

# **REPORT OF THE DIRECTOR OF AUDIT**

## **ADMINISTRATION OF INVALIDITY PENSIONS AND OF MEDICAL FOLLOW-UP FOR THE ELDERLY**

Ministry of Social Security, National Solidarity & Senior  
Citizens Welfare and Reforms Institutions. (Medical Unit)

Performance Audit Report No 1

March 2010

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## EXECUTIVE SUMMARY

The report examines the administration of Invalidity Pensions and of medical follow-up for the elderly. This work is undertaken by a Medical Unit within the Ministry of Social Security, National Solidarity, Senior Citizens Welfare and Reform Institutions, and there is a Medical Tribunal that hears appeals against decisions taken by the Medical Unit. The activities covered in this report are:

- the processing of claims for the basic invalidity pension (BIP) under the National Pensions Act 76 to recipients aged 15-59 years
- the processing of claims for additional pension or Carer's Allowance (CA) to BIP recipients who need constant care or supervision
- the scheduling of routine home visits to the elderly
- the functioning of the Medical Tribunal.

Invalidity pensions are awarded on the basis of medical examinations, and in some circumstances, the claimant is examined at home. Doctors also carry out routine home visits for the medical follow-up of bed-ridden claimants over 75 years of age and of people aged 90<sup>+</sup>.

Basic invalidity pensions for the period 2007/08 amounted to Rs 992 million.

### Audit Methodology

We conducted the assignment in the following ways:

- interviews and submission of questionnaires to management and staff
- evaluation of the exercise undertaken by the ministry into public allegations over pension awards
- review of the system for processing applications in respect of pension benefits
- analysis of assessment methods used in determining awards
- scrutiny of sample claim files
- international benchmarking with the view to getting an insight into the various concepts of disability and of its assessment
- review of the system for scheduling routine domiciliary visits and for obtaining customer feedback.

## Key Findings

The Ministry's disability pensions system requires greater strategic focus and coherence. More needs to be done to modernise the systems and ensure that they are efficient and effective. A comprehensive review of accountability structures, quality assurance, management information and process performance for both the Medical Unit and the Tribunal system is required. The basis upon which pensions are awarded also needs to be reviewed, to bring it in line with international best practice. Key findings are as follows:

### 1 Oversight and Accountability

The Ministry obtains occasional feedback regarding the Unit's operations. There is a need however for greater oversight and accountability. For example:

- Suitable recording and reporting of performance to senior officials above the Unit would be useful; certain initiatives should require ministerial sanction, for example the adoption of guidelines by the Unit for deciding on pension entitlement (paragraph 1.2)
- Measures towards evaluating the experience of recipients visited at home should be introduced (the Medical Unit carries out some 45,000 home visits a year). A survey of some customers was however started early 2009 (paragraph 2.6.1)
- At present some doctors are making two home visits where only one is warranted, because doctors are also visiting on behalf of the Ex Services Trust Fund (ESTF) and the taxpayer is paying in both cases. ESTF was requested to implement some monitoring at its end but this could prove inadequate to fully address the problem as the scheduling of assignments is done at the level of the Unit (paragraph 2.6.2)
- A greater effort towards the equitable distribution of visits among the pool of doctors must be made in accordance with Ministry instructions. Some doctors were getting paid Rs 1.1 million over one year and others at some Rs 50,000. We could not confirm that allocation was based on doctors' performance and availability, as explained by the Medical Unit (paragraph 1.3.2).

### 2 Quality Assurance

Regarding assessments of benefit claims more is required from the Ministry/ Medical Unit in the area of quality assurance because of the risk of errors. Issues to be addressed are:

- assessment methods in respect of some 25,000 cases processed annually: there is a need for some review and questioning of assessments, which result in the payment of basic benefits totaling some Rs 992 million annually (paragraph 2.2.1)
- doctor assessment records including the scores achieved by claimants: the records are to be written in suitable detail, explaining why a particular decision was reached and providing a basis for challenging the technical evaluation (paragraph 2.2.1)
- medical report from the treating source: too frequently the report produced lacked essential details about the patient's medical condition, such as disease severity and examining doctors rely heavily on such reports (paragraph 2.2.2)

- Board reports' compliance with the specific criteria contained in the guidelines relating to additional pension, so that the validity of awards is more clearly established (paragraph 2.2.4).

### **3 Assessment of Disability**

Assessments were being undertaken from a medical angle, based on the presence of diseases and not on their functional outcomes. In some countries on the other hand, benefits are awarded on the extent of disability suffered by claimants; the adoption of such a stand by the Unit in accordance with law, whereby a person is entitled in case of minimum 60% disablement, should provide greater assurance that decisions are fair and consistent. Examinations of disability are a complex exercise; for example there could be a wide variability in the degree of disability experienced by different persons with the same medical condition. There is a need for reviewing the conduct of medical examinations which often last a few minutes only (paragraph 2.2.5).

### **4 Quality of Management Information**

**4.1** More needs to be done so that the Medical Unit receives sufficient relevant and reliable information to enable it to monitor the performance of its operations effectively. Measures are required towards improving the reliability of automated statistics and dispense with the compilation of manual reports. At present there are discrepancies between both types of reports, and time wasted on duplication of effort. Meaningful information could be produced on (paragraph 1.2):

- the number of Medical Board sessions and average time taken per applicant boarded
- type and frequency of diseases suffered by applicants
- statistics about long term awards made. The Ministry was right in addressing in 2007 the problem of circumstance changes. A review was undertaken following concerns expressed about pension benefits being enjoyed by apparently undeserving members of the public; in consequence, benefits were stopped and periods of award reduced in 505 long term cases.

**4.2** The following processes, currently performed manually, could be carried out on computers (paragraph 1.3.1):

- the validation of applicant data by local offices and scheduling of applicants for medical board
- the allocation of routine home visits among doctors; this would require the maintenance of claimant databases in the stand-alone system.

## 5 Conduct of Tribunal Hearings

The conduct of Tribunal hearings needs to be reviewed (paragraph 2.5):

- a mechanism must be put in place to ensure that tribunals are conducted effectively
- as aforementioned, more is required so that Medical Board assessments are sufficiently detailed, thus providing tribunals with suitable bases for review
- contrary to the UK practice, tribunals were, on appeal, examining evidence not available at the lower level.
- Evidence leading to Medical Tribunal's decision needs to be recorded.

### Key Recommendations

It is time for a review of the work of the Medical Unit, to make its operations more accountable and more efficient and effective. We recommend that the Ministry should:

- re-structure the Medical Unit so that it comes under appropriate internal scrutiny, with suitable performance indicators, performance monitoring and reporting;
- introduce an efficient and effective management information system and ensure that information necessary for decision making and performance monitoring is made available to senior managers at the right time;
- review the current basis of awards of disability pension, taking account of international recommended practice where awards are made on the extent of disability, rather than on the presence of medical conditions;
- ensure that the recording of assessments is transparent and that official guidance clarifies what is required;
- improve the internal claim processing systems to reduce delays, examination cancellations and lengthy manual processes;
- review the conduct of home visits and ensure that there is no duplication of effort, that assignments are allocated on a fair and transparent basis and that the performance of doctors is monitored; and
- review the basis and operation of Tribunal hearings taking account of international recommended practice, for example, the UK model.

## INTRODUCTION

The Ministry of Social Security, National Solidarity, Senior Citizen Welfare and Reform Institutions is responsible for the administration of invalidity and other pension systems. Applications for invalidity pension are made at local offices throughout the island and directed to a Medical Unit which functions under the aegis of the above Ministry.

The National Pensions Act was passed in 1976 to cater, inter-alia, for the payment of invalidity pension to disabled persons. According to the Act, the disablement should be to the extent of at least 60% to qualify for the pension and should result from loss of mental or physical faculty for a period of at least twelve months. The universality of the pension is implied in law and therefore payment of the benefit is not means tested.

The decision to provide medical services to the elderly was taken at administrative level since 1996.

### Types of Invalidity Pensions:

Basic Invalid Pension (BIP) is paid to claimants aged between 15 to 59 years and assessed disabled at 60% or more.

Additional BIP also known as Carer's Allowance (CA) is paid to BIP recipients who need the constant care or attention of someone else.

On reaching 60, BIP recipients are awarded the universal Basic Retirement Pension (BRP) and the former BIP and CA lapses. Fresh applications, if justified, have to be made for additional allowance, namely Severely Handicapped allowance (SH). The allowance is also payable to persons above 60 years who were not BIP recipients in the past but whose condition has sufficiently deteriorated since reaching the age of 60.

### Operations

Basic invalidity pensions paid for the last fiscal years are illustrated in Table 1.

*Table 1 Expenditure on Basic Invalidity Pensions*

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Fiscal Year	BIP+ABIP (Rs million)	% Increase
2005/06	882.9	-
2006/07	939.4	6.4
2007/08	991.8	12.3

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Claims for invalidity pensions are examined by Boards set up by the Medical Unit. Doctors of the Unit regularly visit persons aged 90+ at home (domiciliary visits), for the purpose of issuing prescriptions and performing basic examinations. As from 2005, this service was extended to bedridden persons aged 75+ and unable to attend hospital. For the last fiscal years, benefits' processing volumes in respect of BIP+ABIP were as shown in Table 2 and the number of routine domiciliary visits (DVs) undertaken in 2008 was as in Table 3:

**Table 2 Pension Benefits Processing Volumes**

No of Benefits Cases	2007/08	2006/07	2005/06
examined	23,323	24,696	23,251
approved	12,583	13,387	14,175

**Table 3 Number of Routine Domiciliary Visits**

Age group	Number of DVs
75-89	25,512
90+	19,172
<b>Total</b>	<b>44,684</b>

Medical tribunals hear appeals lodged by customers unsatisfied with the determination of their claim at Board level. The number of appeals heard and subsequently allowed for fiscal year 2007/08 is as shown in Table 4:

**Table 4 Outcome of Cases Heard by Medical Tribunals**

No of Cases	2007/08	2006/07	2005/06
heard	4,679	4,531	4,214
allowed	571	633	471
% allowed	12.2	14	11.2

## CHAPTER ONE

### STRATEGY FOR THE ADMINISTRATION OF INVALIDITY PENSIONS AND MEDICAL FOLLOW-UP

This chapter examines whether the Ministry has an effective strategy for the administration of invalidity pensions and medical follow-up.

#### 1.1 Objectives, Indicators and Targets

With the introduction of Performance Based Budgeting of July 2009, objectives, indicators and targets were included therein over a time span of three years.

The indicator for the claim assessment programme for 2009 (July 2009 to December 2009) was the reduction in the average processing time in weeks. Based on files examined for the month of November 2008, time from application to medical board decision was seen to average eight weeks (56 days) while the baseline processing time for 2008/2009 was six weeks. Another indicator for the effective support to bedridden persons was the reduction in number of complaints. The baseline figure for 2008/2009 was four. Though the unit was not formally registering complaints in the past, it is worth to note that since recently customer surveys as well as registration of complaints are being undertaken in a more structured way by the Unit.

There are no indicators for measuring performance of medical tribunal, such as the waiting time from appeal to Tribunal's decision, as in the case of medical board.

#### *Recommendations*

1. The Ministry has a mission, amongst others, to improve the quality of life of senior citizens. One of the strategies to achieve this mission is the provision for the welfare of senior citizens through various activities. However, there is no strategic plan for the Medical Unit.  
It is recommended for the Unit to develop a strategic plan to pursue the overall strategy of the Ministry.
2. It is recommended to set indicators for the medical tribunal as a measure to meet customers' satisfaction in a reasonable time.

## 1.2 Management Reporting and Accountability Issues

### 1.2.1 Management Information

Feedback on the Unit's operations was received at the Ministry through occasional reports and meetings.

More is required however in terms of the production and reliability of management reports as manual compilations were still being done in parallel with the IT system since more than five years and there were discrepancies between both. The system was reportedly not accepting data entries relative to medical board scheduling. Some discrepancies are listed in Table 5.

*Table 5 Discrepancies in Reported Number of Applications between Officers' Returns and the IT Systems*

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In respect of 2007/08	examined	No. of Applications	
		allowed	not allowed
As per Computer System	23,323	12,583	10,740
As per Return	23,758	13,065	10,932
<b>Difference</b>	<b>435</b>	<b>482</b>	<b>192</b>

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### 1.2.2 Accountability Issues

Key matters should be communicated to the Ministry. The set of guidelines actually being used for assessing percentage disability was developed by the unit in 2004. The guidelines, at that time, had not obtained ministerial sanction.

### *Recommendations*

1. Management needs to be in presence of quality reports for decision making; reports that could be of help include:
  - returns of the number of Medical Board sessions and average time taken per applicant boarded
  - type and frequency of diseases suffered by applicants
  - statistics about long term awards made.
2. Information relative to the objectives behind and the operating mode of important instruments should be communicated to the Ministry for approval.

## **1.3 Work Efficiency and Resource Allocation**

### ***1.3.1 Review of the IT system***

An indicator of improved efficiency has been recorded lately in regard to the reduction in waiting times for customers to be examined by a medical board.

However, there are grounds for reducing IT system bugs and manual interventions in operations, namely in respect of:

- the scheduling of customers' appointments with doctors, which was done manually from hard copies of applicants' lists
- the manual validation of data, for example officers of the appointments unit had to verify applicants' addresses and make corrections to appointment lists, where appropriate; they would subsequently proceed to amending customer database in server
- the non-maintenance of customer databases in the stand-alone domiciliary visit system. This requires the correction of errors on visiting lists used by doctors

Owing to the volumes and frequency of activity, substantial effort was involved in the above operations. Unit management was of the view that supporting staff was overworked.

### ***1.3.2 Distribution of Domiciliary Visits among Doctors***

Claimants usually welcome the visits effected by doctors at their home within the domiciliary visiting schemes. This should not preclude considering improvements.

The situation in 2008 and prior was unbalanced. This was reflected in remunerations which reached Rs 1.1million for doctors topping the list against some Rs 50,000 for others. We were told by the Unit that doctors' performance was evaluated and allocations of assignments made in consequence.

### ***Recommendations***

1. A new management information system had initially been considered with the view to addressing problems in the production and sharing of management information; subsequently however, the decision to consider enhancement of the current system instead was retained.

Until such time as changes are brought about and implemented, some efficiency concerns could be easily addressed, for example:

- Reviewing the networking architecture so that local office staff may amend applicant data in main server before submission to the appointments unit
- Resorting to spreadsheets for the scheduling of applicants for medical board
- Migrating customer databases aged 75<sup>+</sup> and 90<sup>+</sup> (routine DVs) from the current stand-alone system to a simple spreadsheet and systematic communication of names of persons having passed away. This would enable the maintenance of databases and consequently facilitate the allocation of visits among doctors.

2. One of the ways of improving the service of domiciliary visits could be the more equitable distribution of workloads among doctors

## **CHAPTER TWO**

### **THE ADMINISTRATION OF THE MEDICAL UNIT**

2. The activity of the Medical Unit is organized around four departments, namely:

- Medical Board Department
- Medical Tribunal Department
- Eldercare Department
- Services to Rehabilitation Youth Centre

The first two are concerned with invalidity pensions and were covered under this audit.

The **Medical Board Department** prepares and schedules medical board examination sessions with a view to inter-alia assess the eligibility of claimants for invalidity pensions and severely handicapped allowance. This concerns the following category of applicants:

- Claimants aged between 15 and 59 years applying for Basic Invalidity Pensions (BIP)
- Claimants aged between 15 and 59 years applying for additional basic pension (ABIP), since they need the constant care of someone else for life sustaining activities.
- Claimants aged 60 years and above, benefiting from Basic Retirement Pensions but applying for Severely Handicapped allowance as they need the constant personal attendance of another person for their daily activities.

The **Medical Tribunal**, which consists of a Chairman, appointed by the Attorney-General and two specialists, hears appeal from claimants who are not satisfied with the decision of the Medical Board regarding their claim for pensions. The appeal should be lodged within one month from the date the claim has been disallowed by the National Pensions Officer.

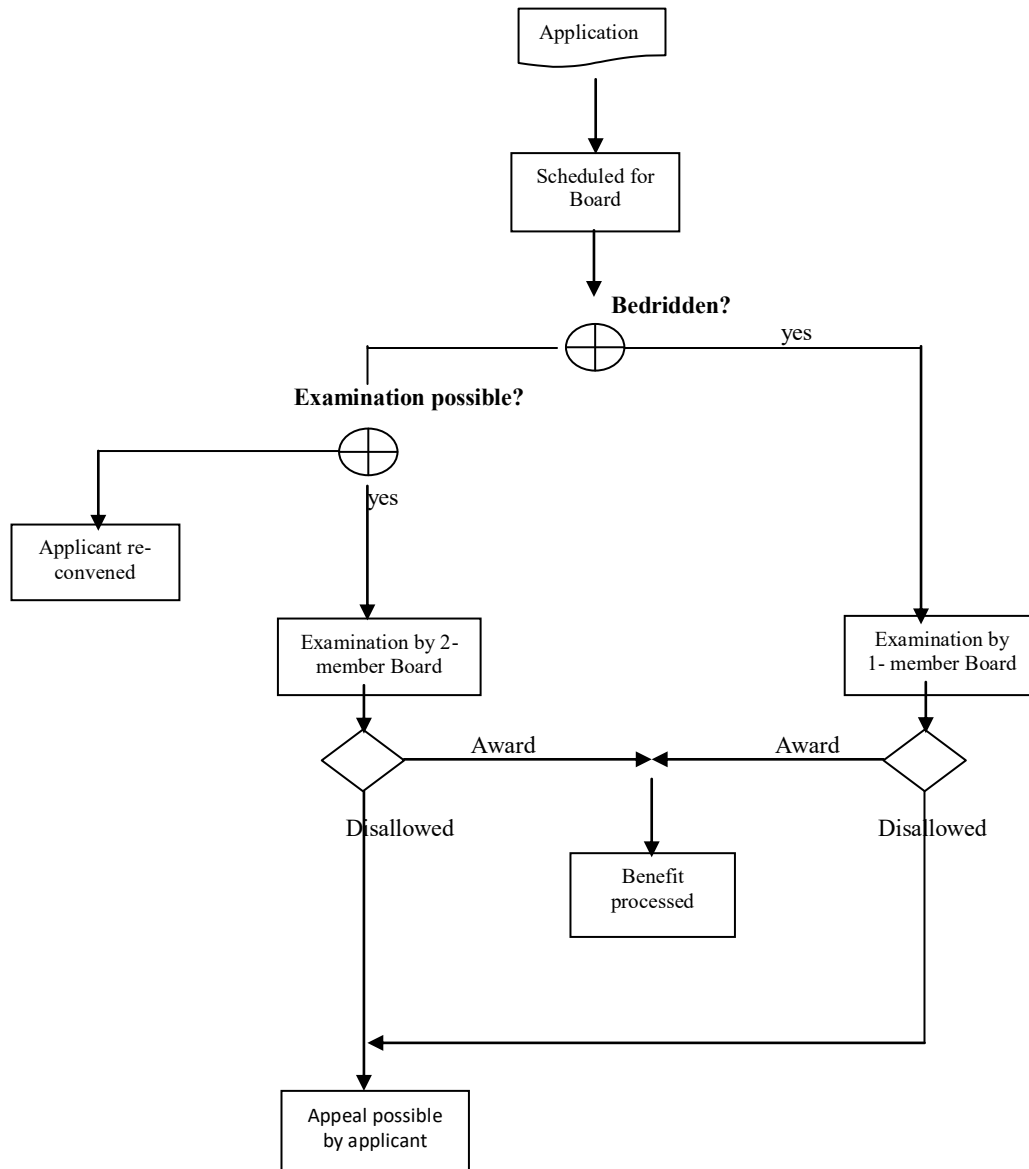
The Medical Unit also undertakes domiciliary visits for persons aged 90 + and those above 75 years in a bedridden condition.

This chapter examines whether the Medical Unit is being administered effectively.

## 2.1 Application Processing

The processing steps in respect of the application for disability benefits are shown in Figure 1:

*Figure 1 Processing of Applications for Benefits*



### ***2.1.1 Reconvened Cases and Unjustified Domiciliary Visits***

The scheduling of applicants for examination by a medical board proceeded satisfactorily except where:

- the scheduling exercise had to be repeated. When applying, claimants are required to produce their medical report, which is returned to them; 9% of customers scheduled before the Board in November 2008 had to be reconvened since they did not bring the original copy of the report along. Overall some 22% of customers have to be rescheduled for various reasons
- applicants attempt to circumvent the normal setup. Home examinations are exceptionally carried out at home by a single doctor instead of the two member panel in cases where customers put forward reasons of limited mobility. In November 2008, more than one in ten such applicants had their claim for benefits turned down and thus were deemed capable of personal appearance before the Board.

Medical examinations carried out unnecessarily at home disturb the normal process.

### ***2.1.2 Monitoring of waiting time for application process***

A notable improvement was recorded in the waiting time for application process. According to our evaluation, delays were reduced from 56 days in November 2008 to some 37 days a few months later. This indicator of efficiency in the processing of claims must be evaluated alongside compliance with quality norms.

### ***2.1.3 The Fast Track Mechanism***

#### ***2.1.3.1 Conditions for eligibility of fast track facilities***

Service delivery improved with the introduction of the fast track mechanism, effective since February/ March 2009 though the principle had been approved some while ago. Thus customers unable to go through normal procedure are channeled through a faster route.

Two broad conditions normally underlie recourse to the mechanism, namely:

- in respect of an application filed normally, where customers' condition deteriorates substantially enough for their application to be expedited,
- where subsequent to the rejection of a claim, customers' condition worsens, as supported by evidence from the treating source, the normal delay for re-application being waived.

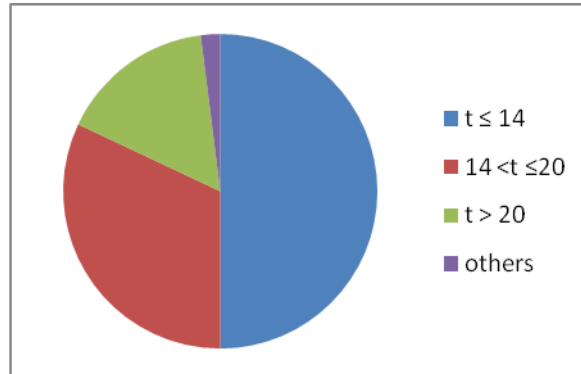
#### ***2.1.3.2 Non-compliance with criteria for fast track eligibility***

Local offices need however to ensure better compliance with instructions authorizing the procedure, given that, as seen from an April 2009 sample, some 78% did not have a qualifying medical condition in accordance with the Ministry circular; moreover for almost one case in two (48%), waiting time exceeded 14 days and one instance was seen where the person waited 106 days, which is more than if they took the normal route.

Restricting the fast track mechanism to genuine cases would enable a more judicious use of the facility.

The length of delays and their frequency are shown in Figure 2:

**Figure 2 Time Lag for Fast Track Medical Boarding (Days)**



#### **2.1.4 Repetitive Applications**

Certain customers, somewhat abusively, avail of opportunities to submit fresh claims following determination of their case by the tribunal. The law allows re-application six months from the date the former claim was disallowed by the medical board. From examination of selected files, we concluded that it was not uncommon for the whole application- appeal cycle to be repeated several times once legal clearance was obtained. There is a risk of applications being filed frivolously.

#### **Recommendations**

1. Medical certificates submitted at time of application should be retained/ copied, for eventual production before medical boards, thereby lowering re-convocation figures.
2. The applicant for home examination should be required to produce a medical report from the treating doctor, certifying lack of mobility.  
The application of the measure should ensure that:
  - the time wasted on unjustified home examinations is minimized
  - examinations done at home are restricted to genuine cases. It is pertinent to note that such examinations involve only one instead of the usual two doctors.
3. The Ministry needs to have a system for measuring waiting times for appointment with medical boards
4. Local offices should be more watchful regarding compliance with instructions over when to award the fast track status to applications. Such genuine fast track applications will then be given priority and forwarded in real time to the appointments unit.  
This would ensure only genuine applications are given special treatment and processed speedily.
5. There are grounds for limiting the number of applications over a given time period, say a maximum of two over a period of three years from the date the first application was turned down by the medical board.

In case there is genuine aggravation of the claimant's health, supported by evidence, the restriction is waived and the claimant may have recourse to the fast track procedure for examination.

The law will require amendment.

## **2.2 Medical Board decisions**

### ***2.2.1 Evidence of record of scores***

Applications for pension benefits are received at local offices following which a medical examination is conducted by a medical board; assessment of the claim is based on a set of guidelines which lists different diseases and cases of anatomical loss. The 2004 version of the guidelines was improved with the addition of new diseases and more definitions.

Scores are attached depending on the severity of the medical condition, entitlement to the benefit being subject to reaching a threshold score; doctor assessments need to be recorded in greater detail however, explaining why decisions are reached and providing a basis for challenging the evaluation.

### ***2.2.2 Treating doctor's reports***

Decisions reached by Medical Boards are founded on the treating doctor's medical report and on physical observation of the claimant during the session. Treating doctors should be advised to improve their reports which were frequently inadequate, for example the level of severity of grand mal epilepsy, upon which awards depend, was not mentioned; in other cases, a Board conclusion of diplegia was returned though the report was about hemiparesis, which does not qualify for pension benefits.

Inaccurate treating doctor reports may lead to the wrong decisions.

### ***2.2.3 One-member Medical Board Examination***

Claims are normally determined by a two-member medical board. Exceptionally, when one of the general practitioners is late or unable to attend, the remaining doctor proceeds with the examination. One-member determinations were made in six out of 50 applications sampled during October/November 2008.

### ***2.2.4 Assessment of Carer's allowance***

Customers already in receipt of BIP may apply for carer's allowance or additional basic pension (ABIP) and guidance was provided to examining doctors. The validity of ABIP awards could be established, except however where, as in 30% of cases sampled by us, the severity of the disease afflicting the customer and the qualifying circumstances associated with the medical condition were not adequately reported. Table 6 lists some of those parameters.

**Table 6 Parameters for Awarding ABIP**

Medical Condition	Qualifying Circumstances	
	General	Specific
100% invalidity or conditions requiring daily specialized medical care	Confinement to bed or chair Incapacity to sustain certain activities of daily living (ADL)	
Paraplegia		Walking difficulty and impaired ADLs
R/L sided hemiplegia		Limited mobility
Diminished visual acuity		Cannot move alone

When recommending ABIP (an area where some reference to the guidelines would still be pertinent), examining doctors should be instructed to specify the severity of the disease and associated circumstances in accordance with the guidelines.

### **2.2.5 Evidence of Record of Medical Findings**

The Unit needs to ensure that the recording of medical board findings and assessment of the disability suffered by the claimant are adequate. As required by law, evidence of at least 60% disability must be shown to qualify for benefits.

Annex I makes reference to the trends of assessment methods overseas and details the need for the adoption of a new approach. It follows therefore that, in recording their findings, doctors will explicitly establish the link between incapacities experienced by the customer and the decisions made.

### **Recommendations**

1. Examining doctors currently refer to a set of scoring guidelines based on the severity of disease while it was alleged that the disabling effects of the disease/s were also accounted for when awarding scores and making awards; however this was not confirmed, given the fact that examination findings on disability and scoring particulars were not reported and assessments frequently last for five minutes or less (such as when 30 applicants are examined in 3 hour sessions). As discussed in Annex I section 2, the focus should now shift from medically based assessments towards the evaluation of disabilities suffered by the customer in line with international practice and what the law says. In that connection, Health Care Professionals (HCP) are better suited to provide a critical appraisal of a person's care and mobility needs, especially given the wide variability of disabling effects of the same disease on different customers. In such a set-up, the current guidelines may not be very useful.

Following recruitment on a full time basis, HCPs, who in the UK may be nurses, physiotherapists, occupational therapists or doctors etc will receive training in disability assessment medicine. Thus the current system of medical board examinations, where assessments frequently last for a few minutes, will need to be replaced by more thorough evaluations carried out by HCPs or their local equivalent; such an approach should lend itself to fairer and more coherent evaluations, as evidenced by a new precise scoring framework and detailed reporting.

Stages of the assessment process are analysed in Annex I. Based on supporting evidence including advice from the HCP, the decision maker decides to award or not or alternatively requests further information. They may, in addition, record on-line the findings of the case in the ministry's system, which was an option envisaged within the management information system to be put in place.

The decision maker will be a person of appropriate caliber, who, for example, in the UK comes from a non-medical background.

Amounts spent on HCP training should not be prohibitive given its short duration and as seen in Annex I section 4, remuneration costs would be of the same order as medical board fees. Reductions in the number of examinations could even be achieved given the decision maker's discretion not to have customers examined in certain circumstances.

A further non-negligible advantage of the suggested approach lies in the involvement of the customer in the application process; they will be required to fill a self-assessment questionnaire regarding their perception of disability in different areas. In addition, this in itself should have a dissuasive effect on the repetitive filing of frivolous applications, a feature currently noted.

2. More should be done to restrict one-member determinations to a minimum however, as they are a departure from the normal setup.
3. When recommending ABIP (an area where some reference to the guidelines would still be pertinent), examining doctors should be instructed to specify the severity of the disease and associated circumstances in accordance with the guidelines.

### **2.3 Training of Doctors**

Disability assessment for pension purposes is an activity requiring specific skills, a situation with which, doctors, in their practice are not usually confronted with. Doctors servicing medical boards, drawn from the national pool of general practitioners, expressed the need for training in 2006 and 2007 during meetings; a wide variety of disciplines were mentioned, namely psychology of the old, cardiology, orthopaedics, neurology, psychiatry and ophthalmology.

In effect general practitioners are not trained and do not assess a patient's function and are therefore not usually in a position to give information about their patients' ability to perform daily living activities <sup>(3)</sup>.

In addition to the usual brief guidance to newcomers, a one-day training for doctors took place in the area of common orthopaedic problems in May 2009. However only twenty-two of fifty-one doctors convened actually turned up.

## ***Recommendation***

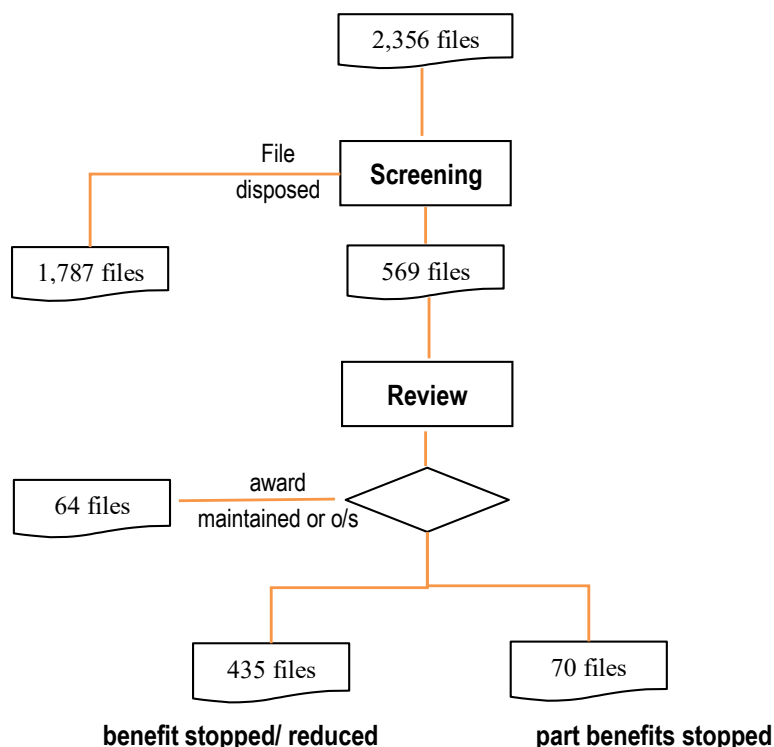
Pending the eventual appointment of health care professionals (please refer to Annex I section 3), training sessions should be undertaken in as many disciplines as felt necessary and every effort made to ensure satisfactory attendance numbers.

Advice was sought from the Medical Council who stated that the Mauritius Institute of Health can liaise with the Medical Unit for the conduct of training courses.

## **2.4 Review of Permanent Awards Following Public Complaints**

Concerns expressed about pension benefits being enjoyed by apparently undeserving members of the public were relayed by the Minister in 2007 and the press commented on the issue. Some 2,350 questionable award files were put aside and following preliminary screening, 569 cases were selected for detailed review by the tribunal, as a consequence of which, benefits were stopped and periods of award reduced in 505 of these. The main findings of the tribunal are laid out in Figure 3.

***Figure 3 Selected Files Reviewing Exercise***



- Decisions pertaining to long term benefits were made some while ago; with time, technological advances have resulted in standards of care unknown previously and improved customers' condition. The pension benefits therefore ceased to be payable on account for example of improved mental condition and insufficient grounds for the

benefits to be maintained (awards had been made on a permanent basis till year 2023 and beyond).

- By undertaking the review of selected awards, the Ministry and tribunal did rightfully address the risk of an absence of mechanism for detecting circumstance changes.

In the UK, there was concern that original awards were too lenient and that changes in circumstance were not reported; they are now reviewing awards after a certain period, which we understand is also the approach to be followed by the Unit.

### ***Recommendations***

A mechanism for reviewing long term awards (say over 3<sup>+</sup> years) should be set up, whereby the case would be brought up for reassessment at a scheduled date. Thus changes in circumstance or technological developments could be taken into account when re-evaluating the merits of the case and deciding whether or not to maintain the payment of pension benefits.

A longer time interval for subsequent reviews may however be considered in specific instances such as:

- cases of permanent anatomical loss,
- patients with mental disorders where frequent medical boarding might be stressful.

## **2.5 The Functioning of the Medical Tribunal**

Tribunals hear appeals mostly from customers whose claim for basic and additional invalidity pension was not entertained by medical boards. Currently only 12% of appeals lodged are allowed; this is not worrying unless all those cases relate to doctor error. The Ministry needs therefore to have a system for reviewing appeals otherwise they lose opportunities for quality assurance; suitably detailed doctors' findings are required however to provide tribunals with adequate bases towards the determination of appeals.

Other areas which could be subject to review include:

- The examination of evidence by tribunals are based on applicants' more recent medical reports and evidence of employment rather than the one on which it was disallowed at the medical board. The advisability of admitting such evidence should be considered, as for example in the UK<sup>(1)</sup>, tribunals operate differently.
- The chairman, who is a legally qualified person, gives a deliberation based on the claimant's statement of facts and conclusion from the specialists' findings. The reasons as to why the Medical Board's decision is upheld or overturned are not clearly stated.

### ***Recommendations***

The Medical Tribunal can improve its functioning by comparing it with what other countries have been doing. Below are a few examples of what UK has been doing so far:

1. Examining doctors' technical assessments are to be recorded in detail and made available to tribunals hearing a case on appeal.
2. The principle of retaining only the evidence produced at the lower level of decision should be upheld. However a fast track facility must be introduced to cater for an earlier hearing in case the appellant's condition deteriorates materially, as evidenced by a new medical report.
3. Evidence leading to the Medical Tribunal's decision should be adequately recorded. Examples of evidences are as follows :
  - The Tribunal accepted evidence that the medical board had available but was not willing to accept.
  - The Tribunal forms a different view of the same evidence.
  - The Tribunal was given additional evidence that was not available to the Medical Board.
  - The evidence was based on insufficient facts/evidence.
  - The Medical Board overlooked evidence that would have affected the decision.
  - The Medical Board did not give relevant facts/evidence due weight.

## **2.6 Domiciliary Visits and Medical Follow-up**

Home visiting schemes (routine DVs), which are performed on a monthly basis in favour of old age persons, were being operated by 47 doctors employed on sessional basis at the Unit, in accordance with the programme for the protection and well being of the elderly. Some 25,000 monthly visits were undertaken for the year 2008, as hereunder:

- above 75 years old if bed-ridden and upon application
- de facto if above 90 years.

Medical Unit doctors carry out a similar scheme for the benefit of members of the Ex Services Trust Fund (ESTF), on a two or three monthly basis depending on circumstances.

### **2.6.1 Submission of doctor's claims for visits**

A quality assurance monitoring exercise, in respect of the visiting schemes, was done by the Unit in 2009; some 30 customers were invited to respond to brief pre-set questions about the standard of the service.

Attention should also be directed however to addressing issues of duplication of visits and of the submission of doctor claims where visits are carried out twice to the same claimant or for visits not carried out.

### **2.6.2 Database at the Medical Unit and ESTF**

ESTF complained in April 2009 about 115 visits made in recent years to their members aged 90<sup>+</sup>, ineligible by reason of age; in consequence the Fund has been requested to notify the Unit as and when their members reach the age of 90.

More should be done however in respect of duplication arising this time between customers of the Fund and of the Unit, as both entities, to a certain extent, shared the same customer database in respect of bed-ridden persons aged 75 to 90; 23 duplicated claims were thus entertained between March and May 2009.

On the other hand, improvement in the monitoring of visits should be made possible with the timely submission of claims for assignments carried out by doctors; a case was noted concerning the submission of claims covering 12 months, which were submitted on two occasions at the end of 2008.

### ***Recommendations***

Steps need to be taken towards enhancing the value of the home visiting schemes and we welcome the fact that the Unit has just started a survey of some customers.

- Survey questionnaires could however be made more informative by the inclusion of additional issues such as information about customer's treating sources
- The Ministry needs to introduce measures to ensure that appointments and distributions of assignments are fair, thereby lowering feelings of resentment expressed a few years ago. Moreover this should relieve pressure off the shoulders of doctors with heavy workloads and reflect positively on the quality of service delivered
- The home visit consists of a general physical examination, blood pressure measurement and the issue of prescriptions, services which could be useful to a customer confined to bed and unable to attend hospital. The same services could be of limited benefit to customers undergoing treatment and getting medication from another source.

The targeting of customers' needs will be more useful. For example, a mobile person suffering from diabetes or obesity could be offered advice related to eating habits, followed by monitoring at subsequent visits; longer intervals between visits could be felt more appropriate in such circumstances

- The wholly state financed trust fund should be invited to discontinue their parallel visiting scheme except in regard to members not already included in the Ministry's programme; this would concern members up to 90 years and found bed-ridden by the Fund's own criteria.

The Fund could direct sums thus saved towards schemes that their members could find more appealing, like the extension of the current allowance for diapers or the introduction of food vouchers for the needy.

## **BENCHMARKING RELATIVE TO THE ASSESSMENT OF DISABILITY**

### **1. The present assessment method**

The National Pensions Act 1976 provides for the payment of an invalidity pension to claimants found disabled at a minimum of 60%, the term 'disabled' being defined here as loss of physical or mental faculty.

From what could be seen, the Unit has, up to present day, been examining pension claims (basic invalid pension) from a strict medical point of view; points were scored by the claimant on the severity of their medical condition/s, with reference to the indications contained in a set of year 2004 guidelines developed by the Unit. We could not verify that the focus was placed on functional outcomes or impaired activities of daily living (ADL), as we were told, since:

- it was not possible to make out how those impacts would fit in the guidelines scoring system,
- details of a claim's assessment and score achieved were not recorded.

The absence of documented assessments results in further difficulties, namely in the following situations:

- where several medical conditions are present and one attempts to determine how claimant's ability is evaluated within the present scoring structure,
- during the conduct of eventual quality reviews, as well as appeal hearings, being given that the bases of the original decision have not been communicated.

### **2. Evolution of concepts of disability**

The US Social Security Administration (SSA) began moving to functionally based Listings<sup>(2)</sup> in 1985; originally based on little more than diagnostic criteria, the Listings now include a wide variety of both clinical and functional measures, to confirm not only the existence of a medical condition, but also its impact on the functioning of the claimant. Advantages of the new criteria include:

- the definition of disability, which is based on functional limitations is more realistically represented,
- often there are no specific clinical findings which correlate with impairment severity; functional indicators will then assist evaluation,
- combinations of impairments are better evaluated.

In the American context, disability is defined as the inability to engage in any substantial gainful activity; thus, functional limitations are measured by treadmill tests, pulmonary

function tests, for example and are used to determine impairment of ability to work and hence disability benefits.

### **3. The Proposed Assessment Method**

#### *Assessment stages*

Examination of a claim for benefits should thus focus primarily on the disability suffered by the claimant in accordance with law. It is up to the Ministry to decide on the option or mix of options to retain when assessing disability; in the local context the chosen approach might be geared towards:

- impairment in exercising activities of daily living
- severe limitations to social interaction
- temporary inability to work.

For our purposes, the initial evidence required by decision makers would be:

- a statement from the doctor setting out a diagnosis of the customer's condition and its disabling effects, without providing an opinion on pension eligibility
- the medical history of the customer and results of clinical tests done
- the application history from the ministry's system.

At this stage, a decision maker, as described at page 10 of the 'Personal Capability Assessment' guide of the UK Department for Work and Pensions<sup>(3)</sup>, considers whether there is sufficient information to approve entitlement without the need to have the claimant examined; the decision maker may also at this stage, return the treating doctor's medical report for completion or request further tests.

On the other hand, where claimants are required to undergo examination, they will, in the first instance, be sent a self-assessment questionnaire regarding their condition.

The file is transmitted to health care professionals (HCP) who consider all the available evidence and perform a personal capability assessment which looks at the ability to carry out a range of everyday activities (Table 8 refers). Various descriptors illustrate the different impacts which the disease has on performance of the related activity by the customer. Since each of those descriptors is assigned points, an overall score is computed and advice forwarded to the decision maker.

Finally, based on the evidence available and on advice from HCPs where appropriate, the decision maker decides on the entitlement of the claim. They will also indicate when the question of the customer's incapacity should be reviewed.

#### *The examination*

Except for exempt and special cases, claimants will be sent a questionnaire to complete with assistance if required; the questionnaire will seek the customer's views on the effects of their medical condition. They do so by ticking the box which best describes the descriptor for each affected area and by giving any relevant further information.

During examination, HCPs take full account of factors such as pain and fatigue; for example someone will be classed as incapable of performing an activity if its performance involves a considerable degree of pain. The HCP will provide a full explanation of their advice particularly where the opinion is different from the customer's own perception of their functional limitations.

Many people suffer from two or more disabilities; the assessment provides for the evaluation of the combined effects of the different disabilities by attaching weighted scores (from a pre-determined formula) to each relevant descriptor.

In case of some degree of similarity between functions, for example where a person scores in both 'Walking' and 'Walking up and down stairs', only the highest score applies.

There may be circumstances where scores obtained during examination do not reach the threshold but where it would still be reasonable to treat the individual as incapacitated for benefit purposes; one such circumstance would be evidence of a severe or uncontrollable disease.

#### 4. Training and Remuneration Issues

The local equivalent of HCPs will have had specialized training which will involve brief classroom training and assessments carried out under the supervision of an experienced trainer. HCP equivalents will provide among others, health care services, treatment and assistance with activities of daily living. They are practitioners trained to provide a critical appraisal of whether a person's care and mobility needs are reasonable in the light of the disabling condition/s.

The decision maker would be a suitably experienced person and in the UK, comes from a non-medical background since 1992.

On the basis of available data and given certain assumptions, as set out in Table 7 , HCP remuneration costs if the new approach were adopted are of the same order as fees paid to existing doctors for servicing medical boards:

*Table 7 Comparison of Remuneration Costs in relation to Medical Examinations*

	New Approach	Existing System
No of expected/ examined applications (yr 08/09)	24,989	24,989
No handled per HCP p.a	1,470	
HCP staff required	17	
Total remuneration expected/ actual (08/09)	Rs 4.4 million	Rs 4.3 million

*Assumptions:*

7 applicants seen daily by HCP x 210 working days = 1,470

Salary Rs 20,000 p.m x 13 mths x 17 no = Rs 4.4 million

## 5. Exempt and Special Cases

A press report (Le Defi-Plus\_12.09.09) told the story of a bus conductor who was prevented by accident to exercise his activity and earn income for some time. Though it is not the Ministry's policy to assess incapacity to work, it might be considered appropriate, where the customer was in gainful activity, to award benefits for a maximum period even though disability criteria are not legally met.

Under the current system, persons with severe scars/ disfigurements but with no medical condition as such, would probably not qualify for pension benefits. With the new approach suggested, limitations in interacting with the social environment could be assessed as significant enough to warrant the award of benefits.

Severe medical conditions, such as those in Table 8, can be so disabling that it is possible to treat the threshold of incapacity (here 60%) as being met without the need for functional medical assessment:

- people terminally ill or registered blind
- functionally paraplegic people, those suffering from tetraplegia, dense paralysis on one side of the body, dementia etc.

*Table 8 Examples of Activities and Descriptors (Disability Assessment)*

**Physical/ sensory**

***Rising from sitting in an upright chair with a back but no arms***

Cannot rise from sitting to standing 15 points  
(illustrative)

Cannot rise from sitting to standing without holding on to something 7

Sometimes cannot rise from sitting to standing without holding on to something 3

No problem with rising from sitting to standing 0

***Walking up and down stairs***

Cannot walk up and down one stair 15

Cannot walk up and down a flight of 12 stairs 15

Cannot walk up and down a flight of 12 stairs without holding on and taking a rest (and so on) 7

Cannot walk up and down a flight of 12 stairs without holding on (and so on) 3

***Other areas: bending and kneeling, consciousness/ seizures, balance co-ordination, continence, lifting/ carrying, vision, hearing etc***

**Mental**

***Daily living***

Needs encouragement to get up and dress

Needs alcohol before midday

Is frequently distressed at some time of the day due to fluctuation of mood

Does not care about appearance and living conditions

Sleep problems interfere with daily activities

***Interaction with other people***

Cannot look after themselves without help from others

Gets upset by ordinary events and it results in disruptive behavioural problems

Gets irritated by things which would not have bothered them before they became ill

Is too frightened to go out alone

**GLOSSARY TERMS**

ABIP	Additional basic invalidity pension for BIP recipients in need of constant care and attention
BIP	Basic invalidity pension
Board, Medical Board	The one or two doctor panel constituted for the examination of claimants for invalidity pension
Boarding	The examination of claimants by a medical board
DV	The examination of claimants by a medical board at the claimant's home (domiciliary visit) or routine follow-up visit to the elderly
HCP	Health care professional
Law	The National Pensions Act 76
Tribunal, Medical Tribunal	Tribunals constituted for examining appeals against medical boards' decisions
Trust Fund	The Ex-Services Trust Fund

**REFERENCES**

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<http://www.nap.edu>
- (3) Department for Work and Pensions, UK (April 2008)  
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