IN THE HUMAN RIGHTS TRIBUNAL HRRT 043/2009

UNDER THE HUMAN RIGHTS ACT

BETWEEN IDEA SERVICES LTD

Plaintiff

AND ATTORNEY-GENERAL ON BEHALF OF THE MINISTRY OF HEALTH

Defendant

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# STATEMENT OF KIERAN MURRAY

17 SEPTEMBER 2010

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## Introduction

1. My full name is Kieran O'Neill Murray. I am a director of LECG Ltd, a subsidiary company of LECG, LLC, an expert services firm. LECG has offices in the United States, Europe, and in Australasia and employs about 1000 experts and professional staff. I am a member of the senior executive team for LECG's global energy and environmental practice and serve as an International Arbitrator for the PNG Independent Consumer and Competition Commission.

2. I provide economic advice and expert analysis in the areas of public-policy, regulation, and institutional structure. I have served as an economic consultant on these matters in Australia, Canada, New Zealand, Philippines, Singapore, Tonga, Vietnam and the United States. A copy of my curriculum vitae is annexed to this brief.

3. I have given expert evidence or advice on matters associated with public policy before Select Committees of New Zealand's House of Representatives, the High Court of New Zealand, the New Zealand Commerce Commission, the Australian Consumer and Competition Commission, the Australian Energy Market Commission, the Energy Regulatory Authority in Singapore, the Energy Regulatory Commission of the Philippines, and presented to the Federal Energy Regulatory Commission of the United States.

4. My public-policy engagements have included Principal Advisor to the Ministerial Inquiry into the Electricity Industry; Economic Advisor to the Hon Mike Moore (subsequently Director-General of the WTO) during his term as Leader of the Opposition; member of the Prime Ministerial Task Force on Targeting Social Assistance with particular responsibility for modelling health funding; Economic Advisor to the New Zealand Minister of Finance, the Hon David Caygill; and senior analyst at the New Zealand Treasury.

5. I have read the Code of Conduct for expert witnesses. I understand my obligations under the Code and agree to comply with it.

## Scope of evidence

6. I have been asked to review and comment on cost estimates associated with the Ministry of Health (**"Ministry"**) assuming responsibility for funding day services for people aged 65 and over with non age-related disabilities. The cost estimates have been prepared by Mr Jean-Pierre de Raad of the New Zealand Institute of Economic Research (NZIER).

7. My review focuses on the model and modelling approach used by Mr de Raad, in particular the logic, inputs, outputs and assumptions used. By examining the logic and adjusting key assumptions and parameters, I derive alternative estimates of the potential costs of the proposal.

8. I confirm that such an exercise is within the scope of my expertise.

## Principles

9. I start by setting out what I believe are the key guiding principles for cost modelling of this nature. Given imperfect foresight and bounded

rationality (ie the need to rely on rules of thumb given limits on information, capacity and time) estimating future costs necessarily requires judgement. Rather than perfection or precision, the goal is generally to make a "best guess" based on the information to hand and the specifics of the policy parameters being evaluated.

10. I consider the following principles to be important when generating and assessing the robustness of cost estimates:

    (a) *Attribution* - correctly ascribing costs to a particular proposal or policy. In practice, this means only those costs that directly result from or immediately relate to the proposal are relevant.

    (b) *Additionality* - counting only those costs that are marginal or incremental in nature. In practice, this means excluding costs that have already been incurred and will continue to be incurred regardless of the proposal or policy being considered.

11. In general, I have found that costs (and perhaps benefits) can be over-estimated / inflated when insufficient attention is given to attribution and additionality concerns. Put simply, effects get overstated, either through spurious inclusion (ie attributing costs to a proposal that are not related to the proposal) or effective double-counting.

12. I will refer to these principles further in the material that follows.

**Updated assumptions**

13. In his evidence, Mr de Raad estimates (at paragraph 36) the cost of extending the full cost of day services to those over 65 would fall in the region of $12.5 to $28.5 million ex GST per annum, for 773 to 1750 people, once the programme has fully matured in 20 years.

14. This range of costs is predicated, *inter alia,* on the following assumptions:

    (a) At the least, 53 clients and at the most 120 clients, exit Ministry of Social Development (**"MSD"**) funded day services and enter Ministry funded services per annum (paragraphs 24 and 29).

    (b) All of the clients would be funded by the Ministry at a payment rate of $16,317 per annum (ie $33.30 per half day, 10 half-days per week, for 49 weeks).[1]

    (c) Exit rates (based on the age profile of Ministry day service clients) of 1% per year for clients aged 65-74, 15% per year for clients aged 75, and 100% for clients aged 85 and over.

    (d) Cost estimates were undertaken on an *ab initio* basis (ie assuming no existing costs were being incurred for the specific group of clients who are the subject of the proposal).

15. I am comfortable with the basic approach taken by Mr de Raad. For the reasons I gave in paragraph 9 above, a methodology that is simple, transparent and relatively flexible is most suitable. In my view, the

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[1] Note that while paragraph 29 of Mr de Raad's evidence refers to a cost of $16,170 per client per annum (and paragraph 35.1 refers to a figure of $16,650 per client per year), the calculations in Table 3 of his evidence use the correct figure.

structure of the estimation model (ie a stylised version of a stock-flow model) is appropriate.

16. However, I question the reasonableness of some of Mr de Raad's assumption and propose alternative assumptions. The effect of these updated assumptions is a significant difference (ie a reduction) in estimated total costs.

**Domain**

17. The relevant starting point is the number of people entering a Ministry funded day service at age 65 - Mr de Raad assumed there would be between 53 and 120 people entering the service. The "upper bound" figure of 120 people effectively represents all MSD day service clients near age 65. Mr de Raad calculated this number by averaging the number of MSD clients remaining on the service aged 63 and 64. He calculated his "lower bound" figure the same way, but his lower bound represents only those MSD clients who have an intellectual disability.

18. Mr de Raad's assumptions of 53 to 120 people entering the service do not represent the upper and lower bounds for estimating the cost of the services at issue in this case. The figures represent two separate interpretations of costs associated with two distinct policy decisions; they measure different things and therefore do not represent an appropriate interval within which costs associated with the proposal might fall.

19. The figure of 120 people adopted by Mr de Raad for calculating his upper bound assumes that all MSD day service clients aged 63 and 64, whether intellectually disabled or not, will "transfer" to Ministry funded day services upon reaching age 65. This assumption is neither realistic nor relevant.

20. The claim of IDEA Services Limited ("**IDEA Services**") relates to services provided to those with an intellectual disability only. The nature of services offered by MSD is not restricted solely to people with such a disability. Other funding sources (eg DHB-funding, or other Ministry-funded services) may be available for non-intellectually disabled people who need day care services.

21. Further, as I understand it, not all service users exiting MSD at 65 years of age may require Ministry funding as their Ministry residential services are funded on a 24/7 basis. These individuals therefore receive some funding during the day from the Ministry when their MSD funding stops. I understand this Ministry 24/7 funding is not the case for IDEA Services. Mr de Raad estimates that the cost of extending to IDEA Services clients would be $7 million once the programme is fully mature, including the current funding of $2.5 million for those aged over 65; that is, the *additional* cost of extending the funding for IDEA Services clients would be around $4.5 million, once the programme is fully mature, using Mr de Raad's assumptions.

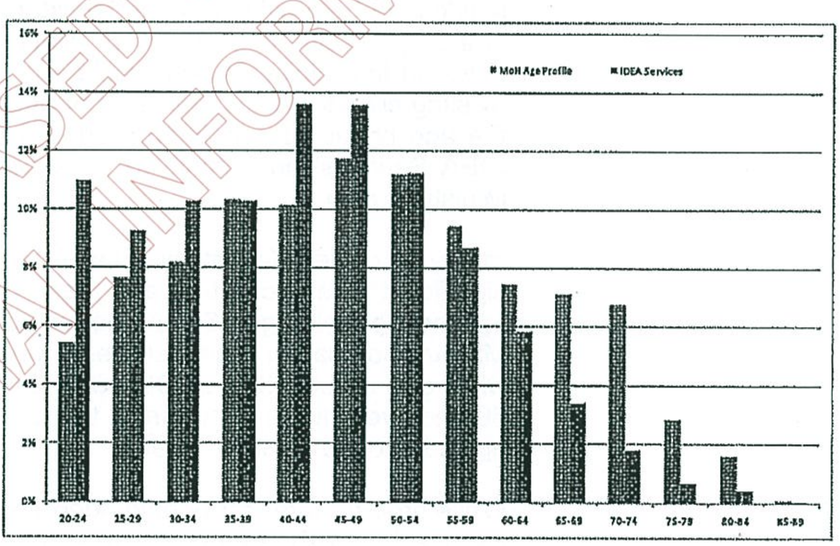
22. In respect of the principle of attribution in paragraph 10 above, including *all* MSD clients as an upper bound in the cost estimates is an improper attribution, which has the effect of inflating the apparent costs associated with the proposal. The relevant "pool" of people is the minority of MSD clients who have an intellectual disability, which Mr de Raad estimated at 53 people.

23. The second alternative assumption I make in relation to the volume data affects the actual number of clients with a disability likely to enter Ministry day services at age 65; this assumption requires adjustment to reflect attrition rates obvious in the data. Implicit in Mr de Raad's evidence is that he weights equally the two years used to calculate the starting volumes; he takes the 240 remaining clients aged 63 and 64 and divides by two to derive his figure of 120. Similarly, he takes the 105 clients with an intellectual disability and divides by two to derive his estimate of 53 intellectually disabled clients in his second scenario (see paragraph 24 of Mr de Raad's evidence).

24. Rather than treat these two years equally, I make use of the observed drop-off rate in the data. Figure 1 and figure 2 of Mr de Raad's evidence and the paragraphs around these figures make it clear that there are noticeable reductions in client numbers year-to-year. IDEA Services has provided me with data on the age profile of its client base, which suggests a much stronger drop-off rate than assumed by Mr de Raad.

25. Figure 1 below compares the age profile of IDEA Services' clients with estimates of the Ministry age profile contained in figure 2 of Mr de Raad's evidence. The relevant difference relates to ages 60-64 to 70-74 where the rate at which clients exit day services (**"drop-off rate"**) for IDEA Services clients is much more pronounced. This means it is likely that the volume of clients Mr de Raad assumed to enter at age 65 (using the Ministry age profile) is overstated.

**Figure 1 Age profile comparison**



26. Assuming the drop-off rate is linear within age intervals I estimate the annual rate of decline is around 8% for the 60-64 age group. Applying this drop-off rate to the original number of 240 people gives estimates of 115 and 50 respectively as "starting volumes". Using the model set out in Table 3 of Mr de Raad's evidence with no other changes means that costs reduce by $1.2m (4.2%) for scenario 1 and $714,000 (5.7%) for scenario 2. While I set out below additional analysis and alternative assumptions that modify cost estimates, all else equal, these numbers indicate the minimum amount by which the total costs may be reduced while still using Mr de Raad's incorrect "upper bound" domain.

27. Correcting for the relevant starting volume, I use an estimate of 50 clients entering Ministry funded day services and the model assumptions as outlined in Mr de Raad's evidence as my "upper bound" estimate of costs. Confining the costing exercise to estimating the cost of day care services to intellectually disabled people aged over 65 results in an "upper bound" estimate of $11.9m per year for a fully "mature" scheme catering for 729 clients. This estimates compares to estimated costs of $12.6m per year for 773 clients contained in Mr de Raad's evidence (paragraph 36), which he incorrectly labelled as a lower bound figure.

28. Similar corrections to the data are required to estimate the cost of IDEA Services' service users only (ie the service users who are the subject of this claim). Mr de Raad uses current IDEA Services' clients funded by MSD as a proxy for clients who may be funded post age 65 (paragraph 31). He assumes 30 clients, based on there being 30 clients aged 63 and 27 aged 64 currently. Correcting this starting number to reflect observed attrition results in a starting number of 25 clients (i.e. 27 clients aged 64, less the observed attrition rate per year). The cost (once the programme was fully mature) associated with this number of clients is around $4.1m for scenario 1 and $4.8m for scenario 2. These estimates include the $2.5m of current funding for those aged 65+, and hence the *additional* cost would be just $1.6 million for scenario 1 and $2.3 million for scenario 2.

**Duration**

29. A major driver of total costs is the duration that clients would require the services to be provided by the Ministry. The key determinant of duration is the age profile of day service clients. Figure 1 shows the difference between the Ministry's age profile and the age profile of IDEA Services' existing clients. While both sets of data are not likely to perfectly predict the age profile of people who do end up as clients, I judge the use of IDEA Services' age profile to be a better proxy than the broad based Ministry profile.

30. In the key ages (ie between the 60-64 and 70-74 intervals) there are significant differences between these profiles - see table 1 below. For instance, people aged 60 and above account for around 26% of the total Ministry population (aged 20 years and above) receiving day services, while only around 12% of IDEA Services' clients (aged 20 and above) are 60 and over. More importantly, the rate at which volumes drop between age categories differs markedly.

31. While drop-off rates for people aged 75 and above are very similar, IDEA Services' data shows a much greater rate of drop-off than is the case for the Ministry day services population. Assuming (conservatively) a linear annual distribution, the difference per year for people aged between 65 and 74 lies between a factor of eight and nine.[2] That is, the data shows that the annual rate of drop-off for IDEA Services' clients is eight or nine times that shown by the Ministry data for these age groups.

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[2] This linear distribution assumption is conservative in the sense that it may actually underestimate the "true" exit rate, as the percentage applies to a lower starting point each year and thus the actual drop-off rate would need to be greater than a linear interpolation. I use this assumption for reasons of simplicity.

**Table 1 Drop-off rate comparison**

| Interval (age in years) | Proportion (of total population over 20) | | Drop off rate for interval | | Annual drop rate | |
|---|---|---|---|---|---|---|
| | Ministry | IDEA | Ministry | IDEA | Ministry | IDEA |
| **60-64** | 7% | 6% | -21% | -33% | -4% | -7% |
| **65-69** | 7% | 3% | -5% | -42% | -1% | -8% |
| **70-74** | 7% | 2% | -5% | -47% | -1% | -9% |
| **75-79** | 3% | 1% | -58% | -62% | -12% | -12% |
| **80-84** | 2% | 0% | -44% | -38% | -9% | -8% |
| **85-89** | 0% | 0% | -94% | -95% | -19% | -19% |

Source: IDEA Services Limited and de Raad evidence (estimated from figure 2).

32. Figure 2 shows the different profiles for three assumed drop-off rates. The profile Mr de Raad adopted is set out in table 3 of his evidence (ie 1% per year between ages 65 and 74, 15% between ages 75 and 84, and 100% at age 85). The "hybrid" profile is based on IDEA Services' data and assumes a drop-off rate of 8.4% between ages 65 and 69, 9.4% between the ages of 70 and 74, 15% between ages 75 and 84, and 100% at age 85.

33. The smoothed profile assumes a 1% exit rate initially, rising by one percentage point each year to age 74, a 15% exit rate at age 75 rising by five percentage points each year following this, until a 100% exit rate at age 85. This profile is included for the purposes of exposition. It is based (loosely) on patterns observed in the central death rate by age data produced by Statistics New Zealand.[3] The basic purpose of the smoothed profile is to consider less "stepwise" assumptions about exit rates.

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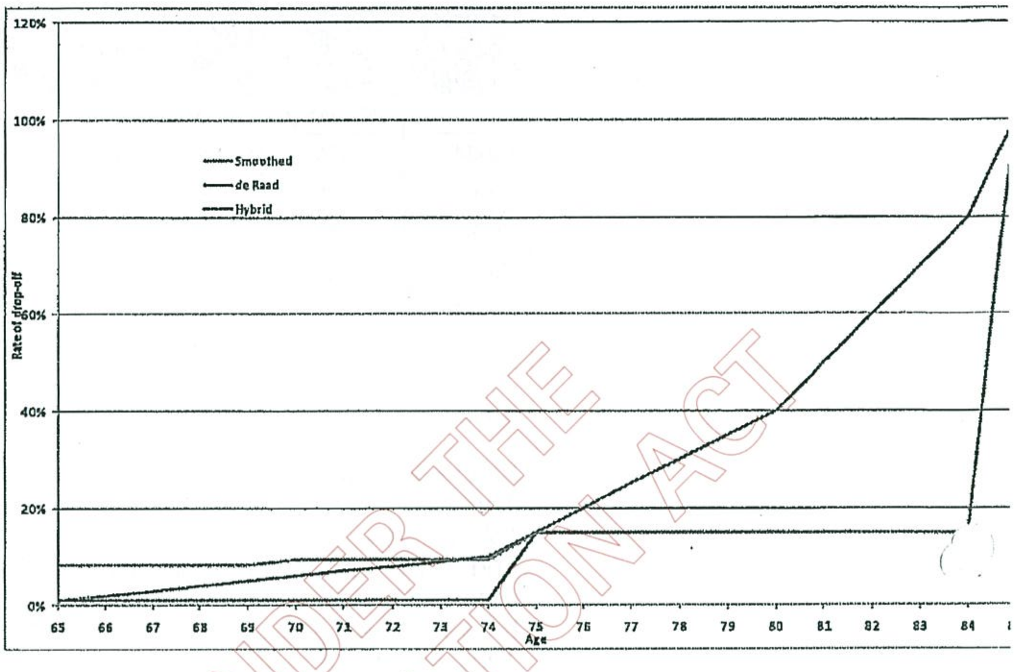
[3] http://www.stats.govt.nz/browse_for_stats/health/life_expectancy/cohort-life-tables.aspx

**Figure 2 Drop-off rate profiles**



34. I re-estimated table 3 of Mr de Raad's evidence using the updated drop-off rates (ie based on IDEA Services' client age profile) and starting from the premise of 50 clients entering at age 65. In this approximation, I continue to use the same drop-off rates of Mr de Raad for people aged 75 and over. This is scenario 1 in table 2 below. Scenario 2 assumes instead that, rather than proceed in a stepwise fashion, the exit rate per annum (ie the drop-off rate) rises smoothly each year, with similar actual rates of drop-off at similar points - 15% at aged 75 and 100% at age 85.

35. The costs associated with such revised assumptions would lie between $7.4m and $8.8m excluding GST per annum for 454 to 536 people once the programme has fully matured in 20 years. As noted in paragraph 28, the additional cost (once the programme was fully mature) associated with IDEA Services' service users only would be just $1.6 million for scenario 1 and $2.3 million for scenario 2, after deducting the existing cost of $2.5 million per annum of current funding.

36. I exclude the longer-term consideration of individuals who have very high needs entering the system at age 65 on the understanding that these people are covered under particular policy settings. It is my understanding, for example, the very high needs individuals are funded by the Ministry for one-to-one supervision. Therefore, if these individuals are attending MSD day services, when this service stops at age 65, they will already have in place one-to-one support from the Ministry and will not require, and therefore will not be eligible for, further funding during the day for reason of the one-to-one Ministry support (not for reason of age). In addition, there may be a small number of individuals for whom the Ministry has statutory responsibility under the Intellectual Disability (Compulsory Care and Rehabilitation Act) 2003 (ID (CC&R) Act). The costs of caring for these people are costs that would be incurred regardless of the proposal under consideration (ie they are not costs that arise due to the proposal). Moreover, I have not been able to estimate the actual numbers involved (ie paragraph 35.6.1 of Mr de Raad's

evidence) and apply updated assumptions accordingly. Given the relatively minor costs involved and the uncertainty around exit rates, I consider this exclusion not to be material.

| Scenario 1 | | | | Scenario 2 | | |
|---|---|---|---|---|---|---|
| Age | clients | Exit rate pa | Costs | clients | Exit rate pa | Costs |
| 65 | 50 | 8% | $ 815,850 | 50 | 1% | $ 815,850 |
| 66 | 46 | 8% | $ 747,319 | 50 | 2% | $ 807,692 |
| 67 | 42 | 8% | $ 684,544 | 49 | 3% | $ 791,538 |
| 68 | 38 | 8% | $ 627,042 | 47 | 4% | $ 767,792 |
| 69 | 35 | 8% | $ 574,371 | 45 | 5% | $ 737,080 |
| 70 | 32 | 9% | $ 526,123 | 43 | 6% | $ 700,226 |
| 71 | 29 | 9% | $ 476,668 | 40 | 7% | $ 658,212 |
| 72 | 26 | 9% | $ 431,861 | 38 | 8% | $ 612,137 |
| 73 | 24 | 9% | $ 391,266 | 35 | 9% | $ 563,166 |
| 74 | 22 | 9% | $ 354,487 | 31 | 10% | $ 512,481 |
| 75 | 20 | 15% | $ 321,165 | 28 | 15% | $ 461,233 |
| 76 | 17 | 15% | $ 272,991 | 24 | 20% | $ 392,048 |
| 77 | 14 | 15% | $ 232,042 | 19 | 25% | $ 313,639 |
| 78 | 12 | 15% | $ 197,236 | 14 | 30% | $ 235,229 |
| 79 | 10 | 15% | $ 167,650 | 10 | 35% | $ 164,660 |
| 80 | 9 | 15% | $ 142,503 | 7 | 40% | $ 107,029 |
| 81 | 7 | 15% | $ 121,127 | 4 | 50% | $ 64,218 |
| 82 | 6 | 15% | $ 102,958 | 2 | 60% | $ 32,109 |
| 83 | 5 | 15% | $ 87,515 | 1 | 70% | $ 12,844 |
| 84 | 5 | 15% | $ 74,387 | 0 | 80% | $ 3,853 |
| 85 | 4 | 100% | $ 63,229 | 0 | 100% | $ 771 |
| 86 | 0 | | $ - | 0 | | $ - |
| 87 | 0 | | $ - | 0 | | $ - |
| 88 | 0 | | $ - | 0 | | $ - |
| 89 | 0 | | $ - | 0 | | $ - |
| 90 | 0 | | $ - | 0 | | $ - |
| Total | 454 | | $ 7,412,334 | 536 | | $ 8,753,807 |
| Average rate | | | $ 16,317 | | | $ 16,317 |

## Other

37. Various other assumptions have a bearing on the estimated total costs of the proposal for the Ministry to assume responsibility for day service provision for people aged 65 and over.

*Price-based assumptions*

38. In addition to volume-based assessment, a "price-based" assessment is also relevant. Throughout the estimation exercise an average "price" of $16,317 per client per annum has been assumed. As stated by Mr de Raad in his evidence (at paragraph 35.1) it is possible that this price does not apply to all clients who may transfer from MSD to the Ministry, thereby reducing the estimated costs. I do not have any basis upon which to estimate the intensity of services likely to be required by potential clients and the subsequent cost reduction that might result.

39. It is possible that the "unit price" of $16,317 assumed throughout the estimation exercise is an understatement of likely costs that might be faced. This figure (representing the 2010 funding rate for IDEA Services) is below both the average spend per person for all Ministry funded day support services ($17,939) and the average spend per person for Ministry funded day support services obtained from other providers ($18,831) referred to in table 1 of Mr de Raad's evidence. Using the $17,939

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average figure would result in the costs set out in paragraph 33 rising by $736,827 in scenario 1 and $870,176 in scenario 2.

40. While illustrative, I caution against placing too much weight on these alternative price-based assumptions. Ultimately, the detail around price will be negotiated as part of service contracting. I note there are risks around quality and quantity of service provision from a lower "price". In addition, the lower "price" used above effectively compares "apples with oranges" in terms of funding approaches. The higher "price" is also indicative only, given the nature of the IDEA Services' claim.

*The role of "sunk" costs*

41. A further consideration of relevance is the extent to which "sunk costs" feature in the system. By "sunk costs" I mean costs that are not necessarily dependent upon the proposal itself and would be incurred regardless. I mentioned such costs in relation to individuals covered under the ID (CC&R) Act at paragraph 34 above. Other instances where the Ministry assumes funding responsibility for individuals aged 65 and over include deinstitutionalised clients and others who have been referred by a Needs Assessment and Service Coordination organisation and other "grand-parented" arrangements. The cost of these clients is around $4.3m per year (paragraph 14 of Mr de Raad's evidence).

42. I understand that a key principle in any decisions around transfer of funding responsibility is that existing arrangements may be "grand-parented" (refer paragraph 19 of **[1/85]** and paragraphs 17 & 18 of **[4/1734]**). Therefore, it is not appropriate to include such costs as part of this claim as the costs would be incurred regardless. However, it would not be correct to "net off" this amount in full from the revised costs as the quantum of costs would most likely reduce to zero over time. I do not have any basis on which to estimate the speed and nature of reduction, but note (as Mr de Raad did in paragraphs 35.4 and 36 of his evidence) that these costs are already being faced and should be subtracted from the total cost estimates in considering the additional cost of the proposal.

*Discounting*

43. The cost estimates produced so far have all been expressed in current (2010) dollars, which is fairly routine in terms of determining fiscal implications associated with policy decisions. However, a cost-benefit assessment - which is a very useful analytical inclusion in policymaking - usually involves discounting future costs and benefits to allow decisions to be made with the most relevant information to hand at a given point in time. A net present value analysis expresses costs in present value terms to reflect the fact that a dollar today is valued more than a dollar in the future, or equivalently a dollar of cost today has more "impact" than a dollar of cost tomorrow. A net present value analysis therefore allows costs (and benefits) incurred over different time-periods to be compared.

44. Given the timeframes involved, the effect of discounting is likely to be material. Discounting would have the effect of lowering total costs in all scenarios. For example, using a discount rate of 10% and a 20-year timeframe, my scenario 2 estimate of $8.8m as the cost of a "mature" programme has a present (discounted) value of $5.5m at the point the decision is taken. I have not attempted to apply discounting techniques to the full range of cost estimates here, as the effect will be absolute

rather than relative; that is, it would not necessarily affect the relative magnitudes of cost differences between Mr de Raad's estimates and my estimates.

*Context around health spending*

45. I understand from the discovered material that the change in funding arrangements in 2005 was motivated by fiscal considerations (ie an environment of limited scope for budget increases). I could not determine a clear policy rationale from the documents. I note the life expectancy of individuals with intellectual disability has been increasing along with the life expectancy of the general population, and hence that the estimated cost of the proposal is one of a series of impacts on the cost of health services as the population ages. The New Zealand Treasury, in its 2009 long-term fiscal outlook statement, forecast that health spending would increase from 6.9% of GDP in 2008/9 to 8.5% of GDP in 2029/30. This represents a nominal increase of some $9.5 billion dollars. My estimated cost of extending day care services to intellectually disabled people aged over 65 is less than 0.093% of the forecast *increase* in Vote Health.

**Summary**

46. Mr de Raad's estimates of the costs of extending day services to those over 65 fall in the region of $12.5 to $28.5 million ex GST per annum, for 773-1750 people once the programme has fully matured. Mr de Raad estimates that in a further 35 years, the cost estimates would start to rise and in 55 years they would range between $14m and $32m (paragraphs 36 and 37 of Mr de Raad's evidence).

47. Using the same simple modelling approach applied by Mr de Raad, with updated assumptions, I estimate that the "upper bound" of costs would fall in the region of $7.4m and $8.8m ex GST per annum, for 454-536 people once the programme has fully matured. My updates to assumptions relate to the initial number of clients (ie I estimate the cost of providing day care to clients aged over 65 with an intellectual disability, rather than to all MSD clients aged over 65) and the rate at which clients exit the programme (ie use of IDEA Services age profile data rather than the Ministry age profile).

48. Furthermore, up to $4.3m of costs associated with day services provision for people aged 65 and over is already being faced (as acknowledged in paragraph 36 of Mr de Raad's evidence). Thus, the *additional* cost associated with the proposal will actually be lower than the range above, however, is not possible for me to estimate the potential "lower bound" of costs here without better data.

49. Using the average spend per person for Ministry funded day support services of $17,939 rather than the $16,317 being claimed by IDEA Services, means that costs would increase by between $0.737m and $0.870m.

50. If these costs were limited to day services for IDEA Services' service users who are aged 65 years and over only, the increase would be between $1.6 million and $2.3 million, after deducting the $2.5 million per annum of current funding.

51. I do not attempt to estimate the relevant costs in 55 years time as there is too much uncertainty around the treatment of very high needs clients (ie whether they are a statutory responsibility of the Ministry, in which case they are non-discretionary/sunk costs rather than additional costs) as well as the assumed rate of exit/drop-off. The omission of such costs is not material, in my view.

52. At paragraph 39, Mr de Raad's admits that there are a number of reasons that suggest costs would fall at the lower end of his identified range; once Mr de Raad's assumptions on entry are corrected, there are a number of reasons to suggest that the total costs would be significantly lower than the "lower bound" of his estimate. In discounted present value terms, the cost of the mature scheme at 20 years is likely to be less than half of the lower bound estimate suggested by Mr de Raad.

Kieran O'Neill Murray

Dated this 17 day of September 2010

# Kieran Murray, Managing Director, LECG

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## BIO/SUMMARY

Kieran works primarily in the fields of public-policy reform, competition analysis and regulation. He has served as an economic consultant on regulatory, public policy, and competition issues for public agencies and private companies in Australia, Canada, New Zealand, Philippines, Tonga, Singapore, Vietnam and the United States. Kieran is a member of the senior executive team for LECG's global energy and environmental practice, and serves as an International Arbitrator for the PNG Independent Consumer and Competition Commission.

Kieran has testified before Select Committees of New Zealand's House of Representatives, the High Court and Commerce Commission, and the Energy Regulatory Commission of the Philippines. He has provided expert evidence and reports to the Australian Consumer and Competition Authority, the Australian Energy Market Commission, and the (former) National Electricity Code Administrator in Australia, the Energy Regulatory Authority in Singapore, and presented to the Federal Energy Commission of the United States.

Before joining LECG, Kieran led the design of the trading arrangements for New Zealand's wholesale electricity market.

Previous public-policy engagements have included Principal Advisor to the Ministerial Inquiry into the Electricity Industry; Economic Advisor to the Hon Mike Moore (subsequently Director-General of the WTO) during his term as Leader of the Opposition; member of the Prime Ministerial Task Force on Targeting Social Assistance; Economic Advisor to the New Zealand Minister of Finance, the Hon David Caygill; and senior analyst at the New Zealand Treasury.

## EDUCATION

Graduate Certificate in Management, Monash University, Australia, 1997
Advanced Management Programme, Monash University, Australia, 1997
Bachelor of Commerce, Otago University, New Zealand, 1985
Post Graduate Diploma in Commerce, Otago University, New Zealand, 1986

## PRESENT POSITIONS

LECG Ltd - Managing Director since 2007, Director 1997-2007
Chairman, Board of Directors, LECG Ltd (Australia and New Zealand), since 2006
Member of senior executive team, for LECG global energy and environmental practice

## ILLUSTRATIVE ENGAGEMENTS

### Testimony

Expert testimony to the New Zealand Commerce Commission on input methodologies for regulating prices charged by utilities in markets which are not workably competitive.

Expert submission to the Horizon Regional Council on a methodology for carrying out a cost benefit analysis of rules within a regional plan for the allocation of water.

Expert testimony to Environment Waikato on measuring the costs and benefits of alternative allocation rules for water.

Expert testimony to the Environment Court on economic effects of allocating water to hydro generation relative to irrigation for dairy conversions.

Expert evidence to the Commerce Select Committee of the NZ House of Representatives on the economic costs and benefits of appeals on merit of economic regulation decisions.

Expert evidence to the Australian Energy Market Commission in relation to electricity and gas retail competition in South Australia.

Expert submission on the meaning of 'reasonable cost' for the purposes of setting credit card charges.

Expert testimony to the New Zealand High Court with regard to competitive effects of leasing and purchasing electricity meters

Expert testimony in arbitration proceedings relating to payments by developers to a local authority for infrastructure services.

Expert witness statement to the Singapore Energy Market Authority on estimating the long run marginal cost of efficient new entrant generator for the purposes of calculating vesting contract prices.

Expert witness statement to the New Zealand High Court with regard to charges by a local authority to developers for infrastructure services.

Expert witness statement to the Australian Consumer and Competition Commission in relation to Air New Zealand and Qantas Airways application for a code sharing agreement.

Expert witness statement to the Energy Regulatory Commission of the Philippines on the efficient costs for the purposes of calculating the maximum allowable revenue for the National Transmission Corporation.

Expert witness statement to New Zealand High Court in the judicial review of the Electricity Commission's transmission pricing guidelines.

Provided expert evidence to the Regulations Review Select Committee of the NZ House of Representatives on the setting of levies to recover the costs of the Electricity Commission.

Expert witness statement, jointly with Professor Jerry Hausman, MIT, in Air New Zealand and Qantas Airways vs New Zealand Commerce Commission concerning welfare impact of proposed merger.

Expert witness statement to the High Court on the meaning of opportunity cost in the cost of valuation of specialised assets, in proceedings between Wellington Airport, Air New Zealand, Qantas, Air Pacific Limited and Polynesian Airlines.

Expert witness statement in Contract for Differences arbitration between Contact Energy Ltd and Shell New Zealand Ltd.

Assisted Professor David Teece, University of California, Berkeley in preparing expert testimony on forestry tax litigation matters before the New Zealand High Court.

Provided testimony to the Philippines Energy Regulatory Commission on the pricing methodology for transmission services.

Provided expert testimony to the Philippines Energy Regulatory Commission on the terms for open access transmission services.

Provided expert testimony to the Singapore Energy Market Authority on incentive based regulation of the electricity market operator.

Provided expert testimony to the New Zealand Commerce Commission regarding the application by Qantas and Air New Zealand for authorisation of an alliance.

Provided expert testimony in the arbitration proceedings between Wellington Airport, Air New Zealand, Qantas, Air Pacific Limited and Polynesian Airlines with regard to the application of economic concepts in valuing specialised assets such as airport runways.

Provided expert testimony to the NZ Commerce Commission in regard to its price control investigation of Auckland, Wellington and Christchurch International airports.

Provided expert testimony to the NZ Commerce Commission on the setting of thresholds for the price control of electricity lines businesses.

Provided expert testimony to the NZ Commerce Commission on the application by the electricity industry to merge its governing rulebooks and introduce a process for governing transmission investment decisions.

Assisted in preparing expert testimony to National Competition Council of Australia on the affiliation of the Trade Practices Act and the Gas Access Code regulatory regime to price setting and rate regulation for gas pipelines.

Provided expert testimony to the New Zealand High Court on efficient pricing of HVDC transmission interconnect in New Zealand.

Prepared expert testimony for the NZ Commerce Commission on the public benefits and detriments of releasing generator offer data.

Estimated the damages suffered by Contact Energy Ltd with the failure of its Otahuhu Combined Cycle Plant.

Expert witness WEL Energy vs ECNZ, testifying on the loss suffered by WEL Energy on its hedge portfolio on the break-up of ECNZ.

Provided expert testimony to the Commerce Select Committee of the NZ House of Representatives on the proposed price-control regime for lines companies.

Prepared expert testimony to the NZ Commerce Commission an application for authorisation of the proposed contractual arrangements governing the setting, monitoring, and enforcement of security of electricity supply over the national grid.

Provided expert testimony to the NZ Commerce Commission on the application by TransAlta for Clearance to acquire Contact Energy.

Prepared and presented the economic arguments for authorisation of the Rules of the NZ Electricity Market to the NZ Commerce Commission.

**Public policy**

Reviewed the public policy reasons for exempting the Pharmaceutical Management Agency (Pharmac) from Part 2 of the Commerce Act (the Act), which deals with restrictive trade practices.

Reviewed for the United Nations Conference on Trade and Development the New Zealand experience with foreign direct investment and sector reform.

Developed for the Ministry of Economic Development an analytical framework for evaluating sector performance.

Reviewed for the New Zealand Treasury proposals that the New Zealand government should trade its AAU's under the Kyoto Agreement.

Principal advisor to the Ministerial Inquiry into the New Zealand electricity industry during the first phase of its work, including drafting its Issues Paper, travelling with the Panel internationally and attending public hearings.

Participated in a group of economists and former public officials commenting on California State Government on electricity crisis.

Wrote for the New Zealand Treasury a major review of the institutional arrangements for delivering social policy, including evaluating the circumstances in which the Government should own the delivery mechanisms.

Advised a consortium of NZ electricity companies on the development of a robust regulatory framework for lines companies consistent with New Zealand's light-handed regulatory regime.

Prepared for the Ministry of Economic Develop a draft discussion paper reviewing access rights by utilities to private land.

Evaluated for the New Zealand Government the options for a further break-up of NZ's largest state-owned generator, ECNZ, including estimating the impact of increased competition on spot and forward prices, generator operating costs, and security of supply.

**Complex contracts**

Led the design of the set of contracts to apply between the Philippines transmission company and its customers (i.e. generators, distributors, and the wholesale market operator) as part of the electricity sector privatisation program. These Open Access Transmission Service Rules (OATS) covered the transmission service, connection arrangements, ancillary services, the system operator function, metering, and the pricing of and billing for all such services.

Led a process involving New Zealand's transmission company and its customers to specify and record in contractual terms transmission service definitions, measures and service levels for output based contracts.

Advised an international airport on approaches to pricing for airport activities and approaches for contract negotiation with airlines companies.

Project managed an electricity industry project to establish the contractual structure under which transmission customers would determine security policy, technical standards, and the quality of electricity supply from the national transmission grid. This included advising on how the various services necessary to maintaining quality would be purchased, the costs allocated among grid users, and arrangements for setting standards governed under an open access policy.

Advised on the contractual structure and pricing mechanisms for open access fibre optic telecommunication loop.

Advised on contractual issues arising from integration of a telecommunications network company and an electricity network company.

Advised an international consortium on contractual structures underpinning a bid to purchase a national telecommunications company with a view to restructuring the business into three companies: a standalone network company providing open access under a system of capacity rights, a clearing company, and a retail company.

Reviewed for distribution companies the terms and conditions of Transpower's connection contracts and how those terms allocate risk.

Advised a major generating company on terms and conditions for access to the national grid.

Advised a large distribution company on the design of contracts between a divested retail business and its lines business, and on the design of a pricing methodology for lines functions services consistent with the Electricity Industry Disclosure Regulations.

**Water resource projects**

Economic adviser and negotiator for a group of six water utilities negotiating a contract for the supply of bulk water with a water wholesaler in New Zealand's largest city, Auckland. Contract scope includes the allocation of risks, determining an appropriate price structure and price levels, the valuation of assets, and estimating cost of capital.

Reviewed the nature of existing water rights held by the 5 major hydro generators in New Zealand, assessed international best practice, and prepared report recommending changes to the Resource Management Act for submission to the Ministry for the Environment.

Prepared submission on the draft Waitaki Catchment Water Allocation Plan reviewing the changes in allocation and form of property rights to water.

Reviewed security of property rights under resource consents for use of water resources and implications for efficient investment.

Reviewed the methodology and models used by the Northshore City, Auckland City, and Manakau City Councils, to determine the amounts charged to developers to compensate for the impact of development on city infrastructure, with a particular focus on urban water infrastructure.

**Electricity market design and governance**

Evaluated options and alternatives for scarcity pricing and incentives for conservation campaigns.

Evaluated the governance and regulation of the New Zealand electricity sector (this report was referred to a Ministerial Review of the electricity sector).

Reviewed for the Australian Energy Market Commission electricity and gas retail competition in South Australia.

Reviewed the mechanisms and processes for approving major transmission investments in New Zealand.

Advised Western Power retail on establishing its trading capability as a standalone entity.

Completed for the New Zealand Electricity Commission an assessment of the state of competition in the wholesale and retail electricity markets and an analysis of barriers to investment and entry in generation.

Reviewed for a major generator the pricing methodology for transmission services and engaged with the Electricity Commission's consultants reviewing the transmission contract structure.

Commented on the new regulations governing transmission investment and the extent to which those regulations allow substitutes to transmission, such as generation investment, to capture avoided costs of transmission.

Reviewed proposed regulations governing terms of access by small-scale generation and co-generation plant to distribution networks.

Reviewed the new Electricity Governance and Rules, including commenting on the move to the 'mandatory gross pool' and the exemption provisions for small-scale and co-generation plant.

Reviewed the method for allocating the Electricity Commission's levies, and providing expert opinion in relation to an appeal to the Regulations Review Select Committee.

Advised the Council of Australian Governments (COAG) on a number of energy market reform issues including demand side participation and supply reliability.

Reviewed and prepared comments on the Standard Market Design proposed by US Federal Energy Regulatory Commission for electric utilities in the southeast United States.

Reviewed the design and experience worldwide with electricity vesting contracts for a major US utility in preparation for its filings under Chapter 11 bankruptcy proceedings.

Developed an alternative approach for setting price control thresholds under the price control regime proposed for New Zealand.

Led an industry process to devise new arrangements for contracting for transmission enhancements and replacement in New Zealand.

Advising the Energy Market Company in its negotiations with the Singapore Energy Market Authority on performance based regulation.

Coordinated and principal adviser to an industry wide review of the contractual arrangements for electricity distribution and retail activities, drafted model distribution use-of-system agreements and model distribution pricing arrangements.

Advised a Steering Group for the Chief Executives of New Zealand's largest energy companies on how the industry might achieve the Government's objectives for a unified market governance structure.

Prepared for the Board of New Zealand's largest network company a pricing policy designed to maximise shareholder value by optimally allocating risks while providing certainty to its customers as to the factors that would influence price.

Advised a forum of chief executives of New Zealand's largest energy companies on the design of ancillary services markets and transmission issues.

Undertook an independent appraisal for Australia's National Electricity Code Change Panel concerning who should pay for ancillary services.

Prepared for Ontario Hydro (Canada) a review of ancillary services markets in Australia, United Kingdom, New Zealand.

Evaluated the role of organised markets in the NZ electricity industry and the opportunities for 'free-riding' on the spot market price discovery process.

Participated in an LECG team advising Ontario Hydro on the design for a spot market, including methodologies for establishing spot prices.

Analysed the likely outcome of ongoing reform to the institutional structures which support the NZ electricity market, including assessing the implications for the market company and the transmission company.

Evaluated proposals for contracting and pricing voltage support arrangements and other ancillary services in the Auckland region.

**Market evaluation**

Market adviser to Korean Water Corporation for the acquisition of the Angat Hydro Power Station in the Philippines;

Market adviser to Banpu PCL, Thailand, for the acquisition of the Calaca Power Station in the Philippines;

Market adviser to Denham Capital Management for its investigation of renewable energy projects in New Zealand.

Market adviser to the lenders (Sumitomo Mitsui Banking Corporation, The Export-Import Bank of Korea) for the development of the KEPCO SPC power project in Cebu in the Philippines.

Market adviser to Suez Energy International for the acquisition of the Tiwi-MakBan Power Station in the Philippines.

Market adviser to Emerald Energy on establishing trading and regulatory functions for the Calaca Power Station in the Philippines.

Regulatory adviser to the National Transmission Corporation to assist it respond to the Energy Regulatory Commission Reset Issues Paper for determining TransCo's revenue for the period 2010 to 2015.

Market adviser to Suez Energy International for the acquisition and financing of the Calaca Power Station in the Philippines.

Market adviser to Mighty River Power for the acquisition of Philippine National Oil Corporation (PNOC) in the Philippines.

Market adviser to Suez Energy International for the acquisition of the Masinloc Power Station in the Philippines.

## PROFESSIONAL EXPERIENCE

**Electricity Market Company, Manager, Research and Development, 1994-1997**

Project-managed the design and successful implementation of the trading arrangements for NZ's wholesale electricity spot market. This included facilitating industry working groups, preparing issues papers, reports and draft rules.

Designed and gained industry acceptance of a structure for creating and changing the rules for a spot market in electricity, including arrangements for voting and market governance.

Managed a programme of extensive communication and consultation with industry participants and government officials, including workshops, newsletters, and regular progress reports to Government Ministers.

Oversaw (as deputy CEO) the development of the Electricity Market Company from a concept funded by project money, to a profitable company providing power exchange services to the NZ electricity industry on a competitive basis.

Oversaw the design of a real-time electronic trading and information system, handling all transactions for the NZ electricity market. This project utilised up-to-date database and intranet technology and was completed under budget within a very tight time frame.

**NZ Treasury, Advisor, 1994**
Carried out a strategic review of welfare policy, and suggested an approach for evaluating alternative expenditure proposals during periods of sustained fiscal surpluses.

Prepared background paper for the Prime Ministerial Task on Employment concerning the Evolution of Economic and Social Policy in New Zealand.

**Parliament, Economic Advisor to Leader of the Opposition, 1992-1993**
As principal economic advisor, held a senior position in the Leader of the Opposition's office. Provided policy and strategic advice and undertook policy costings. Interpreted economic statistics and monitored market trends.

Liaised and maintained good relations with senior members of Labour's caucus, the media, market participants, and senior figures within the public and private sectors.

**State Services Commission, Economic Consultant, 1991-1992**
Contracted to assist in bringing the Government's structural reforms to the Housing Corporation back on track.

Identified and overcame bottlenecks in the reform process and advised Government Ministers on how to resolve conflicting advice from officials.

**Prime Ministerial Task Force On Targeting Social Assistance, Member, 1991**
Estimated the fiscal savings that could be achieved through greater targeting of social assistance and evaluated the distributional impact of such changes on the NZ population. Delivered an oral presentation of its recommendations to the Prime Minister's Cabinet Committee.

**Parliament, Economic Advisor to the Minister of Finance, 1990**
Anticipated the development of issues within the finance portfolio and developed strategies to manage these issues both within the Government caucus and external environment.

Provided policy advice to the Minister. Key policy programmes implemented during this period included the Reserve Bank Act, the Public Finance Act and the sale of Telecom.

Prepared reports for Cabinet and Government caucus, the media, and for general public release and drafted speeches and press releases.

**New Zealand Treasury Department, Financial and Economic Analyst, 1987-1990**
Reviewed medium-term fiscal strategy and sectional adjustment issues.

Responsible for a range of tasks in the direct and indirect tax policy areas. These included responsibility for bedding in GST, and policy advice relating to personal and business tax reform at a time of significant structural change to the NZ tax system.

Prepared taxation revenue forecasts during the annual Budget cycle and estimated the cost of tax policy changes in a Budget and Tax Package context.

Investigated and monitored Inland Revenue's annual operational budget of approximately $600 million.

**Business Affiliations**
Previously Member, Appeal Board, New Zealand Electricity Market

## PUBLICATIONS AND PRESENTATIONS

1. "Water allocation: The strengths and limits of economic analysis", Water 2020: From fragmentation to efficiency, September 2009.
2. "Determining outcomes or facilitating effective market processes: a review of regulation and governance of the electricity sector", Energy Law Association, 26 March 2009.
3. "Sunk? Fixed? Defining costs in infrastructure pricing", Competition & Regulation Times, New Zealand Institute for the Study of Competition and Regulation, Victoria University Wellington, July 2006
4. "The Economics of Contract Damages" Auckland District Law Society Conference, March 2002.
5. "Technological change, innovation, and regulating to ensure fair value to consumers: the case of electricity networks" with Stuart Shepherd, March 2002.
6. "Regulatory Takings and the Common Law in Australia: Implications for Network Industries" Australian Law and Economics Association Conference, Canberra November 2001.
7. "Market Governance and the Role of Government: Some principles for good government" Electricity Industry Reform Conference, Wellington 4 July 2000.
8. "Energy Market Reform in New Zealand" Energy Market Regulation Conference, Melbourne, 30 November 1999.
9. "Getting the price right: is price control the answer?" National Power Conference, Wellington, October 1999.

10. "Natural monopoly: A problem looking for a home?" Australian Law and Economics Association Conference, September 1999.
11. "New Zealand electricity market: evolution of a successful self-regulated electricity market" with Lincoln Gold, Asia Pacific Economic Cooperation (APEC), July 1999.
12. "What is the policy problem?" Major Electricity Users Conference, Wellington, March 1999.
13. "Factors driving changes in the market?" Market Structure Workshop, March 1999.
14. "Financial and Physical Security in a Competitive Market" Chairman of workshop, The changing profile and future direction of the New Zealand electricity industry, Transpower Conference, Wellington, November 1998.
15. "Contracting for electricity supply integrity over the New Zealand national electricity network", Energy Supply Conference, Melbourne, October 1998.
16. "The new grid security policy and the impact on the industry" The New Electricity Environment Conference, Wellington, 1998.
17. "Market design and security of supply" La Problematic Del Sector Electrico Colombiano Posibles Alternativas, Bogota, November 1997.
18. "Implications of a voluntary market", Competition in the Electricity Industry, Transpower Conference, Wellington, 1997.

# Family Caregivers for Persons with Disabilities

November 2011

## Final report

### Policy Options

MARTIN JENKINS

# Preface

This report has been prepared for the Ministry of Health by Dr Alan Barker and Nick Hunn from MartinJenkins (Martin, Jenkins & Associates Limited).

Our goal is to improve the effectiveness and efficiency of the organisations we work with. We do this by providing strategic advice and operational support in the following areas:

- Strategy, Transformation & Performance
- Policy & Economics
- Evaluation & Research

MartinJenkins was established in 1993 and is 100per cent New Zealand owned. It is governed by executive directors Doug Martin, Kevin Jenkins, Michael Mills, Nick Davis and Nick Hill, plus independent directors Peter Taylor (Chair) and Sir John Wells.

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# Background

## Court decisions

1 The Human Rights Review Tribunal and the High Court have ruled that the practice of not recognising parent spouses and resident family members as paid care-givers is discriminatory on the ground of family status, and breaches Part 1A of the Human Rights Act 1993.

2 The Ministry of Health's position is that funded disability support services are provided to complement and not replace natural supports (such as those provided by parents, spouses and resident family members). The Ministry's argument is that families are the fundamental social unit of society, whose role would be disrupted if parents or spouses were employed to care for their family members.

3 The Human Rights Review Tribunal issued orders suspending the effect of its decision, allowing the current policy to continue with no immediate change in practice. The Ministry has appealed to the Court of Appeals. The case will be heard in early 2012.

## History

4 In 1997 the four Regional Health Authorities were combined into one Health Funding Authority. The HFA was subsequently merged into the Ministry of Health in 2000. Under this structure the Ministry took over full responsibility for funding, policy and planning responsibilities for disability support services in all age groups.

5 From 2003, the responsibility for disability support services for people 65 years and older (and people 50-64 with needs similar to older people) was devolved from the Ministry of Health to the District Health Boards. Since then, the Ministry has been responsible for disability support services for people with long-term physical, sensory and intellectual disabilities (or a combination of these) up to 65 years old, and some beyond that age if they are more appropriately supported by long-term disability support services.

6 The Ministry of Health offers only one part of the services and supports available to disabled people and their families in New Zealand. Eleven government agencies are involved in funding support for people with long term disabilities.

7 For example, Work and Income provides disability-related income support through the Sickness Benefit, Invalid's Benefit, Disability Allowance and Child Disability Allowance; the Housing Corporation provides housing support; the Ministry of Education offers educational support; the Ministry of Social Development provides vocational support, and so on. Where disability has been caused by an accident, the ACC's social

insurance scheme provides income support and other compensation and rehabilitation services.

8 The level of support has increased in recent years. Some substantial initiatives – for example, the introduction of more accessible train carriages – are being staged according to the availability of funding over time, and are improvements upon existing services. But the 2010 budget provided an extra $93 million to expand existing disability support services over the next four years, with $72 million for improving access to disability support services.

9 Despite these improvements in support, recent evaluations continue to show most care givers consider the supports and services available to them are complex, fragmented and difficult to navigate. There are multiple assessments and different treatments of income and assets in different parts of the system. Services are viewed as inflexible, reactive and sometimes lacking understanding, care and compassion.

10 The National Advisory Committee on Health and Disability (National Health Committee – NHC)[1] recently recommended a review of the structure of funding streams that provide support and services to informal carers and the people they provide care for, to reduce fragmentation in the care system and improve equity and consistency in service provision.

## The current support system

### Disability Strategy

11 The different support services available to disabled persons and their carers are brought together under the umbrella of the *New Zealand Disability Strategy*. The Strategy presents a long-term plan for changing New Zealand from a disabling to an inclusive society to enhance the participation and independence of people with disabilities.

12 The Strategy identifies 15 objectives, the last of which has direct relevance to paid family care givers:

> "value families, whānau and people providing ongoing support".

### Needs Assessment and Service Co-ordination organisations (NASCs)

13 NASCs perform three core functions in the disability framework:

- *Facilitated Needs Assessment* determines the current abilities, resources, goals and needs of a disabled person. The aim is to maximise independence so that

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[1] *How Should we Care for the Carers, Now and into the Future?* Wellington: Ministry of Health, 2010

the disabled person can participate as fully as possible in society, according to their abilities, resources, culture and goals. The needs assessment process has to take into account the natural supports already in place. Support is not defined by the level of disability, but the individual's needs in light of what they (and their natural supports) can do for themselves.

- *Service Co-ordination* co-ordinates the services funded by the Ministry and other services available from other agencies and in the community. NASCs refer the person to appropriate agencies.
- *Budget Management* allocates cost effective packages of services within the indicative budget, according to the Support Package Allocation tool, and within Benchmark Indicators determined by the Ministry for the identified population for a region.

14 Needs assessment is viewed as a separate function from co-ordinated services to address those needs, which is separate again from the actual delivery of services.

## Service delivery

15 Service providers (which are separate from the NASCs) deliver Ministry funded services. There are about 800 service providers.

16 There is no set amount of dollars paid per level of severity of disability. However, the Ministry employs the principle that services must be properly targeted to remain adequate and fair to those who use them, and affordable and fair to those who pay for them. The Ministry focuses on meeting the essential (and otherwise unmet) care needs of the disabled person. It does not attempt to meet the higher expectations or added extras that clients may demand.

17 Not all agencies that provide services to disabled people are funded by the Ministry. For example, some voluntary organisations provide services for disabled people. Some of these are small and rely on their own community resources (for example, church based groups).

18 Other organisations are large, and receive separate direct funding from the Ministry as well as relying on public support and extensive volunteer assistance, e.g. the IHC, the Royal New Zealand Foundation of the Blind, the Brain Injury Association and CCS Disability Action. The funds these organisations receive are separate from the disability support services funds that the Ministry pays to its contracted service providers.

# Ministry of Health disability services

19 The overall 'package' of services for people with disabilities is known as the Home and Community Support Services (HCSS). The Ministry of Health aims to keep the community support package at a maximum of about $55,000 per year, using this as a rule of thumb level when assessing whether needs can be addressed in the home or whether residential service might be a better option. However, most people are on higher packages for individual reasons. If a community support package is over $70,000 the NASC has to refer it back to the Ministry for approval.

20 Within the HCSS package, the Ministry funds the following services for people under the age of 65 (and a limited number of people over that age whose disability needs are best dealt with under the Ministry's framework):

- Home based support services
- Respite care and carer support services
- Individualised funding (Manawanui in Charge) services for those on individualised funding packages
- Contract board
- Residential care
- Supported independent living.

21 The Ministry also funds other disability support services, including:

- Disability Information and Advice services
- Child Development services
- Support programmes for disabled children and young people (for example, holiday programmes)
- Training for family and other carers
- Behaviour support programmes
- Day programmes for adults
- Inpatient Rehabilitation and Habilitation services
- Equipment and home and vehicle modification services
- Services to support those under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003.

22 **Home based support services** aim to fill in the gaps in family care which are identified through the needs assessment process, rather than providing full time care for an individual. The services address the needs of the disabled person, not the needs of their family as such, but they reflect the key need for a disabled person to have a family able to manage their ongoing care.

23 Approximately 11,000 disabled people in New Zealand use Ministry funded home based support services, not counting those who receive these services as part of their supported independent living package. The total cost of this service is estimated for the year end 2008 at $86 million.

24 **Individualised funding** is a mechanism for paying for home based support services by providing disabled persons with more control over selecting and recruiting the people who come into their home, rather than having to accept someone from a contracted service provider.

25 Because it is a mechanism and not a service in itself, individualised funding does not have a separate allocation from the Ministry, but the Ministry separately funds the Manawanui in Charge, the Individualised Funding Agency (IFA) established by the Ministry. This funding was set at $315,000 for approximately 200 users (2008).

26 IFA coaches assess the individual's (or their agent's) competence and confidence to manage the budget and have the final say in determining whether the applicant will become a budget holder. Coaching is then given on how to implement the funding packages and monitor its on-going management.

27 **Respite services and carer support services** support the family unit so that they can continue to care for their disabled family member in their family home. Around 16,000 disabled people use respite and carer support services, at a cost of around $43 million (2008).

28 **Residential care** is offered when disabled person needs to move out of their home, despite the fact that (in some instances) they may want to stay with their family. Following the closing of the large residential institutions, residential care is now provided in ordinary houses (or groups of houses or flats) that are not separated from their neighbourhoods.

29 Residential services provide 24/7 care and support for a small group, rather than for individuals, and can achieve economies of scale. The critical point for residential care is usually around night care, which their family can no longer provide safely, or where the person needs to be lifted or supervised constantly.

30 Residential services require the development and application of individual plans for each person. These are developed with the individual, their family, and with other service providers and organisations. Individual plans are reviewed at least 6 monthly but often more regularly, and cover all aspects of the individual's support needs and timeframes for achievement of the goals set.

31 Residential services are not set up to provide permanent hospital level care, which is usually provided through the hospital units of rest homes or hospitals.

32 Approximately 6,500 disabled people in New Zealand use community residential services. The majority of these people have an intellectual disability. Community residential service providers are paid approximately $319 million (2008).

33 **Contract board** occurs when a person no longer wants to, or is not able to, continue living with their own family but still require (or want) the kinds of supports that the family environment can give. They move in with another family,

34 Each person living in a contract board situation has an individual plan based on a full assessment of the person's needs and the available support. The plan is reviewed on an ongoing formal and informal basis. Contract board care givers are required to attend training when the provider requires this and to participate in evaluation and monitoring to ensure service standards are met.

35 Around 400 families receive these payments. The average cost to the Ministry is about $18,000 per annum per user, with a total expenditure around $7 million per annum (2008).

36 **Supported independent living** aims to support people to live independently in the community away from their family without the level of support provided by the community residential services. It consists of individual support services and household and accommodation support services.

37 Individual support services are provided by a support person who helps the individual learn new skills, then 'disappears' to allow independence[2]. Disabled people living independently frequently use home based support services where the person is not likely to develop the skills needed for the particular task.

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[2] E.g. a support person will coach how to use the community library, and work out a plan with the individual. The first time they might take the person to the library. The second time they help the person to go by themselves, and might further look for people in the community that could assist.

38 A transition option is offered to those wanting to transit into independent living from a home environment, because often it is better for the person to acquire some skills before moving out.

# The policy context

39 The policy framework for these home and community services has not been defined by legislation in New Zealand. Instead, public policy employs the convention that public services and support should supplement and not replace family responsibility. This implies a partnership where the state and families each contribute to offset the costs of disability.

40 The approach has focused on providing adequate support to encourage families to volunteer their support. However, it has been designed around the concept of a 'traditional family', which typically had a member at home to provide full-time care for children and elders. This concept is rapidly breaking down.

41 Families are now smaller and more geographically mobile than before. Increased levels of divorce have resulted in a larger proportion of single parent families. This may mean that sources of extended support from friends and family are no longer available, with caring often being left largely to one family member. Australian research shows, for example, that 45 per cent of young primary carers live in sole parent households[3].

42 The policy convention of a social contract is set against a demographic background where a steadily ageing population is intensifying the pressure on an already strained health and family support system. For instance, the Government agreed in 2010 to promote, protect and monitor the implementation of the *UN Convention on the Rights of Persons with Disabilities*, in addition to the 2001 *Disability Strategy*. This requires a framework of roles and functions within government and independent of government

43 The government mechanism is the Ministerial Committee on Disability Issues, which has the job of co-ordinating implementation across government. It has charged a Chief Executives' Group to develop a whole-of-government action plan on disability issues. The Office for Disability Issues in MSD is the focal point for executing the outcomes of the Convention.

44 The independent mechanism is made up of three parts:

- the Human Rights Commission, which has a full-time Disability Rights Commissioner and an existing mandate for human rights across all three functions of promotion, protection and monitoring
- the Office of the Ombudsmen has a role in the areas of protection and monitoring within its existing mandate, which is confined to agencies in the state sector

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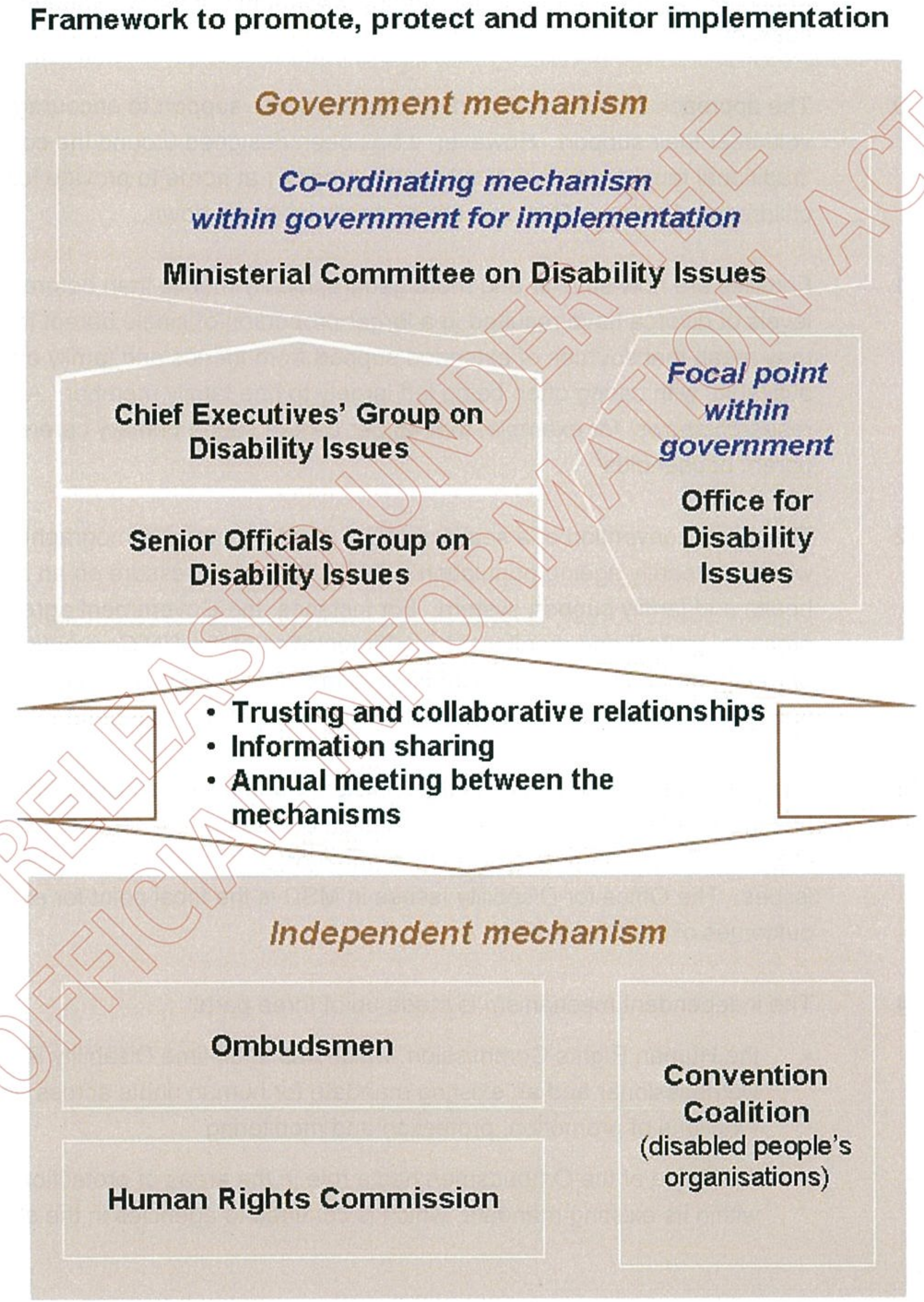
[3] Reibelt 1999, cited in *Young Carers Research Project* 2001.

- the Convention Coalition, a governance-level steering group formed by six major disabled people's organisations to run a rights monitoring programme using the Disability Rights Promotion International methodology.

**Figure 1: Human Rights Convention Framework**



45 The Disability Strategy and the HR Convention Framework provide evidence of a growing awareness of policy complexity. However, this sits uneasily with the implicit convention of a social contract which supports a traditionally conceived family to volunteer their own (unpaid) support.

## International precedents

46 There are multiple international precedents for paid family care givers. The USA, Sweden and Australia are examples.

47 **United States** federal Medicaid law and regulations permit the hiring of most family members with the exception of those "legally responsible" for the person with special needs. This precludes spouses caring for spouses and parents caring for their minor children. There is a widespread difficulty in recruiting and retaining home support workers due to the low wages paid, one result of which has been the need to offer financial incentives to family members to provide care to fill this gap. As of 1990, at least 35 states allowed care allowances to be paid to relatives providing personal care services.

48 Almost all American home support programmes apply the following conditions for payment to family members:

- There are eligibility restrictions based on low income and low assets.
- There is some kind of cap on services. In New Jersey the cap is 25 hours per week for most clients, and for those with serious health concerns the cap is 40 hrs per week.
- Wages paid are not much more than minimum wage.
- Care givers are often paid through an independent provider program or a consumer directed program (rather than a home support agency), and are paid at rates that are usually close to minimum wage.
- Some states have very strict codes of practice for various professionals, including nursing, which restricts the specific functions paid home support workers can carry out. In Washington, for example, the Nurses Practice Act is very prescriptive and allows delegation of nursing tasks only in residential facilities.

49 **Sweden**'s 1990 Care for the Elderly legislation provides family members with care giver salaries that are equivalent to those paid by home health care agencies. They are fully taxable. Care givers are entitled to both pension and vacation time benefits. Sweden provides training to salaried care givers when their personal caregiving experience ends.

50 Sweden also has a care leave insurance program that continues employees' salaries for 30 days if they must leave their employment in order to care for an elderly family

member. A written application and a doctor's statement of need are required for these benefits.

51 Sweden provides an allowance to parents who are caring for a child under 16 years whose functional impairments mean they need special attention and care for at least six months. It includes compensation for both the care provided and any additional disability related costs. The allowance is taxable and provides pension credits.

52 **Australia** has a long tradition of compensating family care givers. An independent Adult Disability Assessment Tool (ADAT) is used to assess a person's level of disability. It contains 2 questionnaires that together measure the amount of help the care receiver needs to undertake basic activities of daily living such as mobility, communication, hygiene, eating and management in a range of cognitive and behavioural areas. The carer is required to complete one part of the ADAT and a Treating Health Professional (THP) completes an independent assessment.

53 A minimum qualifying score must be achieved on the THP component as well as a minimum qualifying total ADAT score to establish eligibility for the Carers Payment (CP) and/or the Carers Allowance (CA).

54 The Carer Payment is a Social Security payment for people who provide "constant care" for a "disabled adult". Centrelink will not accept work, study or training for more than 25 hours per week, and any income earned must be declared to it. The allowance is A$671 per week or A$506 each for a couple (2011).

55 The Carer Allowance, a fortnightly payment of around A$110, which is not income or assets tested, and can be paid in addition to Carer Payment or on its own. It requires:

- the person cared for to be a family member (sometimes a person other than a family member can qualify)
- the carer and the person cared for live in the same home (there are exceptions)
- the person cared for has a score of at least 30 from the ADAT
- care is provided on a daily basis
- the care is required permanently, or for a minimum of 12 months (unless the condition is terminal).

56 Recipients of Carer Payments and Carer Allowances also receive a Carer Supplement of $600 each year for both payments, and receive a Pensioner Concession Card and the Pension Supplement automatically.

57 **National Disability Insurance Scheme.** Recent Australian reviews have concluded the Australian disability support system is underfunded, unfair, fragmented, and

inefficient, and gives people little choice and no certainty of access to appropriate supports. Stresses on the system are growing, with rising costs for all governments.

58 This has led the Australian Government to endorse a national disability insurance scheme in August 2010. The scheme was proposed by the Productivity Commission following a comprehensive feasibility study. It is based on the simple insight that most families and individuals cannot adequately prepare for the risk and financial impact of significant disability. The costs of lifetime care can be so substantial that the risks and costs need to be pooled.

59 The National Disability Insurance Scheme (NDIS) will provide insurance cover for all Australians in the event of significant disability, long-term high quality care and support (but not income replacement). Around 410 000 people will receive funding support.

60 The Australian Government currently provides funding to the disability sector of around $2.3 billion, while state and territory governments provide funding of around $4.7 billion — a total of over $7 billion. The Productivity Commission estimated that the amount needed to provide people with the necessary supports is about double this (an additional $6.5 billion per annum).

61 The Federal Government intends to finance the entire costs of the NDIS by directing payments from consolidated revenue into a 'National Disability Insurance Premium Fund', using an agreed formula entrenched in legislation. The amount needed will come from a combination of cuts in existing lower-priority expenditure, fiscal drag and (if necessary) tax increases.

62 The benefits of the scheme are considered to significantly outweigh the costs. The NDIS would only have to produce an annual gain of $3800 per participant to meet a cost-benefit test. Given the scope of the benefits, the Productivity Commission considered that test would be passed easily.

63 The scheme will involve a common set of eligibility criteria, entitlements to individually tailored supports based on the same assessment process, certainty of funding based on need, genuine choice over how their needs were met (including choice of provider) and portability of entitlements across borders. Local area coordinators and disability support organisations will provide grass roots support. The insurance scheme is intended to take a long-term view and have a strong incentive to fund cost effective early interventions, and collect data to monitor outcomes and ensure efficiency.

64 A single agency, the National Disability Insurance Agency, will oversee these conditions. It will have an independent commercial board, an advisory council of key stakeholders, clear guidelines to ensure a sustainable and efficient scheme, and legislation that protects the scheme from political influences.

65 The agency will be the assessor and funder, but not the provider of care and support. Services would be provided by non-government organisations, disability service organisations, state and territory disability service providers, individuals and mainstream businesses. Increased funding, choice and certainty are the key features of the recommended scheme. Advocacy would be funded outside the scheme.

66 The intention is to roll out the NDIS from mid-2014, starting in a few regions to allow fine-tuning of the scheme, while providing high quality services to significant numbers of people. In 2015-16, the scheme should cover all regions of Australia for the highest priority groups, and progressively expand until it covers all people by the end of 2018-19.

67 A separate no-fault National Injury Insurance Scheme is proposed for people requiring lifetime care and support for catastrophic injuries. It would draw on the best schemes currently operating around Australia. State and territory governments would be the major driver, developing a comprehensive scheme by 2015.

# Policy context

## A social model

68 Current disability care services are based on an assessment of what support an individual disabled person needs. They are not allocated according to the level of disability.

69 This reflects a gradual change in the development of services for people with disabilities from a medical model to a social model of disability, characterised as a shift from exclusion and care outside mainstream society, to inclusion and mainstreaming. At the same time disabled people were moved towards greater independence with supplementary support services as required.

70 These changes instituted the family as an expected contributor to disability care. They also resulted in substantial differences in funding from one person to another with a similar level of disability. This has acted as a disincentive for paid family care givers because the outcome would be inequitable, i.e. paid family members would receive different amounts of money for similar levels of disability.

71 In addition, the Ministry argues paid family care givers would seek to maximise payment by minimising what the disabled person and their family were able to do, with the effect of undermining the independence model on which the services are framed, by encouraging the disabled person's dependency.

## Blurred demarcations

72 One major disadvantage of the focus on the holistic needs of the individual is that the administrative demarcations typical of most rational funding schemes are missing.

73 There is no current demarcation made between natural support, and support which exceeds or goes beyond natural support. As a consequence, there no baseline to anchor the funding of additional support beyond natural support or provide a platform for negotiated exceptions. Instead the Ministry juggles with a comprehensive, individualised approach where each funding decision is made on a case-by-case basis.

74 This is now emerging as a policy weakness. To manage it this paper proposes that a baseline definition of what a family *reasonably can* and *cannot* be expected to offer should replace the open-ended, socially inclusive definition of disability.

75 A baseline definition is normative and will need to be established with the wider carer community and refined through careful implementation. This matter is picked up in the second half of the paper which discusses a managed implementation approach.

76 The current weakness in control is discussed by a recent Deloitte report[4] aiming to enhance the purchasing framework for disability support services. Deloitte notes considerable variation in the utilisation of support across the country and age cohorts, caused by the variable tools and methods used to assess needs, plan support packages and co-ordinate support packages in conjunction with clients' natural supports.

77 Deloitte also observe an historical inability to benchmark NASC performance and assess whether support packages optimise funding and deliver value for money over the life of the client.

78 This inability has been aggravated by the tension between the role of the NASC agencies as advocates for clients, and being responsible simultaneously for support packages that deliver the best value for money. Deloitte consider the balance presently leans more toward the advocacy role[5].

79 The Ministry is clear that NASCs do not have a role as advocate for clients, but incipient advocacy seems inevitable in a social model of disability when there is no accepted definition of what is family responsibility and what is not.

## Social contract

80 Equally, the social model of disability has lent support to the notion of a 'social contract' between families and society. The Courts have been sceptical about the ambiguity of this contract.

81 The social contract approach leaves the Ministry believing, for instance, that it could not:

> " turn up at a family home and check the expiry dates of food in the cupboard, the standard of cleanliness, and critique the level of menu planning. We could not audit whether parents have facilitated appropriate individual plans and goals for the disabled person, and whether appropriate steps are being taken to meet those. The State simply does not involve itself in family life like that[6].

82 In reality, nothing impedes the Government from establishing a clear contractual basis for family care givers where the care provided goes beyond the natural family support expected from all families. This contractual framework does not have to invasive or draconian but can be structured inside the overarching principle of community care for

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[4] *Review of the Purchasing Framework for Disability Services*, Deloitte, April, 2010

[5] However, Deloitte acknowledges improved contracting processes have reduced price gaps between high cost and low cost providers, although average package prices (across all providers) have generally increased over the last five years. It recommends the Ministry should continue to close these price gaps.

[6] Brief of Evidence of P H Davis to the High Court

the disabled. But extra-natural services can be provided by contractual care for which family members are eligible, as they are for other employment activities and relationships.

83 In establishing and operating this contract, the funder can set clear standards for extra-natural care. The MOH already has very extensive quality assurance requirements for service providers. For instance, it already requires and monitors individual plans for a disabled person.

84 Because the current policy position does not draw the boundary between natural and extra-natural care, a circular argument ensues. Additional support beyond the natural resources of the family is considered, ipso facto, as above and beyond the family's capacity, and therefore cannot be provided by the family.

## Exceptions

85 A long time general "exception" to the non-payment of family members exposes this circular argument. Non-resident family members can be employed to provide support, although this general "exception" does not extend to parents or spouses of the disabled person, even if they do not live in the same house. Spouses and parents are considered natural supports, whether or not they live with the disabled person. This seems a forced conclusion, which does not reflect practical realities for a disabled person.

86 There are also specific ad hoc exceptions. Short term exceptions have been allowed in a few cases to allow families to make alternative care arrangements. These cases generally involve a change in the status of a carer who was eligible to be employed. For example:

- a carer marries the disabled person, and changes from an independent carer to a resident spouse
- a distant family member eligible to provide funded care moves in with the family for personal reasons, and continues to provide care
- a grandparent moves in with the family to assist in short term care for a very ill child.

87 A Ministry review found that of the approximately 11,000 home based service users, 272 users were involved in arrangements where family members in the home were being paid. The income earned by the resident family member to provide the support ranged from $20 a week to $1,500 a week.

88 The Ministry argues that it agreed to only two of these cases, and suggests that unless everyone moved to Individualised Funding, service provider agencies would be

forced to adopt unsatisfactory employment arrangements. Family members would not be prepared to act as normal employees, in that they would not provide care to anyone else. Equally, they may not meet the agency's employment criteria (such as training, passing police checks, engagement with the agency's policies and practice requirements, and so on).

# Basic policy options

89 There are two basic options open to the Ministry.

90 One option is to establish an *exceptions policy* which continues the current policy convention which excludes paid family care givers except for those unusual circumstances when that may be the only or the clearly best option. This would formalise the 272 exceptional arrangements above, and invite a limited number of other exceptions based on unusual individual circumstances. It continues with the individualised, case-by-case approach.

91 A second option is to reverse the exclusion of paid family members and establish a *mitigations policy* based on managing the known risks. This would shift the foundations of the current convention by drawing a boundary between natural and extra-natural support. It would make paid extra-natural support accessible to all care givers without discrimination. But at its foundation is a definition of what is natural support, which a family can reasonably be expected to provide, and what is beyond natural support.

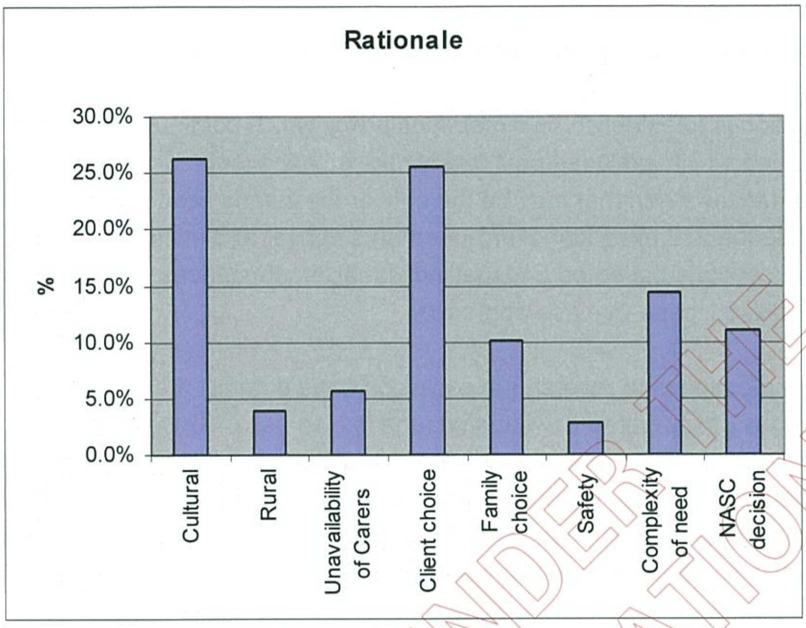
92 Both of these broad options are discussed in turn. Both would probably need legislation or regulations to formalise them.

## An exceptions policy

93 An exceptions policy continues to be based on the convention that family members are debarred from payment. However, exceptions are allowed where unusual circumstances warrant it.

94 This builds on the existing exceptions that have occurred (albeit without direct Ministry approval). A Ministry survey of service providers found decisions to pay family care givers were justified on the following grounds:

Figure 2: Rationale provided by providers for payment of family care givers



95 **Cultural reasons (26.3 per cent)** were frequently cited as the reason for payment of family care givers. This included the cultural norm of 'whānau for whānau', a preference for closeness and understanding of culture, and an understanding of language. Some clients found someone from another culture touching them offensive, and did not want to explain what body parts could or could not be touched.

96 **Client choice (25.5 per cent)** was also prominent because disabled persons felt high levels of trust and comfort with the family providing care. This was sometimes connected with avoiding the shame or guilt felt by family about disability. There was also an element of protecting privacy by preventing others knowing about the level of disability.

97 Pacific Island and Māori service providers often considered that it was the right of the client to decide who they felt comfortable with and could trust to provide services – particularly personal care. Data shows that where several reasons were provided for payments, there was a high correlation between client and family choice and cultural reasons.

98 **Complex care requirements (14.5 per cent)** was the third prominent reason. It reflected the difficulty in finding care givers with the skills to provide appropriate care where clients have high medical and behavioural needs. Higher competencies are required as medical/ behavioural needs increase. Service providers noted the difficulty of attracting staff willing and able to address complex needs, particularly because this challenging work is not well paid. Shift work, high turnover rate and

travel were further reasons given for the small pool of care givers. As a result, families were often the only ones able to provide care.

99 **Family choice (10.2 per cent)** was also a factor, partly because lack of appropriate respite options/ support services and because disabled persons take time to accept a new care giver. Consistency was considered important to ensure behavioural problems don't escalate.

100 Other reasons were the **unavailability of carers (5.7 per cent), rural isolation (4.0 per cent) and safety (2.8 per cent).** The last category was **NASC decisions (11.0 per cent)**, which covers decisions whose rationale has been lost in time.

## Pros and cons

101 There are inherent difficulties in an exceptions policy based on these reasons.

102 A policy maintaining the ineligibility of family care givers for payment unless there are exceptional circumstances would need to exclude client and family choice because these are essentially personal preferences rather than 'enforced' exceptions. Once this choice becomes available it is likely to be a widely employed and not an unusual or exceptional circumstance. This removes 35 per cent of the current exceptions.

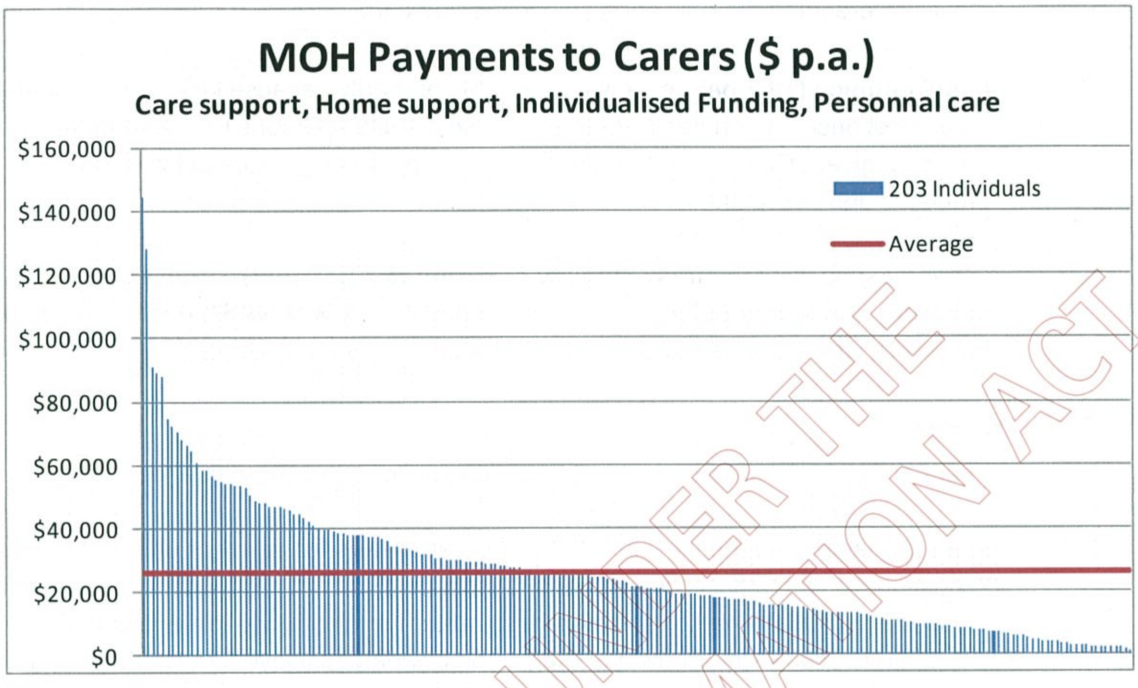
103 The main reason offered for an exception - cultural considerations – also poses inherent difficulties. All citizens have cultures, though some cultures are more conventionally recognisable. It is hard to differentiate a cultural choice from a personal choice or preference.

104 Just as cultural reasons and client and family choice are entwined, the Ministry's, research shows that complex care requirements, the unavailability of careers and safety also run together.

105 Consequently, it is hard to imagine a robust exceptions policy and implementation that would not run into constant interpretative difficulties. Value judgements need to be made. This could be handled on a case-by-case basis, but it will be open to constant challenges and high transaction costs. Some creep in the interpretation seems inevitable, which creates political risk.

106 There are further reasons to doubt the wisdom of an exceptions policy. MOH payments data shows that for 203 individuals who are currently being paid a combination of care support, home support, individualised funding and personal care support payments, the average cost over 12 months is $26,000 per person. There are 12 people paid over $60,000; and a further 25 people paid between $40,000 and $59,000. The following chart shows the distribution of payments across the 203 recipients with the highest payment $144,000 and the lowest $1,000.

Figure 3: MoH Payments to Carers ($ p.a.)



107 The precedent set by the annual payments made to this group of people could lock the Ministry into funding support at these levels. For full-time care this is likely to be towards the higher end of the scale.

108 Finally, an exceptions policy continues to rely on discrimination against family members as a foundation, which has been challenged in the Courts.

# A mitigation policy

109 Unlike an exceptions policy, a mitigation policy accepts as a foundation that family members can be paid as care givers as long as the known risks of doing so are mitigated.

110 The known risks are set out in the Ministry of Health's current objectives:

- The need to encourage the independence of disabled persons
- The preservation of the integrity of the family unit
- The need to avoid creating unsustainable care burdens
- The danger of commercialising relationships
- The potential problem of families becoming dependent on Ministry payments
- Difficulties in monitoring (where disabled persons may find it difficult to criticise family members and feel pressure not to report inadequate care or abuse)
- The need to be fiscally sustainable.

111 This generates the ingredients of a mitigation framework:

- A selection process (possibly including interviews) for contracted family care givers
- Training for contracted family care givers
- Sustained mentoring for contracted family care givers
- Consistent support to encourage the independence of the disabled person, using support facilitators to access and utilise circles of support
- Use of an independent disability advocate to represent the disabled person
- Monitoring of contracted family care
- Avoiding the paid care giver also being a fund holder (for independent funding)
- Regular support needs reviews of the disabled person, leading to plans for care
- Audit to ensure families do not become financially reliant on income
- Retention by the Ministry of the right to cancel the contract with a family care giver for a failure to meet specified criteria.

112 Many of these practices already apply to service providers, and those that do not are good practices that should be invoked.

113 Underpinning the mitigation policy as an essential lever of control an accepted definition of what a family can support reasonably as part of its natural resources and duties, and what it cannot be expected to support.

114 A score against a comprehensive list of factors would continue to build an individual profile for each disabled person, which maintains some continuity with current individualised policy settings, but scores would locate the level of funding support within a fixed price band depending on the degree of extra natural support that is identified.

115 Each band should trigger a discussion with the disabled person and family care givers on whether planned actions can shift the disabled person into a lower band. Again, this maintains some continuity with current policy settings. However, the 'push down' needs to be realistically considered, given that a common trajectory for a disabled person is progressive deterioration with a movement towards higher bands.

116 The aggregated score from the multiple factors would establish whether a disabled person falls into the 30 per cent high complexity category of clients who Deloitte call "Managed Clients" under their recommended new purchasing framework. Deloitte observe that that the 30 per cent high complexity "Managed Clients" use 80 per cent of the resource available for disability support. It recommends negotiating funding prices for the top 30 per cent of packages with oversight by a national coordinator.

117 If the aggregated score does not cross that threshold, the disabled person would be in the "70 per cent" category of low complexity clients which Deloitte term "Administered Clients".

118 For both categories of Managed and Administered Clients, Deloitte recommends a whole of life procurement approach and contracting at fixed price bands to increase cost efficiency and the Ministry's ability to forecast future needs. These recommendations are consistent with the approach taken by this paper.

119 There is an option to further reduce costs by making respite care a service that should be funded by the paid family care giver. However, this may be counter productive to the quality of care and is not factored in. Rather, respite care costs might increase as a new category of care givers (paid family care givers) emerges.

# Implementing a mitigation policy

120 The risks of implementing a mitigation policy are high because the size of the potential uptake of paid family care givers and the costs that determine the level of their payment are both unknown, and subject to wide variations in conjecture (which is discussed in the next section). Consequently, a 'managed implementation' is recommended to create certainty on these parameters.

121 The two axes of a managed implementation are:

- the Government sets a capped fund for a defined period of 5 years. This creates certainty on costs
- in that period implementation is phased by setting a targeted number of paid family care givers (10,000). This creates certainty on uptake.

122 The managed implementation employs two existing principles:

- that services must be carefully targeted to be adequate and fair to those who use them and affordable and fair to those who pay for them
- resources should be targeted to those with the greatest needs.

123 The implementation simplifies the current policy of individualised needs funding by:

- Narrowing the open-ended definition of needs by drawing the boundary between what is natural support and what is extra-natural support.
- Specifying the amount paid in each band (which groups needs by the aggregate score from an independent assessment).

124 The ceiling of 10,000 assumes that in practice not everyone will enter paid employment as a family care giver, but provides for a significant number of paid family care givers to be credible. It maintains good faith with the mitigation policy while retaining fiscal control. The phased implementation would be used to refine the operational tools and conditions so that the capped sum is protected for 5 years, and provides a basis for the next period of implementation.

125 The recommended approach is for the Government to present this option to the care giving community and negotiate the parameters of the implementation. In parallel, the parties need to settle the key boundary line between natural and extra-natural support.

126 Funding and other parameters for the next phase after the 5 years elapses would be set subsequently by the Government, taking into account the lessons learnt from the managed implementation. Demographics and factors such as increasing long term

severe care are likely to require either more budget or more radical approaches in the future.

## Numbers

127 Statistics New Zealand defines disability as any self-perceived limitation in activity resulting from a long-term condition or health problem lasting or expected to last six months or more, and not completely eliminated by an assistive device. This aligns with international definitions.

128 Applying this definition, 660,300 New Zealanders reported a disability, representing 17 per cent of the total population. Rates of disability were roughly equal between men and women but boys make up 59 per cent of disabled children, reflecting higher rates of some disabling medical conditions. The most common types of disability were mobility, agility, hearing and psychiatric/psychological.

129 Forty-five per cent of adults aged 65 and over had a disability, comprising one-third of all people with disabilities. The number of disabled people in New Zealand is expected to grow by 60 per cent over the 40 year period from 2006 to 2046. This expectation is based on the marked increase in disability prevalence with increasing age, and a projected steady ageing of New Zealand's population.

130 J-P de Raad's evidence shows the number of disabled people by age, level of disability and support services provided, drawing on the Statistics New Zealand reports: Household Disability Survey 2006; and Disability Survey of Residential Facilities 2006.

**Table 1: people aged 0 to 64, with disabilities that are not due to ageing or injury (rounded to '000s)**

| Degree of disability | No or minimal external support | Funded home-based support | Total |
|---|---|---|---|
| Mild | 127,000 | n/a | 127,000 |
| Moderate | 123,000 | 3,000 | 126,000 |
| Severe | 30,000 | 7,000 | 37,000 |
| **Total** | **280,000** | **10,000** | **290,000** |

131 De Raad bases his analysis on the severe clients, aged 0-64 with no or minimal external support (30,000 in the table above). He subtracts 1,000 clients identified by the Ministry as receiving minimal support, leaving approximately 29,000 people that could potentially take up a new entitlement.

132 De Raad acknowledges there is no basis on which to determine the likely take-up, NS provides a take-up range from 10 per cent to 90 per cent of the 29,000 total potential clients. This equates to 2,920 people at a 10 per cent take-up and 26,280 people at a 90 per cent take-up.

133 Easton derives a similar number of total potential clients as de Raad – although in a slightly different way. Easton takes the total severe cases from the table above (37,000) and subtracts the total severe cases funded by the Ministry (8,000). The result is also 29,000 people who could potentially take up an entitlement. (The evidence provided by de Raad and Easton uses slightly different numbers so they are not exactly the same, but the difference is negligible).

134 Easton also cannot provide any evidence supporting the actual take-up of funded support likely from the potential population of 29,000 people.

135 To overcome this, he develops a "worse case" scenario based on his experience, that "... a programme is thought to be doing very badly if it covers only three-quarters of the target population". He takes the 8,000 people funded by the Ministry as representing 75 per cent of the total population who are potential clients. Therefore there are 11,000 total clients, and approximately 2,720 (after rounding) that are currently not funded.

136 Easton's worst case calculation of the number of people who are eligible but are not in receipt of support services represents 9 per cent of the total of 29,000.

137 However, Easton's calculations are not based on the same programme he is attempting to measure, i.e. there is no programme or policy for paying family members who look after disabled relatives. The 8,000 people who are currently funded must therefore represent non-family members who are paid under the existing arrangements. There does not appear to be a strong case for extrapolating potential take-up from a group of paid non-family members to the target group of family members seeking to be paid.

138 This leaves significant uncertainty about:

- the total number of persons with disabilities who do <u>not</u> access care giving services under the present policy, and

- the total number of persons with disabilities who might access those services if family care givers were eligible for payment, but were also subject to conditions such as training and monitoring.

139 Nonetheless, J-P. de Raad and B. Easton, using different methodologies, both arrive at around 29,000 people with severe disabilities receiving little or no funding under current policy settings. This total represents only people with severe disabilities and does not include the large and potentially more costly group of carers that look after people with moderate and mild levels of disability.

140 Also, having derived this figure of 29,000 people who are severely disabled and not funded for family care, neither de Raad nor Easton is able to estimate a reasonable figure for how many people would take up paid carer assistance for family members. D Raad uses a wide range of 10% to 90%, and Easton postulates 9%.

141 An alternative approach is to seek guidance from the Australian programme of financial assistance for carers, which provides a comprehensive package of benefits made up of the following initiatives:

- Carer Payment – currently A$728 per fortnight for a single carer, and A$564 per fortnight for each carer in a couple providing care. Carers must be full-time, prevented from engaging in full time employment due to the demands of the care required. The Carer Payment is means tested and those receiving the payment are prohibited from receiving other social security assistance such as unemployment benefits.
- Carer Allowance – currently A$110 per fortnight. This is an income supplement paid to someone who provides daily care at home to a person with a disability or medical condition. It applies to adults and children with disabilities. The Allowance can be paid in addition to the Carer Payment.
- Carer Supplement – A$600 per year. An annual lump-sum payment to those receiving a Carer Payment or a Carer Allowance (and some other related benefits). If a carer received both a Carer Payment and a Carer Allowance then 2 Supplements would be paid.

142 The Australian payments include carers of disabled people over 65 years old, and those whose disability was caused by an accident - factors which need to be excluded for the New Zealand context. From a total national perspective, the Australian carer programme has a total cost of approximately A$4 billion.

**Table 2: Australian Programmes, numbers of paid carers and annual fiscal costs**

| Initiative | Number of Paid Carers | Annual Fiscal Cost |
|---|---|---|
| Carer Payment | 147,000 | A$1.9 billion |
| Carer Allowance – adult | 334,000 | A$1.3 billion |
| Carer Allowance – child | 120,000 | A$0.5 billion |
| Carer Supplement | n/a | A$0.4 billion |
| **Total Cost** | | **A$4.1 billion** |

143 A scheme with similar eligibility and payment rates in New Zealand, converted to New Zealand dollars, adjusted for relative population sizes, and excluding approximate costs related to disabled people over 64 (38 per cent) and accident/injury (16 per cent) would result in an annual fiscal cost of NZ$580 million.

144 Using the Australian numbers for actual paid carers it is possible to estimate the equivalent number of carers that would be paid in New Zealand if a similar scheme was introduced. This would include both family and non-family carers, full and part time carers, and part payment for means tested carers.

145 The Australian data is useful because it reflects actual take-up of an open and comprehensive programme. Those families who don't want or need to apply for assistance are already excluded – as are those who don't qualify for payments.

146 The following table sets out the forecast equivalent number of New Zealand carers based on the Australian take-up rate:

**Table 3: Australian numbers adjusted to New Zealand numbers**

| Eligible Carers | Carer Payment Carers | Carer Allowance Carers | Total Number of Carers |
|---|---|---|---|
| Australian Carer Payments – total number of carers (for disabled of all ages) | 147,000 | 455,000 | |
| Adjusted to equivalent single carers (as some above are couples, some care for 2+) | (41,000) | (4,000) | |

| | | | |
|---|---|---|---|
| Remove already counted (Payment & Allowance are paid to same carer) | | (147,000) | |
| **Estimated Australian Carers** | **106,000** | **304,000** | **410,000** |
| Population adjustment factor (4.3 / 21.9) | 0.1963 | 0.1963 | 0.1963 |
| **New Zealand equivalent carers** | **21,000** | **60,000** | **81,000** |
| Less aged over 64 (38 per cent) | (8,000) | (23,000) | (31,000) |
| Less accident/injury related (16 per cent) | (2,000) | (6,000) | (8,000) |
| **Net New Zealand eligible carers (0-64)** | **11,000** | **31,000** | **42,000** |

147 The 42,000 is the expected number of New Zealander carers that would be paid assuming a payment structure and take-up rates similar to those in Australia. The amount represents 8% of the total identified disabled population living in households in New Zealand, comprising 539,000 adults and 90,000 children. This compares to approximately 6% for the same ratio in Australia[7].

148 At a higher level, in 2006 New Zealand's total estimated disabled people, including those in residential care, were 660,000. This was 17% of the total population at the time. The latest 2009 estimates from Australia[8] list the total people with disabilities as 4 million, being 18% of the Australian population. This demonstrates a level of consistency between the two countries with respect to overall numbers of disabled as a percentage of population, giving some basis for using Australian experience to estimate potential new policy take-up in New Zealand.

149 The total of 42,000 represents carers of people aged 0-64 with severe, moderate and mild disabilities. This is 14% of the forecast 291,000 eligible population of disabled people, aged 0-64 years old and not in residential care, used by de Raad. The 11,000 shown under Carer Payment are the more severe cases, requiring constant care. If we assume that these people are representative of the severe cases, and the remaining moderate and mild cases are in proportion to the current MOH payments to moderate and mild clients (Table 2 of the de Raad evidence) then the following table summarises the expected unrestricted take-up:

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[7] Being 410,000 carers less those assumed caring for disabled over 64 and injury related, divided by 3.8m total Australians with disabilities not in residential care.

[8] Australian Government Productivity Commission, Disability Care and Support Inquiry report. No. 54, 31 July 2011

**Table 4: Forecast New Zealand Carer Take-up and percent of Total Disabled aged 0-64**

| | Take-up Number | Total Disabled | Take-up Percent |
|---|---|---|---|
| Severe | 11,000 | 38,000 | 29% |
| Moderate | 20,000 | 126,000 | 16% |
| Mild | 11,000 | 127,000 | 9% |
| **Total** | **42,000** | **291,000** | **14%** |

150 These estimates include disabled people who are already funded. Of the 42,000 expected paid carers, 46% are already funded by MOH:

**Table 5: Forecast New Zealand Carer Take-up – already funded and new carers**

| | Take-up Number | Already Funded | Un-funded Carers |
|---|---|---|---|
| Severe | 11,000 | 8,000 | 3,000 |
| Moderate | 20,000 | 7,000 | 13,000 |
| Mild | 11,000 | 4,000 | 7,000 |
| **Total** | **42,000** | **19,000** | **23,000** |

151 Of the total un-funded carers of 23,000 shown in the table above, 10,000 is chosen as the number of participants targeted for a managed implementation. *(Assumption 4)*. This level of managed implementation represents 43% of the total unfunded carers.

## Costs

152 Both de Raad and Easton arrive at similar average costs, at the high level, of approximately $9,000 to $10,000 per carer per year.

153 To determine the annual cost per carer, de Raad uses the average expenditure for people aged 0-64, with severe disabilities, and who are high use, non-residential clients of the Ministry. The source of this data is Ministry of Health transaction data. The average annual cost per user in 2006 was $10,000.

154 This is the average cost of non-family members looking after severely disabled people aged 0-64, paid for by the Ministry. There is likely to be a wide range of care offered and a wide range of hours worked. Presumably the average includes a significant number of part time carers because $10,000 is considerably less than the average annual salary for a full-time carer role of approximately $33,000.

155 Easton's evidence does not explicitly calculate an annual cost per carer, but his data implies an average additional annual cost of approximately $9,000 per carer (being $25 million cost and 2,700 carers).

156 De Raad presented two scenarios for the full-time cost of a disabled person moving from residential care to care in the home. The first was for full time, 24 hours-a-day care, at the current Ministry rates. This was $495 per day (or $181,000 p.a.). His second scenario reflects an 8 hour day and overnight care. This rate was $315 per hour or $115,000 p.a.

157 These rates and annual salaries are so large they are not particularly helpful. But equally, the average of approximately $9,000 to $10,000 per carer per year is significantly less than the full cost that might be expected if a carer was paid for an equivalent full-time position for caring for a severely disabled relative.

158 The cost data summarised above does not provide adequate detail to apply annual costs to the 42,000 carers calculated in the preceding section. The average cost is useful as a cross check but a top-down approach, starting with verifiable full-time salaries, would provide a better estimate of forecast total costs. To this end, the models described in the following section apply a range of paid carer rates to the 10,000 carers under the managed implementation.

## Models

159 Three implementation models are set out below. All are based on a 10,000 cap on participants, but each model applies different assumptions for the annual payments to carers:

- The first model uses an average cost of residential care as its starting point
- The second model uses the average annual salary of care givers in New Zealand
- The third model applies the annual cost in Australia for those receiving all three carer payments, converted to a New Zealand equivalent, using percentages of the average wage and the unemployment benefit.

160 All models are based on payment bands beginning with the most severely disabled in Band 8 and moving to the least disabled in Band 1. The numbers of carers in each

band is based on the disabled population distribution assumptions for severe, moderate and mild disability.

161 The relativity of payments between bands has been set to reflect the current cost relativities between average severe, moderate and mild payments. The average cost within each severity level has been set to equal 75% of the maximum, based on the Australian Carer Payment profile.

162 As only 10,000 of the possible 42,000 disabled are funded in the managed implementation, the total cost calculations assume that all of the 10,000 are new carers that are not currently paid, i.e. they do not replace any of the currently paid non-family carers. This is a conservative assumption. .

## Model One

163 The figure for the cost of residential care sets the benchmark for intense disability care (taking into account the ability of residential care to leverage economies of scale). De Raad used the figure of $48,245. The Ministry of Health used the figure of $54,570 p.a. in 2006.

164 Paragraph 105, has the top quartile of the current paid family exceptions at $55, 000 p.a., with a high point of $144,000. Given the Ministry acknowledges its figure is usually exceeded in practice, a figure of $65,000 p.a. is set as the benchmark for this proposal.

165 Persons in residential care represent those persons demanding the most care. It is assumed that:

- Persons being cared for at home do not have such intensive needs. The default setting is to move intense needs into residential care
- Family care giving does not include the capital costs of residential care
- Family care giving allows some breaks and provides additional conditions for sharing some aspects of a normal family life.

166 Modelling includes a discounting from 90 to 70 per cent. This sets the ceiling for the top band, which reflects the most intense level of care in the home.

167 Further bands are paid at abated rates from the level set for the previous band. For simplicity of modelling, all rates are for single care givers (couples usually receive a lesser amount each, but a greater amount when combined).

*168* Although the bands reach all levels and types of disability, the managed implementation approach recognises the insights of Deloitte which show that 30 per cent of disabled persons use 80 per cent of the available resource. *(Assumption 9)*

**Table 6: Payment bands for family care givers – Model 1**

| Band | Percent of Carers in Each Band | Ceiling at 90% | Ceiling at 70% |
|---|---|---|---|
| Band 8 – Severe A | 8.6% | $58,500 | $45,500 |
| Band 7 – Severe B | 8.6% | $43,900 | $34,100 |
| Band 6 – Severe C | 8.6% | $29,300 | $22,800 |
| Band 5 – Moderate A | 15.8% | $18,100 | $14,100 |
| Band 4 – Moderate B | 15.8% | $13,600 | $10,500 |
| Band 3 – Moderate C | 15.8% | $9,000 | $7,000 |
| Band 2 – Mild A | 13.4% | $6,700 | $5,200 |
| Band 1 – Mild B | 13.4% | $5,000 | $3,900 |
| **Average per Care p.a.** | | **$19,400** | **$15,000** |

169 An initial tranche of 1,000 carers is assumed in the first year. The year 1 costs by band and in total are:

**Table 7: First Year Tranche by Bands**

| Band | Year 1 Paid Carers | Total at 90% Ceiling | Total at 70% Ceiling |
|---|---|---|---|
| Band 8 – Severe A | 86 | $5.1m | $3.9m |
| Band 7 – Severe B | 86 | $3.8m | $2.9m |
| Band 6 – Severe C | 86 | $2.5m | $2.0m |
| Band 5 – Moderate A | 158 | $2.9m | $2.2m |
| Band 4 – Moderate B | 158 | $2.1m | $1.7m |
| Band 3 – Moderate C | 158 | $1.4m | $1.1m |
| Band 2 – Mild A | 134 | $0.9m | $0.7m |
| Band 1 – Mild B | 134 | $0.7m | $0.5m |
| **TOTAL** | **1,000** | **$19.4m** | **$15.0m** |

170 For the 70% ceiling, a second tranche of an additional 1,500 paid carers in the second year would cost $23 million. The cumulative cost would be $38 million for the two years of operation. For the 90% ceiling scenario, a second tranche of an additional 1,500 paid carers in the second year would cost $29 million. The cumulative cost would be $48 million.

**Table 8: Five year payment costs**

| Year | | 90% Ceiling Accumulating Total | 70% Ceiling Accumulating Total |
|---|---|---|---|
| Year 1 | 1000 clients | $19m | $15m |
| Year 2 | +1,500 new clients | $48m | $38m |
| Year 3 | + 2,000 new clients | $87m | $68m |
| Year 4 | + 2,500 new clients | $136m | $105m |
| **Year 5** | **+ 3,000 new clients = 10,000** | **$194m** | **$151m** |

171 Under Model 1, the overall total annual cost for 10,000 paid carers will be approximately $194 million for the 90% case and $151 million for the 70% case. (The total cost in the 90% and 70% cases for funding 42,000 carers is $814 million and $633 million respectively. Subtracting the currently funded amount of $97 million leaves a new funding requirement for an uncapped programme of $717 million (90% case) and $536 million (70% case)).

172 The total figures can be set against the provision in the 2010 budget of $93 million to expand existing disability services. They can also be compared with the existing costs of:

- $86 million for home based support services in 2008
- $43 million for respite services and carer support services in 2008
- $319 million for community residential care in 2008.

## Model Two

173 An alternative model begins with a different starting point, not derived from the costs of residential care, but from the average salary of paid care givers.

174 There are several sources for this figure:

- CareersNZ 2008 average gross salary for a Healthcare Assistant is $33,000
- TradeMe Salary Survey July-December 2009 for Care Givers is $32, 551

- Statistics New Zealand NZ Income Survey June 2010 quarter average hourly earnings for a Community and Personal Service Worker is $18.75 = $750 a five day week x 45 weeks = $33,750

175 Assuming $33,000 is the average, the same discounting of 70 per cent, to recognise the pre-existence of a residential base and the advantages to the carer of their own home environment, establishes a top band (rounded) of $23,000. This band is subsequently is abated in the same way as Model 1.

**Table 9: Payment bands for family care givers – Model 2**

| Band | Carers in Each Band | Ceiling at 100% | Ceiling at 70% |
|---|---|---|---|
| Band 8 – Severe A | 8.6% | $33,000 | $23,100 |
| Band 7 – Severe B | 8.6% | $24,800 | $17,300 |
| Band 6 – Severe C | 8.6% | $16,500 | $11,600 |
| Band 5 – Moderate A | 15.8% | $10,200 | $7,100 |
| Band 4 – Moderate B | 15.8% | $7,700 | $5,400 |
| Band 3 – Moderate C | 15.8% | $5,100 | $3,600 |
| Band 2 – Mild A | 13.4% | $3,800 | $2,600 |
| Band 1 – Mild B | 13.4% | $2,800 | $2,000 |
| **Average per Carer p.a.** | | **$10,900** | **$7,600** |

176 An initial tranche of 1,000 carers is assumed in the first year.

**Table 10: First Year Tranche by Bands**

| Band | Year 1 Paid Carers | Total - 100% Ceiling | Total at 70% Ceiling |
|---|---|---|---|
| Band 8 – Severe A | 86 | $2.9 | $2.0 |
| Band 7 – Severe B | 86 | $2.1 | $1.5 |
| Band 6 – Severe C | 86 | $1.4 | $1.0 |
| Band 5 – Moderate A | 158 | $1.6 | $1.1 |
| Band 4 – Moderate B | 158 | $1.2 | $0.9 |

| Band | Year 1 Paid Carers | Total - 100% Ceiling | Total at 70% Ceiling |
|---|---|---|---|
| Band 3 – Moderate C | 158 | $0.8 | $0.6 |
| Band 2 – Mild A | 134 | $0.5 | $0.3 |
| Band 1 – Mild B | 134 | $0.4 | $0.3 |
| **TOTAL** | **1,000** | **$10.9m** | **$7.6m** |

177 For the 70% ceiling, a second tranche of an additional 1,500 paid carers in the second year would cost $12 million. The cumulative cost would be $19 million for the two years of operation. For the 100% ceiling scenario, a second tranche of an additional 1,500 paid carers in the second year would cost $16 million. The cumulative cost would be $27 million.

**Table 11: Five year payment costs**

| Year | | 100% Ceiling Accumulating Total | 70% Ceiling Accumulating Total |
|---|---|---|---|
| Year 1 | 1000 clients | $11m | $8m |
| Year 2 | +1,500 new clients | $27m | $19m |
| Year 3 | + 2,000 new clients | $49m | $34m |
| Year 4 | + 2,500 new clients | $77m | $54m |
| **Year 5** | **+ 3,000 new clients = 10,000** | **$109m** | **$77m** |

178 Under Model 2, the overall total annual cost for 10,000 paid carers will be approximately $109 million for the 100% case and $77 million for the 70% case.

179 The total cost in the 100% and 70% cases for funding 42,000 carers is $460 million and $321 million respectively. Subtracting the currently funded amount of $ 97 million leaves a new funding requirement for an uncapped programme of $362 million (100% case) and $224 million (70% case).

180 Again, the total figures can be set against the provision in the 2010 budget of $93 million to expand existing disability services. It can also be compared with the existing costs of:

- $86 million for home based support services in 2008

- $43 million for respite services and carer support services in 2008
- $319 million for community residential care in 2008.

## Model Three

181 The annual cost under the Carer Payment scheme in Australia (including all payments) is A$23,000 per carer per annum, which equates to NZ$29,000. However, the Australian payment is 34 per cent of the average Australian wage whereas the equivalent New Zealand amount would be 58 per cent of the average New Zealand wage. If the New Zealand payment is re-calculated using the same percentage of average wage as that in Australia, the annual cost reduces to NZ$17,000 per carer.

182 A second comparison that could be made between the Australian and New Zealand payments is the percentage of the Carer Payment against the unemployment benefit in each country. The A$23,000 carer payment represents 186 per cent of the single person unemployment benefit in Australia. If this percentage was applied in New Zealand, the carer payment would be NZ$22,000 per annum.

**Table 12: Australian costs converted to New Zealand costs**

| Cost per Carer | Annual Cost per Carer |
|---|---|
| Australian standard Carer Payment (single person, incl Carer Allowance and 2 Carer Supplements). 34 per cent of average wage; 186 per cent of unemployment benefit | A$23,000 |
| New Zealand equivalent (at 0.7920). (being 58% of average wage; 248% of unemployment benefit) | NZ$29,000 |
| **New Zealand at 34 per cent of average wage** | **NZ$17,000** |
| **New Zealand at 186 per cent of unemployment benefit** | **NZ$22,000** |

183 Model 3 uses these starting points to calculate costs in each band and total annual costs:

**Table 13: Payment bands for family care givers – Model 3**

| Band | Percent of Carers in Each Band | Ceiling at 186% of Unemployment Rate | Ceiling at 34% of Average Wage |
|---|---|---|---|
| Band 8 – Severe A | 8.6% | $22,000 | $17,000 |
| Band 7 – Severe B | 8.6% | $16,500 | $12,800 |
| Band 6 – Severe C | 8.6% | $11,000 | $8,500 |
| Band 5 – Moderate A | 15.8% | $6,800 | $5,300 |
| Band 4 – Moderate B | 15.8% | $5,100 | $3,900 |
| Band 3 – Moderate C | 15.8% | $3,400 | $2,600 |
| Band 2 – Mild A | 13.4% | $2,500 | $1,900 |
| Band 1 – Mild B | 13.4% | $1,900 | $1,500 |
| **Average per Carer p.a.** | | **$7,300** | **$5,600** |

184 An initial tranche of 1,000 carers is assumed in the first year. Resulting costs are:

**Table 14: First Year Tranche by Bands**

| Band | Year 1 Paid Carers | Total at 186% of Unemployment Rate | Total at 34% of Average Wage |
|---|---|---|---|
| Band 8 – Severe A | 86 | $1.9 | $1.5 |
| Band 7 – Severe B | 86 | $1.4 | $1.1 |
| Band 6 – Severe C | 86 | $1.0 | $0.7 |
| Band 5 – Moderate A | 158 | $1.1 | $0.8 |
| Band 4 – Moderate B | 158 | $0.8 | $0.6 |
| Band 3 – Moderate C | 158 | $0.5 | $0.4 |
| Band 2 – Mild A | 134 | $0.3 | $0.3 |
| Band 1 – Mild B | 134 | $0.3 | $0.2 |
| **TOTAL YEAR 1** | **1,000** | **$7.3m** | **$5.6m** |

185 For the 34% of average wage case, a second tranche of an additional 1,500 paid carers in the second year would cost $8 million. The cumulative cost would be $14 million for the two years of operation. For the 186% of unemployment benefit scenario, a second tranche of an additional 1,500 paid carers in the second year would cost $11 million. The cumulative cost would be $18 million.

**Table 15: Five year payment costs**

| Year | | 186% of Unemployment Rate Accumulating Total | 34% of Average Wage Accumulating Total |
|---|---|---|---|
| Year 1 | 1000 clients | $7m | $6m |
| Year 2 | +1,500 new clients | $18m | $14m |
| Year 3 | + 2,000 new clients | $33m | $25m |
| Year 4 | + 2,500 new clients | $51m | $39m |
| **Year 5** | **+ 3,000 new clients = 10,000** | **$73m** | **$56m** |

186 Under Model 3, the overall total annual cost for 10,000 paid carers will be approximately $73 million for the 186% unemployment benefit case and $56m for the 34% of average wage case. (The total cost in the 186% and 34% cases for funding 42,000 carers is $306m and $236m respectively. Subtracting the currently funded amount of $97m leaves a new funding requirement for an uncapped programme of $209m (186% case) and $139m (34% case)).

## 187 Models Summary

**Fiscal Impact - With 10,000 Cap**

| | | Model 1 - Residential | | Model 2 - Paid Carer Rate | | Model 3 - Aust Equivalent | |
|---|---|---|---|---|---|---|---|
| *(excluding administration costs)* | Carers<br>#| 90% Discount | 70% Discount | 100% Total | 70% Discount | 186% Unemploy | 84% Avg Wage |
| Maximum Carer Salary p.a. | | $58,500 | $45,500 | $33,000 | $23,100 | $22,000 | $17,000 |
| **New Funding** | **10,000** | **$193.6m** | **$150.5m** | **$109.3m** | **$76.5m** | **$72.8m** | **$56.2m** |

**Net Fiscal Impact - Full Programme**

| | | Model 1 - Residential | | Model 2 - Paid Carer Rate | | Model 3 - Aust Equivalent | |
|---|---|---|---|---|---|---|---|
| *(excluding administration costs)* | Carers # | 90% Discount | 70% Discount | 100% Total | 70% Discount | 186% Unemploy | 84% Avg Wage |
| Maximum Carer Salary p.a. | | $58,500 | $45,500 | $33,000 | $23,100 | $22,000 | $17,000 |
| Total Annual Cost as Above | 42,086 | $814.9m | $633.3m | $460.0m | $321.8m | $306.3m | $236.7m |
| Less Existing Funding | (19,204) | $(97.7)m | $(97.7)m | $(97.7)m | $(97.7)m | $(97.7)m | $(97.7)m |
| **New Funding** | **22,882** | **$717.2m** | **$535.6m** | **$362.3m** | **$224.1m** | **$208.6m** | **$139.0m** |

## Administrative costs

188 Further costs are incurred in administering the managed implementation of a mitigation policy.

189 Activities or items which incur administration costs are:

- A selection process (possibly including interviews) for contracted family care givers
- Training for contracted family care givers
- Sustained mentoring for contracted family care givers
- Consistent support to encourage the independence of the disabled person, using support facilitators to access and utilise circles of support
- Use of independent disability advocates to represent the disabled person
- Monitoring of contracted family care
- Regular support needs reviews of the disabled person, leading to plans for care
- Audit to ensure families do not become financially reliant on income
- Retention by the Ministry of the right to cancel the contract with a family care giver for a failure to meet specified criteria.

190 The nearest parallel in current policy settings is individualised funding support (IF), a payment mechanism which empowers disabled people to directly manage the funded disability support they receive.

191 The implementation of IF has some parallels with paid family care givers. It was piloted in 2003 in response to the development of ad hoc informal arrangements, and was designed to formalise arrangements, create national consistency and reduce the risk of different and inconsistent models evolving across the country.

192 IF provides increased flexibility and control, but brings with it important responsibilities including:

- keeping detailed records showing services used, costs incurred and who payments have been made to
- satisfying Ministry of Health policy requirements (such as paying only those family members able to be paid as carers)
- negotiating employment agreements with staff (must include either a Contract of Service or a Contract for Service). In some instances, this may become the responsibility of the provider/host
- being a good employer and meeting the legal requirements for payment of tax, ACC and Kiwi Saver as an employer.

193 The NASC must ensure that financial resources of the proposed support package are within the overall budget management responsibilities of the NASC. In effect this creates a cap on the funds.

194 A Support Plan for the disabled person is developed by the NASC, which steers the service provider to support the person in line with the goals identified in their Plan[9]. The disabled person then chooses an IF Host Provider which manages the payment for the support services.

195 The IF Host Provider roles include many activities or items that are set out in paragraph 134, which augment the selection, assessment and planning function of the NASC:

- providing set-up coaching for the disabled person and their family to establish and manage the required services
- receiving information that verifies the delivery of the support service (such as timesheets or invoices from staff), and invoicing the Ministry for services delivered in the payment period
- assisting the person to manage their support hours including budget oversight
- developing networks to ensure IF consumers are connected to other disabled people and able to share support, or provide advice and support where appropriate
- involving the NASC in a review if there has been a significant change in support needs.

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[9] IF can not be used to manage Ministry funded disability support services, e.g. Supported Living, Respite provided in Ministry contracted facilities, or Carer Support, but some of these services may still be allocated by the NASC as part of a support package.

196 The Ministry conducts periodic audits and random checks to ensure that monitoring and reporting of service delivery is occurring appropriately, a quality service is being delivered, and that supports purchased are relevant and effective.

197 Services for IF are differentiated and an administrative charge is applied at a rate determined by the Ministry. Level 1 services are:

- set-up advice, information, and coaching
- access to a peer-support network of IF users
- information collection to verify IF use
- routine monitoring and an annual evaluation
- Police Check
- expense reimbursement service (without payroll services).

198 The fees charged by the Host Provider range from 6 per cent of the client package for 1-20 hours of IF support a week, to 4.75 per cent for over 45 hours.

199 Level 3 services are more comprehensive and additionally include:

- Free phone helpline
- EMA membership
- access to Employer Liability Insurance
- Quarterly statement of funds
- Payroll service (includes administration of ACC, PAYE and Kiwisaver for all IF employees).

200 The Ministry set fees for level 3 services is 8.2 per cent.

201 Assuming a high end of this range of percentages (8 per cent) to cover the full spectrum of services required for paid family care givers:

- the 70 per cent discount for model one has an administrative cost of $12,040,000
- the 70 per cent discount for model two has an administrative cost of $6,120,000
- the two variants on model 3 (186% Unemployment Benefit, and 34 percent of the average wage) have administrative costs of $5,824,000 and $4,496,000 respectively.

MINISTRY OF HEALTH
MANATŪ HAUORA

**Health Report number:** 20120262

# Health report (draft)

**Hon Tony Ryall, Minister of Health**

**Ministry of Health v Atkinson & Others (payment to family carers) litigation**

**[Excerpt]**

### Fiscal implications

9. The HRRT's declaration may have significant fiscal implications. The size of the fiscal pressure depends on policy choices and on the extent to which disabled people and their families seek funding for care that would otherwise have been provided free of charge.

10. In 2008 Crown Law commissioned the New Zealand Institute of Economic Research (NZIER) to estimate the size of the fiscal impact. Their results were subsequently submitted as evidence to the HRRT.

11. NZIER estimated the first order direct impact on the Ministry's disability support services expenditure[1] of paying family carers a similar amount to that paid to non-family ('external') support services. They made key assumptions about eligibility and how changes in payment might affect client/family behaviour. They assumed that:

    a. for home-based clients, direct substitution of family members for external carers is fiscally neutral

    b. if 10 percent of home-based high use or severely disabled clients seek additional funded care, perhaps for care that was previously provided free of charge by family members, the additional cost will be about $23 million per year. If 25 percent of clients seek additional funded care, the cost will be about $68 million, and if 50 percent seek it, the cost will be about $166 million ($NZ 2011).

    c. in addition, if 10 percent of residential clients switch to home-based care provided by a family member, NZIER assumed additional costs of about $39 million

    d. taken together, these estimates suggest that a 25 percent increase in demand from home-based clients and a 10 percent shift from residential to home care will generate annual costs of around $107 million.[2]

12. The Ministry would like to test NZIER's assumptions with sector experts, to come up with more precise estimates of the likely cost. The Ministry would also like to incorporate into the analysis the following factors:

    a. offsetting savings from a reduction in the number of family-carers receiving the Domestic Purposes Benefit – Care of the Sick or Infirm (Vote Social Development). Currently 6,630 people receive this benefit

    b. the magnitude of second order fiscal pressures on District Health Board expenditure, particularly care of older people and people with mental illness, and services providing support for people following hospital discharge, receiving palliative care, with chronic conditions, and so on

    c. the impact on these estimates of changes since 2008 including, for example, the impact of the 'Sleepovers case'[3]

    d. the costs, benefits, and risks of alternative payment models.

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[1] Vote Health National Disability Support Services Non-Departmental Expense Appropriation.

[2] NZIER's estimates ranged from $17 to $593 million per annum ($NZ 2006). Adjusting for inflation, the range is $20 to $688 million ($NZ 2011).

[3] Settlement between IDEA Services Ltd, Timata Hou Ltd, the Service and Food Workers Union and the Crown.

MINISTRY OF HEALTH
MANATŪ HAUORA

**Health Report number:** 20120520

# Health report (draft)

**To: Hon Tony Ryall, Minister of Health**

**Atkinson and Others v Ministry of Health (payment for family carers) – Next Steps**

**[Excerpt]**

### Impact of the HRRT declaration

6. If the HRRT declaration stands, it applies directly to the organisation and funding of disability support services. It also establishes a principle that could be used to challenge the organisation and funding of other Vote: Health funded services, such as short-term support following discharge from hospital, and long-term support for people with chronic health or age related conditions. The case is also likely to affect other sectors.

7. The Ministry has been working with other agencies to determine the implications of the HRRT declaration for their services and practices. Preliminary advice on the implications of the Court of Appeal decision for Vote: Health funded services and other agencies will be provided by 21 May, with further advice to come.

### Fiscal implications for the Ministry

8. The HRRT's declaration may have significant fiscal implications for the Ministry's Disability Support Services (DSS). The size of the fiscal pressure depends on policy choices in response to the litigation and on the extent to which disabled people and their families seek funding for care that would otherwise have been provided free of charge.

9. In 2008 the Ministry commissioned the New Zealand Institute of Economic Research (NZIER) to estimate the size of the fiscal impact. Its results were subsequently submitted as evidence to the HRRT.

10. NZIER estimated the direct impact on the Ministry's disability support services expenditure[4] of paying family carers a similar amount to that paid to non-family ('external') support services. They made key assumptions about eligibility and how changes in payment might affect client/family behaviour (e.g. the proportion of family carers who might seek to be employed and paid to provide care they had previously given without payment). They assumed that:
    a. for home-based clients, direct substitution of family members for external carers is fiscally neutral
    b. if, for example, 10 percent of home-based high use or severely disabled clients seek additional funded care to employ family members to provide care that was previously provided free of charge,[5] the additional cost will be about $23 million per year. If 25 percent of clients seek additional funded care, the cost will be about $68 million, and if 50 percent seek it, the cost will be about $166 million ($NZ 2011)
    c. in addition, if 10 percent of residential clients switch to home-based care provided by a family member, NZIER assumed additional costs of about $39 million

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[4] Vote: Health National Disability Support Services Non-Departmental Expense Appropriation.

[5] International and New Zealand research consistently shows that around 70 to 75 percent of the support required by disabled people is provided by unpaid natural supports, primarily family members, with the majority of disabled people not requiring support from paid carers. Most people who get support from paid carers receive that support for a few hours per week (e.g. 57 percent of people supported by the Ministry receive fewer than five hours of paid home and community support per week). A relatively small number of people receive a significant level of support from paid carers (e.g. five percent of people supported by the Ministry receive more than 30 hours of paid home and community support per week). Almost all of the support required by people in residential services is provided by paid carers.

d. taken together, these estimates suggest that a 25 percent increase in demand from home-based clients and a 10 percent shift from residential to home care will generate annual costs of around $107 million.[6]

11. The Ministry would like to develop more precise estimates of likely costs and incorporate the following factors into the analysis:

    a. offsetting savings from a reduction in the number of family-carers receiving the Domestic Purposes Benefit – Care of the Sick or Infirm (Vote: Social Development). In 2010/11 the total expenditure on this benefit was $107.74 million

    b. the magnitude of second order fiscal pressures on District Health Board expenditure, particularly care of older people and people with mental illness, and services providing support for people following hospital discharge, receiving palliative care, with chronic conditions, and so on

    c. the impact on these estimates of changes since 2008 including, for example, the impact of the 'Sleepovers case'[7]

    d. the costs, benefits, and risks of alternative payment models.

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[6] NZIER's estimates ranged from $17 to $593 million per annum ($NZ 2006). Adjusting for inflation, the range is $20 to $688 million ($NZ 2011).

[7] Settlement between IDEA Services Ltd, Timata Hou Ltd, the Service and Food Workers Union and the Crown.

MINISTRY OF HEALTH
MANATŪ HAUORA

**Health Report number:** 20120830

# Health report

**Hon Tony Ryall (Minister of Health)**

## CABINET PAPER ON PAID FAMILY CARERS CASE: WORK TO DATE AND SCOPE OF FUTURE POLICY WORK

**[Excerpt]**

5. The Cabinet paper summarises other agencies' initial advice to the Ministry of Health, which will be reviewed by Crown Law, on the level of risk arising from the Family Carers decision for the programmes and services for which they are responsible. The appendix to this report provides you with additional background on what other agencies have provided to us.

### Cost estimates

6. The Cabinet paper provides the Ministry of Health's initial estimates of the risk to Vote Health (the Ministry of Health and District Health Boards) of the Family Carers case. The Ministry of Health's estimate is that the risk is in the order of $120 million to $200 million per annum. These figures differ significantly from the estimates that were provided by the New Zealand Institute of Economic Research (NZIER) during the litigation. NZIER's estimates were between $17 million and $593 million per annum (2006 dollars). The Courts, however, were very critical of the NZIER's analysis, and preferred estimates provided by Brian Easton which suggested that the cost was about $38 million per annum.

7. The differences between these various estimates stem from their very different assumptions and the difficulties in deciding which ones are the most appropriate. The Ministry of Health's initial estimates are based on a preliminary review of data sources that could help establish more robust assumptions. These data sources include: the Accident Compensation Corporation (which already pays family carers); Statistics New Zealand information about the provision of family care; Ministry of Health data related to respite care and carer support; and benefit data from the Ministry of Social Development.

8. Estimating the fiscal risk and the likely costs associated with alternative policy options is, however, a complex and challenging task. The fiscal impact will depend in part on behavioural responses to changes in financial and non-financial incentives. The Ministry therefore intends to establish an expert group to oversee the modelling work. We envisage that this would comprise economists, operations researchers and actuaries. We will also invite the Treasury and the two consultants who presented estimates in evidence to the Human Rights Review Tribunal, Jean Pierre de Raad (from NZIER) and Brian Easton, to be on the group.

## Appendix

### Summary of responses received from other departments regarding the risks raised by the ‘Family Carers’ case

| Department | Programme/s the department considers relevant | Risk as assessed by department | Fiscal impact as assessed by the department |
|---|---|---|---|
| Veterans' Affairs | [redacted] | [redacted] | [redacted] |
| Department of Labour | [redacted] | [redacted] | [redacted] |
| Women's Affairs | [redacted] | [redacted] | [redacted] |
| Education | [redacted] | [redacted] | [redacted] |
| Ministry of Transport / NZTA | [redacted] | [redacted] | [redacted] |
| MSD | [redacted] | [redacted] | [redacted] |
| ACC | [redacted] | [redacted] | [redacted] |
| Corrections | [redacted] | [redacted] | [redacted] |
| Customs | [redacted] | [redacted] | [redacted] |
| Foreign Affairs | [redacted] | [redacted] | [redacted] |
| Pacific Island Affairs | [redacted] | [redacted] | [redacted] |
| TPK | [redacted] | [redacted] | [redacted] |
| NZDF | [redacted] | [redacted] | [redacted] |
| Housing NZ | [redacted] | [redacted] | [redacted] |
| Internal Affairs | [redacted] | [redacted] | [redacted] |
| Building and Housing | [redacted] | [redacted] | [redacted] |

Withheld under s9(2)(f)(iv) of the Official Information Act 1982 (to maintain the confidentiality of advice tendered by Ministers of the Crown and officials).

In Confidence
Office of the Minister of Health

Cabinet Social Policy Committee

# PAID FAMILY CARERS CASE: WORK TO DATE AND SCOPE OF FUTURE POLICY WORK

## Proposal

1 This paper updates Ministers on work to date and outlines a future work programme for responding to *Ministry of Health v Atkinson & Others*[1] (the Family Carers case).

## Executive summary

2 In May this year the Court of Appeal found the Ministry of Health's policy of excluding specified family members from payment for the provision of care to be unjustified discrimination. The case was focused on the parents of disabled adult sons and daughters who wished to deliver Ministry of Health funded support at home.

3 The Government has decided not to seek leave to appeal the Court of Appeal's decision in the Family Carers case to the Supreme Court (CAB Min (12) 20/13 refers). This means the Ministry of Health must change its policy of not allowing the payment of family carers (parents, spouses and resident family members) who deliver disability support services.

4 The Ministry of Health has developed three preliminary policy options to respond to the discrimination against the parents of disabled adult sons and daughters that was the focus of the case:

- a Option One – Remove the prohibition on the payment of these parents so that they can be paid on the same basis as formal carers.
- b Option Two – Pay these parents for care provided above a reasonable level.
- c Option Three – Pay these parents for care they provide in exceptional circumstances (which could also be combined with Option Two).

5 For each of these options, consideration needs to be given to a range of issues, including:

- a whether payment can be limited to the parents of disabled adult sons and daughters, or whether an approach encompassing all family carers would be required;
- b whether the immediate policy change can be limited to Home and Community Support services only, or if a broader approach would be required;
- c whether family members should be paid as employees or in some other way (e.g. an allowance);
- d what level of payment should be made;
- e what is required to monitor the quality of support; and
- f the likely fiscal costs and risks.

6 Further development and evaluation is required before a preferred option can be selected. As part of this work, there will be public consultation on how the Government might respond. The Technical Advisory Group, established to provide advice during the policy process, strongly supports consultation with the disability and carers communities to gain their input. An Expert Group will also be established to provide assurance about the estimated fiscal costs and risks.

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[1] *Ministry of Health v Peter Atkinson (on behalf of the Estate of Susan Atkinson) & Others* (O'Regan P, Glazebrook, France, Harrison and White JJ), 14 May 2012, [2012] NZCA 184

7 Officials have also considered the broader implications of the case for other government policies and programmes. The most significant of the broader legal risks arising from the Family Carers case is related to the general Vote Health policy of not allowing the payment of parents, spouses and resident family members to deliver support to a range of other groups, including older people. A similar policy applies to support for veterans funded through Veterans' Affairs New Zealand, which is likely to be affected in the same way.

8 The Ministry of Health is seeking agreement from the plaintiffs to have a year from the date of the Court of Appeal decision in which to develop, consult on and implement an alternate policy. If agreement cannot be reached with the plaintiffs, the Ministry of Health will approach the Courts. Having less than a year may limit or prevent consultation.

## Background

9 The decision by the Government to not seek leave to appeal the Court of Appeal's decision in the Family Carers case to the Supreme Court means the Human Rights Review Tribunal's declaration stands (CAB Min (12) 20/13 refers). That declaration was that the Ministry of Health's policy of not allowing the payment of specified family members for the provision of funded disability support services is inconsistent with section 19 of the New Zealand Bill of Rights Act 1990 (NZBORA) in that it limits the right to freedom from discrimination, both directly and indirectly, on the grounds of family status and is not, under section 5 of that Act, a justified limitation.

10 The Family Carers case focused on the parents of disabled adult sons and daughters who required an ongoing and high level of care. These parents wished to support their adult sons and daughters at home but were not able to be paid to do this with Ministry of Health funding. The Courts held that the policy of not paying parents to provide this care when non-family members would be paid to do so was not justified. That was because there is no duty or expectation to provide ongoing unpaid care to adult sons and daughters.

11 Work responding to the Family Carers case is led by the Ministry of Health and overseen by the Social Sector Forum, which comprises Chief Executives from the Ministries of Health, Education, Social Development, Housing and Justice, and supported by a multiagency Senior Officials Group established to address issues related to Family Carers. The focus of the work has been on the following two issues:

a developing policy options the Ministry of Health could implement in the near future to respond to the discrimination in the particular programmes that were identified by the Courts. The Ministry of Health has been assisted by the Senior Officials Group, as well as a Technical Advisory Group consisting of people with expertise and/or lived experience of disability, caring, the disability support system, and fiscal management; and

b understanding the implications of the case for other support and programmes funded by the Ministry of Health, District Health Boards (DHBs) and other government agencies.

### NEXT STEPS IN THE LEGAL PROCESS

12 The next step in the legal process for the specific programmes considered by the Courts is for the parties to try and agree on when the order suspending the Human Rights Review Tribunal's declaration (that the policy of not paying family caregivers contravenes the NZBORA) will be lifted. This date is crucial in determining how long the Government has to develop, consult on and implement an alternative policy. That is because once the suspension order is lifted, the current policy will become unlawful.

13 The Crown will be seeking to have 12 months after the Court of Appeal decision to develop and implement a new policy for parents of adult disabled sons and daughters before the suspension order is lifted. If a date to lift the suspension cannot be agreed

between the parties, the Courts will need to determine the date. A separate remedies hearing is expected to take place near the end of 2012.

## Comment

14 The Family Carers case raises issues which go the heart of the relative responsibilities of the state and families, and the degree of responsibility that family members in different situations have towards each other. Resolving this issue will involve making choices on issues on which there are deeply held and difficult to reconcile views across society, with substantial implications for the way that government overall operates and/or fiscal costs. At the same time, it will be necessary to choose an option that, if it involves discrimination that is contrary to section 19 of NZBORA, can be justified under section 5 of that Act.

### OPTIONS

15 The primary focus of work to date has been on responding to the discrimination against the parents of disabled adult sons and daughters who wish to deliver Ministry of Health funded Home and Community Support Services, as that will have the most direct bearing on the future legal process. The following options are currently being considered:

a ***Option One – Remove the prohibition on the payment of parents of disabled adult sons and daughters so that they can be paid on the same basis as formal carers:*** this would involve allowing these parents to be paid to deliver Home and Community Support Services when the level of support required is above what unpaid family carers *are willing to provide*. The current needs assessment and service coordination (NASC) process (under which paid supports complement gaps that are not met by unpaid natural supports) would continue to be used.

b ***Option Two – Pay the parents of disabled adult sons and daughters to provide care when the amount of care provided by unpaid natural supports is above a reasonable level:*** this would involve allowing these parents to be paid to deliver Home and Community Support Services when the level of support required *is over and above what it is reasonable for unpaid natural supports to provide*. What constitutes reasonable care would need to be defined, and a process for determining it developed, both of which could be controversial.

c ***Option Three – Pay the parents of disabled adult sons and daughters for care in exceptional circumstances:*** this would involve allowing these parents to be paid to deliver Home and Community Support Services when the level of support required is exceptional. What constitutes exceptional circumstances would need to be defined, and a process for determining it developed, both of which could be controversial.

***Some possible scenarios***

*Joanna and Michael have a 25 year old son, Sam, who has muscular dystrophy and requires 28 hours of support each week. Sam's strong preference is that his parents provide him with support. Together, Joanna and Michael are willing to provide five hours each week unpaid, but are not willing to give up their jobs or their weekend to provide the other 23 hours of support each week without payment. Michael is self-employed and has some flexibility over his hours of work, so would be willing to provide the additional support provided he got paid to do so.*

*Under Option One, Michael could be paid to provide the 23 additional hours of support each week.*

*Under Option Two, the assessment may show there is a reasonable expectation on Joanna and Michael to provide ten hours of natural support for Sam. So Michael could be paid to provide the 18 additional hours of paid support each week.*

*Under Option Three, Joanna and Michael are unlikely to be paid to provide support as there are no exceptional circumstances.*

### INITIAL ASSESSMENT

16 Because of the complex challenges raised by this work, there has been a strong focus on developing criteria to evaluate the policy options. The following criteria have been identified:

- a the impact on disabled people's choice and control over the support they receive
- b the impact on carers' life choices and opportunities
- c the impact on the quality and safety of paid support received by disabled people
- d the broader implications for other parts of government and society generally
- e the impact on the availability of unpaid natural supports
- f fiscal costs and risks
- g whether any discrimination under NZBORA can be justified
- h operational feasibility and implementation issues and risks
- i the likelihood that disabled people and family carers will understand and accept the approach.

17 Officials' initial assessment is that no option is clearly better than the others when considered against these criteria, with each of the options involving trade-offs. Whichever option is chosen, consideration also needs to be given to a range of other issues, including the following:

- a whether it is possible to limit consideration only to parents of disabled adult sons and daughters, or if a broader approach encompassing other close family members is required;
- b whether any policy change is limited only to Home and Community Support Services or if it should also be applied at the same time to other support that is funded by the Ministry of Health;
- c whether family members should be paid as employees or treated in some other way, and paid another form of payment (such as allowances, grants, subsidies or tax credits) and what level of payment should be made;
- d determining what steps may be required to monitor the quality of support provided by paid family members and to maintain the choice and control of the disabled person or the family carer (e.g. preventing people becoming 'trapped' in an unsuitable caring arrangement); and
- e determining what steps may be required to manage the overall fiscal cost and risks that arise from paying family carers, aside from the changes to the allocation process that result from allowing them to be paid (e.g. having a cap on payment to family carers).

18 Further development and evaluation of the policy options is required before a preferred option can be selected. This should include a public consultation process to ensure wide input on this complex policy issue. The Technical Advisory Group is of the view that the disability and carers communities should be widely consulted before any decisions are made. Such an approach is likely to be viewed favourably by the Courts, result in a greater degree of acceptance by the disability and carers communities of the agreed approach, and lead to policy that is more robust than would otherwise be the case.

## Broader implications

19 The focus of work to date on identifying the broader implications of this case has been on assessing the extent of legal risk arising from the particular decisions made by the Court in the Family Carers case. Agencies have undertaken a comprehensive assessment of the areas of potential legal risk arising from the Family Carers case. Their assessments

were reviewed by the Crown Law Office, with a summary considered by the Family Carers Senior Officials Group and Social Sector Forum Chief Executives. Appendix One summarises the range of potential risks that were identified by agencies.

20 Some policies or programmes have been assessed as having a significant risk of being found to involve unjustified discrimination. Significant risks arise when the Government is prepared to pay non-family members to provide support and/or assistance to another family member, but not pay family members for the same support and/or assistance in circumstances where the expectation of unpaid family support goes beyond what is normally expected of a family.

21 The areas assessed as having the most significant level of legal risk are the following:

a Vote Health: There are two areas of significant risk that were not the direct focus of the Family Carers case:

  i Ministry of Health: Family carers, other than the parents of disabled adult sons and daughters, who are not able to be paid to provide support. These family carers include spouses, parents in the case of younger children, and other resident family members. The support these family carers cannot be paid to provide includes Home and Community Support Services, Carer Support and, potentially, other services such as Respite Care, Day Services and Residential Care.

  ii DHBs: Family carers who are not able to be paid to support people with age-related and long-term medical conditions, people requiring short-term support following discharge from hospital and people experiencing mental health conditions. The support these family carers cannot be paid to provide includes Home and Community Support Services, Carer Support and, potentially, other services such as Respite Care and Residential Care.

Current expenditure across Vote Health on professionally-provided Home and Community Support Services is about $350 million per annum. The Ministry of Health's early estimates of the additional fiscal risk implied by the Court decision is in the order of $120 million to $200 million per annum across Vote Health (of which, $40 to $70 million per annum relates to disability support funded through the Ministry of Health). The actual fiscal costs, however, will depends on the policy option chosen, how it is implemented and behavioural response by disabled people and carers (i.e. there is an element of how long is a piece of string).

b Vote Veteran's Affairs: Support for veterans. This risk arises from family members or partners/ spouses not being able to be paid to provide care to veterans for their disability (or other care needs) resulting from recognised operational deployments.

The conservatively estimated risk is up to $1.6 million per annum, although the actual cost will depend on uptake rates and could be considerably higher.

22 Estimating the possible fiscal impact of these risks is a complex and challenging task as they involve modelling how people will change their behaviour in response to alternative policy options and, in the early stages, making assumptions relating to their design that may have a significant impact on the actual costs. To provide assurance that its future cost estimates are reasonable, the Ministry of Health will establish an Expert Group, including external reviewers, to oversee this work. Other agencies will be able to access the Expert Group to assist with assessing their fiscal risks.

23 There is also a range of areas where there is differential treatment on the basis of family status but where the risk that policies or programmes will be found to involve unjustified discrimination is lower. The lower level of risk arises primarily because the differential

treatment arises in circumstances where there is a higher level of expectations that families have the primary responsibility for providing care and support to each other and that they would not normally be paid by the Government to meet those responsibilities. Examples of such family responsibilities include the care and support that spouses provide to one another and parental care and support to children and young people.

24 Some policies and programmes that were considered as posing a potential risk were found to involve no differential treatment of the sort that was at issue in the Family Carers case.

### OTHER RISKS

25 There may also be non-legal risks arising from the wide-spread attention that the Family Carers case has received that need to be taken account of in the policy development process. One risk is that families may seek to increase their use of existing mechanisms that transfer responsibility from unpaid natural support to the government. For example, more families than at present may indicate during the NASC process that they will not provide unpaid support for family members with disabilities. This risk relates to support funded through both the Ministry of Health and DHBs. This would effectively mean that the Government will either need to fund increased demand for paid support and/or reduce the amount of support or funding allocated to other people.

26 There may be similar risks arising for other Government programmes. There is also a risk that the Family Carers case may highlight the differential treatment of families when caring for family members depending on which agency is providing the funding.

## Next steps

27 The decision on when the suspension order is lifted determines when an alternative policy for the payment of family carers needs to be in place. The Ministry of Health is seeking agreement from the plaintiffs to a year from the date of the Court of Appeal decision to develop, consult on and implement an alternative policy. If a date to lift the suspension cannot be agreed between the parties, the Courts will need to determine the date.

28 Table One sets out an indicative timeline for future work, assuming that a year is available to develop, consult on and implement an alternate policy. If, however, the Suspension Order is lifted in less than 12 months, the work programme may need to be streamlined, e.g. by limiting consultation, not consulting, and/or by considering only the immediate issue of discrimination arising from not being able to pay parents of disabled adult sons and daughters. The indicative timeline will be revised once the date on which the suspension order will be lifted is known.

**TABLE ONE: INDICATIVE TIMELINE RELATING TO MINISTRY OF HEALTH FUNDED SUPPORT**

| Date | Deliverable |
|---|---|
| Early to mid-August 2012 | TAG and Social Sector Forum consider policy options, costings and implementation issues |
| 29 August 2012 | SOC considers detailed policy options, costings and implementation issues and a draft consultation document |
| 3 September 2012 | Consultation document circulated |
| September/ October 2012 | Consultation workshops with the sector |
| 31 October 2012 | Consultation period closes |
| 10 December 2012 | Cabinet considers the results of the consultation process and decides on new policy |
| January 2013 | New policy announced |
| February to June 2013 | Ministry of Health implements the agreed policy option(s) |

29 While there will continue to be ongoing work assessing the risks arising from the case for support funded through DHBs, the in-depth policy work needed to develop, consult on and implement any policy responses for DHBs will begin once Cabinet has made decisions relating to disability support funded through the Ministry of Health. If the timetable outlined in Table One above is followed, the in-depth work relating to DHB funded support could commence in the first part of 2013.

30 Veterans' Affairs New Zealand will work with the Ministry of Health as the Ministry reviews policy relating to the care of older people so that these policies can be closely aligned where relevant.

## Consultation

31 The Treasury, Crown Law Office, the Ministries of Education and Social Development, Veterans' Affairs New Zealand, the Office for Disability Issues, the State Services Commission and ACC were consulted on drafts of this paper. The Department of Prime Minister and Cabinet was informed of the contents of the paper.

32 Information on the risks arising from the Family Carers case was also sought from the Departments of Building and Housing, Corrections, Labour and Internal Affairs, the Ministries of Pacific Island Affairs, Women's Affairs, Transport and Foreign Affairs and Trade, the New Zealand Defence Force, the New Zealand Customs Service, the New Zealand Transport Agency, Te Puni Kokiri and the Housing NZ Corporation.

33 The Technical Advisory Group was consulted on the options that are included in the Cabinet paper. It strongly recommends consulting with the disability and carers communities on this issue prior to final decisions being taken. They saw consultation as likely to improve the quality of the decisions that are made and the ownership of them within the disability and carers communities.

### Regulatory impact analysis

34 There are no proposals in this paper that require the preparation of a Regulatory Impact Statement.

## Human Rights Implications

35 The Court of Appeal has upheld the decisions of the High Court and the Human Rights Review Tribunal that the Ministry of Health's policy of not paying family carers amounts to unjustified discrimination under NZBORA. The Courts' rulings have given some guidance on tests for compliance with NZBORA, and ensuring that policy solutions do not involve unjustifiable discrimination will be a key criterion for policy design.

## Legislative Implications

36 There are no legislative implications arising from the recommendations in this paper.

## Gender Implications

37 The group of people most directly affected by the Family Carers decision are those who provide unpaid care to their adult sons and daughters who have disabilities. The majority of this unpaid care is provided by female family members.

## Disability Perspective

38 There are differing views in the disability and carers communities on whether family members should be paid for providing care, with many people recognising the dilemmas raised by the Family Carers case. A core objective of the policy process is to find a way of addressing the issue that recognises and respects these differing views.

## Financial Implications

39 The financial implications are discussed in paragraph 21 above.

## Publicity

40 The Minister of Health will continue to take the lead role in making public statements about the Family Carers case. The Ministry of Health and Crown Law are considering the best way to communicate with plaintiffs during the policy development process provided that doing so does not jeopardise the legal process.

## Recommendations

41 The Minister of Health recommends that Cabinet Social Policy Committee:

1 **Note** that the decision to not appeal the Court of Appeal's decision in the Family Carers case (CAB Min (12) 20/13 refers) means that the focus of future work is now on understanding the implications of the decision and developing policy responses.

2 **Note** that the highest priority for future work is developing a response to the particular discrimination that was considered by the Courts in reaching their decisions - the Ministry of Health's policy of not paying the parents of adult sons and daughters to deliver Home and Community Support services.

3 **Note** that the next highest priority is developing responses to the other significant legal risks that have been identified as arising from the general policy across Vote Health of not allowing the payment of parents, spouses and resident family members to deliver support and for some support funded through Veterans' Affairs New Zealand.

4 **Note** that the date on which the order suspending the Human Rights Review Tribunal's declaration of discrimination is lifted will be determined either through agreement with the plaintiffs or through a decision by the Courts.

5 **Agree** that, if the timeframe for lifting the Suspension Order allows, the Ministry of Health consult with the disability and carers communities on how the Government might respond to the issues raised by the Family Carers case.

6 **Invite** the Minister of Health to report to Cabinet Social Policy Committee in August 2012 on:

6.1 the policy options, costings and implementation issues for responding to the particular discrimination that was considered by the Courts in the Family Carers case.

6.2 If there is sufficient time to consult with the disability and carers' communities, a document on which to base a consultation process.

Hon Tony Ryall
**Minister of Health**

___/___/_____

# The costs of paying family carers

## Draft analysis for consultation

**Sam Warburton**

**August 2012**

# Disclaimer

Every effort has been made to ensure the information in this draft cost analysis is accurate.

The author and the Ministry of Health do not accept any responsibility or liability whatsoever for any error of fact, omission, interpretation or opinion that may be present, however it may have occurred.

Any views and opinions expressed are those of the author and do not necessarily represent the views of the Ministry of Health. The analysis in this paper is for review and consultation purposes, and does not necessarily represent agreed Government positions or policy.

## Contents

# 1. Executive summary

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- xxxx;
- xxxx

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## 1.1. MAIN ASSUMPTIONS

## 1.2. RESULTS

**Xxxx**

# 2. Background and context

## 2.1. GLOSSARY

1. For ease of reading, this paper uses a number of simplifying terms. The terms:
   - 'Ministry' means the Ministry of Health;
   - 'Health' means the wider public health sector including the Ministry and District Health Boards (DHBs), but excluding the Accident Compensation Corporation (ACC);
   - 'the Tribunal' means the Human Rights Review Tribunal;
   - 'family carers' means carers in the home that are family members (parents, partners, etc);
   - 'formal carers' means carers in the home that are currently paid out of government budgets and operating under government programmes;
   - 'original plaintiffs' means those carers who originally challenged the Ministry's policy of not paying family carers;
   - 'original NZIER paper' means the New Zealand Institute of Economic Research paper titled *Statement of Evidence of Jean-Pierre de Raad* that was presented as evidence at the Tribunal hearing;
   - 'revised NZIER paper' means the NZIER paper titled *The Potential Fiscal Impacts of Paying Family Caregivers* that was produced for the Ministry;
   - 'Easton paper' means the Brian Easton paper titled *Reply Brief of Evidence of Brian Henry Easton* that was presented as evidence at the Tribunal hearing.

**Comment [SW1]:** Include definition of residential care.

## 2.2. HISTORY OF THE CARER'S CASE

**Comment [D2]:** Actually, will be good to summarise some of this here, particularly the discussion of 'reasonableness', as it comes up later.

## 2.3. PREVIOUS COST ANALYSES

2. The Ministry contracted NZIER to produce analyses of the potential costs of allowing the payment of family carers. NZIER produced two reports in 2008.

3. The original NZIER paper included only Ministry expenditure on disability and put the costs of paying family carers at between $17m and $593m per year[1].

4. The revised NZIER paper included District Health Board (DHB) expenditure and put probabilities on the behaviour change of disabled people and family carers. The revised NZIER paper put the expected cost at $525.3m per year[2].

5. The original plaintiffs contracted Brian Easton to produce another analysis. Easton largely used, and critiqued, the original NZIER paper. Easton put the total cost at no more than $32m to $64m per year.

6. The Easton paper and the original NZIER paper were presented as evidence to the Tribunal. Both authors – Jean-Pierre de Raad for NZIER, and Brian Easton – also appeared in person at the Tribunal.

**Comment [D3]:** Maybe include quotes from the courts about the analyses.

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[1] Original NZIER, 2008, paragraph 75, p. 20.

[2] Revised NZIER, 2008, paragraph 86, p. 25.

# 3. Purpose of the analysis

## 3.1. PURPOSE OF THE COST ANALYSIS

7. The purpose of this paper is to seek input from Ministry and external reviewers, with the intention of producing a Ministry view of the expected costs of policies that pay family carers.

8. The Ministry analysis will aim to serve a number of purposes:
   A. To help inform public discussion during consultation.
   B. To seek further information from the public to further refine the analysis.
   C. To inform the Ministry's policy analysis.
   D. To help advise Ministers ahead of their decisions on a final policy.

## 3.2. SCOPE OF THE COST ANALYSIS

9. The analysis covers two main topics. The first is a review of the NZIER and Easton analyses. The second covers the method and results of my model.

10. My model includes the costs of all disabilities that Health has policy responsibility for. That is, all disabilities are included except those caused by accident an injury. The Accident Compensation Corporation (ACC) has policy responsibility for disabilities due to accident.

11. My model includes the costs from all types of relationships where a person is caring for a disabled family member, not just parents caring for their disabled adult children.

12. My analysis is not an economic analysis. It includes only estimates of the costs to government of paying family carers. It does not include any other costs, or benefits, that may be incurred by other parties.

13. This analysis is draft. There are limitations and uncertainties that are raised throughout the paper. The analysis is intended to stimulate discussion and encourage improvements to the model and assumptions. I welcome feedback, corrections and further information.

## 3.3. PROCESS AND ROLES

XXXX

**Comment [D4]:** Section for the consultation version only. To cover who is responsible for the paper, who inputted into it.

# 4. Previous analyses

14. This chapter reviews the previous analyses by the New Zealand Institute of Economic Research for the Ministry of Health, and by Brian Easton for the caregivers.

15. A review of the previous analyses is required as my model does not use original source data. My model uses data from the original and revised NZIER papers. For this reason, it is important to identify what information I require for my model, and which of that information can be confidently sourced from NZIER's data, and which needs amendment.

16. Therefore, this chapter summarises the approach of the NZIER and Easton analyses, and identifies what information is important for my model and whether that information can be confidently used as is, or requires amendment.

## 4.1. OVERALL COMMENT

17. There are several problems with the data sets NZIER constructed. These data sets need to be amended before I can confidently use them in my model.

18. Neither the NZIER nor the Easton papers identified or used much evidence for some of their cost and behaviour change assumptions. Both were transparent about this. I have no particular view about these assumptions and leave these cost areas for my model to estimate.

19. Other assumptions cannot be estimated using my model, and need to be exogenously assumed. I have identified a number of information sources to that can inform these assumptions.

20. My amendments to the data and analysis of what are appropriate assumptions suggests the costs to Health of paying family carers is much less than the $525.3m estimated in the revised NZIER paper.

21. ACC data, however, provides the best source of information and, as it is used as the basis of my model, is left for later chapters.

22. Table 1 summarises the estimates of costs that appear in each analysis.

**Table 1: Overall estimates of the costs to Health**

| Area | Original NZIER | Revised NZIER | Easton | Warburton |
|---|---|---|---|---|
| Disabled people who switch from formal carers to family carers | -$3.1m to $0.0m | -$1.7m | Negligible | Negligible or cost-saving depending on the policy |
| Disabled people who switch from residential care to home care | $0.0m to $243.3m | $88.4m | Negligible | Negligible or cost-saving |
| Family carers seeking payment where the disabled person receives formal and family care | $8.7m to $78.0m | $98.1m | $9.6m | Largely addressed in later chapters |
| Family carers seeking payment where the disabled person receives minimal or no formal care | $11.4m to $271.7m | $340.5m | $28.2m | Largely addressed in later chapters |

## 4.2. THE DATA SOURCES

23. The main data sources used in the analyses are Statistics New Zealand's *2006 Disability Survey*, and Ministry and DHB disability support expenditure and client information.

### 4.2.1. 2006 DISABILITY SURVEY

24. The *2006 Disability Survey* reports, among other things, the number of people with disabilities by level of need: low, medium, and high. High needs people need help every day – 'help with personal care such as taking medication, washing or dressing'. Medium needs people mostly need equipment, but occasionally need help with other things – they 'use some type of assistive device, aid or special equipment, or receive help with shopping, looking after personal finances or communicating because of their condition'. Low needs people do not require regular help or technical aids.[3]

25. The survey records people who need help, whatever the cause: disease, ageing, injury, etc. After removing those with disabilities caused by injury, the survey puts an upper limit on the number of people who might be eligible for services (family care or formal care) from the Ministry and DHBs.

26. The survey records formal care and 'informal' care. Informal care includes care from family, and also from friends, neighbours, flatmates, etc. The prohibited discrimination is family status, and so does not apply to these other carers. Some disabled people who receive informal care from people other than family may switch to receiving care from family members if family members are paid. Some will not. Therefore, the use of Statistics New Zealand's informal care as a proxy for family care will overestimate the true cost to some extent.

27. NZIER included only those disabled people with disabilities not due to ageing or accident.

### 4.2.2. DISABILITY SERVICES

28. NZIER included Disability Support Services (DSS) provided by the Ministry. The scope of disability covered by Ministry DSS was defined by Cabinet as [CAB (94) M 3/5 (1a)]

> *A person with a disability is a person who has been identified as having a physical, psychiatric, intellectual, sensory or age-related disability (or a combination of these), which is likely to continue for a minimum of six months and result in the reduction of independent function to the extent that ongoing support is required.*
>
> *Where a person has a disability which is the result of a personal injury by accident which occurred on or after 1 April 1974, it should be determined whether they are eligible for cover under the Accident Rehabilitation and Compensation Act*[4]*.*
>
> *Where a person's level of independent function is reduced by a condition which requires ongoing supervision from a health professional (e.g. in the case of renal dialysis), that person is considered to have a personal health need rather than a disability. Where a person has both a disability and a personal health need, the*

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[3] http://www2.stats.govt.nz/domino/external/omni/omni.nsf/outputs/824BF1D262424991CC25736F00781139.

[4] Accident Compensation Act 2001

> *services provided to address those needs are disability support services and personal health services respectively.*

29. Since that decision, the responsibility for psychiatric and age-related disability was devolved to DHBs. NZIER excluded DHB expenditure in their original paper, but included it in the revised paper.

30. Overall, when a disabled person is largely free of other health needs, the disability services they receive are provided through DSS. When a disabled person requires ongoing contact with Health – for example, those with chronic conditions, those receiving palliative care, etc – the disability services they receive are provided along with their other health needs from non-DSS budgets. NZIER do not appear to have included disability services provided outside of DSS, such as other health care provided by DHBs.

## 4.3. COMMENTS ON DATA INTERPRETATION AND CONSTRUCTION

31. NZIER constructed data by aligning Statistics New Zealand information with Ministry and DHB information. Both NZIER and Easton used this data in their cost estimates.

32. DSS data doesn't record whether someone was low, medium, or high needs (the categories used by Statistics New Zealand, see section 4.2). The revised NZIER paper summarised the method NZIER used to allocate DSS clients to the level of need.

33. NZIER took *2006 Disability Survey* data of the number of people with disabilities by age, level of need, and the intensity of service people report having received. The intensity of service is divided into 'residential care', 'home-based support', and 'no or minimal external support'. Home-based support is defined as those who get 'daily or at least twice weekly help with meals, shopping, housework, personal care provided by a person paid by someone or an organisation other than family'[5]. The number of clients receiving 'minimal' formal care is the number of DSS clients minus those receiving residential and home-based care.

34. NZIER then matched DSS clients the survey data by distributing clients to between minimal and home-based formal care based on the amount of time of service provided, and then between high, medium, and low needs based on the average daily cost.

35. In their revised paper, NZIER estimated that there are 39,900[6] people with high needs receiving minimal or no formal care. Of these, 12,428[7] were estimated to have received minimal formal care. The remaining 27,472 were estimated to receive no formal care.

36. Given the limitations of the source data, the method NZIER uses to construct their data sets looks good. There, however, appear to be several problems that will need to be amended before the data can be used further. Two of them relate to undercounting of government services, as Easton noted was a possibility in his paper when he stated that 'presumably some of those not being

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[5] Revised NZIER, p. 5.

[6] Revised NZIER, table 2, p. 6. Excludes accidents and older people where the disability is due to ageing rather than other causes like disease.

[7] Revised NZIER, table 7, p. 11.

supported by the Ministry are receiving support from... another government agency (such as the DHB, or Work and Income New Zealand)'[8].

### 4.3.1. MINISTRY OF SOCIAL DEVELOPMENT SUPPORT

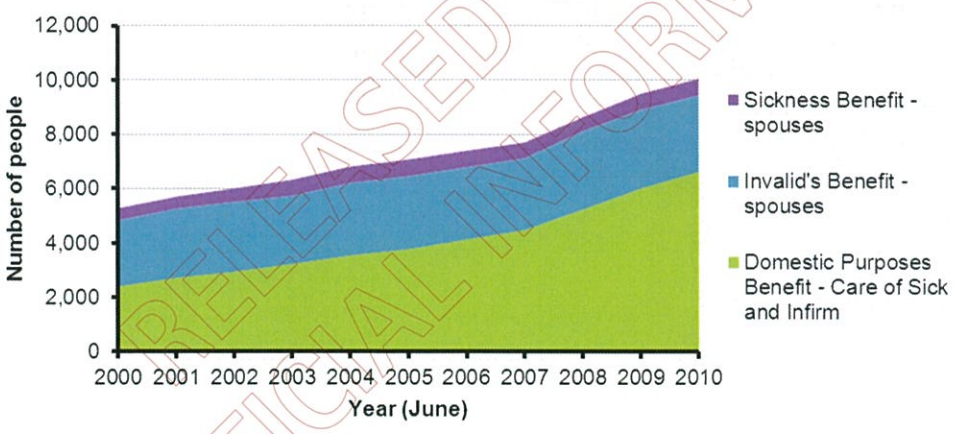
37. Though disabled people may not receive formal care, the informal care they receive may be by family members who receive support from the Ministry of Social Development (MSD).

38. 7,598 people received the Domestic Purposes Benefit – Care of Sick and Infirm (DPB CSI) as at 31 March 2012. The DPB CSI provides support of about $16,000 per year to people who are caring full-time at home for a disabled person who would otherwise need residential, hospital, or equivalent care. Full-time care means 'that the person will require 24-hour access to care and attention'. It doesn't mean that 24-hour care is provided, but that care can be provided when required. The DPB CSI is income-tested, but not work-tested. The carer does not have to live at the same residence as the disable person. Spouses cannot receive the DPS CSI to care for disabled partners, but can be included on the disabled person's Invalid's Benefit or Sickness Benefit.

39. Spouses can be included in their partner's Invalid's Benefit or Sickness Benefit as a carer and be exempt from those benefits' work tests. Both benefits are income-tested.

40. Figure 1 shows the number of people receiving these three supports between June 2000 and June 2010[9].

Figure 1: Number of people receiving support from MSD for caring for family members



41. Family carers' take-up of payment from Health will be limited somewhat as the payment will be considered income, which causes MSD supports to abate at a rate of 70c for every dollar earned. Take-up would be further limited if a policy involves not paying people where they opt to receive MSD supports.

### 4.3.2. NON-DSS DISABILITY SERVICES

42. As noted in section 4.2.2, NZIER do not appear to have included services provided to people with non-DSS disabilities. The 2006 Disability Survey data

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[8] Easton, paragraph 31, p. 9.

[9] Statistics provided by the Ministry of Social Development.

include people with a wider range of disability types (eg, those caused be a chronic condition) than those covered by DSS. Thus, NZIER's data will exclude disabled people who receive formal care through non-DSS services.

43. NZIER reported[10] that 16,100 people of all ages received home-based formal care. However, I have inferred from Statistics New Zealand's *Disability and Informal Care in New Zealand in 2006* publication[11] that 20,100 adults received formal care every day, and another 15,100 adults received care twice weekly, for a total of 35,200 adults that received home-based formal care. When I add the 3,300 children[12] that received home-based formal care[13], I have a total of 38,500 people of all ages that received formal care. Using my model, I estimate that about 4,300 of these were ACC clients[14]. This leaves 34,200 which were Health clients; more than twice that reported in the revised NZIER paper.

44. Table 2 presents the number of people receiving informal and formal care as inferred from *Disability and Informal Care in New Zealand in 2006*. Using home-based care (every day, and twice a week), figure 2 shows how to interpret table 2.

**Table 2: Care received by adults in households**

| Frequency of care | Informal care only | Informal and formal care | Formal care only | Total | Total formal care |
|---|---|---|---|---|---|
| Every day | 51,400 | 15,100 | 5,000 | 71,500 | 20,100 |
| At least twice a week | 13,200 | 7,300 | 7,800 | 28,300 | 15,100 |
| At least once a week | 18,600 | 7,000 | 22,600 | 48,200 | 29,600 |
| Other | 17,700 | 1,700 | 21,800 | 41,200 | 23,500 |
| Total | 102,300 | 31,200 | 59,200 | 192,700 | 90,400 |
| Home-based | 64,600 | 22,400 | 12,800 | 99,800 | 35,200 |

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[10] Revised NZIER, table 6, p. 10, and table 7, p. 11.

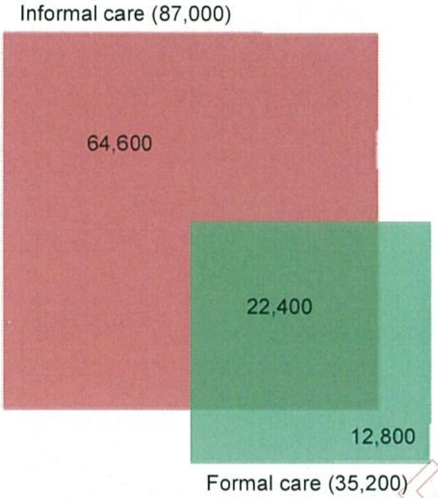
[11] Disability and Informal Care in New Zealand in 2006, Statistics New Zealand, 2009, appendix table 27, p. 70. The publication uses data from the *2006 Disability Survey*.

[12] Children are aged 0 to 14 years.

[13] Disability and Informal Care in New Zealand in 2006, p. 32.

[14] Reference to later in this paper

**Figure 2: Home-based care received by adults**



### 4.3.3. HEALTH OF OLDER PEOPLE

45. NZIER appear to have made an error in allocating DHB's provision of support services for older people.

46. NZIER's table 2 reports the number of disabled people by age, severity of disability, and the intensity of formal care received, including those that receive no formal care. NZIER's table 7 reports the number of Health disability clients by age, severity of disability, and the intensity of formal care received.

47. Because table 7 includes only clients, it excludes those disabled people who receive no formal care. I can, therefore, identify how many people NZIER estimated receive no care by subtracting the numbers of people in table 7 from the numbers of people in table 2.

48. My table 3 on the next page shows the result of this calculation.

49. Looking at the 65-and-over age group, we can see that NZIER estimated that no people – actually, negative people – received zero formal care across all levels of need. For other age groups, the proportion of people that received formal care ranged between 14% and 16%. The proportion of 65s-and-over age group that received formal care was 101%.

50. It appears that NZIER allocated all services received by older people to only those older people without ageing and accident disabilities.

### 4.3.4. MEDIUM NEEDS

51. It's not clear that NZIER properly used data about those with medium needs. As section 4.2.1 notes, medium needs people generally require only irregular assistance (if any). As I note later in my paper (reference here), some of NZIER's costs may be overestimated due to assumptions about behaviour change that are inconsistent with the definition of medium needs. Specifically, NZIER estimated[15] increases in the use of paid disability services by medium needs people who are already receiving minimal care.

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[15] Revised NZIER, paragraph 62, p. 21, and appendix table 1, p. 30.

**Table 3: Number of disabled people by age, severity of disability, and the level of formal care received**

| Age | Severity of disability | Amount of formal care | | | | Total receiving formal care | Total with disability | % receiving formal care | % receiving no formal care |
|---|---|---|---|---|---|---|---|---|---|
| | | None | Minimal | Home-based | Residential | | | | |
| Children | Low | 31,798 | 3,902 | | | 3,902 | 35,700 | 11% | 89% |
| | Medium | 34,638 | 4,262 | 300 | | 4,562 | 39,200 | 12% | 88% |
| | High | 8,639 | 1,061 | 2,900 | 91 | 4,052 | 12,691 | 32% | 68% |
| | Total | 75,075 | 9,225 | 3,200 | 91 | 12,516 | 87,591 | 14% | 86% |
| 15-44 | Low | 43,997 | 4,203 | | | 4,203 | 48,200 | 9% | 91% |
| | Medium | 31,855 | 3,045 | 600 | | 3,645 | 35,500 | 10% | 90% |
| | High | 9,585 | 915 | 2,300 | 4,853 | 8,068 | 17,653 | 46% | 54% |
| | Total | 85,437 | 8,163 | 2,900 | 4,853 | 15,916 | 101,353 | 16% | 84% |
| 45-64 | Low | 40,181 | 3,119 | | | 3,119 | 43,300 | 7% | 93% |
| | Medium | 45,745 | 3,555 | 2,397 | | 5,952 | 51,697 | 12% | 88% |
| | High | 9,283 | 717 | 2,003 | 4,473 | 7,193 | 16,476 | 44% | 56% |
| | Total | 95,209 | 7,391 | 4,400 | 4,473 | 16,264 | 111,473 | 15% | 85% |
| 0-64 | Low | 115,976 | 11,224 | | | 11,224 | 127,200 | 9% | 91% |
| | Medium | 112,238 | 10,862 | 3,297 | | 14,159 | 126,397 | 11% | 89% |
| | High | 27,507 | 2,693 | 7,203 | 9,417 | 19,313 | 46,820 | 41% | 59% |
| | Total | 255,721 | 24,779 | 10,500 | 9,417 | 44,696 | 300,417 | 15% | 85% |
| 65+ | Low | -227 | 19,527 | | | 19,527 | 19,300 | 101% | -1% |
| | Medium | -278 | 29,378 | 2,900 | 1,518 | 33,796 | 33,518 | 101% | -1% |
| | High | -35 | 9,735 | 2,700 | 9,731 | 22,166 | 22,131 | 100% | 0% |
| | Total | -540 | 58,640 | 5,600 | 11,249 | 75,489 | 74,949 | 101% | -1% |
| Total | Low | 115,749 | 30,751 | 0 | 0 | 30,751 | 146,500 | 21% | 79% |
| | Medium | 111,960 | 40,240 | 6,197 | 1,518 | 47,955 | 159,915 | 30% | 70% |
| | High | 27,472 | 12,428 | 9,903 | 19,148 | 41,479 | 68,951 | 60% | 40% |
| | Total | 255,181 | 83,419 | 16,100 | 20,666 | 120,185 | 375,366 | 32% | 68% |

## 4.4. COMMENTS ON ASSUMPTIONS AND COSTS

52. My comments on the assumptions of the past analyses follow the same cost areas used by NZIER and Easton:
    A. Disabled people who switch from formal carers to family carers.
    B. Disabled people who switch from residential care to home care.
    C. Family carers seeking payment where the disabled person receives formal and family care.
    D. Family carers seeking payment where the disabled person receives minimal or no formal care.

53. Each area is introduced with a summary of my comments, followed by further detail. The costs depend on the policy design. For this reason, I do not provide conclusive estimates in this section.

### 4.4.1. DISABLED PEOPLE WHO SWITCH FROM FORMAL CARERS TO FAMILY CARERS

54. I agree with NZIER and Easton that the costs of this will be negligible or negative (cost saving). This change involves people switching from formal carers to family carers who are paid at a lower rate.

55. The degree to which this cost area is cost-saving depends on how much lower the family carer rate is. [redacted]

Redactions made under s(9)(2)(ba)(ii) of the Official Information Act 1982 to protect information which is subject to an obligation of confidence

56. There may be higher administrative and monitoring costs depending on the policy design, but the overall cost change is likely to be negative

57. Further information, particularly about administrative and monitoring costs, could be obtained from ACC. Information from ACC suggests[17] that intensive monitoring may not be necessary as family care is on average as good – probably better –than formal care.

### 4.4.2. DISABLED PEOPLE WHO SWITCH FROM RESIDENTIAL CARE TO HOME CARE

58. NZIER and Easton have very different assumptions about the costs of people switching. I come to the same conclusion as Easton about the costs – that they are negligible – but for different reasons. I consider that a lower rate than NZIER assumes would likely be paid[18], and that fewer hours would be claimed than NZIER assumes. Both wages and eligibility can be set in policy, however. Therefore, in later chapters I will look at policy options that pay a higher rate. Additionally, if costs look to be more than government is willing to spend, I can look at what effect adjustments to eligibility might have.

59. This cost area needs particular review as it is not explicitly included in my model.

**NZIER**

60. NZIER created several scenarios for the amount of family care people who leave residential facilities will need. NZIER's preferred scenario was one based

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[16] http://www.acc.co.nz/PRD_EXT_CSMP/groups/external_providers/documents/faq/wpc109971.pdf.

[17] ACC reference here. Court determinations also refer to this.

[18] If a wage is paid, or the wage equivalent if the final policy is an allowance, grant or benefit rather than wage.

on costs of $315 per day and on eight hours of care a day plus overnight care[19]. The highest cost scenario costs $495 per day and provides sixteen hours of care a day plus overnight care.

61. These scenarios put the annual payment for family care per disabled person at $115,000 and $181,000 respectively per year. By comparison, the average cost of residential care is $45,000 for people aged 0 to 64, and $26,000 for those aged 65 and over[20]. NZIER attributed the difference in costs to economies of scale: residential carers look after more than one person.

62. NZIER assumed[21] the likelihood of different switching rates as:
    - 10% probability that 0% of residential clients switch to family care;
    - 20% probability that 10% switch;
    - 60% probability that 25% switch;
    - 10% probability that 50% switch.

63. Overall, NZIER expected that 22% of disabled people in residential care would switch to family care, with a cost of $88.4m per year.

### Brian Easton

64. Easton considers the expected costs will be negligible because the funding regime ultimately adopted in response to the Courts' decisions will be to allow people to offer family care if they are willing to do so at no higher than the cost of residential care.

65. Easton also offers views on other aspects:
    - Looking after people who would otherwise be in residential care is 'extremely demanding', such that the switching rate will be lower than assumed. Easton describes the 50% upper limit as 'unreasonably high'.
    - The $495 per day[22] ignores lower capital costs of home care.

### Comment

66. Easton's suspicion that the final policy might allow family care only if it costs no more than residential care might be a reasonable guess. However, there is other information which can help us understand this area and whether an explicit policy like the one Easton suggests is necessary.

67. There are two immediate sources of information that can help:
    - The compensation sought by the original plaintiff carers.
    - NZIER's cost distribution of formal home-based care which appears in the revised paper.

68. NZIER reports two payment rates – $16.59 and $22.50 per hour – and uses the higher $22.50 rate for its costs[23]. Ultimately, the payment rate is a matter of policy, but there are a number of things that suggest a lower rate should be used instead:
    - As Easton notes, NZIER's costs don't account for lower capital costs / overheads.

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[19] Using a payment rate of $22.50 per hour. Revised NZIER, p. 22.

[20] Revised NZIER, table 9, p. 13.

[21] Revised NZIER, appendix table 4, p. 33.

[22] Easton critiqued the original NZIER paper, where $495 per day was the main assumption, rather than the $315 figure in the revised NZIER paper.

[23] Revised NZIER, p. 22.

- The original plaintiffs have asked for about $16 to $17 per hour.
- [redacted]

**Comment [D5]:** Maybe include Bronwyn's inferred payment rate for exemptions, and the inferred payment rate for the DPB CSI.

69. I then checked the number of hours that might be claimed for[24].

70. Four of the larger claims are for contract board[25] and don't detail hours. Three claims were for $38,000 per year. One was for $28,000 per year. These amounts include formal care or other government assistance on top of the family care.

71. The three other claims involve 7.9 hours per day, 5.6 hours per day, and 4 hours per day. The claims were for $49,000, $34,000, and $22,000 per year respectively. It's unclear whether they used formal care in addition to the family care. If so, this should be added to the claim numbers for the purposes of this analysis.

72. The person receiving 5.6 hours per day was later transferred to residential care.

73. None of the original plaintiff caregivers has included sleep hours in their claim, which are included in NZIER's estimates. [redacted]

74. By comparison again, residential care costs average $45,000 for people aged 0 to 64, and $26,000 for those aged 65 and over.[26]

75. Some claims don't fully detail what type of care is claimed for, but most look like they include claims for personal care (eg clothing, bathing, toileting), rather than activities people would largely do anyway (house cleaning, shopping). Where an activity like home maintenance is claimed, it's where formal services were offered by government.

76. The important point is that informal carers will still be providing a reasonable level of care with a definition to be determined. For instance, house cleaning and shopping may only receive small compensation (or none) as much of that work would happen anyway. The same applies to overnight care, which may explain why this is not claimed – the actual work done overnight, eg toileting might be above a reasonable level, but the sleep section may not be. This differs from residential care where these services and time are additional, and which carers are paid for.

77. I further checked the costs by looking at NZIER's formal costs constructed from Ministry and DHB data, and Statistics New Zealand's *Disability and Informal Care in New Zealand in 2006* report.

78. NZIER reports the distribution of costs of formal care by quintile[27]. The distribution, reproduced below, shows that the highest 20% of costs average $23,000.

**Figure 3: Average cost, by quintile, for all ages**

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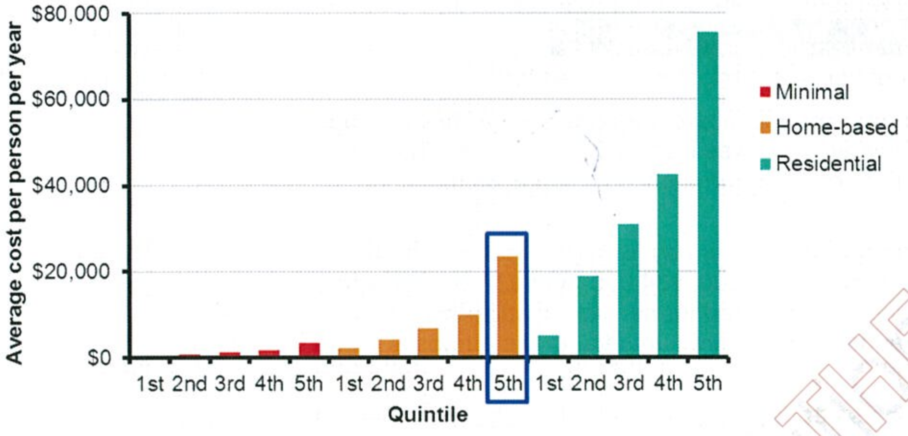
[24] S Warburton, 2012, 'original plaintiffs' sheet of *Revising the Costs*.

[25] The High Court noted that contract board 'is a service where a disabled person moves in with a family that is different from the disabled person's own family, and so generally applies to family environments that do not feature relatives. The service is primarily for people with an intellectual disability. Contract board families receive a reimbursement package to meet the costs of the individual that boards with them'. Judgment of Asher J, Ms J Grant MNZM and Ms P Davis, 17 December 2010, High Court of New Zealand, paragraph 18.

[26] Revised NZIER, table 9, p. 13.

[27] Revised NZIER, 2008, figure 3, p. 14.



79. Of the 16,100 people reported to have received formal homecare in the revised NZIER paper[28], 3,220 people are in the highest quintile. This quinitile likely includes many of those who might switch to residential care. Using Statistics New Zealand information, I estimate that there are about 2,200 people[29] with high needs receiving formal care every day, but receiving infrequent, if any, family care. People receiving daily formal care and little family care are likely to be at the higher end of home-based costs as, for those people without family supports, formal care must cover all needs.

80. My estimate of 2,200 people is quite close to the 3,220 in the highest (5th) quintile of home-based care costs. It seems likely, therefore, that the $23,000 above mostly reflects people receiving regular formal care and little family care. Thus, the $23,000 should be a reasonable indication of the cost of caring for people who switch from residential care. The cost will be less if family carers cost less per hour than formal carers.

81. I concluded that the true average cost of family care for disabled people who switch from residential care is likely to fall somewhere between $20,000 and $50,000[30]. The actual average cost may perhaps be at the lower end when we consider that the Statistics New Zealand and NZIER data include all affected people, and the claimants costs might bias upwards (the idea that those facing higher costs are more likely to take court cases).

82. Again, these costs are similar to average residential costs of $45,000 for people aged 0 to 64, and $26,000 for those aged 65 and over, or $39,000 for a weighted-average for all ages.

83. My conclusion, therefore, is that the cost of switching from residential to homecare is, at worst, negligible, and probably cost-saving, rather than NZIER's $88.4m per year.

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[28] Revised NZIER, table 6, p. 10, and table 7, p. 11.

[29] S Warburton, 2012, 'Revising the costs' (spreadsheet), original plaintiffs sheet. Estimate is scaled to reflect that NZIER appear to have included only about a half of all Health clients.

[30] There will be outliers for whom costs may be significantly higher than the average cost.

### 4.4.3. FAMILY CARERS SEEKING PAYMENT WHERE THE DISABLED PERSON RECEIVES FORMAL AND FAMILY CARE

84. I have no particular views on the likely costs of this area. I leave these estimates for my model.

85. This section summarises NZIER's and Easton's assumptions and results.

**NZIER**

86. NZIER stated that there 'are no data which can provide insight into the extent of use of unpaid carers by this group or the possible magnitude of the new demand for funding'[31].

87. NZIER put the likelihood of increased demand for paid care by people receiving regular formal care at[32]:
    - 5% probability of a 10% increase in demand;
    - 10% probability of a 25% increase in demand;
    - 15% probability of a 50% increase in demand;
    - 55% probability of a 75% increase in demand;
    - 15% probability of a 90% increase in demand.

88. Overall, NZIER expected that there will be a 61.5% increase in demand for paid care in this area, with a cost of $98.1m per year.

**Brian Easton**

89. Easton assumed that formal help doesn't provide sufficient care 10% of the time, such that current expenditure is 90% of what people would receive all they needed. Easton stated that 'the 10 percent [figure is] illustrative, and I would welcome a more precise figure'[33]. Easton calculated a cost increase of about $9.6m, but says that. The equivalent figure using NZIER's revised numbers is $15m.

**Comment**

90. The difference in assumptions between NZIER and Easton is quite large. Easton assumes a 10% increase in demand; NZIER assumes a 61.5% increase in demand.

91. Neither draw on evidence to inform the assumptions. Both were transparent about this.

92. There is a lot of information in the Statistics New Zealand document *Disability and* Informal *Care in New Zealand in 2006* and the Ministry of Health document *Living with Disability in New Zealand* from 2001. However, many assumptions would need to be made to make use of this information.

93. I, therefore, leave discussion of what an appropriate set of assumptions is for the next chapter.

### 4.4.4. FAMILY CARERS SEEKING PAYMENT WHERE THE DISABLED PERSON RECEIVES MINIMAL OR NO FORMAL CARE

94. I have no additional views on the likely costs of this area that haven't been raised earlier. I leave these estimates for my model.

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[31] Revised NZIER, paragraph 47, p. 17.

[32] Revised NZIER, appendix table 4, p. 33.

[33] Easton, paragraph 55, page 14.

95. This section summarises NZIER's and Easton's assumptions and results.

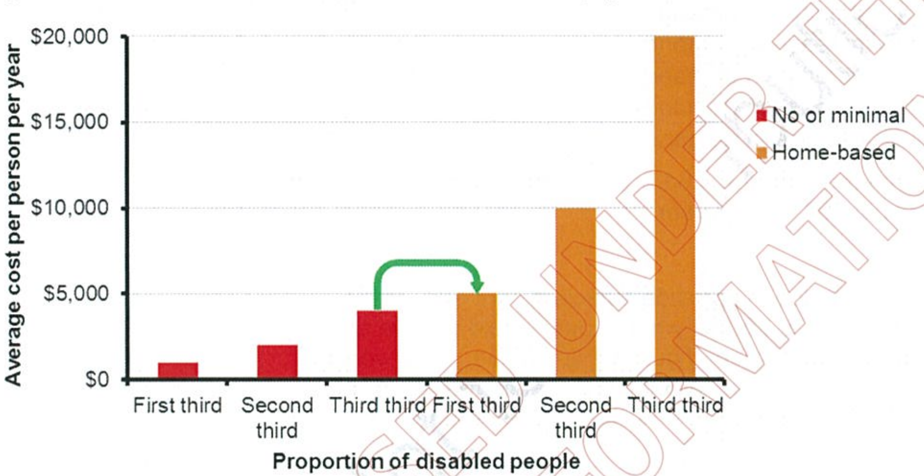
**NZIER**

96. NZIER estimated that there are 39,900 people with high needs[34] receiving minimal or no formal care.

97. NZIER constructed cost distributions within home-based care and within no-and-minimal formal care; distributions similar to those in Figure 3.

98. NZIER then estimated the cost increase by assuming that the one-third, for example, most-costly no-or-minimal formal care recipients increase their cost to the level of the one-third least-costly home-based care recipients. The sketch below illustrates the method.

**Figure 4: Sketch of NZIER's method where one-third seek payment**



99. In the sketch above, NZIER assumes that if a third of no-or-minimal care recipients take-up payment for family care, it is most-costly third of no-or-minimal care recipients. The new cost for these people is assumed to equal the cost of the lowest-cost third of home-based care recipients.

100. I note from NZIER's appendix table 4, that NZIER's costs increase at a faster-than-proportional rate as the percentage of people seeking payment increases. For instance, as 25 percentage points are added between 25% and 50%, costs for high needs people increase by $59.7m ($101.7 minus $42.0m). A further 25 percentage point increase from 50% to 75% causes costs to increase by $90.4m.

101. This is not an intuitive result, and is driven by how NZIER assumed current costs and new costs of those that take up payment. I illustrate the effect of this assumption on costs is illustrated in the sketch below. If, for example, one third of people take up payment, current costs are the highest one-third of no-or-minimal formal care recipients, and new costs are the lowest one-third of home-based care recipients (the cost increase shown by the green arrow). If, two thirds of people take up payment, the additional current costs are the middle third, and the additional new costs the middle third (the cost increase shown by the blue arrow).

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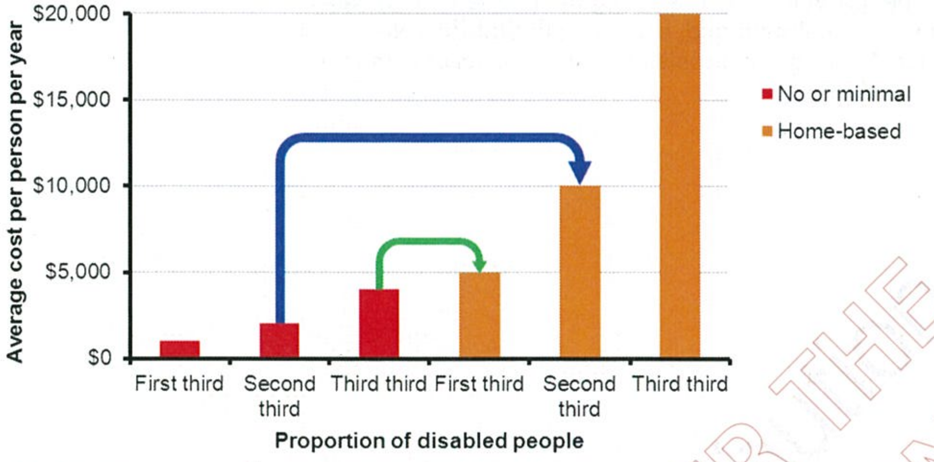
[34] Revised NZIER, table 2, p. 6.

**Figure 5: Sketch of NZIER's method where two-thirds seek payment**



102. NZIER assumed[35] that high needs people receiving no or minimal care would seek payment for care, but that only medium needs people who receive minimal care would do so as '[NZIER] suspect that they are receiving no external support more because their disabilities are not severe enough to qualify for home support than because it is their preference to be cared for by family members'[36].

103. NZIER put the likelihood of increased payment for people providing family care for each of the two groups above at[37]:
- 5% probability of 10% of people seeking payment;
- 5% probability of 25% of people seeking payment;
- 25% probability of 50% of people seeking payment;
- 55% probability of 75% of people seeking payment;
- 10% probability of 90% of people seeking payment.

104. Overall, NZIER expected that there will be a 64.5% of these high needs and medium needs people would seek payment for their family carers. NZIER's estimated cost increase was $340.5m per year[38]. Looking at NZIER's appendix table 1, approximately $102m per year of this is for medium needs people.

### Brian Easton

105. Easton used an assumption that government programmes are performing poorly if they only reach 75% of the targeted population. This leaves 25% of people who were not receiving paid care. Easton estimated the cost of this at $28.2m per year.

### Comment

106. I largely leave discussion of this cost area for later chapters about my model.

107. As I discussed in section 4.3, NZIER appear to have overestimated the number of people receiving no formal care or no paid family care.

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[35] Revised NZIER, paragraph 62, pp. 20-21.

[36] Revised NZIER, paragraph 60, p. 20.

[37] Revised NZIER, appendix table 4, p. 33.

[38] Revised NZIER, appendix table 4, p. 33.

108. I am unsure whether medium needs people should be included in the estimates as, by definition, they are people who do not need regular (home-based) care. They are already receiving ‘minimal’ care and, according to Statistics New Zealand definitions (section 4.2.1), this is consistent with the level of care they need.

# 5. Method

109. I identified two methods by which appropriate assumptions might be determined, and costs re-estimated.

## 5.1. ALTERNATIVE METHOD: CARER AND RESPITE SUPPORT

110. One way of estimating how many people might take up payment for family care is to consider how many people are receiving respite and carer support.

### What is respite and carer support?

111. Respite and carer support are two separate types of support provided by Health. Both are provided only to those people who qualify for DSS services (see section 4.2.2). Respite and carer support are intended to provide relief to carers.

112. Carer support involves the primary carer arranging for another carer, a friend for example, to care for the disabled person. That care can be provided in the disabled person's home, or another residence. The Ministry does not contract for carer support, and the payment is often only a subsidy with other parties having to pick up the remaining cost. To be eligible for carer support, carers must be providing four hours of care or more a day ('full-time'care).

113. Respite care involves the disabled person going to a setting outside of the home, for example, to a residential facility, another person's home, or to an activity in the community. In addition to providing relief to the carer, respite care sometimes gives the disabled person an experience they wouldn't normally receive at home. The Ministry contracts for respite care. Carers do not need to provide a minimum amount of care time to be eligible for respite.

114.

**Comment [D6]:** Number people receiving here.

115. DHBs may provide the equivalent of respite and carer support to for people they are responsible for and have disabilities not covered by DSS.

### Why might respite and carer support numbers help estimate the costs

116. People who access respite and carer support are those who are providing relatively significant amounts of care. It's reasonable to assume that, if these carers are prepared to apply for respite and carer support, they are also more likely than other carers to seek payment for the care they provide themselves.

### Difficulties with using this method

117. There are several difficulties with using this method.

118. First, as respite and carer support is provided only to carers of those with DSS-type disabilities, there will be people who are not counted in the above numbers. This is not a crucial difficulty as, using the analysis in section 4.3.2, a reasonable assumption might be to double the number of respite and carer support clients for a total estimate across all Health disabilities.

119. Second, as discussed in section 4.3.2, take-up of payment will be limited by the availability of MSD supports. It is difficult to estimate how take-up would be affected by this factor.

120. Third, and perhaps most crucially, as with the eligibility for MSD support in section 4.3.2, the definition of full-time care is broad. Full-time care includes care that might be provided irrespective of whether a disabled person was in the

home, for example, some household maintenance. That is, some of this care will be care that is deemed 'reasonable' under any policy.

121. Statistics New Zealand's *Informal Care in New Zealand in 2006* shows the frequency different types of care are accessed by disabled people in the home. However, constructing a reliable data set such that a reasonable estimate can be made of a generic policy option, let alone alternative options, is prohibitively difficult.

122. For these reasons, I have not adopted this method.

## 5.2. PREFERRED METHOD: ACC DATA

123. [redacted]

124.

125.

Comment [D7]: Include an example here.

### Summary of the method

126. With more time, I would have accessed the same original data NZIER used to construct its data sets, and used some of the same methods – the distribution of costs is very helpful – to construct my own data sets.

127. Without the time to do that, I have, instead, amended NZIER's estimates, or chosen parts of NZIER's data sets that I think will better reflect the true data.

128. I take these amended data sets of expenditure and client numbers for formal care, and compare them to ACC's. [redacted] I have been able to estimate how the distribution of paid care will shift from entirely formal care to a mix of paid formal and paid family care.

129. The method is fairly complicated, but has the advantage of being based on the actual experience of a service that is similar to Health's, operating alongside MSD's supports for carers.

# 6. Costs of an ACC-equivalent option

130. I use selected data and amended data from the DSS data sets NZIER constructed, and ACC data to estimate costs to Health. I largely use the same cost areas as NZIER and Easton did (section 4.4), except that minimal and home-based care are combined, rather than minimal and no care. I do this because ACC data only reports how many people received care and, without individual data, there is no way to fully replicate NZIER's method. In this chapter, I call these areas 'choice of care' or 'care choices'.

131. Although it is not possible to report final results by individual care choices, I use these choices to generate intermediate results. I report these intermediate results before using them to generate final costs.

132. This chapter details the method and results for an ACC-equivalent option, that is, what the estimated costs to Health are if services for disability had eligibility criteria and payment rates equivalent to ACC's. Different options are estimated in chapter 7.

133. There is uncertainty in many of the assumptions of the model. The sensitivity of results to different assumptions are tested in chapter 8.

## Care choices

134. I assume that it is high needs people who may choose to take up payment for family care. If low and medium needs are among those that take up payment, then the magnitude of some of the cost changes estimated in this chapter will be lower.

135. I assume that low and medium needs will not take up more paid care for the reasons outlined in sections 4.3.4 and 4.4.4.

**Main assumption 1**: It is high needs people, not medium-and-low needs, who may choose to take up payment for family care.

136. The assumed care choices modelled are outlined in table 4:

**Table 4: Care choices**

| Category | Choice of paid if family carers are not paid | Choice of paid care if family carers are paid |
|---|---|---|
| A | Formal care | Formal care only |
| B | Formal care | Family care only |
| C | Formal care | Formal and family care |
| D | No paid care (unpaid family care only) | Family care only |
| E | Residential care | Family care only |
| F | Residential care | Residential care |

137. Choice A involves some people who are currently receiving formal care continuing to receive paid formal care only. This might be for several reasons. Some people have no family supports, or family members are unwilling to provide care. Other times, family members may be providing care, but at low levels such that it's not worth their time to apply for payment.

138. Choice B involves some people who are currently receiving formal care opting to entirely substitute formal care for family care. These people may or may not currently be receiving family care.

139. Choice C involves some people who are currently receiving formal care opting to receive some paid care from family members. These family members may already provide this amount of care, or provide more care as a result of the policy. People may substitute some of the formal care for family care.

140. Choice D involves all people who are currently receiving only family care taking up paid family care. My model assumes that all high needs people take up some form of paid homecare. If, in reality, some high needs people do not take up some form of paid homecare, then my model overestimates the true cost in this regard. This may be the case as the definition of high needs is people who need care every day. This care may be of low intensity, requiring little time, or involve tasks that the family carer would do largely irrespective of whether there was a disabled person in the house. In these situations, carers might decide to not claim payment. In any case, this assumption is relaxed after the intermediate results are generated.

141. It should be noted that choice D involves people choosing to take up only paid family care. This is assumed because these high needs people are already receiving family care (high needs people need some care every day; if it's not formal care, it must be family care). If these high needs people also needed formal care, it seems likely that they would be accessing it already. There is at least one situation where this might not be the case. People may want formal care, but only at such a low level that it's not worth the hassle of making the application and getting the needs assessment. Where payment for family members is available, in applying for that, families may also apply for formal care; the idea that while applying for family care, they might as well apply for formal care. Nevertheless, the level of formal care will be low such that a simplifying assumption that people are receiving only family care should be a good approximation of reality.

142. Choice E involves some people choosing family care over residential care. Some people end up in residential care after their family gets to a point where they can't carry on with the resources they have. With payment, families some families will be able to continue caring, at least for a period of time. This choice includes people who would, absent a policy to pay family carers, be in residential care, and for a period immediately following the introduction of that policy, involve a switch of some of those people currently in residential care.

143. An alternative choice is that some people choose a mix of family and formal care instead of residential care. This is left for the sensitivity analysis.

144. Choice F involves people remaining in residential care, perhaps for similar reasons as those in choice A.

### MSD supports

145. Choices to take up paid care from Health are impacted by other options being available. In particular, people can receive payment from MSD in the form of the Domestic Purposes Benefit – Care of the Sick and Infirm, the Invalid's Benefit, and the Sickness Benefit (section 4.3.1). People may choose to continue receiving those benefits as, for instance, they may be eligible for more funding from MSD supports than under Health services. Using ACC's data allows us to account for this effect.

146. Similarly, where people take up payment from Health, they may previously have been receiving MSD supports. MSD supports are income-tested, thus if people take up enough payment from Health, MSD supports begin to abate. I estimate these cost savings to MSD.

**Differences between ACC and Health**

147. There are three major differences between ACC and Health. The model accounts for both of these differences.

148. First, Statistics New Zealand information shows that of those people with disabilities, people with injuries due to accident or injury are more likely to have medium to low needs than high needs, as compared to disabilities that Health are responsible for.

149. Second, ACC operates an entitlement-based system. That is, budget constraints are not a determining factor in the amount of care people are eligible for. Health is budget-constrained; if not for caps on the total amount of money available people would receive more paid care.

150. Third, as section 6.2 will show, there are very few high needs children with disabilities caused by accidents. I have, therefore, constructed two models. One for adults in which many assumptions can be estimated directly using ACC's data, and one for children in which` we may want to assume a quite different set of assumptions.

## 6.1. CONSTRUCTING THE ACC DATA

[redacted]

[redacted]

152. The National Serious Injury Service (NSIS) is part of Home and Community Support Services (HCSS). The NSIS covers those people with 'catastrophic injury'[40], such as multiple amputees. The average costs of these clients are many times average cost of a person in the top quintile of home-based DSS care.

153. Ministry advice[41] is that any Health policy would have people with equivalent needs cared for in residential or hospital settings, rather than by formal or family care in the home. For this reason, I have subtracted NSIS clients from the total number of HCSS clients.

154. I also subtracted those clients under the 'none' column.

[redacted]

156. [redacted] We are interested in cost changes with different family payment rates. Therefore, I created second version of table with family care costs scaled up to reflect what costs would be if family carers were paid the same rate as formal carers.

157. In reality, changes in the family payment rate will affect the choice of family care and family care, but not overall take-up as people only get payment if eligible and I have assumed that all high needs people access formal and/or family care. The ACC data cannot help[45] inform assumptions about substitution between family and formal care. I test the impact of substitution in sensitivity analysis.

158. In 2010, ACC introduced its 'reasonableness' policy. [redacted] I can get an indication of the impacts of a reasonableness policy versus a policy that pays for all needs irrespective of whether that care could be reasonably expected to be provided or not.

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[40] http://www.acc.co.nz/making-a-claim/how-do-i-make-a-claim/ECI0012.

[41] Sally Maclean

[42] Cells A65:I69 of the 'ACC method – adults' sheet of *Revising the Costs*.

[43] http://www.acc.co.nz/PRD_EXT_CSMP/groups/external_providers/documents/faq/wpc109971.pdf.

[44] Withheld due to commercial sensitivity.

[45] Perhaps with data for more years.

## 6.2. PREVALENCE OF DISABILITY

159. The next step is to estimate how many of ACC's clients are high needs, medium needs, and low needs. I used two methods for this.

160. The first method involved combining of public information about the causes of main disabilities from Statistics New Zealand's 2006 and 2001 disability surveys. Those calculations estimated that there are 12,718 adults[46] with disabilities caused by accident and injury.

161. This method generated estimates of the numbers of people with Health disabilities that were higher – 13% higher in the case of high needs adults – than those reported in NZIER's papers[47].

162. The second method involved using NZIER's data on the number of people with high needs, medium needs, and low needs. This data was made to order by Statistics New Zealand, but it's unclear how it excluded those with disabilities caused by ageing and accident. Because the data excludes accident *and* accident, some estimates still need to be made.

163. Statistics New Zealand's *Disability and Informal Care in New Zealand in 2006* reports an estimated 12,800 high needs children[48], and 67,200 high needs adults[49], in households.

164. According to table 2 of the revised NZIER report, there are 12,600 children with high needs not due to ageing or accident. Children do not have ageing disabilities, which means that the remaining 200 high needs children have accident disabilities.

165. Table 2 also reports 39,900 high needs people receiving no or minimal formal care, and 9,900 high needs people receiving home-based formal care. Subtracting the 12,600 children leaves 37,200 high needs adults. The reaming 30,000 high needs adults includes those with disabilities caused by ageing and those caused by accident.

166. There is little public data that can inform the shares of that 30,000, but from my first method, my calculations suggest that about half of these 30,000 may have disabilities due to accident[50].

167. The first methods suggest about 13,000 high needs adults with accident disabilities. The second method suggests about 15,000. I use the 13,000 figure as my assumption and test the 15,000 figure in the sensitivity analysis.

**Main assumption 2**: There are 13,000 high needs adults with disabilities caused by accident.

168. The final estimates are detailed in table 8.

**Table 8: Number of high needs people in households by cause of disability**

| High needs people | Not ageing or accident | Ageing | Accident | Total | Total Health |
|---|---|---|---|---|---|
| Children | 12,600 | 0 | 200 | 12,800 | 12,600 |

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[46] Cell AA45 of the '2006 info' sheet of *Revising the Costs*.

[47] Cells Z33:AC36 of the '2006 info' sheet of *Revising the Costs*.

[48] Disability and Informal Care in New Zealand in 2006, p. 15.

[49] Disability and Informal Care in New Zealand in 2006, p. 11.

[50] [redacted] Cell AA45 of the '2006 info' sheet of *Revising the Costs*.

| | | | | | |
|---|---|---|---|---|---|
| Adults | 37,200 | 17,000 | 13,000 | 67,200 | 54,200 |

169. All of the NSIS clients are in this 13,000. Therefore, I subtract the number of NSIS clients from the 13,000. I call this number $HN_{2009}$.

170. In 2009 when [redacted] I assume that all high needs people received paid family or formal care. I take the total number of clients in 2009, $TN_{2009}$ from table 7, and subtract the 13,000 after subtracting the number of NSIS clients. This leaves the total number of medium-and-low needs clients[51], $HN_{2009} - TN_{2009}$.

## 6.3. TWO IMPORTANT ASSUMPTIONS

171. [redacted]

172. My first assumption is about how many people who would, in the absence of a policy to pay family carers, would be in residential care – care choice E. The opinion of the members of the Technical Advisory Group was that the number of residential clients would reduce by a maximum of 10%[52]. I assume 5%, and test different rates up to 10% in the sensitivity analysis.

**Main assumption 3**: 5% of high needs people who would be in residential care absent a policy to pay family carers, choose family care.

173. My second assumption is about the number of people receiving formal care substituting entirely to family care. The opinion of the members of the Technical Advisory Group was that 25% of people receiving formal care would switch to family care[53]. The Group's opinion was that these would include some people who have complex needs not well met by Health, and some people with few needs that were more conveniently done by a family carer than a formal carer. The effect of different percentages will be tested in the sensitivity analysis.

**Main assumption 4**: 25% of high needs people receiving formal care choose family care instead.

174. Both opinions were given in the context of family payment of about $15 to $16 per hour. The percentage of people choosing family care will depend on the rate of payment.

## 6.4. CHOICES OF CARE

175. Using the same two assumptions in section 6.3, I estimate the percentage of people that make each of the six choices in table 4. To calculate the effects of different aspects of policy, I start with the 2009 data. Choices of care are listed in the order they are calculated.

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[51] Cell B46 of the 'ACC method – adults' sheet of *Revising the Costs*.

[52] S Warburton, 2012, *TAG notes*, p. 3.

[53] S Warburton, 2012, *TAG notes*, p. 2.

### Total number of people receiving formal care pre-policy

176. [redacted] Of these, $BN_{2009}$ were receiving family care only. This leaves $HN_{2009} - BN_{2009}$ people who were receiving formal care.

177. This number is post-policy, so I scale it up to reflect the 25% that would have switched to family care. The number of high needs people receiving formal care if ACC did not have a policy to pay family carers is:

$$\frac{HN_{2009} - BN_{2009}}{0.75}$$

### Care choice B

178. 25% of those receiving formal care switch to family care. The number of people that are estimated to switch from formal care to family care is:

$$0.25\left(\frac{HN_{2009} - BN_{2009}}{0.75}\right)$$

### Care choice C

179. The number of people receiving formal care who opt to receive some paid care from family members can be found by inspecting table 7:

$$CN_{2009}$$

### Care choice A

180. The number of people receiving only formal care who continue to receive only formal care is found by subtracting the numbers under choice A and C from the total number of people that would have received formal care without the policy:

$$\frac{HN_{2009} - BN_{2009}}{0.75} - 0.25\left(\frac{HN_{2009} - BN_{2009}}{0.75}\right) - CN_{2009}$$

181. A simplified version of that formula is:

$$HN_{2009} - BN_{2009} - CN_{2009}$$

### Care choice E

182. IF $RN_{2009}$ is the number of residential clients ACC has, then $\frac{RN_{2009}}{0.95}$ is the number of residential clients ACC is estimated to have absent a policy that pays family carers. The number of people who choose family care over residential care is:

$$0.05\left(\frac{RN_{2009}}{0.95}\right)$$

### Care choice F

183. The number of people who remain in residential care is:

$$RN_{2009}$$

### Care choice D

184. The number of people receiving unpaid family care who take up paid family care is found by subtracting the total number of people who receive formal care absent a policy to pay family carers, and the number of people who switch from residential care to family care, from the total number of high needs people:

$$HN_{2009} - \frac{HN_{2009} - BN_{2009}}{0.75} - 0.05\left(\frac{RN_{2009}}{0.95}\right)$$

### Overall

185. Although I can't [redacted] due to commercial sensitivity, in table 9 I report the percentages of people who make each care choice.

**Table 9: Percentages of high needs people who make each care choice**

| Category | Choice of paid if family carers are not paid | Choice of paid care if family carers are paid | Number of people | Percentage of people who would receive formal care without the policy | Percentage of high needs people in homes with the policy |
|---|---|---|---|---|---|
| A | Formal care | Formal care only | $HN_{2009} - BN_{2009} - CN_{2009}$ | [redacted] | [redacted] |
| B | Formal care | Family care only | $0.25\left(\frac{HN_{2009} - BN_{2009}}{0.75}\right)$ | [redacted] | [redacted] |
| C | Formal care | Formal and family care | $CN_{2009}$ | [redacted] | [redacted] |
| D | No paid care (unpaid family care only) | Family care only | $HN_{2009} - \frac{HN_{2009} - BN_{2009}}{0.75} - 0.05\left(\frac{RN_{2009}}{0.95}\right)$ | [redacted] | [redacted] |
| E | Residential care | Family care only | $0.05\left(\frac{RN_{2009}}{0.95}\right)$ | [redacted] | [redacted] |
| F | Residential care | Residential care | $RN_{2009}$ | [redacted] | [redacted] |

186. For example, of [redacted] of them are estimated to seek no paid care – only unpaid family care – without the policy to pay family carers.

## 6.5. COSTS WITH AND WITHOUT A POLICY TO PAY FAMILY CARERS

187. In section 6.4, I estimated the number of people accessing different types of care with and without a policy to pay family carers, by people's care choice.

188. The next step is to estimate the average costs per person by care choice with and without the policy to pay family carers. In section 6.7, I will use the percentage change in costs per person estimated in this section, and the estimates of the percentage of people for each care choice from table 9, to estimate the costs to Health of an ACC-equivalent option.

189. Average costs per person with a policy can be found by dividing the costs in table 7 by the numbers of people in table 7. It is more difficult to estimate the average costs per person without a policy.

### 6.5.1.COSTS WITHOUT A POLICY TO PAY FAMILY CARERS

190. Because [redacted] – I have to estimate it.

**Numbers receiving formal care**

191. I estimated the numbers of [redacted] people in section 6.2. In 2009, the 'without policy' scenario has $HN_{2009} - TN_{2009}$ number of medium-and-low needs people receiving formal care. The number of high needs people receiving formal care is:

$$\frac{HN_{2009} - BN_{2009}}{0.75}$$

**Average costs**

192. My calculations[54] suggest that the [redacted] other causes. An alternative explanation is that I omitted too many people from the calculations when I removed NSIS clients; that some of the less costly people with NSIS-equivalent disabilities would receive home care within Health's services. I will investigate this second possibility at a later time.

193. Nevertheless, I use an assumption that, whatever the actual level of payment for high needs people and medium-and-low needs people, the ratio of the average cost of high needs people to the average cost of medium-and-low [redacted]

**Main assumption 5:** [redacted]

194. I use selected and amended NZIER data about DSS clients to estimate the average costs to Health. [redacted] 8), I omit DSS clients who are children. Also, as NZIER appear to have made an error in allocating the number of clients aged 65 and over, I omit these clients. I, therefore, only use NZIER data for those aged 15 to 64 years old[55], and assume that the averages are true for those aged 15 and above. I include people receiving any amount of formal care: home-based or minimal care.

195. Table 10 shows the data.

**Table 10: NZIER's DSS costs by level of need**

| Level of need | Number of clients aged 15 to 64 | Total cost | Average cost per person |
|---|---:|---:|---:|
| Low | 7,322 | $5,122,081 | $700 |
| Medium | 9,597 | $23,446,020 | $2,443 |
| Medium-and-low | 16,919 | 28,568,101 | $1,689 |
| High | 5,935 | $60,963,175 | $10,272 |

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[54] 'ACC method – adults' sheet of *Revising the Costs*.

[55] Cells C110:F115 of the 'ACC method – adults' sheet of *Revising the Costs*.

196. Data from the *2001 Disability Survey* suggests that [redacted] After making this adjustment[57], the average costs are:

**Table 11: Adjusted average DSS costs**

[redacted]

197. Finally, as discussed in section 4.3.3, NZIER does not appear to have included all Health clients in its data; only DSS. I assume that the average costs by level of need are the same for non-DSS services.

### Comparing high needs to medium-and-low needs

198. Using table 11, I calculate that high needs people who receive formal care cost 6.06 times the cost of medium-and-low needs people who receive formal care.

**Main assumption 6**: For those who receive formal care absent a policy to pay family carers, the ratio of the average cost of high needs people to the average cost of medium-and-low needs people is 6.06.

### Comparing high needs people who will choose B or C to those who choose A

199. I do not yet estimate the new cost of those who make care choices B or C, but those who will make those choices may have different formal care costs absent a policy, than those who make care choice A.

200. NZIER report in their revised paper[58], the distribution of costs for home-based care and minimal care by quintile and by level of need.

201. Unfortunately, NZIER's error in allocating the over 65s makes neither the home-based distribution or minimal distribution perfectly usable. The minimal care distribution will be particularly biased as it will include a number of people who are will be receiving home-based level care from non-DSS services.

202. NZIER's distributions also include children, [redacted]

203. I, therefore, select the best data set and crudely adjust it to account for these problems.

204. Table 12 shows NZIER's distribution of formal care costs for high needs clients for home-based care only.

**Table 12: NZIER's distribution of costs of high needs clients receiving home-based care**

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[56] Living with Disability in New Zealand: A Descriptive Analysis of Results from the 2001 Household Disability Survey and the 2001 Disability Survey of Residential Facilities, Ministry of Health, 2004, figure 2.29, p. 59. Also, cells AU67:AY69 of 'ACC method – adults' sheet of *Revising the Costs*.

[57] Cells J110:L115 and cells L103:N104 of the 'ACC method – adults' sheet of *Revising the Costs*.

[58] I have replicated NZIER's data in cells AN2:BC24 of the 'ACC method – adults' sheet of *Revising the Costs*.

| Quintile | Number of people | Average cost per person |
|---|---|---|
| 5th quintile (most costly 20%) | 1,981 | $27,900 |
| 4th quintile | 1,981 | $11,967 |
| 3rd quintile | 1,981 | $8,332 |
| 2nd quintile | 1,981 | $5,567 |
| 1st quintile (least costly 20%) | 1,981 | $3,307 |
| Total | 9,903 | $11,413 |

205. A crude adjustment to this data to better reflect the actual distribution I'm interested in – one that includes people aged 65 and over, and those receiving minimal care, and excludes children – is to scale the distribution such that the overall average of $11,413 is equal to the $10,272 average in table 11. The results of this scaling are in table 13. Table 13 also reports the relativity of the quintiles versus the overall average.

**Table 13: Adjusted distribution of high needs clients**

| Quintile | Average cost per person | Ratio of average cost per person to lowest quintile |
|---|---|---|
| 5th quintile (most costly 20%) | $25,107 | 8.44 |
| 4th quintile | $10,769 | 3.62 |
| 3rd quintile | $7,498 | 2.52 |
| 2nd quintile | $5,010 | 1.68 |
| 1st quintile (least costly 20%) | $2,976 | 1.00 |
| Total | $10,272 | 3.45 |

206. [redacted]

**Main assumption 7**: [redacted]

207. Figure 6 shows the shape of the assumed distribution of ACC's.

**Table 6: The assumed cost distribution of ACC's high needs formal care recipients**

[redacted]

208. Section 6.3 reported the Technical Advisory Group's view that those who switch will be some people with complex needs, and some people with few needs. Complex needs is not necessarily the same as those who currently cost the most as some of those peoples' needs will be met by family members. If those that make care choices B and C are the most costly people, a policy to pay family carers is cost-neutral even before accounting for lower payment rates to family carers and a reasonableness policy.

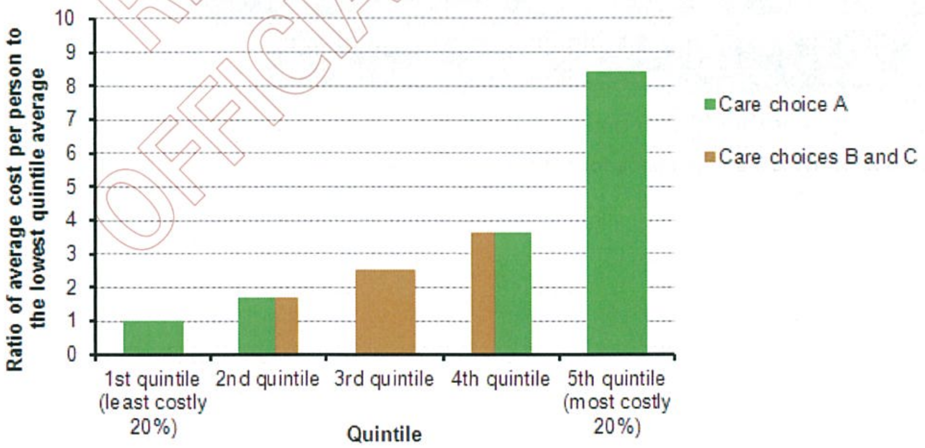
**Comment [SW8]:** This was true in an early version of the model. I need to check that it's true of later versions of the model.

209. I assume that the people who make care choices B and C come from the middle of this distribution.

**Main assumption 8**: The high needs people who substitute entirely to (care choice B), or take up payment for (care choice C), family care with a policy to pay family carers, come from the middle of the cost distribution of formal care.

210. For instance, table 9 shows that 36% of high needs people receiving formal care make care choices B or C. Twenty percentage points of that 36% are assumed to come from the 3rd quintile, with the remaining 16% being made up of eight percentage points from the 2nd quintile and eight percentage points from the 4th quintile. Figure 14 shows this graphically.

**Table 7: Which formal care recipients make which care choices**



211. Table 14 shows the average costs of those who eventually make care choices A, B, and C[59].

**Table 14: Average formal care costs by care choice**

| Care choice | Average cost per person |
|---|---:|
| Care choice A | $11,730 |
| Care choices B and C | $7,671 |
| Care choices A, B, and C | $10,272 |

212. Using table 14, I calculate that high needs people who make care choices B and C cost 0.65 times the cost of high needs people who make care choice A[60].

**Main assumption 9**: For those who receive formal care absent a policy to pay family carers, the ratio of the average cost of high needs people who substitute entirely to (care choice B), or take up payment for (care choice C), to the average cost of those who continue receiving formal care (care choice A) is 0.65.

### Comparing high needs people who will choose A to medium-and-low needs

213. Using table 14 and table 11, I calculate that high needs people who make care choice A cost 6.92 times the cost of medium-and-low needs people.

**Main assumption 10**: For those who receive formal care absent a policy to pay family carers, the ratio of the average cost of high needs people who continue receiving formal care (care choice A) to the average cost of medium-and-low needs people is 6.92.

### Average costs

214.

Important assumption is which high needs people shift. Probably not the most costly as that leads to an unlikely cost-neutral conclusion even before assuming a lower wage and a reasonableness policy. Also, as discussed in previous section, the highest cost are likely to include those people with no natural supports. Assuming, then, that it's the middle group that shift. Use NZIER's distribution for 15-64 year olds (similar to that in figure 3 - [redacted] are, and excluding over 65s due to NZIER's error in calculating that).

Can use NZIER's DSS total cost, NZIER's distribution of cost, and numbers that change and do not change to estimate the original cost of those that change and those that don't.

Also have the NZIER's DSS cost for medium and low needs people.

[redacted]

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[59] Cells L115:L117 of the 'ACC method – adults' sheet of *Revising the Costs*.

[60] Cell L115:L117 of the 'ACC method – adults' sheet of *Revising the Costs*.

Can use NZIER's DSS costs and my calculations to estimate ratios (relativities). List them.

Use the number of clients, the expected relative share of the costs, and the actual total cost of currently (in 2009) receiving formal care (high needs formal who stay put, and medium and low needs), to estimate the average cost of high needs formal who don't change. Use the other ratios to work out average cost of medium-low, and original average cost of those who change.

[redacted] groups. List those.

Can work out the ratios of the new cost to old cost for each of these groups

Will later use these ratios to work out cost increases for Health services.

## 6.6. CONSTRUCTING CURRENT HEALTH COSTS

As previously discussed, it looks like NZIER missed more than half of all Health clients with disability. If not, coverage rate is only 26%. [redacted]

Thus, first assumption is to take NZIER's numbers and say what if they were a bit more than doubled.

Also upped the number of high needs a bit to account for ageing disabilities

List estimated numbers of people by behaviour change.

Now using NZIER's DSS distribution of costs for all age groups but 65+ (excluding 65s due to their error; including children because we have non-negligible number of children).

Include numbers and cost table.

Separate costs by DSS and non-DSS (includes DSS 65+). Estimate of current numbers

Assume that because Health is budget-constrained, our expenditure would be higher if it was like ACC's entitlement system. Calculate expected expenditure.

Sum them for estimate of current Health expenditure

## 6.7. ESTIMATING THE INCREASE IN HEALTH COSTS

Use ratios from 6.5

New costs

Then adjust for lower wage

Then adjust for reasonableness

## 6.8. DISABLED PEOPLE WHO SWITCH FROM RESIDENTIAL CARE TO HOME CARE

## 6.9.

Final from 6.7 plus residential plus MSD

# 7. Alternative options

xxxx

## 7.1. XXXX

**Key Result:**

Xxxx:

- Xxxx.

## Appendix 1: Xxxx

### XXXX