IN THE COURT OF APPEAL OF NEW ZEALAND

CA460/2017
[2017] NZCA 619

BETWEEN	SHANE BARRY CHAMBERLAIN First Appellant
AND	DIANE MOODY Second Appellant
AND	MINISTER OF HEALTH Respondent

Hearing: 31 October 2017 and 1 November 2017

Court: Harrison, Asher and Brown JJ

Counsel: P J Dale for Appellants
P T Rishworth QC and V McCall for Respondent

Judgment: 7 February 2018 at 12.30 pm

JUDGMENT OF THE COURT

A The appeal is allowed.

B The decision granting the first appellant a maximum of 17 hours of funded family care weekly for disability support services provided by the second appellant is set aside.

C The respondent is directed to reassess the first appellant's application in a manner consistent with the purposes of the New Zealand Public Health and Disability Act 2000 and the content of the family care policy as set out in this judgment.

D The respondent is ordered to pay costs to the appellants on a band A basis as for a standard appeal together with usual disbursements.

REASONS OF THE COURT

(Given by Harrison J)

Introduction

[1] Shane Chamberlain is a middle-aged man with a profound level of intellectual disability.[1] His elderly mother, Diane Moody, has been his fulltime carer for almost all his life. The Ministry of Health funds Shane for his mother's performance of 17 hours of care weekly as well as funding for third parties to perform additional services. Shane and his mother claim that he is entitled to funding for family care up to the maximum of 40 hours weekly. Both say that the Minister of Health, through the contracted agency of private assessors, has erred in exercising a statutory power of decision.

[2] Shane, acting through his litigation guardian Jane Carrigan, and Mrs Moody appeal against Palmer J's judgment in the High Court declining his application for a declaration that the Minister's funding decision was unlawful for want of consistency with the relevant family care policy (the Policy) under the New Zealand Public Health and Disability Act 2000 (the Act).[2] The appeal requires our determination of the meaning of phrases used in layers of statutory provisions and derivative instruments to identify the relevant disability support services eligible for funding. Palmer J described these documents, with a degree of understatement, as "complex and difficult to follow".[3] The resultant challenge for impaired persons in understanding the nature and scope of their eligibility is obvious.

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[1] As in the judgment under appeal and the weight of evidence before us, we shall refer throughout this judgment to Shane by his forename.

[2] *Chamberlain v Ministry of Health* [2017] NZHC 1821, [2017] NZAR 1271 [HC judgment]. Palmer J's rejection of the alternative claims of unreasonableness, statutory inconsistency and breach of substantive legitimate expectation were originally challenged on appeal but not pursued in argument before us.

[3] At [29].

[3] The ultimate question, however, is confined. It is whether the Judge was correct that Shane's funding eligibility is limited to his mother's performance of discrete services identifiable within the phrases "personal care" and "household management" where they are used in the relevant specifications;[4] or whether, as the appellants submit, these categories of eligibility must encompass the provision of broader services such as safety supervision and intermittent care in the light of the purpose for which family care is funded.

Background facts

[4] The relevant facts are derived principally from Mrs Moody's detailed and uncontested affidavit.

[5] Shane is 51 years of age. He suffers the result of severe birth-related complications caused by the misuse of forceps during delivery. He is paralysed down his right side. He was also born with Williams Syndrome, a developmental disorder caused by genetic abnormality which affects many parts of the body. It was not diagnosed until he was aged about 30 years.

[6] Shane is Mrs Moody's eldest child. She is now 76 years old. She and her former husband divorced in 2003 and he died in 2007. She has cared for Shane in the family home all her life except for a few years when he was in an adult care facility.

[7] Shane is incapable of normal day-to-day self-care. He has no genuine or meaningful understanding of anything other than his most basic likes or dislikes. He is able to give his name, although it is difficult to understand him. He gives his age as nine years and says he lives in Taupō. In reality he resides in Beach Haven, Auckland. He is able to count with assistance up to 20. He can also recite the alphabet with assistance. He has no traffic sense and is unable to cross a road or catch a bus on his own. He does not drive and is unable to do up his seatbelt.

[8] Shane is unable to read or write and has no conceptual understanding of either medium. He is able to listen to the reading of a book but at the basic level of a child's

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[4] At [51]–[57].

story like the Three Little Pigs. Shane is also autistic, and he is easily mesmerised by certain things — such as a big picture of monkeys in a book. He is able to go to the cinema with his mother but only on a restricted basis. He spends most of his time sitting in his bedroom. He listens endlessly to his radio, or CD music and stories. He loves Chinese television and his favourite DVDs involve aeroplanes and the Muppets.

[9] Shane's behaviour is also repetitive, another autistic characteristic. He loves fixed-wing aircraft and helicopters — living near the Whenuapai airbase provides him with entertainment. He has age-inappropriate special toys of the type an 18-month-old child would enjoy, such as talking animals. His favourite activity is using the family spa and swimming pool. In the winter, he will sit in the spa for hours at a time or by the pool holding a hose over it to fill it up. Mrs Moody must keep him within sight always.

[10] Mrs Moody takes Shane out of the house whenever and wherever possible. He likes attending concerts by the Royal New Zealand Navy Band and visiting the zoo where he sits for hours watching elephants — he has no interest in the other animals, not even monkeys. He loves concrete trucks and enjoys sitting at the Devonport Wharf to watch passenger ferries. He is, however, unable to go to public swimming pools because of difficulties controlling his bowels.

[11] Mrs Moody is able to take Shane to visit centres like Taupō and Palmerston North. She last took him overseas to Rarotonga in 2009. He is enjoying these trips less with age.

[12] Shane sleeps fairly well but he must get up regularly during the night to go to the toilet. He can manage most of these nocturnal visits on his own because his mother has installed motion-sensor lights. However, his internal organs regularly fail him and Mrs Moody must clean up the lavatory the following morning. While he usually returns to bed following these visits, it is not unusual for Shane to sit in his chair and turn on his television or the radio. Some nights he suffers reflux or leg cramps, requiring his mother to be up to care for him.

[13] Mrs Moody's daily routine starts by cleaning out the lavatory and bathroom and preparing breakfast for Shane, followed by showering and dressing him. He loves milky coffee and during the course of a morning will have as many cups as he is allowed. Mrs Moody must make the coffee for him. If the day is spent at home, Shane will usually alternate between his room and the spa pool. If he is in the spa his mother must ensure that he is always hydrated.

[14] Mrs Moody prepares Shane's lunch around midday, followed by afternoon tea and an early dinner, usually about 5 pm. This routine helps to contain his reflux. His propensity for choking requires her to be particularly careful in food preparation and she must watch him consume his meals.

[15] Shane has suffered from lifelong ill-health, particularly affecting the heart and cardiovascular system, which is typical of those born affected with Williams Syndrome. He only began to walk at five years of age. He has scoliosis and walks with a distinctive gait. He is vulnerable to falls, causing joint and bone fractures and bruising. He has asthma and uses an inhaler from time to time. He is particularly susceptible to anxiety and reacts badly to many drugs — Mrs Moody suspects his history of self-harm by biting can be attributed to hallucinatory reactions from prescription medication.

[16] Mrs Moody describes hospital visits with Shane as "fraught affairs" where she is unable to leave him alone. He has had two operations to improve his urine flow or lack of it. He often has diverticulitis — an inflammation of the bowel — and he endures a generally sensitive stomach to certain foods. He suffers a chronic lack of bowel control which is worsening with age. His mother is required to take him frequently to hospital, doctor, specialist, dental and other medical appointments.

[17] Between the ages of 21 and 25 years, Shane spent his days at the IHC Sheltered Workshop in Northcote where he participated in programmes with other adults who shared his profound intellectual disabilities. Mrs Moody withdrew him from this institution after he was violently assaulted by another attendee. Despite trying other facilities, she has been unable to find suitable care for Shane since that incident.

[18] Mrs Moody says this about Shane's care:

> I know if Shane was living in residential care he would be a very different person. His health and his anxiety would be two areas that I am sure would be adversely impacted upon, just by the very nature of residential care (changing staff/different staff during the day and alternating flatmates). I'm sure Shane would be placed on anti-anxiety drugs for the benefit of staff and possibly other residents. I have no doubts that medication would effectively be the end of him. Even if it wasn't, Shane would really struggle with the lack of continuity. In summary I am in no doubt that if Shane lived in residential care, he would have been a lot sicker. Part of keeping on top of Shane's health is being very "in tune" with changes in his body, and understanding when he appears to be sickening. Realistically with rotating staff, and his inability to identify his own ailments both would combine to ensure that many of his health conditions would not be identified until it was serious.

[19] Mrs Moody does not refer to the inestimable benefits for Shane and the state of her constant and continuous availability to care for him within the security of the home environment and of the quality of the care provided with a mother's devotion to her son's continued wellbeing.

[20] Shane is, Mrs Moody says, "my life". He requires her constant care for 24 hours a day, seven days a week. It is plain that Shane can never be left unattended and unsupervised.

The funding decision

[21] The Ministry of Health is responsible for administering the provision of and payment for disability support services. The Ministry engages Needs Assessment and Service Coordination (NASC) providers to conduct individualised needs assessments to determine funding eligibility and coordinate services to ensure support needs are met.

[22] The Ministry contracts with the Taikura Trust, a charitable trust, to act as a NASC agency. In May 2014 Taikura undertook an assessment of Shane's needs in support of his application for funded family care. Taikura, and later the NASC National Reviewer, assessed Shane as having "high end" disability-related needs by reference to the Ministry's Support Package Allocation (SPA) tool, which was published in May 2010 to "promote transparent, equitable and robust decision

making" in NASC. The SPA tool sets out levels of need in five bands ranging from Very Low to Very High. Shane met the eligibility criteria for the second highest band, placing him in a position where he could qualify for up to $900 of support services per week. The highest band extends to $1,500 per week.

[23] Shane was assessed originally as being entitled to only 11 hours of funding for his mother's care services. Assessments are quantified by use of time-measurement tools allocated as hourly units for defined functions. In Taikura's initial advice to Mrs Moody on 7 July 2014, the 11 hours of funded family care comprised:

(a) 7.5 hours of household management per week — "Shane requires assistance to make his bed, change his linen, assistance for meal preparation, chopping meat or solid foods, dishes, vacuuming, laundry, household safety & security and managing his finances"; and

(b) 3.5 hours of personal care per week — "Shane requires assistance for washing hair & body, shaving, finger & toe nails, washing his face, brushing his teeth & hair, wiping after toilet, supervision for appropriate clothing, dressing, zips etc."

Family care is funded at the minimum wage, which was $14.25 an hour before tax. Thus the initial assessment translated to gross payments of $156.75 per week for Mrs Moody's constant care.

[24] Mrs Moody protested. In a letter to her dated 30 July 2014, Taikura explained:

> The criteria for the allocation of [funded family care] support is currently limited to the identified personal care and household management tasks required to support a person's disability. While NASC recognises the 24/7 support that you have provided and continue to provide for Shane, [funded family care] cannot fund support which is not directly related to the provision of personal care and household management tasks.

[25] Mrs Moody maintained her objection to Taikura's assessment. The Ministry engaged AccessAbility Otago, another NASC agency, to review Taikura's work. On 7 November 2014, after completion of the peer review, the Ministry notified Mrs Moody that her son's eligibility had been revised to 19 hours of care weekly.

She was to provide 15 hours of that care, with the other four hours of funding allocated to the outside provider Geneva Healthcare.

[26] In September 2015 Shane and Mrs Moody applied to the High Court for judicial review of the funding decision made by the Ministry through the agency of the NASC providers. Shortly after the application for judicial review was filed, Taikura undertook a further assessment of Shane's needs. The final support plan prepared for Shane on 31 May 2016 provided for: (a) 17 hours weekly for Mrs Moody's care services; (b) four hours of care from an external provider; (c) an additional 30 days of carer support per year; and (d) 12 days of respite support for Mrs Moody per year.

[27] It is common ground that the final support plan is our focus in examining the delegated exercise of the Minister's funding decision under the relevant statutory power, even though it post-dated the initial application for judicial review. Mrs Moody originally maintained that Shane is eligible for the maximum 40 hours of funded family care. However, before us Mrs Moody's counsel, Mr Dale, modified her position in the manner which will become apparent in our judgment.

Statutory power for the funding decision

[28] The NASC process is just one of many government functions now contracted out to private-sector organisations.[5] It is important to locate the legal basis for the process and the ultimate funding decision. The relevant statutory power here is s 10(2)(a) of the Act, which empowers the Minister of Health to negotiate and enter funding agreements for the provision of disability support services:

> **10 Crown funding agreements**
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> (1) In this Act, **Crown funding agreement** means an agreement that the Crown enters into with any person, under which the Crown agrees to provide money in return for the person providing, or arranging for the provision of, services specified in the agreement.
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> (2) The Minister may, on behalf of the Crown,—

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[5] Compare *Attorney-General v Problem Gambling Foundation of New Zealand* [2016] NZCA 609, [2017] 2 NZLR 470 at [3]–[8].

> (a) negotiate and enter into a Crown funding agreement containing any terms and conditions that may be agreed; and
>
> (b) negotiate and enter into an agreement that amends a Crown funding agreement; and
>
> (c) monitor performance under a Crown funding agreement.
>
> …

[29] The exercise of that power, which is the focus of this claim,[6] is however, fettered by s 70C. Payment for services provided by a family member is expressly prohibited unless permitted in these terms:

> **70C Persons generally not to be paid for providing support services to family members**
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> On and after the commencement of this Part [4A], neither the Crown nor a DHB may pay a person for any support services that are, whether before, on, or after that commencement, provided to a family member of the person unless the payment is—
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> (a) permitted by an applicable family care policy; or
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> (b) expressly authorised by or under an enactment.

[30] The arguments advanced by both counsel before us share the underlying assumption that the Minister and his agents must exercise the s 10(2)(a) discretionary power where an application for funded family care is permitted by the eligibility criteria in the Policy or expressly authorised by another enactment.[7] That is why our interpretation of the Policy in its broader legal framework is of decisive importance to this appeal.

Legal framework for the funding decision

International obligations

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[6] HC judgment, above n 2, at [20].

[7] Compare *Attorney-General v Haronga* [2016] NZCA 626, [2017] 2 NZLR 394 at [65]; and *Commissioner of Inland Revenue v Michael Hill Finance (NZ) Ltd* [2016] NZCA 276, [2016] 3 NZLR 303 at [80].

[31] New Zealand is a party to the Convention on the Rights of Persons with Disabilities and its Optional Protocol.[8] Our interpretation of all relevant legal and policy instruments must account for New Zealand's international obligations.[9]

[32] The overarching purpose of the Convention is instructive:

> **Article 1: Purpose**
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> The purpose of the present Convention is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.
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> 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.

[33] The following article is also relevant to Shane's situation:

> **Article 19: Living independently and being included in the community**
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> States Parties to the present Convention recognize the equal right of all persons with disabilities to live in the community, with choices equal to others, and shall take effective and appropriate measures to facilitate full enjoyment by persons with disabilities of this right and their full inclusion and participation in the community, including by ensuring that:
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> a. *Persons with disabilities have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement*;
>
> b. Persons with disabilities have access to a range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community;
>
> c. Community services and facilities for the general population are available on an equal basis to persons with disabilities and are responsive to their needs.
>
> (Our emphasis.)

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[8] Convention on the Rights of Persons with Disabilities 2525 UNTS 3 (signed 30 March 2007, entered into force 3 May 2008); Optional Protocol to the Convention on the Rights of Persons with Disabilities 2518 UNTS 283 (signed 30 March 2007, entered into force 3 May 2008).

[9] *Ye v Minister of Immigration* [2009] NZSC 76, [2010] 1 NZLR 104 at [24]; and *New Zealand Air Line Pilots' Assoc Industrial Union of Workers Inc v Director of Civil Aviation* [2017] NZCA 27, [2017] 3 NZLR 1 at [56]–[58].

General statutory context

[34] One way in which New Zealand fulfils its international obligations is through the funding and support provided by the Ministry of Health under the Act. As noted, the Act authorises the Minister to negotiate and enter into funding agreements whereby the Crown pays people to provide specified services such as disability support.[10] The primary statutory purpose is "to provide for the public funding and provision of … disability support services" in order to pursue several objectives.[11] The two most directly relevant objectives are: (a) "the promotion of the inclusion and participation in society and independence of people with disabilities"; and (b) "the best care and support for those in need of services".[12] The Minister is to pursue these objectives "to the extent that they are reasonably achievable within the funding provided".[13] Disability support services include goods, services and facilities "provided to people with disabilities for their care and support or to promote their inclusion and participation in society, and independence"; or goods, services and facilities provided for incidental or related purposes.[14]

[35] Section 8(2) requires the Minister for Disability Issues to adopt a strategy "to provide the framework for the Government's overall direction of the disability sector in improving disability support services". The New Zealand Disability Strategy 2016–2026 (the Disability Strategy) is the most recent version.[15] The document adopts the voice of impaired persons to describe a future New Zealand in which eight aspirational objectives have been achieved. One is particularly relevant to Shane's case — to have "the highest attainable standards of health and wellbeing" for persons with disabilities:[16]

> We have choice and control over all the supports and services we receive, and information about these services is available to us in formats that are accessible to us. … We are not secluded within services, and not segregated from or isolated within our communities.

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[10] New Zealand Public Health and Disability Act 2000, s 10.

[11] Section 3(1).

[12] Section 3(1)(a)(ii)–(iii).

[13] Section 3(2).

[14] Section 6(1).

[15] Office for Disability Issues *New Zealand Disability Strategy 2016–2026* (Ministry for Social Development, November 2016).

[16] At 28.

> …
>
> The importance of belonging to and participating in our community to reduce social isolation, and increase our overall wellbeing, is recognised and supported. …

[36] Section 88 creates an artificial contractual relationship between a person with disabilities and his or her carer. The receipt of payments made by the Crown in return for disability support services, whether performed by a family member or a third party, is deemed to be the provider's acceptance of the terms and conditions contained in a notice of general application.[17] The relevant notice must be published in the Gazette before it takes effect.[18]

[37] Section 88 appears to be directed more to the person providing disability support services under a funding arrangement than to the person with disabilities. However, as we shall describe, in this case it has been used to set up a legal structure whereby Shane receives the funds and then pays them to his mother. Despite Shane's obvious incapacity to manage his affairs, Mrs Moody is effectively his subcontractor or employee. As Palmer J noted, Mrs Moody is unable to comprehend the Ministry's treatment of her as Shane's employee.[19]

Part 4A of the Act

[38] The history to this artificial arrangement is important. Until very recently, the Ministry of Health's policy was to refuse payment to the spouses or resident family members for provision of support services to people with disabilities. However, in what is known as the *Atkinson* litigation, the Human Rights Review Tribunal, the High Court, and finally a Full Court of this Court held that the policy discriminated unlawfully on the basis of family status contrary to s 19 of the New Zealand Bill of Rights Act 1990.[20] The Government responded to the *Atkinson* decisions by agreeing to allow some funding for parents or resident family members to care for adults with disabilities.

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[17] Section 88(1)(a).

[18] Section 88(3).

[19] HC judgment, above n 2, at [12].

[20] *Atkinson v Ministry of Health* [2010] NZHRRT 1, (2010) 8 HRNZ 902; aff'd (2010) 9 HRNZ 47 (HC) and [2012] NZCA 184, [2012] 3 NZLR 456.

[39] This funding was made available by creating a statutory mechanism enabling family members to obtain access to Home and Community Support Services (HCSS), a pre-existing set of entitlements along with Community Residential Support Services (CRSS). Entitlement to HCSS was previously limited to three categories of in-home services provided by contracted third parties — personal care, household management, and sleepover care or night support. The ambit of these categories assume some importance in our decision.

[40] Parliament enacted the New Zealand Public Health and Disability Amendment Act 2013 shortly after the *Atkinson* decisions as the means of introducing pt 4A to the principal Act. The legislation was passed under urgency without public consultation or select committee scrutiny.[21] In express response to this Court's finding of unlawful discrimination, pt 4A of the Act recognised the eligibility of specified family members to enter into Crown funding agreements to provide disability support services.[22] This entitlement was subject, however, to purposive limitations:

> **70A Purpose of this Part**
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> (1) The purpose of this Part [4A] is *to keep the funding of support services provided by persons to their family members within sustainable limits* in order to give effect to the restraint imposed by section 3(2) [objectives are to be pursued to the extent that they are reasonably achievable within the funding provided] and to affirm the principle that, in the context of the funding of support services, *families generally have primary responsibility for the well-being of their family members*.
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> …
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> (Our emphasis.)

The Policy

[41] The Policy is the source of Shane's entitlement to receive funded family care. However, in restricting the scope of the Minister's statutory power to enter funding

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[21] See *Attorney-General v Spencer* [2015] NZCA 143, [2015] 3 NZLR 449 at [84]; and Philip A Joseph "Constitutional Law" [2015] NZ L Rev 683 at 699–705.

[22] New Zealand Public Health and Disability Act, s 70B(2).

agreements, the Policy is an instrument with direct force of law.[23] We endorse Palmer J's general approach to its interpretation in these terms:

> [50] … The [Policy] is a legal instrument under Part 4A of the Act. Accordingly, interpretation of the [Policy], and of those terms, should be approached using the usual legal principles of interpretation of text in light of purpose. Their interpretation must be consistent with the purposes of Part 4A of the Act, under which the [Policy] is promulgated, consistent with usual principles of administrative law. And their interpretation must be consistent with the rights and freedoms in the [New Zealand] Bill of Rights [Act], as provided by s 6.

[42] The Policy is defined by the Act as:[24]

> (a) any statement in writing made by, or on behalf of, the Crown or by, or on behalf of, the District Health Board that permits, or has the effect of permitting, persons to be paid, in certain cases, for providing support services to their family members; and
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> (b) includes any practice, whether or not reduced to writing, that has the same effect as a statement of the kind described in para (a), being a practice which was followed by the Crown or by a District Health Board before the commencement of pt 4A.

[43] We endorse also Palmer J's concerns about the legal uncertainties arising from this nebulous definition:

> [26] The inclusion in the definition of family care policy in (b), of certain practices "whether or not reduced to writing", is inherently unsatisfactory in terms of the rule of law. The effect of Part 4A is to confer legal status on family care policies which means they must be interpreted as such. It is difficult to interpret a practice that has not been reduced to writing as a legal instrument and it should not be regarded as, or defined to be, one. That is not helped by the power accorded a public servant in s 70F to define the terms of such an unwritten practice retrospectively. Wisely the Crown, in this case, does not rely on any unwritten practice.

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[23] See also [30] of this judgment.

[24] New Zealand Public Health and Disability Act, s 70B(1), definition of "family care policy".

[44] Despite its broad definition, s 70D(1) provides formal powers for the Minister of Health to adopt, change, cancel or replace the Policy, which can include one or more of the following in its content:[25]

(a) Cases in which persons may be paid for providing support services to family members, including, without limitation, by reference to one or more of the following matters:

 (i) the *nature of the familial relationship* between the person who provides the support services and the family member to whom the support services are provided;

 (ii) the *impairment or condition of the family member* to whom the support services are provided, which may include references to the effects of the impairment or condition or the degree of its severity, or both;

 (iii) the *age of the family member* to whom the support services are provided;

 (iv) the place of *residence of the family member* to whom the support services are provided;

 (v) the place of *residence of the person who provides the support services*; and

 (vi) the *needs of the family member* to whom the support services are provided and the *needs of his or her family*.

(b) The *conditions that must be satisfied* before payments for support services provided to a family member are made.

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[25] Section 70D(3).

(c) The *rates, or ways of setting the rates, of payment for support services* provided to family members, which may be lower than the rates of payment for comparable support services provided to persons who are not family members.

(d) The *limits on funding* for support services provided to a family member, which may be expressed in any way, including by limiting the amounts that may be paid or the number of hours for which payment may be claimed.

[45] This detailed exposition suggests that the Policy itself creates substantive entitlements to disability support services. However, the Crown's position advanced by Mr Rishworth QC is that the Policy is a procedural mechanism only, designed to provide the same services which predated pt 4A. In Mr Rishworth's submission, pt 4A did not change the scope and nature of funded care services but simply extended the categories of those eligible for payment. He notes that assessments for eligibility are made as they always were by NASC providers using the SPA tool.

[46] Palmer J held that the Policy adopted under s 70D(1)(a) comprises two main documents: (a) the Funded Family Care Notice 2013 (the Notice), which refers to (b) the Funded Family Care Operational Policy (the Operational Policy).[26] The Judge excluded both the HCSS and CRSS from the definition of a family care policy for the purpose of pt 4A.[27] But earlier he acknowledged that "pt 4A confers on [HCSS] policies the status of legal instruments and their text and purpose must be interpreted accordingly".[28]

[47] In our view, the Policy incorporates the relevant content of the HCSS specifications in order to function in the way intended by Parliament. It sets out whether a payment to a family carer is permitted and thereby provides the necessary limits for the Minister and his agents in exercising the statutory power to enter funding arrangements. Therefore we cannot accept Mr Rishworth's submission

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[26] HC judgment, above n 2, at [38]–[42].

[27] At [38].

[28] At [30].

that the Policy is a mere conduit to the underlying entitlements. Instead, as Palmer J noted: “The [Policy] itself, with its status as a legal instrument conferred by Part 4A, determines entitlement to services.”[29] Our construction is borne out by the express content of the uncontested components to the Policy which we shall next address.

The Notice

[48] The Notice, issued by the Minister of Health and published in the Gazette pursuant to s 88, came into effect on 1 October 2013 and is incorporated expressly as part of the Policy.[30] Its purpose is to set out “the funding arrangements of the Government’s [Policy] that are required to enable the Ministry to pay a disabled person to receive funded family care, and for that disabled person to use that funding to employ a family carer”.[31] The language of employment, to which we have referred, is used throughout the Notice to describe the relationship between the person with disabilities and the family carer. The Crown accepts, however, that this statement is a mere fiction which is not subject to the Employment Relations Act 2000, and that many persons with disabilities are so impaired that they do not have the necessary capacity in law to employ another person.

[49] The named parties to the Notice are the Minister of Health and the person with disabilities.[32] The Notice also recognises the responsibilities of the family carer, the Ministry and its agents, including the NASC agencies and the so-called Host assigned by the Ministry to facilitate the arrangement and provide ongoing advice.[33] The five-way relationship between these various parties is guided by a shared acknowledgement that:[34]

> (a) the person with disabilities has the right to accept and manage his or her responsibilities;

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[29] At [69].

[30] “Funded Family Care Notice 2013” (26 September 2013) 131 *New Zealand Gazette* 3670, cls 3, 4 and 8.

[31] Clause 9.

[32] Clause 5.

[33] Clauses 5, 11 and 72, definition of “Host”.

[34] Clause 12.

(b) choices on how those with disabilities live their lives at home are respected;

(c) the unique dynamics of the home and family/whānau/aiga setting are respected;

(d) the contribution of family carers, with the assistance of other members of the family, is valued; and

(e) a partnering relationship among the parties will ensure that the interests of the person with disabilities are promoted.

[50] Beyond setting out these principles, the Notice largely provides for the payment, monitoring and auditing of funded family care, referring throughout and in the endnotes to the Operational Policy as the source for provision and payment of disability support services. Its definition of "home" assists in identifying the scope of services eligible for funding by describing the relevant setting for their provision as follows: "the disabled person's usual place of residence, or any other place where the disability support services are regularly provided (including outdoor activities and community based activities that are directly related to the funded family care)".[35]

The Operational Policy

[51] The Operational Policy, first published in September 2013 and updated in March 2016, begins with the Ministry's recognition of "the important role of families and whānau in providing care and support to their disabled family/whānau".[36] The Ministry therefore "provides funding to contracted disability services to support families in this role".[37] The Operational Policy then sets out how disability support services are to be assessed by incorporating the documents which predate the extension of funding to family carers: "Funded Family Care incorporates the Ministry's needs assessments policy and practices into the Ministry's Part 4A

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[35] Clause 72.

[36] Ministry of Health *Funded Family Care Operational Policy* (2nd ed, New Zealand Government, Wellington, March 2016) at [1].

[37] At [1].

policy."[38] At the stage of service coordination it may be identified that "some or all of the disabled person's needs are best supported through an allocation of HCSS".[39]

[52] In our judgment two factors are directly material. One is the express inclusion of HCSS categories within the Operational Policy formally adopted under s 70D(1)(a). The other is the definition of the Policy under s 70B(1), which includes any practice followed by the Crown before pt 4A commenced. The NASC and HCSS policies are plainly components of the complete Policy. In our view, Palmer J erred in confining his construction of the legal instrument to the Notice and the Operational Policy.

[53] The Operational Policy explains that:[40]

> HCSS supports a disabled person to live in their home and take part in family/whānau and community life. The HCSS service may include *personal care* such as assistance with showering and consuming of food or assistance with *night support* in some cases. It can also include *household management* such as cooking and cleaning as well as some supports for the person to access community activities in certain circumstances.
>
> (Our emphasis.)

[54] Both counsel agree we should take into account documents which specify HCSS. However, they should be construed in the light of the Operational Policy such that the full range of HCSS is incorporated into the Policy to the potential benefit of an eligible person with disabilities and their family carer.

Service specifications

[55] HCSS are provided in the home environment, whereas CRSS are provided fulltime in a fully funded state facility. The distinction is important. Before pt 4A's enactment, HCSS were provided solely by third parties who were unrelated to the person with disabilities. HCSS were specified in a range of documents which predate the extension to family carers and were never revised adequately to take account of changes effected by pt 4A. Mr Dale initially relied on the 2008 HCSS specification. However, the hearing before us focused on two tiers of specification updated in 2015.

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[38] At [2.2]–[2.3].

[39] At [2.4].

[40] At [2.4].

[56] The Tier One Service Specification applies to both CRSS and HCSS, setting out high-level objectives for the provision of all disability support services:[41]

> **2. Disability Support Services**
>
> [The aim of disability support services] is to build on the vision contained in the New Zealand Disability Strategy of a fully inclusive society. New Zealand will be inclusive when people with impairments can say they live in 'A society that highly values our lives and continually enhances our full participation.'
>
> With this vision in mind, [disability support services] aims to enhance disabled people's *quality of life* and enable their *community participation* and maximum independence. *This is achieved by creating linkages that allow people's needs to be addressed holistically, in an environment most appropriate to them.* The vision of [disability support services] is to ensure *"Disabled people and their families are supported to live the lives they choose*".
>
> [Disability support services] seeks to ensure that people with impairments experience autonomy on an equal basis to others. *Support options are required to be flexible, responsive and needs based. They must focus on the person and, where relevant, their family, whānau and aiga, and enable people to make informed decisions about their lives.*
>
> (Our emphasis.)

[57] The funding and provision of disability support services should also ensure that the families, whānau and carers of disabled people:[42]

> - Feel valued and are appreciated for the skills, roles and contributions made
> - Have a balanced sense of wellbeing / whānau ora; which encompasses cultural, physical, mental and spiritual elements
> - Feel well and are supported to stay well
> - Are active and engaged learners and have access to training and education to meet people's needs
> - Have the information and resources to fulfil their roles of choice
> - Are respected for their diversity and choices
> - Are culturally safe and support
> - Are financially stable
> - Enjoy life and live life to the fullest
> - Fulfil collective and individual goals and aspirations
> - Have trust-based and mutually respected relationships with their loved ones
> - Are included in communities of choice
> - Are identified as being part of hapu and iwi

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[41] Ministry of Health *Disability Support Services: Tier One Service Specification* (August 2015).

[42] Clause 4.4.

[58] The Tier Two Service Specification is the seminal document, going beyond generic objectives to specify the types of services capable of delivery as HCSS:[43]

> **6.6 Types of Services Delivered**
>
> The Provider may deliver a combination of the following services.
>
> > **6.6.1 Household Management**
> >
> > Services which assist a Person with a disability to maintain, organise and control their household/home environment, *enabling them to continue living within their own environment.*
> >
> > **6.6.2 Personal Care**
> >
> > Assistance with activities of daily living that enables a Person with a disability *to maintain their functional ability at an optimal level*.
> >
> > **6.6.3 Sleepover Care or Night Support**
> >
> > A Service where the Support Worker or Other Staff Member is required to sleep at the home of the Person in order *to provide intermittent care throughout the night*.
> >
> > (Our emphasis.)

[59] The Tier Two Service Specification does not refer anywhere to funded family care. However, Palmer J focused his inquiry on that document as follows:

> [51] The issue comes down to whether the meanings of “personal care” and “household management” contained in the HCSS Tier Two Service Specification are confined to specific discrete tasks or whether they extend to oversight of a person with a disability. Unfortunately, the current text of cl 6.6 used to describe these terms refers to general and even vague purposes and does not provide explicit definitions. The best aids to interpretation are the examples inaccessibly provided in different parts of the policies and the methodology of assessment.

[60] The Judge then reviewed the non-exhaustive examples of discrete tasks given in older HCSS specifications dating back to 2002[44] — such as personal hygiene, eating and dressing — which he had recited earlier in his reasons.[45] On this basis, he upheld the Minister’s conclusion that Mrs Moody’s general supervision and intermittent care of Shane — described by Palmer J as “being there to make sure [Shane] and the

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[43] Ministry of Health *Disability Support Services: Tier Two Service Specification: Home and Community Support Services* (September 2015).

[44] HC judgment, above n 2, at [52]–[56].

[45] At [35].

household are safe”[46] — does not qualify for funded family care within the defined categories of eligibility.[47] That is why the Judge declined to grant the application for judicial review.

The Ministry’s approach

[61] Toni Atkinson is a senior Ministry official with overall responsibility for provision and funding of disability support services. She filed a comprehensive affidavit explaining in detail the Ministry’s practical operation of the Policy and its various components, much of which we have recited above.

[62] Ms Atkinson confirmed that when allocating HCSS hours the Ministry makes allocations for household management and personal care on the premise that they “must reflect direct, hands-on disability-related support needs and accordingly HCSS is not a 24 hour support service”. The Ministry’s longstanding practice is that a person’s mere presence in the home of a person with disabilities cannot be allocated as a household management or personal care service. Ms Atkinson referred to this service generically as “supervision”. She acknowledged that it is necessary to specify sleepover support as a separate aspect of HCSS because that is the only circumstance in which somebody may be paid for being present. She described this presence as not being to supervise the person “but in case personal care needs intermittently arise”. She acknowledged that sometimes a person with disabilities will have high care needs, requiring another person to be present at many times.

[63] Ms Atkinson said this:

> The only live-alone residential care arrangements support disabled people with such severe behavioural issues that they would be a risk to themselves or other service users. Residential care cannot be delivered outside such a facility, for example in a disabled person’s own home or their family home. If a person has particularly high personal care needs of the kind described above, HCSS will only be allocated to meet those needs up until the point that [CRSS] becomes a more cost-effective option.

However, Ms Atkinson later said the family funded care “is intended to facilitate a disabled person’s choice to live with and receive HCSS from a family member”.

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[46] At [53] and [55].

[47] At [57].

[64] To give appropriate context to the Ministry's submissions on budgetary constraints, we record Mr Rishworth's advice about the Crown's current costs of providing disability support services for the 2016 financial year. Payments of $96 million were made to 55 HCSS contractors under Crown funding arrangements. Another $53.4 million was paid under the Crown funding arrangements for individualised funding, the mechanism enabling people with disabilities to employ their own staff to provide HCSS. And a further $8.8 million was paid for family care funding under HCSS, with which this appeal is concerned.

Decision

[65] The High Court's jurisdiction to hear and determine this application for judicial review is undisputed. By s 70C(a) the Policy limits the Minister's ability under s 10(2)(a) to enter into Crown funding agreements. The act of entering into a funding agreement is the statutory power of decision effectively exercised by delegation when NASC providers assess a person's eligibility for HCSS to be provided as funded family care. The Policy is an instrument with direct force of law in fixing the parameters of the Minister's statutory power. Thus a failure by Taikura and its reviewers to interpret the Policy correctly in the course of assessing needs and coordinating services will be an error of law which is attributable to the Minister. In that event the decision should be set aside and made again in the light of the purposes of the Act and the content of the instruments which together comprise the totality of the Policy.

[66] A degree of perspective is necessary in defining our inquiry. As noted, Mrs Moody's original position was that Shane was entitled to 40 hours of her paid care weekly. In argument before us Mr Dale recognised that Shane's entitlement was not of that absolute nature and must be assessed by reference to the Policy.

[67] In what may have been an overreaction to Mrs Moody's original stance, the Crown's written submissions, but not Mr Rishworth's oral argument, described the proceeding as an attack on "the philosophy and mechanics of New Zealand's entire disability support system". The Crown asserted that acceptance of Mrs Moody's argument about supervision would completely change the basis upon which HCSS is

provided and funded across all its recipients. We reject the Crown's proposition. At most, the acceptance of Mrs Moody's argument would have a marginal funding impact on the modest annual cost of funding family care. And we repeat that the issue now before us is of a confined nature: it is about the proper construction of statutory and derivative instruments.

[68] Our approach leads us to a different conclusion from that favoured by Palmer J. We depart from his construction of the relevant provisions of the Tier Two Service Specification in the light of the relevant statutory and Convention provisions. The Judge faced the difficulty, as do we, that the older HCSS specifications take no express account of the pt 4A extension of funding to family members living in the home with and caring for a person with disabilities. However, we disagree with his view that examples of discrete tasks found "inaccessibly"[48] elsewhere in older documents dating back to 2002 are the preferred guide to interpretation of the Policy, especially when the examples specified in the older documents were expressly non-exhaustive. The specifications have moved beyond discrete examples and instead explain why the state provides funding under the categories of personal care, household management, and sleepover care or night support.

[69] We agree with Mr Dale that the Judge was wrong in particular to reject cl 6.6 of the Tier Two Service Specification simply because its language is general and without explicit examples in its definitions. In our judgment its three purposes are the guides to determining the scope of services which are eligible for funding. That is (a) to enable persons with disabilities to continue living within their own environment; (b) to maintain their functional ability at an optimal level; and (c) where the family member is required to sleep at the person's home to provide intermittent care throughout the night.

[70] Mr Dale correctly notes that the purposes set out in cl 6.6 recur throughout the relevant documents, consistent with the key statutory purposes of (a) promoting the inclusion and participation in society and the independence of people with disabilities and (b) achieving the best care or support for those in need of services.[49]

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[48] At [51].

[49] New Zealand Public Health and Disability Act, s 3(1)(a)(ii)–(iii).

Where possible, these purposes are best served in the home environment with family care. Clause 12 of the Tier Two Service Specification, for instance, reinforces the purposive definitions by providing that household management and personal care are “services that enable a person to continue living within their own environment”. In our judgment the relevant phrases are not to be construed narrowly and limited to specific examples of discrete tasks or tied to earlier specifications which predate the enactment of pt 4A. Instead they must be interpreted in a way which advances the purposes of funding HCSS within the Act at large.

[71] Mr Rishworth submits that it was never Parliament’s intention when enacting pt 4A — nor the Ministry’s intention in formulating its particular policy — to pay family members to sleep in their own home. But that is not the point. Family relationships cannot justify the exclusion of carers from the defined category of “Support Worker or Other Staff Member” under the Tier Two Service Specification when the law now recognises that they are equally eligible for funding in performing the same disability support services as contracted third-party carers. There would be no purpose in distinguishing between members of these two groups once their equal eligibility is acknowledged. As Mr Rishworth himself submits, the Policy has not changed the nature of funded services. Their underlying content remains the same and, as we have found, must be incorporated into the Policy.

[72] We are satisfied that funding for a family member if it qualifies under the Tier Two Service Specification can be incorporated into the category of “personal care” without requiring payment for the fact of sleeping over. The true purpose of state funding is the provision of intermittent care which maintains a disabled person’s functional ability at the best possible level within the home environment. The Ministry’s focus on avoiding payment for mere supervision time has apparently caused its failure to recognise that at certain times, particularly at night, essential services must be provided and are provided by carers on an intermittent basis. This need can arise unavoidably when the person receiving care has a certain type of disability. Some reasonable allowance can be readily made on an hourly basis for each night in recognition of the services performed by the carer. We are satisfied that this step will not require a major realignment of HCSS. It will, however, require the

NASC providers to alter their narrow approach to needs assessment by making a modest adjustment to the appropriate service coordination and funding arrangement.

[73] Our construction is supported by a number of factors. First, the Operational Policy states that “the HCSS service may include personal care such as showering and consuming food or assistance with night support in some cases”. These are the very services performed by Mrs Moody in the event of Shane’s night-time accidents. Mr Rishworth seeks to minimise the importance of this phrase. In his submission, it should not be construed as meaning that the service of night support can be funded under the Policy. Instead, he submits, the cited passage simply sets out the full range of HCSS, some of which can be provided by a family carer but not all.

[74] However, Mr Rishworth’s construction strains the plain language of the Operational Policy. We read the document as incorporating the full range of HCSS into the Policy. The rest of the document deals with limits on allocation and exceptions, further procedural points about payment, and the roles and responsibilities already affirmed in the Notice. It does not explain further the scope of funded services which might be provided by a family carer, or exclude a family carer’s provision of incidental night-time care from the range of HCSS which can qualify for funding.

[75] Second, there is the Disability Strategy. Palmer J mentioned the existence of this instrument but did not take it into account in his analysis.[50] While it is not a direct component of the Policy, we consider that the terms of the Strategy are relevant. A constant theme of Mr Rishworth’s written submission, although not accentuated in argument, is that fulltime funding for supervision is the exclusive domain of CRSS which offers efficiency and economies of scale in reducing the cost of care and support spanning a group of people with disabilities. To similar effect is the Crown’s proposition that, if a person chooses to remain in his or her own home with high levels of support rather than entering the residential service, the Ministry will generally only fund HCSS up to the equivalent amount which would be spent if the person were to enter a multi-client residential facility. The proposition is that the Ministry does not fill a gap to fund lifestyle choices where other state services have been rejected.

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[50] At [19].

Elsewhere it is said that "a full time care service [is] available to people like [Shane] but it is not HCSS".

[76] Mr Rishworth is correct that Mrs Moody cannot expect Ministry funding for Shane's fulltime care. However, the Ministry must take into account New Zealand's obligations deriving from the Convention and reinforced by the Strategy to ensure "the importance of belonging to and participating in our community to reduce social isolation", to be achieved through the provision of "high quality, available and accessible" services. The Ministry is required to construe the Policy broadly so as to fund Mrs Moody's care of her son within the home environment where that is possible and in his best interests. We are satisfied that achieving that objective is more aligned with New Zealand's Convention obligations than forcing Shane into a CRSS facility simply because that is a more cost-efficient expedient. We are not satisfied that the proviso set out in s 70A — to keep funding "within sustainable limits" — can override the weight of legal materials pointing toward a generous assessment of funding, especially when the Ministry already has accounted for that proviso in imposing a funding cap of 40 hours per family carer.

[77] Third, there is the express exclusion of services which do not qualify for funding. The Minister is empowered by pt 4A to exclude certain services. Clause 10 of the Tier Two Service Specifications provides that "[t]here are some closely related Services that are not covered under this Service specification" including services funded by (a) a separate specification — presumably CRSS within a fulltime facility — and (b) other government agencies such as the Accident Compensation Corporation (ACC). The Ministry's HCSS Implementation Guide, dated August 2008, also notes the services that are offered — "to provide individualised support for a person with physical, intellectual and/or sensory disabilities that will enable them to participate in everyday activities" — before referring to the following exclusions:

> **9. What the Service does not deliver**
>
> There are some closely related Services that are not covered under this service specification. … Any service funded, or mandated to be funded by a separate service specification or agreement from ACC, MOH [Ministry of Health], or any other government agency is not provided for under the new service specification. Additionally, Services which can be provided through the use of

> natural supports, such as friends and family, are not provided for under the new service specification.
>
> Gardening and lawn mowing are not included in the Services purchased by either ACC or [disability support services], as these Services may be accessed through other funding avenues e.g. Work and Income.
>
> …

[78] The only other express exclusions are contained at the end of the Notification of Service Coordination prepared for Shane's needs on 9 March 2016, setting out the final arrangements now the focus of this judicial review:

> Also please note the following areas are **not eligible** for support under the MOH HCSS/FFC guidelines
>
> Health
> Communication
> Behaviour
> Family contact
> Emotional support
> Going out with shopping
> Personal shopping
> Budgeting/finances
> Other agencies

[79] Taikura and other NASC agencies operate on the apparent assumption that these areas do not qualify as HCSS to be provided by family funders. We were not referred to the source of these listed areas, but our main point is that general supervision to ensure safety in the home environment or the provision of incidental care throughout the day and night does not fall within these exclusions.

[80] Other relevant documents support the more expansive construction which we favour. The NASC Guideline — an annotated version of the Operational Policy to assist NASC agencies updated in August 2015 — provides a "principles based" approach when considering "the approval of high cost support packages for disabled people who want to remain in their own homes in the community". The document records the following:

> **Background**
>
> …
>
> Historically NASC have always been of the understanding that the Ministry does not fund a 24/7 residential service in the person's home nor is night

> support (usually sleepover) ongoing or 7 nights per week. The current policy is up to 28 nights per annum for sleepovers.
>
> … Client expectations are now challenging this position. Increasingly NASCs are tasked with making decisions around how much support can be applied to a "home based" support package, and when/if a residential package should be sourced instead. *This increasing trend to have people access high levels of support in their homes is related to the well-established international trend, supported by the NZ Disability Strategy, New Model for Supporting Disabled People and Enabling Good Lives, of supporting people in their homes as much as possible, and enabling them to live "ordinary lives".*
>
> *There is increasing need to apply a logical and sympathetic approach to enabling people to remain in their own home*, in the face of increasing costs. While DSS seeks to achieve an "ordinary" life, with choice and control for disabled people, the need to manage within fiscal constraints prevails.
>
> …
>
> (Our emphasis.)

[81] This background information observes that there is a trend toward supporting broader funding in the home environment, and that agencies should make assessments and coordinate services in a logical and sympathetic manner subject to fiscal constraints. However, in setting out "principles to consider", the Guideline does not expressly exclude kinds of services from allocation. It simply provides the following:

> **Guidance – Principles to consider**
>
> …
>
> - All processes should be aligned with established protocols and SPA bands.
> - Service coordinations need to be based on ESSENTIAL NEEDS only.
> - MOH does not fund lifestyle choice (ie where natural support would otherwise fill the need) — for example when the family refuse other government funded supports (ie rehab/respite or [Ministry of Social Development] funded day services).

> - NASC must use the ICARe process [Individual Client Allocation of Resources][51] to determine the need for direct physical support (hands on support needs) at all times ensuring that natural supports (not considering lifestyle choices such as full time work) are included in the support plan. Funding will be based on assessed support hours and will be based on core staff costs.
>
> …

[82] A distinction appears to emerge from these principles. On the one hand there are services directed to meeting *essential needs*, which are funded; on the other there is provision of *natural supports*, which are not funded. The question of whether general supervision and intermittent care falls within the former category of eligibility is answered by asking whether that service is essential to maintaining the person with disabilities' mental and physical health in the home environment. If the starting premise is that the person's best interests are served by continuing to live in the home environment, and if a service is necessary to support that situation, it must qualify as essential given the overarching purposes of the legislative regime. It would include night-time attendances where such services are provided.

Summary

[83] In our judgment the Ministry's failure to take into account this intermittent type of personal care performed by Mrs Moody, whether during the day or at night, amounts to an error in assessing the scope of disability support services for which a family member is eligible for payment.[52] The fact that the service cannot be quantified discretely or routinely by use of the Ministry's unit-based measurement model does not justify its exclusion. A formulaic approach to assessment is inconsistent with the spirit and purpose of the Policy. What is required is a fair estimate of the essential care which Mrs Moody provides and which the Policy is intended to support.

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[51] There was almost no detail before us about the Individual Client Allocation of Resources process, and it was not mentioned by Palmer J in his reasons. This is perhaps explained in a letter from the Crown Law Office to Mr Dale dated 1 December 2015: "The premise of ICARe is that the person being allocated services is entering a residential group home because of intellectual disability. If the home they are entering is known, the actual support needs of the existing clients are taken into account. If no existing home has been identified, the person is assumed to be entering a residential home with three other clients of similar need. ICARe can also be used as a guide for allocation of other services, including HCSS, although not all of the aspects of [CRSS] are relevant when allocating other services."

[52] See at [65] above.

[84] It is uncontested that Mrs Moody performs intermittent but recurring services for her son which require her constant presence. Shane falls within the category of people with disabilities described by Ms Atkinson as requiring an intense level of oversight. In that sense, Mrs Moody's service meets Ms Atkinson's requirement of sleepover care as a separate aspect of HCSS where personal care needs intermittently arise; Ms Atkinson herself distinguishes that service from mere supervision.

[85] We are satisfied that the NASC providers' assessment of Shane's funding eligibility failed to recognise fully the range of services which can be performed by family members. That failure must stem from a misinterpretation of the Policy by the Minister and his agents. Therefore the Minister has erred in law. He has incorrectly interpreted the relevant policy documents and made a decision contrary to the instruments which bind him. For the reasons we have set out the error is serious and warrants judicial review.

Result

[86] The appeal is allowed.

[87] The decision granting the first appellant a maximum of 17 hours of funded family care weekly for disability support services provided by the second appellant is set aside.

[88] The Minister is directed to reassess the first appellant's application for funding in a manner consistent with the purposes of the Act and content of the Policy as set out in this judgment. In particular, the Minister must make appropriate allowance for Mrs Moody's provision of personal care services to meet Shane's immediate intermittent needs as they arise at any hour of the day.

[89] The respondent is ordered to pay one set of costs to the appellants on a band A basis as for a standard appeal together with usual disbursements.

Postscript

[90] We make two additional points. First, we note that this is the third occasion on which a dispute between the Ministry of Health and parents who care for disabled adult children has reached this Court. We hope that in the future parties to disputes over the nature and extent of funding eligibility are able to settle their differences without litigation. Second, we have referred to our unease, which is shared by Palmer J, about the complexity of the statutory instruments governing funding eligibility for disability support services. They verge on the impenetrable, especially for a lay person, and have not been revised or updated to take into account the significant change brought about by pt 4A. We hope that the Ministry is able to find an effective means of streamlining the regime, thereby rendering it accessible for the people who need it most and those who care for them.

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