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Building Act Reform for Building Users

Abstract

The Building Act 1991 established the New Zealand government's role in ensuring the safety, health, independence and well-being of building users. To this end, the 1991 Act and subsequent iterations recognise that people with disabilities need buildings that meet disability design standards. However, these standards are not required for the design of private dwellings. This article uncovers the historical practices that made such exclusion acceptable, and challenges policymakers to rethink the relationship between government, private dwellings and the health and wealth of the nation. The purpose is to highlight flaws in the framing of the review of the current Building Act, identify critical questions that need to be addressed by policy analysts, and call for a full review of the Act's failure to achieve its stated purposes.

Keywords Building Act, private dwellings, disability design, population health, safety, wealth, shower, institutions, law reform

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In April 2019, New Zealand's Ministry of Business, Innovation and Employment published discussion papers regarding reform of the Building Act 2004 (Ministry of Business, Innovation and Employment, 2019). The Building Act 2004 has the following purposes:

> (a) to provide for the regulation of building work, the establishment of a licensing regime for building practitioners, and the setting of performance standards for buildings to ensure that –
> (i) people who use buildings can do so safely and without endangering their health; and
> (ii) buildings have attributes that contribute appropriately to the health, physical independence, and well-being of the people who use them; and
> (iii) people who use a building can escape from the building if it is on fire; and

> (iv) buildings are designed, constructed, and able to be used in ways that promote sustainable development:
>
> (b) to promote the accountability of owners, designers, builders, and building consent authorities who have responsibilities for ensuring that building work complies with the building code. (s3a)

The focus of the April 2019 discussion papers was on building products and processes rather than design, thereby minimising the effect that the review could have on the contribution buildings make to the health (and thus the wealth) of people who use buildings.

In this article we argue that the narrow and ahistorical scope of the review particularly disadvantaged people with disabilities and effectively quashed consideration of accessibility issues in the nation's housing stock. To that end, we offer a historically situated examination of the Building Act, with a particular focus on building users and the politics that have sustained the practice of separating people with disabilities from the rest of the population throughout the 1900s. By uncovering the history of excluding people with disabilities as building users, we challenge the assumptions that maintain their exclusion and identify questions that should have been asked, and were not, to inform the review. The discussion is part of a larger research project which explores governing practices in relation to government-funded housing modifications.

Politics and the use of buildings

The New Zealand government established the right to govern building performance for the people who use them in the Building Act 1991. That right is the culmination of incremental change as the government extended its involvement in building regulation in the interests of population safety, health, independence and well-being since the late 1800s. A key driver for state involvement has been to improve the productivity of the nation's citizens, and, equally, address the problem of the upkeep of 'non-productive' (and thus 'dependent') citizens.

The idea that the unproductive, or potentially unproductive, present a calculable cost to the population creates a public interest in identifying and limiting the burden of such individuals on the nation.

Towards the end of the 20th century New Zealand policymakers and citizens put forward radical ways of thinking about the relationship between people and buildings to address that problem. While some of these ideas led to revolutionary ways of governing, others became marginalised as a result of ignorance and prejudice towards a subset of the population.

The task of governing the state might be popularly thought of as the activities that occur within parliamentary buildings. However, it is the governing activities that influence the taken-for-granted practices of ordinary citizens that more directly create the health and wealth of the nation. Building legislation is a particularly important influence because, unlike the rapid change that can occur in the population's thoughts and activities, built structures and manufactured objects make historically accepted practices more durable and resistant to change. The study of governing at this material level reveals the complex relationship between the state and privately owned buildings and shows how the interests of the health and wealth of the nation are connected to the business of building legislation, establishing permission for the state to have a stake in the private capital of its citizens.

A commonplace example of governmental control of privately owned buildings is the design and materials used in the construction of showers. Showering may be thought of as one of our most private self-care activities. However, the beliefs that make present-day showering practices acceptable and that make showers available to building users have connections that stretch out across nations and through time. The practice and use of showering emerged in the 18th century as a sudden, sustained fall of cold water onto the heads of patients diagnosed with mania (Cox, Hocking and Payne, 2019). By the late 1800s the shower had been transformed into a means of washing people's skin to reduce the spread of disease. Bathing facilities are now a requirement within dwellings and showers have now become an accepted feature of the New Zealand bathroom. However, the Building Act 1991 connected wheelchair-accessible showers to some buildings and not others, meaning that building users do not have equal access to a typical New Zealand shower box. The discussion that follows traces the contested relationship the government has with the private lives of citizens (particularly those who may be 'dependent') as they have materialised in policies and practices through the 1900s. Our aim is to reveal the harmful implications of current legislation for some members of the population (particularly those with disabilities), demonstrating the need for a complete review of the Building Act.

The problem of the dependent citizen

In the early 1900s a relationship between the good of the nation and those deemed 'dependent' citizens was established by viewing the minds and bodies of the population as possessing a collective labour potential:

> Every unit of sound physical and mental health in the community is a public asset, and it is plainly in the public interest that no step should be

> neglected which, if taken, may have a value in checking any tendency that may exist towards the depreciation of the physical capital of the country. (Otago Daily Times, 1906, p.8)

The health of each citizen was thus connected to the economic well-being of the nation. Those lacking in human capital were calculated as a deficit against the interests of the population: 'the number of dependents which can be maintained by any community necessarily rests upon that proportion of the population which is not dependent – the producers' (Barton, 1919, p.5). The idea that the unproductive, or potentially unproductive, present a calculable cost to the population creates a public interest in identifying and limiting the burden of such individuals on the nation.

The problem of the dependent person was not a new phenomenon. Since the birth of New Zealand's colonial government, strategies were employed to manage the problem they presented. Legislation initially placed liability on the family (the Destitute Persons Relief Ordinance 1846) and on those who facilitated their immigration to New Zealand (the Imbecile Passengers Act 1873). Despite these measures, within a relatively short time municipal councils were tasked with maintaining the destitute and sick (the Municipal Council Ordinance 1860) and subsequently resolved to tax their working population to fund institutions that would house orphans, the sick and the insane (the Sick and Destitute Ordinance 1868). In the later part of the 19th century a review of New Zealand's hospitals found that 'they are made the home of aged, infirm, and chronic cases, corresponding very closely to the permanent pauper inhabitants of an English union workhouse' (Inspector of Hospitals, 1883, p.ii).[1]

In the early 1900s, two schools of scientific thought emerged on resolving the urgent need that the proposed imbalance of dependents presented. These schools of thought were made material through practices and architecture, including the production of new forms of showers. One school of thought, eugenics, was a medico-scientific approach that would eliminate dependents by removing them from the population's breeding stock (via isolation, sterilisation and, in some instances, death). Another was the scientific engineering of tasks and materials to transform the 'dependents' into 'producers'. These sciences opened the possibility of calculating the relative costs and benefits for determining where and how (and indeed if) certain members of the population should live.

Solution for the dependent 1 – useless eaters and concentrated dwelling

Eugenics emerged as a solution to the problems of population health and wealth that involved identifying and segregating subsets of the population. While most commonly remembered for its race-based policies, the focus of eugenics was equally on people with 'defects', including those we might today consider 'people with disabilities'.[2] In the interests of the nation and overseen by medical professionals, people with disabilities were identified and institutionalised. While one might wish to distance modern-day government of building users from such history, we demonstrate that the prejudices and practices of eugenics remained in circulation at the time of the Building Act's emergence. Further, we point to the harmful practices of identifying and separating subsets of the population that eugenics advocates and which the current Building Act sustains.

> While New Zealand may have largely rejected eugenics, however, it is important to identify eugenics practices that remained acceptable at the time the Building Act 1991 was passed ...

A central tenet of the eugenics discourse is that inheritance of defective genes creates a proportion of the population which consumes more resources than they contribute (the 'useless eaters'). It argues that modern government practices increase this proportion of the population by permitting technology to artificially keep alive those who nature would have allowed to die. Securing the health of the nation involves identifying the so-called 'defective' proportion of the population and preventing them from passing on their genes. Citizens' rights to anonymity, to control over one's body, to determine where and even if one should live are removed in the interests of population health. In the early 1900s the New Zealand government supported the eugenics practice of identification of defectives (e.g. Otago Daily Times, 1906; New Zealand Tablet, 1913; Otago Daily Times, 1917) and advocated for state control over where and how they lived.[3] Institutions in which to permanently house defectives were approved by health boards (Bush Advocate, 1910; Evening Post, 1911), educators (Free Lance, 1914; Auckland Star, 1917) and business networks (New Zealand Herald, 1924). This was followed by some advocating for the natural death of defective infants (Press, 1917), approval of sterilisation (Evening Star, 1923; Otaki Mail, 1932) and entertaining the idea of euthanasia (Otago Daily Times, 1935).[4] There was also mention of 'lethal chambers' for 'imbecile children' (Spencer, 2017).

Despite a level of acceptance of the eugenics discourse in New Zealand, newspaper articles during World War Two, such as 'Peace talk – Nazi brutality: mass murder of mental defectives' (Evening Star, 1941), indicate a repugnance of the practice of state-sanctioned murder. While New

Zealand may have largely rejected eugenics, however, it is important to identify eugenics practices that remained acceptable at the time the Building Act 1991 was passed, and to recognise the danger presented by these accepted practices:[5]

- A eugenics discourse promotes the identification and concentration of people with disabilities in separate dwellings ('institutions') as being in the interests of the health and wealth of the nation, and in the best interests of the people with disabilities themselves.
- Identifying and co-locating a subset of the population who are seen to detract from the health and wealth of the nation puts their privacy, autonomy and right to live in the hands of others.

We return to these practices later in our discussion.

> The country was also about to see the Accident Compensation Act 1972 and its 1973 (No. 2) amendment revolutionise the relationship between the state and the activities of citizens in their private dwellings, leading to the possibility of resolving the problem of architecture depreciating the country's human capital.

Solution for the dependent 2 – rehabilitation and disability design

Alongside the eugenics school of thought, a form of human engineering was developing in the early 1900s with the aim of increasing production. The mechanisation of work saw productive roles appear for people previously deemed incapable of being in paid employment. The possibility emerged of people with disabilities being rehabilitated, thus gaining both human and material capital (health and wealth) and becoming socially and economically mobile. Spaces developed for specialised training highlighted the discriminatory nature of architecture in its creation of dependence and generated the birth of disability design. New Zealand's Building Act (from 1991 to today) recognises the idea of disability design, referring to design standards for people with disabilities. However, such design is limited to spaces where they might work, shop or otherwise take part in civic life and excludes private dwellings.

In the United States principles of 'scientific management', which aimed to automate bodily movements to measurably enhance productive performance, were employed. A person could be deemed productive if able to perform even one such movement: 'The work of every workman is fully planned out … complete written instruction, describing in detail the task … specifies not only what is to be done but how it is to be done and the exact time allowed for doing it' (Taylor, 1911, p.39). Factories, in which workers' eyes, ears and limbs could be employed to operate machinery, were the sites of several studies which advocated for the work potential of impaired bodies (Dietz, 1933; Ford, 1922). Thus, constructed as a body with some productive parts, the previously 'crippled dependent' could be trained via 'rehabilitation' to become a paid worker, with the capacity to compete for work alongside the 'able-bodied' man (Disabled Servicemen's League, cited in Waikato Independent, 1945, p.2). Although originally construed as 'scientific management', the shift into the realm of disability saw 'training' become 'rehabilitation' and become transformed into a health service. Other nations (including New Zealand) followed suit and called for all disabled members of the population to be identified and systematically placed into facilities which would enable this transformative promise (Auckland Star, 1940, p.11).

These facilities were not intended to be permanent accommodation, but rather a temporary space in which to collect people with disabilities together in order to facilitate transformation (Giles, 1944, p.1). The wheelchair-access shower was born in the US polio rehabilitation facility Warm Springs, where the grounds and buildings were engineered to permit wheeled mobility and a sense of freedom for the residents (Toombs, 1931, p.1; Polio Chronicle, 1934; Donnelly, 1935, para 5). What emerged from this facility was not simply transformed bodies, but rather a radical way of thinking about the role of building design in the creation of disability (Donnelly, 1935, para 32).[6] A new form of 'people with disabilities', seeking the freedoms to work and shop, but dependent on a particular set of architectural conditions and mechanical aids, became possible (Rusk et al., 1953, p.11). In the United States such citizens successfully breached the confines of the rehabilitation facility to transform the University of Illinois into a space modified for students with disabilities to be able to study, compete in sports and live (e.g. Blankenship, 1949). This same group were involved in developing the American standard that would then inform New Zealand's first Code of Practice for Design for Access by Handicapped Persons, NZS4121:1971 (American Standards Association, 1961; Standards Association of New Zealand, 1971).[7] The Disabled Persons Community Welfare Act 1975 brought the New Zealand standard into legislation to improve access to streets and premises open to the public.

It is at this point that the contentious relationship between the state and private building ownership in modern government comes to light. Rehabilitation claims to produce citizens who, with the help of disability design, have freedom of social and economic mobility. Therefore, they may compete with others to develop their human and material capital. This capital becomes a feature of both the person's and the nation's economy, and facilitates participation in the activities of government. While there is acceptance of state involvement in protecting the population from dangers, it must also ensure that citizens have the freedom to compete for and benefit from personal capital (which includes their health). Therefore, while rehabilitation and disability design led to the existence of facilities such as a shower that people with disabilities could use, a new problem emerged regarding where such facilities should exist, and at whose expense.

At the time the Building Act 1991 was passed, the accepted ideas associated with rehabilitation and disability design, and the dangers of the associated practices, were:

- As neo-liberal discourse proposes, rehabilitation combined with disability design in the places where people work, shop and take part in the activities of government can transform people with disabilities into free citizens. They are able to compete with other citizens to further develop their human and material capital, and, as members of the productive population, they are free to make choices regarding where and how they live.
- The practice of leaving it to the market to determine what building users need aims to free the market from restrictions that could detract from the nation's wealth, but results in design that discriminates, creating disability. This perpetuates the exclusion of people with disabilities from obtaining human and material capital, being able to compete in the housing market, and having their needs recognised by government.
- Private dwellings do not typically have attributes that contribute appropriately to the health, physical independence and well-being of building users with disabilities; building users with disabilities would have difficulty escaping from many private dwellings should they catch fire, for example. Thus, leaving the design of private dwellings to market forces has meant that building users with disabilities cannot use most private dwellings safely.

The role of the state in managing dangers through building control – injury, the burden of care, and safer buildings for everyone

Although buildings accessible to people with disabilities had become a possibility, NZS4121:1971 consistently limited its reach. Disability design was limited to general public buildings and facilities,[8] maintaining the notion that access for people with disabilities to private dwellings sits outside the state's interests. However, by this time New Zealand had nearly 130 years of central or local government jurisdiction over private dwellings in order to manage dangers to the health of the general population.[9] The country was also about to see the Accident Compensation Act 1972 and its 1973 (No. 2) amendment revolutionise the relationship between the state and the activities of citizens in their private dwellings, leading to the possibility of resolving the problem of architecture depreciating the country's human capital.[10]

In order to eliminate the waste of resources caused by litigation related to personal injury, the Royal Commission of Inquiry into Compensation for Personal Injury in New Zealand (Woodhouse, 1967) proposed a connection between the interests of the nation and the cost of injured citizens. Recognition of the cost of personal injury to the nation's human capital, regardless of whether the person slips in the shower at work or at home, extended the state's interests into the safety (or otherwise) of the activities of citizens within their private dwellings:

> It is obvious enough that a worker does not cease to be a worker as he leaves his factory at 5 o'clock … If he slips and is disabled in the factory shower-room as he prepares to go home, he will be entitled to all the advantages of the Workers' Compensation legislation and may even succeed against his employer in a negligence action. Yet if he suffers the same accident upon his arrival at his home he will receive nothing at all, or at best the assistance provided by the Social Security Fund. From the point of view of the injured workman these inconsistent results develop from a diagnosis by causes and a disregard of their similar effects. When it is recognised that in each case it is the community which pays, the discrimination assumes an air of unreality. (ibid., p.35)

For individuals with disabilities from injury, the Accident Compensation Commission (later renamed the Accident Compensation Corporation) took control of the distribution of material compensation, the resourcing and regulation of rehabilitation processes employed to regain the lost human capital, and monitoring and regulation of the causes of injury. Hospitals and other institutions employed rehabilitation practices to transform the injured, and, with the institution's approval, those deemed capable of being discharged into

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the community could receive state funding to install a wheelchair-accessible shower (among other things) that would realise the promise of transformation (Accident Compensation Act 1972, s49(2)c).

Although the Accident Compensation Act initially maintained tradition by not recognising the human capital of non-earners, the potential for housewives to be a cost or benefit to the productive worker[11] saw the 1973 amendment (No. 2) ensure that all injured citizens would be eligible. That entitlement was given whether they had quantified their human capital in the workforce, sustained that capital by providing members of the workforce with a supportive environment, or had been or potentially could be a member of the workforce. State-funded modification of private dwellings, where there was a demonstrable benefit,[12] was then extended to other citizens with disabilities following the passing of the Disabled Persons Community Welfare Act 1975.[13] This Act also legislated for NZS4121 to improve access to streets and premises open to the public,[14] and for the registering, resourcing, inspecting and determining of standards for collective/group living facilities.[15]

As the installation of disability design into private dwellings by the state, via accident compensation or welfare, was limited to the particular circumstances of the injured or otherwise disabled individual, there was no apparent need for further government involvement in private dwellings in this regard. However, in addition to rehabilitation of the injured, the Accident Compensation Act established a role for the state in monitoring the causes of injury. In 1986 a national series of 'safe house' seminars drew on this data to advocate for government interest in the design of houses to reduce the cost of accidents within the home. Aspects of disability design, such as the level-access shower, were identified as safer for everyone (Pope, 1986).

With New Zealand being in the unique position of having information about the causes and costs of disability associated with injury within homes, disability design was connected to resolving loss of human capital via discriminatory architecture in private dwellings, while preventing the creation of disability via injury. The idea of connecting the interests of disabled users of private dwellings with the health and wealth of the nation was considered revolutionary. A World Rehabilitation Fund monograph – *From Barrier Free to Safe Environments: the New Zealand experience* – was received as presenting 'a way of thinking about our built environment which we have hinted at but never fully conceptualised ... the concept that an accessible environment is an intrinsically safe one' (Wrightson and Pope, 1989, p.68). Drawing from this idea, the NZS4102 Code of Practice for Safer House Design (Standards Association of New Zealand, 1990) was published, providing advice on design for all new dwellings to 'eliminate or reduce the risk of injury by accident' (p.5), and recommending level-access showers for everyone to prevent trips and slips.[16] Thus, only one year before the passing of the Building Act 1991, New Zealand was considered at the forefront of thought regarding the safety, health, independence and well-being of all building users. However, when the Building Act 1991 was passed, disability design remained reserved for social and commercial spaces and private dwellings were excluded.

While rehabilitation and disability design discourses had promised to transform people with disabilities into citizens able to compete with others to meet their needs in the housing market, the persistence of institutionalised living into the 1990s shows that this promise was never fully realised.

The passing of the Building Act 1991

With the passing of the Building Act 1991, nearly 30 years ago, the state established its current relationship with building users and building design. The Act's purpose was (among other things) to ensure the safety, health, physical independence and well-being of building users. Alongside this stated purpose, the Building Act centralised the government of building activities and established a commercial relationship with local authorities, who could charge fees and be held liable for costs. Similarly, the early 1990s saw significant change in the government of people with disabilities in New Zealand, with a shift away from funding or providing disability supports to a market model where services would be purchased (Lay, 1991; Shipley and Upton, 1992; Moore and Tennant, 1997). The rationale for this shift was increasing costs and a lack of consistency for consumers (Building Industry Commission, 1990; Shipley and Upton, 1992).

Although the Disabled Persons Community Welfare Act 1975 had gone some way towards addressing architectural discrimination, it was clear that its purpose was to provide financial assistance to individuals with disabilities and to support voluntary and private organisations that were concerned with the community welfare of individuals with disabilities. In contrast, the Building Act provided an opportunity to make all buildings safe and usable for all people, including those with disabilities. However, parliamentary debates demonstrate that in 1991 politicians could draw on discourses that allowed the safety, health, independence and well-being of people with disabilities to be excluded from private dwelling design.

Despite an apparent rejection of eugenics, the view that 'disabled people' should not have autonomy over their lives and that concentrated living in institutions was in the interests of the nation and the 'disabled people' themselves was still considered acceptable. National MP Hamish Hancock argued, for instance:

> In recent years there has been a lot of talk about all disabled people moving into the community as of right. In some cases that has been found not to be in their best interests. It has also been found to be enormously expensive and there can be duplication, not only of housing, but also of medical care and other care that those people need … it could open up a whole area of litigation in which disabled people, or those people who represent them, could argue about what is appropriate or inadequate ... It is really for the medical people to make a decision that is in the best interests of the disabled people concerned. (Hancock, 1991)

While rehabilitation and disability design discourses had promised to transform people with disabilities into citizens able to compete with others to meet their needs in the housing market, the persistence of institutionalised living into the 1990s shows that this promise was never fully realised. Furthermore, although there had been strong involvement of people with disabilities in politics around the time the Disabled Persons Community Welfare Act was passed and into the 1980s (Angus, 1996; Tennant, 1993), their interests were poorly understood by those creating the 1991 Building Act. As National MP David Carter stated:

> The committee received many submissions – and I must say that they were very good submissions that the committee was pleased to receive because those of us who are not affected by disabilities have some difficulty in understanding the problems of those who do – from some people who were able to advise us and to point out the problems that they encounter. I am confident that as a result of those submissions the committee has acknowledged those difficulties and it has done its best in the Bill to provide for people with those problems. (Carter, 1991)

Indeed, in the early 1990s there was much debate about whether people with disabilities should have the right to be protected from discrimination, and the human capital of those disabled other than due to accident remained largely unrecognised (Dalziel, 1991; Cullen, 1991a). While there was a well-established connection between housing, building activities and the health and wealth of the nation,[17] at the time the Building Act 1991 was passed the economy was said to be in decline (Matthewson, 1991) and the proportion of dependents was said to be growing.[18] In determining that private dwellings were not required to be designed in accordance with disability standards, the government was simultaneously attempting to both reduce costs associated with housing modifications and withdraw state responsibility for housing conditions (Shipley, 1991; Cullen, 1991b; Luxton, 1991; Swain, 1991; Tizard, 1991).

> When the Building Act was enacted nearly 30 years ago, members of Parliament were immensely pleased that they had maintained the allowances given to people with disabilities to access such public spaces.

Conclusion

Since the establishment of New Zealand's colonial government, the need to construct places and passages that free citizens can access for the purpose of social or commercial interaction has been deemed essential for the creation of 'one great nation' (Wynyard, 1854, p.8). When the Building Act was enacted nearly 30 years ago, members of Parliament were immensely pleased that they had maintained the allowances given to people with disabilities to access such public spaces.[19] Despite a 165-year history of New Zealand government involvement in ensuring that private dwellings do not risk population health, private dwellings were excluded from regulation that would make them accessible to people with disabilities. Such exclusion highlights a problematic relationship between the government and citizens with disabilities.

Whether or not the government sees an ethical responsibility in ensuring the same benefits for people with disabilities as for other users of private dwellings, the interests of the state are entangled with the problem of architecture that creates dependence. This is despite a century of efforts to address the problem of the 'dependent'. At present, state-funded assessment and modification of private dwellings to meet the situational needs of individual citizens represent costs to the nation. This situation not only excludes people with disabilities from free movement within the housing market; it creates additional issues, as many private dwellings now function as guest houses, childcare centres, businesses, and medical and dental surgeries, which means either further exclusion of people with disabilities from participation in society, or that expensive retrofitting by small business owners is required. The dangers of this current practice are several:

- Retrofitting of buildings that are or were private dwellings is the most expensive way to include disability design (Page and Curtis, 2011). These costs will remain and continue to grow while new buildings are designed in ignorance of the problem that endures.
- By attaching disability design to individuals with disabilities (via Ministry of Health or Accident Compensation Corporation funding), the idea that people with disabilities should be under the control of health

practitioners is maintained, putting their privacy and autonomy at risk. This practice also limits the ability of the population to be freely mobile in the housing market and to contribute to the health and wealth of the nation. Furthermore, once the person with the disability vacates a private dwelling, there is no incentive for the homeowner to keep accessible features, meaning accessible dwellings may be converted back into inaccessible ones.

- Current legislation means that people with disabilities do not have their safety, health, independence or well-being assured in private dwellings in New Zealand.
- The lack of availability of private dwellings that people with disabilities can use encourages institutionalised living, with the associated danger of putting their privacy, autonomy and right to live in the hands of others.

The problematic exclusion of people with disabilities as users of private dwellings must be addressed. A full review of the Building Act 1991 in terms of building performance for all building users is needed. Consideration should be given to the buildings that must be required to meet disability design standards (for example, by adding private dwellings to the list of buildings that must meet the NZS4121 standard), or state involvement in the building market to ensure that people with disabilities are included as building users. This could involve development of incentives to encourage homeowners and developers to meet disability design standards in private dwellings (see, for example, Hamilton City Council's development contributions policy and Thames–Coromandel District Council's disability strategy). Radical rethinking about the exclusion of people with disabilities as members of the population of building users is needed, along with recognition that the current exclusion risks citizens' privacy, autonomy, freedom to live outside institutions, and ability to build human, social and physical capital.

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1 See Moore and Tennant, 1997 and Tennant, 1996 for a detailed history of New Zealand policy and disability.

2 See Sullivan, 1995 for an analysis of eugenics discourses in relation to people with disabilities in New Zealand. See Mostert, 2002 for a detailed study of the management of people with disabilities as a population of 'useless eaters'.

3 In 1923 the minister of health asked: 'What is our duty towards the deficient. The answer which common-sense dictates is to place them in an environment where with their little comprehension they will not feel their disability; where they will be as happy as possible; where they will be trained for and engage in simple employments according to their capacity; where, as children, they will not, by association, prejudice the outlook of their normal brothers and sisters; and where, as adults, they will not have the opportunity to come in conflict with the law or to reproduce their kind … for the vast majority, in its interest and the public's, this should be the permanent home' (Pomare, 1923, p.2). The Mental Defectives Act 1911 and its 1928 amendment established and extended legalisation of permanent segregation of the mentally defective.

4 See Paul, Spencer and Stenhouse, 2017 for a more detailed account of the practices of eugenics in New Zealand.

5 Indeed, debates related to rights to life and freedom for people with disabilities continue in recent history (e.g. Jaye et al., 2019; Klausen, 2017; Stace, 2013).

6 This radical way of thinking is associated with the so-called 'social model of disability'.

7 The American steering committee had originally included shower design (Nugent, 1961); the final version limited its scope to 'general buildings' for the purpose of efficiency, eliminating reference to shower facilities (American Standards Association Project A-117 Steering Committee, 1961, p.2).

8 The 1971 version only considered passenger and transport terminals, and public lavatories as essential. While there was mention of hospitals, rest homes, hotels, motels, hostels and swimming baths where showers would likely be available, it was not until the 1985 edition that shower specifications were included.

9 For example, the Raupo Houses Act 1842, Auckland City Council Act 1853, Canterbury Municipal Ordinance 1860, Public Health Act 1872, Bubonic Plague Prevention Act 1900, Maori Councils Act 1900, Health Act 1956.

10 Although the Act also applies to visitors to the country, it is the relationship with citizens that is of interest here.

11 'If the scheme can be said to have a single purpose it is 24-hour insurance for every member of the workforce, and for the housewives who sustain them' (Woodhouse, 1967, p.26).

12 'The Director-General shall not make a grant to any person … unless he is satisfied that the disabled person can be expected to enjoy the benefit of the alteration to the home for a period sufficient to justify the amount of the expenditure involved' (Disabled Persons Community Welfare Act, 1975, s14(3)).

13 This funding is now governed by the New Zealand Public Health and Disability Act 2000.

14 Limited to new or reconstructed streets, new buildings or buildings undergoing major alterations, and with the proviso that the director-general may at any time exempt any or all from the requirement for modification. Reference to this section of the New Zealand Public Health and Disability Act was included in the Building Act 1991. The current Building Act refers to NZS4121 directly.

15 This regulation is now included in the Health and Disability Services (Safety) Act 2001 and in the categories of buildings that the current Building Act states must now meet NZS4121 standards.

16 Universal design has extended this discourse of what was 'disability design' into design that is better for 'everyone'. 'The basic premise of Universal Design is that all people have differing abilities and needs when using the environment and to create a positive experience for the building user'. The aim is to create 'Buildings for Everyone' (BarrierFree New Zealand, 2019).

17 'Housing is a basic social need. Housing is one of the building blocks of the so-called decent society. The Opposition knows that having decent housing leads to good health, proper education, a stable community, and a chance for people to take part in their community, irrespective of wealth' (Swain, 1991); 'Everyone knows that the building industry is absolutely pivotal for the economy – it provides jobs and skills, and it has a multiplier effect in the sense that it is able to impact on other industries, and particularly on regional Communities' (Swain, 1992b).

18 'For the first time in our history we have reached the point at which every full-time worker in New Zealand – every single one of the people who are working full time – pays taxes to support a person on a benefit or a pension, their spouses and their children. Somebody had to make hard and unpopular decisions' (McLay, 1991).

19 'Members of the House will note that the purposes and principles of the Bill include commitments to people with disabilities. Section 25 of the Disabled Persons Community Welfare Act lays the groundwork by spelling out the categories of buildings to which people with disabilities must have access. The Bill will reinforce that commitment and will help to make it happen. I am particularly pleased about that aspect' (Lee, 1991).

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