Northern Ireland Assembly

Committee for Finance and Personnel

OFFICIAL REPORT (Hansard)

Public Service Pensions Bill: British Medical Association

16 October 2013

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Mr Daithí McKay (Chairperson)
Mr Dominic Bradley (Deputy Chairperson)
Mr Leslie Cree
Ms Megan Fearon
Mr Paul Girvan
Mr John McCallister
Mr Mitchel McLaughlin
Mr Adrian McQuillan
Mr Peter Weir

Witnesses:

Mr Andy Blake	British Medical Association
Dr Paul Darragh	British Medical Association

The Chairperson: I welcome Dr Paul Darragh, chairman of the NI council of the British Medical Association (BMA), and Andy Blake, the head of the pensions department. If it is OK with you, we will go straight into questions.

I want to flag up an issue in the paper that you submitted to the Committee on the career average revalued earnings (CARE) scheme. You said:

> *"The NI Executive should commit to adopting a fairer approach by ensuring that subsequent regulations prescribe a much flatter structure for the NHS scheme contribution."*

Perhaps you could elaborate on that.

Mr Andy Blake (British Medical Association): Historically, the NHS pension scheme has been a final salary scheme. We accept that that gives better value to higher paid members of the scheme because there is an expectation that their salary will rise steadily throughout their career to its highest point at retirement; whereas, if you have a flatter earnings pattern throughout your career, a final salary scheme will be less beneficial. In a career average scheme, it is, essentially, worth the same to everyone, and therefore the steep tiering of contributions is not so justified.

The Chairperson: Are there any specific amendments that you would propose to the Bill having seen the Department's response to your written submission?

Dr Paul Darragh (British Medical Association): We list proposed amendments in our document. We want stronger amendments to curtail sweeping new powers that would allow successive

Executives to make unilateral and retrospective changes to accrued benefits in public sector pension schemes. If those powers are enacted, they will completely undermine the guarantee that this is a settlement for a generation. It is supposed to last for 25 years. We have had experience of that, because we entered into negotiations in good faith in 2008. We were told at that time that the settlement would last for a generation, only to see it upturned within four years.

We also ask for assurances that the arrangements for the scheme will be robust and that the proposed arrangements will meet the requirements for effective governance. Specifically, we ask that

> *"The Department of Finance and Personnel's control over valuations and over the employer cost cap must be tempered with requirements to consult more widely"*

and that

> *"The N I Executive should commit to adopting a fairer approach in the new Career Average Revalued Earnings (CARE) scheme".*

Amendments to the Bill are needed to allow the Working Longer review to be completed because, as it is, it looks as though the Bill will be pushed through without consideration being given to its findings.

The Chairperson: I am looking at paragraph 7 of your submission, which raises a general point about clauses 4 to 6. Is there a particular issue with compliance with the Pensions Regulator?

Mr Blake: Sorry. Could you repeat the question?

The Chairperson: In paragraph 7 of your paper, there is reference to the Pensions Regulator.

Mr Blake: Yes. At the moment, in England and Wales, there is a governance group, and a technical advisory group below that. There are Northern Ireland and Scottish representatives on that committee, representing all three schemes. There is representation from employers, the Health Department and trade unions. We would like to see the continuation of that level of trade union/employee representation continue.

The Chairperson: Just to be clear, you want compliance with the Pensions Regulator to continue?

Mr Blake: Absolutely.

Mr Girvan: Thank you very much for coming along. On the career average issue, changes probably have to be made because it has been demonstrated that many people are promoted a year prior to retirement and therefore leave the job on a fairly enhanced salary scale. After just one year, they can reap the benefit in the pension because it is a final salary scheme. I wonder whether that has been the case in the medical profession. Has that been evident in the BMA? Have surveys of your profession picked that up?

Mr Blake: I cannot speak about the whole public sector, but, in the health service, there is internal governance to pick that sort of anomaly up. That is reported in the media quite often, in my experience, quite often in local government, but there are internal governance procedures in the health service that pick up that sort of spike to avoid any gaming of the system.

Mr Girvan: To be honest, I do not have the same faith in the governance within the health system.

Mr Blake: I am not saying that I have particular faith in it. I am simply stating that I am aware that it is there, on behalf of the Department.

Mr Girvan: If the proposed changes to the scheme go ahead, do you see many of your members wanting to opt out of it?

Mr Blake: The evidence that we have seen shows that quite a lot of people have already opted out. The BMA has carried out surveys of our members in the three schemes in England and Wales, Northern Ireland and Scotland, and it is evident that a lot of doctors have brought forward their

retirement plans. Over the past 18 months to two years, we have seen a spike in attendance numbers at the pre-retirement seminars that we run.

Mr Girvan: Do you have a figure for the percentage of the overall numbers who have opted out?

Mr Blake: I cannot give you a definitive figure at this point.

Dr Darragh: Perhaps your question was geared towards whether this is still a beneficial scheme, compared with others. We are saying that people are voting with their feet and are leaving the scheme by retiring early.

Mr Weir: Are they switching to a different scheme though?

Dr Darragh: No. They are retiring early and leaving the health service. We have to deal with that, because it will have an effect on manpower. Several colleagues have told me privately that they are leaving early, and several have already left. I know that that is anecdotal evidence, and I do not have precise figures, but that is what I see on the ground.

Mr Weir: I appreciate the point that you make, but it is an answer to a different question. Paul asked whether people are switching to a different scheme.

Mr Blake: I do not understand what you mean by that.

Mr Weir: For example, are they seeking a different private pension provider? Retiring early is different from switching to a different scheme.

Mr Blake: No one would really consider switching from a public sector pension scheme to a personal pension because the employer does not pay anything into a personal pension.

Mr Weir: So the scheme, even as adjusted, is massively advantageous to your members?

Mr Blake: The scheme is better than that which is offered on a private basis, but not as good as the one that has been in place historically.

Mr Weir: We are dealing with a slightly different situation now. Realistically, using a final career salary as the basis of the scheme as opposed to career average earnings is simply not sustainable. I respectfully submit that senior doctors are paid a very large amount of money, and that perhaps makes the idea of promotion a moot point, because they do not need a promotion.

Paragraph 16 mentions "steep tiering". Could you expand on the point about steep tiering being unjustified in a CARE scheme? How do you see that operating?

Mr Blake: As I said earlier, higher earners in any final salary scheme will always receive a proportionately higher benefit than someone with a flatter earnings structure over their career. It is completely different in a career average scheme because you are just pensioning income in year, and so you are accruing a percentage of your income in that year. Therefore, relatively speaking, you are getting the same value per pound as anyone else in the scheme, regardless of your earnings, because you are paying a percentage of your pay.

From next year, the highest earners in the NHS pension scheme would be paying 14·5%, compared with the lower earners, who would be paying, I think, around 6% or 6·5%. To extend the current steep tiering and carry it over into a situation where 75% of members of the NHS pension scheme are in a career average scheme is not, in our view, justifiable.

Mr Weir: If steep tiering were retained in the career average scheme, it would hit the higher earners a lot harder, effectively.

Mr Blake: It would mean —

Mr Weir: Or disproportionately.

Mr Blake: Yes. It would mean that they would pay disproportionately a good deal more than lower earners.

Mr Weir: Would that, therefore, disproportionately hit your members?

Mr Blake: I suggest that it would.

Mr Weir: OK. Thank you.

The Chairperson: In paragraphs 18 and 19 of your submission, which are about the Working Longer review, you recommend adopting a wait-and-see approach. Do you expect any particular recommendations to come out of that on the capping of the pension age?

Mr Blake: The Working Longer review has just closed its call for evidence. Organisations, stakeholders, individuals, employers, and so on, have had the opportunity to submit evidence to the review for consideration. We understand that the report of the Working Longer review is due in the next month or so.

The Chairperson: Do you have any expectation that it will come out with something that will back up your arguments?

Mr Blake: The point I would make about the Working Longer review is that it was set up to look at the effect of individuals who are employed in the public sector working longer. Therefore to bring in changes to pensions that include extending working life before that review has had an opportunity to make recommendations seems slightly illogical.

Mr Mitchel McLaughlin: It can be quite problematic to try to develop a case that is based on particular sectoral pressures and dynamics. I think that people generally recognise that there are very significant stresses and dynamics in the broad medical practising profession. You have already talked about the Working Longer review. Clearly, societal and demographic issues, such as people living longer, have impacts, not necessarily in labour market terms but in society, with people perhaps requiring more intensive medical support as they get older. To what extent would a medical workforce planning process inform or provide an evidence case for setting a specific retirement age that is different from the national pension levels?

Dr Darragh: We have always been pushing for more effective medical workforce planning in the Northern Ireland context. It has been a long time coming. We keep getting promises. We need that information if we are going to meet the rising demographic challenges that you mentioned, Mitchel. The increase in population and inversion of the age pyramid is a challenge that we really need to meet. Look at the evidence on linking the normal pension age to the state pension age, rising to 68 by 2046, with the exemption of firefighters, police and the armed forces — those working on the front line. You will have police and firefighters dealing with someone, then bringing them to a 68-year-old consultant in a casualty department with all the stresses associated with that.

You are probably aware of Sir Michael Marmot, who did a lot of work on health inequalities and how we can deal with the health service. He made a very good point when he asked Andrew Lansley whether he had considered what would happen to stress levels and sickness absence if the proposals were brought in. How would that be managed in the medical workforce? Traditionally, the medical workforce has been one that does not take a great deal of time off sick. That will change if you force people in a stressful situation to work even harder.

In 2010, the then Health Minister was approached by consultants from emergency departments who warned him of the catastrophe that was about to face us regarding staffing emergency departments. Since then, we have had pay freezes, there have been great changes in grants affecting young doctors so they are now graduating with enormous debt, they are facing a pension scheme that means that they will have to pay in more for longer to get less out when they retire at the age of 68, and we wonder why we are having a bit of a staffing crisis. It can only get worse.

Mr Mitchel McLaughlin: I suspect that that pretty well describes the situation, which I am convinced will develop. I am trying to build on the acceptance that there are exceptions for some front line services. The question is about how we provide convincing evidence that such an exception should be applied to the medical profession. There is a front line dimension.

My sense is that there is no political support for this, and I think that is predictable from the point of view of the approach of the Government at this stage. There is little that the Assembly can do about developing a bespoke approach, but I would certainly like to explore it. Are there any examples, even in international practice, that we can look at where this kind of process occurs? You would think that such evidence would be de rigueur, anyway, in planning for the future. If we were talking about a settlement, say for the next 25 years, we certainly should have a clear perspective regarding the trends and projections of the type of services that will need to be sustained in all circumstances over that period.

I think that we are operating pretty much blind — it would appear that Westminster is, too — when we consider the Working Longer review and the back-to-front approach. Is there anything that you could point us towards that would give us an argument, either internationally or whatever? Is any economic modelling being done on the workforce requirements of the medical profession?

Mr Blake: Perhaps this is an obvious point, but you mentioned that the budget for health is fixed, to an extent, and within that, you have essentially got an ageing workforce. Take the particular case of doctors. If you were expecting consultants and GPs to work longer, perhaps until 68, clearly they would be a lot more expensive to employ than junior doctors coming up through the ranks. This legislation would add to that cost by forcing people to work longer for economic reasons.

A line can be drawn in the sand regarding protected groups and their normal pension ages. We look across at the fire service and the police service and note that there are desk-bound employees with a protected normal pension age of 60, yet an A&E consultant in a busy hospital would be expected to work until age 68. That seems illogical.

Mr Mitchel McLaughlin: Yes. However, we have been told in evidence sessions that there is limited ability for those services to absorb that particular opportunity for, say, desk-bound activity, when you consider the fitness levels that are required for operational activity.

With regard to the medical profession, I, and, I suspect, a lot other people, would be looking at the number of consultants who manage to juggle their public health service role with a private consultancy practice. That also has to bring pressures. What I am particularly concerned about in this context is the numbers of people who, thinking about their own future, would opt for private practice rather than staying in the health service.

Dr Darragh: It is a worry, Mitchel. I have heard younger doctors saying, "Well, I will just go and do more private practice." To be perfectly honest, I am a great believer in the NHS. I studied in Dublin. I came back to Northern Ireland because I believed in the NHS. I could have stayed down there and earned a lot more, but I believed in the NHS, in Northern Ireland and its people. I came back. What I see happening fills me with horror. We are working together and endeavouring to work with the Minister to implement Transforming Your Care for the betterment of the people of Northern Ireland. I see changes being made to the payment scheme for doctors that I think will act only to deter people from choosing and being retained in that career in future.

Mr Mitchel McLaughlin: I read your submission over the past number of days. To an extent, you almost have to dig into it to find that issue. You allude to that particular dynamic, but it seems to me that it is quite a strong issue that should have been explored more. Did you consider that as part of compiling the submission and decide against being explicit about the pressures that it would put upon the workforce?

Dr Darragh: I do not think that we have any exact evidence on the effect of shifting people into taking on more private practice work. All that I can do is repeat anecdotes that have been expressed to me in my normal working day. I do not know whether any work has been done on it.

Mr Mitchel McLaughlin: The point is that anecdotes do not really help the Committee, nor will they influence the Minister.

Dr Darragh: I understand that.

Mr Blake: The problem is that that sort of thing requires a great deal of supposition. However, if you look at data for the England and Wales NHS pension scheme, which I was looking at last week, you see that, at the top of the scale of higher earners' contributions, there has been something like an 8%

reduction in membership. That is significant because, essentially, in the pension scheme, the average contribution — what they call the "yield" — is 9·7%. So, some people pay one and a half times that and others pay significantly less. The important point to note is that higher earners essentially subsidise lower earners who pay lower contributions. So, when you have withdrawals of higher earners, that pushes up the requirement for contributions from the rest of the members. That is an example of something that we warned about prior to contributions being increased. At that time, it would not necessarily have been possible for us to say that x% of doctors, for example, will leave the NHS because of that, but this is a very similar example. So, unfortunately, I cannot give you any specific evidence as such because, as I say, it requires too much supposition. However, I think the example of higher contributions leading to withdrawal from the scheme is interesting.

Mr Cree: If you accept the premise that pensions are really deferred pay, is your main concern the tiering structure that is proposed in this career average scheme?

Mr Blake: I will be quite open and tell you that our main concern is the working longer aspect. BMA accepted, when normal pension age increased from 60 to 65 for new entrants and contributions increased by over 40% as part of the 2008 changes, that working longer was a reality. We accepted it at that point. As I say, it is 65 years of age for new entrants. The thing that particularly concerns us is the unfettered link to the state pension age. Not only has the normal pension age for the NHS pension scheme increased to 68 immediately for some people, it will go on increasing as state pension age increases. The current Westminster Government have applied, shall we say, a fast-track catch-up approach to state pension age. That is a separate argument, but it is a fact. It is not something that previous Governments looked at particularly. They have applied a fast-track catch-up approach to state pension age to reflect perceived improvements in mortality rates. So, it is the unfettered link to the state pension age that we are concerned about.

Mr Cree: That is your main concern.

Mr Blake: In reality, it is easy to see that, if we continue to go down that road, we are not very far away from doctors being expected to work until they are 70, 75 or, perhaps, 80.

Our second concern, as you mentioned, is the around tiered contributions. We accept that tiered contributions are fair. We accept that higher earners should pay more and that lower earners should be encouraged to join the scheme and to remain in it and that, generally speaking, good pension provision should be something that all members of the NHS, for example, should expect as a right. However, what we do not accept is the very high rate of tiered contributions in a career average scheme — we are no longer in a final salary environment — and also the disparity between the NHS and, for example, the Civil Service. You have got a situation whereby, from April 2014, the highest paid civil servants will pay almost half as much as the highest paid members of the scheme in the NHS, which simply does not seem fair.

Dr Darragh: To get the same benefit.

Mr Blake: Exactly, yes.

Mr Cree: You mention that members coming into the profession at the bottom end should be encouraged to join a scheme. Under the contract that exists, do they have the right to make their own provision?

Mr Blake: They do, but as I mentioned earlier, in reality, if you are offered access to a public sector pension or, indeed, any employer sponsored pension, you will not turn that down in favour of private provision.

Mr Cree: Because it is more advantageous.

Mr Blake: It is more advantageous because your employer pays into it. So, for example, if you worked for Tesco or Sainsbury's, it would, essentially, be foolish to waive access to their pension scheme, not just because the employer pays into it, but because personal pensions are something of a minefield, as you may be aware. Essentially, they rely on the ups and downs of the stock market, the prevailing rate of annuities at retirement, and so on. So, there is simply no comparison between, as you say, making your own provision and an employer sponsored pension scheme. That is, of course, why auto-enrolment of employer pension schemes is being implemented as we speak.

Mr Cree: OK. Thank you for that.

The Chairperson: I just want to clarify an issue about clause 10. Obviously, you have concerns about the pension age being 68. We have asked some of the other unions this as well. Would you be satisfied if that was amended to still refer to 65 but left flexibility for further increases? You said that it was 65 for new entrants. Would you be happy for it to remain 65 with regard to clause 10(b)?

Mr Blake: We would. As I said, we accepted, as part of the 2008 changes, that the normal pension age had to increase, but we believe that 65 is a fair limit on that.

The Chairperson: Thank you very much, gentlemen.

Dr Darragh: I thank the Committee very much for inviting us to give evidence. We very much welcome this opportunity to present our case. I think that the deputy Clerk has our contact details. If you require any further information from us, we would be more than delighted to get it to you.

The Chairperson: Thank you.