Written submission of evidence to the
NHS Working Longer Review
by the
British Medical Association

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About the BMA
The BMA is an independent trade union and voluntary professional association which represents doctors and medical students from all branches of medicine throughout the UK. With a membership of more than 150,000 worldwide, we promote the medical and allied sciences, seek to maintain the honour and interests of the medical profession and promote the achievement of high quality healthcare.

Key points

Changes to doctors’ normal pension age

• The BMA remains opposed to the blanket linkage of the NHS Pension Scheme normal pension age to the state pension age. No doctor should be required to work until the age of 68 in order to receive their accrued NHS pension.

• We believe there is a strong case that frontline medical staff have roles that are particularly physically, mentally and/or emotionally demanding and so should have their normal pension age capped at 65.

• Tasks that require physical exertion, good vision, dexterity, eye-hand coordination skills, rapid responses to events (including decisions in the middle of the night), or long periods standing are commonplace across medicine. Evidence demonstrates these can become harder with age for some doctors.

• In a survey of BMA members over 50, two-thirds of doctors of current working age said they would not be confident of being able to practise to at least the same level of competence if they worked to a later retirement age.

• The NHS Pension Scheme needs to accommodate the retirement choices of older doctors without undue financial penalties for those who choose not to work after the age of 65.

The high cost for employers

• Modelling by the Centre for Workforce Intelligence demonstrates the significant additional potential costs to NHS employers of a higher normal pension age. There is a strong financial case for the Government to make voluntary early retirement more attractive for doctors aged over 65 but below a higher normal pensionable age.
Preparing for an older workforce

- Given existing policy, employers must start to make provision for having an older workforce, including improving the evidence around longer working. There are a multitude of issues involved in managing and supporting older doctors – planning should start now, with employees engaged in the process.

Improving the evidence base

- Forcing doctors to work beyond the age of 65 takes the NHS into unknown territory as there is no sizeable cohort of doctors who have been working past 65 and no evidence on the implications of change.

- Improving the data available on older doctors is a critical first step if awareness is to be raised, proper training and support provided, and guidelines and regulations set down for supporting older doctors to work in ways that best fit their strengths.

The need for flexible working

- The BMA member survey demonstrated that the majority of doctors over 50 feel the need for greater flexibility in how their working time is arranged and the balance of their responsibilities as they get older.

- Employers must acknowledge that changes in the ability to cope with unusual sleeping patterns, fatigue and psychological distress may be legitimate reasons to alter an employee’s work patterns.

- It should be made easier for doctors to reduce their hours and change roles when approaching retirement.

- Employers should have to demonstrate that they offer flexibility and provide evidence of the take up.

- The experience within general practice illustrates how doctors respond constructively to flexible work options and provides models that should be explored more widely.
Occupational health support

- An ageing workforce creates a need for a more proactive approach to Occupational health support (OHS) that embodies early intervention, a more managed approach to sickness absence, and a focus on mental health and lifestyle health.
1. Introduction

The Public Service Pensions Act 2013 links the normal pension age for public sector pensions to the state pension age,¹ which is currently set to rise in stages to 68 by 2046. This will apply to all public sector workers except for fire-fighters, police and the armed forces, for whom the normal pension age will remain at 60.

The list of occupations exempted from the Act will create an iniquitous situation whereby a public sector worker in an exempted occupation with a physically undemanding ‘desk’ role will be able to retire on their accrued occupational pension aged 60, whereas a doctor who works in a challenging front-line clinical care role – for example in an emergency or intensive care unit – will have to work until the state pension age before drawing their accrued NHS pension.

The BMA:

- remains opposed to the blanket linkage of the NHS Pension Scheme normal pension age to the state pension age. No doctor should be required to work until the age of 68 in order to receive their accrued NHS pension;
- believes there is a strong case that frontline medical staff in particular have roles that are particularly physically, mentally and/or emotionally demanding and so should have their normal pension age capped at 65;
- believes the Working Longer Review should have been allowed to report before legislation was passed increasing the NHS normal pension age beyond 65.

2. Background

2.1 The NHS Pension Scheme

In 2008, changes made to the NHS Pension Scheme created two sections, the 1995 and 2008 sections. The 2008 section increased the normal pension age to 65, whereas those in the 1995 section can take their accrued pension from the age of 60. Following the changes brought in from 2008, approximately 25 per cent of pension scheme members now have a normal pension age of 65. The 2015 scheme will introduce a link between the normal pension age and the state pension age and will mean that doctors will have to work until the state pension age in order to draw an unreduced pension, unless they were eligible for transitional protection.

Doctors are, and will continue to be, able to opt for voluntary early retirement, subject to conditions, but the benefits payable are adjusted by an actuarial reduction i.e. will be lower, as the pension will potentially be in payment earlier and for longer. If a doctor is unable,
through illness, to work in their present job and the condition is permanent, it may be possible to retire early and take pension benefits without actuarial reduction (and possibly with an enhancement if further conditions are met).

### 2.2 Retirement patterns

Limited and sometimes inconsistent data are available on the age profile and retirement patterns of the medical workforce. According to data cited by the research audit carried out for the NHS Working Longer Review (WLR), almost a quarter of medical practitioners are currently over the age of 50 and around half are over 40 (Figure 1). It is predominately existing pension scheme members who, at April 2012, were under the age of 46.5 (1995 scheme) and 51.5 (2008 scheme), plus new joiners after April 2015, who will be affected by linking the normal pension age with the state pension age. Under current plans, the state pension age will initially rise to 66 in 2020, and 67 by April 2028.

![Figure 1. Medical practitioner age distributions](image)

The age at which doctors will actually stop working is difficult to predict. Data are not collected on retirement from the NHS, making it difficult to establish existing retirement patterns or to project future behaviour. In the UK, the age at which doctors retire has varied greatly; some feel exhausted by their work or find they have reduced abilities before the age of 55, whereas others continue to work well after most of their peers retire.

Data collected for the WLR shows that the average age at retirement for medical practitioners is 62.1 for men and 61.6 for women, excluding retirement on grounds of ill-health. Most of the doctors represented in this data are likely to be in the 1995 NHS pension section, with a normal pension age of 60, so the data illustrate how it is not uncommon for
doctors to work beyond their normal pension age of 60, but retire before 65. These data show the average age of retirement, not the average age people stop working.

There has been little research into levels of voluntary retirement from the NHS. Data on the number of UK doctors who relinquish their GMC registration (termed voluntary erasure) suggest that voluntary retirement may be relatively common among doctors in their 50s and 60s.

There is an urgent need for improved data across different specialties and regions on the age profile of the medical workforce and the retirement decisions made by doctors, including the numbers who move on to new jobs before and after retirement. Age-related data are not consistently analysed across the NHS. Reports from different NHS organisations show that some employers do not separate information into different types of staff or areas, and many do not collect information on the age of staff when they are recruited, promoted or when they retire. Some analyse the data that they collect, but very few seem to make any comparisons over time or evaluate the data against pre-determined goals or strategies.

2.3 What doctors tell us

In February 2013, the BMA conducted a survey of a sample of its members on attitudes and factors in working longer. The survey was sent to approximately 20,000 members considered either to be most likely approaching retirement (aged 50 plus) or already registered as retired on the BMA membership database. We recognise that doctors in our survey were not going to be affected by changes to the NHS pension age. However, the benefit of our approach was that we were able to ask questions about the factors that affect later life working in a cohort with practical experience of considering such issues.

The majority of survey respondents were still working. They were asked if they intended to continue working after drawing their NHS pension. One-third (34 per cent) reported that they did intend to continue working. Of these, four-fifths of respondents (82 per cent) intended to work part time compared to just one-tenth that intended to work full time (11 per cent); (7 per cent were ‘don’t knows’). While it is notable that a proportion envisage working part time beyond the current normal pension age (27 per cent of survey respondents currently working), their expectations are that the workplace will be able to accommodate part time working.

Respondents with a normal pension age of 60 who told us at what age they intended to stop working completely said that they intended to continue until, on average, 64.7 years (median: 65 years). A small proportion (3 per cent) of these respondents reported intending to stop working between 55 to 59 years and almost one quarter intended to work past 65
years (66 to 75 years – 24 per cent). This indicates that even before the changes to the normal pension age begin to have an impact employers will need to accommodate a sizeable older medical workforce.

For respondents (with a normal pension age of 60) who were no longer working one third (33 per cent) had stopped working prior to 60 years but approaching one-half (46 per cent) stopped working after the age of 60 years.

Respondents were most likely to identify the rewarding nature of patient care and the need for financial assurance as a reason to work longer.

Choosing to work longer, and having to do so in order to draw their accrued pension, are conceptually different and present very different challenges when seeking to maintain a desirable work-life balance. Intentions to work longer among respondents to our survey with a pension age of 60 are possibly influenced by the ability to draw a pension at age 60 or earlier, while continuing to work, and not merely by the attractions of working to a later age per se.

The survey results confirm the varied perspectives towards retirement among doctors and the need for the NHS Pension Scheme to accommodate these choices without undue financial penalties for those who choose not to work after the age of 65.

The survey also asked doctors what their approach to work would be if they were required to work to a new pension age of 68. Only 15 per cent of respondents said their approach would be unchanged. Seven in 10 respondents said they would be less likely to work outside their contracted hours and six in 10 were less likely to do work not specified in their contract (Figure 3).

The response to being required to work to 68 would have a considerable impact for NHS employers on workforce productivity. According to the research audit carried out for the WLR, medical practitioners aged over 50 years work an average of 8.8 hours of unpaid overtime and 6.1 hours of paid overtime. So a sizeable proportion of working hours of older doctors is usually outside contracted hours.

Figure 3. Imagine you are impacted by proposals to change the normal pensionable age for the NHS pension scheme. If you were forced to continue to work to a new state pension age of 68 what would your approach to work be?
3. Financial impact on NHS employers of a higher pension age

The NHS, as an employer of doctors, faces increased direct costs following the planned increase in retirement age. Additional costs, for example, will arise from:

- The payment of salaries to doctors who would previously have retired and will instead continue working until the new, higher normal pension age.
- The payment of employer national insurance contributions for the additional working years of older doctors.
- These doctors will be at, or near the top of, the salary scale, and are more likely to have Clinical Excellence Awards and other responsibility payments – hence their extra salaried years will be relatively expensive compared with the cost of employing younger doctors in the same posts.

The BMA commissioned a project from the Centre for Workforce Intelligence (CfWI) specifically to estimate the range of additional costs to employers that will arise as a result of raising the normal pension age for doctors in line with Government legislation. The CfWI’s spreadsheet model\(^\text{11}\) shows the impact on the number of hospital doctors above the CfWI’s baseline model, which assumes no changes to pension age.\(^\text{12}\) The model translates the growth in doctors’ numbers that will specifically arise from a higher pension age into cost implications for employers, using a number of scenarios. GPs are excluded from the analysis.\(^\text{13}\)

As with any model that looks to the future, a number of underlying assumptions are made.\(^\text{14}\)
3.1 Modelling results

Several scenarios and possible employer responses were modelled. Here we present findings from the central scenario that assumes the current retirement profile of doctors is maintained as the normal pension age increases, but shifts forward by the number of years the pensionable age will increase. Thus some doctors will continue to retire early and some will still work beyond when they can draw their accrued pension.

The model estimates the costs associated with different employer responses to a higher pension age. Three of the responses that were modelled are shown in Table 1, below. We selected an example year of 2026 to illustrate the potentially substantial sums involved. By that year all staff (male and female) will have a normal pension age of 66.

The results illustrate the significant additional potential costs to NHS employers of a higher normal pension age, based on the model’s assumptions. The central scenario – which incorporates general patterns of retirement behaviour similar to now – shows a gross annual cost to employers of £205.7m if the pension age-related increase in the number of consultants is absorbed by the system. Alternatively, there would be a one-off cost £327.7m if a redundancy programme was introduced for consultants to counteract that increase in consultant numbers. (There would likely need to be recurring rounds of redundancies in later years; the costs of these are not included here.)

Table 1: Gross cost to NHS employers in 2026 from higher pension age\(^{15}\)

<table>
<thead>
<tr>
<th>Employer response</th>
<th>Gross cost</th>
</tr>
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<tbody>
<tr>
<td>Annual cost to accommodate the surplus consultants in the pay bill, with the additional costs based on the average consultant income.</td>
<td>£205.7m</td>
</tr>
<tr>
<td>One-off cost of removing the surplus by making consultants redundant, with redundancy payments based on the average consultant income.</td>
<td>£327.7m</td>
</tr>
<tr>
<td>Annual cost if Junior doctors become specialty doctors not consultants, with no redundancies.</td>
<td>£133.4m</td>
</tr>
</tbody>
</table>

Employers could instead absorb the surplus of doctors by appointing doctors who hold a Certificate of Completion of Training (CCT holders) to Staff, Associate Specialist and
Specialty doctor (SAS) grade posts or to post CCT fellowships or other temporary non-consultant appointments instead of to consultant posts; this would be less expensive (£133.4m) but could demotivate staff and have a negative impact on attracting and retaining high calibre candidates into the profession. Alternatively, junior doctors could be made redundant at the end of their training. While this would likely be the lowest cost action for employers, if repeated it could lead to shortages of trained hospital doctors at some future point. It would also represent a huge cost to the Exchequer in terms of the training ‘wasted’ when junior doctors are made redundant. This lost cost of training is estimated by the CfWI model at £420.9m for the central scenario.

3.2 Implications for employers

It will be some years before the planned cuts in medical school intake will mean the growth in the number of doctors returns to the replacement rate (leavers and joiners in balance). Until then, there will be a financial impact each year on NHS employers as a result of the higher pension age – with a step change effect for the years in which rises occur.

Given the difficulties inherent in workforce planning and in making major service reconfigurations, the CfWI figures provide a valid indication of the high additional potential future costs to NHS employers if the challenges associated with a higher pension age are not addressed.

4. What makes working longer more difficult and why? (Feedback question 2)
Are there special issues for particular groups of staff? (Feedback question 3)

4.1 Impact of age on doctors’ physical and mental capacities

Like all individuals, doctors age differently and their fitness to practise before and post-retirement will vary for each individual. It is therefore unwise to try to make assumptions or generalisations about a ‘typical ageing doctor’. Many individuals do not experience serious physical or mental limitations until well after normal pension ages, but others may experience age-related physical or mental effects that impact on their ability to carry out some, or even all, aspects of medical practice.

Tasks that require physical exertion, good vision, dexterity, eye-hand coordination skills, rapid responses to events (including decisions in the middle of the night), or long periods standing are commonplace across medicine. These can become harder with age for some doctors. Roles that require problem solving, learning and speed may be particularly affected. Emergency and intensive care posts can be especially demanding – mentally, physically and emotionally. As an example of a specific aged-related issue, degenerative neck disorders can cause difficulty using a microscope or endoscope.
For hospital doctors, the nature and length of shifts vary widely, as does the flexibility and control that individuals have over the hours they undertake. Many jobs involve working nights and irregular shift patterns. The requirement to cope with on-call and out-of-hours commitments is an aspect of medical work that doctors often say they find much harder as they get older.

“As I age, being called in at night becomes increasingly difficult and can affect performance for a number of days, not just the following day.”

BMA member

Some medical jobs may have particular exposures where cumulative doses can materially increase risks to health. One obvious example is exposure to ionising radiation, if cumulative exposure is not controlled. There is also some evidence that increasing years worked at nights is linked to increasing incidence of heart disease and some cancers attributed to night work.

To date, there has been limited research specifically into the health of older doctors. The most useful information therefore comes from the research on the health of the working population that focuses on those physical and mental faculties that are most relevant to the work that doctors do.

There is evidence that some physical and mental faculties deteriorate as we age. Problems with vision, hearing and energy become more common, and cognitive functioning is likely to slow and become less precise. Chronic diseases and periods of ill health affect many ageing individuals, requiring time off work and sometimes gradual transitions back to work, along with occupational health provision within the workplace. Musculoskeletal functioning, motor skills and general physical fitness decline, with the risk of disability increasing as individuals reach advanced ages.

One issue likely to affect some older doctors is the tendency for decreasing speed of recognising and processing visual information. This is combined with reduced cognition and motor skills, to produce slower reaction times and reductions in the accuracy and speed of eye-hand coordination. This may lead to difficulties for doctors undertaking some tasks, especially those requiring precision.

As well as vision, it is very common for hearing loss to increase with age, which also brings increased incidence of tinnitus. Hearing impairments cause difficulty in understanding speech, which may cause problems for doctors in communicating with patients.

Removing distractions and ensuring that older doctors take enough time with patients
may alleviate some issues related to hearing loss, low reaction times and dexterity.\textsuperscript{30,31} This suggests that reducing caseloads or other commitments may help.\textsuperscript{32,33,34} Eventually, some doctors may have to stop working because of problems with their vision or hearing.

Although they are less well recognised in the workplace than problems with vision or hearing, increased levels of fatigue have a significant impact on the lives of ageing workers.\textsuperscript{35,36} Fatigue reduces physical and mental ability, and is often linked to a lack of sleep. As people age they tend to feel less restored after sleeping. Older adults recover less easily after interruptions to their circadian rhythms than younger adults.\textsuperscript{37,38} Sleep deprivation leads to slower reaction times which are already lower in older people.\textsuperscript{39} Along with generally lower levels of physical fitness, this may mean that older doctors have a decreased tolerance to the types of shift work that many undertake as part of their jobs.\textsuperscript{40,41}

\begin{quote}
‘The most stressful part of my daily work was the on-call commitment and the fact that it was taking longer than 24 hours to recover fully from a very busy night.’
\end{quote}

BMA member

The research audit carried out for the WLR found evidence that shift work (particularly some types of rotation) is detrimental to health across all age groups. ‘The evidence is mixed, but some sources suggest that working longer than eight hours can be detrimental to older workers’ health, while others (especially multivariate and meta-analysis studies) find no association with age and no evidence that it is worse for the over 60s than it is for people in their 50s. However, contemporary shift working practices in the healthcare sector are cited as an important influence on intention to quit. The devolution of the management of shift rotas to local unit level may mean that best practice in shift patterns is less likely to be followed than in organisations where shift patterns are centrally managed.\textsuperscript{42}

There are currently no clear guidelines throughout the NHS relating to on-call and shift work. Earlier work by the BMA has already argued that more research is needed into the health effects of shift work on doctors, and into ways of minimising the negative impact on health and work.\textsuperscript{43}

There is similarly limited evidence on mental health issues among older doctors. Complaints about overworking are common among older doctors; these can lead to work related psychological distress and an increase in accidents.\textsuperscript{44} Studies have found that psychological distress, depression, and ‘burnout’ affect doctors of all ages.\textsuperscript{45,46,47}

The research audit for the WLR cited evidence that 27.8 per cent of doctors overall report mental health issues, compared with a UK average of 17 per cent.\textsuperscript{48} Analysis of the GMC data found that for doctors aged 41–60 years, the health issues affecting their fitness to

\textbf{14}
practise were proportionally more likely to be linked to depression and neuroses than to substance misuse or alcohol. Affective disorders, which include different types of depression, arose for proportionally more doctors aged 41–60 years, while neuroses particularly affected those aged 51–60 years. Dementia and other organic mental disorders, as would be expected, affected more older doctors.49

More research is needed to investigate whether mental health problems affect older doctors more than younger doctors, and to clarify whether these problems get worse over time or tend to appear later in life.

Overall, we know very little about what impact a larger number of older doctors is likely to have on patient care as the pension age rises. A 2005 systematic review of research on the relationship between clinical experience and the quality of healthcare found that, on average, clinical performance declined later in medical careers.50 Activities such as diagnosis and appropriate use of particular therapies were affected by age, but the most common reasons for low performance in older doctors were a lack of up-to-date knowledge or a disinclination to follow guidelines.51 The study called for further research in order to investigate this relationship. In particular, research is needed to examine the performance of older doctors across all specialties and within different healthcare settings.52

While the research above confirms our view that no doctor should be required to work beyond the age of 65, it also supports our arguments that all doctors approaching the end of their careers should have access to flexible working options as outlined below.

4.2 What doctors tell us

Doctors themselves are perhaps the best judges of the impact of age on medical practice. In our survey53 of doctors over the age of 50 we asked respondents: ‘If you had been required to work up to a higher pension age, are you confident that you would have been able to practise to at least the same level of competence?’

Two-thirds of doctors of current working age said they would not be confident of being able to practise to at least the same level of competence if they worked longer. Over half of respondents who had already past their pension age replied that would not be confident of maintaining the same competence. We had expected that the proportion of respondents sure of their competence would be higher, particularly among those with real experience of working beyond their pension age. So these results are indicative of the extensive work that must be undertaken to establish:

- the material impact of aging on quality and safety across medical specialties;
- the specialties, sub-specialties and working arrangements older doctors prefer.
As demonstrated above, there is no typical pattern of retirement for doctors:

- Some doctors will feel willing and able to work for longer, including beyond the normal NHS pension age.
- Many older doctors may want to address the physical or mental limitations of older age by transferring to new types of medical work, or by winding down the hours they work, or the levels of physical exertion that their work entails. Most will have to secure the agreement of their employers to avail themselves of such options.
- Others may seek to take voluntary early retirement, either out of choice or because of circumstances outside their control, including age-related deterioration in their capabilities. This will mean taking a lower pension, as a result of actuarial reductions.
- A relatively small number will qualify to retire early on ill-health grounds, without any reduction to their pension entitlement. Historically that option has affected relatively few doctors; data provided to the WLR show a total of 662 hospital and community health doctors (including locums) taking early ill-health retirement from 2008-12, however with an eight year increase in normal pension age this will inevitably affect increasing numbers of doctors.

‘My personal experience is that older doctors are less well suited to dealing with emergency or rapidly changing clinical situations than when they were younger. They cope less well with sudden changes in routine such as working changing shifts. They become more visually and aurally challenged with increasing age and manual dexterity and prolonged adoption of unnatural body postures becomes more difficult.

‘However, older doctors also get better at routine tasks and in social skills. This is, of course, the main feature of most patient-doctor consultations. They develop a wider range of coping abilities and many become less stressed by normal clinical situations. I felt that as I aged I got better and better at less and less!’

BMA member

5. What do you think could be changed to support people working longer and how? (Feedback question 4)

As demonstrated above, there is no typical pattern of retirement for doctors:
5.1 What doctors tell us

A desire for flexibility and a greater say in their job arrangements when working longer was a consistent theme in doctors’ responses to our survey.\(^{54}\) When asked to consider their actions in response to their pensionable age being changed to age 68, four in 10 respondents replied that they would pursue options for flexible working, while almost four in 10 would not change their plans (we did not ask about current plans, so these existing plans could also have included flexible working). Significantly, when we asked respondents who had already worked beyond their pension age, almost four in 10 (37 per cent) cited being able to move to their preferred working arrangements as a critical factor in their decision. When these respondents were asked how flexible working had affected their motivation in their role, two-thirds reported that their motivation had remained the same, and one-third of respondents were more motivated as a consequence.

These findings suggest that while flexible working may be seen as a desirable prospect for those seeking to work longer, it may not be critical to motivating doctors in their roles. Rather, such flexibility at work might be assumed as a key condition and expectation of modern employment.

Our survey specifically asked doctors what aspects of their role they would like to be different in order to support working longer. Respondents were most likely to wish to do fewer unsocial shifts (81 per cent), out of hours (79 per cent), full time hours/shifts (76 per cent) and management (56 per cent). Conversely, respondents preferred to do more part-time working (54 per cent) and have more time for personal development (54 per cent). Importantly, respondents were most likely to wish to maintain at least the same amount of direct patient contact (72 per cent), work with complex cases (64 per cent), academic/research (50 per cent) and travel in the course of their work (49 per cent).

These responses indicate that, while doctors wish to remain fully committed to providing patient care, the majority feel the need for greater flexibility in how their working time is arranged and the balance of their responsibilities. The findings are indicative of the importance of the partnership approach that will be needed between individual doctors and their place of work to achieve desirable and productive working patterns for older doctors.

Our survey results on the desirability of flexible working options are in line with data cited by the research audit for the WLR. They show that 60.7 per cent of male medical practitioners and 77.9 per cent of female medical practitioners aged 50 to 59 years old would prefer to work fewer hours even if this means lower pay.\(^{55}\)

Our survey also showed that doctors are aware of the wider medical workforce issues associated with working to a greater age. We asked whether if, as a result of working longer
there were fewer opportunities for doctors to work in their desired specialty/grade/location with potential medical employment, this would affect their decision to work longer. Six in 10 respondents (who had stated an intention to work beyond their pension age) said this would cause them to reconsider their decision, compared to one-third of respondents whose decision would be unaffected.

The most popular reasons for not working longer related to declining job satisfaction (50 to 70 per cent), being able to draw a pension/to afford to retire (47 to 63 per cent), and personal circumstances (e.g. time with family) (48 to 63 per cent). However, respondents also reported the new demands of revalidation (22 to 25 per cent) as a concern. Although we did not follow up each area with more specific questions, the deterrent effect of revalidation to working longer is likely to be at least two-fold: the process may be perceived as onerous; and may actually be more difficult to achieve as clinical contact is reduced.

Finally, a reason reported by a minority of respondents for choosing not to work longer was experiencing unfavourable attitudes to older doctors (5 to 8 per cent). We later asked these respondents about the groups that had displayed negative attitudes. Seven in 10 replied that managers had been unfavourable towards them; one-half said other doctors and four in 10 perceived the media as negative towards older doctors. Negative attitudes among the public (one in five respondents) and patients (one in 10 respondents) were less common by comparison. Taken together, these data suggest there are negative perceptions of the medical competence of older doctors within the health service which must be explored further to be better understood, addressed and challenged where appropriate.

5.2 Making workplace flexibility a reality

Barriers

Support for gradual or phased retirement varies, but many employers only make this available for around four to six months before retirement. Employers should provide doctors with opportunities to reduce their hours and/or take on other types of work more than six months before retirement. Some doctors still find they face the limited choice of staying on in a high-pressured full-time job that they have been doing for years or doing no medical work at all.56

For many doctors there appears to be a significant gap between the theory of being able to work flexibly and what happens in practice. The research audit for the WLR cites data showing that only 12 per cent of older NHS employees who prefer to work shorter hours report having approached their employer on this issue. Of those who have approached their employer over reducing their hours, 55 per cent claim that their employer ‘can’t’ or ‘won’t’ allow them to work fewer hours.57 These data cover all NHS employees, rather than just
medical practitioners, but well illustrate how far employers are from a positive approach to more flexible work options. This can create an environment where older doctors with concerns about their capability to continue practicing under existing working arrangements are very cautious about approaching employers about change. Such a situation is difficult for the doctors concerned, and could potentially increase risk to patients. **Doctors should be encouraged to talk to their employers about their needs, and managers should be approachable and willing to talk about flexible working options.**

> ‘After a major abdominal operation, I returned to my job as a consultant specialist surgeon. I’m confident that I am competent at my job, but I now find it difficult when I have to stand at an operating table for up to 12 hours. I’m concerned about my ability to do my job under the current arrangements, but am terrified of raising these concerns with my managers or human resources. I fear that if I ask for an adjustment to my working patterns it could lead to redundancy, when all I need is some flexibility from my employers.’

**BMA member**

**Rigid work practices and a lack of allowance for individual needs are major obstacles to older doctors finding suitable and fulfilling work.** At a time when policy is to require doctors to work for longer, this situation leaves older doctors feeling that their skills and experience are not valued. **Flexible working practices, adjustments to workplaces, good management and training can take time and resources to implement, but they are necessary to meet the needs of an older medical workforce and would increase their motivation for their work.** Research from the US even suggests that the valuable knowledge and skills inherent within older healthcare workers makes it more cost effective to keep employees working for longer than to employ younger workers. This is despite the costs of changes such as extra training, workplace redesign and the implementation of flexible working.  

Equality legislation means it is not possible to give ageing workers preferential treatment simply on the basis of age. Accommodating the needs or expectations of ageing workers by reducing out-of-hours or on-call work for those over a certain age could be unlawful if there was no other justification for such a change. As far as possible, workplaces should seek to introduce opportunities for flexible working for all doctors. However, although age itself can no longer be used as a reason for changing employees’ work patterns, the types of age-related reasons mentioned earlier such as ill health, impairments, or changes in the ability to cope with odd sleeping patterns, fatigue and psychological distress should allow adequate adjustments to be made.
Employers must acknowledge that changes in the ability to cope with unusual sleeping patterns, fatigue and psychological distress may be legitimate reasons to alter an employee’s work patterns. We recommend that NHS Employers work with employers in the NHS to ensure appropriate guidelines are available and consistently followed to ensure that employees are treated fairly.

**Occupational health support**

Employee health and wellbeing have an important bearing on whether people are able to work at their peak. As such they are critical factors for both individual and organisational performance. NHS employees should be supported at work by programmes that protect and promote the highest attainable levels of physical and mental health and wellbeing so that the NHS consistently delivers the highest quality care to patients.\(^ {59}\)

**An ageing workforce creates a need for a more proactive approach to Occupational health support (OHS) that embodies early intervention, a more managed approach to sickness absence, and a focus on mental health and lifestyle health.**\(^ {60}\) OHS initiatives are needed to address the specific challenges of an ageing medical workforce, including the prevention of work-related diseases, reduced work performance due to chronic diseases, reduced tolerance of shift working, and the promotion of health and the ability to work. OHS is thus likely to play a key role in ‘healthy ageing management’ in the workplace.\(^ {61}\)

**Established roles for OHS include to:**\(^ {62}\)

- Ensure a good fit between person and job, so that individuals can perform in their roles safely and effectively with regard to any health problems they may have.
- Recommend suitable job adjustments to enable each person to undertake their work to the best of their physical and mental capabilities.
- Recommend suitable alternative work when a person cannot perform their normal job.
- Monitor the health of people potentially exposed to hazards at work.
- Case manage people who are on sick leave, working with community health professionals to ensure the earliest return to functional capacity and to work.
- Manage ill-health retirement ethically, fairly and objectively to avoid unnecessary wastage or ‘invalidism’ of individuals.
- Ensure people have the necessary health information to undertake their work safely.

These roles and the focus on enhancing and maintaining health are more important for OHS teams that support older doctors. Since health problems, early retirement, and sickness absenteeism will particularly increase among ageing workers, it is important that OHS
effectively and systematically supports people’s ability to work through the use of health examinations, workplace visits, counselling, and organising work activities. Age-related physical and psychological changes can be moderated by increased physical and mental activity and other lifestyle factors. Reduced function associated with ageing and many chronic diseases can be accommodated via equipment or workplace adjustments and OHS intervention can reduce the risk of early retirement.

Implementing change

The BMA believes that greater freedom of choice and more opportunities to work in different ways should be promoted, and that unfair restrictions should not be placed on the ways individuals work. All doctors, whatever pension scheme section they are part of, should have access to the whole range of flexible retirement options. The box below illustrates some typical flexible working options.

### Types of flexible working

- Part-time work
- short term contracts
- career breaks
- opting out of on-call or out-of-hours
- tailored tasks and rotas
- reduced case loads
- sabbaticals
- secondments
- job shares
- time off for further education, training or voluntary work.

The 2008 changes to the NHS Pension Scheme added flexible retirement options for employees in each of the two scheme sections in terms of when they retire and the nature and intensity of their work prior to retirement. The new rules in theory have made it easier to take up these options without jeopardising the amount of pension a doctor receives. The range of flexible retirement options are:

- ‘Step down’ – downgrade to a less demanding job but protect their higher pension entitlement (available only in the 1995 section).
- ‘Wind down’ – work fewer hours in their current post while keeping the same pension entitlement (available in both 1995 and 2008 sections).
- ‘Draw down’ – draw part of their pension in order to change to a lower paid job or reduce hours (available only in the 2008 section).
‘Retire and return’ (‘24 hour retirement’) – retire and draw pension benefits but also return to work, often on a flexible basis (available in both 1995 and 2008 sections, with doctors in the 2008 section also able to continue to accrue pension benefits after they return to work).

However, in reality, doctors can request but do not have the right to these arrangements as they require the agreement of employers. There are no data on the extent to which employers actually do offer these options or on actual take up. There is also no evidence that employees are being informed by employers about these possibilities, and many older doctors may be unclear about what is potentially on offer.

The BMA understands from anecdotal evidence from members that take up of these options is quite low. It is unclear why, or the extent to which, the reason is employer inflexibility. Before doctors are required to work longer, we need to know more about these schemes and how they work. **Employers should have to demonstrate that they offer flexibility and provide evidence of the take up.** We need an understanding of the reasons behind doctors’ thinking on whether to apply for such arrangements, and employers’ decisions on whether to agree. Future work in this area should examine more closely the current cohort of doctors already working longer across the NHS and what models of flexible employment they have secured.

Our members’ experiences show how both sides gain when employers do provide opportunities for flexible working, including reductions in hours and making it easier for doctors to transfer skills from one position to another.

> ‘I found as I got older I was less able to cope with the physical demands of on-call duties. I had back problems and my energy was not as it was. I felt this could affect my performance. I went to my clinical director with a plan to reduce my workload in a way that I thought could work. We agreed to shift the work around so that everyone was happy. I learned from this that employers need to be flexible and support older workers. The key is to present the employer with a plan, a solution to your problem, then it should be possible to fix things.’

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BMA member
Governments should strengthen opportunities for part-time working, flexible working and post-retirement working as options for doctors and as legitimate ways of practising medicine. Employers should promote and utilise the flexible working options within doctors’ pension schemes. And occupational health advisors and disability employment advisors should be used to assist in making these adjustments and supporting older doctors with impairments and particular needs.

*General practice as a model*

Doctors in general practice where the GP partnership plays the role of employer, have tended to have more workplace flexibility than hospital doctors. This flexibility in general practice provides good examples of how varied working arrangements can have a positive impact on workplace productivity and patient care. While we recognise that hospitals have different constraints on workforce management, the experience within general practice illustrates how doctors respond constructively to flexible work options and provides models that should be explored more widely.

‘One senior partner at our GP practice had a number of chronic health problems. Having to do home visits, struggling up and down blocks of flats, was making her ill. When the practice extended its opening hours, she took on extra hours in exchange for dropping her home visit obligations. This allowed her to continue working for another two years, and she remained an extremely valuable member of the team.’

BMA member
Pension arrangements can complicate decisions around retirement. It should be made easier for doctors to reduce their hours and change roles when approaching retirement. With more flexibility, doctors could be enabled to make decisions that allow them to continue working for longer, and in appropriate roles that they find fulfilling.

Inflexible pension rules can place impossible financial constraints on individuals. At worst, this can mean that, when the normal pension age is increased, doctors who do not feel wholly competent to continue in their existing working arrangements beyond the age of 65 might nevertheless decide for financial reasons that they have no option but to carry on. To feel financially ‘trapped’ in this way is detrimental to the wellbeing of doctors and potentially puts patients at risk.

As demonstrated earlier, there will be substantial additional direct costs for NHS employers if highly paid consultants do work longer each time the state pension age increases. If the financial penalty to doctors for retiring early is reduced, then they may be more likely to stop, or significantly reduce, work at the age they had planned before the increase in the normal pension age. If, for instance, the actuarial reduction were to be halved, with a further reduction each time the state pension age rises, it seems likely that there would be a net financial benefit to the Government if this does lead to older doctors taking early retirement at the same age they would previously have done. Thus there appears to be a financial incentive for the Government to make voluntary early retirement more attractive for doctors aged over 65 but below the normal pensionable age. A detailed actuarial model would be needed to provide estimates of the net impact on costs.
Evidence gaps, workforce planning and good practice

A recurring theme in this submission is the lack of available evidence on the issues faced by older doctors. **Forcing doctors to work beyond the age of 65 takes the NHS into unknown territory as there is no sizeable cohort of doctors who have been working past 65 and no evidence on the implications of change.**

The NHS does not analyse the age profile of its workforce, and there is a lack of research into the work capacity or performance of older doctors. This makes it hard to assess what challenges will arise following legislation to raise the pension age. It also obstructs the search for positive examples of improvements to working practices.

The Royal Colleges have an important role to play in considering the impact of longer working. Research should be commissioned by doctors’ professional bodies to improve understanding of the needs, working capacity, and performance of their ageing members, and especially the effects on individuals of different working conditions. Studies should cover all medical specialties and control for variables other than age. Longitudinal research is needed to look at the impact and occupational health services will need to monitor implementation.

**For employers there are a multitude of issues involved in managing and supporting older doctors – planning should start now, with employees engaged in the process.** If consultants are staying in their posts for longer, planning also needs to include managing the career aspirations of doctors as they emerge from specialty training. In this context, it is important employers collect and share information on the age, workloads and career progression of their employees, as well as overall data on impairments and concerns, in order that they can identify challenges and emulate best practice.

We know from our members that, as well as difficulties in securing flexible working, there are also examples of good practice. However, too little is known overall about what takes place within departments as much of the flexibility is agreed between individuals rather than being expressed in formal employment policy. Evidence is urgently needed about flexible working arrangements that are successful and any barriers to implementation.

**Improving the data available on older doctors is a critical first step if awareness is to be raised, proper training and support provided, and guidelines and regulations set down for supporting older doctors to work in ways that best fit their strengths.**
References

1 Section 10 of the Public Services Pensions Act 2013.
3 For the audit, this category includes: Anaesthetist, Consultant (hospital service), Doctor, General Practitioner, Medical Practitioner, Physician, Psychiatrist, Psychoanalyst, Registrar (hospital service), Surgeon.
6 These data show the average age of retirement, not the average age people stop working.
7 GMC data, extracted May 2011.
8 British Medical Association (2013) BMA survey of pension age. London:BMA.
9 A link to the electronic survey was sent to a 20,114 sample of BMA members on 1 February 2013, followed by a further email reminder on 25 February. The survey was closed to further responses on 4 March when 4,887 replies were received; a response rate of 24.3 per cent.
11 Details of the CfWI model can be found at http://www.cfwi.org.uk/publications/leaders-report-shape-of-the-medical-workforce.
12 If the pension age were to remain unchanged, there would still be substantial growth in the number of doctors.
13 GP partnerships will face extra costs, e.g. from employer national insurance costs, but it is assumed they will find a way to absorb these costs, possibly by reducing non-GP staff or not taking on new partners.
14 The model assumes no significant behavioural changes, for example the proportion of doctors in the model who choose to take early retirement or to work part-time remains the same as now. As NHS pension proposals include an element of protection for those doctors near to retirement, the model also assumes that employers will not take any significant actions to reduce their paybill (beyond existing pay restraint and vacancy control) before 2020.
15 From a societal point of view, the extra gross costs needs to be offset by any gain to the Government as a whole from pension savings, with extra employee (as well as employer) contributions and a reduction in the number of years over which the pension will be drawn. The CfWI model does not provide these estimates as it focuses on the impact on NHS employers.
16 The lost cost of training includes various elements such as tuition fees (paid by medical students, but using a Government loan) and additional Government funding for the cost of medical school.
18 Comments were collected during earlier work by the BMA relating to older doctors.
43 British Medical Association (2010) Health effects of working unsocial hours and shift work. London: BMA.
51 Ibid
54 Ibid

