Pension ill-health retirement benefits

1. For some years the Deployment Remuneration and Conditions of Service Committee (DRACSC) and the Church of England Pensions Board have been concerned about the equity of current arrangements – which enhance to full potential service the pension of a member who retires on ill-health grounds even after only a very short period of service. Recent changes in selection procedures required by the Disability Discrimination Act sharpened concerns.

2. In Spring 2008, DRACSC agreed that the arrangements should be reviewed. This was before the credit crunch prompted the Church to launch the more far-reaching review of the pension scheme that the Archbishops' Task Group has had to undertake.

3. In September DRACSC and the Pensions Board received and warmly endorsed the Review Group's attached report. It was circulated to the dioceses for immediate consultation, on the basis that if they supported the recommendations it might be helpful for General Synod to consider them at the February sessions when the Task Group proposals would be debated.

4. As can be seen from the summary of responses, the recommendations have widespread support from the dioceses – who are the main funders of the pension scheme. All those who have considered the report have expressed their gratitude to the Chair, Bishop David Jennings and members of the Review Group for their careful and thorough work.

5. In the light of dioceses' responses DRACSC and the Archbishops' Council have now endorsed the review Groups' recommendations and agreed that they should be submitted to the Synod for approval. They deal with issues that are separate from the wider package of changes recommended by the Archbishops' Task Group and will be the subject of a freestanding debate.

6. If the eight recommendations set out at the beginning of the Review Group's report are approved by Synod scheme members will be consulted formally with a view to the necessary pension rule changes being brought to Synod in July. In parallel DRACSC will begin work with dioceses to agree how effective national standards for occupational health provision can be established.

The Rt Reverend John Packer
Chair of DRACSC

January 2010

THE REPORT OF THE PENSION ILL HEALTH BENEFITS REVIEW

1 Summary

This review seeks in its recommendations to address both the collective financial cost of the current arrangements in terms of strain on the pension fund and, more importantly, the individual and psychological costs that can arise from ill-health retirement. The two proposals that we hope might have the most significant positive impact are the introduction of consistent occupational health support for clergy, and improved procedures to encourage earlier occupational health intervention, rehabilitation, and reasonable adjustments. We believe that the implementation of these proposals could lead to a reduction in the numbers of ill-health retirements, and the retention of more clergy in active service.

The possibility of ill-health retirement is a valuable safeguard for the individual. We have aimed to make recommendations that preserve this important protection for those who encounter serious illness or accident during their working lives, whilst seeking to ensure that it is not a course inappropriately adopted in cases where better, alternative routes, for the good of both the individual and the Church, could be followed.

Our recommendations are as follows:

1. Continued rigour in the medical assessment adopted in selection and further rigour in the interim medical assessment at the end of the penultimate year of training to ensure so far as possible that the candidate is fit for the work of ministry. (paragraph 5.9)

2. That a consistent nationwide standard of occupational health support is made available to serving clergy; and that it is also available to ill-health retirees in order to promote rehabilitation. (6.4)

3. That the initiation of the Terms of Service Capability Procedure should be a necessary prelude to an application for ill–health retirement; and that where ill-health retirement may be an outcome of a capability procedure the Pensions Board is notified at an early stage. Thereafter the scheme member, the diocese and the Pensions Board should work collaboratively to ensure that all alternatives have been fully explored. (7.5)

4. The CEFPS rules are amended so that benefits paid where an application for ill-health retirement is made within three months after the termination of pensionable service are on the same basis as for other deferred members (ie based on completed service only).(7.6)

5. In future a standard ill-health retirement pension is based upon years earned without reduction for early payment plus a graduated enhancement calculated according to years of service. (8.12)

6. Whatever ill-health benefits are agreed for the future, the advantages to the CEFPS and to members of insuring for these benefits outside the pension fund be given further detailed consideration. (9.8)

7. Early consideration be given to a funding mechanism to support delivery of the occupational health resource described in recommendation 2. (9.13)

8. The lump sum paid to any qualifying survivor on the death of a member retired on ill-health grounds should be subject, in the event of the death occurring between one and three years after retirement, to tapering in monthly rather than annual stages. (10.5)

+ David Warrington

Chair, Pension Ill-Health Benefits Review   September 2009

2 Introduction

2.1 In April 2008, the Ministry Division’s Deployment, Remuneration and Conditions of Service Committee (DRACSC) and the Pensions Board agreed to review pension ill-health benefits in the Church of England Funded Pensions Scheme (CEFPS)[1]. The review was prompted partly by concern about costs but also by changes to procedures required as a result of the Disability Discrimination Act. The review group began work in November of last year and met six times in the period up to July 2009. Full terms of reference and membership, together with a glossary, are set out in the appendix. Our remit was to review and make recommendations about:

(a) the appropriate level of benefits in ill-health and death-in-service cases;

(b) the costs associated with the options identified; and

(c) the procedures followed in deciding upon ill-health retirement and eligibility for benefits.

2.2 Concern about the overall position of the CEFPS emerged during the period of the review, following a severe downturn in financial markets. The Archbishops' Pensions Task Group was re-appointed to explore ways to address the very serious funding problems faced. We hope that this review will usefully contribute to the process of addressing the future structure of pension provision.

3 Principles

3.1 The review covers sensitive and complex issues, and at its outset we discussed a number of principles to try to guide our work. The first principle we considered to be an appreciation of the great importance of work for an individual's wellbeing and dignity. In the light of this we welcomed the changing approach to occupational health, together with the requirements to make reasonable adjustments and to support rehabilitation where practicable that are enshrined in the Disability Discrimination Act.

3.2 We recognised the significant cost to individuals and to the whole Church of the loss of ministry arising from ill health retirements.

3.3 We affirmed that the maintenance of good health and the continued ability to work is the responsibility of individual CEFPS members, the responsible bodies and the Church at large. Ill health is unfortunately a fact of life - but may be preventable and each of us has a part to play in that.

3.4 Principles of fairness and justice are central to this review. In practice deciding what is a fair collective arrangement when individual members' circumstances vary so widely is hard. Similarly, those who must make decisions about individual cases face

[1] The CEFPS is the pension scheme for clergy, deaconesses and licensed lay workers of the Church of England.

the difficulty of taking those decisions in the context of the needs of the whole membership. We consider that clear guidelines are needed to assist objective, impartial decision making; and expert advice should be available where it can improve decision-making.

3.5 Finally, we acknowledged the importance of ill-health retirement as a protection for active scheme members who are affected by serious ill health or an accident. At the same time we consider it desirable that there be a thorough exploration of all the alternatives, including rehabilitation, reasonable adjustments or other work in or outside of the Church, before a decision to apply for ill-health retirement is made.

4 The current position

4.1 An active member of the CEFPS can retire on ill-health grounds and receive a lump sum and pension if the Pensions Board is satisfied that the member is "suffering from disability which is likely to be permanent". Disability is defined as: "…physical or mental disability which prevents a Member in Service from performing the duties of his or her office or doing any other remunerated work, or which would prevent a Member who has already left Service from doing any remunerated work."

4.2 The pension is based upon accrued service plus full prospective service to normal retirement age (65). There is no reduction for early payment. (The maximum normal pension at age 65 is calculated as two-thirds of the previous year's National Minimum Stipend – currently £13,093; the maximum tax-free lump sum is three times the pension - £39,280).

4.3 To apply for an ill-health pension a member completes an application and a Medical Report Consent form. The application must be signed by the Diocesan Bishop (or appointed officer) for someone retiring from active service. The Bishop is invited to make comments on the application, which are then taken into account in the assessment of the application. The Pensions Board writes to the member's GP for a medical report. The report is forwarded to the Pensions Board medical adviser, who may seek additional evidence as required before making a recommendation to the Pensions Board. The claim could be approved, rejected or subject to obtaining further information.

4.4 When the application is approved the member must retire within six months, or further medical evidence may be required before payment can begin. Confirmation must be received from the diocese of the date of retirement before any benefits can be paid.

4.5 Members are informed by the Pensions Board that: "Subject to any medical evidence the Board may require from time to time of your continuing disability through ill-health, to resume paid employment, the pension is normally payable for life. If, subsequent to retirement, your health improved so that you are able to resume paid employment, your pension will be reduced so that your earnings plus pension do not exceed the current National Minimum Stipend". (The reduction in pension cannot be made in the case of retirements prior to April 1989, when the relevant amendments

were made to the scheme rules). Most cases are reviewed around once every three years.

4.6 In line with a trend in the population as a whole[2], a significant proportion of ill-health retirements among the clergy are the result of psychological ill health, particularly stress and depression.

4.7 There are a number (around 3- 4 each year) of ill-health retirees who resume active stipendiary ministry. In this case the ill-health pension will cease and the member can re-join the scheme and continue pensionable service. When he or she subsequently retires, no lump sum will be payable, as the member will have received the maximum lump sum when previously retired.

4.8 Figure 1 below shows the number of ill-health retirements in the last ten years. Numbers have stabilized in recent years at around 65, having fallen from previously higher levels. The proportion in relation to numbers of stipendiary clergy – total membership – has also fallen.

4.9 The Pensions Board regularly undertakes an analysis of ill-health retirements of clergy with less than ten years service, numbers of which range between 5-10 each year. The Board also looks closely at members retiring aged under 50 – currently around five each year.

4.10 The pensions contribution rate contains an allowance of (currently) 3.5% towards the costs of ill-health retirement benefits. If the benefits were based upon accrued service only, without reduction for early payment, there would be a saving of 2.4% in the contribution rate, which would approximate to £3m to £4m per annum. An assessment of the *full* cost of ill-health retirement would of course also need to take into account housing costs and the loss to the ministry-force and associated training costs, loss of expertise and experience.

Figure 1

Year	Total Disability Retirements	Three-Year Average	Proportion of Total Retirements in year	Retirements from Active as Proportion of Active Members
1999	91	99	18%	0.77%
2000	88	92	16%	0.70%
2001	96	92	17%	0.78%
2002	103	96	19%	0.90%
2003	76	92	15%	0.59%
2004	67	82	14%	0.54%
2005	66	70	16%	0.63%
2006	63	65	17%	0.58%
2007	67	65	15%	0.68%
2008	59	63	13%	0.64%

[2] K Sparks, B Faragher & C L Cooper, *Well-being and occupational health in the 21st century workplace* (Journal of Occupational and Organizational Psychology (2001), 74)

5 Fitness for work

5.1 The procedures followed in selection for ordination training require the completion by the candidate of a medical questionnaire and a report from the candidate's GP. In the light of this information the Ministry Division medical adviser decides if the candidate is fit for ordained ministry or if further medical evidence is required. At the end of the penultimate year of training a second, shorter medical form is completed. This asks the candidate to disclose any significant changes since the completion of the earlier questionnaire.

5.2 This procedure was reviewed in 2008 by Occhea Limited, an occupational health specialist firm. The review recommended some improvements, including the use of a more efficient medical questionnaire and clarification of the occupational health expertise required in the roles of the Ministry Division and Pensions Board medical advisers. The review also recommended the addition of required external evidence in the ordinand’s end of penultimate year review. Being reliant on self-disclosure was seen to entail a risk, as the candidate may choose not to declare an adverse change in health. The review therefore recommended the questionnaire be augmented by the GP's condensed notes from the preceding three years, which could then give the evidence to prompt further investigation if necessary. This particular recommendation, concerning the augmentation to the questionnaire, has so far not been implemented.

5.3 A very recent development has been the publication of *Medical Standards for Assessing Medical Fitness for Ordained Ministry* (Church House Publishing 2009). This document sets out the criteria on which medical assessments of candidates for incumbent ministry and assistant ministry should be based. It should be noted that there are in fact few medical conditions which can be considered an absolute bar to ordination and the law does require that all cases must still be considered individually and on their merits.

5.4 The Disability Discrimination Act (DDA) had a major effect upon the operation of medical procedures for recruitment. One feature of this is that the decision about whether a candidate is fit to enter stipendiary ministry must be detached from any decision concerning entry to the CEFPS; and employers are now obliged by the Act to make reasonable adjustments with respect to a candidate with a medical condition. As a result a change was introduced last year to help to protect the pension fund from an increased risk of ill-health retirement or death in service.

5.5 The Pensions Board medical adviser now reviews all candidates at the point of selection where the sponsorship has indicated possible ordination to stipendiary ministry. The review is based upon the same Ministry Division medical questionnaire and, again, further medical evidence may be sought. The ordinand’s qualification for entry to the CEFPS is based on the medical review at the end of the penultimate year of training. Again, further medical information may be sought before a recommendation is made by the Pensions Board medical adviser to the Pensions Board.

5.6 When the medical procedures identify a significant existing risk, the Board may now restrict access to full benefits where the assessment shows that the condition or lifestyle constitutes an unacceptable risk to the scheme. The new arrangements have

applied since September 2008 and also apply in the case of candidates transferring from non-stipendiary to stipendiary ministry. In practice this has meant that candidates with pre-existing risks may still enter the CEFPS, but that in the event of ill-health retirement (or death in service) resulting from the identified medical condition, benefits will be restricted.

5.7 This change has been made possible through a rule of the CEFPS which permits the Pensions Board to refuse entry to any candidate where evidence of good health is not provided. As the rule only applies where such evidence has been specifically requested, evidence is now formally requested in all cases of candidates who may be ordained to stipendiary ministry. Rather than excluding someone entirely, the Board is applying its discretionary powers to admit them but with restricted benefits. The legal advice is that this approach is justified where evidence clearly shows that funding the risk of ill-health retirement is substantially greater than for the average employee. Thus the employee may do the job but not be entitled to the full pension. The need for actuarial evidence is important and this led to a further recommendation in the recent review of medical procedures that there should be greater use made of actuarial tables in the Pensions Board's medical advice.

5.8 The group has carefully considered the new arrangements made for candidates with identified medical conditions prior to ordination and entry to the CEFPS. They seem to the group to be, on balance, fair and appropriate, taking into account the fact that candidates are not being denied access to the scheme but only to full benefits in the event of a claim arising from the identified pre-existing condition; and their position on reaching normal retirement is the same as that of other members. It was reported to the group that experience seemed to indicate that most candidates identified so far in this category recognized the sense of the arrangement and were pleased that the opportunity was open for them to proceed.

5.9 The review group noted that the Pensions Board intends to seek to change the CEFPS rules to incorporate, in place of the current use of discretionary powers, an explicit power for dealing with pre-existing risks. The group welcomed this proposal.

Recommendation 1 - Continued rigour in the medical assessment adopted in selection and further rigour in the interim medical assessment at the end of the penultimate year of training to ensure so far as possible that the candidate is fit for the work of ministry.

6 Occupational health provision

6.1 The role of occupational health has in general been increasingly valued in recent years and recognized to be good for both employer and employee. Its value is seen not just in medical screening but in the regular assessment of the effect of work on the individual and the individual's ability to be effective at work. Its principal aims have been stated to be:

(i) to prevent people being made ill or injured by work;

(ii) to help people who are, or have been, ill or injured to return to work;

(iii) to improve work opportunities for people currently not in employment due to ill-health or injury; and

(iv) to use the work environment to help people to maintain or improve their health.

6.2 The review of medical procedures by Occhea (an occupation health specialist firm) and the appointment of the new Ministry Division's medical adviser (an occupational health doctor) already indicate a movement towards an occupational health approach. Our medical procedures now do reflect an increased sensitivity to occupational health issues. What has so far not been achieved, however, is a proper occupational health service for clergy. This was noted in Occhea's review, which referred to "the cost to the employer and Pension Scheme generated by the lack of in-service Occupational Health provision leading to a failure of appropriate timely workplace rehabilitation and a greater likelihood of Early Ill-Health Retirement." Occhea made two recommendations which were referred by DRACSC to the present review and which the review group wishes to endorse: "that a nationwide Occupational Health service be established" and that there should be "access to health surveillance and lifestyle support programmes for all members of the clergy".

6.3 The arrangements made by dioceses for occupational health do vary considerably, as does also the use made by dioceses of their appointed Diocesan Disability Advisers. In some dioceses there is very little provision and occasional expenditure may be met by the Bishops' Discretionary Fund or diocesan trust fund; in others it may be an item included in the diocesan budget. There are a small number of occupational health firms which have made themselves available to dioceses, developing an expertise in working with clergy and Church life and issues. One such firm is Health Management Ltd; another is Inter-Health, which also provides a service to other denominations. Inter-Health's services include psychological health services in the form of *Ministry Reviews* ("an opportunity for reflection and debriefing"), *Work-life balance Consultations* and *General Consultations* ("professional support for specific concerns and challenges"). The *Christian Ministry Medical* provided by Inter-Health is a comprehensive medical check-up, which it is suggested should be undertaken at two-year intervals.(Costs are around £195 which, on this basis, would represent for a diocese with 200 clergy a cost of £19,500 per annum).

6.4 There is a large body of evidence which demonstrates that work is good for people and there is a very strong correlation between job satisfaction and good health (*Environmental Medicine* 2005; 62:119-23). Prevention is always better than cure and, in both psychological and physical illness, intervention is always more effective the earlier it is undertaken. The evidence also shows that occupational health is a sound investment for employers, in general fostering a happier, more productive workforce, and reduced expenditure on sick pay. The review group wishes to recommend strongly that the resources of occupational health should be used as far as possible to prevent ill-health in clergy and to help those who are, or have been, ill to return to work. In relation to those retired on ill-health it seemed to the review group that the present arrangements for the review of cases do not go far enough in helping to promote rehabilitation. There are of course costs entailed in each case, which need to be taken into account alongside the potential savings involved, including the individual's renewed service to the Church.

Recommendation 2 - That a consistent nationwide standard of occupational health support is made available to serving clergy; and that it is also available to ill health retirees in order to promote rehabilitation.

In relation to this recommendation our comments on funding are given below (section 8).

7 Qualification for ill health retirement

7.1 The new capability procedure to be introduced under the draft Ecclesiastical Offices (Terms of Service) Regulations is an important development in the life of the Church and will have a significant bearing upon the management of ill-health. The procedure is being developed by the Terms of Service Implementation Panel and is expected to be considered by the General Synod in 2010 prior to its introduction in relation to offices held under Common Tenure. Its aim is primarily rehabilitation, "to help people to improve and to deal with problems of poor performance before they become too serious to be remedied". Where recovery is not possible, the procedure also provides a "just and clear way of removing someone from their current office".

7.2 The review group has considered the draft procedure and supporting advice and recognizes their potential, in relation to ill-health, to both help keep clergy in post and to curtail the use of ill-health retirement to deal with problems which could be more satisfactorily resolved by other means. The procedure involves a structured series of meetings, accompanied by appropriate notification and consultation and opportunities for appeal; a shortened form of the procedure is available which, it is suggested, may be suitable in some cases of ill-health. The capability procedure formally only applies to offices held under Common Tenure, but a similar procedure taking the same steps in relation to ill-health – including gathering evidence, consultation with occupational health advisers, and considering whether reasonable adjustments would enable them to continue to perform the duties of their office – should be applied to clergy in freehold posts who are applying for ill- health retirement.

7.3 We have noted in particular that under Common Tenure:

(i) diocesan bishops will have the power to direct that an office holder undergo a medical examination where they have reasonable grounds for concern about the physical or mental health of an office holder;

(ii) diocesan bishops will have the power to permit office holders to be absent from work for such period as they consider appropriate and make provision for the discharge of those duties in cases where they are satisfied that the office holder is by reason of illness unable adequately to discharge the duties of their office;

(iii) detailed advice is given in the supporting documents on finding alternative posts (such posts may be designated as probationary where the office holder has been the subject of the capability procedure); the possible need for career counselling and coaching; the use of resources such as Ministry Development Officers, the Clergy Appointments Adviser, and reference to occupational health advisers;

(iv) advice on making reasonable adjustments to work - examples given include the installation of stair lifts or providing alternative computer technology, and arrangements for some of the duties of the office to be covered for a limited period;

(v) the requirement on office holders to report illness;

(vi) advice on the need in cases of long-term sickness for regular meetings to discuss the likelihood of, and timescales for, a possible return to work .

7.4 Ill-health retirement is seen in the procedure as one "option in cases where the condition is permanent and there is no likelihood of a return to work either in the current office (whether to full duties or duties adjusted after mutual agreement) or in an alternative position (whether in priestly ministry or not)". The procedure includes a helpful checklist of points to be taken into account:

(i) whether medical advice has been sought or an occupational health referral has been made;

(ii) whether, if the Disability Discrimination Act 2005 applies, steps have been taken to make reasonable adjustments to the working environment or the way the role is carried out;

(iii) whether in other cases of sickness absence steps have been taken to make temporary adjustments to the working environment of the way the role is carried out to ease the office holder back to full duties;

(iv) the likelihood of, and timescale for, a resumption of the full range of duties to the required standard;

(v) whether alternative work outside the Church is available and what support might be required to enable the office holder to obtain such work;

(vi) the effect of the absence on the parish or other area of ministry;

(vii) how similar situations have been handled in the past.

The review group has noted the possibility of there being disciplinary or criminal proceedings. These may have a bearing on cases of ill-health and should not be overlooked.

Application for ill-health retirement

6.5 The review group has examined the procedures currently followed in applications for an ill-health retirement pension (see para 3.3). The group has considered the desirability of a more integrated procedure whereby the diocese and Pensions Board work together to ensure that all possibilities – in general covered by the capability procedure - have been explored before the decision to apply for an ill-health pension is reached. An approach along these lines would harness the new

capability procedure to full advantage, and help to ensure that ill-health retirement is only used when appropriate.

Recommendation 3 - That the initiation of the Terms of Service Capability Procedure should be a necessary prelude to an application for ill–health retirement; and that where ill health retirement may be an outcome of a capability procedure the Pensions Board is notified at an early stage. Thereafter the scheme member, the diocese and the Pensions Board should work collaboratively to ensure that all alternatives have been fully explored.

7.6 Benefits on ill-health retirement are currently calculated as follows:

- For members in active service, as mentioned earlier (para 3.2), the calculation is on the basis of the member's prospective service to age 65;

- For deferred members, the calculation is on the basis of completed service only.

However, the Rules provide that, where a member applies for ill-health retirement within three months after the date of termination of pensionable service, the benefits are calculated on the same basis as if the application had been made while still in active service (ie on prospective service to age 65). This is an unusual provision in the CEFPS rules, not generally found in other pension schemes. The review group has found this provision difficult to justify and considers that it should not be continued.

Recommendation 4 – The CEFPS rules are amended so that benefits paid where an application for ill-health retirement is made within three months after the termination of pensionable service are on the same basis as for other deferred members (ie based on completed service only).

8 Level of benefits

8.1 In practice the current rules of the CEFPS mean that, depending on his or her age, a new member can qualify for ill health retirement and have a pension paid for life to them, and their qualifying survivors, enhanced by up to forty years prospective service. This is regarded as too generous by many, although it was not untypical of private sector DB schemes at the time the funded scheme was devised; many of these schemes have since closed.

8.2 Before considering what recommendation to make in respect of future benefits in the CEFPS we looked at the ill health retirement benefits provided by a range of DB schemes that remain open. Some (for example, Legal & General, and Nationwide) are based upon accrued service plus prospective service to normal retirement age, but often have a length of service qualification period. Some (for example, HSBC) are based on accrued service with trustee discretion to enhance to full potential service. Some (for example, British Airways) are based on accrued service plus some enhancement, such as 50% of prospective service. Many public sector schemes (Police, Teachers, Fire Service, NHS) have recently adopted two-tier provision, which pays a different benefit to members who are judged to be permanently unable to carry

out any type of work (total incapacity) and members who are unable to carry our their current work (partial incapacity). In many schemes there are variations in the length of service qualification period and other variations in enhancements based on length of service.

8.3 In respect of the CEFPS we considered four options.

Option 1: No change to current benefits.

Option 2: An ill-health pension based on years earned at the date of retirement, subject to actuarial reduction for early payment. (The current rate of actuarial reduction for voluntary early retirement is 4.5% for each year before age 65). This places no strain[3] on the pension fund but could result in a very small pension.

Option 3: Pension based on years earned with no actuarial reduction for early payment. This is effectively an enhancement because the pension for those years is coming into payment sooner than would normally be the case - therefore this a strain on the fund.

Option 4: Pension based on years earned with no actuarial reduction for early payment and with an additional enhancement, but one that is less than that currently paid; recognising that the greater the enhancement, the greater the strain on the fund.

We also considered the option of introducing a qualifying period for ill-health pension benefits.

8.4 The Actuary advised that:

(i) option 2 would give a saving on the contribution rate of around 3.5 % ;

(ii) option 3 would save around 2.4%;

(iii) option 4, on the basis of 50% prospective pension, around 1.3%; and

(iv) that the saving on contribution rate for introducing a qualifying period of 5 years would be negligible.

8.5 The present provisions for ill-health retirement were made at a time when the financial pressures on the Church and the Pensions Scheme were considerably less severe than now. They were also made at a time when comparable provisions made by other employers were not uncommon. In taking a realistic view of the present financial position, we must conclude that to continue to provide the ill-health benefits guaranteed at present is difficult to justify as a priority. We consider that a reduction in the present levels of benefit is necessary, and that it is justifiable and fair in relation both to the provisions of other schemes, and to the resources available to the CEFPS to fund the pensions of all members. **Option 1 – leaving benefits as they are - has therefore been rejected.** (It should be noted that ill-health pensions already in payment are unaffected)**.**

[3] 'Strain' is the term used to describe the real cost to the pension fund of any enhancement to the benefits of a member. .

8.6 This would move us away from treating people in different circumstances in the same way, and raises the difficult question of how to treat people in different circumstances equitably. We felt that the more years of stipendiary service an individual has given the greater the Church's responsibility is to him or her. On the other hand enhancements triggered by a specific length of service can seem arbitrary, and the experience of other schemes is that they can create unhelpful incentives. In the light of this and the lack of any real saving to be made there seemed little to be gained by introducing any qualifying period**. Therefore the option of introducing a qualifying period has been rejected**.

8.7 In option 2 the actuarial reduction would be greater the further the retiree was from normal pension age. This was felt to unreasonably disadvantage a member who entered stipendiary ministry when young and has done many years of pensionable service, yet is still a considerable way off 65 when obliged to take ill-health retirement. **Option 2 has therefore been rejected.**

8.8 In option 3 the collective fund takes some strain in order to pay earned pension without any reduction for going into payment early. The amount of pension received would reflect exactly the period of service. However, we were still concerned that even those with a substantial amount of service would have to manage on quite a small pension. For example the ill health pension of a qualifying member with 20 years service would be half of a full clergy pension; although this would be somewhat mitigated by qualification for state benefits (see para 8.14). **We feel that some degree of enhancement is needed. Option 3 has therefore been rejected**.

8.9 Option 4 would provide enhancement - albeit at a cost. But what should the enhancement be? We have looked at ways of giving a greater degree of enhancement to those who have worked longer. This can be done by the use of a graduation formula.

8.10 We propose a graduated method that works by providing an ill health pension based on service completed in CEFPS plus an addition based on the member's prospective service to Normal Pension Age (currently 65) but directly related by reference to the amount of pensionable service completed to the date of retirement. This is the same formula that is currently applied to a benefit arising in respect of a member who takes ill health early retirement as a result of a condition or illness identified as being of concern at the member's date of joining (para 4.6).

8.11 The formula is designed to pay a pension based on a minimum of completed pensionable service but provides an addition that increases as the member completes pensionable service in the scheme. As the member approaches Normal Pension Age, the ill health benefit payable is very close to the existing potential service definition.

The following formula is used:

Service enhancement to count towards ill-health pension to be calculated as: $\frac{A}{T} \times P$

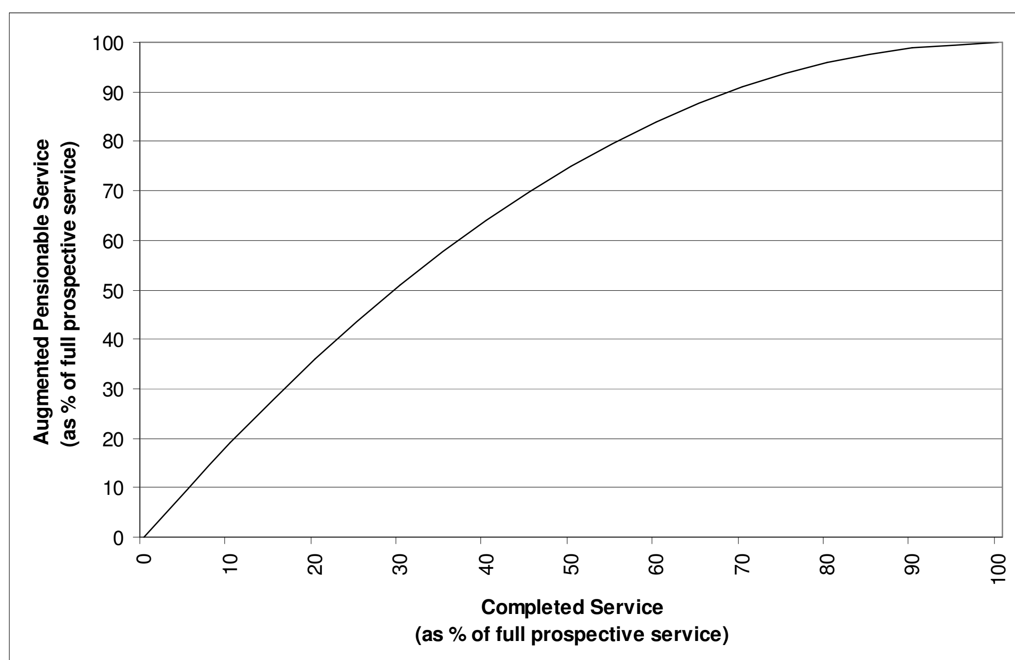
Where:

A = Completed service to date of retirement

T = Total prospective service from date of joining scheme to normal pension age

P = Prospective service from date of retirement to normal pension age

The use of the formula is illustrated in the following graph. (Further details are given in Annex 2).



8.12 This approach seems to us to strike a reasonable balance between provision for ill health retirement and the strain on resources, which are needed to provide pensions for all members. The adoption of the same method as that already being followed for those members who join the scheme with a pre-existing medical condition means that those in this category would no longer have to be treated differently (para 4.6). **The saving on the contribution rate in the adoption of the use of this formula has been estimated to be in the order of 1.3%.**

Recommendation 5 - In future a standard ill-health retirement pension is based upon years earned without reduction for early payment plus a graduated enhancement calculated according to years of service.

Two-tier schemes

8.13 We went on to consider whether there would be any merit in creating a two-tier system as a way of reflecting the nature of the ill health causing the retirement. Such schemes provide different levels of benefit to those judged permanently incapacitated and those judged to be partially incapacitated. There are two benefit formulas commonly in use by the schemes:

(a) The upper tier (Tier 1) is usually based on accrued service plus some enhancement;

(b) The lower tier (Tier 2) is usually based on accrued service only

8.14 We looked at the mechanics involved in the possible adoption of a two-tier system. The first tier could be used, in the event of the medical advice indicating that the member is permanently incapacitated, in the same way as in the current rules but very rigidly adhered to. Tier 2 would provide a benefit based on accrued service for

those unable to fulfil the duties of their present post or other ministerial post but judged capable of performing other remunerated work (or in some other way not defined as permanently incapacitated).

8.15 The costs of a two-tier system are difficult to estimate. Savings may be achieved if fewer members receive the full benefits of Tier 1. However costs could increase if members who were previously not successful in their application for an ill-health pension became eligible for the Tier 2 benefit with its less rigorous qualification requirement.

8.16 We recognize the prima facie appeal of the two-tier system, which provides the possibility of reducing the number of cases in which members are classified as permanently incapacitated. Categorizations such as "permanently incapacitated" discourage a return to work and inhibit rehabilitation. We are also mindful of the trend towards two-tier schemes across the whole public sector. However, savings are uncertain and a further difficulty is the necessity of making judgements in cases between total and partial incapacity. The experience of public sector schemes suggests that there could be an increase in the number of disputes and potential referrals to the Pensions Ombudsman. In conclusion, we feel that the advantage lies with the relatively clear-cut existing definition of disability in the present scheme and do not recommend the adoption of a two-tier system.

9 Funding ill-health benefits

Income continuation schemes

9.1 We have looked at the option of using an insurer provided income continuation scheme (ICS) for ill health benefits, rather than covering them from the main pension fund. This type of scheme has been adopted by an increasing number of employers, and is in fact already operated by the National Church Institutions alongside the Church Administrators Pension Fund Defined Contribution Section for NCI employees appointed since July 2006.

9.2 In standard ICS schemes the employee who is unable to work due to ill health is not retired but continues to receive an income (benefit) during this period - typically this might be half salary - paid for by the insurance company, which also covers the employer's National Insurance and pension contributions. There is usually a waiting period of up to 6 months before the benefit becomes payable. The benefit is paid until the member recovers and returns to work, dies or retires. If the member returns to work, pensionable service is credited for the period of the claim and the member continues future service as before. If the member retires or dies before returning to work, the usual scheme benefits become payable.

9.3 Under ICS, the insurer takes an interest in the progress of the illness and disability, and will actively promote their occupational health service and monitor the member's state of health throughout the period of the claim. It is of course in the insurer's interest to keep claim periods to a minimum. One point to be noted is that, as the member is not retired, there is no lump sum payable at the date benefit comes into payment.

9.4 We received a provisional estimate of the cost of an ICS for a benefit of 50% of NMS, deferred for 6 months from the date sick leave commences and payable to the earlier of recovery, death, leaving or age 65. The benefit would also pay the employer NI and pension contributions The indicative cost was quoted at 3.5% of National Minimum Stipend, which is broadly similar to covering the cost via contributions to the CEFPS.

9.5 The appeal here lies in providing an independent and impartial review of cases. The engaged approach to the individual and her or his rehabilitation is also strongly attractive, providing a service generally lacking in our present arrangements for managing ill health.

9.6 The main disadvantage is that generic ICS does not involve the individual retiring. This would not work for clergy for two reasons:

(i) if the cleric does not retire their office is not vacated; no-one else can therefore hold the office and there remains the question of housing for the cleric;

(ii) only on retirement is the pension lump sum paid, and this may be needed for housing purposes.

9.7 As an alternative, it may be possible to establish a specific type of scheme sometimes referred to as a 'pay direct' scheme. The 'service' with the Responsible Body would cease when the claim starts to be paid (e.g. the member would become eligible for the benefit by giving up their living), and the insurer pays the benefit directly to the member. It is not normal to insure pension contributions on such a policy as it is set up to cut ties between the member and 'employer' (e.g the Diocesan Board of Finance) in the event of a claim. However it may be possible to negotiate on this because of the potential size of the scheme. (A clergy scheme would be very large by insurance industry standards and this may offer significant benefits with regard to being able to negotiate flexibility or non standard features with an insurer.)

9.8 Investigating this further was not part of our terms of reference. However, we feel there may potentially be advantages in the insurance approach. On this basis we consider that, whatever the qualification for and level of ill health retirement benefits agreed for the future, the cost of providing for these by insurance be obtained, and detailed consideration given to using this route.

Recommendation 6 - Whatever ill health benefits are agreed for the future, the advantages to the CEFPS and to members of insuring for these benefits outside the pension fund be given further detailed consideration.

Diocesan contribution to individual ill-health retirement cases

9.9 This report has referred earlier to the need for an exploration of all alternative avenues before decisions are made about applying for ill-health retirement. We have recommended (section 6) that dioceses and the Pensions Board work together to ensure that the new capability procedure is fully harnessed in this respect. It is the case, however, that in the present system there remains a short-term financial incentive for dioceses to support an application for ill-health retirement rather than

explore other options, because the costs involved will be met not by the diocese but through the CEFPS (although all dioceses do of course contribute to the CEFPS and it is in all their interests to keep strain on the fund to a minimum).

9.10 We have therefore considered the argument for shifting to dioceses some of the financial strain of ill-health retirement in order to increase the incentive to make early occupational health interventions, explore other options and to discourage too easily reaching the decision to back or initiate an application for ill-health retirement. It might also serve as an incentive to develop pro-active occupational health management programmes.

9.11 Such a contribution could be set at the full cost to the CEFPS of the early retirement in question, or a contribution; or it could be a nominal sum of perhaps £10,000 - 20,000, considered large enough to prompt dioceses not to pursue ill-health retirement until all other possibilities have been considered.

9.12 We had a number of concerns about this proposal:

(i) cases of ill-health vary considerably. Sometimes costs are very large, in others - for example, the quite common cases of candidates retiring in their 60s - relatively small. It would be difficult to devise a method in which the diocesan payment could be seen as operating fairly applied to diverse individual cases;

(ii) the payments could create budgetary problems, the distribution of cases between dioceses is historically quite random; numbers range from zero to five per annum, with little obvious general consistency in the number or pattern from year to year;

(iii) inappropriate pressure might be exerted to keep clergy who are not in good health in post until retirement age;

(iv) the proposal is contrary to one of the main principles of a pension scheme, *pooling* risk;

(v) making a retirement conditional upon a responsible body being prepared to meet or contribute towards costs will create uncertainty for the member; and

(vi) complicating the processing of a retirement could increase administration costs.

9.13 Acknowledging these objections, we believe that a reasonable alternative approach is to focus on the provision of consistent occupational health support across the dioceses. The review group has recommended (section 5) the introduction of a national occupational health service. The most suitable mechanism for its funding will require further consideration.

Recommendation 7 - Early consideration be given to a funding mechanism to support delivery of the occupational health resource described in recommendation 2.

State Benefits

9.14 There are state benefits available to those retired on grounds of ill-health and occupational health assists in applying for these benefits. State benefits represent a source of help which, in addition to the help towards housing costs available to all retired clergy, will mitigate the effect of any reduction in the level of pension. We assume that retirees will apply for state benefits where entitled to them.

9.15 Up until November of last year the principal state benefit for which an individual unable to work through ill-health was eligible was Incapacity Benefit. This has been replaced by Employment and Support Allowance (ESA). The Government's approach with this new benefit is - along occupational health lines - to get people back to work and its stated aim on the introduction of this allowance was to get "one million people off incapacity benefits by the year 2015". It has aimed to achieve this through Work Capability Assessments designed to "look at what people can do rather than what they can't"[4] and to give appropriate support. The Disability Living Allowance (DLA) is a further benefit for which some will be eligible.

10 Death benefits

10.1 When a member dies in service, their spouse[5] is entitled to a pension at the level of two-thirds of the ill-health pension the member would have received if she or he had taken ill-health retirement. A lump sum is payable, at the level of three times the National Minimum Stipend for the previous year – currently £57,210 - which is tax-free. We do not suggest that these are changed.

10.2 When a member dies after retirement, their spouse[6] is entitled to a pension of two-thirds of the pension at the time of death. If the death is within one year of retirement, the balance of the first year's pension is payable to the estate.

10.3 If a member retires on an ill-health pension and dies before the age of 65, a lump sum is provided as follows:

(a) Death within 1 year of ill heath retirement: £57,210 (3x NMS) less the retirement lump sum already paid

(b) Within 1-2 years: £37,186 (65% of 3xNMS) less the retirement lump sum already paid

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[4] As announced by James Purnell, the Work and Pensions Secretary, on the Welfare Reform Bill, October 2008

[5] A civil partner would also be entitled to a pension based on pensionable service completed from 5th December 2005 and in respect of the potential future service granted under the rules of CEFPS. There may also be some entitlement to a proportion of the contracted out rights earned prior to 5th December 2005.

[6] A civil partner would be entitled to a pension based on the pension payable to the member at the date of death in respect of pensionable service completed from 5th December 2005. There may again also be some entitlement to a proportion of the contracted out rights earned prior to 5th December 2005.

(c) Within 2-3 years:£17,163 (30% of 3xNMS) less the retirement lump sum already paid

10.4 Thus the overall amount paid on death-in-service, and on death shortly after ill-health retirement, are the same. This arrangement (which is unusual among DB schemes) was introduced to reduce anxiety for someone who is so seriously ill they expect to die in the near-term, and believe their survivor would be better off financially if they die in service rather than take ill health retirement. As time goes on and pension is paid the financial differential reduces, hence the stepping down of the lump sum over the next two years.

10.5 We have been made aware that there is still a measure of anxiety because these steps can mean that the precise timing of death may have an abrupt and significant bearing upon the level of lump sum paid. Introducing a scale tapered by months rather than stepped by years would reduce this anxiety.

Recommendation 8 - The lump sum on the death of a member retired on ill-health grounds should be subject, in the event of the death occurring between one and three years after retirement, to tapering in monthly rather than annual stages.

Glossary

Active Member	A person in active stipendiary or ecclesiastical service in respect of whom a Responsible Body is paying contributions to CEFPS
Actuary	Person appointed by the trustees of a pension scheme to carry out an examination of the scheme funding
CEFPS	Church of England Funded Pensions Scheme
Contribution rate	The amount each Responsible Body participating in the scheme must contribute to the scheme under the trust deed
DB Scheme	Defined benefit pension scheme – a scheme where members' benefits are determined by a formula, usually involving pay and/or service with the employer. Often termed *Final Salary* or *Salary-related* schemes.
DC Scheme	Defined contribution scheme – a scheme where the benefits are calculated by reference only to the amounts paid into the scheme, the investment return, and how much pension this would buy at retirement. Often termed *Money Purchase* schemes.
DDA	Disability Discrimination Act 2005
Deferred member	A former member of the scheme who has preserved benefits, i.e. benefits which have not yet come into payment
DRACSC	Deployment, Remuneration and Conditions of Service Committee of the Archbishops' Council
ESA	Employment and Support Allowance – State Benefit introduced in November 2008 replacing Incapacity Benefit
ICS	Income Continuation Scheme
The Pensions Board	The Church of England Pensions Board
Responsible Body	A body which has a duty to make contributions for the purposes of the CEFPS to the Pensions Board in respect of one or more CEFPS members

ANNEX 1

Terms of reference for a review of the ill-health retirement provisions in the clergy pension scheme for report to DRACSC (Deployment, Remuneration and Conditions of Service Committee) and the Pensions Board

Purpose

1. The purpose of the review is to reassure DRACSC, the CEPB, the Archbishops' Council and the responsible bodies that the scheme's arrangements for ill-health retirement remain fair, reasonable and proportionate in the light of:

(i) rising contribution rates and the recent reduction in scheme benefits for all members

(ii) the Disability Discrimination Act, and the response to it made by Ministry Division and the CEPB;

(iii) the planned introduction of a capability procedure under the Terms of Service legislation;

(iv) the particular conditions of service of the clergy; and

(v) current practice in other schemes.

Reason

2. The Pensions Board has been concerned for some years about the strain on the fund caused by the ill-health provisions. The greater degree of prudence required by the Pensions Regulations has led to concern that the provisions for ill health retirement (which take full prospective service to normal retirement age into account) may be more generous than the scheme, which is currently in deficit, can prudently afford.

3. Concern has been heightened by recent changes in the selection procedures for ordained ministry made in response to the Disability Discrimination Act, that have resulted in more candidates with existing medical conditions entering training for stipendiary ministry. The Board has introduced interim measures to mitigate the resulting risks to the scheme.

4. Questions have been raised about the proportionality of the existing arrangements in the light of the reduction in benefits across the board in order to keep the scheme affordable.

5. There remains a risk that individuals who are regarded as fit to work but are excluded from some of the benefits of a pension scheme could still bring a claim under the Disability Discrimination Act.

Evidence of need for review

6. Numbers, reasons and years of service for ill-health retirements in recent years: consequent costs to fund . Numbers of candidates under review since changes to selection procedure. A lack of clarity about the difference between incapability and

ill health, has been revealed by the Terms of Service review. The published guidance *Moving out of Full-Time Ministry* is out of date.

Boundaries

7. The systems, policies, procedures, legislation, etc., that are outside the scope of consideration by the review group are:

(a) diocesan compromise agreements and severance arrangements;

(b) parallel work being done on occupational health standards to determine 'fitness for ministry' by the Ministry Council for the House of Bishops;

Specific Issues to be Addressed

8. The work to be undertaken by the group is a review of the following:

(a) the appropriate level of benefits granted in ill-health/death-in-service cases;

(b) the costs associated with the options identified

(c) the 'Benefits Gateway' - how a judgement on whether someone should receive the benefits is reached (possibilities for re-deployment); and

(d) the qualification for benefits - years of service, fitness at point of entry etc.

Desired Outcomes/Outputs

9. A report to DRACSC & CEPB setting out:

(a) the options and the associated costs ;

(b) options regarding: access to benefits; managing the gateway; and risk reduction;

(c) a communication plan and timetable for the implementation of any recommended changes.

Review Group Members

1. The Rt Revd David Jennings, Bishop of Warrington (Chair)
2. The Rt Revd David Walker, Bishop of Dudley (Vice-Chair), Member of CEPB (Church of England Pensions Board)
3. Mrs April Alexander, Member of DRACSC (Deployment, Remuneration and Conditions of Service Committee) & Vice Chair CEPB*
4. The Revd Maureen Allchin, Member of CMDDP (Committee for Ministry of and among Deaf and Disabled People)
5. Mr Philip Arundel, Diocesan Secretary, Diocese of Ripon and Leeds
6. Mrs Gill Morrison, Member of DRACSC
7. Mr Timothy Walker, Third Estates Commissioner

Staff resources

Dr Mark Hodge, Grants Officer, Ministry Division (Secretary)
Mr Tony Williams, Pensions Manager, CEPB
Mr Peter Dickinson, Deputy Pensions Manager, CEPB
Mr Patrick Shorrock, Secretary, Terms of Service Implementation Panel
Mrs Sarah Smith, DRACSC Secretary

* Mrs Alexander has since become a Church Commissioner and so has resigned her seat on the Pensions Board.

ANNEX 2

Example of proposed graduated enhancement according to years of service

The formula outlined earlier (para 7.11) shows service enhancement to count towards the ill-health pension calculated as: $\frac{A}{T} \times P$

Where: A = Completed service to date of retirement

T = Total prospective service from date of joining scheme to normal pension age

P = Prospective service from date of retirement to normal pension age

For example:

A member joins scheme age 40. Total prospective service to age 65 (T) = 25 years

Member retires on ill-health grounds at age 45. Completed service to date of retirement (A) = 5 years

Prospective service from date of retirement to age 65 (P) = 20 years

Enhanced service to be used in calculation of benefit = $\frac{5}{25} \times 20 = 4$ years

Using the same example but calculating the benefit throughout his or her working life, the potential ill-health benefit payable at each year end would be based on the pensionable service completed plus the enhancement shown in Figure 3.
To give an indication, if the member had completed just 1 year's service at the date of ill-health retirement, the pension payable would be based on the accrued service of 1 year plus an enhancement of 350 days. The total pensionable service used to calculate the ill-health pension would be 1 year and 350 days.

If this member was required to retire due to ill-health at the age of 60 having completed 20 years of pensionable service, the enhancement would be 4 years, and the total pensionable service used to calculate the benefit would be 24 years.

It should be noted that this table is specific to this particular example and the amount of enhanced service provided would be different if the period of total potential service from joining to normal pension age was higher or lower.

Figure 3

Age	Accrued Pensionable Service (Years)	Ill health Pensionable Service Enhancement (Years and Days)
41	1	350/365
42	2	1 307/365
43	3	2 234/365
44	4	3 131/365
45	5	4
46	6	4 204/365
47	7	5 15/365
48	8	5 161/365
49	9	5 277/365
50	10	6
51	11	6 58/365
52	12	6 88/365
53	13	6 88/365
54	14	6 58/365
55	15	6
56	16	5 277/365
57	17	5 161/365
58	18	5 15/365
59	19	4 204/365
60	20	4
61	21	3 131/365
62	22	2 234/365
63	23	1 307/365
64	24	350/365

Pension Ill health benefits – responses to the consultation with dioceses

The review was circulated to dioceses on 11th September. Dioceses were particularly asked for their views on the recommendation to reduce the level of ill-health retirement benefits.

Responses were received from 33 dioceses. The report's 8 recommendations are set out below, followed by a brief summary of the response to each recommendation. In some cases responses have not referred to all of the recommendations and this has been noted.

Recommendation 1: Continued rigour in the medical assessment adopted in selection and further rigour in the interim medical assessment at the end of the penultimate year of training.

All bar one of the 28 dioceses referring to this recommendation support it. One diocese has expressed concern that "this should not further disadvantage those with existing disabilities who are applying for ministry".

Recommendation 2: That a consistent nationwide standard of occupational health support is made available to serving clergy; and that it is also available to ill-health retirees in order to promote rehabilitation.

Twenty-four positively endorsed this, four had reservations. The objections to the recommendation included concern with potential cost, and the view that "we believe it is more appropriate, to allow each diocese to enter into its own arrangements".

Recommendation 3: That the initiation of the Terms of Service Capability Procedure should be a necessary prelude to an application for ill–health retirement; and that where ill-health retirement may be an outcome of a capability procedure the Pensions Board is notified at an early stage. Thereafter the scheme member, the diocese and the Pensions Board should work collaboratively to ensure that all alternatives have been fully explored.

This recommendation was supported by 26 of the 29 responses referring to the recommendation, although several raised some concern about the use of the capability procedure.

Recommendation 4: The CEFPS rules are amended so that benefits paid where an application for ill-health retirement is made within three months after the termination of pensionable service are on the same basis as for other deferred members (ie based on completed service only).

Fully supported by each of the 28 dioceses referring to the recommendation.

Recommendation 5: In future a standard ill-health retirement pension is based upon years earned without reduction for early payment plus a graduated enhancement calculated according to years of service.

Among the 33 referring to this, there are 3 dissenters. One strongly argued that the recent reduction in the number of ill-health retirement cases, coupled with the anticipated further reduction following the implementation of the review's other recommendations, means that a lowering of benefits does not seem to be justified since "a drastic scenario could await a priest who becomes seriously ill during their ministry." Another said that, " the risk is that if clergy need to retire, but felt that they cannot afford to, they will soldier on and either further damage their health and/or the ministry in the parish".

Finally, the third expressed the quite different view that, "many clergy who medically retire from ministry subsequently find gainful employment in another capacity and those that do have not have access to state aid, the preference for any change would be an ill-health pension based on years served with an actuarial reduction for early payment."

Recommendation 6: Whatever ill-health benefits are agreed for the future, the advantages to the CEFPS and to members of insuring for these benefits outside the pension fund be given further detailed consideration.

Fully supported by each of the 27 dioceses referring to the recommendation.

7. Recommendation: **Early consideration be given to a funding mechanism to support delivery of the occupational health resource described in Recommendation 2.**

This recommendation has been supported by 24 of the 27 responses referring to the recommendation. As noted earlier a few dioceses expressed opposition to the proposed nationwide occupational health provision. One diocese, whilst supporting the recommendation, does make the point that, "any funding mechanisms being considered should be discussed with dioceses as there are potentially heavy costs to such a proposal".

Recommendation 8: The lump sum paid to any qualifying survivor on the death of a member retired on ill-health grounds should be subject, in the event of the death occurring between one and three years after retirement, to tapering in monthly rather than annual stages.

Supported by all of the 28 responses referring to the recommendation.

DRACS Unit
November 2009