royal Commission on Services for the Intellectually Handicapped's findings, in 1985 the Labour Government announced the beginning of a gradual deinstitutionalisation programme for people with intellectual disabilities residing in mental hospitals. This announcement signalled the beginning of a deinstitutionalisation process that lasted twenty years.⁶³

⁶⁰ Angus, "DPA: The Beginning".

⁶¹ Education Act., s 8 of the Act provides the right for disabled children to be enrolled at any state primary or secondary school after January 1, 1990.

⁶² State Sector Act, s 56 (1) (2) (3) and (4). These provisions stipulate the 'good employer' requirements that state sector chief executives are required to meet. These requirements include, amongst other things, to provide equal employment opportunities programmes for employment-disadvantaged groups including Māori, women and people with disabilities.

⁶³ Claire Stewart and Brigit Mirfin-Veitch, The impact of deinstitutionalisation on the families of the Kimberley Centre, (Dunedin: Donald Beasley Institute, 2008), 3.

These first successes heralded a move towards a social model in disability policy making where the slogan ‘nothing about us, without us’ gained full currency for the first time. Disabled people moved to the forefront of influencing the policy process on the issues that concerned them.⁶⁴

Managerialist theory, the State Sector Act 1988 and the NZDS

However, there were policy developments under the Fourth Labour Government not directly related to the disability sector but which nonetheless impacted upon it in later years. Managerialist theory came to have a profound impact on the development and implementation of the NZDS. Australian academic Stuart Rees refers to managerialism as:

*An ideology with two distinct claims: a.) efficient management can solve any problem; b.) practices which are appropriate for the conduct of private sector enterprises can also be applied to public sector services.*⁶⁵

Margaret Thatcher’s Conservative Government in the United Kingdom first piloted managerialism inside the British public sector during the early 1980s.⁶⁶ Prior to 1988, the public sector in New Zealand had been organised on traditional British-style civil service lines. Public policy specialist, John Martin, outlined the three fundamental characteristics of the pre-1988 New Zealand civil service as being apolitical in that civil servants could only be hired and fired on merit and had to remain independent of political influence; protection by the civil service of the anonymity of individual officials; and lifetime employment within the public service.⁶⁷

⁶⁴ Charlton, *Nothing About Us*, 3.

⁶⁵ Stuart Rees. “The Fraud and the Fiction” in *The Human Costs of Managerialism: Advocating the Recovery of Humanity*, ed. Stuart Rees and Gordon Rodley, (Leichardt, NSW, Australia: Pluto Press Australia, 1995), 15.

⁶⁶ John Martin. “Remaking the State Services” in *The Fourth Labour Government: Politics and Policy in New Zealand* ed. Martin Holland and Jonathan Boston (Auckland: Oxford University Press), 123.

⁶⁷ *Ibid*, 124-29.

The Fourth Labour Government's introduction of the State Sector Act in 1988 overturned this model. This government, influenced by neo-liberal thinking, initiated a programme of wholesale economic and social reform that included efforts to reduce public expenditure. State sector reform became a crucial element in the reform process as private sector practices were introduced into government departments for the first time. Consequently, the Act introduced on a larger scale managerialist practices (which had hitherto existed on a smaller scale prior to Labour's election in 1984) such as, for example, managerial autonomy into the public sector enabling departmental chief executives to freely manage inputs (for example staffing and resources) to produce outputs (for example, services or policy advice). Further, since the passage of the Public Finance Act 1989, all Cabinet ministers have annually negotiated service delivery contracts with their departmental chief executives. These contracts enable ministers to set out for their chief executives what government expects of them in terms of service delivery or policy outcomes from their departments in any given year. Accordingly, chief executives (and lower level management) have market-based incentives and disincentives (in the form of pay rises or dismissal) to motivate them.⁶⁸

For all these reasons, the authority of public sector management has grown since the late 1980s. This growth in executive management authority has undercut the public's ability to influence departmental decisions. Under generic management models, departments should ideally treat taxpayers as customers who want services. However, due to departmental managers placing greater emphasis on cost containment, taxpayers sometimes receive a lesser level of service that they would otherwise expect. Pollitt cited the consequences of placing public spending decisions in managerial hands:

When decentralisation takes place (as it has done) within the framework of centrally determined cash limits and other performance norms much of the responsibility for maintaining services within reduced circumstances or, alternatively, deciding where to impose unpopular cuts, can be loaded onto local management.⁶⁹

⁶⁸ Ibid, 133.

⁶⁹ Christopher Pollitt, *Managerialism and the Public Services: Second Edition*, (Oxford: Blackwell Business, 1993), 57.

Thus, public sector managers have effectively become agents of government by having devolved onto them by politicians the power to make potentially unpopular decisions. Further, Pollitt argues that managerialism also undermines any notion of taxpayers as citizens given that neo-liberals view citizenship as ‘an awkward concept’ preferring the terms ‘consumer’ and ‘customer’ instead. He goes on to define citizenship as representing the wider ideals of ‘justice, representation, participation and (most recently) equal opportunities.’⁷⁰ For all the above reasons, American political philosopher, Willard F. Enteman, describes managerialism as ‘a lethal challenge to democracy, because it discounts the importance of the individual in general.’⁷¹

How might managerialism impact on the implementation of the NZDS? First, managerialist practices have undermined NZDS implementation given that government managers, as will be discussed in the DHB case studies, have viewed their Strategy obligations differently. Second, the concept of managerial autonomy has given managers the ability to either support or undermine strategy roll-out efforts within their departments. Third, the desire of departmental managers to engage in cost containment has sometimes affected agencies ability to adequately resource Strategy related initiatives. Lastly, managerialism is antithetical to the social model of disability that seeks to promote the ideal of citizenship and inclusion for all disabled people. The specific impact of managerialism on the Strategy will be discussed in the DHB case study chapters.

The Fourth National Government’s regression into the medical model (1990-99)

The Fourth Labour Government’s changes to the state sector formed a significant part of its free market-driven reform programme during the 1980s. The Fourth Labour Government’s belief in neo-liberalism during this period had negative ramifications for disability policy as the National Party sought to continue and extend its predecessor’s economic and social policy programme after its election in 1990. For the disability sector,

⁷⁰ Ibid, 129.

⁷¹ William F. Enteman, *Managerialism: The Emergence of a New Ideology*, (Madison, Wisconsin: University of Wisconsin Press, 1993), 159.

with National in power, it became a case of one step forward and two steps back for DPA and the wider disability sector. A series of regressive measures introduced by National threatened to undo much of the progress made in the preceding two decades. As one of its first social policy reform measures, National sought to revamp the health sector into a free market-driven model.⁷² As part of these moves, Simon Upton (Health Minister) and Jenny Shipley (Social Welfare Minister) put out a consultation document entitled *Support for Independence: a discussion paper on the funding and delivery of disability support services*.⁷³ The government conducted consultation with individuals and groups throughout the country to gain feedback on the document. This feedback resulted in the National Government's decision to transfer disability support services funding from the soon to be disestablished Department of Social Welfare into the health sector via the Regional Health Authorities.⁷⁴

This was a blow to disability rights advocates and represented a regression back to the medical model.⁷⁵ Sullivan lambastes other elements of National's programme such as the regulatory framework behind, for example, the Building Act 1991 (under which building accessibility standards were mandated).⁷⁶ In fact, the resurgence of the medical model

⁷² Robin Gauld, *Revolving Doors*, 81-85.

⁷³ Hon. Jenny Shipley and Hon. Simon Upton, *Support for Independence: a discussion paper on the delivery of disability support services* (Wellington: New Zealand Department of Social Welfare and New Zealand Department of Health, 1992), 1-46.

⁷⁴ Hon. Jenny Shipley and Hon. Simon Upton, *Support for Independence for people with disabilities: a new deal: a government statement on the funding and delivery of disability support services* (Wellington: New Zealand Department of Social Welfare, 1992), 1-30.

⁷⁵ Martin Sullivan, 2000, "Does it Say What it Means", 44. 'The repeal of the Disabled Persons Community Welfare Act and enactment of the Health and Disability Services Act was a severe blow. It marked a retreat from legislation based on the social model of disability to legislation based firmly in the medical model. This, quite simply, heralded the remedicalisation of disability in Aotearoa.' In fact, the DPCW Act was still in force as of 2009, but Sullivan correctly notes the repeal of its equipment support and home modification provisions when disability support services funding was transferred from the Department of Social Welfare to the new Ministry of Health under the Health and Disability Services Act 1993. The DPCW Act's building access provisions were incorporated into the Building Act 1991 and subsequent updates.

⁷⁶ Sullivan, "Disabled People and the Politics of Partnership", 2001, 102.

demoralised many DPA members, and by the time benefit cuts came in 1991, disabled people, in Sullivan's words, 'had little energy left to complain'.⁷⁷

Despite its demoralising actions the National Government also initiated some positive reforms. In 1993 it established another significant marker in the journey towards full civil and political rights for disabled people in Aotearoa/New Zealand with its passage of the Human Rights Act.⁷⁸ The new human rights law broadened the grounds for complaint to include disability, amongst others.⁷⁹ A year later, National introduced and passed the Health and Disability Commissioner Act 1994 laying down the framework for consumer complaints relating to health and disability services operated by both public and private sector providers.⁸⁰ Then in 1998 the National-New Zealand First Government oversaw the creation of the new Mental Health Commission with a mission to improve both mental health services and attitudes towards people with mental illness and addiction issues within the community.⁸¹

⁷⁷ Ibid,103.

⁷⁸ Beatson, *The Disability Revolution*, 2004, vi-vii.

⁷⁹ "Human Rights Act" Human Rights Commission, accessed February 1 2010, <http://www.hrc.co.nz/home/hrc/humanrightsenvironment/humanrightsinnzeland/humanrightsact.php> .. The Human Rights Act 1993, besides disability, made discrimination illegal on the grounds of age, colour, employment status, ethical belief (lack of religious belief), ethnic or family origins, marital status, political opinion, race, religious belief, sex and sexual orientation.

⁸⁰ "Background" Health and Disability Commissioner, accessed March 23 2009

<http://www.hdc.org.nz/aboutus>, <http://www.hdc.org.nz/aboutus>, (accessed March 23 2009). The Health and Disability Commissioner Act became law in October 1994 (with Helen Clark initiating the legislation as Minister of Health in the fourth Labour Government) and following the enactment of National's health reforms, the original Bill included the disability sector.

⁸¹ Mental Health Commission, *Annual Report of the Mental Health Commission: Te Kaitātiki Oranga for year ended June 30th, 2008* (Wellington: Mental Health Commission, 2008), 2-4. The fourth National Government established the New Zealand Mental Health Commission under the terms of the Mental Health Commission Act 1998. The 1998 law contained a sunset clause enabling the disestablishment of the commission by 2008. However, the Labour-led minority government passed the Mental Health Commission Amendment Act 2007 extending the Commission's life out to 2015 on the basis that it needed to continue

By the mid-1990s, the medical model still dominated government thinking on disability issues, although as seen, some concessions had been made by both Labour and National governments to the social model of disability. At the turn of the century, however, a paradigm shift was to occur and the genesis of this change took place during the later stages of the Fourth National Government's tenure (1995-99). The next chapter will examine the conception, birth, development and implementation of what became the New Zealand Disability Strategy.

work on rolling out the blueprint for improving both mental health services and attitudes towards mental illness.

Chapter Two

The Development of the New Zealand Disability Strategy by Central Government (1995-2000)

This chapter focuses upon the development, implementation, and progress of the NZDS under successive National and Labour Governments from 1995 to 2010. By the mid-1990s disabled people had been buffeted by two decades of change where they had seen successive governments slowly moving towards an acceptance of the social model of disability only to see this progress stalled by the backwards slide into the medical model under the Fourth National Government. The disability community desired that government firmly commit to basing its disability policy on the social model alone. Accordingly, by the mid-1990s, DPA would use its growing political influence to lobby for the Disability Strategy's development with both the Fourth National Government and the opposition Labour Party. This chapter examines the political background to the Strategy's development and the process surrounding it.

The genesis of a Strategy 1995-2000

The Strategy had its genesis in preliminary discussions held during the Fourth National Government's tenure. In April 1995 the Ministry of Health convened a workshop with disability advocates to discuss the outlines of such a strategy.⁸² Former DPA president, Paul Gibson, considered the timing auspicious as he recounted the prevailing mood within the New Zealand disability movement at the time:

⁸² Ministry of Health, Development of New Zealand Disability Strategy for Government Services Project: Meeting Reports: April-May 1995 (Wellington: Ministry of Health, 1995), 1-15.

Well, I suppose even before my time there as DPA president back in the 1990s, there was a lot of discussion about the fact that our needs cross many government departmental boundaries. We use many different types of services and our lives are complex. Around disability, there was a need for some joined up action around how that would all work together. At that point in time, there was an emerging rights discourse – the academic social model discourse. Also the Human Rights Act 1993 included disability as a ground for discrimination for the first time. So there was an increasing movement, not just a movement of consumers of disability services or a movement of disability organisations, but a disability rights movement of disabled people who recognised that who we are is okay but that what happens to us is not and to change that.⁸³

Many prominent disability figures attended the Ministry of Health's workshops and they included, amongst others, Robyn Hunt, Mary O'Hagan and Maaka Tibble. These three people went on to become members of the disability sector reference group, which drew up the Disability Strategy five years later. Officials from the Ministries of Health and Education, Department of Labour, State Services Commission and Human Rights Commission attended as observers. Notably, a staffer from the Minister of Health's office also sat in indicating ministerial interest in the proceedings.⁸⁴

This workshop established the guiding principles for a disability strategy. These principles included that the Strategy would recognise the Treaty of Waitangi and that it would be Government led; that cross-governmental accountability would be paramount; that implementation progress would be reported to Parliament; and that strict monitoring was undertaken. A strong sentiment was held by disabled attendees that the Strategy be developed by disabled people and implemented by government in partnership with them. When it came to consultation, organisations *of* disabled people were preferred over organisations *for* disabled people. Crucially, the participants decided that the Strategy would hinge on a rights-based approach with the aim of seeing disabled people treated as citizens first with all the reciprocal rights and obligations this entailed. The proposed Strategy would all be underwritten by the social model which, according to the meeting

⁸³ Paul Gibson, face-to-face interview, May 19 2010, Wellington.

⁸⁴ Ministry of Health, *Development of New Zealand Disability Strategy*, 1995, 3.

minutes, was ‘based on...the understanding that disability is a complex interaction of impairment, the social and physical environment and self-perception.’⁸⁵

A follow-up meeting on May Day 1995 at the Ministry of Health’s national office in Wellington discussed framework options. This meeting included some of the same participants as the first meeting but some of them opted to attend as observers on this occasion.⁸⁶ Disability sector attendees at this second meeting hoped that that the Ministry of Health would initiate advice to the National Government over the need for a strategy. Along these lines it was felt that a formal Government statement would be necessary as a means of signalling this and that the appropriate time to make one would be when New Zealand signed an important United Nations Asian-Pacific regional declaration on disability rights.⁸⁷ Other issues discussed included those relating to departmental ownership of any future strategy and, most vitally, mechanisms for its implementation. Reference was made, for example, to the idea that an assessment of policy proposals for their impact on disabled people be incorporated into Cabinet papers and other policy checklists.⁸⁸

After the second meeting, the National Government decided not to proceed with a strategy. One interviewee closely linked to the disability sector suspected that the reason for this was that the government of the time lacked the political will to proceed.⁸⁹ Nonetheless these first discussions were to lay the philosophical foundations for what became the New Zealand Disability Strategy five years later.

As a new human rights culture became established around disability, New Zealand went through its first mixed member proportional (MMP) election in 1996. This returned a National-New Zealand First Coalition Government that, apart from the creation of the Mental Health Commission, gave scant recognition to disability issues in their coalition

⁸⁵ Ibid, 9.

⁸⁶ Ibid, 3.

⁸⁷ Ibid,11. This declaration became known as the United Nations Proclamation on the Full Participation and Equality of People with Disabilities in the Asian and Pacific Region.

⁸⁸ Ibid, 13.

⁸⁹ Anonymous, telephone interview by author, April, 2010.

agreement.⁹⁰ Due to this level of inertia on the part of the coalition government, DPA commenced a dialogue with all parliamentary political parties ahead of the 1999 election. This dialogue centred around the need to make a second attempt at developing a disability strategy and this time one which would have firm government backing.

The Labour Party proved to be the most receptive to this lobbying. Within the party disability issues spokesperson, Ruth Dyson, was the main contact with the disability sector in the lead up to the 1999 election.⁹¹ Dyson outlined that Labour fully shared the disability sector's concerns as stated by Gibson above. Dyson provided the Labour Party rationale for developing the strategy:

Well, in the 1990s when we were in opposition, it was really clear that disability issues had never been considered from a whole of government perspective as they were marginalised in silos, they didn't have that whole of government or whole person perspective. We changed our perspective. We changed our policy thinking in Labour to being disability issues rather than disability services being part of health and agreed to get grunt in behind this new policy, [and to do this] we had to have a Minister for Disability Issues and we had to have a strategy to drive our policy agenda in government.⁹²

Even with a change of government expected DPA turned up its lobbying by issuing its election year disability issues manifesto *Our Vision*.⁹³ This document made clear DPA's belief in the need for a Minister for Disability Issues and that the portfolio holder should prepare a 'strategy document' in partnership with the entire sector. In late 1999, the Labour Party announced its own election policy indicating that the party would develop and

⁹⁰ Fiona Barker "Negotiating with New Zealand First: A Study of its Coalition Agreements with National and with Labour," in *From Campaign to Coalition: The 1996 MMP Election*, ed. Jonathan Boston, Stephen Levine, Elizabeth McLeay and Nigel S. Roberts (Palmerston North: Dunmore Press, 1997), 254-273. Disability had not been specifically mentioned in either of the proposed coalition agreements that New Zealand First had negotiated with both National or Labour.

⁹¹ Sullivan, "Disabled People and the Politics of Partnership", 2001, 104.

⁹² Hon. Ruth Dyson, face-to-face interview, May 20, 2010, Wellington.

⁹³ Disabled Persons Assembly (New Zealand) Incorporated, *Our Vision (2000-2002)*, (Wellington, New Zealand: DPA (NZ), 1999), 1-19.

implement a disability strategy in line with the disability community's wishes.⁹⁴ After the election Ruth Dyson was duly appointed as the country's first ever Minister for Disability Issues with a specific mandate to draw up this strategy. Despite this development, according to then DPA chief executive, Gary Williams, further post-election lobbying of Dyson by his organisation took place with a view to ensuring that the new Labour-Alliance Government honoured its commitment.⁹⁵

During the strategy's development, though, DPA opted for non-direct representation on the disability reference group. According to Williams, the organisation strategically opted to influence the results through getting as many people as possible appointed who were aligned to DPA's vision. Through taking this path, the organisation was able to critique freely whatever came out of the group. This move did not diminish the organisation's influence over events. Williams recalled that the people he spoke with during the process 'were quite receptive to my ideas.'⁹⁶

The passing of the Public Health and Disability Act in 2000 provided the legal mandate for the drawing up of the disability strategy. According to Ministry of Health official, Kylie Clode, the Labour-Alliance Government designed the NZDS to sit alongside the New Zealand Health Strategy in the legislation and, therefore, it became the only other social policy strategy developed by that government to gain legal recognition.⁹⁷ Clode also confirmed that the Government had specifically directed the incorporation of both strategies into the legislation prior to their final content being determined. Nonetheless both the disability and health strategies would provide the overall direction for health and disability support services hence the need for reporting requirements and statutory recognition.⁹⁸

⁹⁴ New Zealand Labour Party, *Focus on patients: Labour on health*, (Wellington: New Zealand Labour Party, 1999), 10.

⁹⁵ Gary Williams, telephone interview by author, May 3, 2010.

⁹⁶ *Ibid.*

⁹⁷ Kylie Clode, face-to-face interview, May 20, 2010, Wellington.

⁹⁸ *Ibid.*

Development of the NZDS 2000-2001

Policy development began in mid-2000 when Dyson appointed two working groups. According to Clode the Ministry of Health, under the direction of former CCS New Zealand chief executive, Kevin Allen, facilitated the overall process of developing the strategy from the bureaucratic end.⁹⁹ There were two reference groups which the Ministry serviced. One was a disability sector reference group (DSRG), comprised of disabled people nominated to represent different sector groups and provider networks. The second working group included officials from ten government agencies with the bulk of representation coming from social sector agencies.¹⁰⁰ Clode, then a senior policy analyst for disability support at the Ministry, recalls this working group as a more informal, collaborative grouping that aimed to keep various government agency officials updated on progress. Officials utilised this group to engage in discussions about the content and structure of the document. The group conducted much of its business via email with only occasional face-to-face meetings.¹⁰¹ While the officials group sounded innocuous enough, it came to exert an increasing influence over the process, particularly during the Strategy's final drafting phase.

However, the DSRG took the leading role in the strategy's formulation. In interviews all those closely involved in the Strategy's formulation emphatically stressed the central role that this group played in its development. As one example the reference group members sometimes wrote up various drafts of the document and, on other occasions, strongly

⁹⁹ Ibid.

¹⁰⁰ Saucier, *Promoting a National Vision*, 18. The core officials group was initially comprised of representatives from the Ministry of Health, Health Funding Authority, Ministry of Education, Ministry of Social Policy, Department of Labour, Work and Income New Zealand, State Services Commission, Specialist Education Services, Accident Compensation Corporation and the Ministry of Transport and other agencies came in on other meetings.

¹⁰¹ Clode, interview by author, May 20, 2010. She cited the case where, for example, Missy Morton, a reference group member with an interest in inclusive education issues assisted in the drafting of the text around education for disabled people. She also commented about the strong influence that group members had on issues, including the need for accessible transport to be included as part of the Strategy.

influenced the Minister to side with them against officials.¹⁰² Some DSRG members, such as former DPA President, Paul Gibson, even communicated via email throughout the process with significant disability sector actors outside of the group in order to seek feedback on issues as they arose.¹⁰³ Sections of the Wellington bureaucracy viewed the DSRG as a radical departure from normal policymaking practice as departmental officials usually drive the policy process. Former reference group co-chair, Jan Scown, represented the situation this way:

What happened is, basically, we asserted ownership of this project. I am sure the Ministry and the officials group would say they didn't give it away completely but I don't believe we ended up being a hands-length advisory group. It was ours and what we ended up saying to the officials... that the sector group will hold [you] to account... We talked very definitely about what should be in it [the Strategy] and we told the Ministry [of Health] what we expected.¹⁰⁴

Consequently this arrangement initially caused officials some discomfort. In the end, though, they gradually accepted this seemingly radical way of policymaking. As a positive outcome of this process, the DSRG gained a completely new and unexpected set of allies, namely Ministry of Health officials. Ruth Dyson noticed this transformation as officials heard, probably for the first time and first hand, about the real life experiences of disabled people. This level of exposure ensured that the Ministry of Health would become a valuable ally on issues such as, for example, accessible transport.¹⁰⁵

Reference group members asserted their new power in other ways, and they did so from day one. At the first meeting disabled group members concerned that Minister Dyson had appointed an able-bodied person, Jan Scown, to chair the group staged a mini-revolt.¹⁰⁶ As Scown recollected, the disabled members rebelled because they wanted the group to operate as a partnership between disabled and able-bodied people. To symbolise this they nominated Robyn Hunt, a blind woman with extensive disability sector experience, as co-

¹⁰² Gibson, interview by author, May 19, 2010. 'At that point in time, I had an email list well I think of initially twenty or thirty people and that reached out to other organisations too.'

¹⁰³ Jan Scown, interview by author, Wellington, May 19, 2010.

¹⁰⁴ Dyson, interview by author, May 20, 2010.

¹⁰⁵ Ibid.

¹⁰⁶ Gibson, interview by author, May 19, 2010.

chair. The arrangement suited both Scown and Hunt, and the Minister subsequently ratified the move.¹⁰⁷

Scown and Hunt played crucial roles as DSRG co-chairs, a fact touched upon by a number of former reference group members. Other members especially praised their ability to analyse issues and forge consensus within the reference group. Former member Missy Morton commented that ‘the key thing that facilitated consensus was the way that the chairs went about checking about how people felt about the direction the debate was taking.’¹⁰⁸ Scown reflected that, as co-chairs, both she and Robyn Hunt possessed complementary skills that enabled, for example, Hunt to listen closely to people’s arguments while she, as the sighted co-chair, signalled who would speak next.¹⁰⁹

Another vital cog in the Strategy’s development was Kylie Clode. She won praise from the anonymous interviewee for enabling the disability reference group to take the leadership role it did as ‘the officials who were running it [the process], people like Kylie, were sensible enough in that they let us have a head, pretty much, in terms of process, and what we wanted to say throughout the process.’¹¹⁰ Clode also wrote the various drafts of the document and the final version itself.

The facilitative roles played by both the co-chairs and Clode enabled the DSRG to reach consensus, even on potentially divisive issues. They also discussed the best structure for the NZDS in terms of formatting; for example, whether it should take a sector group or clusters approach. The former approach focused around looking at health, education, and housing for disabled people while the latter sought to examine issues for disabled Māori, Pacific peoples, women and children, and youth.¹¹¹ In the end, both reference groups

¹⁰⁷ Scown, interview by author, May 19, 2010.

¹⁰⁸ Dr. Missy Morton, telephone interview by author, April 20, 2010.

¹⁰⁹ Scown, interview by author, May 19, 2010.

¹¹⁰ Anonymous, telephone interview by author, April 19, 2010.

¹¹¹ Clode, interview by author, May 20, 2010.

decided to take what Clode called a ‘mixed’ approach whereby the NZDS would cover both sector and population-based issues.¹¹²

The combined groups’ early views shaped a discussion document released in September 2000 *Making a World Of Difference: Whakanui Oranga: The New Zealand Disability Strategy Discussion Document*.¹¹³ This discussion paper outlined an initial vision of what a non-disabling society could look like. Ideally it would be: ‘A fully inclusive society, where our capacity to contribute and participate in every aspect of life is continually being extended and enhanced.’¹¹⁴ The first formal recognition of the social model of disability by the New Zealand state came in the discussion document’s statement that:

*The proposed Strategy will be based on a social model of disability which recognises that people experiencing disability are disadvantaged by social and environmental barriers ... to participation in their communities.*¹¹⁵

The document also referred to the Treaty of Waitangi in terms of acknowledging the special relationship between Māori and the Crown and it further extended this principle to promoting a partnership between disabled people and Government, support agencies and communities as an integral part of the proposed NZDS.¹¹⁶

Public comment was invited by the Ministry of Health on these critical actions and the steps to be taken in implementing them during the consultation process. The Ministry ran sixty-eight public and sector group meetings as part of the consultation process. Thousands of discussion documents were either downloaded from the Ministry of Health website or distributed by the Ministry to interested individuals and groups. When the process concluded, over six hundred submissions had been received from individuals and groups on the draft NZDS.¹¹⁷ Overall the consultation process ran smoothly and was largely

¹¹² Ibid.

¹¹³ Dyson, *Making a World of Difference*, 26.

¹¹⁴ Ibid.

¹¹⁵ Ibid, ix.

¹¹⁶ Ibid.

¹¹⁷ Ministry of Health, *A Brief Summary of the Analysis of Submissions to the New Zealand Disability Strategy Discussion Document: Making a World of Difference* (Wellington,:Ministry of Health, 2001),1.

positive. Kylie Clode specifically remembered that the consultation had seen ‘an awful lot of goodwill demonstrated throughout it and [disabled] people were excited that the Government was doing this and wanted to be able to contribute....’¹¹⁸

Most of the written submissions came from disabled people and sought to validate many of the actions proposed. A consensus emerged that the main barrier to participation within society was the attitudes and behaviour of the wider society itself and that these needed to be addressed if any progress was to be made. Secondly, submitters identified access to services as another significant barrier. This related to the state of disability support services themselves. People often reluctantly spoke out about poor service and the lack of co-ordination and integration that resulted.¹¹⁹ While consensus existed on these issues, some divisions emerged as well. One key area of contention was around the language to be used in the strategy and the role of inclusive education.¹²⁰

The discussion document’s vision of a non-disabling society based on the social model of disability won widespread support. Some dissent also appeared. A minority believed that the strategy should be a more open document, while others believed that the social model was somewhat limiting and that the ‘medical versus social paradigm was spurious.’¹²¹

After the November 1, 2000 close off for submissions, the official and sector working groups and the Ministry of Health began work on the preparation of the final NZDS draft.¹²² In the interim Disability Issues Minister Dyson had suddenly resigned in late October 2000, and Senior Citizens Minister, Lianne Dalziel, replaced her and oversaw what remained of the strategy development process. As Dalziel herself admitted, by the time she assumed the portfolio only a minimal amount of work remained given that her

¹¹⁸ Clode, interview by author, May 20, 2010.

¹¹⁹ Ministry of Health, 2001, 4.

¹²⁰ Clode, interview by author, May 20, 2010. ‘Yes, inclusive education was the one that was hanging in there the whole way along. Mainstreaming - how would you write an action that would increase your chances of getting it done, instead of causing problems with people getting up and saying ‘no, no, no, we’re not going to do that!’

¹²¹ Ministry of Health, A Brief Summary of the Analysis of Submissions, 2001, 5.

¹²² Saucier, 18.

predecessor had done ‘the hard yards’ on the NZDS. Also despite Dyson’s resignation, according to Dalziel, the former minister remained a key player behind the scenes in the final stages.¹²³

The interval between the end of consultation and the official launch, however, did not pass without controversy. A debate broke out between the disability sector and state sector officials’ groupings over the level of detail that should be incorporated into the final version. Members of the DSRG wanted greater detail inserted into the document with references to service gaps, resourcing issues and specific implementation timeframes included. In other words, it preferred a more directive document, and the second draft reflected this.¹²⁴ Conversely the officials group wanted a less directive, more generalised framework document that could easily be applied across government and without too many specific strictures as to timeframes.¹²⁵ The officials would have wanted a less directive document too, given that a more prescriptive document would have undermined managerial autonomy within government departments.

The resulting compromise recommended a content document and a further letter from the sector reference group to Disability Issues Minister Dalziel mentioning other steps, such as the elimination of special schools, a need for government funding to implement the strategy and the need to seek cross-party support for the NZDS. Dalziel further brokered a compromise in that the disability sector group content document would be condensed into the final version of the strategy. This came at the price, though, of sacrificing the more directive approach that the reference group had favoured, and this significantly compromised the Strategy’s ability to effect change in the long-term.

A four-way teleconference involving DSRG members, officials, and both Dyson and Dalziel brokered this agreement.¹²⁶ This teleconference, according to several former reference group members, focused on the role of inclusive education.¹²⁷ In fact the success

¹²³ Hon. Lianne Dalziel, interview by author, Wellington, May 19, 2010.

¹²⁴ Saucier, *Promoting a National Vision*, 18.

¹²⁵ Ibid.

¹²⁶ Scown, interview by author, May 19, 2010.

¹²⁷ Ibid.

or failure of the whole document, in terms of how it would be publicly received, came to hinge on this issue. The DSRG assertively pushed for the need to abolish segregated education for disabled children in favour of an inclusive model where all children, regardless of their impairment level, would be accommodated in mainstream classroom settings. Politically the Ministry of Education steadfastly supported the status quo. Furthermore when Dalziel acquired the Disability Issues portfolio she remained Associate Minister of Education with responsibility for special education. As Jan Scown noted, for all these reasons, Dalziel very strongly averred that a gradual move towards an inclusive system was preferred to instant abolition.¹²⁸

The reference group also pushed strongly the need for accessible transport. Dyson stated that the Ministry of Health (acting as the reference group's official secretariat) became the 'hummus in the sandwich' over this issue. According to Dyson, Transport officials had bought into the free-market thinking that predominated in the 1990s. Consequently the Ministry of Transport, for philosophical reasons, opposed central government mandates that private bus company fleets should become accessible. Dyson sided with the DSRG over this issue by maintaining that if government funding were to be provided for this purpose, then accountability would be required of bus companies in return.¹²⁹

One more potentially politically difficult issue emerged. Reference group members suggested calling the document 'Closing the Gaps for Disabled People'. However, at time of the Strategy's formulation this language had become politically explosive for the Labour-Alliance Government. Its own 'closing the gaps' policy, designed to bridge the socio-economic divide between Māori and Pākehā New Zealanders, had created a public backlash.¹³⁰ Prime Minister Helen Clark abandoned 'closing the gaps' policy during

¹²⁸ Ibid.

¹²⁹ Dyson, interview by author, May 20, 2010.

¹³⁰ "Speech: Closing the Gaps," Hon. Tariana Turia, accessed September 30 2010

<http://www.beehive.govt.nz/speech/closing+gaps>. In an earlier political life, Tariana Turia had been a Labour-Alliance Government Cabinet Minister. Her portfolio responsibilities included acting as an Associate Minister for Māori Affairs. In this role, she announced the 'Closing the Gaps' policy, designed to alleviate Māori economic and social disadvantage through various policies, including additional funding for Māori

2000.¹³¹ Accordingly the Government sent the message for the reference group to discard the idea as well. This had some negative implications for the Strategy going forward as Gibson recounts:

During the development of it, that [the closing the gaps issue] politically exploded so that language was wiped off our map. We were told we couldn't get that. That I think slightly weakened [the Strategy] because part of the rights-based discourse was that disabled people do not participate/achieve within society because of society [and its attitudes].¹³²

The submission of the final NZDS draft by Dyson, to both the Labour and Alliance parliamentary caucuses and Cabinet for final approval, occurred after these remaining issues had been resolved. The principal actors disagree as to how smoothly this process unfolded. Former Ministers Dyson and Dalziel contend that there was no dissent in either of the coalition party caucuses or within Cabinet to the NZDS. Conversely, DPA's Williams holds that some Labour ministers and caucus members resisted the document. He points to 'concerns about the economic impact of the Strategy' as the cause.¹³³

By the time the NZDS finally received Cabinet approval in April 2001, some changes had been made to the original document, mainly around aspects of wording and terminology.¹³⁴ More importantly, however, the emphasis placed on the social model of disability and the need to remove barriers remained largely intact.

organisations to build up their capacity to deliver services to tangata whenua. The majority of Pākehā/European New Zealanders resented extra funding being given to Māori under this policy.

¹³¹ "Closing the Gaps: Policy or Slogan," Brian Easton, accessed September 30 2010, <http://www.eastonbh.ac.nz/?p=1>. Even socially liberal commentators such as Brian Easton critiqued the Labour-Alliance Government's approach to closing the gaps in terms of, for example, opposing proposals for separate Māori representation on health boards and other representative bodies.

¹³² Gibson, interview by author, May 19, 2010.

¹³³ Williams, telephone interview by author, May 3, 2010. Although Williams provided no collaborative evidence, he holds that some Labour-Alliance Government ministers and caucus members did have fiscal concerns about the document.

¹³⁴ Saucier, *Promoting a National Vision*, 18. A cabinet minute gave formal government sign-off to the NZDS in April 2001.

The amendments made the Strategy's definition of disability more readable as it included everyday examples of the barriers encountered by disabled people:

*Disability is a process which happens when one group of people create barriers by designing a world only for their way of living, taking no account of the impairments other people have. Our society is built in a way that assumes that we can all move quickly from one side of the road to the other; that we can all see signs, read directions, hear announcements, reach buttons, have the strength to open heavy doors and have stable moods and perceptions.*¹³⁵

This set a tone for the document that could be easily read and accessed by all people.

At the outset the disability sector held high hopes about the Disability Strategy and its ability to deliver positive change for disabled people and their families. However, even before its architects presented the Strategy to Government for final approval it had become a much weaker document. As the following chapters indicate, this had a detrimental long-term impact on the Government's ability to implement the NZDS.

¹³⁵ Minister for Disability Issues, *The New Zealand Disability Strategy*, 3.

Chapter Three

The Implementation of the New Zealand Disability Strategy by Central Government (2001-2011)

Perceptions differ between government officials and disabled people about progress on the Disability Strategy's implementation over the last six years. Central government agencies view the Disability Strategy as the government's commitment to creating incremental change alongside other priorities and work streams within current budgets. They perceive that incremental change is occurring.

However disabled people, disabled persons' membership organisations and disability support providers expected greater progress in implementation by 2007, so that New Zealand would be closer to becoming a fully inclusive and enabling society.¹³⁶

This is how the two main parties to the Strategy, the government and disabled people, were seen to view progress on the Strategy's implementation during its first six years according to the *New Zealand Disability Strategy Implementation Review 2007* (hereafter to be referred to as the 2007 Review) commissioned by the Office for Disability Issues (ODI). On the one hand, government officialdom was pleased with progress given the financial and resource constraints that existed. On the other hand, the wider disability sector wanted faster progress than the Government could seemingly deliver. In 2001 the launch of the NZDS spawned great optimism about creating a non-disabling society. So, why was Government so tardy in delivering on its promises of change made to disabled people in the Strategy? What happened during the Strategy's implementation to produce this slow

¹³⁶ Litmus Consulting Limited, *New Zealand Disability Strategy Implementation Review 2001-2007* (Wellington: Litmus Consulting Limited, 2007): Office for Disability Issues <http://www.odi.govt.nz/nzds/index.html> (accessed March 11,2009), 4.

pace of change? What were the political and bureaucratic factors that contributed to this state of affairs? This chapter examines actual Strategy implementation under both the Fifth Labour and National Governments (1999-2011). Most of this chapter focuses on an analysis of the 2007 Review and also annual departmental and ODI implementation reports, which have all expounded on how well both governments have proceeded with strategy implementation (or not) during this period.

Understanding Disability Strategy accountability mechanisms

Before launching into a full analysis of the Strategy's implementation, it is important to understand the various approaches taken regarding its implementation and reporting by government.

Thematically the review referenced two distinct phases in the Strategy's evolution. During the first years of the Strategy's life many government agencies took a narrow approach. The review states 'the focus of implementation from July 2001 to June 2002 was on extending or enhancing work already planned within existing budgets.'¹³⁷ Agency action plans focusing on outputs marked this initial period. These, according to the review, often reflected 'a human resource/EEO focus as their co-ordination was mainly the responsibility of government agencies' human resource divisions.'¹³⁸ The ODI wrote a letter in May, 2003 to all government agency chief executives suggesting that all aspects of their departmental activity be included within future work plans. Furthermore, the ODI requested that government agencies produce plans on accessible service delivery for disabled people.¹³⁹ A greater emphasis on priority areas with multi-year plans followed.

From the second half of 2001, as the implementation reports and subsequent 2007 Review indicate, the Disability Strategy became the benchmark for the assessment of all current and future government policy on disability. The Minister for Disability Issues has been

¹³⁷ Ibid,15.

¹³⁸ Ibid.

¹³⁹ Ibid.

required since 2001 to table annual reports prepared by the Office in Parliament on implementation progress. Subsequently government agencies reported on their Disability Strategy implementation progress annually to the Office for Disability Issues. Each agency, in turn, reported progress according to their annual work plans. A common work plan template, provided by the ODI, informed these plans. Within the work plans, government agencies showed what principal areas they intended to implement the NZDS in over the course of the following financial year.

By the time of the Third Annual Report's publication in 2002-03, the number of government agencies reporting on their progress in implementing the NZDS had increased dramatically from the original ten to thirty-seven departments. The new agencies reporting that year included the Department of the Prime Minister and Cabinet, Statistics New Zealand, the Police, the Treasury, Department of Inland Revenue, Ministry of Agriculture and Forestry, Department of Internal Affairs, New Zealand Customs Service and the Ministry for Culture and Heritage.¹⁴⁰

During the first years of the Strategy's life, agencies and departments submitted their implementation reports separately. However, by 2007-2008 government departments submitted their work plans for the coming year together with their implementation reports from the preceding year. Many disability sector actors interviewed for this research observed, from their perspective, that while government agencies have been attempting to convey an image of actively implementing the strategy, the reality has been far different.

An analysis of individual departmental and agency work plans/implementation reports and the 2007 NZDS Review indicate that social policy agencies made more of an effort to implement the Strategy than non-social policy agencies.¹⁴¹ Key social agencies had made

¹⁴⁰ Hon. Ruth Dyson, *Progress in Implementing the New Zealand Disability Strategy –The Third Annual Report from the Minister for Disability Issues to the House of Representatives*, (Wellington: Office for Disability Issues, Ministry of Social Development, 2003): Office for Disability Issues <http://www.odi.govt.nz>, (accessed March 12 2009),6.

¹⁴¹ For example, the page lengths of the Work Plans 2007-2008 and Progress Reports 2006-2007 from the Ministry of Social Development are 91 pages; Ministry of Health (45); Ministry of Education (66); Housing New Zealand Corporation (50) and the Accident Compensation Corporation (45). Comparatively smaller

some progress by 2007 in developing strategies, programmes, and policies to address or ameliorate the barriers facing disabled people within our communities whereas non-social policy agencies did not actively engage in Strategy implementation.

The Office for Disability Issues actively encouraged agencies highly utilised by disabled people and their families, for example Work and Income, to implement the NZDS. As ODI Director Jan Scown noted, at the time of the Strategy's inception, the ODI placed an initial emphasis on partnering with nearly all departments to determine what should be in their plans. But this soon changed to a more focused approach. Scown conveyed this approach to departmental chief executives by stating that 'instead of you all trying to do the Strategy, why don't we [the ODI] recognise that some of your departments are more important or going to have more impact, put it that way, on disabled people than others'.¹⁴² Scown and her team stressed the need for agencies to focus only on principal areas of the document. For example, all public sector agencies had to make their services and buildings accessible. Otherwise the ODI expected government agencies to concentrate on the Strategy actions relevant to their core activities.¹⁴³

The 2007 Review also identified five different approaches that government agencies took in implementing the NZDS. Firstly, a human resources focus where an agency's human resources section had sole responsibility for NZDS planning and reporting. Secondly, a disability specific focus where a specific section, for example corporate services, had responsibility for Strategy implementation. Thirdly, mainstreaming disability issues where each division incorporated disability perspectives into their work. Fourthly, supported mainstreaming where an agency used a governance style approach in terms of, for example, disability reference groups. Fifthly, a disability champion approach where a disabled staff member had the role of overseeing disability issues.¹⁴⁴ In respect of the last approach the 2007 Review could have gone further by adding a sixth: the Disability

Work Plans and Progress Reports were filed by the Treasury (25); Department of Inland Revenue (26); State Services Commission (25) and the New Zealand Police (20). Reasonably sized reports were filed by the Ministry of Foreign Affairs and Trade (35) and the Ministry of Justice (35).

¹⁴² Scown, interview by author, May 19, 2010.

¹⁴³ Ibid.

¹⁴⁴ Litmus Consulting Limited, New Zealand Disability Strategy Implementation, 55.

Strategy champion approach. Disability Strategy champions are individual bureaucratic or political actors, who irrespective of whether they had a disability or not, played an instrumental role in advancing the Strategy within their agency or across government. Some of the key interviewees for this thesis, for example, former Disability Issues Minister Ruth Dyson, and Capital and Coast DHB managers Maurice Priestley and Paul Gibson best fit this definition.

Therefore, agencies treated the Strategy as either being a compartmentalised document where disability had a separate place in the policy making process, or as an inclusive document that had to be integrated into all aspects of the agency's work. Under National these same reporting systems and implementation methods have been retained with respect to the Strategy.

NZDS implementation under Labour (2001-2008)

According to the 2007 Review what work did government agencies undertake around the Strategy during its early years under Labour? On the positive side the review noted that wide disability sector acceptance assisted the implementation of the Disability Strategy. Early gains included the appointment of a Minister for Disability Issues and the creation of the ODI.

Establishment of the Office for Disability Issues

The establishment by Ruth Dyson of the ODI on July 1, 2002 marked a seminal moment in the Strategy's implementation as it signalled the Labour-Alliance Government's desire to see disability policy framed within a social model framework. Initially, the Ministry of Health had overseen the first fourteen months of the Strategy's implementation from April 2001 to June 2002. Historically the ministry had been responsible for funding disability support services across the age spectrum since the Fourth National Government's health and disability sector reforms of the early 1990s. Interestingly Labour had proposed in its 1999 disability election policy that policy advice to the Minister for Disability Issues would still be provided by the ministry, albeit from within a new and separate

directorate.¹⁴⁵ However, once in office, the Health Ministry advised Government not to do so owing to the need to prevent potential conflicts of interest given the ministry's role in funding disability services.¹⁴⁶ Consequently the change would give the new ODI a degree of independence and autonomy. Furthermore the ODI would have the capacity to tackle wider disability issues. Moreover this structure aligned with that used for other existing population-based agencies, such as the Offices for Senior Citizens and Ethnic Affairs. Kylie Clode recalled that a number of government departments acted as midwife at the birth of the new Office with the State Services Commission and the Ministries of Health and Social Development all collaborating in the process.¹⁴⁷

The ODI primarily functions as the lead agency with responsibility for overseeing the implementation of the Strategy, providing advice on disability issues (including strategic and cross-sectoral disability policy) to government and the Minister for Disability Issues.¹⁴⁸ The ODI also has responsibility for administering the New Zealand Sign Language Act 2006, and it oversees a requirement that the Department for Building and Housing implement the public access provisions of the Building Act.¹⁴⁹ Furthermore the Office established a Disability Advisory Council in 2004. This gives the ODI a mechanism to seek advice on disability issues as they arise and to acquire feedback on the implementation of the New Zealand Disability Strategy from representatives of disabled people and their families/whānau.¹⁵⁰ In 2011 the Council has thirteen appointed members

¹⁴⁵ New Zealand Labour Party, Focus on patients: Labour on health, 10.

¹⁴⁶ Clode, interview by author, May 20, 2010.

¹⁴⁷ Ibid.

¹⁴⁸ Ibid.

¹⁴⁹ "What we do", Office for Disability Issues, accessed August 3 2009, <http://www.odi.govt.nz/what-we-do/index.html>.

¹⁵⁰ Office for Disability Issues, Disability Advisory Council: Terms of Reference, (Wellington: Office for Disability Issues, Ministry of Social Development, 2008), 2-3. According to the Terms of Reference (updated in November 2008), the Council is broadly representative of the different impairment and population-based groups within the disability sector. Therefore, representative groups include people with experience of mental illness, people with sensory impairment (hearing impaired, vision impaired and Deaf), people with learning disabilities (intellectual disability), people with experience of chronic illness, people with an impairment caused by accident, Māori, Pacific people, older people, youth and family members, those living

selected by disability consumer organisations, which appoint suitable candidates directly. Council members chosen on an impairment/sector group basis by consumer organisations all serve three-year terms. The majority of the Council is comprised of disabled people.¹⁵¹

After the launch of the *New Zealand Disability Strategy*, the ODI tasked ten government departments with the responsibility of preparing annual work plans for Strategy implementation in the 2001-02 year. The ten government departments directed to develop work plans were: the Department of Labour, as well as the Ministries of Education, Health, Justice, Pacific Island Affairs, Social Development, Transport, Women's Affairs and Te Puni Kokiri (Ministry of Māori Development) plus the State Services Commission.¹⁵² The Office for Disability Issues required annual NZDS implementation reports from each of these state sector organisations outlining progress against their agency's initial work plans.¹⁵³

The ODI and its existence had made some impact in terms of wider government recognition of disability issues. But constraints have been placed upon its effectiveness as well, and this has led to criticism, particularly from the disability sector, about its performance as will be discussed further on when examining the negatives of Strategy implementation.

in urban and rural areas. Also the Council membership is gender balanced. The ODI appoints the Chairperson and Deputy Chairperson.

¹⁵¹ Office for Disability Issues, *Disability Advisory Council: Terms of Reference for Appointing Organisations*, (Wellington: Office for Disability Issues, Ministry of Social Development, 2008), 1-3. The ODI chooses the nominating organisations on the basis that they are disability consumer organisations or represent disabled people and their families. The ODI, at the end of the Council's term, has the right to change the appointing organisation after consultation with that organisation.

¹⁵² Litmus Consulting Limited, *New Zealand Disability Strategy Implementation*, 4.

¹⁵³ Ibid.

Other positives of Labour's NZDS implementation

Also at the executive level of government another positive development was the Cabinet decision of August, 2001 that any papers submitted to the Cabinet Social Development Committee and other Cabinet committees where appropriate, should incorporate a disability perspective.¹⁵⁴ In December 2005 the ODI also launched the *Including a Disability Perspective: A Toolkit for Policy Makers* guide to further assist this process. The Toolkit outlined how government agencies should go about developing policy from a disability perspective and as to the role and purpose of the Office within the government policymaking machinery.¹⁵⁵ Both the Cabinet decision and the Toolkit acted to force government agencies to consider the potential impacts, if any, of all policy proposals on the lives of disabled people and their families/whānau, extending the already standard practice of providing for a Māori, Pacific Island and women's perspective within Cabinet papers. This requirement simply brought disability into line with other social equity groups.

The establishment of the Office for Disability Issues and the requirement that Cabinet papers contain disability perspectives enabled NZDS implementation to proceed within government agencies.

The Education Ministry had responsibility for implementing the Strategy's third objective 'to provide the best education [for disabled people].'¹⁵⁶ The Ministry within the review timeframe had integrated the Specialist Education Services (SES) within the Ministry, and all divisions within the Ministry became responsible for implementing the strategy across the entire education sector. Other initiatives included the introduction of a High Health

¹⁵⁴ Ibid.

¹⁵⁵ Office for Disability Issues, *Including a Disability Perspective: A Toolkit for Policy makers* (Wellington: Office for Disability Issues, Ministry for Social Development, 2003): Office for Disability Issues <http://www.odi.govt.nz/resources/guides-and-toolkits/disability-perspective.html> (accessed June 22 2011), 1-45.

¹⁵⁶ Minister for Disability Issues, *The New Zealand Disability Strategy*, 16.

Needs Fund to support schools with high proportions of enrolled disabled students. The Government allocated additional funding to enhance specialist support provision for disabled children enrolled in early childhood services. The Ministry developed a New Zealand Sign Language (NZSL) curriculum for schools. The Tertiary Education Commission and the Ministry of Education jointly endorsed best practice guidelines for the support of disabled tertiary students. Work had begun on improving learning outcomes for children and young people with Autistic Spectrum Disorders.¹⁵⁷

In the employment and income support areas, encompassing both the Ministry of Social Development (including Work and Income New Zealand) and the Accident Compensation Corporation, the launch of the *Pathways to Inclusion* strategy in September, 2001 marked a milestone in terms of attempting to meet NZDS objective four's goal 'to provide opportunities for employment and economic development' for disabled people.¹⁵⁸ The *Pathways* document expressly called for an improvement in the quality of employment opportunities available for disabled people within the open labour market.¹⁵⁹ The 2007 Review made specific reference to the delivery of more 'higher quality [employment support] services' for disabled people under *Pathways*. Up to 9,000 disabled people gained open employment during the first seven years of the Disability Strategy. Social Development also made changes aimed at recognising the desire of disabled New Zealanders to enjoy the same employment opportunities as non-disabled New Zealanders. Through changes to the 'Working New Zealand' programme, the Ministry recognised the need for disabled people to receive ongoing social and financial support.¹⁶⁰ ACC developed supported employment and living services for people with traumatic head injury.¹⁶¹

¹⁵⁷ Litmus Consulting Limited, *New Zealand Disability Strategy Implementation*, 27-29.

¹⁵⁸ Minister for Disability Issues, *The New Zealand Disability Strategy*, 17.

¹⁵⁹ Department of Labour, *Pathways to Inclusion: Nga ara whakauru kit e iwi whanau: Improving Vocational Services for People with Disabilities*, (Wellington: Department of Labour, 2001): Office for Disability Issues <http://www.odi.govt.nz/documents/publications/pathways.pdf> (accessed October 27 2009), 1-16.

¹⁶⁰ Litmus Consulting Limited, *New Zealand Disability Strategy Implementation*, 29.

¹⁶¹ *Ibid.*

Both Housing New Zealand Corporation and the Department for Building and Housing engaged in work to underpin one of the action points of the Disability Strategy to support quality living in the community for disabled people.¹⁶² Housing New Zealand upgraded and modified some of its existing housing stock to suit the needs of disabled tenants and made commitments to improve housing choices for disabled New Zealanders by promoting universal design principles.¹⁶³ Standards New Zealand updated building access standards in its *NZS 4121:2001 Design for Access and Mobility – Buildings and Associated Facilities* guide, outlining minimum access requirements for public buildings and other aspects of the built environment (for example, pedestrian crossings).¹⁶⁴ The revised Building Act 2004 further promoted the concept of accessibility for all by addressing issues such as the need for assistive listening devices to be placed in public amenities including cinemas, theatres, public halls and old people's homes where more than twenty people reside.¹⁶⁵

Improving access to public transport became an important issue for the disability community during the years 1995-2007. The disability community campaigned to improve accessibility for disabled travellers on trains, passenger ships and especially urban bus/long-haul passenger transport networks throughout New Zealand. Under the objective to support quality living in the community for disabled people, the NZDS states that all authorities, local, regional and national, responsible for planning of public transport

¹⁶² Minister for Disability Issues, *The New Zealand Disability Strategy*, 22. Under the eighth objective's call for supporting quality living in the community for disabled people, action 8.1 stipulated the need to: 'Increase opportunities for disabled people to live in the community with choice of affordable, quality housing.'

¹⁶³ Housing New Zealand Corporation, *Building the Future: The New Zealand Housing Strategy*, (Wellington: Housing New Zealand Corporation, 2005): Housing New Zealand Corporation <http://www.hnzc.co.nz/hnzc/dms/380D2C40C069A4CE4665F55A8C4523D1.pdf> (accessed October 29 2009), 65-67. 'Area 7 – Meeting Diverse Needs' specified the accommodation needs of disabled people and people with mental illness. The Strategy called for the adoption of universal design principles so New Zealand housing could accommodate a diverse range of users, including disabled people, across a home's lifetime.

¹⁶⁴ Standards New Zealand, *NZS 4121:2001 Design for Access and Mobility-Buildings and Associated Facilities Guide*, (Wellington: Standards New Zealand, 2001), 1-124.

¹⁶⁵ *Building Act 2004*, s 117, 118, 119 and 120 stipulate minimum building accessibility requirements.

services should 'Require all new scheduled public transport to be accessible in order to phase out inaccessible public transport.'¹⁶⁶ The *Human Rights Commission Inquiry into Accessible Public Land Transport* in 2005 pushed the issue along, generating awareness amongst transport planners, providers and the public.¹⁶⁷ With both the Strategy and the Human Rights Commission's inquiry creating an impetus for change, the Ministry of Transport developed an assessment of the Human Rights Commission's inquiry findings with a view to taking a firm set of recommendations to government. Local councils worked to improve the accessibility of their public transport networks as well, notably in the highly populated regions of Auckland, Hamilton and Wellington.¹⁶⁸

The passage of the Human Rights Amendment Act in 2001 ended the Government's exemption from complaints under human rights law. This change enabled the policies, programmes, procedures, and actions of Crown agencies to be scrutinised from a human rights perspective, and specifically whether they discriminated on the grounds of disability.¹⁶⁹ The Labour-Alliance Government, in passing this legislation, fulfilled

¹⁶⁶ Minister for Disability Issues, *The New Zealand Disability Strategy*, 22.

¹⁶⁷ Human Rights Commission, *The Accessible Journey: Report of the Inquiry into Accessible Public Land Transport*, (Auckland: New Zealand Human Rights Commission, 2005), 1-157.

¹⁶⁸ Hon. Ruth Dyson, *Work in Progress 2007: The annual report from the Minister for Disability Issues to the House of Representatives on implementing the New Zealand Disability Strategy*, (Wellington: Office for Disability Issues, Ministry for Social Development, 2007): Office for Disability Issues <http://www.odi.govt.nz/nzds/progress-reports/july06-june07/index.html>, (accessed October 29 2009), 21.

¹⁶⁹ "Human Rights Act," New Zealand Human Rights Commission, accessed October 30 2009 <http://www.hrc.co.nz/home/hrc/humanrightsenvironment/humanrightsinnzeland/humanrightsact.php>. Under the Human Rights Act 1993, the Government remained under an exemption from having complaints taken against it. This created an inequity whereby the state remained exempted from discrimination complaints while private and voluntary sector organisations could have complaints made against them. The other grounds for discrimination (besides disability) include age (from the age of 16 years), colour, employment status, marital status, ethical belief (lack of religious belief), political opinion, race or racial harassment, sex and sexual harassment, and sexual orientation (heterosexual, homosexual, lesbian or bisexual). The areas of discrimination include the provision of goods and services; access to education and/or training opportunities; employment; the provision of accommodation, land and housing; access to public places vehicles and facilities; partnerships; industrial and professional associations, qualifying bodies and vocational training bodies. Part 1A of the Human Rights Amendment Act 2001 ended the Government's

objective two's requirement to ensure rights for disabled people.¹⁷⁰ Subsequently, the Human Rights Commission's *New Zealand Action Plan on Human Rights* sought to develop a framework for both upholding and extending human rights within New Zealand and offered practical suggestions to government agencies as to how to achieve this. The Commission recommended that government take a leadership role in the development of a human rights convention for disabled people, eliminate poverty amongst disabled people and improve rights for mental health service users.¹⁷¹

The passage of the Disabled Persons Employment Promotion Repeal Act 2006 further extended the human and employment rights of disabled people and in so doing Government carried out its commitment under Strategy action 4.9 to 'Ensure disabled people have the same employment conditions, rights and entitlements as everyone else has, including minimum wage provisions for work of comparable productivity'.¹⁷² In 1960 the Second Labour Government's Disabled Persons Employment Promotion (DPEP) Act legally sanctioned the exploitation of disabled people in segregated sheltered workshop settings. The 2006 Repeal Act removed this iniquity in the treatment of a small but still vulnerable group of intellectually disabled people and those with mental illness.

Another advance came with the passage of the New Zealand Sign Language (NZSL) Act 2006. Although the Strategy did not specifically call for legislative recognition of NZSL, several actions namely 3.2 (support for education in New Zealand Sign), and 11.26 and 12.4 (support for trilingual interpreter training for Deaf Māori and Pacific peoples) called

exemption from the law and therefore enabled anyone who felt discriminated against by the actions of the State to take up a complaint.

¹⁷⁰ Minister for Disability Issues, *The New Zealand Disability Strategy*, 15. This move to amend the Human Rights Act more than fulfilled its obligations under Strategy action 2.4 to: 'Review human rights legislation to ensure the ongoing enhancement and strengthening of the rights of disabled people.'

¹⁷¹ "New Zealand Action Plan for Human Rights," Human Rights Commission, accessed October 30 2009 <http://www.hrc.co.nz/home/hrc/humanrightsenvironment/newzealandactionplanforhumanrights.php> . The Action Plan detailed a number of specific actions by Government to strengthen the rights of children and young people, Māori, Pacific Island and other ethnic groups, as well as enhancing economic, social, cultural, civil and political rights for the wider population.

¹⁷² Litmus Consulting Limited, *New Zealand Disability Strategy Implementation*, 18.

upon Government to recognise the linguistic needs of the Deaf community in these respects.¹⁷³ This legislation made NZSL an official language of New Zealand meaning the state and its agencies had to accord equal recognition alongside English and Māori to the New Zealand version of sign language used by the Deaf community. The Act's passage in December, 2006 also made this country the first in the world to grant sign language equal recognition as an official language.¹⁷⁴

On the international legal front, New Zealand became a catalyst and prime mover behind the *United Nations Convention on the Rights of Persons with Disabilities*.¹⁷⁵ The New Zealand Government, in taking the lead on UN Convention, implemented the NZDS action pledging that it would 'Investigate and, if appropriate, support, the development of a United Nations convention on the rights of disabled people.'¹⁷⁶ Interviewees, such as Paul Gibson and Ruth Dyson, placed great store on the Convention as a potentially more effective tool for promoting disability inclusion and one that would complement the Strategy going forward.¹⁷⁷ To ensure governmental compliance, the Convention contains some robust monitoring mechanisms with government reporting as well as shadow reporting by non-governmental disability organisations.¹⁷⁸

Interviewees identified what for them had been the positive outcomes from the Strategy during Labour's time in office. One anonymous interviewee commented that 'the development of the Office for Disability Issues' had been a highlight and also believed that 'it's been a platform for Deaf people to get their rights but certainly in getting New Zealand Sign Language recognised.'¹⁷⁹ Other sector interviewees, including the DPA's

¹⁷³ Minister for Disability Issues, *The New Zealand Disability Strategy*, 16, 25 and 26.

¹⁷⁴ Litmus Consulting Limited, *New Zealand Disability Strategy Implementation*, 18. Official recognition provided for the right of Deaf people to use New Zealand Sign Language (NZSL) in legal proceedings, and provides guidelines for departments to consult with Deaf people's representative organisations over the use of NZSL in official transactions.

¹⁷⁵ United Nations, "Convention on the Rights of Persons with Disabilities," 2006.

¹⁷⁶ Minister for Disability Issues, *The New Zealand Disability Strategy*, 15.

¹⁷⁷ Dyson, interview by author, May 20, 2010, and Gibson, interview by author, May 19, 2010.

¹⁷⁸ Anonymous, telephone interview by author, April 19, 2010.

¹⁷⁹ Ibid.

Gary Williams, concurred and added that the passage of the DPEP Repeal Act had been another milestone.¹⁸⁰ From a parliamentary perspective former Minister Dyson agreed that the passage of the DPEP repeal and the New Zealand Sign Language Act had been the highlights of her time in the Disability Issues portfolio. Furthermore she noted the role that the Strategy played in helping to shape the official response to the closure of this country's last mass institutions for disabled people, Kimberley and Templeton.¹⁸¹ In the end both Government and disability sector players agreed about the Disability Strategy's role in facilitating these positive moves.

Challenges to Strategy implementation under Labour

Challenges remained for Strategy implementation, though, with no overarching implementation plan and linked funding from Government. Negative social attitudes towards disabled people still impeded their integration into society. The reluctance of government departments to adopt a disability perspective also gave cause for concern.¹⁸² Furthermore, the Government expected departmental chief executives to familiarise their staff with the Strategy's vision, objectives, and actions.¹⁸³ This undertaking would not be easy given the size of many state agencies and the need to proceed with this task alongside other work. As the 2007 Review found, the Disability Strategy constituted one of several strategies that central government agencies had an obligation to implement and this placed pressure on their limited resources. The Review summarised that these demands could 'cause it [the NZDS] to drop from view. Likewise, Ministers have to manage numerous competing demands on their time.'¹⁸⁴

With respect to funding the implementation of the Strategy, the Government expected agencies to re-allocate resources within their existing budgets to fund their implementation

¹⁸⁰ Williams, telephone interview by author, May 3, 2010.

¹⁸¹ Dyson, interview by author, May 20, 2010.

¹⁸² Ibid.

¹⁸³ Ibid.

¹⁸⁴ Litmus Consulting Limited, *New Zealand Disability Strategy Implementation*, 56.

plan objectives. They could also submit bids through the annual budget round if they believed they needed additional funding to implement Strategy-related policy.¹⁸⁵ The absence of an overall national plan and the level of Crown funding allocated to the document's implementation have been sources of contention between Government and the non-governmental disability sector ever since the Strategy's introduction as highlighted by the comment at the beginning of this chapter.

Thus, under Labour, the Strategy had led to some successful policy outcomes for disabled people but gaps remained. The 2007 Review and the September 2008 report of the parliamentary Social Services Select Committee, *Inquiry into the quality of care and service provision for people with disabilities*, primarily identified these gaps.¹⁸⁶

The 2007 Review found that four major obstacles remained, in the view of disability actors, to Government successfully implementing the NZDS. A fifth gap not identified in the Review and Select Committee inquiry emerged in interviews for this research.

First, the non-existence of a national implementation plan and linked funding. From a disability sector perspective the lack of any coherent national plan and earmarked funding presented a serious challenge. The development of a cross-government national implementation plan, involving all agencies with full input from disability sector stakeholders, should have marked the first step in the process rather than leaving individual agencies to come up with their own plans that were (at best) minimal from the start. The ODI's creation of the *Including a Disability Perspective Toolkit*, while a useful document, did not even come close to the national plan desired by the disability sector. Former Minister Dyson counter-argued that the requirement for the tabling of departmental

¹⁸⁵ Dyson, interview by author, May 20, 2010.

¹⁸⁶ New Zealand House of Representatives Social Services Select Committee, *Report of the Inquiry into the quality of care and service provision for people with disabilities*, (Wellington: Social Services Select Committee, 2008): New Zealand Parliament http://www.parliament.nz/NR/rdonlyres/06259D2F-780B-40A0-9170-005C8C046E72/93089/DBSCH_SCR_4194_6219.pdf, (accessed September 1 2010).

implementation plans in Parliament and their requirement for ministerial sign-off already provided sufficient scope for accountability.¹⁸⁷

Expecting government agencies to meet their Strategy obligations from within their existing funding produced a significant obstacle given that disability oriented programmes had to compete with other internal priorities for resourcing. Human Rights Commissioner Robyn Hunt pointed out an example of Disability Strategy programme-related under funding in June 2009 when she noted the lack of resources that had been devoted by the previous Labour Government to implementing the New Zealand Sign Language Act.¹⁸⁸

On the contrary, Dyson argued that departmental budgets were sufficient. She also pointed out that if dedicated funding existed, it would take away agencies' autonomy in determining in how to implement the NZDS:

*Well the funding is within their [parliamentary] Vote. Every department gets a huge vote and they decide what to do with it. We just add it on by the way. Implementing the strategy is one of the things you must do. So it's very unusual for a Minister to say here is your vote and by the way so much is going to go towards implementing the Disability Strategy. All that would do is to pass that thinking over to a Minister and you would never change the thinking of a government department. They have to internally go, 'how are we going to progress this strategy and how are we going to resource it?'*¹⁸⁹

While Dyson's argument about the need for no tied funding has some validity, she turned away from the idea that for some government agencies tied funding would have incentivised them to implement the Strategy. Her thinking also represents another example of how far managerialist ideology has permeated ministerial thinking. Therefore, Dyson, in giving departments the autonomy to determine how much resource they would allocate to

¹⁸⁷ Dyson, interview by author, May 20, 2010.

¹⁸⁸ "Speech delivered by Human Rights Commissioner Robyn Hunt at the launch of the Deaf People and Human Rights Report, Wellington, 6 May 2009 New Zealand Human Rights Commission," accessed March 2 2010 New Zealand Human Rights Commission www.hrc.co.nz/hrc_new/hrc/cms/files/documents/06-May-2009_15-04-02_DeafReportLaunch_RobynH.doc,. Commissioner Robyn Hunt commented on this at the New Zealand launch of an international report into the global human rights status of Deaf people.

¹⁸⁹ Ibid.

the NZDS, effectively gave chief executives and lower management the ability to under fund Strategy programmes.

Second, the small size and status of the ODI hampered its ability to monitor Strategy implementation. The 2007 Review correctly surmised that a small Office sitting within a larger government department has minimal impact given the limited resources and staff numbers it has. Owing to these constraints, the Disabled Persons Assembly has made strident calls in their successive disability election manifesto documents for the establishment of an adequately resourced and more independent Disabilities Commission. The Commission would provide independent advocacy on disability issues. The main role of such a body 'would be to complement the work of the Human Rights and (other) related Commissions'.¹⁹⁰

Ruth Dyson and Jan Scown both elaborated on the issues that confronted the Office. During the first years of its existence, for example, the Office proactively engaged with the disability community. Scown recalls that, in her early days as Director, she and other staff members travelled regularly to meet disability groups throughout New Zealand. These forays into the disability community enabled the Office to communicate with its key constituency as well as learn first-hand about the implementation of the NZDS. As the years passed, however, resourcing became an issue and outside travel impossible. Consequently Scown and her staff became more office bound.¹⁹¹ At the same time, workloads grew and, as Dyson admitted, she erroneously gave the Office a policy advisory role:

*Yes, they did [well] in terms of monitoring the plans and monitoring their implementation. I don't think though ... that the Office should have been given policy advice [to work on]. I already gave them too much to do. They should have been more responsible for getting the Disability Strategy embedded within the culture...*¹⁹²

¹⁹⁰ Disabled Persons Assembly, *Our Vision*, 6.

¹⁹¹ Scown, interview by author, May 19, 2010.

¹⁹² Dyson, interview by author, May 20, 2010.

Therefore Dyson concedes that if the Office had been able to work more effectively with government agencies on embedding a disability perspective, then the NZDS would have been better implemented, thereby reducing the disability community's criticism about the NZDS not being implemented effectively.

Third, society's ongoing poor attitudes to disabled people inhibited progress towards NZDS implementation. During Labour's time in office, disability organisations including DPA, continually called for a government funded mass disability awareness campaign to help combat discrimination and prejudice against disabled people.¹⁹³ As we have seen in Chapter One, the Strategy's first objective seeks to 'encourage and educate for a non-disabling society'.¹⁹⁴ DPA pointed to the successful Ministry of Health funded 'Like Minds, Like Mine' campaign that aimed to counter stigma and discrimination around mental illness as the best model for such a campaign.¹⁹⁵ However, some government agencies did launch small-scale programmes aimed at effecting attitudinal change. The Office for Disability Issues, for example, published *Life is for Living 2005*, a resource outlining the life stories of twenty-five disabled New Zealanders.¹⁹⁶ These small-scale initiatives, however, did not have the same reach of a mass media campaign. Politically for Labour, the launch of a disability awareness campaign presented a political risk given that National had attacked them for favouring so-called 'politically correct' causes (i.e. minority groups) in government policy.¹⁹⁷

¹⁹³ Disabled Persons Assembly, *Our Vision*, 15.

¹⁹⁴ Minister for Disability Issues, *The New Zealand Disability Strategy*, 14.

¹⁹⁵ Disabled Person Assembly, *Our Vision*, 15. 'It is recognised that the "Like Minds, Like Mine" campaign has successfully increased the inclusion of a small part of the disability spectrum, and this campaign continues.'

¹⁹⁶ Office for Disability Issues, *Life is for Living 2005 -25 New Zealanders with disability tell their life stories*, (Wellington: Office for Disability Issues, 2005), <http://www.odi.govt.nz/resources/publications/life-is-for-living/index.html> (accessed February 7 2011).

¹⁹⁷ "The Problem With Political Correctness," New Zealand National Party accessed February 7 2010, <http://www.national.org.nz/Article.aspx?articleId=5321>, . Mapp held the role of Spokesperson on Political Correctness during Dr Don Brash's time as National Party Leader. In this article, he discussed the supposed origins of political correctness and specifically attacked the Labour Government for spending '... a great deal of its energy and time promoting minority and alternative causes.'

Fourth, central government agencies internal processes acted as a barrier to adopting and embedding a disability perspective and to implementation.¹⁹⁸ Disability actors interviewed for this thesis questioned the overall effectiveness of government departments in implementing the strategy. Real scepticism existed on their part about agencies understanding of disability issues and of the Strategy itself. The feeling existed on the part of disability sector actors that, while some laudable work had been done, a question mark remained as to whether any of it had added real value to the lives of disabled people. In this regard, they commented about the ad hoc nature of government agency implementation of the strategy. Two former disability reference group members, Lorna Sullivan and Mike Gourley, and the anonymous interviewee connected with the disability sector, reflected these sentiments. On the issue of progress, Lorna Sullivan offered a scathing critique:

*Well, I would challenge people to show me any [objectives] that have been met. I would say that there have been some small attempts made to address issues, but the reality is that if you read the documents that the Office [for Disability Issues] puts out every year on the progress of the Strategy, there is none. Government ministries are saying we're wonderful for doing this but they're not really doing anything different from what they've been doing before.*¹⁹⁹

Effectively Sullivan concedes that government agencies have attempted to implement the NZDS. However, in her view, they largely opted to reiterate their pre-NZDS programmes and policies instead of undertaking the fundamental change demanded of them by the Strategy.

The anonymous interviewee specified the areas of non-progress:

The ones we haven't done so well in is educating for a non-disabling society. Human rights for disabled people have improved, but I wouldn't say that is solely the result of the strategy and the employment and economic development [area] is going backwards. Quality living in the community, I think there is some work being done around the area of intellectual disability where people have used the strategy as a platform. Life choices, recreation and leisure, well, there might have been some improvement but I think that is still an area where work needs to be done as in hard times, things like that go on the back burner. Collecting statistics and

¹⁹⁸ Litmus Consulting Limited, *New Zealand Disability Strategy Implementation*, 4.

¹⁹⁹ Lorna Sullivan, telephone interview by author, April 19, 2010.

*information on disabled people and disability issues, well, progress is incredibly much too slow in that area. Disabled children and youth, there still remains a lot of work to be done there. Disabled women, I fail to see any progress at all. Families, whānau and carers providing support, there has been some work done with carers but you would have to ask them...*²⁰⁰

The anonymous interviewee also conceded that while some progress has been made on the NZDS, the lack of work undertaken by the Labour Government in addressing key areas of concern for disabled people and their families, for example, in economic and social development, had impeded progress.

Mike Gourley explained why government departments varied in their strategy commitments:

*It would depend, I think, on who is reporting and if you like the commitment of the person, of the team, of the ministry or department concerned to the strategy. But it's true that some of the things that departments have come up with have been very tokenistic, such as have some disability awareness training sessions. It doesn't say whether people were paid to come in and deliver those sessions or not. They may have done it voluntarily, who knows? So many people are appointed on Mainstream or whatever. Mainstream is a programme where you get money, subsidies to employ people, so it is hardly a big deal that you're employing people in that sense. What about your equal employment opportunity policy, how is that working in terms of recruiting disabled people? Have you got information about disabled people in your staff, that kind of thing?*²⁰¹

Gourley's comments go further than those of Sullivan in specifically identifying how government agencies' limited understanding of the NZDS shaped their responses to it. Primarily he referred to how individual officials and whole sections of the bureaucracy have misunderstood the intent of the NZDS. Gourley also specifically alludes to the impact that managerialism has had on NZDS implementation in terms of managers being able to decide whether to engage with the Strategy or not and, if so, what to report upon. Overall, Gourley and Sullivan back up the 2007 Review's finding that government agencies' internal processes acted as a block to full Strategy implementation.

²⁰⁰ Anonymous, telephone interview by author, April 19, 2010.

²⁰¹ Mike Gourley, interview by author, May 19 2010, Wellington.

Fifth, the lack of accountability by government departments for strategy implementation to both the disability and wider communities presented a problem. This issue was the one identified by interviewees and not specifically referred to in the 2007 Review. For example, specific strategy-related reporting requirements for departmental chief executives did not exist. Instituting reporting requirements for departmental heads, in the view of an anonymous interviewee, ‘was just a bridge too far for the government.’²⁰² This made the reporting process itself one of the Strategy’s weaknesses according to former reference group member, Missy Morton, who believed that it encouraged departments merely to ‘tick the box rather than engage with the sense of it.’²⁰³

The chief reason the government did not enforce accountability at the chief executive level is due to a belief by both Dyson and Scown that taking, in the latter’s words, ‘a carrot approach and not a stick approach’ with them was best.²⁰⁴ They felt (in line with managerialist thinking regarding agency autonomy) that departmental heads could be persuaded voluntarily of the merits of buying into the Strategy and then implementing it. Scown raised the further point about not being able to get traction on the Strategy as departments gave disability-related matters a low priority. Even where policymakers sympathised with disability concerns, she admitted that it still required intervention on the part of the Office with the relevant minister to give these issues higher priority. By comparison the discussions on creating a disability strategy during the National government years envisaged that departmental chief executives would have strategy implementation marked down as one of their performance indicators.²⁰⁵ If this approach had been taken with the actual NZDS, then a greater level of cross-government commitment might have been achieved.

²⁰² Ibid.

²⁰³ Morton, telephone interview by author, April 20, 2010.

²⁰⁴ Scown, interview by author, May 19, 2010.

²⁰⁵ Ministry of Health, *Development of New Zealand Disability Strategy*, 13. A suggestion came from attendees that the Minister of Health, the Hon. Jenny Shipley, should announce that the Government saw disability strategy implementation as a Strategic Result Area (SRA) for all government departments. Stemming from this, Key Result Areas (KRAs) would be developed by departments outlining how they would produce these outcomes.

This lack of accountability also manifested itself in the type of government agencies obliged to report on their NZDS progress. Crown entities and State-Owned Enterprises (SOEs) have no requirement to report on their NZDS related activities. An example of a non-mandated Crown entity is the Sport and Recreation Council of New Zealand (SPARC). One of its former employees, ex-reference group member Mike Gourley, recalled that SPARC had ‘elected to report’ on its strategy-based activities.²⁰⁶ Other examples of Crown entities with no reporting requirements include schools and local authorities.²⁰⁷ DHBs did not have any requirement to file reports on their progress in implementing the NZDS, at least until the Ministry of Health requested they do so beginning in 2003.²⁰⁸

How did Dyson react to the conclusions of the 2007 Review? She dismissed its findings and outlined her reasons for reacting in this way by stating:

Well, there has been a review of the Disability Strategy. That was part of [the deal] when it was launched that it was [to be] reviewed. I thought the Review was very lightweight, I was really underwhelmed by it. I didn't think it was a really good review at all. I think it was quite shallow and it didn't really get to the nub of how people thought and your work will probably tell us more actually in answer to the question than the review. So I simply expressed my view about the review process, it was simply a waste of money.²⁰⁹

In doing so Dyson failed to read the signals emanating from the disability sector whose perspectives informed a large element of the Review about the slow pace of its implementation and the reasons behind it. She could have reacted differently to the Review's findings by directing, for example, that the ODI work with government agencies and the disability sector on preparing a national implementation plan.

Dyson's inaction on the 2007 Review's recommendations meant that the valid criticisms of the disability sector about Strategy implementation, or the lack thereof, soon re-appeared

²⁰⁶ Gourley, interview by author, May 19, 2010.

²⁰⁷ Ibid.

²⁰⁸ Ministry of Health, *New Zealand Disability Strategy Implementation Work Plan 2002-2003*, (Wellington: Ministry of Health, 2002), 8; Office for Disability Issues <http://www.odi.govt.nz> (accessed August 3 2009).

²⁰⁹ Dyson, interview by author, May 20, 2010.

elsewhere as they did in the 2008 report of the parliamentary Social Services Select Committee, *Inquiry into the quality of care and service provision for people with disabilities*. This report made similar criticisms to those contained in the 2007 Review about the Labour Government's slow progress in implementing the NZDS.²¹⁰ A series of media stories and parliamentary discussions, around the activities of two disability service providers accused of mistreating their clients and engaging in financial mismanagement, triggered this inquiry.²¹¹ The committee's findings exposed the systemic problems bedevilling the disability support sector including poor coordination and leadership; and the poor pay and training provided to support service staff.²¹² Overall, the select committee found that high needs, disabled clients experienced poor quality service provision from providers.

In reaching these conclusions the select committee reinforced the findings of the 2007 Review that the lack of a coordinated national plan for the NZDS had impeded its implementation.²¹³ Hence the select committee backed calls from the disability community for the creation of a new lead agency charged with overall responsibility for implementing the NZDS.²¹⁴ The inquiry also recommended that the agency draw up and monitor a national plan of action for the coordination and monitoring of the disability sector. If this arrangement failed to achieve its purpose within six years, the committee advised the appointment of a disability commission. In the interim the committee recommended that government investigate the option of appointing an independent disability commissioner within the office of the Health and Disability Commissioner.²¹⁵ On service provision and quality issues the committee made a number of specific recommendations. These included the creation of a local area coordination system based on the Western Australian model

²¹⁰ New Zealand House of Representatives Social Services Select Committee, *Report of the Inquiry into the quality of care and service provision for people with disabilities*, 8. 'In particular, the New Zealand Disability Strategy, introduced in 2001 to widespread support from the disabled community, has not been effectively implemented.'

²¹¹ Ibid.

²¹² Ibid, 11.

²¹³ Ibid, 16.

²¹⁴ Ibid, 13-15.

²¹⁵ Ibid, 36.

where disabled people could choose their disability support provider; that Needs Assessment and Coordination agencies focus on supports to ensure quality living in the community; and for Government to introduce individualised funding to disabled people so that they could determine their own support needs.²¹⁶

The Fifth National Government and the NZDS (2008-2011)

Both the 2007 Review and the select committee inquiry report influenced the opposition National Party's 2008 general election disability policy.²¹⁷ Prior to the November 2008 election, which most pundits expected National to win, the party had signalled its commitment to the NZDS and other key disability policy documents, including *Pathways to Inclusion*.²¹⁸ More significantly, through National signalling its support for the NZDS, the hope that the Labour Government had of the document receiving cross-party support at launch time had been fully realised.²¹⁹

The party stressed that it supported the disability movement's self-deterministic philosophy of 'nothing about us, without us' and that this would drive its policy in office. Utilising the select committee inquiry's findings, National embraced the call for individualised funding so that disabled people and their families exerted greater control over support service delivery. Further it pledged to trial the 'local area coordination' system of service delivery. The party also wanted to review auditing and monitoring processes for disability service providers; improve needs assessment and coordination services by introducing greater coordination of health, welfare and housing services; and improve access to disability

²¹⁶ Ibid, 23, 26.

²¹⁷ "Health Policy: Disability Issues," New Zealand National Party, accessed September 15 2010, http://national.org.nz/files/2008/disabilities_policy.pdf, , 1-2.

²¹⁸ Ibid,1.

²¹⁹ "30 April 2001: Hon. Lianne Dalziel, Minister for Disability Issues," Office for Disability Issues, accessed June 13 2011, <http://www.odi.govt.nz/nzds/speeches/30apr2001-dalziel.html>. The Minister stated at the launch that: 'I am confident that there will be genuine cross party-support for the Strategy, which is something that the Disability Sector Reference Group identified as important.'

equipment and the streamlining of its distribution. In addressing workforce capacity issues, National declared its desire to work alongside the disability sector to ‘address staff issues over time, including improved training and career pathways.’²²⁰ The party’s policy paper pledged the appointment of a Deputy Commissioner (Disability Issues) within the Office of the Health and Disability Commissioner.²²¹ Other issues covered by National’s policy included providing disabled people with ongoing access to employment and community participation activities, and promoting greater Cabinet-level collaboration on disability issues.²²²

How far have National gone in meeting these pledges? What has been the reaction to them?

Positives of Strategy implementation under National

In its disability policy National made a very slow start in government. After the 2008 election, Paula Bennett became Minister for Disability Issues with Pansy Wong and Tariana Turia (the latter from National’s support and confidence partner, the Māori Party) as Associate Ministers.²²³ Bennett made minimal impact in this portfolio, a point commented upon by nearly all interviewees. Eventually Bennett handed over the portfolio to Turia in June 2009.²²⁴

²²⁰ Ibid, 2.

²²¹ Ibid, 1-2.

²²² Ibid.

²²³ “Ministerial List for Announcement on 17 November 2008,” New Zealand National Party, accessed September 15 2010,

http://www.national.org.nz/files/2008/cabinet/2008_Ministerial_List_for_Announcement.pdf.

²²⁴ “Media Release: Turia welcomes disability role,” Hon. Tariana Turia, accessed September 15 2010, <http://www.beehive.govt.nz/release/turia+welcomes+disability+role..>

Before exiting the portfolio, however, Bennett announced the creation of a Cabinet-level Ministerial Committee on Disability Issues.²²⁵ This honoured National's pre-election commitment to improve Cabinet-level coordination of disability policy. According to the Minister, the committee would 'ensure that the Government's multi-billion dollar annual disability spend is meeting the needs of disabled people fairly and effectively.' Further, the committee would provide 'coherent overall direction for disability issues across government.'²²⁶ As of 2011 the committee's membership comprises the Deputy Prime Minister/Minister of Finance, the Minister for Disability Issues and also the Ministers of Health, Education, Justice and Transport.²²⁷ Disappointingly the ministerial group had, as of early 2010, met infrequently. The Labour Party's disability issues spokesperson Lynne Pillay criticised this lack of ministerial engagement over disability issues in a Radio New Zealand National interview, which aired in May, 2010.²²⁸ A number of planned meetings were cancelled and the Party particularly criticised the Government over this. To this extent Pillay pointed out in the interview that the absence of Cabinet committee level discussion signified National's lack of interest in disability issues.²²⁹ As of April, 2011, this poor record continued as the ministerial committee had only met six times during National's first twenty-nine months in office.²³⁰

Parallel to the ministerial committee is another comprised of departmental chief executives. Dyson and Scown originally mooted the cross-government chief executive's group on disability as part of the strategy to persuade chief executives to implement the Strategy. Scown underscored the real authority that chief executives wield (in line with

²²⁵ "Media Release: Ministers' group to oversee disability policy," Hon. Paula Bennett, accessed September 15, 2010 <http://www.beehive.govt.nz/release/ministers%e2%80%99+group+oversee+disability+policy>.

²²⁶ Ibid.

²²⁷ Jan Scown, telephone interview by author, June 28, 2010.

²²⁸ Lynne Pillay, interview by Mike Gourley, *One in Five*, Radio New

Zealand, September 15, 2010 (originally aired June 13, 2010),

<http://www.radionz.co.nz/national/programmes/oneinfive/20100613>. She commented that the Ministerial Committee on Disability Issues had only met three times in the year since its formation in May, 2009.

²²⁹ Ibid.

²³⁰ "Ministerial Committee on Disability Issues," Office for Disability Issues, accessed May 31 2011

<http://www.odi.govt.nz/what-we-do/ministerial-committee-on-disability-issues/index.html>.

managerialist theory) as ‘they have a huge influence on what gets concentrated on within agencies.’²³¹ The membership of this group is different from the ministerial group in that it includes the chief executives of the Accident Compensation Corporation, Housing New Zealand Corporation, Department of Building and Housing and the Ministry for Culture and Heritage.²³²

After Bennett’s departure, National’s disability policy continued to drift under Tariana Turia. She was not as influential in the role as her Labour predecessors had been. Compared to Bennett, though, she eventually managed a slightly better performance in the portfolio (and one that continued into 2011). Still, as her predecessor Ruth Dyson reflected, Turia’s position as Māori Party co-leader meant that she was disadvantaged by not being a member of the governing National Party.²³³ This meant, as the Minister herself revealed in a Radio New Zealand National interview in 2010, that while she could influence some decisions, National sometimes ‘left [her] out of the loop’ on others impacting upon her portfolio. For example, she cited the new restrictions on Training Incentive Allowance (a supplementary grant covering higher education costs for invalids and domestic purposes beneficiaries) announced in early 2010 as one example.²³⁴ Still even former Minister Dyson considered her onetime Labour caucus colleague ‘a good person to hold it [the disability issues portfolio] ... in my view’.²³⁵ She thought this way about Turia given the minister’s personal commitment to the Disability Strategy and understanding of human rights issues.²³⁶

Nonetheless, as Disability Issues Minister, Turia presided over the implementation of National’s disability policy. Her first ministerial report to Parliament *Work in Progress 2009 – The Annual Report from the Minister for Disability Issues* noted the Ministry of Health’s work to address the issues that formed the basis of both National’s election policy

²³¹ Ibid.

²³² Scown, telephone interview by author, June 28, 2010.

²³³ Dyson, interview by author, May 20, 2010.

²³⁴ Hon. Tariana Turia, MP, interview by Mike Gourley. *One in Five*. Radio New Zealand. September 15, 2010 (originally aired June 13, 2010), <http://www.radionz.co.nz/national/programmes/oneinfive/20100613>.

²³⁵ Dyson, interview by author, May 20, 2010

²³⁶ Ibid.

and the select committee inquiry's recommendations.²³⁷ The report indicated that the development of a national framework for individualised funding for disability support services had commenced; that work on streamlining needs assessment and service coordination was underway; and the government had directed officials to investigate the viability of introducing a local area coordination system into New Zealand. The new government had also pledged that it would expand opportunities for supported independent living, and in particular, arrangements for disabled people to choose where they lived and with whom they lived. From late 2009 onwards, the Ministry started trialling individualised funding arrangements throughout the country.²³⁸ Further Turia, alongside Health Minister the Hon. Tony Ryall, announced an additional \$93 million for disability support services as part of Budget 2010.²³⁹ A Workforce Strategy and Action Plan was being implemented which encouraged providers to recruit and retain staff through offering them paid training and career opportunities.²⁴⁰ In early 2009 Government announced the appointment of a Deputy Commissioner (Disability Issues) to work alongside the Health and Disability Commissioner.²⁴¹ National, through these initiatives, sought to meet the

²³⁷ Hon. Tariana Turia, *Work in Progress 2009: Report from the Minister for Disability Issues to the House of Representatives on Implementing the New Zealand Disability Strategy*, (Wellington: Office for Disability Issues, Ministry of Social Development, 2009): Office for Disability Issues <http://www.odi.govt.nz/documents/nzds/progress-reports/2009-nzds-progress-report.pdf>, (accessed August 15 2010).

²³⁸ "Individualised Funding: Update November 2009," Ministry of Health, accessed February 7 2011 <http://www.moh.govt.nz/moh.nsf/indexmh/disability-keyprojects-ifp..>

²³⁹ "Media Statement: \$93 million more for disability support services," Hon. Tony Ryall and Hon. Tariana Turia, accessed September 15 2010 <http://www.beehive.govt.nz/release/68+million+improve+lives+disabled+nzers..>

²⁴⁰ Turia, *Work in Progress 2009: Report from the Minister for Disability Issues to the House of Representatives on Implementing the New Zealand Disability Strategy*, 27-30

²⁴¹ "Media Statement: Health Minister announces appointment of Deputy H&DC Disability," Hon. Tony Ryall, accessed September 29 2010, "<http://www.beehive.govt.nz/release/health+minister+announces+appointment+deputy+hampdc+-+disability..> The Minister announced the appointment of Tania Thomas, an existing assistant commissioner, and one with previous experience of management in Māori and disability sector services.

NZDS goal (stated in objective seven) of creating long-term support systems centred on the individual.²⁴²

Turia, as part of National's May 2010 Budget, also announced the Government's intent to realise objective one of the NZDS through plans for a \$3 million nationwide disability awareness campaign.²⁴³ This move sought to address the 2007 Review's concerns about the absence of a mass awareness campaign to combat poor attitudes towards disability. Through this decision National stripped away its image as the champion of the anti-political correctness cause, at least in relation to disability.

Negatives of Strategy implementation under National

In the area of employment and community activity opportunities for disabled people, the National Government has focused on introducing a neo-liberal inspired, welfare-to-work agenda. Under the 'Future Focus' reforms announced by Social Development Minister Bennett, from early 2010, sickness beneficiaries (many whom live with impairments), faced the expectation that they would be required to work for at least fifteen hours per week. Invalid beneficiaries faced lesser work testing requirements but, nonetheless, the eligibility criterion for this benefit tightened as well.²⁴⁴ The Government defended its moves by stating that the benefit reforms would meet the desire of disabled people for equal treatment in the labour market.²⁴⁵

In the late 1990s, American academic and disability activist, Marta Russell, argued that this trend against welfare for disabled people reflected an official 'you can't have it both ways' mentality. According to Russell this meant, that disabled people could not

²⁴² Minister for Disability Issues, The New Zealand Disability Strategy, 21.

²⁴³ "Media Statement: \$6.8 million to improve the lives of disabled New Zealanders," Hon. Tariana Turia, September 15 2010 " <http://www.beehive.govt.nz/release/68+million+improve+lives+disabled+nzers..>

²⁴⁴ "Media Release: Future Focus: A Better Off in Work Approach," Hon. Paula Bennett, accessed September 15 2010, <http://www.beehive.govt.nz/release/future+focus+better+work+approach..>

²⁴⁵ Hon. Tariana Turia, MP, interview by Mike Gourley, September 15, 2010.

simultaneously advocate for the ‘right to employment and the right to [receive] benefits.’²⁴⁶ In a complete turnaround from historical, classic, liberal dogma, disabled people are now part of the ‘undeserving poor’. But as Russell argues it is ‘discrimination to deny a disabled person who can work an opportunity to do so, but it is not ‘special’ treatment for people who cannot work to be guaranteed a humane standard of living – rather it is a measure of a just civilisation that they are decently catered for.’²⁴⁷

Social services agencies, for example the New Zealand Council of Christian Social Services, raised concerns about this policy. First, the detrimental impact this move might have on the health of people living with physical health-related conditions. Second, the entrenched discrimination disabled people faced in the labour market would make finding work for them difficult. Furthermore, the reform proposals came at a time when both the New Zealand and global economies were still recovering from the worst recession in seventy years.²⁴⁸ From early 2010 an official Welfare Working Group, whose membership consisted mainly of neo-liberal sympathisers, formulated further reform proposals for consideration by Government, and this included changes to invalids and sickness benefits.²⁴⁹ This group presented an options paper in late 2010 recommending, amongst

²⁴⁶ Marta Russell, *Beyond Ramps: Disability at the End of the Social Contract*, (Monroe, Maine: Common Courage Press, 1998),82.

²⁴⁷ Ibid.

²⁴⁸ “Policy Watch”, New Zealand Council of Christian Social Services, accessed September 15 2010, http://christiansocialservices.blogspot.com/2010/08/policy-watch_16.html.. Their blog noted that “...for Sickness and Invalids Beneficiaries (two target groups for the WWG) achieving the best level of wellness needs to be their primary focus and work may or may not be part of this.” The blog also noted that: “It would be good to see the State meeting its obligations to find appropriate supported employment for long term beneficiaries – and this means more than making people prove they are looking for jobs that don’t currently exist.”

²⁴⁹ Welfare Working Group, *Long Term Benefit Dependency: The Issues*, (Wellington: Institute of Policy Studies, Victoria University of Wellington, 2010), 1: Institute of Policy Studies <http://ips.ac.nz/WelfareWorkingGroup/Downloads/Issues%20Paper/WWG%20Summary%20Paper%20-%20Long-Term%20Benefit%20Dependency%20-%20The%20Issues%20-%20August%202010.pdf>, (accessed September 22 2010). The Government in the Welfare Working Group’s terms of reference had tasked it with, amongst other things, assessing ‘how to promote opportunities and independence from benefit for disabled people and people with ill health.’

other measures, shifting work capable sickness and invalids beneficiaries onto the unemployment benefit.²⁵⁰

Neo-liberal dogma also drove the National-led Government's intentions on special education. In August 2009 the Government announced a full review, under an advisory panel chaired by former Business Roundtable chairperson Dr Roderick Deane, of the special education sector.²⁵¹ According to the *Review of Special Education 2010* discussion document the principles of both the New Zealand Disability Strategy and the UN Convention underpinned this review. The original motivation behind the review centred on the Government's desire to promote 'choice' with regard to the schooling of disabled children. Under the heading 'Changing the way that schools work together', for example, the discussion document acknowledged that the majority of disabled children attended their nearest neighbourhood school (as was their legal right), but 'Some students go to special schools and they and their parents and caregivers value having this choice available.'²⁵² The document in fact laid out a series of options for the future of special education, including the current system (a mix of special and integrated schools), no special schools, special schools as resource centres, and the current system with open access to special schools.²⁵³ Given the National Party's favourable disposition towards special (segregated) schooling in its election manifesto, however, it seemed to inclusive

²⁵⁰ Welfare Working Group, *Reducing Long Term Benefit Dependency: The Options*, (Wellington: Institute of Policy Studies, Victoria University of Wellington, 2010), 65: Institute of Policy Studies
<http://ips.ac.nz/WelfareWorkingGroup/Downloads/Options%20Paper/Welfare-Working-Group-Reducing-Long-Term-Benefit-Dependency-The-Options.pdf>, (accessed February 7 2011).

²⁵¹ "Submissions Pour In On Special Education Review," Hon. Heather Roy, accessed February 7 2010
<http://www.beehive.govt.nz/release/submissions-pour-special-education-review>. The advisory panel assisted the Minister in conducting the review. Other members included Dr Brian Hinch (a school principal), Heather Lear (parent representative), Paul Gibson (disability advocate) and Dr Jill Bevan-Brown (academic).

²⁵² Ministry of Education, *Review of Special Education 2010*, (Wellington: Ministry of Education, 2009): Ministry of Education
http://www.minedu.govt.nz/theMinistry/Consultation/ReviewOfSpecialEducation/~/_media/MinEdu/Files/TheMinistry/Consultation/ReviewSpecialEducation/ReviewOfSpecialEducationDiscussionDocument.pdf, (accessed September 14 2010), 3.

²⁵³ *Ibid*, 16-19.

education advocates as if the review aimed in that direction. After all National promised to support the expansion of special education schools and their satellites in 2008, a move condemned by educationist Missy Morton as akin to ‘turning back the clock’ on moves towards inclusive education.²⁵⁴

The Associate Minister of Education with responsibility for Special Education, the Hon. Heather Roy, personally championed the philosophy of educational choice. Until mid-2010 Roy served as associate minister and as deputy leader of the free market-oriented Act Party. Act had since its founding strongly advocated educational choice, especially through the distribution of taxpayer-funded vouchers to parents.²⁵⁵ While educational choice might sound like a desirable objective, in reality the outcomes for disabled children have been negative. Wherever free market driven educational policies have applied, mainstream schools have been less inclined to accept disabled children, according to Missy Morton. ‘In countries with a strong policy of educational choice’, she noted, ‘there is a lot of segregation of [disabled] children.’²⁵⁶ Thus despite the government’s assertions, a policy of

²⁵⁴ “2008 Education: Crusade for Literacy and Numeracy” New Zealand National Party, accessed September 10 2010, <http://www.national.org.nz/Article.aspx?ArticleId=28781> and Dr Missy Morton, April 19 2010.

²⁵⁵ “Act Education Policy”, Act New Zealand Party, accessed September 1 2010, <http://www.act.org.nz/education-policy>.

²⁵⁶ Morton, telephone interview by author, April 19, 2010. And Nancy Higgins, Jude Macarthur and Missy Morton, “Winding Back the Clock: The Retreat of New Zealand Inclusive Education Policy,” *New Zealand Annual Review of Education*, no.17: 148-157. Morton and other New Zealand inclusive education researchers wrote about the slow retreat of New Zealand inclusive education policy. This had even begun under the Fifth Labour Government with a slowly rising number of segregated special education school enrolments being recorded between 2000 and 2007. In 2006, National, under then Education spokesperson the Hon. Bill English, stated that he wanted to shift thinking about inclusive education towards “winding” the clock back to more disabled children being educated in separate special education units, hence Morton’s and the article’s reference. The article also noted both overseas research and even the Ministry of Education’s own independently commissioned research showing as to how disabled children performed better, both academically and socially, when they were educated in ordinary classroom settings. This research forms the context in which Morton expressed her fears about both the Act and National Party commitments to promoting greater educational choice.

greater educational choice would effectively undermine the NZDS's objective to 'ensure that no child is denied access to their local, regular school because of their impairment.'²⁵⁷

The new Associate Minister of Education with responsibility for Special Education, the Hon. Rodney Hide, announced the Government's response to the *Special Education Review* on October 20, 2010.²⁵⁸ Under the Government's *Success for All – Every School, Every Child* policy Hide outlined the goal that eighty percent of all New Zealand schools will have to demonstrate inclusive practice through including disabled children in mainstream classrooms by 2014. Schools are required to report to the Ministry of Education on their progress towards achieving this goal.²⁵⁹ To facilitate this process, the Government pledged to streamline the application process and increase the funding for Ongoing and Reviewable Resourcing Schemes by \$6.4 million per year. These schemes fund support services and equipment for disabled children in inclusive education settings.²⁶⁰

The Government's special education announcement appeared, on the surface, to favour the focus of both the UN Convention and the New Zealand Disability Strategy on inclusive education. However, Hide also announced the retention of special schools, albeit with a renewed emphasis on outreach teaching by special school staff in mainstream schools.²⁶¹ Critics, including the Inclusive Education Action Group (a pro-inclusive education lobby group) and even the review advisory panel, believed the Minister did not move far enough

²⁵⁷ Minister for Disability Issues, *The New Zealand Disability Strategy*, 16.

²⁵⁸ "Launch of Success for All: Every School, Every Child," Hon. Rodney Hide, accessed December 1 2010, <http://www.beehive.govt.nz/speech/launch-%E2%80%98success-all-%E2%80%93-every-school-every-child%E2%80%99>.

²⁵⁹ Office of the Minister of Education and Associate Minister of Education, *Cabinet Social Policy Committee Minute of Decision SOC Min 10 24/1 in Review of Special Education: Recommendations for Change*, 1-3, (Wellington: Cabinet Office, 2010):

http://www.minedu.govt.nz/NZEducation/EducationPolicies/SpecialEducation/~/_media/MinEdu/Files/EducationSectors/SpecialEducation/CabinetPaperSuccessForAll.pdf, (accessed February 1 2011). The Cabinet Social Policy Committee's recommendations formed the basis of the final Cabinet decision on the review of special education.

²⁶⁰ Hon. Rodney Hide, "Launch of Success for All: Every School, Every Child."

²⁶¹ *Ibid.*

towards inclusion. The Inclusive Education Group summarised the contradictions of the Government's announcement:

*The Ministerial Review of Special Education has been a significant event this year for those interested in inclusion. Many of us were pleased to see the Review's promise of a "fully inclusive education system in New Zealand," but we have concluded that the Review delivers little in the way of positive change and, most importantly, it is not about inclusion at all. It is disappointing to see ideas about 'special education' and 'difference' that have marginalised and disadvantaged students with disabilities for so long being promoted.*²⁶²

The group further elaborated that:

*Support teachers need to understand and believe in inclusion, and have experience in regular classrooms, with the New Zealand curriculum, and their work should be consistent with the goals of the New Zealand Disability Strategy and the UN Convention on the Rights of Disabled People.*²⁶³

Given these misgivings on the Action Group's part, National's special education plan represented a significant step in the right direction but will still not completely realise the goal of full inclusion in the school system for all disabled children.

Also on the same day as the special education policy release, Tariana Turia announced the creation of a Disability Rights Commissioner role on the Human Rights Commission. In 2009, the Government's response to the select committee inquiry ruled out the appointment of a Disability Commission to coordinate disability policy.²⁶⁴ The

²⁶² Inclusive Education Action Group, "Success for All? The Ministerial Review of Special Education," *IEAG Holiday Newsletter*, December 2010, 2, accessed February 7 2011, <http://www.ieag.org.nz/images/newsletters/dec%2010.pdf>.

²⁶³ Ibid. 'It is disappointing to see ideas about 'special education' and 'difference' that have marginalised and disadvantaged students with disabilities for so long being promoted. Segregation remains with students attending special schools, units and classes. Staff in special schools will also provide 'specialist' advice about inclusion to teachers in regular schools. However, so called 'specialised' approaches is [sic] not what is needed..'

²⁶⁴ New Zealand Government, Government Response to the Report of the Social Services Select Committee on its Inquiry into the Quality of Care and Services Provision for People with Disabilities, 2 (Wellington: New Zealand House of Representatives, 2009): New Zealand Parliament

Government, in a compromise move, agreed to the creation of the commissioner role as part of measures to promote the monitoring of disabled people's human rights in this country under the UN Convention. The new Commissioner will assist the Human Rights Commission in meeting its enhanced obligations to promote the rights of disabled people. The Office of the Ombudsmen had also conferred upon it the role of 'monitoring and protecting' disabled people's rights. Disabled people's organisations will receive government funding to enable them to conduct independent monitoring of the Convention.²⁶⁵

Overall, Disability Strategy implementation has been a case of two steps forward, and one-and-a-half steps back. By 2011 the same promises about improving support services and the overall quality of life for disabled people had been made repeatedly by government officials and politicians from across the political spectrum for almost a decade. Owing to the dominance of managerialist theory within government, political and bureaucratic actors had stymied the Disability Strategy's implementation since its inception, mainly citing resourcing issues. Further, the lack of a viable road map in the form of a national plan and well-resourced government agency enforcing strategy implementation had also impeded progress. These factors can explain why the level and degree of strategy implementation has varied from agency to agency. The following chapters explore these variations in Disability Strategy implementation at the District Health Board level.

http://www.parliament.nz/NR/rdonlyres/8A7D9F6E-E272-41E4-BB27-63A3C4557F07/151793/DBHOH_PAP_17698_GovernmentResponsetoReportoftheSoc.pdf, (accessed September 2, 2010).

²⁶⁵ "Disability Rights Commissioner Appointed," Hon. Tariana Turia, accessed December 1 2010, <http://www.beehive.govt.nz/release/disability-rights-commissioner-appointed>.

Chapter Four

Background – New Zealand’s Public Health and Disability System and Case Study One: Capital and Coast District Health Board

New Zealand’s public health and disability support system has endured a tumultuous two decades where restructuring and reform have been the predominant themes. In the early 1990s the Fourth National Government introduced free market-driven health reforms splitting the funding and provision of services between the Regional Health Authorities (RHAs, funders) and Crown Health Enterprises (CHEs, providers) promising greater efficiencies within the system so that health consumers and taxpayers would receive (ideally) better value-for-money.²⁶⁶ Under the National-New Zealand First Coalition of 1996-1999 re-centralisation of health funding tempered this experiment in the application of market theories to health service provision. The Coalition created a single National Health Funding Agency to replace the RHAs; these merged into the new body. Health and Hospital Services (HHSs) became the softer-sounding, less market driven replacement for the CHEs.²⁶⁷ This chapter briefly backgrounds the history and structure of DHBs (which evolved from HHSs, see below) and their legal obligations towards disabled people and concludes with the first of two DHB case studies, an analysis of the CCDHB’s implementation of the NZDS.

²⁶⁶ New Zealand Parliamentary Library, *New Zealand Health System Reforms: Parliamentary Research Library Research Paper 09/03*, (Wellington: New Zealand Parliamentary Research Library, 2009),14-16: New Zealand Parliament <http://www.parliament.nz/en-NZ/ParlSupport/ResearchPapers/e/d/1/00PLSocRP09031-New-Zealand-health-system-reforms.htm> (accessed September 23 2009).

²⁶⁷ Ibid.

The Fifth Labour Government formation of DHBs, their powers and functions

In 1999 both the Labour and Alliance parties pledged to end this experiment with a free market style health system and reverse large elements of it. Labour drove the reform process in the subsequent Labour-Alliance Coalition Government. Labour's document, entitled *Focus on patients: Labour on health, 1999*, criticised the National Government for having health policies too driven by a competitive ethos, and for failing to seek community input. Labour condemned the inefficiencies and unaccountability that permeated the system and mooted its replacement with a series of District Health Boards (DHBs).²⁶⁸ Accordingly the same New Zealand Public Health and Disability Act 2000 that mandated the Disability Strategy, also established the DHB system with the legislation coming into force on January 1 2001.²⁶⁹

The Labour-Alliance Government did not remove disability from the health sector's responsibilities, at least in terms of funding Disability Support Services (DSS), retaining the previous Government's policy. According to Ruth Dyson, the main reason for Labour's desire to keep DSS within the health system was simply the need for it to stay there.²⁷⁰ Dyson's response indicates that Labour at that time had picked up on the public's underlying antipathy towards any further radical reforms of the public health and social services sectors—or at least any more on top of what it was proposing.

The new legislation empowered DHBs to act as the government's principal health funding and service delivery organisations.²⁷¹ The DHBs' legal objectives hold them responsible for improving, promoting and protecting the health of people within their communities;

²⁶⁸ New Zealand Labour Party, *Focus on patients: Labour on health*, 11-12.

²⁶⁹ *New Zealand Public Health and Disability Act*, s.2 (2).

²⁷⁰ Hon. Ruth Dyson, email message to author, July 22, 2011.

²⁷¹ *New Zealand Public Health and Disability Act*, Schedule 1 outlines the 21 health board regions which are Northland, Waitemata, Auckland, Counties-Manukau, Waikato, Lakes, Bay of Plenty, Tairāwhiti (Gisborne), Taranaki, Hawke's Bay, Whanganui, MidCentral (Manawatu), Hutt (Upper Hutt City and Lower Hutt City), Capital and Coast (Wellington and Kapiti Coast), Wairarapa (Masterton), Nelson-Marlborough, West Coast, Canterbury, South Canterbury, Otago, Southland.

integrating health services, particularly primary (community) and secondary (hospital-based) health services; fostering community involvement in health service provision; and reducing health disparities by improving health outcomes for Māori and other minority population groups.²⁷² This move ended the democratic deficit that had prevailed within the health system since the abolition of the old Area Health Boards by the previous National Government. Under the new system elected board members constituted fifty percent of a board's membership with the other fifty percent (including the chairperson) appointed by the Minister of Health.²⁷³

While the Government devolved more health and disability support decision-making to local communities, it retained a degree of centralised control through both the Public Health and Disability Services Act and the Crown Entities Act 2004.²⁷⁴ These two laws legally proscribe the powers of District Health Boards. Hence, a hybrid system of shared local and national control of the public health system evolved during the years 1999-2008. This hybrid system developed, according to former Fourth National Government ministerial advisor Chris Fraser, owing to central government (through the Ministry of Health) needing to exercise greater oversight over how DHBs spent their allocated government funding.²⁷⁵

Notably, in terms of central government powers to direct health boards, section 33B of the Public Health and Disability Act also empowers the Minister of Health to issue directives

²⁷² Ibid, s 22 and s23 cover the objectives and functions of health boards and s 32 mandates the issuance of written ministerial directions to boards.

²⁷³ Ibid, s 29 (1). Seven members of each board are elected and four are ministerial appointments. Board chairpersons are also ministerial appointees and the Minister of Health has the ability to either appoint an elected member or one of their appointees to this role. This mixed membership system and appointment system serves as another means of assuring centralised oversight of the health system.

²⁷⁴ "Crown Entities Act 2004" State Services Commission, accessed February 9 2011, http://www.ssc.govt.nz/display/document.asp?docid=4341&pageno=1#P4_0. Crown entities are government funded organisations that possess autonomous decision-making powers. The Crown Entities Act provides a 'consistent framework for the establishment, governance and operation of Crown entities.' The legislation also seeks to 'Clarify accountability relationships between Crown entities, their board members, their responsible Ministers on behalf of the Crown, and the House of Representatives.'

²⁷⁵ Chris Fraser, email message, July 4, 2011.

to DHBs ‘to comply with the stated requirements for the purposes of supporting government policy on improving the effectiveness and efficiency of the public health and disability sector.’²⁷⁶ Any directives have to be countersigned by the Minister of Finance and all DHBs and other affected stakeholders must be consulted prior to their being issued. The fact that Health Ministers possess this power is important given that, as will be discussed in the ODHB case study, the Labour Government’s Minister of Health, Pete Hodgson, failed to intervene sufficiently to secure that DHB’s full engagement with the NZDS. The need for government to possess these powers aligns with managerialist thinking around the need to obtain value for money for taxpayers but they also have the potential to effect positive change on the part of boards, particularly when they are failing to take account of the needs of disabled people.

Within DHBs managements play a very strong role in line with managerialist theory. Each board appoints their own chief executive officer who oversees day-to-day management of board affairs.²⁷⁷ Each chief executive in turn appoints managers throughout the organisation to cover, for example, clinical services. The most important layer of board management consists of the regional planning and funding arm. Headed by the regional planning and funding manager, every board planning and funding arm has responsibility, in the words of former ODHB manager Paul Martin, to ‘strategically plan [the] funding, resourcing, prioritisation [and] direction of services that have been allocated to DHBs by government.’²⁷⁸ Therefore both the chief executive and regional planning and funding managers, because of their power to make resourcing decisions and shape board recommendations, play highly influential roles within each DHB.

All DHB planning and funding arms are responsible for the preparation of board statements of intent and annual reports for presentation to Parliament. Crown funding agreements between the Minister and each board reinforce individual DHB monitoring and accountability mechanisms. A contingent requirement upon boards mandates that they

²⁷⁶ *New Zealand Public Health and Disability Act*, Part 3, 33B.

²⁷⁷ *Ibid.* Schedule 3 clause 44(1) (2) (3) and (4) sets out the legal requirements that DHBs have to follow with respect to appointing chief executives and the powers that chief executives possess with respect to employing DHB staff.

²⁷⁸ Paul Martin, interview by author, December 11, 2009, Dunedin, New Zealand.

prepare a district strategic plan with a ten year timeframe and a district annual plan with a one year timeframe. The former document requires that each DHB engage in extensive community consultation before adoption while the latter can be prepared internally each year as a means of measuring progress against the district strategic plan and foreshadowing major board goals for the next financial year. Both documents require board approval and the Health Minister's sign-off before implementation can proceed within the region concerned.²⁷⁹

Beginning July 1 2003 the Government allocated funding to all DHBs via a controversial model known as the Population Based Funding (PBF) formula. The Ministry of Health allocates funding to each board based on their census-derived regional population figures with some moderation allowed for, through 'adjustors' that take into account variables such as the ethnicity, age and geographical profile of a region.²⁸⁰ From this all DHB planning and funding arms draw up budgets to show how available funding might best be allocated, and they submit these budgets to their board for discussion and approval.

Over the last decade the existence of this funding model may have limited the ability of DHBs to allocate health and disability funding in ways that truly reflect the needs of their communities. Moreover, given the ministerial power of dismissal this raises the question: what level of autonomy do health boards really enjoy? The 'Third Way' driven, Labour-led governments of 1999-2008 were just as wedded to neo-liberal concepts, such as fiscal prudence and managerialism, as their Fourth Labour and National government predecessors had been. Retaining the twin pillars of New Zealand's neo-liberal fiscal policy, the Fiscal Responsibility and Public Finance Acts, gave Labour minimal leeway to increase spending on health and other social policy priorities.

Despite ongoing fiscal concerns, as of 2011 DHBs continue to fund their provider arms to deliver a wide array of health services to the public within their respective districts. These provider arms include within their ambit inpatient and outpatient hospital services, mental

²⁷⁹ New Zealand Parliamentary Library, New Zealand Health System Reforms: Parliamentary Research Library Research Paper 09/03, 19.

²⁸⁰ Ibid.

health services (both hospital and community-based), treatment, assessment and rehabilitation services as well as public health units. Some of these services are delivered through non-governmental organisations in the form of community trusts, which contract with district health boards to deliver both primary and secondary level care.²⁸¹

Overall, District Health Boards form the vital linchpin in the health system. Almost every New Zealander will utilise their services, either directly or indirectly, on an annual basis.²⁸²

DHBs and their legal responsibilities towards disabled people

The Government mandates DHBs, both legislatively and in policy terms, to meet the needs of disabled people within their regions and in particular to fulfil the NZDS action to ‘ensure [that] disabled people are able to access appropriate health services within their community.’²⁸³ Accordingly the Public Health and Disability Act, expresses this action through two key objectives. The first objective seeks ‘to promote effective care or support for those in need of personal health and disability support services’. The second objective aims ‘to promote the inclusion and participation in society of and independence of people with disabilities.’²⁸⁴ Internal responsibility for monitoring disability-related issues within all health boards rests with Disability Support Advisory Committees (DSACs), originally established under the Public Health and Disability Act to advise health boards on disability issues. DSACs complement other statutory committees, the Hospital Advisory Committees (HACs) and Community and Public Health Advisory Committees (CPHACs), within all district health boards. All committees comprise a mixture of board and co-opted/appointed

²⁸¹ Ibid, 20.

²⁸² Health boards either fund and/or provide a wide range of publicly funded services, which stretch across the life span of an average New Zealander. Along the lifespan continuum, board funded and/or provided services stretch from the provision of maternity care at the beginning of a person’s life to palliative care at the end. In between, many New Zealanders will attend a general practitioner, be communicated with regarding public health prevention measures and may (if needed) visit a board specialist or therapist for the treatment of illnesses and/or injuries, etc.

²⁸³ Minister for Disability Issues, *The New Zealand Disability Strategy*, 22.

²⁸⁴ *New Zealand Public Health and Disability Act 2000* Part 3, s 2, (1), (c) and (d).

members with Maori representation being mandatory.²⁸⁵ Most importantly, the DSACs have no responsibility under the Public Health and Disability Act for NZDS implementation, but this has not prevented various board DSACs from driving this process around the country.²⁸⁶

District Health Boards and the NZDS

In terms of creating an incentive for health boards to implement the NZDS, the Ministry of Health in their *New Zealand Disability Strategy Implementation Work Plan 2002-2003* sought to ensure the sensitivity of all health services funded by boards and other non-DHB crown entities ‘to the needs of people with disabilities.’ Service providers also had to see that ‘their facilities are physically accessible, in compliance with current regulations.’²⁸⁷ The Ministry of Health developed quality measures and timeframes for DHBs to measure their progress in implementing the strategy.²⁸⁸

The Health Ministry required that DHBs incorporate specific reference to the New Zealand Disability Strategy into their district annual plans submitted for ministerial approval before September 30 2002. This same stipulation applied to other non-DHB crown entities funded to provide health and disability services.²⁸⁹ By March 31 2003 the Ministry of Health requested health board planning and funding arms to submit reports on the accessibility of DHB health services funded to disabled people within their regions. The Ministry required the same of non-DHB crown health entities by February 28 2003.²⁹⁰

In the following financial years Ministry of Health work plans stipulated that this recognition of the Disability Strategy extend to District Health Boards’ being required to develop specific plans to make health services in their regions fully accessible to all

²⁸⁵ Ibid, Part 3, Sections 34, 35 and 36.

²⁸⁶ Litmus Consulting Limited, *New Zealand Disability Strategy Implementation*, 14.

²⁸⁷ Ministry of Health, *New Zealand Disability Strategy Implementation Work Plan 2002-2003*, 8 (Wellington: Ministry of Health, 2002): Office for Disability Issues <http://www.odi.govt.nz> (accessed August 3 2009).

²⁸⁸ Ibid.

²⁸⁹ Ibid.

²⁹⁰ Ibid.

disabled people. The Ministry required DHBs to file reports with its Funding and Planning Directorate on progress towards this goal. The Directorate also assessed each board's adherence to service accessibility and appropriateness standards for disabled service users and provided feedback to boards on their performance. The Ministry requested that each DHB collaborate with Quality Health New Zealand in developing service appropriateness and quality standards for disabled people. From 2002-2003 all DHB National Planning and Funding Contracts and non-DHB Crown entity documents had to make reference to the Disability Strategy and its implications for health service providers.²⁹¹

Beginning with the fiscal year 2004-2005 each DHB's annual plan had to provide evidence of having developed the required service accessibility plans for both themselves and contracted providers. The Ministry further requested that DHBs outline any initiatives designed to 'advance the objectives of the New Zealand Disability Strategy.'²⁹² This same work plan requested that every board report on the role that their DSAC's played and the committee's work plan for the coming year.²⁹³ From 2006-2007 the pressure on health boards to carry out their Disability Strategy obligations increased further with accountability documents covering both the previous and upcoming financial years being required to show how each DHB planned to achieve Strategy goals. By this period as well, local and national service contracts administered by both health boards and the ministry's DHB Planning and Funding Directorate had to be consistent with the Disability Strategy.²⁹⁴ In the 2007-2008 year all boards needed to show how they would implement

²⁹¹ Ministry of Health, *New Zealand Disability Strategy Implementation Work Plan 2003-2004*, 20 (Wellington: Ministry of Health, 2003): Office for Disability Issues <http://www.odi.govt.nz> (accessed October 22 2009).

²⁹² Ministry of Health, *New Zealand Disability Strategy Implementation Work Plan 2004-2005*, 5 (Wellington: Ministry of Health, 2004): Office for Disability Issues <http://www.odi.govt.nz> (accessed October 22 2009).

²⁹³ Ibid.

²⁹⁴ Ministry of Health, *New Zealand Disability Strategy Implementation Work Plan 2006-2007*, 15 (Wellington: Ministry of Health, 2006): Office for Disability Issues <http://www.odi.govt.nz> (accessed October 22 2009).

the New Zealand Sign Language Act 2006 so that the needs of both Deaf and hearing impaired service users could be accommodated.²⁹⁵

In the area of disability support services in 2011 all health boards only have responsibility for the funding and provision of services for people aged over 65 years and those considered as close in need.²⁹⁶ Concurrently disability support funding for people under the age of 65 years remained the responsibility of the Ministry of Health while that for injury-related disability remained with the Accident Compensation Corporation (ACC).²⁹⁷ This situation transpired as on October 1 2003 all funding to provide community and hospital /rest-home level services for older people in each district devolved from the Ministry of Health to the DHBs, and boards have to consider both the *New Zealand Positive Ageing Strategy* and the NZDS when providing services to this group.²⁹⁸ However, as several interviewees pointed out, at the time the new health structure came in, the expectation existed that the funding of disability support services for all age groups would transfer fully to DHBs. According to DPA's Gary Williams when this failed to happen, ramifications followed for the role and functions of DSACs as expectations were that they would cover disability issues across the age spectrum.²⁹⁹ This factor has contributed to the regional variations in NZDS implementation as we will see in the DHB case studies.

With these various monitoring and accountability measures in place, how have District Health Boards acted on the challenge of implementing the New Zealand Disability Strategy in their regions? What have been the successes and failures? Where have the gaps emerged and how have boards sought to address them in terms of providing both accessible and appropriate services for disabled people across the age spectrum? How has

²⁹⁵ Ministry of Health, *New Zealand Disability Strategy Implementation 2007: Work Plan 2007-2008 and Report on Progress 2006-2007*, 25 (Wellington: Ministry of Health, 2007), (accessed October 22 2009),

²⁹⁶ "Media Statement: Older people's disability funding transferred to DHBs", Hon. Ruth Dyson, accessed October 31 2009 <http://www.beehive.govt.nz/node/16090> .

²⁹⁷ "Disability in New Zealand," accessed October 31 2009, <http://www.moh.govt.nz/moh.nsf/indexmh/disability-othersupportservices>.

²⁹⁸ "The New Zealand Positive Ageing Strategy," Office for Senior Citizens, accessed October 27 2009, <http://www.osc.govt.nz>.

²⁹⁹ Williams, telephone interview by author, May 3, 2010.

each Board engaged with their local disability, mental health and wider communities over the development and introduction of NZDS implementation plans? Where have the barriers emerged to the Strategy's implementation at the board governance, clinical and financial levels within health boards and how have these obstacles been overcome? Within this context it is important—before launching into the case study chapters—to be mindful of the important research undertaken by British academics Judith Emanuel and David Ackroyd about the value of directly involving disabled people in health service strategic planning. Emanuel and Ackroyd found their involvement crucial when it came to improving equity of access to medical treatment for disabled people. Their research, conducted within the British National Health Service (NHS), established that improved service delivery for disabled people could be assured through the active involvement of them in, for example, the development of comprehensive disability awareness training programmes for staff.³⁰⁰

To address these questions and taking into account Emanuel and Ackroyd's research finding, the next part of this chapter begins an analysis of the Disability Strategy's implementation by Capital and Coast (Wellington). A second case, of the Otago DHB, will be examined in the following chapter.

Capital and Coast District Health Board

The Wellington-based Capital and Coast District Health Board (CCDHB) has been engaged in a positive journey in implementing the *New Zealand Disability Strategy* since 2004. While this journey has not been without its challenges, the organisation has at least acceded to the need to accommodate disabled people within every aspect of its operations. Across the full spectrum of its health services the CCDHB has demonstrated its commitment to the Strategy and in the face of severe budgetary constraints. In doing so, the CCDHB has taken both mainstreaming (all divisions being required to implement the NZDS) and supported mainstreaming (reference group) approaches to embedding the

³⁰⁰ David Ackroyd and Judith Emanuel "Breaking Down Barriers" in *Exploring the Divide: Illness and Disability*, ed. Geoff Barnes and Colin Mercer, 187-88.

NZDS throughout its organisation. Disability champions within management have also pushed Strategy implementation along.

As of 2011 a total population of 66,658 people resided within the CCDHB's boundaries. Two-thirds of this population live in Wellington City, with the remainder in Porirua City and on the Kapiti Coast.³⁰¹ In contrast with the ODHB, the catchment of the Board is mainly urban in character. In terms of its disability population, the CCDHB estimated in 2009 that 15 percent of the region's people experience some form of impairment.³⁰²

In the 2009-2010 year, the Board employed 5,000 staff on a full-time, part-time, temporary or casual basis.³⁰³ As with other boards around New Zealand the CCDHB operated within strict financial constraints. In this board's case, it ran an operating deficit of \$52.7 million to June 30 2009.³⁰⁴ This poor fiscal indicator prompted the Minister of Health, the Hon. Tony Ryall, to ask the Board to re-submit its *District Annual Plan* in 2009. The Minister eventually approved the re-submitted plan on the proviso that the Board work its way back to a more financially viable position.³⁰⁵

³⁰¹ Capital and Coast District Health Board, *Capital and Coast District Health Board Annual Report 2008/2009*, 10 (Wellington: Capital and Coast District Health Board, 2009): Capital and Coast District Health Board http://www.ccdhb.org.nz/aboutus/Annual_reports/annual-report-2009.pdf (accessed September 27 2010).

³⁰² *Ibid*, 11.

³⁰³ *Ibid*, 10.

³⁰⁴ *Ibid*, 101. This deficit was one of the highest for any DHB in New Zealand. Another interesting aspect is that the CCDHB's actual deficit was greater than the Otago DHB's own forecast deficit of \$7 million for the 2009/10 period (see Chapter Five).

³⁰⁵ Capital and Coast District Health Board, *District Annual Plan 2009/2010-2011/2012*, (Wellington: Capital and Coast District Health Board, 2008), 7: Capital and Coast District Health Board <http://www.ccdhb.org.nz/aboutus/Documents/DAP09-10.pdf> (accessed September 27 2010). The Minister of Health wrote in his approval letter that he had rejected the original District Annual Plan on the basis of its original financial estimates. In doing so he acknowledged that these estimates had been altered due to the change in timing of the booking of a land sale at Kenepuru Hospital by the DHB.

Governance-wise the board and its three main statutory committees have tended to meet separately during the Board's lifetime.³⁰⁶ As a result, the DSAC leads the push for Disability Strategy implementation within the DHB. The DSAC has been committed to placing disability issues on its agenda and not just confining itself to monitoring aged care services. Through this structure disability issues have been able to be raised before the full Board itself.

The Wellington Regional Hospital and Kenepuru Hospital act as the region's provider arm delivering health services to the people of the Wellington region. The Kapiti Health Centre and other community-based services support these operations.³⁰⁷ The Board also provides tertiary (specialist) services to 900,000 residents in the Lower North Island and Upper South Island.³⁰⁸

The CCDHB's Disability Strategy begins its NZDS implementation journey

From the outside looking in people might think that, given the financial issues facing the CCDHB, it could well have taken a fiscally conservative stance on implementing the NZDS. However, at this Board, all the principal players maintain positive attitudes despite financial constraints. Notably CCDHB management have not been as encumbered by managerialist thinking in applying the NZDS, as we will see was the case with the ODHB.

Maurice Priestly, a man with lived experience of disability, headed the implementation process at management level. Priestley's personal experience and long-term involvement in the disability sector initially saw him appointed on a six-month contract to 'facilitate a framework for implementing the NZDS.'³⁰⁹ This position, based in the Board's Planning and Funding section, gradually became a permanent, full-time role. In 2010, at the time of

³⁰⁶ Capital and Coast District Health Board, Capital and Coast District Health Board Annual Report 2008/2009, 65-66.

³⁰⁷ Ibid, 10.

³⁰⁸ Ibid.

³⁰⁹ Paul Gibson and Maurice Priestley, interview by author, May 19, 2010, Wellington.

being interviewed, Priestly held the role of Inclusion and Disability Programme Coordinator. In 2008 Paul Gibson had joined Priestly as Senior Disability Advisor.³¹⁰ These two disabled men became the principal disability champions for NZDS implementation within the CCDHB.

Both men received solid backing from both the governance and management arms for their work. From within DSAC Gibson identified two key people as being crucial in providing this support during the early years of the DHB's existence: John Foreman, the parent of adult disabled children and a foundation board member, and Wendi Wicks, a foundation DSAC member with personal experience of disability, and who, coincidentally, had direct links to DPA.³¹¹ Priestley noted that, from the time of his appointment in 2003, he had had the support of his colleagues within Planning and Funding but admitted an ever-present need to bridge the gap between rhetoric and action:

I have got to say that . . . in Planning and Funding [and] all the way through . . . with the organisation . . . a lot of the management discourse has [always] been supportive, okay. Paul would understand that there's a difference between discourse and action. That's basically a fundamental problem with this whole thing [that] in moving from a talk to the walk is the fundamental problem.³¹²

The journey towards NZDS implementation within the CCDHB began only a year after the launch of the *New Zealand Disability Strategy*. The Board's first *District Strategic Plan 2002/07* made reference to the 'six vision components which will guide the planning and actions of the DHB over the next three to five years.'³¹³ At a series of DSAC-facilitated workshops held during 2001 these vision components became broken down into five goals. The first goal centred on the need to develop 'a web of information' whereby the Board designated itself the facilitator of information in accessible formats about health and

³¹⁰ Paul Gibson was a former member of the DSRG and Ex-President of DPA (see Chapter Two).

³¹¹ Wendi Wicks was, at the time of the CCDHB's establishment in 2001, and in 2011 is still, employed as DPA's National Researcher.

³¹² Ibid.

³¹³ Capital and Coast District Health Board, *District Strategic Plan 2002/07*, (Wellington: Capital and Coast District Health Board, 2002), 50-51: Capital and Coast District Health Board http://www.ccdhb.org.nz/aboutus/dsp/Final_Draft_DSP.pdf.

disability services in the region.³¹⁴ The second concerned the DHB's agreeing to champion 'sector leadership by people with disabilities' and, in this respect, utilising the skills and knowledge of disabled people through, for example, their use in disability awareness training.³¹⁵ The third centred on the 'need to overcome a disabling society' as the Board undertook to do this across the entire spectrum of its activities by removing any physical or other barriers that could be identified.³¹⁶ The fourth emphasised that the 'person is at the centre' of service delivery with this goal deemed to be 'core to the entire strategic plan from a disability perspective'.³¹⁷ The DHB pledged to develop service evaluation schedules, holistic assessment programmes and models of integrated aged care to meet this goal. The fifth and final goal called for 'a whole of life approach' to be taken.³¹⁸ This goal envisioned integrated service delivery would be paramount throughout the CCDHB. Alongside this the DHB acknowledged the diversity of disabled people in terms of both the impairments they experienced and the needs they had.³¹⁹

The *Kotahi Tātou* NZDS framework documents

These goals informed the guiding documents for NZDS implementation at Capital and Coast. Two documents emerged from extensive primary consultation. The first document, *Kotahi Tātou – Promoting Participation – Framework for Implementation of the New Zealand Disability Strategy 2004-2007* laid out the specific actions that the CCDHB would take to implement the Strategy within the organisation.³²⁰ The second document, *Kotahi Tātou – Information and Guide for Implementation of the New Zealand Disability Strategy*

³¹⁴ Ibid, 50

³¹⁵ Ibid.

³¹⁶ Ibid.

³¹⁷ Ibid.

³¹⁸ Ibid, 50-51.

³¹⁹ Ibid.

³²⁰ Capital and Coast District Health Board, *Kotahi Tātou: Promoting Participation: Framework for Implementing the New Zealand Disability Strategy 2004-2007*, (Wellington: Capital and Coast District Health Board, 2004): Capital and Coast District Health Board.

served as an explanatory guide to the Strategy and its underpinning philosophies.³²¹ Taken together the *Promoting Participation* framework became the guiding documents on Strategy implementation for staff, management, and governance within the CCDHB.³²²

During 2008-2009 the *Promoting Participation* framework expanded in the wake of two important developments. Firstly, the opening of the new Wellington Regional Hospital had entailed a review of organisational infrastructure and cultural values, and secondly, a review was undertaken by Litmus Consultants (the consultancy that had reviewed the NZDS) of the framework in the wake of New Zealand's adoption of the UN Convention. Consequently the DHB decided to produce an updated version of the framework in the form of *Kotahi Tātou – Valued Lives, Full Participation*.³²³

Reviewing NZDS implementation progress within the CCDHB

For the remainder of this chapter, the analysis focuses on the report by Gibson and Priestley on the *Implementation of the New Zealand Disability Strategy – Review of Progress in the Capital and Coast DHB 2007 to 2010* (hereafter referred to as the *Implementation Review*) tabled at the August 2010 DSAC meeting.³²⁴ This report encompassed the progress that had been made on implementing all of the various framework documents. Specifically emphasis will be on the progress made towards realising the five initial goals developed by the Board within the original *Framework for Implementation*: disability competence training; improved physical access; communication

³²¹ Capital and Coast District Health Board, *Kotahi Tātou : Promoting Participation: Information and Guide for Implementation of the New Zealand Disability Strategy*, (Wellington: Capital and Coast District Health Board, 2004).

³²² Ibid, 3.

³²³ Capital and Coast District Health Board, *Kotahi Tātou: Valued Lives, Full Participation*, (Wellington: Capital and Coast District Health Board, 2007).

³²⁴ Capital and Coast District Health Board, *Implementation of the New Zealand Disability Strategy: Review of Progress in the Capital and Coast DHB 2007 to 2010*, (Wellington: Capital and Coast District Health Board, 2010).

and access to information; improved employment opportunities; and enhanced community/consumer engagement.³²⁵

Both the *Implementation Review* and the interviews make it clear that Strategy implementation has been a priority for the CCDHB. But obstacles have arisen along the way. In 2008 Litmus identified these in their report on the findings of a DSAC-hosted forum held in March that year.³²⁶ This DPA-facilitated forum reviewed Strategy implementation within the Board after the first three year period (2004-2007). Forum participants shared their views on the Board's performance against the five goals outlined in the *Framework for Implementation*. On the need for disability competence training, attendees commended the hard work of CCDHB staff in improving their NZDS knowledge and commitment to delivering services in an appropriate manner. The belief remained, however, that more work needed to be done on improving both the disability competence of staff and also service structures and support systems.³²⁷ Attending to access issues became another priority with the need to improve access to buildings and board-operated shuttle services identified as key issues by attendees.³²⁸ Around improving communication and access to information, the needs of people with hidden disabilities, for example, those living with intellectual impairments or learning difficulties, had to be met and Deaf and hearing impaired people wanted their issues resolved too.³²⁹ Employment-related issues did not receive much attention from participants, a surprising development given the high level of labour market disadvantage faced by disabled people.³³⁰ On the issue of

³²⁵ Litmus Consultants, *Summary of the Disability Support Advisory Committee's Community Forum 12 March 2008*, (Wellington: Litmus Consulting Limited, 2008): Capital and Coast District Health Board http://www.ccdhb.org.nz/meetings/DSACpapers/2008_05_14/Litmus_DRAFT_DSAC_Forum_Report_250408%20.pdf (accessed September 27 2010).

³²⁶ Ibid, 14-15.

³²⁷ Ibid, 18-19.

³²⁸ Ibid, 20-21.

³²⁹ Ibid, 21-22.

³³⁰ Ibid, 22.

community/consumer engagement a consensus emerged that while the Board had been actively listening, action still needed to occur around past consultation feedback.³³¹

In the wake of the Litmus Report, the Board embarked on the preparation of *Kotahi Tātou – Valued Lives, Full Participation*. This new version of the framework focused on the need to remove health disparities between disabled and non-disabled people in the Capital and Coast region. The document acknowledged the centrality of the NZDS but also noted the role that the UN Convention would play in reinforcing disability rights in the future.³³² A set of eighteen goals previously included in the Implementation Review underpinned *Kotahi Tātou*.³³³ The updated framework reinforced the five central goals of the *Framework for Implementation* and added new ones including, for example, the need to develop specific disability population group action plans to cover Māori and Pacific people, children and refugees.³³⁴

These framework documents and reports set very ambitious goals for the CCDHB when it came to implementing the NZDS. However, the management duo of Gibson and Priestley sought to meet these goals through forging an open partnership with the Wellington disability sector.

Goal one focused on increasing the level of disability awareness amongst staff. Priestley recounted that he was fortunate to get onto the clinical management group, a very influential body when it came to securing support from the most crucial group of all – frontline medical staff.³³⁵ Being a member of this management group successfully enabled Priestley to present the case for disability awareness to the DHB's clinical leadership. In a recurrent problem for Priestley, though, disability awareness workshops have tended to attract staff already working in a professional capacity with disabled people:

³³¹ Ibid, 23.

³³² Capital and Coast District Health Board, *Kotahi Tātou: Valued Lives, Full Participation*, 1.

³³³ Ibid,1-2.

³³⁴ Ibid,2.

³³⁵ Gibson and Priestley, interview by author, May 19, 2010.

*At the moment, we are building on what we already had because what we had wasn't really working. We just had a series of disability responsiveness training workshops but one of the problems is that because disability responsiveness is not on the career pathways of clinical staff or receptionist staff, it is not a requirement. It is just [based] purely on whether they are interested. In all these workshops it was constantly apparent that the people who were turning up had an actual interest in the field, they were OTs [Occupational Therapists] and allied health staff, social workers and things like that. We didn't actually get the target audience . . .*³³⁶

The real target audience for disability awareness is medical staff who may not have had previous exposure to social model theory. Gibson saw the responsibility of administering disability awareness training to five thousand employees as a 'considerable task.'³³⁷ Nonetheless by 2010 the *Implementation Review* recorded progress in this area. It indicated that disability responsiveness, blindness awareness, and Deaf culture workshops had been conducted by contracted disability awareness trainers for DHB staff. Disability responsiveness had been included as part of the generic orientation programme for new staff as well.³³⁸ Dr Pauline Boyes, another person with disability, had been employed by the DHB to oversee the delivery of these training packages. These successes had not come easily, though. Priestley stated that getting the Disability Strategy modules incorporated into staff orientation had taken him 'four years.'³³⁹ Still, by 2010, disability awareness had become an integral part of the training culture at all levels of the organisation from the governance level down.³⁴⁰

In terms of goal two, improving physical access, the CCDHB has placed a strong priority on getting these issues right within the new Wellington Regional Hospital. During the years 2004 - 2010, associated site re-development projects also commenced at Kenepuru

³³⁶ Ibid.

³³⁷ Ibid.

³³⁸ Capital and Coast District Health Board, *Implementation of the New Zealand Disability Strategy: Review of Progress in the Capital and Coast DHB 2007 to 2010*, 6.

³³⁹ Gibson and Priestley, interview by author, May 19, 2010.

³⁴⁰ Capital and Coast District Health Board, *Implementation of the New Zealand Disability Strategy: Review of Progress in the Capital and Coast DHB 2007 to 2010*, 2. Immersion in disability awareness was seen as vital at all levels of the organisation as it was even suggested in the review that the incoming Board (to be chosen after the 2010 local government elections) and DSAC should be given responsiveness training.

Hospital and Kapiti Medical Centre. All this construction activity, according to Priestley, constituted ‘quite a big building project.’³⁴¹

With millions of dollars being expended on these capital works by the CCDHB, it needed to ensure that it largely resolved any access issues before construction began and certainly before they opened to the public. According to Priestley, he gave disabled people a central role in the process of identifying potential barriers from the outset:

*In the hospital, a lot of the access features in there were a product of disability reference groups. Before I came along, there was already a disability reference group that was specifically tasked with advising the architects.*³⁴²

The recommendations of the various reference groups, while useful, still had their shortcomings. Throughout the process Priestley found himself continually reminding architects of the need to go beyond minimum accessibility standards:

*When I came along I was pushing the NZS [New Zealand Standard] 4121 approach that we needed to have an ‘exceeding minimum standards’ approach to it, but the architects basically kept referring to the recommendations of the disability reference group which were kind of - although they were along the lines of making things accessible - they weren’t standard-based. They were kind of a little bit random.*³⁴³

Even after the new Wellington Regional Hospital officially opened in March 2009, accessibility continued to be routinely scrutinised in two ways. Firstly, through an audit report by Wellington-based building consultants, Wrightson Associates, in April 2009.³⁴⁴ Secondly, Gibson initiated a ‘way finding’ exercise where a group of people with a wide range of impairments tested hospital systems. Gibson elaborated:

³⁴¹ Ibid.

³⁴² Ibid.

³⁴³ Ibid.

³⁴⁴ Wrightson Associates, *Executive Report on: Accessibility Assessment New Wellington Regional Hospital, Riddiford Street, For: Capital and Coast District Health Board*, (Wellington: Wrightson Associates, April 2009): Capital and Coast District Health Board
http://www.ccdhb.org.nz/meetings/DSACpapers/2009_05_06/2009%2004%20Bill%20wrightson%20CCDHB%20Wgtn%20Hosp%20Accessibility%20Report.pdf, (accessed September 27 2010).

Recently with the new hospital, we had a way finding exercise where we got a group of people with diverse needs to test the system from the point you receive an appointment in that does the format meet your needs? Does the communication meet your child's needs? The disabled people [who took part] came up with a long list of recommendations, some of them [relating to] physical access and some of them process-orientated around how we can identify blind and vision impaired people who need to be sent an appointment [and] Deaf people so that their communication needs are met when they get to reception. We are implementing a whole lot of things around that.³⁴⁵

Inquiring into the level of accessibility to primary health care services became another priority. Priestley recalled that the CCDHB, in conjunction with the Wellington Disability Information Centre, undertook a survey of general practitioner (GP) practices in 2005. The survey sought to examine accessibility features in GP practices in terms of, for example, the availability of mobility parking spaces and reception counter heights.³⁴⁶ Despite this assessment Priestley acknowledged that the Board had no way of ensuring that the GP funding bodies, known as Primary Health Organisations (PHOs) could ensure that their practices became fully accessible. He admitted that although the DHB could 'make noises about their [the GP practices] need to do something' on access, it could do little about enforcing change as: 'We [the board] don't have the funds to get them to actually do any improvements.'³⁴⁷ The issue of improving access to GP practices illustrates that managerialist thinking even took place at the CCDHB on disability issues, albeit, not to the extent that it did in Otago (see Chapter Five). At least CCDHB management remained open to addressing access issues in a way that, as will be seen, their Otago colleagues did not.

The Board's openness on access issues extends to the way it dealt with access complaints. One such complaint came to the CCDHB's attention in March 2008 through Wellington mental health consumer, Wendy Randall. She wrote to Priestley about the physical accessibility problems she encountered while staying at a board funded, crisis respite house. Randall, a person living with both physical impairment and mental illness,

³⁴⁵ Gibson and Priestley, interview by author, May 19, 2010.

³⁴⁶ Capital and Coast District Health Board, *Implementation of the New Zealand Disability Strategy: Review of Progress in the Capital and Coast DHB 2007 to 2010*, 6.

³⁴⁷ Gibson and Priestley, interview by author, May 19, 2010.

recommended that the CCDHB fulfil its obligations under the Human Rights Act and the NZDS to provide fully inclusive and physically accessible mental health services.³⁴⁸

Randall's letter was tabled at DSAC, and shortly afterwards Randall appeared before the committee to personally discuss her case.³⁴⁹ The DSAC had to act on her complaint owing to the committee's *Terms of Reference* directly referencing the NZDS and the statutory requirement that the Board promote the full independence, participation and inclusion of all disabled people.³⁵⁰ Randall's complaint exemplifies the CCDHB's failure to meet these obligations but the Board still believed that they had an obligation to be accountable and address any shortcomings.

Besides complaints and accessibility surveys the CCDHB collated data from other sources to inform itself about the journey of disabled people within the health system. Gibson describes the work undertaken in this area and some of the tools used:

One of the pieces of work we're working on is to try and keep something on people's patient information/health record which is there permanently and [which] flags their needs, and hopefully we can get some better ability to track what happens to them in the system. There are other processes of monitoring like through the DAP [District Annual Plan] and the Statement of Intent. We are putting in some underlying measures, which we would like to achieve. There is a tool around here - people talk about a Dashboard where the measures come up and

³⁴⁸ Wendy Randall to Maurice Priestley Disability Advisor Capital and Coast District Health Board, March 10, 2008, accessed September 27 2010,

http://www.ccdhb.org.nz/Meetings/DSACpapers/2008_05_14/LetterWendyRandall080312.pdf.

³⁴⁹ Capital and Coast District Health Board, *Minutes of the Disability Support Advisory Committee, May 14 2008: Capital and Coast District Health Board* (Wellington: Capital and Coast District Health Board, 2008): Capital and Coast District Health Board http://www.ccdhb.govt.nz/DSAC_Meeting_Minutes_Pub140508.pdf (accessed September 27 2010). 'Ms Randall was invited to tell her story to the committee at this meeting. A discussion ensued following her presentation where various points were raised. These included the need for the CCDHB to: better connect with government agencies, provide more integrated services and transition from an institutional to human rights mindset when it came to service delivery.'

³⁵⁰ "Disability Support Advisory Committee: Terms of Reference," Capital and Coast District Health Board, accessed September 27 2010," http://www.ccdhb.org.nz/meetings/DSAC_ToR.htm.

*[these include] different measures relating to disabled people even, and [as to] what's happening [to them in the health system].*³⁵¹

Through the CCDHB's use of the Dashboard and other measurement tools, it met the NZDS requirement for government agencies to 'collect and use relevant information about disabled people and disability issues.'³⁵² Therefore the Board through the availability of disability-related data could measure its performance against the goals set in the Framework documents and its compliance with the NZDS.

The *Implementation Review* reported that marked progress had been made on securing improvements to accessibility, communication and information. Around the former the Review confirmed that Wellington Hospital complied with building access legislation. GP practice accessibility monitoring had been conducted with a view to identifying accessible practices. On the latter issue Gibson's health flag project had been making headway and had become part of a Health Passport project led by the Office of the Health and Disability Commissioner. Increased responsiveness to the communication needs of blind and vision impaired people had been noted too. Information about disability issues and a range of associated links had been placed on the CCDHB website.³⁵³

The goal three issues of securing employment opportunities for disabled people has not been a high priority for the Board compared to the first two issues. However, Priestley and Gibson have undertaken statistical tracking surveys on employment issues. Priestley commented that these surveys showed that the proportion of disabled people employed by the CCDHB had remained 'constantly at three percent.'³⁵⁴ The majority of disabled employees worked in administrative roles with a smaller number in nursing and clinical functions. Gibson believed that 'the [lack of a] career pathway is a barrier' to disabled people progressing within the DHB.³⁵⁵ In an attempt to redress these inequities, the board

³⁵¹ Ibid.

³⁵² Minister for Disability Issues, *The New Zealand Disability Strategy*, 24.

³⁵³ Capital and Coast District Health Board, *Implementation of the New Zealand Disability Strategy: Review of Progress in the Capital and Coast DHB 2007 to 2010*, 6.

³⁵⁴ Gibson and Priestley, interview by author, May 19, 2010.

³⁵⁵ Ibid.

utilised the Mainstream subsidised employment programme as one avenue.³⁵⁶ Otherwise, the CCDHB had made minimal progress in promoting equal employment opportunities by 2010.

Around the goal four issues of improving community engagement, the *Implementation Review* made reference to ongoing community engagement on disability issues. The report noted a Māori and Pacific Disability Forum planned for mid-September 2010 where disabled people, their families and carers from these groups would be invited to share their stories about the state of health and disability services. Community engagement had also been carried out through other means such as, for example, meetings between the Chief Executive and local disability community leaders.³⁵⁷

This case illustrates that the CCDHB opted for a broad interpretation of their legal duties towards disabled people under the New Zealand Public Health and Disability Act. Gibson explained the legal rationale that has underpinned both his and Priestley's work with the CCDHB, this way:

*I will tell you that most management would know the NZ Disability Strategy is connected with the Public Health and Disability Act, and they are obliged to act consistently with it.*³⁵⁸

Gibson notes the centrality of the NZDS in public health and disability legislation. CCDHB management, in both word and deed, have aimed to place the Strategy at the heart of their disability-related decision-making. However, from early 2010, the CCDHB decided to reduce domestic assistance for older disabled people, and then from September 2010 to means-test clients. Board management defended these moves on the basis that they had to target their aged care funding appropriately. Moreover the Board saliently pointed out that it had been the last DHB in New Zealand to announce means-testing measures.³⁵⁹

³⁵⁶ Capital and Coast District Health Board, *Implementation of the New Zealand Disability Strategy: Review of Progress in the Capital and Coast DHB 2007 to 2010*, 6-7.

³⁵⁷ *Ibid*, 7.

³⁵⁸ Gibson and Priestley, interview by author, May 19, 2010.

³⁵⁹ Alistair Stewart, "Home help for aged cut after phone chat," *Kapiti Observer*, January 18 2010, accessed July 19 2010, <http://www.stuff.co.nz/dominion-post/news/local-papers/kapiti-observer/3236821/Home->

Nevertheless, this decision on aged care support slightly tarnished the Board's otherwise good record on disability issues. It also signalled a rare lapse by the CCDHB into managerialist thinking on disability issues.

This chapter has elaborated on the structure of DHBs and their legal responsibilities regarding disabled people. While the Fifth Labour Government developed a less free market-driven public health system, its desire to retain managerialist practices and fiscal controls within the state sector somewhat undermined this philosophy. In the CCDHB's case, we have already seen how managerialism dictated its response to funding GP practice access alterations and age-related disability support. On the positive side, though, the CCDHB did not let managerialism dictate its overall NZDS implementation efforts despite the huge fiscal deficits that faced it. The CCDHB's good fortune in having both Priestley and Gibson as disability champions within management enabled Strategy implementation to proceed smoothly within the CCDHB. The next chapter details the ODHB's less enthusiastic implementation of the NZDS.

Chapter Five

Case Study Two: Otago District Health Board

In 2002 just one year after the launch of the New Zealand Disability Strategy, the Otago District Health Board (ODHB) developed a plan to implement the strategy within its organisation.³⁶⁰ This marked the beginning of what was to become, from a disability perspective, a story of two halves. Initially management and governance accepted the need to meet NZDS goals but, after a change in management in 2003, implementation significantly slowed. This chapter traverses why the ODHB, when compared to the CCDHB, took a completely different track on NZDS implementation after the management change. This chapter covers Strategy implementation from the time of the Board's inception in 2001 until 2010 when it merged with its Southland counterpart to form the Southern District Health Board (Southern DHB).

The ODHB, prior to its demise in 2010, serviced a total population of 179,388 people. The majority —118,677 (66.1 percent) — resided in the Dunedin City area. The rest—60,711 people (33.9 percent) — lived in provincial towns and rural communities.³⁶¹ In terms of the total disability population (physical, intellectual, mental health, sensory, age related) the ODHB served approximately 35,000 or 36,000 people (20.0 percent).³⁶²

The ODHB region was the third largest by geographical area in New Zealand. The region is sparsely populated (5.6 people per square kilometre) when compared to the New

³⁶⁰ Otago District Health Board, *Minutes of the Board Meeting, Meeting of December 5 2002*, (Dunedin: Otago District Health Board, 2002).

³⁶¹ Otago District Health Board, *Otago District Health Board: District Annual Plan 2009/10*, (Dunedin: Otago District Health Board, 2009), 14.

³⁶² I have calculated this figure based on the estimate that 20 percent of the New Zealand population lives with some form of impairment/disability as determined by past Statistics New Zealand census figures.

Zealand average (13.1 people per square kilometre). These factors made the Otago Board area more rural in character than other DHB regions.³⁶³

In its last financial year of operation 2009-2010, the Board employed approximately 3,100 staff.³⁶⁴ In the same year the Board's government budget allocation amounted to \$532.2 million and it had a projected fiscal deficit of \$7 million. According to the Board's District Annual Plan's projections around population-based funding (PBF), the Board faced being 'over-funded relative to other District Health Boards (DHBs) by \$13.1 million.'³⁶⁵ However, the Plan noted that this 'is a significant improvement from being approximately over-funded by \$32 million in July 2003, and past strategies have been aimed at maintenance of service access and efficiency improvement on the journey to PBF equity.'³⁶⁶ This meant that the Board had engaged in cost containment measures to address this fiscal measure as well as projected deficits. These PBF-induced funding pressures came to impact upon the Board's Disability Strategy implementation plan.

All DHBs operate nationally consistent and statutorily determined funder, provider and governance arm structures. However, a slight difference existed in Otago's case where the Community Public Health Advisory Committee and Disability Support Advisory Committee met jointly for almost the entire period of the Board's existence.³⁶⁷ In other words, the DSAC did not exist as a stand-alone body and it devoted most of its time to aged care issues, two more factors that impinged on Strategy implementation.

³⁶³ Otago District Health Board, *Otago District Health Board: District Annual Plan 2009/10*, 14.

³⁶⁴ *Ibid*, 11.

³⁶⁵ *Ibid*, 6.

³⁶⁶ *Ibid*.

³⁶⁷ "Latest News: Otago DHB Disability Services Advisory Committee", CCS Disability Action Southern Region, (Dunedin: CCS Disability Action, accessed June 13 2011

<http://southern.ccsdisabilityaction.org.nz/News/LatestNews/OtagoDHBDisabilityServicesAdvisoryCommittee/tabid/1001/Default.aspx>.. Former ODHB manager, Paul Martin, in his capacity as Southern Regional Manager for CCS Disability Action, made reference in a letter to the *Otago Daily Times* that: 'Almost since its inception, the Otago DHB Disability Services Advisory Committee (DSAC) ... has met in conjunction with the Community Public Health and Advisory Committee (CPHAC), on the insistence of the Board.'

Public health, personal health, mental health and community services were (and are still in 2011) delivered at a number of sites around the region. Services are primarily located within either the Dunedin or Wakari hospitals with others delivered out of smaller regional hospitals in Alexandra, Balclutha and Oamaru. The ODHB also operated service centres in Southland even prior to the two Boards' amalgamation.³⁶⁸

During the period 2006-2010, the Otago and Southland Boards engaged in a process of gradual amalgamation leading up to their formal merger. This process began in December 2006 with the creation of an operational entity known as the 'Southern Alliance'. It aimed to 'immediately bring together [the] key functions of both DHBs in order to create shared service arrangements'.³⁶⁹ The operational entity aimed to increase efficiencies and create cost savings across the two regions' health services. A number of functions and services, such as human resources and clinical services, merged so that they could operate inter-regionally.³⁷⁰ The two regions' governance arms thus became increasingly intertwined.³⁷¹ Shared management roles also emerged across the two regions and this eventually led to the appointment of a single chief executive and one regional planning and funding manager.³⁷² Inevitably the Boards agreed to merge in February 2010 and formal approval by the Minister of Health swiftly followed.³⁷³ On April 30 2010 the Otago District Health

³⁶⁸ Otago District Health Board, Otago District Health Board: District Annual Plan 2009/10, 12.

³⁶⁹ Ibid, 29.

³⁷⁰ Ibid, 11.

³⁷¹ Southern Alliance, Minutes of the Southland and Otago Disability Support Advisory Committee, Meeting of May 13 2008 (Dunedin: Southern Alliance, 2008). The Otago and Southland DHB advisory committees began meeting jointly during the late 2007-early 2008 period to discuss common issues. Under the terms of the Southern Alliance arrangement, the boards and their committees still remained autonomous entities up until the time of full merger but, for all intents and purposes, joint decision making began to take place from around this time.

³⁷² Ibid. It was noted in these minutes that Brian Rosseau held the position of full Chief Executive Office (CEO) and was Interim Chief Executive of the Southland DHB. Later, Rosseau was to be appointed the joint CEO of the two regions.

³⁷³ John Lewis, "Decision just the beginning: Chairman," Otago Daily Times, February 23 2010, accessed October 1 2010, <http://www.odt.co.nz/your-town/dunedin/94659/decision-just-beginning-chairman>.

Board ceased to function after being formally merged with its Southland counterpart to become the Southern District Health Board (SDHB).³⁷⁴

Initial NZDS implementation at ODHB (2001-2005)

In 2001-2002 both the ODHB's management (under Chief Executive Bill Adam) and governance arms (under Chairman Richard Thomson) enthusiastically pursued implementation of the NZDS. One of the principal actors who drew up the ODHB's Strategy implementation plan, former board manager, Paul Martin, reflected:

It was my proposal that there needed to be a disability strategy set up by planning and funding to be implemented by the DHB and that proposal would go to DSAC and then to the Board for sign off. That proposal was developed by me in conjunction with the DSAC team, Donna Rose-McKay, Helen Algar, and other people with knowledge of disability issues. They were enthusiastic to have that plan in place. So those things involved a mix of issues around the provider arm and right across the DHB inclusive of the provider arm ensuring that everything was fully accessible so we implemented a barrier free audit of Dunedin Hospital. There was the whole involvement of people with disabilities in the planning process and the advisory committees ... That was pretty much how it stood. Latterly, I think that the CEO of the time of the DHB [Bill Adam] was generally sympathetic to the process.³⁷⁵

The requirement for progress reports to be filed with the Ministry on NZDS implementation spurred the Board to action as well. In 2002 the CPHAC/DSAC appointed a working party 'to facilitate the implementation of the New Zealand Disability Strategy via an action plan.'³⁷⁶ In fact Martin recounted that as a Ministry of Health official he had developed the national NZDS consultation plan.³⁷⁷ He marshalled this experience to assist

³⁷⁴ Ibid.

³⁷⁵ Martin, interview by author, December 11, 2009.

³⁷⁶ Otago District Health Board, Community and Public Health and Disability Services Advisory Committees: Update and Recommendations on ODHB Disability Issues, (Dunedin: Otago District Health Board, 2007), 2.

³⁷⁷ Paul Martin, interview by author, March 12, 2010, Dunedin, New Zealand.

DSAC in preparing an extensive consultation process that involved Board members as well as disabled people and their support organisations in the wider community.³⁷⁸

Out of this process emerged an ambitious plan. At the November/December 2002 CPHAC/DSAC meeting, the tabling of the *Strategy for Implementing the New Zealand Disability Strategy* occurred and after that meeting, it went to the Board. Both bodies approved the document.³⁷⁹ The Otago plan ranged over all fifteen objectives and outlined the actions to meet every relevant strategy action point.

Initially the ODHB took a mainstreaming approach in implementing the NZDS as it sought to eliminate the barriers that faced disabled people in seeking health care throughout the organisation. One interviewee, a person with previous ODHB experience, highlighted the key challenges in this regard not only for Otago but for other boards around the country:

Well, part of its (the government's) fault, there is no way within the DHB system to determine whether a person has a disability. You have got your hospital number but there is nowhere within the health system to note on their profile that they are disabled. So people who are blind get things sent out in print. People who get an appointment to turn up to the optometrist, orthodontist or chiropodist [and] if they are Deaf, there is no interpreter waiting for them. Everything is done in isolation [and] it is assumed [by staff] that everyone is able bodied [and therefore when disabled] people turn up to gynaecology for a check [the staff often say] oh god, we don't have a hoist, what do we do? Everything is done in isolation with the assumption that the person with the impairment will know what to do, how to organise themselves and find their way around the system. It's just a mess. So, people with disabilities aren't getting holistic health care.³⁸⁰

The ODHB's plan aimed to promote better health service access for disabled people through improved awareness, physical access, communication and coordination. It also sought to improve disabled people's participation at all levels of the organisation.

³⁷⁸ Otago District Health Board, *Strategies to Implement the New Zealand Disability Strategy*, (Dunedin: Otago District Health Board, 2002).

³⁷⁹ Martin, interview by author, December 11, 2009.

³⁸⁰ Anonymous interviewee with previous Otago DHB experience, interview by author, March 19, 2010, Dunedin.

Hence, the ODHB focused on the NZDS objectives of encouraging and educating for a non-disabling society; ensuring rights for disabled people; providing opportunities in employment and economic development for disabled people; fostering an aware and responsive public service; and creating long-term support systems centred on the individual.

To encourage and educate for a non-disabling society, the Otago plan pledged that a disability awareness programme, aimed at both Board members and staff, would be developed. On the basis of recognising disabled people as the experts on their own experience, the plan promised that appropriate levels of disability representation would be maintained on all board committees and working parties. And to encourage debate on disability issues, the DHB undertook to run open DSAC meetings on an annual basis to discuss Strategy implementation progress.³⁸¹

On ensuring rights for disabled people, the ODHB plan outlined the need for a policy on alternatively formatted information. This policy saw the Board pledge over time to convert its consent, complaints and health information forms into alternative formats so that they would become disability user-friendly.³⁸² This, for example, would eliminate the risk of written patient appointment letters being sent to blind people.

The Board also reinforced its commitment to equal employment opportunities for disabled people. Being one of Otago's largest employers the Board had tremendous scope for employing more disabled people. To this end the ODHB responded to the NZDS's emphasis on equal employment conditions by stating that all its employee 'policies, procedures and job terms and conditions' would never directly or indirectly discriminate against disabled persons.³⁸³ The Board's Human Resources section implemented this requirement.³⁸⁴

³⁸¹ Otago District Health Board, *Strategies to Implement the New Zealand Disability Strategy*, 5.

³⁸² *Ibid*, 6.

³⁸³ *Ibid*, 8.

³⁸⁴ *Ibid*.

To foster an aware and responsive organisation, the Board made a number of important commitments. Putting in place policies to ‘ensure that all government agencies treat disabled people with dignity and respect’ had a high priority.³⁸⁵ The ODHB pledged to develop patient satisfaction surveys with disability specific questions included. This would enable the collation of relevant disability-related patient data by the Board. Further, the Board recognised the need for complaints services to be provided in an ‘accessible, appropriate and available’ manner for disabled people.³⁸⁶ The Board envisaged introducing exit interviews for disabled patients and staff to ascertain their treatment as service users or employees.³⁸⁷ To deal with the quality of information available about disability issues, the idea was floated of a one-stop shop for staff to access information about disability.³⁸⁸ Most importantly, the Otago Board opted to conduct a barrier-free audit of its premises and services.³⁸⁹

The Otago Board’s response to the NZDS objective of creating long-term support systems centred on the individual, focused on how to deliver flexible models of care.³⁹⁰ Flexible care would help in trying to end the stranglehold that the medical model had over health care delivery for disabled people. The Board would also attempt to address issues around appropriate treatment and service coordination for disabled people like those noted by the interviewee with previous ODHB experience earlier. Therefore, action points regarding government agencies’ need to ensure that disabled people were at the centre of service delivery, and the development of holistic approaches to assessment and service provision, received special attention in the Otago plan. In order to meet these points, the Board declared that it would ‘allow disability related treatments to be integrated with health treatments that allow coordination of care, and reduce or remove fragmentation of care’.³⁹¹ The Board also aimed to develop systems to identify disabled patients and their needs in

³⁸⁵ Ibid,11.

³⁸⁶ Ibid.

³⁸⁷ Ibid.

³⁸⁸ Ibid.

³⁸⁹ Ibid.

³⁹⁰ Ibid,12

³⁹¹ Ibid.

relation to health and disability services.³⁹² The Board undertook to collaborate with the Ministry of Health in making these changes.³⁹³

A firm, written commitment from Chris Crane, the then community health manager, stated ‘that many of the strategies can be implemented within existing resources and can be planned for over the rest of this financial year and 2003/04.’³⁹⁴ This signalled management’s support for the New Zealand Disability Strategy, and the governance arm did consent to it as well. By contrast, the management team that succeeded both Crane and Adam did not display the same level of commitment.

Obstacles to NZDS implementation (2004-2011)

By early 2004, however, the ambitious plans of the ODHB to put the NZDS in place had to be scaled back. Former Board chairperson, Richard Thomson, put this down to the need to prioritise resources and staff workloads effectively.³⁹⁵ Further, during Labour’s time in office, the financial pressures created by the population-based funding formula affected the ODHB’s plan.³⁹⁶ These two men, in comparison to their predecessors, took a more conservative approach to Disability Strategy implementation within the ODHB. Chris Fraser and Brian Rousseau both came from health management backgrounds with minimal, if any, experience of disability. Of the two, Fraser had some disability experience given that he had been the board chairperson of a disability service provider in Mosgiel. Yet both men, as we will see, strongly adhered to managerialist nostrums, including those around the need to maintain tight fiscal discipline, even when this compromised moves to improve equity of access to services for disabled people.

³⁹² Ibid.

³⁹³ Ibid.

³⁹⁴ Ibid,1.

³⁹⁵ Richard Thomson, email message to author, August 16, 2010.

³⁹⁶ Chris Fraser, email message to author, July 6, 2011. Fraser confirmed that both he and Rousseau started within two months of each other. Rousseau commenced duties as CEO in March 2003 and Fraser as Chief Planning and Funding Officer in May of that year.

Accordingly, in May 2004, the CPHAC/DSAC committees discussed a revised work programme for NZDS implementation. The revised recommendations included the need for disability representation on the Hospital Advisory Committee (HAC); that discussions be held with the Disability Information Service around providing its service henceforth from the Dunedin Public Hospital front desk; that hospital front desk services be reviewed for disability friendliness; that a senior management team member be appointed to cover disability issues; that a Barrier Free audit of provider arm buildings be conducted; that a disability awareness training programme be created and rolled out for all staff; that the Board develop a communications Style Guide and incorporate a disability issues page onto its website; that Board publications include positive stories on disability issues; and a stock take of other DHB DSACs be undertaken so that recommendations could be made on how the Otago committee could best function. The idea also came up that the Board's planning and funding team should write clauses relating to disability-friendly service provision within all external health provider contracts. The CPHAC/DSAC requested that management report to it on a quarterly basis regarding progress. The Board endorsed these recommendations in a resolution passed on June 3 2004.³⁹⁷

The June 2004 board meeting minutes reveal the extensive debate surrounding some of the recommendations. These discussions resulted in further changes around how the Board and its committees oversaw disability issues. On the issue of the Board appointing a disability representative to the Hospital Advisory Committee, CPHAC/DSAC opted to drop this idea after concluding that any such appointment 'might not achieve the underlying intent.'³⁹⁸ Instead the DSAC became a stand-alone committee. At the same time, though, the idea emerged that DSAC continue to meet jointly with CPHAC 'given the considerable synergies between the two advisory committees.'³⁹⁹ Nevertheless consumer representatives on CPHAC/DSAC still supported the concept of direct disability representation on the HAC.⁴⁰⁰ The Chief Executive accepted the idea of appointing an executive manager to

³⁹⁷ Otago District Health Board, *Minutes of the Board Meeting, Meeting of June 3 2004*, (Dunedin: Otago District Health Board, 2004).

³⁹⁸ Ibid.

³⁹⁹ Ibid.

⁴⁰⁰ Ibid.

cover disability issues with the proviso that the employment conditions of the identified individual would have to be re-negotiated. Significantly management held mixed views on the idea that disability- friendly services clauses should be inserted into provider contracts. According to the minutes, Rousseau, the Chief Executive, thought that this idea ‘should not be read as black and white as it would cost a significant amount of money to achieve, although the principle was a sound one.’⁴⁰¹ Therefore Rousseau supported the appointment of a manager responsible for disability issues in principle, but remained fixated with the managerialist notion of needing to control costs.

In late 2004 the Board began implementing the revised NZDS plan. First off, the DSAC became a stand-alone committee once again, and management eventually acceded to the appointment of an executive manager to service it. Ants Howie, an existing manager within the planning and funding team, assumed managerial responsibility for servicing DSAC and overseeing disability issues in December 2004.⁴⁰² In two reports, filed in March and September 2005, Howie reported to DSAC on a flurry of activity around disability issues. This flurry stemmed from both the December 2002 Board *Action Plan* and the June 2004 resolution. The March 2005 report included the findings of a disability service audit conducted by CCS Disability Action of the DHB’s paediatrics and respiratory services. The audit made recommendations to improve physical access and to ensure that admission and discharge procedures took account of the needs of disabled people.⁴⁰³ In the same report the provider arm acknowledged the need for disability awareness training with staff and that it would explore with CCS Disability Action the best ways to incorporate this in employee orientation. Further, the provider arm advised that it would consult with Disability Information Services about where to place their information stalls as part of ongoing foyer re-development.⁴⁰⁴

⁴⁰¹ Ibid.

⁴⁰² Otago District Health Board, *Management Report to DSAC Meeting: 8 March 2005*, (Dunedin: Otago District Health Board, 2005). The March 2005 report was the first report signed off by Ants Howie as Executive Team Member assigned to DSAC.

⁴⁰³ Ibid, 1, 4-8.

⁴⁰⁴ Ibid, 2.

Also the March 2005 report contained the findings of another audit, this time a Barrier Free audit conducted by consultants Fraser and Chalmers Limited on accessibility at Dunedin Hospital. The Hospital's Chief Operating Officer estimated that approximately \$400,000 would be required in capital outlay to address the access issues identified. The Chief Operating Officer's report accepted that the identified access issues could not be tackled in the short term but it was hoped that the proposed Dunedin Hospital Site Development Plan would address access in the longer term.⁴⁰⁵ Another significant point was that concerning work on placing disability-related questions within patient satisfaction surveys. The DHB could not include some disability-related questions on its patient surveys because of having to meet standard Ministry of Health questionnaire requirements. Yet the Board had an option to develop another disability-related tool for inclusion in the patient survey but this did not happen as the Board viewed the development of such a tool as a low priority. Instead the DHB opted to obtain information from disability service audits.⁴⁰⁶

The September 2005 report provided another snapshot of activity. On the governance level the Otago DSAC had acquired information on the activities of other DSACs around the country to give them a steer on best practice and processes going forward.⁴⁰⁷ The Report noted a need for further discussion at the DSAC level on the development of a consumer pool for DHB working groups.⁴⁰⁸ Management decided it would write disability clauses into service provider contracts where appropriate. Existing contracts were to be reviewed over time to see if NZDS clauses could be inserted into them as well.⁴⁰⁹ The Board's publications disseminated information about disability issues and this included information on DSAC proceedings.⁴¹⁰ The DHB's new Style Guide stipulated the availability of patient information in alternative formats. Discussions took place at DSAC around the accessibility of complaints processes for disabled people.⁴¹¹ Human Resources began

⁴⁰⁵ Ibid 2, 9-11.

⁴⁰⁶ Ibid, 2.

⁴⁰⁷ Otago District Health Board, *Update on Previous Actions in Respect of the New Zealand Disability Strategy*, (Dunedin: Otago District Health Board, 2005), 4.

⁴⁰⁸ Ibid.

⁴⁰⁹ Ibid.

⁴¹⁰ Ibid,5.

⁴¹¹ Ibid,7

fulfilling their obligations to promote equal employment opportunities for disabled people through regularly reviewing Human Resources policies.⁴¹² The Board began forging relationships with key local disability and consumer- based groups.⁴¹³

However, the March and September 2005 DSAC reports marked the last time that the ODHB seriously reported on NZDS implementation. After this management and governance neglected the Disability Strategy and the local disability sector became highly concerned about this neglect. Two disability representatives on DSAC, Donna Rose-McKay and Patsy Wakefield, lobbied the Minister of Health and Dunedin North MP, the Hon. Pete Hodgson, over the issue. Hodgson did not remember meeting with them but Wakefield specifically recalled both the meeting with Hodgson as well as the pair publicly raising the issue at DSAC meetings.⁴¹⁴ Even after this meeting, Hodgson did not exercise his ministerial powers by writing to the DHB about their lack of progress. The former Minister argued that Rousseau would have referred any letter to DSAC and then asked the committee ‘what do you think I should do about it? The DSAC might have told him [Rousseau] what to do without me [having] to write a letter about it.’⁴¹⁵ Given that former Minister Hodgson had his section 33B powers to fall back on, he abdicated all responsibility and failed to issue a legal directive that, not only the ODHB, but all boards throughout New Zealand meet their responsibilities to disabled people under the NZDS.⁴¹⁶ Instead Hodgson believed that this was an issue for Otago management and board members to resolve with the disability community, thereby taking a managerialist-inspired, non-interventionist stance on the issue.

Despite the Minister’s refusal to intervene, disability stakeholders continued to push the case for full Strategy implementation within the ODHB. CCS Disability Action also acted

⁴¹² Ibid,8.

⁴¹³ Ibid,4.

⁴¹⁴ Hon. Pete Hodgson, telephone interview by author, May 3, 2010. And Patsy Wakefield, interview by author, March 11, 2010, Dunedin, New Zealand. Wakefield stated that ‘Donna Rose and I discussed this with Pete Hodgson before we resigned.... that it (the DSAC) didn’t have a great deal of standing as against the other committees that seemed to have more power behind them.’

⁴¹⁵ Hodgson, telephone interview by author, May 3, 2010.

⁴¹⁶ The Minister of Health’s powers under Section 33B are explained in the previous chapter.

by requesting a meeting with senior DSAC members in early 2007 to discuss this issue. The meeting between DSAC and disability sector representatives occurred, and consequently the Otago CPHAC and DSAC, meeting as a joint committee, resolved in February 2007 to establish a Disability Strategy progress review working party.⁴¹⁷ At this meeting, Chris Fraser had admitted that the main reason for the neglect was management's need to concentrate on the deficit that had arisen in Disability Support Services for older people. Fraser agreed however, according to the Minutes, that the review presented a good opportunity to undertake a 'stock take' of NZDS progress.⁴¹⁸

In August 2007 the progress review working party, chaired by DSAC and Board member, Helen Algar, reported back to CPHAC/DSAC. Its report acknowledged that some progress had been made, but concern remained over the lack of disability awareness training and further barrier free audits. The working party report scathingly noted 'that key elements for implementation of the [June 2004] recommendations appear to be absent.'⁴¹⁹ These findings confirmed the concerns of local disability sector representatives about the lack of NZDS roll-out within the DHB. In doing so the report recognised the capacity issues faced by management in light of the Southern Alliance shared services arrangement. The working party sought to placate management by asking it to concentrate on four key areas. First, reviewing the combined CPHAC/DSAC committee structure to ensure that it could adequately address disability issues; second, investigating the best means of undertaking further Barrier Free audits of the proposed Master Site plan for Dunedin Public Hospital; third, the provision of disability awareness education; and fourth, improved communication.⁴²⁰

In May 2008 the Executive Management Team meeting tabled a progress report before a joint Otago/Southland CPHAC/DSAC concerning progress around the Disability Strategy

⁴¹⁷ Otago District Health Board, Minutes of the Joint Community and Public Health and Disability Support Advisory Committees, Meeting of February 20 2007, (Dunedin: Otago District Health Board, 2007) 3.

⁴¹⁸ Ibid.

⁴¹⁹ Otago District Health Board, Community and Public Health and Disability Services Advisory Committees: Update and Recommendations on ODHB Disability Issues, 2.

⁴²⁰ Ibid, 3.

review working party's revised recommendations.⁴²¹ The report showed that management had made minimal progress in addressing the physical access, disability awareness and data collation issues raised in the working party report. Still, the Otago and Southland Boards proposed that, with the new Southern Alliance shared services arrangement now in place, a regional approach be taken in dealing with these outstanding issues. While both DHBs were working to progress the NZDS, Southland pursued the Strategy objectives more actively than Otago.⁴²²

During the ensuing CPHAC/DSAC discussions on the executive management progress report, the main reasons for neglecting NZDS implementation within the ODHB became publicly apparent for the first time. Largely, for the ODHB, lack of progress towards better NZDS implementation came down to the need for more money. Also, as we will see, some ODHB management and governance actors displayed poor attitudes towards disability and a lack of knowledge about disability issues in general.

Committee members queried the resources being given to Strategy implementation. Southland DSAC member, Dot Wilson, believed the two Boards considered disability awareness training as a 'tag on', rather than a 'very important', element in staff training.⁴²³ On behalf of management Regional Chief Executive Rousseau responded 'that the NZDS received a fair amount of resource, in comparison with other client groups.'⁴²⁴ Regional Planning and Funding Manager Fraser joined the discussion by stating, according to the Minutes, 'that the Barrier free audit recommendations would be done progressively, as anything requiring prioritisation would have to go through the capital expenditure (capex) process. He noted there was not an expectation that every recommendation would be implemented.'⁴²⁵ In an interview Fraser further elaborated on his comments:

⁴²¹ Southern Alliance, *Minutes of the Joint Otago and Southland Disability Support Advisory Committee, Meeting of May 13 2008*, (Dunedin: Southern Alliance, 2008), Appendices 1 and 2, 2-4.

⁴²² Ibid, Appendices 2-4. Under the heading of 'Work in Progress NZDS Activity' Southland had eight activities underway with respect to Strategy implementation whereas Otago only had one.

⁴²³ Ibid, 4.

⁴²⁴ Ibid.

⁴²⁵ Ibid .

The thing is if you sit down with the capex budgets of the DHB, the way that [it] works is people put up bids for the things they want to spend money on. They [the Ministry of Health] have a prioritisation system where [if] we have bids for \$100 million and we only have \$10 million to spend, how are we going to choose what are the \$10 million most important dollars to spend? Before the dollars are spent, how are we going to pick the projects with the highest priority? And, to be brutally honest improving access to a building for people in wheelchairs would wipe them all [other DHB capital expenditure priorities] off the list because it is not a life threatening situation.⁴²⁶

Fraser objected to spending more money to improve disability access as it would threaten (in his view) other capital spending priorities within the DHB. His statement betrays a fundamental misconception that some managers have that their organisations can end up financially crippled if they institute access improvements. Therefore, managerialist ideology blinded ODHB management into thinking that funding access improvements equalled fiscal irresponsibility.

The Otago DSAC placed a higher priority on discussing older people's issues compared to wider disability issues and this affected Strategy implementation within the DHB as well. During the March 2008 joint meeting of the Otago and Southland DSAC committees, Chairperson Neville Cook commented that the committee 'should also be thinking about elderly issues (sic) and a lot of energy should be focused on this area.'⁴²⁷ Wakefield thought that this emphasis on aged care issues derived from the deficiencies of the legislation:

And to me the other thing is that I think that the [Public Health and Disability] Act that actually developed the consultative committees ... doesn't give the DHBs direction in how they should actually develop those committees, what role they should play in terms of what you must have, it doesn't say.⁴²⁸

From a management perspective Fraser proffered the opposing view:

⁴²⁶ Fraser, telephone interview by author, 17 February, 2010.

⁴²⁷ Southern Alliance, *Minutes of the Joint Otago and Southland Disability Support Advisory Committee, Meeting of March 11 2008*, (Dunedin: Southern Alliance, 2008), 5.

⁴²⁸ Wakefield, interview by author, March 11, 2010.

I have the legislation right in front of me. This discussion was had at the Board on a number of occasions, and Brian and I presented the meaning of the legislation and what it meant and it was quite black and white. My view is that the balance is about right and that the DHB has a scope of responsibility set out in the Act ... that DHBs fund age-related disability services and the Ministry of Health funds services for under 65s. The governance of the DHB's business and what it does is for the over 65s, and there is an accountability framework through the Ministry of Health and if the community are wanting to express on issues related to under 65 issues, then those go through the Ministry of Health. Those are [wider disability issues] operational issues for the provider arm and they should be raised through the Hospital Advisory Committee. A DSAC committee is a sub-committee of the board, the responsibility of the Board is strategic oversight, and it's a gross failing of a board when it's an operational matter.⁴²⁹

Fraser and Wakefield disagreed about the scope and role of the DSAC in relation to their ability to cover non-age related disability issues. However, a closer reading of the Public Health and Disability Act contradicts both Fraser and Wakefield in that DSACs do have the power 'to advise on disability issues.'⁴³⁰ This means that in reality, the law is not as silent as Wakefield implies and nor does it preclude discussion on other disability issues as Fraser asserts. That latitude for interpretation is the reason why other DSACs around New Zealand have given equal weight to both aged and non-age-related disability issues.

The DSAC's continuing to meet in joint session with CPHAC further undermined NZDS implementation within the ODHB. Wakefield observed that this had been detrimental to the discussion of disability issues as 'they [largely] didn't get on the agenda at all.'⁴³¹ An examination of one agenda for the CPHAC and DSAC meeting of October 16 2007 supports Wakefield's assertion that only two agenda items out of eighteen (one on the health of people with intellectual disabilities and the other on mental health) related to disability.⁴³²

⁴²⁹ Fraser, telephone interview by author, February 17, 2010.

⁴³⁰ New Zealand Government, *New Zealand Public Health and Disability Act 2000*, s 35.

⁴³¹ Wakefield, interview by author, March 11, 2010.

⁴³² Otago District Health Board, *Minutes of the Joint Community Public Health Advisory Committee and Disability Support Advisory Committee, Meeting of October 16 2007*, (Dunedin: Otago District Health Board, 2007).

This lack of attention to Disability Strategy issues forced Wakefield and McKay to write an open letter dated September 24 2007 to Board members emphasising their frustration with the DSAC's sidelining of the NZDS and its preoccupation with aged care issues.⁴³³ Rousseau's response to their letter dated September 26 2007 stated that he had discussed the role that DSACs played in other regions with his fellow DHB chief executives. He had concluded from these discussions that the issues around its role and functions 'are not unique to Otago.'⁴³⁴ Rousseau also invited both women to raise their concerns at a proposed Board workshop. Interestingly his reply contained the statutory requirements for DSACs under the Public Health and Disability Act including reference to the fact that DSAC advice 'may not be inconsistent with the New Zealand Disability Strategy.'⁴³⁵ Overall he did not entirely address the concerns that both Wakefield and McKay had about the Board's lack of attention to NZDS issues.

At interview Wakefield asserted that, given Rousseau's attitude, the committees had been merged purely 'as a cost cutting measure, it had nothing to do with anything else.'⁴³⁶ Evidently, in line with managerialist theory, this meant the Board placed a greater premium on achieving fiscal goals than on supporting a separate committee focused on disability issues. The Board's decision to restructure their committees for fiscal reasons also provides an actual example of how managerialism undermines democratic processes.

All of these factors affected how the Board treated disability issues. Board member, Peter Barron, believed that the DHB as a whole should treat disability issues as part of its 'core business.'⁴³⁷ Over the ten years since the Strategy's introduction, however, he saw that this had not been the case. He cited the example of DSAC's representations to the Human Rights Commission's accessible transport inquiry in 2004. DSAC recommended that it make a submission based on the fact that improved transport access for both disabled and older people could improve their access to health services. He recalled, though, that the full

⁴³³ Otago District Health Board, *Minutes of the Otago District Health Board, Meeting of October 4 2007*, (Dunedin: Otago District Health Board, 2007), 14-15.

⁴³⁴ Ibid, 14.

⁴³⁵ Ibid, 15.

⁴³⁶ Wakefield, interview by author, March 11, 2010.

⁴³⁷ Peter Barron, Interview by author, March 11, 2010, Dunedin, New Zealand.

Board did not support DSAC in this undertaking as they concluded ‘that it wasn’t their core business’ to be involved in advocacy around non-health related issues.⁴³⁸ Consequently, he considered this an example of the board ‘compartmentalising’ the issues faced by disabled people and other socially disadvantaged groups.⁴³⁹

The lack of attention afforded to disability issues came down to having no overall management and governance buy-in to the NZDS. Disability sector actors emphasised this point during interviews. The interviewee with previous ODHb experience made negative comments about the role played by Rousseau as chief executive:

The DHB, once Brian Rousseau was there, knew they had to have it [the New Zealand Disability Strategy], [but] nothing was done. We were hearing about things that were far too late; we were asking why things weren’t happening, [and] why wasn’t the Board passing things through us? The comment was ‘oh, we’re sorry.’ We kept hearing that continually. It wasn’t good enough. It wasn’t just the consumers saying that. It was some elected Board officials [who] were hamstrung and for things to happen, we could have given valuable input. But again it came down to Brian’s understanding that we were only here for the over 65s. We had some stand-up angry arguments between him and some of the members as he couldn’t see how if you enter the health system, and you are disabled, how that impacts on your treatment. There were some pretty heated conversations, and it was awful.⁴⁴⁰

Fraser recollected that management not being involved in drawing up the Strategy plans had an impact as in his view the process, ‘was mainly driven by board members’. Consequently he became concerned about the DHB Strategy *Action Plan* plans for a whole host of reasons, not the least of these being its potential fiscal impact:

There were no resources allocated for it, and a lot of the plan was very operational and related to the way the hospital did its job. It wasn’t the strategic planning that Planning and Funding would be interested in.⁴⁴¹

⁴³⁸ Ibid.

⁴³⁹ Ibid.

⁴⁴⁰ Anonymous, interview by author, March 19, 2010.

⁴⁴¹ Chris Fraser, telephone interview by author, February 17, 2010.

For these reasons Fraser held the provider arm responsible for implementation. But the plan even met some resistance within the provider arm. As Paul Martin recounted, this occurred at the senior management level due to the belief amongst some of them that the Disability Strategy had no place within the organisation. Yet Martin also recalled that some second-tier management ‘saw the benefits’ of putting the Strategy into practice so as to improve service delivery for disabled people.⁴⁴²

Management still believed that cost containment superseded in significance the need to deliver on a Strategy that would, in the long term, improve access to health services for disabled people. Disability sector interviewees overwhelmingly took the view that fiscal imperatives mattered more to management than did achieving meaningful social outcomes. The interviewee with previous ODHB experience asserted that this resulted from management attitudes and behaviour as they: ‘were hiding behind this dollar thing, it’s a load of rubbish.’⁴⁴³ Fraser made a revealing statement that largely supports this assertion about management attitudes:

Maybe the solution is that, one, you could educate the person with the disabilities about the need for them to self-identify, so that if they understand they have got rights to expect something, they shouldn’t expect people to come and chase them to find out if they have got a disability and that it is their responsibility to identify it. The second thing is as happens in many, many workplaces in New Zealand, if you’ve got a disability, if you have a hearing disability, there are signs you can get saying I have a hearing disability, could you please speak up or make sure I can see you when you are talking. If they actually put those in a prominent place, people who are interacting with them can see that. You could put the onus right back onto the patient and say you have a disability and by training the disability community, it would actually be cheaper as [it would prevent] 3,500 staff who are constantly turning over being educated on an ongoing basis. That is one solution. The other solution is to have a policy that on admission, that there is a question as to whether you have any disability that may impact on the ability of any staff to interact with you. So you would have a policy inside the organisation which says that any patient who has a disability would have signage placed around their bed to ensure that the staff understand they have a disability.⁴⁴⁴

⁴⁴² Martin, interview by author, December 11, 2009.

⁴⁴³ Anonymous, interview by author, March 19, 2010.

⁴⁴⁴ Fraser, telephone interview by author, February 17, 2010.

Fraser thus acknowledges the need for better data to be collected on disability-related needs at admission. However, the rest of his statement betrays some discriminatory attitudes towards disability. Largely these centre on the belief that a disabled patient should have signage identifying their impairment displayed around their hospital bedside. Many disabled people live with invisible impairments; for example, they can experience head injury or partial sight loss. If the need to identify invisible impairments became mandatory, then people living with them would lose the right to privacy that non-disabled people take for granted. Another facet of the statement harkens back to the non-social models of disability where society has no responsibility at all for removing the barriers that people with impairments face. Therefore, the anonymous interviewee cited above makes the link between managerialist theory and disability theory through her belief that the managerial claim to exercise fiscal responsibility often acts as a cover to mask poor attitudes towards disability. Fraser's comment also reinforces the finding of the 2007 NZDS Review that poor attitudes within sections of the bureaucracy became a barrier to its implementation.

Management and governance interviewees confirmed that they also held the document to be aspirational rather than directive. Inaugural ODHB Chairperson, Richard Thomson, believed that 'some of the strategy is actually about aspiration as opposed to technical implementation...that has always been my view.'⁴⁴⁵ Furthermore, Fraser believed:

*It was quite clear when the Disability Strategy was put out, it wasn't intended to be a guidance for the way that DHBs spent the money that they were allocated. It was never suggested by government that this was something you needed extra funding for.*⁴⁴⁶

On this point Fraser is correct as successive governments have provided no additional funding linked to the NZDS. Simply the lack of any tied funding has given Crown entities, such as the ODHB, numerous opportunities to slow down the Strategy's progress.

Despite the ODHB's reticence, some positive change has resulted. Interviewees noted the changes that had resulted from the limited Strategy implementation. From a service user perspective, Wakefield noted that she had received good service when she spent a day in

⁴⁴⁵ Richard Thomson, interview by author, May 3, 2010, Dunedin, New Zealand.

⁴⁴⁶ Fraser, telephone interview by author, February 17, 2010.

hospital in 2009. She added the caveat that she had only been in one department and had noticed some improvements.⁴⁴⁷ From management and governance perspectives, a greater awareness had been generated about disability issues, if nothing else. Fraser argued that incorporating accessibility into the Master Site redevelopment plans had been an achievement during his time with the Board.⁴⁴⁸ Aside from those small achievements, minimal progress had been made by 2010. Former Board Chairperson Thomson when asked to identify the achievements that could be traced to the Strategy, found it difficult to name any. Nevertheless, he believed that, through DSAC, the need for improved physical access had been highlighted. Otherwise he had no idea ‘how far down the [Strategy] had gone through the organisation, I cannot honestly answer that.’⁴⁴⁹ If he was seriously looking for a firm answer, a scathing critique noting that numerous physical barriers remained to accessing ODHB services was provided by the anonymous interviewee:

I have only seen it because either myself, or others, have laid formal complaints. I remember a lady complaining about the women’s toilets in the area where they do breast screening. I [have] got a letter back since the check, and they told me a list of the things they were going to change. We are told it is to code. Well, we all know things which are up to 4121 New Zealand Standard Code, but they are not usable.⁴⁵⁰

During 2010 the Board continued to promote an agenda inimical to the interests of disabled people and especially older people. Alongside some other Boards around the country (such as the CCDHB), it cut domestic assistance for older disabled people as part of moves to reduce the deficit in aged care services, and to align service delivery with the PBF model.⁴⁵¹ This move contradicted the principles and intent of the Disability Strategy in promoting the need for services to be delivered around the individual and especially the

⁴⁴⁷ Wakefield, interview by author, March 11, 2010.

⁴⁴⁸ Fraser, telephone interview by author, February 17, 2010.

⁴⁴⁹ Thomson, interview by author, May 3, 2010.

⁴⁵⁰ Anonymous, interview by author, March 19, 2010.

⁴⁵¹ Staff Reporter, “ODHB to provide housework support update,” *Otago Daily Times*, March 18 2010, accessed September 18 2010, <http://www.odt.co.nz/news/dunedin/98014/odhb-provide-housework-support-update> .

Positive Ageing Strategy that stresses the need for ageing in place.⁴⁵² Crucially the ODHB's decision on home-based support for older people means that they have failed to deliver in the one disability-related area they have full control over. Therefore, by 2011, the ODHB, because of its adherence to managerialism, has failed to deliver better, more appropriate care and support, based on the NZDS, for all disabled people in the region.

This discussion of how the ODHB implemented the NZDS, and the contrasts that can be made with the implementation efforts of the CCDHB, allows us to draw some good conclusions about government agencies and their implementation of the Strategy. This will be the focus of the final chapter that also briefly discusses the Strategy's future and how it can be successfully implemented in the wake of both the UN Convention and harder economic times.

⁴⁵² Office for Senior Citizens, "The New Zealand Positive Ageing Strategy," Action Five outlines steps towards promoting ageing-in-place for older people. This philosophy is premised on the belief that older people should be able to age in their own home and community environments. Under this philosophy, placement in residential care settings is viewed as only being necessary at around the very end stage of an older person's life.

Chapter Six

The New Zealand Disability Strategy: Are we living the vision of an inclusive society?

New Zealand government disability policy over the last three decades has transitioned from the medical model to the social model. Historically, the New Zealand Disability Strategy was the most significant vehicle transporting this shift. However, some government agencies, such as the ODHB, have not fully embraced the Strategy while others, such as the CCDHB, have done so. After ten years of the NZDS and its ad hoc implementation by government, how far has New Zealand moved towards realising the goal of inclusion for disabled people? What elements have gone into producing successful Strategy implementation outcomes? Why did both Labour and National governments of the last decade fail to bring about full Strategy implementation? Following the UN Convention, what is the future of the Disability Strategy especially during this time of economic austerity? This final chapter sums up the achievements made and obstacles encountered throughout government during the Strategy's first years. This will be done through reference to the comparative case studies of the CCDHB and ODHB.

The seven positives of NZDS implementation

My research uncovered seven positive elements of the NZDS's development and implementation. The data supplied by the disability and government sector interviewees affirm the Strategy's strengths as identified by the 2007 Review.

Firstly, the NZDS became the first government document in our history recognising the social model of disability. The Labour-Alliance Government, in launching the NZDS, re-initiated social advance for disabled people after a decade of the Fourth National

Government's reforms had nearly wiped out the early gains of the disabled people's movement. Labour Governments, more than National Governments, have been responsible for passing legislation that has improved the lives of disabled people. Despite Labour's 1984-1990 flirtation with neo-liberalism, the party had, by the late 1990s, reverted to its traditional social democratic belief in the need for social justice. Labour's decision to develop a Disability Strategy naturally fitted the party's renewed mission to promote social equity, especially for disadvantaged groups such as disabled people.

Secondly, the presence of NZDS champions within Government and its agencies has been essential for successful Strategy implementation. Ruth Dyson's active championing of the NZDS, as this country's first Minister for Disability Issues, helped bring it to fruition, as acknowledged by both government and disability sector interviewees. She played a significant role in steering the Strategy through the process of securing both Cabinet and parliamentary approval. She possessed considerable political skills in being able to secure the support not only of her own Labour-Alliance caucus colleagues, but also (in the longer-term) that of the opposition benches. Moreover, her active support of the DSRG's call for an action on accessible transport being included in the Strategy (against the Ministry of Transport's advice) demonstrated a minister prepared to challenge the disabling attitudes of officials. Dyson, unusually for any Cabinet minister, held out against total capture by officialdom on this and some other disability issues.

Strategy champions have been crucial to NZDS implementation at the DHB level as well. Maurice Priestley and Paul Gibson, as people with lived experience of disability and significant combined management and advocacy experience, championed the NZDS's implementation within the CCDHB. Admittedly, they would not have been able to do so without DSAC support. Further, the personal standing of both men in the disability world enabled the Board, through them, to effectively network with the Wellington disability community.

Thirdly, the central role that disabled people played in Strategy formulation and implementation cannot be emphasised enough. Letting disabled people take the lead in NZDS development through the DSRG marked a significant departure from normal government policymaking practice. The Labour-Alliance Government adhered from the outset to the disability rights movement's mantra of 'nothing about us, without us.' If

Ministry of Health officials had taken full responsibility for the Disability Strategy's drafting without reference to the DSRG, the Strategy would have run the risk of not gaining the same level of buy-in from the disability community.

The wider political context behind government granting disabled people a central role in the NZDS's development deserves acknowledgement as well. Previously, under the neo-liberal Fourth Labour and Fourth National Governments, free market, managerialist-sympathising politicians and officials drove policy development. These Governments had discouraged the involvement of grassroots community advocates in decision-making as they were determined to implement free market reforms with only minimal recourse to citizen consent. The Labour-Alliance Government, however, sought to push back neo-liberalism from occupying a central place in government policy, and aimed to restore some of the trust lost by citizens during the years of neo-liberal reform by seeking to involve ordinary people more in public policy making.

The NZDS development process exemplified the Labour-Alliance Government's commitment to this through placing disability advocates in the driving seat, and through the Ministry of Health's extensive public consultation process. Further, for previous neo-liberal Labour and National Governments it would have been anathema to give disability community representatives (let alone any community group representatives) policymaking roles. For these governments, letting ordinary disabled people into the inner sanctums of bureaucratic policymaking (through reference groups) would have been ideologically unthinkable. Government officials took a back seat, acknowledging that the disabled members of the DSRG possessed a better working knowledge of social model theory. In the past officials would have also excluded disability advocates on the managerialist grounds of wanting to avoid capture by interest groups. Instead, as exemplified by Kylie Clode, officials directly listened to the lived experiences of disabled people enabling them to work more effectively alongside the disability reference group during the drafting process. The Ministry of Health's extensive NZDS consultation process indeed represented a renewed desire by it to engage with the public in a way they had not done during the health reform years.

Fourthly, and linked up with the previous element is the ideal of partnership between disabled and able-bodied people. The disabled members of the DSRG desired partnership

from day one as demonstrated by their mini-rebellion around their demand to have a disabled co-chair appointed to work alongside Jan Scown. The quick and effective resolution of the chairing issue enabled the group to move forward in a mature way. The successful way in which disabled and able-bodied members of the DRG worked together enabled them to model the partnership that the DSRG wished the NZDS to aspire to.

From 2001 onwards the NZDS's embodiment of a partnership approach afforded both government and its agencies an historic opportunity to partner with disabled people and their organisations to address disability issues. The CCDHB case study outlined that Board's vigorous attempts to engage disabled people in decision-making on issues directly affecting them through, for example, their inclusion on access reference groups. By contrast, the ODHB made an initial effort pre-2003 to fully involve disabled people and their non-disabled allies in NZDS-related policy formation but, as outlined in Chapter Five, this changed after the arrival of a new management team in the form of Brian Rousseau and Chris Fraser. From then on the disability voice in policymaking was almost completely ignored at the ODHB. The CCDHB more than the ODHB also followed the best empirically-based evidence from Ackroyd and Emanuel when it came to involving disabled people in health care decision making. In fact, the ODI and CCDHB both found the direct involvement of disabled people vital to successful NZDS implementation within their organisations.

Fifthly, the NZDS has benefitted from statutory recognition. The Labour-Alliance Government's decision to include the Strategy within the Public Health and Disability Act 2000 gave the Strategy a privileged status afforded no other population group strategy. This gave the Strategy the same degree of legal recognition given to one other partnership document only - the Treaty of Waitangi. Thus the Government sent a clear message that disabled people deserved better. In sending this message, the Government hoped that its agencies would not lose sight of the need to implement the NZDS alongside other population group strategies. This specific legal recognition and the resulting relationships forged between some government agencies and disabled people have lent credence to the view of DPA's Gary Williams that disabled people should view the Strategy as *their* equivalent of the Treaty of Waitangi.

Sixthly, Government agencies have successfully implemented the NZDS when they have used mainstreaming approaches. At the central government level, as recounted in Chapter Two, the Education, Health and Social Development ministries published extensive Disability Strategy annual work plans and implementation reports illustrating their commitment to fully implement the Strategy throughout their organisations. The CCDHB case study chapter, in particular, clearly exemplified how mainstreaming Strategy implementation could also improve policy outcomes for disabled people at the DHB level. The CCDHB showed a strong commitment from 2004 onwards in to making its entire organisation disability-friendly. This approach enabled the Board's management to successfully introduce initiatives, such as, for example, disability awareness training for all staff.

Even the ODHB initially planned to mainstream the NZDS throughout its entire organisation. The flurry of Strategy-related activity within the Otago Board from 2002 to 2005 marked the highpoint of its implementation there. The Otago disability community held high hopes that initiatives such as, for example, improved physical access to hospital buildings would take off and see the Strategy become mainstreamed within the Board's operations. After 2005, though, the CCDHB continued to implement the Strategy in a mainstreamed way whereas ODHB management scaled back all attempts at doing so.

Seventhly, the NZDS since 2001 has driven both Labour and National Governments to introduce policies and enact laws that have aimed to improve the lives of disabled New Zealanders. In legislative terms, government and disability sector interviewees correctly identified the Labour Government's Human Rights Amendment Act, the Disabled Persons Employment Promotion Repeal Act, and the New Zealand Sign Language Act as significant achievements attributable to the Strategy. In policy terms, also under Labour, government departments and entities, primarily the Ministries of Health, Education, and Social Development, the Accident Compensation Corporation, and Housing New Zealand Corporation all launched initiatives aimed at improving the responsiveness of their services to disabled people. Another achievement has been the ability of more disabled New Zealanders to physically access their communities through the introduction of updated building access codes and accessible buses. The Labour Government also utilised the Strategy as a platform for taking a leadership role in negotiating the UN Convention on the Rights of People with Disabilities.

Under National, the pace of Strategy implementation has slowed, but since the Hon. Tariana Turia's assumption of the Disability Issues portfolio from the Hon. Paula Bennett, there have been some significant NZDS-related decisions taken. As discussed in Chapter Three, National took up some of Labour's unfinished NZDS business in the form of Turia's announcements during 2010 on the trialling of individualised support funding and the development of a public disability awareness campaign. The Associate Minister of Education, the Hon. Rodney Hide's October 2010 announcement that government would aim for an eighty percent participation rate for disabled children in mainstream schools by 2014, while imperfect in retaining vestiges of the segregated special education system, marked another small step forward for disabled children. National's creation of the Cabinet-level Ministerial Advisory Committee on Disability Issues and its counterpart for departmental chief executives, despite their having met infrequently, still represented a milestone in efforts to improve the coordination of disability policy across government.

The six negatives that impeded NZDS implementation

Evidently, the Strategy has delivered many positive outcomes for disabled people. At the same time it has faced significant obstacles to its full implementation across government. My findings regarding the negative aspects of Strategy implementation also serve to reinforce the outcomes of the 2007 Review, the 2008 Parliamentary Select Committee Inquiry, as well as the views of disability and government sector interviewees.

Before I proceed, it must be emphasised that strategic documents by their nature merely outline the direction that an organisation (in this case the Government) wants to head in, and how it will achieve its goals. More directive focused action plans outlining implementation specifics should ideally flow from strategy documents.

Firstly, the absence of an NZDS national action plan with tied funding significantly hindered Strategy implementation throughout government agencies between 2001 and 2010. Disappointingly Dyson ignored advice from the DSRG on the need for a more directive-focused NZDS through the development of a national action plan. Dyson and Office for Disability Issues Director, Jan Scown, instead became captured by the

managerialist belief that departmental managers knew best when it came to NZDS implementation. Strategy implementation consequently suffered as officials had no central blueprint to which they could refer. Conversely, if central government had developed an implementation plan for the Strategy in 2001, then all its agencies (including DHBs) would have had firm deadlines to meet.

The availability of tied funding would also have incentivised government agencies to deliver upon their NZDS commitments. In Chapter Two Ruth Dyson confirmed that government departments had the ability to request additional funding through annual budget rounds to meet their NZDS-related commitments. However, as DPA's Gary Williams recollected in the same chapter, some Labour-Alliance Cabinet ministers and officials expressed concerns about the potential fiscal impacts of the Strategy and that is why government never considered tied funding. Leaving government departments to bid for additional NZDS funding through the budget process provided no guarantee that they would receive any money at all. As it was the Labour Government produced successive budget surpluses between 2001 and 2008 thereby having additional money available to expend on Strategy initiatives if they so wished. Labour significantly blotted its social democratic copybook in not using the historic fiscal opportunity they had, to invest heavily in the future of disabled New Zealanders. At the ODHB, for example, Chris Fraser would have been able to fund access improvements at Dunedin Hospital, and at the CCDHB tied funding would have given them an opportunity to, for example, make general practises more accessible. The possibility of making NZDS compliance a crucial performance measure for government when deciding to allocate future funding to DHBs is discussed further on in this chapter.

Secondly, the Labour-Alliance Government's failure to make all government agencies implement the Strategy and then hold them fully accountable, has served as another critical roadblock. The chief reason is Government adhered to the nostrum, particularly when it came to the NZDS, that *only* core government agencies, for example, the Ministry of Social Development, should prepare annual NZDS work plans and report on their implementation. By contrast smaller government entities, for example, Sport and Recreation New Zealand, had no obligation to either develop Strategy-related activities or report on their implementation, unless they opted to do so. A credible argument for this two-tiered accountability arrangement is that it freed smaller government agencies with

fewer resources from having to report on their Strategy obligations. On the other hand, though, this two-tiered Strategy implementation and reporting system only encouraged officials and managers within non-core government agencies to choose to have a minimal amount to do with it if that is what they desired.

Both the 2007 Review and disability sector interviewees also asserted that the ODI's small size and status hindered any effective monitoring of NZDS-related activity across government. Both Scown and Dyson confirmed the Office's inability to provide such through their disclosures about how overworked and under-resourced the Office had been from day one. Disability interviewees, for the aforementioned reasons, rightly identified the ODI as being the weakest link in the Strategy accountability chain.

Thirdly, the lack of disability awareness amongst some officials seriously impeded the ability of government to implement the NZDS in a consistent way. In stating this, the attitudes shown by officials, such as Brian Rousseau and Chris Fraser, are merely representative of the general ignorance about disability that exists within the wider population. However, it would have been unrealistic for Rousseau and Fraser, let alone any official, to become fully conversant with disability theory and thus more disability-aware in the years immediately following the Strategy's launch. Moreover for many able-bodied people, the process of becoming disability-aware takes time and can involve their attendance at disability awareness workshops or greater direct exposure to disabled people themselves. Nonetheless, the comments of Fraser, on the need for disabled hospital patients to display impairment-related information above their beds, supported the claims of disability sector interviewees and the 2007 Review about sections of the bureaucracy possessing a poor knowledge of disability. Further, if Fraser and Rousseau had actively listened to the disabled members of their local DSAC then they may have become just as disability-aware as their DHB managerial predecessors Adams and Crane had become. In fact, if every government agency in New Zealand had introduced awareness programmes for all of their employees then NZDS implementation would have been more effective.

Fourthly, the wider political environment at the time of the Strategy's development dictated its longer-term ability to influence change. The Labour-Alliance Government, even though it promoted policies to create greater social equity for disadvantaged population groups including Māori and disabled people, could only go so far electorally in

doing so. This is because many voters held prejudices towards minority groups. At the same time, however, the Labour-Government wanted to improve the socio-economic circumstances of these groups. Unfortunately Dyson and her ministerial colleagues had to pay heed to political realities during the Strategy's drafting phase as exemplified by the Government's decision to reject the DSRG's proposal to call the Strategy 'Closing the Gaps' and by the Hon. Lianne Dalziel's decision to oppose the full abolition of special schools. These decisions diluted the Strategy's ability - in a minor way - to serve as a fully social model-based document.

Fifthly, the prevalence of managerialist approaches within sections of the bureaucracy definitely contributed to the non-embedding of the NZDS within many government agencies. The managements of both the ODHB and CCDHB adhered to managerialist principles in their NZDS implementation but more at the former than the latter board. After all, CCDHB management actively continued Strategy implementation even when facing high deficits while their Otago colleagues, who faced comparatively smaller deficits, virtually brought implementation to a standstill.

Why did managerialist practices hold greater sway in Otago than at Capital and Coast? The reasons are complex but they can be attributed largely to the backgrounds and work experiences of the people involved in Strategy implementation at both Boards. At Otago, after Paul Martin's departure in 2005, Rousseau and Fraser readily asserted their authority within the ODHB. These two men adopted managerialist approaches to dealing with the fiscal issues facing the Board. Unlike their predecessors, both men took an approach to the NZDS that repeatedly failed to take account of the views of disability stakeholders on it. Both men's actions serve to reinforce Pollitt's and Entemen's arguments about the undemocratic nature of managerialism.⁴⁵³

In both men's mindsets, the need to expend *any* money on Strategy implementation equated with fiscal irresponsibility as represented by their respective attitudes on the costs of employing a disability portfolio manager and making access improvements. They

⁴⁵³ Enteman, *Managerialism: The Emergence of a New Ideology*, 159 and Pollitt, 129. Both authors make reference to the anti-democratic nature of managerialism.

thought that the ODHB's first priority had to be deficit reduction and that any other matters, including NZDS implementation, had lower priority. In the whole time they worked together, they did not re-orient their managerialist thinking to view short-term spending on, for example, improved physical accessibility, as a long-term investment that would deliver improved health outcomes for disabled people. Therefore, they did not grasp the argument that—if the board spent money on removing barriers to disabled people accessing health care— it would contribute to the Board's longer-term goal of deficit reduction. Their managerialist thinking also drove the Otago Board to focus on aged care disability issues rather than disability across the age spectrum. The ODHB's negative approach to the Strategy supports another of Pollitt's main arguments: managerialism undermines social equity and equal opportunities for minority groups such as disabled people.⁴⁵⁴

The CCDHB's Maurice Priestley and Paul Gibson, by contrast, ensured that their Board did not take an overly managerialist direction in dealing with disability issues. Priestley and Gibson's disability sector backgrounds put them in a better place than Rousseau and Fraser when it came to understanding disability issues. Their Board only adopted a managerialist approach to disability issues when it came to not funding physical disability access improvements for general practices, and in making aged care home support service reductions in 2010.

Overall, the contrasting attitudes of the two DHBs to NZDS implementation are representative of those shown by agencies across the state sector. The fact that Minister Dyson and ODI Director Scown had to *persuade* agency chief executives of the Strategy's merits, illustrated the sway that managerialist thinking had within government agencies. Scown's numerous interventions with Cabinet Ministers asking that they instruct their departmental chief executives to accord higher priority to the Strategy also provided further evidence of the pervasiveness of managerialist thinking within government.

As another comparison, Government and its agencies cannot opt out of meeting their Treaty of Waitangi obligations to Māori. Every agency has a Treaty-based obligation to

⁴⁵⁴ David Ackroyd and Judith Emanuel, "Breaking Down Barriers," 187-88.

promote and protect the interests of Māori and to enable their participation within decision-making. Under the Public Health and Disability Act 2001, these Treaty-based obligations specifically extend to DHBs.⁴⁵⁵ In fact, both boards fully discharged their Treaty of Waitangi responsibilities as each, for example, stated in their annual plans and reports how they would tackle Māori health issues.⁴⁵⁶

The Treaty comparison, though, raises a central question – why did the ODHB fully meet its Treaty obligations and, on the other hand, not fully meet their statutory commitments to disabled people? This was owing to Otago management taking a narrow view of their legal commitments because of the managerialist desire to achieve fiscal goals first. These attitudes came through in the comments of former ODHB Chairperson, Richard Thompson, about the Strategy being merely an aspirational document, and those of Chris Fraser on the ODHB only having legal responsibility for the disability support needs of older people. By contrast, the CCDHB’s Paul Gibson correctly presented his Board’s view that they had an absolute legal mandate from government to engage with the Strategy. That is why the CCDHB gave first priority to the social model of disability and secondary placing to managerialist concerns around fiscal issues in their NZDS implementation.

The ODHB’s narrow definition of its legal duties towards disabled people, as Chapter Five recounted, frustrated local disability community stakeholders. ODHB DSAC members, Donna-Rose McKay and Patsy Wakefield, failed to secure the intervention of then Minister of Health, Pete Hodgson, on the issue of the Board’s non-implementation of the Strategy. This was owing to Hodgson’s feeling that any discussion with Rousseau on the matter would achieve nothing. Furthermore, Hodgson’s failure to use his legal powers, to effect positive change on the part of DHBs around disability issues, shows how captured he was by the managerialist mantra of non-intervention. Interestingly McKay’s and Wakefield’s negative experience with Minister Hodgson contrasted with Jan Scown’s

⁴⁵⁵ *New Zealand Public Health and Disability Act*, s 4 outlines DHB responsibilities towards recognising and respecting the principles of the Treaty of Waitangi and Schedule 3 outlines how boards should ensure Māori representation.

⁴⁵⁶ Otago District Health Board, *Otago District Health Board: District Annual Plan 2009/10*, 13 and Capital and Coast District Health Board, *District Annual Plan 2009/2010-2011/2012*, 67-86. Both boards outlined in their annual plans and reports progress on meeting Maori health targets in their regions.

positive dealings with chief executives whose departmental Strategy implementation had slipped as noted earlier. These differing experiences demonstrate that there are more limits on a cabinet minister's ability to interfere with the managerial prerogatives of chief executives than there are on the ability of fellow government managers to do so.

As the DHB case studies have shown, in terms of the overall relationship between the NZDS and managerialism, governments can pass very specific, detailed legislation and make policy. However, it all comes down to the willingness of bureaucratic stakeholders to implement policy and legislation. The ODHB's and CCDHB's differing interpretations of their NZDS-related obligations under the Public Health and Disability Act, clearly demonstrate this. Further qualitative research into the attitudes of bureaucratic actors around policymaking, specifically in relation to disability issues, should be undertaken.

Sixthly, the dismissive attitude of Ruth Dyson towards the 2007 Review's recommendations represented the end of any hopes that the Labour Government would improve Strategy implementation. Her failure to listen to disability stakeholders, who had expressed their disappointment at the pace of Strategy implementation through the Review, is the only blemish on her otherwise exemplary record as Minister for Disability Issues. When interviewed Dyson never specified any reason other than dissatisfaction with the review team as to why she ignored the 2007 Review. If Dyson had acted on the Review's findings then Strategy implementation might have gained renewed traction during Labour's last year in office.

On balance, the NZDS had a strong set of positives going for it at the time of its launch in 2001. These factors—that the Strategy had been based on the social model of disability; had influential political and bureaucratic champions; had been developed by disabled people themselves in an historic partnership with government; and had received legislative backing—all lent the document credibility and, more importantly, authority. For these reasons, government and disability stakeholders fully endorsed the Strategy as a means of beginning the process of truly liberating disabled New Zealanders from decades of second-class citizenship. The disability community, for this reason, placed its faith in government to deliver upon the Strategy's actions. At the same time, government could not realistically have met all of its NZDS commitments inside ten years. Disability sector interviewees

recognised this generally, but strongly believed that government could have made even greater progress within the ten year timeframe studied.

The fact that moves towards the Strategy's vision have not been substantially realised as of 2011 comes down to the lack of a central government implementation plan for the NZDS, limited funding to back it, an abysmal lack of disability awareness within sections of the bureaucracy and the impact of managerialism on decision making at agency level. These factors have all contributed to the Strategy's uneven implementation across government. If the Labour-Alliance Government had bravely ignored political concerns around, for example, the Strategy's name and special education issues in 2001, disabled people would have been living in a far more inclusive New Zealand than the one they are actually living in ten years later. The *Disability Rights in Aotearoa New Zealand 2010* report held that minimal, if any change, had occurred in societal attitudes towards disability in the wake of the Strategy.⁴⁵⁷ The report reflected how disabled people continued to experience ongoing disadvantage in, not just health care, but also education, income security, and employment.⁴⁵⁸

Future directions and recommendations for the NZDS

What future does the NZDS have given the shortcomings in its implementation? This is a salient question as, under National, the UN Convention has come to sit alongside the NZDS as one of the twin pillars of government disability policy. In light of the UN Convention, what should government do with the Strategy?

The first recommendation concerns the requirement for a substantial re-write of the NZDS to accommodate the UN Convention. A number of disability and government sector interviewees offered suggestions. Ruth Dyson argued that 'I think a refresh of it would be quite good but I don't think it needs a fundamental rewrite as it is a sound document.'⁴⁵⁹

⁴⁵⁷ Disability Rights International, *Disability Rights in Aotearoa New Zealand*, 1-121.

⁴⁵⁸ *Ibid*, 49-57.

⁴⁵⁹ Dyson, interview by author, May 20, 2010.

Paul Gibson came up with the idea that the Strategy should be re-oriented to focus on disability support services with a UN Convention Implementation Plan taking precedence. Dyson's and Gibson's ideas do have merit but they should be taken one step further by having the New Zealand Disability Strategy re-written to serve as the government's guiding strategy for UN Convention implementation. This fusion of the NZDS with the UN Convention would see the Convention's objectives outlined and under each, the Government's actions for meeting them. A parallel implementation plan, covering both central and local government, with milestones developed for each government agency and local council should also be drawn up.

The second recommendation is for Government to disestablish the ODI and replace it with an adequately resourced, independent Disabilities Commission. This reiterates the call of the 2007 Review, the 2008 Select Committee Inquiry, and DPA for the creation of such a body. Ideally, the Commission's membership should reflect the same partnership model as the current Disability Advisory Council of the ODI with the majority of appointed Commissioners being disabled people themselves with non-disabled representatives being required to demonstrate long-term experience of working in the sector.

The third recommendation is for Government to introduce mandatory reporting on Disability Strategy and UN Convention compliance for *all* government agencies (including currently non-core agencies). Further, all NZDS UN Convention-based work plans and progress reports should be filed by agencies and councils with the Disability Commission.

The fourth recommendation is for Government to create a UN Convention and Disability Strategy Implementation contestable fund. The proposed Disabilities Commission should administer this fund but, if government continues to ignore calls for the establishment of a Commission, then the fund could sit within the ODI. The fund would receive bids from government agencies to fund Strategy and Convention related programmes and activities. Furthermore, future governments, in terms of funding NZDS and UN Convention related programmes within DHBs, should also include Strategy implementation as another precondition for Boards receiving more health funding under either the current PBF regime or any future funding system. This might just incentivise future DHB managements throughout the country to universally implement the Strategy within their organisations.

The fifth recommendation concerns the need for government to introduce mandatory disability awareness training for all government employees. The National Government could realistically implement this requirement as part of its planned mass disability awareness campaign. Government could easily set aside some of the \$3 million in allocated campaign funding to support its agencies in delivering awareness training to their staff. Introducing compulsory awareness training requirements will address the lack of disability awareness that has hindered Strategy implementation within some sections of government.

Should National or any future Government agree to implement these recommendations, then it would go some distance towards truly realising the main aims of the NZDS and, through it, the UN Convention: that of bringing about the full emancipation and inclusion of disabled people in Aotearoa/New Zealand.

But what will a truly inclusive society, when we reach it, actually look like? Paul Gibson sketched out his vision of an inclusive society:

They would be living alongside everyone else in their community, being well supported, going to school alongside everyone [else], achieving within those environments, they would be achieving in the workplace and be employed at the same rate as everyone else. They would have money and, more importantly than all those, they would have families, friends, and good relationships and a good quality of life where they would laugh and love alongside everybody else. They would be seen in leadership roles, especially leadership roles with a disability component and they would speak on their own life experiences and be listened [to]. People in general would have a sense that disability touches everyone and can touch everyone through family members or, as they age, [that] they are very likely to become disabled themselves. We would all prepare for that in a positive way and it [disability] would not be the living tragedy that it is now. A disabled child born into this world would be a celebration.⁴⁶⁰

New Zealand has travelled some distance on the road towards becoming the fully inclusive society of which Gibson speaks. The New Zealand Disability Strategy has enabled that journey to proceed at a slightly faster pace than would otherwise have been the case without the Strategy. As this thesis has argued, however, Strategy implementation has been

⁴⁶⁰ Gibson, interview by author, May 19, 2010.

high on aspiration but low on implementation within some parts of the bureaucracy due to successive governments failing to provide the greater clarity, funding, and direction needed. Barriers - such as proposed welfare reforms - continue to be created by government. That is why the New Zealand Government, using the recommendations of this thesis and official reports, must continue to implement the Strategy utilising the social model of disability in the new UN Convention age. Also the disability rights movement in New Zealand should continue to push both present and future governments into doing so. This should be the case as the journey towards full societal participation for disabled people that commenced on the afternoon of April 30 2001 is not finished yet.

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Appendices

Interviews with former Labour-Alliance Cabinet Ministers

1. Interview with Hon. Ruth Dyson, Parliament Buildings, Wellington

**Former Minister for Disability Issues, Labour-Alliance/Labour-led governments
1999-2000 and 2001-08**

What were the crucial drivers behind the desire to develop a Disability Strategy?

Who drove that policy? Was it you, or was it other people who were involved in that process?

What do you really understand to be the intent and purpose of the NZDS?

Who did you interface with in terms of key individuals and disability sector organisations with regards to developing the Disability Strategy?

What role was played through the Labour Party itself with such organisations as the Kirk Branch?

What policies and processes did the Disability Strategy policy have to go through within the Labour Party? You've already alluded to pushing it through conferences.

How well was the Disability Strategy policy received within the wider Labour Party, electorate and, in particular, by the disability sector?

You go onto win the 1999 election and go into coalition with the Alliance. After that the development and consultation process begins for the Strategy. What role in the process did you play as Minister for Disability Issues?

How did officials react to the fact that disabled people were steering the process?

How did you go about the process of selecting the reference group? Was it based on disability group membership, impairment?

You wanted to ensure that all groups in the sector were heard equally?

What advice was tendered to you by the Ministry of Health during the development of the NZDS?

Was it a case of them holding the traditional medical or charitable view of disability or was it just bureaucratic stasis?

I understand that there was tension between the reference group and the official working group. How, as Minister, did you try and resolve that tension, that's if you did so?

Now to the next step in the process of getting approval from the Labour-Alliance cabinet and caucus. What concerns, if any, did they have and how did you address those as Minister?

And so therefore Labour decided it had a commitment to honour too (in drawing up the Strategy?)

What role did you play as Minister after the Disability Strategy was launched?

Actually Lianne said that it was the Prime Minister, Helen Clark, who launched the Strategy?

When the Office for Disability Issues was established, did it play an effective role in both monitoring the implementation of the Strategy and providing advice back to you?

To your mind, what have been the key gains made by disabled people under the Disability Strategy?

But some interviewees, mainly ex-reference group members have stated that government departments have paid lip-service to the document and also have said that the document lacks resources, timeframes and implementation plans?

But do you believe that looking back, could you have improved things by—rather than let government departments decide what funding they allocated to it—that perhaps you could have tagged some specific funding to it?

What are the key things that remain to be tackled from the Disability Strategy that haven't been effectively dealt with as yet?

How can these barriers to progress be overcome particularly now we have a National Government in office?

What direction do you think the Disability Strategy is heading in? Where do you think it will take disabled people and their families/whānau?

What about the role of the Strategy now we have the UN Convention? Might it supersede the Strategy or should it be rewritten to take account of it?

And finally, do you have anything to add?

So it didn't have x amount of money tagged as Disability Strategy money?

2. Interview with Hon. Lianne Dalziel, former Minister for Disability Issues, Labour-Alliance Government.

What were the crucial drivers for a Strategy out of the Labour Party?

Do you see that the Disability Strategy sits alongside those other population group strategies as well?

What was the intent and purpose of the Disability Strategy to your mind?

And to your memory, who were the key individuals and disability sector organisations pushing for the Strategy?

And Gary Williams whom I interviewed a number of weeks ago?

What roles were played by disabled people inside the Labour Party, including by the Norman Kirk branch, which I understand is quite influential within the Party?

What support was offered by non-disabled members of the New Zealand Labour Party in pushing for the Strategy to your recollection?

What barriers, if any, were there to getting the Disability Strategy through the Labour Party and how were these overcome through both the work of Ruth and yourself?

What processes did the disability policy go through to get accepted as Labour Party policy?

How well was the policy received within the Labour Party and the wider electorate in particular when it was unveiled?

After the 1999 election, there were a lot of development and consultation that went on around formulating the Strategy. What role did you play in your time as Minister?

At that time, what advice was tendered to you by the Ministry of Health, which was the lead agency charged with implementing and developing the Disability Strategy and what were some of the pros and cons raised by the Ministry and so forth?

What issues were addressed by the Labour Cabinet and caucus in relation to the NZDS?

What ongoing role did you play once the Strategy was launched?

Perhaps you might like to reflect on what do you see for the Strategy now that the Nats (National) are in office?

What direction could the Disability Strategy take in the future and what direction could it take disabled people and their families/whānau in?

And have you anything to add?

My question is why didn't Labour move to do that when it was last in government?