

FEBRUARY 2019



Current state: the welfare system and people with health conditions or disabilities

BACKGROUND PAPER

Executive summary

The purpose of this paper is to provide information on people with work-limiting health conditions and disabilities in receipt of benefits, including the supports currently provided as well as the challenges with the system. The Government is committed to ensuring that all New Zealanders are earning, learning, caring or volunteering, and that where this is not possible people are able to live dignified lives.

Definitions of wellbeing, health, ill health and disability vary and have changed over time

There is no consensus on a single definition of wellbeing, but it is usually defined as a multidimensional concept. In its broadest sense, wellbeing encompasses physical, mental and social domains.

Ill health is caused by a range of social, economic, psychological and biomedical factors. These determinants not only affect individuals in contributing to ill health, but also generate highly patterned health differences in populations that reflect inequalities in society. Inadequate income (poverty) is linked to poor health outcomes, especially where it is long term.

Ill health and disability are not the same. While some disabled people have health problems associated with their disabilities, many do not. The United Nations Convention on the Rights of Persons with Disabilities has a broad definition of disability that encompasses physical, mental, intellectual and sensory impairments that may hinder people's full and effective participation in society on an equal basis with others.

The number receiving benefits for health conditions or disabilities is high and outcomes are poor

Life outcomes for people with work-limiting health conditions and disabilities are poor compared to those for the general population.

The proportion of people receiving benefits for health conditions or disabilities is high. Unemployment is often detrimental to wellbeing. Recipients of health and disability benefits now make up the largest group of working-age benefit recipients. The number of people on benefit with health conditions or disabilities is likely to be an underestimate, as we do not know the health status of people receiving non-health and disability benefits (e.g. Sole Parent Support benefit recipients).

The population on benefit for reasons of ill health or disability has changed. It has increased since the 1980s and proportionately more people now receive benefits for health conditions or disabilities because they have mental health conditions. People with mental conditions make up the largest proportion of people receiving the Jobseeker Support – Health Condition or Disability (JS-HCD) and Supported Living Payment (SLP) benefits. This is likely to be an underestimate as comorbidity is common and the Ministry of Social Development (MSD) often only reports on the primary incapacities listed on medical certificates. Musculoskeletal disorders are also common. Amongst those receiving SLP, a large proportion have intellectual disabilities or congenital conditions.

While some people with health conditions or disabilities do leave benefits, long-term receipts of benefits are common – especially amongst SLP recipients.

Drivers of the increase in people receiving benefits for health conditions or disabilities are varied. However, increases in adverse living conditions, labour market changes and policy responses have contributed to this growth.

There are differing levels of financial assistance for people with work-limiting health conditions and disabilities across the social sector

MSD, the Ministry of Health (MOH) and the Accident Compensation Corporation (ACC) all work in a shared health and disability sector, delivering support and services to a sometimes shared recipient base. The three agencies have very different incentives and purposes.

- MOH funds health services and has broad health and social priorities that do not include employment.
- MSD provides means-tested financial and other support as appropriate to help people to support themselves and their dependants while not in paid employment – including where this is because they have health conditions or disabilities. Decisions about eligibility for both SLP and JS-HCD are underpinned by medical assessments and the individual's relationship status. Some people with work-limiting health conditions and disabilities miss out on income support from ACC and MSD (e.g. those who develop health conditions or disabilities not related to accidents but have earning partners).
- ACC operates as a levy-based income protection scheme for personal injury, which provides compensation for lost earnings in return for the loss of the right to sue. ACC provides both income support and rehabilitation to its recipients. Eligibility is not affected if they have earning spouses. People in employment at the time of their accidents receive up to 80% of their pre-injury incomes. ACC has no obligation to pay loss-of-income support (weekly compensation) to people not working in paid employment at the time of disabling accidents. The amount of financial assistance that people may receive from ACC is usually higher than that provided by MSD for the same level of incapacity.

Having health conditions or disabilities imposes extra costs on individuals. Calculating the costs of a health condition or disability is difficult. There is no agreed way of calculating it. In New Zealand various agencies provide financial assistance to compensate for the additional cost of having a disability. The system involves multiple agencies, is complex for people with health conditions and disabilities to navigate and is not user centred.

More could be done to support returns to work for people with work-limiting health conditions and disabilities

Suitable work appears to be good for wellbeing, but there is no one-size-fits-all return-to-work intervention. New Zealand, along with other Organisation for Economic Co-operation and Development (OECD) countries, has struggled to support people on health and disability benefits successfully into work.

There are various reasons for New Zealand having had limited success in getting people with work-limiting health conditions and disabilities into work.

- In New Zealand, spending on active labour market programmes is low and it is lower for recipients of health and disability benefits than it is for other groups of working-age benefit recipients.
- New Zealand spends very little on supported employment and vocational rehabilitation compared to other OECD countries. Such interventions focus on integrating health and employment support and are more effective in returning people with work-limiting health conditions and disabilities to work.
- There is a lack of early intervention in the welfare system for people with work-limiting health conditions and disabilities. Unlike ACC, MSD and MOH do not have a vocational rehabilitation focus on people with health conditions and disabilities.

- As part of the last round of welfare reforms there were changes to assessment processes for recipients with health conditions or disabilities, but it is unclear how effective they have been. Assessment processes are not routinely linked to evidence-based return-to-work supports.
- The take-up of mainstream employment supports appears to be lower for people with work-limiting health conditions and disabilities receiving benefits than others.
- Case management is the intervention most commonly offered to people with health conditions or disabilities, but there is only limited evidence of its effectiveness for this group of people.
- There is a lack of support for people with work-limiting health conditions and disabilities to engage in part-time work.
- There is a lack of specific interventions at scale targeting those with common health conditions or disabilities on benefits.
 - Return-to-work support for people with mental health conditions is insufficient. There are too few publicly available mental services for people with common mental health conditions. There are effective approaches available that, if funded, could improve health and employment outcomes. Improving access to psychological therapies is likely to be beneficial. There is limited coverage of such interventions to assist people with mental health conditions into work (Government Inquiry into Mental Health and Addiction, 2018; OECD, 2018). MSD is trialling evidence-based interventions such as Individual Placement Support, and these may inform future services if shown to improve outcomes for people with mental health conditions.
 - Return-to-work support for people with musculoskeletal conditions is insufficient.
 - There is very little support to assist people in receipt of SLP, including people with learning disabilities, into work. The Supported Living Payment Opt-In service is a useful way forward.
- A greater focus on the role of employers in supporting people with work-limiting health conditions and disabilities into work is needed.

Across the social sector there is a limited focus on preventing unemployment arising from health conditions:

- There is a lack of early intervention to retain people in employment once they develop health conditions.
- Preventing ill health and disability and lessening the severity of their impacts could reduce the number of people needing to claim health and disability benefits. More needs to be done to promote wellness and prevent ill health in young people and in workplaces.

There is a need to improve outcomes of those who are likely always to require assistance from the welfare system for all or most of their income due to health conditions or disabilities

The welfare system faces a number of challenges in this area:

- Beyond providing income support, MSD's role in improving the life outcomes of those who are likely always to require assistance from the welfare system due to health conditions or disabilities is unclear.
- The need for intensive, long-term support for people with work-limiting health conditions or disabilities is increasing.

- Disabled people and their families and whānau¹ have sought a more responsive disability support system for some time.
- The cost of the current system is high to Government and not delivering good outcomes for recipients.
- The development and implementation of evidence-based interventions to improve the wellbeing of those who are assessed as not being able to work have been limited. Funding for providers has changed little in over a decade. In terms of what MSD funds, evidence of what is working is limited.
- Some people are poorly served in terms of supports and services to support social inclusion (e.g. people with severe mental illnesses, people with significant neurodevelopmental disorders including intellectual disabilities, and those with few natural supports).

Other government reviews may also assist people on benefits with health conditions and disabilities

The reviews of the health and disability system and mental health and addictions may:

- improve access to primary and secondary care for adults and children on low incomes
- improve support for young people and adults with health conditions or disabilities to participate in suitable work
- better support the wellbeing of people with health conditions and disabilities and carers reliant on financial assistance from the state.

The OECD's review of mental health and employment services in New Zealand examined how policies were performing in fostering the labour market inclusion of people with mental health conditions. This review, jointly commissioned by MSD and MOH, concluded there was significant scope for improvement (OECD, 2018).

Key questions

1. What is the role of the welfare system in providing financial support to people with ill health or disabilities? To what extent and how should the Government address the differential treatment of people with ill health or disabilities across the social sector?
2. What is the role of the welfare system in assisting people with the additional costs of ill health or disability? How can accessing support be made easier?
3. How could people with work-limiting health conditions and disabilities relying on the welfare system be better supported to engage in work? Who should provide this support?
4. What role does the welfare system have in preventing ill health and disability and lessening the severity of their impacts to reduce the number of people needing to claim health and disability benefits?
 - What role does the welfare system have in supporting people with work-limiting health conditions and disabilities to remain in work?
 - What role does the welfare system have in supporting them to stay well?
5. What is the role of the welfare system in supporting the wellbeing of people who always require assistance from the welfare system?

1 In this paper the terms used are 'disabled person and their whānau' or 'disabled people and their whānau' because 'whānau' is able to cover the diverse range of family (both kinship based – immediate or extended – and kaupapa/subject based where there is a shared common bond, other than descent, with similar values as kinship based). 'Whānau' can also serve reasonably to refer to the Pacific values and family structures of āiga and kainga. In addition, 'disabled person' covers all ages including children and young people.

Contents

Executive summary	02
Contents	06
Purpose of the paper	09
Definitions of wellbeing, health, ill health and disability vary and have changed over time	09
Part 1: Characteristics of the population on benefit with health conditions and disabilities	10
Life outcomes for disabled people are poor compared to the general population	10
The number of people on benefits with health conditions or disabilities is high	10
The population on benefits for reasons of ill health or disability has changed.	12
More have mental health problems	
Other conditions are also common	17
Musculoskeletal disorders are also common	17
Many SLP recipients have intellectual disabilities and congenital conditions	17
Current pathways on and off health and disability benefits	18
What has driven the rise in people claiming health and disability benefits?	20
Growth in the number of people with chronic conditions is only part of the explanation	20
Labour market changes appear to have contributed to some of the growth in receipt of health and disability benefits	20
Policy approaches have contributed to growth in the number on health and disability benefits	22
Other reasons have played only a limited role in growth in New Zealand	23
Part 2: Financial assistance for people with work-limiting health conditions and disabilities	24
MSD provides means-tested financial assistance for people with health conditions or disabilities	24
MSD provides a lower level of income support than ACC in most cases	27
Some people with work-limiting health conditions and disabilities miss out on income support from ACC and MSD	30
ACC provides income support for earners incapacitated as a result of accidents	31
Additional assistance to address the costs of having health conditions or disabilities	34
Health conditions and disabilities impose extra costs on individuals who have them, but determining the amount is difficult	34
Several agencies provide financial assistance to compensate for the additional costs of having a disability	37
MSD provides assistance to cover the costs of disability	38

Part 3: Supporting return to work	42
Supporting return to work	42
Unemployment is detrimental to wellbeing	42
Suitable work appears to be good for wellbeing, but there is no one-size-fits-all return-to-work intervention	42
All OECD countries have struggled to reduce numbers on health and disability benefits	43
Reasons for limited success in returning people with work-limiting health conditions and disabilities to work	44
Spending on active labour market programmes for people with work-limiting health conditions and disabilities is lower than for other groups of working-age benefit recipients	44
New Zealand spends very little on supported employment and vocational rehabilitation compared with other OECD countries	44
There is a lack of early intervention in MSD for people with work-limiting health conditions and disabilities	46
It is unclear how effective changes have been to MSD assessment processes for recipients with health conditions or disabilities	47
The take-up of mainstream employment support appears to be lower for people with work-limiting health conditions or disabilities receiving benefits	47
Case management is the intervention most commonly offered to people with health conditions or disabilities, but there is only limited evidence of effectiveness for this group	48
There is a lack of support to engage in part-time work	49
Return to support for people with mental health conditions	50
There is a lack of specific interventions targeting those with other common health conditions or disabilities on benefits	51
A greater focus on employers is needed	53
Across the social sector there is a limited focus on preventing unemployment due to ill health	53
There is a lack of early intervention to retain people in employment once they become unwell	53
Prevention of ill health and disabilities could limit the number of people who need to claim health and disability benefits	53
Other Government reviews may lead to improvements for people with health conditions and disabilities who are on benefits	55

Part 4: Improving life outcomes of those who may always require welfare assistance	56
MSD faces a number of challenges in this area	56
MSD's role in this area is unclear	56
The need for intensive, long-term support is placing increasing pressure on public spending	56
Disabled people and their whānau have sought a more responsive disability support system for some time	56
The cost of the current system is high	57
Interventions to improve the wellbeing of those who are assessed as not being able to work have been limited and impacts not assessed	57
Access to supported housing for people with health conditions and disabilities	60
Current wider work to improve outcomes for disabled people	61
New Zealand Disability Strategy	61
Enabling Good Lives Demonstrations and the transformation of the disability support system	61
A new system of disability support is being trialled in the Mid-Central region	61
References	63
Appendices	72
Appendix 1: Assistance with additional cost of disability	72
Financial support	72
Non-financial support	76
Appendix 2: Spending on support for different groups of MSD benefit recipients (financial year 2016-2017)	77
Appendix 3: Employment assistance from the Ministry of Social Development	78

Purpose of the paper

The purpose of this paper is to provide information on people with work-limiting health conditions and disabilities in receipt of benefits, including the supports currently provided as well as the challenges with the system. The Government is committed to ensuring that all New Zealanders are earning, learning, caring or volunteering, and that where this is not possible people are able to live dignified lives.

Definitions of wellbeing, health, ill health and disability vary and have changed over time

There is no consensus on a single definition of wellbeing, but it is usually defined as a multidimensional concept. In its broadest sense, wellbeing encompasses physical, mental and social domains. Definitions often include dimensions such as physical wellbeing, material wellbeing, emotional wellbeing, personal relationships, social connectedness, development and activity, and self-determination. There is no sole determinant of individual wellbeing, but in general wellbeing is dependent upon good health, positive social relationships and the availability of and access to basic resources (e.g. shelter, income).

Ill health is caused by a range of social, economic, psychological and biomedical factors. These determinants not only affect individuals in contribute to ill health, but also generate highly patterned health differences in populations that reflect inequalities in society (Kelly et al., 2009). Inadequate incomes (poverty) are linked to poor health outcomes, especially where it is long term (Health Promotion Agency, 2018). Growing up in poverty has long-term detrimental impacts on children (Chaudry & Wimer, 2016; Virtanen et al., 2016). In New Zealand there is a strong association between poverty and benefit receipt, and Māori and Pacific People are disproportionately affected (Gibson et al., 2017). Poor-quality housing, overcrowding, homelessness, alcohol and drug addictions and intergenerational trauma are some additional factors ((Gibson et al., 2017; Gluckman, 2011; Howden-Chapman & Chapman, 2012; Potter et al., 2017).

Ill health and disability are not the same. While some disabled people have health problems associated with their disabilities, many do not. Moreover, many health conditions – even severe ones – are not, or not necessarily, disabling if well managed (OECD, 2012). According to the United Nations Convention on the Rights of Persons with Disabilities,² *“persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others”* (United Nations Convention on the Rights of Persons with Disabilities, 2006: article 1, purpose, in Stats NZ, 2017).

2 United Nations (2006) *Convention on the Rights of Persons with Disabilities*. United Nations. <http://www.un.org/disabilities/convention/conventionfull.shtml>

Part 1: Characteristics of the population on benefit with health conditions and disabilities

Life outcomes for disabled people are poor compared to the general population

An indication of the wellbeing gap is Stats NZ's New Zealand General Social Survey finding that disabled people rated themselves lower on several wellbeing indicators than non-disabled people. In terms of overall life satisfaction, 37.6% of disabled people rated their life satisfaction at 0-6 (the lower end of the rating) compared with 15.1% of non-disabled people.³

In the June 2018 quarter, 22.3% of disabled people were working. This compares with 70% of non-disabled people. They were also likely to have lower levels of income. The median weekly income (from all sources collected) for disabled people was \$358, about half that of non-disabled people. Disabled people were more likely than non-disabled people to receive some or all of their income from Government transfers. Disabled people were also less likely to earn income from wages and salaries, and self-employment.⁴

The number of people on benefits with health conditions or disabilities is high

In New Zealand, the number of people receiving working-age benefits has fallen, but people receiving health and disability benefits are overrepresented. People on working-age benefits with health conditions or disabilities make up the largest group of working-age beneficiaries (Figure 1). As at September 2018 people with health conditions or disabilities made up the largest group (49%) of working-age people receiving benefits. The number of people on health and disability benefits has remained high despite efforts to reduce numbers. As at September 2018,⁵ 83,828 were receiving Supported Living Payment (SLP) and 58,234 were receiving Jobseeker Support – Health Condition or Disability (JS-HCD)⁶ – the two main benefits a person may receive within the welfare system if they have a work-limiting health condition or a disability.

The number of people on benefits with health conditions or disabilities is likely to be an underestimate. To receive benefits for health or disability reasons, recipients are required to provide Ministry of Social Development (MSD) with medical certificates. Other benefit recipients (e.g. sole parents) are not required to provide information on their health or disability status. However, people on other main benefits may also have health conditions or disabilities e.g. 16,700 people on other benefits (including Sole Parent Support) accessed mental health services in the year to January 2017. A recent analysis of people receiving Sole Parent Support showed that 2,037 had current medical certificates and for 50% their primary incapacities were psychological or psychiatric conditions.

There are similarities between those people granted SLP and JS-HCD (Table 1).

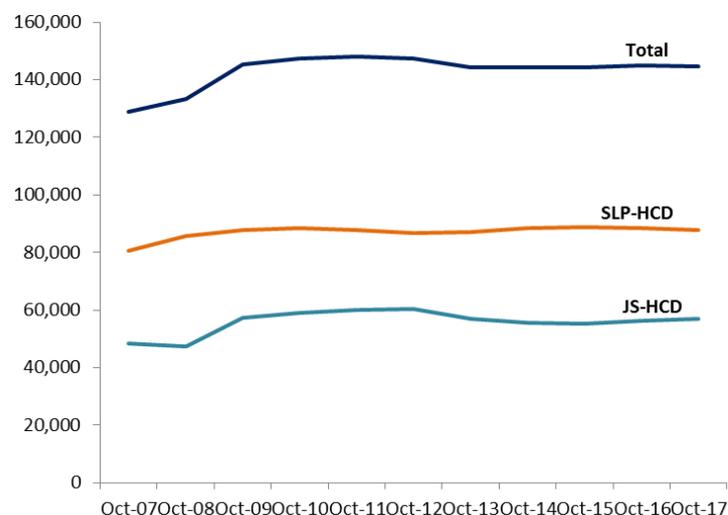
3 http://archive.stats.govt.nz/browse_for_stats/people_and_communities/Households/WellbeingStatistics_HOTP16/Commentary.aspx.

4 <https://www.stats.govt.nz/news/disabled-people-three-times-less-likely-to-be-in-work>.

5 Quarterly Working-Age Benefit Numbers – September 2018. <https://www.msd.govt.nz/documents/about-msd-and-our-work/publications-resources/statistics/benefit/2018/quarterly-benefits-sept-18-a3-final.pdf>.

6 SLP replaced the Invalids Benefit, introduced in 1939, and JS-HCD replaced the Sickness Benefit, introduced in 1939.

Figure 1: Trends in the number of working-age people receiving benefits for health conditions or disabilities



Ministry of Social Development

Note: SLP-HCD is the SLP population excluding SLP carers

Table 1: Key facts about SLP and JS-HCD recipients

	Key facts about SLP recipients	Key facts about JS-HCD recipients
There are slightly more males than females	47% are female, 53% are male.	48% are female, 52% are male.
Māori make up a significant proportion of recipients	23% are Māori, 5% are Pacific People.	30% are Māori, 7% are Pacific People.
Most recipients are over 40 years old	73% are over 40 years old.	64% are over 40 years old.
Many have no educational qualifications	Based on data from the IDI, ⁷ 9% are highly qualified and 50% have no qualifications.	Based on data from the IDI, 15% are highly qualified and 30% have no qualifications.
Most are single, without dependent children	91% are single and 92% have no dependent children.	Just over 90% are single and 88% have no dependent children.
Few have earnings while on benefit	10% had earnings from employment in the 12 months to June 2017.	13% have work obligations (part-time obligations) and just under 12% have earnings from employment.
Long-term receipt of benefit is common	Most (83%) have been on the benefit for over two years. Just over 50% have been on the benefit for 10 or more years.	44% have remained on the benefit for more than two years.
Mental health conditions are common, especially amongst young recipients	Mental health conditions are the primary incapacity group for 48% of recipients 24 years or younger and 34% of recipients over 40 years old.	Mental health conditions are the primary incapacity group for 70% of recipients 24 years or younger and 42% of recipients over 40 years old.

7 The Stats NZ Integrated Data Infrastructure (IDI) is a large research database. It holds microdata about people and households.

There are some differences between people granted the SLP and JS-HCD benefits:

- SLP recipients are more likely than JS-HCD recipients to have congenital disabilities or intellectual disabilities.
- SLP recipients are likely to stay on the benefit, whereas it is common for people receiving JS-HCD to have repeat spells on this or other benefits.

Most industrialised countries, including New Zealand, are facing an aging workforce. As the workforce ages, the incidence of people developing work-limiting health conditions or disabilities increases (OECD, 2010, 2012).

The population on benefits for reasons of ill health or disability has changed. More have mental health problems

As in many other OECD countries, people with mental health conditions make up the largest group receiving the SLP and JS-HCD benefits (Table 2). As at June 2018, over a third of SLP recipients and almost half of JS-HCD recipients had mental health conditions listed as their primary incapacities. This is likely to be an underestimate of the proportion of people receiving health and disability benefits with mental health conditions, as MSD often only reports on the primary incapacities listed on medical certificates. Table 2 does not include mental health conditions listed as additional to the primary incapacity e.g. someone may have a physical condition listed as their primary incapacity but also have a mental health condition. Co-morbidity is common (see Table 2).

Table 2: Primary incapacity of people receiving SLP and JS-HCD as at June 2018

Incapacity group	Total SLP	Total JS-HCD
Accident	4%	5.4%
Blood and blood-forming organs	Less than 1%	Less than 0.5%
Cancer	2.4%	1.6%
Cardiovascular disorders	6.1%	4.6%
Congenital conditions	5.8%	Less than 1%
Digestive system disorders	1.2%	1.8%
Entry of foreign bodies	Less than 0.5%	-
Genito-urinary disorders	1.4%	1%
Ill-defined conditions	1.5%	2.5%
Immune system disorders	Less than 0.5%	Less than 0.5%
Infectious/Parasitic diseases	Less than 1%	Less than 1%
Intellectual disability	11.1%	Less than 0.5%
Metabolic and endocrine disorders	2.8%	3.8%
Musculoskeletal system disorders	10%	16%
Nervous system disorders	7.8%	2.9%
Pregnancy related	Less than 0.5%	1%
Psychological or psychiatric conditions	35.5%	48.2%
Respiratory disorders	3.1%	2.6%
Sensory disorders	2.6%	1.1%
Skin disorders	Less than 0.5%	Less than 1%
Substance abuse	1.7%	4.8%
Unspecified	1%	-
Total	100% (83,896)	100% (55,249)

Source: Ministry of Social Development IAP.

Across health and disability benefits, there has been a steady increase in the number of recipients with mental health conditions. The share for both benefit types has increased in the past decade, by nearly five percentage points for SLP and 10 percentage points for JS-HCD (Taylor Fry, 2017).

Figure 2: Proportion of recipients with mental health incapacity as their primary incapacity

Source: Taylor Fry, 2017

Note: SLP-HCD is the SLP population excluding SLP carers

The increase in recipients with mental health conditions occurred when the number of working-age people receiving main benefits in June 2017 were lower than in June 2012.⁸ This is a common trend across the OECD. It is of concern, as many mental disorders are persistent and show high rates of recurrence. The more chronic a mental disorder, the more disabling it is and the larger are the challenges for labour market inclusion (OECD, 2012).

Also of concern is the increase in young people receiving SLP or JS-HCD for mental health conditions.

- Amongst SLP recipients, mental health conditions are the primary incapacity group for 48% of recipients 24 years or younger and 34% of recipients over 40 years old.
- Amongst JS-HCD recipients, mental health conditions are the primary incapacity group for 70% of recipients 24 years or younger and 42% of recipients over 40 years old.

The incidence of mental health incapacity at younger ages is associated with longer-term benefit receipt and unemployment, as well as increased healthcare costs over an extended period (Taylor Fry, 2017). Mental ill health places young people at a higher risk of educational underachievement and difficulties in transitioning from school and post-school education and training to work, and it appears that joblessness and benefit receipt can in turn contribute to mental ill health (OECD, 2015; Potter et al., 2017; Virtanen et al., 2016).

There is diversity within the group of people receiving benefits due to mental health conditions:

- Those with bipolar disorder or schizophrenia make up 42% of those with mental health conditions receiving SLP.
- Those with stress and depression make up 45% of those with mental health conditions receiving JS-HCD.
- Those with other psychiatric/psychological conditions make up 38% of those with mental health conditions receiving SLP and 42% of those with mental health conditions receiving JS-HCD. Moreover, their number and relative share have been growing substantially over time (Taylor Fry, 2017).

The number of people receiving health and disability benefits with mental health conditions may be an underestimate. Significant depressive and anxiety symptoms are associated with chronic diseases such as diabetes, cardiovascular disease and asthma (Williams et al., 2017). The physical diseases may be listed as the primary incapacity.

⁸ <https://www.msd.govt.nz/about-msd-and-our-work/publications-resources/statistics/benefit/archive-2017.html>.

Table 3: Mental health incapacity amongst SLP and JS-HCD recipients as at June 2018

Incapacity	SLP	JS-HCD
Bipolar disorder	11.0%	7.3%
Depression	12.5%	33.4%
Other psychiatric/psychological	37.8%	41.9%
Schizophrenia	31.4%	5.8%
Stress	7.2%	11.5%
TOTAL	100%	100%

Source: Ministry of Social Development IAP.

MSD does not know enough about the degree to which a person’s mental health condition affects their ability to go about their daily activities. MSD collects information on the type of incapacity but not the severity of the condition. It is sometimes assumed that common mental health conditions such as depression and anxiety are mild or moderate in their impacts on people’s lives. However, Potter et al, (2017) state:

... describing disorders as mild-to-moderate is rather misleading: they may represent a lower burden on treatment resources than the psychoses and bipolar disorder, but people suffering from the higher prevalence anxiety, depression, and substance-dependence disorders experience substantial distress and dysfunction, with persistent interference in their ability to function socially and occupationally. The distinction is a relative one, mainly because comorbidity⁹ is the rule, not the exception, for mental illness. In other words, people that we regard as having severe mental illness – and even sometimes those with apparently more moderate dysfunction – typically experience multiple disorders, either simultaneously or sequentially.

Potter et al (2017) add that many people graduate from milder forms of disorder before ending up at the extreme end of the need continuum.

Moreover, physical health is poorer for people with mental illnesses and/or addictions than it is for the general population for a variety of reasons (e.g. lifestyle factors, socio-economic status, adverse health effects of some medications, issues with accessing healthcare, lack of coordination between mental and physical health services) (Office of the Health and Disability Commissioner, 2018).

9 People with diagnosed mental disorders have a higher prevalence of several chronic physical conditions than others, and it is common for people to be diagnosed with two mental disorders. International research has identified multiple reasons for premature mortality in people with mental illnesses, such as the impact of higher smoking rates and medication side effects on cardiovascular health, lack of appropriate treatment of medical conditions, discrimination and social deprivation. Mental Health Foundation: Quick Facts and Stats 2014 <https://www.mentalhealth.org.nz/assets/Uploads/MHF-Quick-facts-and-stats-FINAL.pdf>.

While there has been a strong and universal trend increase across the OECD in people claiming health and disability benefits for mental health conditions, little is known about what is driving it (OECD, 2012). The causal relationships between mental health issues, joblessness and welfare benefit receipt are complex and not well understood. Mental health is shaped by the wide-ranging characteristics (including inequalities) of the social, economic and physical environments in which people live. Various reasons have been suggested:

- *The increase in the number on benefit with mental health conditions may in part be due to the increasing prevalence of mental health conditions in the population* (Ministry of Health, 2017a). The prevalence of mental health conditions in New Zealand is higher among women than men, higher among young people than among those of working age, and highest for those with low educational attainment and for Māori and Pacific populations.
- *There may be more people being assessed as having mental health conditions due to the decreasing stigma associated with mental health problems and improvements in diagnosis* (OECD, 2012). In the United Kingdom there is evidence that this has meant people are claiming benefits for mental health conditions when previously they would have been diagnosed as having other conditions, such as back pain (Viola & Moncrieff, 2016).
- *Labour market changes (e.g. an increase in work intensity) may have contributed to the increase.* The changes may have increased the risk of developing a mental health condition as well as making it more difficult for those with mental health conditions to find suitable work (Viola & Moncrieff, 2016).
- *Unemployment and poverty increase the risk of mental health problems and can be both causal factors and consequences of mental ill health.* In New Zealand, people living in the most socio-economically deprived areas are nearly three times more likely to experience psychological distress than people living in the least deprived areas, after adjusting for age, sex and ethnicity (Ministry of Health, 2017a). Australian and New Zealand research indicates a strong link between welfare receipt and poor health, especially mental health (Gibson et al., 2017; Kiely & Butterworth, 2013, 2014a, 2014b; Kvalsvig, 2018). The Australian research indicates that much of the association between poor mental health and receipt of sole parent benefits is explained by financial hardship. However, it also finds evidence of a direct link between welfare receipt and poor mental health that could be due to factors such as welfare stigma or other adverse life events coinciding with welfare receipt for those receiving unemployment or disability payments (Kiely & Butterworth, 2013). New Zealand research indicates that the mental wellbeing of beneficiaries is poor compared to that of non-beneficiaries (Kvalsvig, 2018).¹⁰
- *The increase is also an indication that MSD has not been successful in supporting recipients with mental health conditions off benefits and into work.* New Zealand's health and disability benefits were established when most benefit recipients suffered from physical ailments. They may not be well set up to respond to the growing number with mental health conditions. Data shows that, with the exception of cancer and congenital conditions (which rose by 373 claims between 2010 and 2016), people making claims for mental health reasons are the only health and disability MSD recipient group to have increased in number in the past five years (OECD, 2018).

10 Kvalsvig (2018) found that 34% of beneficiaries reported feeling unable to deal with the stresses of everyday life. Beneficiaries were significantly more likely than people in full-time work to report that they felt isolated (62% vs 35%), and they were significantly more likely to experience moderately severe or severe levels of depression. New Zealand research indicates that sole parents have higher rates of mental ill health than partnered parents (Tobias et al. 2009).

Other conditions are also common

Musculoskeletal disorders are also common

Musculoskeletal conditions are a group of disorders affecting the bones, muscles, tendons, soft tissue and joints. They include osteoarthritis, rheumatoid arthritis, osteoporosis and neck and back pain. In New Zealand, the largest contributor to health loss among these disorders is low-back and neck pain (Ministry of Health, 2018).

Musculoskeletal conditions cause health problems ranging from discomfort and minor aches and pains to more serious medical conditions that can lead to permanent disability. They are caused or aggravated primarily by activities (e.g. work) and they can affect the upper limb extremities, the neck and shoulders, the lower back area and the lower limbs (Cullen et al., 2017). Obesity and a lack of physical activity are important contributors to the risk of developing musculoskeletal disorders, alongside environmental and metabolic factors (Ministry of Health, 2018).

As at June 2018, MSD data indicates that:

- 8,702 (10%) SLP recipients had musculoskeletal disorders listed as their primary incapacity. People with musculoskeletal disorders on SLP are more likely to be on the benefit for more than two years (80%). In terms of ethnicity, 54% are NZ European, 21% are Māori and 6% are Pacific People. Most are aged over 45
- 9,366 (16%) of JS-HCD recipients had musculoskeletal disorders listed as their primary incapacity. People with musculoskeletal disorders on JS-HCD are more likely to be receiving the benefit for more than two years (60%). In terms of ethnicity, 38% are NZ European, 27% are Māori and 8% are Pacific People. Most are aged over 45.

Many SLP recipients have intellectual disabilities and congenital conditions

Almost 17% of SLP recipients have intellectual disabilities or congenital conditions¹¹ that prevent them working more than 15 hours a week. Long-term receipt of the benefit is very common – 97% of SLP recipients with intellectual disabilities and 88% of SLP recipients with congenital disabilities have been receiving that benefit for two years or more.

11 Congenital disorders can be defined as structural or functional anomalies (for example, metabolic disorders) that occur during intrauterine life and can be identified prenatally and at birth, or sometimes may only be detected later in infancy. In simple terms, congenital refers to the existence at or before birth (e.g. Down syndrome, spina bifida, cerebral palsy).

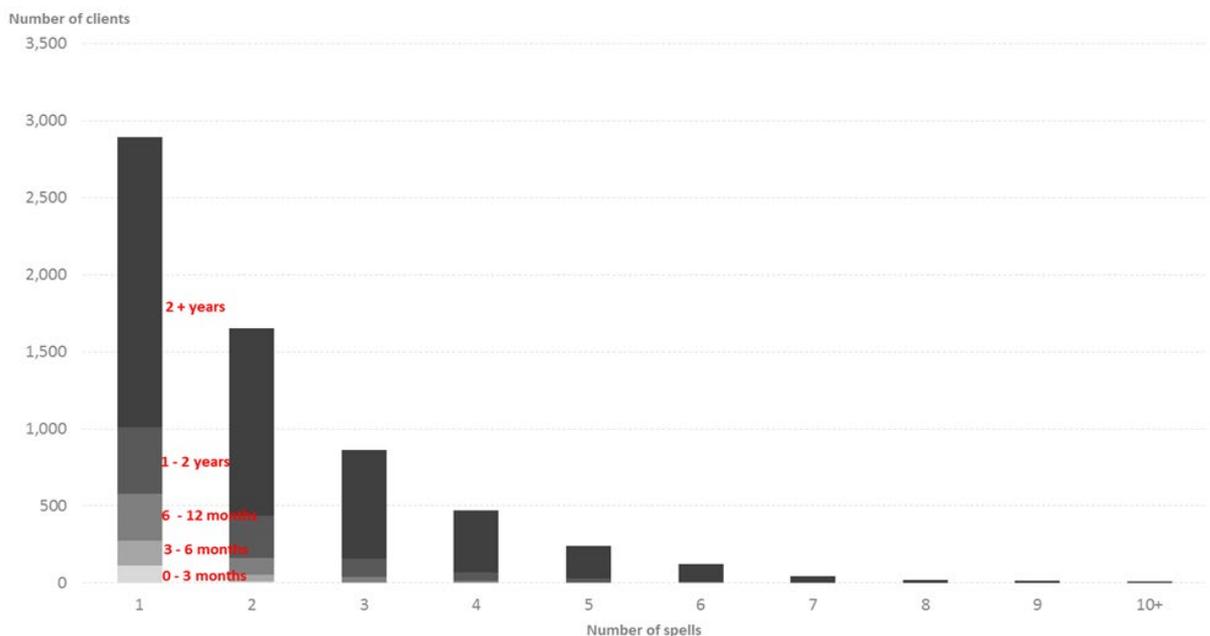
Current pathways on and off health and disability benefits

There are different pathways to MSD's health and disability benefits. There are several routes to SLP:

- Transferring from another benefit to SLP: 55% of new SLP recipients come from JS-HCD.
- Going straight to SLP at a young age: once a child turns 16 years they may be able to receive SLP on the grounds of having a health condition, injury or disability that permanently and severely restricts their capacity for work. Those on SLP prior to the age of 20 most commonly have psychological or psychiatric conditions,¹² congenital conditions, intellectual disabilities or nervous system disorders.¹³ Some of these recipients will have received Child Disability Allowance (CDA) or Disability Allowance (DA) as children. An analysis of MSD data showed that where CDA was cancelled between 1 July 2013 and 30 June 2018, and people began receiving adult benefits, most (71% or 2,525) were receiving SLP.¹⁴
- Going straight to SLP at an older age with no previous history of benefit receipt (e.g. as a result of developing a severely work-limiting health condition or disability).

People on SLP typically stay on the benefit for a long time (Figure 3). As at 31 August 2018, 82% of SLP recipients had been on the benefit for two or more years. Just over 50% had been on the benefit for 10 or more years. The most common reasons for people leaving SLP is that they move to New Zealand Superannuation or they die.

Figure 3: SLP recipients' distribution of spells on any benefit, 1 July 2013 – 30 June 2017



Source: Ministry of Social Development, 2018.

12 Based on primary incapacity. Some of the raw data categorisations do not reflect the current approach to disability (e.g. autism is sometimes defined as a psychiatric disorder).

13 A neurological disorder is defined as any disorder of the body's nervous system. There are many neurological disorders (e.g. epilepsy, spina bifida).

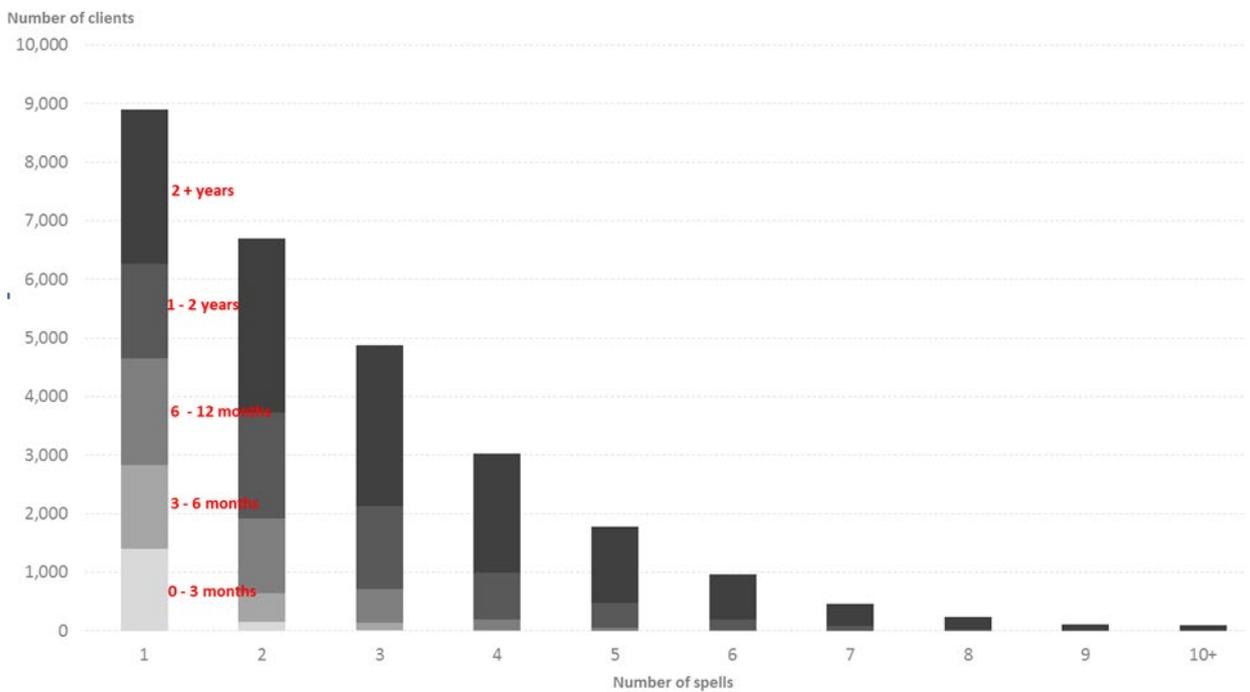
14 If a child had more than one CDA cancellation during the period, only the last cancellation (last cancellation date) is reported. As this was a data match, it is possible that not all the children matched perfectly to adult Social Welfare/ Recipient Numbers (SWNs). Some children may have falsely matched to adult SWNs. If the name of a child changed between the cancellation of CDA and the grant of a benefit, the child may not have been matched.

Common routes to JS-HCD are:

- moving from Jobseeker Support – Work Ready (JS-WR)¹⁵ to JS-HCD. People may start receiving JS-WR and develop work-limiting health conditions or disabilities, or existing conditions may worsen to the point where they are eligible for JS-HCD
- moving from another benefit such as Sole Parent Support or Youth Payment/Young Parent Payment to JS-HCD
- moving to JS-HCD from outside the benefit system (e.g. developing a health condition or a disability while in work that prevents someone working).

While 44% of JS-HCD recipients remain on the benefit for more than two years, others only receive JS-HCD for a short time before exiting the benefit. However, repeat spells on JS-HCD or another main benefit are common (Figure 4).

Figure 4: JS-HCD recipients’ distribution of spells on any benefit, 1 July 2013 – 30 June 2017



Source: Ministry of Social Development, 2018.

15 This benefit used to be called Unemployment Benefit.

What has driven the rise in people claiming health and disability benefits?

While considerable research has been conducted into the causes of the long-term increase in health and disability benefit receipt, conclusive findings have not emerged. Factors that appear to have influenced the growth are:

- the incidence of health conditions and disabilities
- the functioning of the labour market
- policy changes.

Growth in the number of people with chronic conditions is only part of the explanation

With increasing age there is a risk of people developing work-limiting chronic health conditions (e.g. cardiovascular disease, cancer, diabetes and respiratory diseases) or disabilities. There are other factors contributing to the rise in chronic health conditions:

- Medical advances mean that more people with previously fatal conditions are surviving, albeit with work-limiting health conditions or disabilities. In addition, diagnostic improvements and changing attitudes mean that conditions that have always existed are more widely recognised (e.g. mental health conditions).
- There has been an increase in lifestyle risk factors – in particular low levels of physical activity, poor nutrition, and tobacco and other substance use (National Health Committee, 2007).
- More people are experiencing poor social and economic circumstances (e.g. homelessness, unaffordable and/or unsafe housing, no meaningful employment, inadequate income, social exclusion, violence, lack of reliable social support). *“Socially disadvantaged and marginalised groups have poorer health, greater exposure to health hazards, and less access to high quality health care than the more privileged”* (National Health Committee, 2007: 12). Children living in poor social and economic circumstances is detrimental to child health but also increases the likelihood of worse outcomes in adolescence and adulthood.

However, in New Zealand, as in other OECD countries, the growth in health and disability benefits cannot all be explained by increases in ill health and disability among the working-age population (OECD, 2010, 2012; Fletcher, 2009).

Labour market changes appear to have contributed to some of the growth in receipt of health and disability benefits

The OECD (2010) has argued that changes in business cycles explain little of the overall trend, although it states that there are variations across countries. In New Zealand, the United States¹⁶ and the United Kingdom, receipt of disability benefits is more common in areas with, or times of, high unemployment and among the low skilled.

16 In the United States, in areas that have seen large job losses (e.g. rural areas in Appalachia, the Deep South and along the Arkansas-Missouri border), disability benefits function as unemployment insurance. See <https://www.bloomberg.com/news/features/2016-12-16/mapping-the-growth-of-disability-claims-in-america>.

There are several possible reasons for people with health conditions or disabilities being disadvantaged in the labour market – especially in a tighter labour market:

- *The greater competition for jobs associated with a tight labour market disadvantages people with work-limiting health conditions and disabilities, putting them at a higher risk of experiencing unemployment.* In New Zealand and other OECD countries, there has been more competition for jobs from a wider group of healthy working-age people (e.g. higher numbers of women entering the labour market and increased migration of healthy working-age people) (Böheim & Leoni, 2018; Fletcher, 2009). Researchers have found that workers in poor health and/or with lower levels of wellbeing are more likely to be in poor-quality work or unemployed than those who were well (Kawada, 2018; OECD, 2015).
- *People with ill health or disabilities are vulnerable to job loss when the labour market is tight, and struggle to re-enter the labour market once on benefits.* The OECD (2010) has reported that employment opportunities for people with disabilities tend to drop significantly during economic downturns and do not recover in the subsequent recoveries. If they are assessed as having health conditions (either at benefit entry or later) rather than unemployed, the chances of finding work diminish (whether due to greater competition for work, employer perceptions or discouragement) (Fletcher, 2009; Llana-Nozal & Xenogiani, 2011; OECD, 2015). As one research report has stated: “*worklessness gravitates to the men and women least attractive to employers – those with low skills, poor health, low-grade experience, long periods out-of-work and advancing years*” (Fothergill & Gore, 2013).
- *People with some disorders (e.g. less severe, common mental health disorders, musculoskeletal conditions) may be particularly sensitive to changes in labour market conditions.* They are able to work in the right work environment, with accommodating employers and security of employment, but struggle when these are not available. More precarious and/or more intense working conditions are linked to poor health, especially mental health (Viola & Moncrieff, 2016).
- *Once people become unemployed, the risk of their health deteriorating increases.* There is a strong association between unemployment and poor health (see Part 3).

Internationally, recent research indicates that the relationship between the labour market and health is mediated by gender, age, education and income, but this does vary across time and place:

- A Norwegian study found that for men, job loss more than doubled the risk of permanent disability retirement and accounted for one quarter of new disability insurance claims (Bratsberg et al., 2013). A German study found that the mental health of older men was affected most severely by job loss. The psychological distress following job loss appeared to be linked to a loss of identity (e.g. as the breadwinner). Men may feel the loss of a job more where paid employment, associated occupational status and wage are very strongly linked to wellbeing (Unger et al., 2018). In the UK there is evidence that younger men are more willing to work in jobs that may have in the past been more female dominated. This has meant an increase in older women as well as older men claiming benefits in depressed regions.
- Young people experiencing precarious employment and unemployment appear to be at risk of poor mental health (Canivet et al., 2016). Unemployment at a young age appears to be linked to claiming health and disability benefits later in life (Vancea & Utzet, 2016). Moreover, developing a work-limiting health condition or a disability at a young age affects education and work participation, with long-term negative consequences. Meanwhile, in all OECD countries disability prevalence increases strongly with age. This is associated with a greater risk of developing a health condition or disability.
- People with lower levels of education than others are more likely to receive health or disability benefits (Poterba et al., 2017).
- High household income can provide a protective effect since high income is associated with a low probability of disability benefit (Llana-Nozal & Xenogiani, 2011).

Policy approaches have contributed to growth in the number on health and disability benefits

There is evidence that changes in policy have influenced recipiency rates for health and disability benefits. In New Zealand until the late 2000s, little attention was focused on people receiving health and disability benefits. The main focus was on encouraging those in receipt of the Unemployment Benefit and to a lesser extent those receiving sole parent benefits to move into work (e.g. delivering active labour market programmes; more work-focused case management). Initiatives focused on health and disability recipients that were put in place (e.g. 'Jobs Jolt', the Sickness Benefit and Invalid's Benefit Strategy, which included the PATHs initiative,¹⁷ and changes that were part of Working New Zealand) had little impact on the overall prioritisation given to managing those on unemployment benefits (and to a lesser extent those on sole parent benefits). This focus on those receiving unemployment benefits was common in many OECD countries (Böheim & Leoni, 2018).

In the past decade the growth in the number of people receiving health and disability benefits has slowed but numbers remain high. The slowing in the growth of people on health and disability benefits can in part be attributed to a greater focus on moving benefit recipients with work-limiting health conditions and disabilities into work. In this time New Zealand (along with other OECD countries) has strengthened the activation and reintegration components of its health and disability policies, while at the same time increasing benefit conditionality for working-age people (Böheim & Leoni, 2018; OECD, 2010).

Key changes in New Zealand have included:

- *attempts to manage gateways to benefits*. For example, under Future Focus conditions attached to the Sickness Benefit (now JS-HCD) were tightened – additional medical assessments were required after eight weeks in receipt of the benefit, but the third and any subsequent medical certificates would continue to cover up to 13 weeks. A compulsory review of eligibility to the benefit was required after 12 months
- *the introduction of a revised medical certificate*. This was to capture more relevant information about people's capacity to work and better information about the duration of incapacity to work, instead of the durations of medical conditions
- *tighter eligibility requirements* for the Invalids Benefit (now SLP)
- *return-to-work planning requirements for people receiving the Sickness Benefit (now JS-HCD)*, which were introduced under Working New Zealand, continued under Future Focus and were extended under Welfare Reform
- under Welfare Reform, *requirements to look for part-time work* where people were assessed as having the capacity to do some work.

However, as in other OECD countries, increased activation in New Zealand has had limited impacts on improving outcomes for recipients of health and disability benefits. The OECD (2017:15) has argued that "*the standard approach taken in most countries' unemployment systems today is to exempt jobseekers with health problems from their participation and job-seeking requirements, and to hope that, and wait until, they return treated and cured*". The OECD argues that this is not the right approach as many people on health and disability benefits have chronic conditions (e.g. mental health, musculoskeletal conditions) that cannot be cured. In New Zealand most people on health and disability benefits have either deferred or no work obligations – only 13% have work obligations (part-time obligations). People receive benefits but there is little return-to-work management. A better approach would be to focus on better condition management and what people are able to do.

17 This was an MSD initiative called Providing Access to Health Solutions.

Other reasons have played only a limited role in growth in New Zealand

Reduced partnering rates amongst people with work-limiting health conditions and disabilities may have had a small effect in New Zealand. For example, the joint spousal income test may have reduced the proportion of the working-age population in relationships, increasing the number of people eligible for health and disability benefits (Fletcher, 2009).

According to Fletcher (2009), the combined effects of other policy changes in New Zealand have been limited. For example, the increase in age of entitlement for New Zealand Superannuation, deinstitutionalisation and the Accident Compensation Corporation (ACC) changes¹⁸ accounted for only a minor part of the increase in people receiving health and disability benefits from 20,000 (1% of the working-age population) in 1978 to 140,000 (almost 5%) in 2009.

18 See *Cheer (2005)*.

Part 2: Financial assistance for people with work-limiting health conditions and disabilities

MSD, the Ministry of Health (MOH) and ACC all work in a shared health and disability sector, delivering support and services to a sometimes shared recipient base. The three agencies have very different incentives and purposes. The result is that, in New Zealand, people with similar levels of incapacity arising from health conditions or disabilities may receive different levels of financial assistance, social support, and rehabilitation and treatment services. This section discusses financial assistance. See Part 3 for a discussion on access to rehabilitation and employment assistance.

MSD provides means-tested financial assistance for people with health conditions or disabilities

MSD provides financial and other support as appropriate to help people to support themselves and their dependants while not in paid employment – including where this is because they have health conditions or disabilities. MSD provides two main means-tested benefits for people with identified health conditions and disabilities:

- SLP for those who are permanently and severely restricted in their capacity for work. ‘Permanently’ means that the person’s health condition, injury or disability is expected to continue for at least two years. A recipient’s health condition, injury or disability is also considered permanent when they have been diagnosed with a terminal illness (i.e. are not expected to live for more than two years). ‘Severely’ means that a recipient cannot regularly work 15 hours or more per week in open employment.
- JS-HCD for people assessed as being temporarily unable to work or only work part-time (e.g. 15–29 hours a week). People in receipt of JS-HCD may have their work obligations deferred. As at June 2018, 88% of JS-HCD recipients had deferred work obligations.

The benefits provide different levels of financial assistance. SLP has a higher weekly benefit payment than JS-HCD. For example, a single adult 25 years or older would receive a payment of \$265.54 per week on SLP and \$212.45 per week on JS-HCD.¹⁹ The welfare system is not responsible for providing health services. The assumption is that the health system addresses people’s health needs. The highest rates in each main benefit are for couples with dependent children.²⁰ The lowest rates are for single people.²¹ Most people receiving SLP or JS-HCD are single.

19 There is no difference in payment between a person claiming JS-HCD and a person claiming JS-WR. Prior to 1991 payments for Sickness Benefit and Invalid Benefit were higher than those for Unemployment Benefit, making it more advantageous financially to be on a Sickness Benefit and Invalid’s Benefit than on the Unemployment Benefit. In 1991 there were pro rata cuts to both Unemployment and Sickness Benefits, but not to the Invalid’s Benefit. From 1998 there was an alignment of Sickness Benefit rates with Unemployment Benefit rates for new grants.

20 Payment rates differ between benefit types and family groups in each benefit, reflecting the different family and other costs for each of these groups.

21 Those aged under 18 (aside from those on Young Parent Payment) receive less than other single people. Single people aged under 24 years on Jobseeker Support are also on a lower rate than single recipients aged 25 and over.

Decisions about eligibility for both SLP and JS-HCD are underpinned by medical assessments. As the JS-HCD benefit is considered a temporary, work-focused benefit, those applying for JS-HCD also need to complete health and disability self-assessments²² and Recruitment jobseeker profiles. They may be required to attend appointments with MSD-designated doctors to get second opinions.

People in receipt of SLP are reassessed every two years, or never if they permanently have little or no work capacity (about 33% of SLP recipients). JS-HCD benefit recipients are required to undergo more frequent reassessments than those on SLP. When a recipient applies for (or transfers to) JS-HCD they need to provide a current medical certificate based on a medical review. The first certificate covers up to four weeks. People on JS-HCD are required to submit medical certificates at four weeks, eight weeks and then every 13 weeks, and must reapply for JS-HCD after 52 weeks.

JS-HCD recipients may also be required to undergo assessments of work ability (including ongoing assessments through structured interviews during case management services) – and if earlier, less intensive approaches (i.e. self-assessments and structured interviews) have not given clarity about what they can do or the help they need to work, independent Work Ability Assessments (WAAs) may be necessary.

22 A self-assessment questionnaire collects the recipient's view on the sort of work they can do and would like to do, and any supports required. There is some evidence internationally that self-reported health can be a good predictor of likelihood of return to work.

A Jobseeker Support applicant will need to provide an initial medical certificate if they: are more than 27 weeks pregnant; have a job to return to within 13 weeks of their original incapacity date; and are participating in Contracted Case Management

Table 4: SLP and JS-HCD eligibility, assessment processes and financial assistance

	MSD: SLP	MSD: JS-HCD
Eligibility	<p>People are eligible for SLP if they are 16 years or older and either totally blind or permanently and severely restricted in their ability to work. This means that their disabilities are expected to continue for at least two years (or their life expectancy is less than two years) and they cannot work more than 15 hours in open employment.</p> <p>The unit of entitlement is a couple.</p>	<p>JS (HCD) is a subset of Jobseeker Support. People who are eligible for Jobseeker Support, but are also limited in their capacity or unable to work full-time, or are in employment but cannot work or can only work at a reduced level.</p> <p>The unit of entitlement is a couple.</p>
Assessment and reassessment	<p>Assessment. Applicants must provide medical certificates or suitable existing medical/disability assessments. Recipients with one of the following diagnoses have simplified access to SLP and do not need to have detailed assessments of their capacity to work:</p> <ul style="list-style-type: none"> • Totally blind. • Terminally ill. • Severe intellectual or cognitive impairment. • Their impairment has reached a stage of deterioration to the extent that it severely affects their ability to function (i.e. they need help with all aspects of their personal care) and is unlikely to improve. A detailed report about the level of care needed may be required. <p>Reassessment. Required every two years, or the benefit may expire. People with little or no work capacity (about 33% of SLP recipients and including those with simplified SLP access) are exempt from reassessment.</p>	<p>Assessment. Those applying for HCD will have part-time or deferred work obligations²³ and are required to provide completed benefit applications, medical certificates, health and disability self-assessments and Recruitme jobseeker profiles.²⁴ They may be required to attend appointments with MSD-designated doctors to get second opinions. Recipients may also be required to undertake pre-benefit activities e.g. attending Work for You seminars.</p> <p>Reassessment. Under current policy, recipients must provide new medical certificates four weeks after benefit grant, four weeks after that, and then every 13 weeks thereafter (unless they are pregnant, have jobs to return to within 13 weeks or are undergoing treatment for cancer).</p> <p>As JS-HCD (as part of Jobseeker Support) is a temporary, work-focused benefit paid for up to 52 weeks, recipients need to reapply for the benefit at 52 weeks, unless they are in hospital or residential support services or adverse events have happened in their regions.</p> <p>The recipients' benefits are typically cancelled if they fail to provide medical certificates in the correct timeframes. If they do not reapply for the benefit at 52 weeks the benefit will be cancelled unless there are exceptional circumstances.</p>

23 People with deferred work obligations still have work preparation obligations.

24 Jobseeker Support applicants will need to provide an initial medical certificate if they: are more than 27 weeks pregnant, have a job to return to within 13 weeks of their original incapacity date, are participating in Contracted Case Management.

	MSD: SLP	MSD: JS-HCD
Financial assistance	<p>Benefit rate. For a single adult 18 years and older, \$265.54 a week.</p> <p>Abatement. Abatement applies when a person reaches a certain level of income, including through earnings, resulting in reduced benefit payments (partial).</p> <p>Abatement begins after \$100 of weekly earnings (calculated annually) at:</p> <p>30 cents for each dollar of income up to \$200 a week (an effective marginal tax rate of just under 50%), and</p> <p>70 cents for every dollar of income over \$200 (an effective marginal tax rate of 88.9%).</p> <p>If a recipient receives tier two assistance this will also abate.</p> <p>SLP never abates for recipients who are considered totally blind or severely disabled, because their personal earnings are not counted under the Social Security Act 1964.</p> <p>Cut-off. Abates to zero at a gross weekly income of \$533 or cuts off completely when a recipient works for more than 15 hours. Because of this 15-hour rule, SLP recipients need to work for 33 hours (at minimum wage) to earn the \$436 they would receive if they worked 14 hours and continued to collect SLP, and this is before taking into account tier two assistance.</p>	<p>Benefit rate. For a single adult 25 years or older, \$212.45 a week. The rate for recipients younger than 25 years not living at home is \$177.03.</p> <p>Abatement. People can work up to 30 hours per week (depending on abatement levels) before they are no longer considered eligible for JS-HCD.</p> <p>Abatement begins after \$80 of weekly earnings (calculated weekly) at 70 cents in every dollar (an effective marginal tax rate of 88.9%). If a recipient receives tier two assistance this will also abate. After tax and abatement, a recipient working more than about five hours on the minimum wage is only better off by \$1.75 extra per hour of any additional work.</p> <p>Cut-off. Abates to zero at a gross weekly income of \$381 i.e. 25 hours on the minimum wage.</p>

MSD provides a lower level of income support than ACC in most cases

People who are assessed as not being able to work due to ill health or disability not caused by accidents are not eligible for ACC support. New Zealand has a tiered system, with higher benefits (in terms of income replacement) for people under ACC compared to those who are eligible for support from MSD. If people are out of work for health- or disability-related issues and do not have financial support from working partners, they could start to receive SLP or JS-HCD from Work and Income. However, the amount received from SLP or JS-HCD is significantly less than what people eligible for ACC income replacement receive under most scenarios (see Table 5). The exceptions are people working part-time at the minimum wage when they are injured, and single people not earning at the time of their injuries.

Table 5: Income assistance for a person with a health condition, disability or injury

Scenario ²⁵	Health condition, disability or injury not covered by ACC	Personal injury covered by ACC ²⁶
Scenario 1. <i>A person over 25 years old, with no dependents, working 40 hours a week at the minimum wage, develops a health condition that temporarily affects their ability to work</i>	<p>MSD main benefit</p> <p>JS-HCD \$215.34 net in hand a week²⁷</p> <p>MSD supplementary assistance</p> <p>AS \$105 net in hand a week (maximum AS rate)</p> <p>DA \$23 net in hand a week (average DA rate)</p> <p>Total \$343.34 net in hand a week</p>	<p>ACC earnings-related weekly compensation</p> <p>80% of the recipient's average weekly income: \$447.11 net in hand a week²⁸</p> <p>MSD supplementary assistance</p> <p>AS \$70 net in hand a week²⁹ (maximum AS rate after calculating income reduction)</p> <p>DA \$23 net in hand a week (average DA rate)</p> <p>Total \$540.11 net in hand a week</p>
Scenario 2. <i>A couple, both over 25 years old, with no dependents, both working 40 hours a week at the minimum wage, where one person develops a health condition that temporarily affects their ability to work</i>	<p>MSD main benefit</p> <p>Not eligible for main benefit (benefit is fully abated due to income test for a couple)</p> <p>MSD supplementary assistance</p> <p>AS \$154³⁰ net in hand a week (maximum AS rate for a couple after income reduction)</p> <p>DA \$23 net in hand a week (average DA rate)</p> <p>Total: \$177 net in hand a week</p>	<p>ACC earnings-related weekly compensation</p> <p>80% of the recipient's average weekly income: \$447.11 net in hand a week</p> <p>MSD supplementary assistance</p> <p>AS \$7 net in hand a week (maximum AS rate for a couple after income reduction)</p> <p>DA Not eligible (above maximum income limit for couple)</p> <p>Total: up to \$454.11 net in hand a week</p>

25 All scenarios are based on the following assumptions:

- The recipient/couple lives in Area 2 (<https://www.workandincome.govt.nz/map/deskfile/extra-help-information/accommodation-supplement-tables/definitions-of-areas.html#Area23>) and receives the maximum Accommodation Supplement (AS), which factors in an income reduction where applicable.
- The recipient/couple has no cash assets and the only source of chargeable income is their wage earnings or earnings-related weekly compensation.
- The recipient/couple does not receive Temporary Additional Support or the Winter Energy Payment.
- DA received is the average amount of \$23 per week, based on data as at the end of March 2018. Note however, that 36% of all recipients receive \$10 or less a week, and over half of these receive \$5 or less a week.
- Any available MOH funding has not been included in the scenarios.

26 Any health condition, disability or injury that is 'covered' as a 'personal injury' under ACC's statutory eligibility criteria. Note that a person who is covered by ACC for personal injury may also qualify for MSD supplementary assistance. However, most of their personal injury costs are likely to be fully funded by ACC, meaning they are less likely to receive the average DA rate.

27 The recipient would be eligible for Jobseeker Support on the grounds of a health condition or disability (JS-HCD) that temporarily affects their ability to work. A stand-down period may apply.

28 The first week is usually paid by the employer if the injury occurs at the place of work. ACC weekly compensation, based on 80% of the adult minimum wage of \$660 for a 40-hour week, is approximately \$447.11 net (excluding KiwiSaver and Student Loan deductions).

29 This assumes that the person will take up AS. However, take-up rates for AS are considered low among non-beneficiaries.

30 The maximum payable for a couple with no dependents in Area 2 is \$155 per week. However, based on the partner's income level this is reduced by \$1 a week.

Scenario ²⁵	Health condition, disability or injury not covered by ACC	Personal injury covered by ACC ²⁶
<p>Scenario 3. <i>A person over 25 years old, with no dependents, if the person develops a health condition or an injury that permanently and severely affects their ability to work</i></p>	<p>MSD main benefit SLP \$269.15 net in hand a week</p> <p>MSD supplementary assistance AS \$105 net in hand a week (maximum AS rate) DA \$23 net in hand a week (average DA rate) Total: \$397.15 net in hand a week</p>	<p>ACC earnings-related weekly compensation 80% of the recipient's average weekly income: \$447.11 net in hand a week MSD supplementary assistance AS \$70 net in hand a week (maximum AS rate for this recipient after income reduction) DA \$23 net in hand a week (average DA rate) Total: \$540.11 net in hand a week</p> <p>ACC compensation for permanent impairment Lump sum payment within a range from \$3,455.24 to \$138,209.55, depending on the level of impairment³¹ or Independence allowance assessed weekly but paid quarterly, with rates ranging from \$197.73 to \$1,186.64.³²</p>

Few SLP and JS-HCD recipients receive income from elsewhere. Most main benefit recipients, including those with health conditions or disabilities, rely on supplementary assistance to meet the gap between their main benefit payment income and their housing and other essential living costs. The take-up of supplementary assistance is less than ideal. Few SLP and JS-HCD recipients have part-time earnings. Many who leave benefits for work return to benefits (Judd & Sung, 2018). As a consequence, SLP and JS-HCD recipients have very limited money for spending on other necessities after paying for housing costs (refer to the example families – WEAG, 2019a).

While the main benefits have been adjusted annually by CPI (as legislatively required for most of these benefits), the payment rates for most benefits have not generally kept up with wage growth and the growth in housing costs (relative to their significance for low-income families), so they have inadequate income for basic needs.

31 Claims for injuries that occurred on or after 1 April 2002 are eligible to be considered for this lump sum. Earlier claims are eligible to be considered for an independence allowance. The lump sum payment for impairment is not treated as income for MSD benefit purposes and is not subject to the ACC direct deduction. It is also excluded as a cash asset for Accommodation Supplement, Residential Care Subsidy and hardship benefits for the first 12 months.

32 Claimants can elect to receive a one-off payment covering five years, in lieu of quarterly payments. The allowance is not income and not a direct deduction. It is excluded as a cash asset for AS or Residential Care Subsidy and hardship benefits for the first 12 months.

People in receipt of SLP or JS-HCD may also face greater costs in accessing supports than those in receipt of ACC support. ACC provides a single purchaser to coordinate services for an individual. The welfare system and health system do not provide a similar service. MOH funds health services and has broad health and social priorities that do not include employment. People in the welfare system with disabilities, including those with health conditions, may have to navigate an at-times fragmented and poorly coordinated health and welfare system to get their needs met. Some commentators have argued that difficulty accessing services is more problematic than the differences in financial entitlement. Stephens (2004:787) has stated:

The major issue facing disabled people and their families is not the level of benefit entitlement but the wider issue of appropriate and equitable access to the full range of non-income services, covering access to work, education, rehabilitative equipment, household and vehicle modifications, health care and other social service support such as domestic assistance, personal care and residential support services. In respect of these service delivery issues, the coverage of ACC is more integrated than that of the income tested benefit system, where separate application is often required for each individual service.

Some people with work-limiting health conditions and disabilities miss out on income support from ACC and MSD

For many New Zealand families, two incomes are necessary to provide a reasonable standard of living. However, if one partner in a couple becomes unable to work because of illness or disability they will not usually be entitled to a benefit payment because of their partner's earnings. This is because entitlement to most benefits and social assistance transfers is based on the couple's joint income where people are defined as partnered. This means that many families find themselves too well off as households to qualify for health and disability benefits, but too poor to pay mortgages or rent and food bills.

Some families may be able to mitigate the risk if they are able to purchase income-protection or mortgage insurance³³ or the working partners earn sufficient income. However, this is unlikely to be the case for lower-income couples. Women are less likely than men to have income-protection insurance as it is significantly more expensive for women. Women are more likely to have long-running mental health and stress-related claims, which are harder to terminate, and this is built in to the pricing.³⁴ Moreover, in couples where men earn more than women, it is often assumed that only they need cover. However, if a non-earning or lesser-earning spouse becomes ill or incapacitated, it can cost the family a considerable amount in childcare and other costs. Private insurance does not cater well (if at all) for people with congenital or age-related conditions. It may be better suited to those with illness-related conditions.

33 The New Zealand Financial Services Council states that only about 15% (one in seven) of New Zealand households have income protection insurance and that there are nearly one million households with incomes above \$20,000 that would be vulnerable if they faced long-term illnesses that stopped major earners in the households working. See <https://www.fsc.org.nz/Insurance/Q++A+Income+Protection+Insurance.html>.

34 https://www.nzherald.co.nz/personal-finance/news/article.cfm?c_id=12&objectid=11292136.

ACC provides income support for earners incapacitated as a result of accidents

The accident compensation scheme provides a comprehensive, no-fault system of accident prevention, rehabilitation and compensation for people injured as a result of accidents. The scheme began in 1974 following the recommendations of the Woodhouse Report.³⁵ Currently:

- ACC automatically covers 80% of an earner's income in the event of an accident that prevents them working, until retirement or until they are assessed as being able to work. Most claims to ACC are for treatment only (ACC, 2013)
- lump sum compensation is also available if earners and non-earners had injuries on or after 1 April 2002 (e.g. to compensate for the loss of a limb). The amounts available are specified in ACC's legislation, and are adjusted annually
- a person may be able to claim for loss of potential earnings if they either were under 18 at the time of their injury and are unable to work when they turn 18, or have been in continual full-time study since turning 18. The weekly payments are equal to 80% of the adult minimum wage
- eligibility for financial assistance from ACC is not dependent on whether or not a person has an earning partner.

However, not everyone injured in an accident receives income support from ACC. ACC has no obligation to pay loss-of-income support (weekly compensation) to someone not working in paid employment, even if the paid work is only one hour per week³⁶ at the time of the disabling accident. The no obligation to pay applies if the person was not earning at the time of the accident³⁷ or later when they are working and need further treatment. In these situations, ACC is paying for the treatment but will not pay for the lost income during recovery.

ACC provides earners who have had accidents with support to return to work and most do (e.g. in 2016-2017 67.6% of those eligible for weekly compensation had returned to work within 10 weeks, and 93% had returned to work within nine months) (ACC, 2018). For those who do not and where ACC assesses them as being able to return to work, their entitlement to ACC weekly compensation ceases. At this point if they need financial assistance they may be eligible for an MSD benefit. Between 2001 and 2011, on average 5% of claimants per annum moved from weekly compensation to MSD benefits. ACC reports that there was a strong relationship between time on weekly compensation and the likelihood of transfer to a health benefit (16% for >24 months on weekly compensation) (ACC, 2013).

35 The 1967 *Woodhouse Report on Compensation for Personal injury in New Zealand* is commonly known as the Woodhouse Report after its chair, Sir Owen Woodhouse.

36 28 days after stopping work, if a person does not have a job to return to within 90 days, ACC can consider them a non-earner for weekly compensation.

37 Claimants did not meet ACC criteria for being in paid employment at the time of injury e.g. students, retired people, home makers, overseas visitors, workers between jobs.

Table 6: ACC compensation

Name	Purpose and eligibility	Rates, abatements, cut-offs
Weekly compensation (loss of earnings)	<p>Purpose. To provide replacement income for loss of earnings due to injury.³⁸</p> <p>Eligibility. Available to claimants who were in paid employment at the time of their injuries and immediately before they were incapacitated from employment due to their injuries.</p> <p>Entitlement ceases³⁹:</p> <ul style="list-style-type: none"> • where a claimant is no longer incapacitated from their pre-injury employment • where a claimant has successfully proceeded through the vocational rehabilitation process • based on the New Zealand Superannuation qualification age. 	<p>Payments represent 80% of a claimant's weekly earnings lost due to their injury.</p> <p>The minimum rate paid to full-time earners (30 hours or more of work per week) who are injured is the greater of either 80% of the minimum wage or 80% of the rate of supported living payment for a single person over the age of 18. This minimum rate is currently \$528.</p> <p>Weekly compensation is reduced by abatement when a person continues to earn during the period when they are receiving weekly compensation from ACC.</p> <p>People can earn the difference between what ACC pays in weekly compensation and what they were earning pre-injury before weekly compensation reduces dollar for dollar.</p>

38 The first week is usually paid by the employer if the injury occurs at the place of work.

39 Weekly compensation is usually limited to a period of time. ACC may assess that a person has achieved 'vocational independence' and is capable of working full-time in a job for which they are suited by their experience, education or training. In that case the weekly compensation will continue for another three months to allow the person to find employment (with the help of ACC services), then it will stop. If a person cannot find a job during those three months, they can register with Work and Income to apply for a benefit.

Name	Purpose and eligibility	Rates, abatements, cut-offs
Weekly compensation (loss of potential earnings)	<p>Purpose. To provide earnings compensation for claimants who are injured at a young age and, as a result of their injuries, are unlikely to gain paid employment or will face significant challenges securing paid employment.</p> <p>Eligibility. Available to claimants who:</p> <ul style="list-style-type: none"> • were under the age of 18, or engaged in full-time study that began before the age of 18, at the time of their injuries, and • are unable to engage in suitable employment due to their experience, education or training, and • have been incapacitated for six months or more. <p>Entitlement ceases:</p> <ul style="list-style-type: none"> • where a claimant is no longer incapacitated from suitable employment • where a claimant has successfully proceeded through the vocational rehabilitation process • based on the New Zealand Superannuation qualification age. 	<p>Payments are the greater of either 80% of the minimum wage or 80% of the rate of supported living payment for a single person over the age of 18. The rate is currently \$528.</p> <p>Weekly compensation is reduced by abatement when a person continues to earn during the period when they are receiving weekly compensation from ACC.</p> <p>People can earn the difference between what ACC pays in weekly compensation and what they were earning pre-injury before weekly compensation reduces dollar for dollar.</p>
Compensation for permanent impairment (lump sum)	<p>Purpose. To provide financial compensation for non-economic loss related to the permanent loss or impairment of bodily function.</p> <p>Eligibility. Claims with a date of injury on or after 1 April 2002 are eligible to be considered for lump sums.⁴⁰ Earlier claims are eligible to be considered for independence allowance.</p> <p>A lump sum is payable where a claimant is assessed as having an impairment of 10% or above.</p>	<p>Payment rates currently range from \$3,455.24 to \$138,209.55, depending on the level of impairment. A lump sum is paid as a one-off payment.</p>
Compensation for permanent impairment (independence allowance)	<p>Purpose. To provide financial compensation for non-economic loss related to the permanent loss or impairment of bodily function.</p> <p>Eligibility. Claims with a date of injury between 1 April 1974 and 31 March 2002 are eligible to be considered for independence allowance.</p> <p>An independence allowance is payable where a claimant is assessed as having an impairment of 10% or above.</p>	<p>Payment rates currently range from \$197.73 to \$1,186.64, depending on the level of impairment, and are paid quarterly.</p> <p>Claimants can elect to receive one-off payments covering five years in lieu of quarterly payments. This is called a single payment option.</p>

40 There are some exceptions for sensitive claims (i.e. mental injuries caused by sexual violence), work-related gradual process disease or infection claims, and treatment injury claims, where the date of the causative event is considered, as well as the date of injury.

Several researchers have highlighted the differential treatment of people unable to work due to ill health and those unable to work due to injury (Duncan, 2017; Fletcher, 2018; Oliphant, 2004; Palmer, 2018; Stephens, 2004). Over the years various reports have considered this. The 1989 Budget announced that ACC cover was to be extended to all forms of incapacity from 1991, but a change of government reversed that decision (Stephens, 2004). When the accident compensation scheme was established, the intent was to eventually extend equivalent coverage to people with a health condition or disability not arising from an accident. *“The community had a responsibility to protect all citizens from the burden of sudden individual losses, when their ability to contribute to the general welfare by their work was interrupted by physical incapacity”* (Palmer, 2018: 4).

There are various options for resolving the problem, each with its own not inconsiderable challenges. These could include:

- extending coverage of an ACC-type scheme to people with health conditions and disabilities not caused by accident to give equivalent financial and other support.
- partially extending coverage of an ACC-type scheme to include at least some illnesses such as, for example, all chronic work-related health problems and/or permanent and severe conditions not arising from work. This does not resolve the question of where coverage starts and stops
- learning from the successful features of ACC’s approach and introducing as many of them as possible to MSD. This would require increases in the funding/assistance available through MSD to narrow the gap with ACC
- establishing a single purchaser for non-ACC recipients. Various streams of existing support (for example, Disability Allowance and funding provided through other agencies) could be aggregated and channelled through a single agency. This agency could coordinate services for disabled people, reducing compliance costs and providing more patient-centric services.

Stakeholders – especially people with work-limiting health conditions and disabilities – should be involved in the development of options and the design of whatever approach is selected.

Additional assistance to address the costs of having health conditions or disabilities

Health conditions and disabilities impose extra costs on individuals who have them, but determining the amount is difficult

Disabled people’s basic needs are similar to everyone else’s (e.g. eating, getting up in the morning, keeping warm, connecting with others, going shopping). However, there is considerable evidence that having health conditions or disabilities imposes additional costs on individuals and families (Mitra et al., 2017). Internationally (Melnychuk et al., 2018) and in New Zealand (Wynd, 2015) there is evidence that families with disabled children or children with significant health conditions have lower incomes and living standards and higher levels of social exclusion.

The costs associated with having a health condition or a disability are difficult to calculate and vary from person to person, depending on factors such as:

- *the type and severity of impairment.* Typically, people with severe impairments have high additional costs. People with high physical, intellectual and mental health impairment needs may incur considerably higher additional resource costs than those with high vision- or hearing-impairment needs. The degree of impairment may change over time (e.g. people may have deteriorating or fluctuating conditions), leading to changes in support needs
- *the availability and accessibility of resources to reduce barriers*

- *the additional time required by people with work-limiting health conditions and disabilities to complete everyday activities*
- *the different costs associated with different life cycle stages or transition points.* UK evidence suggests that families with disabled children have lower incomes, living standards and levels of social inclusion⁴¹ than those who do not. Life-cycle transitions (e.g. leaving school, leaving the family home and becoming an adult living independently in the community) can lead to changes in the costs. People aging with impairments may find that their informal carers are also aging and less able to assist them. When in the life cycle a disability occurred is also important. People who become disabled early in life may be particularly disadvantaged as they have less opportunity to make financial provision to enable them to meet disability-related expenses
- *the extent to which people have natural supports⁴² and are expected to rely on them*
- *whether or not people are living in community settings.* There has been a move in recent decades to people with significant disabilities living in the community. There is strong evidence that living in community-based settings leads to better outcomes for disabled people, although there is still considerable room to improve outcomes (Francis et al., 2014) and differing views on what constitutes living in the community. Community living may cost the state less than residential care, but more robust research is needed on the circumstances in which this is the case (Sakellariou & Rotarou, 2017). There is evidence that the costs of supporting those with high levels of need are high wherever these residents live, and higher than the costs of those who are more independent (Mansell et al., 2007).

Despite issues with defining the cost of disability, there is evidence that the out-of-pocket costs of meeting people's health and disability needs are high and that many on low incomes cannot cover them (Callander et al., 2017; Kirby et al., 2013; Sum et al., 2018). The costs are typically greater for those with:

- severe limitations on their ability to undertake everyday activities
- multiple and/or chronic health conditions or disabilities.

Many people on working-age benefits have work-limiting health conditions or disabilities that are long term. The number of people receiving benefits for such conditions is high and expected to increase in coming decades. This is as a result of the aging population, improvements in treatments that allow people to live for longer, and the rise of non-communicable risk factors such as obesity (Cumming, 2017) along with work practices that do not support mental wellbeing.

People with long-term conditions and/or multiple conditions are often required to carry out numerous tasks to maintain their health and administer their healthcare.⁴³ Amongst people receiving SLP and JS-HCD, it is common for people to have long-term conditions and/or multiple conditions.

41 A recent UK study, using data on 54,641 families from the Family Resources Survey (2004-2012), matched families with (cases) and without (controls) a disabled child on family and child characteristics plus living standards and calculated the income difference inclusive of disability benefits. The findings suggest that across families with the most disabled children, a compensating variation equal to an extra £56-£79 a week was required to achieve the same living standards as matched families without disabled children compared with the mean level of state disability benefit £47-£71 a week in this group (Corcadden et al., 2017; Royal Australian and New Zealand College of Psychiatrists, 2015).

42 'Natural supports' often refers to the resources inherent in community environments, including personal associations and relationships that enhance the quality, and security, of life for people. Natural supports usually involve family members, friends, co-workers, neighbours and acquaintances. Some people have few natural supports and may need help in developing and maintaining these connections.

43 This includes: managing different tablets to be taken at specific times of the day, of the week or only occasionally; keeping stock of their pills, creams, inhalers and injections; requesting repeat prescriptions on time; and visiting the pharmacy to collect items (Corcadden et al., 2017; Royal Australian and New Zealand College of Psychiatrists, 2015).

Currently SLP recipients receive a higher rate of benefit than those in receipt of JS-HCD. In 1991 the Sickness Benefit was reduced to a level slightly higher than the Unemployment Benefit to provide a greater incentive for people who had health conditions or disabilities and some work capacity to move into paid work.⁴⁴ People receiving the Invalids Benefit (later SLP) were seen as having no alternative possibilities for receiving income owing to the long-term and severe nature of their health conditions or disabilities. This was the rationale for paying them at a higher rate.

There are a number of implicit assumptions underpinning this approach: the higher benefit rate acted as a disincentive to move into work; people on the Sickness Benefit had temporarily limited work capacity; and if people needed to access healthcare they had sufficient resources to do so through the health system.

These assumptions may not be realistic:

- Creating a greater gap between what someone receives on a benefit and what they receive in paid employment has not been sufficient to move people with health conditions or disabilities into employment. At a time when benefit rates are low relative to wages, we have still seen growth in the number of people on health and disability benefits.
- There is evidence that people with health conditions and disabilities cycle between low-income jobs and benefits. Under these circumstances they are unlikely to have substantial savings to fall back on.
- Many people receiving JS-HCD have long-term chronic conditions (e.g. mental health conditions, musculoskeletal conditions). While many are still able to work in suitable employment with the right support, the range of jobs available to them may be more limited.
- There are significant inequities in health, with Māori, Pacific People and low-income people having poorer health than other New Zealanders. Cost is a significant barrier to accessing health and disability services and filling prescriptions.⁴⁵

People may also incur costs in staying well. Many disabled people are not unwell, but some have health complications arising from their disabilities that impose additional costs (e.g. additional doctors' visits, prescriptions). Moreover, various studies have shown that disability is an added impediment in accessing health services (Sakellariou & Rotarou, 2017). In New Zealand there is evidence that people on benefits have considerable difficulty accessing the health and disability supports and services they need. Improving access to primary care, dental care, drug and alcohol services, mental health care, secondary care, vision services and spectacles, hearing services and hearing aids, and healthy housing is particularly important for those on low incomes (Children's Commissioner's Expert Advisory Group on Solutions to Child Poverty, 2012; Potter et al., 2017; Sural & Beaglehole, 2018).

In New Zealand various agencies provide financial assistance to compensate for the additional costs of having a disability.⁴⁶ The system is complex for people with work-limiting health conditions and disabilities to navigate and not user centred. This is especially the case for people who have complex needs requiring frequent interactions with different parts of the health system (e.g. those with chronic conditions and/or multiple conditions⁴⁷).

44 At the time, the benefit rates were seen as being too high relative to wages. The Government sought to widen the gap between wages and benefits.

45 Internationally and in New Zealand there are indications that people skip medications and do not go to the doctor because of cost (Corscadden et al., 2017; Ministry of Health, 2017a).

46 How Government helps with the cost of disability <https://www.msd.govt.nz/about-msd-and-our-work/publications-resources/literature-reviews/cost-of-disability/index.html>.

47 MOH does not generally fund disability support services for people with: personal health conditions such as diabetes or asthma; and mental health and addiction conditions such as schizophrenia, severe depression or long-term addiction to alcohol and drugs.

Internationally there is no agreement on how to determine objectively the size or adequacy of allowance payments. It is difficult to compare the cost of disability across countries (Antón et al., 2015). The ways in which disability and costs are defined vary and appear to be pragmatic responses to local situations. However, four common additional resources are consistently mentioned as necessary by disabled people,⁴⁸ regardless of their wider circumstances:

- Human support to undertake the ordinary activities of daily living and social participation.
- Accessible and timely transport for disabled individuals who cannot drive their own vehicles is a significant need for some.
- Unique resources and equipment that might be purchased solely because of disability (e.g. wheelchairs, counselling or skills training to support disabled people in tackling the barriers they experience in daily life).
- Support to cover the costs of commonly available resources that may need to be modified for use (e.g. telephones, special foods) or used at a higher rate (e.g. heating).

The costs may be one-off or recurrent.⁴⁹ Some costs may be difficult to calculate e.g. bias and discrimination as obstacles to access.

In New Zealand a study found that, based on a budget standards methodology,⁵⁰ the additional weekly costs for a single disabled person living alone ranged from just under \$200 a week to over \$2,500 a week, depending on the impairment type and level of need. This work needs to be updated (Travalgia et al., 2010).

Several agencies provide financial assistance to compensate for the additional costs of having a disability

In New Zealand various agencies provide financial assistance to compensate for the additional costs of having a disability (Travalgia et al., 2010). Within the welfare system, income support for disabled people may come from SLP and JS-HCD (see earlier). In addition to the main benefits, financial assistance can be given through supplementary benefits, of which most are means tested. ACC provides income support and compensation for people who have disabilities resulting from injuries and/or accidents (see earlier).

Disability-related support services are provided via a number of agencies, including MSD, MOH, the Ministry of Education, ACC, District Health Boards (DHBs) and the NZ Transport Agency (Appendix 1). Government-funded disability-related support services include those for:

- personal support
- equipment and modifications (such as wheelchairs, hoists, hearing aids and housing and vehicle modifications)
- carer support
- assistance for people who have accidental injuries
- special education services
- support with activities of daily living and to participate in the community
- other financial assistance (such as DA).

48 How Government helps with the cost of disability <https://www.msd.govt.nz/about-msd-and-our-work/publications-resources/literature-reviews/cost-of-disability/index.html>.

49 Adaptations to a disabled person's home, or the cost of purchasing and moving into more suitable accommodation, can be regarded as capital items that would not need to be repeated. Expenditure on fuel, food and clothing is recurring spending that would have to be met out of current income. A borderline category consists of durable goods such as wheelchairs, washing machines and so on, which impose costs from time to time when they need to be replaced.

50 A budget standards methodology involves defining the basket of goods, services and activities required for a given household to achieve a certain standard of living. Costs are attached to each item, and budgets achieved by calculating average weekly costs for all items over the person's lifetime. Final budgets are constructed by comparing the resource use of disabled and non-disabled people (Travalgia et al., 2010).

MSD provides assistance to cover the costs of disability

MSD provides several supplementary forms of assistance that can assist in covering the additional costs of disability. These include DA, Temporary Additional Support (TAS) for those with excess disability costs, and CDA (see the WEAG carers paper – WEAG, 2019b).

The take-up of DA from MSD may not be as high as it could be. DA is capped supplementary assistance of up to \$63.22 a week⁵¹ to help meet the verified additional, ongoing and direct costs of a health condition or disability. The types of cost for which recipients receive DA include medical fees, pharmaceuticals, transport, power and gardening. To be eligible to receive DA a person must:

- meet an income test
- have a disability that is likely to last at least six months
- have additional ongoing costs arising from that disability
- be a New Zealand citizen or permanent resident, or deemed to hold a residence class visa in New Zealand under the Immigration Act 2009 (e.g. an Australian citizen or resident)
- generally be ordinarily resident in New Zealand.

People on health and disability benefits are the biggest group taking up DA after New Zealand Superannuation recipients (Table 7). NZ Europeans represent the ethnic majority of recipients of DA (Table 8).

Table 7: Disability Allowance receipt as at August 2018

Benefit group	DA recipients
Other (Emergency Benefit, Emergency Maintenance Allowance)	1,747
Jobseeker Support related:	
• JS-HCD	25,534
• JS-WR	4,740
New Zealand Superannuation, Veteran's Pension, Transitional Retirement Benefit	128,198
Non Ben	7,387
Orphan's Benefit, Unsupported Child's Benefit	275
SLP related	57,282
Sole Parent Support	6,789
Youth Payment/Young Parent Payment	38
TOTAL	231,990

Source: IAP Data Warehouse, prepared by Business Reporting Team, Insights MSD Group, Ministry of Social Development.

51 It is not a flat rate – \$63.22 is the current maximum weekly rate a person can receive, but many people receive less than the maximum as smaller weekly payments. The maximum rates are discretionarily subject to adjustment as part of the Annual General Adjustments process. http://legislation.govt.nz/act/public/1964/0136/latest/DLM367136.html?search=ta_act_s_ac%40ainf%40anif_an%40bn%40rn_25_a&p=2.

Table 8: Disability Allowance receipt by ethnicity as at August 2018

Ethnic group	DA recipients
Unspecified	21,894
Māori	37,287
NZ European	123,781
Other	38,493
Pacific People	10,535
TOTAL	231,990

Source: IAP Data Warehouse, prepared by Business Reporting Team, Insights MSD Group, Ministry of Social Development.

Supplementary assistance such as DA is important in helping to meet additional costs associated with disability e.g. medication and therapy. This funding is particularly important for those on low incomes. However, the process of accessing the reimbursement of costs often requires more effort and energy than the affected person has, meaning they miss out.

There are indications that some people have disability-related costs that are not able to be met by DA due to the weekly capped limit. If a person with excess disability costs meets the disability exception criteria and other eligibility criteria, they may have a portion of those excess costs included in a formula assessment for TAS (another form of supplementary assistance) (see Table 9).

Table 9: DA supplementary and showing excess DA costs being included in TAS

Date	Benefit group	Number of recipients	Number of DA recipients paid	DA costs included in TAS			Mean DA costs
				Number	Sum	Mean	
Jun-18	New Zealand Superannuation, Veteran's Pension	128,794	128,822	589	\$59,858.21	\$101.63	\$25.61
	Emergency Maintenance Allowance	37	44	1	\$139.77	\$139.77	\$19.76
	Sole Parent Support	6,030	7,022	238	\$26,461.98	\$111.18	\$26.17
	SLP related	54,527	57,404	2,110	\$250,996.06	\$118.96	\$28.73
	Youth Payment/ Young Parent Payment	35	36	0	\$0.00	\$0.00	\$11.15
	Jobseeker Student Hardship	14	16	1	\$79.00	\$79.00	\$45.19
	Emergency Benefit	1,425	1,749	8	\$682.30	\$85.29	\$12.33
	Jobseeker Support related	28,881	30,087	793	\$80,290.89	\$101.25	\$17.66
	Non-beneficiary	6,850	7,453	54	\$5,842.95	\$108.20	\$25.02
	TOTAL	226,593	232,633	3,794	\$424,351.16	\$111.85	\$25.26

Source: IAP Data Warehouse, prepared by Business Reporting Team, Insights MSD Group, Ministry of Social Development

Notes: Where DA costs are included in TAS, this does not necessarily reflect the amount of TAS actually paid.

In many cases the recipient has other TAS costs as well and the rate of TAS has prescribed upper limits.

This table excludes Orphan's Benefit and Unsupported Child's Benefit.

A recipient may receive DA for themselves, their partner and their child(ren).

All DA costs for each individual are included in calculating the 'DA maximum rate' and this is included in TAS as 'DA component'.

The DA component in TAS may be made out of DA costs from multiple DAs (e.g. DA for the benefit recipient and children in their care).

MSD is currently undertaking work to better understand the requirements, processes and challenges around the DA service. There are concerns that the take-up of DA is less than ideal.⁵² Given the link between poverty and poor health, a higher take-up of DA could be expected.

Barriers to taking up DA may include:

- a lack of exposure to Work and Income services and awareness that the allowances are available. People receiving SLP are not required to go to MSD and are usually streamed into General Case Management (GCM), where they typically have less contact with case managers and lack continuity, even though their situations are long term
- a negative perception of MSD and reluctance to approach sites for assistance
- a high administrative burden: the application process is considered daunting by some; there are sometimes difficulties in sourcing supporting documentation; and applying for relatively small claims is seen as burdensome by potential recipients
- an applicant having a health condition or disability that impairs cognitive functioning – especially where the person has few natural supports to assist them.

52 There are limitations on this analysis and measuring the take-up of supplementary assistance payments. The key limitation is that agencies have limited knowledge of who is not applying. Additionally, it may be possible that the take-up levels are low because once people have moved into employment they are not aware that they are still eligible to receive this assistance.

Part 3: Supporting return to work

Unemployment is detrimental to wellbeing

There is considerable evidence that unemployment has detrimental impacts on health and wellbeing. Unemployment and transitions into worklessness are known to be associated with increased morbidity and mortality, worse self-rated health and reduced social activity and social support. This body of evidence is well established and includes systematic reviews and robust meta-analyses, although the direction of causality may still be contested (Curnock et al., 2016).

As well as its health effects, unemployment negatively affects the likelihood of a person finding work again (Helgesson et al., 2016). This effect of unemployment is more severe when the economy is performing poorly, as there are fewer available jobs. Young people can be particularly disadvantaged as they experience long periods of unemployment (OECD, 2010).

In New Zealand one of the lessons of the reforms of the 1980s and early 1990s was that long-term unemployment is particularly harmful. Even in the good times, long-term unemployment amongst disadvantaged communities persists. In 1987 unemployment was low and the proportion of people unemployed who were out of work for six months or more (long-term unemployed) was only 27%. However, by 1991 unemployment had risen to over 11% and 44% of these people were long-term unemployed. Furthermore, this proportion remained above its 1987 level until 2003, as employers were relatively unwilling to take a chance on people who had been out of work for sustained periods of time (Nolan, 2013).

While increasing absence from work is associated with a lower probability of returning to work, this does not show a causative relationship. The reasons for someone not returning to work are typically multifaceted (Martin, 2014).

Suitable work appears to be good for wellbeing, but there is no one-size-fits-all return-to-work intervention

The balance of evidence is that work can make working-age benefit recipients better off, but outcomes for any individual will depend on a range of factors, including whether the work accommodates their individual capacity or caring responsibilities, the quality and accessibility of the job, and the financial gains from working. However, the connection between work and wellbeing is not a straightforward one.

- The evidence that work is good for wellbeing is less direct. While employment can assist with recovery, poor-quality jobs⁵³ and jobs and work environments that have a poor fit with people's conditions can be detrimental. There is a lack of high-quality evidence on the impacts on wellbeing when those receiving disability benefits move towards labour market participation (Curnock et al. 2016; OECD, 2015, 2018).
- People may experience improvements in income but not necessarily health. The evidence is stronger that engagement in suitable work improves mental health (Curnock et al. 2016). Re-employment has been found to lead to improved self-esteem, improved general and mental health, and reduced psychological distress.
- While work can be positively associated with good health, for example, it could be that people in work are healthier because employers prefer to hire healthy people, rather than because work causes good health.
- Further research is needed to better understand the impacts of work on wellbeing – especially for those who have been out of work because of ill health.

53 Canivet et al., 2017; Canivet et al., 2016; Kawada, 2018, Vancea & Utzet, 2016.

All OECD countries have struggled to reduce numbers on health and disability benefits

In New Zealand (and internationally) health and disability benefit recipients are a heterogeneous group. There are few interventions that are successful for all in this population, underscoring the need for a variety of approaches.

Across the OECD, concerns about the rising number of people receiving health and disability benefits have driven significant changes. In the past two decades there has been a move away from providing generous and easily accessible incapacity benefits with little emphasis on moving recipients into work towards greater activation (OECD, 2010). Key changes have included a greater focus on:

- assessing capacity not incapacity
- requirements to participate in work-related activities
- assessments of medical conditions that are tied to effective return-to-work assistance
- making work pay
- getting the right services to the right people at the right time.

The OECD has recommended implementing a coherent combination of policies that work on changing the behaviour of individual recipients of health and disability benefits, employment agencies, health practitioners who work with people with work-limiting health conditions and disabilities, and employers to improve outcomes for people with work-limiting health conditions and disabilities (Böheim & Leoni, 2018).

Within OECD countries, there are considerable variations in the application of policies related to people on health and disability benefits. For example, the Scandinavian countries are characterised by a high degree of social protection and strong support for labour market integration. Anglo-Saxon countries such as New Zealand have been characterised by lower and more conditional levels of social protection and a work-first approach (Böheim & Leoni, 2018).

To date, activation approaches have been less successful in helping recipients of health and disability benefits to find work compared to other groups (e.g. sole parents, unemployed). Martin (2014) states:

Given the large numbers of working-age people on such benefits and the relatively low exit rates from such benefits to work, it has to be a very high priority to determine how activation strategies can be made more effective for people with health-related issues. What mix of rehabilitation, benefit conditionality and workplace supports could work better for such people than the current one? How can one achieve the necessary coordination between the health care sector, the PES⁵⁴ and private employment service providers, rehabilitation and employers so as to boost the employment and career prospects for the disabled with some work capacity?

Reasons for limited success in returning people with work-limiting health conditions and disabilities to work

Spending on active labour market programmes for people with work-limiting health conditions and disabilities is lower than for other groups of working-age benefit recipients

New Zealand spends less than many other OECD countries on active labour market programmes, and the amount has been declining for many years (OECD, 2017). However, we also spend less on people with work-limiting health conditions and disabilities receiving benefits relative to other groups of jobseekers. This is despite the fact that they are the largest group of working-age benefit recipients (Appendix 2).

New Zealand spends very little on supported employment and vocational rehabilitation compared with other OECD countries

There is no one definition of supported employment and vocational rehabilitation. However, key elements are:

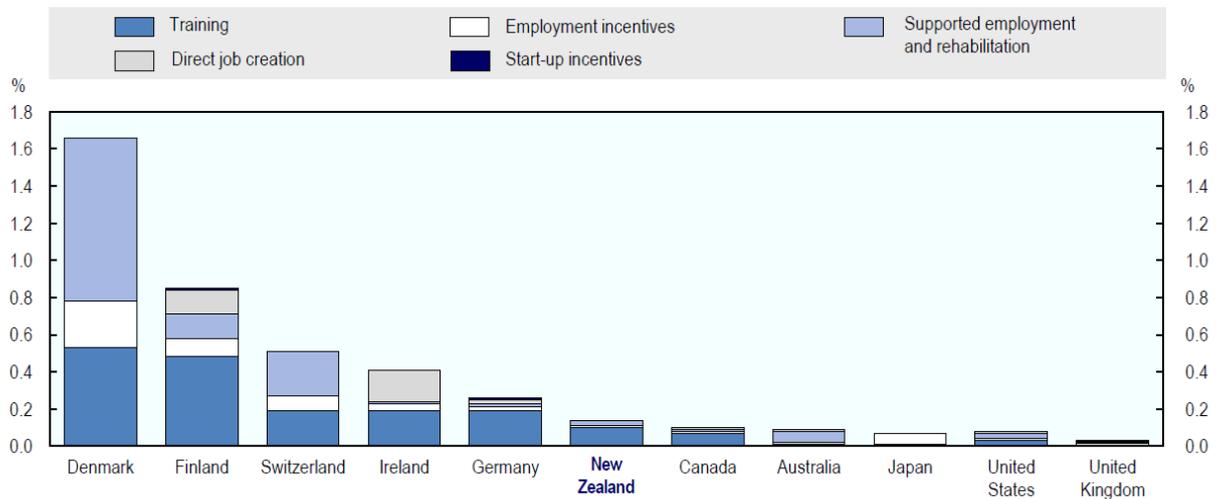
- intervening early with a focus on early placement in the regular labour market (Cullen et al, 2017)
- listening to and understanding the person in their context
- working with the person to plan and deliver an agreed rehabilitation pathway (Scaratti et al., 2018)
- mobilising support and services (often multidisciplinary, multi-stakeholder) to access, maintain or return to employment or other useful occupation. Having integrated employment and health services and accommodating workplaces is important
- understanding that moving into work is not an all-or-nothing event. It is a process where people prepare for, move closer to and engage in work. This process may not be linear.

Evidence-based, integrated health and employment approaches, such as supported employment and vocational rehabilitation, have been shown to be beneficial for several groups of people with work-limiting health conditions and disabilities – for example those with:

- *mental health conditions*. For example, the most well known supported employment model for people with mental health conditions is Individual Placement and Support (IPS). In systematic reviews and meta-analyses and a Cochrane review, IPS has consistently demonstrated significantly greater effectiveness than the best locally available alternative approaches in helping adults with severe mental illness into work (Drake et al., 2013; Kinoshita et al., 2013; Modini et al., 2016)
- *musculoskeletal conditions*. Multi-domain interventions (i.e. with healthcare provision, service coordination and work accommodation components) have been shown to be effective for people with musculoskeletal or pain-related conditions and mental health conditions (Cullen et al, 2017).

Integrated health and employment approaches may be effective for other groups (e.g. those with addictions, autism spectrum disorder or chronic pain) (Lones et al., 2017; Mavranezouli et al., 2014; Rødevand et al., 2017). The OECD has reported that New Zealand has low expenditure on these types of employment support relative to countries such as Denmark, Finland and Switzerland (Figure 5) (OECD, 2018).

Figure 5: Expenditure on supported employment and rehabilitation



Source: OECD database on active labour market programmes, 2011

Not everyone needs an intensive, integrated service response. People with work-limiting health conditions and disabilities may face a range of barriers to employment that affect them to varying degrees. A person's health condition or disability may not be the main barrier to their getting a job (e.g. a lack of educational qualifications may be the main barrier). Others may just need some time to recover from illnesses and can then quickly return to work.

However, some face multiple, complex barriers to returning to work (e.g. housing problems, no educational qualifications) alongside their health conditions or disabilities (many have more than one). Added to this, the environment can act as a barrier (e.g. discriminating employers, inaccessible buildings). The way in which these play out varies from person to person, requiring an individualised, nuanced approach to address the range of barriers, such as that offered through evidence-based supported employment interventions.

ACC provides integrated return-to-work assistance but only to earners who have had accidents

ACC has a strong focus on early intervention, medical and occupational assessment, vocational rehabilitation and a fast return to work, but only for earners injured as a result of accidents, not illnesses unless they are caused directly by work. Earners who are injured in accidents receive considerable bespoke support to return to work. ACC may provide occupational therapy and coordinate with a claimant's employer as part of a gradual return to work or rehabilitation plan. Vocational rehabilitation is open to individuals who are currently employed but absent from their work. This includes income support at 80% of their pre-accident earnings.

The primary aim of the ACC process is to return eligible claimants to their pre-injury jobs. If this is not possible, there are various options. ACC may:

- offer a back-to-work programme and help a claimant to find a new job where the claimant's work capacity has been restored successfully. Such assistance is only available for a limited time before the person is referred to MSD
- transition a claimant to MSD if they develop an illness during the rehabilitation process that is not related to the initial accident
- get a claimant to the point where they are vocationally independent. Once rendered vocationally independent, ACC payments are stopped after another three months. Many are not in work at this point.

ACC provides social but not vocational rehabilitation to non-earners who have had accidents.

There is evidence that the approach taken by ACC is effective in returning earners to work. New Zealand research comparing outcomes for ACC recipients with those for non-ACC recipients found that the ACC approach had a positive impact on outcomes. A comparative cohort study undertaken of stroke versus injury found that earnings-related compensation and rehabilitative support, available to injured people via ACC, largely prevented the downward spiral into poverty and ill health. In the study, the Illness Group, with 'safety-net' income support, had considerably poorer socio-economic outcomes than the Injury Group. The Injury Group, eligible for earnings-related compensation, returned to work earlier. Those who did not return to work, with minimum income support, were most vulnerable to declines into poverty and ill health (McAllister et al., 2013; Paul et al., 2013).

MSD has implemented trials aimed at providing integrated health and employment support, but nothing has been implemented at scale

MSD is building up its knowledge of what works to assist people with work-limiting health conditions and disabilities to return to work. MSD is currently trialling IPS. There are other trials underway aimed at improving outcomes for people with work-limiting health conditions and disabilities (see Appendix 3).

MSD funds vocational services for disabled people, but these are not typically evidence-based, integrated employment and health services. MSD has been undertaking work to strengthen these services.

MOH and DHBs provide patchy rehabilitation support for people who have ill health or disabilities that do not arise from accidents

People with work-limiting health conditions and disabilities not caused by accidents are typically required to navigate the health system to receive the support they need. They include:

- workers struggling with chronic, often stress-related mental health conditions. They may drop out of the labour market without receiving any such support
- a large number of people who develop physical illnesses of a chronic nature (e.g. musculoskeletal conditions, diabetes) that are not caused by work or cannot clearly be linked to work
- anyone born with a disabling health condition or disability
- those who develop illnesses requiring time away from work but from which they are likely to recover.

The availability of rehabilitation services to support returns to work is varied and often inequitable (Ministry of Health, 2011), especially for people who have health conditions or disabilities that are not caused by accidents. The health system is complex, which contributes to the difficulties people have in accessing the care they need. More recently there have been efforts to provide free primary-care access and expand the Very Low Cost Access scheme⁵⁵ to additional groups.

There is a lack of early intervention in MSD for people with work-limiting health conditions and disabilities

There is no focus in the welfare system on early intervention to support returns to work for people with work-limiting health conditions and disabilities. Better assessment and support systems are needed that quickly identify health issues among all people claiming benefits, regardless of the primary reasons for claims, and link them to appropriate, evidence-based return-to-work support.

55 The scheme supports general practices with enrolled populations of 50% or more high-needs patients, where the practices agree to maintain patient fees at a low level.

It is unclear how effective changes have been to MSD assessment processes for recipients with health conditions or disabilities

The original intent of these assessment tools was to support staircasing recipients with health conditions or disabilities into sustainable employment and independence. The assessments, if used correctly, may also help case managers to determine if recipients are streamed into the most appropriate case management services and are receiving correct financial assistance.

Case management practice has evolved, and recently some regions have given staff flexibility in how and when they use workability assessment tools to better align these tools with case management practice. It is unclear whether these assessments have been delivering on the original intent of the policy.

Evaluations and internal reviews indicate there is room for improvement:

- There is no accurate information on the volume of self-assessments, structured interviews and WAAs undertaken, or on the recipient experience.
- Self-assessments require time and often assistance from case managers to complete and some staff have reported that information collected is not relevant in assisting returns to work.
- Work is needed to better use the work capacity medical certificate to assist returns to work. The large volume of medical certificates (about 432,000 medical certificates are completed each year) imposes costs on recipients, medical practitioners and MSD. More frequent medical assessments do little to increase the time spent off benefit. It is unclear whether or how case managers are using the information provided in medical certificates beyond benefit grants to assist recipients into work. International evidence indicates that medical assessments may be effective in assisting people with health conditions to return to work if matched with appropriate return-to-work support (Clayton et al., 2011; OECD, 2015).
- Structured interview use by case managers is low. Case manager knowledge is low of what a structured interview is, when it is to be used and what it is intended for.
- Information on the use and effectiveness of WAAs is limited. Their use has not been formally evaluated. However, indications are that WAAs are infrequently used as a basis for forming plans with recipients at risk of remaining on benefits for a long time.
- Responding in a timely manner with the right approach to the needs identified in the assessment process is challenging. The various assessment processes can provide MSD staff (e.g. case managers, work brokers) with better information to assist recipients. However, a process evaluation indicated that there are barriers to providing the right assistance at the right time to assist returns to work. For example, case managers reported: not always having enough time available to have work-focused conversations; difficulty connecting recipients with services that may help; employer reluctance to employ recipients with health conditions or disabilities; and work broker reluctance to push employers to take on such recipients.

The take-up of mainstream employment support appears to be lower for people with work-limiting health conditions or disabilities receiving benefits

A variety of supports⁵⁶ are available for all recipients of main benefits (including those with disabilities or health conditions). They are designed to help people find sustainable work in the open labour market. However, only 13% of participants in an employment programme (excluding case management but including some disability-specific programmes) have health conditions or disabilities, despite being half of the population receiving main benefits.

56 To help MSD better target services to those who need the most support in a timely manner, an Employment and Social Outcomes Multi-Category Appropriation was established. You have received a separate briefing on this and the other appropriations in Vote Social Development.

In particular, work-focused case management is often a gateway to employment support, so recipients on SLP who do not have access to this service have little access to support to find work.

Case management is the intervention most commonly offered to people with health conditions or disabilities, but there is only limited evidence of effectiveness for this group

Internationally, the use of case management is widespread. It has become the mainstay of service delivery in welfare and health sectors in many countries. However, there are varying interpretations of the term ‘case management’ (Butler et al., 2012). There is still no consensus among users regarding its components and appropriate application.⁵⁷ Not only do definitions of case management vary across jurisdictions, but its impact as an activity in itself has been difficult to isolate. This is often because it is implemented as part of a package of initiatives. However, evidence indicates that effective case managers are critical to the success of interventions aimed at assisting people into work.

UK research indicates that recipients generally support the case management approach in which personal support and advice are given, with the appropriate provision of services to meet their needs. However, research indicates that existing programmes must be modified and extended for the more complex needs of those workers further from the labour market (Hasluck & Green, 2007). Smaller caseloads are more likely to be effective.⁵⁸

In New Zealand, case management for people with health conditions or disabilities has so far had limited impacts on returning people to work. At some point those receiving JS-HCD with part-time work obligations (only about 13% of JS-HCD recipients) are streamed into Work Focused Case Management – Health and Disability (WFCM-HCD).⁵⁹ This service provides specialised case management support for people with health conditions or disabilities to help them prepare for work and resolve any specific barriers to work they might have. WFCM-HCD caseloads are capped at 100 people who are the primary recipients of main benefits for each case manager. MSD found that after nearly two years, WFCM-HCD was breaking even. However, it achieved only a small reduction in the time participants spent on the main benefits (Ministry of Social Development, 2017b).

The Mental Health Employment Services’ externally contracted case management services did not increase recipients’ time off main benefits compared with MSD-delivered case management (Ministry of Social Development, 2017a). This trial was stopped and a new service – Work to Wellness – was introduced. It is currently being evaluated.

Many people on health and disability benefits do not have access to WFCM-HCD:

- Few people who receive SLP have access to work-focused case management. The overwhelming majority are streamed into GCM when they especially need continuity. MSD does not know the effectiveness of GCM. There has been limited research exploring the quality of the service that GCM recipients receive and what improvements could be made.

57 There are several models of case management. For example:

- the ‘broker model’ does not involve any direct provision of service. It is purely information and referral only
- the ‘generalist case manager’ provides coordination of services as well as direct service functions such as advocacy, casework and the development of support systems
- the ‘primary therapist as a case manager’ focuses primarily on the therapeutic relationship with the recipient and supplements this intervention with traditional case management functions ((Hanson et al., 2006).

58 A German pilot of lower caseloads found robust evidence of the utility of reduced caseloads as an effective and efficient strategy for public employment services, but cautioned that it was unclear what would happen if all sites reduced caseloads (Hainmueller et al., 2015).

59 Case managers were responsible for proactively engaging with and providing case management to people who needed support to take steps towards employment, including: (i) creating plans to help people move towards employment, (ii) holding regular meetings to help make progress, (iii) providing income support administration (excluding benefit grants), and (iv) managing any other requirements from people on the case managers’ caseloads.

The GCM service has typically been used as a baseline to compare the effectiveness of more intensive services. We need to better understand case management for people with work-limiting health conditions and disabilities within the New Zealand welfare context.

- People receiving JS-HCD but with deferred work obligations (the majority of JS-HCD recipients) are not streamed into WFCM-HCD. They receive GCM rather than continuity of case managers. GCM is not a proactive service. Caseloads are uncapped and the focus is on meeting people's income support needs.

The Young SLP Opt-In trial⁶⁰ showed the value of working with disabled people. Under the trial SLP recipients aged 16-29 years could voluntarily opt in to WFCM-HCD to focus on employment, up-skilling and higher education outcomes in the medium to long term. The trial found that people were willing to participate and case managers could positively influence outcomes. Based on what MSD learned from the Young SLP Opt-In trial and its early success, the SLP Opt-In service for 16- to 59-year olds has been made available in all sites that have WFCM-HCD services.

People with work-limiting health conditions and disabilities need a case management service that is able to address the multiple barriers many recipients have to getting work. It may be that case management is a necessary but not sufficient approach to achieving positive outcomes for many recipients with health conditions or disabilities. Evidence indicates that models that integrate employment services and treatment services may be more promising than offering either strategy alone (Kools & Koning, 2018; Lammerts et al., 2017).

There is a lack of support to engage in part-time work

In New Zealand people are able to receive additional income from paid employment while receiving SLP or JS-HCD,⁶¹ but few do. In the 12 months to June 2017:

- only 10% of SLP recipients had earnings from employment
- just under 12% of JS-HCD recipients had earnings from employment

The welfare system in New Zealand does not encourage part-time work for people on SLP and JS-HCD, but these are the very people for whom part-time work should be prioritised. Part-time work is seen as a stepping stone to full-time work rather than an outcome in its own right. Case managers focus on off-benefit placements. The JS-HCD abatement rate also incentivises full-time work (30 hours or more) and therefore does not encourage a graduated return to work.

Nor does the system incentivise recipients with intermittent abilities to combine work and benefits. Some people will only ever be able to work part-time or may need to work part-time for a long period of time.

For SLP recipients there is a disincentive to earn more than \$200 or work more than 15 hours a week. SLP abates at a rate of 70 cents to the dollar after a recipient earns more than \$200 per week, and recipients working more than 15 hours per week lose their entitlement to SLP – except for people who are blind. The SLP never abates for recipients who are considered totally blind or severely disabled because their personal earnings are not counted under the Social Security Act. Recipients with fluctuating conditions and support needs are likely to be fearful of moving off SLP in case employment does not work out.

For those on JS-HCD, part-time work under 20 hours a week is not recognised as such under the Social Security Act. However, Stats NZ defines employment as working one or more hours a week when surveying people about their labour force status.

60 SLP recipients aged 16-29 years were given the opportunity to opt in voluntarily to WFCM-HCD.

61 For JS-HCD, abatement rates apply when a person reaches a certain level of income, including through earnings, resulting in reduced benefit payment (partial). People can work up to 30 hours per week (depending on abatement levels) before they are no longer considered eligible for Jobseeker Support (including JS-HCD). Similar rules apply to recipients of SLP. However, if SLP recipients work more than 15 hours per week their eligibility for SLP will be questioned.

Combining benefit payments and part-time hours may have positive effects on employment participation among those able to return to work on reduced working hours. As their health improves, the working hours can gradually be increased until they are able to work the hours they were doing prior to receiving a benefit. Internationally there is increasing evidence that graduated return to work is an effective tool for the rehabilitation of people on benefits due to ill health. Work resumption can be achieved faster when graduated return to work is started early or at a higher rate of initial work resumption. These findings, however, do not hold for individuals who have problems related to mental health (Kools & Koning, 2018).

The design of such schemes matters. In Denmark there is strong encouragement for people with work-limiting health conditions and disabilities to work part-time, but both current and new employees can be granted subsidies. Employers prefer existing employees with health conditions to people who have been in receipt of welfare benefits. In New Zealand part-time work can be a positive stepping stone to better incomes if we can support people to stay in employment. However, a recent study found that close to one out of every two people leaving benefits returns within 18 months, especially when they have lower earnings. More work is needed to understand what post-exit supports might help the two out of three people who are unable to sustain earnings of at least \$1,180 per month (Judd & Sung, 2018).

Return to support for people with mental health conditions

There are few publicly available mental health services for people with common mental health conditions

Policies tend to have a focus on diagnosed severe mental health conditions, with limited attention given and services provided to people with common mental health conditions, including most mood and anxiety disorders, which are frequently unrecognised or undiagnosed (Government Inquiry into Mental Health and Addiction, 2018; OECD, 2018; Potter et al., 2017). This is visible in: services directed at youth (access to which generally requires diagnoses); welfare services (which also generally require diagnoses); and health services (which are tilted towards costly inpatient services while primary and mental health care is relatively under-resourced). People in poverty, in particular, face difficulties in accessing services that enable them to get diagnoses. Successfully supporting the mental health and wellbeing of people living in poverty, and reducing the number of people with mental health problems experiencing poverty, require engagement with this complexity (Government Inquiry into Mental Health and Addiction, 2018; Potter et al., 2017).

There are effective approaches available that, if funded, could improve outcomes

Improving access to psychological therapies is likely to be beneficial

There is clear and substantial evidence from randomised controlled trials that effectively implemented cognitive behavioural therapies for a variety of psychiatric disorders are at least as effective as, and sometimes much longer lasting than, drug therapy. They do not need to be delivered face to face. Computer-delivered courses work for psychiatric disorders at all levels of severity (Potter et al., 2017).

The UK's Increased Access to Psychological Therapies (IAPT) programme may be effective for people with mild to moderate mental health conditions⁶² (Clark, 2018; Gyani et al., 2013). Compliance with the IAPT clinical model is associated with enhanced rates of reliable recovery.

62 IAPT is a national programme to increase the availability of 'talking therapies' on the National Health Service. IAPT is primarily for people who have mild to moderate mental health difficulties, such as depression, anxiety, phobias and post-traumatic stress disorder.

There are indications that many move off benefits (Patel & Saxena, 2014). It is estimated that the cost of the service is fully recovered in savings to the Government in terms of incapacity benefits, increased taxes and reduced expenditure on physical healthcare.

There is limited coverage of evidence-based interventions to assist people with mental health conditions into work

As mentioned earlier, people with mental health conditions make up the largest number of people receiving SLP and JS-HCD.

Evidence indicates that intervening early to support returns to work for people with mental health conditions is important (OECD, 2015). However, the pathway to early and appropriate employment assistance and psychological support is unclear, inconsistent and inequitable.

- People on benefits for mental health conditions do not gain early access to employment assistance and psychological support. The longer a person is out of work, the harder and costlier it is to support them to return to work.
- People receiving SLP for mental health conditions have limited access to mainstream employment assistance. In this respect the distinction between SLP, JS-WR and JS-HCD is unhelpful.
- Current assessment processes are not necessarily picking up mental health issues. MSD has limited knowledge of the mental health needs of people not receiving benefits for health conditions or disabilities, although there is New Zealand and international research indicating that mental health problems are likely to be significant. The system therefore underestimates the number of people with mental health conditions on benefits.

While there have been a number of trials of interventions aiming to assist people with mental health conditions into work, nothing effective has been implemented at scale.

- There is a lack of access to evidence-based psychological support (e.g. cognitive behavioural therapy) for people on benefits. There is a particular need for interventions targeting those with common mental health conditions (e.g. depression, anxiety) (Government Inquiry into Mental Health and Addiction, 2018; OECD, 2018; Potter et al., 2017).
- There is limited access to evidence-based, integrated employment and health services. IPS services, for example, are available only in some regions (OECD, 2018).⁶³

There is a lack of specific interventions targeting those with other common health conditions or disabilities on benefits

Inadequate support for people with musculoskeletal conditions on benefits

Musculoskeletal disorders have declined in importance relative to mental health conditions as a reason for people receiving health and disability benefits in New Zealand and other OECD countries. However, in New Zealand they are the second most common reason for people receiving JS-HCD (see earlier). Research indicates that people with musculoskeletal disorders remain one of the most challenging groups to return to work, even though people frequently have a strong desire to return to work (Cullen et al., 2017). There are multiple factors influencing the likelihood of returning to work, of which some cannot be modified (e.g. age)⁶⁴ or are

63 IPS services have been operating in New Zealand for some years, but are not widely implemented (Porteous & Waghorn, 2009). A number of initiatives have shown encouraging results for people supported by benefits as a result of mental ill health, with positive employment outcomes for young people, including Māori, when compared to international IPS benchmarks. However, to date there has been no rigorous impact study of IPS in the New Zealand context (OECD, 2018).

64 Hamer et al., 2013.

difficult to modify (e.g. economic conditions). Within MSD there have been small-scale trials of interventions targeting people with musculoskeletal disorders, but nothing effective has been implemented at scale.

Work can be beneficial for people with musculoskeletal disorders. Evidence indicates that the following assist return to work:

- Individual factors (e.g. high education and socio-economic status, high self-efficacy, optimistic expectations for recovery and return to work, and lower severity of the injury/illness) (Smith et al., 2017).
- Intervening early and having supportive employers (Cancelliere et al., 2016).
- Cognitive behavioural therapies may be effective in assisting people with chronic pain to manage their conditions (Ehde et al., 2014).
- Multi-domain interventions (e.g. with healthcare provision, service coordination and work accommodation components, and employer support) are effective at returning people to work quickly (Cullen et al., 2017).
- There is moderate evidence that these multi-domain interventions have positive impacts on cost outcomes (Cullen et al., 2017).

Evidence for the effectiveness of other single-domain interventions is mixed, with some studies reporting positive effects and others reporting no effects on lost time and work functioning.

There are few employment supports for those furthest from the labour market with health conditions or disabilities

There is limited information on the effectiveness of employment assistance for people on SLP, reflecting their low participation in employment assistance interventions. MSD has information on only five interventions for SLP participants. Job Plus and Skills Investment were the only interventions with a positive impact on these participants. The limited information on this group reflects the low participation in employment assistance interventions by this group.

The development of specific assistance to help those on SLP who want to work has been limited. In recent years the main focus has been on assisting people on benefits who have been assessed by medical professionals as having some work capacity into employment. There are four Disability Employment Supports: Employment Services, Support Funds, Mainstream Employment Programme and Mainstream Internship Programme. The four programmes have been established in an ad-hoc way at different times in the past 40 years. Some of them have been modified several times over the years, but they have never been reviewed as a whole. Some of the programme components are outdated and not aligned with best practice. There are overlapping objectives and target groups, and limited evidence of their cost effectiveness and outcomes.

There is evidence that, with the right supports, some far from the labour market can engage in paid employment.

- In New Zealand, the Young SLP Opt-In trial, discussed earlier, appears to be a useful approach
- As stated earlier, IPS has been shown to be effective for people with severe mental illnesses.
- There is emerging evidence that supported employment approaches are effective for people with learning disabilities (Ham et al., 2014; McLaren et al., 2017; Wehman et al., 2016).
- Moderate evidence supports the use of assistive technology, especially apps for cueing and peer support to increase work participation for people with intellectual disabilities, neurological/cognitive disabilities, and autism spectrum disorder (Smith et al., 2017).

A greater focus on employers is needed

Another key and related issue is the focus on employers and the demand for workers with disabilities. MSD provides support to employers to enable them to employ people with work-limiting health conditions and disabilities (see Appendix 3). Currently many interventions focus on getting people work ready (e.g. motivation, financial assistance, equipment, workplace modifications); however, involving employers to a greater extent, and placing greater responsibility on employers, seem to be key aspects of increasing employment outcomes for people with health conditions and disabled people.

Employer obligations related to workers with health conditions are minimal and employer-provided sick pay is meagre. The extent to which sick workers receive support is highly variable and largely depends on whether or not they, or their employers, have any private insurance (see earlier). Other jurisdictions have greater requirements for employers to support people who are unwell (OECD, 2010).

Across the social sector there is a limited focus on preventing unemployment due to ill health

There is a lack of early intervention to retain people in employment once they become unwell

Within the New Zealand welfare system there is little early intervention for people who become unwell at work to remain in work or return to work quickly (OECD, 2018). The focus in the welfare system has been on getting people off benefits rather than providing support for people to stay in work and securing more sustainable employment outcomes.

For many people with health conditions there is considerable evidence that intervening early in the right way is crucial in supporting returns to work and improving earnings.

Prevention of ill health and disabilities could limit the number of people who need to claim health and disability benefits

More needs to be done to promote wellness and prevent ill health in young people

Most make successful transitions to adulthood, but a significant minority does not. Poor mental health amongst young people is a significant problem in New Zealand (Gluckman, 2011; OECD, 2018). Many mental health conditions have a very early onset, most often in teenage and childhood years, but early intervention can help. In New Zealand there have been expansions and improvements in access to mental health treatment and the development or strengthening of a range of support structures for young people with mental health problems. However, there are still considerable unmet needs amongst young people with common mental health problems (especially those with mild to moderate mental health conditions), and outcomes for Māori youth remain poor (Gluckman, 2011; OECD, 2018).

There is more that can be done to prevent young people becoming unwell and needing assistance from health and disability benefits:

- Intervening early in the life course – especially with disadvantaged groups. Measures to address disadvantage from early in the life course may have the greatest prospect of enhancing the mental health status of this population group into the future (Gluckman, 2011). Examples of effective interventions include evidence-based parenting programmes (e.g. Incredible Years, Triple P), early intervention and prevention through intensive support for families with difficulties (e.g. Nurse Family Partnership), targeted parent training and child social skills training for preventing conduct disorder in the early years, and universal and targeted cognitive behavioural therapy for anxiety and depression in the school years.
- Improving access to services to address mental health problems when they first develop in childhood or adolescence (OECD, 2015, 2018).
- Investing in the prevention of early school leaving and support for school leavers with mental health problems (OECD, 2015, 2018).

Australian researchers suggest that it is also important to look at young people's current experiences and the underlying social and cultural contexts and influences on their lives (Eckersley et al., 2006; Eckersley, 2011). Researchers need to examine more closely the effects that changes in cultural qualities such as materialism and individualism have on health and wellbeing in young people. Without understanding these changes and young people's interpretations of the changes, *"policies, interventions and services for young people are likely to be fragmented and silo-based and out of step with their lives"* (Eckersley et al., 2006). They emphasise multidisciplinary approaches with a focus on young people's total health and wellbeing.

More needs to be done to promote wellness and prevent ill health in workplaces

With regard to workplaces, ACC puts considerable effort into reducing the incidence of accidents causing injury in the workplace. In workplaces the Health and Safety at Work Act 2015 has initiated a shift in focus from safety to health at work, but the implementation of the new legislation and the focus on mental health in the workplace are weak. Potter et al (2017) state that *"substantial attention to prevention and the full and supportive treatment of mental illness will, in many cases, pay for itself in the form of productivity that is not lost and welfare benefits that are not claimed"*.

Other Government reviews may lead to improvements for people with health conditions and disabilities who are on benefits

The reviews of the health and disability system and mental health and addictions may lead to improvements in:

- access to primary and secondary care for adults and children on low incomes
- support for young people and adults with health conditions and disabilities to participate in suitable work
- the wellbeing of people with disabilities and carers receiving long-term financial assistance from the state.

The OECD's review of mental health and employment services in New Zealand assessed how policies were performing in fostering the labour market inclusion of people with mental health conditions and made several recommendations for agencies to consider (OECD, 2018). If taken up these may lead to improvements in wellbeing for people with mental health conditions. This review was jointly commissioned by MSD and MOH.

Part 4: Improving life outcomes of those who may always require welfare assistance

MSD faces a number of challenges in this area

MSD's role in this area is unclear

The Welfare Expert Advisory Group's Terms of Reference state that the welfare system is part of an integrated Government approach that enables people to be earning, learning, caring or volunteering and ensures dignified lives for those for whom these options are not possible.

Beyond providing income support, MSD's role in improving life outcomes for those who are likely always to require assistance from the welfare system due to health conditions or disabilities is unclear. If the goal is for people with long-term, significant health conditions and disabilities to have improved wellbeing and dignified lives, it is unclear what the role of the welfare system should be in assisting this to happen.

The need for intensive, long-term support is placing increasing pressure on public spending

The number of people with high support needs is increasing, for various reasons:

- There has been growth in long-term conditions that have significant impacts on people's lives (e.g. diabetes, cancers, cardiovascular diseases, respiratory diseases, mental illness [including depression and anxiety], chronic pain, chronic kidney disease and musculoskeletal conditions). In 2013, long-term conditions were responsible for 88% of health loss in New Zealand, up from 83% in 1990 (Ministry of Health, 2017b).
- People in lower socio-economic groups are more likely to have long-term conditions than others.
- Co-morbidity is common – especially amongst those with mental health conditions and developmental disabilities.

Technologies of all kinds can sustain and accelerate improvements in health and quality of life for people with long-term health conditions and disabilities. However, technology can also widen social disparities in healthcare for disabled people. As technological innovation is demonstrated to improve quality of life, access to that technology becomes more important. While health outcomes may improve for those who can afford the technology, they may not for those who cannot (Wise, 2012).

Disabled people and their whānau have sought a more responsive disability support system for some time

Disabled people and their whānau have sought changes to the disability support system for some time. The 2008 cross-party *Report of the Social Services Select Committee's Inquiry into the Quality of Care and Services Provision for People with Disabilities* identified that the disability support system unnecessarily limited disabled people's choices in, and control over, their lives and recommended a work programme in response.

Concerns about the current disability support system include:

- the system is very complicated for users. There are multiple eligibility, assessment and planning processes across the social system; MSD, the Ministry of Education, ACC and MOH all fund assistance for disabled people. Disabled people and their families and whānau have to navigate complex bureaucracies in different agencies to access all the support they need; it is not a person-centred system. Disabled people and their families struggle to get the assistance they need when they need it (New Zealand Productivity Commission, 2015)
- its focus on funding specialist supports and services at the cost of mainstream services and other forms of support. Disability services become the 'hub' of people's lives (Anderson et al., 2014, 2016; Were, 2017)
- its lack of choice. Disabled people and their families report that the current supports and services do not reflect their individual needs and preferences. People are allocated existing contracted services (not what works best for them). The choice of supports and services available is often limited, especially for those with very high needs (Anderson et al., 2014, 2016; Were, 2017)
- its lack of options and decision-making authority for disabled people
- funding being typically allocated based on a medical model rather than on someone's strengths and what they can do.⁶⁵ Eligibility requirements between government agencies are often contradictory. There is limited flexibility in the use of funding
- disabled people and their families and whānau experiencing poorer life outcomes than many other New Zealanders. Disabled people experience poorer outcomes in a range of areas (e.g. health status, education, employment, income and housing). Māori experience disproportionate levels of disability (32%) compared with the general population (24%).⁶⁶

The cost of the current system is high

As in other jurisdictions, the current New Zealand disability support system is costly to Government. Costs have increased but there is little evidence that the additional spending is resulting in better outcomes for people with significant health conditions and disabilities.

Interventions to improve the wellbeing of those who are assessed as not being able to work have been limited and impacts not assessed

Interventions to improve the wellbeing of those who are assessed as not being able to work have been limited – beyond providing income support. However, a portion of Social Development funding has been allocated to support services for severely disabled people. These services cover community participation, supported employment and business enterprises. MSD has not assessed the extent to which the services are achieving the desired outcomes for the participants. There is currently limited information systematically collected on outcomes for disabled people who engage in Government-funded interventions to improve social inclusion.

Providers have typically been funded based on the number of participants, not their needs or outcomes. Contracts and funding arrangements with providers need to encourage the outcomes sought.

65 People get access to funding for supports and services via a needs assessment process, with strict eligibility criteria that focus on impairment.

66 The 2013 Disability Survey found that tāngata whaikaha (Māori disabled people) had a disability rate of 32%, compared with 24% for Europeans, 26% for Pacific People, and 17% for Asian.

The amount of funding people receive depends on whether they are assessed as having high needs or very high needs. Providers and families have been critical of the disparity in the funding levels.⁶⁷ Providers have faced challenges. MSD funding for providers has changed little in over a decade (Anderson et al., 2016). An ongoing challenge will be addressing the financial sustainability of providers.

The mix of services may not reflect what disabled people and their families need. There are indications that some people are poorly served in terms of supports and services to support social inclusion. *“Low incomes, unemployment, lack of education, limited access to transport, poorer physical and mental health, and discrimination are key drivers of exclusion for disabled people”*. Disabled people who need support from family or support workers to participate in the community do not always have access to the support they need (Appleton-Dyer & Field, 2014).

For now, MSD is continuing with its current mix of supports and services to improve the social inclusion of disabled people. The shape of these services is likely to change as the transformation of the disability support system progresses (see later).

Funding to support transitions to life post-school for disabled people with high or very high needs

MSD funds a Transition Service for students with high or very high needs to move into post-school education, employment and/or community services and activities in their last year of school. Services are for one year while the students remain in school and enrolments begin in the last half of the school year, before the students' final year. The purpose of this service is to ensure there are coordinated plans in place to assist the students to achieve their post-school goals. The effectiveness of this service has not been evaluated.

There are evidence-based practices that can be undertaken to support transition. A 2009 US meta-analysis examined secondary transition practices to determine those that correlated with improved post-school outcomes for students with intellectual disabilities (Test et al, 2009). It identified 16 predictors of post-school employment, education and independent living that included interventions focused on curriculum and skill development, student self-advocacy, interagency collaboration, family involvement, transition planning and school programme structures.

Funding to support community participation

MSD and MOH fund community participation services for disabled people. Both seek to help disabled adults who cannot find work to take part in their communities and improve their personal skills by providing access to regular, meaningful social contact and stimulating activities.

MOH funds day services for people who were deinstitutionalised under formal deinstitutionalisation plans and people with high and complex needs and intellectual disabilities (whether or not they are receiving care under the Intellectual Disability Compulsory Care and Rehabilitation Act 2003). Most working-age Disability Support Services (MOH) recipients are receiving SLP.

⁶⁷ Those assessed as having high needs receive considerably less than those assessed as having very high needs, which affects the ability to access the community.

MSD funds community participation programmes for other disabled adults. These are part of MSD's vocational services and are available to working-age disabled people who have a disability or a health condition that is likely to continue for at least six months and who are not receiving compensation through ACC. Funding is contributory, so does not cover the full costs of providing the service. It is not considered income by MSD and does not affect the benefit paid. Community participation services are delivered by contracted providers. MSD works with 168 providers, including key providers:

- IDEA Services – \$89 million (three-year contract to June 2019)
- Workbridge – \$5.5 million (two-year contract to June 2018).

The people participating in these services have a broad range of abilities and aspirations. The providers' role is to facilitate and/or support people to participate in their communities in ways that are meaningful and enhance their quality of life and mana. As at November 2017 there were 8,241 participants, and this number was expected to rise to 10,000 to 12,000 in the full year.

MSD does not actively promote engagement in community participation services. Eligible recipients are typically allocated to the GCM service. There is no requirement to talk to recipients about supports and services available in the community.

The effectiveness of MSD-funded community participation services in New Zealand has not been evaluated. Processes and instruments to collect data on outcomes are poor. There is currently no robust evidence of the differences the service makes to wellbeing outcomes.

Internationally:

- community participation services are poorly defined, as is the concept of social inclusion (Simplican et al., 2015)
- there is a lack of empirical evidence on their effectiveness. People with intellectual disabilities living in community settings participate more than people living in segregated settings, but their participation levels are still much lower than those of non-disabled and other disability groups (Amado et al., 2013)
- there is evidence that disability services have not led to greater social inclusion for disabled people, especially for those who need considerable assistance to participate in their community. While many disabled people are living in the community, too many are segregated from others with few opportunities to play a full part in family and community lives (Simplican et al., 2015).

Business Enterprises

MSD provides funding for Business Enterprises to provide vocational and employment support for disabled people, most of whom are subject to minimum wage exemptions.⁶⁸ Evidence to support these kinds of initiative is weak. Vocational services for disabled people that are not linked to employment in the open labour market (e.g. sheltered workshops, prevocational training and transitional employment) have limited effectiveness in supporting people into open paid employment. Approaches that aim to place recipients into open paid employment from the outset are more effective (Parmenter, 2011).

In New Zealand the services provide disabled people with activities and opportunities to participate in their communities. These services have not been rigorously evaluated.

68 <https://www.employment.govt.nz/hours-and-wages/pay/minimum-wage/minimum-wage-exemptions/>

Access to supported housing for people with health conditions and disabilities

The relationship between different dimensions of housing and social outcomes is complex and determining causality is problematic. Affordable, appropriate housing is necessary but not always sufficient to achieve many social outcomes. However, considerable evidence now exists that there is a connection between poor-quality housing and poor health outcomes.

While it is widely accepted that, as it is for the general population, people with all forms of disability have a right to suitable housing of their choice, this choice is often non-existent or very limited. Housing has become a more pressing concern since community care replaced institutional care for those living with disabilities, including those with health conditions (e.g. mental illness, learning disabilities). People with health conditions or disabilities without family support are particularly vulnerable to housing instability.

For people with chronic health conditions or disabilities, access to stable, appropriately designed and located, affordable housing may lead to improved wellbeing by:

- mitigating the disadvantages experienced by people with disabilities in terms of social inclusion, economic participation, health and wellbeing (e.g. with more secure tenancies, the elimination of domestic health hazards, privacy and space at home for guests and social gatherings, and small scale, enabling social connections with people in the local neighbourhoods) (Wiesel & Habibis, 2015; Wright et al., 2015)
- improving access to services. Stable, affordable and suitable housing may improve health outcomes for individuals with chronic illnesses or significant disabilities by providing stable and efficient platforms for the ongoing delivery of healthcare and reducing the incidence of certain forms of risky behaviour. One guiding principle in aligning services and housing is to meet people where they are. This may mean using a housing service coordinator, more common in the US. There may be opportunities to pool formal and informal supports through sharing arrangements or a KeyRing model⁶⁹ (Wiesel & Habibis, 2015).
- For some (e.g. the chronically homeless and those with severe, permanent mental illnesses), supportive housing may be a permanent arrangement. The evidence on housing suggests that when people with severe, permanent mental illnesses are placed in safe, decent and affordable housing, the impacts of clinical and support services they receive are augmented. People with suitable accommodation are less likely to engage in risky behaviour that endangers their health (Cohen, 2011). An Office of the Auditor-General report highlighted that access to suitable accommodation needs to improve for people with mental illnesses. It found that there is a shortage of accommodation options for people with complex needs (Office of the Auditor-General, 2017).
- reducing the costs of support for people with disabilities by enhancing their access to informal support for their needs (location) and increasing their independence in core activities (design).

Interventions for housing vulnerable people need to:

- be tailored to the individuals – different approaches are needed for different people
- be culturally appropriate
- consider what other supports and services are needed to improve wellbeing. Providing access to stable housing may not be enough to improve wellbeing. Models such as Housing First that offer housing and other services are a way forward (Parsell & Moutou, 2014).

69 KeyRing supports people with disabilities to live in the community (see <http://www.keyring.org/>).

Current wider work to improve outcomes for disabled people

New Zealand Disability Strategy⁷⁰

The vision of the New Zealand Disability Strategy is: *New Zealand is a non-disabling society – a place where disabled people have an equal opportunity to achieve their goals and aspirations, and all of New Zealand works together to make this happen.* To achieve the vision of this strategy, there is cross-governmental work under the New Zealand Disability Action Plan that aims to address issues facing disabled people.

Enabling Good Lives Demonstrations and the transformation of the disability support system

Enabling Good Lives is a partnership between government agencies and the disability sector aimed at the long-term transformation of how disabled people and their families are supported to live everyday lives. The Enabling Good Lives approach is based on supporting disabled people's access to everyday life in everyday places, rather than focusing on 'special' places or activities for disabled people, with a vision that: *"In the future, disabled children and adults and their families will have greater choice and control over their supports and lives, and make more use of natural and universally available supports"*.

The evaluations⁷¹ of the Enabling Good Lives Demonstrations in Christchurch and Waikato show that disabled people, and their families and whānau, value having greater choice, control and flexibility over the support they receive to live good lives (Anderson et al., 2014, 2016; Were, 2017).

A new system of disability support is being trialled in the Mid-Central region

New Zealand is using a co-design approach to transform our disability support system. The new system offers children, young people and adults with disabilities, and their families, greater choice and decision-making over the support they receive.

The objectives of transforming the disability support system ('system transformation') are to give disabled people and their whānau more options and decision-making authority about their supports and lives, to improve their outcomes and create a more cost-effective disability support system.⁷²

The Government is trialling a new system for delivering disability supports in Mid-Central, which started on 1 October 2018. Mid-Central includes the Palmerston North, Horowhenua, Manawatū, Ōtaki and Taranaki districts. The Demonstrations in Christchurch and Waikato are continuing.

The transformed disability support system will include:

- a proactive and responsive front end that welcomes people into the system
- access to independent facilitation to help people plan for the lives they want
- a personal budget made up of funding from multiple government agencies
- flexibility about how to use the personal budget and assist its management

70 <https://www.odi.govt.nz/nz-disability-strategy>.

71 The evaluations provided information to feed into the nationwide transformation of the disability support system, which began in April 2017. MOH is leading this work.

72 In this paper the terms used are 'disabled person and their whānau' or 'disabled people and their whānau' because 'whānau' is able to cover the diverse range of family (both kinship based – immediate or extended – and kaupapa/subject based where there is a shared common bond, other than descent, with similar values as kinship based). 'Whānau' can also serve reasonably to refer to the Pacific values and family structures of āiga and kainga. In addition, 'disabled person' covers all ages including children and young people.

- referrals to other agencies for additional services
- national and local governance groups, including disabled people and whānau representation, which use data analytics and system insights to monitor outcomes, and to identify and continually improve the system.

The transformation will be:

- based on, and reflect, the Enabling Good Lives vision and principles⁷³ and what has been learned about the core elements of a system based on them. This approach would be strongly supported by the disability community
- underpinned by a social investment approach. This is to help disabled people and their whānau to achieve better outcomes and/or reduce long-term disability costs to Government. It involves putting in place measures that are expected to improve outcomes for disabled people and their families and whānau but are also expected to reduce lifetime cross-Government costs.

The new system for delivering disability supports in Mid-Central will focus on people who are eligible for MOH's DSS funded support. This group consists of people who are usually aged under 65 and have physical, intellectual or sensory disabilities or a combination of these, which are likely to:

- remain even after the provision of equipment, treatment and rehabilitation
- continue for at least six months
- result in a need for ongoing support.

Some people disabled because of health conditions are not covered by DSS and therefore not included in the transformation. MOH does not generally fund DSS for people with personal health conditions such as diabetes or asthma and mental health and addiction conditions such as schizophrenia, severe depression or long-term addictions to alcohol and drugs.⁷⁴

73 The Vision is: disabled people and their families have greater choice and control over their support and lives. The Enabling Good Lives principles are Self-determination, Beginning early, Person-centred, Mainstream first, Ordinary life outcomes, Mana enhancing, Easy to use and Relationship building.

74 Most specialist mental health services are provided by DHBs, contracted by MOH. Community- rather than hospital-based services have become the largest part of the mental health system since the early 2000s. A growing proportion of mental health services are provided through non-government organisations. See <https://teara.govt.nz/en/mental-health-services/print>.

References

- ACC (2013) *Life after ACC: The Divide Between Expectations and Reality*. Retrieved from http://www.iscrr.com.au/__data/assets/pdf_file/0010/342595/Life-after-ACC-divide-between-expectations-and-reality-poster-Gaylia-Powell-ACHRF-2013.pdf.
- ACC (2018) *Third Quarterly Report 2017/19: March 2018*. Wellington, New Zealand. Retrieved from <https://www.acc.co.nz/assets/corporate-documents/acc-third-quarterly-report-2017-2018.pdf>
- Amado, A. N., Stancliffe, R. J., McCarron, M., & McCallion, P. (2013) Social inclusion and community participation of individuals with intellectual/developmental disabilities. *Intellectual and Developmental Disabilities, 51*(5), 360–375. <http://doi.org/10.1352/1934-9556-51.5.360>
- Anderson, D., Ferguson, B., & Janes, R. (2014) *Enabling Good Lives Christchurch Demonstration: Phase 1 Evaluation Report*. Wellington, New Zealand: Ministry of Social Development, Ministry of Health and Ministry of Education. Retrieved from <https://www.odi.govt.nz/nz-disability-strategy/other-initiatives/enabling-good-lives>
- Anderson, D., Janes, R., & Pope, P. (2016) *Enabling Good Lives Christchurch Demonstration: Phase 2 Evaluation Report*. Wellington, New Zealand: Ministry of Social Development, Ministry of Health and Ministry of Education. Retrieved from <https://www.odi.govt.nz/nz-disability-strategy/other-initiatives/enabling-good-lives>
- Antón, J., Braña, F., & Muñoz De Bustillo, R. (2015) *An Analysis of the Cost of Disability Across Europe Using the Standard of Living Approach* (Working Paper No. 1508). Linz. Retrieved from <http://www.econ.jku.at/papers/2015/wp1508.pdf>
- Appleton-Dyer & Field, (2014) Understanding the factors that contribute to social exclusion of disabled people. Rapid review for Think Differently. Synergia for Ministry of Social Development, Wellington, NZ. <https://www.odi.govt.nz/assets/Guidance-and-Resources-files/Understanding-the-factors-that-contribute-to-the-exclusion-of-disabled-people-November-2014.pdf>
- Böheim, R. & Leoni, T. (2018) Sickness and disability policies: Reform paths in OECD countries between 1990 and 2014. *International Journal of Social Welfare, 27*(2), 168–185.
- Bratsberg, B., Fevang, E., & Røed, K. (2013) Job loss and disability insurance. *Labour Economics, 24*, 137–150. <http://doi.org/10.1016/B978-1-4832-8421-7.50030-2>
- Butler, D., Alson, J., Bloom, D., Deitch, V., Hill, A., Hsueh, J., ... Redcross, C. (2012) *Enhanced Services for the Hard-to-Employ Demonstration and Evaluation Project: Final Results of the Hard-to-Employ Demonstration and Evaluation Project and Selected Sites from the Employment Retention and Advancement Project*. (OPRE Report No. 2012–8). Washington D.C. Retrieved from [http://www.mdrc.org/sites/default/files/What Strategies Work for the Hard FR.pdf](http://www.mdrc.org/sites/default/files/What%20Strategies%20Work%20for%20the%20Hard%20FR.pdf)
- Callander, E. J., Corscadden, L., & Levesque, J. F. (2017) Out-of-pocket healthcare expenditure and chronic disease: Do Australians forgo care because of the cost? *Australian Journal of Primary Health, 23*(1), 15–22. <http://doi.org/10.1071/PY16005>
- Cancelliere, C., Donovan, J., Stochkendahl, M. J., Biscardi, M., Ammendolia, C., Myburgh, C., & Cassidy, J. D. (2016) Factors affecting return to work after injury or illness: Best evidence synthesis of systematic reviews. *Chiropractic & Manual Therapies, 24*(1), 32. <http://doi.org/10.1186/s12998-016-0113-z>
- Canivet, C., Aronsson, G., Bernhard-Oettel, C., Leineweber, C., Moghaddassi, M., Stengård, J., ... Östergren, P. O. (2017) The negative effects on mental health of being in a non-desired occupation in an increasingly precarious labour market. *SSM – Population Health, 3*, 516–524. <http://doi.org/10.1016/j.ssmph.2017.05.009>

- Canivet, C., Bodin, T., Emmelin, M., Toivanen, S., Moghaddassi, M., & Östergren, P. O. (2016) Precarious employment is a risk factor for poor mental health in young individuals in Sweden: A cohort study with multiple follow-ups. *BMC Public Health*, 16(1). <http://doi.org/10.1186/s12889-016-3358-5>
- Chaudry, A. & Wimer, C. (2016) Poverty is not just an indicator: The relationship between income, poverty, and child well-being. *Academic Pediatrics*, 16(3), S23–S29. <http://doi.org/10.1016/j.acap.2015.12.010>
- Cheer, U. (2005) Social Policy Implications Arising from Legal Aspects of New Zealand's Latest Accident Compensation Scheme. *Social Policy Journal of New Zealand*, Issue 05. <https://www.ms.govt.nz/about-msd-and-our-work/publications-resources/journals-and-magazines/social-policy-journal/spj05/05-accident-compensation.html>
- Children's Commissioner's Expert Advisory Group on Solutions to Child Poverty (2012) *Health Policy and Effective Service Delivery to Mitigate Effects on Child and Youth Poverty*. (Working Paper No.17). Wellington, New Zealand. Retrieved from <http://www.occ.org.nz/assets/Uploads/EAG/Working-papers/No-17-Health-policy.pdf>
- Clark, D. (2018) Realizing the mass public benefit of evidence-based psychological therapies: The IAPT Program. *Annual Review of Clinical Psychology*, 14, 159–183.
- Clayton, S., Bamba, C., Gosling, R., Povall, S., Misso, K., & Whitehead, M. (2011) Assembling the evidence jigsaw: Insights from a systematic review of UK studies of individual-focused return to work initiatives for disabled and long-term ill people. *BMC Public Health*, 11(1), 170. <http://doi.org/10.1186/1471-2458-11-170>
- Cohen, R. (2011) *The Impacts of Affordable Housing on Health: A Research Summary*. *Insights from Housing Policy Research*, Center for Housing Policy, Washington. http://www.nhc.org/media/files/Insights_HousingAndHealthBrief.pdf
- Corcadden, L., Levesque, J. F., Lewis, V., Breton, M., Sutherland, K., Weenink, J. W., ... Russell, G. (2017) Barriers to accessing primary health care: Comparing Australian experiences internationally. *Australian Journal of Primary Health*, 23(3), 223–228. <http://doi.org/10.1071/PY16093>
- Cullen, K. L., Irvin, E., Collie, A., Clay, F., Gensby, U., Jennings, P. A., ... Amick, B. C. (2017) Effectiveness of workplace interventions in return-to-work for musculoskeletal, pain-related and mental health conditions: An update of the evidence and messages for practitioners. *Journal of Occupational Rehabilitation*, pp. 1–15. <http://doi.org/10.1007/s10926-016-9690-x>
- Cumming, J. (2017) Health policy. *Policy Quarterly*, 13(3). Retrieved from <https://ojs.victoria.ac.nz/pq/article/view/4676>
- Curnock, E, Leyland, AH, & Popham, F. 2016. The impact on health of employment and welfare transitions for those receiving out-of-work disability benefits in the UK. *Social Science and Medicine* 162: 1–10. <http://doi.org/10.1016/j.socscimed.2016.05.042>
- Drake, R. E., Bond, G. R., & Becker, D. R. (2013) *Individual Placement and Support: An Evidence-Based Approach to Supported Employment*. <http://doi.org/10.1093/acprof:oso/9780199734016.001.0001>
- Duffield, S. J., Ellis, B. M., Goodson, N., Walker-Bone, K., Conaghan, P. G., Margham, T., & Loftis, T. (2017) The contribution of musculoskeletal disorders in multimorbidity: Implications for practice and policy. *Best Practice and Research: Clinical Rheumatology*. <http://doi.org/10.1016/j.berh.2017.09.004>
- Duncan, G. (2017) Expanding ACC to cover sickness. *Briefing Papers, AUT*. Retrieved from <http://briefingpapers.co.nz/expanding-acc-to-cover-sickness/>

- Eckersley, R. (2011) Troubled youth: An island of misery in an ocean of happiness, or the tip of an iceberg of suffering? *Early Intervention in Psychiatry*. <http://doi.org/10.1111/j.1751-7893.2010.00233.x>
- Eckersley, R., Wierenga, A., & Wyn, J. (2006) *Flashpoints and Signposts: Pathways to Success and Wellbeing for Australia's Young People*. Canberra. Retrieved from <https://australia21.org.au/product/flashpoints-and-signposts-pathways-to-success-and-wellbeing-for-australias-young-people/#.WYosjEsUmUK>
- Ehde, D. M., Dillworth, T. M., & Turner, J. A. (2014) Cognitive-behavioral therapy for individuals with chronic pain. *American Psychologist*, 69(2), 153–166. <http://doi.org/10.1037/a0035747>
- Fletcher, M. (2009) *Addressing the Growth in Sickness and Invalid's Benefit Receipt*. A report prepared for the New Zealand Treasury.
- Fletcher, M. (2018) *Individualising Entitlements in New Zealand's Benefit and Social Assistance Systems*. A report prepared for Superu. Wellington, New Zealand: Superu. Retrieved from http://www.superu.govt.nz/sites/default/files/Individualisation_of_benefits_FINAL_0.pdf
- Fothergill, S., & Gore, T. (2013) *The Implications for Employment of the Shift to High-Value Manufacturing* (Future of Manufacturing Project No. Evidence Paper 9). United Kingdom. Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/283885/ep9-shift-to-high-value-manufacturing-implications.pdf
- Francis, G. L., Blue-Banning, M., & Turnbull, R. (2014) Variables within a household that influence quality-of-life outcomes for individuals with intellectual and developmental disabilities living in the community: Discovering the gaps. *Research and Practice for Persons with Severe Disabilities*, 39(1), 3–10. <http://doi.org/10.1177/1540796914534632>
- Gibson, K., Abraham, Q., Asher, I., Black, R., Turner, N., Waitoki, W., & McMillan, N. (2017) *Child Poverty and Mental Health A Literature Review*.
- Gluckman, P. (2011) *Improving the Transition: Reducing Social and Psychological Morbidity During Adolescence*. New Zealand Government – Office of the Prime Minister's Science Advisory Committee.
- Government Inquiry into Mental Health and Addiction (2018) *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction*. Wellington, New Zealand. Retrieved from <https://www.mentalhealth.inquiry.govt.nz/inquiry-report>
- Gyani, A., Shafran, R., Layard, R., & Clark, D. M. (2013) Enhancing recovery rates: Lessons from year one of IAPT. *Behaviour Research and Therapy*, 51(9), 597–606. <http://doi.org/10.1016/j.brat.2013.06.004>
- Hainmueller, J., Hofmann, B., Krug, G., & Wolf, K. (2015) Do lower caseloads improve the performance of public employment services? New evidence from German employment offices. *Scandinavian Journal of Economics*. <http://doi.org/10.1111/sjoe.12166>
- Ham, W., McDonough, J., Molinelli, A., Schall, C., & Wehman, P. (2014) Employment supports for young adults with autism spectrum disorder: Two case studies. In *Journal of Vocational Rehabilitation* (Vol. 40, pp. 117–124). <http://doi.org/10.3233/JVR-140677>
- Hamer, H., Gandhi, R., Wong, S., & Mahomed, N. N. (2013) Predicting return to work following treatment of chronic pain disorder. *Occupational Medicine*, 63(4), 253–259. <http://doi.org/10.1093/occmed/kqt019>
- Hanson, M., Burton, A., Kendall, N., Lancaster, R., & Pilkington, A. (2006) *The Costs and Benefits of Active Case Management and Rehabilitation for Musculoskeletal Disorders*. London. Retrieved from http://www.kendallburton.com/Library/Resources/Case_Management.pdf

- Hasluck, C. & Green, A. E. (2007) *What Works for Whom? A Review of Evidence and Meta-Analysis for the Department for Work and Pensions*. Department for Work and Pensions, (407).
- Health Promotion Agency (2018) *Wellbeing and Mental Distress in Aotearoa New Zealand: Snapshot 2016*. Wellington, New Zealand: Health Promotion Agency. Retrieved from <https://www.hpa.org.nz/research-library/research-publications/wellbeing-and-mental-distress-in-aotearoa-new-zealand-snapshot-2016>
- Helbling, L. A., & Sacchi, S. (2014) Scarring effects of early unemployment among young workers with vocational credentials in Switzerland. *Empirical Research in Vocational Education and Training*, 6(1). <http://doi.org/10.1186/s40461-014-0012-2>
- Helgesson, M., Johansson, B., Wernroth, L., & Vingård, E. (2016) Exposure to different lengths of sick leave and subsequent work absence among young adults. *BMC Public Health*, 16(1). <http://doi.org/10.1186/s12889-015-2679-0>
- Howden-Chapman, P. & Chapman, R. (2012) Health co-benefits from housing-related policies. *Current Opinion in Environmental Sustainability*. <http://doi.org/10.1016/j.cosust.2012.08.010>
- Judd, E. & Sung, J. (2018) *What Happened to People Leaving the Benefit System During the Year Ended 30 June 2014?* Wellington, New Zealand.
- Kawada, T. (2018) Unemployment, precarious employment and health in young people. *Scandinavian Journal of Public Health*. <http://doi.org/10.1177/1403494817720104>
- Kelly, M. P., Stewart, E., Morgan, A., Killoran, A., Fischer, A., Threlfall, A., & Bonnefoy, J. (2009) A conceptual framework for public health: NICE's emerging approach. *Public Health*, 123(1). <http://doi.org/10.1016/j.puhe.2008.10.031>
- Kiely, K. M. & Butterworth, P. (2013) Social disadvantage and individual vulnerability: A longitudinal investigation of welfare receipt and mental health in Australia. *The Australian and New Zealand Journal of Psychiatry*, 47(7), 654–666. <http://doi.org/10.1177/0004867413484094>
- Kiely, K. M. & Butterworth, P. (2014a) How has Welfare to Work reform affected the mental health of single parents in Australia? *Australian and New Zealand Journal of Public Health*. <http://doi.org/10.1111/1753-6405.12304>
- Kiely, K. M. & Butterworth, P. (2014b) Mental health selection and income support dynamics: Multiple spell discrete-time survival analyses of welfare receipt. *Journal of Epidemiology and Community Health*, 68(4), 349–355. <http://doi.org/10.1136/jech-2013-203179>
- Kinoshita, Y., Furukawa, T. A., Kinoshita, K., Honyashiki, M., Omori, I. M., Marshall, M., ... Kingdon, D. (2013) Supported employment for adults with severe mental illness. *The Cochrane Database of Systematic Reviews*, 9(9), CD008297. <http://doi.org/10.1002/14651858.CD008297.pub2>
- Kirby, E. R., Broom, A. F., Sibbritt, D. W., Refshauge, K. M., & Adams, J. (2013) Health care utilisation and out-of-pocket expenditure associated with back pain: A nationally representative survey of Australian women. *PLoS ONE*, 8(12). <http://doi.org/10.1371/journal.pone.0083559>
- Kools, L. & Koning, P. (2018) *Graded Return-To-Work as a Stepping Stone to Full Work Resumption* (IZA Discussion Paper Series No. 11471). Bonn. Retrieved from <http://ftp.iza.org/dp11471.pdf>
- Kvalsvig, A. (2018) *Wellbeing and Mental Distress in Aotearoa New Zealand: Snapshot 2016*. Wellington, New Zealand: Health Promotion Agency. Retrieved from <https://www.hpa.org.nz/research-library/research-publications/wellbeing-and-mental-distress-in-aotearoa-new-zealand-snapshot-2016>

- Lammerts, L., van Dongen, J. M., Schaafsma, F. G., van Mechelen, W., & Anema, J. R. (2017) A participatory supportive return to work program for workers without an employment contract, sick-listed due to a common mental disorder: an economic evaluation alongside a randomized controlled trial. *BMC Public Health*, 17(1), 162. <http://doi.org/10.1186/s12889-017-4079-0>
- Llena-Nozal, A. & Xenogiani, T. (2011) *What Drives Inflows Into Disability?: Evidence from Three OECD Countries: Australia, Switzerland, United Kingdom* (OECD Social, Employment and Migration Working Papers No. 117). Paris. Retrieved from <http://dx.doi.org/10.1787/5kgg52g26b-en>
- Lones, C. E., Bond, G. R., McGovern, M. P., Carr, K., Leckron-Myers, T., Hartnett, T., & Becker, D. R. (2017) Individual Placement and Support (IPS) for methadone maintenance therapy patients: A pilot randomized controlled trial. *Administration and Policy in Mental Health and Mental Health Services Research*, 44(3), 359–364. <http://doi.org/10.1007/s10488-017-0793-2>
- Mansell, J., Knapp, M., Beadle-Brown, J., & Beecham, J. (2007) *Deinstitutionalisation and Community Living – Outcomes and Costs: Report of a European Study. Volume 2: Main Report*. Canterbury, United Kingdom.
- Martin, J. P. (2014) Activation and Active Labour Market Policies in OECD countries: Stylized facts and evidence on their effectiveness. *IZA Journal of Labor Policy*, 4(4), 1–29. <http://doi.org/10.1186/s40173-015-0032-y>
- Mavranouzouli, I., Megnin-Viggars, O., Cheema, N., Howlin, P., Baron-Cohen, S., & Pilling, S. (2014) The cost-effectiveness of supported employment for adults with autism in the United Kingdom. *Autism*, 18(8), 975–984. <http://doi.org/10.1177/1362361313505720>
- McAllister, S., Derrett, S., Audas, R., Herbison, P., & Paul, C. (2013) Do different types of financial support after illness or injury affect socio-economic outcomes? A natural experiment in New Zealand. *Social Science and Medicine*, 85, 93–102. <http://doi.org/10.1016/j.socscimed.2013.02.041>
- McLaren, J., Lichtenstein, J. D., Lynch, D., Becker, D., & Drake, R. (2017) Individual placement and support for people with autism spectrum disorders: A pilot program. *Administration and Policy in Mental Health and Mental Health Services Research*, 44(3), 365–373. <http://doi.org/10.1007/s10488-017-0792-3>
- Melnychuk, M., Solmi, F., & Morris, S. (2018) Using compensating variation to measure the costs of child disability in the UK. *European Journal of Health Economics*, 19(3), 419–433. <http://doi.org/10.1007/s10198-017-0893-7>
- Ministry of Health (2011) *Rehabilitation Service and Workforce Forecast, Final Report*. Wellington, New Zealand. Retrieved from https://www.health.govt.nz/system/files/documents/pages/rehabilitation-workforce-service-forecast_0.pdf
- Ministry of Health (2017a) *Annual Data Explorer 2016/17: New Zealand Health Survey [Data File]*. Ministry of Health. Retrieved from <https://minhealthnz.shinyapps.io/nz-health-survey-2016-17-annual-update>
- Ministry of Health (2017b) Briefing to the Incoming Minister of Health, 2017: The New Zealand Health and Disability System. Wellington: Ministry of Health
- Ministry of Health (2018) *Health and Independence Report 2017: The Director-General of Health's Annual Report on the State of Public Health*. Wellington, New Zealand.
- Ministry of Social Development (2017a) *Effectiveness of Contracted Case Management Services: Sole Parent Employment Service and Mental Health Employment Service Trials Evaluation: Final Report*. Wellington: Ministry of Social Development (EDRMS: A9293465).
- Ministry of Social Development (2017b) *Welfare ROI of Intensive Case Management Services: Technical Notes*. Wellington.

- Mitra, S., Palmer, M., Kim, H., Mont, D., & Groce, N. (2017) Extra costs of living with a disability: A review and agenda for research. *Disability and Health Journal*. <http://doi.org/10.1016/j.dhjo.2017.04.007>
- Modini, M., Tan, L., Brinchmann, B., Wang, M.-J., Killackey, E., Glozier, N., ... Harvey, S. B. (2016) Supported employment for people with severe mental illness: Systematic review and meta-analysis of the international evidence. *The British Journal of Psychiatry*, 209(1), 14–22. <http://doi.org/10.1192/bjp.bp.115.165092>
- National Health Committee (2007) *Meeting the Needs of People with Chronic Conditions: Hāpai te Whānau mo Ake Tonu*. Wellington, New Zealand. Retrieved from <https://www.health.govt.nz/system/files/documents/publications/meeting-needs-chronic-conditions-feb07.pdf>
- New Zealand Productivity Commission (2015) *More Effective Social Services*. Wellington, New Zealand: New Zealand Productivity Commission. Retrieved from <http://www.productivity.govt.nz/inquiry-report/more-effectivesocial-services-final-report>
- Nolan, M. (2013) *Understanding the Unemployment Problem*. New Zealand: Infometrics. Retrieved from <http://www.infometrics.co.nz/understanding-the-unemployment-problem>
- OECD (2010) *Sickness, Disability and Work: Breaking the Barriers. A Synthesis of Findings Across OECD Countries*. Paris: OECD Publishing. <http://doi.org/http://dx.doi.org/10.1787/9789264088856-en>
- OECD (2012) *Sick on the Job?: Myths and Realities about Mental Health and Work*,. Paris.
- OECD (2015) *Fit Mind, Fit Job: From Evidence to Practice in Mental Health and Work*. OECD Publishing, 1–178. <http://doi.org/10.1787/9789264228283-en>
- OECD (2017) *Back to Work: New Zealand: Improving the Re-employment Prospects of Displaced Worker*,. Paris. Retrieved from <https://doi.org/10.1787/9789264264434-en>
- OECD (2018) *Mental Health and Work: New Zealand, Mental Health and Work*. Paris. Retrieved from <https://doi.org/10.1787/9789264307315-en>
- Office of the Auditor-General. (2017) *Mental Health: Effectiveness of the Planning to Discharge People From Hospital*. <http://www.oag.govt.nz/2017/mental-health/docs/mental-health.pdf>
- Office of the Health and Disability Commissioner (2018) *New Zealand's mental health and addiction services. The monitoring and advocacy report of the Mental Health Commissioner*. Office of the Health and Disability Commissioner, Wellington, NZ. ISBN 978-0-473-43080-1 <https://www.hdc.org.nz/media/4688/mental-health-commissioners-monitoring-and-advocacy-report-2018.pdf>
- Oliphant, K. (2004) Beyond Woodhouse: Devising new principles for determining ACC boundary issues. *Victoria University of Wellington Law Review*, 35, 915–936.
- Palmer, G. 2018. *A Retrospective on the Woodhouse Report: The vision, the performance and the future*. Second Sir Owen Woodhouse Memorial Lecture, Wellington. https://cdn-flightdec.userfirst.co.nz/uploads/sites/accfclone/files/2018_Woodhouse_Lecture.pdf
- Parmenter, T. R. (2011) *Promoting Training and Employment Opportunities for People with Intellectual Disabilities: International Experience*. Geneva. Retrieved from <http://digitalcommons.ilr.cornell.edu/cgi/viewcontent.cgi?article=1560&context=gladnetcollect>
- Parsell, C. & Moutou, O. (2014) An evaluation of the nature and effectiveness of models of supportive housing. *AHURI Positioning Paper*, 158, 1–52.
- Patel, V. & Saxena, S. (2014) Transforming lives, enhancing communities: Innovations in global mental health. *New England Journal of Medicine*, 370(6), 498–501. <http://doi.org/10.1056/NEJMp1315214>

- Paul, C., Derrett, S., Mcallister, S., Herbison, P., Beaver, C., & Sullivan, M. (2013) Socioeconomic outcomes following spinal cord injury and the role of no-fault compensation: Longitudinal study. *Spinal Cord*, 51(12), 919–925. <http://doi.org/10.1038/sc.2013.110>
- Porteous, N. & Waghorn, G. (2009) Developing evidence-based supported employment services for young adults receiving public mental health services. *New Zealand Journal of Occupational Therapy*, 56(1), 34–39. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&AuthType=ip,url,shib&db=rzh&AN=105503072&site=ehost-live>
- Poterba, S., Venti, D., & Wise, J. (2017) *The Long Reach of Education: Health, Wealth, and DI Participation* (NBER Working Paper Series No. Working Paper 23307). Retrieved from <http://www.nber.org/papers/w23307>
- Potter, J., Poulton, R., Gluckman, P., McNaughton, S., & Lambie, I. (2017) *Toward a Whole of Government/Whole of Nation Approach to Mental Health*. Wellington, New Zealand. Retrieved from <http://www.pmcsa.org.nz/wp-content/uploads/17-08-14-Mental-health-long.pdf>
- Rødevand, L., Ljosaa, T. M., Granan, L. P., Knutzen, T., Jacobsen, H. B., & Reme, S. E. (2017) A pilot study of the individual placement and support model for patients with chronic pain. *BMC Musculoskeletal Disorders*, 18(1). <http://doi.org/10.1186/s12891-017-1908-3>
- Royal Australian and New Zealand College of Psychiatrists (2015) *Minding the Gaps: Cost Barriers to Accessing Health Care for People with Mental Illness*. Retrieved from https://www.ranzcp.org/Files/Publications/RANZCP_NZ-Advocacy-www.aspx
- Sakellariou, D. & Rotarou, E. S. (2017) Access to healthcare for men and women with disabilities in the UK: Secondary analysis of cross-sectional data. *BMJ Open*, 7(8). <http://doi.org/10.1136/bmjopen-2017-016614>
- Scaratti, C., Leonardi, M., Silvaggi, F., Ávila, C. C., Muñoz-Murillo, A., Stavroussi, P., ... Ferraina, S. (2018) Mapping European welfare models: State of the art of strategies for professional integration and reintegration of persons with chronic diseases. *International Journal of Environmental Research and Public Health*, 15(4). <http://doi.org/10.3390/ijerph15040781>
- Simplican, S. C., Leader, G., Kosciulek, J., & Leahy, M. (2015) Defining social inclusion of people with intellectual and developmental disabilities: An ecological model of social networks and community participation. *Research in Developmental Disabilities*. <http://doi.org/10.1016/j.ridd.2014.10.008>
- Smith, D. L., Atmatzidis, K., Capogreco, M., Lloyd-Randolfi, D., & Seman, V. (2017) Evidence-based interventions for increasing work participation for persons with various disabilities: A systematic review. *OTJR: Occupation Participation and Health*, 37(2), 3S–13S. <http://doi.org/10.1177/1539449216681276>
- Stats NZ (2017) *Information Release: Well-being Statistics: 2016*.
- Stephens, R. (2004) Horizontal equity for disabled people: Incapacity from accident or illness. *Victoria University of Wellington Law Review*, 35. Retrieved from <https://www.victoria.ac.nz/law/research/publications/vuwlr/prev-issues/vol-35-4/stephens.pdf>
- Strandh, M., Winefield, A., Nilsson, K., & Hammarström, A. (2014) Unemployment and mental health scarring during the life course. *European Journal of Public Health*, 24(3), 440–445. <http://doi.org/10.1093/eurpub/cku005>
- Sum, G., Hone, T., Atun, R., Millett, C., Suhrcke, M., Mahal, A., ... Lee, J. T. (2018) Multimorbidity and out-of-pocket expenditure on medicines: A systematic review. *BMJ Global Health*, 3(1), e000505. <http://doi.org/10.1136/bmjgh-2017-000505>
- Sural, P. & Beaglehole, R. (2018) *Too soon for the tooth fairy: The implications of child poverty for oral health*. New Zealand. Retrieved from https://www.cpag.org.nz/assets/180423_Too_soon_for_the_toothfairy_ORAL_HEALTH2.pdf

- Taylor Fry (2017) *Ministry of Social Development, Valuation of the Benefit System for Working-age Adults: 30 June 2016*. Wellington, New Zealand. Retrieved from <https://www.msd.govt.nz/documents/about-msd-and-our-work/newsroom/media-releases/2017/valuation-of-the-benefit-system-for-working-age-adults-2016/valuation-of-the-benefit-system-for-working-age-adults-2016.pdf>
- Test, D. W., Fowler, C. H., Richter, S. M., White, J., Mazzotti, V., Walker, A. R., ... Kortering, L. (2009) Evidence-based practices in secondary transition. *Career Development and Transition for Exceptional Individuals*, 32(2), 115–128. <http://doi.org/10.1177/0885728809336859>
- Tobias, M., Gerritsen, S., Kokaua, J., & Templeton, R. (2009). Psychiatric illness among a nationally representative sample of sole and partnered parents in New Zealand. *Australian and New Zealand Journal of Psychiatry*, 43(2), 136 - 144
- Travaglia, S., Fitzgerald, T., Ryan, B., Patston, P., Dylan, S., Baker, R., ... McNeill, R. (2010) *The Cost of Disability*. Disability Resource Centre in collaboration with the University of Auckland. Retrieved from <http://carers.net.nz/information/research-cost-of-disability-report-2010/%0A>
- Unger, S., Tisch, A., & Tophoven, S. (2018) Age and gender differences in the impact of labour-market transitions on subjective health in Germany. *Scandinavian Journal of Public Health*, 46(19_suppl), 49–64. <http://doi.org/10.1177/1403494817738430>
- Vancea, M. & Utzet, M. (2016) How unemployment and precarious employment affect the health of young people: A scoping study on social determinants. *Scandinavian Journal of Public Health*, (October), 1–12. <http://doi.org/10.1177/1403494816679555>
- Viola, S. & Moncrieff, J. (2016) Claims for sickness and disability benefits owing to mental disorders in the UK: Trends from 1995 to 2014. *British Journal of Psychiatry Open*, 2(1), 18–24. <http://doi.org/10.1192/bjpo.bp.115.002246>
- Virtanen, P., Hammarström, A., & Janlert, U. (2016) Children of boom and recession and the scars to the mental health: A comparative study on the long term effects of youth unemployment. *International Journal for Equity in Health*, 15(1). <http://doi.org/10.1186/s12939-016-0305-0>
- WEAG (2019a) *Example Families and Budgets: Investigating the adequacy of incomes*. Paper prepared for the Welfare Expert Advisory Group (WEAG), Wellington, NZ
- WEAG (2019b) *Current state: Carers of people with health conditions or disabilities*. Paper prepared for the Welfare Expert Advisory Group (WEAG), Wellington, NZ
- Wehman, P., Brooke, V., Brooke, A. M., Ham, W., Schall, C., McDonough, J., ... Avellone, L. (2016) Employment for adults with autism spectrum disorders: A retrospective review of a customized employment approach. *Research in Developmental Disabilities*, 53–54, 61–72. <http://doi.org/10.1016/j.ridd.2016.01.015>
- Were, L. (2017) *Enabling Good Lives Waikato. Phase Two Evaluation Summary Report*. Wellington, New Zealand. Retrieved from <http://www.enablinggoodlives.co.nz/current-demonstrations/enabling-good-lives-waikato/waikato-evaluations>
- Wiesel, I. & Habibis, D. (2015) NDIS, housing assistance and choice and control for people with disability. *AHURI Final Report*, (258), 1–48.
- Wiesel, I., Laragy, C., Gendera, S., Fisher, K., Jenkinson, S., Hill, T., ... Bridge, C. (2015) *Moving to My Home: The Aspirations, Transitions and Outcomes of People with Disability* (AHURI Final Report No. 246). Melbourne.
- Williams, M. W., Haarhoff, B., & Vertongen, R. (2017) Mental health in Aotearoa New Zealand: Rising to the challenge of the fourth wave? *New Zealand Journal of Psychology*, 46(2), 16–22.
- Wise, P. H. (2012) Emerging technologies and their impact on disability. *Future of Children*, 22(1), 169–191. <http://doi.org/10.1353/foc.2012.0002>

Wright, C. J., Muenchberger, H., & Whitty, J. A. (2015) The choice agenda in the Australian supported housing context: A timely reflection. *Disability and Society*, 30(6), 834–848. <http://doi.org/10.1080/09687599.2015.1038336>

Wynd, D. (2015) *‘It Shouldn’t be this Hard’: Children, Poverty and Disability*. (A Child Poverty Action Group Monograph). New Zealand. Retrieved from <http://www.cpag.org.nz/assets/150317ChildDisability.pdf>

Appendices

Appendix 1: Assistance with additional cost of disability

Financial support

Need	Provider	Name	What/Eligibility	Amount
Additional costs	ACC	Help at home	<p>Assistance to help with cleaning and looking after a person's home or to help with personal activities such as showering and dressing.</p> <p>Once ACC has agreed to cover an injury, this can be requested directly through ACC or a doctor.</p> <p>Depending on recovery time, an assessment may be needed.</p> <p>A person can choose who provides the support (professional, friend and family, mix) and they can receive payment from ACC to pay a carer, or ACC can pay them directly.</p>	
	Ministry of Social Development (MSD)	Disability Allowance (DA) Special Disability Allowance Child Disability Allowance (CDA)	<p><i>Disability Allowance</i></p> <p>DA is capped supplementary assistance of up to \$63.22 a week⁷⁵ to help meet verified additional, ongoing and direct costs of a disability or health condition. The types of cost for which recipients receive DA include medical fees, pharmaceuticals, transport, power and gardening. To be eligible to receive DA a person must:</p> <ul style="list-style-type: none"> • meet an income test • have a disability that is likely to last at least six months • have additional ongoing costs arising from that disability • be a New Zealand citizen or permanent resident or deemed to hold a residence class visa in New Zealand under the Immigration Act 2009 (e.g. an Australian citizen or resident) • generally be ordinarily resident in New Zealand. <p><i>Special Disability Allowance</i></p> <p>Special Disability Allowance is a weekly payment for a person who has a spouse or partner who is in residential care, or has been in a public hospital for over 13 weeks. It is paid to the spouse or partner who is not in care to help with the extra costs of having their spouse or partner in care.</p> <p><i>Child Disability Allowance</i></p> <p>CDA is a fortnightly payment made to the main carer of a child or young person with a serious disability. It is paid in recognition of the extra care and attention needed for that child.</p>	<p>The maximum per week for:</p> <ul style="list-style-type: none"> • CDA is \$47.64 • DA is \$63.22 • Special Disability Allowance is \$39.43. <p>Income limits for DA for non-beneficiaries and New Zealand Superannuation recipients vary according to family circumstances:</p> <ul style="list-style-type: none"> • Single, 16-17 years: \$531.61 • Single, 18+ years: \$648.92 • Married, civil union or de facto couple (with or without children): \$963.80 • Sole parent, one child: \$741.41 • Sole parent, two or more children: \$781.14.

75

It is not a flat rate – \$63.22 is the current maximum weekly rate a person can receive, but many people receive less than the maximum as smaller weekly payments. The maximum rates are discretionarily subject to adjustment as part of the Annual General Adjustments process. http://legislation.govt.nz/act/public/1964/0136/latest/DLM367136.html?search=ta_act_s_ac%40ainif%40anif_an%40brn%40rn_25_a&p=2.

Need	Provider	Name	What/Eligibility	Amount
		Special Needs Grants	<p>There is a range of special assistance options (Special Needs Grants) if a person is struggling with accommodation, bills, food, school costs, etc.</p> <p>Special Needs Grants provide non-taxable, one-off recoverable or non-recoverable financial assistance to recipients to meet immediate needs. In order to receive a Special Needs Grant a recipient must:</p> <ul style="list-style-type: none"> • meet an income and cash asset test • have an essential need or emergency need or require payment for specific circumstances • not be able to meet the need from their own resources or through other sources • have met their hardship obligations, including taking reasonable steps to improve their financial circumstances, and completed a budgeting activity (if required) • be a New Zealand citizen or permanent resident and ordinarily resident in New Zealand • purchase goods and services from a preferred supplier when there is an arrangement in place. 	Income limits for Special Needs Grants for non-beneficiaries and New Zealand Superannuation recipients vary according to family circumstances.
		Temporary Additional Support (TAS)	<p>TAS is a non-taxable supplementary payment that can be paid for a maximum of 13 weeks. It is paid as a last resort to help a recipient with their regular essential living costs that cannot be met from their chargeable income and other resources. If the recipient still needs help with their regular essential living costs and they have received TAS for the maximum 13-week period, they must re-apply.</p> <p>The client must ensure that they are accessing all other assistance available to them and take reasonable steps towards reducing their costs and increasing their chargeable income.</p> <p>The recipient does not have to be receiving a main benefit to qualify for TAS.</p> <p><i>Temporary Additional Support: Disability exception</i></p> <p>A disability exception amount is available to the applicant only when:</p> <ul style="list-style-type: none"> • the recipient has a deficiency greater than the upper limit for TAS, and • any member of the recipient's family, or a child for whom they receive an Orphan's Benefit or Unsupported Child's Benefit, is receiving the maximum amount of DA, and • any member of the recipient's family, or a child for whom they receive an Orphan's Benefit or Unsupported Child's Benefit, has excess disability costs. <p>Excess disability costs are eligible DA costs that are in excess of the maximum amount of DA that has been granted. Excess disability costs must not include counselling costs or transport costs to counselling sessions that are above the maximum rate of DA.</p>	There is no set rate, but rather a formula assessment on a case-by-case basis.
		Recoverable Assistance Programme	<p>The Recoverable Assistance Programme provides non-taxable, interest-free, recoverable financial assistance to non-beneficiaries to meet essential immediate needs for specific items or services.</p> <p>A recipient who meets the income and cash asset tests may have access to Recoverable Assistance Payments up to a maximum amount of six weeks of the rate of Supported Living Payment (SLP). The recipient must be able to identify a particular immediate need for an essential item or service.</p> <p>It could include assistance for hearing aids, dentures or glasses.</p>	Varies.
	MSD	Civilian Amputee Assistance	<p>This is to support a civilian amputee to meet travel and accommodation costs plus loss of earnings when required to attend a limb centre. The assistance is not considered income. It is a reimbursement of costs (e.g. travel, accommodation, meals, attendant, loss of earnings).</p>	Varies.

Need	Provider	Name	What/Eligibility	Amount
		Social Rehabilitation Assistance (e.g. drug and alcohol programme)	<p>Social Rehabilitation Assistance is paid to a recipient who is resident in an approved residential social rehabilitation programme and the recipient's benefit is not sufficient to meet the fees charged.</p> <p>In order to receive Social Rehabilitation Assistance, a person must be:</p> <ul style="list-style-type: none"> • resident in an approved social rehabilitation programme, and • eligible for and receiving an income-tested benefit, or • receiving New Zealand Superannuation or Veteran's Pension and meet the requirements of an income test. 	Payments vary by region.
Medical	Pharmacists	Prescription Subsidy Card	A person is eligible for this subsidy once they have paid for 20 new prescription medicine items from 1 February each year. This can be a combination of items for a partner and dependent child aged 13 to 18 years.	
	MSD (W&I)	Community Services Card	<p>The Community Services Card is used to access health subsidies when the holder needs to visit a doctor who is not registered with a Primary Health Organisation (PHO) or who is outside the patient's PHO area, or when a person needs to visit a doctor after hours.</p> <p>A person may be able to get a Community Services Card if they are:</p> <ul style="list-style-type: none"> • 16 years or over (not a dependent child) • on a low to middle income (defined by income thresholds for different living situations/family types). 	
	General practitioners (GPs)	High Use Health Card	<p>A high user of GP services may qualify for a High Use Health Card. To obtain this card, the patient and the GP together must apply to the Ministry of Health (MOH). This card is valid for the patient only (i.e. not other family members). The person must have made 12 visits in the past 12 months for one or more ongoing conditions. The card commences on the day after the patient's 12th visit and expires on the same date one year afterwards.</p> <p>This card offers the same benefits as a Community Services Card.</p> <p>To qualify a person must have received 12 health practitioner consultations within the previous 12 months for a particular ongoing medical condition.</p>	

Need	Provider	Name	What/Eligibility	Amount
Housing/ Transport	MSD (W&I)	Accommodation Supplement	<p>This is a payment to help with rent, board or housing costs.</p> <p>To be eligible, a person must be a current benefit recipient, earn below a certain threshold and own below a certain asset threshold.</p> <p>The amount a person can receive depends on the zone (1, 2, 3, 4), the benefit they receive, their age and their living situation.</p>	
	Local government	Rates Rebate Scheme	<p>This provides rebates for low-income ratepayers.</p> <p>To be eligible, a person must be the person who pays the rates on the property that is their home, be living in that home and be listed as the ratepayer in the local council's Rating Information Database.</p> <p>A person cannot receive the rebate if the property is used for commercial activities or is a rental property/holiday home.</p>	
	MOH	Vehicle Modification	<p>This is funding for a person with a serious disability to enable them to purchase or modify a vehicle to obtain full-time employment, look after dependent children or attend study/training.</p> <p>The person must complete a needs assessment from MOH, provided by different contractors via occupational therapists. Funding is subject to income and cash asset testing for the person with the disability and their partner.</p>	<p>The maximum amount payable to purchase a vehicle is \$12,165 (GST inclusive).</p> <p>The maximum amount payable for Vehicle Modification funding is \$12,165 (GST inclusive).</p>
	District Health Boards (DHBs)	National Travel Assistance Scheme for Health and Disability Services	<p>This scheme provides financial assistance for travel (and accommodation costs for people who need to travel long distances). Eligibility depends on the DHB area they live in, how far and how often the person needs to travel, and if the person has a Community Services Card.</p> <p>A person may not be eligible if they are already receiving assistance for travel from another part of Government (e.g. ACC or W&I).</p>	
	NZ Transport Agency	Total Mobility Scheme	<p>The Total Mobility Scheme provides subsidised licensed taxi services to people who have impairments that prevent them undertaking any one or more of the following five components of a journey unaccompanied, on a bus, train or ferry in a safe and dignified manner: getting to the place from where the transport departs; getting onto the transport; riding securely; getting off the transport; and getting to the destination.</p>	

Non-financial support

Need	Provider	Name	What/Eligibility
Transport	CCS Disability Action	Mobility Parking Permit Scheme	<p>The Scheme provides a Mobility Parking Permit card, which allows holders to use mobility parking spaces, which are wider than standard parks and closer to venues.</p> <p>The Scheme is available to people of all ages if they:</p> <ul style="list-style-type: none"> are unable to walk and rely on the use of a wheelchair have a severely restricted ability to walk due to a health condition or disability have a health condition or disability that requires them to have physical contact or close supervision to get around safely, and cannot be left unattended.
Assessment and assistance	Needs Assessment and Service Coordination (NASC) service (MOH)	Needs assessments	<p>There are two types of NASC services for different populations:</p> <ul style="list-style-type: none"> For younger people (those generally under 65) with: <ul style="list-style-type: none"> physical, intellectual and/or sensory disabilities that are likely to last for six months or more, or chronic health conditions and high ongoing needs. For older people (aged 65 years and above) and people aged 50-64 who have similar needs as listed above. <p>There are also assessment services for mental health and alcohol and drug dependencies, although these are dependent on DHBs.</p>
	MOH	Respite services	<p>Eligibility for these services is determined through NASC assessments – and a person would need to be eligible for Disability Support System services.</p> <p>Facility-based respite, which provides care for a disabled person out of their home (usually overnight in a dedicated respite house or other facility, which provides care for a group of about five people at one time).</p> <p>Respite, through which disabled people or their families/whānau directly purchase their own respite supports.</p> <p>In-home support or one-on-one 'buddy' support, which may be provided in the home, in the community or through after-school, before-school or holiday programmes (paid at an hourly rate).</p> <p>Host-family respite, which provides an overnight break in the home of another family/whānau. The host family/whānau receives payment through Carer Support or through a provider contracted to MOH. Children and young people are more likely to receive host-family respite.</p>
Assistance for children	Ministry of Education	Learning Support Services	<p>Special education services are free for all those who are eligible. An individual assessment may be needed to determine a child's individual needs and the supports needed.</p> <p>Learning support services include:</p> <ul style="list-style-type: none"> advice/information speech language therapy education support workers special resources (e.g. communication aids) coordinating physiotherapy, occupational therapy, equipment etc.

Appendix 2: Spending on support for different groups of MSD benefit recipients (financial year 2016-2017)

Row Labels	Column Labels	Integrity	Income support	Child care subsidy	Care manager activities	Care management employment	LM training/Work readiness	Job brokering	Direct job creation	Social Housing	Social Services	Study Assistance	Grand Total
Youth	\$36,198	\$1,637,586	\$1,942,012	\$52,888	\$13,895,244	\$833,019	\$201,838	\$160,404	\$27,927	\$45,288	\$18,882,471		\$18,882,471
Student	\$1,459,677	\$8,598,295	\$12,200,500	\$602,575	\$814,580	\$43,925	\$1,299,372	\$161,229	\$425,537	\$425,537	\$10,888,988		\$86,874,457
J8-WR	\$4,329,858	\$65,917,816	\$4,773,488	\$11,241,188	\$44,398,258	\$19,329,793	\$65,927,801	\$2,389,771	\$3,551,012	\$1,468,855	\$977,753		\$24,265,414
J8-HSD	\$2,325,522	\$73,068,949	\$1,824,650	\$2,159,616	\$20,648,188	\$2,411,784	\$11,584,710	\$498,469	\$2,826,971	\$3,181,952	\$357,216		\$120,887,667
SLP	\$1,115,181	\$41,447,084	\$3,929,417	\$9,712,223	\$2,410,564	\$719,396	\$12,090,622	\$2,232,883	\$3,462,817	\$51,827,787	\$191,107		\$129,143,782
SPB	\$2,042,246	\$66,425,651	\$54,029,287	\$7,578,829	\$37,373,671	\$4,765,105	\$15,812,128	\$788,149	\$5,379,507	\$444,973	\$997,246		\$188,144,970
Veterans	\$7,233	\$245,187	\$3,824	\$204,582	\$27,854		\$4,660	\$10,005			\$233		\$88,378
Seniors	\$931,816	\$34,406,374	\$455,194	\$7,600,862	\$2,151,650	\$3,071	\$194,639	\$9,273	\$1,607,101	\$257,962	\$10,169		\$57,827,111
Supp.	\$1,678,514	\$21,747,229	\$41,221,555	\$6,375,295	\$1,194,362	\$100,903	\$8,241,775	\$511,645	\$685,164	\$382,637	\$403,670		\$81,522,749
Unknown	\$608,034	\$613,669		\$388,322	\$13,750,194		\$2,484,281	\$62,945		\$3,184,729			\$20,843,173
None	\$14,552,244	\$81,863,802	\$68,245,488	\$22,524,299	\$23,425,476	\$1,273,489	\$31,478,827	\$683,218	\$3,793,897	\$3,200,238	\$4,563,636		\$278,174,793
Grand Total	\$28,971,622	\$385,969,613	\$208,640,206	\$77,520,886	\$160,589,841	\$29,530,466	\$149,320,749	\$7,452,738	\$21,955,361	\$64,140,290	\$18,803,403		\$1,152,894,975

Source: MSD

Appendix 3: Employment assistance from the Ministry of Social Development

Mainstream assistance		Health and disability-specific assistance
<p>Training and work readiness</p> <ul style="list-style-type: none"> Training Incentive Allowance. Recipients receiving qualifying benefits (Emergency Maintenance Allowance, Sole Parent Support, Supported Living Payment (SLP), or Young Parent Payment) can receive non-taxable assistance to undertake employment-related training that will improve their skills and increase their chances of gaining employment. This funding cannot be used for courses of study above Level 4 on the New Zealand Qualifications Framework (certificate level). Course Participation Allowance. Recipients can receive up to \$1,000 in a 52-week period to help with the costs of short-term courses that address specific gaps in employment skills. In October 2017, 207 recipients on SLP or Jobseeker Support – Health Condition or Disability (JS-HCD) received this payment. Training for Work. Delivers short, skills-focused interventions to support recipients to gain work. It has \$13.746 million in funding. Skills for Industry. Training programmes with employers or providers and work readiness programmes with employers. It has \$14.5 million in funding. Work experience. Recipients can access help to gain up-to-date work experience, explore suitable career options and develop informal contacts. This can include voluntary unpaid experience in community or voluntary organisations as a stepping stone to work readiness. 	<ul style="list-style-type: none"> Training Support. Training Support provides financial assistance for people with health conditions or disabled people to gain or retain open employment through participation in employment-related training and other activities. Training Support provides grants to meet additional costs incurred by people with health conditions or disabled people as a direct consequence of their health conditions or disabilities when undertaking the same training as a person without a health condition or a disability. Workbridge is contracted by the Ministry of Social Development (MSD) to administer the Training Support programme. Training Support does not cover course fees as these are not a cost of disability. Work Ability Assessment. Recipients with Work Focused Case Managers may be required to undertake this assessment to identify what work they can do and what support and services they might need. It has \$1.9 million in funding. Providing Access to Health Solutions (PATHS) programme. MSD, District Health Boards (DHBs), Primary Health Organisations and non-government organisations work together to assist recipients in accessing a wide range of health, employment and community services, enabling recipients to return to employment. PATHS is not available in all regions. Targeted Health Interventions. This is in all non-PATHS sites. The initiative is for recipients who: experience ill health or disability and want to return to full-time employment; and require a single health intervention to enable them to return to work and are unable to access that intervention through the public health system within three months. Mana Taimahi trial (with the National Hauora Coalition). We are working with general practitioners (GPs) to test new approaches for the provision of Work Capacity medical certificates and associated interventions to support people to return to work sooner, whilst creating effective partnerships between MSD and GPs. Oranga Mahi – REACH trial (Waikato DHB). An intensive three-month intervention with coaches utilising cognitive behavioural techniques as part of a wider rehabilitation programme to improve work outcomes. Oranga Mahi – Rakau Rangatira trial (Northland DHB). A kaupapa Māori and Whānau Ora-based, integrated service for those with mental health and substance abuse issues. Peer Support trial. Gives SLP recipients with mental health conditions peer support leading to active case management to prepare for work. 	

Mainstream assistance	Health and disability-specific assistance
<p>Help to search for jobs</p> <ul style="list-style-type: none"> • Case management. Based on their characteristics, recipients are allocated to the types of case management that are considered likely to be the most effective for them. The case management options are Work Focused General, Work Focused Youth, Work Focused Health Condition and Disability, Intensive Services, and General Case Management (GCM). GCM administers the provision of income support. • Work brokers. Provide free recruitment services to employers, including selecting suitable candidates. Industry partnerships with large businesses and industry associations also provide recruitment services. • Job Search Service. Supports people back to work as quickly as possible using either individualised or group job search activities. It is targeted at people who are close to the labour market, and only 12 recipients on SLP and JS-HCD received it in 2016-2017. • Employment Workshops. Short workshops designed to help job seekers search for jobs in a supported and structured environment. • Work for You. Seminars delivered at MSD service centres to help people prepare for job search activities. 	<ul style="list-style-type: none"> • Employment Services. Supported Employment agencies that help disabled people to find work in the open labour market and provide in-work support for up to a year. The largest contract is with Workbridge (\$11 million), and total funding for 2017-2018 (excluding regional contracts) is \$21.5 million. • Supported Living Payment Opt-In. This service allows eligible recipients who receive SLP to work intensively with case managers in the Work Focused Case Management – Health Condition or Disability (WFCM-HCD) service to help them achieve their goal of regularly working more than 15 hours per week. • MSD Employment Coordinator. Works with disabled recipients to help them find and stay in suitable work. There are around 45 Coordinators nationwide. • Work to Wellness trial*. A health-focused case management, placement and post-placement service. • Oranga Mahi – Step Up trial (Canterbury DHB). A 12-week service with 'health navigators' connecting recipients to work and supports. • Individual Placement and Support. An evidence-based practice that integrates mental health and employment services. MSD is in the process of developing a trial of Individual Placement and Support in two locations – Odyssey House, Christchurch and Waitemata DHB.
<p>Assistance to transition into work</p>	<ul style="list-style-type: none"> • Sustainable Employment Trial. Allows recipients to try out going back to work for 15 hours or more a week for up to six months, while still retaining their SLP. • Employment Transition Assistance. A non-taxable payment available for recipients on SLP who have reduced levels of income after completing employment trials. • Work Bonus. A temporary incentive payment for SLP and Sole Parent Support recipients who choose to work even though they have no work obligations. • Disability Allowance. An income-tested payment for ongoing additional costs because of a disability, including transport and counselling.
<p>Support to stay in work</p>	<p>See below.</p>
<p>Support for employers</p>	<ul style="list-style-type: none"> • In-Work Support trial.⁷⁶ Ongoing advice and support for recipients to help them stay in work and receive any financial support they qualify for (e.g. Disability Allowance or Flexible Childcare Assistance). • Flexi-Wage. Time-limited payments to assist employers with wages and/or skills training. It was used for 710 recipients on SLP and JS-HCD in 2016-2017. • Industry Partnerships <ul style="list-style-type: none"> • Mainstream Internship Programme. Provides a 100% wage subsidy to disabled students for 4-16-week, short-term internships that align with their chosen fields of study. 12 people participated in the programme in 2016-2017. • Mainstream Employment Programme. A package of wage subsidies, training and other support to help people with significant disabilities to gain sustainable employment. Provides a 100% subsidy of their salaries for up to a year and then an 80% subsidy for the second year. In 2016-2017 funding was \$3.546 million and 181 people started receiving Mainstream wage subsidies (these included those in the Internship Programme, see above). • Support Funds. Grants to meet additional costs of disability in employment, self-employment and training. In 2017-2018 Workbridge received \$5.3 million for Support Funds. It can be used for a range of assistance e.g. workplace modifications, equipment, wage subsidies, transport and New Zealand Sign Language interpreters. There are three types: <ul style="list-style-type: none"> – Job Support – up to \$16,900 per annum for costs in open employment. – Self-Start – up to \$5,200 (lifetime) for costs in self-employment. – Training Support – up to \$15,600 (lifetime) for costs of participating in training.

76 This initiative is currently a trial and not available in every MSD region.

