

Resource Allocation and Empowerment Practices: Evidence from Disability Support Services

Abstract

This paper investigates the implications of empowerment practices within the Disability Support Service (DSS) sector in New Zealand. The DSS framework is designed as part of the public sector reform process to promote empowerment for the disabled people so that they can lead independent lives in their communities. Implementation of empowerment principles, however, depends on resources to create a support structure at the community level and an atmosphere where there is a choice and flexibility for disabled people to access essential services. The empirical evidence suggests that we need to see such concepts as empowerment as problematic, because it can be perceived as a manipulative strategy where empowerment principles may be only notionally applied when services are offered by following managerialist principles.

Key Words: Empowerment, New Public Management, Disability, Support Services

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INTRODUCTION

Welfare restructuring was introduced during late 1980s in different countries and such reforms were primarily aimed at efficiency gains and better utilisation of resources (Lawrence et al. 1997). Even though the overall thrust of such changes was to introduce market values, underpinned by an increased emphasis on efficiency gains, the manifestation of the reform process also included customer choice, empowerment, and self-determination (Boston, J. 1995, Southon, G. 1996, Southon, G. 1996).. Instead of health care being provided solely by the state, the reform suggested a pluralistic approach whereby different groups would share responsibilities for the provision of health care (Bruegel, R.B. 1998, Hodge 1996). The reform also recognised individual rights within a market place in which service recipients could make choices as to what they wanted to purchase and on what terms. This line of thought closely paralleled what disability rights activists were lobbying for over a long period of time (Hales, G. 1996). The current discourse on disability has the appearance of promoting empowerment but it can also be seen as a manipulative device which can be used by the New Right as a means of introducing market values into public services (Mannion 1991). Empowerment in disability aims to involve disabled people in all aspects of decision making by reducing the role of state in the provision and management of disability services. Critics are suspicious of how empowerment concepts are introduced in DSS areas and how it is superficially conceived. Underpinning this conception may be the motivation to privatize public services and to give disabled people a notion of empowerment so that they make fewer demands on the welfare state. Even though such concepts are consistent with the demands of disability groups, critics question how the concepts are operationalised.

This paper focuses on Disability Support Services (DSS) in New Zealand, which include individual needs assessment and provision of support, rehabilitation and general services. The DSS reform was aimed at achieving the best support for these people in a natural environment, embedded in community- and family-based relationships. Such an environment was viewed as conducive to disabled people feeling more confident and gaining competence in problem-solving (Adams, 1996). The rationale of the DSS reform was promotion of

empowerment for disabled people so that they could choose the services that best suited their particular circumstances (Parker 1990).

This paper specifically looks at the nature of empowerment within the current DSS framework from resource allocation perspectives. A resource focus is important; since it is often recognised that establishment of empowerment-based care may worsen the wellbeing of disabled people if appropriate resources and facilities are not created at the community level. It is apparent that the changes in the New Zealand health sector have concentrated on efficiency gains and better utilisation of resources (Lawrence et al. 1997). Disabled people understand that there will always be funding restrictions which will ultimately affect the availability of services in the community. However, from an empowerment point of view, better results can be achieved if full disclosure is made on the availability of funding and a joint decision-making process that can be achieved within budget constraints. Such an approach will include: a) a system of budget disclosure and supported decision making; and b) a genuine flexibility in the utilisation of resources. Without economic improvement and better utilisation of resources, disabled people may find it difficult to develop all aspects of their lives.

The main objectives of this paper are:

- a) To evaluate whether the nature of empowerment provided within the New Zealand model is merely procedural, or whether it leads to substantial control by service recipients over economic resources and programs that determine the material wellbeing of disabled people.
- b) To evaluate the nature of service design and service availability from budgeting and resource availability perspectives.

This paper is organised as follows. The first part of the paper evaluates the role of budgeting in service design and then disability reforms in New Zealand are described. The context of the case study is described, and a methodological note provided. Next, empirical evidence concerning empowerment and disability support services is examined. The paper concludes with observations on the issues surrounding empowerment principles in New Zealand.

EMPOWERMENT AND DECISION MAKING

Empowerment is an abstract concept with different interpretations and meanings. From a normative perspective, empowerment concepts are seen as providing opportunity so that individuals can be independent and gain a sense of effectiveness (Conger and Kanungo, 1988). Such concepts are close to the principles of citizenship, such as, the establishment of universal rights and the right to freedom of choice. Empowerment is often seen in terms of oppressive relationships and power imbalances. Such imbalances are moderated by relocating decision-making power to those who are oppressed (Vogt and Murrell, 1990; Johnson, 1992; Zimmerman and Rappaport, 1988). Such a power relationship is a political process for gaining and transforming needs into rights (Cochrane, 1989). At the political level, empowerment concepts may also be seen as creating structures, such as, the introduction of market forces and the introduction of support structures so that the empowerment process can take place. Other writers view empowerment from a cognitive sense – how individuals feel psychologically when they are empowered (Shor and Freire, 1987). While empowerment has several meanings, we shall adopt an interpretation that has been explicitly promoted in the disability sector and takes several attributes into account, such as, involving service recipients in decision making, introducing market principles, and creating an opportunity for choice.

Empowerment in disability services is supposed to promote self-determination for disabled people so that they can improve their lives. Before the recent health sector reform, disability services were managed by health professionals under an allocated budget, where the main concern was to stay within budgeted allocations rather than providing services in accordance with the desires of disabled people. Resource allocation and policy decisions were taken in a bureaucratic manner. However, such a basis of service provision was deemed unsustainable because of inherent problems of public sector inefficiency (Alam and Lawrence, 2006, Stewart and Alam, 2000). The recent reforms, especially the New Right's commitment to resource allocation and service management, brought significant changes in organizational design and in the structure of health service provision.

In the areas of disability support services, such reforms introduced de-institutionalisation of disability services in favour of community-based supported living. A new discourse of participation and empowerment has entered the vocabulary of service delivery functions for disability support services. With the dismantling of professional- and medical-based support services, neo-liberalist ideals supported empowerment and client-centred support structures where disabled people can be integrated into communities. However, several critics have commented that such a discourse on empowerment can be meaningless, unless adequate resources are provided and support structures created that meet the diverse needs of disabled people so that they can be truly integrated within the community. In order to evaluate different modes of service delivery in the disability sector it is necessary to analyse how different paradigms view disability and support services.

The traditional approach to disability, often referred as the professional and medical model, emphasises disability as an individual deficit (Marks, 1997; Wicks, 1994; and Munford, 1994). Such an approach concentrates on the medical diagnosis of physical impairment or intellectual limitations of individuals so that services can be arranged for treating individual deficits. The extent of disability is determined through a series of medical and psychological tests. Different policy guidelines were designed within the professional model to compensate disabled people by offering medical treatment and therapies after a process of identifying the nature of the disability (Judge, 1987). People with disabilities were often prescribed different levels of services, which could take care of specific aspects of their disability rather than viewing that disability from a holistic perspective. The medical model of disability came under criticism from different minority groups, including disability groups, which began to claim the right to control their own affairs and to participate in decisions affecting their well-being (Georgeson 1993; Davis, A., Ellis, K. & Rummery, K. (1997).

The managerial models of empowerment tend to move from the position of a negative stereotype view of disability to a position where disabled people are included in society as valued individuals (Oliver, 1990; Munford, 1994). The managerial approach to disability support services implies managing such services within the service objective to achieve efficiency in terms of achieving value for money for each dollar spent. The managerial view supports market principles, which are supposed to provide a choice for disability services.

Such managerial views have been criticised, because service provision is often influenced by financial constraints and, moreover, they fail to address fairness and personal choice. In the private sector the pricing mechanism provides a signal for providing the desired quality of services. As such signals are absent in the public sector, the managerial model tries to maximise the use of the budget allocation by offering a mediocre service. It is questionable whether market principles can be applied to social services where choice and availability of services are limited.

	Professionalism	Managerialism	Empowerment
Problem Definition	Defined by professional groups, with some negotiation with clients Problems seen from a pathological focus	Defined by sponsors with financial targets Problems seen from a resource management point of view	Problems defined from the personal experience of the clients
Method of Problem Definition	Positivism	Positivism	Participative
Service Design	Organised on the basis of medical treatment and rehabilitation	Organised from corporate objective achievement No involvement from clients in the design of services	Organised from the client's point of view Services are designed according to the needs felt by disabled people
Resource Allocation	Patient and treatment focused	Budget focused	Consultative resources allocation and utilisation

Table 1: Disability service design from three perspectives

The empowerment and social model places disability within the social context where people with disabilities can take an active part within the social environment. Such a view projects disability as socially constructed rather than focussing on individual's deficits. Disabled

people can go through a re-adaptation process to community living in a situation of acquired injury impairment. In a situation where a person is born with disabilities, he/she can go through a learning process for independent living within the society. Unlike medical model of disability, where the medical profession has held considerable influence over the lives of disabled people, the social model emphasises on 'having a voice' (Munford, 1994). People with disabilities can be involved in decision making about their lives rather than passively accepting services as diagnosed on the basis of disabilities. Active involvement in decision making usually involves regular consultation with disabled people while making social policies affecting the lives of disabled people.

Resource Allocation and Empowerment

The professional, managerial, and empowerment models differ conceptually. They exhibit different views on how needs assessments and resources can be allocated before services are offered to disabled people. The nature of the resource allocation system has a number of perverse consequences, as it helps to create a supported environment where disabled people can develop their full potentiality. Empowerment in a community setting would involve the integration of individual preferences with information about the formal or paid supports that people may need. The resource implication is critical since no meaningful planning can be done without the creation of a support structure, which depends on funding levels. Even though funding entitlement sets constraints for arranging services for disabled people, the empowerment model can be used for a creative service design. An empowerment model of resource allocation can lead to a better understanding of the availability of funding and the ways of getting a better arrangement from the service recipient's points of view.

The existing funding model sets a constraint in creating new services. A sense of decoupling exists between resource availability and assessment process. Resources are more tied towards existing level of services. Individual service recipients are assessed before they can obtain services that are on offer. The assessors are aware of the existing services through resource allocation process. It is true that there is paucity of funding as compared to increased demand for services. In times of resource constraints, services are cut across the board. Such a situation often leads to service cancellation or offering only little service to a large number of people in small quantities. A move from service based resource allocation to individual client-based allocation will free up resources where services can be developed based on

individual needs. Rather than viewing financial resource constraints as a hindrance, it can be an opportunity for creative service design. When all parties, including assessors, disabled people and service providers are aware of the level of funding, all can work together for designing service within the financial limits. A sense of trust and realism can develop where service design can take inputs from all relevant parties. Such an approach to service design brings all parties together to look beyond the traditional boundaries of service arrangements.

It is possible that a full information on resource availability can lead to a better decision making on the part of disabled people. In situations of financial restrictions, there may be a tendency to provide either mediocre or restricted number of services to as many people as possible. Here, quality may be sacrificed to provide a small number or partial services to a large number of disabled people. Empowerment models make sense only when people with disabilities are given choice to manage their own activities with a sense of direction. The managerialist approach to empowerment is often seen as a manipulative strategy unless choice opportunities are created through allocated budgets. An understanding of resources can be useful in deciding what is feasible and how different services can be arranged. As we intend to evaluate whether the nature of empowerment provided within the New Zealand model is merely procedural or whether it leads to substantial control by service recipients over economic resources, empirical findings will help us to determine which empowerment models (professional, medical, and empowerment) are operating in practice.

RESEARCH METHOD

This research aims to provide a rich description of people's perception of empowerment within the current structure of DSS in New Zealand. Such an approach would require in-depth case studies to reveal individual life experiences. Disability research has been dominated in the past by a positivist paradigm and such research findings were used subsequently to design disability support services.

We are interested in the meanings attributed to disability support services by various people and groups of people. It is not possible to achieve an objective, value-free position from which to evaluate the truth of the matter (Barnes, C. & Mercer, G., 1997). Facts are always value-laden, and researchers have their own values reflected in their research. Even though survey research can provide overall measures of different dimensions of service provision

within disability support services, it fails to reveal the personal circumstances of individual lives.

The positivist methodology attempts to view disabled people and their circumstances from a non-involved stance, with no awareness of their own perspectives. Such an approach tends to be based on objectivity, and such a view provides a fundamental attitude or mind set which enables the researcher to investigate disability from a 'value free' perspective. Such a framework led to the establishment of the view that researchers are 'experts'. The main features of such an approach are: a) there is only one 'truth' and it needs to be discovered; b) it promotes factors such as 'reliability' 'validity' and generalizability; and c) it requires no input from the researcher to enter into the research process. Many authors question such an approach to studying any social phenomena since it ignore contexts which influences people's lives.

As we are interested in the meanings attributed by various people and groups of people to disability support services, it is thought that a positivist approach will provide a partial picture of disability issues. A more interpretive approach would allow the researchers to listen carefully to how people interpret their worlds and give meaning and significance to their daily activities.

The researchers were fortunate to be welcomed into the organisation and were allowed to accompany service assessors in order to observe assessment procedures. This organization, known as the Managed Access to Integrated Services (MAIS), was established in 1996 as a 'one-stop' shop where peoples' needs could be assessed and services offered. In total, ten assessments were attended. These personal lived experiences with the clients within their home environment enabled the researchers to glean insights into experiences with disability. Following these assessment interviews, we carried out a series of semi-structured interviews with the assessors. The interviewees were given a set of questions as a basis for discussion, but they were also encouraged to provide their opinions on any other matters if they wanted to. The assessors were encouraged to reflect on their personal views of the assessment procedures. It was felt important to listen carefully to the clients, because the whole process was designed to offer a better service for their needs. The aim was to accompany assessors on successive visits to undertake needs assessments of clients. In particular, it will be explained

that 1) we wish to be observers at the assessment procedure, and 2) we will seek clarification from assessors about the support that they recommend, what ideally they would like to recommend, and what they do recommend in practice.

EMPOWERMENT AND DISABILITY SUPPORT SERVICES

Since the introduction of the Health and Disability Service Act 1993, changes in the New Zealand health sector have concentrated on efficiency gains and better utilisation of resources (Lawrence et al., 1997). The social policy changes in the early 1990s were underpinned by neo-liberalist ideas that the state should provide no more than a modest safety net for those who are unable to meet their own needs (Shiple, 1991). The reform was seen as a part of a broader scheme whose aim was to dismantle or fundamentally redesign the welfare state in New Zealand (Kelsey, 1996). Inherent in these social policy changes was a schema set by government to reduce public sector expenditure from about 40% of GDP in 1984 to about 35% in 1998. This implied drastic cuts in government expenditure on social welfare, health, and education.

Consistent with neo-liberal ideas, market mechanisms was used to introduce an element of competition between health service providers. Instead of health care being provided solely by the state, the reform suggested a pluralistic approach where different groups would share responsibilities for the provision of health care. Health care services were provided through community-based care services, which significantly changed the nature of disability support services from direct provision to organisation of services (Hodge, 1996). The reform also recognised individual rights by which disabled people can make choices as to what they want to purchase and on what terms. This line of thought closely parallels what disability rights activists have been lobbying for over a long period. The shifts identified are often presented as unproblematic.

DSS was restructured through de-institutionalisation programmes and the development of community care networks. Prior to such reform DSS was provided in a fragmented way, different aspects of services were assessed by at least three organisations, such as the Department of Social Welfare, hospitals and disability institutions, and the Area Health Board. A number of institutional reforms were undertaken to provide access, participation, and empowerment within an integrated rehabilitation program.

Health sector reform in New Zealand promoted a community-based care for disabled people, as compared to institution-based care, and it introduced a market environment for the provision of services. The premise of the market is that it is supposed to provide accessible and appropriate support services in a flexible manner. In this part, therefore, we will evaluate the principles of the market environment and see how these principles can provide empowerment to disabled people, because we know that to be empowered under a market model disabled people need to know what services are available, where these services are available and at what price.

EMPOWERMENT UNDER DISABILITY SUPPORT SERVICES

Empowerment is usually seen in terms of choice and control where individuals can exert choice and hence maximize control of their own situation. Research has shown that, for disabled people to be empowered, they must experience a sense of choice in developing their own support plan. DSS needs to be organized to ensure a properly integrated support network, where recipients can exercise their choice to perform their activities in ways that seem appropriate. Most definitions of empowerment are based basic principles of access, choice, information and representation. This paper seeks to examine how disabled people perceive their interactions with DSS systems as consistent with empowerment principles and it investigates specific issues, such as service design, access to information and services, and flexibility of services. Even though these principles are the cornerstones of empowerment, operationalisation of these principles is dependent of financial resources. Without adequate allocation of funding into disability support services appropriate services may not developed and introduced so that the disabled people can choose between services. This paper adopts resource allocation perspectives to evaluate the significance of empowerment principles.

EMPOWERMENT AND DISABILITY SERVICES

The empowerment model sees services as designed in such a way that they meet the needs of disabled people. In the past, these services were designed from the perspective of providers and from a budget focus. The empowerment focus highlights the importance of choice and

flexibility. So there is a need for close cooperation between service users and service providers. The close connection between these two groups is shown below.

	Empowerment	Service Provision
Involvement of disabled people	<p>Better service design</p> <p>Disabled people can be involved in the design of services based on their needs</p>	<p>Service providers become aware of the needs of users</p> <p>They seek to develop services that are beneficial to users</p>
Performance Evaluation	<p>Better control over service performance</p> <p>Evaluate service performance from the disability needs, such as access, information and quality</p>	<p>Uses performance measures from both financial and customer needs</p>

Table 2: Empowerment and service design

Service design under the new systems is supposed to offers a radical change to the design and delivery of services for disabled people. Under this system service users are not considered as passive recipients of services, but as active participants in the design of support services. As they become more involved in the design stage, they can prioritize their needs and hence improve resource allocation in the DSS sector. Such a DSS design is supposed to empower service recipients since they are no longer passive recipients of services.

Even though the empowerment framework takes the view that services need to be designed by identifying consumers’ preferences, disabled people considered that they had little control over their own future well-being because services were offered without proper consultation. DSS provision remained the same, especially where service providers either offered a specialised service or where there was no other service provider. The following quote comes from a mother of a disabled son:

We need to know what services are available and there has to be a choice of services. As most of the services are in short supply the service providers make decisions about services with little or no consultation with them. As such, service providers do not consider disabled people who should be involved in service design.

Our options are restricted and influenced by the services which are offered in the locality. These services are offered in an inflexible way. The whole approach seems to me is designed to fit us into the existing services rather than producing services around our needs (a disabled person).

To be empowered within the market model, service recipients should have choice. However, marketisation has developed homogeneous services through packaging services. As a result, only certain categories of services are offered, irrespective of the fact that there are different needs. The present service design model virtually remained the same as under the previous system. A disabled person commented:

Even within the home services there are two providers and they are holding contracts with Health Funding Authority. These two agencies provide almost identical services and cover a wide geographical area. If you ask for services which they don't provide, it is most likely that you will have arranged privately.

In some cases certain services were not offered. The mother of a disabled child commented:

I was adamant that Michael needed speech therapy; however, as this service was in short supply, the assessor thought he needed more home care rather than therapy. He is at home, going further and further actually into depression.

The empowerment principle also states that services should be accessible and that clients should be provided with full information as to where services are available. In the past, disability services were dictated by professionals and structured according to their own rules – and often for their own convenience. As discussed previously, disabled people find problems in accessing services at two levels: firstly, information about services is not available, and secondly, services are not available in their local community.

Given the changes in the health sector in New Zealand, it is often difficult for the disabled people to know how the disability support services are structured and their entitlement to resources. Adequate information can be useful for making informed choices as to options, restrictions and service availability in the community. Disabled people need clear and detailed information about service availability to gain access to different services. As part of the reform process, MAIS was established to make sure that service recipients could get all information from one point of contact. Access to services can depend on information about the availability of services. Information on aspects of service delivery is useful, including: a) Are they services that meet universal accessibility guidelines? b) How are services delivered?

c) How can different services be packaged and delivered within the system? And d) how can auxiliary aids and services be accessed? Even though MAIS is supposed to provide most information on services, one respondent commented:

I think MAIS is pretty good in providing information and producing publicity materials accordingly. However, I have experienced that such information is one-sided i.e., what you can get. There is paucity of information from providers and I found out information that might be relevant to me by talking to others.

Another person also expressed similar views:

A lot of agencies such as, MAIS produce nice glossy brochures which explained all these wonderful services available but actually they were simply glossy brochures and nothing ever happened.

Indeed, information takes on an even greater importance in the public sector, because the services at stake are likely to be crucial to consumers' welfare, and because the imbalance in the amount of information possessed by providers and consumers is often so wide. Information can provide real power to disabled people in influencing change and in making informed decisions. The respondents highlighted the importance of accessible and up-to-date information as a basis for taking appropriate decisions on support services. Various respondents commented as:

I did not find service providers as useful source of information. Whenever I enquired about certain services they just told what they offered. They had little information about related or other alternative services offered by other providers. Moreover, in certain instance, I found that they often provide misleading information.

I tend to know about services not from official sources but from 'the grapevine'. I think it is the responsibility of service coordinators to give us the full picture. In the end, I have to find out everything for myself (another service recipient).

In general, the respondents found that such a reliance on grapevine for getting vital information was effective but stressful.

Access to services is deemed to be essential for disabled people so that they can integrate within the community. Access to services can be seen whether the disable people can access to certain services. The consumer principle of access is clearer when consumers can gain access to certain goods or services in a market situation where it works on a pricing mechanism. However, in public services such a connection between payment and right to receive cannot be automatically translated as those of who pay for public services and those who receive services are not necessarily are the same people. The empirical evidence from

respondents suggests that service recipients have little involvement or understanding on how service are rationed. The other aspect of access can be seen from the point of view of accessibility to services. Public services are often viewed as not user friendly and organized in such a way that the disable people can easily access these facilities. They are mostly organized and offered at the discretion of service providers. An empowerment-driven support services need to be accessible either on a single plan basis that includes a point of service option for the disable people to choose where to access disability services or giving them a choice of disability service plans. Since most of the time services are not available within the community, access to services can only be arranged by transporting service recipients to other locations. One assessor commented:

Travel is a big that can often stop people doing a lot of things is access. We always talk about taxi vouchers, if people are having difficulty with mobility, which is half-price taxi fares, but you can get other situations because of market rentals, there is no money left over for lots of social things and so you might see a real need for someone.

As it is difficult to move disable people to different service locations, there have been cases where inappropriate services were provided. The service administrators in such situations try to accommodate different services within the existing services available. An assessor commented:

It is just not acceptable that 32-year-old man is put in a rest home with 70, 80 and 90-year-old people. The level of funding that we apply to keep people in their community would cost us more to create facilities if certain services do not exist in the community. We tend to either move them where such facilities are available or put them to existing facilities, even if they are not appropriate.

Community-based disability care has the potential to offer flexibility of service for the different needs of individual clients. Service providers in the past were insensitive to the demands of their clients and made important decisions about services with little or no consultation with disabled people. Empowerment implies that successful integration within community requires a range of assistance and services for disabled people. However, creative support design requires proper consultation and adequate funding. Present funding arrangements are not designed to offer flexibility in designing support services. One health official commented:

We set our criteria in conjunction with the allocated funds and we have an assessment process for allocating services. A disabled person might come and may be quite disabled, we look and say we can fund x amount of dollars based on the guidelines.

Given that budgets are cash-limited this has made it difficult to design creative services. Each individual client's needs are so varied that the capping of the budget means that only limited services are offered. One assessor explained:

We don't have the money to offer a full range of services. We are focused on essential need rather than desired need, and people with disabilities are very strong advocates for saying that their desired needs aren't met, and I believe they are not, because I see there being quite two different needs. I see there being the essential need. But I see that there is a desired need and people with disabilities, a lot of time, can't have their normal life because the funding isn't there to do that, but I just think that that is how life is.

Disabled people were found to be apprehensive and one service recipient commented:

I have little control over what happens in our lives. I consider my future well-being is unpredictable and this makes me nervous.

The present DSS does not treat different types of disabilities. For example, it does not differentiate older and younger disabled people. While older people may have only limited needs for services, such needs may vary markedly for a younger disabled person. Another assessor explained:

People under 65 with disabilities do not believe they are sick It is easier to fit the over-65s into this budget, as there is no vocational stuff, there is no educational stuff, there is just generally a situation where they are either living alone or with a spouse, and generally speaking it is just a maintaining of their standard of living. With the under-65-year-olds, there is so much that actually happens that is really different. It is a maintaining of the family, it is keeping marriages together; it is making sure that other siblings or children with disabilities are not missing out. It is maintaining a normal lifestyle for the young man of 32 who lives alone and has a severe disability.

CONCLUSION AND DISCUSSION

The empowerment framework has been viewed in terms of choice and control, where individuals can exert choice and hence maximize control of their own situation. This paper has focused on how disabled people experience various dimensions of empowerment, such as choice, so as to develop their own support plan and participation in the decision-making process. As such, empirical evidence were sought to examine how disabled people perceive their interactions with DSS systems, consistent with empowerment principles, and we looked into specific issues such as service design, access to information and services, and flexibility of services.

This paper examined two issues. The first issue was to consider whether the nature of participation and empowerment provided within the New Zealand model were merely procedural or they led to substantial control over economic resources and programs that determined material well-being for disabled people. The second issue was to evaluate the nature of service design and service availability from resource availability and empowerment perspectives. The rhetoric of empowerment created an impression that disabled people were given real access to services and resources for developing their potential. It appeared from the case evidence that disabled people were unable to participate in decision making, neither in processes nor through consultation about service design and delivery. Rather the whole process was dominated by capped budgets and reduced state involvement in creating support structures at the community level. Full inclusion presupposes the existence of fully funded, accessible and appropriate support services. In a market environment, where words such as 'consumer', 'choice' and 'flexibility' are frequently used, one could gain the impression that a wide range of disability support services is fully available to those who need them.

Empowerment issues were considered from service design, access to information and services, and flexibility of services perspectives. To be empowered within the market model, service recipients should have choice and they should be involved in the design of service. As discussed in the literature section, service design was influenced by health professionals. Based on medical assessment, a professional determined the type of services for disabled people. The empowerment framework sees disabled people as taking an active role in deciding and designing services according to their requirements. However, the empirical evidence suggests that services in the disability sector were made homogeneous and standard packages were developed. As a result, only a certain category of services are offered, irrespective of the fact that there are different needs. Disabled people were not involved in either the design or the delivery of services. The whole process of empowerment was dominated by managerialist principles of budgeting, assessment criteria, and rationalization of services.

The empowerment principle also states that services should be accessible and that clients should be provided with full information as to where these services are available. In the past, disability services were dictated by professionals and structured according to their own rules, and often for their own convenience. Here too, the empirical evidence suggests that disabled

people were not given any choice of suppliers. Rationalization of services may mean only limited services through a single supplier, and in some cases these services were not offered in the community even so. Again, we see that managerialist principles are at work and the intention of promoting empowerment was not given any real meaning for disabled people.

Community-based disability care has the potential to offer flexibility of services for the different needs of individual clients. Service providers in the past were insensitive to the demands of their clients and made important decisions about services with little or no consultation with disabled people. Empowerment implies that for successful integration within community a range of assistance and services for disabled people is required.

Based on the empirical evidence the following conclusions are reached:

- a) The empowerment concepts are superficially conceived in the reform process and such concepts are hardly put into practice. Rather it appears that many services, once offered on the basis of needs, are not tested according to meaningful selection criteria. There is a feeling among service recipients that the real intentions of the empowerment agenda are quite different from the stated purposes. Some believe that if people are empowered, they will make fewer demands on the welfare sector. The empowerment framework is commendable, but it breaks down where the system does not allow flexibility of service choice and participation in service design.
- b) The concept of empowerment within the current environment can be interpreted from motivational and manipulative perspectives. With the abolition of institutional care the language has been focused on participation and choice. However, as the empirical evidence suggests, we need to see such concepts as problematic. It is also perceived as a manipulative strategy to confuse disabled people with consumer-oriented market values of New Right policies in public service. It is questionable whether market principles can be applicable to social services.

- c) The present resource allocation system fails to deliver any meaningful entitlement to disabled people. It is clearly important to disabled people that an appropriate level of resources is allocated to create a support structure at the community level.
- d) There can be some confusion between procedural rights and financial resource allocation. Procedural participation, such as a right to a fair hearing, to information on the rationale for decisions, and to complaint, redress and appeal mechanisms may provide some comfort to disabled people. However, these rights do not have positive implications that will satisfy disabled people's substantive needs. Unless more resources are provided, such procedural empowerment can make little sense. Assessment systems have the potential to reduce rights to tightly circumscribed needs within a system that delivers what is economically feasible. Restrictions on resources means that rights are often denied and that needs will frequently not be met. It is all very well to have an elaborate assessment system. Assessment systems for disabled people force them to justify their difference in order to get services. In having to do this disabled people are disempowered, put on the defensive once again by having to prove the right to need.
- e) Inherent in the process of empowerment is an expectation that service recipients will be independent through self-help and community-based aid organizations. The state sector provides a minimum range of services and any unfulfilled needs are left to the community to supply. There is a limit to the extent to which local communities can actually support a wide range of services without government support.

Our study has focused on understanding the empowerment principles that allow disabled people to be involved in the decision-making process. Future research can adopt a similar framework to see whether similar observations can be made in other social welfare areas. Such studies may shed further light on the research issues explored here. It would be interesting to see how empowerment principles are perceived by service recipients in other welfare areas.

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