Supplementary written evidence submitted by the BMA (RTR0149)

BMA additional submission on pension taxation to the Health and Social Care Committee inquiry on workforce recruitment, training and retention in health and social care

About the BMA

The BMA is a professional association and trade union representing and negotiating on behalf of all doctors and medical students in the UK. It is a leading voice advocating for outstanding healthcare and a healthy population. It is an association providing members with excellent individual services and support throughout their lives.

1. Overview of the problem

1.1 The current pension taxation system serves as a significant driver in senior staff leaving, or reducing their working contribution, to the NHS. BMA surveys indicate that two thirds of UK doctors over 55, and one in eight aged between 35 and 54, are considering retiring within three years[1]. Losing these doctors will inevitably impact patient care.

1.2 In the next 18 months alone, modelling from the BMA, as well as surveys from the Royal College of Physicians[2], suggests that without decisive action, more than 10% of the consultant and GP workforce is likely to retire within the next 18 months. A survey of BMA GP members which asked where GPs saw themselves professionally in the next three years stated 14.3% have taken early retirement, and among those currently working as a GP partner, it was nearly 18%. These findings follow clear evidence that average retirement age has already fallen from 61 in 2007/08 to 59 in 2018/19. There has also been a four-fold increase in the number of voluntary early retirements (VER) since 2008, with 30% of consultant and 54.7% of GP retirements in 2020 being VER[3].

1.3 The government's move to increase the annual allowance (AA) threshold in 2020 did remove some doctors from additional charges in relation to the specific issue of the tapered annual allowance. However, as the BMA highlighted at the time, pensions taxation rules and the way in which they interact with the NHS Pension Scheme rules are complex and this was not a definitive solution. Furthermore, the sheer scale of additional work that was undertaken by doctors during the pandemic as well as the huge volume of additional work that is required to tackle the huge waiting lists we now face, mean that many more doctors than predicted remain at risk of tapering and need to limit their work as a result. Furthermore, these changes did nothing to address issues caused by the standard AA or Lifetime Allowance (LTA).

1.4 The freezing of the lifetime allowance (LTA) the following year in 2021 was incredibly disappointing and served only to further exacerbate the problem. This is clearly a significant concern for our members, with our survey[4] of over eight thousand doctors revealing that:

- 72% said freezing the lifetime allowance would make them more likely to retire early
- 61% of respondents said they would be more likely to work fewer hours

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[1] Rest, recover, restore: Getting UK health services back on track p.12 https://www.bma.org.uk/media/3910/nhs-staff-recover-report-final.pdf

[2] RCP, www.rcplondon.ac.uk/news/more-capacity-best-birthday-present-nhs-could-get

[3] DHSC written evidence to DDRB, pp.45-46, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/966692/DHSC-written-evidence-to-the-DDRB-for-2021-to-2022.pdf

[4] BMA, press release March 2021, https://www.bma.org.uk/media/3850/bma-pensions-survey-march-2021.pdf

- 41% said they would be more likely to give up additional responsibilities.

2. Background: The problem

2.1 The NHS has the steepest tiering of employee pension contribution rates of any public sector scheme. The justification for these tiered contribution rates is to offset the benefit of higher rate tax relief. At the current rates higher earners pay up to 14.5 (14.7% in Scotland)% of their pensionable pay in employee contributions compared to 5.2% for the lowest paid NHS workers. From April 2023 the intention is to move towards a flatter tiering structure. But even with the proposed changes, the top rate being reduced to 12.5% in 2023, higher rate tax relief will still be adjusted for at source. This in effect means that in the NHS, effective contribution rates for the highest earners will be greater than the lowest (7.5% compared to 4.2%), despite accruing pension at the same rate. Consequently, this tiering of contribution rates completely removes the benefit of higher rate income tax relief on pension contributions for higher earners in the NHS.

2.2 Despite the NHS pension scheme design already limiting tax relief, the AA and LTA both attempt to remove this tax relief for a second and then a third time. What the system has created is a scenario whereby doctors can find themselves, should they continue to work in the NHS, financially disadvantaged by working more hours or delaying retirement. This in turn can result in a situation where they end up working for no pay, or in extreme circumstances, particularly if impacted by tapering of the AA, actually "paying to go to work". This is compounded by the complexity in identifying when a doctor may be at risk of going above the AA and LTA thresholds. This complexity drives doctors to reduce their work commitments to the NHS or to early retirement, for fear of breaching these thresholds.

2.3 In the NHS pension scheme, pension growth is directly linked to the level of pensionable pay and the amount of pensionable service. It cannot be controlled independently of earnings. The only ways to reduce a pension tax liability in the NHS is to work less, retire early or opt out of the scheme. If a doctor opts out of the scheme, they typically lose the benefit of the employer pension contributions (an important part of the total reward package, at around 20% of pensionable pay) and receive reduced death in service benefits.

2.4 Furthermore, as AA and LTA are "claw back" charges, they are charged at the applicable rate of income tax – i.e., 40 or 45% (41 or 46% in Scotland). Any excess over the lifetime allowance attracts an effective rate of tax of 55%. In many cases, the ***same pension growth*** **will be impacted by both AA taxation and the LTA excess charge.** Once in receipt of this pension, it is then subject to income tax. It is the fact that not only is the same pension growth that is taxed multiple times (despite tax relief being adjusted for at source) but also that pension growth cannot be controlled or limited other than by reducing work that makes this a particular issue for the NHS.

2.5 Part of the rationale for the AA and LTA is to discourage people from paying more than these limits into their pension and as a result draw more income as salary (which is then subject to income tax). Given the only meaningful way that doctors can reduce their pension growth is to work less, it is therefore inevitable that these taxes leave doctors with little option but to reduce their hours or retire early.

3. Background: The impact of the pandemic and paying to go to work

3.1 Many doctors will find themselves caught out by punitive pension taxation in the tax year 2021/22 as a direct result of the pandemic. This is because so many doctors went above and beyond by undertaking extra work, or putting off retirement, to continue to support the NHS and its patients through the COVID crisis. A further contributing factor to this is the effect of applying different rates of the Consumer Price Index (CPI) to the NHS pension scheme. The 'opening values' of the members pension benefits are increased through an assessment against the previous year's CPI, which for 2021-22 is an allowable increase of only 0.5%. Conversely, the

revaluation of pension benefits is based on 1.5% plus the current year's CPI (3.1%), a total of 4.6%. In addition, the pay award of 3% is again assessed against last year's CPI of 0.5%. This in effect means that despite the pay award for 2021-22 being sub-inflationary, higher earners in the NHS may incur additional AA tax charges as a result of the allowable increase in pension not keeping pace with inflation. For many more, this anomaly will utilise a significant proportion of a doctors available AA and further limit their ability to take on additional work.

3.2 Asking doctors to increase their hours, increase their on-call frequency, or take on new roles risks causing them AA tax charges. Unfortunately, this will result in many doctors being unable to take on this extra work due to the risk of it causing significant financial detriment. All of this serves to create a situation whereby senior health care practitioners are in effect prevented from contributing further or continuing to remain within the health care sector as a result of the pension system. Furthermore, if these roles are given up before retirement or on-call frequency falls again, this will result in pensionable pay falling. In this circumstance, the pension growth in the legacy (1995/2008) schemes may be lost and as a result **the member will have paid AA tax on predicted pension growth that ultimately, they will never receive**.

3.3 This is particularly damaging at a time when the NHS is facing unprecedented demand, with demand for services outstripping those available to provide them. Simply put we cannot afford to lose any more NHS workers, and we cannot afford to have healthcare workers' hours constrained by counterproductive tax measures. Doctors want to work to help their patients, but pension rules prevent this. Modelling illustrating the challenges facing senior doctors are included as **Annex 1.**

4. Solutions

4.1 Doctors are not seeking more generous tax provisions than the wider population. The issue is the way the current pension taxation rules interact with the NHS pension scheme regulations, resulting in the perverse scenario that you can be financially worse off if you work for longer or by not reducing hours worked. All of this serves to create a situation whereby senior health care practitioners are in effect prevented from contributing further or continuing to remain within the health care sector as a result of this pension system.

4.2 We note the current government consultation response[5] on NHS pension member contributions but would highlight that the changes go nowhere near far enough in addressing the current issues within the system. Fundamentally, the pension taxation rules are not suitable to be applied to the NHS pensions scheme and only serve to provide barriers for higher earning NHS staff to take on additional work and leaves little option but for them to retire early.

4.3 The BMA believe we need a long-term solution that not only breaks the link between the amount of work doctors and other NHS staff can do and the risk of incurring punitive pension tax charges in the process. Such a solution needs to also be fair across the NHS pension scheme and to the taxpayer. We believe a similar scheme to the one offered to judges to tackle this very same issue achieves that.

5. Solution: A Tax Unregistered Pension Scheme

5.1 The BMA believes that the best and fairest solution is a tax unregistered pension scheme. When faced with similar recruitment and retention problems with the judiciary, issues that were driven by pension taxation, the UK government introduced a tax unregistered scheme for judges. This immediately addressed the issue and resulted in more judges being appointed. This is a fundamentally fair system. Under these arrangements, judges do not receive tax relief on their pension contributions and pay a rate of 4.26%. As they do not receive any tax relief on these contributions and it is in effect paid for by money that has already been subject to income tax, there is no requirement to test this pension growth against the AA or LTA. This system ensures

[5] DHSC, NHS Pension Scheme: proposed changes to member contributions https://www.gov.uk/government/consultations/nhs-pension-scheme-proposed-changes-to-member-contributions#full-publication-update-history

that the correct amount of tax is paid and crucially the tax is progressive rather than the current situation for higher earner in the NHS, whereby the same growth is taxed multiple times, the claw back taxes are at high marginal rates or there are "cliff edges" above which the taxes can be extremely punitive.

5.2 As discussed previously in this submission, it is already the case that NHS higher earners do not currently benefit from higher rate tax relief in the first place because of the contribution structure therefore, extending such arrangements to the NHS would be particularly effective. Indeed, even after correcting for tax relief, higher earners in the NHS pay a net contribution rate far higher than judges. By having a tax unregistered scheme, the link between how much pension tax you pay and how much work that you can undertake would no longer exist, it would allow doctors to stop incurring large additional tax bills for undertaking more NHS work for their patients, but crucially it would do this by ensuring that higher earners in the NHS are paying the correct amount of tax.

5.3 Initial modelling from the BMA and our actuarial partners suggests that introducing a tax unregistered scheme for doctors not only would allow them to work more and additional hours and delay retirement, but once the costs of replacing lost clinical activity and the deferment of pension payments are considered, the overall position for HM Treasury is a more favourable one compared to the current situation. Modelling demonstrating this is included as **Annex 2.**

ANNEX 1. Modelling to demonstrate the impact of pension taxation on doctors pay

The following descriptive analysis is based around a tool (link enclosed here) that will be made available to BMA members to calculate how they can best protect their pension. This model highlights the impact on doctors continuing to work a year after they could have retired where they to retire this year. The following is an illustrative example demonstrating the risk to doctors and the impact the decision they make this year could have on their future value of their pension.

Case study

The profile enabled in the model is based on parameters on behalf of a recently retired consultant (the consultant's details have been provided to the committee separately), to best illustrate the real terms impact that this tool highlights. We would note that we did consider utilising the model put forward by NHS England which they consider to be appropriate. However, the BMA view is that, at present, some of the assumptions made within that model are misleading. These complaints have been raised with NHS England and, for the benefit of ensuring validity, we have taken the numbers for an individual consultant.

Taking his earnings at the April 2022 point of a salary of £131,665 with over 39 years service in the 1995 scheme and, assuming a 2022 pay award of 2% set against a backdrop of 8% CPI at September 2022, our modeller predicts that, should the consultant live to 90 (the average for doctors), they would lose £128,047 in pension. That would include £60,371 which would be lost as a result of NOT retiring in 2022/23, on top of a lost value of £2,333.66 per year following your retirement. The model also highlights the issue around the scheme in effect, as a result of these tax charges, incentivising doctors to work less hours and thereby contribute less to the NHS. Using the consultant's contribution of 11.5 PAs, an average contribution in pensionable pay lost of £17,661.66, with but whilst receiving £19,362.45 in non-pensionable pay (money received for PAs above 10 and for other taxable pay related to his employment), he would only be losing £24.54 every month for retiring and returning at 6.5 PAs. This represents in effect losing half a consultant contribution as a result of forcing doctors into having to make this decision. Further details are enclosed below.

If you are not "ready" to retire, there may be other options such as "**retire & return**". If you provide some further information you can see how this would impact your finances.

How many sessions (PAs) do you currently work (pre-retirement) 11.5

What **pensionable** pay would you **lose** in retire & return (check your policy, for example this could include on-call allowances, pensionable CEAs) £17,661.66

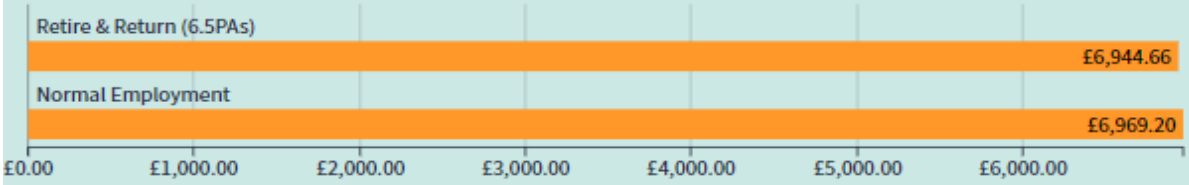
What **non-pensionable pay** do you currently receive from employment i.e. PAs above 10, other taxable pay related to your employment £19,362.45

How many PAs would you consider in retire & return (or select 0 PAs to show full retirement)

6.5

	Normal Employment	Retire & Return (6.5PAs)
Pension Income (taxable but no NI)		£60,370.51
Retire & Return employment income		£75,813.59
Gross Income	**£153,660.40**	**£136,184.10**
Pensionable Pay	£134,297.95	£0.00
Pension Contribution	**£13,500.00**	NA
Taxable Pay	**£140,160.40**	**£136,184.10**
Income tax &NI (NI is averaged over year with LEL change July 22)	£56,529.96	£52,848.16
NET PAY		
Annual	**£83,630.44**	**£83,335.94**
Net Monthly	**£6,969.20**	**£6,944.66**
Hourly (per hours worked, including pension)	£34.87	£61.47
Next year's pension (assuming retirement if not already)	**£62,866**	**£65,200**
Difference in pension by delaying retirement by 1 year	-£2,334	
Value of difference in pension over 29 yrs	*-£67,676*	

Monthly NET pay/pension of continued employment vs R&R



We can not only see the clear financial detriment to consultants in continuing to work and contribute to the NHS Pension Scheme, but more worryingly the greater impact that is being had on younger consultants within the age brackets of the model. Given these are consultants who would otherwise have been likely to have contributed several rather than a further year of service, for the system to in effect be pushing them out the door demonstrates its significant failings and the need for reforms.

ANNEX 2. Tax Unregistered scheme – BMA modelling

The BMA has conducted modelling to look at one specific potential implementation of a tax unregistered scheme, simulating the impact on the public purse in the following (2022/23) financial year, to demonstrate what the costs and benefits would be to the Treasury in terms of tax revenue, to the Department of Health in terms of reduction in costly locum cover, and to the NHS pension scheme in terms of the balance of contributions. Our modelling shows that under each scenario modelled, the net in year impact on the public purse would be positive.

Although there are a potential range of ways a tax unregistered scheme could work, the following implementation of a scheme was modelled:

- This would be a separate section of the current scheme or a new scheme that doctors would have the option to move into once certain conditions are met. Conditions considered were – upon first breach of AA or when the calculated capital value (after any deductions) exceeded the LTA when a particular threshold of income reached, eg. £100,000; or to allow as an option for all doctors at any point they choose. This model considers the threshold income option, using £100,000 for modelling purposes. This was chosen given the complexity of predicting when breaches of the AA/LTA would incur.
- Those utilising the scheme/section would not receive tax relief on employee pension contributions, similar to the situation for judges. They would then not be subject to annual AA or LTA charges on any contributions to the new scheme/section. For the purposes of this modelling, we have assumed a contribution rate would be at least 8.1% of pensionable earnings, as opposed to the 4.26% offered to the judges. This is to ensure that pension benefit for higher earners in the NHS is no higher than that of lower earners in the NHS once all taxes have been taken into account. Clearly however, this rate compares unfavourably with the judge's scheme and highlights the high average yield in the NHS pension scheme compared to other public sector schemes.
- Benefits in prior section(s) would be preserved within the current scheme and could be accessed at retirement along with additional pension accrued under the tax unregistered scheme/section.

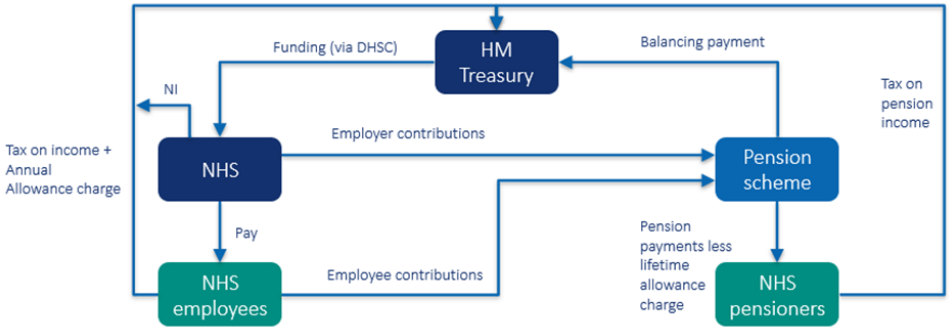
The model compares the impact of a tax-unregistered scheme, as described above, with a 'business as usual' scheme (ie. NHS pension scheme maintained as is currently planned for 2022/23). The model uses a cohort-based approach, simulating the fraction of each age group who retire, work part time, or work full time under each of the two schemes (tax-unregistered and baseline schemes).

Figure 1 below shows how cash flows are modelled, between HM Treasury; the NHS; the NHS pension scheme; NHS current employees and NHS pensioners. Pay-as-you-go public service pensions, of which the NHS pension scheme is one, are paid for by staff through employee

contributions, and taxpayers, through employer contributions and a balancing payment[1] from HM Treasury. The flows in the below diagram are aggregated up in the model to show:

1. the effects on the direct tax effects on the Treasury
2. impact on the NHS/DHSC budget as a result of locum cover required for early retirements/people working part time
3. the impact on the stability of the pension scheme (contributions net of payments)

Figure 1: In-year cash flows of the NHS pension scheme



Source: adapted from NAO (2021) Public service pensions

Under each scheme, we model three retirement pathways and assign a fraction of each cohort to each pathway according to a range of scenarios (further details on scenarios below). The pathways for the 'business as usual' scheme were: a) retire and cease work; b) retire and return at part time rate (50%); c) work full time. With a tax unregistered scheme, can either: a) retire and cease work; b) work part time (80%); c) work full time. It is expected that under a tax unregistered scheme, fewer doctors will retire early and cease working altogether, and that those that choose to work part time, may work longer hours.

As of April 2022 (the start of this financial year), assuming linear projections there would be 5,053 GP partners (11% of GP workforce) and 12,185 consultants over the age of 55 (9% of the medical hospital workforce). Linear projections of expected retirements and early retirements were used as a basis for then considered different scenarios based on this for the tax unregistered and business as usual schemes. The rationale for each scenario was as follows:

Scenario 1	High retirement under baseline and tax unregistered schemes due to burnout workforce
Scenario 2	Slightly higher retirement than linear under baseline scheme due to end of 1995 section, but under tax unregistered more people stay in the workforce, working part time
Scenario 3	High retirement under baseline scheme but tax unregistered schemes at linear projection
Scenario 4	As scenario two, but variation in age (retiring later)
Scenario 5	Linear retirement under baseline and 90% retirement rates under tax unregistered scheme

The results show that under all the above scenarios, the net return to the public purse is positive. Importantly, even our most conservative assumptions, the net return to the Treasury in terms of tax is positive. even under our most conservative scenario (scenario 5), there is a net positive to the Treasury in terms of direct taxes of over £120 million in 2022/23 received due to more people continuing to work.

	Scenario 1	Scenario 2	Scenario 3	Scenario 4	Scenario 5
	High retirement under baseline and tax unregistered schemes due to burntout workforce	Slightly higher retirement than linear under baseline scheme due to end of 1995 section, but under tax unregistered more people stay in the workforce, working part time	High retirement under baseline scheme but tax unregistered schemes at linear projection	As scenario two, but variation in age (retiring later)	Linear retirement under baseline and 90% retirement rates under tax unregistered scheme
NET IMPACT ON TREASURY	£ 189,923,780	£ 412,978,384	£ 111,955,197	£ 184,114,454	£ 31,496,604
LTA tax received	-£ 3,402,632	-£ 7,467,338	-£ 2,296,305	-£ 4,028,967	-£ 1,148,152
Annual allowance tax received	-£ 9,142,161	-£ 9,142,161	-£ 9,972,680	-£ 9,825,335	-£ 11,338,739
Income tax/NI received from staff	£ 208,275,049	£ 302,599,732	£ 196,825,569	£ 204,851,913	£ 182,285,445
Income tax/NI/other tax received from locums	-£ 64,917,117	-£ 122,182,074	-£ 51,830,830	-£ 61,215,468	-£ 37,122,674
NI received from employer (see NHS) - staff	£ 51,870,102	£ 88,463,258	£ 43,344,229	£ 48,164,140	£ 34,462,788
NI received from employer - locum	-£ 64,090,089	-£ 94,796,950	-£ 53,799,506	-£ 58,750,545	-£ 43,578,092
DIRECT TAX RECEIVED, TREASURY	£ 118,593,151	£ 157,474,468	£ 122,270,479	£ 119,195,738	£ 123,560,575
Staff pay - gross including employee pension contributions	£ 344,651,837	£ 587,795,732	£ 288,001,523	£ 320,027,507	£ 228,988,621

Pension contributions (employers) for staff, NHS	£ 112,466,554	£ 189,993,190	£ 121,651,203	£ 127,125,129	£ 121,528,584
Locum pay + additional costs associated, gross, including NI and pension contributions	-£ 483,482,482	-£ 745,068,499	-£ 409,018,040	-£ 454,935,156	-£ 330,009,530
TOTAL NHS COST	£ 26,364,090	-£ 32,720,423	-£ 634,687	£ 7,782,520	-£ 20,507,676
Pension contributions, staff and locums	-£ 140,366,133	-£ 129,796,993	-£ 136,571,173	-£ 137,849,409	-£ 135,001,584
Pension payments to current pensioners (excluding lifetime allowance tax charge)	-£ 43,399,020	-£ 97,838,858	-£ 29,658,516	-£ 45,553,726	-£ 14,829,258
Lump sum	-£ 141,933,650	-£ 320,182,475	-£ 97,232,061	-£ 149,431,879	-£ 48,616,031
TOTAL PENSION SCHEME	£ 44,966,538	£ 288,224,339	-£ 9,680,595	£ 57,136,196	-£ 71,556,295

**** The consultant used in the modelling is Dr. Wayne Jaffe, who gave evidence in the second session***

April 2022