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**FREEDOM AS ANTIPOWER: MECHANISMS FOR  
DISABLED PEOPLE TO RESIST DOMINATION BY THE  
NEW ZEALAND STATE**

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### *Abstract*

Phillip Pettit's republicanism offers a useful framework through which one can assess the constitutional position of disabled people in New Zealand society. For Pettit, a relationship is characterised by domination if one entity has the capacity to interfere, with impunity and at will, in another person's life and choices. Given the medicalisation of disability, which has privileged the voices of medical professionals over disabled people, New Zealand policy and law has placed disabled people in a unique position of domination with the state. Whether this can be overcome depends on mechanisms of antipower, or contestation, available to disabled people. This paper will assess the merit of Pettit's framework through an in-depth assessment of disabled people's legal access to antipower in the health and disability system. It will then demonstrate the framework's worth in other relationships disabled people have with the state- the welfare and electoral system. Finally, it will demonstrate that policy developed in line with the principles of disability justice also has the capacity to meet republican standards, using the United Nations Conventions on the Rights of Persons with Disabilities as an example. Overall, this paper posits a new way of viewing the inequities disabled people face – through a republican lens.

**Key Terms:** 'Disability', 'Republicanism', 'Domination', 'Health Law', 'Welfare Law', 'Electoral Law', 'UNCRPD'.

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## I Introduction

*“If you recognise that freedom requires that you’re not at the beck and call of another person, hanging on their good will, then you have to have a legally established framework that gives people their own areas of sovereign choice.”<sup>1</sup>*

Republicanism and the disability justice movement may seem miles apart, but they share a common belief: a person’s freedom is defined by the extent that they have undominated choice over their lives. All people, including all disabled people, must have tools and mechanisms to exercise control over policy and issues which affect them personally, and as a community. For disabled people, historically perceived as passive subjects of state power, this is particularly pertinent.<sup>2</sup> Phillip Pettit’s republicanism provides a useful framework through which one can assess the relationship between disabled people and the state.<sup>3</sup> As this paper highlights, an application of Pettit’s framework reveals that disabled people have minimal legal tools through which they are able to counter their position of subjugation with the state.

This paper demonstrates how we can use Pettit’s framework, informed by disability justice, to locate disabled people’s position within New Zealand civil society. Due to the medicalisation of disability, where disabled identities are primarily viewed through a medical lens, medical professionals are “privileged at the expense of the devalued experiential knowledge and voices of disabled people”.<sup>4</sup> The relationship between disabled people and the medical institution is thus ripe for subjugation, whereby the medical professional can interfere arbitrarily and with impunity in the disabled person’s life.<sup>5</sup>

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<sup>1</sup> Phillip Pettit as quoted in Joe Gelonesi “Philosopher Philip Pettit argues we should change our definition of freedom” (9 May 2014) ABC <https://www.abc.net.au/radionational/programs/philosopherszone/philip-petit-argues-we-should-change-our-definition-of-freedom/5442200>.

<sup>2</sup> Amber Knight “Democratizing Disability: Achieving Inclusion (Without Assimilation) Through “Participatory Parity”” (2015) 30 *Hypatia* 97.

<sup>3</sup> Phillip Pettit “Freedom as Antipower” (1996) 106 *Ethics* 576.

<sup>4</sup> Cate Thill “Listening for Policy change: how the voices of disabled people shaped Australia’s National Disability Insurance Scheme” (2015) 30 *Disabil Soc* 15 at 17.

<sup>5</sup> Pettit, above n3.

Pettit's framework can help us locate legal deficiencies which heighten this vulnerability. The first half of this paper assesses this particular relationship in depth – demonstrating the strength of Pettit's republicanism in this area.

In the second half of this paper, I briefly explore how Pettit's framework can also be used to assess other relationships disabled people have with the state – namely, through the welfare system and electoral system. After using Pettit's framework to highlight deficiencies in disabled people's access to legal areas of sovereign choice, I briefly demonstrate how the framework can also be used to assess policy and law which is more in line with the principles of disability justice. As I suggest, this can be achieved through upholding the disability rights mantra – “nothing about us without us”<sup>6</sup> – as enshrined in the United Nations Conventions on the Rights of Persons with Disabilities (UNCRPD).<sup>7</sup> The second half of this paper does not attempt to provide an in-depth application of Pettit's framework, but rather seeks to bolster my claim that it is a useful lens through which to assess relationships of domination/subjugation.<sup>8</sup>

However, before assessing disabled people's relationship with the medical institution, I establish how disabled people's constitutional status has created a unique relationship of domination. Ultimately, as I demonstrate, the extent to which disabled people in Aotearoa are able to overcome their position of subjugation depends on legal mechanisms of “antipower” available to them.<sup>9</sup>

## *II Disabled people's constitutional status*

Disabled people in Aotearoa, and globally, have historically been locked out of formal positions of leadership.<sup>10</sup> This can be seen in both the elected legislature and the appointed civil service – as highlighted most recently by the disabled community's struggle to appoint

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<sup>6</sup> For more, see James I. Charlton *Nothing About Us Without Us* (University of California Press, USA, 1998).

<sup>7</sup> United Nations Convention on the Rights of Persons with Disabilities, 2515 UNTS 3 (opened for signature 30 March 2007, entered into force 3 May 2008).

<sup>8</sup> Like Pettit, I use the terms subjugation/domination interchangeably.

<sup>9</sup> Pettit, above n3.

<sup>10</sup> Knight, above n2.

a disabled person as head of the establishment unit for the newly created Whaikaha-Ministry for Disabled People.<sup>11</sup> As a result, decisions continue to be made for disabled people, without disabled people. This has led to often inadequate policy and law regarding disability issues. Certainly, "...the politically active are more likely to achieve their policy goals, often at the expense of the politically quiescent".<sup>12</sup>

Some may argue that disabled people simply need to engage more actively in civil society, however this ignores systemic barriers to participation. Whether a group is politically active often depends on existing public policy – "policy influences the amount and nature of groups' political activity, often exacerbating rather than ameliorating existing participatory inequalities".<sup>13</sup> Disability theorists argue that public policy has relegated disabled people to the position of passive recipients of state policy or private charity. As a result, disabled people are "rarely discussed as active citizens with something valuable to contribute to deliberations about human affairs".<sup>14</sup>

#### *A The medicalisation of disability*

This constitutional status of disabled people (or lack thereof) is primarily the result of the medical model of disability. In disability theory, a 'model' of disability refers to socially constructed 'truths' about disability which meet the purposes of its definers.<sup>15</sup> The medical model of disability continues to inform common understandings of disability. It has historically rendered the issues facing disabled people as both individualised and

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<sup>11</sup> Arielle Kauaeroa "Disabled leaders disappointed non-disabled person will lead set-up of new ministry" (24 Dec 2021) StuffNZ <https://www.stuff.co.nz/pou-tiaki/300485419/disabled-leaders-disappointed-nondisabled-person-will-lead-setup-of-new-ministry>.

<sup>12</sup> Andrea Louise Campbell *How Policies Make Citizens* (Princeton University Press, Princeton, 2003) at 1.

<sup>13</sup> At 1.

<sup>14</sup> Knight, above n2, at 99.

<sup>15</sup> John M. Conley, William M. O'Barr and Robin Conley Riner "The Politics of Law and the Science of Talk" in *Just Words: Law, Language, and Power* (3<sup>rd</sup> ed, University of Chicago Press, Chicago and London, 2019) at 9.

pathological.<sup>16</sup> Consequently, society is relieved of “any obligation other than to care, treat, or cure the person”.<sup>17</sup> The medical model is often positioned in contrast to the more desirable social model of disability – which views a person’s impairment as their physical or cognitive condition, and disability as the barriers which society imposes on top.<sup>18</sup> According to the social model, I have a physical ‘impairment’ and am ‘disabled’ by societal structures which fail to accommodate my different needs.<sup>19</sup>

A medical view of disability places the role of medicine in disabled people’s lives as paramount. This is because disability is seen as an individual deficit or pathology which must be medically ‘fixed’. This prohibits us from considering how society itself excludes disabled people – how it “creates barriers to inclusion and how it shares in the responsibility to eliminate barriers”.<sup>20</sup> Consequently, disabled people are routinely “spoken about rather than listened to as experts”.<sup>21</sup> Participation in civil society is therefore not deemed a priority for disabled people. As a result, legal accountability systems are often inaccessible or inadequate at meeting the needs of the disabled community. Ultimately, viewing disability as an individual deficit has resulted in disabled people being systematically “marginalised from debates about policy direction across a wide range of areas...”<sup>22</sup>

The medicalisation of disability – which sees a deficit before a person- has resulted in the privileging of medical professionals’ voices over disabled people themselves. Relevant to this paper, this has resulted in placing a high level of trust on medical professionals, with a lack of legal accountability mechanisms to safeguard patients and recipients of

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<sup>16</sup> See generally Michael Oliver. *Understanding Disability: From Theory to Practice* (2<sup>nd</sup> ed, Palgrave Macmillan, Basingstoke, 2009).

<sup>17</sup> Arlene S.Kanter “so” in Arlene S.Kanter and Beth A.Ferri (eds) *Righting Educational Wrongs: Disability Studies in Law and Education* (Syracuse University Press, Syracuse, 2013) at 7.

<sup>18</sup> See generally Oliver, above n16.

<sup>19</sup> For more discussion of the models of disability, and their application to the legal sphere, see Alice Mander “The Stories that Cripple Us: The consequences of the medical model of disability in the legal sphere” (2022) 53 VUWLR 337.

<sup>20</sup> Kanter, above n17, at 7.

<sup>21</sup> Thill, above n4, at 17.

<sup>22</sup> At 17.

healthcare. Ultimately, the medical model of disability has placed disabled people in a constitutionally vulnerable position, exposed to domination.

### *III Relationships of domination*

The medicalisation of disability places disabled people in relationships of domination with the state. While intrinsically understood by disability theorists, republicanism corroborates this. According to Pettit, an actor dominates or subjugates another to the extent that:<sup>23</sup>

- 1) They have the capacity to interfere
- 2) With impunity and at will
- 3) In certain choices that the other is in a position to make.

Pettit does not differentiate between actual and potential interference, which is one of the differences between his republicanism and others within the school of thought. In other words, it is irrelevant whether the dominator does interfere with the subject, as the mere ability for them to do so means that “the victim of power acts in the relevant area by the leave, explicit or implicit, of the power bearer”.<sup>24</sup> If a subject’s choices are minimised by the sheer possibility of interference, then they are in a position of domination.

#### *A Domination: disabled people and the medical institution*

As already established, disabled people’s relationship with the medical institution has consequences on their constitutional position in civil society. Because New Zealand law places medical professionals at a high level of trust, the relationship between patient and medical professional is ripe for subjugation. Certainly, “by the word alone of a doctor, most people submit to acts that would otherwise be assault (medical examinations), wounding (surgery), and sexual violations”.<sup>25</sup>

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<sup>23</sup> Pettit, above n3, at 578.

<sup>24</sup> Pettit, above n3, at 587.

<sup>25</sup> Saul Holt, Ron Paterson “Medico-legal secrecy in New Zealand” (2008) 15 J Law Med 602 at 617.



The relationship between disabled citizens and medical professionals involves the “systematic effect of the relationships through which the lives of persons with disabilities are regulated”.<sup>26</sup> Given the conflation of medicine and disability, the medical institution has an extended role in the lives of disabled people. In addition to typical and mainstream healthcare, medical professionals are entrusted with making decisions as broad as disabled peoples’ access to welfare, their capacity to have children, their ability to drive a vehicle, and their right to extra support in education or employment facilities. In all of these situations, a disabled person’s lived experience often requires buttressing by ‘professional’ medical advice.<sup>27</sup> Some disabled people, predominantly adults and children with learning (intellectual) disabilities,<sup>28</sup> undergo fulltime care in residential care facilities.<sup>29</sup> These disabled people are at particular risk of subjugation and domination, isolated from the rest of the community and often having communication barriers as a result of their impairment.

Evidently, disabled people engage more frequently with the medical institution than their nondisabled counterparts. Despite having more frequent involvement, disabled New Zealanders feel disproportionately poorly treated in public healthcare, and report discrimination on the basis of their disability. This issue is exacerbated for disabled people with intersecting identities, particularly Māori, Pasifika, and the LGBTQ+ community.<sup>30</sup> Ultimately, the medical institution can directly interfere with disabled people’s liberty and physical wellbeing, thus being a republican concern.

This issue is exacerbated due to difficulties in locating the source of this domination. When domination originates from the state it is called imperium, whereas domination between

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<sup>26</sup> Tom O’Shea “Disability and Domination: Lessons from Republican Political Philosophy” (2015) 35 *Journal of Applied Philosophy* 133 at 137.

<sup>27</sup> See, for example, Carey-Ann Morrison “A personal geography of care and disability” (2021) *Social & Cultural Geography* (forthcoming).

<sup>28</sup> The term ‘learning disability’ is the preferred term for the community traditionally referred to as intellectually/congenitally/developmentally disabled. For more, see generally “About Us” (PeopleFirst New Zealand) < <https://www.peoplefirst.org.nz/who-what-where/who-is-people-first/>>.

<sup>29</sup> Peter Boshier *Off the Record: An Investigation into the Ministry of Health’s Collection, use, and reporting of information about the deaths of people with intellectual disabilities* (Ombudsman Office, July 2020).

<sup>30</sup> *My Experiences, My Rights: A Monitoring Report on Disabled People’s Experiences of Health and Wellbeing in Aotearoa New Zealand* (Donald Beasley Institute, 2022).

citizens is dominium.<sup>31</sup> Nevertheless, the state itself can become an “agent of the sort of domination associated with imperium rather than dominium” and has a responsibility to reduce the effects of private dominium as well as imperium.<sup>32</sup> The relationship between the medical institution and disabled people may appear to be one of dominium, because it manifests as a relationship between an individual professional and patient. However, it is not accurate to suggest that the state plays no role in this relationship.<sup>33</sup> Public healthcare in New Zealand operates at arms-length. This means that the operation of public rest homes and care centers for disabled people are contracted out to private organisations by the Ministry of Health.<sup>34</sup> This has allowed the state to distance itself “from decisions which are unpleasant and distressing, not only to citizens directly affected but also in the ledger of public opinion”.<sup>35</sup> However, despite these services being contracted out, the fundamental obligations to disabled people are still held by the state. As the Disability Rights Commissioner notes, “the Ministry of Health cannot contract out of the State’s domestic and international human rights obligations to disabled people through the delegation of disability services”.<sup>36</sup> This contracting out pattern adds another dimension of complexity to the relationship between disabled persons and the medical institution.

### *1 A matter of life or death*

Domination in this relationship is not only a matter of quality of life, but of life itself. Many disabled people are made extremely vulnerable by the relationship, as exemplified by recent incidents of accidental death by drowning in residential homes for people with (predominantly) learning disabilities.

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<sup>31</sup> Phillip Pettit, *Republicanism: A Theory of Freedom and Government* (Oxford University Press, Oxford, 1999).

<sup>32</sup> At 171.

<sup>33</sup> For more about the constitutional nature of medicine see O’Shea, above n26.

<sup>34</sup> Tara Shaskey “Disability Advocate puts MoH on notice over bathing ban, threatens complaint to UN” (23 Jun 2022) NZHerald <https://www.nzherald.co.nz/nz/disability-advocate-puts-moh-on-notice-over-bathing-ban-threatens-complaint-to-un/NM3OMWMEDOLKH55X6H3Y6M4LDI/#:~:text=An%20advocate%20for%20the%20disabled,up%20with%20the%20United%20Nations.>

<sup>35</sup> Margaret Allars “Citizenship rights, review rights and contractualism” (2001) 18 *Law in Context* 79 at 79.

<sup>36</sup> Paula Tesoriero as quoted in Shaskey, above n34.

In 2015, disabled 14-year-old Nathan Booker drowned in a bath while he was in the care of IDEA Services Limited— New Zealand’s largest provider of services for people with learning disabilities.<sup>37</sup> No charges were brought against the carer responsible for Nathan, despite the death being described as “totally preventable”.<sup>38</sup> However, the care facility was fined \$63,500 and ordered to pay reparation of \$90,000 to the family. Nathan’s mother noted that Nathan should have never been left in the bath unattended – “If I even knew that anyone was leaving him in a bath unattended I would have pulled him out of the site, because that’s dangerous”.<sup>39</sup> Nathan’s death was not the first or last incident of this kind. In 2016, disabled woman Vicki Campbell drowned in a bath while she was in the care of IDEA Services Limited. IDEA Services Limited was fined \$425,000 for their role in the death.<sup>40</sup>

IDEA Services Limited has since announced a blanket ban on the bathing of its residents. The decision was made without consulting disabled people or their family members.<sup>41</sup> When administered safely and appropriately, baths offer significant comfort for individuals with learning disabilities. WorkSafe has criticised the decision as “cutting corners”. Family

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<sup>37</sup> “Palmerston North respite home fined \$63k over teen’s drowning” (10 Mar 2015) StuffNZ <https://www.stuff.co.nz/manawatu-standard/news/67179705/palmerston-north-respite-home-fined-63k-over-teens-drowning>.

<sup>38</sup> Binns J, as quoted in “Palmerston North respite home fined \$63k over teen’s drowning” (10 Mar 2015) StuffNZ <https://www.stuff.co.nz/manawatu-standard/news/67179705/palmerston-north-respite-home-fined-63k-over-teens-drowning>.

<sup>39</sup> Angela Middlemiss, as quoted in Lynley Bilby “Boy’s death: Serious shortcomings in police probe” Otago Daily Times (21 Dec 2015) <https://www.odt.co.nz/news/national/boys-death-serious-shortcomings-police-probe>.

<sup>40</sup> Leighton Keith “Idea Services pleads guilty after vulnerable Taranaki woman’s death” (9 Dec 2020) StuffNZ <https://www.stuff.co.nz/taranaki-daily-news/news/123647418/idea-services-pleads-guilty-after-vulnerable-taranaki-womans-death#:~:text=Idea%20Services%2C%20the%20service%20arm,who%20drowned%20in%20the%20bath>.

<sup>41</sup> Shaskey, above n34..

members and disabled advocates decry the loss of baths, stating that it is a breach of human rights for residents.<sup>42</sup>

It is evident that the medical institution has the ability to interfere in disabled people's lives, often with tragic consequences. However, it is important to note that state interference in and of itself is not inherently unjust from a republican perspective.

### ***B Domination versus legitimate interference***

Pettit's republicanism is concerned with *arbitrary* interference and domination.<sup>43</sup> Certainly, this paper does not propose to abolish the relationship between disabled people and the medical institution entirely. Rather, it seeks to illuminate accountability deficits within the relationship which facilitate interference on an arbitrary basis. This is a key difference between liberalism and Pettit's republicanism, and is the reason the latter aligns with disability justice, while the former fails to consider disability justice as a "central problem of social justice".<sup>44</sup>

Traditional liberal theory has sustained the philosophical illusion that:<sup>45</sup>

...there are just two ways of understanding liberty: in one, freedom consists in the absence of external obstacles to individual choice; in the other, it involves the presence, and usually the exercise of the facilities that foster self-mastery and self-fulfilment.

The latter is positive liberty –mastery of the self – and the former is negative liberty – the absence of interference.<sup>46</sup> However, both positive and negative liberty require a base level of noninterference. Traditional liberalism has often failed to consider disability justice as a "central problem of social justice" because of its inherent aversion to state interference or support, which is undoubtedly critical for the many disabled people who rely on welfare,

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<sup>42</sup> Olivia Shivas "'Cutting Corners': Worksafe rejects IHC's bath ban for disabled people" (26 Feb 2022) StuffNZ <https://www.stuff.co.nz/pou-tiaki/127893116/cutting-corners-worksafe-rejects-ihcs-bath-ban-for-disabled-people>.

<sup>43</sup> See generally Pettit, above n 3.

<sup>44</sup> Jurgen De Wispelaere, David Casassas "A life of one's own: republican freedom and disability" (2014) 29 *Disabil Soc* 402 at 403.

<sup>45</sup> Pettit, above n 31, at 18.

<sup>46</sup> See generally Pettit, above n 31.

public healthcare, and other statist policies.<sup>47</sup> By comparison, Pettit's republicanism challenges us to consider the "intermediate possibility that freedom consists in an absence, as the negative conception has it, but in an absence of mastery by others, not in an absence of interference"<sup>48</sup>. In other words, domination is characterised as interference which is arbitrary and done with impunity, not interference in and of itself.

Republicans, like Pettit, have no inherent aversion to state interference, but simply require interference to be properly administered and held to account. Pettit's focus is not non-interference, but non-domination.<sup>49</sup> The relationship between disabled people and the medical institution should thus be assessed by the existence of dominating interference. A state actor can practice "non-dominating interference, provided – and it is a big proviso – that a suitable constraining, constitutional arrangement works effectively".<sup>50</sup> One such 'arrangement' is the exercise of antipower.<sup>51</sup>

### *C Antipower*

According to Pettit, antipower counteracts a dominating actor's ability to interfere with impunity and at will:<sup>52</sup>

If X enjoys power over Y in one way, and Y enjoys power over X in another, then each is in a position to exact something from the other in payment for the interference, and so neither may interfere in the other's affairs with impunity; neither enjoys power simpliciter over the other, neither dominates the other.

Evidently, X – the medical institution – exerts power over Y – the disabled person. If the disabled person is able to exercise power over the medical institution in some other way – for instance, through a robust and effective complaints mechanism – then this will counteract the medical institution's ability to interfere with impunity. This means the disabled person has access to antipower, and neither party dominates the other.

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<sup>47</sup> De Wispelaere, above n 44, at 403.

<sup>48</sup> Pettit, above n 31, at 19.

<sup>49</sup> See generally Pettit, above n 3.

<sup>50</sup> At 587.

<sup>51</sup> Pettit, above n 3, at 588.

<sup>52</sup> At 588.

Pettit argues that there are three ways in which antipower can be developed. Firstly, Pettit believes that protection from subjugation can be achieved through protective legal institutions.<sup>53</sup> These legal institutions must satisfy constraints such as “generality, transparency, non-retroactivity, and coherence, and these ought to make it more difficult than it might otherwise be for the law to become a resource for the domination of anyone”.<sup>54</sup> Secondly, citizens can access antipower through the regulation of the resources of power. Pettit envisions that this can be achieved through effective democracy – “regular election, democratic discussion, limitation of tenure, rotation of office, separation of powers, availability of appeal and review, etc., etc.”.<sup>55</sup> Finally, antipower can only be achieved if people have access to positive rights to material comfort which “give them equality in basic capabilities – and thereby guard them against various forms of subjugation, various forms of vulnerability...”.<sup>56</sup>

To recapitulate, the medical institution clearly has the capacity to interfere in disabled people’s lives. This has the potential to be dominating if done arbitrarily and with impunity. According to Pettit, one way that disabled people can counter this domination is through access to protective institutions and mechanisms of contestation. Such public contestation is critical as it ensures “relevant reasons for decision-making are open to public scrutiny, which will restrict the use of reasons to those that are acceptable to a wider constituency”.<sup>57</sup> Thus, contestation ensures that interference in disabled people’s lives is not done on an arbitrary basis, nor without impunity.

The next part of this paper assesses the mechanisms of contestability – thus, antipower – for disabled people in their relationship with the medical institution. I do this through an assessment of the processes in place if a dispute or unfortunate incident arises in a

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<sup>53</sup> Pettit, above n 3, at 590.

<sup>54</sup> At 590.

<sup>55</sup> At 591.

<sup>56</sup> At 591.

<sup>57</sup> De Wispelaere, above n 44, at 412.

healthcare facility, such as the death of Nathan Booker. Ultimately, antipower requires the existence of contestability:<sup>58</sup>

It is only if I can effectively contest any such interference – it is only if I can force it to account to my relevant interests and ideas – that the interference is not arbitrary and the interference not dominating.

#### *IV Antipower in healthcare*

Ultimately, “any system’s success could well be measured by how well those affected are able to have matters put right when things go wrong”.<sup>59</sup> In the health and disability system, this would require a robust dispute resolution scheme, as well as effective external and internal monitoring systems. This would prevent medical professionals from interfering in disabled people’s lives with impunity – as their behaviour and conduct would be held to account. However, as I will demonstrate, the legal framework for complaints and dispute resolution in the medical institution is not a sufficient mechanism of antipower. While the deficits of the health and disability complaints system could be plugged by strong external monitoring and regulatory mechanisms, including international and criminal law bodies, these do not exist for disabled people in Aotearoa.

This section assesses the different mechanisms through which disabled people may attempt to hold the medical institution to account, highlighting significant deficits in all of the processes.

##### *A Introduction*

The Health and Disability Commissioner Act (“The Act”) is the legal scheme governing complaints resolution in New Zealand healthcare.<sup>60</sup> The Act covers instances of serious injury or death, and also covers 24-hour residential or community-based care.

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<sup>58</sup> Pettit, above n 31, at 173.

<sup>59</sup> Māmari Stephens *Social Security & Welfare Law in Aotearoa New Zealand* (Thomas Reuters New Zealand Ltd, New Zealand, 2019) at 383.

<sup>60</sup> Health and Disability Commissioner Act 1994 (NZ).

Under s 31 (1) of the Act, any person may complain to the Health and Disability Commissioner alleging that the action of a healthcare provider or disability services provider is or appears to be in breach of the Code of Health and Disability Services Consumers' Rights ("the Code").<sup>61</sup> The Code consists of a list of generalised healthcare rights such as the right to be treated with respect, to receive services of an appropriate standard, and to be able to make an informed choice and give informed consent.<sup>62</sup> The complaint will be assessed, after which the Health and Disability Commissioner ("the Commissioner") can choose one of the following steps:<sup>63</sup>

- 1) Refer the complaint to another agency.
- 2) Refer the complaint to the provider.
- 3) Refer the complaint to an advocate.
- 4) Call a mediation conference.
- 5) Take no action on the complaint; or
- 6) Investigate the complaint.

The Commissioner has full discretion between these statutory options.<sup>64</sup> If the Commissioner chooses to undergo a formal investigation, and a breach is found, outcomes may include recommendations to apologise to the consumer, continual training, and other non-punitive measures.<sup>65</sup> There is no general right to damages for breach of the Code, though the Commission may recommend this on rare occasions.<sup>66</sup> In some instances, the Commissioner may refer the matter to the Director of Proceedings who may bring action before the Health Practitioners Disciplinary Tribunal ("HPDT") or the Human Rights Review Tribunal ("HRRRT"). An individual can bring a complaint directly to these bodies

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<sup>61</sup> Health and Disability Commissioner Act 1994 (NZ), s 31 (1).

<sup>62</sup> Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 (NZ).

<sup>63</sup> Health and Disability Commissioner Act 1994 (NZ), s 33 (1).

<sup>64</sup> As confirmed in *Legal Services Agency v Garrett* HC Auckland CIV-2008-404-3285, 10 December 2008, at [45].

<sup>65</sup> "Complaints Process" (June 2021) HDC <https://www.hdc.org.nz/making-a-complaint/complaint-process/>

<sup>66</sup> Peter Skegg, Ron Paterson (eds) *Health Law in New Zealand* (Thomas Reuters New Zealand, New Zealand, 2015), at 65.



if the Commissioner declines to do so, but they must first have the complaint investigated by the Commissioner and a breach of the Code must have been found.<sup>67</sup>

### ***B Barriers to justice***

As with all complaints mechanisms, the extent to which this system can act as a protective institution depends on whether disabled people have equal access to it. However, evidence suggests that disabled people come up against barriers to justice in the health and disability system. In an analysis of HRRT decisions regarding breaches of the Code, it was found that disabled people, especially consumers with a learning disability, were amongst the least frequent group to appear in the HRRT with these complaints.<sup>68</sup> This class of disabled people is particularly vulnerable to subjugation, as they are often recipients of full-time residential or community care. It is therefore of great concern that “their ability to initiate and participate in the legal complaints process is often limited”.<sup>69</sup> This is likely because consumers with a learning disability often have to rely on others to make complaints on their behalf, due to communication barriers or a lack of advocacy skills. This presumes a level of informal oversight from family, friends, or community advocates which not all consumers experience. This suggests that the few decisions involving this class of consumers which do exist “may just be the tip of the iceberg”.<sup>70</sup> While there are presumably internal review mechanisms for situations like this, it is imperative that citizens themselves are empowered to hold public bodies to account.

Disabled people and consumers of health and disability services have reported that, even when they do complain, their experiences are wholly negative. The process to accessing justice is said to be overly onerous and reliant on self-advocacy. This is exacerbated by the fact that the Act does not provide for an appeal against the Commissioner for their decision upon receiving a complaint, or the forming of an opinion at the end of an

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<sup>67</sup> “Human Rights Review Tribunal” (January 2021) Justice.Govt.Nz <https://www.justice.govt.nz/tribunals/human-rights/make-a-claim/>

<sup>68</sup> Kate Diesfeld, Lois Surgenor, Marta Rychert “Breaches of New Zealand’s ‘Health and Disability Services Consumers’ Rights’: Human Rights Review Tribunal decisions” (2020) 27 J Law Med 679.

<sup>69</sup> At 688.

<sup>70</sup> At 688.

investigation.<sup>71</sup> This means that the handling of the disabled person's complaint is at the full discretion of the Commissioner. The only avenue for appeal is through judicial review remedies and processes through the Ombudsman.<sup>72</sup> However, this adds to a process which has already been described by disabled people and their family as "taxing, and at times re/traumatising".<sup>73</sup>

The UNCRPD monitoring report on disabled people's experience of healthcare in New Zealand showed that many disabled people felt unable to complain for fear of the consequences.<sup>74</sup> Indeed, some participants reported being 'blacklisted' from service providers following complaints being laid.<sup>75</sup> Unintended consequences of complaints mechanisms can be seen in the IDEA Services Limited bathing incident in which complaints about preventable deaths in baths led to the knee jerk reaction of banning them entirely, despite the therapeutic effect bathing can have on those with learning disabilities. Studies of general complainants show that over one-third of patients and families express dissatisfaction with complaints to the Commissioner, a number significantly lower for complainants than it is for service providers engaging with the process.<sup>76</sup>

Ultimately, given the Commissioner and the HRRT is the main avenue for aggrieved disabled people to obtain justice in the healthcare system, there are some serious deficits in the process itself. If the complaints process is inaccessible or inadequate, then medical professionals have relative immunity when interfering in the lives of disabled people. In the next section I explore how this immunity is exacerbated by a culture of "medico-legal

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<sup>71</sup> Skegg, above n 66.

<sup>72</sup> See Health and Disability Commissioner, *A Review of the Health and Disability Commissioner Act 1994 and the Code of Health and Disability Services Consumers' Rights* (2009) <https://www.hdc.org.nz/your-rights/about-the-code/review-of-the-act-and-code-2009/>, at 20.

<sup>73</sup> *My Experiences, My Rights: A Monitoring Report on Disabled People's Experiences of Health and Wellbeing in Aotearoa New Zealand*, above n 30, at 64.

<sup>74</sup> *My Experiences, My Rights: A Monitoring Report on Disabled People's Experiences of Health and Wellbeing in Aotearoa New Zealand*, above n 30.

<sup>75</sup> At 24.

<sup>76</sup> Joanna Manning "Fair, Simple, Speedy and Efficient"? Barriers to Access to Justice in the Health and Disability Commissioner's Complaints Process in New Zealand" (2018) 4 NZ L Rev 611.

secrecy” which prohibits the disabled community from making informed choices in their healthcare, and softens the consequences of breaches of the Code.<sup>77</sup>

### *C A culture of medico-legal secrecy*

For Pettit, a protective institution must uphold the rule of law and be transparent in order for it to be a source of antipower.<sup>78</sup> Holding an institution or actor to account necessitates “providing various sorts of data about the performance of tasks, about outcomes or about procedures”.<sup>79</sup> Certainly, without transparency, citizens are incapable of knowing whether interference is arbitrary and, as a result, are unable to prevent or contest it. A culture of “medico-legal secrecy” in New Zealand has had this exact effect – awarding medical professionals and organisations’ with anonymity and, thus, freedom from consequences.<sup>80</sup> As a result, even if a disabled person is successful in overcoming the barriers to justice outlined above, the outcome of the health and disability complaints process does little to improve healthcare for the wider community.

Historically, of the few breaches of the Code to be formally investigated by the Commissioner, there has been an almost “blanket non-publication [of names] on a variety of policy grounds”.<sup>81</sup> In 2008 it was found that publication of service providers’ names was only done in very serious cases involving “sex, drugs, deception, and fraud”, suggesting that the public interest to transparency in alleged rights breaches “extends only to salacious information and not to information about substandard care”.<sup>82</sup> Between 2004 and 2014, of the 58.7% of applicants who applied for interim name suppression in the HPDT, 92.2% were approved. Importantly, a finding of not guilty on any charge brought

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<sup>77</sup> Holt et al, above n 25.

<sup>78</sup> See generally Pettit, above n 3, above n 31.

<sup>79</sup> Mark Bovens “Analysing and Assessing Accountability: A Conceptual Framework” (2007) 13 Eur. Law J 447, at 451.

<sup>80</sup> Holt et al, above n 25.

<sup>81</sup> At 604.

<sup>82</sup> At 609.

is rare (5.9% in this study).<sup>83</sup> Interim name suppression hinders the public's right to make an informed decision on healthcare, and impacts on the disability community's ability to monitor healthcare services.

The current Health & Disability Commissioner's naming policy is published on their website, and claims to base its decision to name providers on "whether the public interest in naming outweighs the potential harm to the provider".<sup>84</sup> The general position is that the Commissioner will name DHBs, public hospitals, rest homes, residential facilities, medical centers, pharmacies, and other group providers where there is a breach of the Code, "unless it would not be in the public interest or would unfairly compromise the privacy interests of an individual provider or a consumer".<sup>85</sup> This aligns with a general presumption in favour of openness in the Health Practitioners Competence Assurance Act 2003, which governs the Health Practitioners Disciplinary Tribunal.<sup>86</sup>

However, despite legislative intent, individual providers still enjoy a presumption of name suppression. According to its policy, the Commissioner will only consider naming individual providers when there are serious public safety concerns, non-compliance with HDC recommendations, or frequent breaches.<sup>87</sup> Similarly, the test for displacing the presumption of openness in the Health Practitioners Competence Assurance Act 2003 is whether it is 'desirable' not to apply the presumption.<sup>88</sup> However, 'desirability' has proven to be a low threshold- it is certainly lower than that employed in criminal law.<sup>89</sup> This seems counterintuitive considering the reputational risk of a criminal court case is presumably much greater than a professional misstep or breach of the Code. Furthermore, while the

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<sup>83</sup> Jois J Surgenor, Kate Diesfeld, Michael Ip, Kate Kersey "New Zealand's Health Practitioners Disciplinary Tribunal: An Analysis of Decisions 2004-2014" (2016) 24 J L Med 239.

<sup>84</sup> *Policy Document- Naming Providers in Public HDC Reports* (Health & Disability Commissioner, 1 July 2008) at 2.

<sup>85</sup> At 3-4.

<sup>86</sup> Health Practitioners Competence Assurance Act 2003 (NZ), s92A.

<sup>87</sup> *Policy Document- Naming Providers in Public HDC Reports*, above n 84, at 4.

<sup>88</sup> See generally Skegg, above n 66, at 962 and Health Practitioners Competence Assurance Act 2003 (NZ), s92A.

<sup>89</sup> At 962.

question of desirability is supposed to be a balancing exercise, the interests of complainants are not always considered. For instance, in *BC v Complaints Assessment Committee [2012]* there was full consideration of the interests of the practitioner and their family,<sup>90</sup> “but not a word about the wishes or interests of the complainant”.<sup>91</sup>

The Supreme Court has denied the existence of any legal presumption in favour of granting interim name suppression in disciplinary cases.<sup>92</sup> However, this is what has developed in practice, “since the HPDT grants such orders unopposed by the prosecution in the overwhelming majority of cases in which applications are made”.<sup>93</sup> It is noteworthy that in a disciplinary case involving a lawyer, the Supreme Court has said that it is “untenable to suggest that professionals with a high public profile have a presumptive entitlement to name suppression, even in the interim context”.<sup>94</sup> It seems undeniable that medical professionals, like lawyers, enjoy a high public profile. Both undergo extensive training, and both abide by ethical codes of conduct. In fact, the actions of medical professionals often have more dire and irreversible outcomes than lawyers. Furthermore, the statutory provision, the Lawyers and Conveyancers Act 2006, is almost identical to the Health Practitioners Competence Assurance Act 2003.<sup>95</sup> The inconsistent application of name suppression between the two professions is therefore legally unsatisfactory.

### *1 Contribution to domination*

According to Pettit, subjugation involves an awareness between both parties that the “powerless can do nothing except by the leave of the powerful: that the powerless are at the mercy of the powerful and not on equal terms”.<sup>96</sup> In prioritising privacy over disabled people’s rights, medical professionals act with a great degree of impunity. As such,

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<sup>90</sup> *A BC v Complaints Assessment Committee [2012]* NZHC 1901, [2012] NZAR 856.

<sup>91</sup> For more, see Skegg, above n 66, at 965.

<sup>92</sup> *Hart v Standards Committee (No 1) of the New Zealand Law Society [2012]* NZSC 4 at [3].

<sup>93</sup> Skegg, above n 66, at 969.

<sup>94</sup> *Hart v Standards Committee (No 1) of the New Zealand Law Society [2012]* NZSC 4 at [3].

<sup>95</sup> Compare the Lawyers and Conveyancers Act 2006 (NZ), s 240(2) with the Health Practitioners Competence Assurance Act 2003 (NZ), s 95(2), as emphasised by Skegg, above n 66

<sup>96</sup> Pettit, above n 31, at 59.

hesitance around name publication of medical professionals is a republican concern. Even if a disabled person is successful in bringing a complaint against a medical professional or institution, the result of the complaint may have little reputational consequence on the medical professional. Furthermore, others within the disability community are left ignorant of the complaint, therefore expected to trust the medical professional at face value. Ultimately, disabled people and their family are in a unique situation of powerlessness as a result of this anonymity – they are not on “equal terms” with the medical professional.<sup>97</sup> This is exemplified by Nathan Booker’s mother whose last attempt to seek justice involved having the name suppression of the nurse responsible for Nathan’s death dropped.<sup>98</sup>

Presumptive name suppression inhibits disabled people from making undominated choices about their healthcare. Even when a complaint is disproven, the disabled person ought to have all relevant information before them to make an informed decision. The current naming policy under the Act prohibits this. For instance, in 2010, a surgeon was only named publicly after being found to have breached the Code three times within an 18-month period.<sup>99</sup> The impunity granted to this surgeon meant that members of the public were unable to exercise an informed choice. Similarly, it is unknown whether the nurse responsible for Nathan’s “preventable” death is still practicing in the sector.<sup>100</sup>

Given the expansive role that medical professionals play in disabled people’s lives, it is entirely understandable that a disabled person may wish to know any successful or unsuccessful complaints which exist against a medical professional. In fact, having this information may equalise the relationship between disabled person and medical professional – with each knowing critical information about the other. This may be compared to a citizen having information about potential political candidates, and any

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<sup>97</sup> Pettit, above n 31, at 59.

<sup>98</sup> Matthew Dallas “Twice the anguish for family of Nathan Booker let down by carers and police” (22 Dec 2015) StuffNZ <https://www.stuff.co.nz/manawatu-standard/opinion/75343782/twice-the-anguish-for-family-of-nathan-booker-let-down-by-carers-and-police>

<sup>99</sup> *Policy Document- Naming Providers in Public HDC Reports*, above n 84, at 5.

<sup>100</sup> Mathew Grocott “Nathan Booker’s death ‘totally preventable’, says judge” (11 Mar 2015) StuffNZ <https://www.stuff.co.nz/manawatu-standard/news/67213437/nathan-bookers-death-totally-preventable-says-judge>.

disciplinary actions brought against them in the recent past. Certainly, internationally, it has been argued that the “public interest in information about doctors is ‘completely analogous’ to the public interest in information about political candidates”.<sup>101</sup>

Furthermore, failure to publish the names of practitioners prohibits the disabled community from identifying whether a “breach finding represents an individual aberration or a pattern of conduct attributable to individual underperformance or systems issues or both”.<sup>102</sup> For instance, IDEA Services Limited has had multiple deaths by drowning in its care. However, without name publication, advocates are left in the dark as to whether it is truly the result of individual failure, or a systemic policy failure.

Publication of names is also likely to minimise the chances of unintended consequences for the complainant such as knee-jerk reactions and blacklisting. This is because the provider will presumably be under greater public scrutiny. Without this protection, disabled people are unlikely to feel confident in bringing a complaint. Ultimately, there is a fear that the tendency not to publish the names of providers means that the “opportunity for the public to come forward with further complaints of a similar kind is lost”.<sup>103</sup>

It is also important to consider New Zealand’s unique health law system in comparison with overseas jurisdictions. In other common law countries, “the main way in which complaints of medical error are determined... is through civil courts, in which names are rarely suppressed”.<sup>104</sup> The inability to sue for medical error in Aotearoa places more importance on other review mechanisms, for there are minimal other avenues through which medical professionals and institutions can be held to account.

One of the arguments against individual name publication is that it will impact providers’ privacy, and will have a negative effect on the quality of healthcare. However, the primary

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<sup>101</sup> J Surgenor et al, above n 83, at 618.

<sup>102</sup> Holt, above n 25, at 612.

<sup>103</sup> At 621.

<sup>104</sup> Holt, above n 25, at 612.

purpose of the complaints mechanism is not necessarily to improve quality of healthcare but rather to “provide a voice to patients by enforcing the standards set in the Code – standards that are expressly patient focused and that are given the status of rights”.<sup>105</sup> The rights of healthcare consumers is intended to be paramount – evidently not the case in practice, given the current naming policy.

#### ***D Independent and internal monitoring***

One may assume that accountability in healthcare does not fall entirely on disabled people’s complaints. Certainly, the flaws of the above system may be mitigated if other regulatory systems operate effectively. However, independent and internal monitoring mechanisms of healthcare institutions are equally flawed. This can be seen through poor record keeping, a lack of formal oversight of these institutions, and evidence of inadequate police investigation.

#### ***2 Record keeping***

A 2020 Ombudsman inquiry found that the Ministry of Health’s data collection on the death of those with learning disabilities was concerningly deficient.<sup>106</sup> The inquiry uncovered previously lost records of 30 people with learning disabilities who died living in full-time residential care during 2016 and 2018. Due to unclear and poor record keeping policies, the Ministry of Health had been unaware of these 30 deaths.<sup>107</sup> It was also found that, even where unanticipated deaths were reported to the Ministry of Health, staff responsible for reviewing the death notifications were provided with no clear guidance for determining whether further information or follow-up action was necessary.<sup>108</sup> Where the health and disability provider undertook an internal review of an unexpected death

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<sup>105</sup> Holt, above n 25, at 612.

<sup>106</sup> Boshier, above n 29.

<sup>107</sup> Bridie Witton “Ministry of Health finds records of 30 deaths of those with intellectual disabilities after Ombudsman investigation” (10 Jul 2020) StuffNZ <https://www.stuff.co.nz/national/health/122087505/ministry-of-health-finds-records-of-30-deaths-of-those-with-intellectual-disabilities-after-ombudsman-investigation>

<sup>108</sup> Boshier, above n 29, at 13.



themselves, the Ministry rarely appeared to obtain copies of these reports, nor had a process to follow up with providers to ensure the investigation actually occurred.<sup>109</sup> This is concerning considering reviews are a “pivotal source of information about the quality of that provider’s service” and its compliance with its Ministry of Health contract.<sup>110</sup>

Poor internal processes for incidents in healthcare, especially for those with learning disabilities, means that medical professionals and institutions are freely able to interfere in disabled peoples’ lives without scrutiny. In fact, this report suggests that it is entirely plausible that a disabled person in residential care may die without public knowledge or investigation. While other jurisdictions have independent monitoring bodies – such as the Learning Disabilities Mortality Review programme in the United Kingdom – New Zealand is yet to establish a similar body.<sup>111</sup> Children like Nathan Booker are fortunate to have strong family advocates, meaning they experience greater oversight and their situations are likely to get media attention. This is not the case for many disabled people. There is a need for improved monitoring of residential facilities. Without this, medical professionals will continue to be able to interfere in disabled peoples’ lives arbitrarily, with little threat of consequences or even reputational risk.

The vulnerable position of disabled people in these facilities is analogous to people in places of detention, who enjoy greater degrees of oversight. The Optional Protocol to the Convention Against Torture (“OPCAT”) was intended to monitor facilities in which people are detained and isolated from the community.<sup>112</sup> The purpose of this protocol was to proactively prevent abuse, torture, or ill-treatment in closed facilities. However, while New Zealand has ratified OPCAT, its current interpretation excludes monitoring of disability services.<sup>113</sup> This means that there is no independent or external body investigating Ministry

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<sup>109</sup> At 83.

<sup>110</sup> At 83.

<sup>111</sup> At 89.

<sup>112</sup> Optional Protocol of the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment A Res 57/199 (2006).

<sup>113</sup> Michael White “The role and scope of OPCAT in protecting those deprived of liberty: a critical analysis of the New Zealand experiences” (2019) 25 Australian Journal of Human Rights 44.

of Health facilities, including those in which the deaths of people with learning disabilities went unreported.

The objective of OPCAT is to establish a system of monitoring through regular visits undertaken by independent bodies to places of detention.<sup>114</sup> The Crimes of Torture Act 1989 defines a “place of detention” as any place where someone is deprived of their liberty, including a prison and a hospital.<sup>115</sup> Being “deprived of liberty” means being detained in a “public or private custodial setting which that person is not permitted to leave at will”.<sup>116</sup> This reference to a “custodial setting”, as well as the prescriptive list of places of possible detention, has the effect of excluding many other places where people are deprived of their liberty.<sup>117</sup> This includes community disability residences and aged care homes, including facilities run by IDEA Services Limited. These institutions are therefore excluded from monitoring processes.

While disabled people within residential institutions may technically be free to leave, it is farcical to suggest that this is a genuine option, especially for those with high needs such as Nathan Booker. Disabled people in residential settings may not be held against their will, but it is questionable whether they are permitted to leave as they please without supervision. The particular vulnerability of disabled people in full-time care was acknowledged by the Ombudsman’s inquiry, who rejected the opinion of some Ministry staff that death in residential care is allegorical to death “in their home”, and therefore should be subject to no more scrutiny than that of a person living in the community.<sup>118</sup>

Evidently, disabled people in residential care do not have sufficient antipower mechanisms to protect them from subjugation. They are entirely vulnerable to being interfered with arbitrarily by medical professionals or other staff in medical institutions, and New Zealand’s legal landscape has failed to account for this. In 2013, research undertaken by

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<sup>114</sup> OPCAT, above n112, art 3.

<sup>115</sup> Crimes of Torture Act 1989 (NZ), s16.

<sup>116</sup> Crimes of Torture Act 1989 (NZ), s116.

<sup>117</sup> See generally White, above n113.

<sup>118</sup> Boshier, above n 29, at 13.

Tairawhiti Community Voice showed that disabled people and their families unanimously regarded residential and home-based provision of care services to be insufficiently monitored, and noted that this “maintains disabled people’s vulnerability to abuse”.<sup>119</sup>

Without external monitoring or robust record keeping policies in the Ministry of Health, it is questionable whether there are mechanisms to alert the police or coroner of the death of a person in residential care. However, to be optimistic, one may *presume* that most deaths in residential care facilities are reported. If the criminal justice system operates effectively to hold the medical institution to account, then their ability to exercise arbitrary interference on an “unchecked basis” may be somewhat mitigated.<sup>120</sup> However, research implies that criminal investigation is not a reliable regulatory source of antipower in and of itself.

### 3 *Criminal investigation*

While there is limited research in this area, some have suggested that police processes for handling reports of abuse and violence against disabled people are inadequate. 2013 research showed that when disabled people reported abuse in residential facilities to police, the abused individual remained in the residence or home during the investigative period.<sup>121</sup> Thus, during the investigation, they were exposed to potential re-victimization. The report also revealed a series of poor practices in police investigation which heightens vulnerability and disincentives disabled people from reporting abuse in the first place. This included an “assumption that disabled complainants are not regarded as reliable witnesses”, as well as a “lack of knowledge about disabilities and the vulnerabilities experienced by disabled people”.<sup>122</sup> For instance, police often demonstrated an assumption that a disabled person’s carer or support person could speak on their behalf, ignoring the fact that that person may be the perpetrator.<sup>123</sup> Evidently, there are systemic issues preventing the criminal law from being an effective mechanism of antipower.

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<sup>119</sup> Michael Roguski *The Hidden Abuse of Disabled People Residing in the Community: An Explanatory Study* (Tairawhiti Community Voice, June 2013).

<sup>120</sup> Pettit, above n 31, at 18.

<sup>121</sup> Roguski, above n 119.

<sup>122</sup> At 42.

<sup>123</sup> Roguski, above n 119, at 43.

All of these issues manifested in the investigation into Nathan Booker's death. While the Police were involved in investigating Nathan's death, his mother felt that they "did not take the investigation seriously because they didn't understand disability".<sup>124</sup> An inquiry into the investigation by the Independent Police Conduct Authority found several deficits in the process. This included treating the carers responsible for Nathan when he died as "witnesses rather than people who were potentially guilty of an offense", and obtaining insufficient information from them.<sup>125</sup> It was also found that the particular investigation should have been overseen by a detective inspector but wasn't. Furthermore, the police should have obtained a legal opinion given it was a case of negligence, which is "typically complex".<sup>126</sup> Ultimately, a lack of disability awareness hinders the criminal process from being a protective mechanism.

### ***E Conclusion***

According to Pettit, "there is no antipower without a shared awareness of antipower".<sup>127</sup> It must be understood by both parties that:<sup>128</sup>

You do not have to live either in fear of that other, then, or in deference to the other. The noninterference you enjoy at the hands of others is not enjoyed by their grace, and you do not live at their mercy. You are somebody in relation to them, not a nobody. You are a person in your own legal and social right.

Evidently, disabled people do not have access to antipower in healthcare. This is primarily due to issues with the complaints process itself, and a lack of external accountability or regulatory mechanisms.

As demonstrated, Pettit's republicanism is a useful framework through which one can assess disabled people's relationship with the state. While I have elected to explore this through an in-depth assessment of disabled people's relationship with the medical

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<sup>124</sup> Angela Midlemiss, as quoted in Independent Police Conduct Authority *The Police investigation into Nathan Booker's death* (21 Dec 2015) at 4.

<sup>125</sup> At 6.

<sup>126</sup> At 7.

<sup>127</sup> Pettit, above n 3, at 595.

<sup>128</sup> At 595.

institution, it can easily be applied to other domains through which the state has the ability to interfere in disabled people's lives. To highlight the merits of Pettit's framework in this context, I will briefly demonstrate how the analysis could be applied to other relationships disabled people have with the state – namely, the provision of welfare, and electoral participation. Ultimately, in its focus on autonomy and control, Pettit's republicanism acts as a useful mechanism through which to assess legal domains of freedom for disabled people.

### *V Antipower in the welfare system*

Unlike traditional liberalism, Pettit's republicanism is comparatively sympathetic to welfare and other forms of positive state interference. As briefly mentioned in part three, Pettit asserts that access to antipower necessitates the provision of basic material capabilities which can protect a person “against various forms of subjugation, various forms of vulnerability”.<sup>129</sup> This aligns with the general notion in political philosophy that a group's ability to participate in constitutional and democratic processes often depends on their access to material resources. Indeed, a person is unlikely to contest their political or constitutional position if they are struggling to put food on the table or a roof over their heads. Thus, without a basic income and access to material equality, disabled people will continuously struggle to exercise antipower.

When assessing a welfare system through a republican perspective, Pettit directs us to consider two desiderata. The first is adequacy – the welfare system ought to provide an adequate level of income.<sup>130</sup> The second is independence – the welfare system should allow a person to claim a “nonnullifiable, nonstigmatising basic income”.<sup>131</sup> As I will briefly explain, New Zealand's disability welfare system fails on both accounts. This paper does not attempt to explore this issue in full but, rather, demonstrates how Pettit's framework could be used to critique many areas of state power.

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<sup>129</sup> Pettit, above n 3, at 591.

<sup>130</sup> Phillip Pettit “A Republican Right to Basic Income” (2008) 2 Basic Income Studies 2 at 10.

<sup>131</sup> At 2.

## A Adequacy

Disabled people are amongst the poorest in Aotearoa. In 2019, a CCS Report found that disabled people under sixty-five are almost 2.5 times more likely than nondisabled people to report not having enough income,<sup>132</sup> and Stats NZ reported that disabled children live in material hardship at more than double the rate of non-disabled children.<sup>133</sup> It is widely appreciated that this is the result of a welfare system which provides inadequate levels of support. According to Community Law's 2014 research, "poverty and inadequacy of income is the main problem for people on benefits".<sup>134</sup> Indeed, when compared to international rates, New Zealand's disability benefit is remarkably low. For instance, in 2018, the median payment rate for disability allowances for children in the United Kingdom was almost three times higher than in New Zealand.<sup>135</sup> Disabled children and their families in the United Kingdom are far less likely to live in poverty, whereas disabled children in New Zealand experience high levels of material hardship.<sup>136</sup> New Zealand's welfare provision is inadequate, even assuming that disabled people are receiving their full entitlement, and Pettit's framework helps illuminate these insufficiencies.

New Zealand's inadequate welfare system is rooted in the belief that paid employment provides the best pathway to self-sufficiency.<sup>137</sup> This belief is reflected throughout the Social Security Act 2018 – namely in s 4, which notes that "paid employment offers the best opportunity for people to achieve social and economic well-being".<sup>138</sup> The Social Security Act 2018 has been criticised on the ground that the welfare state may be said to

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<sup>132</sup> Sam Murray *The state of wellbeing and equality for disabled people, their families, and whānau* (CCS Disability Action, December 2019) at 10.

<sup>133</sup> StatsNZ "Child poverty statistics for households with disabled people released for the first time-Corrected" (23 February 2021) <https://www.stats.govt.nz/news/child-poverty-statistics-for-households-with-disabled-people-released-for-the-first-time/>

<sup>134</sup> Kim Morton, Claire Gray, Anne Heins, Sue Carswell *Access to Justice for Beneficiaries: A Community Law Response* (Community Law, October 2014) at 8.

<sup>135</sup> Sam Murray "Breaking the Link Between Disability and Child and Whānau Poverty" (2018) 14 Policy Quarterly 2324.

<sup>136</sup> At 69.

<sup>137</sup> See generally Stephens, above n 59.

<sup>138</sup> Social Security Act 2018 (NZ), s 4.

“owe its existence less to socially democratic notions of citizenship than to that of individualised social contract, dependent on the citizen finding paid employment and carrying out related obligations”.<sup>139</sup> As a result, a fundamental purpose of the supports contained in the Social Security Act 2018 is to incentivise entrance into paid employment. Politically, this has been used to justify the provision of low financial support.

**Commented [AM1]:** Should we add a sentence about the supports disabled people can have?

Despite being excluded from the workforce, disabled people’s access to welfare is still tarnished by the assumption that welfare support must be less than a person could otherwise receive in paid employment. According to Māmari Stephens, the primary focus of health/disability benefits in Aotearoa is the extent to which individuals are prevented from taking part in paid employment.<sup>140</sup> This is a purely capacity-based assessment which has “deepened and sharpened in the last decade, even as our understanding of disability, illness, and injury has also evolved”.<sup>141</sup> Medical certification plays a large role in the application process, and is mandatory for every application for job seekers.<sup>142</sup> According to s 27 of the Social Security Act 2018, a health practitioner must certify the applicant’s capacity for work, the extent to which their disability impacts their capacity, how long the effect is likely to last, and any other relevant information.<sup>143</sup> Section 37 also prescribes that the Ministry of Social Development may require a person to undergo an examination by a prescribed health practitioner when applying for the supported living payment.<sup>144</sup> This also includes an indication of a date for review of the “permanency or severity” of the applicant’s health condition.<sup>145</sup> Whether disabled people can access full welfare entitlement thus depends on a medical assessment of their physical ability to work.

The welfare system is already designed to provide inadequate financial support, and this medicalised assessment often excludes disabled people from full entitlement. This likely

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<sup>139</sup> Stephens, above n 59, at 104.

<sup>140</sup> For more discussion of “incapacity” as a basis for welfare see Stephens, above n 59, at 204-251.

<sup>141</sup> At 204.

<sup>142</sup> Stephens, above n 59, at 199.

<sup>143</sup> Social Security Act 2018 (NZ), s 27.

<sup>144</sup> s 37.

<sup>145</sup> s 37(5).

contributes to the high rates of poverty amongst disabled people. Basing provision of welfare on physical capacity presumes that disabled people are only locked out of the workforce as the result of their medical condition. This ignores evidence of extremely low employment rates across the disabled population in New Zealand, including amongst those who do have full medical or physical capacity to work.<sup>146</sup> Thus, while a medical practitioner may assess a disabled person as physically ‘capable’ of work, they may still struggle to find meaningful employment. This is problematic because those deemed to have some capacity will be liable for higher degrees of reciprocal obligation, as will not normally be able to claim an exemption from work testing. Comparatively, those found to be without any capacity have less formal levels of obligation.<sup>147</sup> While the Social Security Act 2018 envisions a system which supports those “for whom work is not appropriate”, this is evidently not what occurs in practice.<sup>148</sup>

Inconsistencies between support under the Social Security Act 2018 and the Accident Compensation Scheme (“ACC”) also highlights the focus on return to work in our welfare system. Weekly compensation under ACC amounts to 80 percent of your weekly income, which is typically much higher than what one may receive under other disability benefits.<sup>149</sup> However, disabled people who are injured on top of their disability are unlikely to be able to access this greater level of support as they are less likely to be in paid work. Disabled people who do work are more likely to be in part-time work, and are therefore entitled to less under ACC.<sup>150</sup> Ultimately, this exemplifies the principle that citizens are only afforded adequate support if they economically contribute to society.

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<sup>146</sup> StatsNZ “Labour market statistics (disability): June 2021 quarter” (18 August 2021) <https://www.stats.govt.nz/information-releases/labour-market-statistics-disability-june-2021-quarter/#:~:text=Age%2015%20years%20and%20over,divided%20by%20working%20Dage%20population>.

<sup>147</sup> Stephens, above n 57.

<sup>148</sup> Social Security Act 2018 (NZ), s 4 (d).

<sup>149</sup> See *Whakamana Tāngata: Restoring Dignity to Social Security in New Zealand* (Welfare Expert Advisory Group, February 2019) for discussion of the discrepancies between payments under the Accident Compensation scheme and other disability benefits.

<sup>150</sup> *ACC’s Delivery to priority populations: Part 4- Disabled People* (Accident Compensation Corporation, GOV-010519, June 2021) at 3.



According to Eleveld et al, welfare systems designed to incentivise beneficiaries to return to work through punitive supports can't be justified from a republican perspective.<sup>151</sup> This is because they offer inadequate financial support required for a dignified survival and active participation in civic society. Furthermore, the policies encourage a "hard paternalism" in which "obligation has become more fundamental than rights and enforcement has replaced entitlement".<sup>152</sup> Thus, New Zealand's welfare system also fails on Pettit's second requirement— the provision of a "nonnullifiable, nonstigmatising basic income".<sup>153</sup>

### ***B Nonstigmatising***

Welfare to work policies reinforce the stigma and social exclusion of beneficiaries through:<sup>154</sup>

- (1) Their exclusion from basic social human rights;
- (2) Their stigmatisation; and
- (3) Their subjection to arbitrary power.

Eleveld et al note that this is largely due to the "discretionary decisions of street-level bureaucrats".<sup>155</sup> Such discretionary power can become arbitrary power if not restrained by beneficiaries' own voices and use of democratic safeguards.<sup>156</sup> Certainly, according to Sarat:<sup>157</sup>

"being on welfare means having a significant part of one's life organised by a regime of legal rules invoked by officials to claim jurisdiction over choices and decisions which those not on welfare would regard as personal and private"

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<sup>151</sup> Anja Eleveld, Thomas Kampen, Josien Arts (eds) *Welfare to Work in Contemporary European Welfare States* (Bristol University Press, UK, 2020).

<sup>152</sup> At 9.

<sup>153</sup> Pettit, above n 130, at 2.

<sup>154</sup> Eleveld et al, above n 151, at 9.

<sup>155</sup> Eleveld et al, above n 151, at 10.

<sup>156</sup> At 10.

<sup>157</sup> Austin Sarat "The Law is All Over: Power, Resistance, and the Legal Consciousness of the Welfare Poor" (1990) 2 YJLH 2 343 at 344.

Thus, whether this relationship is one of domination depends on mechanisms of contestability—“It is only if I can effectively force it to account to my relevant interests ... that the interference is not arbitrary and ... not dominating”.<sup>158</sup>

Access to appeal and review mechanisms in the welfare system is a potential route for contestation. These mechanisms are particularly important given the level of discretion available to both medical professionals and Ministry of Social Development staff. This discretion is problematic because it results in ad hoc decisions based on a lack of understanding by case managers about “medical conditions requiring the provision of appropriate support and health services”.<sup>159</sup> For instance, Allergy New Zealand report that decisions for applicants of the Child Disability Allowance are made on an “‘ad hoc’ basis, with inconsistency seen across all levels of the application from the doctors to the WINZ officers”.<sup>160</sup> This lack of consistency emphasises the importance of sufficient mechanisms of contestability.

If applicants wish to challenge a welfare decision, the system to do so is said to be “complex, difficult to understand, divorced from their reality, confusing and even daunting”.<sup>161</sup> If a person has a dispute regarding a welfare decision, they can take the issue to the Benefits Review Committee. This can then be appealed to the Social Security Appeal Authority. However, if the dispute is related to eligibility or obligations on medical grounds, it is taken to the Medical Appeal Board.<sup>162</sup> The Medical Appeal Board offers a more restricted appeal right than other avenues. Therefore, the “siphoning away of greater numbers of decisions to the medical board” is an issue in and of itself.<sup>163</sup> The board comprises medical practitioners, appointed by the Ministry of Social Development. Unlike the Social Security Appeal Authority, the Medical Appeal Board is also administered by

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<sup>158</sup> Pettit, above n 31, at 173.

<sup>159</sup> Morton et al, above n 134, at 45.

<sup>160</sup> As quoted in Morton et al, above n 134, at 41.

<sup>161</sup> Stephens, above n 59, at 284.

<sup>162</sup> Stephens, above n 59, at 383-413.

<sup>163</sup> At 404.

the Ministry of Social Development. It is therefore perceived to be less independent.<sup>164</sup> There is also no further right of appeal from the board other than through judicial review. Given the makeup of the board, it is only able to deal with matters of fact – medical fact – as opposed to matters of law.<sup>165</sup> It is also criticised for a lack of transparency, as decisions are not publicly available, unlike the Benefits Review Committee.<sup>166</sup> Thus, there are clearly deficits in the jurisdiction and process of the Medical Appeal Board.

Due to an apparent lack of training and legal knowledge, it has also been noted that Medical Appeal Board hearings are often devoid of the principles of natural justice.<sup>167</sup> Beneficiaries' experience of the hearings are largely negative due to reports of unsuitable hearing rooms, the lack of a clear process, a feeling of not being listened to, and support people being prohibited from speaking.<sup>168</sup> Regarding a lack of clear hearing processes, there is currently no national quality management process in place for Medical Appeal Boards.<sup>169</sup> This means the process is often ad hoc and inconsistent. For instance, while the Ministry of Social Development guidelines prevent Medical Appeal Board members from undergoing medical examinations during the hearing, evidence shows that this is not always adhered to.<sup>170</sup> Furthermore, while evidence shows that attending hearings in person increases the chance of having a decision overturned, many beneficiaries report feeling as though "little allowance is made for their disability/illness and how challenging it might be for a beneficiary to attend a MAB hearing".<sup>171</sup> While legal aid is available for Medical Appeal Board hearings, beneficiaries are not informed of this option by MSD and it appears to be rarely attained.<sup>172</sup> Ultimately, "appeals to the medical board comprise one of the most

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<sup>164</sup> Stephens, above n 59, at 383-413.

<sup>165</sup> At 405.

<sup>166</sup> At 384.

<sup>167</sup> Morton et al, above n 134, at 63.

<sup>168</sup> At 63.

<sup>169</sup> At 67.

<sup>170</sup> At 73.

<sup>171</sup> Morton et al, above n 134, at 70.

<sup>172</sup> See generally Morton et al, above n 134, at 74-76.

significant challenges to the ability of the review and appeal system to be able to uphold access to justice”.<sup>173</sup>

The welfare system clearly facilitates arbitrary interference in disabled people’s right and choice to welfare support, a fundamental avenue of antipower. Decisions are made by “street level” bureaucrats,<sup>174</sup> and disabled people have little ability to ensure decisions are made fairly and according to law and policy. While there are limited appeal processes in place, these processes are not sufficiently robust enough to equalise the “resources of dominator and dominated”.<sup>175</sup> Welfare decisions are ultimately based on the unchecked opinion of medical professionals- thus, it is subject to the “arbitrium, the decision or judgement of the agent; the agent was in a position to choose it or not choose it, at their pleasure”.<sup>176</sup> Welfare in New Zealand fails on both of Pettit’s desiderata- being inadequate and facilitating stigma due to a lack of democratic safeguards.

### ***C Conclusion***

In assessing disabled people’s relationship with the state through the welfare system, I have sought to show the merit of Pettit’s framework in assessing areas of domination and subjugation. Another key interaction disabled people have with the state is through the electoral system. However, a brief analysis highlights that this is also an insufficient source of antipower for disabled people.

### ***VI Antipower in the electoral system***

One may assume that New Zealand’s democratic system enables disabled people to exercise antipower, as they are able to contest policy which places them in positions of subjugation in the first place. Certainly, deliberative democracy is a key tenet of republicanism. Antipower can be promoted by the “battery of traditional measures that

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<sup>173</sup> Stephens, above n 59, at 405.

<sup>174</sup> Eleveld et al, above n 151, at 10.

<sup>175</sup> Pettit, above n 31, at 67.

<sup>176</sup> At 55.

have been devised for the purpose” – including regular election.<sup>177</sup> However, Pettit also notes that democracy must be “not just deliberate, but inclusive”.<sup>178</sup> A particular group will only be able to use democracy as a mechanism of antipower if they are “capable of protesting against the pattern in question in a potentially effective manner: they can make themselves heard in decision-making quarters”.<sup>179</sup> As I explain, New Zealand’s democracy is not sufficiently inclusive to be a mechanism of antipower in and of itself.

### *A Capacity*

The Electoral Act 1993 does not have an explicit mental capacity test for enrolment.<sup>180</sup> This means that most people with disabilities – namely, learning disabilities – have formal legal enfranchisement in New Zealand unless disqualified on other grounds. However, a person detained in a hospital under the Mental Health (Compulsory Assessment and Treatment) Act 1992,<sup>181</sup> or in a secure facility under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003,<sup>182</sup> is disqualified from registering to vote if they have also:<sup>183</sup>

- 1) Been acquitted of a crime on account of his or her insanity.
- 2) Been found by a court on conviction to be mentally impaired.
- 3) Been subject to, for a period exceeding 3 years, a compulsory treatment order;
- 4) Or would be imprisoned for a term exceeding three years if not for detainment under the Mental Health (Compulsory Assessment and Treatment) Act 1992.

It could be argued that this exclusion is not justified, even by its own standard. It is typically accepted that prisoners are disenfranchised because they have “transgressed against society” and “abused the rights that the community values”.<sup>184</sup> The justification of the disenfranchisement of prisoners is therefore not incapacity but, rather, that they have broken a social contract. Disenfranchisement is construed as part of their punishment. Even

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<sup>177</sup> Pettit, above n 3, at 590.

<sup>178</sup> Pettit, above n 31, at 191.

<sup>179</sup> At 191.

<sup>180</sup> Electoral Act 1993 (NZ).

<sup>181</sup> Mental Health (Compulsory Assessment and Treatment) Act 1992 (NZ).

<sup>182</sup> Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (NZ).

<sup>183</sup> Electoral Act 1993 (NZ), s 80 (1).

<sup>184</sup> Paul Quinn, as reported in (21 Apr 2010) 662 NZPD 10339

if this justification is accepted, it does not naturally extend to those disqualified under s 80 (1) (c).<sup>185</sup> Being found not guilty for reason of mental health or impairment is intended to relieve an individual of the personal responsibility for their ‘transgression’, and thus ‘treatment’ is favoured over punishment. Given punishment and personal guilt is subordinate to treatment for this category of offenders, disenfranchisement must presumably be justified for different policy reasons. While not an explicit mental capacity assessment, the disqualification of this group of citizens appears to be rationalised based on mental illness or learning disability- thus effectively being a capacity assessment. This is therefore an exclusion on the basis of disability.

Even without these legal disqualifications, the extent to which our democratic processes are sufficiently inclusive is unclear, despite formal legal equality. As Fraser has highlighted, there can be “no democratic citizenship without social rights, assuming that a certain threshold of social and economic equality is necessary for inclusion”.<sup>186</sup>

### ***B Ability to exercise democratic rights***

Overseas scholarship suggests that a lack of social rights hinders disabled people’s ability to exercise their right to vote. In the United States, it has been shown that disabled people not only have a lower voter turnout than nondisabled people, but are also less likely to participate in other forms of political activity.<sup>187</sup> In a study of electoral participation in 24 EU countries, Dammeyer et al found that a disability gap in voter turnout existed in most.<sup>188</sup> The disability gap is often explained by the fact that disabled people have higher levels of poverty and lower levels of education, but the gap in voter turnout remains when controlling for other potentially confounding variables such as income and political

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<sup>185</sup> Electoral Act 1993 (NZ), s 80 (1) (c).

<sup>186</sup> Nancy Fraser *Unruly Practices: power, discourse, and gender in contemporary social theory* (University of Minnesota Press, Minneapolis, 1989) as cited in Knight, above n 2, at 101.

<sup>187</sup> Lisa Schur, Meera Adya “Side-lined or Mainstreamed? Political Participation and Attitudes of People with Disabilities in the United States” (2013) 94 *Social Science Quarterly* 811.

<sup>188</sup> Jesper Dammeyer, Madeline Chapman, Freideriki Carmen Mamali, & Jonas Henau Teglbjaerg “The disability gap in voter turnout and its association to the accessibility of election information in EU countries” (2020) 37 *Disabil Soc* 1342.

efficacy.<sup>189</sup> Disability specific barriers clearly exist, such as stringent voter registration requirements, lack of alternative voting methods, lack of training and guidance, lack of requirements to provide accessible election information, inaccessible polling places, etc.<sup>190</sup> Globally, it is accepted that disabled people's ability to exercise antipower against elected representatives is weaker than their nondisabled counterparts.

In New Zealand, the "act of choosing political representatives is perhaps the defining characteristic of full membership of the constitutional 'public'", and yet disability voter turnout is undocumented.<sup>191</sup> This lack of data is an issue in and of itself given policies and practices relating to those with disabilities can be "wasteful if developed without rich, valid information on the lived experiences of those with disabilities".<sup>192</sup> Given New Zealand's electoral system has similar barriers as overseas equivalents- such as a lack of alternative voting methods, or legal requirements to provide accessible election information- one can safely presume that disabled people in Aotearoa would have a lower voter turnout than nondisabled people.

The Electoral Act 1993 does include some provisions aimed at increasing disabled people's electoral participation- such as s 85 which allows enrolment to be done through a representative.<sup>193</sup> Furthermore, s 155 requires that at least 12 polling places within each district shall be accessible for persons who are physically disabled.<sup>194</sup> However, given electoral districts are created by population size, some are very large in land mass, meaning the set number of 12 accessible places may not always be sufficient. There are also no legal requirements for the provision of sign language interpreters at voting stations, or other

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<sup>189</sup> Dammeyer et al, above n 188.

<sup>190</sup> Dammeyer et al, above n 188.

<sup>191</sup> For information on New Zealand's democratic culture see Fiona Barker, Kate McMillan "Constituting the democratic public: New Zealand's extension of national voting rights to non-citizens" (2014) 12 NZJIL 61 at 69.

<sup>192</sup> For more information on the importance and difficulties involved with disability data collection see Adele Leagh, Jacqueline McIntosh "Projecting disability in New Zealand" (2017) 43 New Zealand Population Review 135, at 136.

<sup>193</sup> Electoral Act 1993 (NZ), s 85.

<sup>194</sup> Electoral Act 1993 (NZ), s 155.

accessible formats. Furthermore, a 2011 inquiry into disabled voters' experiences of the New Zealand general election found that disabled voters were more likely to find voting instructions unclear, and more likely not to vote due to health reasons, the polling places being too far away/having no transport, and the belief that a change in government would make no difference to their lives.<sup>195</sup>

There are also reports of attitudinal barriers to voting. Section 86 provides for people incapable of registering as an elector to be registered by a representative.<sup>196</sup> However, in the form that representatives have to sign, disabled people are described as "mentally incapable persons".<sup>197</sup> According to the Disabled Persons Assembly, parents of people with learning disabilities have reportedly not been prepared to sign the related form as they do not agree with the language and find it insulting.<sup>198</sup>

Ultimately, the "continued existence of barriers to voting not only poses a problem of legitimacy from the standpoint of democratic theory but also constitutes a breach of the law in countries where the CRPD has been ratified".<sup>199</sup>

### ***C Conclusion***

It is evident that disabled people in Aotearoa likely have limited access to democratic resources which regulate those in power. As such, disabled people have limited ability to truly contest their position of subjugation. Furthermore, the elected Government is capable of interfering arbitrarily in disabled lives, as the electoral system is not a sufficient mechanism for holding the Government to account.

Through a brief assessment of disabled people's relationship with the state in welfare and electoral participation, I have sought to demonstrate how Pettit's theory of antipower

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<sup>195</sup> Ian Binney *Disability voter and non-voter survey report* (The Electoral Commission, March 2012).

<sup>196</sup> Electoral Act 1993 (NZ), s 86.

<sup>197</sup> Electoral Regulations 1996 (NZ), sch 1.

<sup>198</sup> Disabled Persons Assembly NZ "Submission on the Inquiry not the 2020 General Election and Referendums" (2020) DisabledPersonsAssemblyNZ <https://www.dpa.org.nz/>

<sup>199</sup> Dammeyer et al, above n 188, at 3.



provides a useful framework through which to assess disabled people's domination by the state. While the outlook appears dire, Pettit's framework can also be used to assess existing legal solutions to many of the issues this paper has highlighted. The final part of this paper will demonstrate that policies and solutions rooted in the principles of the disability rights movement will equally satisfy a republican assessment. This is because both theories are concerned with recasting disabled people as active political citizens with choice and autonomy over their lives. To demonstrate how this can be done in a practical sense, I will briefly indicate how the UNCRPD upholds both republican and disability rights ideals. As opposed to upholding the UNCRPD as the solution to all the issues in this paper, I wish to highlight how republican and disability justice is an appropriate tool to use to begin to locate legal solutions.

### *VII The UNCRPD – A way forward?*

Policy and law designed with the input of disabled people, and thus the principles of disability justice, will inevitably create stronger mechanisms of antipower according to Pettit's framework. This final section briefly assesses this claim in relation to the UNCRPD. However, first I examine the similarities between Pettit's republicanism and theories of disability justice. In doing so, I demonstrate how Pettit's republicanism is a useful framework through which one can assess law and policy which seeks to alleviate disability injustice.

#### *A Republicanism and disability justice*

Pettit's focus on domination aligns closely with principles of disability justice, with both theories recognising the benefits of a powerful yet regulated central state. Traditional liberal theory has often been criticised for its "unwarranted repugnance for interdependence".<sup>200</sup> In prioritising individual freedom over any form of interference,

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<sup>200</sup> Marilyn Friedman "Pettit's civic republicanism and male domination" in C. Laborde & J. Maynor (eds) *Republicanism and Political Theory* (Oxford University Press, Blackwell, 2008) at 254 as cited in O'Shea, above n 26, at 140.

liberal theory often fails to account for the experiences of those who may require or prefer relationships of interdependence.

As a school of thought, liberalism and notions of freedom of choice were popularised in conjunction with the rise of capitalism and the free market.<sup>201</sup> It was in this environment that dependence was construed as the opposite of freedom – arguably to justify an economic and social structure which relied on citizens to feel individual responsibility for their lot in life. It was during the advent of capitalism and liberalism that the medical model of disability was also popularised.<sup>202</sup> Society was faced with the issue of what to do with those who “either cannot or will not conform to the norms and discipline of capitalist society”.<sup>203</sup> Changing ableist structures which locked disabled people into poverty, unemployment, and disempowerment would require the acceptance of state intervention and collective responsibility that was the antithesis of liberalism. Thus, disability policy was centered on curing or ‘fixing’ the disabled person, as opposed to social structures.<sup>204</sup> Ultimately, liberalism as a theory has contributed to medicalised perceptions of disability and thus can never be a satisfactory theory of disability justice.

By comparison, Pettit’s republicanism accepts that the state has a responsibility to alleviate inequity. Policy and law which focuses solely on ‘fixing’ the disabled person will never be satisfactory from a truly republican perspective, which is more concerned with autonomy, protective legal mechanisms, and the provision of material equality.<sup>205</sup> In this way, Pettit’s republicanism aligns with the social model of disability which encourages us to consider

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<sup>201</sup> This claim borrows from academic discussion of the failings of traditional liberalism to liberate those who have been so socially oppressed as to render freedom as non-interference impossible (the poor, women, racial/ethnic minorities, etc). For example, see Marilyn Friedman “Pettit’s civic republicanism and male domination” in C. Laborde & J. Maynor (eds) *Republicanism and Political Theory* (Oxford University Press, Blackwell, 2008).

<sup>202</sup> See generally Oliver, above n 16 and Mander, above n19.

<sup>203</sup> Oliver, above n 16, at 93.

<sup>204</sup> Stephen Burnbury “Unconscious bias and the medical model: How the social model may hold the key to transformative thinking about disability discrimination” (2019) 19 Int. J. Discrim. Law 26 at 28.

<sup>205</sup> Pettit, above n 3.

how society disables people with impairments, as opposed to simply seeking to ‘cure’ the impairment.<sup>206</sup>

While accepting that it may create opportunities for subjugation, republicanism and disability justice views state interference as a potential source of liberty, depending on whether state powers are “regulated in a constitutional manner”.<sup>207</sup> Rather than reject relationships of dependence inherently, republicanism aims to “ensure that those relationships of interpersonal support in which we stand are shaped in ways that resiliently protect us against arbitrary interference”.<sup>208</sup> The key question is one of accountability—whether the “arrangement offers enough incentives for officials and agencies to refrain from abuse of authority”.<sup>209</sup> Republicanism thus places its focus on autonomy and control—both central components of disability theory and the disability rights movement. Pettit himself recognised the relevance of this to disability — noting that antipower will:<sup>210</sup>

...require not just the protection of such individuals from domination but the expansion of the domain in which they can exercise undominated choice, for example, by providing the physically handicapped with the means of getting about.

Republican political theory thus favours policy which maximises the autonomy and control that citizens have over their own lives. This is pertinent for disabled people, whose lives are traditionally dominated by ‘professionals’ making decisions about how they should live, whether they should work, “the type of school they should attend, the type of support they need and whether or not they should become parents”.<sup>211</sup> Control is critical in the disability justice movement – “because the needs of people with disabilities and the potential for meeting these needs are everywhere conditioned by a dependency born of powerlessness, poverty, degradation, and institutionalization”.<sup>212</sup> “Nothing about us without us” is the motto of the disability rights movement in recognition that “when others

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<sup>206</sup> See generally Oliver, above n 19.

<sup>207</sup> Pettit, above n 3, at 597.

<sup>208</sup> O’Shea, above n 26, at 141.

<sup>209</sup> Bovens, above n79, at 465.

<sup>210</sup> Pettit, above n 3, at 593.

<sup>211</sup> Thill, above n 4, at 17.

<sup>212</sup> I. Charlton, above n 6, at 3.

“speak for you, you lose”.<sup>213</sup> This aligns closely with Pettit’s assertion that when interference is exercised arbitrarily and with impunity, it is dominating. Critical to both theories is the belief that I should have control over my own destiny.

Republicanism thus offers a framework through which one can not only assess antipower deficits, but also identify policy and law which may enable disabled people to have undominated choices in their lives. Properly implemented, the UNCRPD has the potential to improve disabled peoples’ access to antipower and widen their area of sovereign choice.

### ***B Undominated choice and the UNCRPD***

Before the UNCRPD, disability rights documents were heavily influenced by the medical model of disability. As opposed to advocating for the equal enjoyment of human rights and social participation, they were more narrowly focused on “rehabilitation, vocational training, and social assistance”.<sup>214</sup> While these areas are undoubtedly important for disabled people, this placed the entire focus of policy on the disabled individual, as opposed to disabling social structures. In this way, previous disability rights documents aligned with traditional notions of liberalism by idealising individual freedom, and thus focusing on ‘fixing’ the disabled person so that they can attain it for themselves through traditionally liberalist and capitalist means. However, in doing this, they failed to uphold disability justice which centralises autonomy and control- two policy objectives which require more than rehabilitation and medical treatment, but also opportunities for civic participation.

The UNCRPD marked a clear deviation from previous disability rights documents, developed in partnership with global disabled communities.<sup>215</sup> Ratified by New Zealand in 2008, the UNCRPD didn’t propose to create ‘new’ rights but, rather, specified how existing human rights apply to the lives of people with disabilities.<sup>216</sup> Seeing disability

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<sup>213</sup> Diane Driedger *The Last Civil Rights Movement: Disabled Peoples’ International* (St Martin’s press, New York, 1989), at 28 as cited in I.Charlton, above n 6.

<sup>214</sup> Andrew Power, Janet E Lord, Allison S DeFranco *Active Citizenship and Disability: Implementing the Personalisation of Support* (Cambridge University Press, New York, 2013) at 20.

<sup>215</sup> For discussion on the history of the UNCRPD see Power et al, above n 214.

<sup>216</sup> Power et al, above n 214.

through the lens of the social model, the UNCRPD considered how disabled people could access the same social and legal rights as others without having to fundamentally change their identity through medical treatment. As with Pettit's republicanism, this has the potential to consider disabled people's rights "in a matter that does not depend on them having a distinctive status from the non-disabled majority".<sup>217</sup> The UNCRPD clearly contemplates that disabled people should be enabled to exercise undominated choice in all areas of their lives. For this, it has both republican and disability justice aspirations.

These aspirations can be seen throughout the UNCRPD and is, in fact, the first principle underlying it – "respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons".<sup>218</sup> Properly implemented, the UNCRPD requires that this principle underlines disabled peoples' relationship with the state in all domains- thus including welfare, electoral participation, and healthcare. For instance, art 29 iterates that the universal right to vote comes with obligations to ensure voting procedures are "appropriate, accessible, and easy to understand and use".<sup>219</sup> Article 15 extends the right to be free from torture or cruel, inhuman or degrading treatment to disabled citizens, noting that the right includes not being subject to medical or scientific experimentation without free consent.<sup>220</sup> Regarding the provision of welfare, art 28 recognises the right of persons with disabilities to an "adequate standard of living for themselves and their families".<sup>221</sup> The UNCRPD has antipower requirements built into it.

Ultimately, as signatories to the UNCRPD, the New Zealand state has obligated itself to ensure disabled people have the opportunity to be actively involved in decision-making processes about policies and law directly concerning them. This clearly anticipates that disabled people should be free from intervention which is arbitrary and done without impunity, for they should be the ones involved in the design of intervention and thus

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<sup>217</sup> De Wispelaere, above n 57, at 404.

<sup>218</sup> UNCRPD, above n 7, art 3.

<sup>219</sup> Art 29.

<sup>220</sup> Art 15.

<sup>221</sup> UNCRPD, above n 7, art 28.

holding it to account. The UNCRPD meets republican aspirations by reflecting the disability rights mantra – “Nothing about us without us”.<sup>222</sup>

In this brief analysis of the UNCRPD, I have demonstrated how Pettit’s republicanism can be used not only to highlight antipower deficiencies but also to assess law and policy which seeks to alleviate those issues. Because disability rights and republicanism have similar aspirations, law and policy which centralises principles of disability rights and justice will satisfy Pettit’s framework. The UNCRPD is an example of this. This paper does not seek to assess Aotearoa’s successes or failures in implementing the UNCRPD. Rather, I have sought to use it as another example to demonstrate the merits of Pettit’s framework in the area of disability justice.

### *VIII Conclusion*

Approximately one in four New Zealanders live with a disability, and yet the disabled in Aotearoa are systematically failed by the state. In 2018, working disabled people aged 15-64 years earned a median \$901 a week from wages or salaries, \$98 less than nondisabled workers. Nevertheless, most disabled people are not in paid employment- with the employment rate in 2018 being 39.1 percent, compared with 78.5 percent for nondisabled people.<sup>223</sup> 9.7 percent of disabled people report finding it hard to be themselves, compared with 1.6 percent of non-disabled people. Furthermore, 37 percent of disabled people reported experiencing discrimination in the past 12 months, compared with 19 percent of non-disabled people.<sup>224</sup> Disabled people also experience higher rates of violence – 40 percent of disabled women experience physical intimate partner violence over their

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<sup>222</sup> This phrase is said to have been first used by disabled advocates in South Africa and Eastern Europe as per I. Charlton, above n 6.

<sup>223</sup> StatsNZ “The disability gap” (28 October 2020) <https://www.stats.govt.nz/infographics/the-disability-gap-2018/>

<sup>224</sup> StatsNZ “The disability gap” (28 October 2020) <https://www.stats.govt.nz/infographics/the-disability-gap-2018/>.

lifetimes, compared with 25 percent of non-disabled women.<sup>225</sup> In education, disabled people continue to experience poor outcomes. 2022 research conducted by the Education Review Office found that one in four parents have been discouraged from enrolling their disabled children at an Early Childhood Education service, and one in five disabled learners have been discouraged from enrolling at a local school.<sup>226</sup>

This paints a dire picture of disability in Aotearoa. For a state which has ratified the UNCRPD, these statistics also suggest that the New Zealand Government is failing to uphold its international obligations. All of these areas of state power and state failure would benefit from a republican analysis. As I have sought to demonstrate, Pettit's framework illuminates legal gaps which have failed to provide disabled people with the mechanisms and tools through which they can counter relationships of subjugation. In conducting this analysis in depth with the healthcare system, and briefly with the welfare and electoral system, I hope for this paper to propose a new way of assessing the position of disabled people in Aotearoa.

Pettit's framework allows us to see the processes which lead to the dire statistics and stories I have mentioned in this paper, thus revealing areas which can be bolstered and strengthened to improve the situation. Through this analysis I have revealed key areas in which the healthcare system could be improved in order to alleviate disabled peoples' domination – namely, complaints resolution processes and internal/external monitoring processes. Similarly, I have highlighted a need for electoral reform which improves accessibility for disabled people, and noted key deficiencies within our welfare system which lock disabled people into positions of domination.

Thus, while I have argued that disabled people are dominated by the state, Pettit's framework has provided an avenue through which I have diagnosed the problem, whilst

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<sup>225</sup> Janet L. Fanslow, Zarintaj A. Malihi, Ladan Hashemi, Pauline J. Gulliver, Tracey K.D. McIntosh. "Lifetime Prevalence of Intimate Partner Violence and Disability: Results from a Population-Based Study in New Zealand" (2021) 61 Am J Prev Med 320.

<sup>226</sup> *Thriving at School? Education for Disabled Learners in Schools* (Education Evaluation Centre, September 2022).

revealing potential solutions. The final part of this paper has attempted to highlight the positive and forward-looking potential of Pettit's framework by examining how policy and law developed with disabled people, informed by the principles of disability justice, will satisfy a republican assessment. While we are yet to see the full implementation of the UNCRPD in Aotearoa, it offers a pathway for improving disabled peoples' access to legal areas of undominated, sovereign choice. I aspire for this paper to be the starting point for a wider exploration of this potential.

Ultimately, it is only by handing power back to disabled people and providing mechanisms of contestation that we will be able to exercise undominated choice over all areas of our lives. Without this, we will never achieve a truly free Aotearoa New Zealand.



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