Pension Scheme Modernisation

A Millennium Health Check for The NHS Pension Scheme

NHS Pensions Agency

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Annexes

Executive Summary

1. This report is based on work done during 2000 and 2001 to examine the NHS Pension Scheme. The work was prompted by two factors;

    - It formed part of wider work undertaken by the Department of Health and its Agencies on 'Modernising Government'; and

    - To promote an open debate with staff about pensions as part of the Joint Superannuation Consultative Committee arrangements

2. The project, titled 'Pension Scheme Modernisation (PSM), was set up in February 2000, and was led by a steering group jointly chaired by David Amos, Deputy Director of Human Resources, Department of Health and Michael Lowe, British Medical Association, and co-Chair of the Joint Superannuation Consultative Committee. The steering group was supported by a project team, which met during 2000/2001 and both groups were drawn from the stakeholders in the NHS Pensions Scheme. The project had the overall objective to "Prepare a set of coherent and manageable NHS Scheme proposals … recommendations to be forwarded to Ministers by 2001". However, publication of the ideas generated has been delayed by work rising from Shifting the Balance of Power and other policy issues, which meant that the NHS Pensions Agency had to give priority to looking after NHS Scheme members.

3. As a considerable time has passed since the work and discussions took place, the Agency based this report on the information generated –and it is not a report by the steering group. Because of the delay, it has reported in the context of later developments, some of which were prompted and informed by the findings of the project. Nevertheless the project has pulled together an important body of information on:

    - the current NHS Pension Scheme in context and other public sector comparators

    - Members' views on the Scheme and the need to improve Agency contacts with customers and communicate the extent of current scheme flexibilities to members and HR departments

4. At that time the Agency was able to conclude that there is no compelling case for major change at the moment. Given that change has cost implications, the Department's HR policy stresses the need to make changes based on evidence that benefits will be achieved. Little evidence exists for behavioural effects arising from pension changes:

    - The NHS Pension Scheme remains a very good scheme – one of the best in its class. It is valued by and provides good value for employees.

    - Few, if any, improvements to the current scheme are possible at little or no cost to employer or employee.

    - Some options would be possible if members choose to pay for them. The current mutual scheme assumes payment spread across all the membership.

    - Wider access to scheme benefits and more flexible personal choice of benefits would require a new scheme – and may increase member costs. The project did not attempt to make a proposal for a new scheme, nor did it conclude that there was significant demand for one at present.

5. Many ideas are discussed in the report - and those raised by stakeholders have not been restricted – some are the requests of a small group, others more generally raised. Nor have any of them been specifically tested for legal robustness or affordability or in any way

approved. However, where there was weak demand, no consensus or there are service reasons to the contrary, some ideas have been expressed as a negative intention.

6. The debate on pensions has come into sharper media focus since the project was commissioned. The pension marketplace has experienced a turbulence, which has had implications for AVC holders in the NHS scheme and there have been a number of withdrawals from final salary schemes by large private sector organisations. As a final salary scheme with significant employer contribution, the attractiveness of the NHS scheme is a positive aid to recruitment and retention. Any changes to the Scheme must be seen to be both relevant to members and sustainable in the longer term.

7. The following initiatives have been achieved or are ongoing:

   - Introduction of 'Pensions on Line'
   - Introduction of optional Stakeholder Pensions
   - Specific discussions with Consultants and GPs as part of contract negotiations
   - 'Improving Working Lives' work with HR Directors on de-mystifying pensions
   - Access to the Scheme for free-lance Locum GPs
   - Improvements in processing claims

8. A summary of issues raised by stakeholders is at annex B. These can be grouped under the following headings:

   - Publicity communications, and training for employers
   - Employer support for and engagement with the Scheme
   - Admission to the Scheme - links to Social Care
   - Equal treatment, partner and family benefits
   - Issues affecting specific professional groups
   - Retirement rules and accrual rates

9. The Agency would like to thank all those who participated in commenting and gathering information on the NHS Pension Scheme, the Steering Group and the Project Teams. Future work to keep the Scheme under review will continue to engage Scheme members and their representatives and external stakeholders.

CHAPTER ONE: THE PROJECT

Introduction

1. The NHS Pension Scheme was introduced in 1948. It incorporated best pension practice of the day with its structure drawn from a template for the existing public service schemes covering workers in education, the civil service and local government. Over 50 years on, it remains an excellent scheme offering good value for money but its design is largely based on traditional employment patterns and family units, and the 40-year whole-time career.

2. The Scheme was reviewed in 1995 and a number of changes made. More choice and flexibility were introduced with benefit improvement financed by withdrawing special early retirement rights for new entrants. Even so, the NHS has moved on and pension arrangements need to keep pace if the NHS Pension Scheme is to help facilitate change in human resource management rather than obstruct it.

3. During 1999, the 'Modernising Government ' agenda was launched with the key aim of delivering better public services to all those who need and use them. The delivery of pensions to NHS staff clearly came within this agenda and the requirement to both consult and respond to customers was already an established part of the Agency's business plan.

4. At around the same time, owing to cost and public service pension policy constraints, discussion within the Joint Superannuation Consultative Committee (JSCC)[1] had become rather academic. The members wanted improvements. The Department would consider them if the members would pay. The members thought the employers should fund changes. The employers thought the members should pay for beneficial changes. This circularity made any progress impossible.

5. It was agreed that the issue of costs and funding should be put to one side and there should be an open debate and examination of the arguments and scope for change. The JSCC agreed that a wider reference group, including employer representatives and pensions consultants, was needed and, as a first step, a "Pensions Workshop" was arranged.

The Pensions Workshop

6. The workshop took place 25 May 1999 with a remit of reviewing NHS pension arrangements in the context of emerging NHS organisational changes and workforce practice, and policy initiatives such as "Working Together" and "Agenda for Change". The idea was to develop a vision of a future Scheme that might more closely suit its many stakeholders.

7. At the workshop, delegates looked at a wide range of issues from the factors influencing pension development in the private sector to the impact of social and demographic changes, and from specific NHS employment issues to new technology and information services. A number of strategic issues were identified.

[1] The JSCC is the forum in which the Department of Health has traditionally discussed pension arrangements with the Staff Interests. There is a statutory obligation under section 12 of the Superannuation Act 1972 to consult with member representatives on proposed pension changes

Developing Themes

Rationale and governance

- the NHS Scheme needed to be part of national terms and conditions, supporting workforce strategies in which improved NHS Scheme education and communication, and re-designed reward packages should lead to increased recruitment and retention.

- the Scheme's Trusteeship should be revised, to offer employers and employees greater opportunity to influence development.

- employees in differing circumstances wanted more choice, including flexible benefits at flexible cost and alternative calculation methods, e.g. a 60ths instead of an 80ths scheme, to reflect shorter working lives.

- the Scheme needed to become more responsive to flexible working patterns, with improved ability to stop, start or top up pension cover, according to individual circumstances

- Mobility and continuity

- there was an increasing desire for greater job and pension security, and the ability to maintain or re-build Scheme membership following career breaks, especially amongst female staff.

- the emergence of a widening health sector through management mergers, PFI, partnership arrangements and contractual relationships made it appropriate to review the Scheme's traditional boundaries.

- Extended working lives and family friendly policies

- the extension of working lives would be encouraged by more flexible and supportive stepping-down arrangements, including variable retirement ages and the ability to partially retire without pension abatement.

- a more 'family friendly' Scheme, providing a wider range of dependents benefits, would help make the NHS a more attractive workplace, assure equal treatment and improve resistance to legal challenge.

- the trend towards earlier retirement and inflexible re-employment rules that encourage staff to resume careers outside the NHS, looked at odds with the government's retention aims.

- Administration and benefit design

- the delivery of the Scheme needed to be modern too, with seamless integration of payroll and pensions activity and improved access to pensions data for employees and employers.

- early retirement terms needed to be reviewed, including redundancy, enhancement beyond age 60 and Ill health qualification and support.

- Change barriers and drivers
- there were a number of barriers to change, including the size, structure, statutory nature and final salary basis of the Scheme. Member apathy and the attitudes of some employers following recent contribution increases would also need to be overcome.
- improving mortality and social change was impacting costs for all pension schemes and would be a significant factor in the development of NHS modernisation proposals.
- to contain these effects and simplify procedures wherever possible, changes would need to be made to the Scheme as a whole, not the individual parts.
- last, but not least, the Treasury would want changes and improvements to be affordable, cost neutral and NHS centered.
- Workshop Conclusions

8. There was a general consensus about taking forward the developing themes within a wide stakeholder review. It was agreed therefore that a Steering Group should set up a modernisation project and appoint a team of member, employer and NHS Pensions Agency staff, supported by actuaries, to undertake the research and analysis and report its findings. (Steering Group and Project Team members are listed at annex A.)

Terms of Reference

9. At its first meeting on 15 February 2000, the Steering Group commissioned the project team to work to the following terms of reference:

> "Prepare a set of coherent and manageable NHS Scheme modernisation proposals, which would underpin recruitment, retention and mobility strategies in the NHS, be consistent with "Working Together" principles and welfare reform policies, and offer all interested parties "value for money". The proposals to pay full regard to opportunities for streamlining administration, and carry the broad support of the membership and employers. The recommendations to be forwarded to Ministers in April 2001."

10. As work progressed during 2000/01 it became apparent that there were a range of issues of interest to stakeholders and that it was necessary to progress them to different timescales. The requirement to respond to:

    - improving service delivery through 'The NHS Plan', (July 2000),
    - changing pension arrangements for groups of staff arising from 'Shifting the Balance of Power in the NHS' (May 2001)
    - the negotiation of pay reform via 'Agenda for Change', and professional contract negotiations (ongoing)

    meant that a report was not produced by the Steering Group as originally envisaged. Agency resources have been appropriately diverted to those priorities.

11. Instead, the Agency has pulled together the work done by the steering group and project teams into this report which flags up the issues discussed in the current context of public debate on pension provision. Over the past two years the material collected during the project and the discussions held with stakeholders, both in project teams and in smaller focus groups has provided an invaluable source of reference.

12. That period has seen a reversal in the fortune of some private sector pensions and a withdrawal from final salary schemes for some providers. Its stakeholders may perceive the NHS Scheme more favourably in 2002 than was the case when the debate began in 1999. That is not the point of this report, it is to set the current scheme in context and to provide a critique of the Scheme and summary of stakeholder views – it is not a list of recommendations – rather a list of issues for discussion and notes of action taken.

CHAPTER TWO: THE CURRENT SCHEME IN CONTEXT

Introduction

1. Options for changing NHS pensions cannot be considered without a clear understanding of the nature, value and context of the current arrangements. This chapter describes the benefits structure, statutory and regulatory framework, funding arrangements and membership of the present scheme.

Type of Pension Scheme

2. The NHS has a **statutory** scheme. Its provisions are made through regulations[2] made under the Superannuation Act 1972. The effect is that benefits are **guaranteed** and that members have protection against detrimental scheme changes.

3. The NHS is a **defined benefits** scheme. Benefits on retirement are calculated from a formula based on the length of service and salary earned in the NHS. The scheme is contracted-out of the State[3] Second Pension (S2P) and must guarantee minimum levels of personal and dependants' benefits.

4. For the vast majority of members (94%), the **final salary** method applies. This uses the best salary in the last 3 years of service. Service is reckoned in years and days. Pensions **accrue** at 1/80th (1.25%) for every year or part year of service.

5. The main advantage of this method is that it promises income into retirement that is relative to earnings near to retirement. It is less beneficial to those who do not have significant career progression or whose earnings tail off within 3 years of retirement.

6. The remaining 6% - General Medical and Dental Practitioners (GMPs and GDPs) tend to come into this category. They have instead a **whole career earnings averaging** method. At retirement each year's earnings are uprated to their current value and converted to the average and the pensions have a higher **accrual** rate (1.4%), to place them on a broadly equal footing with other public service workers who expect a 50% pension after 40 years service.

7. Whichever method applies, at retirement most NHS members[4] receive a one off, **tax-free lump sum**, equivalent to 3 times their initial rate of pension.

8. Once in payment, NHS pensions are **increased** every year, in line with the Retail Price Index (RPI). There is no upper limit to this cost of living protection

9. The NHS scheme also provides **risk benefits**, in the form of life insurance for nominated beneficiaries; enhanced payments for ill health or early compulsory retirement[5]; and ongoing family pensions for married members.

10. It also includes **choice provisions** for members, such as access to reduced pensions on voluntary early retirement from the age of 50 and extra contribution plans to purchase additional years of service.

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[2] The National Health Service Pension Scheme Regulations 1995, as amended.
[3] The Second State Pension (2SP) – reforms were introduced from April 2002
[4] There are some historical exceptions for members with pre 1972 service
[5] Redundancy payments are covered in separate regulations "The National Health Service (Compensation for Premature Retirement) Regulations 1981, as amended."

11. The **normal retirement age** is 60, but members can continue in pensionable employment until they are 70. Nurses, midwives, physiotherapists, health visitors and mental health officers with protected rights may retire from age 55.

Other Pension Options For NHS Staff

12. On top of their main NHS pension, members can invest up to 9% [10% for manual staff] of their pay in a **Group Money Purchase Additional Voluntary Contribution (MPAVC)** arrangement. This will provide a personal fund that can be converted into additional income at retirement. If they wish, employers can help to fund an MPAVC. Staff may contribute to a provider of their own choice through a Free Standing Additional Voluntary Contributions (FSAVC) scheme.

13. NHS staff are not obliged to join the NHS Scheme. They can opt to stay in the State Scheme, take out a personal pension plan or since 2001, invest in a **Stakeholder Pension**. But if they are earning less than £30,000 a year, they can be in the NHS Scheme and still pay up to £3,600 into a Stakeholder Pension, on top of any MPAVC or FSAVC contributions.

14. Trusts have powers to offer other/additional pensions arrangements should they choose, but they must also offer access to the NHS Scheme

15. The range of pension benefits and options available to NHS staff and employers is summarised in Annex C

Funding Arrangements and Contributions.

16. Members pay a fixed gross contribution of 6% of pensionable pay. Manual workers pay 5%. These attract tax relief and exemption from certain National Insurance contributions.

17. There is no invested fund. However, the Scheme must demonstrate to Parliament and others that the financial basis of the Scheme is sound and that the costs of benefits are being effectively **defrayed.**

18. To do this the NHS Scheme is treated as having a **Notional Fund**. The Government Actuary reviews the Scheme's liabilities every 5 years and makes recommendations on contribution levels. NHS employers pay contributions to cover any extra costs needed to maintain the Scheme's viability and to fund the guarantee; currently these are set at 7 %. The combined employer and member contributions cover the costs of **basic benefits**.

19. Annual **pension increases** to maintain value in line with the Retail Price Index (RPI) have been paid for directly by the Treasury. These are currently the equivalent of a 7% contribution. So the **full contribution** required each year to pay for future NHS pensions is some 20% of NHS pensionable earnings. This is an average charge across the whole scheme. The cost of benefits for individuals and different occupational groups will vary. Employers pay the same rates of contribution, irrespective of whether they employ classes of staff with higher than average pension costs.

20. In the NHS defined benefits scheme there is **no concept of an individual fund**. The Scheme operates on the principle of **mutuality**, which means that the cost of risk benefits, like those for ill health and life insurance are shared. Some members will therefore gain more than others from the Scheme.

21. Responsibility for funding Scheme changes is between the Department of Health and Treasury, as the two stakeholders bearing the **variable** costs of the scheme. Under primary legislation, each change must have formal Treasury approval and the Lords' Commissioners consent to the making of scheme regulations. There are no delegated

powers for Health Ministers at this point in time. This is because the Scheme costs are not subject to cash limits in the same way as other government expenditure. The financial aspects of the NHS Scheme are explained in more detail at annex D.

Inland Revenue

22. At present all UK pension schemes receiving **tax concessions** are expected to conform to over-arching fiscal controls. The main constraints on defined benefits schemes such as the NHS are:

    - Benefits are subject to a maximum of 2/3rds of final salary
    - Member's pension contributions cannot exceed 15% of pay in any year.
    - Only actual earnings should count towards pension. This means that "notional" payments are usually excluded.
    - Linked to this, part time service must be treated as a proportion of whole time.
    - Pensionable earnings are capped for new entrants joining pension schemes after 1 June 1989, currently at £97,200 per annum.
    - There must be some notion of retirement in order to draw a pension

23. Changes to NHS Pension Scheme Regulations are considered for compliance with IR rules by the Pensions Schemes Office of the Inland Revenue.

State Scheme and DWP

24. The NHS Scheme is contracted out of the State Second Pension Scheme (S2P).

25. More generally, the NHS Scheme is subject to **wider pensions legislation**[6]. The main impacts of this legislation are:

    - Mandatory provisions for divorcing members
    - Minimum guarantees relative to the state scheme
    - Disclosure of information to members
    - Compliance with Equal Pay and EC Directives
    - Authority of OPRA in regard to timely contribution payments
    - Authority of Pensions Ombudsman in matters of administration and interpretation of regulations.

Public Service Pensions

26. The NHS Scheme is a public service scheme and must operate, therefore, within the government's public service pensions policy. The consent of Treasury is required before NHS Scheme regulations may be amended. It is important also, to consider the possible wider repercussive effects of changes both across other parts of the public service and, outside, in the private sector. Public service schemes are expected to follow rules and practices that operate generally, even when in some instances their statutory basis excludes them from technical liability or compliance.

27. The following are some of the general tenets of public service pensions policy that need careful consideration when contemplating NHS pension scheme changes:

    - pensions should be based on actual, not notional pay
    - scheme changes should be paid for by members, or
    - there should be no increase in overall expenditure
    - changes should not be made retrospectively

[6] Pensions Act 1995 Chapter 26

- provisions should align with wider social and employment policies
- employers should pay for their employment decisions

NHS Scheme Membership

28. In total there are some 1 million staff contributing currently to the pension scheme. In addition, there are 0.5m pensioners and a further 0.3m members who have left the NHS but retain entitlement to their pension at age 60.

29. Unlike some public service schemes, the NHS covers a whole sector of workers. It encompasses more than 150 professions and trades, including: doctors, dentists, nurses, midwives and allied health professionals, scientists and technicians, manual workers, such as porters, managers, administrative staff, paramedics, transport staff, engineers & electricians.

Conclusion

30. This chapter sets the starting position for consideration of the scope of scheme modernisation. It is clear that the size, nature and funding of the Scheme raise many practical considerations. Major changes would take a considerable time to implement.

31. In recognition of this the modernisation project started with a predisposition to identify possible early changes that could be accommodated within the current arrangements. However it was accepted that at some stage of its work the group might have to consider the arguments for a new kind of Scheme or Schemes.

32. In order to encourage a fresh line of thinking the group considered the issues without prejudice to costs.

CHAPTER THREE: REVIEWING THE CURRENT SCHEME

Introduction

1. This chapter summarises the group's analysis of the relative strengths and weaknesses of the current scheme and from that identifies some prima facie arguments for change. It is drawn from initial stakeholder workshops, research through the stakeholder project team, field focus groups, surveys and an initial invitation to employers and members for their views.

2. The group collated the perceptions of members, employers, staff representatives, scheme managers and some DOH policy interests. These lines were followed up through further focus groups and then some litmus testing of emerging ideas. The initial perceptions are summarised below.

Comparison of NHS Scheme With Other Public Service Schemes

3. A logical starting point was to benchmark the NHS Scheme against our closest public service analogues:

   - Principal Civil Service Pension Scheme
   - Teacher's Pension Scheme
   - Local Government Pension Scheme
   - Armed Forces Pension Scheme
   - Fire Scheme
   - Police Scheme

A matrix summarising arrangements current during 2001 is at Annex E.

The Civil Service

4. The Principal Civil Service Pension Scheme (PCSPS) is in many ways the closest analogue to our position in the NHS. The PCSPS is a relatively complex scheme, widely misunderstood, and facing significant employment and workforce changes with the move to agency working and outsourcing in the civil service. The review began in 1997and is the nearest to effective completion, with implementation of a package of changes that was planned for 1 October 2002. An improved scheme is offered, funded by increased member contributions.

The NHS Scheme and the Private Sector

5. The KPMG member of the Steering Group was invited to provide a wider appraisal using the survey of the National Association of Pensions Funds (NAPF)[7]. Their survey of pension provision across the UK makes no reference to the costs or drivers behind particular levels of provision. However it provides a useful snapshot of how the NHS Scheme package currently compares and some conclusions relevant to this study are:

   - the majority have a normal retirement age of 65

   - most *new* schemes in the last 10 years have chosen defined contribution (DC) arrangements rather than defined benefits, to reduce employer risks on costs

[7] NAPF represents around 700 private and public sector employers, who operate occupational and group pension schemes valued at nearly £550bn and with 6 million active members.

- an increasing number of large private sector final salary schemes, (for example BT, British Airways, Sainsburys and Marks & Spencer), are being restricted to existing employees with DC schemes for new staff.

- private scheme member contributions average 4.58%, compared with 5/6% in the NHS – but no assessment of comparability of benefits

- 73% of private final salary schemes have an accrual rate of 1/60th (1.66%)

- 69% of public final salary schemes have an accrual rate of 1/ 80th (1.25%)

- 8% of private sector schemes permit a higher rate of accrual for a higher rate of contributions

- 89% of private schemes provide pensions for the life of dependants

- 68% of private DC schemes and 57% of private final salary schemes provide life assurance of 4 x pay, twice more than the NHS

- 49% of private schemes pay pensions for common law spouses

- 50% of private schemes may pay pensions to same-sex partners.

6. Private sector schemes are small by comparison to the NHS Scheme and none probably has to deal with the range of different employment groups. They are also governed by rules, not statutory provisions, and Trustees are better able, therefore, to use discretion in individual or particular circumstances. In general terms, though, the outcome of this analysis points to three main conclusions:

    - private sector employers are finding it increasingly difficult to afford final salary pension schemes

    - the private sector has responded more quickly to changes in social behaviour

    - private sector 60th schemes offer members more choice at retirement on the level of pension v lump sum.

7. Next, the perceptions of various stakeholders on the relative merits and demerits of the current scheme were tested and their views collected on the need for improvements.

Views From NHS Scheme Members

8. There was a wide consensus that the current scheme package offered extremely good **value for money for the member.** It is still accepted as a very positive feature in the NHS rewards offered to staff, second in importance only to pay.

9. Despite this, there is a perception that the Scheme is **not sufficiently flexible**.

10. There is nothing to suggest, however, from members comments that finer points of the package are in any sense critical to initial decisions to **join the NHS** itself.

11. It was very clear that the membership in general did not **fully understand** the details of the Scheme and options available to them more generally. Although there is a good deal of pensions literature available, this does not provide a good enough personal understanding of the positive and negative consequences of employment decisions.

Views From Staff representatives

12. The staff representatives from their more detailed knowledge of the Scheme, perceived a number of relative weaknesses and scope for potential improvements. The BMA and MSF ran member surveys, which have contributed, to this list. In broad terms, the following were raised as issues:

Flexibility about retirement.

- The Scheme is designed to be a retirement scheme – that is, it requires members to leave the NHS in order to draw their pension and lump sum. This is part of the current Inland Revenue regime, but it is seen as counter-intuitive to policies to persuade staff to remain longer than traditionally they have. Aside, the flat rates of accrual offer no "back loaded" value to pensions, that is, no incentives to stay on special terms.

Flexibility approaching retirement

- Linked with the above, there was perceived to be little practical scheme support for policies that are designed to help workers ease up at later stages of their career. The dependence on their final salary was in itself an obstacle to taking less onerous, but lower paid work. Ambulance staff representatives pointed to the particular perversity of this in regard to the high ill health retirement rates amongst paramedics.

Incentives to return to the NHS in mid career

- Staff leaving for short periods, for example on sabbaticals or to raise a family, may lose the links to their previous service and this is arguably a disincentive to return to NHS employment. The charging of top-ups at the full cost is also seen as a disincentive.

Obstacles to NHS structural changes

- Staff representatives saw problems with emerging NHS developments and boundary changes. It was important to them that there should be no detrimental impact on pensions. Retention or protection of pension rights, and the importance staff attach to them, is often over-looked in initial planning for change.

Perceived inequalities

- The staff representatives had a list of issues, the biggest being the refusal of the government to pay for benefits for unmarried partners. Also highlighted were arguments for parity of treatment between certain occupational groups for example, between GMPs and consultants and, more widely, between ambulance staff and the other emergency services.

The current benefits structure

- There were many initial suggestions for improving the scheme within its defined benefits final salary structure, ranging from introducing a 1/60th accrual rate with an **option** to commute final pension to a lump sum to parity with private sector schemes on death cover. The radical option of moving to a funded or other model of scheme was also raised.

Administration, communications and information

- There was a clear demand for better information, tailored to individual needs, chiming with the general member perception.

Views From Employer Representatives

13. The employers, as co-administrators (and most of them members) of the scheme had very similar perceptions about information, inflexibility and, to an extent, potential obstacles in the scheme. Their main additional assessments covered:

Inflexibility

- Their initial perceptions were, interestingly, in the barriers to earlier retirement, such as actuarial reductions for voluntary retirements. But they also felt that inflexibility to re-deploy staff who were slowing down was a particular hindrance.

Information

- The employers added their weight to the need for better information about individuals, not just for the members, but also to help them in advising their staff. They also added a view that sources of independent financial advice would be a helpful addition to administration, given the wider availability of products in the market.

Governance

- Employers wanted greater involvement in decisions about the Scheme, given their financial contribution to it.

Scheme Managers and Administrators

14. The managers endorsed the need for members to be better informed – and with it weaknesses in the current links with employers to be overcome to make the improvements needed. They also cited the increasingly complex patterns of employment as being a major complication to the defined benefit scheme model.

The Department of Health

15. Officials responsible for NHS HR policy were aware of the breadth and coverage of the scheme. Their perception was that it was not always seen as an important component of a wider NHS rewards strategy.

16. Although not initially a review consideration, the need to keep scheme improvements cost neutral under current Treasury policy has been a brake on developments. This heightened the need to take the widest possible view of the benefits of any emerging changes.

17. Treasury control in other aspects, such as adherence to consistency across the wider public service pensions scene, were also limiting factors to a more tuned NHS arrangement.

18. The comparisons with other arrangements and the stakeholder perceptions set the wide parameters for exploring options further, still without prejudice to any final outcomes for Ministers.

Other Developments

19. In parallel with the project, a number of developments were taking place. These have either sharpened the agenda or provided further context for the modernisation of NHS pensions: They include:

    - The publication of the NHS Plan
    - Winter Pressures initiatives
    - A Treasury Review of Ill Health Retirements in the Public Sector
    - Employer Forum For Age Report
    - PIU Report: "Winning the Generation Game"
    - Shifting the Balance – The Department of Health's programme to empower front line health agencies.
    - Integrated health and social care partnerships
    - Agenda for Change – a review of NHS pay arrangements

The NHS Plan

20. Published in July 2000[8], the Plan sets out the government's 10-year programme for the development of the Health Service. At first glance the ramifications for pensions are limited. There are specific references to pension protection for consultants who step-down by reducing their fixed clinical sessions. However, the Plan raises other major issues for pensions. These include:

    - Recruitment and retention: the need to *increase and retain NHS capacity* for nurses, consultants, GMPs and other key occupations.

    - Improving Working Lives: the raft of measures designed to bring *flexibility to the workforce,* especially in regard to family friendly policies, and working patterns, especially closer to retirement.

    - Pay and contracts: commitments to *improving rewards systems*, new ways and terms of working and their impact upon pensionable pay

    - The *key role of the Primary Care Trusts*: the implications for GMPs pensions of moving between self employed and contract status

    - "Social partnerships" & *cross sector collaboration*: the pensions challenge of co-locating NHS staff with Local Government and other workers.

21. A first order emerging question was whether the scheme would **impede any NHS Plan measures**. There was then the question of whether specific pensions changes could **accelerate or incentivise** any of these developments.

Winter Pressures

22. The present NHS capacity issue is compounded with additional pressures in the winter season and Ministers have commissioned short- term measures, including promotion of aspects of the pension scheme, to help.

23. This was instructive, in that it provided credence to the perception that the pension scheme was not fully understood by employers and members. In a campaign focussing on:

    - **Misconceptions** about detrimental effects of part time working close to retirement

[8] The NHS Plan: DH, July 2000

- Employers' **authority to manage** pension protection for staff "stepping down" to less stressful, but lower paid duties

- Employers' **discretion to fund** members additional voluntary contributions

the virtues of scheme promotion by employers became apparent. This introduced the wider question around how much is known about the **behavioural impact** of the current Scheme and the effect of its (understated) value to members and employers.

Interdepartmental Study of Ill Health Retirements in the Public Sector

24. In another parallel development in August 2000, the Chief Secretary to the Treasury reported the findings of an official study into ill health retirements[9]. The background was an explosion of numbers and costs right across the public sector, particularly over the previous 10 years. It is estimated, aside from the personal issues involved, that on average each ill health retirement in the NHS costs an additional £60,000 and that this was probably closer to £120,000 when the replacement consequences were factored in.

25. The Secretary of State for Health has accepted most of the report's recommendations, many of which are linked to the Improving Working Lives themes in the NHS Plan, in the area of good health at work practice and intervention.

26. There were also recommendations for improving the structure of benefits to minimise the risk of inappropriate ill health retirements. The main thrusts were:

    - A need to consider whether the current "all or nothing" benefit was either equitable or reasonable.

    - A need to consider whether the formulae for enhancing pensions was perversely incentivising retirement patterns. For example, there is evidence of a large clustering of early retirements on health grounds at 54, when the maximum enhancement is paid.

27. The issues raised by this study cut across occupational health and retention policies, the appropriateness of benefits structures, behavioural and cultural changes and the role, influence and impact of management activities and decisions on pension costs. The Department of Health and NHSPA have devised and are implementing an action plan to ensure compliance with Treasury recommendations.

Other Parallel Work

28. Over the last 2 years there have been a number of wider studies and developments on pensions that are relevant to this group's work. In particular, the Government commissioned reports from Ron Sandler - **review of pensions and tax rules** and Alan Pickering - **the simplification of pension administration** and the relevant tax regime were published this month. Briefly, other studies cover a wide range:

    - The DWP are interested in the **economic issues of UK workforce supply** and the impact of pensions in that context.

    - The Institute of Actuaries has been advising employer organisations and Government on the implications of **improved longevity** and its implications both for pensions and UK labour supply.

[9] Review of Ill-health retirement in the Public Sector , HM Treasury, July 2000

- The Policy Intelligence Unit published its report “Winning the Generation Game” and alongside the Government has advanced its proposals for ensuring that the skills of the **older members of the workforce** are valued and retained.

- The Employer Forum for Age has been pressing for **relaxation of the pensions tax regime** to facilitate this. This is also an issue for the NAPF.

- European studies are increasingly seeking harmonisation of policies, especially in regard to **equal treatment**; and the final directions of the Employment Tribunals on part-timers access to pension arrangements are awaited.

- The National Audit Office is looking at flexibility in the workplace, considering the fiscal, economic and social effects in the demographic trends.

- The Cabinet Office Women’s Unit has examined the female population’s income over a lifetime.

Organisational Change

29. In recent years, organisational changes and public/private partnerships have seen staff moving to other parts of the public service, to private sector contractors and voluntary organisations. On almost every occasion, the retention or protection of NHS pension rights has been a major issue and, in some cases, an obstacle to transfers.

30. There are two separate issues to consider. First, Scheme access to new groups or organisations operating on the periphery of mainstream NHS. Allowing GP Practice Staff into the scheme has awakened a keener interest in Scheme membership from dental practice staff, out of hours practices and co-operatives and voluntary organisations involved with patient services.

31. Second, retention of scheme membership on leaving direct NHS employment. Broadly comparable arrangements should be available to transferees but it is difficult to replicate the special early retirement rights of Mental Health Officers in other schemes and, with integrated service provision, staff may move regularly between sectors in which two public service schemes operate.

32. Resolving boundary issues and facilitating the free movement of staff across health and social care sectors are important facilitators for flexible working and integrated healthcare service delivery. It was important therefore to consider the circumstances in which the pension scheme would be an influential factor in service reorganisation and to establish ways, which might support rather than obstruct wider policy initiatives.

Conclusion

33. This chapter provides a backdrop for considering the scope for changes to the scheme more specifically in the next chapter. The NHS Plan and the developments since have provided an agenda for looking further ahead. Also the potential developments in UK pensions policy, for example the Inland Revenue’s attitude to facilitating flexible retirements in the UK, need to be taken into account.

CHAPTER FOUR: WIDER SCHEME ISSUES

Introduction

1. In this short Chapter some general concerns and ideas for improvement are discussed. All need to be considered alongside the strategic policy and HR objectives for the NHS.

Understanding the Current Provisions

2. The direct and indirect investment in pensions by the NHS is equivalent to around 14% of the pensionable pay-bill. The employee contribution is more than doubled and their benefits are guaranteed. This is a significant component of the **NHS rewards package**.

3. The detailed understanding of the current NHS pension arrangements amongst employers and members is generally very low. It is a pre-requisite to intelligent debate about any future changes that the high value of the current arrangements is recognised. All of the measures targeted as improvements are really marginal additions to an **already very good scheme**.

4. Employers, with support from the NHS Pensions Agency, need to do much more to promote the scheme at individual level. Moreover, it will help in employer retention policies if their workforce planning policy includes intervention with their potential retirees in good time. This will ensure that retirement decisions are being taken for the right reasons.

5. Even in the current scheme there are already **flexing of retirement options**. But if others are introduced as the result of this study, it will become even more important to ensure that they are understood and used appropriately. Otherwise the Scheme will continue to be perceived as a material reason why people feel they must leave the NHS around the age of 60.

6. There have been some developments in this area. Ministers have insisted that promotion of pensions becomes part of the **Improving Working Lives accreditation** process. To make this work, members and employers need regular and up to date access to their pensions position. In April 2002, the NHS Pensions Agency launched a **new Pensions OnLine service** for Trusts from which **benefit statements** can also be derived. Also as part of the accreditation process, the Agency has arranged a series of IWL/Pension workshops for NHS HR staff to help them understand how Scheme options and flexibilities can underpin their employment policies. In addition to this, it is important that the Agency does everything it can to ensure that all members have up to date web based information on the wider nuances of pensions via its web-site.

7. Though increasingly, web based information will become more easily accessible and, perhaps, the normal way of communicating with members and employers, the Agency must recognise that the NHS workforce is multi-cultural and, to a degree, multi-lingual. Pensions is a complex business and guides and other scheme literature need to be clear and understandable.

8. The Agency and employers need also to consider whether there is a need for special or non-English versions of scheme booklets, or translation services. And they should conduct research into the reasons for “opting-out” and take appropriate steps to remedy any weaknesses in their communication and information services.

9. These are regarded as **essential modernisation** efforts to ensure that the pension scheme is fully integrated into the wider Human Resources Strategies for the NHS.

10. **Issue 1 - That the NHS Pensions Agency reviews its scheme literature to ensure it remains relevant, easy to understand and continues to meets the needs of a culturally and ethnically diverse workforce.**

11. **Issue 2 –That research is undertaken into the reasons why NHS employees opt out of the pension scheme and takes appropriate steps to address any educational, promotional or procedural weaknesses.**

12. **Issue 3 That the Pensions OnLine system be rolled out to individual members and GP practices and the development of support training for HR managers be continued.**

13. **Issue 4 - That NHS employers review their local arrangements for publicising and promoting the pension scheme and include pension awareness and modelling in their workforce planning assumptions.**

14. **Issue 5 - That employers conduct mid-career reviews with staff on their pension options and retirement intentions so that both employer and employee can plan more clearly for the future.**

Scheme Governance

15. The new Governing Board of the NHS Pensions Agency is widening its membership to include some ordinary members, pensioners and employers. That will considerably improve the debate on delivery issues but, in the inclusive approach to NHS developments in the future, there needs to be a new forum for addressing the scheme itself.

16. The exclusion of employers from formal negotiating machinery on NHS pensions is an obvious omission. This suggests a more active role for the NHS Confederation or an emerging one, perhaps, for the new Strategic Health Authorities or Primary Care Trusts but, whatever the representation, pensions should be more closely integrated with the wider workforce consultative machinery. Member representatives are also unhappy with the current forum for pensions, the Joint Superannuation Consultative Committee (JSCC), and would welcome employer participation. In both Education and Local Government, there are long established examples of joint consultative bodies.

17. **Issue 6 - That the Department review the current pension consultation arrangements with a view to bringing NHS employers formally within the negotiating machinery.**

Wider Independent Advice

18. There is a clear desire for pensions guidance that goes beyond the scheme itself. This has been sharpened with the emergence of Stakeholder products and the problems with Equitable Life. NHS Pension Scheme managers and employers are neither legally empowered nor equipped to provide ‘best advice’ on wider pension choice to suit individual circumstances. Scheme members currently have to go to an Independent Financial Advisor (IFA) and pay for such help but many trade unions and professional staff associations offer free, independent financial advice.

19. The NHS Pensions Agency takes appropriate professional advice when necessary, through the Government Actuary’s Department or, for example, by using consulting actuaries such as Hewitt Bacon & Woodrow Limited. But clearly it cannot provide individual members with access to such services. However, the Agency should explore whether it could facilitate IFA contacts, either by providing a choice of links on its website or by designating some approved providers, perhaps on preferential terms.

20. **Issue 7 - That the NHS Pensions Agency consider with employers and staff representatives, the feasibility of providing members with structured links to independent financial advice.**

Scheme Access

21. Since the project began it has been agreed that free-lance GP Locums should be accepted into the Scheme retrospectively from 1 April 2001, subject to their inclusion on new PCT 'Supplementary Lists'. This will facilitate capacity in the GP sector, as locum activity is drawn closer into the scope of PCT planning and management.

22. There are, and will be, other "demands" for access in the areas of wider partnerships and in the creation of new fringe bodies. The Secretary of State is empowered to admit bodies, or individuals, where he is satisfied they will be making a real contribution to the delivery of NHS patient services, but this will be tested as more cross boundary bodies are created.

23. Traditionally the NHS Scheme has been regarded as the occupational scheme for NHS employers. But health boundaries are changing and health workers are moving between sectors, either to private employers or other public service employers. Those leaving want to stay in the scheme, particularly staff with special early retirement rights. And those working in comparable employment want to join it. This is a real issue for staff, the employers, the scheme and the Treasury.

24. Unless only directly employed NHS staff are deemed eligible for membership, drawing the right boundary for Scheme access is difficult. Where it is likely that transferred staff will return to NHS employment, there may be a case for allowing continued membership. Where that is unlikely or particularly where the new employer operates for profit, access would seem inappropriate. In this respect, so long as the NHS Scheme remains financed by taxation it will be difficult to widen the scope of Scheme membership.

25. However, with more integrated working in the delivery of health and social care services, particularly partnership arrangements with local government under Section 31 of the Health Act 1999, the Department will need to work closely with the Office of the Deputy Prime Minister (ODPM[10]) on understandings around pension cover. With more NHS and local authority staff moving regularly between sectors, there is a strong argument for allowing them to remain in their existing pension scheme. Both the NHS and Local Government Pension Scheme provide a similar range of benefits.

26. **Issue 8 - that the Department work with ODPM and the Treasury to set in place pension arrangements that will facilitate the smooth development of integrated health and social care services**.

27. **Issue 9 - that the scheme's admissions policy is reviewed in the context of developing healthcare policies and clear guidance issued on the criteria for scheme access and membership retention.**

Conclusion

28. NHS pensions are valuable. Most people recognise that, though maybe at different times in their lives. Some never recognise the value and miss out, through ignorance or mischance. The NHS Pensions Agency and employers have clear roles in making sure that every NHS employee understands both the importance and value of pension rights. The Agency in fulfilling its statutory duties, employers in pursuing integrated recruitment and retention policies. The Governing Board should oversee and support the programme.

[10] formerly the Department of Transport, London and the Regions (Dtlr)

29. Information about pensions must be given to staff at the right time, in the right way, in the right amounts and at the right level. That means co-ordinated and structured communications and advice platforms. Employers and staff representatives need to work with the Agency in setting and implementing this policy – on education and training, information and advice, flexibility and choice. Many of the misconceptions about the Scheme and transfer concerns stem from basic misunderstandings of both the scheme and pension options generally. Employers have a duty to inform, the Agency has a duty to provide the information and the staff representatives have a duty to make sure they get the message out too.

CHAPTER FIVE: CAREER BREAKS, FLEXIBLE WORKING AND FAMILY FRIENDLY POLICIES

Introduction

1. All NHS employees are becoming increasingly concerned about their workloads and balancing the work/life relationship. New ways of working, flexible working and work/life balances are being encouraged and enshrined within Improving Working Lives (IWL), to which all NHS employers are now firmly committed.

2. The NHS Pension Scheme was designed to cater for the 40-year full time career and the final salary/years of service structure does not cope easily with fragmented work patterns and variable employment. All the Scheme can do is give credit for hours worked and salary earned. It cannot pay benefits on anything less. It can help people try to recover lost ground but only at full cost. And, as people get older, those costs increase proportionately and are often unaffordable. This leaves many members, especially women, with reduced pensions in retirement.

3. The NHS has a predominately female workforce. Even in the traditional male dominated professions, there are now many more female workers. For example, there has been a marked increase in the number of female doctors in recent years, particularly in general practice. Ten years ago, just over 25% of hospital doctors were women and only around 20% of GPs. Now about a third of all doctors are female. And this trend seems set to continue with around 55% of medical students being women.

4. While male employees may be just as concerned to balance work and family commitments, female staff are still much more likely to face the conflicts of career and childcare responsibilities. Many will need to take maternity leave, probably more than once, and then take career breaks or resort to part-time working to look after young children. Currently, for example, 45% of nurses and around 20% of female GPs are working part-time.

5. By taking breaks in employment, career pensions are reduced unless the member makes additional voluntary contributions on their return to work. This can be expensive because there is no contribution from the employer and the member has to pay the full cost, including the RPI indexation. Female staff feel they are being penalised for their family responsibilities and they often see little or no encouragement, or inducement, from their employers to return to work.

6. On pension rights, they and their male colleagues are seeking support to cover breaks in employment, especially in circumstances where there is a clear intention to return to work within a reasonable period, say between two and five years. Or, in cases of study leave, where enhanced skills and experience will benefit the NHS. They want therefore:

   - better pension cover for maternity and paternity leave
   - continued free scheme membership for study leave and sabbaticals
   - half-cost added years to cover career breaks

Maternity/Paternity Leave

7. Paid maternity or paternity leave is pensionable. Contributions are deducted from pay. Unpaid leave is pensionable, based on previous pay levels, so long as the members pay their contributions. But many members may elect not to pay for periods when they had no earnings, leaving gaps in their overall pension scheme membership.

8. Members want a free pension credit for unpaid maternity or paternity leave to encourage returners. They suggest that employers should recognise family responsibilities as an important part of IWL policies and should pay for a maternity pension credit as a matter of good, visible employment practice. An automatic free credit may prove to be unaffordable, so a more realistic option might be to give NHS employers the discretion to fund or support a pension credit for unpaid maternity or paternity leave as part of a "returners" package.

9. Employers will be keen to retain the services of good staff after unpaid family leave and, including continuous pension scheme membership within an agreed package, (which might also include re-training and career development plans) could prove a powerful incentive for many key staff to return quickly. Costs could also be contained by stipulating a maximum period of pension subsidy, which should probably not exceed 2 years.

Study Breaks

10. There will be times when NHS staff, particularly doctors, leave their posts temporarily to further their professional education and training. Whether these periods of study leave are pensionable will depend on the employment relationship. If members continue to be employed and paid by their NHS employer, study leave will be pensionable. Unpaid study leave is also pensionable on the same basis as maternity and paternity leave.

11. Where the employment relationship is terminated, the study leave may still be pensionable but this will depend on the circumstances. For example, if doctors leave to take up a funded, fixed period, university based research post, but intend to return to the NHS, they can apply for continuity of membership in the NHS Scheme.

12. Similarly, and in particular in response to EL(95)69 "Overseas Work Experience and Professional Development of NHS Staff", continued scheme membership may be available, though usually time-limited, to staff going overseas to either further their professional skills or to help with healthcare provision in developing countries.

13. NHS staff recognise that improving or augmenting their skills, keeping track of new techniques and developments, and seeking further professional qualifications will enhance their career prospects. But they consider also that the NHS is the real beneficiary and, in that respect, the NHS should help support periods of unpaid study leave. One way of doing so for those, who clearly intend to return to the NHS, would be for employers to support continuous pension scheme membership.

Career Breaks and Half Cost Added Years

14. Apart from maternity/paternity and study leave, there will be other times when NHS staff take career breaks. Sometimes for personal or other family reasons, on other occasions, to broaden their experience. The staff representatives are seeking financial help for members, who take career breaks to manage family responsibilities, in the form of half cost added years.

15. Currently, members who want to purchase extra years of pension scheme membership to bridge gaps in employment must pay the full cost. It has been suggested that staff should only pay half the cost, the remainder being met by the pension scheme or the employer. The concept is that supporting staff to maintain their pension record may provide a greater incentive for them to return to NHS employment.

16. There is no hard evidence yet that pension arrangements are the decisive factor in the recruitment and retention of staff. The staff representatives point to the take up of current scheme provisions that allow returners to pay half-cost added years to buy back pension cover where the membership was refunded before 6 April 1978. This is not quite the same as introducing a new provision. Those special terms are available because the service pre-dates the contracting out requirements and in circumstances where the pension scheme

only refunded the employee's share of the contributions. The employer's share was retained and it would be unfair, therefore, to charge again for those contributions.

17. A general half-cost added years' scheme could not be justified on cost grounds. It would seem preferable, as with maternity leave etc, to leave it to the discretion of employers to design local packages that included a pension element, such as financial support for bridging scheme membership gaps.

Conclusion

18. The NHS pension scheme has a membership of around 1 million, of whom 80% are female. Members of both sexes will take career breaks of various sorts for a variety of reasons. In total, the gaps in membership will be significant. Members retire with an average of only 18 years in the scheme. Though the Department of Health is very supportive of fostering good family friendly policies, scheme wide, guaranteed free membership credits to plug employment gaps would place an unrealistic financial burden on the Scheme and employers.

19. However, it will be in the employers' interests to regain the skills of experienced workers in all specialities and the availability of local, "retainer" packages for key staff may encourage an early planned return to work.

20. The review of the Added Years scheme has considered the financial arrangements for purchasing additional service. The ability to pay by lump sum payments at any time, rather than within the first 12 months of membership, is a favoured option. With such a flexible lump sum facility it would be open to employers to consider financial support to bridge membership gaps, for example, by meeting the equivalent cost of the normal employer contributions or providing interest free loans.

21. **Issue 10 - That the added years scheme is re-designed to provide for flexible lump sum payments to allow NHS employers, as part of local packages designed to encourage the early return to work of key NHS staff, to consider funding or supporting the provision of additional service to cover unpaid periods of maternity, paternity, family and study leave.**

CHAPTER SIX: FAMILY BENEFITS

Introduction

1. Although the NHS pension package includes good survivor benefits, members are looking for improvements in the scope and level of cover for their dependants. Generally, the range of child benefits are welcomed and deemed appropriate. But the absence of pension rights for those in common law or single sex relationships, and the rules for paying widow and widower benefits, continues to attract criticism. In this Chapter, these issues are considered in the context of a scheme wide review.

Level of Benefits

2. Spouses of scheme members are generally entitled to half the member's pension on death. This is the normal provision in 80ths schemes and complies with the contracting out requirements. But the Inland Revenue will allow higher dependants' benefits to be paid, to a rate of two-thirds of the member's pension.

3. Though the current rate is less than the maximum that could possibly be paid, it reflects the structure of the scheme and the overall benefits package. Clearly, increasing the rate of dependants' benefits would increase scheme costs significantly and any change in benefit level would need to be considered in the context of change to the overall benefit structure.

Common Law and Single Sex Partners

4. At present public service pension schemes only provide survivor benefits for legal spouses. However, in the NHS scheme, members may nominate any person to receive the relevant death gratuity.

5. The government has recognised the change in social attitudes and the growing number of people living in stable relationships outside marriage. In its 1998 Green Paper "A new contract for welfare: Partnership in Pensions" the government indicated that, in principle, it had no objection to public service schemes offering survivor benefits to unmarried partners. But it set out some pre-conditions:

   - costs should be met by the members; either through extra contributions or scaling back other benefits.
   - the general membership must want the change, and
   - the arrangements must be practicable

6. The Staff representatives take the view that all scheme members have paid the same level of contribution over the years. They argue that it be would be unfair and discriminatory to charge unmarried members again when, so far, their share of the benefits package has been less than for married members. They have already been subsidising married members.

7. The problem is that the NHS has an un-funded scheme operating under mutual assurance, shared risk principles. Members pay standard contributions for a defined benefit package, even though each individual's final share of benefits is not always the same. The Scheme is only funded to provide benefits to legal spouses. And in 1999, the Government Actuary estimated that, for future service alone, paying survivor benefits to non-spouse partners would add an extra £40m a year to employer costs. Cover for past service has a capitalised cost of £400-500 million.

8. There is a general consensus that extending dependants' cover to non-spouses would be a positive first step to modernising the pension scheme. It was generally the one issue on

which there was common ground on principles. Scheme managers and employers would welcome this improvement but, at present, unless the general membership was prepared to fund the new cover, it would seem that this major change could only realistically be achieved in the context of a new Scheme**.** This has been the approach in the Civil Service where a new pension package has been developed, with enhanced benefits but at higher contribution rates**.**

Lifetime Pensions

9. At the moment, widow(er)'s pensions cease to be paid on re-marriage. There are provisions that allow reinstatement in cases of financial hardship. But for many, application is seen as an undignified and intrusive process. Staff representatives have pressed for lifetime pensions for some time. They feel that their members have paid for their pension benefits and that full rights should pass on to their dependants. Some see the continuation of pension benefits as recognition of the underlying support NHS staff get from their families whilst working. Male GPs in particular see survivor benefits as part of the natural reward to wives who helped run their practices.

10. Members often point to the private sector where lifetime pensions are common, though with limitations to account for age disparity and exposure to "death-bed marriages". But in the private sector, payment is usually at the discretion of Trustees and costs can be more easily controlled. Introducing statutory provisions into the NHS scheme would increase contribution rates by £40m a year for all members for future service alone. The capital cost of allowing all previous membership to count would be £400-500 million.

11. Lifetime pensions could be introduced on a standalone basis but the issues are inexorably linked with those around adult dependants' benefits outlined in earlier paragraphs. It would be difficult to introduce improved benefits for existing widow(er)s without extending cover to the partners of unmarried members. Again, in the current climate, change would seem more appropriate to new scheme considerations.

Back-dating Widowers' Pensions

12. Widowers' benefits were introduced into the Scheme from 6 April 1988 to comply with the Social Security Act 1986. However, unless a female member purchased cover for her earlier service and before 30 June 1989, widowers' benefits are only based on membership from that date.

13. Over the years, Staff representatives have pressed Ministers to grant free back–dated cover. These claims have been resisted on the grounds that the Scheme fully complies with EC and national law, the no retrospection policy of public service schemes and cost. On the latter, the Government Actuary has estimated that, on 1999 salary levels, the capital costs of back -dating widowers' cover would be around £500m.

14. In the majority of cases, men will predecease their wives and widowers' benefits will not be relevant. But female members sense a real injustice and argue that half-rate widows' pensions have been available since 1972. Women are the main constituents of the NHS scheme and feel they have subsidised their male colleagues. The counter-argument of course, and often forgotten is that female members live longer and may enjoy, therefore, a greater share of personal benefits from the Scheme.

Full Membership Credits for Post-retirement Marriages

15. Where male scheme members marry or re-marry after retirement, the widows' pension is only based, if relevant, on their membership from 6 April 1978. The Staff Representatives have long argued that it is unfair to penalise widows who happened to marry NHS staff after they have retired and that the cost of change must be relatively small.

16. Although Ministers have been sympathetic, they have resisted an improvement because of concerns around the wider repercussive effect of retrospective changes. Also with the passage of time, this change is largely irrelevant to most current members and, though costs would not be significant, any additional expenditure would divert resources away from more positive recruitment and retention initiatives.

Conclusion

17. This chapter is concerned with retrospectivity and with partner benefits. Most of the retrospective claims seem also destined to fail, not only on cost and policy grounds but also because they relate to periods of service now long in the past.

18. Any pension scheme changes ought to forward looking. The NHS Scheme has already provided equality of treatment for future membership and claims for retrospective improvements should not merit priority in any restructuring, particularly when there are more contemporary and relevant candidates for improvement.

19. The inclusion of benefits for unmarried partners is the one key area in which the public service schemes have failed to keep pace with social and behavioural change. Broadening the scope of dependants' cover to those in common law and single sex relationships tops the Staff representatives' agenda and the Government has already agreed in principle to the change. But costs remain the major stumbling block. If the current membership is not prepared to fund the change then it seems likely that a new benefit could only be introduced in the context of a new Scheme. And even then, it seems likely that benefits could only be linked to prospective membership.

20. The Principal Civil Service Pension Scheme has been unable to introduce this change without moving to a new Scheme for new entrants, restructuring and improving the existing benefits package but with increased member contributions.

21. With the government's position clear, the continued unwillingness of the membership to pay extra for the new benefits outlined in this Chapter leaves no alternative but to suggest that this issue can only be taken forward in the context of considering a new NHS scheme. Until this important question has been debated it is not appropriate to consider introducing any special arrangements under which members might pay individually for these extra benefits.

22. **Issue 11 - Survivor pensions for unmarried partners in common law and single sex relationships should continue to be reviewed. If the present impasse cannot be resolved, then this issue would be central to any considerations of re-packaging the existing NHS benefits in a new pension scheme.**

CHAPTER SEVEN: DIVERSITY OF OCCUPATIONAL GROUPS

Introduction

1. Each NHS occupational group tends to have its own terms and conditions of employment. Some follow the General Whitley Council provisions; others are governed by professional requirements and Review Body arrangements. But the nature and diversity of occupational groups and, in particular, their discrete recruitment and retention needs pose a major problem for a scheme largely structured to deliver a single pensions package. It is expected that the 'Agenda for Change' initiatives will lead to greater harmonisation of terms and conditions for employed staff.

2. Overall, there are 80+ different NHS employment groups. This Chapter examines the particular pension concerns of some of the main groups to highlight the wide range of issues facing the Scheme. They sit alongside claims for general structural improvements, full equality of treatment, enlightened family friendly policies, and wider flexibility and choice, covered in the other chapters.

3. The NHS Scheme is unique in providing occupational pension arrangements for self-employed contractors. They do not fit easily within a final salary scheme and the way they are paid and "employed" has always created uneasy situations, conflicts and pressures. Special provisions have helped but the pace of primary care and service developments and evolving new roles for GPs, in particular, have tested the Scheme's ability to respond quickly to the changing scene. It seems appropriate then to start with primary care and first with some background.

General Medical Practitioners and Their Staff

General Practitioners

4. Although they are self-employed, independent contractors, GPs were admitted to the NHS Pension Scheme in 1948. The relevant Health Authority currently acts as the employer for pension purposes. However, because there are no salary scales for GMS GPs a complex formula (reviewed regularly in consultation with the BMA General Practitioner Committee) is used to ensure that the profession as a whole generally pensions the sum of:

   - Intended Average Net Income (IANI);
   - Higher Target payments (which are otherwise "outside IANI");
   - Other GMS payments "outside IANI" (eg. payments for administering the second dose of MMR vaccine, and for administering 'flu vaccines for the over 75s).

5. These calculations produce a factor that is applied to certain fees and allowances payable to all GPs in Great Britain. For GPs who work in partnerships, pensionable income is calculated at practice level. GPs themselves notify the Health Authority of their "practice shares" (typically the same as their profit shares) which the HA then uses to apportion the pensionable income/contributions for individual GPs. Because the factor is based on the average of all GPs, the pensionable income for the individual GMP may well be more or less than the actual net profit he or she derives from general practice.

6. GP pensions are based on their cumulative career earnings from GMS/PMS, and – because almost all will have been members of the NHS Pension Scheme prior to entering general practice – they can "carry over" up to ten years' of this earlier "officer" service. In effect, the individual GP is credited with a "personal fund" (their career earnings, uprated – "dynamised", in the jargon – to take account of successive Doctors and Dentists Review Body awards (DDRB)), and his or her pension is a percentage (currently 1.4%) of this. This approach is used for three main reasons.

- a GPs self-employed status means that there is really no “final salary” on which to calculate pension entitlement.

- the typical GPs’ earnings tend to peak some years before retirement, rather than at the end of working lives as with most salaried employees – so a “final earnings” basis could be unfair.

- it has been argued that allowing GPs to acquire pensions based on the actual level of net income in their final year(s) is open to the manipulation of “practice shares” in the years immediately before retirement in order to maximise pension benefits.

7. The policy aim of these arrangements is to ensure that, so far as is possible, GPs acquire equivalent benefits to salaried members of the NHS Pension Scheme, for equivalent contributions.

8. However, there are special features of the Scheme as it applies to GPs. First, because they are self-employed contractors there are no fixed hours and so GPs can acquire additional benefits in respect of other NHS earnings; for example, as part-time doctors in NHS hospitals. This is not an option for salaried members of the NHS Pension Scheme (or of other public service pension schemes) who are capped at “maximum full-time” (typically 37 hours).

9. Second, certain extra GMS earnings can be pensionable within the Scheme, notably earnings from Local Development Schemes under s.36 of the Primary Care Act. Third, GPs enjoy an extra-statutory concession (the “A9 concession”) from the Inland Revenue. This allows them to set up an additional private pension fund on their “Net Relevant Income” (defined as the difference between their NHS pensionable income in any year, as derived from the national formula outlined above, and their actual net profits). They can claim tax relief on such contributions in lieu of relief on contributions to the NHS Pension Scheme if that is more advantageous.

10. The position under Personal Medical Services arrangements is different in that GPs contract with Health Authorities to provide services for an agreed sum. The parties agree the level of pensionable income under the PMS contract at the outset. A NHS Plan objective is to facilitate greater fluidity in primary care services. The advent of Primary Care Trusts and better co-ordination and planning in the delivery of local primary care services will see new roles and challenges for GPs. The important role of the generalist GP will be retained, but with much greater diversification.

11. GPs will become increasingly important players in local health strategies. Their professional development and activity will blend more subtly into local needs and environment. In extended roles, they will be found working on advisory and healthcare policy groups. The new GP Specialist will routinely handle cases currently referred to the hospital sector.

12. Future GP career pathways will require Improving Working Lives policies to generate the more flexible, family friendly environment needed, with appropriate and, at the margins of local needs, better packaged remuneration. New models must recognise that GP salary, fees and allowances will increasingly be derived from a wide range of primary care and employment situations. There will be less distinction and dependence on wholly funded GMS earnings. GPs will increasingly dip in and out of contracted work. This is happening already.

13. Having their own separate pension arrangements may compensate GPs for the mid-career peaking but new ways of working, severing the traditional links to GMS and pension relativities with other groups raise a number of pension concerns. Their unique position makes GPs sensitive, in particular, to issues around:

    - the pensionability of their NHS earnings

- the up-rating factors for those earnings –"dynamisation"
- comparisons with their hospital colleagues
- pension consequences of changing to PMS contracts
- career moves into salaried posts
- mixed sector working

Pensionability of all NHS Earnings

14. As a general principle, GPs should be able to pension all their personal NHS earnings. Clearly, income from private practice and private contracts outside the healthcare sector and expenses ought to be excluded. But restricting GP pensions to GMS/PMS income could inhibit GPs from taking on wider responsibilities. The perverse alternative of older GPs undertaking only work that will generate income for their retirement would not be in the best interests of primary care services.

15. An argument against any extension in scope of GP pensionable pay is that it is analogous to "overtime", which is not generally pensionable. However, unlike final salary arrangements, there is no concept of a working week under the career earnings model. GPs can, and do, work full time in GMS and PMS alongside sessional hospital appointments. In these circumstances, high commitment in mid career should be rewarded in retirement. This is what the total earnings method is designed to do.

16. Pensioning current non-pensionable income would increase Scheme and employer costs. It would be more appropriate to consider the pensionability of all payments and the relative costs within the new GMS contract negotiations. Pension provision is an integral part of the overall remuneration package.

Earnings Up-rating Factors –"Dynamisation"

17. In the GMS system, Intended Annual Net Income (IANI) is the amount the DDRB traditionally sets as the appropriate level of GMS net income for the average GP. Career earnings are up-rated in line with the annual increase in IANI. This is known as "dynamising". Factors are produced by which each year's income is increased at retirement to give it a current value.

18. However, the GP GMS pay system is complex and new types of payment have not always been incorporated by the DDRB into IANI. Linking the indexation to DDRB increases should provide an assurance to GPs that their pensions will keep pace with the general movement in GP pay throughout their careers. But for the IANI link to work there must be consistency in the treatment of earnings over time and confidence in the underlying assumptions. Otherwise, GPs will continue to worry that their pensions do not adequately reflect the true movement of GP earnings over time.

Comparison with their consultant colleagues

19. GPs look to the relative value of their pensions compared, in particular, to hospital consultants. The latter are generally higher paid, with late career earnings boosted by pensionable distinction awards. As an occupational group this tends to make consultant pensions more expensive - on average 23.2% of pay against 20% for GPs. The BMA has claimed that increasing the GP pension accrual rate of 1.4% to 1.6% would achieve parity on value with consultants.

20. The current GP accrual rate of 1.4% compares with a 1.25% rate for scheme members, including consultants, pensioned under the final salary method. In terms of overall value and fairness the different rates are intended to provide broadly comparable pension returns. The NHS Pension Scheme operates under mutual assurance principles. It costs more to pension some groups than others but, essentially, all members and employers share the risks and cover each other by paying the same rate of contribution. The benefits package is the same for all NHS staff, despite the cross sector subsidies. Consultants get

relatively higher pensions because they earn more money than GPs and most other groups. It might also be the case that an increase in accrual for GPs to the rate suggested by the BMA would breach Inland Revenue maximum benefit limits.

21. Pension values result from different pay structures. While there might be arguments for equating the status of GPs with consultants that might not necessarily mean paying and treating them the same throughout their careers. Both may start on similar levels of pay but, thereafter, different career patterns can lead to wide variations and GP Principals, as self-employed contractors, enjoy other pension advantages under tax and pensions law.

22. When compared to other scheme members, GPs already fare rather well. Improving their relative position further would lead to pressure for improvements all round, not least from consultants. And there seems to be no obvious argument for giving GPs a pension edge over nurses and other members. Their accrual rate is already higher than the other groups. In the context of this stakeholder review, there would seem to be no case for improving the pension accrual rate of one particular group. It would seem more appropriate, therefore, to develop GP pensions in future wholly within the context of primary care changes and the new GP contract negotiations.

Personal Medical Services

23. Aside from ad hoc work at the margins of GMS, GPs are concerned that moving to permanent Personal Medical Services (PMS) salaried posts will devalue their existing pensions, which are based on their whole career average earnings. In the PMS pilot arrangements, existing GMS GPs were allowed to continue to use this method, but final decisions on the pension treatment of permanent PMS earnings have not been announced. However, to enable GPs to move freely between GMS and PMS without pension concerns, it seems right that both PMS GP providers and their GP performers should continue to be pensioned under the career earnings method.

24. GPs employed in PMS by NHS Trusts pose a more difficult problem, because all other Trust doctors have final-salary pensions. In the pilot arrangements new GP PMS Trust doctors, not previously pensioned under the career earnings method, are accruing pension rights on a final salary basis. Some may prefer this for the future, especially if they intend to continue to work in Trust based employment. However, the advantage would seem to lie in differentiating between Trust doctors employed on primary care PMS duties and those engaged in traditional hospital work because the former are much more likely to move on and pursue their careers wholly within the primary care sector. It would make sense in such circumstances to make Trust-based PMS doctors pensionable under the career earnings method, even where the employment is their first post after qualification. A single GP pension model would go a long way to encouraging mobility.

25. The meaning of a primary care practitioner would need to be defined for these purposes. This will be important if hospital doctors, who would otherwise be properly pensioned on a final salary basis, are not to be inadvertently disadvantaged if they do some work for their employer on the PMS contract. But clearly there will need to be future discussions with the professions on the final arrangements for PMS.

Career Earnings and Moves into Salaried Posts

26. For a GP, taking up a permanent salaried post, means switching from whole career earnings to final salary pension arrangements. This means that at retirement the GP will usually take a pension based on two separate components. When the employment switch occurs, the GP pension is frozen at that point and remains protected against increases in RPI. But set against annual DDRB salary increases, the RPI link will probably reduce the relative value of the pension over time. This could discourage GPs from taking up full-time salaried posts.

27. However, for the GP making the major career move out of general practice, for example, to a full-time public health post, conversion of earlier career earnings into final salary membership is not really practical. There is no concept of accruing membership in days/years for GPs. There would appear to be three possible solutions.

28. First, one way to avoid GPs being disadvantaged would be to index-link the preserved GP pension against salary increases ("dynamising factors"). In principle, it would seem justifiable to maintain the link to earnings where there is no break in employment or in scheme membership, just a change in the source of remuneration. Final salary members can always link earlier periods of service, and perhaps lower pay, with their later higher pay. And they can do so even where there is a significant break between the periods of employment. The GP pension would then be added to the benefits based on the final salary employment. The same principle might also be applied to former hospital doctors making a late decision to go into general practice.

29. Second, for doctors with mixed service who end their career in general practice all pension benefits could be based on the career average method. Or, third, for those who finish their career as hospital doctors, all pension benefits might be based on total membership and final salary. However, as noted above, it would be very difficult to base all pension benefits on final salary and total membership unless a method could be devised to ensure that earlier part-time GP earning did not attract whole-time calendar membership.

30. The ultimate option of retrospective choice of pension methods at retirement would be a difficult concept for a final salary scheme. There need to be safeguards to avoid selection against the scheme and, for long term funding, there has to be some certainty in assumptions made about future liabilities. Therefore, it is unlikely that a package containing absolute choice, would secure Treasury agreement but all the options should be fully explored and considered further in the context of developing primary care policies and new contract discussions.

Mixed Sector Working

31. At some time, most GPs will work outside GMS or PMS but do not move permanently to a salaried post. Where GPs are also employed by NHS Trusts under a contract of employment, for example, on a sessional basis, their earnings in that capacity may be pensioned under the final salary method. This leads to small separate pensions in addition to their main GP pension.

32. Often GPs complain that the relative value of these pensions is less than their main GP pension. They believe they should have the option of including their additional Trust earnings in the total career calculation, if this would produce a more favourable result.

33. It has already been said that, for a final salary pension scheme, retrospective choice runs the risk of selection, with members opting for the best pension return. But with hybrid career and different pension accrual, the variables can often only be determined at retirement, when it is possible to look back over the separate service patterns.

34. For the career GP, one who will always retain a commitment to general practice, it seems reasonable that there should be the option of full conversion of the final salary pension membership into GP career earnings calculations. In principle, this would allow GPs to convert early service in hospital-based posts and pension later periods of employment like sessional posts, under the best pension method. It would avoid, as now, GPs having to take very small, separate final salary pensions and encourage them to widen their service commitments.

35. There are issues around the retrospective effect of any pension changes that improve the position of past service. The primary concern of suggested changes for GP pensions is to facilitate greater flexibility and promote new ways of working. Any proposal must be mindful of potential Treasury objections but, in these particular circumstances, the

technical revisions suggested are intended to encourage GPs to fully participate in all those facets of healthcare delivery where their skills are valued and sorely needed.

GP Practice Staff

36. GP Practice Staff were admitted to the pension scheme on 1 September 1997. They were able to transfer in previous pension rights and buy added years of service at full cost but access was not made retrospective. Around 85,000 practice staff have joined the Scheme but they remain concerned that they do not enjoy the same employment rights as other NHS staff. They have no entitlement to the early payment of pension on redundancy or an unreduced pension on voluntary early retirement. Also, but outside the pension scheme, they are not covered by the NHS Injury Benefits Scheme.

37. These three particular benefits are not funded by normal employee or employer contributions. So, in that respect, they have the same basic pension package as all other members. Employers must pay for the separate benefits directly and, in many cases, particularly where there is long service, the costs can be significant.

38. So far, GPs, who employ their practice staff directly, are not prepared to take on the risks and potential liabilities attached to these extra benefits. But this leaves practice staff disadvantaged and NHS nurses, in particular, may be reluctant to move from a hospital base into primary care services if these aspects of the employment package are not available. GP practice staff were admitted to the Scheme to help facilitate the free movement between the two sectors in pursuance of the renewed emphasis on primary care healthcare delivery. Where practice staff become employees of Primary Care Trusts under developing policies, they would automatically be covered by the redundancy etc arrangements but, otherwise, practice staff will continue to regard themselves as second class citizens within the healthcare community.

39. Ministers have made it clear that they cannot support opening up the Scheme to practice staff for periods prior to 1 September 1997. However, it would make sense to review the current position on future access to redundancy, early retirement and injury as part of the new GP contract discussions with a view to seeing whether Primary Care Trusts would be able to assume the financial responsibilities.

40. Issue 12 - That detailed arrangements for GP pensions and those of their staff are considered within the new GMS contract discussion.

Consultants

41. The Government wants to develop the system of medical care in hospitals so it becomes a consultant delivered service. Consultants will have a critical role in transforming the services provided by the NHS, ensuring the delivery of high quality care to all patients.

42. To achieve this, apart from increasing consultant numbers, there will need to be a change in working patterns, with younger consultants bearing more of the burden of front line care. But it will be vital also to maximise the contribution of older consultants, though maybe in less demanding roles to ensure that their skills and experience are not lost prematurely through early retirement.

43. The careers of hospital doctors are much better suited to, and typical of, final salary pension arrangements. As juniors progress to consultant status, with the prospect of marked salary increases through discretionary points and the distinction awards scheme (and the proposed NHS Clinical Excellence Award scheme), the expectation is that they will receive their highest pay at retirement.

44. The majority of the current consultant workforce will have joined the scheme before 1 June 1989 and will not therefore be caught by the Inland Revenue earnings cap. In the next few

years, new consultants will increasingly be drawn from post-1 June 1989 new entrants and will be affected by the cap.

45. For consultants, therefore, pension concerns tend to centre around:

    - the impact of reducing commitment
    - taking lower paid posts near to retirement
    - pension for additional sessions and out of hours commitments
    - the earnings cap

46. New portfolio careers for consultants envisage three stages of development. Pay in the first two phases is likely to relate to uniform work patterns. As consultants move into phase three, possibly from age 55, it is expected that, subject to service needs, there will be more discretion over job content and greater scope for reducing workload.

47. Stepping down to a less demanding job provides an option to reduce pressures and responsibility whilst still making good use of skills and experience. But by “stepping down” consultants will probably see their pensionable pay go down. More flexible working in late career, and retaining consultants thereafter to age 65, will only be attractive therefore if they can be assured that their pension rights and expectations will be protected.

48. The Scheme already provides for protection. Any decision to reduce commitment or split responsibilities would have to be agreed with the employer. But on that basis the pension scheme would protect the years of membership and higher pensionable salary at the point of change. The “frozen” pension rights would be index- linked against inflation until retirement.

49. Consultants would continue to accrue pension rights but based on their further years of membership and later (lower) salary. At retirement, two separate pensions would be put into payment, although if the final salary at retirement had increased above the “frozen” salary, then all pension benefits would be calculated on that higher rate.

50. The current protection at stepping down, therefore, provides an assurance against pension reduction but does not deny consultants the right to link the “frozen” rights to later higher earnings, if their situation changes.

51. Issue 13 - that pension issues for consultants are considered as part of the consultant contract negotiation.

Nurses

52. The age profile of nurses means that in the coming years a large number will come into the retirement window. In March 2001, it was estimated that about 86,800 nurses were aged between 50 and 65. Historically, female nurses, midwives, health visitors and physiotherapists could take their pension from age 55. This right was withdrawn for new entrants from 6 March 1995 but older nurses in the current workforce retain these special rights.

53. The NHS Plan target (met in 2002) and the new expanded target, call for many more nurses to be employed in the NHS. While more student nurses and wider recruitment may provide the majority, it will be important to retain skilled and experienced older nurses. That will mean finding ways of encouraging nurses in their 50s to stay in work.

54. NHS Professionals will help discourage the haemorrhage to private sector agencies, with continued membership of the Scheme a clear inducement. But, for those nurses over age 55 who can access their pension benefits, the current abatement provisions may act to deter further NHS employment.

55. Although abolished for those over 60, the abatement of pension still applies before that age. Abatement means that a pension is reduced where the total of pension and pay in NHS re-employment exceeds the pre-retirement earnings. It does not apply where nurses take their pensions and find employment with nursing agencies.

56. Of the major public service schemes, only the NHS Scheme does not apply abatement of pension or salary after age 60. In such circumstances, it may be difficult to justify further relaxation to those who retire before that age. In practice, the average age of nurses who retire on age grounds is 60 so, in that respect, abatement may not be an issue. But for those who do take their pension between 55 and 60, the temptation might be to move to Agency work to avoid pension abatement rather than seek full-time re-employment in the NHS. The NHS can ill afford to lose the skills and experience of older nurses in its directly employed workforce. At the moment, though, there is no clear evidence that abatement is a barrier to nurse recruitment and retention. Nurses will cite other reasons, such as pay, work pressure and lack of flexibility and time to deliver quality care, for not wanting to work in the NHS.

57. In Chapter eight, the issues around abatement are discussed generally, but, in any considerations, the interplay of other suggested changes must be taken into account. For example, no abatement linked to further pensionable employment, would increase scheme costs significantly as it seems likely that most nurses would inevitably take their pension, and lump sum, before age 60, even if they were going to carry on working. Further concessions on abatement would also require a strong business case to Treasury. This would be particularly so for Mental Health Officer nurses who are entitled to additional membership credits at no extra cost.

58. **Issue 14- That the Department consider further whether the case for abolition of abatement can be justified on cost/benefit grounds or whether improving other pension flexibilities and family friendly policies is more likely to increase nurse numbers.**

Ambulance Staff

59. The incidence of ill health retirement of ambulance staff is the highest in all NHS employment groups. There is considerable evidence that front-line staff face health problems in their 50s after the stresses and strains of blue-light emergency and lifting work. Their representatives would favour an earlier retirement age of 55 in line with current practice in other emergency services.

60. With the early retirement age for nurses and Mental Health Officers withdrawn, it may be unrealistic to re-introduce such favourable terms for another occupational group, especially for one, which is predominantly male. And lowering retirement ages would be out of step with wider government plans for encouraging people to stay in work longer.

61. The genuine concerns of ambulance staff, though, need to be addressed and the recommendations of the Ill Health Retirement Review relating to occupational health and re-deployment should help. But there needs to be wider, and imaginative, co-operation between all Trusts if re-deployment, instead of retirement, is to be a realistic option. For example, skilled and experienced paramedics, unable to continue on front-line duties, might prove useful additions to hard pressed A&E units.

62. Where redeployment is not possible, then it is already open to employers to support an early retirement from age 50 at cost. They can also plan for and finance structured early retirement schemes through AVC arrangements. So far neither has proved attractive but that is not really surprising when the ill health retirement option, currently at no extra cost to employers, is available.

63. Although improved pension rights and an early retirement age have long been the preference of both Ambulance employers and staff representatives, the issues go far beyond the narrow field of pensions. Any consideration of the problems facing long-serving ambulance staff must start with future plans for the service and embrace wider employment issues, inter-related terms and conditions, the overall management of ill health, including health and safety, and integrated re-deployment and retention policies. A relevant pension package will be a key element but only within a co-ordinated employment policy for this important group, one based on the future needs and organisation of the ambulance service.

64. There have been previous studies and reports, notably the findings of a 1980s working group and the more recent Ambulance Services Report. But with the NHS Plan and new initiatives in the organisation and delivery of patient services, the position of the Ambulance Service and its staff needs to be reviewed in the context of operational requirements and good employment practice. Any consideration of these issues should ensure that "client" NHS trusts are represented along with policy leads with responsibility for operational services, employment and pay issues, workforce planning and occupational health policies as well as technical pension and actuarial advisers.

65. **Issue 15 - That, jointly with the Ambulance Services Association and Ambulance Staff Side organisations, the Department considers whether existing employment policies and practice fit the needs of a 21st century ambulance service and its integration in the delivery of modern patient services.**

Other NHS Staff

66. In all other occupational groups, employees face similar pressures in adapting to new ways of working in a continually changing NHS. Each wants more flexibility with age, to counter health and stress related problems and to extend working lives. Access to pension benefits while remaining in employment, without obstacle or financial detriment, is popular. So too is protecting existing pension rights on stepping down to lower paid or part-time jobs.

67. Not every issue though necessarily requires a pension scheme change. One example is a move to part-time working. Certainly, a reduction in hours in the years before pensionable age will affect the level of pension. But as pension salary calculations are based on the whole-time rate for the job, the impact is in the reduction in membership credit, not necessarily the pensionable pay figure. And, of course, if the alternative was retirement, then going part-time with further pension entitlements will enhance, rather than reduce, the benefits which otherwise would have been taken.

68. The Agency has tried to get the right messages across in "Flexing Retirement" guidance to address the misunderstandings and misconceptions but the issues around part-time working and winding down may still not be fully understood.

Conclusion

69. This Chapter highlights both the strengths and weaknesses of the present scheme. On the one hand, the core pension package underpins the basic employment contract - excellent value for money by any standard. But expectations are high, and many see the scheme as unresponsive, unable to adapt to the changing needs and demands of the various occupational groups.

70. Final salary schemes by their nature are invariably bound by mutuality and shared risks, with choice and flexibility come higher costs and perverse incentives. Possible candidates for change are identified and discussed in more detail in the next chapter.

CHAPTER EIGHT: SCHEME CHANGES: SHORT AND LONG TERM OPTIONS

Introduction

1. The NHS Plan has concentrated minds on increasing the number of NHS staff to deliver faster, more responsive services. And not just recruiting new staff but retaining the services of skilled and experienced older staff.

2. Good pension arrangements are an important, attractive and valuable part of the remuneration package, a factor in career and employment choice. But they are unlikely to be the deciding factor at entry. Most young recruits will not think of pensions, and planning for retirement will be far from their minds. But over time, pension provision and protecting pension rights becomes more and more influential in career and retirement planning.

3. The newly published 'HR in the NHS Plan'[11] provides a clear workforce strategy. It covers a wide range of issues and pension arrangements need to be considered in the context of the strategy. In looking at scheme improvements, therefore, it must be clear how changes would offer value in increasing staff numbers, enhancing workforce planning, supporting new ways of working, underpinning organisational change and improving working lives.

4. This report has already underlined that different occupational groups face different challenges. Untargeted scheme wide changes may not be appropriate, therefore, in the context of new contract discussions, pay and conditions reviews, revised working practices and sector change. Some options might, especially those of a social and family nature, but increasingly pension changes, where affordable, will need to be based around clear business agendas and introduced in circumstances where they can clearly be self-contained. And by the very nature of the pension scheme itself, that is not an easy proposition.

5. Against that background, this Chapter looks at two key areas:

   - pensions as an aid to retaining older staff in the workforce and facilitator of new working practices. A number of possible scheme structural changes are discussed as short term options and their effectiveness considered. These measures could be applied to overcome particular recruitment or retention problems.

   - Improving the benefits package. The proposals considered here would have scheme wide implications and it is difficult to see how their application could be contained within individual groups or for a limited time.

   There is already scope for members and employers to fund extra contributions voluntarily.

Possible Scheme Structural Changes

Retirement and membership conditions

6. Following the 1995 restructuring, the current scheme is more clearly designed around voluntary retirement. Members choose when they want to "retire" and take their benefits, and they can do so anytime from age 50. Before age 60, they may only get a reduced pension but from age 60 there is full entitlement to a pension.

7. A condition of taking a pension though is that there must be a break in employment and no return in a full time capacity for the next month. Otherwise the pension is suspended. Re-employment is not pensionable but, from age 60 at least, further NHS earnings have no effect on the level of pension payable.

[11] HR in the NHS Plan – More staff working differently. DH. July 2002

8. The project team considered whether relaxing the retirement conditions, with the further accrual of pension rights in re-employment without abatement, would help recruitment and retention policies. At first glance, these appear attractive options. Access to pension benefits at age 60 without actually retiring might encourage staff to remain at work longer. And being able to earn more pension benefits in re-employment might attract more retired staff back into the NHS.

9. However, the downside of these proposals is that they risk unwelcome behavioural change and could introduce perverse incentives. If members could access unreduced pensions at 60 and continue to accrue further pensionable service, then it seems likely that most people would do so. Also, access to extra income might encourage part-time working at a time when the supply pool needs to be increased. In some cases, it might actually bring forward final retirement dates. Investment of the retirement lump sum, and saving the pension while in full time employment, might encourage key NHS staff, who may have stayed on to age 65 or beyond, to bring forward their final retirements by a year or two.

10. At present, the average age at which pensions are taken on age retirement is around 62.5 for GPs, 62.5 for consultants and 60 for nurses. The Government Actuary has estimated that access to pension at 60 without a formal retirement condition would bring forward scheme costs at around £720 million a year.

11. It would be possible of course to maintain the current retirement conditions for accessing and paying pension benefits but allow scheme members to accrue further pensionable service in re-employment. NHS employers now offer a Stakeholder Pension to re-employed pensioners but without guaranteed employer contributions. Further accrual of NHS benefits would increase employer costs, therefore, and it is speculative as to whether further pension accrual would induce more retired NHS staff to come back into employment. As re-employed pensioners can already earn a full salary and receive their pension at the same time, an extra bit of pension at final retirement based on their further employment may not be an overwhelming and decisive factor.

12. Paragraph 38 of this chapter refers to the work being done around government on the future of retirement. That work is expected during the summer of 2002 and will be influential in decisions on scheme structure. For example, pension schemes operate under licence, so to speak, from the Inland Revenue who determine the underlying basis on when and how pensions should be paid. Changes to the tax regime around retirement rules are key to wider structural reform.

13. Despite staff representations, there is no evidence of early advantage to the NHS in changing the current NHS Scheme's retirement rules. With the abolition of abatement in all circumstances after age 60, Treasury will not sanction further reforms that would allow easier access to NHS pensions unless there were clear offsetting value for money and business returns. As yet, there is no persuasive evidence that relaxing the retirement rules would increase the overall supply position. There is insufficient evidence also to link the further accrual of pension benefits for re-employed pensioners to extra recruitment gains.

14. The NHS needs to respond to changing demographic and employment policies and retirement rules will need to reflect changing workforce pressures. For the future, all employers will need to move towards phased retirement options. Reforms to over-riding pensions and tax law would be needed to facilitate more flexible arrangements. As early retirement becomes perhaps a less attractive option for members and employers alike and both seek to prolong working lives, the future relationship between pension access and continuing employment needs to be clearly determined. This would need wider government and industry co-operation and agreement.

15. **Issue 16 That the NHS Scheme should not restructure the current retirement rules, including post-retirement options, until there is wider agreement within government on the extent to which occupational pension schemes can, and should, respond to the longer term issues around retirement.**

Higher accrual for deferred retirement

16. In many pension schemes, pension deferment results in increased accrual after normal retirement age. Such increases though are usually modest to reflect the balance of pension saving and investment returns against higher final salaries. The principle appears sound and that consideration should be given to increasing accrual rates after age 60. The question is by how much?

17. One suggestion is that that increasing the pension accrual rate from 1/80th to 1.5/80th for each year after age 60 will help retain key staff. The BMA survey suggests that GPs, for example, would find this an attractive proposition and would be more inclined to stay on. But, equally, some who would otherwise have stayed anyway, and to 65 and beyond, would reach their target pension rate quicker and probably retire earlier.

18. Increasing post 60 accrual by 50%, even for key groups, like doctors and nurses would have considerable cost implications. Based on those doctors who are already aged 55 or over capitalised costs would be around £238m - £92m for GPs and £146m for other doctors. This would add about 0.1% to the contribution rate for all NHS employers over 15 years. The capitalised cost for similar higher accrual for nurses would be £205m, adding 0.9% to employer contribution rates.

19. Faced with those potential costs and the uncertainty on gains to the supply pool, it may be difficult for Ministers to see justification for an across the board increase in the accrual rate after age 60. The option of targeted and time-limited proposals for key groups might be considered where there is clear evidence that this would improve retention of older staff and offer value for money. But structural scheme changes for individual employment groups may be difficult to implement and they would certainly increase administrative complexity.

20. An across the board higher accrual for all scheme members who defer their retirement beyond age 60 would be more consistent and in keeping with wider practice. But the level of graduation acceptable to scheme actuaries and the Treasury, without further funding, is likely to be small. It is often assumed that, because the retirement age is 60, the scheme is funded on the basis that members will retire at that age. So if they delay retirement, the scheme makes a profit. That is untrue. The Government Actuary sets the Scheme's funding requirements on assumptions made in the light of actual retirement experience.

21. Another important consideration though, and a recurring theme perhaps, is striking the right balance between the potential for change in the current Scheme and the wider opportunities that may be afforded by a major and radical restructuring of the whole benefit package; a full re-packaging of benefits with different accrual options might be an attractive feature of any new Scheme.

22. As higher accrual factors are inextricably linked to proposals for changes to the retirement rules and employment retention policies, it follows that that any proposal for scheme–wide changes should only be considered in the context of more radical and longer-term structural changes. Higher accrual for certain groups is not ruled out where this is affordable, justifiable on business grounds, in keeping with equal treatment requirements and could be "ring-fenced" as a matter of contractual agreement. Although in such circumstances, provisions might be time-limited, and/or discretionary, to avoid giving younger members continuing statutory rights that may not be appropriate or relevant to employment situations in the longer term.

23. **Issue 17. -That where clear supply gains could be linked to affordable costs and "ring-fenced" provisions, then the use of short-term or time-limited pension inducements around higher accrual should be considered. But these should be developed within contractual arrangements with due regard to equal treatment requirements and the wider policy agenda.**

Best of the last three years

24. NHS Pension Scheme benefits are calculated by reference to length of membership and the best years' pensionable pay in the three years before retirement. This is just one of several methods available to final salary schemes and even those using the best of the last three years' approach have different methods of calculation.

25. The Inland Revenue allows schemes further options to calculate final penultimate earnings. First, schemes can go back over a 10-year period prior to retirement and look at blocks of three consecutive years. But rather than simply take the highest year, the earnings in the three consecutive years need to be averaged. In the calculations, pay in earlier years is increased by RPI for comparison against the final salary at actual retirement.

26. Alternatively, schemes can simply look at the five years before retirement and choose the actual best year.

27. For the vast majority of scheme members, and with normal career progression, the final years' pay is the best year. Some people, however, may achieve their highest earnings at an earlier age. Overtime is not pensionable so it is usually people who have either stepped down at some point to a lower paid job or worked job patterns that have boosted pay in particular years with additional pensionable allowances.

28. Where stepping down is involuntary or part of contractual review and agreement with the employer, pension protection at the point of step down seems appropriate. But final salary schemes by their nature need to safeguard against pension boosting or selection against the scheme. And, in turn, they should not be putting members into situations where contributions are paid on earnings that are unlikely to feature in final benefit calculations. That is why overtime is generally not pensionable.

29. It has been suggested that assessing final salary over an extended period, that is the 10 year method, would introduce greater scheme flexibility and reassure members that their pension would actually be calculated on their best years' pay. But would this really have any great material impact? Over the past 10 years, for example, salary increases for doctors have outstripped PRI by, on average, 1% a year. This means that the higher pay figure in year 10, increased by RPI, is unlikely to be higher than final salary unless the level of pay after year 10 was substantially reduced. That seems unlikely for most people and stepping down protection arrangements could adequately deal with other situations.

30. The 10 year rule is used by the Universities Superannuation Scheme (USS), a scheme of around 90,000 active members. But unlike the NHS scheme, USS does not have alternative pay protection arrangements on stepping down. In practice, few USS pension awards are based on other than the last years' pay.

31. USS has modern computer and payroll systems designed to cope with different assessment periods. NHS Pensions Agency systems re-engineering is on track to deliver computer enhancements by 2005. With the size of the scheme and 10,000+ employers, it would be unrealistic to consider a radical change in benefit calculation before new systems were available, particularly the link to employer payroll via the HR Shared Services project. That also is unlikely to be available before 2005.

32. One other suggestion is that irregular or fluctuating payments and allowances should be pensionable. The Inland Revenue allows "fluctuating emoluments" to be assessed and

averaged over periods of at least three consecutive years ending with the final year used in the calculation of the best years' pay for the basic pension. For most people, irregular payments attach to higher commitment and usually therefore to early or mid career. It seems unlikely that the best three years' averaging would occur after age 50 and this would mean a poor return for members paying contributions on all their fluctuating payments in their high activity early years.

33. Currently, the calculation of "fluctuating emoluments" would have to be linked to the best of the last three years' pay, even though the assessment period may go further back in time. An earlier link would require structural change in the basic pension calculation or the introduction of hybrid arrangements under which fluctuating payments were pensioned under a career averaging scheme. But increasing the level of pensionable pay would increase employer liabilities without any clear business gains. It may make more sense to leave members to find alternative ways of investing fluctuating payments, through AVC or other savings plans.

34. Calculating pensions over longer assessment periods would have major administrative, systems, cost and resource implications for employers and the NHS Pensions Agency. And introducing new arrangements that might actually only significantly benefit relatively few members would be unjustified. It would also not make business sense to consider such radical restructuring until longer-term options have been fully reviewed.

Stepping Down and Extending Working Lives

35. Both employers and staff are keen to develop flexible employment practices and policies that will reduce burnout, value the skills and experience of older workers and prolong working lives. Pension schemes need to respond to the same challenge. But at the moment there are some inconsistent messages around and it is necessary to strike the right balance between flexibility and early access to pension rights and policies, which encourage retention.

36. EC Directives will ban compulsory retirement ages and, in earlier EC considerations, there has been the suggestion that pension schemes should be restructured to discourage early access to pension benefits. On the other hand, there have been plans within government to facilitate draw -down of pension in continuing employment with a view to encouraging older employees to remain at work.

37. This latter work follows on from the Policy Initiative Unit's Report, 'Active Ageing – Winning the Generation Game' which has suggested changes to the rules for accessing pensions. The idea is that from, say, age 50, all pension scheme members would be able to draw part of their future benefits, on an actuarially reduced basis, as income, whilst continuing in employment. The income would support stepping down if required and, within limits, members would remain able to build further benefits. There are still a number of unresolved issues and it is believed that a joint DWP/Inland Revenue working party is considering all the issues with the National Association of Pension Funds (NAPF).

38. Public Service Schemes collectively, under Treasury stewardship, intend to review all the issues around the future of retirement, in the context of the PIU report, EC Directives, Inland Revenue rules, integrated employment policies and prolonging working lives. Within the NHS, the "Flexing Retirement" initiative under the IWL umbrella has publicised existing flexibilities and further step down provisions on the Teachers' model (see paragraph 47) can only help encourage longer working lives and the phasing of retirement.

39. Within any final salary scheme, and certainly a statutory scheme as big as the NHS, there is a limit to the degree of flexibility members can enjoy. The NHS scheme already embraces a range of flexible options – voluntary early retirement, additional voluntary contributions, choice about retirement and part-time options – and further untargeted refinements may not be appropriate. Pensions alone are not the answer to either

improving or extending working lives. They have a part to play, obviously, but only within a co-ordinated employment and remuneration package.

40. As stated earlier, until there is a clear consensus within government on the future of retirement and agreement with the Inland Revenue on the scope for tax-related pension changes, major Scheme structural change around retirement seem inappropriate.

41. However, it is clear that whatever policies are developed on extending working lives beyond age 60/65, there is a need to consider the position of those members who, to prolong their working lives, want to step down from higher responsibility posts once they turn age 50.

42. Here then, stepping down relates to employees reducing their commitment in later years or taking a lower paid job on health grounds or as a result of organisational change. In final salary schemes, unless protections are in place, stepping down more than three years before retirement or a pension event usually means taking a lower pension than might have been expected.

43. The NHS Scheme already has provisions to cover the situations described above that would protect pension rights accrued on higher rates of pay. It has been discovered from the work on Flexing Retirement, however, that generally they are little known and then often misunderstood. This report has highlighted the fact that work is ongoing to make sure that employers and members are better informed but here stepping down is discussed in a wider context.

44. At the moment, the Scheme's protection arrangements link the higher protected salary rights to RPI indexation. Pension accrual on the lower salary continues and at retirement two different calculations are done. Pension benefits based on the protected rights plus those accruing from the further lower salary service are added together and compared with a calculation based on all scheme membership and the actual final salary. The better of the two levels of benefit is paid.

45. The further away from final retirement the stepping down occurs, the more likely it is that the lower salary will increase above the level of the protected pay. Over the last ten years, for example, salary rises have generally outstripped RPI by an average of 1% a year for some employment groups. Where this happens, protection has no advantage other than the security it brings at stepping down that the level of pension will never be less than the value of the accrued rights.

46. However, where stepping down occurs nearer final retirement but outside the "best of the last three years", the protected pay linked to RPI will usually be higher than final salary. Though pension benefits will take account of the protected salary in such circumstances members may feel that being forced to step down has reduced the level of pension they might otherwise have expected.

47. There have been calls to allow members, who step down, to be able to continue to accrue further pension benefits on the higher salary. Pension accrual on notional pay (pay based on higher former salary) runs contrary to the government's general policy under which, for example, staged pay awards are not fully pensioned. But there is an example, though, in the Teachers' Scheme of continued pension accrual on a higher, former salary. The arrangements were put in place for use, principally, by Head-Teachers, or Heads of Departments, who want to step down in late career to classroom duties. The facility offers a genuine alternative to early, or possibly ill health, retirement and helps with teacher supply.

48. Since the provisions were introduced in 1998, almost 700 teachers have made elections to pay contributions on their former level of pay. It is not clear though as to how many of those teachers have been supported by their employers in meeting the employer contribution cost. If the employer does not contribute, the teacher has to pay both the member and employer contribution – currently 13.4% - on the "notional" pay.

49. It might be worthwhile to consider the Teachers' option further. There are some basic conditions, the main ones being that the teacher must:

    - be aged 50 or over when the reduction in salary occurs
    - have served in the post of higher responsibility for at least 5 years
    - elect to pay extra contributions within three months of stepping down
    - take up the lower paid post within 12 months of leaving the higher paid job
    - not be in receipt of pension benefits from the Teachers' Pension Scheme

50. The higher former salary is indexed-linked by RPI but contributions are not refunded in cases where the actual salary exceeds the adjusted former salary at retirement. The teacher has had the benefit of insurance cover on the higher salary for death and premature retirement in the intervening period. However, unless step down is relatively near to final retirement or the pay differentials are marked there may be little advantage in taking up the option.

51. Although the current NHS arrangements offer a reasonable measure of protection, at no extra cost, a further enhancement on the lines of the Teachers' model could offer NHS staff greater flexibility. The Teachers option included consideration on whether the index linking of the former salary should be to pay increases rather than RPI. The Teachers Scheme rejected this in the context of a scheme-wide change.

52. Although with Review Bodies, there might be some degree of pay increase standardisation within certain groups, on a scheme-wide basis it is unlikely that there would be a common annual figure by which to increase a particular salary. Administratively, the NHS Pensions Agency could not operate an individual annual increase system. Also, with pay delegation, performance related pay and other local pay discretion, it would be impossible to track how much an individual would have been paid had they stayed in their former post, especially if they had since changed employer.

53. Issue 18 - That pension scheme changes to foster more flexible, phased retirement should await the outcome of wider reviews within government on the future of retirement and the relevant tax regime.

Abatement

54. In Chapter seven, in relation to nurses, paragraph 57 confirms that abatement of pension in re-employment still applied up to age 60. Apart from those members of the special classes – nurses and Mental Health Officers – who retire before age 60, abatement also applies to those returning to the NHS following redundancy, interests of efficiency retirement or Voluntary Early Retirement (VER) where the employer consented to meet the cost. Abatement does not apply to those who have actuarially reduced pensions.

55. The Treasury has recently advised the public service schemes that the Chief Secretary is prepared to see the blanket application of abatement relaxed where there are clear business grounds for doing so. Schemes and employers would have to justify a relaxation in any particular case and meet fairly strict criteria. The move is aimed at schemes that apply abatement after age 60 but it might be possible to allow employers to waive pension abatement before that age in the NHS where, in particular, it would help retain nurses.

56. The report flags up as an issue whether a robust value for money case can be made for nurses. For other members who take their pensions before age 60, it is doubtful whether

any general relaxation could be achieved. These members will have been retired with their employers financing the early retirement pension costs. In such circumstances, it would be difficult to convince the Treasury that, having retired someone on an unreduced or enhanced pension before age 60; it makes sense to pay even more to get them back. For Treasury and others this would be seen as a waste of public money.

57. It would be necessary to demonstrate to Treasury that, amongst other things:

- there were clear business objectives in terms of improving retention or outputs
- the value for money case was robust
- comparability claims were defensible with no read-across to others
- the scheme actuaries approved and had costed the full effects of the proposal
- alternative ways of meeting the business objectives had been considered and rejected

58. It may be possible to consider a temporary relaxation in the abatement rules to meet particular supply problems, e.g. where the absence of key staff needs to be covered for a short period. Treasury would need to be satisfied as to the temporary nature of the relaxation and guarantee that there was no underlying obstacle to reversing the easement once granted. And Treasury would insist that special waivers for individual members would need to be justified by Departmental Ministers on the basis of exceptional circumstances.

59. No evidence was found to support a case for a temporary relaxation in the abatement rules to resolve general supply problems. This is an issue for workforce planners to consider.

Improving the Benefit Package

Death benefits

60. The Scheme pays a benefit of twice salary for death in service. In broad terms, the Inland Revenue would allow the scheme to pay a tax-free death gratuity of four times salary. Members can buy the extra cover through voluntary additional contributions under the in-house Money Purchase AVC arrangements. And, unlike premiums to other forms of personal life assurance, such contributions attract tax relief and are deducted through payroll. NHS Trusts can also set up premium-based local additional life cover through private sector companies.

61. NHS Scheme life benefits are currently in line with those of other public service schemes but in the private sector, death benefit levels are generally higher. Around 45% of private schemes pay four times salary, with an equal number paying three times. But, of course, death benefits are only one feature of a pension scheme and, in other areas the value of NHS pensions may be better. Final salary pension schemes offer an overall package and have to strike a balance between benefit levels and affordable costs. Both members and employers have to decide what features are important to them and how the overall remuneration package should be structured. Nevertheless, it is clear that in this particular respect the NHS, and the public service, has fallen behind private sector provision.

62. There would be no scheme design issues around upping the level of death in service benefits. It would simply be a case of amending the existing provision to increase the salary relationship. There seems to be no groundswell for change as a preferred option and members can voluntarily up their cover if they wish. Any improvements could be considered in evaluating the case for general restructuring of the benefit package.

Making all pay pensionable

63. Apart from practitioner groups, NHS pensions are based on final salary – the best of the last three years' approach. For the vast majority of members this ensures that their pensions are based on their highest pay or perhaps, more precisely, the highest pensionable pay. Normal career progression will usually see salaries rise proportionately over time and final salary at retirement will normally exceed the pay in earlier periods, even

when overtime pay has been earned. Increasingly staff may step down in late career but, with protections in place, the final salary method is still likely to produce the better pension result.

64. If current non-pensionable elements of pay – overtime, additional sessions, non-pensionable allowances etc – were to be pensioned, then members would expect to see a reasonable rate of return for contributions paid. Overtime, for example, is generally earned in early to mid career when employees are young and fit enough to work irregular and intensive working patterns and long hours, whether by choice or not. Unless all NHS pensions were based on a career averaging method, or hybrid method, members and employers would pay contributions on earnings that would not improve their benefit calculations.

65. This section explores how it might be possible to include certain items that are currently non-pensionable within pensionable pay. Although it might be possible technically to run two accrual methods side by side there would need to be clear value for money gains for both employers and members and workable administrative arrangements. Overall, pensioning all NHS pay would add significantly to scheme costs, and however much members might want to increase their pensions, and pay their share, there seems no justification for potentially diverting resources away from direct patient services.

66. There is scope within “Agenda for Change” or contractual reform to rationalise pay arrangements, including the appropriate level of pension provision. But generally there is no advantage in widening the definition of pensionable pay. There is already scope to members to pension them through additional voluntary contributions.

Completing 40 years service before age 60

67. In the past, there have been occasions when members have earned 40 years membership before age 60, usually around age 58. It probably happens less today as the true 40 years’ career pattern become less evident. However, because the Inland Revenue does not allow more than 40 years pensionable service to count at age 60, the affected members feel aggrieved that they must continue to pay contributions for no extra membership credits.

68. Members can choose to save on extra contributions by opting out of the Scheme. But they would lose some life insurance cover and their benefits might not reflect any increases in salary above price inflation. That might not matter if they intend to retire at age 60. And if they proposed to stay to age 65, they could opt back in at age 60 and earn a further 5 years membership, linking their earlier service to actual final pay. But opting out would mean paying higher National Insurance contributions, even though they would secure benefits under the State Second Pension scheme.

69. It is not uncommon in private sector schemes for contributions to cease when 40 years has been completed. If this was to happen in the NHS scheme there would probably be a relatively small addition to employer contribution but accurate costing is difficult because of the way scheme valuation data is grouped. On practicalities, it would also be difficult for employer payroll systems to identify those approaching 40 years scheme membership. Also, at least currently, NHS Pensions Agency systems updating would mean delayed recognition of over-funding and lead to refund payments.

70. The option of continuing accrual might be possible if account could be taken of non-pensionable earnings, which can be included in the Inland Revenue definition of final remuneration, but that would have to be done on an individual basis. This would increase administrative complexity and would be a more costly option than discontinuation of member contributions. In the current climate though, this can hardly rate as a priority issue. It seems much better to take this forward as part of general discussions on how the NHS Scheme should incorporate Inland Revenue limits within its future benefit structure.

Differential Contribution Rates

71. Scheme members in manual grades pay contributions at the rate of 5% of pensionable pay. Non manual members pay a 6% contribution rate. At the 1994 scheme valuation, about 12% of active members were in manual grades but their pay represented only 7% of total pensionable pay for all members.

72. Manual staff have paid lower contributions because, traditionally, they have had flatter pay scales with limited career progression. Final salary schemes favour those with stepped career patterns with earnings rising progressively over time. Also manual workers tend to have lower earnings levels and, discounting overtime, perhaps disproportionately less pensionable pay. A lower contribution rate may make the scheme more affordable but there is anecdotal evidence that opt out rates are still higher than for other groups.

73. In the Local Government Pension Scheme (LGPS) differential 5/6% contribution rates have been equalised for all new members at 6%, with existing manual staff paying 5%. This helped in funding a scheme restructuring. The NHS has the option of status quo, equalising at 5% and equalising at 6%, though any change really ought to be considered in the context of wider structural redesign.

74. If the NHS contribution rate were equalised at 5% then this would add around 1% to the employer contribution rate, increasing employer costs by about £180 million annually. And, of course, lowering the rate for nearly 90% of staff would effectively give them a pay rise whilst maintaining the same level of pension cover.

75. If the contribution rate were equalised at 6%, in the same way as for LGPS, then manual staff might be disadvantaged even if the benefit package was restructured. Also, new staff would pay more, reducing take home pay. And though the Scheme would get extra contribution income the overall cost could be expensive. If current manual staff had to pay 6% they might expect a compensating pay rise and it might be difficult to restrict this to scheme members only. But pay modernisation models might facilitate this. Also, a pensionable pay rise would add to scheme costs. And a higher rate would reduce the scope for manual staff to pay additional voluntary contributions from 10% to 9% of pay.

76. **Issue 19 - That equalisation of member contributions should be considered as part of any Scheme restructuring but only if the position of manual staff is protected so they do not end up financing improvements for higher salaried career groups.**

Added Years

77. There is a general consensus that the current Added Years arrangements are too inflexible and expensive, with the member having to pay the full cost of extra membership. A working group of scheme managers, employer and member representatives has considered a number of options to facilitate stop/start arrangements, flexible payments and variable membership credits. One real issue for the group, however, is that standard industry mortality tables combined with scheme actuarial assumptions suggest higher cost factors compared with existing rates. Further work needs to be done to confirm the underlying assumptions but, presentationally, if rates do have to go up, it may be difficult to persuade members that higher factors are linked to people living longer and not to greater flexibility.

Conclusion

78. This Chapter examines a number of options for scheme structural changes to support NHS Plan initiatives. Relaxing retirement rules, pensionable re-employment and higher accrual rates have their supporters and each has its own merits. But in supply and value for money terms, there is no clear-cut business case for recommending changes at this time. Higher accrual rates are not completely ruled out as a retention tool but they should only be

introduced with tight controls and on a time-limited basis, if at all. There is no objective justification for introducing general across the board improvements, with statutory protections, when wider pension policies within government remain undecided.

79. The time is not right, particularly in relation to changing the basis of calculating final salary, to introduce major structural changes when they sit at the heart of any longer term considerations. It would seem much better to look at the case for more radical restructuring first, in the new Scheme option, and certainly before new administrative and system processes were developed.

80. Abatement of pension is a source of much resentment but it is a feature of public service pensions. It is a Government policy designed to avoid the excessive payment of pay and pension where there has been a significant employer, and therefore taxpayer, contribution to pension accrual. The NHS has managed to abolish abatement for those over 60 but a robust business case would need to be made to extend abolition to early retirees. The Treasury may be more willing to listen to a case for the temporary relaxation of abatement to support NHS Plan targets but the Department would need to demonstrate clearly the supply gains on value for money grounds.

81. The issues discussed in paragraphs 61 to 78 of this Chapter would form part of any new scheme considerations. It is difficult to see how the current scheme could incorporate most of them on a cost neutral basis. Ill health retirement and Added Years changes will need to be considered both for the current and existing scheme but the others are more critically centred on scheme restructuring.

CHAPTER NINE: PENSION SCHEME OPTIONS

Introduction

1. In this Chapter, the basis of the current NHS Pension Scheme is compared with some other possible alternatives. In any consideration of a new scheme option, it would be essential to examine and explore the different ways of providing staff pensions to decide which would best suit the needs of a modern and developing service. Not just for the short-term, or to meet necessarily current member aspirations, but to develop flexible arrangements that would support future employment policies and underpin further NHS structural change.

2. Pensions are a long-term business. Decisions taken today could impact on taxpayers forty years on or more. Of course, schemes can be changed over time to reflect emerging needs but, with statutory protections, pension rights cannot be withdrawn for past periods. For example, tens of thousands of NHS mental health staff today still enjoy special, and costly, early retirement rights that originate from the Asylum Act 1909 and were designed for working conditions that have long since disappeared. Those arrangements, though now withdrawn for new entrants, continue to apply at a time of supply shortages.

3. It is difficult, of course, to predict with any certainty either the long-term structure of healthcare delivery, the future basis of pension provision or the shape and responsibilities of the public sector. The current private pensions market is also an influencing factor and is currently volatile. The next few years are likely to bring more flexible and family friendly employment practices, changing social attitudes, higher retirement ages over time, a steadily increasing longevity and, inevitably, increased pension costs in the future. The design of any new Scheme would need to take account of all these things, and more. The following sets out some broad structural options.

Defined Benefit Schemes

4. These schemes offer members a defined benefit package for a standard fixed contribution. Employers contribute to a level required to meet the balance of scheme benefit liabilities. Pension benefits are normally related to years of scheme membership and final salary on leaving employment. After leaving employment, benefits are increased in line with inflation, at least to a statutory minimum of 5% or the Retail Price Index for the relevant year, if lower. Total benefits must not exceed two thirds of final gross salary, as defined by the Inland Revenue. Total member contributions to the Scheme, including any voluntary contributions to increase benefits, are restricted to 15% of gross pay for each tax year.

5. This type of scheme can be less generous to early leavers than some other forms of pension provision, as design and funding is geared to long service and final retirement. Younger employees with wider career ambitions might be better suited to more flexible pension plans. Where members have several concurrent employments, or a series of contracts, or frequent breaks in service, or may step down to lower paid work, final salary schemes become not only more complex to administer but also there is the increased risk of devalued benefits.

6. Schemes may offer different accrual methods within Inland Revenue maximum contribution and benefit limits. For example, they might be:

80ths final salary schemes

7. The NHS Pension Scheme is based on 80ths, with pension and lump sum accrual rates of $1/80^{th}$ and $3/80^{th}$ respectively, of pensionable pay for each year of membership. This is broadly equivalent to a $1/60^{th}$ pension accrual rate, based on a commutation factor of £9 cash for each £1 per annum of pension commuted. Dependants' benefits are usually based on the level of members' actual pension.

60ths final salary schemes

8. 60ths schemes broadly provide Inland Revenue maximum benefits of 2/3rd of gross pay on completion of 40 years' membership. Around 70% of private sector schemes have a 1/60th pension accrual rate with the option to commute part of the pension into a tax-free lump sum. Commutation terms vary but currently tend to lie in the range £10 to £15 cash for every £1 per annum of pension commuted and are limited to £12 for every £1 for people with full careers (40 years). Dependants' benefits are usually based on the uncommuted level of pension, giving an accrual rate of 1/120th for each year of membership compared with 1/160th in the NHS Scheme.

Defined benefit revalued career average schemes

9. In these schemes, benefits are based on a proportion of the employee's total pensionable earnings over the period of membership. The earnings from prior years are revalued by an index; usually reflecting average earnings increases. The cost of benefits is less sensitive to salary changes in the period before leaving and can therefore be seen to be fairer. In the NHS, the benefits of general medical and dental practitioners are calculated on this basis. The Inland Revenue contribution and maximum benefit limits for career average schemes are broadly the same as for final salary schemes.

10. This type of scheme is well suited to employees with fluctuating earnings, concurrent employments or more modest salary growth. However, they are less beneficial to "high flyers" with significant salary progression and employees promoted late in their career. An adjustment to the accrual factor might compensate but this would be difficult to apply on an individual basis. Also, revaluation would need to be in line with a readily available index like 'national average earnings'. However a national earnings index might not be representative of NHS earnings or individual NHS employment groups.

11. A career average scheme would be simpler to administer but would perhaps provide less assurance to members. Even if a scheme was introduced with an overall value the same as the current NHS scheme, this could only be equivalent on average. There could still be significant winners and losers.

Defined Contribution Schemes

12. Defined contribution schemes may be set up as occupational money purchase pension (OMPP) schemes, group personal pension (GPP) plans or stakeholder pension (SP) schemes. They operate generally on the basis of the employer and the member each paying an agreed percentage of pensionable pay into the scheme. Contributions are allocated to individual member accounts and, at retirement, the accumulated investment returns provide cash and pension benefits. Member contributions to the scheme in any tax year are limited to15% of gross pay but there is no limit on employer contributions. Inland Revenue benefit limits for approved OMPP schemes are the same as those for final salary schemes.

13. In this type of scheme, the member, not the employer, bears the risk of poor investment returns and/or low annuity rates at retirement, both of which will reduce the level of final benefits. Conversely, employees will gain if these factors prove favourable. Benefits are based on the contributions paid and investment returns achieved, so there is no penalty for early leavers but separate death and ill-health benefits cover is normally necessary.

14. Members with fluctuating earnings may be more suited to defined contribution schemes. And they can be better than a final salary scheme for those with limited salary growth. However, they are likely to be less beneficial to "high flyers" and those promoted late in their careers where there would be little time for investment growth on the contributions paid on the higher salary.

15. Despite the uncertainties, some final salary pension scheme members may favour a defined contribution option. As benefits at retirement are purchased from the member's own fund, more individual choice and greater flexibility is afforded. This means that single members, for example, can maximise or tailor their personal benefits. And members can choose their own level of pension indexation to meet their individual circumstances.

Cash Balance Schemes

16. Cash balance schemes are uncommon in the UK but are becoming popular in the USA. Member benefits are determined by the accumulated value of individual notional accounts. For each year of membership, an account receives two credits. The first, a pay credit, is a percentage of pensionable earnings. The second, an interest credit, represents interest on the accumulated cash balance. At retirement, the value of the notional account is used to provide pension and lump sum benefits. The interest credit can either be a fixed percentage, or linked to returns on specified investments, but it is not linked to the actual investment returns achieved.

17. Although employees hold notional accounts, the scheme's assets are not actually segregated into individual accounts and may be more or less than the sum of members' accounts. So there is some limited scope for the employer to vary the pace of pension funding. The overall cost of the scheme will depend on the level of the pay credit and the formula used to calculate the interest credit.

18. Cash balance schemes are well suited to providing benefits for employees with fluctuating earnings. There is a direct link, in each year of membership, between pay and the amount of benefit accrued. The interest credit might be variable and closely linked to the returns on the scheme's assets, or a fixed amount (e.g. 5% per annum). The former approach moves the scheme's benefits characteristics closer to those of a defined contribution scheme; the latter moves them closer to those of a defined benefit scheme.

Conclusion

19. Defined benefit arrangements offer members clear guarantees at retirement but as part of an overall benefit package. This provides assurance and certainty in retirement planning but means that members have limited scope to design their own personal retirement package. By the nature of final salary schemes, structure and funding assumptions inhibit active flexible career choices and, certainly in a scheme of 1 million members, it would be unimaginable to allow unrestricted freedom of choice.

20. Defined contribution schemes offer more choice and flexibility but can leave members exposed to the vagaries of market performance and wider economic climates. The Cash Balance Scheme seems to offer more certain returns and, being individually based, allows similar flexibilities. Career averaging will be relevant where earnings fluctuate or peak before retirement and, in concept, such schemes are fairer because they reflect actual earnings and contributions during employment.

21. It seems unlikely that defined benefits alone will deliver the range of flexibility and choice both employers and members seem to want. It may be, therefore, that the NHS needs a Scheme that combines the core features of a defined benefit, final salary arrangement with elements of one or more of the other models. There can be no preferred option. Any new scheme considerations should essentially start from first principles, perhaps with the radical option of introducing separate schemes for different groups of employees. But any of the design options outlined in this Chapter would provide decent pension arrangements. The key, of course, is the level of funding that underpins the pension accrual. And with current costs averaging around 20% of pay, no indication of the general membership being prepared to pay more and tight public expenditure controls, any radical re-design will prove a difficult challenge.

CHAPTER TEN: CONCLUSION

Introduction

1. This chapter summarises the findings of the project and proposes some broad options for developing NHS pension arrangements of the future. There are a number of suggestions throughout the report to help develop the present scheme and the way it is viewed, and used, by the Service. But it will be clear that it makes no fundamental recommendations about radical structural change to the existing scheme.

2. The NHS already has a very good pension scheme worth around 20% of pay. It offers a core package of personal and dependants' benefits, life assurance, ill health and redundancy protection, together with a range of voluntary options to increase the level of basic cover. This is not a low pension threshold – by any measure, NHS employees enjoy a high level of pension cover, value for their money and, in that context (with perhaps one or two exceptions), further improvements might be regarded as relatively marginal.

3. Staff Representatives want to see improvements and they want to see every member maximise their rights, and at all times. But the NHS Scheme covers all employment groups. It is a final salary scheme operating under mutual assurance and shared risk principles. It offers a standard package. By its nature, size and costs there is a limit to its flexibility. Changes that would improve the recruitment and retention of key NHS staff might succeed but otherwise, and unless members generally want to pay more, modernising pensions might really only be about re-packaging and restructuring within the current cost envelope. And that, realistically, would mean a new scheme or schemes.

Overall Findings

4. Previous Chapters have explored the basic elements of the pension scheme, its structure and costs. They have examined short and longer-term options for changing the current scheme and alternative ways of making pension provision. Key issues have been flagged up, aimed at improving the present arrangements or reviewing them further in the context of wider HR and employment considerations. But the broad conclusion reached is that radical structural change would require a new scheme.

5. The value of NHS pensions is understated and misunderstood. There are frequent calls for modernisation but, often, these stem from a failure to appreciate the full range and flexibility of current provisions. The report has commented elsewhere on educational and promotional weaknesses and it is essential that the level of understanding and awareness about the Scheme is raised – this work is now in hand. The NHS pension scheme provides good value for money and offers the range of benefits most members want. With an active membership of around 1 million, it would be impossible to please everybody all of the time and it would be impracticable to tailor a final salary scheme to suit every individual's personal circumstances. That would be extraordinarily expensive.

6. It is important that the cost of pension provision is not underestimated. Since this review started, there has been a growing trend in the private sector away from final salary schemes. Pension schemes are expensive and getting more and more expensive to operate. In final salary schemes, employers face the prospect of the long term funding of rising liabilities, as costs spiral upwards with increased longevity. In the NHS, for example, and excluding RPI indexation costs, current pension scheme liabilities already exceed £70 billion.

7. Pensions are deferred pay and play an important role in the overall remuneration package. They should be considered, therefore, within the total cost envelope of employing staff, not separately as has so often happened in the past. It is also essential to consider structural pension changes integrally with wider NHS policy initiatives, HR developments and Service needs. If healthcare re-organisation requires new contractual arrangements and working practices, then it is right to review the underpinning employment terms and

conditions. And to address the particular pension aspects as part of the negotiating process.

8. However, no overwhelming evidence has emerged to indicate that pension provision is a key factor in the recruitment and retention of NHS staff. It is speculative, for example, whether improving rights for those nearing age 60 will influence their retirement decisions. Some argue that the promise of higher pension would encourage continued employment. Others worry about the perverse effect and actually bringing forward the retirement of those who would have stayed on longer. It may be a little of each, but introducing statutory entitlements needs more than the speculative intention of 'doing good'.

9. The pension scheme covers all NHS employment groups. Its standard provisions apply across the board and this makes it difficult to implement changes in respect of one particular group. While certain provisions might be "ring-fenced", subject to satisfying equal treatment requirements, it is more difficult to introduce structural changes for individual groups. Not least because of administrative and systems implications. If pensions are to support recruitment and retention policies and underpin improved working practices and patterns, then untargeted scheme wide changes are inappropriate.

10. Issue 20 –that any short to medium term pension changes should only be considered and taken forward within Workforce Taskforce strands and new contract negotiations.

11. Proposals for structural reform tend to centre around the retirement rules and pensionable re-employment, and the way benefits are calculated. Each is commented on in the relevant sections of the report but overall the case is not persuasive, given the cost and operational implications, of their value as recruitment or retention tools. Unless Ministers want to spend more of the healthcare budget on pension reform, radical structural changes will require, and should wait on, a new scheme.

12. It is for Ministers to decide whether they want to explore the new scheme option but:

Issue 21 - Short of moving to a new scheme, there should be three levels of consideration for dealing with pension changes:

- **those that are essential for new contracts and structural changes in the NHS**
- **self financing changes based on business returns for the NHS**
- **those arising from wider government social policies.**

13. The first of these must be overcome otherwise the scheme will be an obstacle to progress. It should be possible to consider and largely accommodate contractual claims, if affordable, provided they do not require major structural, scheme wide changes.

14. The second should only go ahead if the business case is clear. At the moment, that is not always easy to demonstrate. For example, in the past, Ministers have rejected claims for improvements where there is no evidence that increased pension costs will improve capacity.

15. The third group should arguably only be entertained if Treasury make provision in NHS baselines. And, at present, that only seems likely where government is being forced by the courts to implement policy changes. For example, the government is content to see unmarried partners covered in public service schemes but only where the general membership is willing to pay the costs.

New Scheme Option

16. A new scheme option would allow the Department to design a NHS scheme for the 21st Century. It would be a major task and require, initially, a full option appraisal. There could be significant cost and resource implications with the need to contract professional pension consultants. And there might be a timing issue. For example, it might make sense to delay until the position on the future of retirement and Inland Revenue tax rules are clarified.

17. In any options review, full consideration should be given to different types of pension provision. The exercise should not simply be a final salary restructuring. A final salary scheme might continue to offer the best option for the NHS but some members might prefer the choice between final salary and defined contribution, an arrangement for example on the lines of the new Civil Service Scheme. One important question is whether the "one size fits all" approach continues to be relevant. Or whether there should be separate schemes for different employment groups, for example separate schemes for doctors, nurses, ambulance staff etc. Having different schemes with different benefit structures and discrete contribution rates would add to administrative costs but it might make it easier over the longer term to respond to contractual changes and specific recruitment and retention problems and initiatives. Another alternative might be to deliver a slimmer core package with flexible options on the voluntary purchase of extra benefits, subject to over-riding contracting–out requirements.

18. The question of costs cannot be discounted. One inherent problem for the NHS is the current employee contribution rate. 5% is a common rate across the private sector, but at 6% for most NHS members, this is already considered a little high in industry terms. An issue for the NHS therefore is how to incorporate the best advantages of a new Scheme option and balance costs.

19. Any new Scheme would be expected to be obligatory for new entrants. Existing members should have the option of transferring into the new scheme and it would make sense therefore to make both the terms and the Scheme attractive. But inevitably once a new Scheme was up and running, the case for changing the old Scheme would diminish and amendments would be made only as required by pension legislation.

Conclusion

20. Pension changes are not necessarily the answer to short-term supply problems. Pensions store up long term liabilities and full costs may not be exposed for many years. In the short term, increased pay is probably a more influential factor and offers personal choice on how to spend the money. It seems much more appropriate to get the overall structure for pensions right for the future, whether that is different Schemes for different staff, different types of Scheme for different staff or the continuance of a single, standard Scheme for all. To do that, and incorporate the modernising opportunities described in this report, the new scheme option seems to offer the best way forward.

21. The report raises a number of issues, which, if developed, may improve the current position. Some can be taken forward in contractual discussions, others within the Department of Health and the NHS Pensions Agency, in consultation with its stakeholders.

Steering Group and Project Teams — Annex A

Steering Group

Joint Chairs: David Amos Department of Health
Michael Lowe BMA

Members:

Alec Cowan	Chief Executive NHS Pensions Agency
Ian McHenry	Director of Policy NHS Pensions Agency
John Lindsay	Head of Superannuation BMA
Phil Green	Staff Side Secretariat UNISON
Grant Ballantine	Chief Actuary Government Actuary's Department
David Fairs	Partner KPMG
Ralph Garden	Chief Executive, Scottish Office Pensions Agency
William Wraith	Director of HR, The Royal Wolverhampton NHS Trust
Colin Pitcher	Director of Personnel Tees East & North Yorkshire Ambulance Service
Neil Chapman	Director of Finance Leeds Teaching Hospitals NHS Trust

Project Team

Project Manager:

Paul Robinson	NHS Pensions Agency

Project Team:

Gordon Smith	Director of HR South Yorkshire Ambulance Service
Ray Henry	Senior Superannuation Manager- BMA
Zora Francis	Pensions Officer, Legal Department, Unison
Bryan Freak	Pensions Officer, Manufacturing Science Finance
Josie Irwin	Senior Employment Officer RCN
Roger Turner	Director of Personnel, Worthing and Southlands Hospitals
Garry Cole	Royal Free Hampstead NHS Trust
Warwick Mason	Government Actuary Department
Angela Walsh	NHS Pensions Agency
Helen Carter	NHS Pensions Agency

Project Team - Reference Group

Wayne Harris	Director of Finance North East Wales NHS Trust
Phil McCusker	Superannuation - Northern Ireland NHS Pension Scheme
Dennis Patrick	Welsh Office
Kevin Hammersley	Finance – Walsall
Nicky Laming	Kingston Hospital Trust

Summary of Issues Raised In the Report — Annex B

Publicity, communications, and training for employers

1. That Pensions Scheme literature is reviewed to ensure it remains relevant, easy to understand and continues to meets the needs of a culturally and ethnically diverse workforce. [Chapter 4, Para 10]

2. That research is undertaken into the reasons why NHS employees opt out of the pension scheme and takes appropriate steps to address any educational, promotional or procedural weaknesses. [Chapter 4, Para 11]

3. That the Pensions OnLine system be rolled out to individual members and GP practices and development of support training for HR managers be continued. [Chapter 4, Para 12]

4. That NHS employers review their local arrangements for publicising and promoting the pension scheme and include pension awareness and modelling in their workforce planning assumptions. [Chapter 4, Para 13]

Employer support for and engagement with the scheme

5. That employers conduct mid –career reviews with staff on their pension options and retirement intentions so that both employee and employer can plan more clearly for the future. [Chapter 4 Para 14]

6. The Department review the current pension consultation arrangements with a view to bringing NHS employers formally within the negotiating machinery. [Chapter 4, Para 17]

7. That the NHS Pensions Agency consider with employers and staff representatives, the feasibility of providing members with structured links to independent financial advice. [Chapter 4 para 20]

Admission to the Scheme – links to social care

8. The Department work with ODPM and the Treasury to set in place pension arrangements that will facilitate the smooth development of integrated health and social care services. [Chapter 4, Para 26]

9. That the scheme's admissions policy is reviewed in the context of developing healthcare policies and clear guidance issued on the criteria for scheme access and membership retention. [Chapter 4, Para 27]

Equal treatment, partner and family benefits

10. That the added years scheme is re-designed to provide for flexible lump sum payments to allow NHS employers, as part of local packages designed to encourage the early return to work of key NHS staff, to consider funding or supporting the provision of additional service to cover unpaid periods of maternity, paternity, family and study leave. [Chapter 5, Para 21]

11. Survivor pensions for unmarried partners in common law and single sex relationships should continue to be reviewed. If the present impasse cannot be resolved, then this issue would be central to any considerations of re-packaging the existing NHS benefits in a new pension scheme. [Chapter 6, Para 22]

Issues affecting specific professional groups

12. That the detailed arrangements for GP Pensions, and those of their staff, are considered within the new GMS contract discussions. [Chapter 7, Para 40]

13. That pension issues for consultants are considered as part of the consultant contract negotiation [Chapter 7 Para 51]

14. That the Department consider further whether the case for abolition of abatement can be justified on cost/benefit grounds or whether improving other pension flexibilities and family friendly policies is more likely to increase nurse numbers. [Chapter 6, Para 75] and [Chapter 7, Para 58]

15. That, jointly with the Ambulance Services Association and Ambulance Staff Side organisations, the Department considers whether existing employment policies and practice fit the needs of a 21st century ambulance service and its integration in the delivery of modern patient services. [Chapter 7, Para 65]

Retirement Rules, and accrual rates

16. That the NHS Scheme should not restructure the current retirement rules, including post-retirement options, until there is wider agreement within government on the extent to which occupational pension schemes can, and should, respond to the longer term issues around retirement. [Chapter 8, Para 15]

17. That where clear supply gains could be linked to affordable costs and "ring-fenced" provisions, then the use of short-term or time-limited pension inducements around higher accrual should be considered. But these should be developed within contractual arrangements with due regard to equal treatment requirements and the wider policy agenda. [Chapter 8 Para 23]

18. That pension scheme changes to foster more flexible, phased retirement should await the outcome of wider reviews within government on the future of retirement and the relevant tax regime. [Chapter 8 Para 44]

19. That equalisation of member contributions should be considered as part of any scheme restructuring but only if the position of manual staff is protected so they do not end up financing improvements for higher salaried career groups. [Chapter 8, Para 77]

General Issues

20. That any short to medium term pension changes should only be considered and taken forward within Workforce Taskforce strands and new contract negotiations. [Chapter 10, para 10]

21. Short of moving to a new scheme, there should be three levels of consideration for dealing with pension changes.

    - those that are essential for new contracts and structural changes in the NHS
    - self financing changes based on business returns for the NHS
    - those arising from wider government social policies.

    [Chapter 10, para 12]

RANGE OF PENSION SCHEME BENEFITS AND OPTIONS — ANNEX C

BENEFITS	OPTIONS
1. Normal Retirement Age (NRA)	60, but members can continue in pensionable employment until age 70 Certain members employed prior to 6.4.95 retain a right to retire at 55.
2. Pensionable earnings	Basic pay plus allowances deemed to be pensionable up to full-time, overtime is not pensionable
3. Pay for calculation	GPs and Dentist career average of pensionable earnings. All other members, best of the last 3 years pensionable pay.
4. Relation to State Earnings Related Pension Scheme (SERPS)	Contracted out of SERPS – reduced NI contributions
5. Member's contributions	5% of pensionable pay for manual staff 6%of pensionable pay for non-manual staff Tax relief – contribution deducted prior to taxation real costs near 3.5% for a standard tax payer
6. Entitlement to Benefits	Completion of at least 2 years membership (***or over age 60)*** 1/80th of pensionable pay for each year of membership, OR Earnings uprated to current value
7. Pension	Membership: a. Z/80 x Pensionable pay = annual pension b. 3 x Z/80 Pensionable Pay = tax free lump sum GPs and Dentist a. 1.4% of all career uprated earnings = annual pension b. 4.2% of all career uprated earnings = tax free lump sum
8. Benefits for Early Leavers	Ill Health – from any age with minimum of 2 years membership Redundancy – from age 50 with minimum of 5 years membership
9. Voluntary Early Retirement **10. Ill Health enhancement** Accrued Membership a. 2 to 5 years b. 5 to 10 years c. More than 10 years	• From age 50 • Accrued pension reduced to meet cost of early payment, OR • Accrued pension unreduced (employer can choose to meet the cost) - option not available to GPs and Dentists Increased to compensate for involuntary early retirement a. No enhancement b. Membership doubled [1] c. Greater of: • Service enhanced to 20 years [1] • Extra 6 2/3 years membership [2]

[1] Subject to a maximum enhancement of the potential membership to 65

[2] Subject to a maximum enhancement of the potential membership to 60

BENEFITS	OPTIONS
11. Redundancy enhancement Accrued Membership a. Less than 10 years b. 10 years or more **12. Death in Service** a. Lump Sum b. Spouse's pension c. Child Allowance	Increased to compensate for early retirement • option not available to GPs and Dentists • employer meets cost of enhancement and early payment a. Membership doubled [1] b. 10 years maximum [3] a. 2 x annual pensionable pay – tax free b. 50% of member's pension based on enhanced pension [4] c. 25% of members pension based on enhanced pension for each child up to a maximum of 50% [5]
13. Death in retirement a. Lump Sum b. Spouse's pension c. Child allowance	a. 5 years pension less pension and lump sum already paid b. 50% of member's pension [4] c. 25% of members pension based on enhanced pension for each child up to a maximum of 50% [5]
14. Allocation – giving up part of a pension	Members can choose to allocate up to 1/3rd of their pension for a dependant, but is irrevocable [6]
15. Refund and Preservation **16. Increasing Benefits**	• • Less than 2 years membership, member's contributions refunded. Deductions include 20%"tax charge" and an amount to buy employee back into the state scheme. Overall refunds generally amount to the net contributions paid into the Scheme [7] • Preservation 2 years or more membership, benefits are preserved in the Scheme and increase in line with Retail Price Index (RPI). Payable from age 60 Overall contributions cannot exceed • 15% of pensionable pay in any one year • pension benefits must not exceed 2/3rd of gross pensionable pay at retirement Different Methods available: a. Purchase of additional membership b. Money Purchase Added Voluntary Contributions (AVCs) c. Stakeholder Pensions d. Free Standing Added Voluntary Contributions (FSAVCs)
17. Purchasing additional membership	Purchase by: a. Single Lump Sum payment [8] b. Additional contributions [9]

[3] Subject to a maximum enhancement of the potential membership to 65 or 40 years membership

[4] only membership from April 1988 accrues for widower's benefits. Additional Contributions may be paid to improve these contingent spouse's pensions. Certain short-term (up to 6 months) spouse's pensions may be paid in addition.

[5] Allowance may increase if there is no surviving parent or alter if there are children to more than one partner.

[6] Subject to a medical to prove good health. Cost depend on age difference between scheme Members and recipient.

[7] Less than 2 year and over 60 entitlement to benefits

[8] Subject to purchase within the first year of scheme membership and an overall maximum of 40 years membership

[9] Subject to an overall maximum scheme membership of 40 years and a contract of 2 years minimum

BENEFITS	OPTIONS
18. Money Purchase AVC	The Scheme offers a choice of providers • Additional Contributions are invested in a fund which is used to buy an annuity at retirement
19. Stakeholder Pension	The Scheme offers a choice of stakeholder providers a. No employer contribution b. Charge of 1% or less on person's fund c. Maximum annual contribution of £3,600 d. 25% of fund may be taken as a lump sum
20.Free Standing AVC	Independently arranged outside scheme
21. Transferring Pension Benefits into the NHS Pension Scheme	Application within 12 months of joining the NHS Scheme and before age 60 Acceptable from: a. Occupational Pension Scheme b. Personal Pension [10] c. Annuity Contract [10]
22.Transferring Pension Benefits outside the NHS Pension Scheme	Application after leaving the Scheme and under age 60 Acceptable to: a. Occupational Pension Scheme b. Personal Pension [10] c. Annuity Contract [10]
23. Non NHS Employments – application for "Direction" status	Non NHS employers may be allowed to operate the NHS Pension Scheme in respect of ex NHS employees Criteria • Status is approved under Section 7(1) or 7(2) of the Superannuation (Miscellaneous) Act 1967 • Charitable or voluntary bodies providing health care • Employees who have contributed to the NHS pension scheme during the previous 12 months • Application to retain membership should be made within the first 3 months Early retirements are not included in the provisions but employers have the option to make equivalent payments [11] Direction employees typically include: • Hospices • Voluntary Overseas Service • Care in the Community

[10] Approval under Section 620 (formally 226) of the income and Corporation Taxes Act 1988 are not acceptable

[311] Funded employer retirement include Redundancy and employer agreed Voluntary Early Retirements

HOW NHS PENSIONS ARE FINANCED ANNEX D(i)

The NHS pension scheme, like most other schemes for public servants, is not funded. Pension payments are met from a separate superannuation vote, which scores as Annually Managed Expenditure (AME). Employee contributions at 5 or 6 per cent help to finance the pension payments. However, there is also a system of internal employer contributions sometimes known as Accruing Superannuation Liability Charges (aslcs).

These charges are paid by employers from within their budgets and have ultimately to be met by DH's Departmental Expenditure Limit (DEL). So although they are only an internal government flow, the employer contributions or aslcs are a key part of the budgetary process whereby employers are made aware of the cost of pension commitments when they employ staff. The rate of employer contributions are set by the Government Actuary in a calculation, which involves the use of a notional fund.

Every five years the Government Actuary publishes a report showing what the state of a pension fund would have been if these contributions had been invested in a variety of gilts. At each valuation any deficit or surplus in the notional fund would give rise to an adjustment of level of employer contributions from the estimates cost of pensions looking forward.

Through an historical anomaly this notional fund and hence employer contributions cover the cost of providing the basic pension that someone gets on retirement and not the cost of subsequent indexation to the RPI. This is a significant omission, which means that the aslcs seriously understates the true cost of NHS pensions by over £1 billion a year. The cost to the government of a full pension is around 14 per cent of salary but the basic element which employers are charged for is only 7 per cent of salary.

NHS PENSION SCHEME FROM 1997-1998 TO 2000-2001 Annex D (ii)
SUMMARY OF INCOME AND EXPENDITURE

	2000-2001		1999-2000	
	£000's	£000's	£000's	£000's
INCOME				
Contributions				
(i) Employees		1,247,511		1,138,551
(ii) Employers		909,896		717,883
Transfer Values				
Transfers	203,186		242,868	
Capitalisation early retirement receipts	106,603		62,610	
		309,789		305,478
Contribution equivalent premiums		-		-
Miscellaneous receipts		1,328		-
		2,468,524		2,161,912
EXPENDITURE				
Benefits				
(i) Annual Pensions				
Age	1,335,882		1,251,014	
Compensation	268,367		236,946	
		1,604,249		1,487,960
(ii) Lump sums		362,228		316,502
(iii) Death gratuities		37,662		36,948
(iv) Widows', Widowers' and				
Children's pension		83,389		82,209
Refund of contributions		11,783		10,702
Transfer Values		215,493		74,443
Contribution equivalent premiums to the State Pension Scheme		112		15
Contribution to other superannuation Arrangements under Regulations 48 & 79		-		-
		2,314,916		2,008,779
Net income/(expenditure)		153,608		153,133

Pensions Increases	**2000-2001 £000's**	**1999-2000 £000's**
Payments under Pensions (Increase) Acts on Awards under the National Health Service (Pension Scheme) Regulations		
(i) Annual Pensions	489,003	495,930
(ii) Lump Sums	2,880	2,521
(iii) Death Gratuities	223	241
(iv) Widows' Pensions	90,153	88,819
(v) Bulk Transfers	-	5
	582,259	587,516
Payments to Local Authorities	33,217	11,928
	615,476	599,444

NHS PENSION SCHEME FROM 1997-1998 TO 2000-2001
SUMMARY OF INCOME AND EXPENDITURE - continued

	1998-1999		1997-1998	
	£000's	£000's	£000's	£000's
INCOME				
Contributions				
(i) Employees		1,045,492		949,491
(ii) Employers		663,265		605,053
Transfer Values				
Transfers	451,116		115,962	
Capitalisation early retirement receipts	56,061		72,193	
		507,177		188,155
Contribution equivalent premiums		-		2,613
Miscellaneous receipts		-		-
		2,215,934		1,745,312
EXPENDITURE				
Benefits				
(i) Annual Pensions				
Age	1,161,329		1,084,345	
Compensation	216,528		231,394	
		1,377,857		1,315,739
(ii) Lump sums		299,620		309,043
(iii) Death gratuities		34,316		32,719
(iv) Widows', Widowers' and				
Children's pension		75,984		70,660
Refund of contributions		10,011		10,926
Transfer Values		57,201		89,460
Contribution equivalent premiums to the				
State Pension Scheme		125		4,359
Contribution to other superannuation				
Arrangements under Regulations 48 & 79		3		11
		1,855,117		1,832,917
Net income/(expenditure)		360,817		(87,605)

Pensions Increases	**1998-1999 £000's**	**1997-1998 £000's**
Payments under Pensions (Increase) Acts on Awards under the National Health Service (Pension Scheme) Regulations		
(i) Annual Pensions	471,001	444,520
(ii) Lump Sums	2,379	2,455
(iii) Death Gratuities	225	214
(iv) Widows' Pensions	84,003	78,927
(v) Bulk Transfers	485	47
	558,093	526,163
Payments to Local Authorities	13,454	13,588
	571,547	539,751

Comparison of Public Sector Schemes — ANNEX E

	NHSPS	TPS	PCSPS	LGPS	FIRE	POLICE	AFPS	USS
Funded/ Unfunded	Unfunded	Unfunded	Unfunded	Funded	PAYG	PAYG	Unfunded	Funded
Pension Age	60	60	60	60-65 depending on length of service	50-60 depending on length of service	48-55 depending on length of service	Officers: 37-55 Others: 40-55	65
Qualification for retirement benefits	2 years	Normally 2 years	2 years	2 years	2 years	2 years	2 years	5 years
Employee contribution	Manual: 5% Non-Manual: 6%	6%	1-1.5% to provide for a widow(er)'s pension New scheme from 2002 3.5%	5% manual 6% non-manual. (From 1.4.98 ALL new members to contribute 6%).	11%	11%	Nil, but estimated to be 7%	6.35% (0.35% to supplementary section to pay additional benefits in certain circumstances
Employer contribution	7%	7.2%	Grade-based: 11-21%	Varies between LA's.	23.25%	20.5%	Officers: 33.5% Others: 17.9%	14%
Standard contribution rate	18%	18.5%	18%	17%[1]	34.75%	32%	22% (33.8% for Officers, and 18.1% for all other ranks)	N/A
Retirement pension	1/80 (Mental Health Officers: every year after 20 years is doubled) (Medical and Dental Practitioners: 1.4% of total career earnings	1/80 x average salary for each year of service	1/80 x average salary for each year of service	1/80	1/60 for first 20 years, 2/60 for additional years	1/60 for first 20 years, 2/60 for additional years	Officers: 28.5-48.5% of pay between 16-34 years. Officers: 31.8 – 48.5% of pay between 22-37 years	1/80

[1] Each Local Government Pension Scheme has its own funding arrangements and use their own actuaries when setting contribution rates. It was not possible to confirm a weighted average across all schemes but 17% is thought to be reasonably representative.

	NHSPS	TPS	PCSPS	LGPS	FIRE	POLICE	AFPS	USS
Retirement lump sum	3 x pension	3 x pension	3 x pension	3 x pension	3/80 by commuting portion of pension	3/80 by commuting portion of pension	3 x pension	3 x pension
Average salary	Pensionable pay averaged over last year	Best 365 days on last 3 years	Best 365 days in last 3 years	Final year's pensionable pay	Pensionable pay averaged over the final year	Average pay over the last 12 months	"Representative" pay for each rank	Highest (according to rise in retail prices) salary over last 3 years, or highest revalued salary over any 3 consecutive years within the last 13
Children's allowances	Where there is a widow or widower receiving a pension, an amount equal to ½ member's own pension entitlement will be divided equally between the children, with no child receiving more than ¼ of member's entitlement. If there are no parents then the member's pension is divided (with each child receiving (up to a maximum)	1 child: ½ widow(er)'s pension 2 or more: amount equal to widow(er)'s pension	¼ of member's pension for each child in care of member's widow or widower. For each child in care of another person.	¼ of notional ill-health retirement pension if a spouse's pension is payable, if not. These amounts increase to ½ or where there are 2 or more children	Other parent alive: 18.75% x fire-fighter's notional pension per child to a limit of 37.5% No other parent alive: 25% x fire-fighter's notional pension per child to a limit of 50%	Child's allowance at 37.5% of officer's deferred pension	Where there is a widow or widower receiving a pension, an amount equal to ½ member's own pension entitlement will be divided equally between the children, with no child receiving more than ¼ of member's entitlement	1 child: of pension the member would have received at age 65. 2+ children: ¾ of pension the member would have received at age 65.

	NHSPS	TPS	PCSPS	LGPS	FIRE	POLICE	AFPS	USS
Widow(er)'s benefits	½ member's pension	½ member's pension (i.e. 1/160 of average salary for eligible service)	½ member's pension. Employees are required to contribute an extra 1-1.5% to provide for a widow(er)'s pension	½ member's pension. (From 1.4.98 this pension is to be payable for life, and not terminated on subsequent re-marriage or co-habitation).	½ of the pre-commuted pension	½ of the pre-commuted pension	½ member's pension	½ the pension that would have been received had the member stayed in the scheme until 65.
Injury Benefits	Yes	No	Yes	Yes	Yes	Yes	Yes	
Ill-health Benefits	Dependent on the amount of reckonable service, the service counting for benefits is enhanced.	Permanency criterion. Dependent on the amount of reckonable service, the service counting for benefits is enhanced.	Benefits paid where breakdown in health is likely to be permanent. Service is enhanced	Lump sum and pension paid for permanent breakdown. For 5 years+ membership service is enhanced	Payable immediately on the event of permanent incapacity, normally with an enhancement of service	Payable immediately in the event of permanent incapacity, normally with an enhancement of service	Different types of benefit available; these depend on the DSS War Pensions Agency's assessment of the illness or injury as "attributable to service" and whether the disability degree is smaller or greater than 20% or less than 1%	Unreduced pension and lump sum based on the amount of pensionable service the member would have completed by 65th birthday.
In-service death grant	2 x pensionable pay	2 x average salary	2 x pensionable pay	2 x pensionable pay, depending on service	2 x pensionable pay	2 x pensionable pay	1-1.5 x pen'able pay, depending on service	2 x pensionable pay
Actuarially reduced pensions	Yes	No	Yes	Yes	No	No	No	Yes

	NHSPS	TPS	PCSPS	LGPS	FIRE	POLICE	FPS	USS
Premature retirement	Early retirement, + immediate payment of benefits, can be taken at or after age 50 by a member with at least 5 years' service and whose employment has been terminated by redundancy or in the interests of the efficiency of the service. A member with at least 2 years' service who retires after 50, will if the employer meets the cost of providing the pension between the cessation of pensionable employment and 60, be paid a pension	If retired between 50 and 60, benefits paid immediately with employer's agreement. The TPS pays a portion (using the factor relevant to the teacher's age at retirement) and the former employer pays the remainder for the pensioner's lifetime). Alternative to granting benefits is a severance payment	Different provisions exist, depending whether the early retirement is of the compulsory, flexible or approved kind. For those under 50, there are compulsory and flexible early severance arrangements. At Departments' discretion, repackaging arrangements are available.	Provided a minimum of 2 years' membership, an employee has the option of deferring benefits to normal retirement date or taking immediate reduced benefits (which cannot be less than the GMP or 1/80th of pensionable remuneration x period of contracted-out membership). From 1.4.98 an 85 year rule will take effect, enabling members aged 50-59 whose age and length of service total at least 85, to retire (subject to employer consent) on an unreduced pension	Voluntary early retirement from age 50 possible, provided at least 25 years' service has been undertaken. A fire authority has the power to require a fire-fighter aged 50 or over with at least 25 years' service to retire in the interests of efficiency.	Voluntary early retirement from age 50 possible provided at least 25 years service has been undertaken. A police authority has the power to require a policeman aged 50 or over with at least 25 years service to retire in the interests of efficiency (this is seldom used).	Members who retire before the full career term but with at least 16 years' reckonable service (officers) or 22 years (other ranks) are entitled to an immediately payable pension.	If the member is aged 50 or over with 5 or more years pensionable service and retires due to redundancy or employer's request then the benefits are unreduced pension and lump sum calculated in the same way as for normal retirement.