Ancillary staff pensions

The General Medical Services Committee has issued the following advice to general practitioners via local medical committees and BMA divisions.

(1) This note is being circulated to bring general practitioners up to date with what has happened since 1 April 1978. On that date new arrangements came into effect by which in certain circumstances full reimbursement was to be made to practitioners of the amount of their contributions to private superannuation schemes in respect of ancillary staff employed by them.

(2) The history of the negotiations with the Department of Health and Social Security between November 1977 and March 1978 was set out in circular M14 sent to LMCs on 17 March 1978 (25 March, p 799). During these negotiations agreement was reached on two occasions with DHSS officials as to the wording of the new provision that it was intended to implement. But on each occasion the Department withdrew from the agreement. Finally the wording of the determination of the Secretary of State was published in these terms: "From 1 April 1978, reimbursement will be made of 100% of the Employer's National Insurance contribution and of his—that is, the doctor's—*reasonable* contribution (if any) to private superannuation schemes to which the doctor was *irrevocably* committed at 6 March 1978."

The words in italics were inserted into the original agreed draft by the Department and without the agreement of the GMSC.

(3) The statutory provisions which govern the matter make it the duty of family practitioner committees to arrange for payment to doctors "in accordance with such rates and subject to such conditions as the Secretary of State may determine." It is, therefore, the duty of family practitioner committees to ensure full reimbursement to a doctor who can show that he has made contributions that fall within the terms which the Secretary of State determined and which are set out above.

(4) Since 1 April 1978 family practitioner committees have been considering applications made by doctors for reimbursement and have in many cases turned down claims. No problems have arisen in respect of contributions to private schemes into which doctors had entered by 15 February 1978, but arrangements made by doctors with insurers during the period 15 February to 6 March have given rise to a number of problems. In the most part committees have sought to justify refusal on one of two grounds, namely (*a*) that the contributions were said not to be "reasonable," and (*b*) that the doctor was not "irrevocably committed" at 6 March to the scheme to which he had made payments.

(5) Different committees have given different decisions on facts that were indistinguishable, and in one area different decisions have been given by the same committee on two applications that were precisely similar.

(6) Furthermore, it would appear that some of the decisions to refuse reimbursement were, at least arguably, wrong in law. For example, it seemed that committees were in some cases saying that a doctor who had firmly agreed to enter a scheme was not irrevocably committed to it if the terms of the scheme enabled him, on notice, to stop making contributions, or to reduce the amount of his contributions.

(7) General practitioners whose schemes have been rejected by FPCs should certainly lodge appeals with the Secretary of State in accordance with paragraph 80.1 of the Statement of Fees and Allowances if they are dissatisfied with the decision of the FPC.

(8) In the somewhat confused situation that the Department and the FPCs had thus created the GMSC decided to consult leading counsel on the legal position, and the wisest course to adopt to ensure that doctors were reimbursed in cases where they were legally entitled to be reimbursed and to ensure that in future family practitioner committees acted uniformly.

(9) As a result of the advice received the GMSC is taking steps which will, it hopes, result in the direct reimbursement of reasonable contributions. The problems that arise are, however, not straightforward and it may take some time to reach an acceptable conclusion. It is hoped that it will not be necessary to take action in the courts to resolve the matter, but the GMS Committee feels it wise to warn doctors that this might become necessary. If it should become necessary, for example, to take a number of test cases to court it is unlikely that a final decision would be reached in much less than 12 months.

(10) The committee appreciates that this is not a satisfactory position for doctors who are at present paying contributions to private schemes where a final decision on reimbursement has not yet been made. The committee wishes to remind general practitioners of two factors.

(11) Firstly, if doctors are not reimbursed, contributions to a scheme approved by the Inland Revenue are, by section 21(3) Finance Act 1970, a deductible expense in computing their income tax.

(12) Secondly, most schemes provide for the alteration by agreement between the doctor, the employee, and the trustees of the scheme concerned of the amounts of the employers' contributions. In the MGM Design for Retirement Pension Plan (as in many other pension schemes), to which many doctors contribute, the power to alter contributions by agreement is to be found in Rule 2(3) of the rules of the scheme. It is important to note that agreement must be reached with the employees and the assurance society before contributions are varied.

Conclusions

The GMS Committee's advice to doctors whose schemes have not yet been accepted is:

(1) To appeal to the Secretary of State under paragraph 80.1 of the Statement of Fees and Allowances.

(2) To consider:

(*a*) continuation of payments at existing contribution levels, or

(*b*) reducing their contributions to a lower level as outlined in paragraph 12 above. The MGM scheme does not permit these payments to be reduced below £100 per annum for each practice.

Hospital disputes

Advice to consultants

Representatives of the medical defence societies and the Central Committee for Hospital Medical Services have agreed the following statement of advice to consultants working in hospitals where services are being disrupted because of industrial disputes.

"When hospital resources or facilities for patient care are adversely affected consultants will wish to know how to act to secure the best possible arrangements for their patients. The following guidance is offered.

Inpatients

"A consultant has a duty of care to every patient admitted under him. Where he is unable to provide the normal standard of care the position and any practical alternatives should be explained to the patient and the fact that this has been done should be recorded in the patient's notes. The AHA should be informed in writing when it is considered that patients are in danger of being exposed to increased risks from lack of staff or facilities. Partial or complete cessation of certain aspects of a consultant's work may exceptionally become necessary in patients' interests.

Waiting lists

PATIENTS WITH PROMISE OF TIME OF ADMISSION

"If a consultant finds himself unable to fulfill his promise of admission, or the reasonable expectations of a patient on an urgent list, he should advise his patient of the reasons. Informing the patient's general practitioner also may permit of the patient's treatment being arranged elsewhere.

PATIENTS WITHOUT PROMISE OF TIME OF ADMISSION

"A consultant is not under any obligation to act. It is recommended, however, that the AHA and local general practitioners be kept informed of the effects on waiting lists.

Emergencies

"The decision that a patient requires emergency treatment is one which only a doctor is competent to make. If lack of staff or facilities submit the patient to an increased hazard he should be informed of the risks of the treatment and of not being treated, and of the practicalities of transfer to another hospital. A record of information and advice given should be made.

"In tendering this advice it is appreciated that conditions may vary considerably from hospital to hospital. Consultants taking such action as they deem proper in the best interests of their patients may rely on the full support of the BMA and the defence societies."

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