

THE DISCREDITED, INDEFENSIBLE WORK CAPABILITY ASSESSMENT (WCA), RESPONSIBLE FOR ENDLESS HARASSMENT OF SICK AND DISABLED IN THE UK, AND WHAT ITS DEMISE MUST MEAN FOR NZ WELFARE REFORMS

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A) INTRODUCTION – THE WORK CAPABILITY ASSESSMENT (WCA)

It was only weeks before Christmas last year, when in November 2014 the Department of Work and Pensions (DWP) in the United Kingdom (UK) published the fifth and last ‘Independent Review of the Work Capability Assessment’. The Reviewer who conducted his second review of the highly controversial, now widely discredited ‘Work Capability Assessment’ (WCA), was Dr Paul Litchfield, who is a member of the so-called ‘Fit For Work Coalition’, and who has been Chief Medical Officer for ‘BT Group plc’ (British Telecom) for over 14 years. On his ‘LinkedIn’ profile he is quoted as having a main professional interest in occupational mental health. Dr Litchfield did also conduct the fourth review of the same WCA a year earlier. In the 5th and final review he is described as an occupational physician. Following his predecessor Professor Malcolm Harrington, he was clearly a different kind of appointment as a professional with an established “corporate” business background. Dr Litchfield’s involvement with ‘Fit For Work’ and BT drew criticism from some stake holders and in the public, but he also received more favourable consideration by other stake holders.

The WCA was introduced during 2008 following the passing of the Welfare Reform Act 2007. The functional kind of assessment was intended to help determine eligibility to the Employment Support Allowance (ESA), and it is a further development from earlier assessments that were used to establish the functional and work capability of sick and

incapacitated. The WCA has received strong criticism from the time of its inception. A key role in the development and evaluation of the UK's medical assessments was played by **Professor Mansel Aylward**, now Director at the so-called '**Centre for Psychosocial and Disability Research**', a special Department at Cardiff University in Wales. He did for many years also work closely with '**UnumProvident**', a major health and disability insurer, who did during his former role as Chief Medical Adviser at the DWP also have significant input into welfare reforms in the UK. Mansel Aylward terminated his role at the DWP in 2005, and did from already 2004 head "research" at the mentioned Centre at Cardiff, which was for years being "sponsored" by UnumProvident. It was Dr Aylward who once created the stringent so-called '**All Work Test**'. He was also heavily involved in development of the equally controversial '**Personal Capability Assessment**' (PCA), both of which preceded the further developed **WCA**. It can be said, that Professor Mansel Aylward had significant input into the development of all UK work capability assessments, indirectly also into the now used WCA.

Professor Aylward did furthermore lead the Corporate Medical Group on the UK Government's Welfare Reform initiatives, and made a major "*contribution*" in establishing the new postgraduate diploma for doctors in Disability Assessment Medicine. Hence he has over many years represented a strong influence on the way welfare reforms affecting sick, impaired and thus disabled persons were being formulated and implemented in the UK. Mansel Aylward has over the years written and co-authored a number of publications, many based on studying and interpreting statistical and other reports, some of which have been questioned in regards to their actual medical scientific value and reliability. He has been accused of re-interpreting the so-called "**biopsychosocial model**" for diagnosis and treatment.

The WCA itself was introduced as a means to apply a new approach and focus in the way persons with chronic, serious health conditions, and with longer term, or permanent, physical and mental impairments, would be assessed for their capability to perform certain functional activities. With that came also the presumption that the same assessment could determine who could potentially and hypothetically perform various work related types of activities. The assessment is presented and administered by the DWP, and the Department expects the contracted assessment 'Provider' (until March 2015 still 'Atos Healthcare'), to follow, use and apply it, while conducting interviews and examinations of DWP clients that are referred to them. The assessor employs approved **Health Care Professionals (HCPs)** who conduct the commonly called "*fit for work*" tests. They are expected to adhere to the guidelines set out in a '**Revised WCA Handbook**' (the most current one appears to be Version 6, from 19 March 2013), and to act as so-called "Specialist Disability Analysts", which is a different role to the one ordinary health care professionals perform in diagnosis and treatment.

At the initial stage a kind of assessment is conducted on paper during a "Filework" stage, usually based on a Med 3 certificate ("Fit note") from a claimant's general practitioner (GP). If a face to face assessment is required, clients will first be sent a self assessment form called ESA 50 ('Limited Capability for Work Questionnaire'), or in some cases an ESA 50A form, to fill out. They may be asked to provide further medical certificates and other relevant records. "Medical" assessments under the WCA are supposed to determine whether a person has a limited capability for work, or even a limited capability for work related activity, or whether there is after all a full capability to perform work. Depending on a points score based on relevant descriptors for both physical and mental function abilities, a person will as a result of the WCA be either put into the '**Support Group**' (for those with severe functional limitation, or with special circumstances), or into the '**Work Related Activity Group**' (WRAG) (for those less severely incapacitated). If persons may after all be found "fit for work", they will be put into the category of ordinary jobseekers, and will have to apply for the 'Jobseeker's Allowance' (JSA). This is though not decided upon by the HCP at Atos, or the soon to follow new assessor, but by a so-called 'Decision Maker' (DM) at the DWP. The HCP of the assessment Provider (presently Atos) will send a functional assessment report called ESA 85 to the DM to base their decision on. Legally the HCP acts only as an "advisor". On page 60 (see 3.1.6, second section) of the '**Revised WCA Handbook**' (fr. 19 March 2013) it states that the Decision Makers "*are not medically qualified*"! On the bottom

of page 60 (3.1.6.1) it also says: *“the use of medical terminology should be avoided”*. This raises concerns about how cases are decided on, where complex medical conditions exist.

As mentioned, the WCA is initially done on paper, and if a face to face assessment is considered necessary, the HCP will notify DWP, or rather the Jobcentre Plus Office of this, who will then make arrangements for a referral of the “claimant” to attend an examination centre. At the actual assessment a specially structured interview will be conducted, aimed at establishing the physical and mental functional capabilities - rather than the disabilities of a person. The HCP of the assessor (Atos) is instructed to first read all presented medical records and other relevant documents, and will then conduct an “effective” interview, during which she/he is expected to also *“listen between the lines”*. This is generally followed by a physical examination. As there are usually set time limits for the assessment, this places pressures on HCP staff. While HCPs have to record all medical conditions and a concise medical history, the whole examination or assessment is in its form only marginally “medical”. A strong focus is put on the *“social and occupational history”* and *“the typical day”* of a “customer”. The assessing HCP is also instructed to carefully *“observe”* the behaviour of the person they interview and examine. On page 112 of the ‘**Revised WCA Handbook**’ (under 3.5.1) the HCP is advised: ***“The HCP must have a high level of suspicion about the presence of any mental function issue and must carefully explore mental health symptoms that may be overtly “provided” by the claimant”***! At least 15 points need to be scored during such a WCA for the claimant and “customer” to meet the “limited capability for work” criteria for ESA. To qualify for the Support Group a claimant must be severely incapacitated, e.g. score at least one of the highest points (15) scoring descriptors for 16 ***“activities”*** (see Appendix 1 from page 150 in the WCA Handbook). Only those meeting Support Group criteria will be exempted from work expectations. Those who only meet the criteria for *“limited capability for work”* will by the DM at DWP be put into the Work Related Activity Group, which usually means there are conditional work expectations.

While the WCA was initially only meant to be applied to new applicants for - and claimants of - the newly established ESA benefits, the DWP did in 2010 decide and announce that they would from 2011 onwards also re-assess virtually all existing Incapacity Benefit (IB) recipients (about 2.5 million). This made it abundantly clear that the new approach to test “work capability” was not simply a new measure for new beneficiaries, it was intended to fundamentally and generally shift the goal posts in relation to medical and work capability assessments and with that for benefit eligibility. Without doubt the aim was to reduce benefit entitlements by substantially tightening the criteria for being accepted as incapacitated to perform work. The draconian nature of the WCA (same as its predecessors) should lead to hundreds of thousands of formerly considered “disabled” to lose that status, and to be re-categorised as being “fit for work”, no matter whether there was any realistic chance of them finding real jobs, let alone perform and keep such employment on the open market.

Since its introduction the WCA has experienced a number of changes, because it was found to give insufficient considerations to mental health sufferers, because some descriptors for limitations on activities lacked sufficient clarity, because the DWP decided to review certain provisions themselves, because annual reviews suggested improvements, and because substantial public criticism and pressure (particularly from disability advocacy and support groups, but also the British Medical Association and other stakeholders) forced the government to further amend Regulations and change processes. See ‘**Appendix 1**’ – ‘The Support Group Descriptors’ (from page 150 onwards, in the ‘**Revised WCA Handbook**’ issue 2013) for details how tightly the criteria has been set for activities and descriptors in use. But all these changes, mostly brought in very reluctantly, did not abolish or replace the excessively strict and tight criteria used by way of descriptors within the WCA itself. Most changes only affected parts of the WCA processes. The DWP and UK governments insisted on continuing with using the WCA to achieve the originally stated and sought outcomes, which in hindsight though appear to provide remarkably little true and effective “assistance” for the affected, to enable them to access and maintain sustainable employment.

While the WCA is used only in the United Kingdom, the underlying changes in approaches towards medical and work capability assessments, brought about by a well known group of certain key “experts”, and suggested and supported also by a vested interests holding health and disability insurer by the name of **UnumProvident** (who had effective influence on political decision-makers), have over recent years also played a significant role in shaping welfare reforms in New Zealand. Some of these “experts”, such as Professor Mansel Aylward, even visited government officials, professional medical organisation leaders, and lobbied strongly for the adoption of similar approaches and processes in Australia and New Zealand. It is this evident cooperation between “advisors” in the UK and like minded “experts” and “decision makers” here in New Zealand and Australia, which should be of concern, as with the WCA having lost all credibility and justification, the “experts” that developed and promoted it, deserve to come under intense scrutiny, same as their “research” and claimed “findings”.

Reference – Wikipedia: The ‘Work Capability Assessment’ (WCA)
http://en.wikipedia.org/wiki/Work_Capability_Assessment

B). THE WORK CAPABILITY ASSESSMENT HANDBOOK FOR HCPs

The DWP has for the purpose of ‘Training and Development’ of Health Care Professionals (HCPs), that are employed or commissioned by the Provider (so far Atos Healthcare) of contracted assessment services, published a handbook. An updated version is called the ‘**Revised WCA Handbook**’, dated 19 March 2013. It contains important and essential guidelines for the HCPs when conducting assessments, and also shows on what information and processes the DWP Decision Makers rely and base their decisions on claimants’ benefit entitlements on. It contains the list of activities and descriptors that qualify a person for the so-called ‘Support Group’ under the ESA, where persons are exempted from work expectations. Going through the 16 “activities” reveals that the criteria to meet is set extremely tightly, it is draconian, harsh and unreasonable. The handbook is found on the internet and can be downloaded as a PDF. Look up the following links/websites for details:

‘Department for Work and Pensions’:

<https://www.gov.uk/government/publications/work-capability-assessment-handbook-for-healthcare-professionals>

Link to the down-loadable revised, 6th and final version of the ‘Hand Book’ for health care professionals authorised to conduct WCA assessments (from 2013):

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/252637/wca-handbook.pdf

On **page 11** it states the following:

“The handbook provides guidance on Employment and Support Allowance procedures and also recognises that these form the foundation of experience to progress to the generation of Evidence Based reports utilising the LiMA application. This handbook will make considerable reference to the LiMA application throughout as all ESA reports will be completed using the LiMA application except in exceptional circumstances. Much of the work carried out by Atos Healthcare, including ESA and DLA, is completed using the LIMA system. LiMA (Logic Integrated Medical Assessment) is an evidence based computer programme which allows the practitioner to document evidence gathering and supports the evaluation of data and provision of advice on levels of disability using logic based on evidence based medicine protocols. We will also use this system to provide advice for decision makers for Revised WCA assessments.”

On **page 21** it says under ‘**1.6 The role of the Atos Healthcare HCP**’:

*“In carrying out this function, ESA approved HCPs act as specialist disability analysts. The role of the disability analyst is different from the more familiar clinical role of reaching a diagnosis and arranging treatment. **For the disability analyst, a precise diagnosis is of secondary importance. The primary function is to make an assessment of how a person's day to day life is affected by disability, and to relate this to the legislative requirements.**”*

On page 46 under ‘3.1 The Medical Assessment’ it states:

*“The **medical assessment process** as a whole differs in many respects from traditional history taking and examination as carried out in the general practice and hospital setting. It entails **bringing together information gained from questionnaires, history, observation, medical evidence and examination in order to reach an accurate assessment of the disability of a claimant** and so to provide the information and the opinion which the Decision Maker requires. It is a complex procedure, involving careful consideration of history, observed behaviour, examination, logical reasoning and justification of advice.”*

The revised Handbook reveals that there have over the last few years and since its introduction only really been some moderate “improvements” to the ‘WCA’. Activities that are looked at to assess work capability are still set at very basic and restrictive levels, same as the descriptors used to tightly classify the level of incapacity. The criteria applied to assess functional capabilities or lack thereof remains extremely rigid, so that only very serious, long lasting, permanent or terminal disease, illness and physical or mental impairments will be viewed as causing sufficient degrees of disability, so that persons will be categorised as having only “limited capability for work”, or “limited capability for work related activities”.

There is still insufficient consideration for people with complex mental health conditions, or with various comorbidities (physical, mental and psychological), and especially for those with fluctuating conditions. Simply using this points system, does not allow for sufficient recognition of complex medical and psycho-social aspects that may be covered by the WCA in its only slightly altered form. It is also of concern that a face to face interview, a physical and possible other examination, in a limited time frame, will likely miss important aspects and details to consider, despite of the assessors being expected to carefully look at all documented medical records. Observation may offer some insights worth noting, but it seems irresponsible, to reduce any input by a client’s own medical practitioner and/or specialist, by using a largely functional assessment, that only has a marginal focus on the still important medical side of things. The assessments also totally ignores the realistic chances any person assessed as “fit for work” under the “limited capability for work” category may have to obtain paid employment on the open market. When “*manual dexterity*” is being assessed based on the question, whether a person can push a button, turn pages of a book, or to some humble degree perhaps use a mouse or even keyboard, or when a person’s “*mobility*” is assessed based on the question whether she/he is able to move (with or without an aid) 50, 100 or 200 metres without any interruption, or when a person may not be able to move between two seated positions without assistance, then this does in my view tell me nothing convincing, that this is a form of assessment useful to establish actual work ability on the existing employment market. But a person able to do the mentioned, or to lift a half litre carton of milk, would likely be considered to have a “*limited capability for work*”.

The same applies to questions about how a person is coping with a “typical” day’s activities, which are again designed to look at whether a person can only perform extremely basic level activities to qualify for referral to the ‘Support Group’. Within a well equipped and familiar home a person may be able to cope relatively well with doing basic chores, but that will again mean very little in regards to how such a person would cope in a work place, like an office, a work-shop, at an assembly line, at a customer service point or whatsoever.

The assessment remains overly focused on claimants having to “prove” their disability, and appears to only have the aim to single out the extremely, most impaired and disabled from

the perhaps more moderately impaired and disabled, in order to reduce benefit entitlements, and thus save the DWP and UK government COSTS. As those considered fit for some work will have expectations placed on them, or otherwise face lower benefits, it is the logical conclusion that the purpose behind this exercise is to reduce claims and costs, although the whole exercise has by now proved to be an abject failure. The WCA does nothing to bring about social and environmental changes, like such that employers would be expected to cooperate, same as society as a whole, to change their attitude towards, and the treatment of those with serious sickness and physical, mental and psychological disabilities. Simply replacing “sick notes” with “fit notes”, changing the official focus from “disability” to “capability” does not create more suitable jobs, better employment and pay conditions for the people that are supposed to be supported. Such are ideologically driven, cosmetic and bureaucratic changes that have not delivered the outcomes they were meant to deliver.

I recommend that readers have a thorough read of the ‘Revised Hand Book’ to get a grip of what this WCA is all about, when applied in practice! It will open the eyes of those that have little knowledge of what the WCA and applied processes actually mean and look like.

C). THE ASSESSMENT PROVIDER ATOS AND THE NEW PROVIDER MAXIMUS

For years now the DWP has worked with the contracted Provider Atos Healthcare to use and apply the WCA in assessments of new, potential and existing claimants of benefits, while gradually phasing in the ESA. Atos Healthcare has gained an appalling reputation, but while some serious failures can rightly be blamed on that Provider, it must also be accepted, that Atos has generally only been doing the job for the DWP, as the law and processes expect them to. The ultimate responsibility for major failures in applying the seriously flawed WCA should lie with the DWP and UK governments. Nevertheless, Atos deserves to be looked at and to also be criticised for delivering unconvincing, poor services that cost some persons their remaining well-being, yes their lives. It should not surprise any informed persons that Atos decided to opt out early from a long term contract with the DWP, given the total loss of faith in their delivery. The following contains essential, revealing information about Atos Healthcare, still the Provider of WCA assessment services in the UK:

ATOS Healthcare, the provider that asked for an early exit from a contract with DWP:

Their corporate website:

<http://www.atoshealthcare.com/>

They state rather clearly on their website:

‘ESA Claimants’

*“Atos Healthcare carries out disability assessments on behalf of the Department for Work and Pensions (DWP). If you are claiming benefits as a result of a disability or injury, you may be required by the DWP to have an assessment with a qualified health care professional as part of your claim process. **Atos Healthcare conducts disability assessments, using criteria set out by government, and provides the DWP with independent advice which is used by a DWP Decision Maker, along with any other information they have received, to decide on your entitlement to benefit. These benefits include: Employment Support Allowance, Disability Living Allowance, and Industrial Injuries Disablement Benefit. We also conduct assessments for Veterans UK.**”*

They also stress:

‘We do not decide your entitlement’

“We cannot give you advice or provide an opinion on the outcome of your claim. Our role is to carry out an assessment and provide this to the DWP in the form of a report. The DWP Decision Maker may use other information when considering your entitlement to benefit. We are not usually informed of the outcome of individual decisions and we have no targets related to decisions made.”

See: <http://www.atoshealthcare.com/claimants>

They also make clear:

‘What to expect’

*“The assessment is not like a medical examination you may have with your GP or at a hospital which is to diagnose your condition and treat it. **The assessment carried out by Atos Healthcare is focused on how you are affected by your physical and/or mental health condition in daily life; this is called a functional assessment.** The healthcare professional will be interested in what you are able to do and how you do it, whether your condition varies daily, or over a period of time, and how this affects your ability to undertake the tasks of daily living.”*

See: http://www.atoshealthcare.com/claimants/before_your_assessment

With Atos having sought an early termination of their contract as assessor, the DWP not long ago announced a new contract with a new Provider, who is though by many considered to be equally ill suited to deliver supposedly better outcomes, that is at least by the affected and their representative disability support groups. It is questionable, whether any other private sector Provider such as **‘MAXIMUS UK’** will perform at a higher and better level than Atos, as they will have their hands tied with a contract paying them a set amount for service delivery, out of which they will of course also wish to make a sound profit.

What we have had now for decades, is the replacement of once perceived “over bureaucratic” state service delivery agencies or departments, with corporate business service providers, who are generally providing the same services, with admittedly some variations here and there. But with a profit margin needing to be met by private, or public shareholder owned corporate businesses, there will be limits to what can be delivered, and as history has shown in many cases in Europe and elsewhere, a tendency to streamlining, rationing, using of short-cuts and other “cost effective” measures, will often also compromise the quality of services being delivered, no matter how well the intentions behind outsourcing.

See the following information on MAXIMUS UK:

MAXIMUS UK – the newly contracted service provider to work with the WCA:

<https://www.maximusuk.co.uk/health-programmes/independent-health-assessments>

Own concluding comments on MAXIMUS

This US originated corporate style business does on their website unsurprisingly present many “simple” and “positive” short messages, accompanied by glossy visual imagery. They reveal only little in detail - or of substance - of what they will actually offer. They claim to provide both speedy, automated system based assessments, same as reviews, reconsiderations and appeals. This sounds bizarre, as one would expect that reviews and appeals would ultimately be handled by an independent outside body, not the provider of the assessments. This raises questions about fairness and transparency.

We get “packaged” services that require human input that will cost, and like with any outsourced providers, they will have to make their calculations how much of their resources can actually be put into each client and the staff that are supposed to “serve” and “assist” them. I do not see how such services can and will do a better, more effective and more successful job in putting sick and disabled into jobs, that in most cases already the fitter and healthier workers compete for. To bear in mind also is the fact, that the WCA will be the same test that Atos Healthcare was expected to work with, and that MAXIMUS will have to work with. Using the same “test” for “work capability” means little of substance will change, and outcomes are not likely to be much different to what Atos delivered.

The DWP will of course have set a budget under a contract that includes clear outcome and target expectations when negotiating and agreeing with MAXIMUS.

Rationing of limited, available resources for the delivery of largely computer driven “services” will be the true day to day experience the affected end-users will generally have, and they either accept the limited “help” they will actually get (mostly verbal advice and referrals), and do the rest themselves. If they cannot do this, they will be facing the same hurdles and problems finding employment that people already have without such types of services.

The question arises again, how will sick and incapacitated persons, that may under the existing WCA still be assessed as being “fit for work”, cope with the demands and stress of day to day routines that work and preparation for work naturally brings. As many - if not most - will not cope, the “achievements” may only be very temporary, and only lead to in and out of work rotations, and to further marginalisation within the precarious society we have.

The news about MAXIMUS UK taking over from Atos has generated much debate and criticism. See the following reports on the DWP taking on MAXIMUS as a new Provider for the WCA service delivery.

Criticism of MAXIMUS UK being chosen to conduct the WCA:

‘**dns DISABILITY NEWS SERVICE**’ report on their website (31 Oct. 2014):
‘ESA claimants set for leap ‘from frying-pan into fire’ as Maximus wins WCA contract’
<http://disabilitynewsservice.com/2014/10/maximus-wins-wca-contract/>

‘**DPAC**’ report on their website:
‘Secrets & Lies: Maximus the new leader of the inhumans?’
<http://dpac.uk.net/2014/10/secrets-lies-maximus-the-new-leader-of-the-inhumans/>

The **‘Black Triangle Campaign’** sent an open letter to Ian Duncan Smith, Secretary in charge of DWP (12 Nov. 2014):
<http://blacktrianglecampaign.org/2014/11/12/open-letter-to-iain-duncan-smith-maximus-contract/>

D). INTERPRETATION OF ‘DECISION MAKER’ AT DWP

Under the above chapters repeated reference was made to the DWP’s “Decision Makers”. This key role is held by staff members within the Department that are not medically qualified, but appear to have an understanding of medical and work capability assessment processes. It is of some concern that they are not expected to be familiar with medical terminology, and yet will decide on claimants’ work capability and benefit entitlements. It has besides of incompetency or mistakes made by the Provider’s HCPs also been a serious issue, how DMs made wrong and inappropriate decisions, based on “recommendations” or advice from assessors. Like in New Zealand with the ‘Regional Health Advisors’, ‘Regional Disability

Advisors' and also 'Designated Doctors' used by Work and Income (WINZ), responsibilities are split. HCPs only serve as "advisors", and DMs in the UK make the decisions based on their advice. There is some information available on the internet that explains the position and responsibilities of such DMs. The following links lead to what is provided by the DWP:

"Decision Maker" at DWP, Freedom of Information request 2066/2013 (fr. 02 May 2013):
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/209374/FOI.2066_pub_summary_template.pdf

"Decision Maker" at DWP, relevant, important staff guides:
<https://www.gov.uk/government/collections/decision-makers-guide-staff-guide>

DMG Vol 8 CH 41: ESA conditions of entitlement:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/373219/dmgc_h41.pdf

DMG Vol 8 CH 42: Limited capability for work and limited capability for work-related activity:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/388570/dmgc_h42.pdf

Also of interest may be this guide for DMs:
<https://www.gov.uk/government/publications/decision-makers-guide-vol-10-benefits-for-incapacity-disability-maternity-and-bereavement-staff-guide>

E) THE 5TH AND FINAL REVIEW OF THE WORK CAPABILITY ASSESSMENT

As already mentioned under the 'Introduction' under '**A**,' in November 2014 a final Review was completed on the WCA, and then published by the DWP. This Review followed four earlier ones, as so required under statutory law in the UK. This Review is the last one that was required under law, and while it makes further recommendations to improve the WCA, there appears to be no clear certainty that the recommendations made earlier, and the new ones, will all be fully implemented over time. To this date many earlier recommendations have only been partially implemented, or are "*in progress*", some have not been accepted by DWP. This last Review mentions on page 19 (see under '*Recommendations from previous reviews*', paras 18 + 19) that 'Citizen Advice Scotland' (CAS) requested or suggested that ongoing, further scrutiny of the WCA related recommendations and their implementation should follow, but there is apparently insufficient legal requirement to ensure this.

Indeed the '**Work and Pensions Select Committee**' of the UK House of Commons is quoted as having in 2014 called for a "**fundamental redesign of the structure of ESA outcomes**" (see page 2). This is a call for major changes, which need further clarification.

The 5th and Final Review of the WCA can be found on the internet. The 'Department for Work and Pensions' publication is titled the following, and is found via the link provided:

'An Independent Review of the Work Capability Assessment – year five', Dr Paul Litchfield, November 2014:
<http://www.dsdni.gov.uk/an-independent-review-of-the-wca-year5.pdf>

By way of carefully selected, important extracts from the full text - I present the following:

"Foreword" (see pages 2 and 3)

*“This is the fifth, and final, independent review of the Work Capability Assessment (WCA) as established by the Welfare Reform Act 2007. It is the second review that I have carried out and the three previous reviews were conducted by Professor Malcolm Harrington. The WCA is intended to distinguish between people who cannot work because of health related problems and those who are fit for some work or who could, with support, eventually return to the world of work. It has been operational since 2008 but has been subject to multiple changes in both form and interpretation, some resulting from independent review recommendations. Despite the passage of a considerable period of time, the assessment remains highly controversial and the subject of much criticism. **Indeed, the Work and Pensions Select Committee has recently called for a “fundamental redesign of the structure of ESA outcomes”.**¹*

*“Mental health has also remained an area of particular focus for me. Almost half the people going through this system have a mental health problem as their primary condition and when comorbidities are included the number rises to two thirds. This is not particularly surprising given the prevalence of mental illness in our society but the scale of the issue indicates that **mental health should be front and centre in any discussion about the WCA; that has not always been the case in the past.**”*

*“Last year I concentrated particularly on the Work-Related Activity Group (WRAG) and this year I therefore turned my attention to the other main outcome area, the **Support Group**. **The number of people falling into this category has been rising rapidly** and while at the inception of the WCA approximately 10% of new applications were assigned to the Support Group, **that proportion has now risen to almost 50%.**² I have tried to understand the drivers behind this change but, necessarily in a review such as this, I have mainly identified lines of enquiry to be pursued rather than concrete answers. **An area that has caused me particular concern is the large number of young people under 25 that are assigned to the Support Group, mainly as a consequence of mental health problems.** I would suggest that this is an issue that goes much wider than the WCA and which has long term implications for the employability of what could become a “lost generation”.*

*“In thinking about the future, **I have looked at systems in some other countries.** The UK must have a system which is optimal for this country but **there may well be learning from other places that can be built upon.** It appears to me that we have taken the WCA about as far as it can sensibly go in terms of modification and adjustment.”*

Extract from the **“Executive Summary”** (see page 4)

“1. The Work Capability Assessment (WCA) is designed to determine eligibility for Employment and Support Allowance (ESA). It is a functional assessment based on the premise that eligibility should not be determined by the description of a person’s disability or health condition but by how their ability to function is affected, which may vary considerably between individuals. ... “

*“3. In conducting this Review, **it has become apparent that despite these changes and some undoubted improvements, there remains an overwhelming negative perception of the WCA’s effectiveness amongst people undergoing an assessment and individuals or organisations providing support to them.** “*

Further extracts from the Review:

“Key findings and themes from this review “

“• Evolution of the WCA - The scale and scope of the many changes to the WCA since its introduction may have had unintended consequences and further developments have occurred since the previous Independent Review. Mandatory reconsideration was introduced

in 2013 and a step which might have been expected to receive a favourable reception has become associated with much negative perception. A number of factors appear to have contributed to this. The Evidence Based Review tested the WCA against a set of alternative descriptors. The methodology used was not ideal in scientific terms but it is, nevertheless, a useful piece of work that has improved the understanding of both the content of the WCA and the way in which it is applied. Overall, the published conclusion that there is no strong case for replacing the WCA with the alternatives tested is supported. There is learning about the use of semi-structured interviews and more complex issues relating to sensitivity and specificity that should be taken into account in the design of any future assessment. Overall, the sense is that the WCA has never really had time to bed down and each change serves to resurrect public interest and may serve to reinforce what are generally negative perceptions.

- **Support Group** – Since its introduction in 2008, there have been significant changes in outcomes for individuals going through the WCA. In 2009 63% of people first assessed were found fit for work with 26% assigned to the WRAG and a further 10% placed in the Support Group.³ By 2013 these outcomes had shifted significantly with 47% of people making a new claim entering Support Group with only 34% being found fit for work. There have been a number of drivers for this shift and some are likely to be transient but the change is remarkable and, in particular, the growing number of young people being placed in the Support Group is of concern. The main driver for the increase appears to be the use of Regulation 35 (2) (b), where an individual is considered to constitute a substantial risk of harm. This category has increased substantially in both numerical and proportionate terms – some 38% of new Support Group cases now enter on those grounds.⁴ Surprisingly, two thirds of these decisions are made on a papers only basis. The issues warrant further investigation to ensure that the application of the WCA is meeting the policy intent and that individuals are placed in the most appropriate group.

- **Perceptions** – The previous review highlighted the importance of the WCA not only being fair but also being perceived as such across a wide spectrum of opinion. Effective communication is key to improving this perception of fairness, both for people going through the WCA and for staff administering the system. This Review has sought to capture views from a wider range of stakeholders through the analysis of social media trends, as well as seeking feedback from the those members of staff within the DWP, working on ESA. Analysis of social media confirms that perceptions of the WCA remain overwhelmingly negative. The degree of negativity is perhaps telling given it is more than six years since the introduction of the WCA. One might have expected that views would have softened as people became used to the new system and saw that efforts were being made to improve it but that would seem not to be the case. Particular concerns about the level of information provided by the DWP in advance of a WCA were raised. The reliance on traditional written communications works to the disadvantage of the DWP and an investment in better quality multi-media resources appears indicated.

- **Decision Making & processes** – Decision Makers have rightly been empowered to make decisions on eligibility for benefit but the high and rising overturn rate of Healthcare Professional recommendations was commented on last year. The overturn rate in moving people into the Support Group is not as high as it was for the Work Related Activity Group but there is again an almost total lack of movement in the opposite direction; it is implausible that in any system changes would only occur in one direction if a balanced view was being taken. When a person is awarded ESA the duration of their award is also set and this may be for as short a period as 3 months or as long as 3 years. Frequently setting short re-referral periods for those so severely incapacitated as to be allocated to the Support Group appears counter-intuitive and using the Support Group for young people with acute, and generally self-limiting, conditions may cause more harm than good.

- **Groups meriting special attention** – There are 1.4m people in the UK with a learning disability and only a small proportion of those of working age are in employment.⁵ A great deal of feedback was received concerning the barriers that individuals with a learning disability face with the WCA process. This includes difficulties with DWP standard

communications, which are written in a way that many find impossible to comprehend without support. The introduction of Easy Read communications would go some way to overcoming these difficulties. The face-to-face assessment is also a particular challenge for many people with a learning disability given the common propensity to interpret questions literally, give responses that they think will please and overstate their capability. Vulnerability can be situational as well as intrinsic to the person. The Review has looked at those leaving the armed forces, those spending extended periods in hospital and those being liberated from prison. Each group faces its own barriers to interacting with the WCA process and have in common non-standard health record arrangements.

• **Future of the WCA** – As well as looking back, it is appropriate for the last statutory independent review to look ahead. The report by the Work and Pensions Select Committee published in July 2014 calls for a ‘fundamental redesign of the structure of ESA outcomes’.⁶ The Reviewer has been asked to contribute to this debate in relation to the structure of work capability assessments and their application in determining eligibility for benefits. If it is decided to undertake a fundamental redesign of the WCA, there are a number of key principles that the Department should take into account:

- o Any assessment should not only be fair but be perceived as such
- o There must be clarity of purpose - determining benefit eligibility and supporting employment outcomes may not be compatible objectives
- o Residual elements of the medical model of disability should be eradicated in favour of a biopsychosocial model
- o Departmental staff should be at the heart of the assessment and should drive information requirements
- o Any revised assessment should exploit information already provided to the DWP, rather than duplicating effort and incurring unnecessary expense
- o Decision Makers and HCPs should see a representative range of cases and have appropriate training in the capability impact of common conditions”

Further information contained in the Fifth Review:

The Reviewer also reflects on and summarises past changes that were made upon earlier Reviews, which are referred to and described in the 5th Review. He was for the ‘Fourth Independent Review’ assisted by an appointed ‘Independent Scrutiny Group’, which provided “oversight”, “challenge” and “support” to Dr Litchfield. That group was appointed by the Secretary of State for the DWP (see page 12 of the Review). Of the 49 recommendations that resulted from the reviews in years 1 to 3 under Professor Harrington, the Fourth Independent Review found that the DWP had only accepted 35 of those in full and ten “in principle”. Of the ones fully accepted only 29 recommendations had been fully implemented, 3 partially implemented and 3 were in progress. Of the ones accepted “in principle” 5 appeared to have been fully implemented, 2 partially implemented and 3 were in progress. 37 further recommendations were made in the Fourth Independent Review (see page 18).

Details on the implementation of previous recommendations can be found from page 19 on, under the heading ‘Recommendations from years one to three’, and from page 20 onwards under the heading ‘Recommendations from year four’. It shows that a fair number of recommendations have not been fully implemented, some going back to year 2 and 3 of the Independent Reviews. In para 27 it says re year four recommendations: “There are also a number of recommendations where DWP has demonstrated encouraging progress, though they cannot yet be considered fully implemented.” Under para 30 the Reviewer even states: **“There are some recommendations where progress appears to have stalled, or it appears that DWP will not be implementing them as originally envisaged.”**

On pages 21 and 22 to 25 the Fifth Review describes how a newly introduced “mandatory reconsideration process” appears to have significantly reduced appeals against DWP decisions on ESA, based on WCAs. It is unclear whether such appeals have simply been

deferred, and there are evident new problems with that process itself. It has been described as taking too long and causing stress on the clients seeking reconsiderations of decisions. **Also was there substantial criticism that the ESA payments are not continued during the process, forcing people to apply for JSA** (see page 25 – 26). An ‘Evidence Based Review’ recommended by the former Reviewer Professor Harrington presented rather mixed results (pages 26 to 29). The DWP put out a response to the Evidence Based Review findings in March 2014, and it is quoted in the Review with:

“DWP will explore practical improvements to the assessment process in light of the EBR findings, in particular the feasibility of healthcare professionals using prompts from a semi-structured topic guide for WCA discussions. DWP will also explore the scope to further review healthcare professional training and guidance on considering and recording fluctuation during assessment discussions without placing undue burden on claimants. On the whole, the EBR results do not suggest that changes to the descriptors would improve the effectiveness of the WCA.” (page 30).

That does in short mean nothing much more than a bit more “tinkering” around the edges of the WCA process. The Reviewer makes 7 further recommendations for possible improvements of the WCA, particularly in regards to considerations by policy officials and operational staff prior to making further material changes, in regards to mandatory reconsiderations, in regards to better communication, and better use of feedback to improve quality in decision making, and also in regards to working more on developing semi-structured interviews (see pages 31 and 32 of the Review for details).

Under **Chapter 3**, and from page 33 on, the Reviewer reports specifically on the ‘**Support Group**’ and how there has since late 2013 been a marked trend of persons being placed into the ‘Support Group’, following DWP decisions upon a WCA. Under Para 8 on page 34 the Review states: *“There have been significant changes in outcomes following a WCA since its implementation. In 2009 63% of people were found fit for work with 26% being assigned to the WRAG and a further 10% to the Support Group.²³ The WRAG outcome has been the most stable with a small reduction to 18% in 2013. However, the proportion of people found fit for work has dropped significantly to 34% and that for the Support Group has increased markedly to 47%. Allocation to the Support Group is now the most likely outcome of the WCA for new claims by a considerable margin.”*

It is presumed that a spike in the Support Group clientele may be due to DWP processing a backlog of applications for ESA and necessary WCAs. The Reviewer expresses concern over the noticeable increase of new applicants or claimants to ESA aged 16 to 24 and also 25+ being assigned to the Support Group. He notes with further insight into the statistics that there is a greater number of persons being placed in the ‘Support Group’ under **Regulation 35 (2) (b), where there is deemed to be a substantial risk to the mental or physical health of any person** (see para13, page 36). A high number of these individuals were analysed as suffering a mental health condition, some of whom were considered at risk of suicide and self harm. The Reviewer appears to consider that the shift since 2009 reflects a change in which manner the Regulation is being used by HCPs, Decision Makers and/or the Tribunal Service. Only 34 percent of the people, who were placed in the ‘Support Group’ as a result of “Mental and Physical risk”, were so, following a face to face assessment. The Reviewer asks how about two thirds could be assessed as “not fit for work” on that basis through an assessment on the papers. Under ‘*Young People*’ (page 35) the Reviewer expresses his extreme concern about the fact that 49 percent of young people making a claim for ESA were in 2013 being put into the ‘Support Group’, with no work expectations.

One may wonder about the true independence of Dr Litchfield as Reviewer when looking at his remarks there, as the WCA had for years been considered as too unreliable, as giving insufficient consideration to mental health conditions and as being very rigid, harsh, unfair, yes inappropriate. Here he is defending the WCA, and questioning a change in assessment outcomes, which may actually be due to the realisation by the claimants’ own GPs, and then the assessment Provider’s HCPs and consequently DWP’s DMs, that there are more

deserving cases of persons that should be placed into the 'Support Group', given their incapacity due to complex, fluctuating and vulnerability causing mental health conditions.

On **page 41** of the Review he makes the following recommendation in this regards:

"The Reviewer therefore recommends that:

The Department investigates the substantial increase in the proportion of Support Group outcomes as a matter of urgency to determine whether the WCA is being applied correctly.

- o In particular, the use of Regulation 35 (2) (b) should be subject to close scrutiny with a particular focus on decisions made on a papers only basis.*
- o The drivers for the high rate of young people (16-24) being assigned to the Support Group should be examined not only to ensure that benefit decisions are correct but also to help provide the type of support that will avoid the creation of a "lost generation".*

Then Dr Litchfield does under **Chapter 4** report on the "**Perceptions**" of the WCA, which have remained rather negative. The review gathered information on the perceptions of the WCA in the wider public and also amongst DWP staff, besides of those by people being assessed and those representing them. Strangely he talks about "**effective communication**" as a "**key to improving the perception of fairness**". This suggests it is in his view not so much the WCA and processes followed, it is poor "communication" that is to blame for negative public perception. DWP communications to claimants were being examined as part of the Review. Also were "social media" content on Twitter and Facebook looked at. The analysis of "social media" for perception of the WCA was overwhelmingly negative. DWP staff were generally satisfied with staff training, but a "*perceived need for additional follow-up support*" was evident, and "*differing levels of confidence in the effectiveness of the assessment*" was noted between staff groups. Hence the Reviewer appears to recommend the bundling of necessary future changes, same as the review of mechanisms in place to monitor levels of understanding amongst staff, and improved advance communication (also from the Provider) about the WCA, and that the DWP work with the new Provider to improve the range, quality and contents of online resources relating to the WCA.

Chapter 5 covers the decision making within DWP on ESA applications and WCA assessments. Dr Litchfield reflects on some issues with re-referral periods for the claimants in the Support Group and the Work Related Activity Group. The Reviewer generally supports the use of varying re-referral periods, of different duration, but appears to recommend a more careful and appropriate approach, which does not always seem to be applied. He suggests DWP should review some of their practice in this area.

Under **Chapter 6** Dr Litchfield looks more closely at groups meriting special attention, such as persons suffering mental health conditions, and in particular those with learning disabilities. He describes difficulties these groups experience, including a few other special groups of persons, when facing a WCA, starting with the completing of the ESA 50 questionnaire, but also with presenting needed medical and other documentation, and how to deal with a face to face interview with a HCP of the Provider (to this date still Atos). 8 recommendations for improvements are made on pages 64 to 65.

I will not bother covering **Chapter 7**, which covers special aspects that apply to how the WCA is being used in Northern Ireland. Of more concern to me is **Chapter 8** about "**The future direction of the Work Capability Assessment**". Under "**The changing landscape**" the Reviewer raises concerns about whether the WCA is, as a replacement of the earlier 'Personal Capability Assessment', while using a more functional assessment of capability, still fit for the remainder of this new century. He describes the changes in the nature of work, the disappearance of many physically demanding jobs and the new technologies offering different forms of employment. Also mentioned is the change in the workforce over recent decades, partly due to changes in demographics. He mentions public health improvements, but also the rise in the incidence of mental health conditions.

Dr Litchfield considers that **“the current assessment model, though founded on capability rather than diagnosis, retains a strong medical flavour.”** “Modern thinking favours a biopsychosocial model of disability, which considers not just capability but also other factors such as skills and readiness for the labour market”, he writes. He continues on **page 80**: “Integrating these various factors is more complex than a simple capability assessment, such as the WCA, but the power of modern computing facilitates the integration of multiple sources of data quickly and cheaply. The WCA is often viewed as being machine driven but the assessment is one that could easily be conducted using pencil and paper. **We would therefore seem to have the worst of both worlds at the moment with a perception of automation without the benefits of comprehensive data analysis to inform decisions.**” The Reviewer expresses concerns about the lack of information sharing.

Then he goes over to look at **international experiences and practices**, which may be of some interest, but his comments should perhaps also be of concern, given his apparently very one sided, rather superficial understanding, especially in regards to what has been done and is happening here **in New Zealand**. While there are many similarities in the way sick and incapacitated on benefits are being assessed and now “supported” into potential employment or training, there are indeed also some fundamental differences between the systemic approaches now used here in New Zealand, and those presently used in the UK. The following is a further extract from the Review, starting from **page 81**:

“International approaches” (see pages 81 – 82)

“15. The demographic issues outlined above are by no means unique to the UK. The Review has therefore examined the approach taken in some other parts of the world to support people of working age who have incapacitating health conditions and disabilities.

16. There have been a number of common developments in recent years. Many countries have moved from systems based on health conditions and disabilities to ones that assess functional capability. In parallel there has been a shift from the use of people’s own doctors as the “gatekeepers” to benefit eligibility and towards the use of independent assessors. Some countries have separated the issues of benefit eligibility from work capability and gear assessment of the latter towards the definition of adjustments that might allow reintegration into the workforce. It is beyond the scope of a review such as this to provide a detailed analysis of different social security systems but **the Reviewer found developments in the Netherlands, Denmark, Australia and New Zealand of particular interest.**

17. In the Netherlands, most people’s capacity for work is assessed by an insurance company using a ‘Functional Capability Checklist’, which is based on an individual’s capability and not health condition or disability. The examining doctor assesses the probable duration of incapacity as well as the likelihood of recovery. If the individual is found to have some prospect of employment, an ergonomist will review appropriate jobs and make a calculation of salaries to determine if loss of earnings is significant enough to award benefit, on either a temporary or permanent basis.

18. Denmark has a system which maps closest to a pure biopsychosocial model of disability. Eligibility for benefit is assessed against a ‘Resource Profile’ which consists of 12 components addressing an individual’s education and work history, cognitive and mental fitness and social circumstance. Only one component of the profile is health-related. This principle of taking a wider range of factors than simply functional capability is already applied in Northern Ireland through the Job Readiness Indicator tool referred to in Chapter 7. Systems such as this have been considered overly complex in the past but developments in information technology make their operational use practicable.

19. Australia has had some success with focussing its assessment on identifying and overcoming barriers to work in its dual role as assessing eligibility for benefit and referring individuals to service providers. An assessment of functional impairment is made against

'Impairment Tables' and individuals point-scored against a range of descriptors that include physical exertion, stamina, mental health function and functioning related to substance abuse. The assessment is then used to identify barriers to work an individual may face and refer for appropriate support.

20. New Zealand has taken a fundamental approach which the Reviewer was able to explore in some detail with the assistance of the New Zealand Government. Reforms have recently been introduced with the aim of simplifying the benefits system. There are many similarities with the UK system but also some key differences. The new system amalgamates sickness benefit and several other benefits with unemployment benefit as Jobseeker Support. A self-assessment focusses on the type of work an individual could undertake currently or in the future and the support they might require to do so. **There are differing levels of obligation (analogous to UK conditionality) but benefit payments do not differ. A case management approach is taken to assist people into work with specific additional support for those with mental health problems.** Independent capability assessments may be undertaken but are sited at the very end of the process, if required at all, and relatively few had been undertaken at the time of writing.

21. The New Zealand reforms are at an early stage of implementation and it is not yet possible to determine their impact. However, the approach of uncoupling levels of benefit eligibility from work capability and focussing on overcoming barriers to employment has appeal and merits further exploration."

„Principles for any redesign“

“22. The WCA has now been the subject of five independent reviews as well as, perhaps unprecedented, external scrutiny. The Independent Reviews have concluded that broadly it fulfils its remit but that it is far from perfect and there has been considerable scope for improvement.

23. The EBR has examined the current descriptors against an alternative set and has highlighted a number of strengths and some weaknesses. Substantial changes have been made to the assessment since its introduction and those may, at least in part, explain the significant shift in outcomes described in Chapter 3; it is unclear whether those outcomes now reflect policy intent. There have been many changes in the world of work, an evolution of thinking in relation to work related benefits and a step change in the capacity to handle complex information since the WCA was designed. **The Work and Pensions Select Committee has called for “a fundamental redesign” and it is questionable whether that can be achieved by further tailoring of the current tool.**

24. It may therefore be that policy makers will choose to initiate a comprehensive overhaul of the system. If so, it would seem prudent to look more widely than the WCA and to revisit the basic assumptions for ESA so that any assessment is properly aligned to what is required of it. Consideration should then be given to whether an assessment of functional capability is the most appropriate means of determining eligibility for benefit or whether that decision is better uncoupled from activity geared to helping disadvantaged people finding employment. **The Reviewer would counsel in the strongest terms that sufficient time and suitable expertise be allocated to design, develop and test any new assessment as part of drawing on the learning from the WCA.**

25. If it is decided to undertake a fundamental redesign of the WCA, the Reviewer would recommend that there are a number of key principles that the Department should take into account.

26. As has been stated in this review and its predecessor, there is an overriding requirement for any assessment not only to be fair but to be perceived as such. That perception must be broadly shared by those experiencing the process, those administering it and society at

large. There remains widespread disquiet about the WCA and the way that any replacement is designed will be critical to building trust in it. The Department should therefore give careful consideration to how this would be best achieved but transparency and consultation will be critical.”*

* Please read the original Review to see what Dr Litchfield recommends for that case from para 27 onwards!

Also note the following revealing bit of information in Annex 4 to the Review:

“Annex 4: Acknowledgments:”

Extract:

“1. Although this has been my second review of the Work Capability Assessment (WCA), I have had a great deal more to learn about its application and I am most grateful to all those who have graciously given their time to help me.”

*“10. I would also like to thank **officials at the Ministry of Social Development in New Zealand** – particularly Sacha O’Dea, Anne Hawker and **Dr David Bratt** – for providing invaluable insight into the challenges they are facing and the reforms being made into how incapacity for work is assessed. “*

******Please read the rest of the full Review and recommendations by Dr Litchfield!******

F). CONCLUSIONS AND COMMENTS ON THE ‘INDEPENDENT REVIEW OF THE WCA – YEAR FIVE’, AND THE ONES BEFORE

On having read most of the Review, it is clear that since the introduction of the WCA there have been a number of changes proposed and in a fair few cases also made. The Fifth Review has in Chapter 2, ‘*The development of the Work Capability Assessment since 2008*’ from page 18 to 22 covered previous recommendations that resulted from earlier Reviews, and looked at which had been accepted by the DWP in full, and which in principle. I looked at the ones which have been partially implemented, which have in some cases been fully implemented, and which have not been implemented. Some are described as being “*in progress*”; some recommendations have been superseded by recommendations in Review Four. It appears that some recommendations have to this date not been implemented.

Further information re each outstanding recommendation that was made under Reviews in years one to three can be found under Annex 2 (see page 90), listing them individually, and showing the progress or lack thereof. Annex 3 lists recommendations from the Review in year four (see pages 94 to 103), which have only been partly implemented, some not at all.

Detailed new recommendations have been made in the Review for year five, and they are individually listed as bullet points on the following pages:

Chapter 2	Page 31 to 32	7
Chapter 3	Page 41	1 (with 2 sub bullet points, listed as 3 in Annex 1)
Chapter 4	Page 47	5
Chapter 5	Page 54 to 55	5
Chapter 6	Page 64 to 65	8
Chapter 7	Page 77	5
Chapter 8	Page 84 to 85	6 (not listed in Annex 1 as suggested for WCA redesign)

Total: 37

As some of these appear to have been broken down differently, **they show as only 33 total recommendations**, as they are listed in **Annex 1** (see from page 86 onwards).

Going through the various recommendations listed in the Annexes 2 and 3, it shows, that most of the still outstanding ones, and of the recent (year four) ones listed there, have either only been partially implemented, or are still *"in progress"*. Only a few have been fully implemented, and some (including important ones) have not been implemented at all. It appears the DWP and also the UK government have been dragging their feet when challenged with further improving the WCA. **The valid question though is and remains: Can the WCA be sufficiently improved, to be applied reliably in all cases, and at the same time be perceived as a fair way of assessing sick and disabled persons?**

My personal view is, and it appears that it is the view of a majority of the affected, and many in the UK public, that it cannot. **The WCA is not fit for purpose** has never been so, and the changes or *"improvements"* that may have been made, do even in the eyes of the Reviewer now question, whether the WCA and the process in place do still fulfil the "policy intent".

Having a functional assessment like the WCA, that is as restrictive and harsh, by using selected activities and associated descriptors, that only classify persons as sick and disabled, when they can barely move or mobilise (with even reasonable aids), when they cannot lift half a litre of milk, and when they can only change from one seated position to another with another person's support, thus being considered "not fit for work", is draconian, inhumane and mean. Considering persons "fit for work", when they can lift a half a litre of milk, when they can walk a minimal distance, when they can push a phone button, when they can do other very basic activities, and extremely simple tasks, is completely unreasonable, as there are virtually NO realistic employment opportunities for individuals that can just do that, or a little bit more.

All changes and support will not enable most such persons categorised as "fit for work" to compete with the considered "more healthy" and "able bodied" on the open job market. And still today the WCA is not fit for appropriately assessing many with mental health conditions, that fluctuate, and that may not appear as severe as expected, as many with such supposedly "moderate" or *"common mental health conditions"* will also not realistically be able to cope with the expectations that come with jobs being offered on the competitive job-market. The very fact that the WCA had to be changed as often as it has been, or rather the process while using it, shows that it is seriously flawed, and does not stand up to scrutiny.

It is essential that a different method of assessing sick and disabled for work capability is introduced and followed, which also still considers medical aspects, as it is impossible to exclude medical diagnosis and treatment from the process. A functional assessment must continue to give sufficient consideration to the assessed person's GP's reports and recommendations, which should be combined with other considerations, and the assessed person must be given sufficient respect and allowed fair and reasonable input into the process, as otherwise the "social" will be missing from the "biopsychosocial model" now so often propagated. Also without employers, and society as a whole, recognising and accepting their responsibilities towards the incapacitated, the disabled and long term ill, there will be little improvement in the situation of the persons that are supposed to be "supported".

The whole history of the disastrous results of the WCA being applied over the years only reveals, that the "policy intent" is primarily a cost saving exercise, and little else, and even that has failed, given the large percentages and numbers of appeals and now also sought mandatory reconsiderations of decisions. **Therefore the WCA must be abolished and replaced.** If the WCA and associated measures would be truly designed to "support" people with disabilities into sustainable work, they would be very different to the ones in use in the UK. It is true that many disabled would like to work, but many could have tried so under previous kinds of benefits and systems. The actual major problem is not the persons' lack of motivation or alleged "malingering" or exaggerating conditions, the major problem and challenges are the lack of suitable jobs, the lack of supportive, accommodating employers,

the lack of work environments where disabled people can work safely and be respected and appreciated, for the work they can realistically do. With a highly competitive job market, designed to favour the fittest of the fittest, mentally and physically, with less security and often insufficient pay to cover basic living expenses of workers, it may rather be the environmental conditions that prevail, that make it impossible for most disabled to find work, that is those that actually can do regular, somehow more or less demanding work.

Also is it absurd to overly marginalise the medical aspects when conducting assessments, as it happens to be physical and mental health conditions, besides of injury and disability due to loss of limbs and such, which are generally the cause for impaired function and incapacity. No matter what redefining of language, reformulated approaches and restructuring of work capability assessment “tests” may happen, to achieve certain outcomes. There will be physical, mental, psychological, and environmental and other limitations to what can be achieved. It would be more respectful and humane to simply accept that various persons need benefit support, and additional support, to perhaps find suitable employment, and it may make more sense to provide real incentives to the individuals concerned, and employers and other stake holders, to provide the conditions that can bring better outcomes. The WCA simply puts pressures on the weakest in society, by re-categorising them and laying endless new expectations onto them, which will be enforced through sanctions. This is not a productive and constructive approach to get disadvantaged persons into employment.

Governments that use such assessments as the WCA, and similar measures to pressure sick and disabled to try and find work, and to do all to keep them, and to even force them to stay in jobs when they are not well, are dishonest. Such measures are NOT about “helping” people, they are about shifting the goal posts and reducing welfare dependence and costs with whatever ruthless means. The drive and “policy intent” is simply to reset the criteria, to tighten it and nothing much else, whether there realistically are the jobs necessary or not.

The peculiar references to assessment practices and processes in New Zealand that are made in the Review will be addressed further below, as they do at least partly appear to be based on some misinformation. The limited number of references and comments Dr Litchfield has made in his review imply, that he only got the New Zealand Government’s and the Ministry of Social Development’s Principal Health and Disability Advisors’ position presented to him. It appears he did not bother to consult disabled persons’ support groups, beneficiary advocates and possibly also not members of the New Zealand medical professions on the welfare reforms. I will discuss this matter in the following chapter(s).

G). DR LITCHFIELD’S SUPERFICIAL IMPRESSION OF NEW ZEALAND’S WORK CAPABILITY ASSESSMENTS AND WELFARE REFORMS, AS REFERRED TO IN HIS FINAL ‘INDEPENDENT REVIEW’ OF THE WCA

It appears to be rather selectively presented and accepted information and advice that the last Reviewer of the WCA in the UK, Dr Litchfield, obtained from the New Zealand Government and senior Advisors of the Ministry of Social Development. There are some apparent inaccuracies, there is a lack of other important, relevant information not mentioned, and there appears to be a degree of misunderstanding of the way reforms in New Zealand have been introduced and are being applied. Firstly we need to look again at the Review:

See again the extracts from ‘Chapter 8’ on page 82 of the Independent Review:

20. New Zealand has taken a fundamental approach which the Reviewer was able to explore in some detail with the assistance of the New Zealand Government. Reforms have recently been introduced with the aim of simplifying the benefits system. There are many similarities with the UK system but also some key differences. The new system amalgamates sickness

benefit and several other benefits with unemployment benefit as Jobseeker Support. A self-assessment focusses on the type of work an individual could undertake currently or in the future and the support they might require to do so. **There are differing levels of obligation (analogous to UK conditionality) but benefit payments do not differ. A case management approach is taken to assist people into work with specific additional support for those with mental health problems.** Independent capability assessments may be undertaken but are sited at the very end of the process, if required at all, and relatively few had been undertaken at the time of writing.

21. *The New Zealand reforms are at an early stage of implementation and it is not yet possible to determine their impact. However, **the approach of uncoupling levels of benefit eligibility from work capability** and focussing on overcoming barriers to employment has appeal and merits further exploration.*

Also please reflect on this additional information presented at the end of the Review:

“Annex 4: Acknowledgments:”

Extract:

“1. Although this has been my second review of the Work Capability Assessment (WCA), I have had a great deal more to learn about its application and I am most grateful to all those who have graciously given their time to help me.”

*“10. I would also like to thank **officials at the Ministry of Social Development** in New Zealand – **particularly Sacha O’Dea, Anne Hawker and Dr David Bratt** – for providing **invaluable insight** into the challenges they are facing and the reforms being made into how incapacity for work is assessed. “*

Dr Litchfield’s apparent failure to fully understand the New Zealand system

It always requires a bit of gathering of essential, relevant information, and careful analysis and study to fully understand systems used and applied in other countries. Even with having done such research and investigations, which often rely on certain official records and documents, and position statements and other data presented by public officials that are consulted, there is always a risk of only seeing part of the whole picture, and of misunderstanding complexities and details. I fear this has happened with **“advice”** the Independent Reviewer of the WCA received from New Zealand.

The question arises, what **“invaluable insight”** did MSD’s known Principal Health Advisor Dr David Bratt, together with the usually never heard from or noticed Principal Disability Advisor Ann Hawker, give to the Reviewer, Dr Litchfield?

What we have so far had delivered in New Zealand does not seem anything much more convincing and “ground breaking”, as the “reforms” here (from 2012/13) were largely taking over very similar, if not partly identical approaches, that were adopted with “reforms” previously introduced in the UK. One major, noticeable difference may be Dr David Bratt’s extra emphasis, that the benefit is supposedly as harmful as **“a debilitating drug”** (see his many presentations stating that, and also selectively quoting Drs Aylward and Waddell and others, who set the agenda and tone for reforms in the UK):

‘Ready, Steady, Crook – Are we killing our patients with kindness?’ (pages 13, 20, 21, 35)

<http://www.gpcme.co.nz/pdf/GP%20CME/Friday/C1%201515%20Bratt-Hawker.pdf>

Special features or aspects of the NZ system, in comparison to the UK system

In order to look at the more important and serious aspects of what differences there are between the UK and New Zealand systems, I can list the following:

1. “Simplifying the benefits system”

It is correct that there has been a “simplifying” of the benefit system in New Zealand, but while there has been a merger of the former ‘Sickness Benefit’ with the former ‘Unemployment Benefit’, and also the inclusion of some former ‘Domestic Purpose Benefit’ recipients into the new ‘Jobseeker Support’ category, there are still other types of benefits. One important benefit that exists for those severely and permanently (for at least 2 year) incapacitated is the ‘**Supported Living Payment**’ benefit category, formerly known as the ‘Invalid’s Benefit’. Dr Litchfield may know about it, but failed to make any mention of this, while it is actually a rather important benefit that is so far still being maintained here in New Zealand. It also includes persons that may need to care for an incapacitated person, but such “carers” may themselves need to face “work ability” and other assessments. Sick and disabled with medical conditions, injuries and incapacities of a less severe or temporary kind are included in the ‘Jobseeker Support’ category, but can be deferred from work test obligations, similar as the ‘Work Related Activity Group’ under the ESA in the UK may be. But in New Zealand, ALL persons on benefits can be assessed for work ability, or expected to attend work preparation measures, at any time, if so considered as being justified.

Now there may be the temptation to compare the ‘Supported Living Payment’ benefit with the ‘Support Group’ under the ESA in the UK. That would not be quite appropriate, as there is still a somewhat less restrictive, not as rigid and harsh way applied when assessing persons that may be entitled to this benefit. Also have many persons that received this benefit since before the last major welfare reforms, that took effect mid July 2013, remained on it, and only in some cases been re-assessed. While the general approach by the Ministry of Social Development’s (MSD’s) department called Work and Income (WINZ), the agency comparable to the DWP in the UK, is to now rather look at what people can do, than what they cannot, there is NO one clear set of guidelines or “descriptors” for activities, that is used for assessing sick and disabled here. This means, there is at least not a publicly known “test”, for how the individual persons that may qualify for this benefit are being assessed. The ‘Supported Living Payment’ recipients are likely to face more re-assessments and re-examinations over time, but there has to date not been a clear, general move to have all recipients re-assessed for their eligibility to that support.

2. Assessment regime and criteria

As mentioned above, the truly **fundamental difference** between the way work capability is being assessed in the UK, compared to here in New Zealand, is the one, **that we do in New Zealand not have one clearly defined, structured, point scoring assessment such as the WCA. There is NO such one official document, no clear “test” at all being used.** Despite of initial promises we have since the reforms were implemented since mid 2013 not had any clear communications at all from WINZ, the Ministry of Social Development (MSD) or the government, about what the exact criteria is, for assessing persons for their work capability. This is a very serious matter, as it leaves a huge degree of discretion to assessors that MSD and WINZ may use, and also to the “Advisors” and “Case Managers” making final recommendations and decisions on a case by case basis. It was the unreasonable degree and level of discretions the Chief Executive (and his/her staff) now have, which was during the submission process to the ‘**Social Security (Benefit Categories and Work Focus) Amendment Bill 2012**’ (presented in September 2012) raised as a major concern by the ‘**Legislative Advisory Committee**’. See their submission via this link:

<http://lac.org.nz/assets/submissions/Submission-on-Social-Security-Benefit-Categories-and-Work-Focus-Amendment-Bill.pdf>

This means there is a lack of clarity and transparency in the whole assessment process!

3. Benefit entitlements or eligibility

What Dr Litchfield has made no mention of is the fact, that it is simply not quite correct to say, that there is no difference between benefit payments. It is not true, as the 'Supported Living Payment' is actually set at a somewhat higher rate than the 'Jobseeker Support' benefit payment. Already before the reforms were the former 'Sickness Benefit' (paid for only short to medium term sick and disabled, not able to do full time work) and the former 'Unemployment Benefit' set at the same rather low levels. So there has been no change between those beneficiaries now receiving 'Jobseeker Support', whether they are fully healthy and able to look for work, or whether they are temporarily "deferred" from work and training expectations, due to health issues and disability. It is also not correct that benefit eligibility is "uncoupled" from work ability and resulting expectations. There are severe sanctions in place if a benefit claimant fails to fulfil obligations, which include working with contracted service providers. So if a work capability is established, there will sooner or later be an expectation that a client will look for work or at least do training, which may happen through contracted employment referral and training service providers. If a person refuses to cooperate, sanctions will be enforced, such as halving or fully stopping benefit payments. That can hardly be seen as "uncoupling" benefit receipt from work ability. Perhaps have a look at the information found via the following link:

<http://www.workandincome.govt.nz/individuals/brochures/benefit-rates-april-2014.html>

4. Requests for review and appeals on medical grounds

Also important to note is the fact, that in New Zealand, a WINZ client has the right to seek a review of any decision made, also where she/he may feel to have been assessed as "fit for work" by a "case manager", on health grounds. The request for review will go to WINZ, and usually to the branch office manager. This may to some degree resemble the now in the UK used "mandatory reconsideration" process. Once another look was taken and a decision reviewed, the client can, if still unhappy with a decision following such a request, under certain circumstances appeal to a '**Medical Appeal Board**', now in the statute called '**Medical Board**' (MAB). This appeal body is rather different to the "Tribunal Services" in the UK, there coming under the 'Courts and Tribunals Judiciary'. An appeal against a decision made by WINZ on health grounds, or relating to decisions on ability to work, can only go to the mentioned Board, which is actually not part of the judiciary at all. It is a panel of doctors and other appointed health and disability professionals, mostly so-called "Designated Doctors", appointed by a "Coordinator" employed by the MSD itself. They take a fresh look at a person's health and disability situation, and review decisions made. Only if a decision made by such a rather less "*independent*" Board gives reason to be challenged under law, is there the difficult to pursue option of filing for judicial review before a High Court here. A beneficiary may qualify for legal aid for such a civil proceeding, but first a lawyer needs to be found, who can also present a statement that proves a likelihood of success of such proceeding, as otherwise legal aid will not be granted at all. As legal aid nowadays hardly covers a legal representative's costs, the chance of finding one is extremely difficult for a start. And if a proceeding commences, then MSD will most likely offer a "settlement" out of court, and deal with the case in discretion. The MABs are known to have appointed panel members that tend to raise questions about independence and objectivity. See these links:

<http://www.workandincome.govt.nz/individuals/brochures/a-guide-to-medical-appeals-board-hearings.html> ; <http://www.legislation.govt.nz/act/public/1964/0136/latest/DLM5487423.html>

5. Decisions on benefit entitlement based on work ability and medical conditions

While in the UK a 'Decision Maker' at the DWP makes a final decision about an applicant's eligibility to claim the ESA, in New Zealand it is the ordinary 'Case Manager' at WINZ, who makes the formal and legal decision, under the authority of the Chief Executive. Case Managers decide who may be entitled to claim a benefit on health or other grounds. Like in the UK they mostly rely on "recommendations" made by the here employed 'Regional Health Advisors' (RHAs) and 'Regional Disability Advisors' (RDAs), based at Regional Offices of MSD and WINZ, when making their decisions. But they do not make decisions based directly on reports and recommendations from an outside examiner, e.g. a 'Designated Doctor' or

another contracted assessor. There is sometimes an involvement of such 'Designated Doctors', who are actually "mentored", "trained" and "supervised" by the Principal Health Advisor (PHA), Dr David Bratt, and their recommendations will go directly to the RHA or RDA. The latter will though mostly accept these and pass their further recommendation on to the Case Manager handling an application or re-assessment of a WINZ client. 'Designated Doctors' are supposed to act "independently" when examining and assessing sick and disabled clients, but they are commissioned and paid by MSD. There is now also the occasional use of separate, contracted 'Work Ability Assessors' (mostly physiotherapists, occupational therapists, and some psychologists), but their recommendations and reports appear to also go through the hands of RHAs and RDAs, who may in some cases consult with the PHA and/or PDA for further advice or clarifications. Hence in New Zealand there is not one major outsourced assessor, and there are also these internal Work and Income NZ Health and Disability "Advisors" who Case Managers receive "recommendations" from!

6. Case management approach and supposed "specific additional support"

Dr Litchfield does comment in his report: "***A case management approach is taken to assist people into work with specific additional support for those with mental health problems.***" This claim is misleading, and only in part correct. So far this additional support, especially in the case of those with mental health problems, consists primarily only of "more intense case management", and very little else. There is now a use of some newly contracted outside service providers to deliver "mental health employment services", but they are facing difficult challenges, as they are paid set fees to deliver expected outcomes, which may not be achievable, if referred clients are not capable to live up to certain expectations. There are similar services for single parents on benefits, and some others with other health problems or "barriers". But the emphasis is on achieving a set percentage of successful, at least temporarily lasting job referrals, with a very limited focus on "additional support" of a medical or psychological kind. If a provider does not achieve enough placements of clients into lasting employment, they will not get paid enough fees, which may mean they become economically nonviable. That means there is also significant pressure to "perform", which can lead to clients facing risks of being referred into jobs, where they may not actually be well placed and hence cannot cope. These services are still in the testing phase, and there has been very little, even conflicting information, on their level of success. **Lack of transparency and of evaluation information on the welfare reforms here are a major issue!**

7. Overcoming barriers to employment

Like in the UK, the "barriers" that may be established and looked at here in New Zealand are usually only the ones that the affected sick and disabled beneficiary may face her-/himself, due her/his illness and incapacity. There is NO real expectation that can be put into employers, and that can be enforced, for them to fulfil a social duty to employ sick and disabled, and only limited incentives (if any) appear to be given. So the expectations and pressures are primarily placed on the client in receipt of a benefit, with a limited capability to work. Obligations can include seeking and participating in certain treatments, to attend support groups, to attend "courses" aimed at helping people apply for jobs, and to conduct job search efforts, and the likes. Again, if such obligations are not met, there will be severe sanctions that will be enforced, which is one way of "motivating" people through fear, not really by giving positive incentives to them to look at and use any supposed "capabilities". If found "fit" for some work then there will be expectations, and case managers at WINZ are also expected to meet targets when working on placing such persons into employment. In an interview with Radio New Zealand National, MSDs 'Director of Welfare Reform' commented that they would usually not even tell employers of "barriers" their sick and disable clients may have, e.g. mental health conditions, which appears like they are taking irresponsible risks: <http://www.radionz.co.nz/national/programmes/ninetonoon/audio/2592666/winz-expands-scheme-to-support-unemployed-with-illness-issues>

8. Work Capability Assessments by different types of service providers

Unlike in the UK, New Zealand's 'Work and Income' department does not use one major contracted assessment provider, like Atos Healthcare or MAXIMUS. Instead they have for many years maintained a pool of 'Designated Doctors' to provide second opinions, where there may have been a perceived need for such. Either a client's own GP may have suggested a second opinion may be recommended, or WINZ Case Managers themselves may (usually after consulting with a RHA or RDA) decide to have a client with health conditions and/or disability referred for an extra examination by such a doctor, who is generally a GP. Since 2008 MSD have been actively "training" these doctors, officially only to help them "better understand" the WINZ systems and their "needs", but there is anecdotal evidence that this reached levels of trying to influence such doctors. Dr Bratt and his RHAs and RDAs have been expressing certain expectations, which show for instance in the "presentations" Dr Bratt has used. Nowadays WINZ have around 300 "Designated Doctors", and once they had many more. As the involvement of such additional assessors was still perceived as not meeting WINZ's expectations in some cases, they have as part of recent welfare reforms (since 2013) started to contract a range of smaller, regional 'Work Ability Assessment' providers, who are commissioned on a case by case basis. They employ mostly physiotherapists, occupational therapists, some nurses, also the odd psychologist, and may now be asked to also provide an "independent" assessment for work capability for certain individual clients. But like 'Designated Doctors' they are bound by contracts with MSD, which again contain specific expectations, which are though not publicly available, as such information may be deemed "*commercially sensitive*", and will therefore not be made available under the 'Official Information Act'. As this is also a very new measure, there is still little or no information available on how they work. **A number of links to other posts of interest may shine light on what they are about:**

<http://nzsocialjusticeblog2013.wordpress.com/2014/06/21/work-ability-assessments-done-for-work-and-income-a-revealing-fact-study-part-a/>

<http://nzsocialjusticeblog2013.wordpress.com/2014/06/22/work-ability-assessments-done-for-work-and-income-a-revealing-fact-study-part-b/>

<http://nzsocialjusticeblog2013.wordpress.com/2014/06/22/work-ability-assessments-done-for-work-and-income-a-revealing-fact-study-part-c/>

<http://nzsocialjusticeblog2013.wordpress.com/2014/06/22/work-ability-assessments-done-for-work-and-income-a-revealing-fact-study-part-d/>

<http://nzsocialjusticeblog2013.wordpress.com/2014/06/22/work-ability-assessments-done-for-work-and-income-a-revealing-fact-study-part-e/>

<http://nzsocialjusticeblog2013.wordpress.com/2014/06/24/work-ability-assessments-done-for-work-and-income-a-revealing-fact-study-part-f/>

<http://nzsocialjusticeblog2013.wordpress.com/2014/06/25/work-ability-assessments-done-for-work-and-income-a-revealing-fact-study-parts-g-and-h/>

<http://nzsocialjusticeblog2013.wordpress.com/2014/06/26/work-ability-assessments-done-for-work-and-income-a-revealing-fact-study-part-i/>

9. The lack of accountability assessors have in New Zealand

Few people outside of New Zealand will know of the complex legal framework that covers the registration and accountability of health practitioners in this country. One needs to understand the relevant provisions in the 'Health Practitioners Competence Assurance Act 2003', the 'Health and Disability Commissioner Act 1994', possibly also the 'Health Information Privacy Code 1994' and various other legal provisions, and how they are all inter-connected, and basically only leave the end consumer of health and disability services the option to lay complaints about any misconduct and failures by practitioners with the **Health and Disability Commissioner**. That Commissioner oversees and "enforces" the so-called '**Code of Health and Disability Services Consumers' Rights**', but that means rather little here, as again, that Commissioner has very much discretion to take certain actions, or to (very often) take no action. Hence when last year the Office of the Commissioner received over 1,700 complaints, only just over a hundred were "formally" investigated. Even if misconduct is found and established, then **the actions the Commissioner takes is usually limited to warnings or advice on how to remedy**

failures by conducting further training and such. The Commissioner does also only deal with complaints about practitioners acting as third party assessors, if face to face assessments and other conditions applied. And even then, the Commissioner will usually not bother getting involved, and simply refer the complainant to address any issues with the agency that commissioned the practitioner to do the assessment, e.g. WINZ or ACC. The New Zealand specific '**Accident Compensation Act 2001**' also has special, unique provisions, and it provides for compensation to be paid even to persons suffering from medical misadventure, while **the practitioners responsible cannot be sued for damages here.** So assessors will usually have little to be concerned about, as they can make poor, flawed recommendations and will mostly face no serious sanctions or major consequences. <http://nzsocialjusticeblog2013.wordpress.com/2014/05/27/health-and-disability-commissioner-can-we-trust-in-hdc-independence/> (see particularly Parts 2, 3, 8, 15, 16, 20 and 21 for legal and other important details!!!)

See the **relevant legislation** found under these links:

<http://www.legislation.govt.nz/act/public/2003/0048/latest/DLM203312.html>

<http://www.legislation.govt.nz/act/public/1994/0088/latest/DLM333584.html>

<http://www.legislation.govt.nz/act/public/2001/0049/latest/DLM99494.html>

10. The special role by the Accident Compensation Corporation (ACC)

There is here also a separation between responsibilities state agencies have for supporting sick, injured and various types of disabled persons. While persons with congenital diseases, with illness and disability that did not result from an accident of any sort are reliant on the Ministry of Social Development's WINZ department, those that suffer accidents tend to be looked after by ACC. The no fault accident compensation scheme in place here provides compensation payments for lost income (at a certain percentage), and does also offer some additional support, same as in particular cases clear expectations, for claimants to participate in rehabilitation. ACC use assessments that may fulfil a similar purpose as ones such as the PCA and now WCA used in the UK, but they do so with a slightly different approach and agenda. Some examples of what assessments they use will be presented further below in this post. There are though some claimants, who may be re-categorised by ACC as having a limited capability to work, and then get "*exited*" by that corporation to apply for WINZ benefits, should they fail to find and access employment that may be expected of them.

Conclusions

From the various points mentioned above, it becomes clear, that there are some significant differences between the systems and approaches used in the UK and in New Zealand. One very major difference between the way sick and disabled on benefits, or applying for benefit, are now being assessed here in New Zealand, when compared to the UK, is the absence of a formal, clearly structured, points-based "**Work Capability Assessment**"! Despite of all its flaws and deficiencies, there is one only advantage it has: It provides a basic level of clarity by listing certain activities and associated descriptors to conduct assessments. It may lack clarity in other respects, but from a legal point of view, it is "clear" enough to be challenged at Tribunal. Also very different is the way appeals can be made, and when looking at the somewhat favourable references and comments the WCA Reviewer Dr Litchfield has made in his report, this should raise alarm bells in the UK. It appears that the Reviewer considers it worthwhile to perhaps take up similar approaches to the ones used in New Zealand, and integrate these into the UK system. That would mean, having assessments that are lacking transparency and clarity, and that are also difficult to challenge, as it would be more problematic to appeal decisions made by Decision Makers. **The UK would fare better with not following the New Zealand model or system, given it is so vague, and that it leaves so much in respect of diagnosis, assessing and decision making up to extremely unreasonable degrees of discretion, all very much left to the very agency that commissions the work capability assessments and pays benefits.** It appears that there

is already a level of formal and also less formal exchange of information in this area happening between the New Zealand Government and UK authorities and agencies.

Perhaps it is exactly the stated aspects of the New Zealand system that has impressed the UK Reviewer so much, as that approach is so open to flagrant abuse through using endless “discretion”? At the same time it bears a rather low risk of adverse consequences for the assessors and decision makers; because it deals with each case by case, so legal requests for reviews and appeals have little chances to overturn decisions against clearly set standards or established systems and processes, which do not exist here. Yes, decisions can be reviewed and changed, but that will only be done under discretion, case by case, by WINZ. The excessive amount of discretion that exists here in New Zealand, which the **‘Legislative Advisory Committee’** lamented in their submission on the **‘Social Security (Benefit Categories and Work Focus) Amendment Bill’** in 2012, seems to be appealing to the Reviewer, and will probably also do so to the DWP. It may be for the very “murkiness” of the assessment and decision making processes in place here now, that there have been few if any public challenges and discussions about the legality and fairness of it all. **And if WINZ or their “Advisors” get it seriously wrong, they can always use the same discretion, to review cases internally, thus limiting costs, and avoiding litigation AND the setting of legal precedents that may curtail their powers and freedoms to act for future cases.**

H). THE WCA REVIEWER DR LITCHFIELD AND HIS LINKS TO ‘FIT FOR WORK’

Some light deserves to be shed onto the Reviewer **Dr Litchfield himself**, given his involvement with ‘Fit For Work’, his work in other capacities, and also his long term position with BT, a large UK employer. It deserves some questioning, why a Reviewer with his kind of background was the supposedly “appropriate” appointment. The former Reviewer appeared to come from a slightly more independent kind of professional background, some will think.

Dr Paul Litchfield has been Chief Medical Officer for BT (British Telecom) and he is a member of **‘Fit For Work’**, a “think tank” kind of “stake holder group” and lobby organisation:

Re the author or “Reviewer”, look up info via these websites:

<https://uk.linkedin.com/pub/paul-litchfield/44/37b/104>

<http://www.fitforworkeurope.eu/UK/About/paul-litchfield.htm>

From LinkedIn:

“Summary”

“Paul’s main professional interest for the past decade has been occupational mental health and he has been involved in UK national and European initiatives to improve rehabilitation back into work after mental illness and to reduce the stigma of mental ill health. Within BT he has created a framework for health, safety and wellbeing that has driven very significant improvements to the benefit of both the workforce and the business and the company’s performance in these areas is widely viewed as exemplary. Key elements of the approach have been partnership with the Trade Unions and the transformation of data into management information that is of use in managing the company better. He has published and lectured widely not only on mental health issues but also on sickness absence, hazard control and ethics in occupational health.”

He has been ‘Chief Medical Officer’ for BT Group plc (British Telecom) for 14 years, and is thus a medical professional with a corporate business appointment and links.

From the ‘Fit for Work UK Coalition’ website:

<http://www.fitforworkuk.org/>

'Fit for Work Europe' is made up of only 5 partner countries, being the UK, Netherlands, Switzerland, Hungary and Turkey.

<http://www.fitforworkeurope.eu/About/our-history.htm>

Under the page 'Our History' of 'Fit for Work Europe' we find that 'Fit for Work' was originally established in the UK, and "expanded" into Europe.

Their website informs:

"Fit for Work Europe is a multi-stakeholder Coalition, driving policy and practice change across the work and health agendas. We aim to deliver more investment in sustainable healthcare by promoting and implementing early intervention practices. Research shows this approach is the most effective way of ensuring people with MSDs (musculoskeletal disorders) can enter and remain in work across the EU and globally."

Also is some info available on Professor Stephen Bevan, their Founding Director

Professor Stephen Bevan, Founding Director

<http://www.fitforworkeurope.eu/About/stephen-bevan.htm>

"Stephen is Director of the Centre for Workforce Effectiveness at [The Work Foundation](#) and an Honorary Professor at Lancaster University. He joined The Work Foundation in 2002 as Director of Research from the Institute for Employment Studies (IES). In 2007, he founded the Fit for Work project and in 2009 he launched the European Coalition.

Stephen has carried out research and policy work for the Number 10 Policy Unit, HM Treasury, the Cabinet Office, the Department of Health, the Department for Work and Pensions and the European Commission. He has also advised many blue-chip companies on aspects of HR strategy and practice. Stephen has conducted research on high-performance work practices, employee reward strategy, staff engagement and retention."

A UK report from 2007 is quoted, and it was supported by a "grant" from 'Abbott':

'Fit for Work? Musculoskeletal Disorders and Labour Market Participation'

http://www.fitforworkeurope.eu/Downloads/Website-Documents/44_fit_for_work_small.pdf

Stephen Bevan, founder of 'Fit for Work', was co-author of that report. The "**Foreword**" was presented by **Professor Dame Carol Black**, the UK Government's then 'National Director for Health and Work', who is known to have based a lot of her own views on the "research" and "findings" by Professor Mansel Aylward and others at the 'Centre for Psychosocial and Disability Research' (once "sponsored" by 'UnumProvident').

The report starts with the 'Executive Summary' stating a perceived challenge:

*"The health of British workers is giving us serious cause for concern. Up to a quarter of the workforce is **not healthy enough to drive the improvements in productivity which the UK needs to thrive in an increasingly globalised, knowledge-based economy.** Despite record levels of employment and job growth, over 2.6 million people of working age are claiming Incapacity Benefit (DWP, 2007). **There is overwhelming evidence that worklessness is, itself, bad for health** and that rehabilitation back into work can positively affect physical health, psychological well-being and raise people out of poverty."*

While lamenting the poor health, sickness absence and lack of productivity of UK workers, the report does on page 11 (under 'Introduction', 3rd section) bluntly admit the following:

*“But, as ever, the truth about the health and well-being of the UK working population is a little more complex than the headlines imply and, **although the overall rate of sickness absence has stayed at about the same level for the last thirty years or so**, we have witnessed some very significant – and concerning – changes in the nature and composition of work-related incapacity during this period.”*

On **page 12** that report then comes to the crucial issue it tries to address:

“Despite the stability in the headline rate of sickness absence, we have witnessed a significant increase in the proportion of the total made up of longer-term absences: workers with more serious illnesses or chronic conditions. By some margin, the majority of these longer-term absences can be attributed to two ‘clusters’ of conditions. The first is what is now popularly known as ‘stress’, though should more accurately be termed ‘common mental health problems’. These include depression, anxiety disorders and a number of other conditions. The second, known as musculoskeletal disorders, are the subject of this report. ‘Stress’ grabs the headlines because, each year, work-related ‘stress’ results in the loss of over 10 million working days, at a cost to UK employers of in excess of £3.7 billion (Lehki et al, forthcoming).”

Own Comment

These are the same kinds of “issues” Aylward, Waddell, Burton et al have repeatedly been stressing in their reports. They mostly conducted “comparative studies” on paper, and interviews with selected groups of affected. Comparing statistical and other medical and even economic reports on “worklessness” and benefit dependence, may reveal some form of association and apparent correlation between “conditions”. But it does not necessarily give a clear cause and effect explanation; like that unemployment itself causes illness and incapacity. We know from experience that ill health, serious and permanent disease and forms of physical and mental incapacity causes unemployment, but the latter may only cause ill health in some cases. What nobody appears to have considered is, that the usually resulting **POVERTY** that comes with unemployment and long term benefit dependence, may actually be the real cause for further mental and physical illness - not just unemployment itself.

On **page 16** of that report it is revealed how the “research” was conducted for the publication:

Extract:

“In addressing the objectives outlined above, we have used the following methods:

Desk Research:

Here we have drawn on existing published research from the medical, occupational health and health economics literature. This has enabled us to draw together the evidence on the nature, extent, impact and costs of MSDs to the economy, to employers and to individuals. We have examined a range of MSDs to assess the extent to which their impact varies and where policy and practice has been both strong and weak in terms of prevention and intervention.

Expert Interviews:

We have conducted interviews with experts (see Appendix 1 and 2) across a number of disciplines to identify the main areas of policy and practice which need to be addressed by policy-makers, health professionals and by employers.”

Own Comment

That is the way much of the research by Professor Aylward was also conducted, by “researching” other reports, analysing selected data, and writing new reports. What has been shown through reading their reports is, that there is a tendency to “trivialise” certain health conditions or illnesses, such as a fair few mental health conditions that are also

included in the DSM, by simply calling them “*common mental health problems*”. The same is done in this report, also with MSD, simply referring to it as one of “*musculoskeletal disorders*”. These “experts” are actually attempting to blur the line between more severe conditions, and those that **appear** to be less severe. Aylward and others admitted in later reports, that this whole area of disability and “worklessness” requires further research and study, as existing reports do not offer sufficient information to draw well based conclusions.

Hence perhaps their cautionary “note on definition” on **page 17** in this report:

“In the absence of a consensus on a clinical definition of many MSDs, navigating the literature on their prevalence, incidence, diagnoses, epidemiology, treatment and cost to society is a difficult task. The lack of standardisation and validation of the terminology and classification of MSDs is one of the reasons for the contradictory findings in the literature regarding the diagnosis, epidemiology, treatment and rehabilitation of these conditions (WHO, 2003).”

While the contents of the report may not be fully discredited, the above comments do at least indicate, that it should be treated with a lot of caution, in regards to its value and reliability. What appears clear is that MSD can be caused by work, and can become worse if unhealthy work is continued. I note that the medical researchers **Waddell and Burton** are repeatedly quoted in this report. Like with Professor Mansel Aylward, the two are known to have done a lot of “comparative studies”, in the form of comparing statistical data contained in various other reports. These may show some “correlations” between sickness and disability, and work absence with longer term incapacity and benefit dependence. But that alone does not necessarily mean that sickness and disability are the result of not working, it is more likely to be the other way around. Also is there not sufficient evidence to generally claim that work in ordinary paid jobs on the competitive market is “beneficial” to health. Much work has certain detrimental effects on physical and mental well-being, and instead the emphasis should perhaps rather be to promote some moderate physical and mental activity, where possible, as that may be beneficial. This does though not equate to activity in competitive, paid work.

Under ‘**Interventions**’ on **page 36** the “biopsychosocial model” and “work” are brought into the report:

“The biopsychosocial model is an explanatory framework that recognises the importance of psychological and social factors in determining how MSD sufferers cope with their conditions. The following section provides a brief overview of the biopsychosocial model and outlines the implications that it has for the workforce.”

“The biopsychosocial model advocates that clinicians, occupational health professionals and others should assess the interplay between the biological (eg disease, joint damage), the psychological (eg disposition, anxiety) and the social (eg work demands, family support). Figure 3 below illustrates the role which psychological disposition and behaviour can have on the way a physical ‘injury’ (such as back pain) is approached by a patient. In this example, the injured patient risks entering a self-reinforcing cycle of incapacity, delayed recovery and even depression if their dominant response to pain is to ‘catastrophise’ it.”

Under **chapter 5 ‘The wider Impact of MSDs’** the report stresses the costs caused by MSD, by illness generally, particularly through workplace absence, leading to lost productivity. A range of ‘**conclusions and recommendations**’ are presented under **chapter 6**, at the end of the report, which are aimed at reducing the harm and costs caused by MSD, and which could improve workers’ productivity. The underlying message to employers, employees and government is: **Focus on capacity, not incapacity**. Also is there the claim, while MSD affects the ability of some to work, it is work that is generally good for a person’s long term health. Even when unwell or injured, remaining at work in some capacity is better for “recovery” than being absent from work. While some recommendations may represent common sense approaches, others seem rather questionable, like telling employers to challenge GP’s diagnosis, assessment and “sick notes”, same as to avoid a “*risk management*” mentality when dealing with a sick employee. Many GPs will feel challenged

with applying a “biopsychosocial” approach, which involves potentially complex interrelationships and interactions, and can be ambiguous or misleading.

Appendix 1 lists expert witnesses that were interviewed, and amongst others, there was clearly a rather prominent representation by DWP, their favoured “experts” and also the UNUM insurance corporation:

Dame Carol Black -	‘The Government’s National Director for Health and Work’
Dr Bill Gunnyeon -	‘Chief Medical Advisor’ ‘ Department for Work and Pensions ’
Dr Mike O’Donnell -	‘Chief Medical Officer’ ‘ UNUM Provident ’
Prof. Gordon Waddell -	“ <i>orthopaedic surgeon with clinical and academic interests in the field of back pain and related disorders</i> ”, but who also (once) worked at the ‘ Centre for Psychosocial and Disability Research ’ (formerly “sponsored” by UNUM), headed by M. Aylward
Dr Nerys Williams -	‘Medical Policy Advisor’, ‘ Department for Work and Pensions ’

Hence we have a strong line-up of “experts” that come from vested interest parties, who have also a name for their strong position on the “*health benefits of work*”.

But with the further above stated fact that sickness absence in the UK has remained rather steady for over 3 decades, what then is the justification and purpose for the position presented with this report? It appears that the main goal is to create a “healthier” Britain, where more people work longer, and produce more, and where attempts are made, to even engage sick and disabled into work, so that socio-economic costs are reduced, **simply to be better able to compete with work forces of other nations.** The agenda behind “Fit For Work” is therefore rather one of a special interests representing lobby group, and with that a politically and ideologically driven one, it seems, where a step change is asked for to be applied by the medical profession, employers and also government.

Interpretation: MSD’ stands for ‘Musculoskeletal Disorder(s)’

So clearly Dr Litchfield was already rather biased towards their “*fit for work*” approach

The very involvement of Dr Litchfield with “Fit For Work” appears to show at least a “slight” conflict of interest, which he has, as the Reviewer of the WCA. He is with his membership in that organisation already taking a position that supports the underlying approaches and policies that are reflected in the WCA and the “policy intent” behind it. The report shown above shows the strong influence that leading “experts” had on “Fit For Work” and research they rely on, and it resembles a lot the same messages we have over the years heard coming from the likes of Professor Mansel Aylward, former Chief Medical Advisor to the DWP. Also has Dr Litchfield, or have “Fit For Work”, cooperated with the DWP, and allowed input from vested interest parties such as UNUM. One would have thought that a Reviewer of the WCA would be more suited if coming from a more neutral kind of background.

I). OTHER INFORMATION ABOUT DR LITCHFIELD, HIS BACKGROUND AND WORK

‘the void’ reports on the Reviewer, Dr Litchfield, under this link (27 Feb. 2013):
<https://johnnyvoid.wordpress.com/tag/dr-paul-litchfield/>

“Member of ‘Fit For Work Coalition’ Brought in to Scrutinise Atos”

Extract:

“The DWP have brought in a member of the ‘Fit For Work Coalition’ and the neo-liberal think tank the World Economic Forum, to carry out a review of the brutal assessments for sickness and disability benefits.

Dr Paul Litchfield will replace Professor Malcolm Harrington who was sidelined after being mildly critical of the Work Capability Assessment (WCA), the relentless health and disability tests which have driven some claimants to suicide.”

‘dns Disability News Service’ reported on Dr Litchfield’s appointment (13 Dec. 2013):

‘Fitness for work’ test: government ‘should start again from scratch’

<http://disabilitynewsservice.com/2013/12/fitness-for-work-test-government-should-start-again-from-scratch/>

“Disability charities appear to be losing patience with efforts to reform the much-criticised “fitness for work” test, as the government’s new independent reviewer delivered his first report.”

The ME Association reported on Dr Litchfield’s Independent Review of the WCA:

“We report on the fifth and final Independent Review of the Work Capability Assessment 28 November 2014”

<http://www.meassociation.org.uk/2014/11/we-report-on-the-fifth-and-final-independent-review-of-the-work-capability-assessment-28-november-2014/>

“Dr Charles Shepherd reports on a meeting at the DWP on Thursday November 27 at which Dr Paul Litchfield gave a presentation on the fifth and final independent review of the Work Capability Assessment (WCA).”

Extracts:

‘ESA outcomes of WCA: Quarterly official statistics’

“I would also draw attention to the latest quarterly statistics on ESA produced by the DWP: www.gov.uk/government/uploads/system/uploads/attachment_data/file/352885/esa_wca_summary_Sep14_final.pdf

In particular, the most striking change that has been taking place between 2008 and 2013 (provisional figures) is in the numbers of people being found:

- ***FIT FOR WORK:*** 2008 = 64%; 2013 = 27%
- ***UNFIT FOR WORK AND PLACED IN THE WRAG:*** 2008 = 24%; 2013 = 15%
- ***UNFIT FOR WORK AND PLACED IN THE SUPPORT GROUP:*** 2008 = 12%; 2013 = 58%

So there has clearly been some effect as a result of the changes that have been made and the work that both Dr Litchfield and the Fluctuating Conditions Group and Mental Health Groups have been doing – especially the emphasis on the need for claimants to be able to do descriptor tasks reliably, repeatedly, safely and in a timely manner. Anecdotal feedback to The MEA also indicates that there ARE more people being placed in the support group and that less people are having to go to appeal.

But many people with ME/CFS, who have a genuine claim to this benefit, are still having to go to appeal in order to obtain ESA.”

J). CRITICISM OF THE WCA FROM THE UK MEDICAL PROFESSION

Over the years there has also been increasing criticism of the Work Capability Assessment by senior and also less senior members and spokespersons from the British medical profession. It was also the British Medical Association that spoke out clearly against the WCA and how it is being applied and thus causes serious harm to many of the sickest, the disabled and with that the weakest in society. In the following I present various links to critical and condemning reports and statements from various stake holders, also quoting professionals in the medical field:

1. The British Medical Association states this about the WCA:

<http://bma.org.uk/working-for-change/negotiating-for-the-profession/bma-general-practitioners-committee/priorities/work-capability-assessment>

Extract from a publication on their website:

“The Work Capability Assessment”

“Background

The Work Capability Assessment (WCA) is the method used to judge whether claimants are eligible for the Employment and Support Allowance.

The system, first introduced in 2008, is currently administered by ATOS healthcare. As part of the assessment, ATOS will sometimes request a factual report from a claimant’s GP based on the information contained within the claimant’s patient medical report.

It is not part of the GP’s role to provide any opinion or recommendation on the patient’s capability to work as part of this process.”

„BMA position

The BMA has for some time raised concerns about the WCA. We believe that the current process is insufficiently rigorous and consistent, and could cause avoidable harm to some of the weakest and most vulnerable members in our society.”

“The BMA has called for urgent reform to the WCA based on specific concerns about the system:

- *The computer-based process used to assess claims makes it very difficult for health professionals carrying out the assessments to exercise their professional judgement effectively. **We strongly believe the computer system is in need of urgent reform.***
- *The fact that initial decisions are overturned in almost 40 per cent of appeal cases reinforces these concerns. It means that large numbers of claimants are denied the full level of benefit that they are entitled to until their appeal is heard and a fresh decision is made, leaving many in an intolerable position.*
- ***That there has been a lack of progress in implementing the recommendation of the Harrington Report that decision makers should actively consider obtaining further documentary evidence in every case before reaching a final decision. If the recommendation is implemented appropriately, with GPs providing factual information, it should result in better-informed decisions being made about eligibility for ESA by DWP decision makers, earlier in the process. As well as making the system fairer for claimants, this should also significantly reduce the administrative cost of dealing with so many appeals.”***

The following link provides a MS Word document containing a **BMA briefing on the WCA to the UK Parliament** (from January 2013):

bma.org.uk/-
/media/files/word%20files/working%20for%20change/negotiating%20for%20the%20profession/wcabriefing.docx

2. 'My Fibromyalgia' published this on their website (fr. 23 May 2012):

<http://www.myfibromyalgia.co.uk/2012/local-conference-of-the-british-medical-association-votes-against-atos-the-wca/>

'Local conference of the British Medical Association votes against ATOS & the WCA'

3. The Royal College of Psychiatrists publishes this on the WCA:

"The Work Capability Assessment and people with mental health problems: the case for better use of medical evidence"

<http://www.rcpsych.ac.uk/policyandparliamentary/welfarereform/workcapabilityassessment.aspx>

A joint statement the College published with other agencies:

<http://www.rcpsych.ac.uk/pdf/WCA%20Medical%20Evidence%20joint%20briefing%20April%202012%20V%20FINAL.pdf>

4. 'Benefit Claimants Fight Back' published a letter by various stakeholders, support groups and also leading doctors, incl. the BMA (27.09.2011), see this link:

<https://benefitclaimantsfightback.wordpress.com/open-letter-on-atos-healthcare-to-the-bmj-and-rcn/>

Extract:

"Open Letter on Atos 'Healthcare' to the BMJ and RCN"

"27 September 2011"

*"Dr Michael Chamberlain Chairman, BMJ (British Medical Journal) Group Board
Andrea Spyropoulos, President, Royal College of Nursing"*

"Dear Dr Chamberlain and Andrea Spyropoulos",

"Re: Atos Healthcare and parent company Atos Origin"

"As sick and disabled people, carers and other concerned people, including professionals, we are writing to you to urge the Royal College of Nursing and BMJ Group to immediately end your relationship with Atos, including stopping any advertising of Atos jobs or Atos the company on your websites, and not having Atos at the [RCN Bulletin Jobs Fair](#) 13-14 September, or the [BMJ recruitment fair](#) 30 September to 1 October 2011 in London.

As you know, Atos currently has a £100m a year contract with the Department for Work and Pensions (DWP) to carry out examinations for disability benefits.

We are outraged that Atos is profiting from denying those of us who are sick or disabled, the benefits we need to survive and maintain our level of health. In May, at the protest outside Atos headquarters, a number of people spoke about our experiences of the examination,

being denied benefit and having to appeal to get it back. One woman testified that her brother, who had severe depression, committed suicide after being cut off. See:

<http://www.guardian.co.uk/society/video/2011/may/11/disability-protest-atos-origin-video>

The media have exposed more of the dire consequences of Atos' decisions. In February, the Daily Mirror highlighted the case of a Derbyshire man with a heart condition, found fit for work, who had to go through tribunal to appeal, then was awarded Employment and Support Allowance (ESA) but died of a heart attack the day before his next Atos exam was due.

A Channel 4 News report on 27 July 2011 acknowledged what thousands have been saying: it interviewed the heartbroken partner of a critically ill man whom Atos denied his entitlement on grounds that he was 'fit for work' – he died less than three months later. How many more people have died following such cruel and callous treatment? The coverage was prompted by a Parliamentary report from the Work and Pensions Committee of MPs, in which they criticised Atos. Atos the powerful multinational has taken vindictive action against disabled people and carers' websites where it is criticised, getting sites closed down which isolated people rely on for support."

5. The website called 'Grannie's Last Mix' 'Letters from Desolation Row UK', published this extract from a British Medical Journal (BMJ) publication, quoting a letter from Dr Greg Wood, former naval doctor and former ATOS assessor, then whistle blower, about the WCA:

<https://sparaszczukster.wordpress.com/tag/general-medical-council/>

'Another Doctor Speaks Out Publicly Against Atos Work Capability Assessments'

Extract:

"PERSONAL VIEW"

"I blew the whistle on the government's disability assessments"

"Greg Wood former naval doctor and Atos disability analyst."

"Greg Wood went to the media with concerns about the ethics surrounding tests for fitness to work—and eligibility for benefits—that the UK government outsourced to Atos

Actually, two whistleblowers went public before me, and several other doctors have raised concerns anonymously. I am a former general practitioner in the Royal Navy, where work related assessments are bread and butter stuff. The UK Department for Work and Pensions (DWP) devised the work capability assessment (WCA) to judge whether people who receive out of work sickness benefits could, in fact, cope with most forms of work. A more stringent test came into use in 2011, and the government made no secret of the fact that it hoped this would boost the labour market, improve people's self esteem and personal income, and, of course, reduce government debt.

For many years the information technology and "business process outsourcing" company Atos has had a contract, now worth £100m (€116m; \$155.4m) a year, to carry out several social security benefit assessments, including the WCA, for the Department for Work and Pensions. In my view this risks tension between doctors' professional concerns on the one hand and business imperatives on the other.

The WCA had a troubled childhood. From early on, claimants and disability groups were reporting problems. They felt the assessment was a box ticking process, where medical assessors spent most of their time punching superfluous lifestyle data into the computer. And the likely outcome as they saw it? Computer says no. In fact, the test, on paper at least, isn't

too bad, though it isn't going to win anyone a Nobel prize. But it cannot adequately take into account health conditions that fluctuate unpredictably, and it tries to include too broad a range of jobs. Driving, call handling, shelf stacking, data entry, and cleaning, for example, are all theoretically covered. And although the test is nominally a pre-employment medical test of sorts, it is really still about measuring the person's level of disability. In early 2013 the WCA was still causing a rumpus in public, despite a series of external reviews."

One problem that dawned on me over time was the widespread use of five ill conceived so called rules of thumb that were promulgated during the training of new assessors. On one, manual dexterity, the guidance was just plain wrong. The training said that this all boiled down to an inability to press a button, whereas the regulations allow points to be awarded when there are difficulties forming a pinch grip, holding a pen, or operating a computer. The other "rules of thumb" showed a combination of discrepancies and questionable interpretations of medical knowledge — for example, moving from one room to another at home was supposed to be equivalent to moving 200 metres. The effect was to reduce a claimant's likelihood of entitlement to financial help. Another concern was the absence of documentary evidence, which, in my experience, occurred in about a fifth of assessments."

(First published by the BMJ Publishing Group Ltd in 2013)

***I strongly recommend you read the rest of that letter on their website, and a supportive letter by Dr Glyn Phillips, GP, dated 23 August 2013. ***

K). INFORMATION ABOUT THE WCA, CRITICISM OF IT AND THE DWP - BY SUPPORT GROUPS, A TRIBUNAL UNIT AND THE MEDIA

As already mentioned and presented above, there has been endless criticism of the WCA, the DWP and ATOS Healthcare. The WCA has had a fair share of negative reporting, and this continued over the years of its use. Support groups and increasingly also media published information and critical reports on the WCA. Below is just a small sample of these:

1. 'Rethink Mental Illness', website publication – 'factsheet':

'Work Capability Assessment'

<http://www.rethink.org/living-with-mental-illness/money-issues-benefits-employment/work-capability-assessment>

For downloading the PDF 'factsheet', try this following link:

www.rethink.org/resources/w/work-capability-assessment-factsheet

2. From the website 'Birmingham Tribunal Unit':

'The Work Capability Assessment (WCA)'

<http://www.btu.org.uk/guide-docs/44-the-work-capability-assessment-wca>

3. 'The Mirror' reported on 04 April 2012:

'32 die a week after failing test for new incapacity benefit'

<http://blogs.mirror.co.uk/investigations/2012/04/32-die-a-week-after-failing-in.html>

Extract:

"More than a thousand sickness benefit claimants died last year after being told to get a job, we can reveal.

We've [highlighted worries](#) about the controversial medical tests for people claiming Employment Support Allowance which are being used to slash the country's welfare bill.

The Government has boasted that more than half of new claimants are found "fit to work" - failing to mention that over 300,000 have appealed the decision and almost 40% have won. Instead, employment minister Chris Grayling (below) says this "emphasises what a complete waste of human lives the current system has been".

"We've used the Freedom of Information Act to discover that, between January and August last year, 1,100 claimants died after they were put in the "work-related activity group".

This group - which accounted for 21% of all claimants at the last count - get a lower rate of benefit for one year and are expected to go out and find work.

This compares to 5,300 deaths of people who were put in the "support group" - which accounts for 22% of claimants - for the most unwell, who get the full, no-strings benefit of up to £99.85 a week.

We don't know how many people died after being found "fit to work", the third group, as that information was "not available".

But we have also found that 1,600 people died before their assessment had been completed. This should take 13 weeks, while the claimant gets a reduced payment of up to £67.50 a week, but delays have led to claims the system is in "meltdown".

4. The Guardian, 'Breadline Britain', report from 20 June 2012:

'Mental health of benefit claimants is put at risk by welfare reform'

"Work capability assessments, which identify those fit for work, are singled out for criticism by health professionals, campaigners and claimants"

<http://www.theguardian.com/society/2012/jun/20/mental-health-benefit-claimants-risk>

Brief extract:

"At the centre of the controversy is the [work capability assessment](#) (WSA), the test carried out in the UK by the French healthcare firm [Atos](#) that is designed to identify people on incapacity benefit who are "fit for work". Critics say it fails to pick up complex and fluctuating conditions such as mental health. It is widely feared by vulnerable claimants – and for those who are found fit for work, it can trigger a long, stressful cycle of appeals."

5. The Guardian reported on 16 December 2013:

"Ministers 'ignored advice on inhumane fit-for-work tests' "

"Welfare adviser says he wanted a delay to work capability tests but government pressed ahead with reassessments"

<http://www.theguardian.com/politics/2013/dec/16/ministers-ignored-advice-fit-for-work-tests>

Extract:

"A government [welfare](#) adviser has suggested thousands of ill and disabled people were subjected to "inhumane and mechanistic" fit-for-work tests after ministers ignored his advice not to push ahead immediately with plans to reassess 1.5 million claimants on incapacity benefit.

Professor Malcolm Harrington told the Guardian he believed the work capability assessment (WCA) was "not working very well" when the coalition took power in 2010, and he told ministers a big expansion of the scheme should be delayed for a year to enable the tests to be improved.

Harrington, an occupational health specialist who carried out three official reviews of the WCA between 2010 and 2012, said: "If they had changed the system to make it more

humane I would suggest that some of the people who went through it would have had a less traumatic experience."

Ministers pressed ahead with the reassessment of long-term incapacity benefit (IB) claimants in May 2011, despite Harrington's warnings and campaigners' concerns that the system was flawed. The test has since become politically controversial. Critics say it is crude, inaccurate, discriminates against mentally ill claimants, and causes widespread stress, anxiety and even suicidal feelings among claimants."

6. The Guardian, 27 March 2014:

'Atos quits £500m work capability assessment contract early'

<http://www.theguardian.com/society/2014/mar/27/atos-quit-work-capability-assessment-contract-early>

Extracts:

"Atos will receive no compensation and has made 'substantial financial settlement' to DWP for early termination of contract"

"The contract with Atos to administer millions of fit-for-work tests for sick and disabled people a year is ending early, the government has announced.

The £500m agreement to carry out work capability assessments had been due to end in August next year but following widespread public and political anger over the tests, which have been criticised by MPs and campaigners as crude and inhumane, the agreement will now end early next year.

There has been mounting evidence that hundreds of thousands of vulnerable people have been wrongly judged to be fit for work and ineligible for government support. The Department for Work and Pensions (DWP) said that the decision had been reached after "joint negotiations" with Atos. Ministers had been in private discussions with the company since the summer over the quality of its operation but if the government had terminated the contract it would have been faced with a penalty payment.

Mike Penning, the minister for disabled people, said: "The previous government appointed Atos as the sole provider for carrying out work capability assessments and since then we have carried out several independent reviews and made significant improvements to the assessment.

"Today we are announcing that we are seeking a new provider to replace Atos, with the view to increasing the number of assessments and reducing waiting times"."

7. The Guardian, 11 June 2014:

"Work capability assessment system at 'virtual collapse', says judge"

<http://www.theguardian.com/society/2014/jun/11/work-capability-assessment-collapse-benefits>

"Robert Martin, outgoing head of benefits appeal tribunal, says DWP was too optimistic about conducting fit-to-work tests"

L). THE MAN AND MIND BEHIND THE 'ALL WORK TEST', THE 'PERSONAL CAPABILITY ASSESSMENT' - AND CONTRIBUTOR TO THE 'WCA'

Very instrumental in the introduction of the 'All Work Test' as the earlier form of a work capability test used in the UK was **Professor Mansel Aylward**. He also helped develop the 'Personal Capability Assessment' used by the DWP, and had his own indirect input into the

WCA, which is simply a further development of the earlier assessments. See details about Professor Mansel Aylward published on the website of 'Public Health Wales':

<http://www.wales.nhs.uk/sitesplus/888/page/64606>

Extract from the website profile:

*"He is also **Director of the Centre for Psychosocial and Disability Research** at Cardiff University which offers a unique opportunity to extend knowledge and understanding of the psychosocial, economic and cultural factors that influence health, illness, recovery, rehabilitation and reintegration."*

*"From 1996 to April 2005 he was **Chief Medical Adviser, Medical Director and Chief Scientist** to the UK's **Department for Work and Pensions**. He was also Chief Medical Adviser and Head of Profession at the Veterans' Agency, Ministry of Defence. From 2001 - 2009 he was The Royal Society of Medicine's Academic Sub Dean for Wales.*

He is a physician and specialist in rheumatology and rehabilitation, therapeutics and clinical pharmacology; a visiting Professor at several universities in Europe and North America and a **consultant to the United States Social Security Administration and Department of Labour.**

He entered the British Civil Service in 1985 and was appointed Chief Medical Adviser at the Department of Social Security in 1996 and at the Department for Work and Pensions in 2000. From 1974 to 1984 he was Chairman and Managing Director of Simbec Research Ltd, UK, and President of Simbec Inc, New Jersey USA.

He played a key role in development and evaluation of the UK's medical assessment for incapacity (the All Work Test), and was heavily involved in developing the Personal Capability Assessment (PCA). He led the Corporate Medical Group on the UK Government's Welfare Reform initiatives and made a major contribution in establishing the new postgraduate diploma for doctors in Disability Assessment Medicine. He was closely involved in developing the UK's successful "Pathways to Work" initiatives and a framework for Vocational Rehabilitation."

Re 'Department of Social Security' (DSS) see:

http://en.wikipedia.org/wiki/Department_of_Social_Security

Re 'Department for Work and Pensions' (DWP) (created 08 June 2001) see:

http://en.wikipedia.org/wiki/Department_for_Work_and_Pensions

More information about Mansel Aylward, and his somewhat suspicious, peculiar connections to the controversial health and disability insurance corporation 'Unum' can be found in a great Guardian article from 17 March 2008 titled 'E pluribus Unum', by Jonathan Rutherford:

,E pluribus Unum'

<http://www.theguardian.com/commentisfree/2008/mar/17/epluribusunum>

"James Purnell's reforms of incapacity benefit are inspired by a US company with vested interests and a murky record. Now, that's really sick"

Extract:

"The history of the work capability assessment provides some answers. In 1994, the Tory government hired John LoCascio, second vice-president of giant US disability insurance company, Unum, to advise on reducing the numbers successfully claiming IB. He joined the

"medical evaluation group". Another key figure in the group was Mansel Aylward. They devised a stringent "all work test". Approved doctors were trained in Unum's approach to claims management. The rise in IB claimants came to a halt. However, it did not reduce the rising numbers of claimants with mental health problems. The gateway to benefit needed tightening up even more.

In 1999, New Labour introduced its first Welfare Reform Act. All new claimants had to attend a compulsory work focused interview. Mansel Aylward, now chief medical officer of the DWP, devised a new personal capability assessment (PCA). The emphasis was no longer on entitlement, but on what a person is capable of doing. The task of administering the PCA was contracted out and is now run by the US corporation Atos Origin. Its computerised evaluation of claims driven by clearance time targets has resulted in significant numbers of rejected claims, particularly for those with mental illness.

Unum has built up its influence in Britain. In July 2004, it opened its £1.6m [Unum Centre for Psychosocial and Disability Research at Cardiff University](#). The company appointed Mansel Aylward as director following his retirement from the DWP in April. The launch event was attended by Archie Kirkwood, recently appointed chair of the House of Commons select committee on work and pensions. Malcolm Wicks, minister of state in the DWP, gave a speech praising the partnership between industry and the university.

The aim of the centre is to transform the ideology of welfare and so help develop the market for Unum's products. In 2005, the centre produced a monograph *The Scientific & Conceptual Basis of Incapacity Benefits* (TSO, 2005) written by Aylward and his colleague Gordon Waddell. It provides the framework for the 2006 welfare reform bill. Its methodology is the same one that informs the work of Unum."

Own Comments re Mansel Aylward

Professor Mansel Aylward has been a leading promoter of the idea and the related theories that "work is good for health", supposedly even "therapeutic". His position is that sick and disabled would be better off working, in jobs on the open employment market, where they would "contribute" to society, are "active" and thus "participate" socially, and represent less of a burden to society. He claims that many health conditions and various conditions or degrees of impairment - due to injury or a more congenital nature, could be "treated" better by having the persons that have them go and work.

His now often quoted "research", which may in some respects look convincing and even follow some scientific study principles, does though by looking at it more closely reveal, that it was mostly conducted on reading other literature, other medical, economic and social statistical reports, and drawing his conclusions out of perceived "correlations". An apparent association or "correlation" between two sets of data, or two conditions, does though not necessarily give clear, convincing information on whether one is the cause of the other. Presentations used by Mansel Aylward, and some that support his theories, do reveal, that there is some evidence of hand-picked, selected data being used to make a certain point. The claim seems to be that "worklessness" is bad for health, is actually causing "serious harm", and is therefore aggravating already poor health, and adding further ill health. Aylward and like minded "experts" attempt to argue that sick, injured and disabled should not be allowed to take time off to recover and rest for too long, as a return to work would be more "therapeutic". There is only marginal acceptance that much work may also be harmful to health, and no consideration appears to be given to the fact, that is may rather be some moderate, safe physical and mental activity that has the beneficial effect on health, helping sick and disabled "recover". That may be proper advice to give, rather than send them out to find work on an already very competitive job market, where many suffer endless stress, anxiety and many other conditions, due to so much work being insecure and precarious.

Also may the actual cause for much ill health, disease and further incapacity, that is associated with long term unemployment, rather be found in the POVERTY that comes with not being able to work and earning a good enough income to live. And in any case, the attempts by Aylward et al, to blur the lines between the severities that certain conditions may have, to then facilitate “work capability assessors” to classify more sick and impaired as “fit for work” (on the open market), these are ethically questionable approaches. They expose many with serious enough health conditions and disability to risks that they will face, by being expected to go and find work, and then maintain it, while it is often very hard for the fit and healthy people to do so. Encouraging welfare agencies, administered by governments, to also tighten benefit entitlements, and pay the affected lower benefits, is equally questionable.

Here is an earlier post that reveals and presents ample other information on Mansel Aylward, his like minded medical professional colleagues, his “research” and the on the medical and work capability assessments in the UK, to some degree now followed in New Zealand:

<http://nzsocialjusticeblog2013.wordpress.com/2013/09/02/medical-and-work-capability-assessments-based-on-the-controversial-bio-psycho-social-model/>

M). AYLWARD, WADDELL ET AL, ALL WORKING ON THE SAME AGENDA

Besides of Professor Mansel Aylward, there has been repeated reference to, and mention of, a number of his colleagues with similar research interests and also views. Some like **Professor Gordon Waddell** have also worked at the ‘**Centre for Psychosocial and Disability Research**’ at Cardiff, once “sponsored” by ‘UnumProvident’ health and disability insurance company, others have more indirect affiliations. They all share a strong, supportive position on the supposed “**health benefits of work**”, are very critical of the state and consequences of “*worklessness*”, and interpret the “*biopsychosocial model*” in a way, where much in the way of illness is suspected to be merely having its origin in people’s minds.

The following presents a list of interesting publications by Dr Gordon Waddell, Kim Burton, Mansel Aylward, Peter Halligan and John LoCascio (once with UNUM), that give insight into their research theories and thinking behind them.

Also perhaps see and read this post on a blog from 11 August 2006:

<http://www.benefitsandwork.co.uk/news/143-us-medical-scandal-company-at-heart-of-uk-welfare-reform>

Relevant publications of special interest that deserve much scrutiny and that should be treated with some scepticism re their actual scientific reliability and value:

One of the publications by Dr Gordon Waddell, who also closely worked with Dr Mansel Aylward, both based at the ‘Centre for Psychosocial and Disability Research’ at Cardiff University, is the following:

‘IS WORK GOOD FOR YOUR HEALTH AND WELLBEING?’, Gordon Waddell and A. Kim Burton, 2006:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214326/hwwb-is-work-good-for-you.pdf

Further publications by “experts” from that Centre, all apparently designed to “blur” the conventional lines in medical science, and to “soften” the resistance that there may have been, to accept these controversial “new findings” that their research delivered, are these:

‘MODELS OF SICKNESS AND DISABILITY’, Aylward and Waddell, 2010:

<http://www.craigliebenson.com/wp-content/uploads/2010/08/Models-final-proofs2.pdf>
“**APPLIED TO COMMON HEALTH PROBLEMS**”

'The Scientific and Conceptual Basis of Incapacity Benefits', G. Waddell and M. Aylward, not freely available via the internet, but available as a book, 11 Oct. 2005:
<http://www.amazon.co.uk/Scientific-Conceptual-Basis-Incapacity-Benefits/dp/011703584X>

A **presentation** that is now used to serve as an **"evidence base"** for conducting radical social security reforms in relation to health and work ability assessments is this one:

'REALISING THE HEALTH BENEFITS OF WORK', Mansel Aylward, presentation, RACP (Royal Australasian College of Physicians) and AFOEM, Australia and NZ, May 2010:
<http://www.racp.org.nz/page/racp-faculties/australasian-faculty-of-occupational-and-environmental-medicine/realising-the-health-benefits-of-work/may-2010-video-presentation-professor-sir-mansel-aylward/>
www.racp.org.nz/index.cfm?objectid=58C41516-C2D1-1FF1-8CC71B74C8444FB3

That presentation contains summarised selectively chosen statistics and **"research findings"**, all prepared to "convince" the medical professionals, their organisations and governments "Down Under" (in Australia and New Zealand)!

'The Power of Belief', *'Psychosocial influences on illness, disability and medicine'*; edited by Peter W. Halligan and Mansel Aylward (see short book extract), Oxford University Press:
<http://ukcatalogue.oup.com/product/academic/medicine/9780198530107.do?sortby=booktitleascend>

'Malingering and illness deception', a book by Peter Halligan, Christopher Bass and David A. Oakley, "enthusiastically" supported by Mansel Aylward, Oxford University Press, 2003*:
http://www.meactionuk.org.uk/Malingering_and_Illness_Deception.pdf

* See and read Mansel Aylward's own "contribution" in this publication, from page 287 on. Also John LoCascio (once with Unum) provides a "contribution" from page 301 onwards.

To understand the significance of the above publication, read 'Vox Political' on this:
"Found: The book that helps the government smear the sick as 'malingers' ", fr. 04 Aug. 2014 (posted by Mike Sivier):
<http://voxpolygonline.com/tag/mansel-aylward/>

Please also take note of this fact:

Professor Peter Halligan, who published various controversial reports on mental health, also worked with Professor Mansel Aylward at Cardiff University in Wales. See this link:

<http://psych.cf.ac.uk/contactsandpeople/academics/halligan.php>

He is based at the 'School of Psychology', at Cardiff University in Wales, and his "School" has worked closely with Mansel Aylward's "Centre for Psychosocial and Disability Research" based at the same university!

Here is reference to more of his "publications", much apparently pre-occupied with "malingering" and similar behaviours:

<http://orca.cf.ac.uk/58314/>

'Factitious disorders and malingering: challenges for clinical assessment and management'

See Professor Halligan's LinkedIn profile:

<http://uk.linkedin.com/pub/peter-w-halligan/21/43a/91a>

It says in the summary on the front page (as on 17.01.2015):

“Dean of Interdisciplinary Studies at Cardiff University from 2006 until 2012. Professor Halligan joined the School of Psychology as Distinguished Research Professorial Fellow from Oxford University where he was a Research Fellow working in the Departments of Clinical Neurology and Experimental Psychology.”

Since joining Cardiff, he has played a central role in establishing Cardiff University Brain Research Imaging Centre (CUBRIC), Wales Research and Diagnostic Positron Emission Tomography Imaging Centre (PETIC), Wales Institute of Cognitive Neuroscience (WICN), **the UnumProvident Centre for Psychosocial and Disability Research**, the Cardiff Cognitive Neuroscience Seminar Series, School of Psychology MindArt project, Haydn Ellis Distinguished Lecture Series and the Cardiff University Research Institutes.”

N). FORMS OF WORK CAPABILITY ASSESSMENTS IN USE IN NEW ZEALAND

1). ACC’s “Functional capacity evaluation”

So far there has in New Zealand not been a similar approach taken to use a single, points based functional assessment like the WCA in the UK. But there have been and are other kinds of assessment processes, like for instance one called ‘**functional capacity evaluations**’ that ACC (the Accident Compensation Corporation) uses, and which have been conducted by special service providers that ACC use:

Details re this are found on their website, see this link:

<http://www.acc.co.nz/for-providers/contracts-and-performance/all-contracts/WCMZ002169>

Extract from the ACC website:

“Overview”

“A task-specific functional capacity evaluation is a structured process of observing and measuring an individual performing tasks in order to identify performance deficits and safety issues, functional abilities, strengths, skills and capacity to perform specific work-related tasks.

The provider will provide assessment services to ACC claimant’s referred to the provider by a case manager.”

“Purpose of the service”

“The purpose of the task-specific functional capacity evaluation is to provide the case manager with base-line information about a claimant’s ability to reliably and safely sustain specified tasks.

The Task-specific functional capacity evaluation is an assessment undertaken by the provider in respect of a claimant’s ability to sustain specified job tasks which have been identified by the case manager in the referral.

It differs from a full functional capacity evaluation in that a provider is not required to identify suitable vocational tasks or determine broad occupational functioning abilities in respect of the claimant.”

“● A task-specific functional capacity evaluation involves four components:

- reviewing the history
- interviewing the claimant
- observing the claimant undertaking specific tasks, which have been identified in the referral from the claimant's case manager, and
- conducting a variety of measurements while the claimant performs the specific duties/tasks of the claimant's job.

● Task-specific functional capacity evaluations are tools to assist the development or implementation of a rehabilitation plan. They are not stand-alone assessments and must always be used in conjunction with other sources of information about the claimant. Task-specific functional capacity evaluations are useful adjuncts to the delivery of pro-active and positive case management, leading to a safe and durable return to employment, work readiness or independence in activities of daily living.

● The purpose of purchasing task-specific functional capacity evaluations is to:

- provide case managers with access to task-specific functional capacity evaluation services which are cost-effective, provided in a safe environment, and delivered in a timely manner
- support sustainable and measurable improvements in claimant's rehabilitation and return-to-work, work readiness or independence outcomes
- match claimant capabilities to specific identified work tasks where possible
- identify the maximum level of functional performance relating to specific tasks which acts as a point from which to build rehabilitation
- assist rehabilitation planning and implementation
- enhance objectivity in the rehabilitation and return-to-work process, and
- determine the occupational functional ability of the individual claimant to perform specific occupational tasks.

● Task-specific functional capacity evaluation reports are time-limited documents reflecting what a claimant can do at a particular point in time. For most claimants, task-specific functional capacity evaluation reports older than six months should not be relied on to predict performance.

2). ACC's 'Initial Occupational Assessment' and 'Initial Medical Assessment'

Other assessments that ACC use are briefly outlined and explained in the following:

Of particular interest is an official document found via this link:

'Vocational Medical Assessors', 'Operational Guidelines', ACC, October 2008:

http://www.google.co.nz/url?sa=t&rct=j&q=&esrc=s&source=web&cd=3&cad=rja&uact=8&ved=0CCgQFjAC&url=http%3A%2F%2Fwww.acc.co.nz%2FPRD_EXT_CSMP%2Fidcplg%3FidcService%3DGET_FILE%26dID%3D59660%26dDocName%3DPRD_CTRB093519%26allowlInterrupt%3D1&ei=DxrHVOOjA8fd8AW2-YHqBQ&usq=AFQjCNEc9EXo28qo_xWetvSAgV-RVWmcVQ&bvm=bv.84607526,d.dGc

Two main types of assessments are explained in this operational guide (fr. pages 7 -8):

"The Initial Assessments (IOA and IMA)

Initial Occupational Assessment (IOA)

The purpose of the IOA is to:

- Assess the client's skills, experience and ability to undertake employment

- Identify suitable types of work for the client based on their education, experience, pre-incapacity earnings, and training
- Complete a work type detail sheet for each suitable work type.

Initial Medical Assessment (IMA)

Purpose of the IMA

The purpose of the IMA is to produce a report that ACC uses to determine the client's vocational rehabilitation needs and direction. It requires the medical assessor to consider the types of work that have been identified in the IOA and give an opinion on whether any of the types of work are, or are likely to be, [medically sustainable](#) for the client.

The tasks on the work type detail sheet must be considered against the client's post-injury condition, and the sheets used with the Department of Labor Physical Demand Characteristics of Work (see [Appendix 7](#) on page 47 for an example) which defines the terms used by occupational assessors and includes the terms occasional, frequent, and constant with the percentages of the workday, as well as physical demands such as sedentary, light, medium, heavy, very heavy, and the typical energy required.

If the type of work is only **likely** to be sustainable, the report needs to show evidence of the rehabilitation the client will need in order to carry out the identified type(s) of work.

Assessors to list their qualifications

As experts it is important that medical assessors specify their qualifications. This should include all qualifications and experience relevant to the type of report they are writing. In terms of the information considered and the history obtained, the assessor should:

- Identify the documents sent to them by ACC or other sources, eg the client
Note:
If the assessor needs more information from ACC, they should request this from the client service staff member who referred the client to them.
- Detail who attended the assessment, eg support person or lawyer and what input they had, if any
- Identify elements of the history given by, or obtained from, other parties
- Highlight any relevant inconsistencies in the history and information.

For the examination and clinical findings, medical assessors should:

- Document the time taken for the assessment
- Document all the aspects of the examination – it is easy to omit parts of the routine clinical examination, eg pertinent normal findings
- Describe all tests performed – detail reduces the potential for later dispute.

When commenting on the types of work, medical assessors should:

- Comment on the adequacy or otherwise of information provided on the tasks involved in the types of work
- Focus on the generic aspects of the tasks
- Give reasons why a type of work is, or is not, medically sustainable – a simple list is not sufficient
- Tie the reasoning back to the examination findings, the comments and input of the client, and the information provided
- Include comments on the [non-injury related conditions](#), and the impact or otherwise on medical sustainability or the client's capacity to undertake work
- Provide recommendations for treatment/rehabilitation that could assist the client in sustaining a work type, eg pain management, work trial.

The [IMA](#) must determine whether the [types of work](#) identified by the IOA are, or are likely to be, [medically sustainable](#). This is required under [Part 4 section 89](#) of the AC Act.

See also [Qualifications required for Occupational and Medical Assessors](#) on pg 4.”

The following document, found online, from July 2013, contains some more current information on the above types of assessments:

'Initial Medical Assessment and Vocational Independence Assessment', 'Guidelines for Providers', ACC, July 2013:

http://www.acc.co.nz/PRD_EXT_CSMP/groups/external_providers/documents/guide/prd_ctrb_093519.pdf

That Guide does (perhaps not that surprisingly, given the intense efforts by particular "experts" to influence politicians, government agencies and medical professional organisations) also contain this familiar, very revealing bit of information (from **page 28**):

"9. Employment and Work Ability"

"Employment and Health

There have been numerous studies on the effects of employment on a person's physical and mental well being.

In 2006 Waddell and Burton published "Is Work Good for Your Health and Well Being?"¹ in which they examined the role of employment in the wellbeing of individuals, their families and their communities and also looked at the association between worklessness and poor health. They found a strong evidence base that work is generally good for physical and mental health and well-being and that worklessness was associated with poorer physical and mental health.

They also found that work could be could be therapeutic and could reverse the adverse effects of unemployment in the majority of healthy people of working age as well as for sick and disabled individuals and they should be supported and encouraged to remain in or to re-enter the work force as soon as possible because of the benefits.

We do need to remember this evidence in assessing the fitness for work and the relative enhancement of health."

And in relation to these kinds of assessments used by ACC, there are also a number of discussion threads on ACC Forum, debating the policy and practices that ACC has in recent years been following. One highly disturbing development was what was later identified as being their commonly called "exit strategy" for long-term, complex costly claims. Here are two links to relevant discussion threads:

Re **'Functional Capacity Evaluation'** (from 31 January 2008)

<http://accforum.org/forums/index.php?/topic/6175-functional-capacity-evaluation/>

Re **'ACC Limiting Choice For Initial Medical Assessment'** (fr. 15 May 2009)

<http://accforum.org/forums/index.php?/topic/7761-acc-limiting-choice-for-initial-medical-assessment/>

Own Comments

In relation to the above, it is of interest that the **capacity evaluation** or assessment is here only about "**task specific**" functions. So this is not a full functional capacity evaluation. ACC also has more comprehensive assessments, but what intrigues us here, is that a "case manager" may specify what tasks and necessary functions to perform them may need to be evaluated. This is a selective, somewhat narrowed down approach, which can leave an affected ACC claimant exposed to unreasonable presumptions and expectations by a case

manager, who may try and seek any hypothetical functional ability a person has, that may be considered sufficient to expect the person to find some particular forms of work. Whether it is a realistic and reasonable expectation is another question.

The **'Initial Medical Assessment' (IMA)** and **'Initial Occupational Assessment' (IOA)** are more comprehensive, traditional types of assessments, gathering medical, occupational and various other information on the claimant, including past work, education, and social and environmental details. At least for the IOA the "biopsychosocial" approach for assessments is being used. ACC offer support for rehabilitation, and expect claimants to participate where reasonably possible, and efforts are made to establish types of work that a person may be able to perform, for usually at least 30 hours a week.

These assessments and evaluations may generally follow similar approaches as used in the UK, but are still rather different to the WCA itself. The ACC assessments are conducted by using existing medical and other records, and by interviewing the claimant with targeted questions, to which the answers will be noted down and analysed. It appears that all these various evaluations and assessments have over time been updated to integrate the same "*findings*" that are so often quoted, by Waddell, Burton and Aylward et al, from the school of thought, which insurance companies, state welfare agencies and others now prefer to rely on. **The emphasis is on work ability, rather than disability**, and medical factors that may in the past have given reason to categorise a person as not having capacity for work are increasingly being given less credit, as theoretically and hypothetically every person can still perform some kind of functions, to potentially "*work*". The fact that the many limited functions so many people with injuries, with permanent, serious physical and mental health conditions have, and that do not realistically enable them to do jobs on the employment market, is treated as not relevant. **Existence and availability of employment is not meant to be part of the consideration for the assessors.** Through re-assessments of existing conditions and cases, and strict assessments for future cases, an increasing number of persons are thus considered "*fit for work*", and put on welfare or other support, that is at a lower rate, and which has some forms of work obligations attached to them. **It is again the main agenda to simply save costs.** People that suffer from frequent or permanent pain, or other symptoms, will be expected to either use condition management practices or to take medication.

A decision based on evaluations and assessments done for and by ACC can be challenged through the ACC review process. ACC claimants still have the chance to take matters further to the courts, which WINZ clients can only do if a Medical Appeal Board made a decision that was wrong in law, so a judicial review may be possible.

3). Work Ability Assessments now also conducted for Work and Income + MSD

Following the major welfare reforms with the implementation of the **'Social Security (Benefit Categories and Work Focus) Amendment Act'** (in 2013), the Ministry of Social Development and their department Work and Income NZ have in early 2014 also introduced **'Work Ability Assessments'** for clients with ill health, injuries and forms of disability. They introduced a range of newly contracted service providers that are commissioned to assess the probably more complex cases of clients for their ability to perform certain work.

There is though not one single type of "assessment" or "test", nor a clearly defined set of medical criteria or guidelines that have been published, that would give any public insight into how such 'Work Ability Assessments' have to be conducted. There is NOTHING shedding any light on what medical or occupational standards and guidelines are used when conducting these assessments. This is hard to believe, especially since there was some serious concern about this during the Select Committee hearing process, the Readings and the passing of the **'Social Security (Benefit Categories and Work Focus) Amendment Bill'** in 2012 to 2013. But it was only briefly reported on during the "Select Committee" process.

It appears though that the Members of Parliament and their political parties have failed to further examine and follow up this completely irresponsible and unacceptable lack of transparency and information. This serious failure may be due to the fact, that the leading opposition Labour Party did during their last term in government (until late 2008) plan to implementing similar, only slightly more moderate welfare reforms, that included new ways of “assessing” sick and disabled for their fitness for work. Smaller parties may have lacked the human and other resources, or sense of urgency, to conduct their own investigations.

The only tangible, but highly summarised, general information that can be found on ‘**Work Ability Assessments**’ through an internet search is found by clicking the following links:

For general information on the ‘Work Ability Assessment’ and its purpose:

<http://rnzcgp.org.nz/work-and-income-update-on-work-ability-assessment/>

<http://rnzcgp.org.nz/assets/documents/News--Events/Work-Ability-Assessment-Questions-and-answers-3.pdf>

For information on the ‘self assessment questionnaire’ that WINZ clients now have to complete as part of their application for benefit support, and for maintaining support:

<http://www.workandincome.govt.nz/online-services/myaccount/help/self-assessment.html>

For a PDF file copy of the ‘self assessment questionnaire’ itself:

<http://www.workandincome.govt.nz/documents/forms/self-assessment-questionnaire.pdf>

And again, **some very general, brief information on such assessments**, offered by one of the contracted service providers ‘**Linkage**’ (as part of the ‘Wise Group’):

<http://www.linkage.co.nz/services/work-ability-assessments>

For information for clients that claim ‘**Jobseeker Support**’ from Work and Income, re their **obligations**:

<http://www.workandincome.govt.nz/individuals/obligations/obligations-for-getting-jobseeker-support.html>

Further other important info of relevance can be found via these links:

‘*Social Security (Benefit Categories and Work Focus) Amendment Act 2013*’:

<http://www.legislation.govt.nz/act/public/2013/0013/latest/DLM4542304.html>

‘*Social Security (Benefit Categories and Work Focus) Amendment Bill 2012*’:

http://www.parliament.nz/en-nz/pb/legislation/bills/00DBHOH_BILL11634_1/social-security-benefit-categories-and-work-focus-amendment

All evidence and submissions presented on that Bill to Parliament:

http://www.parliament.nz/en-nz/pb/sc/documents/evidence?custom=00dbhoh_bill11634_1

The Select Committee Report on the submission hearings and discussions:

http://www.parliament.nz/en-nz/pb/sc/documents/reports/50DBSCH_SCR5776_1/social-security-benefit-categories-and-work-focus-amendment

[www.parliament.nz/resource/en-](http://www.parliament.nz/resource/en-NZ/50DBSCH_SCR5776_1/8c96283ba5105e2776ac6c6c449518a168b0a164)

[NZ/50DBSCH_SCR5776_1/8c96283ba5105e2776ac6c6c449518a168b0a164](http://www.parliament.nz/resource/en-NZ/50DBSCH_SCR5776_1/8c96283ba5105e2776ac6c6c449518a168b0a164)

Further comments

During the welfare reform process, there was some mention made by some senior staff at the Ministry of Social Development, and by the then Minister for Social Development (Paula

Bennett), that they had looked at how ACC was working with rehabilitating injured persons that claim support from that state run corporation. So it appears that some approaches have been taken over from ACC, but we have little reliable, clear, detailed information about how such assessments are done, what processes are followed, and what guidelines they use.

This astonishing fact, that medical and now also especially work capability assessments conducted for 'Work and Income' and MSD seem to lack any clear set of standards and guidelines, is extremely disturbing. **Despite of all its faults, the WCA in the UK has at least offered some clarity with the activities and descriptors used, although this was applied in a very negative and harmful way.** No such clarity exists here in New Zealand, with the way how MSD and WINZ have their contracted providers conduct and deliver assessments on "work ability".

At least some insightful information has been gathered and published in a range of posts that are found on this blog-site via the following links:

<http://nzsocialjusticeblog2013.wordpress.com/2014/06/21/work-ability-assessments-done-for-work-and-income-a-revealing-fact-study-part-a/>

<http://nzsocialjusticeblog2013.wordpress.com/2014/06/22/work-ability-assessments-done-for-work-and-income-a-revealing-fact-study-part-b/>

<http://nzsocialjusticeblog2013.wordpress.com/2014/06/22/work-ability-assessments-done-for-work-and-income-a-revealing-fact-study-part-c/>

<http://nzsocialjusticeblog2013.wordpress.com/2014/06/22/work-ability-assessments-done-for-work-and-income-a-revealing-fact-study-part-d/>

<http://nzsocialjusticeblog2013.wordpress.com/2014/06/22/work-ability-assessments-done-for-work-and-income-a-revealing-fact-study-part-e/>

<http://nzsocialjusticeblog2013.wordpress.com/2014/06/24/work-ability-assessments-done-for-work-and-income-a-revealing-fact-study-part-f/>

<http://nzsocialjusticeblog2013.wordpress.com/2014/06/25/work-ability-assessments-done-for-work-and-income-a-revealing-fact-study-parts-g-and-h/>

<http://nzsocialjusticeblog2013.wordpress.com/2014/06/26/work-ability-assessments-done-for-work-and-income-a-revealing-fact-study-part-i/>

O). THE CONCLUSIONS THAT NEW ZEALANDERS SHOULD DRAW FROM THE DISASTROUS WELFARE REFORMS IN THE UK, WHERE THE FLAWED AND HARSH APPROACHES HAVE NOT DELIVERED, AND WHERE THE WCA IS NOW DISCREDITED

For New Zealand and New Zealanders, the abundant information presented in this comprehensive blog contribution should make it absolutely clear, that the radical, rather draconian welfare reforms introduced under the last National Party led government here in New Zealand have been based on extremely poor "research" and "advice". The very persons behind the development of the WCA in the UK, first and foremost Professor Mansel Aylward, also "advised" the New Zealand government (Paula Bennett as Minister), and the Ministry of Social Development on welfare reforms. Mansel Aylward and Dame Carol Black (who adopted many of Dr Aylward's and his close colleague's "findings" into her reports), BOTH of them "advised" the appointed, so-called '**Health and Disability Panel**' (which was again "advising" the then Minister and New Zealand government) on the "value" of the "research" into the "**health benefits of work**". A senior role within that 'Health and Disability Panel' was also played by **Dr David Beaumont**, formerly of **Atos Healthcare** in the UK, who has over the years provided sometimes controversial "advice" on ACC review cases, and who runs his own 'Pathways to Work' business here in New Zealand. He is now also the **President of the AFOEM** (Australasian Faculty of Occupational and Environmental Medicine), and **was instrumental in having Mansel Aylward introduce his "findings" and recommendations on the "health benefits of work" into the AFOEM** and with that the New Zealand and Australian medical science professions.

It was the same ideas and approaches that culminated in the introduction of the WCA in the UK, that lie behind the new approaches taken here, in the area of “work ability assessment”. Only because the widely reported harm and damage done by the even more draconian, rigorous welfare reforms and assessments in the UK alerted some media and disabled support groups here in New Zealand, could similar harm be avoided here. They raised questions which the New Zealand government appears to have become concerned about. Yet instead of completely abandoning the new approach, to look rather at what sick and disabled “can do”, than what they “cannot do”, the planned new systems and approaches were given some tweaks, and then still introduced. While in the UK there is at least some clarity with the WCA they use, **in New Zealand there are NO clear standards, legally binding guidelines or “tests” in use, that determine how in particular assessments for “work ability” should be conducted.** Despite of earlier promises by the Minister, there has to date not been any transparency on how doctors or other health professionals - tasked with conducting such assessments for WINZ - are supposed to do their work, and what criteria should be applied. We have a vague, “discretionary”, almost secretive case by case approach, where sick and disabled appear to be “experimented” with, to establish, whether they can do some work on the open market, or not.

As the welfare reforms in New Zealand were introduced and implemented in a rushed manner, relying on insufficiently researched and partly even blatantly biased, unsubstantiated “advice” and reports, they deserve relentless scrutiny and re-examination. The way the reforms were introduced, with a lack of sufficiently convincing, reliable and actually truly independent research and advice, this totally discredits the whole reform approach, and should lead to at least the most draconian measures being immediately reversed. **The information provided in this post and research summary shows again, how a close circle of UK based “experts”, led by controversial Professor Mansel Aylward, and supported by vested interest parties, managed to use concerted efforts and effectively influenced policy formation and implementation.** The background of Aylward and others, their links to **UnumProvident**, and their various “experts” and “research”, cast a dark shadow of doubt about the supposedly “independent” and “evidence based” advice the New Zealand Government received and accepted. While the UK and DWP are now going as far as reconsidering and reviewing the ESA and WCA, further changes here should be avoided - or actually rather be put on an immediate hold. **The New Zealand Government would be well advised to wait until more reliable, objective research is done and completed, by independent researchers, before they proceed with their radical reforms to “support” or rather PRESSURE sick and disabled into questionable, potentially unsuitable employment on the competitive job market.**

It may indeed be a more constructive approach, to perhaps seriously consider the introduction of a Universal Basic Income (UBI), which would be topped up by specific supplements for persons with particular extra needs, such as sick and disabled unable to work. That would abolish the requirement for those having serious health conditions and suffering incapacity to “**prove**” that they are “*deserving*” of financial support, and save an enormous amount of administrative costs. What is certainly needed is a truly science based, proven, fair, respectful and reasonable assessment regime, to have persons with health conditions and disabilities examined for work ability. It would be more constructive to design a smarter welfare system that does away with the punitive, sanction driven approach we have now, and offers sensible, constructive incentives for persons to seek suitable employment, while also introducing legal responsibilities for employers to offer work for such people. At the same time more recognition must be given to voluntary work person may do. What is also more than overdue is the introduction of a different, truly independent, competent and fair review system for those that disagree with WINZ assessment outcomes. The present appeal system offered by the ‘Social Security Act 1964’ (to be “re-written” very soon), is not meeting basic natural justice requirements, and Medical Appeal Boards must not be appointed by MSD staff anymore. A proper further appeal stage must be introduced, to allow persons to take their cases to at least a form of Tribunal, like in the UK, or to the courts as such, not just in the form of judicial review. Also would an official investigation into

the use, training and management of “Designated Doctors” be appropriate, given serious questions about their “independence” in making recommendations.

The present systems in New Zealand and the UK leave much to be desired, and an overhaul of systems is certainly something we need. On this note, I close this post with thanks to the readers for their interest and shared concerns. Those that can take action, please lobby for change and make submissions on any prospective legal and other reforms we may face.

Quest For Justice

31 January 2015

(updated on 05 Feb. 2015)

P). APPENDIX

Here is a list of other publications that reveal more of the truth behind the “reforms”:

<http://nzsocialjusticeblog2013.wordpress.com/2013/09/02/medical-and-work-capability-assessments-based-on-the-controversial-bio-psycho-social-model/>

<http://nzsocialjusticeblog2013.wordpress.com/2013/09/07/the-health-and-disability-panel-and-its-hand-picked-members/>

<http://nzsocialjusticeblog2013.wordpress.com/2013/12/28/designated-doctors-used-by-work-and-income-some-also-used-by-acc-the-truth-about-them/>

<http://nzsocialjusticeblog2013.wordpress.com/2014/10/19/nz-finance-minister-bill-english-insults-beneficiaries-with-mansel-aylwards-work-will-set-you-free-approach/>

<http://nzsocialjusticeblog2013.wordpress.com/2014/06/21/work-ability-assessments-done-for-work-and-income-a-revealing-fact-study-part-a/>

<http://nzsocialjusticeblog2013.wordpress.com/2014/06/22/work-ability-assessments-done-for-work-and-income-a-revealing-fact-study-part-b/>

<http://nzsocialjusticeblog2013.wordpress.com/2014/06/22/work-ability-assessments-done-for-work-and-income-a-revealing-fact-study-part-c/>

<http://nzsocialjusticeblog2013.wordpress.com/2014/06/22/work-ability-assessments-done-for-work-and-income-a-revealing-fact-study-part-d/>

<http://nzsocialjusticeblog2013.wordpress.com/2014/06/22/work-ability-assessments-done-for-work-and-income-a-revealing-fact-study-part-e/>

<http://nzsocialjusticeblog2013.wordpress.com/2014/06/24/work-ability-assessments-done-for-work-and-income-a-revealing-fact-study-part-f/>

<http://nzsocialjusticeblog2013.wordpress.com/2014/06/25/work-ability-assessments-done-for-work-and-income-a-revealing-fact-study-parts-g-and-h/>

<http://nzsocialjusticeblog2013.wordpress.com/2014/06/26/work-ability-assessments-done-for-work-and-income-a-revealing-fact-study-part-i/>

<http://nzsocialjusticeblog2013.wordpress.com/2014/10/04/advice-to-winz-beneficiaries-facing-medical-examinations-and-work-ability-assessments/>

<http://nzsocialjusticeblog2013.wordpress.com/2014/10/05/work-has-fewer-health-benefits-than-mansel-aylward-and-other-experts-claim-it-can-cause-serious-harm/>