

Ill-health retirement: national rates and updated guidance for occupational physicians

C. J. M. Poole, C. M. Bass (co-opted), J. E. Sorrell, M. E. Thompson, J. R. Harrison and A. D. Archer
On behalf of the Association of Local Authority Medical Advisers

Background	Advising on ill-health retirement is an important role of most practising occupational physicians. In recent years, the eligibility criteria and process for gaining early retirement benefits have changed in many pension schemes in the UK.
Aim	To investigate the variation in rates of retirement due to ill-health in National Health Service (NHS) Trusts and Local Authorities and to update previously published guidance on ill-health retirement with specific reference to pension schemes with eligibility criteria that include permanence of incapacity due to ill-health.
Methods	Rates of retirement were calculated for 222 NHS Trusts and 132 Local Authorities with more than 1500 employees. Literature searches and consensus statements by the authors.
Results	Rates of retirement were widely distributed in the NHS Trusts and Local Authorities. The median rates of retirement were 2.11 (IQR 1.37–2.91)/1000 active members and 4.10 (IQR 3.01–6.10)/1000 employees, respectively ($P < 0.001$). Difficulties in the doctor–patient relationship and in ascertaining the true functional ability of some patients were identified.
Conclusion	There continues to be marked variation in rates of early retirement due to ill-health within and between organizations that warrants further investigation. The general and specific guidance that appears as an appendix in Supplementary data to this paper should help occupational physicians to make equitable recommendations when assessing applications for early retirement benefits and fitness to work.
Key words	Audit; early retirement; fitness for work; guidance; guidelines; ill-health retirement; pension.

Introduction

Guidance for occupational physicians on early retirement due to ill-health was first published in 1996 [1]. Since then most public sector pension scheme regulations have changed, medical knowledge has increased and doctors who undertake these judgements have asked for additional guidance. The rapid rise in early retirements and redundancies that were seen in the 1980s and early 1990s have now reversed in Local Government (Table 1) and probably elsewhere.

Most pension schemes now define permanent as until the member's normal age of retirement, which may vary between schemes, with the date of joining, job or grade. The Local Government Pension Scheme recently introduced the additional requirement that the applicant must be unfit to do their own job and any other comparable job with their employing authority. The Civil Service Pension Scheme has introduced a two-tier system for which the

criteria for the lower tier include permanency of ill-health for current job but for the upper tier for any gainful employment. Most pension schemes now require a two-doctor process, whereby, the second doctor acts solely for the pension scheme and is independent of the patient and the employer. A minimum qualification in occupational medicine is usually required and accredited specialist status for advice about an appeal.

Guidance has been published on aspects of early retirement due to ill-health by HM Treasury for all public sector employers [2], the Employers' Organisation for Local Government [3], the Home Office for medical appeals under the Police Pensions Regulations [4], the Office of Deputy Prime Minister for the Fireman's Pensions Regulations [5] and the Department for Education and Employment on fitness to teach [6]. Whether this guidance has led to improved consistency, fairness or robustness of recommendations by doctors, or decisions by employers, on the merits of applications for early pensions or injury awards is uncertain.

To help answer this question, rates of early retirement due to ill-health have been analysed in National Health Service (NHS) Trusts and in Local Government

Association of Local Authority Advisers (ALAMA) website: www.alama.org.uk

Correspondence to: Dr C. J. M. Poole, Department of Occupational Health, Dudley NHS PCT, Health Centre, Cross Street, Dudley, DY1 1RN, UK.
e-mail: www.jon.poole@dudley.nhs.uk

Table 1. Local Government annual rates of retirement per 10 000 pensionable employees due to ill-health, early retirement/redundancy or at age 65 from 1979–2001 (William H Mercer Limited Actuaries)

Years	Ill-health	Early retirement/ redundancy	Age 65
1979–84	85	95	155
1984–89	125	125	100
1989–92	160	160	95
1992–95	180	175	85
1995–98	155	130	80
1998–01	120	NA	NA

NA = not available.

Authorities for England, both of whom require permanence of ill-health as part of the eligibility criteria. To assist doctors with judgements about eligibility attention is drawn to changes in public sector pension scheme regulations and to areas of practice that are likely to create difficulties, available as an appendix in Supplementary data at *Occupational Medicine Online* (www.occmed.oupjournals.org).

Methods

Rates of medical retirements from NHS Trusts and Local Government Authorities for England were obtained from the NHS Pensions Agency and the Office of the Deputy Prime Minister, respectively. For the NHS, rates were by Trust for the years 2002–3, with denominators the number of active members of the pension scheme in the respective Trust; for Local Government rates were by Authority for the years 2000–3, with denominators the number of employees in the respective Authority. To avoid excessive variability due to small sample size only employers with more than 1500 employees were included in the analysis. The data was plotted as a percentage of employers with that rate and the spread in rates measured. Significance between the NHS and Local Government was assessed using the Mann–Whitney test. A normal frequency distribution was obtained by square rooting the rates so that employers falling outside one or two standard deviations of the mean could be identified.

Relevant changes to public sector pension scheme regulations and areas of practise that have created difficulties for doctors were identified by the authors. The electronic databases Medline (1996 to 2004), Embase (1974 to 2004), Psycinfo (1987 to 2004) and Cochrane Library (1990 to 2004) were searched by CJMP for relevant papers using the search terms ill-health retirement, early retirement and controlled trial. Additional searches were made of specific illnesses and linked with the term prognosis. Guidance is based on

the results of systematic reviews, controlled trials and observational studies but where these are not available by a consensus of clinical experience of the authors.

Results

Frequency distributions of rates of IHR for 222 NHS Trusts and 132 Local Government Authorities are shown in **Figure 1** (untransformed) and in **Figure 2** (square rooted). Because of their size only three ambulance trusts were included in the NHS Trusts and no District Councils. Rates were positively skewed and widely distributed. The median rates of retirement for NHS Trusts and Local Government Authorities were 2.11 (IQR 1.37–2.91)/1000 active members and 4.10 (IQR 3.01–6.10)/1000 employees, respectively ($P < 0.001$).

All the authors had experienced specific difficulties with consultations for the purpose of providing advice to a third party about the eligibility of the patient for an early pension, or an injury award, and these difficulties were more common than in a normal doctor–patient consultation. Such difficulties included abnormal illness behaviour, wilful illness deception, or threats and vindictive complaints to the doctor’s employer or the General Medical Council if the doctor did not support the application. No controlled trials of early retirement were found in the electronic databases and the authors know none. Return to work was rarely reported as an outcome in most studies of prognosis.

General guidance is given on process, competence, employment law and injury awards and specific guidance is given on anxiety, functional (non-organic) illness, stress, post-traumatic stress disorder, depression, bipolar affective disorder, obsessive–compulsive disorder, eating disorders, schizophrenia, alcohol misuse, chronic fatigue syndrome, fibromyalgia, back pain, whiplash, diabetes, cardiovascular disease and limited life expectancy in the electronic appendix.

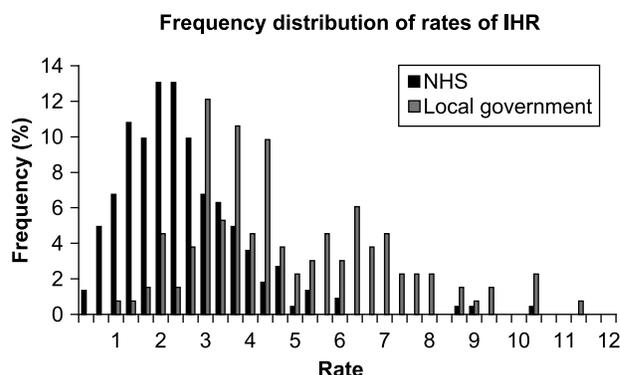


Figure 1. Distribution of rates of ill-health retirement (IHR) in NHS Trusts (2002–3)/1000 active members of pension scheme and Local Government Authorities (2000–3)/1000 employees.

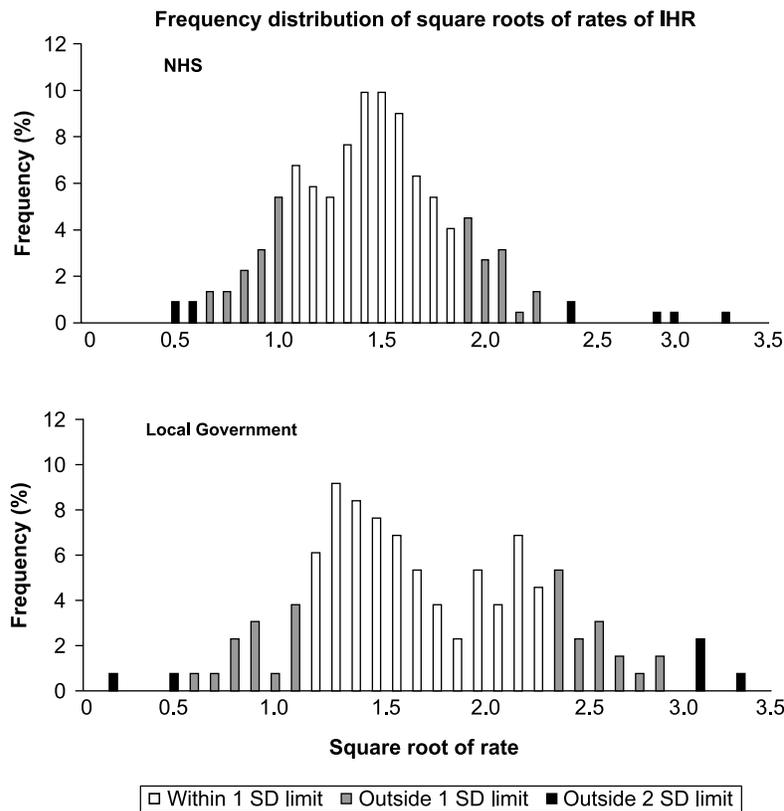


Figure 2. Normal frequency distribution of rates with standard deviations of ill-health retirements (IHR) in NHS Trusts (2002–3) and Local Government Authorities (2000–3).

Discussion

Markedly different outcomes for retirement were found between similar employers in the NHS and in Local Government. This is likely to be due in part to the medical advice that employers and employees receive, but also to the enthusiasm with which both parties pursue the options for rehabilitation or redeployment. The median rate of retirement in Local Government was significantly greater than in the NHS. The true difference is in fact likely to be greater because the denominator used for rates for Local Government was the total number of employees, rather than the number of members of the pension scheme, which because not all employees are in the pension scheme is about 20% smaller.

Ill-health retirement should only be recommended for those employees where appropriate treatment and workplace adjustments or redeployment have been unsuccessful or are medically unjustified. Adherence to these recommendations will help doctors who are asked to advise pension schemes that require permanence of incapacity due to ill-health as part of the criteria for an award of early retirement benefits to give robust and consistent advice. This in turn should reassure both employees and employers that the process is equitable

between occupational physicians. It is recommended that in contentious cases doctors should make their own searches of the relevant literature to make sure that their practise is up-to-date.

Occupational physicians should state the guidelines or standards to which they are working. This is particularly important for illnesses that rely on subjective symptoms for diagnosis. Where the doctor does not feel that he or she has ascertained the true functional ability of the patient, or the degree of disability declared by the patient is more than would be normally expected for that illness or disease, it is recommended that the doctor bases his or her advice on what would normally be expected by way of function or prognosis, in a patient with the same diagnosis but who is not seeking early retirement or financial benefit.

Rates of retirement and compliance with medical standards should be audited and included in an annual appraisal process. Doctors' and their employers' whose rates of retirement fall outside predetermined limits should be identified for special attention. Administrators or trustees of pension schemes should ensure that the process for granting benefits is not vulnerable to misuse and that the criteria for awarding benefits are unambiguous. In this way public confidence in the outcome of the process should be improved.

Acknowledgements

We should like to thank Julie Baron at the NHS Pensions Agency and Robert Holloway at the Office of the Deputy Prime Minister for their help in retrieving data on rates of ill-health retirement in the NHS and Local Government, respectively.

References

1. Poole CJM, Baron CE, Gunnyeon WJ, O'Hanlon M, Raouf A, Robson SA, Turner PEM. Ill health retirement—guidelines for occupational physicians. *Occup Med (Lond)* 1996;**46**:402–406.
2. *Review of Ill Health Retirement in the Public Sector*. HM Treasury 2000. <http://www.hm-treasury.gov.uk>
3. *Guide to Managing Ill Health and Ill Health Retirement*. Employers' Organisation for Local Government, 2002.
4. *Police Pensions Regulations 1987 and Police Pensions (Amendment) (No 2) Regulations 2003*. <http://www.hmsso.gov.uk/si/si2003/2003.htm>
5. *Firemen's Pension Scheme Order 1992*. <http://www.odpn.gov.uk>
6. *Fitness to Teach*. Department of Education and Employment. HMSO, 2000.