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New Zealand's National Health and Disability Advocacy Service: A successful model of advocacy

Jean Drage

Abstract

This paper, in exploring both the debate and practice of advocacy, uses the National Health and Disability Advocacy Service in New Zealand to describe a successful model of advocacy that is based on the concept of empowerment practiced in an independent environment and strengthened by an enforceable framework of consumer rights.

Introduction

Advocacy has been defined as "pleading in support of" another, defending or recommending in favour of a proposal.[1] However, as an action or practice, advocacy is a generic term used in a much more general sense to describe actions that support or empower individuals or groups. On a broad continuum, advocacy can range from representing others to self-advocacy, where individuals either take their own actions or are supported to speak for themselves through information and education.

The term "advocacy" is also used in many different environments. While it has become more commonplace for advocacy to be used as a tool or strategy in the fields of social work, health, or disability, it is nevertheless also used by many professionals, such as lawyers, nurses, or trade union officials. While this notion of advocating for another in a court of law, or within an institution or workplace clearly demonstrates a paradox in the word itself, this type of advocacy is not the focus of this paper.

In this paper, advocacy is defined within the model of empowerment where an individual or group is informed of their rights and choices and, if required, supported and assisted in moving toward a resolution of current and future issues.

The paper has two purposes. First, it briefly explores the ideas and debate around the concept of advocacy, defining the term and outlining a range of approaches taken to working with individuals and groups. Second, it presents a case study of an advocacy service currently operating in New Zealand. I discuss how the thinking behind the practice of advocacy has been applied within the health and disability sector in a practical sense. This case study outlines the background to and origins of this service, how the framework of consumer rights within which

this advocacy service operates, how the service currently operates throughout New Zealand, and ways in which the success of this model of working with and empowering consumers is measured. Research for this paper draws on secondary sources (published research, university-based research papers, websites, and speeches) and interviews with key informants in the Health and Disability Advocacy Service.

It is important to declare my bias and intent as the writer of this paper. I am a member of the National Advocacy Trust, which is contracted to the director of advocacy in the Office of the Health and Disability Commissioner to provide the advocacy service described in the case study, the intention being to promote what the Trust sees as a successful model of advocacy in the health and disability sectors.

The nature of advocacy

While the word "advocacy" is commonly used in an extensive range of settings, there is little consensus or in-depth analysis of how advocacy is used in practice, or what it is to be an advocate. Although the word originated with the legal system, the concept of advocacy has gained prominence as a relatively new approach to social intervention since the social movements of the 1960s.[2] These movements challenged power bases and social injustice and promoted individual rights and acceptance of difference, particularly around race, gender, and age.

This rights-based focus is apparent in definitions of advocacy developed since the 1960s. For instance, Ezell (1994) argues that advocacy is about "permitting equality through promoting individuals' participation, information, voice and power."[3] Parsons (1994) says, "Advocacy should ultimately be aiming to remedy injustices, not simply to make those injustices more bearable. This means that advocacy will generally be aiming to bring about the sort of social and structural change that will give people … a more integral and pivotal place in all the many environments in which people live, work and interact."[4]

Wealleans (1998) points us to a range of situations in which advocacy is practiced and to a number of models that advocates use.[5] She identifies two predominant forms of advocacy: case and cause. Case advocacy refers to advocating with or for an individual, whereas cause (or systemic) advocacy is more issue-based and group oriented, implying a different approach to advocacy. The way that advocacy is actually practiced (that is, the model or type used) can depend on whether the focus is on an individual (as in case advocacy) or a group issue (cause advocacy).

There are a number of models that advocates can use to plead on behalf of, inform, or empower others. These range from formal and legalistic approaches to more independent, supportive approaches. They include:

* Instructed advocacy: Advocates act on the lawful instructions of the individual, so assuming the competency of the individual and respecting their opinion.

* Non-instructed advocacy: Advocates act independently of the individual, in some cases through necessity as the individual may be incapacitated or does not have the skills to advocate for themselves.

* Systemic advocacy: A process that takes on generic issues that affect individuals and groups. The focus here is usually on structural or political issues, with advocates acting as spokesperson.

* Empowerment advocacy: A process that emphasizes sharing resources and information and teaching individuals the skills needed to facilitate their own empowerment, with self-advocacy being the ultimate goal. The empowerment concept here is to help others gain access to power.[6]

Within and across these models, a range of terms is also used. For instance, citizen advocacy (a one- on-one relationship between a trained citizen advocate and a person at risk) appears to sit within the non-instructed model, as does best-interest advocacy and crisis advocacy. Peer advocacy (when one advocates for another experiencing similar difficulties) and legal advocacy (work undertaken by lawyers on behalf

of health and social services users), both align with instructed and systemic advocacy. Types of advocacy range from support, joint, and representative (speaking on behalf of), with the levels depending largely on how much an advocate does for another.

The selected model is generally dependent on the individual or group and the desired result. It is clear, however, that the inappropriate use of a model can perpetuate the social injustice that advocacy is trying to remedy, particularly if an advocate's personal motives or circumstances interfere with the approach.

Definitions and models aside, the current debate around advocacy largely centers on two major issues: the level of independence an advocate needs (and is seen to have) to ensure that they are working for or on behalf of an individual or group, and the difference between advocacy and mediation.

The independence debate has focused on whether advocates have a conflict of interest between those they are advocating on behalf of and those who fund their employment (plus other workplace tensions). In some instances, this has led to a belief that advocates must be volunteers, as payment creates a conflict around the advocate's accountability.

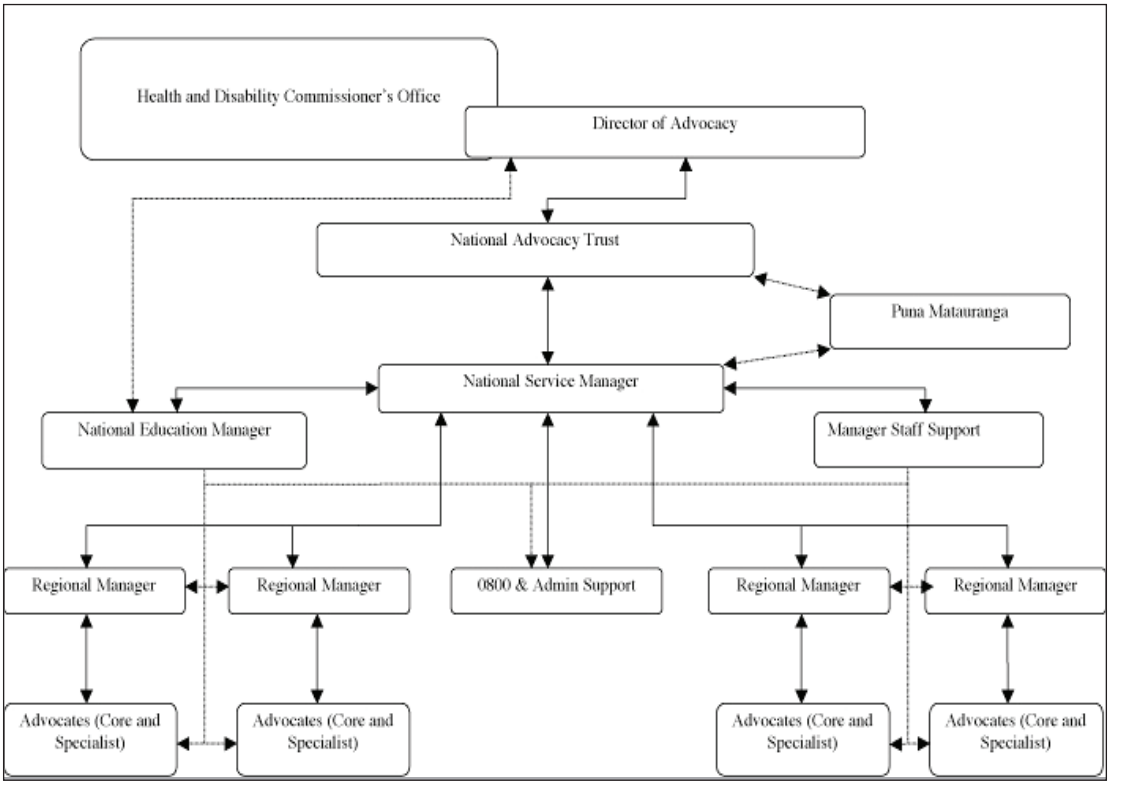
There are similar tensions around the impartiality of an advocate who works within a hierarchical profession or workplace. For instance, nurses have long believed that advocacy is an essential part of their role due to their relationship with vulnerable patients. However, the lack of autonomy that nurses have historically had within health bureaucracies and the doctor-nurse relationship (prior to the advent of the nurse practitioner role) has led to accusations of "challenging authority" and "whistle blowing" when nurses have spoken out on behalf of patients.[7] As a consequence, the issue and the patient can get lost in the dispute over whether and how the nurse is doing her or his job. It is of note that in the report of the Cervical Cancer Inquiry (held in New Zealand in 1987), in recommending that patient advocacy be implemented within National Women's Hospital, Judge Cartwright stated that as nurses were "conditioned to protect patients by stealth…they cannot therefore be effective advocates who will act bravely and independently."[8]

The advocacy versus mediation debate has pivoted around the claim that advocates' work on the consumer or complainant's side is different from mediating a solution or complaint with all involved parties. There has been confusion around these distinct roles, with some initial approaches to advocacy tending more towards the mediation role. But the two roles are very different. A mediator must be neutral to help resolve conflict, while an advocate must be partial in order to work with a consumer or complainant. This debate and the more recent focus on empowerment advocacy are discussed, in greater depth, in the following case study, as they underpin the way in which the Health and Disability Advocacy Service developed and currently operates in New Zealand.

Case study: New Zealand Health and Disability Advocacy Service

New Zealand has had a nationwide, publicly funded health and disability advocacy service since 1996. It is the only independent advocacy service that operates nationwide, and as such, employs the largest number of advocates promoting a code of rights in New Zealand's health and disability sectors. It operates through a national contract between the director of advocacy in the Health and Disability Commissioner's office (a publicly funded crown entity) and the National Advocacy Trust (the governing body). The trust employs a national service manager, who has four regional managers, a national manager responsible for education and training services, and around 50 employees throughout the country (as of February 2011). This organizational model is outlined in Figure 1.

Figure 1. New Zealand Health and Disability Advocacy Service organizational model



BACKGROUND

New Zealand is unique in having a no-fault medico-legal environment. Accident compensation legislation introduced in 1974 provides no-fault personal injury cover for all residents. As a result, all victims of medical error are rehabilitated and compensated through a state-funded scheme. Further, consumers of health care services are protected by a Code of Health and Disability Consumer Rights that applies to all public and private health care providers. Complaints alleging a breach of this code are dealt with by the Health and Disability Commissioner's office through advocacy and other processes.

Independent patient advocacy within a hospital setting was first mooted during the Committee of Inquiry into Allegations Concerning the Treatment of Cervical Cancer at National Women's Hospital (in Auckland) in 1987.[9] This judicial inquiry was launched after a national magazine, Metro, published an article on controversial research that was undertaken without consent in this hospital and had led to a large number of women developing cervical cancer.[10] The resulting report contained specific recommendations on the appointment of an "independent and powerful advocate for the patient" who would ensure a focus on patient needs, better information for patients, the addressing of grievances, and input into ethics committees and teaching.[11] The report also recommended that a health commissioner be appointed to help negotiate and mediate patient complaints and establish and promote a code of patients' rights.[12] Overall, as Paterson (2002) explains: "The Cervical Cancer Inquiry signalled a fundamental shift in public attitudes towards the medical profession. Demands for patient autonomy challenged physicians' traditional approach of beneficence and paternalism."[13]

Legislation eventually passed in 1994 to "promote and protect the rights of health and disability services consumers" and "secure the fair, simple, speedy, and efficient resolution of complaints relating to infringements of those rights."[14] When enacted, the scope of the Health and Disability Commissioner

legislation had widened to cover the disability sector. This statute set up an Office of the Health and Disability Commissioner, who acts as an independent ombudsman, established a consumer advocacy service, and provided for a code of rights. An independent director of advocacy, based within the Health and Disability Commissioner's office, contracts for consumer advocacy services, monitors the performance of these services, and has responsibility for advocacy promotion and education. The protracted debate and process around the drafting and passage of this legislation is outlined in Sandra Coney's book Unfinished Business.[15] Further, the influence that the funder / provider model in health services had on the political environment at this time and on the legislation enacted is outlined in Natalie Weallean's thesis "The Quest for Consumer Voice."[16] A key element of this advocacy service is that while publicly funded, it operates independently of the Health and Disability Commissioner, government agencies, and health and disability services providers.[17]

The Code of Health and Disability Services Consumers' Rights

In 1996, after a period of public consultation, the Health and Disability Commissioner developed and adopted the code of patients' rights used within this advocacy service. This code is a government regulation, so has legal status and can be enforced. Only the Minister of Health can make changes to the code. It also includes an obligation on health and disability services providers that they take "reasonable actions in the circumstances to give effect to the rights, and comply with the duties."[18]

This code states that health and disability services consumers have:

1. The right to be treated with respect

2. The right to freedom from discrimination, coercion, harassment, and exploitation

3. The right to dignity and independence

4. The right to services of an appropriate standard

5. The right to effective communication

6. The right to be fully informed

7. The right to make an informed choice and give informed consent

8. The right to support

9. Rights in respect to teaching or research

10. The right to complain[19]

While there are various other codes in New Zealand that provide consumers with rights in relation to services or practices, they tend to be self-regulatory, so are seen and used as guides and protocols rather than being enforced. For instance, the Accident Compensation Corporation (ACC) has a Code of ACC Claimants' Rights, which outlines a process that encourages positive relationships between staff and those raising concerns and making complaints about ACC's service.[20] The New Zealand Aged Care Association has a code of residents' rights and responsibilities that guides those providing care to older citizens.[21] The Code of Family Rights, for families with a member suffering serious mental illness, provides guidelines for education, advocacy, and support.[22] There are many codes of practice within industry and throughout the public, private, and non-government sectors. These codes are all voluntary, and are based on principles, guidelines, and in some cases, obligations. The Code of Health and Disability Services Consumers' Rights is enforceable and supported by a complaints process and an advocacy service.

Further, the Code of Health and Disability Services Consumers' Rights is backed up by the Health Information Privacy Code of 1994, which protects health information relating to individuals and held by agencies that provide health or disability services or are part of the health sector. This code relates to the confidentiality of collection of health information, the sensitivity of this information, and its ongoing use. Like the Code of Health and Disability Consumers' Rights, the Health Information Privacy Code also has legislative status so is enforceable. These statutes were passed following a period in which recognition of individual rights in New Zealand had resulted in new legislation, such as the New Zealand Bill of Rights (1990), the Human Rights Act (1993), and the Consumer Guarantee Act (1993).[23]

Finally, information about the Code of Health and Disability Services Consumers' Rights and the Advocacy Service is available in 35 languages, ensuring a wide readership among an increasingly diverse population.

The advocate's role

The advocacy service assists health and disability consumers in upholding their rights and resolving complaints about breaches of the code. Broadly, the functions of an advocate are:

- to ensure that health and disability services consumers are aware of their rights, as outlined in the Code of Health and Disability Consumers' Rights

- to promote awareness of the procedures for complaints involving possible breaches of these rights

- to provide consumers with the assistance needed to ensure that informed consent is obtained when health care procedures are carried out

- to promote awareness of advocacy and processes for providing information and obtaining informed consent

- to receive complaints regarding health care or disability services providers who may have breached the Code of Health and Disability Consumers' Rights, and

- to represent or assist complainants in the resolution of complaints.

In essence, advocates "assist consumers in low level resolution of complaints involving breaches of the code of rights and promote awareness of these rights to providers of health and disability services."[24]

Along with the enactment of this legislation, the Health and Disability Commissioner issued guidelines in 1996 that required advocates to "work with the consumer in a manner which supports them and gives them skills, knowledge, and confidence to resolve the current issues with assistance and resolve future issues without assistance."[25] These guidelines emphasize that health and disability advocates practice empowerment advocacy, requiring them to direct a process that assists a consumer in resolving a complaint. These guidelines were revised and updated in 2005 following a consultation process. The revised guidelines were formally gazetted on March 24, 2005 (No. 56, p. 1433).

As stated on its website, the advocacy service aims to assist consumers to see:

- themselves as people with rights who have the resources to find solutions to their own problems

- themselves as having skills and strengths

- advocates as having knowledge and skills that consumers can use

- advocates as peers and partners in finding solutions and driving change

- that power structures are complex and partially open to influence.[26]

This emphasis on empowerment advocacy is written in detail in the national contract between the director of advocacy and the National Advocacy Trust, which employs the health and disability advocates. This contract provides considerable detail on the advocates' role, including that they must adhere to these empowerment guidelines and provide a consumer-driven practice. Principles of operation and performance standards are also included. Advocates also have a code of practice and competencies that they are expected to meet.

In terms of the predominant forms and models of advocacy outlined in the first part of this paper, health and disability advocates clearly practice case advocacy and work, predominantly within the empowerment model. Other models, which are rarely used, include instructed advocacy when consumers are particularly vulnerable (this approach requires approval) and systemic advocacy where the advocacy service is required to report to the Commissioner on public safety type issues for consumers.[27]

The development of the advocacy service

It is pertinent, before we look at how this advocacy service operates today, to review its development after the legislation was passed in 1994. The origins of this service demonstrate the different ideas and approaches that have been discussed in the first part

of this paper, as well as in the debate on advocacy versus mediation. Reviewing the initial setup also clarifies the empowerment approach expected of the current national service.

The debate on how an advocacy service should operate began well before the Health and Disability Commissioner legislation was passed in the New Zealand Parliament. While the Cervical Cancer Inquiry recommended an advocacy service be established and one advocate was appointed almost immediately to work in the National Women's Hospital in Auckland, decisions about how a national advocacy service would operate remained unresolved for about three years.[28] It was initially proposed that the Health Commissioner would employ advocates, but a change of government and opposition from the medical community to much of the proposed legislation resulted in the establishment of an independent advocacy service. Under this new model, a director of advocacy role was established to purchase advocacy services from community providers and provide the link with, and accountability to, the commissioner's office.

Deliberations around models of advocacy during this time are covered in a 1992 report by Margaret Vennell and the response of consumer groups to her recommendations. When asked to report to the Minister of Health on the options of establishing a health advocacy service or a mediation service, Vennell concluded that the imbalance of power and information between health professionals and their clients made a consumer advocacy service essential. She noted, "The advocate is there to put forward the views and requirements of the patient [and] ….is not a mediator between the patient and the health provider."[29] Early intervention was also seen as key to redressing power imbalances, whereas conciliation came too late in the process.[30]

Vennell also suggested that the advocacy service should appear as independent as possible, although this raised concerns among consumer groups about the link between advocacy and the Health Commissioner's office, secure access to funding, and continuity of a nationally consistent and effective service Groups felt that without this direct link, "the Commissioner would be dependent on members of the public laying complaints [which] … would only ever give partial, occasional glimpses of how well the system was doing on patients' rights."[31]

The advocacy service was established in mid-1996, once the code of rights became effective, after a lengthy contract process in which service delivery proposals were considered. The prerequisite for these contracts was that services must be totally independent of health and disability purchasers and providers. According to Wealleans, of more than 300 expressions of interest in tendering for this initial advocacy services, only 72 fulfilled the independence criteria.[32] Initially, there were ten three-year contracts, creating new services in some areas and linking with some existing services (in Northland, Auckland, Waikato, Christchurch, and Otago) that had been set up in anticipation of this legislative change. By 1999, the number of contracts had decreased to three (Northern, Central and Lower North Island, and the South Island) with providers having merged into larger organizations. In 2006, the Director of Advocacy and a National Advocacy Trust agreed to one national contract.

Three types of groups were awarded the initial contracts: existing advocacy groups working within the health and disability sectors; those working within a mediation model or as complaints services; and newly established services. Prior to the health and disability legislation, all patient complaints had been dealt with by health professional boards, which set up disciplinary committees containing mainly health professionals and few consumers. This process has been described as lengthy, difficult to access, and intimidating for consumers.[33] As an alternative, the lengthy debate around the Cartwright Enquiry resulted in some public health authorities establishing advocacy positions within their hospitals well before legislation required them to do so.

In Canterbury, for example, Advocacy Services Canterbury was established in 1991. The commissioner managing the Canterbury health board in 1991 had chaired an ethics committee and saw the value of having health advocates, so took the initiative to set up and fund this service. Tony Daly, who managed the Christchurch advocacy service at this time, described how they were initially situated at the front door of the hospital so several of their first clients were people leaving the hospital unhappy with the service they had received. The health board's guidelines clearly stated that this was to be a free, independent, and "partial" service, emphasizing 'being on the patient's side'.[34] Initially there were five advocates,

their job being to deal with complaints and to promote advocacy through an education/information program. By 1993, this service was being funded by the central government department, the Ministry of Health, and in 1996, when the board won the new contract for the Health and Disability Advocacy service, the number of advocates increased to seven.

According to Daly, different approaches were taken to advocacy in these early services. In Southland/Otago and the Wanganui area, a problem solving or social work approach was taken; in Auckland, the site of the Cervical Cancer Inquiry, the service was seen to be more adversarial. In the Waikato, there was a mediation service, but it was criticized for its structure, composition, and accountability.[35] In those early days, there was little debate about what advocacy actually was, although there was a clear boundary around the basic concepts of independence, partiality to consumers, and a free service. This, of course, changed once the Health and Disability legislation was enacted, outlining clear requirements and guidelines on the advocate's role, but it reflects the on-going debate around advocacy, discussed earlier in this paper.

Consistency in the quality of this advocacy service was clearly spelled out in the contracts between the Director of Advocacy and each service provider. To ensure this consistency, the intention was to eventually have one contract with one service provider and the number of advocates gradually increasing. By 1999 there were only three contracts: the Health Advocates Trust (HAT), which covered Auckland and the Northland region, Advocacy Network Services Trust (ADNET) in the lower North Island, and Advocacy Services South Island Trust (ASSIT) in the South Island. By 2006, the director of advocacy had one contract with a National Advocacy Service.

Today's National Advocacy Service

Today, the National Advocacy Service provides a free, independent, and confidential service throughout New Zealand to all users of health and disability services. Access is provided through a Freephone number coordinated by a national call centre advocate. Around 50 advocates are located in 25 community-based offices throughout the country, and six of them provide specialist services for the deaf community and for refugee/migrant communities. The service is managed by a national service manager, four regional managers and a national education and training manager. A Kaumatua advisory group, Puna Matauranga, trains and supports advocates when working with Maori clients and works with the Advocacy Trust to ensure accessible and culturally appropriate service. Dyall and Marama clearly identify the importance for Maori and other populations who have limited voices, power or influence, of being able to access and use government-funded advocacy services.[36]

The task of supporting people to be heard is broken down into two major areas of advocacy work.[37] In the first area, advocates deal with complaints and promote advocacy and the Code of Rights to providers and consumers, and they work with all residential homes to provide education and training. Advocates listen to consumer concerns, provide information, clarify issues, explain available options, and support consumers in the actions they take to resolve the complaint. Secondly, advocates train consumers and provider groups on consumer rights and provider obligations.

In the financial year ending June 2010, the advocacy service dealt with 10,440 inquiries, with almost 70 percent of callers receiving information on advocacy and the code and most of the rest being referred to other agencies. Advocates dealt with 3,820 complaints (with 88 percent fully or partially resolved), had at least one contact with all rest homes and disability homes in New Zealand, and presented a total of 2,051 education and training sessions to a range of consumers, providers and organizations.[38] Thus, contact with the nationwide service has increased by 61% since it came into operation in 1996.[39] In the same year, advocates made 4,363 networking contacts - an important part of raising their profile, identifying opportunities for future education sessions, and generating confidence among consumers who may be reluctant to make a complaint.

The management of this advocacy service is the overall responsibility of a national service manager who reports to and is accountable to the National Advocacy Trust. The trust is the governance body that sets policy and employs all advocates. A contract between the trust and the director of advocacy outlines the services and required outputs and pro-

vides for funding, monitoring, and quality assurance. Figure 1 provides an overview of this organizational structure.

A database for all inquiries and complaints is managed nationwide, as is an ongoing skills training program. The service will also offer all staff training for a tertiary qualification in health and disability advocacy in 2012, with future skills development and assessment to follow. Advocates attend a national training conference and two regional training events each year, and they are assessed against a set of core competencies and Maori cultural competencies.

Independence: A key factor

Independence is a key factor in a successful advocacy service. There has been a clear expectation from the beginning that the Health and Disability Advocacy Service be an independent, non-medical agency that promotes consumer rights. To ensure this, advocacy services were introduced under separate legislation and independent of a government department.

The decision to appoint a director of advocacy to purchase advocacy services from within the community was also a clear signal that independence was crucial to the successful functioning of this service. While the director of advocacy is an independent statutory officer based in the Office of the Health and Disability Commissioner and accountable to the Commissioner for the efficient, effective, and economical management of the service, the director must act independently. Separating the funding from service provision has ensured this independence, despite the funding coming through the Health and Disability Commissioner's office (from Vote Health).

Even so, there are ongoing tensions. There was concern about the consistency of advocacy service delivery when there were several providers. There was also some early unease around the ability of advocacy services to reinforce legislative regulations, but as Wealleans points out, the government at the time guaranteed "the independence and authority of advocacy services within the overall framework of the Health and Disability Commission."40 This independence is defined in Sections 24 and 26 of Part 3 of this legislation.

There are still concerns regarding the contractual arrangements between the Health and Disability Commissioner and the advocacy service. Former commissioners have consistently argued for advocates to become employees of the commissioner, and in 2009 proposed an amendment to the legislation that would enable this. This recommended change was based on a desire to manage the recruitment of advocates, the quality of service, and efficient use of resources.[41] To date, however, there has been no government support for this recommendation.

Measuring the success of this model

Former Health and Disability Commissioner Ron Paterson has argued that while this new patient protection system was designed to provide a means for resolving complaints, it "was also intended to serve as a catalyst for quality improvement throughout New Zealand's health care system.[42] While no outcomes-based data is available showing a causal link between the quality of service and the complaints mechanism, Paterson points to increased awareness around patients' rights and a wide range of patient safety initiatives as evidence of the benefits to health consumers.[43]

Research is available on the outcomes of the health and disability advocacy service. Early research from 1998 looked at consumers' views on the need for advocacy services, finding that advocacy is beneficial on two levels: on outcomes achieved and on the support extended during the process. Respondents stated that they felt more empowered when working with an advocate who was providing a service backed up by legislation.[44]

Consumer feedback surveys and annual audits also measure the success of the service. In 2010, 90 percent of surveyed consumers expressed satisfaction with the advocate who assisted them, citing as positive their advocate's professionalism, knowledge, communication, and clarity around issues and options. Further, 80 percent of providers were satisfied with the professionalism of advocates as well as their ability to focus on resolution rather than blame.[45]

Independent audits conducted annually for the director of advocacy also reveal a high level of satisfaction. A 2008 Bennett and Bijoux social audit of consumers and providers confirmed that the majority of those surveyed reported positive perceptions and experi-

ences with the service. Examples included working 'on the side of the consumer while maintaining a balanced view of the situation,' flexibility of approach, reliability and quality, and advocates' effective core skills (such as listening, providing realistic advice, and being supportive).[46]

Conclusion

For a service that emphasizes "resolution, not retribution" and "learning, not lynching," the New Zealand National Health and Disability Advocacy Service demonstrates that an empowerment approach and an independent service can provide an advocacy model that addresses the debate and issues around advocacy.[47] The history of this advocacy service points us to the early debates around the type of advocacy practiced, the essential difference between advocacy and mediation when dealing with complaints, and the need for a clear approach to advocacy that ensures health consumers are empowered by the processes used in resolving complaints.

As this case study shows, the key element in the practice is clear and demonstrated independence. And in this case, the element of independence is strengthened by an enforceable framework of consumer rights within which advocacy operates. While these elements contain some tensions that fuel ongoing debate, they also provide a point against which success can be measured.

Perhaps it is a mistake to suggest that the uniqueness of New Zealand's health care system creates an environment in which advocacy can be more successful. Rather, I would suggest that this case study presents a challenge to other countries to provide health consumers with similar rights and empowerment tools that enable them to access information, support, and quality health care.

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33. K. Munro, The implementation of the recommendations of *the Cartwright Inquiry and related women's health issues: A report prepared from an Anzac Fellowship in New Zealand*, February - May 1990, p. 33.

34. Interview with Tony Daly, National Education Manager, February 17, 2011.

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36. L. Dyall and M. Marama, "Health advocacy - counting the cost," *International Journal of Mental Health Addiction* 8 (2010), p. 196.

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38. Health and Disability Commissioner, *Annual report for the year ended 30 June 2010*, pp. 17-22.

39. Wealleans (1998, see note 2), p. 213.

40. Wealleans (1998, note 2), p. 108.

41. Health and Disability Commissioner, *A review of the health disability commissioner act 1994 and code of health and disability services consumers' rights.* Report to the Minister of Health, June 2009, p. 6.

42. Paterson (2002, see note 13).

43. Ibid.

44. Wealleans (1998, see note 2), pp. 209-210.

45. National Service Manager, National Advocacy Trust Annual Report on the Nationwide Health and Disability Service 1 July 2009 - 30 June 2010, p. 5. See also the Health and Disability Commissioner, Annual Report for the Year Ended 30 June 2010, p. 21.

46. Bennett and Bijoux, Social Audit of the Nationwide Health and Disability Advocacy Service 2007-2008, p. 50. Note that this audit of the service is based on an overall 29% response rate although it was supplemented by focus groups to ensure the views of those using the service were covered.

47. R. Paterson, "Protecting patients' rights in New Zealand," *Med Law* 24/1 (March 2005), pp. 51-60.