Resource allocation and empowerment practices
Evidence from disability support services

Manzurul Alam
Murdoch University, Murdoch, Australia, and

Stewart Lawrence
University of Waikato, Hamilton, New Zealand

Abstract

Purpose – The purpose of this paper is to explore 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 people with disabilities so that they can lead independent lives in their communities.

Design/methodology/approach – Taking a qualitative and interpretive approach to fieldwork, this research seeks the actual lived experiences of the disabled as recipients of services offer by the state.

Findings – The empirical evidence suggests that a concept such as empowerment can be 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.

Originality/value – This paper adds to the understanding on relationships between service design, resources, and empowerment practices. Implementation of empowerment principles, however, depends on resources to create a support structure at the community level and an atmosphere where there is choice and flexibility for people with disabilities to access essential services.

Keywords Empowerment, Public sector organizations, Disabilities, New Zealand

Paper type Research paper

Introduction

New Zealand is renowned for its social experimentation. New Zealand was the first country to have a comprehensive social welfare programme for the poor, the sick, and the elderly, but also the first to start dismantling the social welfare edifice and "get government out of people's lives" (Russell, 1996). The reforms of the 1980s and 1990s saw a transformation from a welfare state to a civil society (Bagenstos, 2003; Roulstone, 2000; ACOSS, 2001; Green, 1996; Hudson and Henwood, 2002). 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 (Shipley and Upton, 1992). There was a concerted effort to dismantle and fundamentally redesign the welfare state in New Zealand (Kelsey, 1991). This implied drastic cuts in government expenditure on social welfare, health, and education. The basis of the new order was to be self-reliance and the removal or reduction in support for those less advantaged. Caught up in the reforms were the disabled; like everyone else they were expected to be independent and self-reliant. This paper examines the attempt to "empower" the disabled to lead self-directed, independent life-styles.

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 utilization of resources (Lawrence *et al.*, 1997). The overall thrust of such changes was to introduce market disciplines, underpinned by an increased emphasis on efficiency gains. The rhetoric surrounding the reform process also included concepts such as greater customer choice, empowerment, and self-determination (Boston, 1995; Southon, 1996). The changes that took place were not necessarily to the disadvantage of the disabled, and were seen as allowing a greater autonomy of decision making in a less paternalistic state. It was in line with the general drift of policy in health. Reasons given by the NZ Ministry of Health for the reforms of 1991-1993 were to:

- promote better health;
- create a people centered approach;
- improve safety;
- induce better and fairer access to services;
- produce services more targeted to needs;
- increase output for the money spent; and
- improve risk and financial management.

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 heath care (Bruegel, 1998; Lawrence *et al.*, 1997). The reform also recognized 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 had been lobbying for over a long period of time (Hales, 1996). In this remodeled approach to health service provision, empowerment can be seen as a vehicle to enhance a sense of autonomy and potential for independent living for people with disabilities (Zimmerman, 1990; Dempsey and Foreman, 1997).

The main objectives of this paper are first to evaluate the nature of service design and service availability from budgeting and resource availability perspectives; and second, 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 well-being of people with disabilities.

The paper is organized as follows. The next section presents the methodology based on a qualitative approach. The context for the reform of support services and the institutional framework for the provision of services are then described. The various perspectives on empowerment within health are reviewed before the empirical evidence is presented. Finally, the findings from the research are discussed and conclusions drawn.

Approach and methodology

In the past, disability research tried to understand disability experiences by objective means and such research findings were used subsequently to design disability support services (DSS). Here, in contrast a qualitative, interpretive approach is adopted.

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 requires in-depth case studies to reveal individual life experiences.

The positivist methodology attempts to view people with disabilities and their circumstances from a non-involved stance. Such an approach claims "objectivity", a fundamental attitude or mind set which allows the researcher to investigate disability from a "value free" perspective. Such an approach tends to view researchers as independent "experts". The main features of such an approach are: that there is only one "truth" and it needs to be discovered; it promotes factors such as "reliability" "validity" and generalizability; it requires no subjective input from the researcher in the research process. Such an approach may be problematic in studying any social phenomenon since its search for generality tends to ignore the complex, possibly idiosyncratic, historical, and social context which influences people's lives.

We are interested in the meanings attributed to DSS by various people and groups of people. In this approach it is not possible to achieve an objective, value-free position from which to evaluate the truth of the matter (Barnes and Mercer, 1997). The World Health Organisation (2000) report on disability classification also expressed the need for interpretive and qualitative research. 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 DSS, it fails to reveal the personal circumstances of individual lives.

As we are interested in the meanings attributed by various people and groups of people to DSS, it is thought that a positivist approach would provide only a partial picture of disability issues. An interpretive approach has the advantage in that it allows the researchers to listen carefully to how people interpret their worlds and give meaning and significance to their daily activities.

Various researchers have focused on different dimensions of empowerment ranging from process, component, and outcomes of empowerment (Conger and Kanungo, 1988; Zimmerman and Rappaport, 1987; Simon, 1990; Zimmerman, 1990; Dempsey and Foreman, 1997; Kalyanpur and Rao, 1991). In broad terms, empowerment can be seen from psychological and material aspects. While psychological empowerment focuses on freedom to choose and control of one's life, the material aspects focuses on the accessibility of essential services to change one's life (Shor and Freire, 1987). We shall argue here that material and psychological aspects are complementary to each other. A material aspect can be important as it provides resources and services for developing the full potentiality of people with disabilities, which ultimately helps to build-up the psychological empowerment. It is questionable whether it is possible to feel free without fulfilling one's basic necessities. Empowerment can be achieved by providing facilities and creating support structures in the community setting where support services are designed in collaboration with people with disabilities. In this paper, we intend to explore the concept of empowerment as applied in the current discourse of heath sector reform and critically analyze how such concepts are perceived by people with disabilities.

The researchers were fortunate to be welcomed into a disability support provider organization 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

people's needs could be assessed and services offered. Prior to the establishment of MAIS, needs assessment and service coordination was provided by various organizations, such as the Area Health Board, the Department of Health and the Department of Social Welfare. As these organizations used to specialize in specific services, people with disabilities found it difficult to get a full range of services and satisfy their total needs. The MAIS was mainly responsible for conducting needs assessment and service coordination functions. Apart from regular four assessors, the MAIS also contracted a dozen assessors with specialized skills to deal with different types of disability needs (see WHO, 2000, for disability assessment schedule). Once the assessments were completed, the MAIS was responsible for service coordination and these services were purchased by the Area Health Board. The MAIS was organized into three sections and these were assessment, service coordination and equipment hire. In total, ten assessments were attended. These individual 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 four semi-structured interviews with the assessors. The aim was to accompany assessors on successive visits to undertake needs assessments of clients. In particular, we stated a wish to be observers at the assessment procedure, and indicated we would seek clarification from assessors about the support that they would like to recommend, and what they do recommend in practice. In addition to interviewing the assessors, each of these ten assessments was investigated by interviewing the clients to understand their perception of the assessment and service coordination process. 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. 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.

Context – institutional framework

The DSS in New Zealand 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. The rationale of the DSS reform was promotion of empowerment for people with disabilities so that they could choose the services that best suited their particular circumstances (Ministry of Health, 2000a, b, 2002; Sullivan and Munford, 1998). Such an environment is viewed as conducive to people with disabilities feeling more confident and gaining competence in problem solving (Adams, 1990). An earlier research by Thornton and Lunt (1997) reviewed disability issues of eighteen countries in terms of disability policies, legislation and services. Even though New Zealand was not among the eighteen countries, the New Zealand the Health and Disability Services Act 1993 and 2000 (www.legislation.govt.nz) showed similar changes.

This paper specifically examines the nature of empowerment within the current DSS framework from resource allocation perspectives. A resource focus is important since it is often recognized that establishment of empowerment-based care may worsen the well-being of people with disabilities if appropriate resources and facilities are not created at the community level. People with disabilities 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, it is argued that better results can be achieved if full disclosure is made on the availability of funding and a joint decision-making process is undertaken recognizing budget constraints. Such an approach would require a system of budget disclosure and supported decision making, and a genuine flexibility in the utilization of resources. Without economic improvement and better utilization of resources, people with disabilities may find it difficult to develop all aspects of their lives.

Empowerment and decision making

Empowerment is an abstract concept and may have different interpretations and meanings for various participants in discourse and in practice. 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. Critical theorists often see empowerment in terms of oppressive relationships and power imbalances. Such imbalances are moderated by relocating decision-making power to those who are oppressed (Zimmerman and Rappaport, 1988). 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).

A widely accepted interpretation is that disability is multi-faceted and socially constructed. Various dimensions need to be taken into account in understanding service provision, 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 people with disabilities so that they can improve their lives.

An argument in favor of the recent health sector reform was that previously 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 people with disabilities (Lawrence and Alam, 2000). Resource allocation and policy decisions were taken in a bureaucratic manner. Such a basis of service provision was deemed unsustainable because of inherent problems with public sector inefficiency (Alam and Lawrence, 2007). 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 DSS, such reforms introduced de-institutionalization of disability services in favor of community-based supported living. A new discourse of participation and empowerment has entered the vocabulary of service delivery functions for DSS. With the dismantling of professional- and medical-based support services, neo-liberalist ideals supported empowerment and client-centered support structures where people with disabilities would be integrated into communities. However, several critics have commented (Alam and Lawrence, 2007; Sullivan and Munford, 1998) that such a discourse on empowerment can be meaningless, unless

adequate resources are provided and support structures created that meet the diverse needs of people with disabilities. To understand and evaluate different modes of service delivery in the disability sector, it is necessary to make explicit how different paradigms view disability and support services.

The traditional approach to disability, often referred to as the professional and medical model, emphasizes disability as an individual deficit (Manford, 1994; Oliver, 1990). 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 people with disabilities by offering medical treatment and therapies after a process of identifying the nature of the disability. Within this approach, people with disabilities could be prescribed different levels of services to take care of specific aspects needs but there was no attempt to satisfy the needs 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 (Chenoweth, 1997; Davis *et al.*, 1997).

The managerial models of empowerment tend to move from the position of a negative stereotype view of disability to a position where people with disabilities are included in society as valued individuals (Oliver, 1990; Manford, 1994). The managerial approach to DSS 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 criticized, because service provision is often influenced by financial constraints. They fail to address issues of fairness and personal choice. In the private sector the pricing mechanism provides a signal for the quality of services. Such signals are absent in the public sector and the managerial model tries to maximize the use of the budget allocation by offering a minimalist, cost-constrained service. (Table I).

	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 perspective of 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 considered by people with disabilities
Resource allocation	Patient and treatment focused	Budget focused	Consultative resource allocation and utilization

Table I.
Disability service design from three perspectives

The empowerment model places disability within the social context where people with disabilities can take an active part within the community environment. Such a view projects disability as socially constructed. Unlike the medical model of disability, where the medical profession holds considerable influence over the lives of people with disabilities, the social model emphasises their "having a voice" (Manford, 1994). It assumes people with disabilities can be involved in decision making about their lives rather than passively accepting services as diagnosed on the basis of their disabilities. Such active involvement in decision making usually involves regular consultation with people with disabilities in making the social policies affecting the lives of people with disabilities.

The professional, managerial, and empowerment models differ conceptually on how assessments and resource allocations can be made. 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 allocation is critical since no meaningful planning can be done without the creation of a support structure, which depends on funding levels.

Provision of disability support services in New Zealand

Consistent with neo-liberal ideas, in New Zealand market mechanisms were 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 to be provided partly through community-based care services. This significantly changed the nature of DSS from direct provision to organization of services. The reform also recognized individual rights by which people with disabilities 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-institutionalization programmers and the development of community care networks. Prior to such reform DSS was provided in a fragmented way, with different aspects of services assessed by at least three organizations, 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.

Reform in New Zealand promoted community-based care for people with disabilities, 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 the following sections, therefore, we will evaluate the principles of the market environment and see how these principles can provide empowerment to people with disabilities, because we know that to be empowered under a market model people with disabilities need to know what services are available, where these services are available and at what price.

Empowerment from resource allocation perspectives is useful as it deals with activities and processes to help individual's have control over his/her life. Research has shown that, for people with disabilities 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 on the basic principles of access, choice, information and representation.

The following sections seek to examine how people with disabilities perceived the DSS systems 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, operationalization of these principles is dependent on financial resources. Without adequate allocation of funding into DSS appropriate services may not developed and introduced so that the people with disabilities can choose between services.

Evidence

Service design under the new systems is supposed to offer a radical change to the design and delivery of services for people with disabilities. 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. The empowerment model sees services as designed in such a way that they meet the needs of people with disabilities. Under the new system service users are not considered passive recipients of services, but active participants in the design of support services. The intention remains that as they become more involved in the design stage, they can more effectively 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.

People with disabilities require community-based support structure as per their needs. Fulfillment of these needs is necessary for them to be independent. Some changes were introduced in the areas of assessment and service coordination by decoupling the assessment function from the service provision function. However, most of the respondents found that such changes were negligible and introduced more restrictions. In a quasi-market arrangement, how are the needs/wants of the disabled to be ascertained? Services are offered to people with disabilities though an assessment process. The assessment consisted of going through an extensive questionnaire with the respondents, a process lasting about an hour and a half. The potential recipients of services were encouraged to express their needs and desires. It was intended that the assessment process brought some objectivity and transparency to the assessment so that services could be offered to suit individual needs. In theory, such a process decoupled assessment from service offerings. However, in practice, as financial resources were constrained, it was impossible to offer a complete range of activities based on client assessments; rather certain established services were supported though flexibility was the aim. Some service recipients saw such an approach as merely a hollow promise. One disabled person commented:

> We had to go through a sixteen page assessment criteria. Instead of assessing our total needs such a process tried to see whether we were ineligible for some services.

The assessment process was designed to achieve a number of outcomes to promote empowerment among people with disabilities. A decoupling of assessment process

service delivery was supposed to create an opportunity for creative service design in close collaboration with people with disabilities. Such an activity was considered desirable to promote an active participation on the part of people with disabilities. However, evidence here suggests that such intentions were far from the realities faced by service recipients. Another disabled person commented:

> The support services are mostly contracted to service providers under some budgeted formula. We don't have any involvement with the service providers in deciding what services are needed and how they are offered. I have seen many providers withdrawing services either because there are funding restrictions or it is not economical for them to offer these services. Instead, they are offering services which are popular.

Even though the empowerment framework takes the view that services need to be designed by identifying consumers' preferences, people with disabilities experienced 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 specialized 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. 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 be designed to fit us into the existing services rather than producing services around our needs (a disabled person).

To be empowered within the quasi-market model, service recipients should have choice. However, mercerization 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 new 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 the 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 to arrange them privately.

Another disabled person viewed:

> Whilst services are in short supply, certain services, especially for the young children and young adults, are far scarcer. The present system caters only for home support in a limited sense and it is not responsive to the total need of a person.

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 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, people with disabilities find problems in accessing services at two levels: first, information about services is not available, and second, services are not available in their local community.

Given the changes in the health sector in New Zealand, it is often difficult for people with disabilities to know how the DSS 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. People with disabilities 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:

- Are there services that meet universal accessibility guidelines?
- How are services delivered?
- How can different services be packaged and delivered within the system?
- How can auxiliary aids and services be accessed?

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 a paucity of information from providers and I found out information that might be relevant to me by talking to others.

Another person expressed similar views:

> A lot of agencies such as MAIS produced 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 very wide. Information can provide real power to people with disabilities 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:

> I did not find service providers a useful source of information. Whenever I enquired about certain services they just told me what they offered. They had little information about related or other alternative services offered by other providers. Moreover, 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 "the grapevine" for getting vital information was effective but stressful.

Access to services is deemed to be essential for people with disabilities so that they can integrate within the community. 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 the same people. The empirical evidence from respondents suggests that service recipients have little involvement or understanding on how services 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 neither user friendly nor organized in such a way that the people with disabilities can easily access these facilities. They are mostly organized and offered at the discretion of service providers. An empowerment-driven support service needs to be accessible either on a single plan basis that includes a point of service option for the people with disabilities 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 issue that can often stop people doing a lot of things. We always talk about taxi vouchers if people are having difficulty with mobility, which is half-price taxi fares, but there are restrictions on the use of these vouchers. If we spend money to services out of the area, there is no money left over for lots of social things.

As it is difficult to move people with disabilities 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 a 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 people with disabilities. Empowerment implies that successful integration within community requires a range of assistance and services for people with disabilities. 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 the 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.

People with disabilities 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 offer appropriate differential treatments for clients with different types of disabilities. For example, it does not differentiate older and younger people with disabilities. 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.

Several participants in this study considered the overall service design and service offerings remained unchanged. They felt that their needs were not satisfied and they had little control over the future well-being of their lives. One elderly person commented:

On the surface it appears we have lot of involvement and power to choose from different service options. All office documents promise a lot in this area and show a variety of options for us to be involved. In reality we are not involved in the process and all we hear from official is the lack of funding. I think our future is uncertain and don't know what is coming next.

While the health sector reform promised to provide choice and control where individuals can exert choice and hence maximize control of their personal situations, research has showed that people with disabilities found that support services mostly remained unchanged and provided little opportunity for engaging in the service design process. As the health funding structure facilitated existing DSS, empowerment options tend to be considered by people with disabilities as merely an official intention and publicity device.

Discussion and conclusion
The empowerment framework has been viewed in terms of choice and control, where individuals can exert choice and hence maximize control of their individual situations. This paper has focused on how people with disabilities experience various dimensions of empowerment, such as choice, so as to develop their own support plan and participation in the decision-making process. Empirical evidence was sought to

examine how people with disabilities 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 considered was whether the nature of participation and empowerment provided within the New Zealand model were merely procedural or whether they led to substantial control over economic resources and programs that determined material well-being for people with disabilities. It was argued here that the nature of resource allocation in DSS has a number of consequences as it helps alleviate other dimensions of empowerment such as availability, access and design of support services. Availability of resources is considered to be helpful in creating a supported environment where people with disabilities can develop their full potentiality. 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 people with disabilities were given real access to services and resources for developing their potential. It appeared from the case evidence that people with disabilities 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 DSS 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 people with disabilities. The empowerment framework sees people with disabilities 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 certain categories of services were offered, irrespective of the fact that there are different needs. People with disabilities 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 people with disabilities 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. Again, we see that managerialist principles are at work and the intention of promoting empowerment was not given any real meaning for people with disabilities.

Community-based disability care has the potential to offer flexibility of services for the different needs of individual clients. In the past when the same organization was responsible for assessment and service provision, services were offered with little choice as in most cases there was only one provider. The reform process was meant to improve this situation. Empowerment implies that for successful integration within community a range of assistance and services for people with disabilities is required.

It is possible that full information on resource availability can lead to better decision making on the part of people with disabilities. 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 of partial services to a large number of people with disabilities. Empowerment models make sense, however, 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 resource availability can be useful in deciding what is feasible and how different services can be arranged. We set out 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. 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 as a means of introducing market values into public services. Empowerment in disability aims to involve people with disabilities 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 people with disabilities 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 operationalized.

Based on the empirical evidence the following conclusions are reached:

- 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.

- 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 people with disabilities with consumer-oriented market values and policies in public service. It is questionable whether market principles can be applicable to social services.

- The present resource allocation system fails to deliver any meaningful entitlement to people with disabilities. It is clearly important to people with disabilities that an appropriate level of resources is allocated to create a support structure at the community level.

- 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 people with disabilities. However, these rights do not have positive implications that will satisfy people with disabilities'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 some rights are often denied and all needs will frequently not be met. It is all very well to have an elaborate assessment system, but assessment systems for people with disabilities force them to justify their difference in order to get services. In having to do this people with disabilities are disempowered, put on the defensive once again by having to prove the right to need.

- 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 people with disabilities 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.

References

ACOSS (2001), *Australians Working Together – Listening to the Community*, Australian Council of Social Service Response, Strawberry Hills.

Adams, R. (1990), *Self Help Social Work and Empowerment*, Macmillan, Basingstoke.

Alam, M. and Lawrence, S. (2007), "Visibility of cost function in social care services: a study in New Zealand health sector", *Conference Proceedings of the European Accounting Association Congress, Portugal*.

Bagenstos, S.R. (2003), "The Americans with disabilities act as welfare reform", *William and Mary Law Review*, Vol. 44 No. 3, pp. 921-1036.

Barnes, C. and Mercer, G. (Eds) (1997), *Doing Disability Research*, Disability Press, Leeds.

Boston, J. (1995), "Origin and destinations: New Zealand's model of public management and the international transfer of ideas", in Weller, P. and Davis, G. (Eds), *New Ideas, Better Government*, Allen & Unwin, Sydney.

Bruegel, R.B. (1998), "The increasing importance of patient empowerment and its potential effects on home health care information and technology", *Home Health Care Management and Practice*, Vol. 10 No. 2, pp. 69-75.

Chenoweth, L. (1997), "Policy skills for human services", in O'Brien, P. and Murray, R. (Eds), *Human Services: Towards Partnership and Support*, Dunmore Press, Palmerston North.

Conger, J. and Kanungo, R.N. (1988), "The empowerment process: integrating theory and practice", *Academy of Management Review*, Vol. 13, pp. 471-82.

Davis, A., Ellis, K. and Rummery, K. (1997), *Access to Assessment; Perspectives of Practitioners, Disabled People and Carers*, The Policy Press, Bristol.

Dempsey, I. and Foreman, P. (1997), "Toward a clarification of empowerment as an outcome of disability service provision", *International Journal of Disability, Development and Education*, Vol. 44 No. 4, pp. 287-303.

Green, D.G. (1996), *From Welfare State to Civil Society*, NZ Business Roundtable, Wellington.

Hales, G. (1996), *Beyond Disability: Towards an Enabling Society*, Sage, London.

Hudson, B. and Henwood, M. (2002), "The NHS and social care: the final countdown?", *Policy and Politics*, Vol. 30, pp. 153-66.

Kalyanpur, M. and Rao, S.S. (1991), "Empowering low-income black families of handicapped children", *American Journal of Orthopsychiatry*, Vol. 61, pp. 523-32.

Kelsey, J. (1991), *Rolling Back the State*, Bridget Williams Books, Wellington.

Lawrence, S. and Alam, M. (2000), "Disability support services in a liberalised economy – a NZ case study", *International Journal of Public Sector Management*, Vol. 13 No. 3, pp. 186-205.

Lawrence, S., Alam, M., Northcott, D. and Lowe, T. (1997), "Accounting systems and systems of accountability in the New Zealand health sector", *Accounting, Auditing & Accountability Journal*, Vol. 10 No. 5, pp. 665-83.

Manford, R. (1994), "Reclaiming our rights to citizenship", *Social Work Review*, Vol. 6 No. 3, pp. 5-11.

Ministry of Health (2000a), *The Health and Disability Service Act 1993*, available at: www.legislation.govt.nz

Ministry of Health (2000b), *The New Zealand Public Health and Disability Act 2000*, available at: www.legislation.govt.nz

Ministry of Health (2002), *Future Funding of Health and Disability Services in New Zealand: Report to the Director General of Health, April 2002*, Ministry of Health, Wellington.

Oliver, M. (1990), *Politics of Disablement*, Macmillan, London.

Roulstone, A. (2000), "Disability, dependency and the new deal for disabled people", *Disability and Society*, Vol. 15 No. 3, pp. 427-43.

Russell, M. (1996), *Revolution: NZ from Fortress to Free Market*, Hodder Moa Beckett, Auckland.

Shipley, J. and Upton, S. (1992), *Support for Independence for People with Disabilities. A New Deal*, New Zealand Crown, Wellington.

Shor, I. and Freire, P. (1987), *A Pedagogy for Liberation: Dialogues on Transforming Education*, Bergin and Garvey, Granby, MA.

Simon, B.L. (1990), "Rethinking empowerment", *Journal of Progressive Human Services*, Vol. 1 No. 1, pp. 27-39.

Southon, G. (1996), "Health service structures, management and professional practice: beyond clinical management", *Australian Health Review*, Vol. 19 No. 1, pp. 2-16.

Sullivan, M. and Munford, R. (1998), "The articulation of theory and practice: critique and resistence in Aotearoa New Zealand", *Disability and Society*, Vol. 13 No. 2, pp. 183-98.

Thornton, P. and Lunt, N. (1997), *Employment Policies for Disabled People in Eighteen Countries: A Review*, Cornell University ILR School, York.

World Health Organisation (2000), *Disability Assessment Schedule WHODASII, II*, World Health Organisation, available at: www.who.int/classifications/icf/whodasii/en/ and www.who.int/classifications/icf/whodasii/en/

Zimmerman, M. (1990), "Taking aim on empowerment research: on the distinction between individual and psychological conceptions", *American Journal of Community Psychology*, Vol. 18, pp. 169-77.

Zimmerman, M. and Rappaport, J. (1988), "Citizen participation, perceived control and psychological empowerment", *American Journal of Community Psychology*, Vol. 16, pp. 725-50.

Further reading

Alam, M. and Lawrence, S. (1994), "A new era in costing and budgeting: implications of health sector reform in New Zealand", *The International Journal of Public Sector Management*, Vol. 7 No. 4, pp. 41-51.

Hood, C. (1992), "The new management model and its conception of performance efficiency", paper presented to the Public Sector Convention of the New Zealand Society of Accountants, Wellington.

Ministry of Health (2001), *The New Zealand Disability Strategy: Making a World of Difference Whakanui Oranga*, Ministry of Health, Wellington.

O'Brien, P. and Murray, R. (1997), *Human Services: Towards Partnership and Support*, Dunmore Press, Palmerston North.

Corresponding author
Manzurul Alam can be contacted at: m.alam@murdoch.edu.au