

# Ministry of Social Development: Changes to the case management of sickness and invalids' beneficiaries

This is the report of a performance  
audit we carried out under section  
16 of the Public Audit Act 2001

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## Overview

In 2008/09, the Ministry of Social Development (the Ministry) spent about \$1.9 billion on sickness and invalids' benefits, providing income support to people who were unable to work because of ill health or a disability. In June 2009, there were about 54,000 people receiving a sickness benefit because they were temporarily unable to work, and about 84,000 people receiving an invalid's benefit because they were permanently and severely restricted in their ability to work.

As part of the Working New Zealand: Work-Focused Support Programme, the Ministry put into practice a number of changes in September 2007 to improve how it determined eligibility for sickness and invalids' benefits, and to actively manage cases through regular and effective contact with people receiving those benefits. The aim of the changes was to provide appropriate services and support to beneficiaries so that any who might be able to work (full-time or part-time) could prepare for, make the transition to, and stay in work. By 2010/11, the changes were expected to result in savings of \$49 million each year.

Around one year after the changes were introduced, my staff looked at how well the changes were operating and whether they were starting to have the intended effect. The Ministry had ensured that the systems and staff required to implement the changes were largely in place by September 2007. The systems and staff included a redesigned medical certificate to provide better information, an online medical database to help case managers assess applications, and additional staff (including regional health advisors and regional disability advisors) to support case managers in their decision-making.

At the time of our audit, however, the Ministry had yet to initiate its intended regular and effective contact with many beneficiaries. It had yet to implement a Client Management System and had not secured all the contracts for new health services. Although the changes were starting to take effect, they were not being delivered consistently.

The redesigned medical certificate, when completed well, was providing case managers with better information for determining eligibility. Regional health advisors and regional disability advisors were providing case managers with valuable support for assessing complex applications, but their practice in conducting reviews varied. These advisors and their reviews were not being used consistently.

Where regions had prepared strategies for making contact and actively working with groups of beneficiaries, such as youth on the sickness benefit, there was evidence that people were supported to return to work or participate in their communities. However, the Ministry had yet to establish contact with many long-term sickness and invalids' beneficiaries, either to better support them in the

community or to discuss planning or training for a return to work. The Ministry told us that it expected to establish contact with increasing numbers of sickness and invalids' beneficiaries. It had not set a timeframe for doing so.

The economic and employment environment in which the Ministry has been supporting beneficiaries has deteriorated since it introduced the September 2007 changes, and the Ministry has had to focus on increasing numbers of recently unemployed people.

The Ministry also has a challenging task in managing large numbers of sickness and invalids' beneficiaries who require different kinds of support and services. Sickness and invalids' beneficiaries have a wide spectrum of needs. Some need income support because they are temporarily unable to work because of ill health or a disability. Others need support because they are permanently and severely restricted in their ability to work. Some beneficiaries are not able to work more than 15 hours a week, and some will never be able to work.

We encourage the Ministry to build on the progress that it has made so far. We note that the Ministry has plans to introduce – in stages – more active case management for all groups of sickness and invalids' beneficiaries. Until the Ministry establishes regular and effective contact with all beneficiaries according to their circumstances and needs – as it intended to under the changes – it will not be able to achieve the full case management benefits of the Programme.

Although it is too early to expect to see significant outcomes from the changes, the systems for gathering the monitoring data should have been in place from the outset. We have recommended that the Ministry improve how it is monitoring the effect of the changes, so it will be able to assess how well the various initiatives are working and how well the Programme is achieving its outcomes (including whether the intended savings are made).

I thank the staff from the Ministry for the assistance they have provided.



Phillippa Smith  
Deputy Controller and Auditor-General

13 October 2009

## Our recommendations

### Determining eligibility for sickness and invalids' benefits

We recommend that the Ministry of Social Development:

1. find out why there are variations in the amount and quality of information provided by health practitioners in the medical certificate, and help health practitioners provide – without undue burden on their time – the information that Work and Income needs;
2. in cases of long-term and complex medical conditions, actively use information about treatment to inform decisions about the permanence and severity of a person's condition(s) and how they affect a person's ability to work;
3. improve its monitoring of patterns in how health practitioners issue medical certificates to help ensure that certificates are completed and issued appropriately;
4. when deciding on eligibility for long-term sickness beneficiaries, provide further guidance to case managers on when to refer cases to a regional health advisor or regional disability advisor for a detailed review of the beneficiary's file;
5. consider using vocational assessments more often for beneficiaries with complex and long-term medical conditions and multiple barriers to work;
6. provide Work and Income case managers with more guidance about using the Medical Disability Advisor, clarifying when they ought to use that database to check the expected effect of a person's medical condition on their ability to work and likely return to work;
7. broaden the criteria used to refer benefit applications to regional health advisors and regional disability advisors so that, as resources allow, more cases can be reviewed for ongoing entitlement to the sickness benefit or invalid's benefit; and
8. better promote best practice for Work and Income regional health advisors and regional disability advisors and make best use of these advisors.

### Comprehensive case management

We recommend that the Ministry of Social Development:

9. review the circumstances of longer-term sickness and invalids' beneficiaries to better identify those for whom work is an option, and provide them with appropriate case management and employment-focused services;
10. as resources allow, use the available information to determine whether invalids' beneficiaries classified as "never to be reassessed" should be more actively case managed;

11. investigate why contact with beneficiaries is intermittent and reactive, and introduce improvements to ensure that case managers engage systematically and actively with beneficiaries, in keeping with the Ministry's expectations for periodic contact;
12. ensure that Work and Income case managers contact sickness and invalids' beneficiaries about work planning if information indicates that they may be ready to prepare for or return to work;
13. investigate ways of working more actively with general practitioners and responding to their comments in medical certificates;
14. where fair and appropriate, explore the full range of options for engaging with those sickness and invalids' beneficiaries who do not express an interest in preparing for or moving towards work;
15. reinforce the need for Work and Income case managers to consistently follow the recommendations made by regional health advisors and regional disability advisors; and
16. expand the scope of regular monitoring to help ensure that case managers maintain periodic contact with beneficiaries in keeping with Work and Income's guidance.

### **Monitoring and evaluating the effectiveness of the Programme**

We recommend that the Ministry of Social Development:

17. extend the monitoring framework beyond beneficiary numbers, and prepare measures that will assist the ongoing development of the Working New Zealand: Work-Focused Support Programme; and
18. modify its evaluation strategy to better measure the extent to which the Working New Zealand: Work-Focused Support Programme is achieving the intended outcomes, including increased numbers of beneficiaries case-managed into work (where appropriate) and expected savings in benefit expenditure.

# Part 1

## Introduction

- 1.1 In this Part, we discuss:
- why we carried out our audit;
  - what we looked at;
  - our audit expectations;
  - how we carried out the audit; and
  - what we did not audit.

### Why we carried out our audit

- 1.2 We carried out a performance audit to provide Parliament and the public with assurance that the Ministry of Social Development (the Ministry) – through its service delivery arm, Work and Income – was effectively managing sickness and invalids' beneficiaries.
- 1.3 In 2007/08, the financial year immediately before our audit fieldwork, the Ministry had spent about \$1.8 billion on sickness benefits and invalids' benefits. In December 2008, there were 83,501 people receiving an invalid's benefit and 50,896 people receiving a sickness benefit. In line with patterns in other developed countries, those on sickness and invalids' benefits comprised the largest – and growing – group of beneficiaries.
- 1.4 In 2008/09, the Ministry spent about \$1.9 billion on these benefits. In June 2009, there were about 54,000 people receiving a sickness benefit because they were temporarily unable to work, and about 84,000 people receiving an invalid's benefit because they were permanently and severely restricted in their ability to work.

### What we looked at

- 1.5 Specifically, we looked at how case management changed when the Working New Zealand: Work-Focused Support Programme (the Programme) was extended to include sickness and invalids' beneficiaries from September 2007.<sup>1</sup> Extending the Programme introduced changes that were designed to better assess eligibility for these types of benefit and to more actively help and encourage beneficiaries into work (where appropriate). The Ministry anticipated that it would take five years for the changes to deliver results. Those expected results included a reduction in the number of sickness and invalids' beneficiaries, and reduced spending on these types of benefit.
- 1.6 Effectively applying eligibility criteria, and timely referrals to accessible and appropriate services, are critical to achieving the Government's goal of moving beneficiaries into work as their circumstances allow. For these reasons, our audit

<sup>1</sup> Before September 2007, the Programme was supporting people receiving other types of benefits, such as the unemployment benefit.

focused on how Work and Income assessed a person's eligibility for a sickness or invalid's benefit, and on the comprehensive case management that the Programme was intended to produce.

### Structure of this report

- 1.7 Part 2 of this report explains the Programme in greater detail. Part 3 discusses how Work and Income was gathering and using the information needed to determine whether a person met the eligibility criteria for a sickness benefit or invalid's benefit. Part 4 discusses how well comprehensive case management was helping sickness and invalids' beneficiaries into work, as appropriate, or providing them with ongoing support and services. Part 5 discusses the Ministry's efforts in monitoring and reporting on movements in beneficiary numbers, and in evaluating the progress and effectiveness of the changes that extended the Programme to sickness beneficiaries and invalids' beneficiaries.

### Our audit expectations

- 1.8 We expected the Ministry to gather and use the information needed to determine whether a person was eligible for a sickness benefit or invalid's benefit. Making an informed decision requires case managers to consider and interpret various pieces of information about the applicant. The primary source of information is the health practitioner's assessment of the applicant's medical condition and the effect of that condition on the person's ability to work, as recorded in a medical certificate. Other relevant information can also be held in paper-based and electronic records that Work and Income might already hold about the person.
- 1.9 Deciding whether a person is eligible for a sickness benefit or invalid's benefit often requires careful judgement. We looked at how Work and Income's regional health advisors and regional disability advisors were used to support case managers in making these decisions.
- 1.10 We also expected Work and Income to actively identify the needs of individual beneficiaries and either help them into work or support them in the community. This requires a prompt and effective response to indications that the person is ready to plan for their return to work. It also requires periodic and direct contact with the person to identify their needs and plan with them, as their circumstances allow, for their personal development or eventual return to work.
- 1.11 We expected the Ministry to monitor and report on progress in implementing the changes made as part of the Programme, measure the effect on beneficiary numbers, expenditure, and other relevant outcomes, and monitor progress in achieving the savings expected from the Programme. The Ministry estimated



annual savings of \$49 million by 2010/11, after all the Programme's changes for sickness and invalids' benefits were in place.

### How we carried out the audit

- 1.12 We carried out our audit fieldwork from September to December 2008. We spoke to staff in the Ministry's head office and in Work and Income's national office about the case management of sickness and invalids' beneficiaries. These staff represented the service development, policy analysis, planning and performance, finance, and research and evaluation functions of the Ministry and Work and Income.
- 1.13 We visited five of Work and Income's 11 regional offices – in Dunedin, Waikato, Auckland, Nelson, and Northland – and two service centres in each of those regions. In the offices and service centres, we spoke with a range of staff, examined plans, strategies, reports, and other documents, and selected a sample of case files for 320 beneficiaries to examine. We used the sample to assess how Work and Income staff were deciding whether people were eligible for a sickness benefit or invalid's benefit, and to assess case management processes.
- 1.14 Our sample comprised files from two beneficiary groups: people with psychological or psychiatric conditions; and people with musculoskeletal disorders. These are the two major categories of incapacity among sickness and invalids' beneficiaries. The overall increase in beneficiary numbers is largely because of the increasing numbers of beneficiaries with these types of incapacity.
- 1.15 We have referred to numbers of cases in the report to show the extent of what we found in the sample we examined. The numbers sometimes relate to a subgroup of our sample. Where cases relate to a subgroup, we have given the size of that subgroup. We did not intend that the figures be extrapolated to all sickness and invalids' beneficiaries.
- 1.16 We also sent a questionnaire to general practitioners (GPs), the health practitioners who fill out most of the medical certificates that applicants for a sickness benefit or invalid's benefit must provide to Work and Income. The questionnaire asked GPs about this role, the design of the medical certificate, and their communication with Work and Income.
- 1.17 Appendix 1 has more detailed information about our audit methodology – our visits to the offices and service centres, our sampling, and the questions that we asked GPs in our questionnaire.

## What we did not audit

1.18

We did not audit:

- whether staff were complying with the Ministry's administrative rules and other requirements for considering applications for a sickness benefit or invalid's benefit;
- whether beneficiaries were satisfied with the service they received;
- whether beneficiaries were paid their full and correct entitlements; or
- the effectiveness of the Programme for individual beneficiaries, in terms of, for example, living conditions or participation in the community.

## Part 2

# The Working New Zealand: Work-Focused Support Programme

2.1 In this Part, we describe:

- sickness benefits and invalids' benefits;
- the purpose of the Programme;
- changes to Work and Income's case management of sickness and invalids' beneficiaries; and
- the savings the Ministry estimated would be achieved after the Programme was fully implemented.

### Sickness benefits and invalids' benefits

2.2 The administration of sickness and invalids' benefits is governed by provisions in the Social Security Act 1964 (the Act). These benefits are available to people 16 years of age or older, until they become eligible for New Zealand Superannuation.

2.3 Sickness benefits are paid to people with short-term medical conditions. A person can receive a sickness benefit only if their medical condition temporarily limits their ability to work.

2.4 Invalids' benefits are paid to people with severe longer-term illnesses or disabilities (that is, medical conditions lasting two years or more). A person may be eligible to receive an invalid's benefit if their medical condition permanently and severely restricts their ability to work.

2.5 Appendix 2 has more detailed information about how people qualify for a sickness benefit or an invalid's benefit.

2.6 For both sickness benefits and invalids' benefits, the most commonly reported diagnoses are psychological and psychiatric conditions, and musculoskeletal conditions. This pattern – of stress and depression accounting for a significant and growing proportion of people in this beneficiary group, and for a large proportion of total expenditure – is consistent with overseas experience.

### Purpose of the Programme

2.7 The Programme was announced by the then Minister for Social Development and Employment in October 2006. It introduced measures designed to support beneficiaries – such as those on the unemployment benefit – into work where appropriate, and help beneficiaries prepare for a return to work as soon as their circumstances allowed.

- 2.8 Beneficiaries were placed in one of three different service groups:
- Work Support – for people able to work immediately;
  - Work Development Support – for people who might be able to work if they had extra support to do so, as well as for beneficiaries whose personal circumstances meant that they were not able to work immediately but might be able to do so in the future with the right support in the right job; and
  - Community Support – for people whose personal circumstances meant they were considered unlikely to be able to work in the foreseeable future.
- 2.9 In September 2007, the Programme was extended to include sickness and invalids' beneficiaries.

### **Changes to Work and Income's case management of sickness and invalids' beneficiaries**

- 2.10 Extending the Programme meant a more comprehensive case management approach to dealing with sickness and invalids' beneficiaries. Systems and processes were set up to ensure that case managers had access to better information so they could make more effective decisions, and could access services for these beneficiaries.
- 2.11 Some of the major changes introduced included:
- amendments to the Act;
  - a redesigned medical certificate for health practitioners to complete;
  - additional staff, including regional health advisors and regional disability advisors, to support case managers in their decision-making;
  - an online medical database to help case managers in assessing applications; and
  - a fund enabling the Ministry to purchase health and disability services for beneficiaries.
- 2.12 The first priority for case managers is establishing eligibility for a benefit. Case managers mainly do this by considering the information provided in the redesigned medical certificate. For some beneficiaries, the case manager will use the new resources available, such as the online medical database and the regional advisors.
- 2.13 Once a benefit is granted, beneficiaries are given the opportunity to engage with their case manager – to attend meetings with their case manager, and prepare a Personal Development and Employment Plan. The planning process is designed to identify measures that will help the person into employment.

- 2.14 Participating in this planning for work is an option for all sickness and invalids' beneficiaries. The planning process is designed to include regular reviews, and requires beneficiaries to show a commitment to the goals in the plan. Beneficiaries are not required to carry out any work, work experience, or medical treatment as part of their plan.

### Amendments to the Social Security Act 1964

- 2.15 The Programme was supported by amendments to the Act that introduced the capacity to require sickness and invalids' beneficiaries to participate in work planning. A sanction could be applied – a reduction in the person's benefit – if they refused to take part in the planning process, or failed to demonstrate a commitment to the goals in the plan.
- 2.16 In practice, these powers had not been used for sickness and invalids' beneficiaries. Under the Ministry's policy, it was more appropriate for people receiving a sickness or invalid's benefit to take part voluntarily.

### Changes to the medical certificate

- 2.17 During 2007, Work and Income consulted with health practitioners to redesign the medical certificate. Work and Income wanted to collect more detailed and relevant information to use when determining eligibility for the sickness benefit or invalid's benefit.
- 2.18 The redesigned medical certificate, introduced in September 2007, requires the health practitioner – who could be a medical practitioner (usually a GP), dentist, or midwife – to:
- describe the person's medical condition using specific codes (known as READ codes) that are also used by the Accident Compensation Corporation;<sup>2</sup>
  - describe how the person's medical condition affects their ability to work and when they are able to return to work, including any restrictions on the type of work that they can carry out or workplace modifications that might be needed;
  - identify any other interventions that could help the person into work and provide any comments that would help the case manager to determine the appropriate support for the person; and
  - assess when the person is likely to be able to return to work.
- 2.19 The information in the medical certificate is important. It helps the case manager to determine whether a person will be eligible for the sickness or invalid's benefit. It is also useful in identifying which services or interventions might help the beneficiary return to work and the likely timing of their return to work.

<sup>2</sup> The READ codes replaced much broader diagnostic categories and are designed to provide case managers with a more detailed and accurate description of the beneficiary's ability to work.

2.20 Work and Income issued health practitioners with a comprehensive guideline in September 2007<sup>3</sup> and a handbook in June 2008.<sup>4</sup> The guideline described how to fill out the medical certificate, why particular information was sought, and what Work and Income staff did with the information provided. The handbook provided reference material about Work and Income's processes, and information on health-related benefits, assistance, and services.

### New advisors and other staff to assist case managers

- 2.21 The Ministry recruited specialist advisors and co-ordinators to work with employers, service providers, GPs, and case managers (see Figure 1). The new roles included 13 regional health advisors (and one principal health advisor), 13 regional disability advisors (and one principal disability advisor), 55 new employment co-ordinators, and 13 regional health and disability co-ordinators. These advisors and co-ordinators:
- advise Work and Income staff (usually case managers) on health and disability issues, a person's ability to work, and the services available to help someone return to work; and
  - work with employers and beneficiaries, establish and maintain relationships with external agencies, and provide links to programmes that help people move towards employment.
- 2.22 The 13 regional health and disability co-ordinators have an important education role with GPs and other health and disability providers, and liaise with particular medical practices.

**Figure 1**

#### Responsibilities in relation to sickness and invalids' beneficiaries

Case manager	Has primary responsibility for benefit-related issues. Receives and approves applications, carries out case management that includes identifying and facilitating services required to help beneficiaries back into work. Supported by regional health advisors, regional disability advisors, and employment co-ordinators. Manages beneficiary information.
Health practitioner (usually a GP)	Examines the person, and fills out the medical certificate so that the person may present it along with an application form to Work and Income.
Principal regional health advisor and principal regional disability advisor	Work with regional managers and contribute to community networks. Provide support to the regional health advisors and regional disability advisors.

3 *Sickness Benefit, Invalid's Benefit and Independent Youth Benefit (Sickness): Guide for Health Practitioners* (2007), Ministry of Social Development, Wellington.

4 *Health Practitioner Handbook: Work and Income* (2008), Ministry of Social Development, Wellington.

Regional health advisor	Works with the case manager to identify the service and support needs of the beneficiary, reviews applicant files and supporting health information. Advises on health factors associated with an application, expected outcomes, normal duration of the illness or disability, benefit reviews, and entitlement to services. Has a relationship with GPs.
Regional disability advisor	Responsible for advising on disability factors associated with a person's application, obstacles to employment, benefit reviews, and services.
Health and disability co-ordinator	Works with GPs to improve the standard of medical certificates they complete. Works with all health and disability providers to improve their understanding of Work and Income's operational processes and to strengthen Work and Income's relationship with regional providers.
Employment co-ordinator	Works with beneficiaries (including sickness and invalids' beneficiaries) to explore employment options. Markets beneficiaries to potential employers. Helps people move towards employment, and co-ordinates support to help them stay in employment.

### New medical database to help case managers

- 2.23 The Medical Disability Advisor is a computer-based resource. It describes medical conditions and includes information on the likely duration and recovery time for each condition.
- 2.24 The Medical Disability Advisor was introduced to help case managers:
- understand the beneficiary's medical condition;
  - determine the likely duration of a medical condition before the beneficiary can reasonably be expected to return to work; and
  - decide whether the reassessment period recommended in the medical certificate needs to be reviewed by a regional health advisor or regional disability advisor.

### Funds to purchase services that would help beneficiaries into work or support them in the community

- 2.25 A Health and Disability Innovation Fund for Pilot Health Services (the Innovation Fund) was approved by the Government in 2007. It enabled the Ministry to purchase health and disability services for groups of sickness and invalids' beneficiaries whose medical conditions presented a barrier to them seeking or securing work.

- 2.26 Through the Innovation Fund, the Ministry purchased health-related services from district health boards, primary health organisations, and other agencies. The services included services to address drug and alcohol problems, pain management, access to surgery, and mental health services.
- 2.27 To purchase these services, the Ministry received funding of \$5 million for the 2007/08 financial year, and expected to receive \$10 million for each subsequent year until 2011/12.
- 2.28 However, the 2009 Budget included an announcement that the Innovation Fund would not continue beyond 30 June 2009.

### **Savings estimated to be achieved as a result of extending the Programme**

- 2.29 In a March 2007 paper to Cabinet, the Ministry quoted estimated annual savings of \$49 million by 2010/11, subject to various assumptions. These savings were expected to be achieved through an increase in the number of people who moved off the sickness benefit or invalid's benefit into work, with people expected to spend less time on those benefits. Some people were also expected to continue receiving the benefit but do new part-time work, lowering the average level of benefit payment.



## Part 3

# Determining eligibility for sickness and invalids' benefits

- 3.1 In this Part, we set out our findings about:
- the information recorded in medical certificates;
  - health practitioner practices in issuing medical certificates;
  - Work and Income's use of other information to determine eligibility; and
  - the roles and practices of regional health advisors and regional disability advisors.

### Our overall findings

- 3.2 In the sample we selected, when the revised medical certificates were completed in full they provided relevant information for case managers to use when making decisions about eligibility. However, the quality of the information provided by GPs varied. Some questions were unanswered or the information was not detailed enough to be useful. We also noted instances where information on the medical certificate or in other records suggested that case managers should have referred the application to the regional health advisors or regional disability advisors before deciding on eligibility, but had not done so.
- 3.3 When they were used, the computer-based Medical Disability Advisor and the regional health advisors and regional disability advisors led to better and more informed decision-making. For example, our sample of case files included applications that had been referred to the regional health and regional disability advisors. Based on their advice, some applications for sickness and invalids' benefits had been declined. Some beneficiaries who were considered for an invalid's benefit were, after discussion with the health practitioner, kept on the sickness benefit, and beneficiaries on the invalid's benefit were reassigned to the sickness benefit.
- 3.4 We have made eight recommendations in this Part, about:
- ensuring consistent practices for reviewing applications;
  - improving the quality of information recorded in medical certificates;
  - promoting a more comprehensive and systematic assessment of all available information to determine eligibility;
  - making better use of regional health advisors and regional disability advisors; and
  - reviewing the circumstances of longer-term sickness beneficiaries (that is, people who have received a sickness benefit for more than one year).

## Information recorded in medical certificates

**The revised medical certificate introduced in September 2007 has provided relevant information for determining eligibility. The usefulness of medical certificates was sometimes limited because the information recorded was not complete or sufficiently specific.**

- 3.5 The medical certificate is the main source of information a case manager uses to determine eligibility – and then ongoing eligibility – for a benefit. To help case managers determine eligibility, it is important that health practitioners record sufficient information on the medical certificates.
- 3.6 For our sample of beneficiaries, we examined how health practitioners answered the questions in the medical certificate, how much detail was provided, and how useful that information was for determining eligibility.
- 3.7 The amount and usefulness of the information provided varied. In some cases, the medical certificates did not clearly describe the effect of the person's medical condition on their ability to work. Instead, this was sometimes expressed in general terms, for example "fatigue, insomnia, low mood", "needs supervision", or "depression". These responses provided limited or no information about the person's ability to work (in their own profession or in another line of work).
- 3.8 In our sample, not all the required questions in the medical certificate had been answered. Sometimes the information in the medical certificate was not provided consistently (for example, in relation to work planning and training timeframes).
- 3.9 In our view, the Ministry needs to work with health practitioners to improve the consistency and amount of information provided in the medical certificates.

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### Recommendation 1

We recommend that the Ministry of Social Development find out why there are variations in the amount and quality of information provided by health practitioners in the medical certificate, and help health practitioners provide – without undue burden on their time – the information that Work and Income needs.

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### Optional question about treatment

- 3.10 The medical certificate includes an optional question about any treatment the person is receiving for medical conditions listed as affecting the person's ability to work. The question is asked to help the case manager with planning, not for determining eligibility.

- 3.11 In our view, information about treatment is valuable when considering the prognosis and likely health outcomes for the beneficiary, and is particularly relevant when deciding eligibility for an invalid's benefit or where a person has been receiving a sickness benefit for a long time. Often, treatment is able to control a condition (for example, diabetes or epilepsy) or provide periods of wellness (for example, in some cases of mental illness), during which a person can work. Information about the treatment a person was receiving was one consideration for regional health advisors and regional disability advisors when they reviewed applications – particularly in the case of applications from longer-term sickness beneficiaries and invalids' beneficiaries.
- 3.12 Centrelink, Work and Income's Australian counterpart, considers whether all reasonable treatment options have been pursued before deciding whether a medical condition should be accepted as permanent.

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**Recommendation 2**

We recommend that the Ministry of Social Development, in cases of long-term and complex medical conditions, actively use information about treatment to inform decisions about the permanence and severity of a person's condition(s) and how they affect a person's ability to work.

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## Health practitioner practices in issuing medical certificates

### **Work and Income did not systematically collect or analyse data on health practitioners' practices in issuing medical certificates.**

- 3.13 The Ministry carried out analysis in September 2006 that identified deficiencies and varying practices in how health practitioners issued medical certificates for sickness benefit applicants. In June 2007, the Ministry proposed to create a profile of health practitioners, to identify those whose practices in issuing medical certificates differed significantly from those of their colleagues. The reasons for the differences could then be investigated.
- 3.14 In our view, there are several possible explanations for variations in assessment practice. For example, health practitioners practising in lower socio-economic areas, or specialising in mental health, would be expected to assess a higher number of people eligible for a sickness benefit. In some cases, health practitioners could be more inclined to, or under pressure to, issue medical certificates.
- 3.15 At the time of our audit (from September to December 2008), the Ministry told us that it had not yet created a profile of health practitioners. It was not

systematically collecting or analysing data to establish unusual patterns in how health practitioners were assessing people and completing the medical certificates.

- 3.16 The Ministry's Principal Health Advisor may, on occasion, make contact with health practitioners. This occurs infrequently, and such discussions involve advising health practitioners who might be experiencing pressure to fill out a medical certificate, or consulting with any health practitioners who express serious concerns about Work and Income's processes.
- 3.17 In our view, collecting and interpreting data on the assessment and certification behaviour of health practitioners would enable the Ministry to identify and investigate reasons for varying practices. This analysis would enable the Ministry to take appropriate action, which might include reviewing the design of the certificate, providing additional training and guidance, or reporting any concerns to a health practitioner's professional body.

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### Recommendation 3

We recommend that the Ministry of Social Development improve its monitoring of patterns in how health practitioners issue medical certificates to help ensure that certificates are completed and issued appropriately.

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## Using other information to help determine eligibility

**Case managers were not making sufficient use of other methods and information to help determine a person's eligibility for the sickness or invalid's benefit.**

### Using medical certificates to determine eligibility for the sickness benefit

- 3.18 To establish eligibility for the sickness benefit, Ministry policy requires case managers to consider the information in the medical certificate.
- 3.19 The medical certificate records the beneficiary's current medical status. It generally provides no information about work history and personal circumstances. It does not show the length of time the beneficiary has been receiving the benefit or the progress made towards returning to employment. To review this information, case managers have to look at the Ministry's online records or previous medical certificates.
- 3.20 The sickness benefit is intended to help people who are temporarily off work or working at a reduced level. It is expected that most sickness beneficiaries' ability to work will improve, allowing them to progress towards employment. However,

as at December 2008, almost half of all sickness beneficiaries – 47% or 24,000 people – had been receiving a sickness benefit continuously for a year or more.

- 3.21 Our observations and discussions with case managers indicated that, in line with Ministry policy for assessing eligibility for a sickness benefit, case managers were generally making limited use of information other than the current medical certificate. Their approach was no different when they considered ongoing eligibility for long-term beneficiaries.
- 3.22 In the sample of sickness beneficiary cases that we looked at, we identified apparent inconsistencies in the information available to case managers – including case notes, journals, and past medical certificates (where available) – about a person's medical condition, benefit history, or personal circumstances. In our view, these inconsistencies warranted referring the application to the regional health advisor or regional disability advisor for clarification and advice before the benefit was granted.
- 3.23 Instances where we considered clarification should have been sought included:
- unusual changes to the assessment of when the person would be ready to plan to return to work;
  - changes in diagnosis from one medical certificate to the next; and
  - inconsistencies between the person's work history or intentions and the health practitioner's assessment of when that person would be ready to work.

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#### **Recommendation 4**

We recommend that the Ministry of Social Development, when deciding on eligibility for long-term sickness beneficiaries, provide further guidance to case managers on when to refer cases to a regional health advisor or regional disability advisor for a detailed review of the beneficiary's file.

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#### **Using medical certificates and other information to determine eligibility for the invalid's benefit**

- 3.24 To establish eligibility for an invalid's benefit, Ministry policy requires case managers to consider the current medical certificate as well as other information available about a person, including case notes, journals, previous medical certificates, hard copy files, vocational assessments, and specialist medical assessments.
- 3.25 In all the service centres that we visited, new applications for the invalid's benefit had to be referred to the regional health advisor or regional disability advisor for a

recommendation about entitlement. Some regions had adopted this policy later than others.

- 3.26 Where applications were referred to the regional health advisor or regional disability advisor, the requirement to consider other relevant information was, in our view, met by the case manager. We noted instances where, after the advisor reviewed additional information and talked to the health practitioner, some applications for the invalid's benefit were declined and the beneficiary remained on the sickness benefit. In our view, this shows how useful this specialist resource can be.
- 3.27 We reviewed applications in two service centres that adopted the practice of making referrals to the regional health advisor or regional disability advisor in the last quarter of 2008. In this subgroup of our sample, of the 47 applications that had not been referred to the regional health advisor or regional disability advisor for a recommendation on eligibility, nine applications had information on the file that suggested that such a referral was warranted. For example:
- The beneficiary was carrying out a full-time course of study and the GP did not know whether the condition would last longer than two years.
  - The beneficiary was completing a full-time university course as well as working part-time. The file also contained a medical certificate that said the beneficiary was not permanently and severely disabled and did not medically qualify for an invalid's benefit.
- 3.28 There were 26 applications where ongoing eligibility for the invalid's benefit was assessed. Nine were referred to the regional health advisor or regional disability advisor. Five of the remaining 17 had information on the file that suggested that the application warranted referral. This information included:
- the GP signing the certificate for a 13-week duration;
  - the beneficiary applying for a training incentive allowance for a pilot's licence two months before a renewal was granted, even though the beneficiary's condition was musculoskeletal; and
  - an assessment on file where the beneficiary had said that they were ready and able to work in less than six months.
- 3.29 In our view, where applications for long-term sickness benefits and invalids' benefits are not referred to the regional health advisor or regional disability advisor, there is value in case managers reviewing past online records. If necessary, case managers should refer to previous medical certificates. Any inconsistencies can be referred to the regional health advisor or regional disability advisor for their recommendation before a decision about eligibility is made.

### Verifying the circumstances of long-term beneficiaries

- 3.30 Work and Income had a number of designated doctors<sup>5</sup> who were used to provide second opinions on a person's medical incapacity, to help case managers to determine both benefit entitlement and appropriate interventions.
- 3.31 Case managers were able to refer a beneficiary directly to a designated doctor when:
- the beneficiary's health practitioner advised that they were not best placed to provide the medical information and a second opinion was appropriate; or
  - the beneficiary was not able to, or did not, provide a report or medical certificate and Work and Income records did not hold enough information to determine whether the person was entitled to an invalid's benefit; or
  - the beneficiary chose to see a designated doctor.
- 3.32 Case managers are also required to refer other cases to the regional health advisor or regional disability advisor for advice before deciding if the beneficiary should be assessed by a designated doctor. These situations include when:
- diagnosis is unclear;
  - there is not enough information in the certificate and existing reports, assessments, or Work and Income records to decide entitlement;
  - the medical information is ambiguous or conflicting;
  - a previous medical certificate contains a substantially different diagnosis or recommendation;
  - the beneficiary is involved in activities that appear to be inconsistent with recorded incapacities; or
  - the duration for the particular condition exceeds the duration recommended by the Medical Disability Advisor by 50% or more.
- 3.33 Work and Income's information technology system, SWIFTT, records the "recommended incapacity duration". This is intended to alert case managers to the need to refer sickness beneficiaries to the regional health advisors or regional disability advisors because the duration recommended by the health practitioner exceeds that recommended in the Medical Disability Advisor. In addition, the standard case management reports available to case managers include a report that identifies the sickness beneficiaries in each case manager's portfolio who have exceeded the expected recovery period.

<sup>5</sup> A designated doctor is a health professional to whom a Work and Income case manager or regional health or disability advisor may refer a person for a second medical opinion to establish or review whether they meet the medical requirements for a sickness or invalid's benefit. Designated doctors are usually vocationally registered medical practitioners with a minimum of five years' experience in New Zealand and a demonstrated ability to work constructively with Work and Income staff.

- 3.34 One of the regions that we visited was encouraging its case managers to actively manage this group of sickness beneficiaries. Case managers were asked to identify sickness beneficiaries who had been on the sickness benefit for 50% longer than the average time that it takes to recover from the condition. They would then refer these beneficiaries to the regional health advisor or regional disability advisor to confirm ongoing eligibility for the sickness benefit.
- 3.35 In this region, for the information provided to us for the period from October 2007 to November 2008, the regional health advisors and disability advisors were referring sickness beneficiaries to a designated doctor to confirm their ongoing eligibility for the sickness benefit where the duration exceeded the Medical Disability Advisor guidelines.
- 3.36 In another region we visited, during the same period case managers had referred 114 beneficiaries to the regional health advisors and regional disability advisors because the beneficiaries had exceeded the expected recovery time. Of this group, the advisors recommended that 66 sickness beneficiaries be referred to a designated doctor for a second opinion.
- 3.37 We did not see evidence of this type of systematic review in the other regions that we visited. Instead, referrals relied on the initiative of the individual case manager. In the sample of beneficiary records that we examined, we identified longer-term sickness beneficiaries who could usefully have been referred to a regional health advisor or regional disability advisor for review.
- 3.38 Some case managers referred applications to the regional health advisors and regional disability advisors based on information in the Medical Disability Advisor, but other case managers and other staff told us that this database was not widely used. They said that they did not have time to use it, or that it was not helpful. We understand that caution needs to be exercised in applying the recommended durations to the circumstances of individual beneficiaries. However, the tool did have some practical application. Regional health advisors and regional disability advisors sometimes used the Medical Disability Advisor when reviewing applications referred to them by case managers, and encouraged case managers to refer to it when assessing applications.
- 3.39 For beneficiaries with complex and longer-term conditions, we noted that vocational assessments provided information that helped to identify work opportunities that recognised the effect of the person's medical condition. In our view, more widespread use of vocational assessments would be useful. This view was supported by comments from the GPs who answered our questionnaire.



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### Recommendation 5

We recommend that the Ministry of Social Development consider using vocational assessments more often for beneficiaries with complex and long-term medical conditions and multiple barriers to work.

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### Recommendation 6

We recommend that the Ministry of Social Development provide Work and Income case managers with more guidance about using the Medical Disability Advisor, clarifying when they ought to use that database to check the expected effect of a person's medical condition on their ability to work and likely return to work.

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## Referrals to regional health advisors and regional disability advisors

**Regional health advisors and regional disability advisors were providing case managers with valuable support for complex applications, although their practices could be more consistent from region to region. In our view, the criteria for referrals should be broader so more sickness and invalids' beneficiaries can be referred.**

- 3.40 The main groups of sickness and invalids' beneficiaries referred to the regional health advisors and regional disability advisors were:
- people applying for the invalid's benefit;
  - people receiving the sickness benefit who, in the view of the health practitioner or case manager, might be eligible for the invalid's benefit; or
  - invalids' beneficiaries who were due for their scheduled medical reassessment.
- 3.41 Policies for referring beneficiaries to regional health advisors and regional disability advisors were determined regionally rather than nationally.
- 3.42 Some regions encouraged case managers to refer any new application for an invalid's benefit or reassessments of an invalid's benefit to the regional health advisor or regional disability advisor before an invalid's benefit was granted. Two of the regions that we visited had been monitoring their case managers and randomly auditing applications to see that this was done.
- 3.43 As invalids' beneficiaries become due for their periodic medical reassessments, there will be an opportunity to review a growing proportion of this group. At the

time of our audit, most of this group had not yet been reviewed. This was partly due to the different reassessment periods for invalids' beneficiaries (two years, five years, or never), and partly due to the short length of time that regional health advisors and regional disability advisors had been in place.

- 3.44 In our view, the limited scope of reviews to date also reflects the need for regions to consolidate and broaden their referral and review practices. The Ministry told us that an estimated 35% of all invalid's benefit applications or reassessments in the 12 months to April 2009 were referred to regional health advisors or regional disability advisors.
- 3.45 We noted initiatives to broaden the criteria for referring benefit applications to advisors for review, such as by the nature of their incapacity. In our view, the Ministry should consider further extending the criteria for review to take account of factors such as the person's benefit and work history, their personal circumstances, the nature of their incapacity, the length of time they have been on the benefit, and their age.
- 3.46 We encourage case managers to make better and more frequent use of regional health advisors and regional disability advisors.

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**Recommendation 7**

We recommend that the Ministry of Social Development broaden the criteria used to refer benefit applications to regional health advisors and regional disability advisors so that, as resources allow, more cases can be reviewed for ongoing entitlement to the sickness benefit or invalid's benefit.

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- 3.47 In our view, the support that regional health advisors and regional disability advisors provided to case managers was valuable. The advisors were able to speak with the person's health practitioner to get more detailed information about the person's medical condition, work capacity, and prognosis. It also provided an opportunity for the advisor and health practitioner to discuss other services that could help the person.
- 3.48 The extent of the reviews carried out by the regional health advisors and regional disability advisors varied. Some advisors provided more advice than others. The contribution of these specialist advisors could be improved by promoting more consistent practice. Reviews carried out by regional health advisors and regional disability advisors would be most useful if they:
- included a discussion with the health practitioner to confirm eligibility by clarifying the nature of the medical condition, the prognosis, and the effect of the condition on the person's ability to work;

- identified work opportunities for which the person might be suited, given their circumstances and incapacity;
  - assessed the person's health and other needs, and services that might meet their needs; and
  - recommended to the case manager a plan for actively working with the person to help them in the community or help them move into work, as appropriate.
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**Recommendation 8**

We recommend that the Ministry of Social Development better promote best practice for Work and Income regional health advisors and regional disability advisors and make better use of these advisors.

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## Part 4

# Comprehensive case management

- 4.1 In this Part, we set out our findings about how well Work and Income was case managing sickness and invalids' beneficiaries to help them into work or help them participate in the community, as appropriate. We describe our findings about:
- information to help case managers and beneficiaries with their planning;
  - engaging and planning with beneficiaries;
  - Work and Income's expectations for periodic contact;
  - using information about beneficiaries' work-readiness;
  - case managers' use of provisions in the Social Security Act 1964;
  - following regional advisors' recommendations;
  - available services and referrals to those services; and
  - case managers' use of the available tools, and the Ministry's monitoring of that use.
- 4.2 The Programme introduced a comprehensive case management model that was designed to provide individualised, needs-based case management support and services to beneficiaries.
- 4.3 The main focus of case management under this new approach was increased interaction between case managers and beneficiaries to:
- enable the beneficiary to set goals (for work or increased community participation); and
  - help the beneficiary to work towards their goals by offering help with personal planning and providing access to a range of contracted and community services.
- 4.4 The overall objective was to increase the number of sickness and invalids' beneficiaries entering the workforce.
- 4.5 The success of this approach relies on the case manager actively engaging with the beneficiaries assigned to their caseload. This requires the case manager to periodically review the person's circumstances (including their health needs) and, depending on the person's circumstances, to identify support and services to help them into work where possible, or to help them participate more fully in the community.

### Our overall findings

- 4.6 Based on our examination of a sample of beneficiary case files and interviews with Work and Income staff, comprehensive case management for sickness and invalids' beneficiaries had been limited to a relatively small group. This finding

is supported by the limited number of Personal Development and Employment Plans prepared by sickness and invalids' beneficiaries.

- 4.7 The case management that had occurred had been largely reactive and was initiated by the beneficiary rather than Work and Income staff.
- 4.8 Some regions had begun to actively case manage specific subgroups of sickness and invalids' beneficiaries who appeared to be more ready for work. However, these strategies did not include the large group of long-term sickness beneficiaries.
- 4.9 The Ministry had a framework and expectations for the frequency and timing of engagement with sickness and invalids' beneficiaries. Based on this framework, case managers were expected to have contacted all sickness and invalids' beneficiaries (where appropriate) to initiate comprehensive case management. However, based on our sample, case managers had yet to initiate contact with a large number of sickness and invalids' beneficiaries.
- 4.10 The revised medical certificate (when completed as intended) provided useful information to Work and Income on the work-readiness of individual sickness and invalids' beneficiaries. It also provided indicative timings to help case managers plan for the beneficiary's return to work and identify the services required to help the beneficiary to return to work. However, based on our sample, case managers rarely acted on this information. This finding was supported by the comments made by GPs in response to our questionnaire.
- 4.11 Our interviews with case managers established that the factors most likely to be constraining more active case management were the case managers' workloads, and a reliance on beneficiaries to actively and willingly participate with Work and Income in planning.
- 4.12 Although the Act enables the Ministry to require sickness and invalids' beneficiaries to engage with case managers and participate in personal development and work planning, the Ministry had decided that sickness and invalids' beneficiaries would be invited to participate.
- 4.13 We consider that case management could be further improved and we have made eight recommendations in this Part.

## Information to help case managers and beneficiaries with their planning

**Medical certificates were not usually providing information that could usefully help with work planning. Where useful information was provided, case managers were not using it for work planning purposes.**

- 4.14 The revised medical certificate contained two optional questions that related solely to planning.
- 4.15 The first question sought to establish whether a person's current treatment would have a material effect on their ability to participate in work planning. For example, a person undergoing intensive treatment such as chemotherapy or awaiting imminent surgery would not be able to take part in work planning as readily as a person with a longstanding but stable condition. In other circumstances, effective treatment might stabilise a medical condition enough to enable a person to consider options for returning to work.
- 4.16 The second question related to "other interventions which [sic] could assist the person into work". This question invited the health practitioner to suggest an intervention that could improve a person's ability to work. This information would enable Work and Income to consider referring the person to a service appropriate to the person's needs.
- 4.17 In our sample of case files, these questions were infrequently completed by health practitioners. Where they were completed, most of the responses simply recorded what treatment or other interventions were used (such as "drugs", "medication" or "counselling") rather than how treatment or a given intervention affected the person's ability to work. When adequate responses were given, we found no evidence that the responses were used by Work and Income staff to decide when best to approach the person to begin work planning.

## Engaging and planning with beneficiaries

**Case managers were actively engaging with certain groups of sickness and invalids' beneficiaries. However, the nature and frequency of engagement with many other beneficiaries had not changed.**

- 4.18 The Ministry used the term "engagement" to describe a process where the beneficiary met with Work and Income staff (usually the case manager or an employment co-ordinator) to discuss their future and to identify ways that Work and Income could support them. People who might not have been quite ready to work could discuss how Work and Income could support them in reaching their goals for themselves and their families. This support could take many forms

– training, part-time or casual employment, health services, or helping them overcome practical difficulties like childcare or transport. A beneficiary could prepare a plan as a result of this engagement.

4.19 Engagement could be initiated by a beneficiary or by Work and Income staff.

### **Focusing comprehensive case management on specific groups of beneficiaries**

4.20 In June 2007, the Ministry carried out research to help it make decisions about investing in employment programmes and to inform the design of policy and services to meet the needs of sickness and invalids' beneficiaries. This research included profiling people receiving sickness and invalids' benefits. The Ministry also estimated the future financial costs for different groups of working-age beneficiaries.

4.21 Work and Income's national office used this research to identify groups of beneficiaries who ought to receive more comprehensive case management. It prepared guidelines for regions and service centres to develop strategies for identifying beneficiaries who ought to receive more comprehensive case management. These regional strategies included focusing on groups such as young people on the sickness benefit, beneficiaries with working partners, beneficiaries in part-time work, the longest-term sickness beneficiaries, and people who should possibly transfer from the sickness benefit to the invalid's benefit.

4.22 These regional strategies to target groups of sickness and invalids' beneficiaries represented a positive first step towards working more actively with beneficiaries. However, they addressed only a small proportion of the total population of some 134,000 sickness and invalids' beneficiaries, and excluded large numbers of longer-term beneficiaries. As we noted in paragraph 3.20, as at December 2008 nearly half of all sickness beneficiaries had been on the sickness benefit continuously for more than a year. The sickness benefit is meant to be a temporary benefit.

4.23 At the time of our audit, Work and Income had no strategy for helping this large group of longer-term beneficiaries into work or for exploring their needs. Except where contact was initiated by a beneficiary, case manager contact with this large group of sickness and invalids' beneficiaries was likely to be limited to periodic processing of medical certificates, and administering supplementary income support benefits and allowances.



**Recommendation 9**

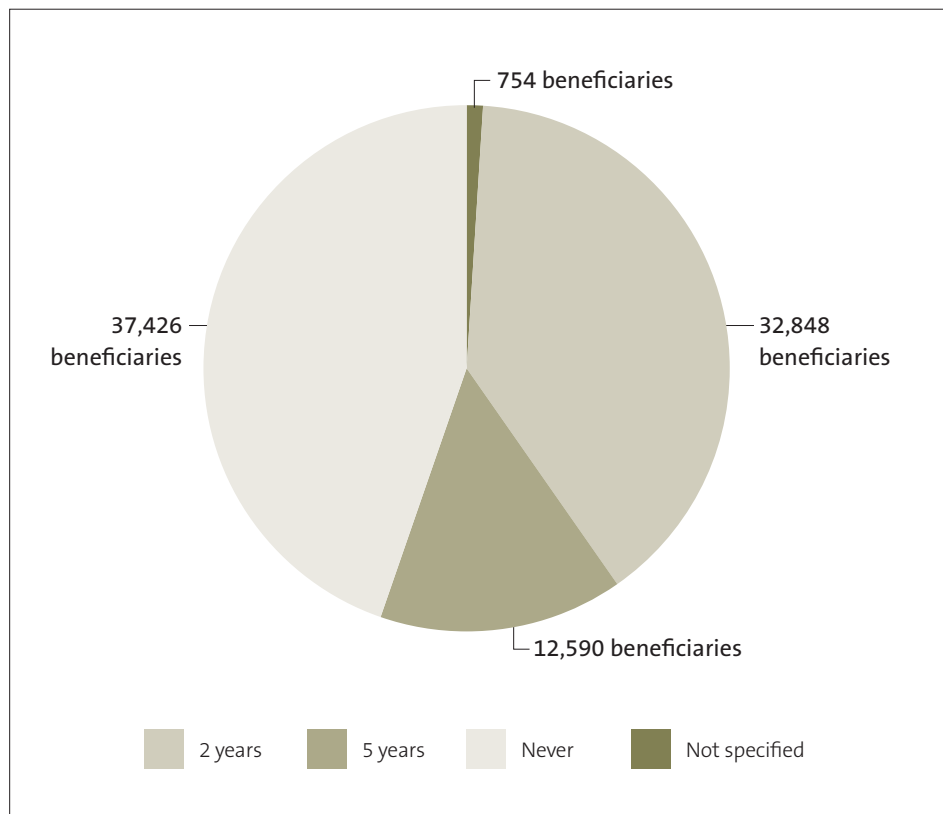
We recommend that the Ministry of Social Development review the circumstances of longer-term sickness and invalids' beneficiaries to better identify those for whom work is an option, and provide them with appropriate case management and employment-focused services.

4.24 For a large group of invalids' beneficiaries, contact was likely to be even more limited because of the longer intervals between medical reassessments (two or five years). At September 2008, 12,590 invalids' beneficiaries were scheduled for five-yearly reassessments. There were another 37,426 who, on the recommendation of the certifying health practitioner (or the national office of Work and Income), were not scheduled for any future medical reassessment. For this group, their medical conditions and ability to work were considered unlikely to ever improve.

4.25 Figure 2 shows a breakdown of reassessment periods for invalids' beneficiaries.

**Figure 2**

**Reassessment periods for invalids' beneficiaries (as at September 2008)**



### Contact with beneficiaries who were classified as not needing reassessment

- 4.26 In our view, all sickness and invalids' beneficiaries should be periodically contacted by Work and Income, including those beneficiaries whose entitlement on medical grounds has been assessed as "never to be reassessed". The policy papers prepared by the Ministry at the start of the Programme noted that:
- ... many people on [invalids' benefits] do not have their eligibility reassessed – indeed, some people qualified for [invalids' benefits] under the old 75% impairment test, and have never been assessed on the 15 hour rule.*
- 4.27 One of the features of the new system was supposed to have been "more frequent reassessment for some people who are currently seldom or never reassessed".
- 4.28 Although this group of beneficiaries might never be able to work, helping them plan for increased participation in the community might be appropriate. A periodic review could identify changes in circumstances that could affect the need for financial support and services, as well as any other types of support to achieve a beneficiary's goals for working or participating in the community.
- 4.29 Moreover, as treatment options and work environment innovations occur, some people who would not have been able to have much community participation or work in the past might now be able to.

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#### Recommendation 10

As resources allow, we recommend that the Ministry of Social Development use the available information to determine whether invalids' beneficiaries classified as "never to be reassessed" should be more actively case managed.

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#### The Ministry's draft strategy

- 4.30 As our audit fieldwork ended, the Ministry was preparing a strategy to identify those beneficiaries who would benefit most from comprehensive case management. The Ministry's initial work had identified four categories for sickness and invalids' beneficiaries:
- those needing income support for only a limited time because they were expected to recover within a certain time, or those on an invalid's benefit and working part-time to capacity – the primary need to be met would be financial;
  - those who were working part-time, or who were able to work part-time and needed employment assistance – these beneficiaries would need less intensive case management but more input from an employment co-ordinator;

- those who were likely to have the ability to work part-time or full-time if provided with the right resources – these beneficiaries would need comprehensive case management; and
  - those who were unlikely to be able to work – these beneficiaries would need the right resources (likely to be community resources).
- 4.31 The Ministry's preliminary estimates of the numbers of beneficiaries in each category were that most beneficiaries (46% of invalids' beneficiaries and 65% of sickness beneficiaries) were likely to need comprehensive case management.
- 4.32 If applied effectively and supported by the necessary resources, the draft strategy had the potential to provide a more systematic and informed framework for Work and Income to engage with beneficiaries, especially those longer-term beneficiaries with whom it had limited contact.

### Work and Income's expectations for periodic contact

#### **Ministry expectations for frequency of contact were often not met. Priority cases and emergency appointments limited case managers' availability.**

- 4.33 Work and Income provided guidance to its case managers on when to make contact with sickness and invalids' beneficiaries. Beneficiaries were assigned to one of three service groups according to their ability to work, as assessed through a structured discussion with Work and Income staff. When and how case managers were expected to make contact with a beneficiary depended on the service group to which the person had been assigned. However, the guidance noted that any such contact was an invitation to the beneficiary to work more actively with the case manager, and the person might choose not to participate.
- 4.34 Figure 3 shows the three service groups and when and how contact was expected to occur. Based on this framework, we expected the Ministry to have initiated contact with all sickness and invalids' beneficiaries by the time of our audit – either to better support them in the community or to discuss planning for a return to work.

**Figure 3**  
Service groups, intervention points, and the frequency and methods of contact for sickness and invalids' beneficiaries

Service group	Intervention point	Frequency	Method
<i>Work Support</i> – people who are able to work now	Initial application or within six weeks of initial application Reassessment	Every six weeks	Case manager interview (in person)
<i>Work Development Support</i> – those people who might be able to work now but need extra support to do so, as well as people whose personal circumstances mean they are not able to work now but might be able to do so in the future with the right support in the right job.	<i>For sickness beneficiaries</i> Initial application First medical review (four weeks) Subsequent medical review	Every 13 weeks	Case manager interview (in person or by telephone)
	<i>For invalids' beneficiaries</i> Initial application or within six weeks of initial application interview Annual benefit review Invalid's benefit medical review Change of circumstances Completion of any activities or services	At least once a year	Case manager interview (in person or by telephone)
<i>Community Support</i> – people who have personal circumstances that mean they are considered unlikely to be able to work at all in the foreseeable future. These are mainly people receiving the invalid's benefit who have a severe illness or disability or a terminal illness.	<i>Invalids' beneficiaries</i> Initial application Annual benefit review Invalid's benefit medical review Change of circumstances Whenever beneficiary wants contact	Yearly or as required/ appropriate	Case manager interview (in person or by telephone)

4.35 In our sample of case files, Work and Income had not contacted beneficiaries at the times shown in Figure 3. Overall, most of the contact was initiated by the beneficiary when they sought additional temporary financial support, rather than initiated and planned by the case manager to review the support and services provided to the person and, where appropriate, assess progress with their return to work.

4.36 We found cases where planned contact, or any other form of contact, between Work and Income and beneficiaries had been infrequent, occurring rarely over months or even years. This situation was corroborated by comments made in the context of a regional programme, carried out in Work and Income's Southern region, to establish whether beneficiaries were receiving their full and correct entitlement (see Figure 4). In analysing the results of that programme, the region reported:

*Clients in general responded very well [to the programme] with some having been without contact from Work and Income for a large number of years.*

#### Promoting more active engagement

4.37 Regions and service centres were looking for ways to promote more active engagement with beneficiaries. Initiatives included:

- using employment co-ordinators and regional health advisors and regional disability advisors to support case managers in identifying opportunities for active engagement;
- seeking to meet some sickness beneficiaries at the time of medical reassessments to discuss the contents of the medical certificate, any services to which Work and Income might refer them, and other support to help their return to work;
- setting aside time each week for case managers to identify and contact their assigned beneficiaries; and
- looking for opportunities to relieve case managers of time-consuming tasks (for example, using a single person to process medical certificates).

4.38 Figure 4 describes an initiative used by Work and Income's Southern region.

#### Figure 4 Southern region's initiative for sickness beneficiaries

The Southern region established a team early in 2008 to interview sickness beneficiaries between the ages of 25 and 49 (in their own home or the local Work and Income office). The interviews were held to ensure that beneficiaries were receiving their full and correct entitlement, and to identify any opportunities or interventions that could help them return to work.

This group comprised a total of 927 beneficiaries. Of these, 129 had recently had contact with Work and Income and did not need to be approached. Letters were sent to the remaining 798 to arrange an interview, and sanctions were used to ensure that beneficiaries responded. In all, 469 beneficiaries were interviewed during the programme, resulting in:

- 47 referrals to employment co-ordinators;
- 86 referrals to the Ministry's Providing Access to Health Solutions (PATHS)\* programme;
- 8 referrals to work brokers; and
- 51 referrals to the regional health advisor.

Of the 329 beneficiaries who were not interviewed:

- 58 had returned to work;
- 57 were not well enough to participate;
- 21 had their benefit cancelled;
- 150 were working with their case manager;
- 6 had begun full-time study;
- 14 had left the district (and might have still been receiving the benefit); and
- 23 had gone to prison (and were therefore no longer eligible to receive the sickness benefit).

In total, 134 people came off the sickness benefit as a result of the six-week programme. However, it was noted that this number did not include those people who might have moved off the sickness benefit later, after their referrals and other initiatives taken by Work and Income.

Lessons and benefits from the programme included:

- Beneficiaries between the ages of 40 and 49 were more likely to participate actively in the programme or to be already working with their case manager. This group was also more likely to have been referred to Work and Income services.
- Many sickness beneficiaries were very unwell, and many had mental health issues.
- Most beneficiaries responded very well to the programme, and some had not been contacted by Work and Income for a large number of years.

\* PATHS is a programme that helps people receiving a sickness benefit or invalid's benefit to access services that can reduce or remove health barriers to employment.

#### Availability of case managers limited by priority cases

- 4.39 Case managers have to follow specific rules for emergency appointments, new business and reapplications, and special needs and grant advances. Figure 5 sets out the timeframes associated with these rules.

**Figure 5**  
Specific rules governing timeframes for appointments with beneficiaries

Type	Examples of circumstances	Timeframe
Emergency	Eviction, medical, or dental emergency, non-payment of benefit, power disconnection notice, funeral, or food needs	Within 24 hours (must be seen on the same day)
New business/ reapplications	A new beneficiary or a previous beneficiary with new or same service centre	Within 48 hours
Special needs grant/ advance	Urgent and necessary need with no other way of meeting costs	Within five days

- 4.40 Some case managers told us that the time available for actively engaging with beneficiaries was limited by the high numbers of medical certificates that had to be processed, and the need to attend appointments with other beneficiaries.

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**Recommendation 11**

We recommend that the Ministry of Social Development investigate why contact with beneficiaries is intermittent and reactive, and introduce improvements to ensure that case managers engage systematically and actively with beneficiaries, in keeping with the Ministry's expectations for periodic contact.

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## Using information about beneficiaries' work-readiness

### Case managers were not always acting on information indicating that a beneficiary was ready to prepare for or seek work.

- 4.41 Engaging with sickness and invalids' beneficiaries was supposed to occur when a beneficiary expressed an interest in work, or when the medical certificate received from the health practitioner indicated that the person was ready to plan for or take up work.
- 4.42 The medical certificate asked the health practitioner for their opinion on the person's ability to work and to indicate the person's likely progress towards work. The health practitioner was required to indicate when the person was likely to be capable of:
- Work planning – that is, engaging with their case manager to determine what services were required to help the person into work. These services might include health interventions, but could also include vocational, educational, social, cultural, or legal services.

- Training – while a person might not be ready to start work, they might be able to undertake training. This could include vocational training or re-training, improving literacy, or gaining self-care skills.
- Light/selected duties – this option would be indicated when a person required a gradual return to work, working part-time hours initially or with modifications to the workplace or conditions of work. For example, a person might not be able to stand for extended periods or might need assistance with mobility.
- Part-time work (for fewer than 30 hours a week).
- Full-time work (for 30 hours or more a week).

4.43 While the stated purpose of this question was to determine the person's eligibility for a benefit, we consider the health practitioner's response also served as a significant opportunity for the case manager to start a conversation with the person about work planning, training, and work opportunities. Information on the readiness of beneficiaries for work planning, selected light duties, and part-time work was recorded in SWIFTT. However, in the service centres that we visited, this information was not consistently analysed by case managers to identify opportunities to work with beneficiaries. The Ministry needs to establish why this is not happening.

4.44 We identified examples of effective collaboration between Work and Income staff in referring beneficiaries for training, work planning, or job search. Successful outcomes we noted or were told of included beneficiaries re-training or finding work. We noted positive outcomes when Work and Income staff had responded effectively to sickness or invalids' beneficiaries who expressed a desire to work.

4.45 One positive outcome involved an invalid's beneficiary who suffered from degeneration of the spine. His work history involved hard physical labour. After a conversation between the regional health advisor and the case manager, he was referred to the employment co-ordinator to identify suitable job opportunities. This beneficiary indicated an interest in driving a truck, and arrangements were made for him to attend a heavy transport course as the first step towards gaining his truck licence.

4.46 We also noted instances where opportunities for engagement had been missed or where no follow-up action had been taken because of ineffective systems for ensuring timely and consistent engagement with work-ready beneficiaries. Twenty-one of a subgroup of 80 sickness beneficiaries in our sample had been assessed by the GP as ready for work planning immediately or within the following one to three months. Only four of the 21 were actively managed by the case manager (or employment co-ordinator, in one case).



### Invalids' beneficiaries

- 4.47 In our sample of invalids' beneficiaries, action had been taken by the case manager in only two of 20 instances where the medical certificates indicated that the person was ready for work planning or part-time work. In one case, the case manager talked to the beneficiary about a referral to other services. The beneficiary wanted to consider the proposal but it was never followed up by the case manager. In the second case, the beneficiary had been referred to other services in 2007 but no action had been noted since that referral. There were a further three instances of young people pursuing full-time study and part-time work. In the remaining 15 instances, no action had been taken by the case manager in response to the comments in the medical certificate.
- 4.48 In our view, when there is only limited action or involvement by case managers, it is more likely that beneficiaries will build a history of benefit dependence and of absence from the workforce. It also limits the opportunities for beneficiaries to get the services and support available through Work and Income.
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#### **Recommendation 12**

We recommend that the Ministry of Social Development ensure that Work and Income case managers contact sickness and invalids' beneficiaries about work planning if information indicates that they may be ready to prepare for or return to work.

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### GPs' views on communication with Work and Income staff

#### **GPs wanted more feedback from Work and Income staff.**

- 4.49 We asked GPs to rate the quality of Work and Income's communication with them over the past 12 months on matters relating to sickness and invalids' beneficiaries. More than half (59%) of the 150 GPs who answered our questionnaire thought communication was poor or worse.
- 4.50 The main frustration expressed by those GPs who chose to expand on their response was not being contacted by Work and Income staff when they expressly asked for contact. GPs also noted that case managers were difficult to contact. In this context, the comment was made that the centralised handling of telephone calls to Work and Income did not help. Several suggested that beneficiaries should be given a Work and Income business card with the case manager's contact details to bring with them to the GP. The GPs expressed a preference for direct dial access to case managers.

- 4.51 Of the GPs who responded to our questionnaire, 69% thought that Work and Income responded “poorly”, “very poorly”, or did not respond to the comments that GPs made in the medical certificate about the person’s needs. Some expressed concern that the only feedback that they received was through their patients, who might not be in a position to provide the best information about their interaction with Work and Income. Some thought that the present system should be improved by Work and Income staff providing the GPs with feedback on the action that had been taken in response to their comments.

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**Recommendation 13**

We recommend that the Ministry of Social Development investigate ways of working more actively with general practitioners and responding to their comments in medical certificates.

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## Case managers’ use of provisions in the Social Security Act 1964

**The full range of legislative sanctions was not used because the Ministry’s policy was to invite rather than compel sickness and invalids’ beneficiaries to engage with their case manager.**

- 4.52 Under the Act, the Ministry can require all beneficiaries to (among other things):
- attend and participate in interviews;
  - plan for personal development and work; and
  - carry out any activity or rehabilitation (other than an activity or rehabilitation involving participation in work, voluntary work, activity in the community, unpaid work experience, or medical treatment) to improve the beneficiary’s work-readiness or prospects for work.
- 4.53 The Act also provides for sanctions (reducing the amount of benefit paid) if beneficiaries fail to meet these obligations without a good and sufficient reason.
- 4.54 Although these legislative provisions were available, in practice the Ministry’s approach was that individual sickness or invalids’ beneficiaries should voluntarily engage in work planning. The Ministry took the view that, with limited resources, it was pragmatic to focus the efforts of its staff on people entering the benefit system and on beneficiaries who were willing and able to prepare for and seek work. It was also conscious that work planning might not be appropriate or might be complex for some sickness or invalids’ beneficiaries.

- 4.55 Therefore, the Ministry had not used sanctions to require sickness and invalids' beneficiaries to prepare for work. This policy position was reflected in the information pack for service centre managers about the September 2007 changes associated with the Programme. It noted:

*From September 2007 people with ill-health and disabled people will be invited to engage with [Work and Income]. They may have planning and activity requirements to support them into work, where work is an appropriate and realistic option for them. It is not appropriate for this group of clients to be sanctioned.*

- 4.56 We found little evidence of Personal Development and Employment Plans for these beneficiaries. Several staff told us that such plans should be considered in only limited circumstances with this group. The then Minister of Social Development and Employment reported that, at the end of June 2008, only 5394 of some 129,000 sickness or invalids' beneficiaries had completed a Personal Development and Employment Plan.

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#### **Recommendation 14**

We recommend that the Ministry of Social Development, where fair and appropriate, explore the full range of options for engaging with those sickness and invalids' beneficiaries who do not express an interest in preparing for or moving towards work.

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### **Following regional advisors' recommendations**

#### **Case managers were not always following the recommendations of the regional health advisors and regional disability advisors.**

- 4.57 The role of Work and Income's regional health advisors and regional disability advisors included making recommendations to case managers about appropriate services and interventions for beneficiaries with complex medical or disability issues. Our examination of case files showed that recommendations made by regional health advisors and disability advisors were not always followed by case managers.
- 4.58 This means that beneficiaries with complex medical or disability conditions might not be able to take advantage of appropriate services and interventions that could help their return to work or increase their participation in the community.

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#### **Recommendation 15**

We recommend that the Ministry of Social Development reinforce the need for Work and Income case managers to consistently follow the recommendations made by regional health advisors and regional disability advisors.

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## Available services and referrals to those services

**Each region was purchasing a number of training and vocational services aimed at addressing the particular needs of sickness and invalids' beneficiaries.**

### Additional training and vocational services

- 4.59 A number of training and vocational services were available to sickness and invalids' beneficiaries through Work and Income. We noted instances of staff in some service centres contacting sickness and invalids' beneficiaries whose needs might be met by referral to one or more of these services. Briefcase, an online caseload management database, was used to identify suitable people for possible referral.
- 4.60 The redesigned medical certificate made it easier to identify beneficiaries whose needs might be met by referrals to such services, because it required health practitioners to use codes to describe the person's condition. These codes replaced broad incapacity groupings used in the previous certificate. Using the codes, Work and Income staff had access to more specific descriptions of medical conditions to better identify which beneficiaries might be helped by a referral to services purchased through the Innovation Fund.
- 4.61 In the 80 sickness beneficiaries' case files that we examined, 21 beneficiaries were referred to and attended services or other interventions. A further eight beneficiaries were invited to seminars or referred to other specialist services but did not attend.

### Health and Disability Innovation Fund for Pilot Health Services

- 4.62 As we noted in Part 2, from 2007 the Ministry was able to use the Innovation Fund to purchase services to help beneficiaries gain, retain, or move into work. These services were for people with mild to moderate mental health conditions, people awaiting medical treatment, people with chronic pain, and people who needed help with life skills in order to work.
- 4.63 The Ministry carried out research to identify the most relevant and cost-effective health and disability services for sickness and invalids' beneficiaries. This research included health-related literature reviews. To estimate the potential demand for each service, data was gathered on existing numbers of sickness and invalids' beneficiaries for each Work and Income region, numbers with particular incapacities, and the availability of other existing health and disability services.
- 4.64 Each region consulted with service centres to identify gaps in services before drawing up its annual service purchase plan. The Ministry was monitoring the

uptake of the services provided through the Innovation Fund. At the time of our audit, the availability of services varied in the five regions we visited. Some contracts, such as those for mild to moderate mental health services with primary health organisations and district health boards, were still being finalised.

- 4.65 The 2009 Budget included an announcement that the Innovation Fund would not continue beyond 30 June 2009.

## Case management tools and monitoring the use of those tools

**Work and Income had the necessary procedural guidance, tools, and information systems to support case managers' engagement with sickness and invalids' beneficiaries. The Ministry needed to better monitor how case managers managed their caseloads, kept records, and used planning tools.**

- 4.66 Briefcase was an online case management tool that enabled Work and Income staff to sort beneficiaries by various characteristics. They could sort, for example, by the type and length of time a person had been on the benefit, their type of illness(s), injury(s), or disability(s), whether they were in or had undertaken part-time work, and by the number of hours that were worked. It was, therefore, a useful tool to help case managers take a planned approach when working with their caseloads.
- 4.67 Case managers were also able to access reports in Briefcase that identified beneficiary groups that should be targeted first – for example, sickness and invalids' beneficiaries:
- with a recent work history, and who might therefore be able to work part-time or do light duties;
  - with reported earnings;
  - with medical conditions making them eligible to access the health and disability services available through the Innovation Fund or PATHS;
  - who had been receiving the benefit continuously for more than 10 years; and
  - who had partners who might be able to work.
- 4.68 Briefcase was not used consistently throughout the regions and its use was not systematically monitored. In the two service centres of one of the regions that we visited, Briefcase was used to varying degrees by the work broker, employment co-ordinator, programme co-ordinator, assistant service centre manager, service centre trainer, and service quality officer. It was used to a limited extent by only three of the 29 case managers.

- 4.69 Work and Income staff were provided with other online tools to record the type, extent, and outcomes of engagement with beneficiaries, including:
- journals;
  - service plans; and
  - an electronic recording system.
- 4.70 The Ministry's procedures required Work and Income staff to update the beneficiary's journal each time that they engaged and planned with the sickness or invalid's beneficiary, including noting any progress that the beneficiary had made in achieving their goals. The journals should have provided a single, readily accessible, and up-to-date source of information about the beneficiary's circumstances. However, we found that journals were seldom maintained for sickness and invalids' beneficiaries.
- 4.71 All interventions offered to a beneficiary could be recorded and tracked through a service plan. Service plans were used for:
- managing the activities and tasks that a beneficiary carried out;
  - managing services offered to a beneficiary; and
  - managing and issuing formal agreements.
- 4.72 During our audit, we noted that service plans were not used for sickness and invalids' beneficiaries. We also noted that the Ministry was developing its "Client Management System", and changes as part of that development should help to ensure that, where appropriate, service plans are completed for sickness and invalids' beneficiaries.
- 4.73 Case managers were recording details of engagement with beneficiaries in the electronic recording system, but because the system recorded all correspondence and interaction with the beneficiary, it was difficult to quickly establish what engagement has occurred. The electronic recording system also made it difficult to establish what, if any, plan existed to help the beneficiary back into work and what progress has been made.
- 4.74 Service centre managers did not routinely check the nature and extent of case managers' engagement with their assigned sickness and invalid's beneficiary caseloads. The extent of engagement with an individual beneficiary should be reflected in plans, case notes, and the journal of contact with the beneficiary that is maintained by the case manager.

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**Recommendation 16**

We recommend that the Ministry of Social Development expand the scope of regular monitoring to help ensure that case managers maintain periodic contact with beneficiaries in keeping with Work and Income's guidance.

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## Part 5

# Monitoring and evaluating the effectiveness of the Programme

- 5.1 In this Part, we discuss the Ministry's progress in:
- monitoring the results of the Programme; and
  - evaluating the effectiveness of the Programme.
- 5.2 Most of the Programme's changes to improve the management of sickness and invalids' beneficiaries were implemented by September 2007. The Client Management System (to provide case managers with more support for decision-making) and the new health services were not in place by September 2007. Although the work on these two initiatives was well advanced at the time of our audit, they were yet to be fully implemented.
- 5.3 The Ministry told us that it thought that it could take up to five years – that is, until 2012 – for the effects of the Programme to be fully realised.

### Our overall findings

- 5.4 The Ministry's assessment of the results and effects of the Programme was limited. For example, there had been significant changes to how case managers managed sickness and invalids' beneficiaries, including providing them with additional specialist health and disability advisors. However, the Ministry had carried out little monitoring of the effect of those changes.
- 5.5 The Ministry expected the Programme's outcomes to include:
- reducing the number of people coming onto sickness and invalid's benefits;
  - increasing the number of people moving off sickness or invalid's benefits and into work; and
  - making savings in sickness and invalid's benefit expenditure – while continuing to provide social and financial support for people with barriers to work.
- 5.6 Although the Ministry was closely monitoring changes in sickness and invalid's beneficiary numbers, it was unable to attribute the changes in the numbers to the Programme. The Ministry had identified outcome goals for the Programme that would help it establish this link. However, at the time of our audit, the Ministry had not measured its achievement against those goals.
- 5.7 The Ministry was not gathering information to enable it to report whether the projected annual savings of \$49 million of expenditure on sickness and invalids' benefits, expected by 2010/11, were likely to be achieved.
- 5.8 The two recommendations we make in this Part focus on the need for the Ministry to better evaluate and report on the Programme's effects on beneficiary numbers, expenditure, and other intended outcomes.

## Background

- 5.9 In approving the wider Programme in December 2006, Cabinet noted that the Ministry would monitor and evaluate the whole Programme (for all types of benefit) to establish:
- how well the initiatives<sup>6</sup> operated in practice;
  - where feasible, the effect the Programme as a whole, and the key initiatives where appropriate, had on outcomes; and
  - an evidence base that supported the design and implementation of new services.
- 5.10 Cabinet directed the Ministry to report back to the Joint Ministers<sup>7</sup> on the main operational and outcome findings from the research, evaluation, and monitoring of the Programme. The reporting was to occur through:
- bi-annual Ministerial updates beginning September 2007; and
  - the Sustainable Employment Annual Reports from February 2008.
- 5.11 When Cabinet approved the delivery of additional health services in April 2007, it noted that, once fully implemented, the Programme was:
- ... estimated by a panel of international experts to generate savings of \$49.0 million a year, compared to current forecasts, in Sickness Benefit and Invalid's Benefit expenditure.*
- 5.12 Before Cabinet approved the Programme, the Ministry provided the Cabinet Policy Committee with its Research, Evaluation and Monitoring Plan (the Evaluation Plan), which identified the following outcomes for the Programme:
- improving labour market participation for beneficiaries already in work (including increasing the hours of employment for part-time employees);
  - reducing the number of people coming onto a benefit;
  - increasing the number of beneficiaries moving into full-time employment, and the speed with which they made that move;
  - increasing part-time employment;
  - increasingly moving people into sustainable employment;
  - meeting working-age benefit population targets;
  - making savings in benefit expenditure;
  - people continuing to have access to social assistance; and
  - people receiving a level of income appropriate to their circumstances.

6 These initiatives include comprehensive case management, better processes, support and services for people with ill health and disabilities, and better processes for establishing benefit eligibility.

7 The Joint Ministers were the Minister of Finance, the Minister of Health, the Minister for Disability Issues, and the Minister for Social Development and Employment.



## Monitoring the results of the Programme

**Regional staff were monitoring changes in the numbers of people on the sickness benefit and invalid's benefit, and carrying out some analysis of the reasons for the changes. They were not monitoring how well the initiatives were operating in practice, or the extent to which the expected outcomes were achieved.**

- 5.13 Monthly targets for numbers of sickness and invalids' beneficiaries were set at a national level, and for regions and individual service centres. Targets were generally set to reduce the numbers of people on the sickness benefit and stabilise the number of people on the invalid's benefit.
- 5.14 Ministry staff closely monitored the numbers of sickness and invalids' beneficiaries, and service centres and regions reported regularly to Work and Income's national office, the Ministry, and to the Minister on their achievement against the targets. Service centres and regions also monitored reasons why the targets were not achieved, and prepared strategies to achieve the targets.
- 5.15 We expected the Ministry to monitor how well the initiatives were operating in practice, and the effectiveness of the changes. Monitoring the numbers of sickness and invalids' beneficiaries provided only a rudimentary measure of how well the initiatives were operating.
- 5.16 Total numbers do not identify or explain movements between the sickness and invalid's benefits, and they do not show whether people have moved off the benefit into work or for some other reason – for example, going overseas. Also, at a service centre level, numbers go down when beneficiaries move and are assigned to another service centre. Therefore, monitoring numbers does not provide enough information to guide the ongoing development and operation of the Programme.
- 5.17 Although the Ministry had created new positions to help front-line staff, there had been little monitoring of the extent to which these new people were used or the effect that their work was having. For example, the regional health advisor and regional disability advisor positions were established to help case managers assess eligibility and identify appropriate services for beneficiaries. There was little monitoring of the number of cases referred to the services or the outcome of the referrals.
- 5.18 In monitoring the effectiveness of the changes, Ministry staff were not collecting data to establish or measure the extent to which the outcomes (see paragraph 5.12) were achieved. Therefore, staff were not able to tell us whether:
- labour market participation for sickness and invalids' beneficiaries was improving;

- there were fewer people coming onto the sickness benefit;
- the number of sickness and invalids' beneficiaries (where appropriate) moving into full-time employment was increasing, and the rate of any such increase;
- the number of sickness and invalids' beneficiaries participating in part-time work, and the amount of part-time work undertaken, was increasing; or
- the anticipated savings in benefit expenditure were being achieved.

5.19 In our view, the Ministry (including regional and service centre staff) needs to better monitor the effect of the changes introduced as part of the Programme. The monitoring needs to occur in the following two areas:

- how well the initiatives are operating in practice – this includes the use and usefulness of the new positions, and the extent to which case managers are carrying out comprehensive case management; and
- how well the Programme is achieving its outcomes.

5.20 The Ministry needs to consider whether the measures are complete and appropriately reflect the progress expected in relation to sickness and invalids' beneficiaries. For example, measuring the number of beneficiaries completing courses or increasing the amount of part-time work that they are doing could also be appropriate measures for sickness and invalids' beneficiaries.

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#### **Recommendation 17**

We recommend that the Ministry of Social Development extend the monitoring framework beyond beneficiary numbers, and prepare measures that will assist the ongoing development of the Working New Zealand: Work-Focused Support Programme.

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## **Evaluation of the Programme**

**The Ministry had carried out only limited evaluation of the effect of the September 2007 changes for sickness and invalids' beneficiaries.**

- 5.21 The Centre for Social Research and Evaluation (CSRE), the unit within the Ministry responsible for social sector policy research and evaluation, prepared an Evaluation Plan that was considered by the Cabinet Policy Committee in late 2006. The unit was responsible for carrying out the research and evaluation set out in the Evaluation Plan and for reporting the results to the Joint Ministers.
- 5.22 The Evaluation Plan covered the whole programme. It noted that a supplementary Programme Health and Disability Research and Evaluation Plan focusing on the effects of the changes for sickness and invalids' beneficiaries would be prepared

by February 2007. The Ministry told us that this plan was not prepared because other work priorities took precedence.

- 5.23 The Evaluation Plan included some evaluation of the effect of health and disability initiatives for the period 2006/07 to 2009/10. However, the evaluation was very narrow, and focused on identifying the other health services required and evaluating the mental health services, rather than the effectiveness of all of the Programme changes. For example, the effectiveness of the new specialist positions and of comprehensive case management were not discussed in the Evaluation Plan.

#### **Bi-annual evaluations**

- 5.24 In keeping with the December 2006 Cabinet decision (see paragraph 5.10), the Ministry provided two bi-annual evaluation briefings to Joint Ministers – the first in November 2007 and the second in June 2008.
- 5.25 The bi-annual reports provided little evaluation of the effectiveness of the Programme's changes for sickness and invalids' beneficiaries. The reports were about the Programme as a whole, and the November 2007 report specifically excluded the changes from the scope of that evaluation.
- 5.26 The second report (for the period from November 2007 to 31 March 2008) included some analysis of the implementation of the Programme's changes. For example, the report noted the proportion of sickness and invalids' beneficiaries assessed using the new medical certificate, and commented on progress in establishing mild to moderate mental health services contracts (which was slower than anticipated because they were in place in only four regions, rather than the planned 11 regions). The report also noted the number of referrals to the regional health advisors and regional disability advisors, but did not look at the results of the referrals or the effect they had. The report identified growth in the numbers of sickness and invalids' beneficiaries participating in work training and employment-related services, but did not explain why that growth had occurred. We consider that the report provided very limited information on the effect of the Programme on intended outcomes for sickness and invalids' beneficiaries.
- 5.27 The Ministry started to prepare a third process evaluation report for the Joint Ministers that focused on the Programme's changes for sickness and invalids' beneficiaries. The objective of the process evaluation was to understand how the new engagement and planning requirements, medical assessments, information collection processes, and specialist health and disability roles were operating in practice. The report was neither finalised nor given to the Joint Ministers because of changing priorities after the 2008 change of government.

### Achieving the savings target

- 5.28 In April 2007, the Ministry had quoted estimated annual savings in sickness benefit and invalid's benefit expenditure of \$49 million by 2010/11, compared with forecasts current at that time. The estimate was based on realising all the benefits from the Programme's changes, and was subject to a large number of assumptions, including the availability of health services purchased through the Innovation Fund. The Ministry did not indicate what this fiscal saving would represent in terms of a reduction in beneficiary numbers.
- 5.29 The Ministry was not formally required to report against its savings estimate until 2010/11. However, at the time of our audit in 2008, the Ministry was not monitoring progress towards achieving the expected savings. It was not in a position to make a preliminary estimate of how likely the expected savings were to be achieved.
- 5.30 We note that funding for the additional health services has since been withdrawn, and the Ministry will need to take this into account when assessing the level of annual savings.

### Achieving the numbers targets

- 5.31 In March 2007, the Ministry noted in a report to the Government that it expected the Programme to have a significant effect in reducing the number of people receiving a sickness benefit or invalid's benefit, by moving them into work (where appropriate).
- 5.32 Between September 2007, when the Programme was extended to sickness and invalids' beneficiaries, and December 2008, the combined number of reported sickness and invalids' beneficiaries increased by 5.6% (see Figure 6). The number of invalids' beneficiaries increased by 6.7% and the number of sickness beneficiaries increased by 3.9%.

**Figure 6**  
Changes in beneficiary numbers between September 2007 and December 2008

Month	Invalid's benefit	Sickness benefit	Combined
September 2007	78,268	48,995	127,263
December 2007	80,082	49,093	129,175
March 2008	81,130	45,676	126,806
June 2008	82,879	46,271	129,150
September 2008	83,618	48,208	131,826
December 2008	83,501	50,896	134,397

- 5.33 The number of invalids' beneficiaries increased from 78,268 in September 2007 to 80,082 in December 2007, with a minimal increase in sickness beneficiary numbers in this same quarter. The Ministry's economic and fiscal updates for 2008 partly attributed increases in the number of beneficiaries transferring from the sickness benefit to the invalid's benefit to the changes introduced as part of the Programme in September 2007. In particular:
- using the new medical certificate, case managers became responsible for determining whether an applicant would receive a sickness or invalid's benefit. (This was previously decided by medical practitioners for the sickness benefit, and designated doctors for the invalid's benefit.) The analysis in the updates noted that some case managers might have incorrectly assumed that the beneficiary qualified for the invalid's benefit if the two-year reassessment period was ticked by the medical practitioner; and
  - medical practitioners completing the medical certificate were not clearly distinguishing between the likely duration of the illness or disability and its effect on the beneficiary's ability to work.
- 5.34 Overall, we consider that the lack of adequate and ongoing monitoring means that the Ministry does not know whether the Programme is achieving the outcomes intended. The Ministry is unable to make well-informed adjustments to the Programme to achieve those intended outcomes.

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**Recommendation 18**

We recommend that the Ministry of Social Development modify its evaluation strategy to better measure the extent to which the Working New Zealand: Work-Focused Support Programme is achieving the intended outcomes, including increased numbers of beneficiaries case-managed into work (where appropriate) and expected savings in benefit expenditure.

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# Appendix 1

## Our audit methodology

This appendix sets out more detailed information about our audit approach. It discusses:

- our audit fieldwork; and
- the questionnaire completed by general practitioners.

### Our audit fieldwork

Our audit fieldwork was carried out from September to December 2008. We spoke to staff in the Ministry's head office and in Work and Income's national office about the management of sickness benefits and invalids' benefits. These staff represented the service development, policy analysis, planning and performance, finance, and research and evaluation functions of the Ministry and Work and Income.

We visited five of Work and Income's 11 regional offices, and two service centres in each of those regions.

Region	Two service centres we visited in that region
Southern	Dunedin Central and South Dunedin
Waikato	Dinsdale and Cambridge
Auckland	Waitakere and Mangere
Nelson	Richmond and Greymouth
Northland	Kaitaia and Kawakawa

In the regional offices and service centres, we spoke to Work and Income's regional health advisors and regional disability advisors, regional and service centre managers, training co-ordinators, employment co-ordinators, staff responsible for purchasing and managing service contracts, and case managers.

### Review of documents and records

We examined regional and service centre plans and strategies where these were relevant to sickness and invalids' beneficiaries, reports on performance against targets for numbers of sickness and invalids' beneficiaries, data about the beneficiary population, management reports, and documentation used for case management. We also examined information held about sickness and invalids' beneficiaries in SWIFTT, the system used by Work and Income to record information about recipients of financial assistance and the assistance they receive.

To assess how Work and Income staff were deciding whether people were eligible for a sickness benefit or invalid's benefit, we examined available computer and paper records for a sample of beneficiaries. We also used these records to assess case management processes.

Our findings on how well eligibility and case management processes were working at the time of our audit were based on our examination of the sample, combined with the knowledge we gained from other sources. We have referred to numbers of cases in the report to illustrate the extent of what we found in the sample we examined. The numbers sometimes relate to a subgroup of our sample. Where cases relate to a subgroup, we have given the size of that subgroup. The figures should not be extrapolated to all sickness and invalids' beneficiaries.

## Sampling case files

In consultation with the Ministry of Social Development (the Ministry), we chose a sample of 160 sickness beneficiaries and 160 invalids' beneficiaries, using data supplied by the Ministry from beneficiary records current at the end of June 2008. We selected 16 sickness beneficiary cases, and 16 invalid's beneficiary cases for each of the 10 service centres we visited.

We drew the cases from two broad incapacity groups recorded by the Ministry:

- psychological or psychiatric conditions – this group includes people with stress, depression, bipolar disorder, schizophrenia, and intellectual disability; and
- musculoskeletal disorders – this group includes people with back pain, muscle strains, and arthritis.

We chose cases from these groups because these are the two major categories of incapacity among sickness and invalids' beneficiaries, and because both types of incapacity have grown significantly in past years. The growth in mental health disorders has been particularly marked. Stress, bipolar disorder, schizophrenia, and depression have become the main mental disorder growth categories for sickness and invalids' beneficiaries. Sickness and invalids' beneficiaries with mental health disorders and musculoskeletal disorders are also among the most likely to remain on a benefit for the longest time.

These two incapacity groups encompass a wide range of medical conditions, with some short-term and others permanent, and with varying levels of severity and effect on the person's ability to work.

From the sample population provided to us by Work and Income, we chose individual beneficiaries across all age groups, but including:



- people who were recorded as having moved to the sickness benefit or invalid's benefit from another benefit, such as the unemployment benefit or domestic purposes benefit; and
- people who had been on the sickness benefit or invalid's benefit for shorter or longer periods of time.

We included these in order to establish whether any differences in practice existed in such cases.

Because our examination of case files was carried out later in 2008, a small number of our chosen sample group were no longer receiving a sickness benefit or invalid's benefit. In these cases, the Ministry's computer system retained only limited records of their history on that benefit.

Each of the service centres we visited had retrieved files for the chosen sample of beneficiaries. Previous medical certificates were occasionally missing from these. In a small number of cases across the sample, paper files had not been retrieved, so we chose other beneficiary cases in their place.

### Questionnaire for general practitioners

We also invited general practitioners (GPs) to complete a questionnaire, because they are the health practitioners who fill out most of the medical certificates that applicants for a sickness benefit or invalid's benefit must provide to Work and Income. The questionnaire asked GPs about this role, the design of the medical certificate, and their communication with Work and Income.

In total, 150 GPs responded to our questionnaire. We analysed responses to each of the questions, as well as their comments. The questions that GPs answered are reproduced below.

**Communication**

In the last 12 months, overall, how would you rate the quality of Work and Income's communication with you on matters relating to sickness and invalids' beneficiaries?

- very good
- good
- satisfactory
- poor
- very poor
- other (please specify below)

Comments and suggestions for improvement:

**Responding to the person's needs**

The medical certificate allows you to ask Work and Income to contact you about a person's diagnosis or ability to work. Does Work and Income contact you when you ask them to?

- always
- usually
- sometimes
- rarely
- never
- other (please specify below)

Comments and suggestions for improvement:

The medical certificate provides for you to tell Work and Income what interventions might help a person into work, when the person is likely to be capable of work planning, training, or likely to be ready for some form of work, and what other support might be appropriate for the person.

In the last 12 months, how well or poorly has Work and Income responded to your comments in the medical certificate about the needs of the person?

- very well
- well
- adequately
- poorly
- very poorly
- other (please specify below)

Comments and suggestions for improvement:

**Ability to work**

The medical certificate asks you to assess how the person's medical condition or treatment affects their ability to work, and when they are likely to be capable of work planning, training or some form of work. You are also asked to judge how many hours the person is able to work in a week.

Do you think that a medical consultation provides the necessary information to make an assessment of the person's ability to seek, undertake or be available for work?

- always
- usually
- sometimes
- rarely
- never
- other (please specify below)

Comments and suggestions for improvement:

**The medical certificate**

Does the medical certificate enable you to express a clear and balanced assessment of the person's medical condition, and its current and future effect on their ability to work?

- yes
- no
- to a limited extent

Comments and suggestions for improvement:

Does the medical certificate enable you to comment on the person's future needs and potential for employment, including any non-medical barriers to work?

- yes
- no
- to a limited extent

Comments and suggestions for improvement:

**Awareness of services**

The medical certificate asks about support services and other services that might be useful to aid recovery and rehabilitation, and help a person move towards employment. Are you aware of the services available through Work and Income?

- yes
- no
- uncertain

Comments and suggestions for improvement:

**Your location (city, town, or region)**

This is optional but will help us identify any significant differences between regions and districts.



## Appendix 2

# How people qualify for a sickness benefit or invalid's benefit

### Sickness benefit

The sickness benefit is a weekly payment that helps people who are temporarily off work or working at a reduced level because of sickness, an injury, pregnancy, or a disability.

To qualify for a sickness benefit, the person must:

- be 18 years of age or older, or 16 to 17 years of age and living with a partner and children whom they support;
- be in a job and have had to stop working or reduce their hours and income because of sickness, injury, pregnancy, or disability; or unemployed or working part-time and find it hard to look for work or do full-time work because of sickness, injury, pregnancy, or disability;
- be a New Zealand citizen or permanent resident who normally lives here;
- have lived in New Zealand for at least two years at any one time since becoming a New Zealand citizen or permanent resident (unless they are a refugee); and
- have an income under a certain level (this includes any partner's income).

To support their application for a sickness benefit, the person is required to provide a medical certificate. The certificate must include:

- a diagnosis;
- the effect of the condition on the person's ability to work;
- the likely duration of the effect of the condition; and
- any other information that the Chief Executive of the Ministry of Social Development requires.

The medical certificate must be signed by a registered:

- medical practitioner;
- dentist (where appropriate); or
- midwife (for pregnancy, childbirth, or any related conditions).

Before granting a sickness benefit, Work and Income staff need to be satisfied that the person is:

- limited in their capacity to seek, undertake, or be available for full-time employment because of sickness, an injury, pregnancy, or a disability; or
- losing earnings through sickness, an injury, pregnancy, or a disability because they are not working or they are working at a reduced level.

This assessment is usually based on the information provided in the medical certificate. However, in some circumstances a person may be referred to a designated doctor for further assessment – for example, when the medical practitioner indicates on the certificate that a second opinion is appropriate.

It is expected that most sickness beneficiaries' ability to work will improve, allowing them to progress towards employment. When completing the medical certificate, the medical practitioner will advise when the person's medical entitlement to a benefit should be reassessed.

Generally, the medical practitioner's recommendation is accepted. However, if there is inconsistent information on the medical certificate, or the "recommended incapacity duration" held in SWIFTT suggests that a further check on the duration recommended by the medical practitioner is needed, the application is referred to the regional health advisor or the regional disability advisor for advice. The regional health advisor or the regional disability advisor may recommend that the applicant be referred to a designated doctor for further assessment.

Work and Income requires beneficiaries to have their medical eligibility to the sickness benefit reviewed regularly. The first medical certificate is accepted for only up to four weeks (even if the certificate states that the medical condition will last longer). The beneficiary has to go back to their medical practitioner, dentist, or midwife to get another medical certificate if they are unable to work and need the sickness benefit for more than four weeks.

The second or subsequent medical certificates can cover a period of up to 13 weeks.

## Invalid's benefit

To qualify for the invalid's benefit, the person must:

- be 16 years of age or over;
- be a New Zealand citizen or permanent resident;
- have lived continuously in New Zealand for two years or more at any one time since becoming a New Zealand citizen or permanent resident;
- be ordinarily resident in New Zealand when they first apply for the benefit; and
- be both permanently and severely restricted in their capacity for work because of sickness, injury, or disability, or be totally blind.

"Permanent" means the sickness, injury, or disability is expected to continue for at least two years or that a person has been diagnosed with a terminal illness and is not expected to live more than two years.

“Severely” means that the person cannot work 15 hours or more each week in open employment (that is, employment other than sheltered<sup>8</sup> employment).

When applying for an invalid's benefit, a person can provide either a medical certificate from their medical practitioner or suitable existing medical or disability assessments.

Work and Income staff can consider granting an invalid's benefit solely from a medical certificate completed by the applicant's own medical practitioner if they are satisfied that the information confirms that the person meets the medical criteria for an invalid's benefit. However, Work and Income staff are encouraged to use all information available because one form of medical or disability information may not be enough to decide entitlement to an invalid's benefit. This additional information includes:

- the existing assessment(s);
- information contained in Work and Income records (for example, information on disability allowance, Child Disability Allowance); and
- previous Work and Income certificates.

Before granting an invalid's benefit, Work and Income staff have to be satisfied from the information available that the applicant is:

- both permanently and severely restricted in their capacity for work because of sickness, or injury or disability from an accident, or a congenital condition; or
- totally blind.

Work and Income staff can refer the applicant to a designated doctor if the applicant is unable to, or chooses not to provide existing reports, assessments or a medical certificate, and Work and Income records do not hold sufficient information to decide entitlement to an invalid's benefit. An applicant may also be referred to a designated doctor for further assessment when the medical practitioner indicates on the medical certificate that a second opinion is appropriate.

Also, if the benefit eligibility is unclear from the information provided, Work and Income staff can refer the application to the regional health advisor or the regional disability advisor for advice. Some regions require their staff to refer all new applications for, and reassessments of, invalids' benefits to the regional health advisor or regional disability advisor for a recommendation before the benefit is granted.

<sup>8</sup> A person is considered to be in sheltered employment if the employment conditions need to be specifically designed to cater for their needs. This applies to full-time employment, self-employment, supported employment, or contract work.

An applicant may also be referred for a specialist assessment. This usually occurs when the applicant's medical practitioner advises on the medical certificate that they are not best placed to provide medical information. This could be because the applicant:

- is under the care of a specialist;
- has a complex condition; or
- has an unclear outcome from treatment.

The medical practitioner can recommend that a specialised assessment is required to clarify the diagnosis and help determine the severity and permanency of the applicant's condition.

In these circumstances, the regional health advisor or the regional disability advisor determines whether a specialised assessment, and the type of assessment, is required.

Work and Income staff need to decide, when they grant an invalid's benefit, whether the person's eligibility should be reassessed.

For those beneficiaries where the impact of their ill health or disability on their ability to work, is unlikely to improve, their eligibility for a benefit will never require reassessment.

For other beneficiaries, the impact of their permanent medical conditions or disabilities may change over time and their ability to work may improve. Reassessment for these beneficiaries is done after two or five years.

The medical practitioner or clinical psychologist will indicate on the medical certificate whether reassessment is required. This is generally accepted by Work and Income staff unless there is inconsistent information on the medical certificate – for example, where the diagnosis and impact on the beneficiary's ability to work is described as severe and permanent with no likelihood of any form of employment for the foreseeable future, yet the medical practitioner has indicated medical reassessment is required in two years. In these circumstances, Work and Income staff will refer the application to the regional health advisor or regional disability advisor for advice.