

SICKNESS AND INVALID'S BENEFITS: NEW DEVELOPMENTS AND CONTINUING CHALLENGES

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Abstract

The proportion of the working-aged population receiving an Invalid's Benefit (IB) has increased steadily between 1994 and 2004, and numbers on a Sickness Benefit (SB) rose sharply in the early 1990s and have continued to increase between 2000 and 2005. New Zealand has witnessed considerable policy activity in the field of SB and IB, as well as disability policy more broadly. To date, there has been relatively little attention paid by academic commentators to the increased emphasis on working actively with SB and IB clients. This is despite the fact that the new directions signalled for SB and IB constitute nothing less than a paradigm shift. At the heart of change is the move beyond individuals – beyond focusing on either *their* disability or *their* lack of motivation.

This paper outlines the package of measures aimed at reforming Sickness and Invalid's Benefits, including the underpinning rationales. It situates these changes within the broader context of both active labour market policy and disability initiatives. SB and IB reform is a wide and challenging agenda, but one with the potential to deliver important economic and social outcomes. The paper reflects on five fundamental issues that will influence the longer-term success of SB and IB interventions: the social model, issues of partnership, "healthy welfare", mutual obligation, and investment social policy.

INTRODUCTION

From the 1990s, a dominant theme of welfare reform focused on shifting from passive welfare delivery to "active labour market policy". The "active social policy agenda" challenges many of the traditional ideas held by social policy, such as the clear demarcation of life stages (i.e. study, work and retirement), or that policy could be

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built on traditional gender roles and family forms. Instead, there is recognition of the increasingly multiple and “hyphenated” nature of social and economic life:

Social policies that work need to fit these new realities. They need to place greater emphasis on investment in people in order to help them change their lives for the better, better nurture children, reduce benefits payments, social exclusion and poverty and create a more cohesive society. (OECD 2005)

Welfare policy is seen to require a better linkage with economic policy, as well as being in need of some “modernisation” to bring it in line with changed social, economic, demographic and attitudinal realities of the 21st century. A constituent of the realignment between economic and social policy has been the “work-first” approach to reducing poverty, and attempts to widen labour market opportunities as a route to fostering social inclusion.

The rise in numbers in receipt of disability benefits has been of shared concern for many Western governments, and has prompted greater policy attention being paid to those in long-term receipt of such benefits.² Measures have included reforming the benefit system and attempts to stimulate innovative service responses. Despite these aspirations, across the OECD, countries spend twice as much on disability related benefit programmes as they spend on unemployment (OECD 2003).³ More recently, an emphasis on reducing the numbers on disability rolls has been complemented by the growing awareness of the important influence of work on overall wellbeing (for example, the UK White Paper, Department of Health 2005).

New Zealand has witnessed considerable policy activity in the field of Sickness Benefit (SB) and Invalid’s Benefit (IB), as well as disability policy more broadly. The (velvet) revolution that has taken place around SB and IB must also be placed in the broader context of changes that have occurred in how “disability”, “disabled people”, “ability” and “capacity” are conceptualised. Under recent Labour-led governments, there have been significant developments across the field of disability policy and strategy. The first Labour term saw the launching of the New Zealand Disability Strategy *Making a World of Difference* (New Zealand Disability Strategy 2001). The Strategy was underpinned by a commitment to the social model of disability and was the result of lengthy consultation with the disability sector. The document’s 15 key dimensions include education, health, employment, rights and leadership. It makes a broad commitment to a non-disabling society, and addresses the participation of particular target populations within the broader disability community.

2 For example, in Britain numbers on the “Incapacity Benefit” are up 300% since 1979. While there have been steep falls in the number of new claims, most have been on the benefit for a very long time, and are very detached from the labour market.

3 In July 2005, the OECD began to undertake a new thematic review on the reform of OECD countries’ sickness and disability policies.

One of the key differences between policy before and after 1999 within New Zealand has been the gradual move towards a social model of disability. The social model draws the distinction between ideas of "impairment" and "disability" (Oliver 1990). "Impairment" can be understood as a functional limitation; for example, a person may have limited hearing, not have the use of their own legs, or experience learning difficulties. Such impairments are "neutral" facts and whether they become a "disability" – a disadvantage for individuals who experience them – is contingent on the economic, social, cultural and political organisation of any particular society (Berger and Luckmann 1966, Oliver 1990, New Zealand Disability Strategy 2001).

Further activity within the disability sector in 1999 has seen a Minister for Disability Issues appointed for the first time, with duties set out under the New Zealand Public Health and Disability Act 2000. This has meant a voice within the Cabinet for disability issues and a strong Ministerial advocate who recognises the salience of disability issues, and the importance of a rights and opportunities agenda for New Zealand society. Within the public sector, an Office for Disability Issues was established in 2002, and, in early 2005, a consumer reference group was appointed to assist the Office in its work. The reference group has an advisory role in bringing issues to the attention of the Office and providing advice and feedback on the implementation of the New Zealand Disability Strategy.

It has long been apparent that many disabled people in receipt of disability benefits wish to work. According to *Fully Inclusive New Zealand* (Office for Disability Issues 2002):

Approximately 20% of people in receipt of Sickness Benefit and Invalid's Benefit also access vocational services. Informal research suggests that up to 80% of people on IB and SB want to work, so existing vocational services are not assisting all those that want assistance.

So while SB and IB reform is driven from a social development portfolio, its overall success is inextricably linked to the implementation of the New Zealand Disability Strategy. At present there is a growing alignment in the priorities expressed by many within the disability sector and the objectives of the government around SB and IB. During consultations around the Disability Strategy:

Dominant themes were the need to be flexible in how work is defined, offered and rewarded, and the need to focus on what people experiencing disability *can* do. (New Zealand Disability Strategy Consultation, Employment/Business Development 2000:9, original italics)

Flexible benefits were seen as a key dimension in making progress around employment opportunities – a point echoed by the Disability Strategy Sector Reference Group, who recommended the importance of providing more flexible income support benefits to facilitate work and training opportunities. This synchronicity between the disability

communities' views and government priorities is not unimportant when considering the future direction and likely success of disability employment policy.

With a focus on outcomes, *Pathways to Inclusion* (Department of Labour 2001) made a commitment to phasing out sheltered workshops and reorienting service providers. Vocational services no longer fund services with purely therapeutic intent, such as day centres and related activities, and, in 2002, \$44 million was allocated for employment support. It is recognised that such far-reaching changes would involve "a mindshift at all levels – among communities, employers, service providers, families/whanau and people with disabilities themselves" (Department of Labour 2001).

To date, there has been relatively little attention paid by academic commentators to the increased emphasis on working actively with SB and IB clients. This paper seeks to address such a gap and to:

- outline the package of measures aimed at reforming Sickness and Invalid's Benefits, including the underpinning rationales
- situate these changes within the broader context of both active labour market policy and disability initiatives
- assess the continuing challenges that exist within the New Zealand context.

THE BACKGROUND TO REFORMING SB AND IB

Sickness Benefit and Invalid's Benefit were introduced during the reforms of the first Labour Government of 1935. The Pension Amendment Act 1936 saw provision extended beyond war veterans, miners, and the visually impaired to include "invalids", and rates were increased and measures expanded to those with sickness in the Social Security Act 1938 (McClure 1998). "Invalid" beneficiaries were defined as permanently incapable of work and viewed as part of the deserving poor, and who required not only support but also insulation from the rigours of the competitive jobs market. Sickness benefit was payable in respect of temporary "incapacity" for work through sickness or accident, i.e. off work or working at a reduced level.

In contemporary times, the disadvantaged position of disabled people⁴ is well documented. Disabled adults are far less likely to be in the labour force than non-disabled adults (36% of disabled adults were not in the labour force compared to 18% of non-disabled adults). Disabled people are less likely to be employed than non-disabled

4 Here I am using "disabled people" to indicate my understanding and commitment to the "social model of disability". Many people in the New Zealand context talk about "people with disabilities" believing this puts the person before the disability. While this is well intentioned, I believe such usage to be conceptually flawed – by downplaying the social dimension of disability and mitigating a more fundamental reappraisal of disability within New Zealand society. See New Zealand Disability Strategy (2001) for a fuller introduction to the social model.

peers (57% compared to 71%) (Ministry of Health 2004). Disabled people are more likely to have no formal educational qualifications (39% of disabled adults in households reported that they had no educational qualification, compared with 24% of non-disabled adults). More than half (56%) of disabled adults reported gross personal incomes less than \$15,000 for the year ended 31 March 2001, compared with 40% of non-disabled adults. Women with a disability are particularly disadvantaged in terms of income, as are other groups including Māori, Pacific Peoples and older workers (Statistics New Zealand 2001, New Zealand Disability Strategy 2001).

The proportion of the working aged population receiving IB has increased steadily between 1994 and 2004, and numbers on SB rose sharply in the early 1990s and have continued to increase between 2000 and 2005. Figures for SB and IB, to the year ending June 2005, stood at 73,186 people aged 18–64 in receipt of IB (an increase over the year of 3%), and 45,176 people (aged 18–64) in receipt of SB (up 3% over the year).

Recent analysis of the rise in numbers on IB and SB, suggests around half of the rise in IB is explained by population growth, the ageing of the population, and the rise in the age of eligibility for New Zealand Superannuation (Wilson et al. 2005:13–14). There has been a rise in almost all incapacities for IB (Wilson et al. 2005:43–9). Whilst not explicitly examining causation, the authors suggest that there are several factors correlated with benefit growth, including the changing structure of employment and types of work available, employer recruitment and retention practices, and changing wage/replacement income ratios. The interaction of SB and IB with other programmes, and shifts in organisational practice may also be significant. For example, the introduction in 1998 of the Community Wage,⁵ reforms to ACC eligibility, changes in case management, and changed operational focus may all contribute to cross-benefit transfers. Changes in the prevalence of incapacity caused by de-institutionalisation, the changing nature of work, and recognition of previously little understood impairments, are further possible reasons (Wilson et al. 2005:1–7). What appears clear is that just as there is unlikely to be one single explanation of the rise (p.103) neither is there one simple solution – changing attitudes, providing services, or fostering incentives are by themselves unlikely to be “golden bullets”.

For SB and IB, greater inflows between 1993 and 2002 rather than increased durations have fuelled the increase (Wilson et al. 2005:20, 66). Research also suggests that 81% of the IB growth for those aged between 15 and 59 is associated with current or recent contact with the benefit system, indicating transfers from elsewhere in the benefits

5 From 1 October 1998, the Unemployment Benefit was called the “Community Wage” and there were developments introducing a requirement for beneficiaries to undertake “training” or “community work”. Other benefit categories, including SB, IB, and Domestic Purposes Benefit were to be integrated into the Community Wage framework. These developments were discontinued and the name changed back under the Labour-Alliance Coalition 1999–2002.

system (particularly SB, but also Unemployment Benefit (UB), Domestic Purposes Benefit and Widow's Benefit) rather than new flows from the workplace (p.26). Estimates from a cohort of beneficiaries granted IB in 1993 suggest that over a 10-year period around 40% of those granted IB remained on the benefit nine years later, and around 17% of the total cohort of IB recipients had left for employment (Wilson et al. 2005:54–55). For the 1993 cohort, the median IB duration was 6 years; for the SB cohort it was 19 weeks (p.63).

From the 1990s, increased numbers moving onto disability benefits and the relatively long stays on IB and growth in inflows of SB, have been perceived as a major thorn in the side of successive governments (McClure 1998). There are clearly financial costs in terms of the taxpayer burden of spiralling benefit payments, as well as the forgone fiscal take of beneficiary inactivity. But there are also the broader social costs, including the wasted potential of individuals languishing on benefits, and associated health costs that are known to arise from long-term sickness and distance from the labour market.

National's *Welfare to Work* brand (Player 1994, Ministry of Social Policy 2001) saw a new approach to medical certification for SB and IB. National's attempts at reform saw the introduction of the Designated Doctor Scheme in September 1995, with designated doctors⁶ having responsibility for assessing benefit eligibility, certifying applications for SB at 13 and 52 weeks, and certifying grants for IB, and recommending a possible review (12, 18, 24 months). From 1998, there was an alignment of SB rates with UB rates for new grants and the introduction of the Community Wage in place of UB and SB. In October 1998, the designated doctor review scheme was revised and doctors signing the certificate were able to certify SB for four weeks and then at 13-week intervals. For IB, designated doctors certify the granting of a benefit, with review being recommended by these doctors for two years, five years, or never. During the first part of 1999, there was also the trial of work capacity assessment for those with sickness, disability, or injury. A Phase one trial was undertaken but Phase two was never completed. The work capacity process for IB and SB sought to identify the level of work, if any, a beneficiary was capable of, and to determine what assistance would help them move into paid work (abridged from Wilson et al. 2005:4–5 Table 1.1).

These approaches sought to narrow the gateway to benefits and to ensure those with work capacity did not avoid the obligations that were at this time being placed on other groups of beneficiaries, including those in receipt of UB and Domestic Purpose Benefit. I would argue that the approach was individualised and an underpinning assumption saw "problems" as located in individual claimants, particularly in their attitudes towards work and unwillingness to meet their obligations.

6 Designated doctors assess a person's medical eligibility for the Invalid's Benefit. Under current regulations, "Designated Doctors must be registered with the New Zealand Medical Council and hold an annual practising certificate. Designated Doctors must be fully informed about their responsibilities under the Social Security Act 1964". www.workandincome.govt.nz/manuals-and-procedures/income_support/main_benefits/invalids_benefit-23.htm

New Directions for Labour Post-1999

Since 1999, Labour administrations have prioritised welfare reform, and this has included attempts to tackle numbers on SB and IB. Discernible within the policy matrix of the three Labour Coalitions (1999–2002, 2002–2005, and from 2005) is a clear emphasis on modernising welfare, active labour market policy, and enhancing “employability” of all disadvantaged groups. Increased numbers in receipt of SB and IB stand in stark contrast to the Labour-led administrations’ social development aspirations, and are a target for political snipers, with criticisms of SB and IB recipients and general practitioners cloaked in discourses of shirkers, malingerers and connivers.⁷

Labour’s attempts at welfare reform since 1999 can be placed within the broader “Third Way” approach: linking economic and social policy; development of a preventative welfare state; the centrality of paid work; opportunities replacing income redistribution; the language of inclusion/exclusion displacing equality; a pragmatism of “what works”; and attention to citizens’ rights *and* responsibilities (cf. Driver and Martell 2001, Lister 2001, Powell 2002). Labour prioritised welfare reform for reasons of equity and efficiency; numbers in receipt of benefits curtail productivity and bloat public expenditure, with current predictions suggesting SB and IB spending will increase to \$1.87 billion in 2007/2008 (Treasury 2001, Maharey 2005a).

In a bid to ensure equity, particular at-risk groups have been targeted for interventions: sickness and invalid beneficiaries, long-term unemployed, young job-seekers, sole parents, mature job-seekers, Māori; Pacific Peoples, and new migrants. Two particular platforms have been *Jobs Jolt* (2003) and *Working for Families* (2004), which complement pre-existing measures aimed at enhancing and matching the supply of labour to employer demand (Department of Labour 1999). New directions include increased regional flexibility in delivering employment services and addressing skill shortages: while at the micro level there have been ongoing attempts to introduce tailored case management. A new language and set of policy prescriptions, resting on “work-first” citizenship, has developed for a range of beneficiaries.

Labour’s intention has been to align its traditional values (which have required some tailoring) with an increasingly changeable and unstable world. Beyond delivery, this has also meant modernising the very rationale and principles of the welfare system itself:

7 For example, see Hansard 12 June 2003 (Social Development and Employment Minister – Confidence in Advice); 3 August 2004 (Questions for Oral Answer: Unemployment Benefit – Sickness Benefit); 2 December 2004 (Questions for Oral Answer: Beneficiaries – Sickness and Invalid Beneficiaries); 2 February 2005 (Questions for Oral Answer: Sickness and Invalid Beneficiaries – Stress and Depression).

We need a social security system that is modern, flexible and more effective in supporting people to take up and stay in paid work. (Clark and Maharey 2001:3)

Modernising welfare provision and maintaining government commitment to “active labour market” intervention are presented as ways of meeting and harnessing new employment realities. The circumstances for which social security was initially developed are seen as outdated, requiring that social security be modernised not only in terms of administration and delivery, but also, more fundamentally, in terms of *purpose*.

Such a vision was clearly laid out in *Pathways to Opportunity* (Clark and Maharey 2001), which juxtaposed the old and the new. Thus, “welfare” is condemned and replaced by social development; income assistance becomes focussed on help, support and facilitating transitions; faster delivery of financial entitlement is combined with a concern to ensure individuals retain or return to work.

New Directions for SB and IB

A previous review of disability employment policy identified a series of key themes emerging throughout the 1990s – individual rights, incentives, marketisation, voluntarism, and fiscal restraint (Lunt and Pernice 1999). While many of these themes are retained within the current policy environment (reducing the fiscal burden, the voluntary compliance of employers, and contracts for external service delivery), elsewhere in policy there have been major shifts in emphasis and approach. At root, it can be argued that National’s policy towards SB and IB was “minimal social policy”, underpinned by a thrust towards cutting and reducing wherever possible, and overlaid with discursive articulations of beneficiary obligation. The latter, for example, included National’s attempts to incorporate SB into work-testing regimes, a move which was strongly criticised by Labour who, under cover of the Third Way, have emphasised investment and outcomes. For Maharey (2005a), there should instead be:

An investment in improving outcomes for people, rather than paying them to remain on benefit. (p.5)

Pathways to Opportunity also talks about the importance of investing in education and health, investment in people, and the importance of opportunities. An investment approach is explicitly signalled in relation to SB and IB, concerned with “how we should invest in people receiving a Sickness or Invalid’s Benefit at an individual client level and identify the type of services and programmes we should fund for people in this client group” (Ministry of Social Development 2004). A constituent part of Labour’s

agenda for welfare reform has been the stress on evidence-informed activity, trialling small-scale innovations and pilot approaches to see “what works”.⁸

The difficulties of SB and IB emanate from how such benefits are labelled, defined and conceptualised. To qualify for IB, a person must have a condition that is defined as “permanent” and “severe”, i.e. be unable to work for 15 hours a week. Sickness Benefit requires a condition or disability that limits capacity to seek or undertake full-time employment (30 hours). This either/or definition of incapacity is problematic for two reasons: it fails to recognise partial capacity, ignoring the spectrum of capacity; and it does not account for the fluctuating nature of impairment and changes over time. Such binary approaches to defining incapacity or sickness fail to acknowledge that “incapacity” is a socially constructed category that is dependent, for example, on the provision of supports and changes to workplaces and practices, social barriers, employer attitudes, as well as the person’s own response to ill health and impairment. In this light, the design of SB and IB is somewhat curious and outdated, presenting as it does a threshold to be crossed; a target to be reached. Such a stress on “incapacity” is in stark contrast to the reconceptualisation suggested by the social model and the shift towards emphasising capacity and abilities.

Successful receipt of IB becomes a terminus, rather than a destination *en route* to re-entry or re-engagement with the labour market. The definition of IB has perverse incentives because it is available at higher rates than unemployment benefits for those that are able to show their incapacity, and has less conditionality than UB. Imposing job search requirements would be paradoxical because to qualify for the benefits persons must have shown themselves to be *incapable for work*. Despite employability being contingent on support, the irony is that those that find themselves on SB and IB may need more support but have received less.

Overall, the configuration of benefits and services is rigid, perverse and constraining, when what is required is a dynamic and transformative system. A flexible system of benefits would recognise partial capacity, and encourage risk-taking within the labour market by offering a sufficient “trampoline” (rather than merely a “safety net”) should it be required. Under historical arrangements, individual incapacity is reinforced at every turn of the benefit system, crowned in no small part by the very naming of a benefit as the “Invalid’s Benefit”, which demeans recipients and reinforces a view that those with disability and long-term illness have solely benefit futures.⁹

8 The research strategy includes research around an international review of benefit receipt; case managers on work readiness of SB and IB (October 2004); health survey analysis (July 2005). There are also service evaluations of the PATHS (primary) and ProCare (mental health services) initiatives.

9 See also Tucker (2004) for a similar point in relation to Work and Income’s ‘Handicapped Child’s Allowance’ that was only renamed the Child Disability Allowance under the Social Security Amendment Act 1998.

New directions signalled for SB and IB constitute nothing less than a paradigm shift. At the heart of change is the move beyond individuals – beyond the focus on either *their* disability or *their* lack of motivation.¹⁰ In contrast to earlier individualised understandings, the new terrain is the social model and recognition of structural inhibitors and complex decision-making contexts. Thus, it is not that people are claiming such benefits inappropriately, but that the structure of benefits are themselves inappropriate for many of the people claiming them (cf. Social Market Foundation 2005:11). Within New Zealand, the Sickness and Invalid's Benefit Strategy (which became the *New Service for People Receiving Sickness and Invalid's Benefits*) has emphasised the importance of recognising the potential for work, and of removing barriers and building bridges for those that wish to avail themselves to such opportunities. Since 1999, there have been a number of changes to the benefits system and in the delivery of service supports.

Changes to Benefit Eligibility

Attempts have been made to “re-wire” the benefit system to allow individuals to take risks and try out labour market opportunities. From 1 July 2004, under the *Working for Families* package, an initiative allows IB recipients to trial a return to work of over 15 hours per week for six months without losing benefit entitlement, and will not have automatic stand-downs if they need to access the benefit later on for the same disability or condition.

Increased attention is being paid to the role of part-time work and recognition of potential capacity and transitions towards full-time work. In June 2005, one-in-seven IB recipients, and one-in-eight SB recipients had current earnings declarations, meaning that they had earned some income in the last 12 months. As Jensen et al. (2005) note, the impact of disability is more modest when employment is measured as part-time rather than full-time hours (p.2). They suggest that part-time participation rates beg interesting policy questions around how support services and employers may be able to facilitate transitions to full-time work (pp.51–2).

Gateways In, Out and Off SB and IB

There has long been a concern about gateways into SB and IB and particularly the most appropriate locus of responsibility for certification. This was an area that subsequent National and Labour governments have sought to address. Most recently, the government has allowed local general practitioners and case managers to seek a

10 Interestingly, the UK Government's own estimate of Incapacity Benefit fraud is low compared to other benefits – less than 1 in 200 (cf. Social Market Foundation 2005). Given that increases are not the result of fraud, numbers will not fall by simply “clamping down” on claimants. There are no comparable estimates of the level of fraud within New Zealand.

second opinion where doubt exists about new and continued eligibility for SB, thus pre-empting patient "capture" that is said to result from close or longstanding personal relationships between claimants and their doctors. This initiative was piloted in the Wellington region with national rollout starting from June 2005. There is also enhanced guidance for general practitioners to "improve the management of inflow" onto SB (Maharey 2005b).

Since the development of case management by ACC in 1994, developments in the role and workload of case managers have been at the forefront of welfare reform. There is recognition nationally (and internationally) of the key role that support and case management can play in ensuring return to work (Singley 2003:37). There have been ongoing debates around the appropriate balance within case management of client support and ensuring client compliance, and whether specialist case management for particular benefit types and those with complex needs is more effective than generic provision (see also Dickens et al. 2004 for comments on British experience).

Enhanced case management seeks to ascertain potential for work and to individualise provision for recipients. Under the 2003 *Jobs Jolt* initiative, each of the 14 "concept sites" – trials at the forefront of delivering employment-related services to SB and IB clients – developed specialist case management for SB and IB recipients with target caseload ratios of 1:160. In other areas, the aim is to reduce ratios from 1:350 to 1:225 for SB and IB.¹¹ Specialist case managers work with medical practitioners and job brokers to devise return-to-work strategies. In emerging evidence, just under half of all clients in the concept sites had Journal¹² entries made for them by case managers focused on employment aspirations and moves towards employment, compared with 10.7% in the non-concept sites, where the tool was introduced from October 2005 (Ministry of Social Development 2005a).¹³ Employment-related Journal entries can include any information regarding employment, including recording that a client is unable to seek employment.

The New Service Model for Work and Income seeks to integrate Employment-Focused Services when an individual is assessed for any benefit. This New Service Model thus offers employment services to all beneficiaries, regardless of benefit type, and is being trialled in 12 sites. Currently, 70% of Work and Income staff time is spent administering 10 base benefits and 36 supplementary payments. Instead of categorising people according to why they are unable to work, these new developments focus on the support

11 At the end of March 2005, this ratio stood at 1:181 for concept sites and 1:252 for non-concept sites.

12 "Journal" is the part of the Work and Income administrative database that records clients' progress towards employment (Ministry of Social Development 2005a: 72).

13 Comparing concept and non-concept sites, the change in proportions moving off SB and IB, compared to the previous 12 months, was 1.2% compared to 0.1% for non-concept sites.

people need to help them move into work. The New Service Model for all clients is preventative and work-focused case management to keep individuals in work, and to ensure rapid return or preparation (including part-time and intermittent work) through employment-focused services for those that move out of work (Clark 2005).¹⁴ In line with this model, for Sickness and Invalid's Benefit recipients, the emphasis is upon recognising the potential individuals may have for work, and providing more effective and personalised services for those that wish to make use of them.¹⁵ It may also include services aimed at retention for those at risk of losing jobs on grounds of ill health and disability (Maharey 2005b). Moves to encompass work preparation, return to work and retention (within the new Support to Work programme) are clearly extensions of previous Work and Income roles.

Preparing for Work vocational assessment, introduced after October 2004 for those who want to work, offers assessment services, a personalised report and a plan. *Preparing for Work* is a vocational assessment tool to help case managers identify the skills and aspirations of those who want work. To encourage SB and IB beneficiaries to enter the paid workforce, pilot projects have been used (employABLE projects 2002–2004). Four were centrally funded but offered by community-based groups (targeting Māori and mental illness), while the scheme provided by Work and Income targeted new sickness beneficiaries, offering voluntary case management to encourage maintenance of labour market links and exploring alternative pathways back into work. Other services include Training Support, Job Search Skills and Job Plus Training. There is also the expansion of the Job Club pilot through Workbridge.

There have been a series of developments aimed at wrapping specialist support services around clients who are identified as being close to the labour market and potentially benefiting from enhanced and intensive support – whether health, motivational or vocational. These “Innovative Employment Assistance” initiatives include the piloting of PATHS (physical health), ProCare (mental health services), Work First (mental health), Workwise (mental health), Te Rau Pani (mental health) and Kaleidoscope (spinal injury) (Ministry of Social Development 2005a). PATHS (Providing Access to Health Solutions), for example, provides access to health interventions, including physiotherapy, pain clinics and fitness programmes. It is individually tailored and explores what healthcare interventions would allow the client to return to work more quickly. Services, including PATHS, ProCare and Workwise, continue to be available even when clients have entered employment.¹⁶

14 This would complete a process that first began with benefit administration and Employment Services moving closer together in 1998.

15 Extra services are available (funded from the 2005 Budget) for expressly supporting people with ill health or disability.

16 By March 2005, 14 out of 161 Workwise participants, 23 out of 117 PATHS participants, and 16 of 65 ProCare participants had moved off their benefits.

The New Zealand Disability Strategy emphasises the collection and use of relevant information about disabled people and disability issues. If reforms of disability benefits are not driven by a good understanding of the problems and well grounded in evidence, there is a danger that groups already at risk of poverty and social exclusion are further disadvantaged (compare to Stanley and Maxwell 2004:1). Attempts at ensuring better-informed policy development have been a part of the SB and IB reform package, involving user and expert views (for example, a Sickness and Invalid's Benefit Client Reference Group, which consists of 10 people and meets regularly), and social science research, and policy and programme evaluation.

Given that long-term beneficiaries often face multiple barriers and have diverse needs, and that disability is a relationship between the individual and their environment, "what works" is likely to be complex. While evidence-based policy has a certain rhetorical appeal, recognition that in practice this may translate to "what works for whom and under what circumstances" (de Boer 2003) may be a less sanguine conclusion (also, Johri et al. 2005).

On the policy horizon is the single core benefit planned for 2007, consisting of one set of rates and one set of eligibility criteria for benefits, but with add-ons to support people who have higher costs such as accommodation or disability-related – whether in or out of work.¹⁷ A cost-based disability payment that is available to all people with higher costs as a result of disability would remove the incentive for individuals to distance themselves from the labour market. Work is underway to ascertain more accurately the extra costs associated with living with a disability.

THE WIDER AGENDA

The similarities of the approaches taken by New Zealand and British policymakers are striking. In relation to New Zealand welfare reform, there is clearly willingness to look overseas – for good ideas, to learn lessons, and for how to brand and communicate policy intentions (see Lunt 2005a). In Britain, there is a familiar emphasis on uncoupling disability status and benefit receipt, developing linking rules, and ensuring individualised and early provision by skilled caseworkers. British developments are different in that they have more in the way of measures to engage employers, both in the form of outreach, and in terms of compliance with provisions of anti-discrimination legislation.

Evaluations are currently underway in New Zealand around pilots including PATHS and ProCare and it is too early for this paper to comment conclusively on these. It is

17 The New Service Model that extends employment services to all beneficiaries underpin the single core benefit planned for 2007.

useful, however, to reflect on five fundamental issues that will influence the longer-term success of SB and IB interventions: the social model, issues of partnership, “healthy welfare”, mutual obligation, and investment social policy. Recent research and emerging insights from experience in Britain are helpful in allowing many of these issues to be located in an informative comparative context.

The Social Model and Employment

The barriers presented by employment are amongst the most disabling. Governments have historically viewed disability as located in the individual (with the individual requiring rehabilitation through health and social services), rather than disability being a concern of labour market policy and the result of disabling environments. The environment refers not only to physical, built characteristics but also includes attitudes, organisational dimensions and work practices such as hours, flexibility and task adaptations. The experience of discrimination is a core part of the way disability is constructed in contemporary society. As well as direct and indirect discrimination, systemic discrimination occurs when practices and policies of an institution or society operate against the interests of a specific group. For example, the design of offices and of workstations may be organised based on a non-disabled person being the norm. Consequently, discrimination is multi-faceted, including both prejudice and disability in employment resulting from work situations and processes set up for the “normal” worker.

A major challenge is to maintain the social model at the centre of SB and IB reforms, and to avoid making individuals the sole locus of intervention despite the importance of “individualised” provision. The social model of disability leads to a policy of alleviation rather than compensation, and calls for policymakers and society to “redesign, reframe, reconstruct and reconstitute inclusionary policies” (Lunt and Thornton 1994:227). However, in a number of areas (e.g. transport and education), the weakness of the 1993 Human Rights Act does not encourage flexibility and discrimination is likely to remain (cf. Human Rights Commission 2004, Human Rights Commission 2005). Difficulties of engaging small firms may doubly disadvantage particular groups that are more likely to be over-represented in such employment opportunities: women, older workers, and those from minority ethnic groups.

The social model is focused on environments and rights, and emphasises education, transport, health and community care services, and housing. Given labour market status is strongly related to educational experience, a quality education is the crucial first step to ensuring employment opportunities. Inflexible transport remains a major barrier to the social and labour market participation of disabled people, with such groups less likely to be car owners and more likely to use public transport when travelling to work. The 2001 Disability Survey found that 47,700 disabled adults and children would travel on buses if they were made easier for disabled people to use (Statistics New Zealand

2001). The future responses of the New Zealand disability community to attempts to tackle SB and IB issues are likely to be conditional on the wider transformations occurring in terms of implementation of the social model and progress of the Disability Strategy.¹⁸

Partnerships and/or Obligation

In seeking to tackle SB and IB responsibility must be apportioned amongst a range of stakeholders – beneficiaries, government departments and agencies, employers, and the health sector. Employers can be seen as users of incapacity services because the initiatives may reduce labour shortage, turnover, and absenteeism (Corden and Sainsbury 2001). Employers are diverse and small employers may present a particular challenge in forging working partnerships around issues including sickness, ill health and disability. Small employers and their recruitment practices present particular issues for New Zealand, given that, in 2001, there were 250,000 enterprises, and of these, 86% employed five or less persons, and 99% employed 50 or less. Some steps have been introduced in New Zealand (“Service to Employers”) whereby employers are supported and given information to help in their hiring and retention of staff with ill health or a disability. This includes a video, information booklet and presentation that are targeted at employers.

Most submissions to the New Zealand Disability Strategy consultation suggested that a coordinated and focused public education programme was required in respect of disability. Despite the success of the “Like Minds, Like Mine” campaign that focused on removing stigma and discrimination around mental illness, there has been no parallel development for disability more broadly, nor in terms of educating employers about abilities of disabled employees (cf. Gourley 2004, 2005, Human Rights Commission 2004).

The New Zealand Disability Strategy is an important landmark on the way to a fuller citizenship for disabled people, yet as the Human Rights Commission (2004) notes:

In spite of significant progress in developing a high-level framework and strategy and the increasingly effective voice of disabled communities, in their daily lives disabled people remain among the most disadvantaged citizens in New Zealand.

18 Similarly in the United Kingdom, organisations including RADAR, Age Concern, Shaw Trust and the Disability Rights Commission have welcomed recent announcements by British Labour to tackle sickness and incapacity benefits. Proposed measures include: the extension of a New Deal to those on SB and IB, the restructuring of the benefits so that those with severe conditions only get a new disability and sickness allowance with no requirement to look for work, but with most being on a rehabilitation support allowance. The recent establishment of a consumer reference group to assist the Office for Disability in its work may give future indication of the New Zealand sector's attitudes towards progress with employment.

A number of countries that introduced anti-discrimination legislation in the 1990s are beginning to question how well such measures are serving the purposes for which they were established (Lunt 2005b). Such re-examination may involve renewed attention to the implementation of legislation and to granting stronger enforcement powers. Within New Zealand, it may be time to undertake a more comprehensive review of legislation; despite discussions within the New Zealand Disability Strategy, this has, to date, remained off the policy agenda.

“Healthy Welfare”

Welfare policy is moving beyond the belief that the individual beneficiary is the only component subject to “activation”. As well as a role for employers, active engagement is also being sought from a range of medical professionals, particularly in primary health care.

The majority of working-age disabled and diseased people have incurred their impairments at work (OECD 2003), and the workplace and health systems are becoming crucial sites for the delivery of employment focused services. (Under new British, plans there will be employment advisers in general practice surgeries.) Recognising the importance of prevention, early intervention,¹⁹ and the role of health services has prompted new trials focused on the role of primary and secondary medical practitioners ensuring quick return to work.

Professionals differ about the extent to which they see work rehabilitation as part of primary care. Overseas research suggests general practitioners were concerned about the conflict of certification activity with a therapeutic role (Hiscock et al. 2005).

Ongoing engagement with the medical profession is likely to be required to clarify general practitioners’ roles of clinician, advocate, and adjudicator in relation to health and wellbeing. Overseas evidence also suggests general practitioners’ views about work sickness depends on a general practitioner’s own personal views, patient characteristics, time available, expertise in occupational health, and views about continuity of care (Mowlam and Lewis 2005). General practitioners often feel pressured and are also inclined to take the wider views of claimants/patients into account, perhaps not wanting to commit them to searches for scarce work or where services are poor (Social Market Foundation 2005). A fuller notion of employability clearly encompasses the supply, demand and matching of labour (Lunt 2006).

19 One component of this is the clear prevention agenda such as New Zealand’s Injury Prevention Strategy of 2001.

It seems likely that prevention and managing long-term sickness-related absence will be increasingly important areas, with medical practitioners encouraged to do more to help workers stay in and retain work. Previously, general practitioners have not seen such dimensions as part of their role and have lacked the tools, training and financial incentives to offer such supports.²⁰

The Scope of Mutual Obligation

"Mutual obligation", "conditionality", or the melding of "rights and responsibilities" is central to discussions of welfare reform, including reform of the disability rolls. As Stanley et al. (2004) note:

"Conditionality" is the principle that entitlement to benefits should be conditional on satisfying certain conditions, most commonly undertaking work-related activity such as job search. (p.1)

While Labour has so far resisted pressures to move from voluntary to compulsory initiatives for SB and IB recipients, continued reform of the benefit and support system will bring such issues back into the spotlight, particularly when international benchmarks and exhortations suggest:

the disabled person is expected to make an effort to participate in the labour market. Failure to do so should result in benefit sanctions. Any such sanction would need to be administered with due regard to basic needs of the disabled person and those of dependent family members. (OECD 2003:5)

Certainly, the United Kingdom has stressed the culture of mutual obligation and the need to be consistent across unemployment/disability benefits. There, proposals are for a new rehabilitation allowance to be paid at a lower rate for those not trying to return to work. Those failing to "engage" (e.g. not taking steps to work such as attending interviews) will receive lower Job Seekers Allowance rates of benefit. Rather than applicants automatically going to incapacity benefits, they will be placed on a holding benefit and this will be built up as they meet their obligations, rewarding claimants when they take steps towards work (Department for Work and Pensions 2005:47). An alternative approach is to sanction "downwards" from a set rate when obligations are not met. A key question, as the quality and range of services increases, is how to engage with those recipients who do not acknowledge an obligation to move towards work (Corden et al. 2005). Thus, successful programmes must be effective and also have a high take-up across the range of potential participants (Department for Work and Pensions 2004). Such issues are likely to be of key interest to New Zealand policy makers as New Zealand's reforms unfold.

20 Also, District Health Boards are not funded or responsible for helping individuals to access a range of health services to ensure an employment outcome (Ministry of Social Development 2005a:83).

Robust "Investment Social Policy"

Labour's commitment to investing in outcomes is laudable and ambitious. To tackle the differences in labour market outcomes and jobs, it is necessary to move further upstream and consider school, education, skills and broader social attitudes. Many disabled people view their own lack of confidence as a major barrier to accessing employment (compare to Barnes et al. 1998). Transitions to work become an important consideration, including the provision of careers guidance for young people at school (New Zealand Government 2004). In 2003, \$3 million was allocated over five years to support disabled students in tertiary study. There is a raft of international evidence that suggests people who were in employment prior to receiving a disability benefit are more likely to return to employment, so what a person was doing before receipt has a bearing on likely success (Johnson 2001:4). Many of those arriving on disability benefits have poor work histories and there is clearly plenty of scope for investment to ensure they are not left behind as the economy grows.

Singley (2003) notes that most beneficiaries want to work but a range of personal, family, community and work-related (skills, experience, education) considerations interact with demand for labour to produce less than optimum outcomes.²¹ Multiple barriers and entrenched discrimination may require considerable ongoing investment.²² Similarly, ensuring employment sustainability will result in *welfare in work* becoming a key consideration. Seeking work, seeking better work, gaining promotion, and development within work would become part of a totality of welfare reform. The New Zealand Government has expressed an interest in the "quality of new and existing jobs" (New Zealand Government 2000:12) and it would appear that work/life balance is an emerging *leitmotif* of labour market and family policy. Whether this responsibility will be shared among other social partners, including employers, remains to be seen, although some recognise that "a skills development strategy on the supply side needs to be matched with policies to induce firms to recognise the social interest in the quality and character of jobs on offer" (Richardson and Miller-Lewis 2002:74).

Investment in case managers, the linchpins of the new system, is crucial, as is resisting the increase of workloads, and providing supervision and adequate support for those engaged in intensive case management activities.

21 As the OECD (2003) notes, older disabled workers face particular difficulties such as having outdated skills and are subject to further discrimination on the basis of age.

22 Of those on IB, around 70% are aged over 40, 33% aged over 55, and 7% are aged 18–24. Twenty per cent of IB recipients are Māori. In relation to impairments, 27.6% of IB claimants had psychological or psychiatric impairments, and 15% had an intellectual disability. For SB recipients, one-in-eight was aged between 18 and 24, and of total recipients 35% had psychological or psychiatric impairments, and 17% musculo-skeletal conditions. One in four SB recipients was Māori and 7% of Pacific Island ethnicities (Ministry of Social Development, 2005b).

On the theme of investment, it is important not to write off the work prospects of those who do not face a specific obligation to work, while recognising that outcomes other than employment may also be appropriate. As Adamson (2004) notes, the Training Incentive Allowance was not effective for those in receipt of IB in terms of moves to employment – but if self-confidence, wellbeing, and interaction measures were chosen then a more positive picture emerged. Overseas research also suggests funding mechanisms need to be sensitive to ensure that more difficult cases are supported, and recognise “slow burners” can be helped to move toward work (Knight et al. 2005, Lewis et al. 2005). The cost of investing in qualifications and basic skills may be high, yet the difference between minimal and investment social policy rests on recognising that the best investments do not always secure short-term dividends.

CONCLUSION

The participation of disabled people within the labour market may be seen as “multiple, malleable, contingent and dynamic” (Mannion 1994). Multiple, because the veritable mosaic of factors that must combine for a successful outcome; malleable, because many of the difficulties faced are resolved by removing existing barriers; contingent, in that participation and success are related to a range of other factors, including education, training, age, gender and ethnicity; and finally, dynamic, due to ongoing change such as technology and economic change.

Arguably, policy has short and long-term targets. In the short term, the focus is on changing behaviours and attitudes, and ensuring steps to work for those closer to the labour market. But there is also a longer-term shift of seismic proportions concerned with reconstructing the terrain around a social model of disability, offering support, facilitating opportunities, encouraging aspirations and changing the way societies think about disability:

Societies need to change the way they think about disability and those affected by it. The term “disabled” should no longer be equated with “unable to work”. (OECD 2003:4)

As part of the long-term agenda, breaking the equation of disability with impairment and incapacity is essential, although no easy task.²³ As a discursive shift, it seeks to introduce new ways of thinking about disability and to change the hearts and minds of policy makers, funders and providers. It is also about enabling health workers to see employment as part of their role, encouraging employers to be more active and less

23 As the British report *Disabled for Life* (Department for Work and Pensions 2002) suggests, stereotypes include disability as always physical and visible impairment, involving incapacity, and being permanent and unchanging.

discriminatory, and ensuring there is a new mindset from those receiving benefits in the future. This is not only a rebranding and simplifying exercise; it is about removing the vocabulary and concept of incapacity/invalidity.

These discursive shifts will go hand in hand with a focus on structural factors, including civil rights, and roles for employers and general practitioners. Ongoing policy will continue to ensure work pays, but this must be balanced with an awareness that most beneficiaries will not become wage earners through incentives alone (Corden and Sainsbury 2001, Corden et al. 2005:3). The social model, partnership, social and mutual obligation, and “investment” will remain crucial contributors to the wider reform platform. All said, SB and IB reform is both a wide and challenging agenda. It is a promising one nonetheless.

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