A new future for social security: Consultation on social security in Scotland

BMA Scotland response

The British Medical Association is a politically neutral registered trade union and professional association representing doctors from all branches of medicine. The BMA has a total membership of over 168,000. In Scotland, the BMA represents over 16,000 members.

PART ONE: A PRINCIPLED APPROACH

1. Fixing the principles
   The BMA recognises the importance of reducing health inequalities and supports the key role that benefits can play.

2. Outcomes and user experience
   Are the outcomes (shown on page 17) the right high level outcomes to develop and measure social security in Scotland?
   BMA Scotland strongly supports the outcome relating to other public and third sector services and considers this a vital element of the new social security system. The current appeals system has placed considerable strain on general practice and it is important that practices experience less pressure due to the changes and do not experience any increase in workload.

   P19 states that modern IT systems could be used to share existing data. We believe this to be a reasonable direction of travel and we would support data sharing as a way to reduce demands on the patient’s doctor’s time and to protect the doctor/patient relationship as long as this is done securely and with the explicit consent of the patient. There needs to be suitable IT in place to enable safe, legal and confidential sharing of data.

   It would be helpful if there could be a review of who the data controller of shared records should be in the future as this is an issue of significant concern for GPs.

3. Delivering social security in Scotland
   Who should deliver social security medical assessments for disability related benefits?
   Should we, as much as possible, aim to deliver social security through already available public sector services and organisations?

   The UK Department for Work and Pensions outsourced “Work Capability Assessments” (WCA) to private providers. There has been much controversy about the involvement of the private sector in conducting these assessments and speculation over whether they had been set targets to reduce the number of people claiming benefit. The percentage of claimants that lost their benefit as a result of the WCAs and have consequently successfully challenged the decision made is high. In short, outsourcing these assessments has been fraught with trouble.

   The Scottish Government is clear that it wants whoever is tasked with undertaking assessments to make this a priority and we support this approach.

   The BMA position is that the computer-based assessments used for WCAs have little regard to the nature or complexity of the needs of long terms sick or disabled people. We believe that they should end with immediate effect and be replaced by a rigorous and safe system instead.
this respect we strongly agree with the Scottish Government’s intention that benefit claimants be treated with dignity and respect.

The issue is how any changes are implemented on the ground. Ideally this should be an independent assessment.

Asking GPs to perform the assessments would add an extra burden onto an already overstretched workforce where over 28% of practices are reporting that they have at least one GP vacancy. GPs do not have sufficient time to undertake a detailed review. If the government is serious about maintaining dignity and respect then people should be assessed under some competent tool, like those produced by the WHO. This is not a simple or inexpensive process.

It is appropriate for doctors to continue to provide medical information but they must not be in a position to decide who gets the benefits as this would seriously undermine the doctor’s key role and jeopardise the doctor patient relationship.

It may be that a panel of health professionals could be employed (including doctors, physios and OTs) to carry out these assessments.

4. Equality and low income

*How can the Scottish Government improve its partial EqIA so as to produce a full EqIA to support the Bill?*

It is important to ensure that the changes proposed to benefits do not impact the Scottish population’s health or health inequalities negatively and we would like to ensure that this is taken into consideration in the EqIA.

5. Independent advice and scrutiny

No comments.

PART TWO: THE DEVOLVED BENEFITS

6. Disability benefits

*Evidence (p39)*

*What evidence and information, if any, should be required to support an application for a Scottish benefit?*

There is a balance to be found between providing adequate information and protecting individuals from inappropriate intrusiveness with regard to their medical records. Diagnosis, medical records and specialist letters could be shared with consent.

It is essential that the initial assessment gathers all the relevant information required to ensure it can make a fully informed decision. This would then reduce the likelihood of appeals. There needs to be suitable IT in place to enable safe, legal and confidential sharing of data. It is also important that timescales for providing information are adequate to allow for preparation of medical reports by health professionals.

*Should the individual be asked to give their consent (Note: consent must be freely given, specific and informed) to allow access to their personal information, including medical records, in the interests of simplifying and speeding up the application process and/or reducing the need for appeals due to lack of evidence?*
We would support the sharing of medical records with the explicit consent of the patient.

The consent should include the possibility that the Social Security agency could request information in relation to their case. It is important to note that medical records may not contain adequate information for eligibility assessments to be made without additional information as records tend to be very diagnosis driven, (for example: an adult with disability since birth may not have any detailed information on the disability in the medical records). In most cases, only factual medical information should be required. For disability-related benefits key questions will be about the degree of disability. This is frequently not well assessed or recorded in the medical records and certainly not to the degree that would allow fair decisions on who should be able to access the benefit.

Ideally, with full patient consent, direct access to the medical record would allow an independent assessor to see any relevant information. In the absence of an information technology solution to this problem, requests for medical information should be made in a way which minimises the involvement of health professionals (i.e. administrative staff should be able to provide the response from the record). The routine gathering of the necessary information should be sufficient to ensure that there be no need, even at appeal, to seek further information from the medical record. There will always be a place for doctors to provide an additional opinion on the patient's case but this should be exceptional, occurring only when there was clearly an unjust decision based on the knowledge of the case. This should be a rare occasion or it would suggest a system which clearly is not working effectively.

Consideration needs to be given to what would happen if a patient did not give consent and whether the individual could opt out of certain elements of the consent.

*If the individual has given their permission, should a Scottish social security agency be able to request information on their behalf?*

Yes, we would support an agency being able to request information on behalf of an individual where explicit consent has been given.

**Automatic entitlement (p41)**

With regard to automatic entitlement for some benefits, we can see merit in this principle. Unfortunately, IT systems are more likely to have medical diagnosis driven read codes, rather than those relating to the biopsychosocial nature of disability, which would probably be more relevant in these cases, so automatic eligibility for these conditions would be appropriate. However, we would expect a more detailed consultation on this issue. There are many conditions where one person can be much more severely affected than another and this may make determining which conditions could qualify for automatic entitlement difficult. There is also a risk of pressure from patients and relatives on doctors for a specific diagnosis to meet automatic eligibility criteria.

**Eligibility (p41)**

*Do you agree that the impact of a person’s impairment or disability is the best way to determine entitlement to the benefits?*

Yes, the key is the impact on their ability to live independently.

*If yes, which aspects of an individual’s life should the criteria cover and why?*
The criteria will depend on what the government decides is the intention of the benefit, whether to compensate the individual for having the disability or to defray the necessary costs as a result of the disability.

If no, how do you suggest entitlement is determined?

Currently there are only special rules for the terminally ill but should there be others?

Consideration should be given to patients who have no chance of recovery, such as quadriplegia or severe neurological disability as a result of a stroke, those born with severe disability and those with long protracted deteriorating conditions expected to last more than 6 months, such as motor neurone disease and severe MS. This would be based on medical prognosis of little or no prospect of future improvement or recovery and would require medical evidence and opinion from the individual’s own doctors. These people should not have to face repeated assessments.

Proposals for assessments (p43)
Could the current assessment processes for disability benefits be improved?

For those people that may require a face-to-face assessment, who do you think should deliver the assessments and how? For example, private organisation, not-for-profit organisation, public sector body or professional from health or social care.

We strongly believe that these assessments should not be done by a GP working for the NHS. There may be a role for occupational health therapists or appropriately trained nurses and physios, but there are workforce issues to consider. Consideration also needs to be given to ensuring that whoever undertakes these assessments has adequate training and understanding of mental health disability.

As a medical profession we support the development of equality and dignity in the new benefit system so that it supports the vulnerable in our society. This new system requires the gathering of robust information and interpretation by qualified and experienced people, not out-sourced to the lowest bidder paying the minimum grade of staff. Individuals carrying out assessments must be properly trained and regularly assessed to ensure consistency and fairness of application of the assessment.

What are the advantages and disadvantages of different types of assessments? e.g. paper based, face-to-face, telephone.

We believe that face to face assessments are preferable and more accurate but we recognise that people do understandably get themselves very worked up and anxious about assessments. Making them as local as possible with uncomplicated transport arrangements can help with this. Factual medical information may be insufficient to allow proper assessment and therefore face to face assessment will often be necessary.

How could the existing assessment process be improved?

Could technology support the assessment process to promote accessibility, communication and convenience?

If yes, please explain what technology would be helpful
Alignment with other devolved services (p46)
How could disability benefits work more effectively with other services at national and local level assuming that legislation allows for this e.g. with health and social care, professionals supporting families with a disabled child.

We are supportive of joint working between services. In the future it is likely that most patients with disability and long term illness will have some form of anticipatory care plan, which may be relevant to decisions on access to benefits.

7. Carer’s allowance
The BMA is supportive of the Scottish Government’s overall approach to developing a Scottish Carer’s Benefit. Given the important role carers play in supporting the social care system, and therefore by implication the health system, this should be welcomed. In particular, we are pleased that the Scottish Government has already begun to explore a Young Carer’s Allowance.

8. Winter fuel and cold weather payments
We have no comment on this section, other than to support payments that are made to protect those who are vulnerable. The Marmot report on health impacts of cold homes and fuel poverty (http://www.instituteofhealthequity.org/projects/the-health-impacts-of-cold-homes-and-fuel-poverty) makes the case that fuel poverty contributes to social and health inequalities.

9. Funeral payments
No comments.

10. Best start grant
We have previously called for more emphasis on early years interventions and so are supportive of this development.

11. Discretionary housing payments
No comments.

12. Job grant
No comments.

13. Universal credit flexibilities and housing element
No comments.

PART THREE: OPERATIONAL POLICY

14. Advice, representation and advocacy
    Advocacy
Patients should be able to access advocacy easily and primary care buildings are an obvious physical support resource, from links workers being available to signposting from staff, but it is essential that there should be no need for a GP to refer to these services or support mechanisms.

15. Complaints, reviews and appeals
    Appeals (p94)
GP letters should not be required to support appeals and should not improve a claimants’ chance of appeal success. It is essential to ensure that the initial assessment gathers all the
necessary medical information so that appeals services do not need to seek additional information.

We have heard anecdotally that under the current system, if a patient has a letter (either from the GP or some other support such as Citizen's Advice Scotland) their appeal is more successful. This is unfair for patients, but also unfair for GPs who are put under pressure to provide a letter. Many GPs (particularly in deprived areas) spend an inordinate amount of time preparing these letters because they are aware of the negative impact if a letter is not provided. Clearly GPs often have concerns about charging patients for this work. This places an additional burden on many GPs which should not be necessary.

16. Residency and cross-border issues
No comments.

17. Managing overpayments and debt
No comments.

18. Fraud
No comments.

19. Protecting your information
Better information sharing (p112)
Would you support strictly controlled sharing of information between public sector bodies and the agency, where legislation allowed, to make the application process easier for claimants? For example, this information could be used to prepopulate application forms or to support applications, reducing the burden on applicants.

Would you support strictly controlled sharing of information between a Scottish social security agency and other public sector organisations (for example local authorities) to support service improvements and deliver value for money?

Whilst we recognise the value of sharing information that has already been collected and recorded, there are serious issues around confidentiality and consent that must be taken into account. Patients must feel able to speak to their doctor or any other health professional without concern that this information will be shared without their consent. It is also important to recognise that there may be information recorded that is not of relevance to a particular organisation but which may be of a sensitive nature, and there needs to be some way of ensuring that this will not be shared, without creating additional work. Any information shared must be redacted data.

It is important that if such sharing did take place, individuals understand the joining up of such data and that they are clearly informed of how information will be shared and with which organisations.

20. Uprating
No comments.