PART A: INTRODUCTION (Policy, History, Training and Role of Designated Doctors)

Over the last couple of years I have been able to collate some highly interesting information from sources like Work and Income (‘WINZ’) clients, advocates, bloggers, certain internet websites, the media and part-time researchers. It includes documents and some other
information that could be found by researching past and present media reports, also reports and online manuals from the Ministry of Social Development (‘MSD’) and WINZ websites, through looking at various other websites on the internet, and last not least also by way of Official Information Act (O.I.A.) requests.

The information discloses what the Ministry of Social Development and WINZ have been doing in the areas of medical examinations, assessments and reviews by commissioned "designated doctors". It includes some valuable other information about medical appeals to Medical Appeal Boards (MABs), and it shows, that the MSD did during 2008 conduct a nation-wide "training program" for the "designated doctors", who they use for getting second opinions, assessments and recommendations on recipients of, or applicants for, sickness and invalid's benefits (now called “deferred jobseeker” and “supported living” benefits).

A television “expose” (or documentary) on what has been going on at ACC (‘60 minutes' programme, TV3 on 09 Sept. 2012, available via 'On Demand' or ‘You Tube’) showed what appalling strategies were followed there. It was revealed that ACC targeted complex, high cost claimants, by using preferred, hand-picked medical assessors, to prepare reports that favoured ACC. Cost saving appeared to come before proper rehabilitation, treatments and compensation, so they used a kind of "exit strategy" to off-load thousands of such claimants, who in many cases ended up having to apply for invalid's or sickness benefits. I am afraid that very similar developments have occurred with Work and Income as part of the MSD, leading to former invalid's beneficiaries having been shifted onto the lower paid sickness benefit, and former sickness beneficiaries been shifted onto the former unemployment benefit.

I wish to provide you with some informative details about the use of so-called "designated doctors", who are expected to perform similar tasks as ACC assessors in this summary report (with relevant resources).

The information available is somewhat complex, and regrettably requires a bit of study and reading to grasp of what has, still is, and what will continue to be done in the areas of medical assessments, reviews, "designated doctor" examinations, Medical Appeal Board hearings and the likes. But I have attempted to summarise it all to keep it within a reasonable amount of information to digest.

A-1) SOME HISTORICAL BACKGROUND INFORMATION:

Major social welfare reforms came into effect in July 2013. They have led to some changes of the law and processes. WINZ are continuing to apply an ever more rigorous, yes very questionable approach, as they have already done since at least 2008. With the introduction of the Future Focus policies in 2010 the criteria for being considered sick, disabled and thus incapacitated to do any work, has been tightened substantially. **WINZ expect their own Health and Disability Advisors, and the “designated doctors” they regularly use and work with, to now primarily look at what a client CAN DO, rather than what they CANNOT DO!** That is of course a bit of a “catchy” but ambiguous phrase, and naturally it can lead to subjective ways of diagnosing and assessing persons, as to what they can individually do or not do when it comes to any work activity.

The MSD has long been concerned about the growth of sickness and invalid's beneficiary numbers, and hence looked at possible ways to contain the trend of more persons qualifying and going onto these types of benefit. The following extract from a report by Dr Neil Lunt, published in the **‘Social Policy Journal of New Zealand’**, from March 2006 (Issue 27), under
the section headline ‘The background to reforming SB and IB’, page 82 gives a brief insight, of what moves were made under the then National led government in the 1990s:

“National’s Welfare to Work brand (Player 1994, Ministry of Social Policy 2001) saw a new approach to medical certification for SB and IB. National’s attempts at reform saw the introduction of the Designated Doctor Scheme in September 1995, with designated doctors having responsibility for assessing benefit eligibility, certifying applications for SB at 13 and 52 weeks, and certifying grants for IB, and recommending a possible review (12, 18, 24 months). From 1998, there was an alignment of SB rates with UB rates for new grants and the introduction of the Community Wage in place of UB and SB. In October 1998, the designated doctor review scheme was revised and doctors signing the certificate were able to certify SB for four weeks and then at 13-week intervals. For IB, designated doctors certify the granting of a benefit, with review being recommended by these doctors for two years, five years, or never. During the first part of 1999, there was also the trial of work capacity assessment for those with sickness, disability, or injury. A Phase one trial was undertaken but Phase two was never completed. The work capacity process for IB and SB sought to identify the level of work, if any, a beneficiary was capable of, and to determine what assistance would help them move into paid work (abridged from Wilson et al. 2005:4–5 Table 1.1).”

The National government of that time did plan to introduce “work capacity assessments”, but this was never implemented, as there was another change of government in 1999, thus putting a stop on National’s welfare plans, which were aimed at restricting welfare access, placing much stronger individual responsibilities on persons on benefits, and enforcing more obligations for them to seek and stay in work, or do training.

The same report from Dr Neil Lunt from 2006 described this in the following section (p. 83):

“These approaches sought to narrow the gateway to benefits and to ensure those with work capacity did not avoid the obligations that were at this time being placed on other groups of beneficiaries, including those in receipt of UB and Domestic Purpose Benefit. I would argue that the approach was individualised and an underpinning assumption saw “problems” as located in individual claimants, particularly in their attitudes towards work and unwillingness to meet their obligations.”

It appears therefore that the first use of so-called “designated doctors” - as we now know them - started with the introduction of that “Designated Doctor Scheme” mentioned above. Prior to that separate examinations and assessments for the earlier Department of Social Welfare (DSW, later WINZ) appear to have been made by certain specialist doctors, if there were uncertainties in host (own) doctor assessments. The writer of that report I quoted from, states that the approach introduced by the government then “saw “problems” as located in individual claimants, particularly their attitudes to work…””. This indicates that the reforms introduced then were an attempt to include a somewhat judgmental, yes possibly prejudicial approach, based on the belief, or view, that persons claiming sickness or invalid’s benefits were claiming these, rather for avoiding work obligations, than being seriously sick or disabled, although medical certificates were required by the then ‘Department of Social Welfare’ to prove that the latter applied.

With a change in government, and a new approach that was taken from 1999 onwards, more supportive and inclusive ways were being proposed and introduced, largely based on a “social model” for dealing with disability and incapacity. The launching of the ‘New Zealand Disability Strategy’ ‘Making a World of Difference’ (New Zealand Disability Strategy 2001)
created a new platform to work from. The Labour government followed a “modern” style welfare policy, with an “investment approach” targeted to assist individual WINZ clients with sickness and disability to achieve better outcomes for themselves, by enhancing employability. “Enhanced case management” was brought in, same as some “Innovative Employment Assistance” initiatives. By about 2005/2006 the then Labour led government decided to follow a yet more “active” approach, which was also somewhat inspired or motivated by new reports and approaches presented in the United Kingdom. I will get to what that meant a bit later. Also were there plans for introducing “single core benefits” from as early as 2007, consisting of one set of rates and one set of eligibility criteria for benefits, but with add-ons to support people who have higher costs such as accommodation or disability-related – whether in or out of work.

Some of these policies were never realised, but trials were run, leading to certain initiatives to be implemented nationally, as this following section from the same report (pages 86-87) mentioned above shows:

“There has long been a concern about gateways into SB and IB and particularly the most appropriate locus of responsibility for certification. This was an area that subsequent National and Labour governments have sought to address. Most recently, the government has allowed local general practitioners and case managers to seek a second opinion where doubt exists about new and continued eligibility for SB, thus pre-empting patient “capture” that is said to result from close or longstanding personal relationships between claimants and their doctors. This initiative was piloted in the Wellington region with national rollout starting from June 2005. There is also enhanced guidance for general practitioners to “improve the management of inflow” onto SB (Maharey 2005b).”

The following chapter from the same report (page 92-93) shows how much the British welfare changes were also given serious consideration by the last Labour government:

“Healthy Welfare”

“Ongoing engagement with the medical profession is likely to be required to clarify general practitioners’ roles of clinician, advocate, and adjudicator in relation to health and wellbeing. Overseas evidence also suggests general practitioners’ views about work sickness depends on a general practitioner’s own personal views, patient characteristics, time available, expertise in occupational health, and views about continuity of care (Mowlam and Lewis 2005). General practitioners often feel pressured and are also inclined to take the wider views of claimants/patients into account, perhaps not wanting to commit them to searches for scarce work or where services are poor (Social Market Foundation 2005). A fuller notion of employability clearly encompasses the supply, demand and matching of labour (Lunt 2006).

It seems likely that prevention and managing long-term sickness-related absence will be increasingly important areas, with medical practitioners encouraged to do more to help workers stay in and retain work.”

From the same report’s “footnotes” on “designated doctors” (page 82) this is quoted:

“Designated doctors assess a person’s medical eligibility for the Invalid’s Benefit. Under current regulations, “Designated Doctors must be registered with the New Zealand Medical Council and hold an annual practising certificate. Designated Doctors must be fully informed about their responsibilities under the Social Security Act 1964”.
And here is the title and link to the quoted report that can be found on the MSD website on the internet (copies can be downloaded in MSD Word and PDF format):

‘Sickness and Invalid's Benefits: New Developments and Continuing Challenges’


By Neil Lunt, Social Policy Programme, Massey University at Albany:

“Abstract

The proportion of the working-aged population receiving an Invalid’s Benefit (IB) has increased steadily between 1994 and 2004, and numbers on a Sickness Benefit (SB) rose sharply in the early 1990s and have continued to increase between 2000 and 2005. New Zealand has witnessed considerable policy activity in the field of SB and IB, as well as disability policy more broadly. To date, there has been relatively little attention paid by academic commentators to the increased emphasis on working actively with SB and IB clients. This is despite the fact that the new directions signalled for SB and IB constitute nothing less than a paradigm shift. At the heart of change is the move beyond individuals – beyond focusing on either their disability or their lack of motivation.”

Also of interest is this separate report, which elaborates on the growth of the invalid’s benefit, also mentioning “reforms” and measures taken by governments, involving also the “designated doctors”. Copies can be downloaded in MSD Word and PDF format:

‘Understanding the Growth in Invalid’s Benefit Receipt in New Zealand’


By: Moira Wilson, Keith McLeod, Centre for Social Research and Evaluation, Ministry of Social Development:

“Abstract

This paper reports on research that uses the Ministry of Social Development’s benefit administration data to advance our understanding of the growth in the number of people receiving the Invalid’s Benefit over the decade to 2002. It investigates the growth in inflows of people to Invalid’s Benefit, as this was the main cause of growth in recipient numbers.”

Of interest will also be the “official” WINZ website information on “designated doctors”:


“Work and Income have established a panel of respected medical practitioners to provide second opinions on medical information – designated doctors. The provision of a second opinion assists Work and Income to determine a person’s capacity for work and entitlement to financial assistance. It also assists us with helping people to move towards employment.”
A-2) CHANGES TO THE USE OF DESIGNATED DOCTORS AND INTRODUCTION OF HEALTH AND DISABILITY ADVISORS:

From the above information it can be seen that MSD and WINZ have been using “designated doctors” under both National and Labour governments, and the involvement of these nowadays actually carefully selected medical professionals has fluctuated.

The clear intention was to use them to find ways to gather more information on clients with health conditions and disabilities, but also to offer additional measures to increasingly “assist” or “usher” WINZ clients back into work or training.

Already under the last Labour led government a stronger work focus was gradually adopted for beneficiaries from as early as 2005 on, this leading to introducing some new processes, rules and ways to assess and “assist” applicants, and consequently even more intensive efforts in 2007 and 2008. This was largely based upon the advice of senior policy making staff and management within MSD.

Following reforms under National in the 1990s the number of “designated doctors” reached over 1,000, although only a small number of them would handle most examinations and reviews. Still in 2007 a memo from MSD states they had 1,090 on their books. About then WINZ still had about 115 psychiatrists, a number of other specialists, but only 3 psychologists in their pool. 226 were only on the “general register”, and 224 “designated doctors” were then based in hospitals. The number of “designated doctors” was so high then, because until about that time a “designated doctor” recommendation was usually asked for (by case managers), before any person was granted an invalid’s benefit. Only a much smaller number were used to examine and assess those on (or before being granted) sickness benefits (for “second opinions”). Only barely half of “designated doctors” were then vocationally registered and based in general practice clinics. In 2005 or perhaps 2007 only 41 “designated doctor” GPs wrote 26 per cent of all reports (according do a 2007 memo).

After the Labour government introduced the ‘Principal Health Advisor’ (PHA) and ‘Principal Disability Advisor’ (PDA) positions, which were filled by appointed persons like Dr David Bratt and Anne Hawker. Both were then put in charge of overseeing, mentoring and instructing Regional Health Advisors (RHAs), Regional Disability Advisors (RDAs) and Health and Disability Coordinators (HDCs) sitting in the regional offices of MSD and WINZ.

Following the appointment of those Principal Health and Disability Advisors, the Regional Health Advisors and Regional Disability Advisors, as well as so-called Health and Disability Coordinators in late 2007 and in 2008, changes were brought in by way of a new medical certificate and by changing the way of using “designated doctors”. They were after then intended to be used rather only for providing “second opinions”, rather than for making initial assessments on potential, new invalid’s beneficiaries, or those being reviewed. Also was the intention to keep and recruit rather vocationally registered practitioners, mostly only GPs, rather than the wider pool of partly not sufficiently experienced and registered practitioners. More balance from region to region was anticipated, and RHAs, RDAs and HDCs were being involved in finding and encouraging GPs - and a few other suitable practitioners - to apply to become “designated doctors”, where there may be a perceived shortage of them. Case managers would also be involved in finding out where shortages existed, and what kind of doctors would be “suitable” for WINZ and MSD.

The result would afterwards be a much smaller pool of “designated doctors”, most of who would though be vocationally registered (and better qualified and experienced). But given the
increased coordination and cooperation of the new MSD staff in the roles of RHAs, RDAs and HDCs (all overseen and instructed by primarily Dr David Bratt, and also Anne Hawker) and the medical practitioners, there would be “designated doctors” considered to be the more “preferred” ones for WINZ. Naturally certain “designated doctors” would be found to have a reputation to deliver certain outcomes, that senior MSD and WINZ staff would consider “helpful”, so it can be concluded, that an unofficial, but understandable “selection” would occur, where a small core of doctors out of the total pool of the “designated doctors” would end up with the larger work-load, given their “preferred expertise” or desired “output” in recommendations.

There appears to have been a somewhat new “culture” within MSD and WINZ in regards to the handling of medical examinations, assessments and reviews, that started to develop under the auspices of Dr David Bratt, who came to the Ministry after having worked as a kind of consultant at the Capital and Coast DHB. He is also known to have done work for ACC, same as a Dr David Rankin, who also worked for MSD.

It was in 2008 also certainly noticeable that there was a kind of media campaign that the National Party opposition appeared to be running, or at least was heavily promoting and driving, and Judith Collins was as their “welfare spokesperson” a main driver behind it, actually “feeding” media with endless National Party “press releases”. There had already been ongoing criticism by certain politicians and some others (likely with ulterior motives) about the fact that the number of persons on the sickness benefit had been increasing under Labour, while unemployment was as low as it had not been for over 16 years.

Various media reports, also from the NZ Doctor magazine, then claimed that there were many incidents of “doctor bullying”, where apparent drug addicts and some sickness beneficiaries were putting undue pressures on GPs to sign off medical certificates, so they could claim a benefit for health reasons. Apart from a questionable “survey” the actual number of such incidents was never clearly established, and there was never sufficient evidence provided, that this was ever serious, wide-spread behaviour. “Drug addicts” were thrown together with “sickness beneficiaries”, as if they belonged into the same “drawer”. Also was there never any proper information on what particular reasons may have been behind cases, where some behaviour perceived as “pressure” may have had occurred. No consideration was given to the possibility that some felt unfairly treated by doctors, some of whom could well have been working as “designated doctors” for WINZ.

One blog entry and comment thread on the (then less controversial) ACC Forum did actually cover these media reports, and the following link does lead you to that one:


From the ‘NZ Doctor’ magazine on 02 July 2008 Lucy Ratcliffe was quoted as reporting: “Just over a third of GPs polled say bullying is a serious concern for them and drug addicts and sickness beneficiaries are most likely to be the culprits.

The latest New Zealand Doctor/IMS Health faxpoll finds a third of GPs (33 per cent) say they’ve been bullied two to three times during their career in general practice, and just over a quarter (26 per cent) say it’s happened four to five times.

Eighteen per cent say they’ve been bullied more than 10 times and 6 per cent say it’s happened so many times they’ve lost count.”
It becomes clear that this “survey” asked “loaded” or ambiguous questions, so doctors referred to incidents “during their career”, which is likely to cover very many years in most cases!

Dr David Bratt did though appear to take up that issue with some passion and added his own comment to certain media reports on incidents, which were only quoting very few GPs. It will not surprise those who know more about Dr Bratt and his clearly biased views that the rounded survey result would later show up in many of his “presentations” that he regularly gives to GP conferences, other medical professional gatherings, to medical trainers and trainees, which are full of such hand-picked, insufficiently proved statistics.

A-3) DESIGNATED DOCTOR TRAINING:

Under Dr Bratt (a common GP from Wellington, with specialisation in obstetrics), who has been Principal Health Advisor since late 2007, WINZ and MSD soon even started "training" the so-called "designated doctors" that WINZ relies on for giving second opinions and conducting reviews of applicants' and sickness and invalid's beneficiaries' health conditions.

In a memo from T. Mulvena, ‘National Manager Strategic Projects’ at MSD and Work and Income, and Steve McGill, ‘National Manager Health, Disability and Financial Outcomes’, dated 27 June 2008 and addressed to ‘Regional Commissioners’, in which a “designated doctor” training program was proposed, it was stated, that “Work and Income has never provided training for designated doctors in the past.” Dr David Bratt as PHA and Dr David Rankin as ‘Senior Advisor’ were mentioned as supporting the move for “training”.

Officially this "training" was supposed to be "neutral" and "objective" and only intended to "assist" designated doctors to understand the WINZ and MSD system and certain administrative and other requirements, but there is sufficient information showing, that the very resolutely "work ability focused" Dr David Bratt has used presentation- and apparently also "training" material, which clearly has a strong, underlying bias to it. In another memo from 27 March 2006 Dr Rankin had already proposed to the ‘Working New Zealand - SDD’ department within MSD, that the role of “designated doctors” needed to be refined. He recommended in one points under his summary: “Designated doctors should be engaged through a robust selection process and be involved in regular training and education.” In other memos, like one from 05 June 2007, Dr Rankin suggested other changes, raising issues with the then present use and selection of “designated doctors”, and how a “robust” new GP Second Opinion service program should be rolled out. In this the roles of RHAs and RDAs (working under protocols and oversight by the PHA and PDA) were described, how they should be involved in client referrals to “designated doctors”.

Training sessions were held during late 2008 all over New Zealand, and the clear intention was to “train” all “designated doctors” that MSD and WINZ could reach. The new Health and Disability Coordinators (HDCs) were involved in supplying materials, contacting doctors, and so forth. “Training scenarios” and other material were used by Dr Bratt and Dr Rankin, who conducted the training, and looking at those shows that especially the “scenarios” and some “presentations” contained quite “biased” case scenarios and other information, which portrayed sick and disabled beneficiaries as tending to be dishonest, untrustworthy, shirkers, malingerers or exaggerators. Participating doctors were offered “medical education credits”, an “education fee” of $ 150 for participating, possible help with “travel arrangements”, and in some cases even with “accommodation”.

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Another internal MSD memo I have seen is from Debbie Costello and Barbara-Anne Stenson as Programme Managers, addressed to Dr Bratt, T. Mulvena and two others, and dated 23 January 2008. It outlines proposed measures, resources and approaches to take in the planned “Designated Doctor Training”, and on page 5 also says rather openly under ‘Costs will include’: “Food and non-alcoholic drinks would be provided on arrival, or to assist social networking after the formal presentation.” On page 3 the same memo states that: “Attending a training course should be compulsory for a doctor to remain a designated doctor.”

In yet another memo dated 19 November 2008 Dr Bratt wrote to Mike Smith, ‘GM Strategy and Service Development’ at MSD, that the fees paid to “designated doctors” doing examinations and giving recommendations on WINZ clients should be reviewed and “adjusted”. It appears that training session attendees expressed dissatisfaction with the way MSD would pay them for the assessments they provided. He refers to an established list of contract “Designated Doctors”. Clearly the WINZ “designated doctors” had expressed their concerns about the time required to complete assessments, which in 1995 was estimated to take only about 30 minutes, but which now was closer to 45 minutes per client. Also did Dr Bratt raise that “designated doctors” had experienced losses in revenue from assessments, as invalid’s benefit applications and reviews were now no longer regularly requiring reports from them. Dr Bratt did thus suggest that MSD increase the standard fee paid to “designated doctors” be increased to $ 180 per examination and report, plus an extra $ 60 for such a doctor for requesting an additional report from a client’s host or own doctor. Dr Bratt argued that GPs generally and on average earn (or charge) $ 250 an hour. Also did Dr Bratt state that over the 6 months until October 2008 DD reports asked for by WINZ increased by 60 per cent, due to the new approaches taken. I have no information on what increase was ever agreed to, but it must be concluded, that a significant increase occurred, as at one stage I heard of $ 136 per report being paid a few of years ago.

There are also memos and other information showing that Dr Bratt proposed training for ‘Medical Appeal Board’ members. The information shows that Dr Bratt was concerned about board members not focusing strictly and firmly enough on only medical conditions and relevant information on these, and on how health issues impacted on the ability to work. Some other concerns were about the selection of appropriate members, and that panel members were not supposed to “diagnose” or “examine” appellants, only question them and examine medical records and other relevant information to make decisions.

A-4) QUESTIONS ABOUT THE INDEPENDENCE OF DESIGNATED DOCTORS:

According to MSD's "official" policies and principles, and certainly according to the law, designated doctors doing reviews under the old sections 44 and 54B (3) and (4) of the Act (now sections 40C, and also 88E (4) and (5)), are supposed to be INDEPENDENT medical professionals providing only truly INDEPENDENT opinions, assessments and advice. Yet, how "independent" would such designated doctors be, while they get "trained", “hosted” and paid by the very agency asking them to provide "independent" opinions on clients and applicants dependent on welfare support from that agency?

This somehow goes down badly with the principles of natural justice and the law, does it not?

Information obtained under the O.I.A. discloses that almost all designated doctors are nowadays simply common GPs (general practitioners). There was in early 2011 NO psychologist available as a designated doctor, while the Social Security Act does in old sections 44 and 54B (3) and (4) (now ss 40C and 88E (4) and (5)) provide for a "choice"
(with good reasons) between a medical practitioner (a specialist doctor, registrar, psychiatrist or GP) and a PSYCHOLOGIST (to presumably examine mental health or psychological conditions and disabilities).

There were in 2011 also only 10 psychiatrists listed nationwide as designated doctors, which hardly meets the needs of sick and disabled with mental health problems, who would be spread across the whole of New Zealand. With about 30 to 40 per cent of invalid's and sickness beneficiaries at least partly having psychiatric, psychological and/or addiction issues, it is a rather dismissive approach by MSD, to rely largely only on common "generalist" doctors like GPs, when the vast majority of them have NO (or totally insufficient) expertise and qualifications in psychology or psychiatry.

I have been given information by persons affected, who were asked by WINZ case managers to undergo a review by a designated doctor. The Act does offer an affected client or applicant some input, because s 44 and s 54B (3) and (4) (now 40C, and also 88E (4) and (5)) speak of an agreement between WINZ and a client to be attempted on who to see as such a doctor. Yet in at least some (I dare to presume very many) cases, the client is NOT offered any choice and input, and rather gets told by a case manager who to see! That is a breach of the law. Only if there is no agreement at first between an affected client and WINZ, then can WINZ case managers (usually in consultation with a Regional Health or Disability Advisor) propose and appoint a particular "designated doctor". In many cases a client is only presented a short list of selected designated doctors to pick from, again not offered any sufficient input. In any case, it appears that MSD and WINZ have their preferred designated doctors, which I presume is, because they are more likely to make the decisions WINZ would prefer! A doctor I spoke with confided to me that he knows a colleague who does a very high number of reviews for WINZ. MSD have themselves records, proving that a small percentage of designated doctors handle a very large volume of examinations (assessments) for WINZ.

Also have there been issues with the appointments to so-called Medical Appeal Boards, who under old section 53A (now new s 10B) hear appeals by the former invalid's and sickness benefit recipients (now ‘Supported Living’ and ‘Jobseeker’ benefits), or applicants for those benefits. Applicants and benefit recipients can appeal against decisions by WINZ staff, that are based on a “designated doctor” recommendations, with which a client may disagree.

There is no further appeal possible after such a board makes a decision. Strangely also many “designated doctors” again sit on such boards, although not the same ones who conducted the disputed assessment or review. Members of such a board are appointed by MSD “medical appeals coordinators”, who are placed in their regional offices.

This is going on under the regime of MSD and their new Principal Health Advisor Dr Bratt, who believes that work is the best kind of "medicine" to assist sick persons on benefits to get well again. Since at least 2010, Dr Bratt appears to have felt very emboldened by the new approach under the new National led government towards social security - and welfare policy in general. He has shown this in the many “presentations” he has since then given, and comments he has made to the media and in public forums.

There is a presentation that Dr Bratt, in that instance “officially” together with his colleague Anne Hawker, that is called ‘Ready, Steady, Crook Are we killing our patients with kindness’, which was given to a GP conference in Christchurch in 2010. In it he makes bizarre statements like this one on page 13:
“Why these cases?
• in both a patient requested a specific “service” from you – and these have clinical or health consequences/outcomes – both positive and negative
• did you react the same way to each? – the drug seeker and the benefit seeker?
• and why?“

In the same presentation Dr Bratt then does in further comments on pages 20 (see reference to “opiates”), 21 and 35 link the medical certification for benefit purposes to promoting drug use - with the risk of causing addiction. It culminates in this extreme comparison:

“• the “benefit” – an addictive debilitating drug with significant adverse effects to both the patient and their family (whānau) – not dissimilar to smoking
• and NZ GPs write 350,000 scripts for it every year!”

On page 30 of that presentation (like others that followed) Dr Bratt lists the doctor patient relationship and patient advocacy as “barriers” to “managing health and work issues”!

Dr Bratt has since then continually linked benefit dependence to drug dependence, or made bizarre comparisons between the two. Also has he presented disputed, unproved statistical information, like that about “30 per cent” of GPs “had experienced a sense of threat and intimidation”! This appears to be based on questionable surveys conducted, like the one by ‘NZ Doctor’ magazine, asking ambiguous or too unspecified questions. He repeatedly claims that being on a benefit is as bad for your health as smoking 10 packets of cigarettes a day, and more dangerous than working in the most dangerous jobs (e.g. on an oil drilling platform in the North Sea).

Furthermore has Dr Bratt drawn substantially on supposed “findings” from UK “research”, like the ones conducted by the ones of Professors Gordon Waddell and Mansel Aylward, who both worked for the ‘Unum Provident’ sponsored ‘Centre for Psychosocial & Disability Research’, based at Cardiff University in the UK. Other similarly inclined “experts” like Wessely and Burton also get quoted. Financed by the highly controversial (and repeatedly convicted) US insurance giant, Aylward and Waddell prepared reports that serve as supposed “scientific” evidence, to prove that open employment is both “good for a person’s health” and even “therapeutic”. Much of the research is based on other reports and on statistics that appear to simply have been used selectively to prove a pre-conceived point and message. Their adopted position is that many mental illnesses, same as musculo-skeletal conditions that people suffer from, are mostly only “illness belief”, and therefore medically “unproved”. This “research” has been used by the Department of Work and Pensions in the UK, which was during Mansel Aylward’s employment there as Chief Medical Officer also repeatedly “advised” by the same insurance company, and which then led to disastrous consequences of welfare reforms there, resulting in over 1,100 deaths of those affected in 2011 alone. There is evidence of Professor Aylward’s long relationship to Unum Provident, and he was later appointed as the director of the mentioned “research centre”.
It is not surprising then to find references to those “findings” and other selected “research” in Dr Bratt’s many presentations, interviews and speeches. In this year Dr Bratt has even now started using presentations together with Professor Mansel Aylward, like one which was given to the annual ‘Rotorua GP CME’ in June 2013. Both spoke there and at some other conferences, and held a joint media interview with ‘NZ Doctor Magazine’. Both appear to be working closely together; and Professor Aylward has been advising MSD and the present government on welfare reforms, especially on how to assess and treat sick and disabled.

Below are some links to a presentation and some You Tube videos that show what “presentations” Dr David Bratt made to the Welfare Working Group Forum in 2010:


(this is the more "moderate version" in circulation, there is a longer presentation with more drastic "information" at the end of it!).

YOU TUBE CLIPS:
http://www.youtube.com/watch?v=R-2C6qL4eAs
http://www.youtube.com/watch?v=ItMY53sIyNQ
http://www.youtube.com/watch?v=XTSbI13V3UA
http://www.youtube.com/watch?v=0kv75ca8dts

Please check the You Tube website to see for other videos on Dr Bratt's Welfare Working Group Forum presentations (if any here are missing or double ups).

With the comprehensive, draconian and even discriminatory “welfare reforms” the present National led government brought in, and which are only just now being implemented, there are likely to be many more reviews and re-assessments of sick and disabled beneficiaries, and it is anticipated that there will be a much higher work load for “designated doctors”, who as said above, are "trained" by MSD and WINZ. The many “on site” training sessions in 2008 were only provided as a starting measure, and further training and consultations continued since then on an ad hoc, but also in an ongoing manner, mostly by online and information sharing, by discussions between RHAs and RDAs on the one hand, and “designated doctors” on the other hand. All is guided, mentored and managed by the PHA and PDA, where Dr Bratt though appears to be the main key person running the whole agenda.

Health and Disability Coordinators continue to be involved also, to liaise between all the advisors and medical and health professionals that are involved. Since early 2012 even the ‘Royal NZ College of General Practitioners’ (RNZCGP) has started additional study modules that are supposed to additionally train GP aspirants and already qualified GPs on special subjects like mental health, offering them more “qualifications” to assess and treat persons with such conditions. The ‘National Health Board’ and ‘Health Work Force NZ’ were also involved in developing this new study approach, and it is of concern, that Mansel Aylward and others have even been able to influence the ‘Australasian Faculty of Occupational and Environmental Medicine’ (AFOEM) and ‘The Royal Australasian College of Physicians’ (RACP), who released a “Consensus Statement” on the “Health Benefits of Work”.

See this link for the website with information:
(Please note – this link no longer works, as it only shows a ‘404’ error message)

Update: New links to relevant – and since 2013 changed - information on the RACP/AFOEM website, active 18 Oct. 2016:

It is clear that there is now a strong drive into one direction, and it is actually based on much less “evidence” than “experts” like Mansel Aylward, also former ATOS employee Dr David Beaumont (who advised ACC and MSD) and Dr David Bratt try to tell their colleagues and the public. These medical professionals that appear to have “hijacked” the medical profession with the help of corporate funding providers like UNUM Insurance, who have ulterior motives, are able to influence medical practice and training. It appears that the ultimate motivator is providing justifications and measures to achieve COST SAVINGS, and little else, by off-loading sick and disabled from benefits and from claims of insurance or ACC payments.

The present government in New Zealand, the Minister for Social Development and her Ministry have all taken on board what the mentioned “experts” and an increasingly bold and unashamedly biased Dr Bratt recommend, and with this in mind, one now has to view the whole involvement of “designated doctors” with utmost suspicion and scrutiny.

There appear to be breaches or at least inconsistencies of/with the Social Security Act, as there is nowhere any provision or reference made to "training" of “designated doctors” that are selected, commissioned and paid for by the Ministry. There certainly appear to have been many cases where natural justice has been - and is being breached, and there are likely to be many, many more in future. As most beneficiaries have little in the way of funds, get poor advice and lack information about their rights, most fully comply with requirements imposed on them. They’ll lack finances to access legal advice and support from lawyers, especially now, since access to legal aid has also been tightened and paid aid is often not even covering costs, as a lawyer informed me. Indeed the fear is justified that the lot of sick and disabled beneficiaries is going to get a lot worse.

As mentioned, the government and other involved health professional organisations (Health Workforce, RNZCGP) were aware of certain deficiencies with expertise of certain health professionals, they started a new training system for GPs in 2012. Additional modules of study and training in areas like "mental health" are supposed to give interested GPs and aspiring practitioners the option to add such modules to their program of study or training.

These are not in-depth studies, but the additional "qualifications" are supposed to give MSD also a chance to get away with using almost exclusively GPs as designated doctors.
for medical assessments and reviews, at the same time also involving them in treating low level mental health conditions (most likely by simply administering medications). That way they can claim the GPs have the needed "expertise" to also review and assess persons with mental health and/or addiction issues and resultant disabilities.

There is a fair amount of information about a lot of these matters, but of course I cannot and do not want to inundate you with it.

**In the following I will list some links to relevant information that can be found online:**

1) ‘Ready, Steady, Crook – Are we killing our patients with kindness?’
   http://www.gpcme.co.nz/pdf/GP%20CME/Friday/C1%201515%20Bratt-Hawker.pdf
   (presentation by Dr D. Bratt and A. Hawker, for Work and Income, to GP conference in Christchurch, 2010, see pages 13, 20, 21 and 35 for comparisons to drug dependence)

2) ‘Medical Certificates are Clinical Instruments Too!’
   http://www.gpcme.co.nz/pdf/2012/Fri_DaVinci_1400_Bratt_Medical%20Certificates%20are%20Clinical%20Instruments%20too%20-%20June%202012.pdf
   (GP presentation by Dr D. Bratt, 2012, see pages 3, 16 and 33 for his likening of benefit dependence to “drug dependence”)

3) ‘Shifting Your Primary Focus to Health and Capacity – A New Paradigm’
   (Prof. Sir Mansel Aylward, Director Centre for Psychosocial and Disability Research, Cardiff University; Dr David Bratt, Principal Health Advisor, Ministry of Social Development; joint presentation at GP CME Presentation – June 2013; questioning “traditional” diagnosis on a medical model basis, and promoting the Aylward version of the “bio psycho-social model”, and even promoting ‘Long Acting Reversible Contraception’ to improveemployability of women, see page 45!!)

4) ‘Happy Docs – true generalism with Welfare Reform’
   (RNZCGP Presentation – July 2013, with the usual one-sided information that “work is generally good for you“, trying to explain some welfare changes, but now avoiding the “benefit” to “drug” comparison, after media and other attention to this)

5) ‘Getting better at work’
   http://www.youtube.com/watch?v=vPNqBJ4n-x0
   (You Tube video with brief interview of M. Aylward and D. Bratt, by Lucy Ratcliffe from ‘NZ Doctor’, published on 10 July 2013)

6) ‘Pressure – No Pressure’ (How to deal with “pushy” patients)
7) ‘Harms lurk for benefit addicts’
(article in NZ Doctor magazine, by Lucy Ratcliffe, 01 August 2012, where Dr Bratt is again quoted with his preposterous claims about benefit dependence being like “drug dependence”, and that: “A UK study found of the main obstacles for going to work, medical problems made up just 3 per cent of the list.”)

**Please search online under the title for the still available article, if the link doesn’t work!**

8) In relation to point ’7’ see this comment by a reader (married to another doctor) on Dr Bratt's views, as presented earlier in the "New Zealand Doctor" magazine, 01 Aug. 2012: ‘Questioning the direction of MSD policy’, by Tim Walker-Nelson, 'New Zealand Doctor', 29 August 2012:

*****Please search online under the title for the still available article, if the link does not work!*****

9) MSD, ‘Regional Health Advisor’, position description, issued 2007
https://www.bfound.net/Company/210-20081217091658.pdf

***Note: The above link under ’9)’ no longer works and only shows an error message!***

Try this link for an original position description obtained by way of an O.I.A. request:

Here are three more recent job adverts for RHA positions:
https://nz.linkedin.com/jobs/view/12833345
(April 2014)
https://nz.linkedin.com/jobs/view/199755760
(Aug. 2016)
https://nz.linkedin.com/jobs/view/188757606
(Aug. 2016)

10) MSD, ‘EXTERNALS’ publication
(Issue 1 of “Externals” with introduction by PHA Dr Bratt and PDA Anne Hawker, and brief explanation of ‘Health and Disability Coordinators’, Nov. 2009)

***Note: The above link under ’10)’ no longer works and only shows an error message!***

Try these links for original position descriptions obtained by way of an O.I.A. request:
A-5) CONCLUSION:

What is happening at MSD and WINZ at the moment may "appear" to be reasonable to many in the public, but there is much more to it than most think. The appointment of the Social Welfare Board by Paula Bennett shows that she and her government selected certain persons, who have also a strong "business" and staunchly resolute "work capacity" focused approach in reforming welfare in NZ. The appointment by Dr David Beaumont to the Social Welfare Advisory Board, a former chief advisor for ACC, and responsible for many appalling decisions there, gives reasons for utmost concern!

Ultimately the goal is to get as many persons off benefits and into any types of “open employment” (on the market), which for sick and disabled will mostly be marginal, selected part time and casual work. The true agenda is cost saving, containing and possibly reducing beneficiary numbers, and the push to achieve this is now extremely forceful. It will cause immense pressures and in many cases actually harmful effects on person's health. I honestly do not know how beneficiaries with mental illness and psychological conditions will cope.

And we also know: The jobs are NOT there, even not so for the fit and healthy!

Most definitely there are many people, who have faced “designated doctor examinations” that resulted in bizarre and clearly biased decisions, and in quite a number of cases the assessors or “designated doctors” being used did not have the particular, appropriate medical qualifications needed, to competently assess clients with specific and complex health conditions. GPs are the “standard” “designated doctors” now, also making decisions about mental health conditions they often have insufficient understanding of. Some handle a very high number of WINZ clients.

I hope this information will raise your awareness to these topics and issues, on which I can and will elaborate on a bit further in following “comments”.

Attached are some further PDF files with the following information:

a) 'Harm Lurks for Benefit Addicts', ‘NZ Doctor’ magazine article, again comparing benefit dependence to drug dependence, referring to Dr David Bratt's philosophy, 01 August 2012;
b) a reader’s letter in response to that article under "a" in ‘NZ Doctor’, raising concern and criticism about Dr Bratt, dated 29 August 2012;
c) a printout of the Medical Council registration of Dr Bratt, current as on 29.08.2012;
d) Position description for Principal Health Advisor, received with O.I.A. reply from MSD;
e) Position description for Principal Disability Advisor, received with O.I.A. reply from MSD.

PART B: MORE ON DESIGNATED DOCTOR TRAINING BY MSD’s “ADVISORS”

MSD have been training, mentoring and consulting "designated doctors" since 2008, initially being conducted and managed through both Dr David Rankin and Dr David Bratt, the latter still Principal Health Advisor for MSD (since 2007).

Dr David Bratt has been and still is also mentoring, training and supervising Regional Health and Disability Advisors in Regional Offices of MSD and WINZ. Health and Disability Coordinators are also used to closely liaise with and "co-operate" with GPs and other medical professionals, which includes those that are not necessarily "designated doctors". The latter Health and Disability Coordinators also play a major role in "recruiting" the kinds of "designated doctors" WINZ and MSD want!

Information gathered since gives ample reason to believe that training went beyond the informing about documentation and other basic requirements Work and Income and MSD have and expect of medical practitioners and other health professionals. All indications are, that here has been a clear attempt to influence the views, perception and judgment of designated doctors, which has led to "bias" of doctors involved (mostly GPs) when making assessments, decisions and recommendations about beneficiaries to Work and Income. See attached to this email some confidential info discretely obtained re designated doctor training by MSD - intended mostly for internal communications! It will simply give you the proof of what has been going on over recent years. MSD is rather quiet on "designated doctor training", as it likes to keep a tight lid on any information related to it.

Newest information is that the involvement of designated doctors appears to have been reorganised slightly, at least for time being, and in at least in some administrative regions of MSD. It appears that MSD got worried about legal complications and challenges, questioning the claimed independence, objectivity, fairness and reasonableness of designated doctor examinations, assessments and decisions.

The reports, assessments and recommendations that were and are being provided by those "designated" "medical practitioners" (mostly GPs) have increasingly been used by Regional Health Advisors and Regional Disability Advisors as supposedly totally "reliable medical reports" for their advice and recommendations to WINZ case managers, who are usually expected to abide by those recommendations, after which usually ALL previous doctor certificates and assessments get ignored!

The fact, that designated doctors have been "trained", are being mentored and consulted by MSD staff, such as Dr David Bratt, raises very serious questions about their "independence" and objectivity. The fact that MSD pay them is another one contributing to concerns.

That seems to have been behind a partial recent review of designated doctor involvement, which has been confirmed to me by a GP (who has not had requests for formerly common
"host doctor reports" for many months), and also by a client in Southland, who was told by WINZ staff, that they had not asked for designated doctor examinations for a year, but suddenly resumed these. Regional Health and Disability Advisors do now appear to increasingly take over some internal assessing on their own, followed by making their own recommendations and advising case managers re clients' medical fitness for work. Any issues clients have with decisions based on any designated doctor - or Health and Disability Advisor - recommendations, must go to the MAB.

What is of particular concern is also, that the Regional Health and Disability Advisors are in at least some cases totally lacking sufficient medical qualifications and experience to assess competently all the cases put before them, due to the diversity of illnesses and disabilities, which can of course include psychiatric and psychological illnesses and disorders.

Naturally the agenda has for a few years now clearly been to limit access to, and to reduce numbers of people on sickness and invalid's benefits, which was already started in 2010 with a very resolute, yes “relentless” approach under the ‘Future Focus’ policy. In a growing number of cases extremely harsh decisions were clearly breaching natural justice by being unfair and unreasonable.

There is very poor or limited transparency offered by MSD in all these controversial matters, and this is appalling. Hence I encourage everyone reading this, to consider making Official Information Act requests yourselves to MSD. They should not be allowed to hide so much!

P.S.:

Re qualifications of RHAs and RDAs, see this example:

Tanya Rissman, ‘Regional Disability Advisor’, and temporarily also “acting” ‘Regional Health Advisor’ for Work and Income, is in charge of the Southern Region. Here is what could be found as some evidence of her lack of medical expertise and qualifications. She merely has a teaching degree, a diploma or so in counselling and some social work qualifications:

Links:

‘MASSEY’ Magazine from Nov. 2002:
(see article on Tanya Rissman, in front of “Antics Ltd”, on page 39)

http://www.adanz.org...19e2b22/Dunedin LOAD website notes 13 Aug 09 final.pdf
(http://www.adanz.org.nz/IM_Custom/ContentStore/Assets/15/43/d0c930c49772ac96044881f9119e2b22/Dunedin)
(Note: Neither of the above, previously working links, now calls up the requested page with a PDF document!)

Main website for ADANZ – active on 17 Oct. 2016, but not loading a sought page with PDF:
http://www.adanz.org.nz/

‘Minutes of the Disability Support Advisory Committees’ Meeting held on Tuesday, 21 July 2009’ (see a report on Tanya Rissman and so forth, from page 2 onwards):
For more information about health conditions and medical certificates relating to Work and Income clients, contact
- Regional Health Advisor
  Anne Tacon (03) 955 6577
- Regional Disability Advisor
  Tanya Rissman (03) 955 6547

Re sundry other info from the Work and Income website:


(This link appears to be redundant and no longer working, given recent law changes for benefits and requirements to be met)


Important Note:

Please bear in mind that MSD and Work and Income are frequently "updating" their websites and certain information offered on them! If any serious questions or challenges re processes and procedures arise, same as when law changes occur, the information will sooner or later be changed! We have noticed how previously available information can no longer be found, or has been re-edited and reduced.

Attachments:

6 various PDF files containing scan copies of internal memos and similar documents, giving clear evidence that MSD conducted designated doctor training by Dr David Rankin and Dr David Bratt (Principal Health Advisor for MSD, who has a very staunch "pro work ability" focus, also comparing in some presentations benefit dependency with "drug dependency").

a) MSD, Design. Dr training proposal, T. Mulvena, memo, to Reg. Commissioners, 27.06.2008.pdf
b) MSD, Working NZ - SDD, Role of Design. Drs, memo, D. Rankin, 27.03.2006.pdf
c) MSD, SDD, Dr D. Rankin, GP Second Opinion, memo, 05.06.2007.pdf
e) MSD, Design. Dr Training Workshop, and H+D Coordintr, info sheet, 12.08.2008.pdf
f) MSD, Dr D. Bratt, Fee Adjustmt for Design. Drs, memo, 26.11.2008.pdf
g) MASSEY-Nov-2002, Tanya Rissman, 'Antics Ltd', prof. qualifications, article, p. 39, d-load, 15.08.12.pdf

PART C: CHANGES IN MEDICAL APPEAL BOARD REPORTING

Following my earlier comments, I have further highly interesting, revealing information for you to look at. This is regarding the apparent substantial increase in Medical Appeal Board hearings held, to deal with an increasing number of medical appeals by distressed and aggrieved Work and Income applicants or clients to/on health related benefits.

I already explained a bit about the involvement of actually more or less "hand picked" and mostly preferred "designated doctors" that MSD and Work and Income use to get additional examinations and assessments done - as "second opinions" and the likes. They have been "trained" by leading MSD health advisors since 2008, and some of whom also sit on Medical Appeal Boards, when as panel members (3) hearing "medical appeals".

True "independence" of designated doctors IS not what the affected persons are faced with, as it is against natural justice that the very agency or department, that seeks supposed "independent" second opinions, is actually at the same time "instructing", "mentoring", "consulting" and "training" them. Naturally they do for Medical Appeal Boards also appoint them, through a so-called ‘Medical Appeals Coordinator’, who of course is an MSD or WINZ employee!

It is extremely hard to get figures about Medical Appeal Board hearings (formerly conducted under section 53A, now under section 10B of the Social Security Act 1964), about the costs associated with them, and re fees paid to attending medical and rehab professionals, but I managed to find some through searching the internet.

Below are links to website pages with relevant documents containing interesting information.

Check these LINKS for statistical data about Medical Appeal Boards:

(see page nr. 137 for MAB costs and meetings details)

(see page number 129, actual page 2, re MAB costs and meetings data)
It is obvious, that the information from annual reports by MSD since 2005 and up to 2010 shows, that there has since 2009 been a kind of "EXPLOSION" of costs for Medical Appeal Bord hearings, as there was an increase from the 2008-2009 year to the 2009-2010 year of over 200 per cent!

Clearly under the National led government and under Paula Bennett there has - according to the above data - been a substantial increase in appeals and hearings, which shows that more clients are dissatisfied with the decisions by designated doctors and Regional Health and Disability Advisors! Also does it appear that there has since mid 2008 been an increase in designated doctor examinations, and further to that internal assessments and recommendations by WINZ health and disability advisors, which would naturally lead to an increase in at least some decisions being disputed.

Anyway, the figures available up to 2010 speak for themselves!

I have also attached the relevant PDF files, stating the details about the "explosion" of costs and hearing by Medical Appeal Boards! MSD have now apparently stopped publishing figures re MAB hearings conducted since 2010!

There is apparently NO mention of them in annual reports anymore, and MSD seem to be keen to not disclose details, which should not surprise, as the "explosion" in numbers and costs has probably continued to date, which in itself could give reason for the interested public questioning what has been going on over recent years!

I can find no other information about MAB hearings, costs and numbers, let alone outcomes, which all appears to be kept very confidential.

It would be interesting to get some reliable statistics on all this from MSD, so that comparisons with past statistics are possible. Maybe an Official Information Act request into this should be considered?

PART D: DOCUMENTS FOR ‘DESIGNATED DOCTOR TRAINING’ AND JOB DESCRIPTIONS OF ADVISORS AT MSD
Please find attached to this 4th chapter in this matter another PDF file that contains some sample scenarios used in "designated doctor training" by Dr David Bratt, Principal Health Advisor of the Ministry of Social Development, which were used by him to train WINZ "designated doctors" in special training sessions all over New Zealand since 2008.

As you will be able to see, there is always a kind of "bias" in the samples used, implying that WINZ beneficiaries on sickness or invalid's benefits, or applicants for them, are likely to be untrustworthy "cheats", shirkers, malingerers and exaggerators!

Furthermore there are 2 position descriptions for key "advisory" staff the Ministry uses to "advise" WINZ case managers and other staff on disabled beneficiaries (usually adopting the recommendations given as results of assessments by the "trained" "designated doctors").

Also is there a position description for the position of Health and Disability Coordinator, one of each of the total 11 (or so) of them are placed in each Regional Office, and tasked with "liaising" with GPs and other health and disability professionals, and also with finding and selecting prospective "designated doctors".

There is more information available on all this, but I focus on presenting only a selected a core of it.

Attachments:

a) 1 PDF file containing 7 sample scenarios used in "designated doctor training" by Dr David Bratt, Principal Health Advisor of M.S.D., in special training sessions;
b) 1 PDF file containing the position description for Principal Disability Advisor, received w. O.I.A. reply from MSD;
c) 1 PDF file containing the position description for Regional Disability Advisor, received w. O.I.A. reply from MSD;
d) 1 PDF file containing the position description for Health and Disability Coordinator (who work very closely also with GPs!), received w. O.I.A. reply from MSD


PART E: O.I.A. AND SUNDRY OTHER INFO ON DESIGNATED DOCTORS, MABs AND MSD’s HEALTH + DISABILITY ADVISORS

Here is official Information and sundry other information re MSD, designated doctors, Medical Appeal Boards (MABs), RHAs, RDAs and relevant processes:

Looking at some of the attached documentation and information that was obtained under the Official Information Act, and comparing it with more current figures, it can be established
that MSD have fewer "designated doctors" now than in March 2011. **Total "designated doctors" number about 290 nation-wide now, and they are almost exclusively GPs.**

They (MSD and Work and Income) apparently have some problems getting enough of the doctors they need and want, under the conditions and expectations that they have. Also do they have issues with paying them fairly for their efforts and inconveniences, which does not motivate many GPs to volunteer and co-operate with them. Ordinary examinations are paid at going GP pay rates, but attendances of Medical Appeal Board hearings pay really well for the doctors taking part.

From what I have learned, most designated doctors "examinations" have been made in rushed processes, basically within a brief, 15-minute encounter. That is mainly, because the doctors commissioned feel not sufficiently reimbursed for the at times complex work and time needed. It seems that the GPs willing to do these tasks have developed a routine to handle such WINZ processes as swiftly as possible, and some seem to make it worth their while by processing large numbers. Mistakes, misjudgements and so forth are likely to happen in such an environment.

There is core number of GPs always available to willingly work as designated doctors, and some of them handle very high numbers of examinations and assessments. Many WINZ clients are not given a proper choice (by case managers referring them), as it appears, and they are rather simply "told" to see particular doctors that are apparently more favourable to the department, when making assessments and recommendations. I personally know a few persons who were told, whom to see, not even being given a short list to pick from.

Attending MAB hearings pays quite well for doctors and rehab professionals, contrary to doing individual assessments as designated doctors.

They have few, if any, experts in mental health that are available, as in early 2011 they had NO psychologists and only 10 psychiatrists on their lists. That exposes mental health sufferers, or persons with addiction and complex issues to likely "incompetent" assessments and decisions by GPs.

A lot of the information attached is over a year - or in some cases a few years old. They (MSD) are not willing or able to give much in the way of information about outcomes of "designated doctor" examinations and recommendations, and similarly Medical Appeal Board hearings. The standard answer is: **"Such information is not centrally collected and kept in thousands of individual client files. It would be unreasonable to expect them to collate the info".** That is how they tend to get off the hook, when they refuse to make such information available in response to an O.I.A. request.

Contrary to website information they do often have more than one "designated doctor" (likely to be trained by MSD) on Medical Appeal Boards, so issues re "independence" arise there also. Often there are two, if not three "trained" designated doctors hearing appeals.

**Attached is a list with "designated doctors" as it was current in late August 2012.** Most appear to have been "long serving" ones, apparently "happy" to risk compromising their profession's 'Code of Ethics' in return to meet MSD's expectations.
As a matter of fact they do risk making serious compromises against their professional ethics, by accepting policy guidelines set by MSD, like the new staunch application of "work capability" focus (already commenced under MSD's 'Future Focus' policy from 2010).

Standard questions asked by "designated doctors" are largely revolving around work related questions, to establish the client's view towards work, certain types of work, previous employment, efforts, preparedness to do "other" or "lighter" types of work, and the focus on this appears to be dominant, health aspects being treated in too many cases almost as only "secondary" matters to consider.

If not work related, the questioning is often targeted to establish whether a sick or disabled client may perhaps be able to do some chores and tasks at home, or perform physically or mentally any other activities, be this in form of "hobbies" or else, that can in any way be "perceived" as indicating that the person "can" do something, which can be applied in any hypothetical kind of work.

Comments in their reports tend to state: "We were meant to look rather at what client X CAN (perhaps) DO, rather than what client X CANNOT DO (expectation by MSD)". So the intended outcome is based on finding any indication of whatever basic physical and mental capability a client or applicant has, so that based on this information, a person can be "considered" to work at least 15 hours a week in whatever hypothetical job, and irrespective of whether there is a realistic prospect of any matching jobs or work existing, that may prove to be an option for paid employment.

The intention is to stop people from meeting the severity criteria for Invalid's Benefit (now 'Supported Living' benefit), and in some cases even for Sickness Benefit (now "Jobseeker" with "deferred status).

This has led to some seriously incapacitated clients of Work and Income being considered to rather meet the criteria for the former sickness (now “jobseeker”) benefit, than the former invalid’s (now “supported living”) benefit, despite being unable to do much work at all, and that for years, if not permanently. Yet the sickness (now deferred status “jobseeker”) benefit is only meant to be a short term benefit for people "temporarily" not fit or able to work (full time)!

Internal Regional Disability and Health Advisors also make (initial) internal assessments, tending to favour recommendations to case managers that benefit Work and Income. They often do this without presenting any realistic scenarios of persons being able to work, and without mentioning any example of a type of work that the client could take up and do in "open employment". The over-ruling (unofficial) criteria rather appears to be, to put the person on a lower paid benefit (sickness – or now “jobseeker”), simply to save costs.

Decisions can be over-turned by a MAB decision, but as usually 2 designated doctors make a two third majority on such an appeal body panel, it can be quite difficult to achieve that this happens. This is how MSD and Work and Income work now, and it deserves very deep scrutiny.

It is nor surprising that any client dissatisfied with any treatment will be severely discouraged to take matters to the media, as MSD have since February 2011 been using a kind of "official" new "privacy consent form" that implies that the Ministry and Minister will disclose anything they may view "relevant", if a person dares to involve the media and the media seeks answers
from WINZ/MSD, which usually only will happen, if they can provide a signed "privacy consent form" from the client in question.

This is a link directly to the MSD main website page for "media", offering the "privacy consent form" to media and public users (who approach media re MSD and WINZ issues):


The following is the very link leading to the document down-loadable from the main MSD website:


The use of this particular form raises very serious legal questions. The text of the "privacy consent form" is quite inappropriate, so that even a lawyer described it as "shocking". It basically gives the Ministry authority to PUBLICLY make available virtually ANY information considered "relevant" to a matter raised by a client to the media. This means the "wider public", as I would understand it. NO advice is given that clients can legally use their own forms of giving consent to media and MSD or Work and Income.

Attachments:

a) MSD, O.I.A. request, Design. Drs, MAB appeals, RHAs, RDAs, C.E.’s response, March 2011, re anonymous.pdf;
b) MSD, O.I.A. request, list of questions, for specified information, sent to Ministry, late 2010.pdf;
c) MSD, O.I.A. request, list of questions, re SB + IB beneficiaries, reviews, statistics, fr. Jan. 2011, re anonymous.pdf;
e) MSD, Med. Appeal Boards, panel compositions, staff info, Manuals + Procedures, website, 31.01.11.pdf;
f) MSD, Designated Doctor List, complete, as in August 2012, PDF version;
g) designated-doctor-application, Work and Income, form, d-load, 12.12.2010.pdf;

Further information on designated doctors:


(apparently redundant link now, and there is no trace of that Guide for Designated Doctors' on the WINZ website, although in an O.I.A. response the Chief Executive or Deputy C.E. claimed it could be downloaded from there!!)

PART F: AUCKLAND CITY MISSION FollowS MSD’s HARD LINE

Last not least I can present some more current information that shows how far the journey has taken WINZ under Dr Bratt and his agenda!

See how Dr Bratt's radical "pro work" focus is even being applied by the Medical Centre of the Auckland City Mission now! So much for the caring approach that such institutions should really take!

From their information leaflet:

“The sickness benefit is not designed to cover illnesses that have a recognised treatment if the patient declines to engage in the treatment of these conditions. This includes also all diagnoses related to alcohol and other drugs addiction problems. If addiction problems are the basis on which you are receiving a sickness benefit, you will be required to show evidence of engagement with a treatment provider (e.g. on-going counselling at CADS or TRANX, having a treatment plan in place with confirmed admission dates for detox (Pitman House or Social Detox) and follow-up treatment programmes (e.g. the Bridge Programme, Higher Ground, Odyssey House, WINGS Trust, AA, NA, Raukura Hauora). Our practice is that the maximum duration for a sickness benefit certificate based on addiction problems is 4 weeks.”

While the City Mission will deal a lot with homeless, and also many alcohol and drug addicts, they are now having their nurse(s) and doctor(s) lay down the harsh rules, by possibly refusing medical certification for needed benefits, if a person seeing them is not able to prove that she/he is “engaged” and committed to treatment, and enrolled with a treatment program provider (for which there usually are waiting lists for weeks if not many months)! How “compassionate” and “caring” a society New Zealand is becoming, under the auspices of Paula Bennett, WINZ and their extremist “Principal Health Advisor” Dr David Bratt!?

The "bio psycho-social model" in its perverted form, as suggested by Mansel Aylward, former Chief Medical Officer for the DWP in the UK, now director of a controversial department doing "disability research" at Cardiff University, and also now advising the
Counties Manukau DHB, and other organisations in Australia and New Zealand, is behind all this drive!

It all smells like a nasty "ideology" is taking hold amongst the medical profession, all coming from supposed "international findings" that "work is good for your health", from Mansel Aylward and his fellows, based mostly at Cardiff University in the UK. And WINZ are pushing for doctors to follow suit here in New Zealand!

See 1 more file attached – and also this link to the document found online:
(Note: This link is no longer active, or only loads an “error” page, as on 18 Oct. 2016)

New, alternative link available via web on 18.10.16:

‘Auckland City Mission Medical Service’

“Explanation of The Calder Centre’s policy on issuing medical certificates for a Sickness Benefit”
http://52.64.35.166/~aucklandcitymiss/wp-content/uploads/2015/12/Sickness-Benefit-explanation.pdf

1 Attachment:
‘Auck. City Mission, Sickness Benefit explanation, Bratt comment, d-load, 08.04.13.pdf’


PART G: WINZ DESIGNATED DOCTORS LIST

WORK AND INCOME’S DESIGNATED DOCTORS - AS PER LISTING IN LATE AUGUST 2012:

As there is usually not much movement by the doctors that MSD and WINZ use, it can be expected that the list is little changed - still up to this date!

AUCKLAND REGION:

CLIFFORD BRIAN AH KIT, GENERAL PRACTITIONER
NEELA AHMED, GENERAL PRACTITIONER
CECIL W ANTONY, GENERAL PRACTITIONER
SAMIR ANWAR, REHAB MEDICINE
MARK ARBUCKLE, GENERAL PRACTITIONER
RICK BARBER, GENERAL PRACTITIONER
FIONA BROW, GENERAL PRACTITIONER
GRAEME BROWN, GENERAL PRACTITIONER
USHA CHAND, GENERAL PRACTITIONER
SIDNEY TASMAN CHoy, GENERAL PRACTITIONER
HUBERT D’CRUZE, GENERAL PRACTITIONER
KALAWATI DEVA, GENERAL PRACTITIONER
MICK EASON, GENERAL PRACTITIONER
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CHRISTINE LIPYEAT, GENERAL PRACTITIONER
GAVIN LOBO, GENERAL PRACTITIONER
DEXTER LOOS, GENERAL PRACTITIONER
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MICHAEL J MILLER, GENERAL PRACTITIONER
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DANIEL J (DANNY) NEAVE, GENERAL PRACTITIONER
JANE O’DWYER, PSYCHIATRY
ASIT PAREKH, GENERAL REGISTER
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RAJINDER K SAINI, GENERAL REGISTER
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IAN ST GEORGE, GENERAL PRACTITIONER
These are the names that were on a list that was current as of 20 August 2012, and the regions listed are MSD regional administrative areas (hence some may also include close neighbouring geographical areas).

Please bear in mind that some of these "designated doctors" are used more frequently than others, yes, anecdotal information says that some are like "hatchet doctors", as they appear to deliver the recommendations that WINZ and MSD prefer, similar to the way ACC uses some "preferred" assessors, although they will of course never admit this!

PART H: MEDIA REPORTS ON WELFARE AND WORK TEST CHANGES

Recent media reports indicate that there may be major changes in the assessment program that MSD use, and it looks like at least some future assessments of sick and disabled beneficiaries will be conducted by contracted out service providers:

See the following headlines, links and extracts from reports:

'Contractors to assess sick and disabled for work'

BEN HEATHER

03/11/2013


"Private contractors will be paid $650 an assessment to get thousands of New Zealand's sick and disabled ready to return to work. From February, Work and Income will pay private "medical assessors" to scrutinise sickness and disability beneficiaries who it believes can work. Only the most difficult beneficiaries, those Work and Income could not find jobs for, would be seen by the assessors. Many could be obligated to complete assessments or face cuts to their benefit."

"The medical assessors will be paid $650 per assessment, which are expected to take about three hours, and are prompted to recommend lifestyle changes to help the beneficiary get a job, such as a "positive approach to life" and more time at the gym. It is expected eventually 3000 disabled people a year will have to visit an assessor, who will judge their fitness for work and report back to Work and Income."

"Disabled people on a benefit are also facing extra scrutiny, with a stronger emphasis on their capacity to work. But disability advocates are wary of the outsourcing scheme, with a similar model in Britain hit by controversy."

Tests for disabled 'flawed model'

"New work assessments for the disabled and people with health conditions will impose "unnecessary angst" and wrongly put the onus on clients rather than employers, CCS Disability Action Otago patron Donna-Rose McKay says.

Details of the tests, which start early next year, have been released to the Government's electronic tenders website in a Ministry of Social Development request for proposal.

Mrs McKay believed New Zealand was adopting the same "flawed model" as Britain, where work-testing the disabled was highly controversial."

"Work and Income expects up to 1000 clients to be referred for a 'work ability assessment' between February and June next year, about 2000 in 2014-15, and about 3000 the next year, the proposal document said. The provider would receive $650 (GST exclusive) for each completed assessment. The process would take about three hours, which included a one-hour face-to-face assessment."

"This assessment will be done by a suitably qualified medical or health professional, who will take a fresh look at a person's ability to work, along with the supports and services they need to find and stay in work." "The work ability assessment is intended to take a broader, holistic approach to the factors affecting a client's ability to work," the document said.

Dunedin disability researcher Chris Ford said the tests were likely to find most people able to perform some kind of work, taking no account of the wider economic situation."

Comment:

It may well be that these outsourced, private contractors will only be used for special clients to be assessed, and that "designated doctors" will continue to be used for the rest of sick and disabled WINZ clients. But this development is a very major one, and an extremely worrying one, as the experience in the UK with ATOS has shown.

All affected should be very much on guard, and prepare to attend any "examinations", "assessments" and the likes with "designated doctors", outsourced "assessors" and even with WINZ "interviewers" conducting "work preparedness" conversations together with a support person. This will minimise the risks of being taken advantage of, and of being pressured or misled into unacceptable decisions and "results".

PART I: ADVICE TO WINZ CLIENTS FACING DESIGNATED DOCTOR MEDICAL EXAMINATIONS

A MUST READ FOR ALL FACING "DESIGNATED DOCTOR" OR SIMILAR ASSESSMENTS:

"What to do if you are required to see a WINZ designated doctor":

Here is an alternative post, found on this blog:

And this thread also looks extremely informative and uncovers what is behind the whole "welfare reform agenda" here and in the UK:


PART J: A FURTHER ‘PRESENTATION’ BY DR BRATT FROM SEPT. 2013

Here is another, newer "presentation" that Dr Bratt put together with Anne Hawker. I suspect though that Bratt has the greater input and only uses her name to "share" the responsibility:

"Overcoming and Challenging Adversity – the Prequel"

(Social Welfare in NZ 2013)

Dr David Bratt – Principal Health Advisor

Ministry of Social Development

Anne Hawker – Principal Disability Advisor

PMAANZ Conference 2013 Sept

See the PDF found via the following LINK to the "web". If it may not work, try searching it with Google, Bing or so, by putting in the title and author’s name into the search box!


There are also two other "scan copies" of presentations obtained by way of an O.I.A. request some time ago. Sadly they are a bit too large to load here.

Now Dr Bratt appears to avoid the likening of "benefit dependence" to "drug dependence", but he now seems to be promoting the availability of "special needs grants" to women, who may wish to have long lasting contraception implants and the likes, helping them to become "more attractive to employers". It all shines more light on the "mindset" and pursued "agenda" of our dear "Dr David - the Bratt"

As I am always doing a bit of part time research, you can count on a bit more to come on all this!
PART K: MSD DESIGNATED DR TRAINING MEMO AND FURTHER BRATT PRESENTATION

There is another interesting "memo" from MSD that is from 23 Jan. 2008, and was sent internally by a J. Russell (Training Manager) and M. Mortensen (Communications Manager) to Dr David Bratt (PHA) and a few others, offering an overview of proposed training for "designated doctors", which somebody made available to me. It appears to have been obtained by way of an O.I.A. request. I made some references to this "memo" above in "PART 1".

I forgot to include it in the above, but referred to it in one "comment". It is titled 'DESIGNATED DOCTOR TRAINING AND COMMUNICATIONS REQUIREMENTS' and gives details about what was already decided and planned, but needed to be done to progress the training program. It ties in with other documents about the planning, preparation, organisation and implementation of the training, which actually later occurred between August and October or November in late 2008 (through work-shops all over New Zealand).

On page 2 at the bottom of a chapter titled 'Background' there is mention of the following:

"To ensure designated doctors understand their role and the expectations placed on them by Work and Income, it is recommended that they receive regular communication and attend a training program."

Under another heading on the same page, being 'Communications Approach', it reads:

"Regional training sessions for designated doctors provide an opportunity to further develop sustainable working relationships with one of Work and Income's key partners - health practitioners."

"This training opportunity sets a platform for further communication and greater understanding of the objectives of the Working New Zealand programme."

It also says:

"Communication will be:
...
tailored to designated doctors
...
regular and ongoing."

On page 3 it says under 'Training Approach' that:

"Work and Income has never provided training for designated doctors..."

"Attending a training course should be compulsory for a doctor to remain a designated doctor. A range of times and locations are available to doctors to ensure they are able to attend a training program. This minimises associated travel costs for the Ministry of Social Development (MSD)."
"Regional staff will be encouraged to attend the training sessions so they can meet the local designated doctors and connect what they have been told about the process with the designated doctors."

On page 5 there are details listed under 'Timing', and further down on the page there are also listed cost items that would be covered, which includes travel and accommodation for presenters, food and drink (i.e. finger food and non-alcoholic drinks), attendance fees, transport costs for out of town doctors, and even accommodation for those doctors traveling from out of town.

One sentence is of interest, and it says:

"Food and non-alcoholic drinks could be provided on arrival or to assist social networking after the formal presentation."

Comment:

Now this gives an idea about how "designated doctors" and WINZ staff were actually going to be encouraged to "connect", exchange themselves and do "social networking", which again raises serious questions about what else may have been "communicated", what Dr Bratt and Dr Rankin verbally communicated also during the formal training, and how attempts were apparently made to "influence" the doctors, who under the law and processes to follow are meant to be totally INDEPENDENT!

P.S.:

Also attached is only half of Dr Bratt's more recent "presentation" called 'Happy Docs - Doctors and Documents' (fr. 2013, 1st file with pages 1 to 18, 2nd file with the rest). I believe that one can also find it on the web, by a link already offered further above (see bottom of attachments to the "PART 1").


PART L: NZMA SUBMISSION ON WORK ABILITY ASSESSMENTS TO MSD

Further to "PART H", where recent media reports were quoted, and where links lead to articles in 'stuff.co' and the 'Otago Daily Times', there appears to have been a major submission made by the 'New Zealand Medical Association' (NZMA) (like possibly from some others), regarding MSD's plans to outsource and use private assessors to assess work capability of sick and disabled dependent on WINZ benefits.
Their submission from 25 September 2013 expressed some serious concerns that certain professionals were apparently intended to be used, who lacked sufficient, proper "medical qualifications". It can be found on the web via this link here:

(Link no longer works, shows only error page, on 18 Oct. 2016).

Alternative, new link, to NZMA submissions page on their website (active 18.10.16):

Alternative and new link to submission and an article on issues with WAA contracted by MSD – in NZ Doctor:
http://www.nzdoctor.co.nz/media/3235750/sub-workabilityassessments-providers.pdf

“NZMA expresses major concerns over work health assessments”, Cliff Taylor, NZ Doctor, 31 March 2014:

Note: As the last link above may require you to log into their website, try instead to search the article by putting the title into your Google, Bing or other search box!!!

So it will be interesting to see, what kind of staff and "professionals" MSD and WINZ will use when they start their new, supposedly "independent" assessments of sick and disabled on benefits from February 2014, which so far all sounds very much as being along the lines of what ATOS were doing for the Department for Work and Pensions (DWP) in the UK.

PART M: FURTHER O.I.A. RESPONSES BY MSD

Work and Income provided another reply to an Official Information Act request by a person who wishes to not be named. There are two more PDF files attached below, which are part of a response from 06 March 2013. The information is on designated doctors, Regional Health Advisors, Regional Disability Advisors, Medical Appeal Boards, also processes used and training of designated doctors. As usual they have withheld some information, which in some cases is for the familiar "excuses" or reasons (especially section 18f of the O.I.A.).

The response letter from Debbie Power dated 06 March shows at least a table with expenses paid per annum for the setting up and conducting of Medical Appeal Board hearings from 2005 to 2012. There was a large increase since the financial year 2009/2010, which reveals that there must have been a substantial increase of appeals, when compared to the years before then. That means more clients were not accepting WINZ decisions based on designated doctor recommendations.

The figures for MAB expenses are for the following years (page 2):

2006 / 2007: $ 135,872
2007 / 2008: $ 91,665
2008 / 2009: $ 196,412
2009 / 2010: $ 610,092
2010 / 2011: $ 690,646
2011 / 2012: $ 449,582

There are also figures for annual expenditure on "designated doctors", covering 2005 to 2012 (page 3):

2005 / 2006: $ 2,845,371
2006 / 2007: $ 2,957,330
2007 / 2008: $ 1,161,185
2009 / 2010: $ 580,381
2010 / 2011: $ 451,785
2011 / 2012: $ 413,854

(I am not listing the extra "host doctor" expenses the Ministry of Social Development paid to client's own doctors for completing medical reports that were requested by "designated doctors", which they also pay for). The expenses seem to be covering only the ordinary fees paid to such WINZ commissioned doctors.

At first sight one would think that there has been a drop in medical examinations by "designated doctors", which is true. Until about 2007/2008 WINZ used to ask for medical examinations by designated doctors for virtually every new application for the former invalid's benefit, or for required reviews of existing claims for that benefit. As the last Labour government decided that it is better to rely on client's own doctors for invalid's benefit applicants and recipients in the first instance, and only involve "designated doctors" for reviews later on (where deemed "necessary"), they did away with case managers asking for "designated doctors" examinations or assessments for all new invalid's benefit applications.

Since then "designated doctors" have mostly been used for "second opinion" reviews and re-examinations of persons applying for that benefit. But sickness beneficiaries continued to be examined and re-examined as usual. Consequently a drop in examinations resulted from that policy change only, but since then the expenses paid, and examinations made, appear to have been rather stable (until mid 2012).

I have no newer figures, so it is not clear, whether the new approach that has been brought in mid this year has resulted in more "designated doctor" examinations or not. As from February next year apparently outsourced, contracted, supposedly "independent" and more comprehensive work capability assessments will be introduced, it is not quite clear, what the role of "designated doctors" will be from then. They may still be used in some cases, or perhaps some will become part of the chosen "experts" that will on an ongoing contract basis be doing these new assessments then.

The O.I.A. response also confirms that from August 2008 to October 2008 MSD conducted 'training sessions' for "designated doctors" across the whole country (see page 3 to 4), and it lists what "training material" was officially used then. The mentioned "scenarios" have been attached to comment 4 further above (1 to 7). To question 12 the letter answers that there was continued training provided - besides of "ongoing engagement with medical practitioners" - and sessions were run, when "significant changes' were "implemented". No details about such sessions and what was covered are given.
But some figures were mentioned re those further training sessions:

2008 / 2009: $26,710
2009 / 2010: $533 (?)

It is stated the costs related to "appointment fees" that MSD paid, but other costs are apparently not included. In papers covering planning and preparation of the training in 2008 (perhaps see PDFs under comment 17 and also further above) there was though mention of help with travel, accommodation, some food and beverages, as well as "education credits" to be paid. Further information has been withheld under section 18 (g) of the O.I.A. (see page 4). Information on "all reports" on "designated doctor" training were also withheld by Debbie Power!

Then there are at least some range figures for the salaries of Regional Health and Disability Advisors:

$57,300 to 78,807 per annum for RHAs and RDAs is a range of incomes paid to them, that is given.

$42,491 to 58,425 per annum are paid for so-called "Health and Disability Coordinators" (working and liaising with GPs and other health professionals - for WINZ and MSD!).

Please see details re these positions further above (described in attached PDFs and also in one or two "links" to online information.

Information on the incomes of Dr David Bratt as Principal Health Advisor, and Anne Hawker as Principal Disability Advisor was WITHHELD for PRIVACY reasons!

Work and Income Board members receive the following "fees" per annum:

$58,500 for the CHAIR,
$26,500 for other members, all per annum (for a nicely paid "part time" occupation they basically have).

This board supports the Chief Executive of MSD in implementing the "investment approach" to their future processes and policies.

The second PDF document attached here contains statistical data on benefit recipients per category per quarter from 2000 to 2012, which can only give limited information on "movements" and impacts "designated doctor" examinations and recommendations did have. There is no information on movements and why they may have occurred.

Comments:

At least this gives some insight into what has been going on, while other information is as usually being withheld. Sadly it is making it very difficult for ordinary citizens and outsiders to get a transparent impression of how WINZ and MSD conduct themselves, and more "digging" in this regard is needed and being worked on!

PART N: MORE ON THE NZMA SUBMISSION TO MSD - ON WORK ABILITY ASSESSMENTS

In an already mentioned submission, which the New Zealand Medical Council sent in to Dr Bratt, and which was dated 25 Sept. 2013, the Association expressed concerns about the Ministry’s and/or Dr Bratt’s plans for bringing in new, supposedly “independent” assessors. It can be found online on the internet and downloaded via this link:


(Note: That link no longer works on 18.10.16! Showing only error ‘404’)

New link to submissions archive page on NZMA website (active 18 Oct. 2016):

It is titled:

'Independent Work Ability Assessments - Providers'

The submission is addressed directly to Dr Bratt and starts with "Dear David". The following are bits out of it, which clearly shows the dissatisfaction that the NZMA has regarding what is being planned:

"In order to formulate our response to MSD, we have consulted with our General Practice Advisory Council, Specialist Advisory Council and the NZMA Board. We note that the request for feedback by MSD was made on 12 September with a deadline of 20 September. We are disappointed with this very short consultation period and trust that you will give consideration to our submission even though we have not been able to meet the requested time frame."

"The NZMA is fully aware of the health benefits of meaningful work and we support, in principle, the aspiration of assisting people with health conditions or disabilities to return to work, to the extent this is appropriate and in the best interests of the individual patient. However, we have two major concerns relating to the draft document on IWAA providers. These concerns are outlined below.

Our first major concern relates to the inclusion of ‘vocational practitioners’ among the range of practitioners identified by MSD as being suitable to provide the assessments. Our understanding is that ‘vocational practitioners’ may have no healthcare background at all and are not registered medical practitioners. Rather, their primary qualifications are in Career Development. Given that the target population for these assessments includes patients with mental health conditions (40%), musculoskeletal system disorders (15%) and people with a range of other conditions such as cardiovascular disease, chronic respiratory diseases, diabetes, cancer and nervous system disorders, the NZMA believes there are significant risks
in engaging the services of non-healthcare workers to review medical information and discuss recommendations on condition management or treatment.

We submit that the role and importance of front line general practitioners appears to have been underplayed in this proposed list of assessment providers; this group of medical practitioners (not just those general practitioners with qualifications in occupational medicine) are well placed to understand a patient’s health-related and other barriers to employment, and we believe they have useful experience to offer MSD in relation to the objectives of this assessment.

Our second major concern relates to the duality of a role in which a seemingly independent assessor is paid by MSD to undertake an assessment of an MSD client but then also provides advice and recommendations on the management for the individual concerned. To avoid a conflict of underlying motivations, we believe that better practice would entail some sort of firewall between these two roles. Such a separation of roles would also be consistent with what occurs in other spheres (e.g. assessments in the military and for members of sports teams).

Finally, we suggest that it would generally be more appropriate for MSD to liaise with the patient as well as their general practitioner when formulating an assessment of their work ability. Where independent assessments are required, we suggest that these are best undertaken by a general practitioner who is not the patient’s own general practitioner. While we appreciate that MSD is keen to avoid an over-medicalised model, we believe that general practitioners and other health professionals (e.g. psychiatrists or psychologists where mental health concerns dominate) are best placed to undertake assessments that focus on how a patient's health condition or disability impacts on their potential for employment."

Further new link to NZ Doctor article on this:

(Do a Google or Bing search by the title, if the link does not load the article!)

Further new link to NZMA website with info supplied to them by Work and Income:

‘Work Ability Assessment - Questions and Answers’

Comment:

Well, how revealing is this now? Clearly the NZMA is well aware of what MSD are trying to do, and they are very concerned about what they have been planning. So while the public at large can only find this one submission on MSD's plans via the internet, there is much of a lack of transparency otherwise. Who else may have made submissions, and of what types? Does anybody know whether there is any other information available on this, and what MSD and WINZ will finally do when bringing in "independent assessors", and who will be used to "staff" them, or perform in those roles?
I am shocked about this lack of transparency, and that there is apparently NO PUBLIC DEBATE ON THIS. It is extremely worrying what is going on here!

NOTE: THIS POST WAS INITIALLY PRESENTED VIA 'ACC FORUM' BY 'MARC' AND HAS ALSO BEEN PUBLISHED HERE WITH THE AUTHOR'S PERMISSION!

See this link for that blog post: http://accforum.org/forums/index.php?/topic/15463-designated-doctors-%e2%80%93-used-by-work-and-income-some-also-used-by-acc/

PART O: HOW THE AFOEM CHANGES ITS POSITION STATEMENTS (added 20 Jan. 2014)

There are signs that the medical profession is getting concerned that their members (particularly GPs, i.e. general practitioners), some of whom are of course working as "designated doctors" for WINZ, or assessors and "specialists" for ACC, may be losing their reputation for professionalism and independence. Recent publications give reason for this to be the case. Both the Royal Australasian College of Physicians, and there it is the AFOEM (one of their faculties), as well as the Medical Council of New Zealand, have late last year published new statements of apparently high importance.

It seems that these professional institutions and organisations have taken some note of concerns that have been raised by various persons, last not least the writer of this post. They have now indeed seen a need to take actions and defend the profession, their members, and certain controversial policies, which particularly the 'Royal Australasian College of Physicians' (RACP) and their 'Australasian Faculty of Occupational and Environmental Medicine' (AFOEM) have started developing, publishing and promoting since 2010. This includes their policy statement on “The Health Benefits of Work”!

That particular policy statement was developed with the help of Professor Mansel Aylward, promoted by Dame Carol Black, and pushed for with the help of Dr David Beaumont (President Elect of AFOEM, formerly working for ATOS Healthcare, the ASSESSORS FOR DWP in the UK!!!). Another one who supports the same policy drive is of course the Principal Health Advisor Dr David Bratt, who has worked for the MSD since 2007. He is of course the man who likens "benefit dependence" to "drug dependence"!

After launching their ideologically coloured policy and consensus statements, and follow-up ones, the AFOEM (led by Dr Beaumont!) have now apparently got a bit worried about their daring claims. Hence they now saw a need to specify what kind of “work” is supposed to be “good” for people's health. They have come up with a statement on “What is good work?”!


Download the poorly explained, unconvincing and bizarre publication they released on that: www.racp.org.nz/download.cfm?downloadfile=E2F6A860-D1D5-E958-6D9D641F04477400&typename=dmFile&fieldname=filename
Here is a further statement to governments, employers, businesses, insurers and the likes:


Note:

As you can see, the originally published three links re the AFOEM's publications no longer work and only show ‘404’ error pages on their website. The truth is, they have since 2013 not only redesigned and rearranged their website, they have got rid of, or shifted, older documents and information pages, and replaced them with reviewed, new publications on new website pages!

UPDATE AND AMENDMENT – 18 October 2016:

So now the RACP and AFOEM have realised that their earlier approach was flawed, and that the initial releases of their Position Statement on ‘The Health Benefits of Work’ did contain assertions and other information that could be disputed. They suddenly came up with a replacement statement, now called ‘The Health Benefits of Good Work’. Hence the have gone about deleting old links to old information on their website, and load new documents with new, amended statements and information releases.

A revamped, redesigned website shows us the following page:


NOW we find the following documents on this website:

’What is Good Work?’, ‘Position Statement October 2013’ –

’Companion Statement to ‘Realising the Health Benefits of Work’ ‘


“This document is intended for those who want a contextual understanding of “good work” so that they can facilitate putting the evidence into practice. It is a companion statement to the New Zealand and Australian Consensus Statements concerning the Health Benefits of Work1 and the RACP’s original Position Statement, Realising the Health Benefits of Work (although the views in this paper are those of the RACP).”

The RACP’s initial findings were presented at the Stakeholder Forum in November 2011 and since then more research has been published. Consultation with a reference group of stakeholders, including the business sector, unions, government and the health industry itself, provided valuable commentary highlighting their respective insights.”
Here is an “evidence update” version, offering yet a further “update” from one already in 2013:

‘Realising the health benefits of work – An evidence update November 2015’


“The new documents offer a kind of “recalibrated” approach, but again seem to be based on statistical data that may show some correlation between time off work and the likelihood of a person’s return to work, which does though not prove the causation of one by the other. And it appears that the return to work data is based on persons suffering injuries due to accidents, or sudden sickness - while in employment, and then at various stages returning to work. It is not based on persons with for instance congenital conditions, who may or may not have been in work, and does not show what chances they have to access and maintain employment. In any case the new or additional “evidence” they presented will again require further scrutiny, as the whole approach appears flawed. It is an improvement for the AFOEM and their “advisors” to at least accept that work must at least be “good” to have some benefits to the persons performing it. But we remain adamant that work in the form of “open employment”, which is usually very competitive, demanding, stressful and not necessarily well paid or secure, is in itself hardly that beneficial or even “therapeutic” for many who have to make a living from it, let alone those suffering sickness and disability.

Here is yet another link to a document titled ‘Improving workforce health and workplace productivity - A virtuous circle - Position Statement October 2013’
It is yet another ‘Companion Statement’ to ‘Realising the Health Benefits of Work’!


Even Mary Wyatt’s presentation from this year (2016) shows how poor support and outcomes remain for persons with psychological and psychiatric conditions:


The graphs and figures should be treated with caution, given the many past “adjustments” they have already had to make!

Here is a link to the original version of their ‘Position Statement’ on ‘Realising the Health Benefits of Work’ – from 2011:
As you can see on the website, it is “currently under review” - yet again, since 2013, because of new issues that arose more recently (2015):

Check out these posts for the reasons:


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


Comment:

But despite of being proved wrong, they still stubbornly stand by their position, and try to justify what they said before, and what the high calibre “experts” that pushed for all this, still firmly adhere to!

And here is also what the 'Medical Council of New Zealand' considered necessary to remind their members of in September 2013:


“Background
1. As a doctor you are expected to sign a variety of medical certificates that range in purpose from confirming sickness to certifying death and are required by receiving agencies, which include employers, insurers, ACC and government departments.
2. This statement outlines the standards that you must follow when completing a medical certificate. It may be used by the Health Practitioner’s Disciplinary Tribunal, the Council and the Health and Disability Commissioner as a standard by which your conduct is measured. A certificate you have completed may also be challenged in a New Zealand court and you may be called upon to justify your decisions.”

“Professional obligations
3. Certificates are legal documents. Any statement you certify should be completed promptly, honestly, accurately, objectively and based on clear and relevant evidence.
4. Your obligation is to the patient and to the law. Issues like the type of certificate being completed or who initiated, or pays, for the consultation must not influence your assessment
5. You must not complete a medical certificate for yourself or someone close to you.”

“Implications of certificates
6. You must be aware that completing a certificate has implications for the patient, yourself, and the agency receiving the certificate.
7. Studies have shown that patient, family and cultural factors may influence how doctors complete certificates. Certificates may have financial implications for the patient and the recipient through benefits, employment and compensation payments and failure to complete a certificate appropriately may have a negative impact on the patient, the patient’s family or the receiving agency. You need to be aware of these influences and recognise that you may be susceptible to them.
8. Completing a certificate may also directly affect the safety and security of others. Certifying a patient to undertake work when he or she is unfit may place the patient or the patient’s colleagues at risk.
9. Because a certificate has implications for the receiving agency, that agency might contact you for more information. You should therefore have a conversation with the patient about the information you are permitted to disclose if you are approached.”

There is a bit more to that statement (incl. footnotes), which can be found via the link above!

So they also warn their members that the Health and Disability Commissioner will ensure rights of sick and disabled are met. If that was really so, some doctors may be concerned and take heed. But as we know better, I think this is more a "message" to the public and media, to pretend they really fear the HDC may hold them to account, which he/she has historically only done very rarely and usually only in very extreme, serious cases:


Personally I would rather advise people to take doctors to court – or the Human Rights Review Tribunal - than go there!!! But we know about the "catch 22" situation with the law usually expecting health and disability end consumers to first take any complaints to the HDC Office.

Closing Comments:

I think the new additional statements by the AFOEM and MC of NZ are just poor attempts to justify the former somewhat misguided, flawed policy and consensus statements from 2010 and 2011. When the selectively chosen "science" and "research" all that is supposed to be based on (incl. the twisted "bio psycho social model" as Aylward and Waddell interpret it) is in itself questionable and lacks sufficient basis, then policy based on it cannot be taken that seriously either. I am sure that much more needs to be sorted out here, and besides of the RACP, the AFOEM and MC, the persons ultimately responsible for all this, including certain government politicians and administrators, need to do a thorough rethink and back off this madness. It is absurd to claim that "worklessness" is the main issue, and that "work" in "open employment" is
the solution to it all! Perhaps they should rather look at poverty, social injustice, marginalisation, social stigmatisation and sundry other areas, that may be the real contributors to poor health. They should also accept that mental illness and musculo-skeletal conditions are not simply based on sufferer's "illness belief".

PART P: DR BRATT AND HIS OTHER, EARLIER ACTIVITIES (added 14 September 2014)

In this long post and thread there has been repeated mention of Dr David Bratt, Principal Health Advisor for the Ministry of Social Development and for Work and Income, who was also involved in the training of designated doctors that WINZ use, and who has also had significant input into the formation of welfare policy, of recent "reforms" and how they are implemented.

He is in charge of the various Regional Health Advisors that WINZ have in each Regional Office, and together with the Principal Disability Advisor Anne Hawker, he is also in charge of the Regional Disability Advisors, as well as the so-called Health and Disability Coordinators (who closely liaise with ordinary General Practitioners and other stakeholders).

After the many revelations about Dr Bratt, and how he blatantly likens benefit dependence to "drug dependence", as he has in many of his bizarre "presentations" to medical professionals and other groups, one may wonder, why he gets away with all this, and why MSD have kept him employed.

The truth is basically, he represents the line of approach that MSD and WINZ follow – and want to continue, when dealing with sick, injured and disabled on social security benefits. He is also part of the medical and wider health administration establishment, and holds a number of positions in related areas.

As I recently found out yet again, Dr Bratt is still a member of the Board at the NSAD (New Zealand Society on Alcohol and Drug Dependence). The Chairman on the Board of Trustees is a Mr Bill Nathon, and Dr David Bratt is the Deputy Chair, as the link to the NSAD website will show further below:


(Update 18 Oct. 2016: It appears Dr Bratt is no longer on the Board of the NSAD!)

I have also attached a PDF with scan copies of the relevant information, in case the website and/or appointments change. Robert Steenhuisen, Auckland Regional Manager of Community Alcohol + Drug Service (CADS) at Waitemata District Health Board is Trustee at NSAD, so are Tim Harding, C.E. at Care NZ, and two others. So these persons all sit alongside Dr Bratt, overseeing the operations and activities of one major society that are the umbrella organisation at the head of a federation of NGOs in the alcohol and drug treatment sector.

We know that Dr Bratt has been a consultant at Capital and Coast DHB, has been involved as an abortion consultant and runs (or at least has run) a few business operations. As he appears to be part of some core networks, he will be supported by senior other professionals and agencies, last not least by the government, to continue his questionable activities, despite of all he has done, written and said. As a strong supporter of
equally controversial UK Professor and “expert” Mansel Aylward (the former Chief Medical Officer for the DWP, then Director at a UNUM “sponsored” Research Centre at Cardiff University, responsible for draconian “welfare reforms” in the UK, that led to over a thousand deaths), Bratt gets the full support by his employer, serving under governments that have the ultimate goal to save COSTS, by pressuring sick, injured and disabled into work.

Now, if that still raises questions about ETHICS or else, put your questions to the persons in charge, Chief Executive Brendon Boyle and Minister Paula Bennett!

Attachment:

PART Q: DR BRATT’s MORE RECENT PRESENTATION ON DESIGNATED DOCTOR TRAINING (added 22 March 2015)

When you read a new post on this blog, you will see some references made to “Designated Doctors”:

I read it and find it interesting how Designated Doctors also sit on Medical Appeal Boards, and not seldom are there more than one sitting on a panel hearing appeals by WINZ clients, who may have disagreed with a decision made by a case manager, that was based on a designated doctor “recommendation”. Of course not the same Designated Doctors sit on the Board, but they will all have been “trained” by MSD’s well known Principal Health Advisor, Dr David Bratt. So much for the “independence” of a Medical Appeal Board, appointed by MSD’s “Coordinator”, paid by MSD and made up by medical practitioners and some other health professionals “trained” by MSD.

There is a new Bratt “presentation” that has surfaced, which is available via this link: http://www.gpcme.co.nz/pdf/2014%20South/Fri_room6_1400%20Bratt%20Designated%20Doctor%20Training.pdf

Otherwise try the attached file, if that does no longer work:

It shows how the new approaches used under the new welfare regime, emphasizing the peculiar “health benefits of work” (propagated by Mansel Aylward et al), are now firmly communicated to WINZ Designated Doctors! The UK welfare approach is here to stay, it seems, and WINZ clients, same as ACC claimants, face more “rigorous” examinations and assessments, expecting sick, injured and disabled to work.

Have a look at it, it seems that Bratt and MSD have become quite aware of some certainly justified criticism, hence the emphasis to the Designated Doctors he “trains” and “mentors” to be careful with their report to WINZ – see page 20!!!

Also does he make a remark on page 23, re complaints to the Health and Disability Commissioner!
It appears they have a “discrete” arrangement with the HDC, which some may call in simple words “collusion”!?

Most certainly some posts here have hit a raw nerve, I presume.

Marcus

Post edited and updated on 18 October 2016