Initiating responsive and efficient disability services

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ABSTRACT

Government interventions in rehabilitation are guided by policies. Advocates of policy too often provide too much information that is filtered or biased due to a strong emphasis on stakeholder participation and citizen engagement in the policy-making process. A lack of scientific evidence and the absence of a culture of evidence-based policy-making in the disability sector lay the ground for policy neglect and inadequate service delivery outcomes. This article examines the reasons behind policy neglect within the South African disability environment. It explores alternative approaches for policy effectiveness and takes a closer look at how collaborative relationships influence the structure of rehabilitation plans and its impact on the overall design of policy value chains for people with disabilities. The article calls for policy action that integrates people with disability into society through the advancement of community based structures supported by the correct mix of policy instruments thereby initiating a responsive disability service.

Key words: Policy-making, policy instruments, rehabilitation, allocative efficiency, disability services

Introduction

Worldwide, governments are forced to become more responsive to the social needs of their citizens. People with disabilities (PWD), women and the aged are the hardest hit by inequalities. Two types of inequalities affect performance of people with disabilities:

- Inequality of outcome (educational attainment, inaccessible disability services, health and social systems and unequal income).

➢ Inequality of opportunity (discrimination and social exclusion).

The result of these two inequalities feed poverty and instability forming an unmanageable spiral of social and economic effects. Coping with change and answering a call for better service delivery within the disability sector entails that capacity building interventions must be supported by policy-orientated actions that occur within the context of restraining and driving forces thereby creating a quasi-stationary balance[1]. Understanding the dynamics of the restraining and driving forces that exacerbate poverty and increase inequities that affect people with disabilities are pivotal in building rehabilitation value chains that bring forth responsive policies to meet the demands of disabled persons.

Policy has a specific purpose, a goal or programme action that answers a specific issue or problem[2]. Policy therefore presents us with a kind of guide or roadmap that delimits action and allows us to allocate resources within the specified field of activity. The core of disability policy centers on creating social change whereby people with disabilities overcome barriers to social exclusion. It is argued that policy action can only be effective and efficient when it supports the integration of people with disability into society through the development of community based structures that are intertwined with social advancement strategies[1]. Hence, social advancement strategies form key elements for creating beneficial social change. Experience has showed that concerns or problems that demand social change and transitions in the disability sector are met more effectively through a community development methodology[1]. By taking on a community development methodology that intertwines with poverty reduction strategies, therefore, not only guarantees collective problem solving of rehabilitation issues but it also encourages joint implementation of rehabilitation plans.

Perhaps the most undervalued and misinterpreted interventions are those based on the economic and social contributions the PWD can make to society. Improving the quality of life of PWD depend on raising their standard of living. Quality of life is influenced by the level of productivity and competitiveness. Improving the determinants of productivity as well as enhancing the rate of productivity growth for PWD, means that disability-related issues become highly complex.

How disability-related issues are judged and the value government awards to solving disability-related problems or issues not only influences the fiscal value placed on meeting the demands but also influence how problems are formulated and alternative solutions offered to solve the problem. Who influences or controls the policy-making process and the power that stakeholders have in pressurising policy agendas determines how social security safety nets, health care reforms, disability services, rehabilitation interventions and poverty reduction strategies are put together in order to create strategies that combine in removing social barriers that impede the performance of PWD. In order to build responsive and seamless services for PWD, the author investigates the reasons for poor performance of disability policies and explores alternative options that compel policies to clearly articulate the impact and benefits gained through access, choice, participation, safety and security as well as empowerment interventions (skills development).

If occupational therapists and other health professionals want to contribute and achieve positive outcomes for disabled people in their respective fields they must have an in-depth understanding of the policy-making processes. A sound understanding of the impact of policy allows them to become proactive participants whereby they form collaborative relationships that serve as a bridge between stakeholders promoting co-operation within the communities and establishing links between national, provincial and local spheres of government.

The design of information efficient systems that underscore the role that different stakeholders play towards reaching policy endorsements are critical success factors in accomplishing smooth policy implementation strategies. The success of policy outcomes in the disability field is therefore closely tied to political and economic agendas.

The policy process: Agenda-setting and its impact on disability-related issues

Policy is about the expression of intentions. What gives rise to a public policy is an issue or problem raised by one or more stakeholders in society to which they demand action that will create change and lead to improved circumstances. The way in which the problem is articulated determines if the problem will reach the agenda-setting stage and mobilise policy-makers to change the status quo in favour of the identified problem[2]. The preliminary process of agenda-setting is a methodical process of planning and action. It clearly defines a problem and provides specific priorities to approach the problem by mobilising support from the decision-makers to take appropriate action.

In the South African environment, policy is all about power and managing power relationships, while policy-making is about structuring the agenda of social and political life. Whereas agenda-setting forms an integral part of the political, social and economic environment, it is the forces in society that accumulate power which determine the direction of the policy agenda. For this reason, the importance and role of agenda-setting in building a responsive disability service must not be underestimated as poor representation and participation in the policy process brings about policy neglect. Participation (ratification, consultation, negotiation, and execution) and building collaborations between people with disabilities and other stakeholders are critical success factors in the agenda-setting process. This encourages social advancement and development through a bottom-up approach that:

➢ Offers PWD the opportunity to exercise their democratic choices in determining development priorities and service delivery outcomes.
➢ Initiates collaborative relationships that offer opportunities to create unique products and services that have more value combined and serve to uplift people with disabilities as it effectively reduces inequities that hinder sustainable development.
➢ Are responsive to the needs and priorities expressed by PWD and health professionals and other stakeholders.

Figure 1 (on page 20) presents a model for policy-making and forms the basis for discussion in the article as it highlights those activities that are critical to achieve positive policy outcomes. The policy cycle always starts with the identification of a problem and the ability of the stakeholders to articulate the problem in such a way that it reaches the agenda state.

When the policy agenda state is reached, stakeholders have to be aware that the status awarded to a specific problem is determined by the perception of associated risks as this governs how government will approach the problem. People differ in their willingness to take risk. Attitudes, assumptions and perceptions towards risk exert considerable influence on strategic choice[3].

The value of the agenda-setting is twofold. Firstly it determines who controls the policy-making process and secondly it determines how stakeholders influence the overall process. The policy-making agenda consists of systemic and institutional types of agenda-setting. A systemic agenda describes the broader set of issues faced within society (*Figure 1*). All problems must pass through the prescreening or systemic stage, justifying policy attention. Gaining support for the problem or issue forms the focus for further clarification, formulation and structuring before the importance of acting on the demand through the policy system is put across by the policy-makers. Only a small portion of the issues on the systemic agenda receive government intervention. The institutional agenda includes problems that were successfully articulated and received formal attention from government.

In order to access and ultimately influence the policy agenda, stakeholders need information and resources. It seems that stakeholders in the disability field have great difficulty in articulating contextual issues and problems as most of the disability-related issues remain systemic in nature and are unable to progress to the institutional agenda[4, 5]. For this reason, the disability sector finds it challenging to move past draft strategic plans or implement

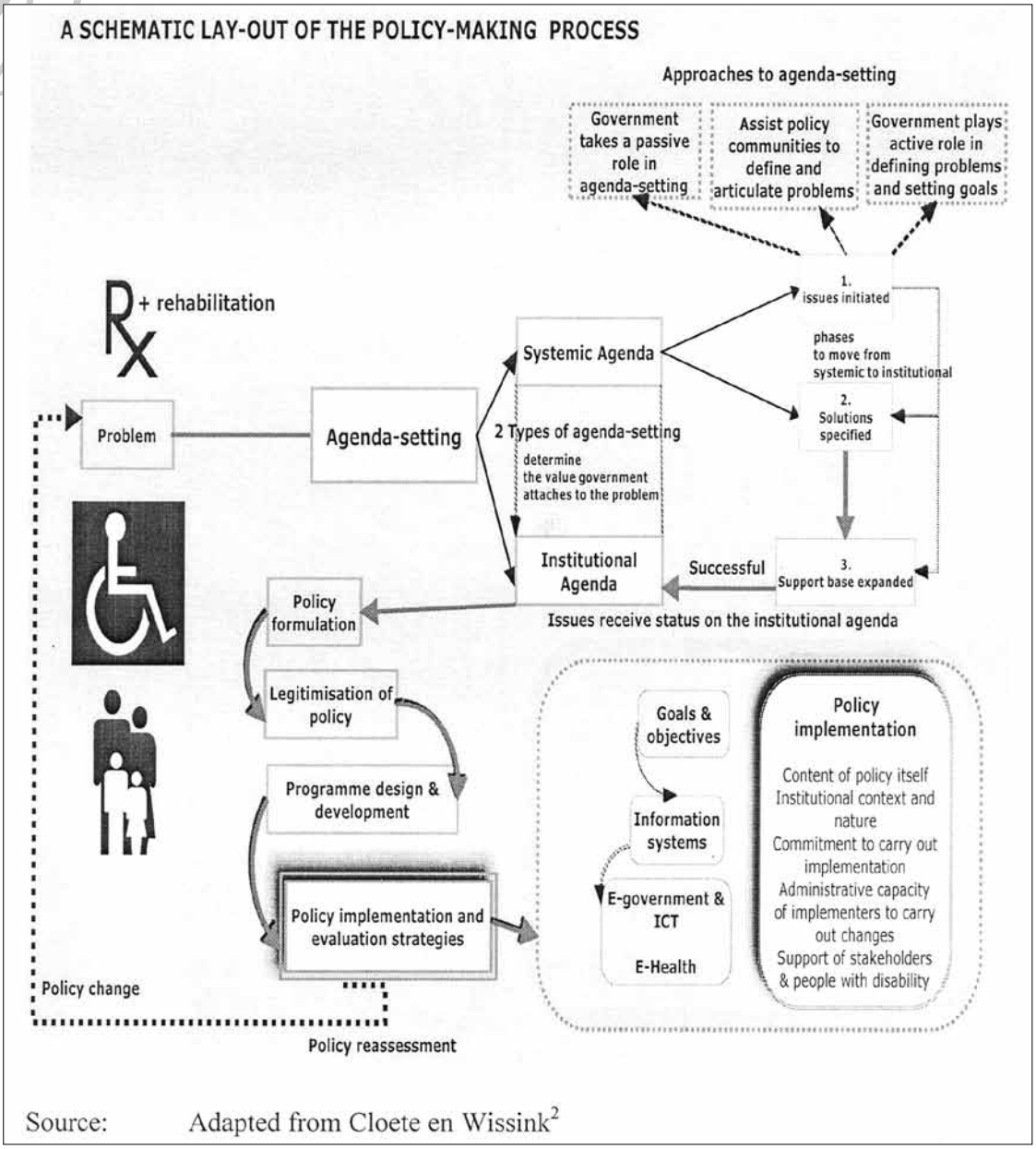

Figure 1: Agenda-setting and its impact on disability-related issues

proposed policies; often directly resulting in policy neglect. While systemic issues are acknowledged by government as problems, allocating adequate resources to meet the demands are not seen as a priority.

It thus becomes imperative for the disability sector to place problems on the institutional agenda as this spells out government's action in the form of resources, legislation and time-frames. A major reason for policy neglect in the disability field is cited as an absence of evidence-based policy-making, poor data collection methodologies, and a lack of scientific evidence. Add an overabundance of irrelevant information and it becomes impossible to measure or provide a true reflection of the size of the problem. The generation and utilisation of evidence is associated with every stage of the policy-making process. Generating knowledge and information thus forms a critical foundation for policy-making, for planning, implementing and evaluating current programmes. Likewise, decision-making and determination of policy are synonymous. Determining objectives are a species of decision-making. Literature indicates that for a decision to be effective, decision-makers must be familiar with situations, have extensive training and experiences dealing with similar or related issues[6]. In the end, how a problem is defined, framed and dealt with is determined by the decision-makers training, basis of intuition and previous experiences[6, 7]. *Figure 2* presents a lay-out of skills and knowledge areas necessary to overcome the constraints that lead to the gap that exists between policy endorsement and policy implementation.

Figure 2 identifies that stakeholders (health care professionals and people with disabilities participating in agenda-setting) have to build skills in designing information systems that cope with change and are able to process data into information and knowledge. Equally, the coupling of information with evaluation demands greater accountability, answerability and responsibility. Data collection which supports methods of investigation such as undirected viewing, conditional viewing or systematic reviewing focus questions and are helpful to those who read reviews or wish to apply findings as part of a situational analysis.

The policy-making process (*Table 1 on page 22*) brings together service delivery needs and develops supporting policies. Assumptions and multiplicity of objectives have a substantial impact on how stakeholders translate their role as it impacts on how accountability is defined, not only in the disability field but it also demarcates the interpretation of meeting the stated objectives during policy implementation. Multiplicity of objectives and assumptions can become a major constraint and influence performance outcomes[8]. This especially seems to be the case in the design of rehabilitation interventions and programmes as participants (health professionals and organisations for PWD) have diverse perspectives on their roles and use different measures to reach the goals. What is often a simple and straightforward programme changes into complex networks of agreements, mainly because the number of steps involved in a

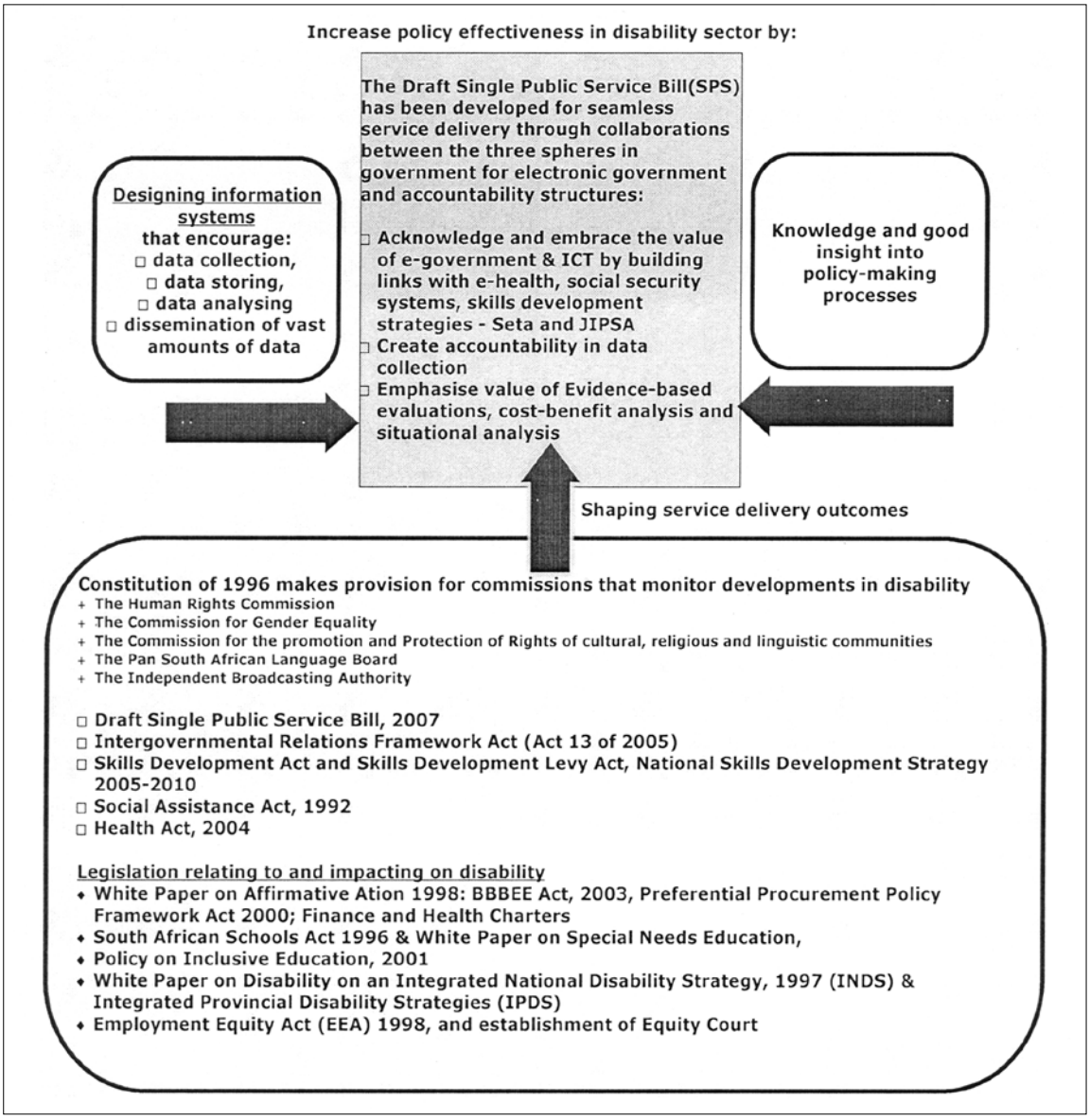

Figure 2: Skills and knowledge that increase policy effectiveness initiating a responsive disability service

social programme gradually expands, growing into a seamless web of collaborations. Policy is described as a "seamless web" because relatively few decisions are clear-cut one-time actions[7].

In an effort to correct the impact of poverty and finding solutions to reduce the social and economic effects of disability-related issues, two strategic approaches developed side by side in the rehabilitation field and strongly influenced actions in each of the different stages of the policy cycle:

- ➢ Strengthening the social end economic vulnerabilities of PWD by promoting change.
- ➢ Managing disabilities through International Classification of Impairments, Disability and Handicaps (ICIDH) to International Classification of Functioning and Disability (ICIDH-2): QUALY: years of life lived or DALY: years of life lost.

As modern democracies are finding it difficult to maintain outcomes in disability through supporting health care and rehabilitation structures in an equitable and cost-effective way, the importance of research that explores effectiveness in service delivery, access and costs of various options (cost-benefit analysis) are becoming increasingly important to frame and define problems[10]. The World Health Organisation's (WHO) definition of health governs decision-making processes on shaping interventions in modern democracies. The WHO defines health as "A state of complete physical, mental and social wellbeing"[10]. Within this definition we tend to consider the bio-psychosocial model which stresses environmental and personal factors and their interaction with a disease on health, as the framework to define disease, disability and illness. Using the bio-psychosocial model to frame problems means that outcomes must enhance security needs as this becomes an intrinsic part of well-being. As a result, the issues of poverty and disability are closely linked to governance structures and how democracy is applied towards strengthening well-being. Nonetheless, the two strategic approaches (critical theories and disability studies) which framed outcomes of evidence-based research strengthened the assumptions that distorted policy outcomes and directly lead to programme failures in the disability field. On the one hand the "critical theories" challenged conventional ideologies, identified insensitive social structures and promoted social change while on the other hand disability studies explored ways in which disabled people might be managed.

Parallel to the type of poverty reduction strategy that government may choose to strengthen society's vulnerability to deal with the inequities and inequalities that affect disability, lies the ideology that health professionals promote their role and own power as they become preoccupied with the characteristics of their own "expertise" against the definitions that frame outcomes in disability[9]. Noticeably, these approaches are not always aligned or complementary to each other as is evident with increased social spending (especially with growing numbers of disability grants allocated) combined with a pattern of reduced spending in education and the special education needs. The pattern of reduced spending in education increased the negative effects of inequality of opportunity. One can thus conclude that the complexities associated in

Policy cycle	Actions
Problem identification	Define and formulate the problem: Data collection strategies and research methodologies must underline norms and values. The WHO designed a classification of unmet needs amongst PWD, the ICIDH that spanned two measures, the QALY (years of healthy life lived) and the DALY (years of healthy life lost), informing the belief that the value of a life is determined by health status. These measures are used for global policy-making and are a quasi-scientific measure designed to prioritise health care and social services: ❍ Quality-adjusted life year (QALY) entails multiplying each year of life of a person who survives illness and expresses the impairment of quality of life to be experienced ❍ Disability-adjusted life year (DALY) measures the burden of disease, thus time lived with impairment as time lost. It uses a set of weights that reflect reductions in functional capacity. It is argued that this system serves to legitimise and institutionalise discrimination against PWD by justifying inequitable distribution of resources[9].
Policy Agenda	Articulating the problem and getting it on the institutional agenda: Since disability and health care enforces values and norms through different aspects of its operation, the empowerment of PWD, the promotion of gender equalities through democratisation and improved efficiency, become critical dimensions in unpacking strategic policy approaches that enhance the creation of sustainable disability reforms[2].
Policy formulation:	Identifying specific goals, objectives and alternative actions. Construct value chains in which the essence of strategies lie in its activities and internal processes. The value of services and products to PWD are strengthened through collaborative and co-operative relationships[2].
Policy legitimisation: Programme design and development:	Legislative support that provides legal parameters to regulate interventions[2]. Programmes often fail due to information overload as too much information impedes or distorts facts as well as reduces meaningful and systematic interpretation of the facts. It becomes impossible to identify the precise objectives or allocate responsibility and accountability effectively[2].
Implementation and evaluation strategies	The success of policy implementation is determined by the ability of stakeholders to bring about change, to monitor performance and on a continuous basis evaluate if the outcomes meet the stated objectives[2].
Source: Adapted from Cloete and Wissink[2], and Hammel[9].	

Table 1: Policy-making process

the disability sector are thus closely linked in creating opportunities and outcomes for social advancement[1, 9, 11, 12, 13,14].

Changing disability policies: Global trends and its impact on service delivery

Schoeman[15] highlighted that trends in global structures identify how transnational interaction occurs while it concatenated interdependencies and produced a variety of border-crossing integration processes[16]. The impact of the transnational interaction is a determining factor in the policy environment. Likewise, it impacts on how development initiatives are put together.

During the 1990's, a paradigm shift occurred in which the new public management movement (NPM) inspired a widespread change in decision-making that transpired in government. Good governance objectives moved policy-making from a dominant steering paradigm to a new form of steering called the governance paradigm[17, 18]. With the governance paradigm the emphasis is on serving and the development of resources. The governance paradigm set in motion a chain of events that resulted in the transformation of health care where interventions shifted from a Medical to a Social Model approach. The keystone of the emerging social paradigm is thus based on commitment to the community, human relationships, functional teaching, individualisation and flexibility that took the professionals in health care out of institutions into the community.

Terminology such as deinstitutionalisation, normalisation, equal rights, access, community-based services and integration characterised change and direction of service delivery. The social model consisting of the primary health care system (PHC) and the district health system (DHC) now structured the entire health system[19]. Concurrent with the PHC and DHC system community-based-rehabilitation (CBR) is a strategy for enhancing the quality of life of people with disabilities by improving service delivery, providing more equitable opportunities and protecting their human rights[1]. A primary justification for disability programmes was the relationship between poverty and disability. Providing for legislative provision that described compensation or pensions (income maintenance benefits) rehabilitation laws had to be enacted that guided vocational rehabilitation interventions by restoring the earning power through assistance. Legislation determines what type of services are available and how such services are provided for thereby playing a key role in defining how people with disabilities are included in society. The essence of the PHC movement was twofold. It first wanted to promote community involvement, tap on community resources and train community workers and secondly wanted to utilise scarce professional expertise and services in the most efficient way. Hence, we saw the movement towards an era of community membership and participation.

The primary health care (PHC) perspective, spurred by the World Health Organisation (WHO) started with the Alma-Ata Conference in 1978. With the implementation of the Alma-Ata Declaration in 1979 the focus was taken away from curative care (Medical Model) and directed towards a primary health care approach in which accessibility and participation in local health care is emphasised. Primary health care was advocated as a basic human right that must be accessible, affordable and socially relevant[19, 20]. Adhering to the constitutional obligations and the Bill of Rights, policy and strategic intent placed an increased focus on public visibility and the empowerment of PWD along with a concomitant increase in legislation mandating the rights of PWD. Disability legislation concentrated on improving PWD's quality of life (common good) and acknowledged their well-being (health) and rights as individuals. However, although modern rehabilitation programmes considered a broad range of services it was established that the most complete set of services existed mainly in urban areas and were primarily available in hospital or on professional level. These systems were expensive and not necessarily conducive to the societal integration of people with disabilities[1].

While the South African rehabilitation services favoured westernised models of biomedical intervention based on a medical model approach in which professionals focused more on alleviating functional inabilities rather than on integrating the person with disability into society, strong lobby groups highlighted the unaccept-

Long-term: Build supporting organisational structures (Identify the size and preferences of market)	Getting knowledge and infrastructure to communities: • Health promotion: Develop community rehabilitation programmes that emphasise effective integration through opportunity, empowerment and enhancing security needs • Provide supports for collaborations that strengthen partnerships between government, NGO and private sector that provide responsive services: o Identify supply and demand-side factors in rehabilitation and governance structures that legitimise services o relative size of public and private sectors o Strengthen political support and local decision-making • Occupational behaviour and occupational role performance within the community o Gender roles, cultural identities and traditional leadership o Social class and status
Medium-term: Increase customer and consumer value (Create a positive economic effect)	Undertake outcome-based studies that validate purposeful activities in the establishment or re-establishment of skills essential for community living[22]. • Management of inequities and inequalities • Poverty and its impact on occupational behaviour and performance - empowerment • Relationship between economic and social policy: mixed economy and its influence on supply and demand side factors • Reduce social spending and improve economic performance of the disabled person • Develop comprehensive rehabilitation programmes
Short-term: Create operational excellence (create an unique service/product, image promotion, create partnerships through collective planning)	Provide specialised services and aftercare services in communities that build resilience through sustainable development: **Empowerment:** • Vocational training and evaluation: work preparation programmes • Skill development : e-government and ICT **Opportunity :** • Work hardening and job placement programmes • Encouragement of business development and private investments for PWD **Security:** • Reduce vulnerability by removing social barriers of gender, ethnicity and social status • Disability grants and influence on performance

Table II: Strategic interventions

able authority exercised by the "caring professional"[1, 13]. Putting the power in the hands of a strong lobby group such as Disabled People South Africa (DPSA) meant that the decision-making powers and disability policy strategies had to be approved by people with disabilities. People with disabilities became more involved and started to play an active role in policy objectives, the type of interventions they preferred and determining strategic outcomes for disability services. In practice disability policy-makers were faced by challenges to reduce the costs of expensive rehabilitation technologies, services and to bring resources to those in most need without fostering a climate of dependency.

Primarily one saw that policy initiatives in rehabilitation and disability outlined structures and measures that support rehabilitation initiatives at community level by utilising and building available resources in communities. One has to recognise that there are choices to be made regarding allocation of limited resources. In order to make informed choices, it is essential to define the driving forces for primary prevention as well as define what is meant by community based rehabilitation (CBR) as this determines philosophies, practices and the type of interventions that lead to policy effectiveness. The CBR provision of rehabilitation services are built around a three-tier referral system[19]. The system shapes the selection of all interventions on:

- ➢ A basic home and community level intervention,
- ➢ Intermediate supports from partnerships between NGOs and government
- ➢ National specialised services (tertiary care and technical support)

The three tier system evolved from global trends that shaped Declarations and Treaties to form and tie together a global rehabilitation, human rights and health strategy into a "Health for All" approach that was guided by the *Ottawa Charter for Health Promotion (1986)* and the *Jakarta Declaration (1997)*. The *Jakarta Declaration(1997)* saw the formation of partnerships between governments, NGOs, development banks, UN Agencies and the private sectors as a mechanism to take the lead in building global initiatives and collaborations or partnerships in disability, health, and social services. In building global health and disability initiatives, the eight Millennium Development Goals (MDG) drawn from the *Millennium Declaration (2000)* adopted by heads of states during the Millennium Summit in September 2000, became an instrument for sustainable development in which governance structures challenged the reduction of poverty through participation, empowerment and investment[21]. This trend, propagated by the WHO underlined rehabilitation and stated that: "…rehabilitation must be integrated into a multidisciplinary process in which participation and empowerment are at the core of an endeavor towards equity and full integration of the person with a disability (PWD) in the community"[1].

The Integrated National Disability Strategy (INDS): Creating a responsive and efficient disability service in South Africa

Meeting the social needs for people with disabilities in South Africa forced government to develop a comprehensive national rehabilitation policy that realigned service delivery needs and outcomes by placing a strong emphasis on value creating strategies. The White Paper on an Integrated National Disability Strategy (INDS), 1997 is formulated on a social model of disability and represents a paradigm shift away from the medical model of disability. While the INDS is not yet an Act government departments are required to formulate their disability policies and strategies so that it falls in line with the INDS[5]. This means that the supply- and demand factors in the disability sector have to be aligned in such a way that it creates customer and consumer value for persons with disabilities.

This entails that policymakers must keep abreast of PWDs expectations when they propose value chains during the policy stage of programme design and development. Interventions must (*Table 11*) shape strategies that work together to create products and services that serve to uplift the person with disability and in doing so, reduce growing inequities amongst PWD. Occupational therapists are able to provide valuable inputs in the design of interventions.

Policy instruments and the benefits brought to service delivery and policy implementation

There are four types of policy instruments (encouragement, financial incentives, regulations and expenditure) that offer government opportunities to achieve sustainable outcomes for disability policy. Each of these policy instruments are specific tools designed to put policy into practice and alter what "would have happened". Moreover, the policy instruments utilse incentives to encourage and enhance sustainable employment of PWD by means of:

- Encouragement (supporting e-government initiatives that provide information and educate users).
- Financial incentives.
- Expenditure.
- Regulations[23, 24].

While the selection of policy instruments is partly a technical question based on identifying which results are the most effective it also analyses the impact of an essential political choice and how the political choice is influenced by diverse economic and social pressures. In selecting instruments, it is imperative to consider the complete range of instruments before a particular mix is opted for and that is likely to meet the overall policy objectives. In addition it is essential to keep in mind that policy instruments should not mask moral dilemmas, competing beliefs, values and ideologies[23].

Because incentives often have complex interdependencies with social costs and benefits gained, it is important that the strategic objectives do not contradict each other in their outcomes. Appropriate rules and regulations that govern market forces are critical in achieving allocative efficiency for disability and rehabilitation interventions. The effectiveness of sustainable employment therefore depends on cost containment, quality of rehabilitation outcome, changes in utilisation and improvement in intervention mix.

Allocative efficiency is the function of many factors and depends on identifying[24]:

- The correct input mix for bringing about interventions (skill development and training policy, price of placement and training, expected earning).
- The supply of the interventions.
- The demand or need for the interventions.
- The occupational therapist's and other health professional's behaviour.
- Collective purchaser's behaviour.
- Policy interventions and alignment of policies in education, health care (rehabilitation), social services, and labour.
- Policy interventions and its influence on market forces that drive the supply-and demand-side factors.

To improve allocative efficiency in rehabilitation, policy instruments (incentives or tools) that affect each of the mentioned factors are needed. Simplifying the process of selecting the correct mix of instruments, three policy anchoring points are identified and used as key leverage points to achieve allocative efficiency towards a responsive disability service.

Policy anchoring points for allocative efficiency in disability intervention

The following three policy anchoring points are designed to assist health care professionals to develop value chains for disability and rehabilitation services in that it serves to build organisational and institutional structures that are able to cope and enhance service competition between public (Government and NGO) and private sectors[24]:

- Controlling intervention input: resource planning.
- Managing intervention provision: informing providers, service guidelines and service delivery reviews.
- Purchasing interventions; economic incentives for users, which include fees and cost sharing, benefit packages, specifying essential services to PWD[24].

Value chains are a unique set of processes (innovation, intervention or treatment, after care services) that together create value for the consumer and brings with it positive or negative financial results[25]. *Figure 3* presents a flowchart that provides a systematic framework (toolkit) in which to construct a value chain for a responsive service. The instruments aim at achieving cost containment and encourage the user to explore alternative approaches through scientific evidence, nurturing a culture of evidence-based policy-making.

It is difficult to recommend universally applicable instruments because the economic, political and disability background varies amongst countries[24]. *Figure 3* is therefore a guide to be used in constructing and framing major problems or issues that lead to allocative inefficiency. This process always involves a situational analysis which must be conducted before constructing and selecting policy instruments. The situational analysis provides the basis in which problems are identified (strengths, weaknesses, opportunities and threats), shaping decision-making and determining priorities. It is however important to take note that the process outlined in *Figure 3* starts after the problems are categorised and the user has identified objectives for service delivery. By following the process laid out in *Figure 3* on page 25, the user is able to test the efficiency and effectiveness of policy decisions as well as determine the allocative efficiency of interventions.

Conclusion

To date, the impact of policy-making on improving the quality of life of PWD has been cited as minimal. It is argued that except for the Social Assistance Act, 1992 (handing out of disability grants) and the implementation of current legislation such as the Employment Equity Act and the Skills Development Act, policies have had no significant impact on reducing inequities or uplifting the quality of life for PWD in South Africa[5].

The development of policies within government departments at national and provincial spheres is still in their infancy with the majority of departments only having draft policies. Very few of these policies are backed by funded strategies which delays and prevents meaningful implementation, mainly because the disability sector finds it difficult to move problems or issues from the systemic agenda to the institutional agenda due to an inability to frame problems systematically and scientifically. A major reason for poor performance of disability policy has been cited as the gap that exists between policy endorsement and implementation. The absence of adequate policy instruments contribute to this gap mainly because there are unrealistic expectations about its potential to deliver against the overall objectives. Additional gaps between policy intention and what the instrument actually achieves add further dimensions to the challenge.

In order to achieve efficiency in policy-making, the following two aspects become critical success factors in realising a responsive and efficient disability service: Firstly, it is critical that stakeholders must understand the policy-making process as this determines how effective their inputs are in initiating a responsive service for PWD. Secondly, stakeholders must have the ability to construct a value chain that adds value through its innovation stage (identify the market and create unique services or products) that lead to the success of policy-outcomes. The innovation stage (content, context, commitment) determines how collaborations are tied together to build responsive services that reduce inequities. Therefore, the contribution and importance that health professionals play by taking on the challenge to work in collaboration with PWD and becoming more active in policy-making processes, can not be stressed enough. Moreover, policy instruments direct the outcomes achieved by interventions and become a powerful tool in creating community involvement and integration.

Glossary of terms

Agenda setting:	An agenda is a list of items to be dealt with during a meeting and prioritises issues for the attention of decision-makers. The higher the item is on the agenda, the better the chances are that it will be dealt with.
Allocative efficiency:	Underpins the decentralisation principle in that it refers to public responsibility in al-

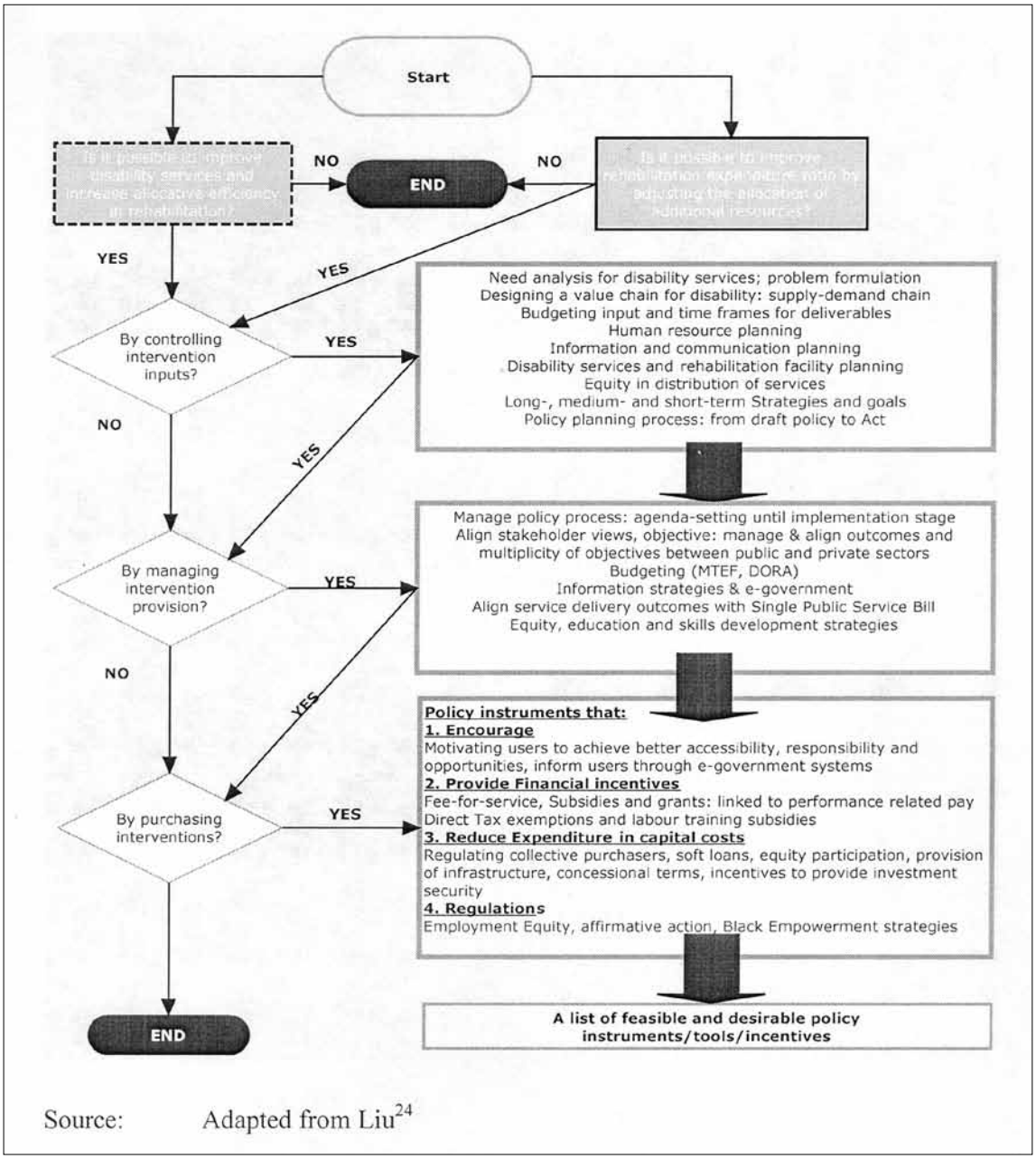

Figure 3: A flowchart for the selection of policy instruments in a toolkit for improving allocative efficiency thereby offering sustainable and responsive rehabilitation services for the disabled person

	locating resources from central, provincial to local spheres of government.
Collaboration:	A fluid process through which a group of diverse and autonomous actors undertake joint initiatives by realising shared concerns in order to accomplish common goals.
Social advancement:	Managing inequities by strengthening resilience of PWD against inequality of outcome and opportunities. Health, education, housing and social security become pivotal points for success.
Value chain:	The unique set of processes that create value for PWD and produces accessible (effective), equitable, efficient and economic results. A generic value-chain provides a template for preparing processes in policy-making: innovation, operations and monitor and evaluation (M&E) of delivery.

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