DÁIL ÉIREANN

AN COMHCHOISTE UM OIDEACHAS AGUS COIMIRCE SHÓISIALACH

JOINT COMMITTEE ON EDUCATION AND SOCIAL PROTECTION

Dé Céadaoin, 29 Aibreán 2015

Wednesday, 29 April 2015

The Joint Committee met at 1 p.m.

MEMBERS PRESENT:

Deputy Ray Butler,	Senator Gerard P. Craughwell,
Deputy Catherine Byrne,	Senator Mary Moran.
Deputy Ciarán Cannon,	
Deputy Michael Conaghan,	
Deputy Aengus Ó Snodaigh,	
Deputy Willie O'Dea,	
Deputy Brendan Ryan,	

In attendance: Senator Trevor Ó Clochartaigh..

DEPUTY JOANNA TUFFY IN THE CHAIR.

The joint committee met in private session until 1.19 p.m.

Medical Eligibility Criteria for Social Protection Payments: Discussion

Chairman: The issue we are addressing today is the difficulties faced by persons seeking to establish that they meet the medical eligibility criteria when they apply for illness-related or disability related social protection payments. We are joined by Mr. John Dunne and Ms Catherine Cox from the Carers Association, Dr. Joanne McCarthy and Ms Joan O'Donnell from the Disability Federation of Ireland, and Dr. Devesh Singh, Mr. Tony Kieran and Ms Catherine Kellaghan from the Department of Social Protection. The Irish Medical Organisation was also invited but its representatives were unable to attend.

I draw the attention of witnesses to the fact that by virtue of section 17(2)(*l*) of the Defamation Act 2009, witnesses are protected by absolute privilege in respect of their evidence to the committee. However, if they are directed by the committee to cease giving evidence on a particular matter and they continue to so do, they are entitled thereafter only to a qualified privilege in respect of their evidence. They are directed that only evidence connected with the subject matter of these proceedings is to be given, and they are asked to respect the parliamentary practice to the effect that, where possible, they should not criticise or make charges against any person, persons or entity by name or in such a way as to make him, her or it identifiable. The opening statement submitted to the committee will be published on the committee website after the meeting.

Members are reminded of the long-standing parliamentary practice to the effect that they should not comment on, criticise or make charges against a person outside the Houses or an official, either by name or in such a way as to make him or her identifiable. I ask everyone to turn off their mobile phones completely or to switch them to airplane, safe or flight mode, depending on their device, otherwise they interfere with the broadcasting equipment. This meeting is being broadcast live.

I invite Mr. Dunne him to make his presentation on behalf of the Carers Association.

Mr. John Dunne: I will defer to Ms Catherine Cox.

Ms Catherine Cox: I thank the committee for having us. Today I will talk specifically around carer-related social welfare payments and the medical eligibility criteria, in particular, carer's allowance, carer's benefit and the respite care grant. We were part of the domiciliary care allowance, DCA, review process over the past two years and we are happy that the changes made have brought about considerable improvement, particularly for parents caring for young children with pervasive developmental disorders, PDDs, such as autism. We have been part of that process and are happy that we have worked closely with the Department on that.

I refer to the issues facing family carers on the ground. The fact that 50% of carer's allowance appeals are successful causes us concern and while it shows that the Department is honest in the appeals process, the problem lies with the fact that not enough information is being sought or given at the application stage. We are working with the Department on this. The application form is 24 pages and that is the amount of space that is given to put in the care duties the carer is providing. That is far too little and we would like to see the introduction of a daily diary that family carers can fill in. This would prompt them to fill in the details of the person for whom they are caring and the issues they face relating to supervision, personal care and whether there are actions the person being cared for takes that would put him or her or others at risk. We are also working with the Department on this. The diary will also deal with medication and the therapies the person is receiving, which will give a more holistic picture of the level of care being provided. In the absence of a face-to-face assessment, the person looking at the form can see at a glance that high levels of care are required.

We believe that question No. 10 on the medical form is flawed. I will not go into this as it is quite technical but we have outlined this in our submission.

Family carers who care for an adult with PDD, an intellectual disability or mental health illness face another problem. The form is strong in capturing information about somebody with a physical disability but it does not capture the issues faced by somebody with a mental health disability. In other words, it leans heavily towards physical disability and it is very much a medical model rather than a social model. For example, a person could be caring for somebody with a mental health illness or an intellectual disability who does not understand money or who cannot use public transport or travel on a bus or who may be vulnerable in relationships or vulnerable to addictions or may have suicidal thoughts or aggressive. None of this is captured in the current application form, which is weighted towards older people and those with a physical disability. This, in turn, proves burdensome for carers who must provide extra reports, which is costly and time consuming. It also places an additional burden on the Department because cases are appealed and it takes more time to review them. In the interests of fairness and consistency, we ask that the DCA review be extended to review the carer's application form. We acknowledge that the Department is reviewing the improvements to the DCA and it wants to do that to make sure the changes working well for everybody. We would like carer's allowance to be reviewed as soon as possible.

The medical assessment presents another difficulty for carers. Carers express extreme frustration when their GP has submitted and signed off that a person requires full-time care but this is often ignored by the medical assessor who does a paper assessment. We understand and sympathise with those views. We ask for a change in current practice in order that there would be a single integrated medical assessment process which would look at health, income support and education. It would cover all those rather than having separate assessments. We ask for them to be combined. It would be more efficient but also more humane to the carers applying for the payment.

While we acknowledge the processing time for applications improved dramatically in 2013 when the gap reduced from 26 weeks to 12, we have noticed over the past 12 months that it has begun to increase again. We ask that this be looked at. We acknowledge the Department is working to improve that.

We welcome some initiatives by the Department in recent days. It has introduced a process whereby if an application comes in and the officials feel the medical information is not sufficient, they will go back to the carer and seek more information before they stop the payment. That is a welcome improvement in the system.

We have highlighted many of the issues I have highlighted to the Department and we are working closely with officials, particularly on the daily diary. We feel that would improve the position of family carers and the Department is keen to work with that. We discussed that at the recent annual forum for carers and there seems to be a positive move towards introducing something like that. We welcome the improvements to the DCA process and those improvements should be spread out to the carer's allowance and carer's benefit processes.

Chairman: I thank Ms Cox. I have been told by the broadcasting service that there is a great deal of interference from a device. I reiterate that people should switch off their mobile telephones or put them on airplane, safe or flight mode. There is a problem and the meeting is being broadcast on UPC, Sky and so on. Viewers will not be able to hear anything.

Dr. Joanne McCarthy: I thank the committee for the invitation to discuss this important issue. The Disability Federation of Ireland, DFI, represents the rights and expectations of those who live with disabilities to be fully included in Irish society. We are an umbrella organisation that supports more than 130 member organisations and these support and provide services to all people with disabilities whether they are hidden, physical, intellectual, mental health, sensory, neurological or emotional.

This issue has been high on the DFI agenda for some time. We have an internal network of interests. The membership is drawn from people with disabilities and interested organisations around social protection and the issue we are here to discuss has come up through that We participate on the Department's disability consultative forum and, along with other disability organisations, brought this issue to the Department and we acknowledge that the Department ran with an initiative to address it. For all of us here, this has been an ongoing issue.

To epitomise some of the challenges we are facing, and I will refer only to the disability allowance because I do not want to go into all the payments to which this relates, we know from the Department's own statistics for 2014 that there were over 111,000 people on disability allowance. In that same period, 27,000 decisions were made on disability allowance eligibility and over half of those were refused on the first application. We know that during the same period almost 6,000 disability allowance appeals were heard and that two thirds of those were granted. It is clear from that snapshot of the Department's own statistics that a disproportionate number of people are being refused disability allowance on the first application, which highlights to us that there are procedural questions that must be asked about protocols and the way systems are operated. Members will appreciate the stress that is causing for the people with disabilities and their families who are involved in submitting these applications.

Drawing on our own work, which Ms Joan O'Donnell chairs, in terms of our network of interests and also the work that has taken place through the initiative of the Department of Social Protection we are using that as our raw data to support what we see as some of the core issues facing us when we talk about this issue. First, we believe the decisions are made largely on a medical assessment. In most cases, that is a desk-based analysis. It does not give persons with disabilities or, as we heard earlier, carers the opportunity to describe the impact the disability is having on their capacity to work or otherwise. It does not provide the opportunity to perform a holistic assessment on that person. The members might use slightly different terms but we are looking for the opportunity of a much more holistic assessment that will examine not just the medical issue around disability but how that has an impact in terms of someone's physical or mental well-being. I refer also to the family circumstances that person may be in or the other inter-relations that take place. For example, if someone who wants to go to work it will vary depending on the educational capital that person has at hand. That is the first issue that is arising repeatedly through our engagement on this issue.

Second, there is evidence to suggest that for the Department, the medical assessor's opinion is taking precedent. This was substantiated significantly in recent case law in the case of a personal application for a domiciliary care allowance where it was found that the assessment did not give what they called due weight to the professional reports from other professionals or multidiciplinary teams that work with the claimant on an ongoing basis. It found that the Department's mindset was that these professional reports were coloured in some way in favour of the applicant. In their findings they said they felt that this was not an isolated case and an issue that was persistent.

What we are saying is that equal regard to all forms of assessment reports must be put on the table, not just the medical assessor's report but also other reports that support people to live with a disability on a daily or weekly basis. Also, we need to highlight the fact that the way decisions are being made is inappropriate. The concept of that desk-based analysis is inappropriate.

The third issue that arises repeatedly in this regard is the wide perception not just among people with disabilities but among general practitioners and other allied health professionals that, typically, people are refused at the initial application stage. People often expect that their application will be refused so they withhold information to substantiate any appeals process. There is also the sense, and we got this from our discussions with people with disabilities, that they believe the appeals officers operate more independently in their decision making, and that is fuelling a particular take within the system.

There are other concerns that interweave with what we would see as the three main areas. For some people it would be the cost of the appeals process. Often people are asked to get independent consultant reports which they have to fund themselves. There is also widespread misunderstanding about the types of payments, how one can apply and the level of information required on the application form, and that is having an impact.

There is a much wider issue, which the OECD stated in 2008, that people with disabilities get parked on these payments. They are not able to access activation measures, similar to people on the live register. The members will be aware of the level of rejections of appeals. Many people with disabilities are almost too frightened to take the risk and investigate whether they could go back to work or further education.

We have spoken a good deal about high level policy issues we believe must be addressed when discussing this topic but we are anxious that the members do not lose sight of who it is we are talking about in terms of the people making applications. We know from the census of population that there are almost 600,000 people with disabilities in Ireland. We also know that in 2014, just over 111,000 of those were on disability allowance. This is a particular cohort of people who are seeking this support and resource from the Department. They need to understand that those people probably feature in the statistics to which I am about to refer.

We know that in 2010, 40% of people with disabilities did not go past first level education, as opposed to 50% of the general population. Some 21% of people with disabilities aged between 15 to 65 are in work, compared to 50% of the population. We know also that 53% of people with disabilities are living in deprivation. That figure has risen significantly since 2009 when the figure was 36%. Those people are bearing the brunt of the recession and are significantly dependent on social welfare payments to ease some of that burden.

In summary, the Disability Federation of Ireland believes there is strong evidence to show that it is time to review the medical eligibility criteria for illness and disability payments and that these claims are substantiated by a number of sources. We know from our internal working group in the DFI, our network of interests, that there is an ongoing issue. The Department's statistics bear fruit in that regard. We also know, and it is now supported in case law, that if we are to be honest-----

Chairman: I must ask Dr. McCarthy to conclude.

Dr. Joanne McCarthy: I will, in less than one minute.

Chairman: She has had nine minutes.

Dr. Joanne McCarthy: If we are to be honest, however, a simplistic focus on the medical eligibility criteria alone without a wider review of the disability and illness social protection scheme in general may be limiting. We have a national disability strategy to protect and ensure that people with disabilities have access to appropriate income. We have a Department that states it will ensure its systems of payment will support people to participate, and that includes back-to-work supports. If we are to ensure that social welfare payments are part of those supports for people with disabilities, we must ensure also that we review not only the eligibility criteria but also the wider schemes.

Chairman: I thank Dr. McCarthy. Our last speaker is Dr. Singh, on behalf of the Department of Social Protection.

Dr. Devesh Singh: I thank the Chairman and the members of the committee for this opportunity to discuss with them the way medical eligibility criteria are established in regard to illness and disability-related social protection schemes. I thank my colleagues in the Disability Federation of Ireland and the Carers Association for their comments.

Before I commence my presentation I would like to introduce myself. I am Dr. Singh, deputy chief medical officer. I am accompanied by Ms Catherine Kellaghan, principal officer, based in Longford, with responsibility for disability allowance, invalidity pensions and carer's allowance; and Mr. Tony Kieran, principal officer, based in Letterkenny, with responsibility for the domiciliary care allowance, DCA.

I will start by sharing with the committee some information on the main illness, disability and carers schemes provided by the Department of Social Protection. The Department provides a wide range of income supports to people with illness, disability or caring needs. The importance of these schemes is underlined by the fact that in 2014 more than €3.4 billion was spent on the various illness and caring related payments. This accounts for around 17% of the overall expenditure of some €20 billion on social protection in 2014. On average, some 330,000 people received weekly payments from these schemes, excluding the annual respite care grant, during 2014.

The number of beneficiaries on all schemes has been increasing steadily. For example, the total number in payment increased from some 230,000 in 2004 to some 330,000 in 2014. Medical opinions are provided to the Department's deciding officers to assist them in determining eligibility for the relevant scheme. These opinions are provided by the Department's medical assessors who are fully registered medical practitioners with at least three years experience. Several of the medical assessors currently working in the Department have post graduate qualifications and experience in relevant specialties. All undergo a structured and focused training programme on commencing their duties as medical assessors and are involved in a continuous professional development programme.

At the outset, it is important to point out that medical assessors do not contest or refute the diagnosis provided by the customers doctor; the objective of the medical assessment is to ascertain the impact of the disability on the customer. That is, to assess the ability for suitable work or the need for additional care due to the illness or injury and the expected duration of recovery. Medical opinions are based on all available medical evidence submitted with the application and, if available, any prior medical evidence held on file is also taken into consideration. The medical assessor uses his knowledge, skills, experience and evidence based guidelines and protocols to provide an informed and unbiased medical opinion.

In undertaking the assessment process the medical assessor considers the following: first, the customer's impairment, that is, the illness or accident, what symptoms they currently have, what investigations, treatments, medical or surgical, they have received and the prognosis of the condition; second, the customer's account as to how they consider themselves to be adversely affected by their condition, with special emphasis on how it affects their ability to cope with the activities of daily living, ADLs, and work-related activities; third, the provision of additional medical evidence is encouraged and all evidence provided is considered in the assessment process, for example, specialist reports, results of investigations, X-rays, CT and MRI scans, and blood tests, etc.; and, fourth, the medical assessor also considers any stated or known comorbidity, in addition to the primary condition.

The medical assessor's opinion is provided to the deciding officer, who then takes into consideration the medical opinion and all relevant criteria for eligibility to the particular scheme, including reviewing the medical evidence provided by the customer before making a decision on the application. The Department accepts that some customers may find the process of determining eligibility difficult, and that a perception may exist that some schemes are hard to qualify for. The following issues have been identified and are being worked on: familiarity or knowledge of the different schemes and the conditionality attaching to them; the level and type of information required at the initial application stage; the fact that it is not the diagnosis but rather the severity of restriction or disability and the expected duration of recovery that is taken into consideration by the medical assessment process; and issues relating to the communication content of decisions.

The Department continually updates information on its website on all schemes, ensuring that information on the purpose, conditionality and information required to be submitted with claims is available to potential customers. Information on the Department's schemes is also available through a wide range of providers, such as, the Department's Intreo offices, citizens information centres and non-governmental organisations. The Department continually stresses the importance of providing as much information as possible on the customer's medical condition with the initial application form. All correspondence issuing to customers stresses this point and encourages them to submit any additional information they may have. I avail of this opportunity to once again highlight to the committee that one of the main reasons for a claim being disallowed at the initial claim stage is that claimants and their doctors often do not provide full and comprehensive details of their condition or disability until they receive notification of a disallowance. The Department has a series of stakeholder forums with disability organisations and representative groups and avails every opportunity to emphasise the importance of providing full information at the initial claim stage.

The Department accepts that it is difficult to get across the concept that it is not the diagnosis but rather the severity of restriction or disability that is taken into consideration by the medical assessment process. To address this, the Department has undertaken a proactive engagement with medical stakeholders including meeting with general practitioners and their representatives. The chief medical officer and deputy chief medical officer liaise regularly with individual general practitioners who have issues or need clarification on specific scheme conditionality. This process is ongoing. Furthermore, these issues are also discussed in ongoing liaison meetings with customer representative groups, that is, the Carers Association, the DCA support groups, and the Disability Federatiion of Ireland.

The Department endeavours to provide as much information as possible on the reason for decisions. Specifically, in any case where an application is being refused additional information is now provided to the customer, which should assist them in deciding whether they should seek a review of the decision or appeal. This process is kept under continual review, with the intention of improving the service and making it as supportive as possible to the customer.

Before concluding, I wish to highlight a number of recent initiatives. The Department undertook a review of the DCA in 2012, all the recommendations of which have been implemented, a major service delivery modernisation programme was implemented in the past three years and a revised process to streamline access to invalidity pension from suitable claimants. These projects have resulted in a substantially improved service to customers, including improved communication. As always, the Department is committed to delivering the best possible service to its customers and continues to review and monitor its processes to ensure it provides a quality service to customers with illness, disability and caring needs.

Chairman: I thank Dr. Singh. I call Deputy Willie O’Dea.

Deputy Willie O’Dea: I thank the Department’s officials and the two representative organisations for their submissions which are illuminating. I thank particularly the DFI and the Carers Association for a number of useful suggestions they have made. I am pleased the Department’s officials are present to listen to them and understand the logic which underlies claims being made in the first place. The major difficulty with claims based on a person’s medical condition, as pointed out by the DFI and the Carers Association, is the number refused at first instance and which are successful on appeal. It means that a person who is eligible for the benefit from the beginning suffers much anguish and distress for an indefinite period before he or she finally receives it. That is and continues to be a very real problem. We must consider the people we are talking about., people who qualify under the Department’s medical criteria for disability allowance, people who are ill, people who are caring for those who are mentally or physically ill. They have enough to get on with in life rather than go through all this hassle to obtain the benefit to which they are entitled.

I have a few specific questions. Ms Catherine Cox mentioned the difficulty in obtaining a carer’s allowance where the caree is a person who suffers from an intellectual rather than a physical disability. We have all come across that problem. When a person comes to my constituency office seeking to make an application for a carer’s allowance for looking after a child, parent or sibling who suffers from a mental rather than a physical condition, I confess to getting a sinking feeling because the success rate in those cases is very low. Is there a breakdown to hand of the percentage-----

Ms Catherine Cox: No.

Deputy Willie O’Dea: Yes, that would be difficult to produce.

It has been suggested the successful review regarding improvements to the application process for domiciliary care allowance be extended to applications for carer’s allowance and, I assume, disability allowance. I would welcome the Department's views in this regard.

Another question that consistently comes up at ground level is about desk reviews. Dr. Singh has explained clearly that the purpose of the medical assessment is to judge. One does not question the medical diagnosis, but one's function is to assess the level of impairment resulting from the condition. Dr. Singh has outlined a number of things one considers. It is difficult to understand how one can properly consider these things simply by looking at a file in Dublin without talking to the individual in question. If one were to go through all of the various criteria as set out in the presentation, no one could dispute that the person making the decision would be much better informed as regards the type of decision to be made, if he or she could see the person himself or herself and listen to what he or she had to say. I realise the problem with manpower and do not know what ideas the Department may have. The Disability Federation of Ireland made some suggestion as to how this issue could be tackled.

As I do not wish to take up too much time, will Dr. Singh explain what exactly is the division of responsibility between the medical assessor in the Department and the deciding officer? It appears as though the medical assessor looks at the medical evidence and decides, as Dr. Singh noted, the extent to which it impairs a person and by so doing the assessor judges whether he or she comes within the qualifying criteria. What then is the function of the deciding officer? Is it simply a rubber stamp or does the deciding officer who, after all, is a non-medical person have the right to overrule the medical assessment?

Deputy Aengus Ó Snodaigh: I thank the representatives of the organisations and the Department for appearing before the joint committee. While this is not an issue for most people, it is an issue for anybody who makes applications for medical supports through the Department of Social Protection. Probably in common with all of the Deputies and Senators present, I have come across absolute frustration among people who often are in stressful situations and trying to fill in forms. Everyone accepts that there is a need for forms and that there is a bureaucracy that goes with making an application. As one issue I had originally hoped to deal with today concerned general practitioners, GPs, and consultants, it is a pity the Irish Medical Organisation, IMO, is not present because this is one cause of delays. I note that one proposal - I believe it was put forward by the Disability Federation of Ireland - is that the Department consider ensuring GPs or consultants receive a payment for filling in the forms because I am aware that there is frustration on the part of some GPs and consultants who are asking why must they fill in forms repeatedly and what really is being sought. I seek a reaction to the proposal from the Department's point of view.

In addition, has the Department been in communication with the IMO or any other consultants' organisation to ascertain what is the problem? If a person applies for carer's allowance or disability allowance, he or she is required to produce a consultant's report. He or she attends the consultant and if he or she is lucky, he or she might be given an appointment after two months or might be on a list. The consultant will meet him or her and agree to fill in the form at some stage, but it could be seven to ten weeks before he or she receives the form. He or she is waiting for it in order to submit his or her forms. I have sometimes found that people have submitted the form initially just to be on the record. In some ways, they do not care that they will be refused because they know that by the time the appeal is heard, perhaps 20 weeks later, they might have the material they need from the consultant and that it will be backdated. Consequently, they submit an incomplete form in order to have it as the date of their application. What can be done to break the logjam? It is not just consultants, the same applies to some GPs. I am not having a go in this regard; I am merely stating there is a logjam that must be overcome.

The forms are substantial enough and can be onerous for somebody who is frustrated and stressed. A person is 19 pages into the carer's allowance application form before the headings of medicine, medical condition and disability are even reached. In the disability allowance section a person is 21 pages into it before his or her disability comes into it. As for the questions asked, one should not need to ask half of them in this day and age. The Department has all of the details, for example, of how many kids a person has because it is paying child benefit. I refer to a way of cutting down on this. Moreover, when a person applies for carer's allowance, he or she may be entitled to free fuel allowance or free travel. Perhaps I am wrong, but in many respects, he or she must then fill in virtually exactly the same form again.

I will ask one or two questions and then come back in. Will the departmental officials explain why more than half of those who appeal are successful? Members understand the substantial increase in the number of those applying which obviously has put a weight on the Department. However, having found a rate of 55%, has an analysis been made? Is it just a lack of understanding of the forms? I note that two cases from the Ombudsman last year or the previous year involved forms not being sent between the Department and the Social Welfare Appeals Office, that is, the full file. In this day and age, I would have presumed that the Department scanned everything. What is the problem in that regard? Is it simply a matter of computer systems not talking to one another?

Senator Mary Moran: I thank the representatives of the Carers Association, the Disability Federation of Ireland and the Department of Social Protection for their attendance. I welcome the holding of this meeting which presents a great opportunity for members. It is great to see my colleagues all going through the same issues and I back absolutely everything that has been said. People with a disability have enough obstacles to face in assessing everything from housing, social welfare payments, medical cards, resources, education and therapies and many of the forms present further worry and obstacles. Ms Catherine Cox who is representing the Carers Association has made the valid point that there must be clear communication with the applicant on what is needed to make the most complete application, as far as possible, to the Department. People often approach me to tell me they applied for an allowance and then waited until they were refused before coming to me. When I ask what they submitted and what they included in their application, they reply that they filled in the form and answered all of the questions asked. When one sees the part about submitting extra reports, unless people are told specifically to include extra consultant or GP reports, many will decide to hold back the information until it is requested.

The point has been hammered home today about the number of disability allowance applications that have been refused. As has been noted, it amounted to almost half of such applications made in 2014. Of 27,608 disability allowance applications, 13,732 were turned down on the basis of the qualifying criteria on initial assessment. That is a huge number which I, too, question. I reiterate that better communication is definitely essential. Much of the confusion could be done away with if information regarding additional documentation was made available. The DFI raises a valid concern regarding the domiciliary care allowance. I have seen the transition from it to disability allowance result in difficulties. I know of one parent last year who lost her carer's allowance, a payment she had received from the birth of her child. The system is confusing for everybody, in particular when a child's situation has not changed from the last day of him or her being 15 years of age to the first day of him or her being 16 years of age. It is a major issue. When people are applying for a disability allowance where they used to qualify for domiciliary allowance once they turned 16 years of age, there now seem to be obstacles for other people trying to qualify for disability allowance.

I take the point that the Department of Social Protection said it does engage with different departments and groups. I would propose that visits are made to special schools. I have experience of them. Many parents whose children attend such schools find through word of mouth or remarks in class that when their children reach 16 years of age they can apply for benefits. I have been amazed at the number of queries I have received in the past two years from people who were not aware of what they were entitled to. It has been said that the information is on websites and available from Citizens Information, but we are talking about a cohort of people who are tending to family members for up to 24 hours a day. Such people may not have the time or opportunities to sit down and source information on everything. A very efficient way of getting the point across would be to provide information for the parents of children, in particular those in special schools or classes within mainstream schools whom we know will be entitled to disability allowance.

When the Department of Social Protection said it regularly engages with GPs, what kind of communication takes place? Is it done by letter or are there formal information evenings for GPs? Deputy Ó Snodaigh raised a very valid point. We all have experience of situations where there is a delay in getting reports or people cannot get reports because a GP is charging €15 for a report and a person cannot pay until he or she receives money at the end of a week. It is horrific that people are put through such a system and made to jump through all of the hoops.

Deputy Brendan Ryan: I would also like to thank the Carers Association, the Disability Federation of Ireland and the Department for coming before the committee to discuss this topic today. As a practitioner in the area and like other colleagues, each of us who have been asked to comment could have raised the same issues as the delegations. We know what is happening on the ground. There are real concerns. In fairness to the Department, it has argued in the past that the high success rate of appeals is down to insufficient evidence being presented at the application stage. I know that to be correct in some cases. I know of a recent case which went to an appeal and it turned out that almost no information was required at the application stage. We knew that the presentation of additional evidence at appeal stage would almost guarantee success, and the person was successful. There is a gap.

I refer to what the Carers Association has asked for, with particular reference to the success of the process around domiciliary care allowance. What is required and what people are asking for is that there be a review process. As a committee we could recommend that should happen. Department officials have said discussions are under way with medical stakeholders, but the process needs to go beyond that and be formalised to a greater degree. From the point of view of the departmental management of the process, it is absolutely inefficient to have a system whereby there is a significant level of success at the appeal stage. If one was managing a system with such a lack of efficiency in the private sector, one would say it had to be re-examined.

My recommendation is that we take on board the request from the Carers Association that there would be a more formal review and the inputs from the various stakeholders would be taken on board. If we could agree that today, we would have had a very successful meeting.

Senator Gerard P. Craughwell: I join my colleagues in thanking the delegations and thank the Carers Association and the DFI for providing services. I do not run clinics or deal with people in my local area. Most of what I deal with comes from ten or 20 years ago when I worked in Citizens Information in Limerick. I want the Department to address my point. There was then and, from what I hear today, still is a suggestion that there is a lack of trust in the evidence submitted from GPs. How does the Department assess on paper what a GP has assessed about a person? An individual presenting with back pain, for example, can be found by one GP to be suffering from a debilitating illness, but can be assessed by another as capable of doing something. A GP can assess that type of thing.

From what I have heard here, the default position seems to be to refuse an application and let the appeal decide. I may be wrong.

Chairman: To be fair, that was not said. In fact, what the Department-----

Senator Gerard P. Craughwell: That was my impression.

Chairman: I want to be fair to the Department. It said it accepted the diagnosis of the doctor. The diagnosis is not the issue.

Senator Gerard P. Craughwell: I will allow the Department to address that. It seems as if waiting times are on the increase. Has a staffing issue arisen due to the Haddington Road or Croke Park agreements which has made the Department's job more difficult in terms of dealing with claimants?

I read the two forms. In 2015 I can walk into any bank or branch of the bank with which I deal and give my bank account number to the bank which is then able to pull up all kinds of details, including mortgages, car loans and insurance details. I have a unique PPS number which works across all Departments. If I am applying for a disability allowance and submit the PPS number of the person concerned, why can all of the relevant information not be automatically entered into the form? Why do we have to put such an intimidating form in front of people? I have come across people, as I am sure the delegations have, who decide the form is too much like hard work and do not bother with it. Why can we not automate a lot of the information?

If I am a carer, I have a PPS number, as do, I presume, my partner and the person for whom I am caring. If there is a proper database in place, I do not see any reason why the meta data cannot be automatically inputted into the form which is then sent out with only the information that is required, rather than people having to fill in all of the information. Maybe there is a reason behind it, but I do not understand why it cannot be done. That bothers me.

I refer to the assessment of disability. Leaving aside what the Chair said, there seems to be a problem in making assessments based on information on paper. I would like Dr. Singh to address that issue because as a medical practitioner he will know that an illness will devastate one person but not another.

The area in which I have most interest is access to education. For some reason, the back to education, VTOS and various other initiatives all seem to be aimed at work. What is the Department's view on access to education for occupational therapy? I refer to cases where one is not looking for certification and if one is then it is merely to reach a certain level. The certification is not for work *per se*. I wonder whether the Department has taken enough steps to encourage access to education. Regardless of the disability, unless it is a severe mental disability, we can all benefit from education in some way or other. Those are all my questions.

Deputy Ray Butler: I welcome the officials from the Department of Social Protection and the groups that represent people with disabilities.

Politicians, in their constituency offices, receive a lot of representations from people who seek help to fill in these forms. The Department has said to us that it has met or is meeting with consultants and GPs. I would like forms to be given to GPs or consultants. GPs and consultants are very busy people. As a result, when a person applies for an allowance for the first time his or her GP or consultant might only write a one or two line letter. Such a short letter has led to a lot of problems in the form of further information being sought by the Department or a claim being refused. I propose that we consider creating a standard form to be filled in by a GP or consultant. It would help the Department and move the process forward. On a regular basis in my constituency people are asked by the Department to seek further information from their GP or consultant. It is on the second occasion that the applicant will receive pages full of information but when he or she started it was only a one or two line letter. It would be an excellent idea to have a standard form to give to a GP or consultant.

My next issue is decisions made about desktops. Can a decision be taken to view the customer with a system that was on-stream before? If a difficult decision must be made then I suggest that the patient or customer is viewed by the Department, consultants and doctors. There is no reason that system cannot be reintroduced.

I totally agree with the Senators and Deputies that the forms are very strenuous. One of the questions asks whether social welfare payments are being made to a family member or other people living in the house. Surely a click of button on a computer can find out such information. A 27-page form is very off-putting. The applicants already have lot of things going on in their lives and must survive from day to day. How much does this toing and froing cost the State when decisions can be made by viewing the customer's records?

I strongly appeal to the officials from the Department that we look at a system for consultants and GPs and suggest the initial form could be supplied to start the process. I apologise for repeating myself but I have seen, on a regular basis, instances where a GP or consultant gives a two line letter on the first occasion but the application is returned. When the patient or customer seeks further information he or she is supplied with pages of stuff. Why can that information not be supplied at the start of the process? It would save a lot of time if a GP or consultant used a standard form when a person seeks the payment.

Deputy Catherine Byrne: I thank the Chairman and speakers. I apologise for being a little late. The first thing that jumped off the page, when I arrived, was that €3.4 billion is spent on various illness and care-related payments. One must be specific when dealing with such a large amount of money. Nowadays, it is important to ensure that every "i" is dotted and every "t" is crossed because that was not done in the past, leading to huge confusion and creating a lot of doubt among people.

I seek clarification of the following matter. I deal with people who seek illness and disability payments. I cannot understand why people must return to their GP or consultant three or four times and it leads to a lot of confusion. The medical forms are very complex but I can understand why that is the case. The Department wants to retrieve as much information as possible. The way some questions are laid out can be very confusing for a lot of people and, therefore, simplifying the questions might be helpful.

I have never asked the following question before. Are all applications viewed by doctors? If so, how many people are granted their appeal following more evidence being submitted? When applications are turned down people can lodge an appeal. Are appeals successful because more information has been given? Do appeals go through a different process? If the information already existed then the initial decision must not have taken everything into account.

The form is frustrating to fill out. It is a large amount of money and for transparency and everything else, I have no problem with a form being as much as 40 pages in length as long as the form and questions are simple. I have noticed that some of the questions have been duplicated which can confuse a lot of people. I suggest the questions are more simplistic.

I agree with one of the other speakers that the people who look for a disability allowance, or whatever it may be, are already dealing with an illness. The process of filling out forms can be complicated when one is not in the right place. As a public representative, when people come into my clinic or visit me it takes me half an hour to go through each form with them. Is there online assistance or a telephone helpline to assist people when filling out a form? Yes, there is.

Chairman: Everybody has spoken and I call on Dr. Singh to commence the replies. Members have raised a lot of issues.

Dr. Devesh Singh: I agree that there are a lot of questions but they are pertinent and I appreciate them. What is of interest to me is that a lot of the questions are the same type of questions that we face as medical assessors. I intend to give the committee the medical assessors' feedback from the perspective of the questions posed. If there are any administrative-related issues then my colleagues will address them.

Deputy O'Dea asked pertinent questions. The difficulty in getting claims processed and desk assessments were two of the issues he raised. He sought clarification on how desk assessments could be perceived as providing an objective opinion. The matter was raised by several other Deputies and speakers today along with queries about the role of the medical assessor and deciding officer. From my own perspective, I have found it reassuring that the Department has not placed a cap on payments and no quota on the number of applicants for this benefit. That means if every application medically qualified then all of the applicants would be paid and it would not matter if the whole population of the country applied, so be it.

When it comes to difficulty in getting claims processed, I agree with Members. There is an ongoing process to improve the application process, the assessment process and communication. However, there is a complex process between the medical and administration elements. It is not only medical criteria that an applicant must satisfy. He or she must satisfy other non-medical criteria such as a means test and natural residence which takes a considerable length of time.

Desk assessments can be reasonable and objective way of assessing medical applications. However, and I must reiterate, this is based on the quality and comprehensiveness of the medical information available to the medical assessor. The committee must understand that what I have heard today is the same experienced by GPs in their day to day practice that initial applications are deficient, limited or restricted. Reaching the right conclusion is also a struggle for us as well. I have heard that a lot of applicants hold back information which does not do them any favours. I take this opportunity to ask Members to convey to their constituents that applicants should do some good for themselves and the best chance is to give everything bit of information to us. It would save on time, costs and mental stress faced by applicants.

I will move on to Deputy Ó Snodaigh's remarks. Communication with medical organisations has been an ongoing process. In the last couple of years we have realised that we could do more and we have been addressing that. There is no formal mechanism or platform for us to engage with them, but we do so at every opportunity, mostly when we find when processing an application that we need more clarification. This happens nearly once a week and we make attempts to ring them and communicate directly. The process is sometimes limited by the avail-ability of the general practitioner. My experience is that the doctor is often in a consultation and one must leave a message and wait for them to respond at the end of the day. It is an ongoing process. In terms of official contacts, the chief medical adviser has taken every opportunity to present the perspective of the medical assessment process at various medical conferences and forums. For example, on 5 February, he presented to the national GP tutor network. Opportunities and platforms like that help a great deal to get the message out.

The Deputy also asked whether the claimants' doctors get a payment for providing reports, which they do. The Department spends at least €18 million to €20 million per year just getting reports back from GPs. That is a significant amount. In fact, last year it went up to €21 million.

The form for the report is designed to give us enough information to make the decision, if it is filled in correctly and comprehensively. There are two things we must ascertain, namely, the severity and duration of the condition. Much of the time, it is the duration we are looking for. For example, if somebody has severe back pain and has an MRI, which might show pathology, this might improve in a couple of weeks or months with treatment. The duration is the information that we do not always get. However, the form is reasonably well designed to provide the information we need. I agree that the forms are lengthy. There are many pages in the initial part of the form covering administrative and general information. Why are half the appeals successful? I cannot answer for the appeals office, which is a quasi-judicial and independent part of the Department, but I gather that if claimants are providing more information to the appeals office, that would dictate a difference of opinion.

Senator Moran's first question related to the large number of disability allowance applications that are turned down. She stated that over 13,000 applications were turned down out of a total of 27,000.

Ms Catherine Kellaghan: I want to clarify that figure, because it has been mentioned a few times. The figure of 27,000 refers to the number of discrete decisions made on disability allowance applications in 2014. However, that would also include applications that were initially disallowed and subsequently allowed after more information was provided. There was actually a total of about 21,000 discrete new applications for disability allowance in 2014. The figures mentioned by the Senator are, therefore, is not exactly comparable.

Dr. Devesh Singh: There is probably a perception that a disproportionate number of disability allowance applications are turned down. To some extent, the disability allowance scheme may have a higher proportion of claimants who are not deemed eligible when they initially apply than the other schemes. This could relate to the issue with information. If we get all the information in the initial claim, perhaps those figures could improve. Senator Moran raised the example of the 16 year olds who are coming off the domiciliary care allowance and being turned down for disability allowance. The disability allowance application relies on a GP report, whereas the domiciliary care allowance application contains a huge amount of information. It is more exhaustive and there is more medical information. This does not transfer to the disability allowance application. They are two separate schemes. Perhaps we could try to harmonise the information for those schemes.

The Senator also asked whether we engage with GPs. In the last seven years, especially with the new certification process, we have been engaging much more with general practitioners, both formally and informally. It is a helpful exercise because I can see some of the issues that general practitioners are facing. It is up to us to engage with each other and get that message across because they are the ones we are depending on for the information.

Senator Craughwell made a very relevant suggestion about the perception that there is a lack of trust. That was his experience, but it is not that we mistrust GPs or any medical certifier or doctor. We look for information on both the severity and the duration of the condition, which is important. General practitioners and certifiers do not seem to be aware of the Department's various schemes, so maybe they do not realise that information is essential for us to give an opinion. The Senator gave the example of back pain, asking how a medical assessor can decide how severe the back pain is. Again, I return to the composite form. It not only has the diagnosis but also information regarding who provides the medical care, what investigations are done, what treatment is given and whether any other treatment is ongoing. When I get a diagnosis of back pain, I do not look only at the back pain, but also at the treatment and the investigations. If the claimant has had an MRI scan, I would be interested to see the result of this and whether it shows significant pathology. Regarding treatment, I am interested in whether it includes several different types of strong medications or pain specialist involvement. There is enough information in the form to extract how severe the back pain is, how long it will last and how it would affect the applicant.

The Senator also asked why so much general information is required every time an application is made. That is relevant as the process of application is onerous and time-consuming. It relates to the administrative side of the Department, but I know the Department has made huge attempts to modernise its processes over the last few years. We have had the illness and disability scheme enhancement, which is a way to improve the services. Technology was a major area for improvements. Efforts have been made to streamline the information. The Department has a huge amount of information and the aim is to make it easier to access. The name of the project is BOMi4. Hopefully it will be implemented shortly and we will get that information.

Chairman: If there is anything outstanding, we can return to the witness.

Dr. Devesh Singh: Finally, I would like to point out that we have improved our own forms, which have come up a couple of times. Besides the medical application form, we also introduced form MR99 in 2012. The latter is sent to the claimant in order that he or she can outline how his or her condition affects him or her in terms of activities and daily living and the impact it has on his or her faculties. This is a very useful form. In the context of the domiciliary care scheme, we recently introduced the Dom Care 3 form. This is issued to the care provider - the medical person - and he or she uses it to provide a comprehensive report on the person being cared for.

Mr. Tony Kieran: Deputy Butler raised the issue of drawing up a standard form which could be given to GPs or other persons who would be certifying. I led the review of the domiciliary care allowance and it was during the latter that the standard form to which Dr. Singh referred, form Dom Care 3, was designed. We put that standard form into use - with the agreement of parents' representatives, the Carers Association, etc., who were involved in our group - but shortly thereafter we discovered that while it captured all the information required, it caused some issues for people who already had obtained consultant reports or whatever. We were obliged to specify that we were not making this mandatory and, where it can be completed, it is a very useful form. We had to clarify on our website that while the standard form is in use, we will also accept evidence in any format in which it can be presented. There are issues with regard to the standardisation of forms, particularly as this might require someone being requested to return his or her GP or consultant in order to obtain specific information for inclusion on form Dom Care 3. Whereas as matters stand, if we get the information, we will accept and process it.

Ms Catherine Kellaghan: I will expand somewhat on the issue of application forms. The disability allowance, DA, form was revised and reprinted recently and has been distributed. However, it will probably take some time before it comes into general use because even though people have been told to get rid of old stocks of forms, they may still be using them. The new DA form requires people to give more detailed information in the context of their own assessment of their disabilities and how they are affected by them in their daily lives. We are hoping this will assist us in making better and more appropriate assessments. The form was also beefed up in terms of encouraging people to submit all relevant information at the outset. Without seeking to bore members, I reiterate that we perceive the quality and quantity of the information supplied as being key to our ability to make decisions in the first instance.

Another point that was raised relates to the DCA review process and how this will benefit carer's allowance, one of the schemes for which I have responsibility. As Mr. Kieran will attest, the group did a huge amount of work on this matter and put forward some excellent recommendations. The Department has taken what was learned on board and is applying it in respect of carer's allowance. We have already examined the procedures by means of which we review carer's allowance for carees or care recipients who are transitioning from DCA. As already stated, what we learned from the DCA review has been used to revise the process in question. All of our communications have been revised and updated in order that people will have a much clearer picture regarding what is happening, why it is happening and what is required of them. In addition, we have changed the process so that if it appears that a person is not going to qualify at first pass, he or she will remain in payment while we explore with him or her whether he or she possesses other information which might be of assistance to us in the context of making a decision. These developments, particularly that relating to the improvement in communications, have been quite well received because they have been of assistance to people. Now that the revised DA form is in circulation, we are examining the position in respect of the carer's allowance form with a view, perhaps, to giving people more opportunities to provide details of their day-to-day activities in the form of a care diary. Ms Cox referred to this in her opening statement.

The deciding officer is the key decision maker. Deputy O'Dea requested clarification with regard to where these officers stand *vis-à-vis* medical assessors. As he quite rightly pointed out, deciding officers do not have medical training. The Department, therefore, considers it appropriate that a deciding officer should obtain the opinion of a medical assessor in respect of the clinical information provided by a claimant in support of his or her application. To be absolutely clear, however, the final decision is made by the deciding officer. A deciding officer will not always go with the view put forward by the medical assessor. There are instances where, having reviewed the totality of the information provided, the officer will decide whether a person is eligible. Obviously, the officer must also decide on the other aspects of the claim, namely, the person's identity, his or her means, his or her habitual residence, etc. Deciding officers are, therefore, very much the key decision makers in the context of the medical and all other aspects of claims and they are supported in this regard.

On the issue of the high level of successful appeals, the appeals office plays a very important part in the decision-making process of the Department. It is there as a final port of call for someone who is not satisfied with the decision relating to his or her claim. The Department also has a decisions advisory office, the purpose of which is to consider the quality of all decisions - and not just those relating to medical matters - made by the Department. This office is obliged to liaise with the appeals office on various issues surrounding quality of decision-making. Information relating to any lessons learned is then fed back to deciding officers and they take it on board. I reiterate that an analysis of the numbers has not been carried out but that, as far as the

Department is concerned, additional evidence which we did not get to see in the first instance is generally provided at the appeal stage. People who are called for oral hearings may bring with them additional information that can swing the decision in their favour on the day. I repeat that the Department takes on board all information garnered by means of the liaison process involving to the decisions advisory office and the appeals office.

On processing times, the numbers applying for disability allowance and carer's allowance are increasing. For example, the number of carer's allowance applications received in 2014 was almost 20% higher than that received in 2013. The figures continue to increase in 2015. This has placed a little extra pressure on us but we have allocated additional resources and we are working on reducing the amount of time it takes to process claims. However, some claims take longer than others to process. Again, it all depends on the quality and the quantity of the information we receive and the standard of the supporting documentation provided. We are working as hard as we can to improve the position for people.

Chairman: Does the increase in the number of applications for carer's allowance relate to the increase in the number of older people?

Ms Catherine Kellaghan: We certainly are of the view that it is due to demographic changes and the increase in the number of elderly individuals.

Chairman: Is it the case that some of those people are on State pensions and that their spouses or whomever might receive carer's allowance?

Ms Catherine Kellaghan: That is correct.

Senator Gerard P. Craughwell: Between €18 million and €21 million is spent on medical reports each year. That seems an extraordinary amount of money, particularly in circumstances where many of the GPs involved are members of the GMS. How much is spent on each report and do consultants receive more money for reports than GPs?

Ms Catherine Kellaghan: I reiterate that the Department does not require people to submit any special or exceptional reports in order to qualify for disability payments. As Dr. Singh stated, we want people to complete the standard form as comprehensively as possible and to include on it all relevant the clinical information from their doctors. Doctors receive a special fee for that report.

Senator Gerard P. Craughwell: What is the amount involved?

Ms Catherine Kellaghan: Just over €44 per report. The €21 million paid out in 2014 also contemplates the fees we pay to GPs for issuing medical certificates in respect of short-term illness benefit.

Senator Gerard P. Craughwell: How much is that?

Ms Catherine Kellaghan: I am not sure. It is about €8 per certificate.

Deputy Aengus Ó Snodaigh: Is Ms Kellaghan concerned that some GPs are demanding a fee from patients upfront? Even though they are paid €44 by the Department, they are in some cases looking for €15 from applicants to fill out the form, which means that in some ways they get substantially more than what is the going rate.

Ms Catherine Kellaghan: I would be dismayed to hear that because the Department pays a fee to GPs for filling in the reports and the medical certificates. When someone is ill or disabled and is attending a specialist, the normal procedure is that the specialist will report back to the person's GP on what is being done, the outcome and the ongoing treatment. It would be sufficient for us if the GP has a copy of the report. We do not expect people to expend money getting special reports filled out by consultants in order to qualify.

Chairman: Any application would have some medical aspect. Is the €44 fee being paid for every application?

Ms Catherine Kellaghan: I apologise for interrupting the Chairman. Is the Chairman finished?

Chairman: Yes.

Ms Catherine Kellaghan: The medical report on the back of the claim forms is standardised. That is the standard report and that is the report that is paid for. A GP may write another letter or a supporting letter, but GPs would be expected to attach whatever information they have in terms of test results or outcomes of specialist investigations to the form for the same charge. There would be no extra charge.

Chairman: I dealt with a case recently in which the doctor was providing very little information. I suggested that the person get all his information from the hospital. under the freedom of information regime. I went through it, pulled out relevant letters and those were enclosed with the application. Some doctors are not really coming up with the goods and yet they are getting paid for it, which is not satisfactory.

Ms Catherine Kellaghan: I cannot comment without knowing the specific case. What I have said is how the Department envisions this operating, which is that the GP fills in the report, sends it into us and is paid for it. He would also attach what he should have in respect of his patient's clinical information and that should be more than sufficient.

Deputy Willie O'Dea: I am amazed at this. I am listening carefully to what Ms Kellaghan is saying but, in my experience, in my area, GPs routinely charge the patient separately for what she tells us they are paid to do by the Department anyway. Can we invite the IMO in to put an end to this?

Deputy Aengus Ó Snodaigh: It was to be here.

Chairman: It was invited but it notified us quite late in the day that it could not attend.

Senator Gerard P. Craughwell: Will the Department find somewhere on the form to advise people that GPs are paid a fee? I do not mind if the sum is not mentioned. However, like Deputies O'Dea and Ó Snodaigh, I am well aware of the fact that people pay the GP a visit fee of €55 or whatever it is purely to get a form completed and the GP is picking up another €44 for it. It seems a bit rich.

Ms Catherine Kellaghan: It is not addressed to the claimant, if one likes, but I believe it is written on the forms - the invitation to the GP - to say he or she will receive a special fee for completing the form.

Ms Catherine Cox: It says, "You can get a special fee for fully completing and returning this report. To ensure payment, please enter your DSP panel number...." That is a note to the doctor.

Deputy Brendan Ryan: That is a note to the doctor but what about the applicant? The applicant should be reminded of that fact.

Ms Catherine Kellaghan: Generally the patient hands the form to the doctor.

Senator Gerard P. Craughwell: Very few of them would read what are the doctor's instructions. A sum of €18 million to €20 million is a lot of money to be paying out.

Chairman: Does Mr. Dunne or Ms Cox wish to add anything?

Mr. John Dunne: I have a few very quick points. Going back to Deputy Catherine Byrne's question, I am happy to say that we have a care line for family carers. If a person is filling out an application form, the person can ring the care line and get support. This is one of the services it provides. Anyone dealing with clinics can be referred to this care line. If they need further help, we will provide it through our local staff. We are examining the possibility of online tutorials. There is an issue with a lot of online information in terms of access, literacy and so on. We are looking at the possibility of providing video tutorials to help.

I do not want to go over everything, but I will mention the domiciliary care allowance reforms because it is being referred to consistently. That was a very useful, albeit stressful, process. A lot of improvements came out of the process which are slowly percolating through. As Ms Cox stated at the outset, we acknowledge the situation but it is not foot dragging. It is moving carefully in what we think is a very good direction.

Deputy Ó Snodaigh mentioned people putting in a form as a marker. I can understand the logic of that from their point of view. From the point of view of an organisation which is trying to monitor carefully the level of delays, I would not be happy holding anyone to account for a delay in processing an application form which has a name and address and nothing else on it. We have spoken to the Department about making a distinction between what is clearly a *bona fide*, albeit perhaps inadequate, application and one that is clearly not a serious attempt at all by not putting the latter into the process and sending it back and asking the applicant to do it again. I understand the logic of the other side but from our point of view, it is a dilemma.

There is nothing inherently wrong with desk reviews. They are normal international practice. The practice becomes slightly problematic and challenging for people on the receiving end who are told, having had this anonymous review, the form they submitted in a *bona fide* way and which they thought was a good case, which if we are being honest is most cases, has been overruled and they cannot understand the connection. Deputy O'Dea asked how one gets past the resource questions. First, only cases which are being rejected are examined. Second, the Department has improved the process, as was stated earlier. In the old days, the applicant would have lost the application because of inadequate evidence and would have had to come back and appeal. Nowadays, the applicant is more or less told beforehand. That is a major improvement in the way it is being dealt with.

I share some of the reactions of the committee members to the issue of payments to GPs. It is not something that was on my radar before today. I do not know if, in the overall scheme of looking at the total costs and expenditures, there are economies or efficiencies to be made, but it will not be easy to take fees away from anyone. The other side of the coin is that we have separate assessments. This committee deals with education and social protection. That is fine and it is the Department of Social Protection which is here. However, a carer may be dealing with the Departments responsible for health, education and social protection and could be dealing with three separate medical assessment processes. In some cases, the Departments are quite explicit in saying they do not care what the HSE says; the person has to pass its criteria. From the customer-client point of view, that is a challenging agenda. However, from a Government point of view, it is a challenging agenda too. However, I wish to make the point on the record that there are three separate sets of obstacle courses which cover much the same ground and they are all problematic in their own way.

Ms Joan O'Donnell: Many of the issues are being echoed from various sides of the debate this afternoon. The primary issue that the Disability Federation of Ireland would have noticed and would have worked quite closely on with the Department was the fact that people were not filling out the forms properly. This was a surprise and a shock to all of us. The biggest surprise and shock was that this had become a deliberate strategy, not only by GPs and psychiatrists but by disability organisations which were routinely helping people to fill out forms. The issue seems to be cropping up here again today.

We have done an awful lot of work via the disability consultative forum in conjunction with the Department to address this issue and many improvements have been made. It will be interesting to see, with the improvement in the forms and, looking down the road, with the creation of a better balance between medical assessments and self-reporting, how much better the picture will look in 12 months' time. We hope there will be a significant improvement.

Deputy Ó Snodaigh's asked about a more holistic process of assessment and there is a couple of things I would like to point out about this. It needs to be done in conjunction with the person him or herself. Our colleagues in mental health in particular would say, on self-reporting in episodic conditions, that predicting over a period of time how well or not someone might be is something patients might know best themselves.

We would also say that our members, and disability and carers' organisations, often have lifelong relationships and professional interaction with many people with disabilities and can provide very insightful information that could aid applications. We see that communications is one of the major issues. The issue of communications not only applies to forms but the relationship between the applicant, or those acting on behalf of family member with a disability and the Department. There is a need to create a trusting relationship whereby people can rely on the fact that if they supply the correct information they will get the correct response. That is a relationship issue and a matter of trust. It is of major importance because the numbers on disability allowance have been rising and this is largely due to demographic changes, changes in population but also changes in eligibility for conditions such as autism. The purpose of disability allowance in particular has changed from when the disabled person's maintenance allowance, DPMA was the responsibility of the Department of Health and Children and the number of people in receipt of that allowance was between 26,000 to 28,000 people up to 1997 when it became the responsibility of the Department of Social Protection. We recognise the value of having a payment such as disability allowance but we also recognise that it is a contingency payment. People are living on this means tested payment as their primary income and therefore it is hugely important that there is the least amount of stress involved in the application process..

Disability allowance is a payment that is predicated on one's capacity to work not on one's medical condition. Dr. Singh has eloquently pointed that out. That needs to be communicated. I know the Department will be profiling all people on disability allowance during the course of the year to look at people's capacity to work. We hope that will encompass a broader sense of what people's capacities might be. We have to recognise that four out of five people acquire a disability during their working life. This is a societal issue. It is an issue that concerns all of us, not just the cohort of people who sit in a space that we do not interact with every day.

Deputy Aengus Ó Snodaigh: I thank each of the witnesses for the comprehensive answers. On the question of forms being filled in as a holding position, the frustration is that it will take two or three months in some but not all instances to get the form filled, yet those concerned want to ensure they may get cover. One needs practical solutions to get around this difficulty.

In fairness to the group that dealt with the domiciliary care allowance form, they raised the question as to how one gets a practical solution. If the applicant presents a form that is incomplete, one tells them that the form is incomplete. If one goes to an Intreo or a Department of Social Protection office, where the form and documentation is scanned in on the spot, the applicant will be told that he or she need to fill out parts of the form. In this day and age when the documentation can be scanned, whether it comes by post or handed in by the applicant, the original can be sent back to the individual. That would mean that throughout the system, whatever stage the application is at, be it the initial stage, or on appeal, the staff member can press a button, the full file goes to the relevant officer and there can be no loss of documents. The investment in technology should be done at this stage and I hope that will help address some of the problems that arose in the past.

During the debate on recent social welfare legislation, provision was made for additional medical assessors. Do the departmental officials wish to take the opportunity to tell us what has happened in dealing with case files since the provision of staff to deal with delays was made?

The Carers Association made the point in its document that there is a perception that the system is weighted in favour of those with a physical disability over those with a mental disability. How can that be overcome? Is there a need for education of or provision of guidelines to GPs, psychiatrists, medical assessors or where should we focus attention? The idea is not to be critical of the Department but to try to come up with practical solutions to issues that come up continuously regarding delays in medical assessments. I support the point made by Deputy O’Dea on the need to have an input from the IMO, a delegation from which was to be here today, as it represents both the GPs and a good number of consultants, and-or other medical organisations. It might have a better view of the issue from its perspective.

Deputy Willie O’Dea: I will return to the issue of desktop assessments. The normal appeal system is conducted on the desktop, but the applicant has the option to look for an oral hearing. Would it be practical in terms of manpower, for the deciding officer at the initial assessment stage, to have the option to entertain a request from somebody who wanted to see him or her?

Chairman: Deputy O’Dea, is that your only question?

Deputy Willie O’Dea: I have been amazed to have it confirmed today, that the deciding officer, who has no medical qualifications, is in a position to overrule the medical expert on what is essentially a medical matter.

Deputy Brendan Ryan: I wish to follow up on my earlier contribution and to propose that the review process, as requested by the Carers Association, would be recommended to the Department.

Chairman: Does the Deputy mean that a review of the overall scheme?

Deputy Brendan Ryan: Yes, a review of the issues raised by the Carers Association in its request today, similar to that carried out on the domiciliary care allowance, if there is agreement to do so.

Chairman: I suppose that is an issue for the Department to take on board.

Deputy Brendan Ryan: Can the committee recommend that it do so?

Chairman: We cannot address that issue now.

Deputy Brendan Ryan: Could the committee make a recommendation that this would happen?

Deputy Willie O'Dea: That is a very helpful suggestion.

Chairman: We can write and reiterate the view of the committee. The officials can take note as well.

Deputy Aengus Ó Snodaigh: A couple of months will be taken up with form filling and changing the forms.

Chairman: To be fair, the Department has outlined that there has been a review. Is the Carers' Association saying an addition review is required?

Mr. John Dunne: We are looking at the forms. The carer's allowance forms might be modified to be more in line with the domiciliary care allowance, DCA forms. We also acknowledge that this is happening and that it is happening on the basis of allowing enough time to try out the form that have been changed and ensure there are no unanticipated problems.

Chairman: When the Carers Association called for a review what does that mean?

Ms Catherine Cox: Let me outline what we are specifically looking for. In the case of question No. 10, there is a list of 16 conditions, 12 of which are physical and the remaining three or four relate to a mental health illness or an intellectual disability. We would like that to be looked. We have also suggested how question No. 10 itself might be changed. There are smaller things that could be done quite quickly without having to go through a year or two of looking into the process.

Chairman: The association has communicated all of this to the Department.

Ms Catherine Cox: We have.

Chairman: Okay.

Ms Catherine Kellaghan: I would like to add to that. The Department's view is that the review is ongoing. We are using much of the learning from the domiciliary care allowance review. I do not think it is necessary to go through that process again. Many of the issues are common. I am looking at my scheme in light of the domiciliary care allowance recommendations. I have made changes already and others are in train. We certainly intend to move forward with that. We are in regular consultation with the Carers Association. We keep in touch there.

I would like to address the perception that a greater weight is assigned to physical disability on the forms. While just one, two or three questions on the ability-disability profile might relate to mental illnesses or learning difficulties, etc. - Dr. Singh can give the committee more information in that respect - the medical assessors have many protocols on the various types of mental illnesses, learning difficulties or intellectual disabilities. There is an a lot underneath the ability-disability profile that is used to guide the medical assessors in their assessments. There is a perception that it is weighted towards the physical rather than the mental, but it is just a perception.

It is the European norm to do assessments at the desk rather than in person. We receive a huge number of applications every year. We receive between 80,000 and 90,000 applications across carer's allowance, invalidity pension and disability allowance each year. It is very large. The suggested change would not make the best use of medical assessors' resources. The Department believes appropriate determinations can be made at the desk where it receives sufficient information, where reports are filled in by general practitioners or doctors and where applicants supply everything available to them in support of their applications. As each deciding officer is independent in his or her views, he or she can suggest there might be an in-person meeting if he or she feels that is needed for decision-making purposes. Generally, there is no requirement for that.

Deputy O'Dea asked why or how a deciding officer might overrule a medical assessor. When a deciding officer is considering a person's eligibility, he or she makes a holistic decision on all aspects of the claim. The officer takes everything into account, whereas the medical assessor might give his or her opinion on a more limited set of criteria. The opinion of the medical assessor is just one part of the evidence that the deciding officer takes into account. That might account for occasions when the deciding officer makes a decision that would be in favour of the claimant. I want to make it absolutely clear that it is not the practice for a deciding officer to overrule a medical assessor in terms of medical eligibility where it is not in favour of the claimant.

Deputy Willie O'Dea: Okay.

Ms Catherine Kellaghan: I did not answer the question on the automation of applications. We were asked why we cannot populate forms automatically. The Department as a whole is looking at the use of online applications. Obviously, the biggest hurdle to be jumped in that regard relates to identification. We need to have appropriate ways of ensuring the person making the online application is the person he or she claims to be. Such issues are being examined by the Department. The use of online applications is something we will look at in the future. I do not know how far into the future it will be when they are used. If online applications are used, there will be more scope for much of the form to be automatically populated with the information we already have. It could then be amended, where necessary.

Mr. Tony Kieran: I would like to make a point in that context. Senator Craughwell spoke about shortening forms. People who have been on illness benefit for a long time are being automatically selected for invalidity pension where certain criteria are fulfilled. They are invited to fill in a much shorter form. We are making those improvements wherever we can and we will continue to do so.

Deputy Catherine Byrne: I would like to ask a final question.

Chairman: Yes.

Deputy Catherine Byrne: How often is disability allowance reassessed? Do people get disability allowance for two or three years? Are people contacted every year? Is there a set length of time? Does it depend, as Dr. Singh may have suggested, on the length of time the illness is going to last? Are people recalled?

Ms Catherine Kellaghan: Disability allowance is subject to a control policy. Such policies are applied to all schemes in the Department to ensure people stay eligible. There are two aspects to medical schemes, one of which is medical eligibility and when it should be reviewed. In the case of a person who has a medical condition which is very unlikely to change, the medical assessor might recommend that it should be reviewed after two, three or five years and we would go along with that. The person might have a much shorter review period in terms of his or her means if there is some indication that his or her means might change. It is basically done on a case-by-case risk basis.

Chairman: If there are no final remarks and everybody is happy, I will bring our discussion to a conclusion. I thank the representatives of the Carers Association, the Disability Federation of Ireland and the Department of Social Protection for their contributions. I thank the members as well.

The joint committee adjourned at 3.10 p.m. until 1 p.m. on Wednesday, 6 May 2015.