Dual Disability Systems in New Zealand: A tandem or two separate bicycles?

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Abstract

There is continuing international debate over the best ways of funding and organising support for people with disabilities. In New Zealand two public sector disability programmes have developed alongside each other. The first (disability support), covering people disabled from non-accident causes, is taxation funded and managed via health and welfare systems. The second, providing cover, on a 'no-fault' basis, for all people disabled by injury, whatever the setting or cause, is a social insurance programme known as Accident Compensation (ACC), administered through a government corporation. This paper traces the fortunes of these two programmes over the last two decades, pointing out the implications for disabled people and for public policy, including issues of equity for people with a similar range of needs. The discussion and conclusion raise broader issues that may be relevant to other countries.

Key words: disability compensation, disability income, disability support, New Zealand

Introduction

In many countries the disability sector has been undergoing rapid change, with a range of key influences internationally on the pace and direction of change. These influences include international and national disability rights movements (United Nations, 1983; Hasler, 1993; Hahn, 2002), the debates between medical and social approaches (Thomas, 2002), changing normative constructions of disability and the pressure to manage economic risk.

The nature of the change has varied across countries and, while acknowledging the multiple factors involved, can largely be summarised under two dimensions. The first dimension is the nature of the disability 'model' prevalent in society, and whether this inclines towards a medical/individual model or a social/collective model (Oliver, 1996: 34). The second dimension is the public policy approach to disability support, and whether this inclines towards individual entitlement or an assessment of need giving access to rationed, government funded resources.

The aim of this paper is to help illuminate the interplay between these dimensions through an analysis of disability in New Zealand. New Zealand provides a particularly valuable case study because two comprehensive but quite separately state-managed disability systems exist side by side. Disability due to 'natural' causes, such as illness or congenital effects, is the province of the welfare and health sectors, and funded through taxation. All disability due to accident or 'unforeseen events,' including medical misadventure, is covered by a compulsory national no-fault social insurance scheme funded through a system of employer, sector and government contributions. These two systems, characterised as progressing along parallel but separate paths, like two bicycles, provide the opportunity to examine contrasting pathways for disability systems development within a single national environment. There are implications for countries considering new developments, including proposals in the United Kingdom for a national NHS Redress Scheme for medical misadventure (Chief Medical Officer, 2003).

This paper will briefly review the frameworks that provide the 'prism' through which disability arrangements can be interpreted. It sets out an analysis of the development of parallel disability systems in New Zealand and assesses their current positions. It then discusses the implications of such systems for public policy.

Disability Sector Frameworks

The classical approach to disability is through an analysis based on alternative medical and social models. This 'tale of two models' (Barnes, Mercer and Shakespeare, 1999: 20) has been developed progressively by a number of authors (Abberley, 1987; Oliver, 1990) and driven by alternative understandings of the nature of disability and appropriate intervention strategies. For example, the dominant disability paradigm of the twentieth century was the medical or individual model, based on traditions of 'objective' professional assessment and a 'prescription' for rehabilitation and support services. This model relies on standardisation of measurement and the ability to assign levels of 'severity', and is characterised by WHO's International Classification of Disabilities,

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Impairment and Handicap (ICDIH) which relies on traditional medical frameworks of 'causality'. The implication of this is that individual interventions and responses will alleviate disability but that disabled people must adjust to their 'lot' in life. This perspective has been strongly criticised by disabled people (Barnes et al, 1999: 27).

Towards the end of the twentieth century, social approaches to disability were acknowledged. Now, in the early twenty-first century, despite the 'weighty presence' (Thomas, 2002: 41) of the medical perspective, the social model has become increasingly important. The social perspective argues that it is society's response to individual impairment that actually creates disability and limits participation in society, and that changes in social and institutional environments are required. Oliver and colleagues in the UK have drawn attention to the role of activism among disabled people as an important component of this perspective (Oliver, 1990; Oliver, 1996; Campbell and Oliver, 1996). The concept of the social model has been widely adopted internationally among both academics and activists, and given appropriate local orientation. For example, in the United States the civil rights tradition has led to a focus on a 'minority group' model of disability and an active use of legal avenues to secure rights (Hahn, 2002). While the social model has been the subject of post-modern (Corker and Shakespeare, 2002) and other, including feminist (Morris, 1991) critiques, there is broad agreement that it remains a robust framework for understanding disability issues.

Moving beyond models of disability towards the public policy frameworks for support for people with disabilities, there are two broad strategies. The first is the 'entitlement' model which specifies levels of income and services to which individuals are entitled, based on the nature of their disability and any other eligibility criteria. The alternative approach is a 'needs assessment' model. This model is more characteristic of welfare than insurance systems and is based on professional assessment of needs, the development of personalised plan and the co-ordination of access to services. Access to income support is usually set within an entitlement framework and is likely to be relatively tightly specified, whether funded via social insurance or social assistance models (Dixon

and Hyde, 2000). In the case of access to services, these will usually be specified as an entitlement in a social insurance model but be more variable and subject to bureaucratic and resource constraints under a 'needs assessment' model. While the concepts of models of disability and models of provision are separate, the way in which they interact is important, creating a range of alternative scenarios (Table 1).

Table 1   Dimensions of disability support

Disability model / Provision model	Medical/ individual	Social
Entitlement	*Box A* Insurance – schedule of income and services Welfare – schedule of income benefits	*Box B* Issues of access, rights, inclusion; personal and group empowerment
Needs assessment	*Box C* Professionally assessed and co-ordinated	*Box D* Assessment and management by disabled people, both individually and collectively

The entitlement model of provision appears differently depending on whether it is set within an individual or social model of disability. For example, in the individual version (Box A) insurance and welfare programmes will specify both levels of and eligibility for benefits. The entitlement approach within a social model (Box B), however, leads to consideration of issues of access, inclusion and full participation in society. Rights may be a focus in both cases, but the social model sees those rights as more broadly defined with policy action directed towards social inclusion as much as provision of services. Similarly a needs assessment model can accommodate both individual and social approaches. The individual approach emphasises professionally assessed need and co-ordinated provision of services (Box C); a social approach provides for both individual and collective control over the management of support resources by disabled people (Box D) (Doty, 1998).

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Disability Developments in New Zealand

Emergence of organisational frameworks

As in most western countries, in New Zealand there was little distinction in the nineteenth century between causes of disability, with a census question from around 1870 enquiring about 'those unable to follow their usual occupation due to sickness, infirmity or accident' (Tennant, 1996: 2). Families and communities were expected to take responsibility for their fellows, but over time the public sector became increasingly involved. Modern disability support moved towards income maintenance through social assistance (1936) and workers' compensation (1956). Rehabilitation and support services were provided increasingly through the public sector, but with significant involvement of voluntary organisations, supported by financial contributions from the state.

Major changes in disability support occurred in the 1970s, led by legislation to establish the Accident Compensation Commission (later 'Corporation' (ACC)) in 1974. The main purpose of this new organisation was to remove the traditional litigious system of compensation for negligence which commentators saw as 'expensive, arbitrary and adversarial' (Kelsey, 1995: 203). Individuals lost the right to sue for compensation for **all** accidental injury, regardless of its cause or setting (including medical misadventure, criminal acts, and events in home, sports, work, transport and any other setting). In exchange, regardless of 'fault', everyone gained entitlement to a range of rehabilitation services, to lump-sum compensation, and to income support at levels in proportion to previous earnings. This innovative programme, funded initially from motor vehicle levies, employers and the government has persisted over three decades, surviving transformations imposed by successive governments with contrasting philosophies, various levels of mismanagement and occasional scandal. Despite these periodic problems, overall ACC receives high levels of public endorsement.

One of the consequences of the introduction of ACC was to highlight the inadequacies of both services and income support for people whose disability was *not* due to an 'injury by accident' but to the bad luck of illness or congenital disorder - by far the majority of people with disabilities. Improvements in both income benefits and services for this group followed with the passage of the Disabled Persons Community Welfare Act 1975. This saw increased participation by the voluntary sector and a wider range of services, but largely *ad hoc* and uncoordinated decision-making. Despite some improvements in both income support and service access, over successive decades there continued to be concerns about the privileged access of ACC 'claimants' to income support and social and vocational services, compared with 'beneficiaries' disabled by illness but with similar needs for service and income (Duncan, 1993).

Throughout the 1980s and 1990s both disability support and ACC systems experienced tumultuous change at the hands of two reforming governments. First, in the 1980s a radical right-wing Labour government (1984-1990) was committed to reform of the public sector. This was followed by an even more radical National (conservative) government (1990-1999), intent on privatising health and welfare services. The following sections trace the fortunes of disability support and ACC under these regimes.

Disability support in the 1980s and 1990s

Between 1984-1990 the Labour government sought to rationalise disability support as part of its overall reform of the public sector. Prior to 1993 responsibility for service funding was divided, somewhat unsystematically, between separate Departments of Welfare and Health. Some programmes were demand driven and others had capped funding, and there were acknowledged 'boundary' issues. Historically both health and welfare sectors had relied on professional assessment systems that were equally as likely to disempower disabled people and lean towards an individual rather than social model. Between 1993 and 1995, under the new National government, most programmes and funding were progressively consolidated within a single health funding appropriation. Programmes were administered by regional health authorities (RHAs), with an emphasis on assessed needs rather than service entitlement (Ministers of Health and Social Welfare, 1992). The debate over whether disability should be part of welfare (with its charitable connotations) or health (with increasing risk of

medicalisation) appeared to be resolved, in favour of health.

The transfer of disability support services to the health sector and its decentralisation to four RHAs led, somewhat paradoxically, to moves towards a more social approach. Health reform legislation required proper consultation and it became possible for the needs and preferences of disabled people to be strongly expressed through their own organisations (Sullivan and Munford, 1998). This provided opportunities for 'sowing the seed' and then developing 'strategic coalitions at local and community levels' (Sullivan and Munford, 1998). One of the outcomes of this was the emergence of a more substantial advocacy movement and promotion of a social model of disability. This was reinforced by the establishment of a Health and Disability Commissioner and Code of Patients' Rights in 1994 and the extension of Human Rights Commission legislation to disability discrimination in 1995. Between 1995 and 1999 26.4 per cent of all complaints of discrimination were on the grounds of disability (Minister for Disability Issues, 2002: 9).

During this period the increased flexibility of the market environment permitted service innovation. For example, new providers were able to participate in new health sector contractual arrangements and there was a range of service experiments, including self-determination pilots and individualised funding options (Ministry of Health, 2002: 16), permitting increased scope for personal autonomy for people with disabilities. One consequence of this flexibility was a decline in national consistency. As funds tightened it became clear that the national Needs Assessment/Service Co-ordination (NASC) model of the health sector (Ministry of Health, 2002: 3) was used as a rationing tool, with increasing concern over variability in access in different parts of the country and for different population groups. There were inevitable tensions between the demands for an evolving rights based approach and the more managerialist tradition of decision-making and resource allocation represented by NASC.

ACC in the 1980s and 1990s
Although disability support experienced successive restructuring, it remained largely within the public

'fold'. ACC, however, was being moved increasingly towards a private insurance model. Between 1974-1984 ACC accumulated considerable reserves to fund the future costs of injury already incurred. Employers, as significant contributors, resented the presence of reserves and persuaded the Labour government, against the advice of ACC, to reduce employer contributions, with the inevitable result that reserves were run down and a 'pay-as-you-go' system developed. This funding model, combined with high standards of entitlement (driven by International Labour Organisation (ILO) conventions) but lack of emphasis on effective rehabilitation, ensured that by the late 1980s ACC faced serious financial difficulties. This crisis, thought by some to have been deliberately engineered (Kelsey, 1995: 204), made ACC an easy target for radical reform and privatisation.

The new National government legislated to reinforce the 'insurance' framework in 1992 and establish regulations to prescribe entitlements, strict eligibility rules and the provision of rehabilitation. Levels of compensation and access to medical and support services were reduced, with lump sum compensation abolished. In 1998 further legislation introduced a competitive market; employers could choose between competing private insurers or to 'opt out' and self-insure.

By the late 1990s privatisation was well under way, with important consequences. First, despite problems of the early 1990s there had been significant improvement in the development of information systems, the management of long-term injury and compensation, and a return to financial viability. Second, part of the price of these gains had been a loss of access for claimants. Regulations had tightened eligibility, particularly for non-earners, with disadvantages for some claimant groups, particularly women. The pressure to reduce liability for long-term compensation led to changes in the management long-term injury, including strategies to remove claimants from ACC compensation to (lesser) unemployment benefits if they were assessed as fit for (any) work. These more managerialist practices of ACC led to a strong consumer backlash. While mechanisms had always been in place for individuals to appeal ACC decisions, claimant groups now began to challenge

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decisions via the media, with ACC being regarded as increasingly capricious and mean. Throughout this period ACC recognised that there was significant risk to its viability if the community regarded it as 'unfair' (ACC, 1993: 20-21).

Disability systems 2000-onwards

By the late 1990s the historical contrasts between disability support and ACC had become more clearly embedded (Table 2).

Table 2   Key features of Disability Support and ACC sectors

	Disability Support Services	**ACC**
Political framework	Minister of Health responsible, with high levels of discretion over service policy.	Minister for ACC appoints ACC board, but limited discretion over service policy.
Accountability systems	Reporting through bureaucracy	Independent board of directors
National consistency	Decentralised approach led to inconsistency/ inequity between regions. Now re-centralised but inequities persist	National consistency embedded in legislation
Financing	Allocation from a capped government appropriation	Social insurance contribution levels can be adjusted by ACC
Benefit drivers	Needs assessment and resource management; no external referencing	Legislative entitlement and reference to ILO conventions
Outcome focus	Maintenance of quality of life; enhanced participation in society	Rehabilitation
Ensuring access to services	Health and Disability Commissioner may not rule on service access issues.	Appeal processes include ruling on entitlements

Disability support had been re-centralised within the Ministry of Health whereas increased privatisation had maintained ACC's distance from government direction. Despite a downward trend in ACC benefit levels, these were still more generous than those from disability support, although the gap was narrowing. For example, for people with neurological disorders the 'service packages' for patients with hemiplegia who have suffered a stroke and those with traumatic brain injury (ACC) are likely to be different. ACC pays for active rehabilitation, neuro-psychological assessment, training for independence, care in the home and supervision. The Health funded disability support package is more limited and access less certain. With the change to a centre-left government in 1999 issues of 'equity and coherence' in access to services and income (Ministry for Social Development, 2002) were highlighted. Although the difference in income support between ACC and disability support was a particular issue, other problems arose from inconsistent cross-sector policy development and from variations in planning and funding across agencies. Issues included diversity in patterns of assessment, inadequate access for rural communities and for Maori and Pacific people, lack of information and the alienation of some individuals and groups from the system.

On election in 1999, the incoming elected Labour government promised to provide strong leadership for disability support and to restore ACC to its original intent. The government took action in a number of areas.

'Renationalisation'

Both disability support services and ACC were brought under greater government control. Disability support remained within the health sector but was to be managed centrally by the Ministry of Health, leading to greater levels of national consistency. Within this national framework some elements of disability support are decentralised to district health boards, but any further trends in this direction are likely to rest on the surety that this does not compromise equity of access. ACC, too, was 'renationalised' with a 'fresh starts from founding principles' (ACC, 2002: 9). The principles of the original scheme were restored with renewed emphasis on injury

prevention, the introduction of a Code of Claimants' Rights, reintroduction of lump sum compensation, more flexible access to assistance and the extension of cover to groups previously excluded (seasonal workers, those on parental leave). The new framework maintains the independence of the ACC board and reinforces the commitment to effective management of both injury episodes and any residual disability requiring long-term compensation and support. More active rehabilitation, while welcome, had also become more tightly 'risk-managed', with case management, packages of care and life-care planning characteristic of managed care models in the US.

Policy co-ordination

In the past commentators have complained of the poor government management of disability issues, with ACC and government departments failing to provide good policy advice (Palmer, 1995). In December 1999 a Minister for Disability Issues was appointed and an Office set up within the Ministry of Social Development. This is independent of both the Ministry of Health and ACC, but the new Minister for Disability Issues is also an Associate Minister for both these areas. The Minister is responsible for the development of strategy and the Office is now the 'lead agency' on all disability issues.

Policy commitment to the social model

The New Zealand Disability Strategy 2000 was developed as part of the policy underpinning the most recent reform of the health sector in 2000 (New Zealand Disability Strategy, 2000). The Strategy represents a strong social model that is directed towards managing social and institutional change, with the Minister for Disability Issues responsible for reporting to Parliament on progress. The Strategy focuses on guiding government action to eliminate barriers to full participation of people with disabilities. It is hard to overestimate the significance of the presence of both the Office and the Strategy in changing, in the first instance, the nature of the discourse around disability issues (Minster for Disability Issues, 2002).

Greater comparability/equity

There remain unresolved issues of equity, some of which can be addressed through service policy and

management actions. Within ACC, for example, the development of protocols for managing rehabilitation has provided greater equity of service across the country. For disability support services and overall co-ordination through the Ministry of Health has ensured more consistent criteria for access. The main inequity, however, is the differential access to income and service support for people with illness-related disability compared with ACC claimants. It was part of the vision of the original architects of ACC that serious illness would also eventually be covered, and proposals were developed for this 1988-1990. A change of government meant that these never progressed, but clearly this is still an unresolved issue (Ministry for Social Development, 2002: 42).

Aside from income support arrangements, some developments suggest there are improved prospects for consistency in social rehabilitation services and a more co-ordinated approach. The Ministry of Health has accepted the notion of more flexible service models and has developed various pilot initiatives (Ministry of Health 2002: 16). In addition, there is work by the Ministry of Health and ACC on joint standards for home and community based support services, with draft guidelines under discussion.

Discussion

In New Zealand two completely different systems, one taxation-based and the other a social insurance model, for managing disability in the community have evolved side-by-side over the last few decades. Both have been under pressure to manage resources more efficiently. In the case of the disability support sector, finite budgets from governments require methods that allocate social assistance as equitably as possible over the full range of assessed disability needs in the community. In contrast, ACC, as a social insurance system, has the capacity to raise its own funds through levies but is constrained by both political and community expectations to manage individual entitlement from injury episodes so that long term financial consequences are minimised.

The impact of the difference in financing and management systems is most clearly experienced at the point where a person requires access to

rehabilitation or support. In the case of a child who has had an accident or experienced medical misadventure, once entitlement is confirmed the assessment process will identify the necessary services and ensure that the medical and social rehabilitation and educational resources are available to meet the child's needs. For a child with disability arising from a genetic/medical condition access to adequate levels of service and support through the Needs Assessment and Service Co-ordination service is less certain, and more subject to limited availability or longer waiting times. Discussions around the proposed new NHS Redress Scheme will need to acknowledge that dealing with one inequity carries the risk of creating others. If disability from one type of cause (accident, negligence) is valued intrinsically more highly than from another (genes) then new bases for inequalities may be created.

Both models of responding to disability to New Zealand have been significantly affected by growth of the disabled persons' movement and social model thinking, although the pathways have differed and reflect the different discourses around individuals. People involved in disability support have been referred to as 'beneficiaries' reflecting a dependent status in relation to the state. This relationship, though, also encouraged mechanisms for more collective public accountability, with disability support strongly influenced by the active involvement of disabled people through mandatory public consultation processes. The establishment of statutory commissioners both for the health and disability services and the inclusion of disability within human rights legislation are consequences of this. ACC, a social insurance institution, has been influenced more its 'claimant' relationships where individual decisions could be challenged through legal channels. Only recently has there been collective action on the part of user networks and a Code of Claimants Rights introduced. The more broadly based approach to inclusion that evolved in the wider disability support area now appears, with government leadership, to be being encouraged also in ACC (ACC, 2002). Nevertheless, human rights legislation is relatively weak in New Zealand, with Palmer (1995) suggesting that people with disabilities have been 'balkanised' into different groups. He also suggests that different disability groups are readily

co-opted and fragmented over individual issues and that, unless they can make 'common cause,' disability rights and social inclusion goals will only be partially achieved.

From a policy point of view, the differing funding and institutional environments for disability support and ACC have created different strategic approaches. Receiving government appropriations, disability support is beholden to short-term political decision-making and although it takes a systematic approach to rationing, it is unable to determine the overall level of resources. ACC, however, because it raises its own funds and manages its own risk, can take a more strategic view, incorporating an actuarial and 'life-course' approach. While this brings benefits to claimants, the commitment to building adequate reserves to ensure full funding of current claims into the future is challenged from time to time by those paying premiums. As 'opting-out' is not possible, this poses some political risk for ACC and the government, and fine judgement to maintain public support.

Conclusion

Dixon and Hyde (2000), in their international overview, reported that New Zealand had a social assistance model for disability support, but failed to mention the ACC social insurance system. This is unsurprising since they based their study on information collected through the US Social Security Administration from individual countries in the early 1990s. At that time the New Zealand government was planning the privatisation of ACC and had already embarked on shrinking benefits and services. However, underlying public support for ACC ensured its survival (and revival) and it is perceived as a healthy public institution that makes a significant contribution to the community. It is unlikely, now that New Zealand has moved to a proportional representation system, that any future government will be able to introduce radical change in ACC.

There is still, occasionally, in New Zealand, debate around the 'no-fault' insurance principle of ACC, and discussions around no-fault schemes generate important debate about social responsibility and spreading risk. However, the 'fault/no-fault'

debate sometimes obscures the consideration of equity issues created by the presence of parallel schemes for injury and non-injury related disability. When insurance schemes are small and designed to meet specialised needs they may be less contentious than more 'universal' schemes introduced alongside an existing programme. Different funding mechanisms and service models in New Zealand have precluded effective integration in the past and although there is some work at the margins there appears little prospect that the two models can be properly integrated without significant additional resources and a radical policy re-think. Clearly the current government is concerned about equity and the establishment of a Minister for Disability Issues provides more optimism than previously. However, it seems that ACC and disability support are destined to remain side by side, rather than riding genuinely in tandem.

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