Item 5d

STATES OF JERSEY

Income Support Sub-Panel
Health, Social Security and Housing

MONDAY, 9th FEBRUARY 2009

Panel:
Deputy G.P. Southern of St. Helier (Chairman)
Deputy D.J. De Sousa of St. Helier
Connétable S.A. Yates of St. Martin
Reverend G. Houghton (Adviser)

Witness:
Dr. G. Ince (General Practitioner)

Deputy G.P. Southern of St. Helier (Chairman):

I will just do the preliminaries and we will see where we are, I think. I am a great believer in starting on time whether we are all here or not. So, welcome to the Income Support Sub-Panel inquiring into the effectiveness of Income Support and how well it is being delivered. It is a Sub-Panel of the Health, Social Security and Housing Scrutiny Panel. Welcome, I know we tried to talk to you last year when we first started to open this can, as it were, and you agreed to come back to us when the system had settled in. As a matter of housekeeping, could you just introduce yourself and tell us what your position is? I will just introduce members of the Panel.

Dr. G. Ince:

Gregory Ince, I am a G.P. (General Practitioner) and I am chairman of the Primary Care Body which is the representative body of general practitioners in Jersey and part of the Jersey Medical Society. It is a fairly new innovation, the Primary Care Body, something we started just about 18 months ago. Prior to that G.P.s had been

represented by a committee of 3 elected by the whole of the Medical Society, but it was thought more appropriate in the light of current events that we should have a committee that mirrored the Hospital Consultants' Committee and was elected by all the G.P.s, represented all the G.P.s and there are 6 of us on that committee. I can truly say we are representative. There was even a contested election so ...

Deputy G.P. Southern:

Oh gosh! Jolly good! If I could just introduce ... obviously I am Deputy Geoff Southern, Chairman. This is my Deputy Chairman, Debbie De Sousa, Deputy De Sousa and Constable Silva Yates on my right.

Connétable S.A. Yates of St. Martin:

Good afternoon. Sorry I am a little bit late.

Deputy G.P. Southern:

Also one of our lay advisers, the Reverend Geoff Houghton from Trinity. We are also, I think, going to be inviting Ed LeCain(?) to come along and share with us their experience as members of the public of what is on the ground. If I could just read to you the notice that is in front of you. It sounds awfully formal, but it is not meant to be. You would need to know what you are letting yourself in for, as it were. "The proceedings of the Panel are covered by Parliamentary Privilege through Article 34 of the States of Jersey Law 2005 and the States of Jersey Powers, Privileges and Immunities Scrutiny Panels, P.A.C (Public Accounts Committee) and P.P.C. (Privileges and Procedures Committee) (Jersey) Regulations 2006. I did well there. Witnesses are protected from being sued or prosecuted for anything said during

hearings unless they say something that they know to be untrue. This protection is given to witnesses to ensure that they can speak freely and openly to the Panel when giving evidence without fear of legal action although the immunity should obviously not be abused by making unsubstantiated statements about third parties who have no right of reply. The Panel would like to bear this in mind when answering questions." So that is the formal bit over and done with but obviously I am sure we can have a conversation without referring to that. So you told us something about who you represent and I mentioned that we did invite you early on last year to come along and chat with us and you said: "Let us see how it settles in", would you like to start by talking to us about the bedding in process over the past 12 months, how you find it, what the communication has been like essentially?

Dr. G. Ince:

The communication with the Health Section of Social Security has been good. They involved us in the medical aspects of Income Support from the very beginning. We have regular meetings with them, well I suppose as long as 4 or 5 years ago when we were first developing the ideas. The doctors have not been involved in Income Support system planning as a whole but purely with regards to household medical accounts and their replacement for the Health Insurance Exemption patient categories in the past, so we just discussed that with them. They told us what their proposals were before we started as a result of the discussions we had and we saw them implemented in the way, you know, they have been. I cannot speak about Income Support in general, only the odd feedback I get from patients, but as far as the H.M.A. (Household Medical Account) scheme goes, to start off with the previous recipients of H.I.E. (Health Insurance Exemption) were quite apprehensive about how it would

affect them. But as time has gone on, I think they have seen that it provides them with the same access to medical care as the old scheme did. But as a result of the way it is planned and presented to them, in other words the individual patients are assessed and told: "Well, you know, you went to the doctor 4 times last year so we will allow you 4 visits or whatever, you know, this coming year", it tends to make, I think, a lot of patients think twice about coming to the doctor. Now initially that could potentially have impacted badly on the care, but with the passage of time and the year I think most patients have come to realise that it does not do that. While their likely needs are assessed their actual needs will be met as well. The way that is done is if a patient needs home ... I am skipping ahead on your list here, but if a patient needs home visits because of an episode of ill health or they need to come to the surgery more often than they would perhaps have been projected to do, then either they, or, I suspect, more usually the doctor writes to the Health Section and explains the circumstances and as far as my practice is concerned those patients' bills have always been met. I understand from the Health Section that they have a separate pot of money for dealing with that sort of thing. That does not impact on some of the older members of the community who did not really ... the people in old people's homes who did not really understand the difference or the significance of the change. But certainly for younger recipients, my impression is they think perhaps a little harder before coming to the doctor but are not put off coming.

Deputy G.P. Southern:

So you have not found anybody, as you say, being put off visiting the doctor?

Dr. G. Ince:

No, not once it is explained to them. Not all my colleagues understood that there was this ability to make supplementary payments according to patients' need at the start of the system but I think they all do now because clearly you cannot predict whether someone is going to be desperately ill and need quite a lot of health care 6 months ahead. You can only look at what their requirements have been over the previous year.

Deputy G.P. Southern:

Certainly. One of the issues was in the original plan there was supposed to be a £5 fee payable by everyone in the system and that seemed to go by the wayside, what the situation was and is with respect to that. Is there a formal agreement that that will not be charged or it is ...

Dr. G. Ince:

No, no, from the outset the Social Security Department said that we could charge if we wished a small fee up to £5 each time we saw them, thinking that that might deter needless consultations. It has been up to the practices whether they charge that or not. Certainly in the case of my practice, I would not say we saw needless consultations and given that virtually all the patients with an H.M.A. account previously had an H.I.E. account and by definition could not really afford any money to come to the doctor, we felt it was an inappropriate charge, so we, as a practice decided not to make it and I do not know of any practices who do although there may be some.

Deputy G.P. Southern:

But there has been no official decision to scrap that?

Dr. G. Ince:

No.

Deputy G.P. Southern:

So there may be some, but not to your knowledge?

Dr. G. Ince:

Yes. The principle behind our charging with the H.M.A. scheme is the Social Security Department's who said: "Treat H.M.A. patients as if they are ordinary patients, not second class patients, as to a certain extent they were under the H.I.E. scheme and charge them what your normal fee would be that you would be charging them were they not H.M.A. patients."

Deputy G.P. Southern:

You touch there on needless consultations and said that your own practice has got little evidence that people are coming needlessly. Could you expand on that a little?

Dr. G. Ince:

Yes. Some people have got the idea that people come to the doctor needlessly. That is always a judgment made after they have come. I mean, if I only saw patients who absolutely needed to come and see me, I would see very few patients each day. Most patients who come and see me want to find out whether they do need to see me, whether there is something wrong with them, whether something needs to be done about it or whether they can be reassured. I mean, in the past over the years one has

picked up occasionally on patients who enjoy coming to the doctor, there are a few of those, but certainly that is something which most of us would discourage these days. If they are H.M.A. patients now and they are coming regularly, then, as a doctor, we have to justify that to the Social Security Department. We do not have a carte blanche of being able to see a patient every week any more than the patient has that carte blanche to come along and see us every week or get us home every week. That now is being checked on and I think that is a good thing.

Deputy G.P. Southern:

The current system is that the first 4 visits to the doctor get paid for out of the patient benefit?

Dr. G. Ince:

I think there are different tiers, are there not? There is 4; with some patients I think are on 6 and I think there is even an 8, is there?

Deputy G.P. Southern:

There is an 8 and a 12.

Dr. G. Ince:

Yes, so they tend to assess the patient according to their needs over the previous year.

Deputy G.P. Southern:

Did you find that in all cases the assessment was pretty spot on at the beginning?

Dr. G. Ince:

Yes.

Deputy G.P. Southern:

Because there was a number of cases I have seen where they have been allocated 4 or 8 and it has clearly been inadequate, they have a monthly visit, I mean there is 12 visits and that is just for routine.

Dr. G. Ince:

Yes, I think though the department was feeling its way to start off with. But I have not had any refusal from the department to recognise that a patient needed more visits than those allocated or that they had a need because of this illness or that illness and I think of all the G.P.s in the Island I have probably got one of the highest number of H.M.A. patients.

Deputy G.P. Southern:

Right, and then the subsequent visits, up to 8 or up to 12 or the additional payments that a sudden onset of an illness requires and the payment for a visit from the doctor rather than to the doctor, a house visit, a home call, they are all paid for by this separate fund so that the fund, the H.M.A. is topped up? That is the way in fact it works.

Dr. G. Ince:

So I understand, yes, yes, yes. But the point being that the department has to be informed why the patient has these extra needs.

Deputy G.P. Southern:

Okay.

The Connétable of St. Martin:

Chairman?

Deputy G.P. Southern:

Yes?

The Connétable of St. Martin:

I must confess that I … you know, the phrase about the H.I.E. old system, as a Constable who dealt with welfare in the past and known welfare as a consumer, had H.I.E., I have got a general feeling that this would cover them for medical expenses and medicines and treatment and I think it was bus passes and an Active Card. I am very interested to listen to your comments and I think what I wanted to ask you about, some of the previous welfare recipients, they were on long-term disability or long-term incapacity, who in fact gave me the impression that they really needed their H.I.E. card to go to the doctor when they wanted to. I presume that they went more than 4 times a year. Can I ask you maybe to confirm that what I have heard from your statement so far is that they are all doing very well thank you very much? I am just wondering whether it is as good as you seem to say.

Dr. G. Ince:

No, they may be not doing all as they want to because patients cannot just come just because they feel like it. I have had to say to a patient: "Look, you know, you are coming more often than I feel is justified. You cannot justify this. I have got to let Social Security know why you need to come back in a week's time." Another patient of mine under the H.I.E. scheme used to get me to go home to see her once a month. She did not really need that and I said to her that: "You know, I have got to justify this to Social Security", and she now comes into the surgery to see me. So, you know, it has had an impact from that point of view. I think the point I am making is that I have not, from my own experience, seen it impinge badly on the healthcare of anyone.

The Connétable of St. Martin:

Just as a follow up, I am somewhat reassured by what you have just said, could you confirm that your attitude to the H.M.A.s is on a common practice throughout the doctors' surgeries throughout the Island? Is there any communication between the deliverers of care and ...

Dr. G. Ince:

Yes, yes. I was saying to Deputy Southern, we meet regularly and we last met a couple of weeks ago to discuss this. So the view I am expressing here is not a personal view, it is the view of the G.P.s in the Island as represented by their 6-man committee. I mean, inevitably you will find one person that says: "Oh, I do not like this" or: "I do not like that", but I am giving you the consensus view. More importantly, perhaps, the view of the Committee of the Primary Care Body because we are charged by the G.P.s to represent them and we have the ability to make decisions on their behalf whether they like it or not. The only way of getting round

that is by sacking us all at the next A.G.M. (Annual General Meeting). But it was felt that their executive committee should be able to represent views and have discussions like this with politicians without saying: "Oh, we have got to go back to the membership to see if they approve."

The Connétable of St. Martin:

Thank you for that.

Deputy D.J. De Sousa of St. Helier:

Initially, when it was changed from H.I.E. to H.M.A. quite a few people seemed to be going to A. & E. (Accident and Emergency) rather than their doctors. Do you feel that this is still going on and is it an added burden to A. & E.? If so, what sort of figures?

Dr. G. Ince:

I think it went on in the beginning because I think it was perhaps badly presented to the recipients of H.I.E. who then went on to H.M.A. and they were really quite alarmed that they would not be able to go and see the doctor as often as they felt there was a clinical need. So that may have impinged on the A. & E. Department. Certainly we have not heard from the A. & E. consultants that there is a problem there and as you may be aware, we run surgeries as part of our G.P. co-op until 11.00pm at the hospital so there is the opportunity, if anyone turns up, to be triaged. Do you know that term? To be triaged around to the G.P. on call there representing their practice rather than be seen in the A. & E. Department. But I think there was a lot of anxiety, you are absolutely right, when the scheme was first introduced. The other

anxiety was I think that they felt that money was being taken from them; that if they did not opt for an H.M.A. account they would get more money each week, which is true I suppose, but I think it could have been perhaps better represented to them: "This is the money that we spent on your behalf for medical services last year, we are going to add it to your income support, but then we are going to take it back because that represents your basic pot which we are giving to you."

Deputy D.J. De Sousa:

So you feel it was initially the way it was implemented, it was not explained sufficiently to the patients so that they understood what was ...

Dr. G. Ince:

I think in many cases that was true. But it takes a lot of explaining to some people, particularly if they are less intellectually gifted and get easily worried by officialdom and forms and that sort of thing. So we spent, certainly my partners and I did in our practice, a lot of time explaining this to people initially before they got the general idea of what was happening. I mean it is a scheme that was devised by the Social Security Department and presented to us to work with. It was not a scheme thought up by the medical profession but when it was explained to us and how it would work our attitude was: "Well, we will give it a go and do our best to make it work."

Deputy G.P. Southern:

After a year you are saying it appears to be better business?

Dr. G. Ince:

Well, it seems to be, yes.

Deputy G.P. Southern:

If we could just come back and go perhaps a bit further, those with serious disability or long-term chronic illness equally do you think it is meeting their need?

Dr. G. Ince:

Yes, I still have patients with long-term chronic illnesses who cannot get into the surgery, who maybe live in residential homes who I go and see perhaps once a month as I always have done because that is an expected need on their part and on the part of their carers in the nursing home. I have just been seeing one old lady at St. Helier House who I thought was going to die she is 92, she defied us all, she recovered, but I wrote to the department and said: "Look we are having to go in a couple of times a week. I am not sending her into hospital." Much more expensive to the State to send her into hospital and I went twice a week for about 3 weeks or so and she pulled through and, you know, the department is meeting those accounts. This is how it should work. It is a bit of a nuisance I suppose is the best way to describe it, to have to write to Social Security about every occasion like that. But if it is protecting public funds then, as doctors, we are perfectly happy to justify to whoever is paying us what we are doing and why we need to do it. It is all about accountability.

Deputy G.P. Southern:

Certainly.

Deputy D.J. De Sousa:

So do you collectively, not just you, do you feel that everyone's needs are being met? That nobody is falling through the net? Or is there any ...

Dr. G. Ince:

I have not come across anyone falling through the net, but it is possible, I suppose, that someone could not fully understand the system and not be sending for us when they should or coming to see us when they should. I suppose that is possible.

Deputy G.P. Southern:

Just again to sum up there, just to give me the opportunity to restate again anyone who needs a visit with their G.P. or a visit from their G.P. will have that visit in 99 point several 9's percentage of the time, fully funded by the system?

Dr. G. Ince:

Yes.

Deputy G.P. Southern:

So it is delivering in that sense?

Dr. G. Ince:

Yes.

Deputy G.P. Southern:

Could I take you on to an associated, linked, thought that occurs to me? H.I.E. in the past used to, for a certain small number of people, give free access to G.P.s and I

believe that principle was a good one, for those who are chronically ill or the very poorest we should be allowing free access to G.P.s. At the moment we have got free prescriptions universally without a means test on them and we have taken away effectively this free access to G.P.s. How do you see that in general terms as going forward?

Dr. G. Ince:

Well, I think that there are 2 issues here. From our point of view, there still is free access to G.P.s for those patients albeit as a result of a bit of a conjuring trick done by the department with its funds. But from a functional point of view it has got to be free access for the poorest and neediest members of society. It would be immoral for that not to be the case. So that does seem to be working in the majority of cases from our experience. But free prescriptions is a different issue. We were not, as the G.P.s in the Island, asked what our views are, it was just announced. I have been here long enough to remember John Lees' views. Do you remember John Lees, he was Comptroller for many years at Social Security? He always used to go on about the health scheme being an insurance scheme, not a form of taxation, that it was a scheme which should benefit everyone equally regardless of how wealthy or poor you were. That it was not a method of taxation. So he felt any benefits from the scheme should be equally available to everyone. Now I suppose ... well I know the department sees it this way because I spoke to Janice Waddell subsequently to the free prescriptions being introduced. They saw it as a means to reducing the cost of seeing a doctor, being ill, which was spread fairly through all levels of society and was of benefit most to those with high medical needs. In other words, people who were on large numbers of medicines. I think as doctors, we do not have any special view about it. I think

there would be an argument, speaking personally, where if you were working you could probably afford a couple of pounds for a prescription but if you were going to look at special groups, you would look at pensioners and perhaps children to exempt. But having said that, the G.P.s feel a better use of those funds would have been to increase the refund which has not gone up for, I think, about 4 or 5 years now and now represents a third of the cost of the average consultation, whereas for the most of the health scheme, it is represented 50 per cent of the cost. That was always the idea at the outset of the 1967 scheme that it should represent 50 per cent of the cost of coming to the doctor.

Deputy G.P. Southern:

We have drifted away from the half and half principle over the years?

Dr. G. Ince:

Yes, yes, down to a third.

Deputy G.P. Southern:

We are now down to a third?

Dr. G. Ince:

But that contrasts, I believe, with 70 per cent in France, I think, the refund. We found it is a similar scheme in France, I think you get 70 per cent when you see the doctor. The G.P.s feel 50 per cent is about right and we are having discussions or we are about to have a meeting with the new Comptroller of Social Security and the new Minister in the forthcoming months to revisit this again. I am in discussions with the

medical officer of health about a new primary care law which would make some changes to the current law so the refunds could be used in other ways, maybe to pay nurses in practices.

Deputy G.P. Southern:

I see. One of the things that H.I.E. did was to give access in a targeted way, whether it was well targeted or not the principle still applies, to free prescriptions for these chronically ill and/or those on very low incomes. At the moment H.I.E. still exists for some people, those with an H.I.E … they have still got an H.I.E. card, and they can still access obviously free prescriptions, but they can also access things like a cheaper referral for an X-ray or a scan. It seems to me that H.I.E. still exists in the form of the card and has some benefits attached to it including the access to public transport, on the back of an H.I.E. and to the Keep Fit scheme, the Active ... that would seem to me to indicate that at some stage in the future, unless we are just going to let it die out as all those people who were previously on H.I.E. die out ...

Dr. G. Ince:

But their cards expire. I had this conversation with someone this morning and he was aggrieved that when he had gone down to the hospital for his X-ray (or was it a scan?) he was asked for £14 and he said he produced his old H.I.E. card which is expired now. But I must say I thought that those benefits would continue, that if you needed X-rays or whatever and you were on H.M.A. that it would be paid for, the fee would be waived.

Deputy G.P. Southern:

I have just received an answer because I asked the Health Minister last week about ... he says it is continuing. Now you are saying that as H.I.E. cards expire, that service, that access to free scans is being withdrawn?

Dr. G. Ince:

I suggested to this patient this morning that he sent the bill to the Social Security Department and ask them whether they can fund it for him.

Deputy G.P. Southern:

Right, so that is a fresh piece of information that is quite recent ...

Dr. G. Ince:

I think the difficulty for H.M.A. patients is they do not have a card saying: "I am an H.M.A. patient."

Deputy G.P. Southern:

Exactly. I mean if we had access to free scans, X-rays at one stage, it seems to me wrong that we should be withdrawing that for whatever reason at some stage for those who are deemed the poorest end of society.

Dr. G. Ince:

I do not see why they should be charged to anyone frankly because if I referred a patient to one of the hospital consultants or a junior doctor in the Accident and Emergency Department and they wanted to do a chest X-ray, it would be free to the patient.

Deputy G.P. Southern:

It is free if you go via the hospital ...

Dr. G. Ince:

The hospital and I have had patients over the years, when I have said: "You need a scan, you need this", "Will you refer me to the hospital?" because they know that that would avoid them having to pay. It seems self-defeating.

Deputy G.P. Southern:

Okay. So something … you think, there is an issue there we need to resolve?

Dr. G. Ince:

Yes, yes.

Deputy G.P. Southern:

Okay.

Deputy D.J. De Sousa:

Staying on that point, so are you or any of the other G.P.s aware of anyone having an X-ray or a scan and being told they have to pay for it, but being on H.M.A. they cannot afford to? So have you or any of the other G.P.s...

Dr. G. Ince:

This morning I saw someone. This patient I was mentioning a moment ago. He has had it done, he has got his bill for £14.

Deputy D.J. De Sousa:

He cannot pay it?

Dr. G. Ince:

Well, he feels he cannot, no. Presumably being on income support and having an H.M.A. card … it is not my affair to look into how much money he has got in his pocket but, you know, even in this day and age people do come to the surgery and they have got nothing.

Deputy G.P. Southern:

Absolutely, yes, yes.

Dr. G. Ince:

Extraordinary. I mean I have waived bills, you know. I remember when prescription charges still existed in the band, that difficult band who were not H.I.E. and they did not have much money, they were just out, a patient looking in their pocket and asking me which of the things on the prescription for their child were the more important ones. I said to her: "Well, do not pay us, you know, spend the money in the chemist shop." Some of us older G.P.s are still a bit like that. I think younger G.P.s tend to see it rather differently, they feel it is the responsibility of the State to look after people like that. So I think we are all aware there is that band of people in Jersey who

are not comfortably off and who are not poor enough to get all the benefits who do struggle.

Deputy G.P. Southern:

Certainly and whenever we discuss this H.I.E. with the department, one is told that: "Oh well, it was badly targeted, it was not just the poorest and it was not just those with chronic needs." But now we have got an H.M.A., presumably as a result of the 26 page document you had to fill in to get on to income support. We have got income support system which is better targeted and spreads the load, spreads the benefit wider and one should be, I think, looking at ways to access, for these people, free services attached to the G.P.

The Connétable of St. Martin:

I would like to talk a little bit about the 26 page application form and going back to my experience with dealing with applicants for Parish welfare, which I dreaded when I first came in, I thought: "What a job to have to do to sort of decide somebody's sort of future for a week or a month and decide the rate", but in fact one of the first things that I became aware of is that in general welfare recipients had a commonality of not being able to manage their lives or their money or their relationships. It was as simple as that. Management of their … filling in a form, they needed a lot of help. The question I want to ask you, where you recognise somebody in your surgery who is of a similar situation where life is just a little bit too much for them and you have obviously seen the form and the daunting aspect of it, could you comment on the format of the questions and does it do enough to reach into that person's situation to present a better picture of need? I am trying to get my head around a way of putting

this into words but I think what I am trying to say is that when a Constable deals with an applicant, he is face to face, eyeball to eyeball and I look at a person and sort of then do the probing without having to fill a box on a form. The box on the form is impersonal, it goes into a computer; the computer says: “No”, so there is no benefit. I would like to know if you have got any comments about something which is intangible and that is dealing with the mental or psychological state of a person in need?

Dr. G. Ince:

Well, I do not think the adjudication is just based on the form. When patients were expressing to me difficulty with the form I sent them along to the department where they could sit down with someone who would fill it in with them. Once the form is submitted and I suppose … you know, I really do not have any comment on the form, it is a long form, it is a difficult form to fill in, but I suppose the questions that are asked need to be asked. But we do get sent a clinical and medical report form to fill in once the patient has applied for H.M.A. which then asks ... it states the conditions the patient has declared they have and then it asks us in quite a lot of detail how the condition affects their everyday life and what investigations they have had for the different conditions, what their prognosis is and there is even a confidential section on that form which would not be available to the patient if they wanted to see our return. So that fleshes out from a medical point of view at any rate the patient’s medical needs and how impaired they are. They call it the Clinical Impairment Component.

The Connétable of St. Martin:

Well, I am grateful for your observation, because I was not aware how it was ...

Dr. G. Ince:

So it does not just go on the declaration of the patient or the civil servant sitting with them helping them to fill it in.

Deputy G.P. Southern:

As you say, it is in some detail, the 3 levels of impairment. Do you feel that is an effective format of particular questions there accurately describes ...

Dr. G. Ince:

Well, I suppose it does. I mean, they researched it long enough in trying to put it together. Again, we were not involved in that, we were involved purely in the - when I say "we", the G.P.s - form that we fill in and I feel the form that we are given to fill in does ask all the right questions and it gives us an opportunity about saying how the patients' illnesses impinge on their everyday life, but it does not invite our opinion on their financial ability or their financial status.

Deputy G.P. Southern:

Nor should it particularly. One of the questions we had when we were looking at it way back, 2 years ago, was that it seemed to be very strong on physical impairments but less so on mental problems or psychological problems which are variable anyway.

Dr. G. Ince:

Yes, I think that the physical impairments obviously you can quantify, you can measure objectively; mental impairment is slightly different. But there is ample

opportunity on that form for us to say exactly what the psychiatric diagnosis is, what medication they are on, how their condition varies from day to day and they invite our opinion on how the condition impinges on their everyday life and their ability to look after themselves and get out and about and so on.

Deputy G.P. Southern:

The problem with psychological illness is that it may be variable and if you see somebody on one day when they are feeling reasonably good about themselves one gets a completely different impression ...

Dr. G. Ince:

Well, that is true enough and the same goes for physical illness. I am afraid I always tell my patients to fill that form in as if they were having one of their worst days because I think that is the only fair way of doing it and if they feel better one day, well that is great.

Deputy D.J. De Sousa:

Carrying on with that topic, what about people that are on long-term incapacity, do the department liaise with the G.P.s as to how that patient is going on before they adjust payments?

Dr. G. Ince:

Yes, they send us a form to complete which they send to the patient who then delivers it to us and it asks for a current update on their condition which is really quite brief and I think they obtain, with the patient's consent, details from the hospital as well if

they are under the care of the consultants there. But it is a fairly brief form which does not invite our opinion on how incapacitated a patient is. I think, possibly deliberately so because clearly we are looking after the patient, we are the patient's agent and one would want to be as helpful to them as possible. But I have noticed that this is one of the major difficulties that patients have, as you obviously know, when someone is off sick they get the normal payments for a year but at the end of the year they are assessed and it can have quite a dramatic effect on a patient to be told they are 40 per cent incapacitated. They have got to go out and find work and they come in to us and say: "We cannot manage on 40 per cent, can you write to the department, Doctor?" We write and we appeal and they have another hearing that maybe goes up to 55 or something like that and then the next year it is knocked back down again. This is what has been happening. I think that would be all right if we lived in a society where jobs were plentiful and I think the principle of long-term incapacity benefit is a good one, someone saying to a patient: "Well you are incapacitated, you are 40 per cent incapacitated, we are going to give you this money in recognition that you cannot perhaps do the sort of work you would normally do, but go and find another job and this will top your money up." I mean that is excellent in principle and for the few patients that I have got who have been able to find a job plus have their incapacity benefit it has worked very well. But it strikes me that it is a minority rather than a majority.

Deputy D.J. De Sousa:

Do you then feel that this is an area where it is failing?

Dr. G. Ince:

I suppose you could say that. It is unfair, I think, to many patients to say to them: "Go and find a job" and they go to the job centre and there is not a job that they can do and they are: "We will do a job", but there just is not one. It does seem that there needs to be some sort of recognition about some ability maybe to say: "Right, well you are 40 per cent disabled, but we cannot find you a job so we are going to give you the other 60 per cent until we can find you a job." That would seem a fairer way of doing it.

Deputy G.P. Southern:

Exactly. Both L.T.I.A. (Long Term Incapacity Allowance) and Income Support which work apparently hand in hand with each other are both technically in-work benefits. They are supposed to be actively seeking work and as one of my constituents put it to me: "Which 40 per cent of me do they think can work?"

Deputy D.J. De Sousa:

Yes.

Dr. G. Ince:

Yes.

Deputy G.P. Southern:

"Where is the part time job that I can cope with?"

Dr. G. Ince:

I think that is the key. I mean, where is the part time job you can cope with, where is the job you can cope with?

Deputy G.P. Southern:

Sure.

Deputy D.J. De Sousa:

Do you then feel that the Income Support Department should liaise more with G.P.s and take on board more information instead of just the little that they ask you?

Dr. G. Ince:

No, I think they are being quite fair when they objectively assess someone as 60 per cent disabled or 40 per cent disabled. These are people, doctors in the department who have done training courses to assess disability. So one could argue over whether someone is 50 per cent or 40 per cent or whatever, but I think, you know, I would not argue with the principle that they are ... I would not argue with the fact that they are making an objective, reasonable, professional assessment. What concerns me is the consequence that has on the patient because I am told by the department they are not allowed to take into account the fact that, well you know, that patient has got their mortgage to pay or their rent to pay and they have got 2 children who need shoes, et cetera, et cetera. They purely take into account the disability.

Deputy G.P. Southern:

There are 2 issues there and certainly one is ... you mentioned 40 and 60 per cent, which might be understandable, but it does make a difference in terms of the amount of money you are receiving. But I have heard of 75 becoming 35 per cent and, whoosh …

Dr. G. Ince:

Yes. Yes, I ...

Deputy G.P. Southern:

… and they get better overnight. What happened?

Dr. G. Ince:

But 100 per cent is virtually unheard of unless you are completely bed bound and severely ill.

Deputy G.P. Southern:

You see, the other thing is the psychological thing that when called before a board, it is almost instinctive that the patient/client puts on their best face and when asked: "Can you cope with …?" and it might be: "Yes, one day in 3 I can cope with that", but I will say "Yes" rather than as you say paint the worst picture, imagine it is your worst day and tell them about that because that is more like the reality. But inevitably people tend to put their best face on and say: "Oh, yes, not too bad." As you do. How are you feeling?

Dr. G. Ince:

I have got a patient who is a cleaner, she is late 40s, she has got badly osteoarthritic knees. She has been given 45 per cent. She cannot do any job which does not involve manual work she is not an educated person, she does manual work, shop work, cleaning, that sort of thing. There is no job she can find.

Deputy G.P. Southern:

That then comes back to the support that is available around retraining or whatever to help people to find the right level of work which may or may not be there yet.

Dr. G. Ince:

As I said, I have already thought having their benefits topped back up to 100 per cent until they can be found a job by the department would be appropriate. Which would equally give the department a sanction of saying: "Well, here is a job", and if the patient says: "No, I am not going to do it, do not like it", then it is dropped down to 30, 35 per cent. But then I am making policy on the hoof here and it is not my job to do that. I am speaking beyond my remit.

Deputy G.P. Southern:

But having gone there, I want you to stay there for a minute just to explore the idea of the return to work ethic which underlies all benefits, I think, in the U.K. (United Kingdom) and certainly across Europe, the return to work ethic which is driving reforms recently. In particular, the idea of income support, in particular, if a person does return to work or does take work or works more, then effectively what happens is they lose 90 per cent of their benefit, of their income support. For each £1 they earn, they are losing 90p. Incentive to return to work, which is a good one in the sense of people who work tend to be healthier in themselves than people who sit at home with the same illness or the same disability, that in fact the incentive to return to work is not in the system that we have got. Given that ethos, do you have a comment to make?

Dr. G. Ince:

No, except that if your long-term incapacity benefit is dropped to 45 per cent from 100 ...

Deputy G.P. Southern:

No, no, long-term incapacity remains, with income support top up.

Dr. G. Ince:

No, well that is not an incentive, is it?

Deputy G.P. Southern:

Indeed, indeed. While I am on, extension of benefits from G.P.s through to dental, chiropody, chiropractic, is there an area there that we ought to be examining? Have you had thoughts as G.P.s about ...

Dr. G. Ince:

We have not really. Obviously we would like patients to be able to afford access to all those things as easily as possible, particularly to dental care which is, you know, very expensive.

Deputy G.P. Southern:

An overlap between? If there is some disease of the mouth ...

Dr. G. Ince:

There is some, there is an overlap.

Deputy G.P. Southern:

… either G.P. or dentist but ...

Dr. G. Ince:

Yes, gum disease we often treat because patients do not want to afford to go to the dentist and it is cheaper to come and see us and we can deal with the gingivitis, you know, the inflamed gums and so on, advise them about cleaning their teeth and flossing and so on, but at the end of the day they are probably going to need to go and see a dentist or a dental hygienist.

Deputy D.J. De Sousa:

With dental the only way that patients on income support can get any help with that is a special payment, am I right?

Deputy G.P. Southern:

Yes.

Deputy D.J. De Sousa:

Yes? Do you, as a G.P… because it is putting added resources on to you because you are treating the gingivitis and things like that and tooth decay and problems can bring on health problems?

Dr. G. Ince:

No, no, they cannot, it is impossible, it is a misconception.

Deputy D.J. De Sousa:

Oh, right.

Dr. G. Ince:

You live and learn.

Deputy D.J. De Sousa:

Yes, we do. I always thought that.

Dr. G. Ince:

No, no, dental problems are dental problems, they will not do anything else to the rest of you. They can make you quite poorly obviously if you have got bad teeth and chronically septic gums, but they will not give you, you know, bad lungs or a bad heart or anything like that. But having a healthy mouth is like having a healthy bottom or, you know, it is part of keeping in good health and it just so happens historically that the dentists have dealt with the teeth and the mouth. The cases we see do not overburden us by any means.

Deputy D.J. De Sousa:

That is what I was trying to get at.

Dr. G. Ince:

Yes. No, no, it does not. Because patients will often come with an inflamed mouth and they will come to us first anyway because we are more accessible and less expensive than going to a dentist and they know that dentists will probably give them some sort of antibiotic or mouthwashes which we do and then we say to the patient: "Then you have got to go and see your dentist."

Deputy G.P. Southern:

One, I think, possibly the last thing on my head list which has come to my notice was that despite there being a homeopathic doctor who the Health Department licences to practice on the Island, the Social Security System, Income Support, H.M.A.s in particular, do not cater for consultations with or receiving a medication from the homeopathic doctor who is allowed to practice here. Do you have an opinion on that?

Dr. G. Ince:

Well, homeopathy is debated whether it works, whether it does not. There are arguments about it. But what you say is not strictly true. One of the doctors in my practice, Sheila Richards, practices homeopathy, not as her principal way of practicing medicine, she is a G.P., but she will prescribe homeopathically for patients. She has got a diploma in homeopathy and she is covered by the health scheme, it is just that patients have to pay for the homeopathic treatments. Any doctor can register under the health scheme over here, provided they are a vocationally trained G.P. Then if they choose to prescribe rhubarb or homeopathic medicines or something on the prescribed list, it is between the doctor and the patient. So the current scheme does not preclude doctors prescribing homeopathically.

Deputy G.P. Southern:

But does not cover payment for those?

Dr. G. Ince:

It covers payment for the consultation but not payment for the medications. So if you are having a medical consultation with a vocationally trained G.P. who is registered under the health scheme then that doctor can prescribe homeopathically for you if they want.

Deputy G.P. Southern:

Okay. That again clarifies my take on what was and was not ...

Dr. G. Ince:

I think the doctor, are you talking about Max Deacon, are you? Yes, I think he is a specialist homeopath so, as such, he would not be able to register under the Social Security Health Scheme which is a scheme for the provision of general medical services and since, I think, about 1980-something the Health Law has said you have got to have a ... you know, you have got to be registered on the General Medical Council's G.P. register.

Deputy G.P. Southern:

So it is more about being a registered G.P. rather than a homeopath?

Dr. G. Ince:

Exactly. I mean there are some consultants at the hospital who registered before the law, who can prescribe under the Health Scheme, but the newer consultants cannot, they have to ask us to do the prescribing, they can only prescribe to the hospital.

Deputy D.J. De Sousa:

One final question that I had. In addition to the medical issues, how do you feel that Income Support is addressing the poverty issues?

Dr. G. Ince:

Truthfully, I do not know because we live a slightly cocooned existence as G.P.s. Patients tell us what they want to tell us and they do not tell us what they do not want to tell us. Chiefly we just talk about the medical aspects of their care. They do not tell us whether they can afford the electricity bill and this, that and the other. Occasionally when you do house calls you can see that a family is struggling, but then sometimes they struggle because they ... I think you were saying, Sir, that they spend their money in inappropriate ways, they do not cope with their lives terribly well. I remember Graham Le Quesne, do you remember the late Graham Le Quesne, at one meeting we went to saying that with some patients no matter how much you give them, they would still be on the brink of poverty because they would spend it on all the wrong things. So I think it is about helping people, delivering a support system.

Deputy D.J. De Sousa:

If, as a G.P., you did a home visit and you did find that somebody really was genuinely in a poverty trap, how would you go about highlighting that? Would you contact Income Support yourself or ...

Dr. G. Ince:

Well, I would do these days. I have not had to so I do not know what sort of response I would get. In the past I would have contacted the local Parish.

The Connétable of St. Martin:

Yes, well nowadays it is Social Services or something.

Dr. G. Ince:

Yes, yes.

The Connétable of St. Martin:

The Parish is still willing to help ...

Dr. G. Ince:

Sure.

The Connétable of St. Martin:

... if we find out. Well, yes, I have got a couple of questions and I am really sort of just tidying up a couple of the points which I have put question marks. This is going back to the old H.I.E. and the new H.M.A. The question is are you aware of any impact on patients as a result of the removal of the free public transport? There is a simple ...

Dr. G. Ince:

I have had one grumble from one patient that he does not have his free bus pass, but that is as far as it goes. But then, as I was saying a moment ago, they might not think it worthwhile complaining to me because they would know that I could not do anything about it.

The Connétable of St. Martin:

The other thing, I do not really know what the Active Card gave under the old benefit system. Has the removal of automatic free Active Cards had any impact on patients on a benefit?

Dr. G. Ince:

That is a first, Fort Regent card, is it not? We have a system called ... it has changed its name, it used to be called Prescription for Health, so if you saw someone who was fat and hopeless, you know, you gave them this form and they went and made an appointment up there. It is called ... what is it called now?

Deputy G.P. Southern:

Health Referral.

Dr. G. Ince:

Health Referral, thank you, it is Health Referral. So the system is the same, I fill in a form, give it to the patient. It is popular and it is good and it used to be free to H.M.A. card holders or H.I.E. card holders and I do not know what the situation is, whether it is ...

The Connétable of St. Martin:

Does it cost money now?

Dr. G. Ince:

Yes, but I do not think it costs a lot, does it? A couple of pounds, £4 a session, something like that. But that is a lot of money if you are not working, you are not earning.

The Connétable of St. Martin:

Well that brings me to another question because what I was sort of skating around the houses for was that when you sort of try and help vulnerable people and you are going to give them a minimum amount of money to make their life possible, I do believe that encouragement … some sort of normality, is probably of greater benefit than money. I mean, in as much as that if you give a vulnerable person the amount of money to survive, where is the pathway forward to give them a bit of hope as well as the survival? I just wonder what your thoughts are on the Active Card as being a certain amount of normality ...

Dr. G. Ince:

I would agree with that. I have got one patient who goes up there 2 or 3 times a week and it has given him something to do and it has restored his purpose in life. It is very good.

Deputy D.J. De Sousa:

It is used with stroke victims as well.

The Connétable of St. Martin:

So is that a point relatively speaking that we should follow up?

Deputy G.P. Southern:

Yes, I think so and I think that is still attached to H.I.E.s and we have got this problem with H.I.E.s, what are we going to do with ...

Dr. G. Ince:

Yes, the bus passes and the scans and X-rays.

Deputy G.P. Southern:

... what are we going to have as an equivalent? Getting transport and activity are the 2 things that give you a rounded life.

The Connétable of St. Martin:

Something to take you out of the trap where you are and give you a way forward.

Deputy G.P. Southern:

It is always fatal for me to say: "A final question from me", because it never is. What we have got coming up in October is the end of the transition section, so when we introduced income support, there were winners and losers. All the losers were protected from any impact until now, October this year. Are you aware of this and do you anticipate …

Dr. G. Ince:

No.

Deputy G.P. Southern:

We are going to get some people who will be losing substantial amounts of benefit in October this year. You are obviously not aware of it but that is the situation. It may well be that when that does happen you may be on the receiving end of a few more complaints, I think, about what is happening.

Dr. G. Ince:

Yes, yes.

Deputy G.P. Southern:

It is supposed to be phased in over 3-5 years and in particular, I mean, I believe that will be the crunch time for the new system when it starts to look like what it is going to be in the end. There are some serious losers on the way, starting this year.

Dr. G. Ince:

Perhaps one thing I should mention about long-term incapacity benefit is that I have noticed patients that are on long-term incapacity benefits, say, for a knee problem and they move off the 100 per cent on to 60 or whatever it is, they often come back finding they have got something else wrong with them so that they can get back to the 100 again. I do not mean they imagine it because a lot of these people have got a number of pathologies, but then they have to use something else, you know, an arthritic neck or something like that to try and get back to the 100 per cent. So

patients like that do struggle through this system and again it is because of the difficulty finding a job in Jersey anyway and finding a job that they can do.

Deputy G.P. Southern:

Certainly in the current climate. Geoff, do you want to …

Reverend G. Houghton:

Yes, this has been fascinating, the first time I have been in this environment myself so I am enjoying listening. It has been very informative in talking about the clients, your patients, but I want to talk about the impact upon you as a doctor, as a practice. You spoke earlier about the need to write to Social Services, Social Security, about patients and their needs, et cetera. I find myself thinking of these policemen who are not on the beat because they are writing reports. Can you say something about the impact on your own time, resources, et cetera and all this?

Dr. G. Ince:

No, no, it takes very little time and few resources. It takes me a few minutes to dictate a letter to the department and then it is typed up by our secretary so I suppose you could say, you know, for every letter I write would take perhaps 10 minutes of staff time. I suppose you could cost that, but spread as it now does, rather thinly, having written most of the letters after the new scheme started, it does not have a significant effect. The idea originally, I think, was that patients or their carers should contact the department, but I find most of them feel slightly inhibited at that prospect and they readily take up my offer to write to the department on their behalf and that we agreed with the department that the details could come either from the patient or

their carer or from a G.P. There may be some G.P.s who decline to write and say: "No, no, it is your responsibility."

Deputy D.J. De Sousa:

In light of what Deputy Southern has just said about October and the phasing out of the protection, do you see this increasing?

Dr. G. Ince:

What increasing?

Male Speaker:

The correspondence or the cross-referencing.

Dr. G. Ince:

I do not know, but I do not know who I would write to unfortunately to get someone and I do not think ... patients do not come in and see us and tell us they have not got enough money to live on because they know that we are the wrong agency. They do not see us as an agency of the State because they pay us. They see us as, you know, they would their solicitor or someone like that.

Deputy G.P. Southern:

Now is your chance to say: "I am surprised you did not ask about this, I have got a big note here. I want to talk to you about this bit."

Dr. G. Ince:

No, I have covered everything, I have given you my opinion on long-term incapacity.

Deputy G.P. Southern:

That was your little study out of there.

Dr. G. Ince:

That is what patients do at the end of my allotted time, they say: “Well that is not what I came to see you about, Doctor.”

Deputy G.P. Southern:

I came about this pain. But nothing else to add?

Dr. G. Ince:

No, I do not think so.

Deputy G.P. Southern:

Well, thank you for your time.

Dr. G. Ince:

It has been very interesting. No, thank you for listening to me. Nice to meet you all.

The Connétable of St. Martin:

Thank you very much.

Deputy D. J. De Sousa:

Very informative.

Dr. G. Ince:

Goodbye.

Deputy G.P. Southern:

Thank you.