APP0002

Written evidence submitted by The BMA (British Medical Association)

The BMA (British Medical Association) 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 health care and a healthy population. It is an association providing members with excellent individual services and support throughout their lives.

The BMA welcomes the opportunity to respond to the Committee's inquiry on the affordability of public sector pensions. Most of our members are part of the NHS pension scheme and have therefore been significantly impacted by the Public Service Pensions Bill which reformed the public sector pensions scheme.

Summary

- It is clear that, as a consequence of the reforms of the public sector pensions scheme there are significant issues of unfairness for senior healthcare workers. Ongoing NHS pension scheme membership is becoming unaffordable for many and others are being forced to reduce the work they do for the NHS or consider voluntary early retirement.
- Without urgent reform, the NHS will continue to see the number of doctors opting out of the NHS pension scheme increase. This will potentially threaten the long-term viability of the entire scheme.
- The current pension taxation structure is ill-conceived in that doctors are effectively taxed for working longer within the NHS.
- There must be an urgent review of pension taxation and the pension scheme rules, to re-establish the scheme as an attractive employment benefit.

1.Background

1.1 In 2013, the coalition government legislated for the introduction of the Public Service Pensions Act 2013[1] to create a framework for new public service pension schemes, including for the NHS Pension Scheme (NHSPS). This was introduced from April 2015 as part of the 2015 NHS Pension Scheme. These reforms followed the publication of reports by the Independent Public Service Pensions Commission[2], which was chaired by Lord Hutton of Furness.

1.2 The new structure implemented alongside the 2015 NHSPS was deliberately designed to minimise some of the costs associated with older pension schemes to the Treasury. This included basing the pension benefits accruable by a doctor on their career average earnings, rather than on their final salary. This is a

[1] Public Service Pensions Act 2013
[2] http://webarchive.nationalarchives.gov.uk/+/http:/www.hm-treasury.gov.uk/indreview_johnhutton_pensions.htm

form of defined benefit pension scheme, which means members get a guaranteed level of benefit at retirement payable to them. The final pension payable to the member is calculated by adding together the revalued pensions earned in each year of membership. The scheme itself, like most other public sector pension schemes, is unfunded and operates on a pay-as-you-go basis. This means there is no fund of assets which is invested and from which pension benefits are paid.

2. Overview of the current situation

2.1 We have always accepted that the NHS Pension Scheme must offer a fair deal to taxpayers as well as to members of the scheme. However, we do not believe there was justification for the scale of the legislative changes introduced in 2015 or the speed at which they were implemented. Additionally, we feel that the reformed pension scheme entrenched significant disparities across and within public sector schemes, and our position is that the government must address the areas in which some members of the NHS pension scheme are treated unfairly.

2.2 The interaction between the current punitive pension taxation system and the scheme rules mean that for higher earners such as doctors, their membership of the NHS pension scheme becomes unaffordable and they are forced to opt out of the scheme, take voluntary early retirement or take steps to reduce their pensionable pay (i.e. reduce their working commitments within the NHS). Not only does this exacerbate the workforce shortages that exist within the NHS, but, unless these issues are addressed, the loss of large numbers of higher earners from the scheme will potentially threaten the long-term viability of the scheme.

3. Cost control mechanism

3.1 As part of the reforms, the government legislated to introduce the cost control mechanism. This in effect created a cost cap on the pension scheme whereby, should valuations demonstrate that the scheme's costs had risen or fallen outside of a target rate, steps would have to be taken to bring them back to target, such as increasing contribution rates or reducing accrual. Following feedback from the consultation, a symmetrical 'cost floor' was introduced whereby if the scheme costs fell below the target rate, member benefits would need to be improved in order to bring the scheme costs back within the target range.

3.2 In examining the costs of the NHSPS in September 2018, the government found that the initial results of the first post-reform valuations indicated that there was a "cost-floor breach" and members were in effect paying too much into the scheme. Consequently, changes were required to ensure that members received "improved pension benefits for employment over the period April 2019 to March 2023."

3.3 The government consulted the NHS Scheme Advisory Board on amendments to the scheme to bring it into line and agreed for these changes to be implemented to the scheme from April 2019. However, before any changes could be implemented, the government paused this process following the outcome of the Court of Appeal judgement in the McCloud v Ministry of Justice, which found that the 'transitional protection' offered to some members as part of the reforms amounted to unlawful discrimination. They asserted that, as a result of the discriminatory claim and the need to readjust the scheme to enable members who had been discriminated against the option to choose to be in their legacy scheme for the remedy period, the costs of the scheme would need to be reassessed.

3.4 This is a position that the BMA refutes. We believe that the Treasury should accept that the valuations from 2019 clearly demonstrate that there was a reduction in the costs needed to run this scheme that was predominantly driven by the expected increases in life expectancy not materialising. Having created this cost control mechanism, the Government must adhere to the legislation and, given the breach of the cost floor, increase member benefits by improving accrual rates or reducing employee contributions. We also reject the

Government's linkage to the McCloud judgement, as many thousands of members are out of scope of this judgement and will have continued to pay too much for their pension benefits as a result of this pause.

3.5 We also maintain that the unlawful age discrimination that was highlighted by the McCloud judgement was the fault of the government, not the scheme members. Consequently, the cost of any remedy must be met by the government and not the scheme members. The Government's suggestion to pause the implementation of the recommendations following the cost floor breach, and then feed the costs of the McCloud remedy into the 2016 valuation, is simply passing this cost onto scheme members and is completely unacceptable.

4. Employee Pension contributions in the NHS pension scheme

4.1 The Public Sector Pension Reforms also led to an increase in the employee pension contributions across public sector schemes. In this regard, we believe that the NHS was treated particularly unfairly, as trade unions worked collaboratively with the Government to undertake a 'once in a generation' reform of the NHS pension scheme in 2008. As part of this, many of the issues in the Hutton review had been identified, and NHS trade unions and the Government worked together to make the NHS pension scheme affordable for the future. These jointly agreed changes included a later retirement age and an increase in member contributions, with the introduction of tiered rates that resulted in higher earners paying 8.5% in employee contribution, compared to 6% previously.

4.2 Despite this change, following the Public Sector Pay Bill, contribution rates were increased across all public sector schemes by an average of 3.2%, regardless of the employee contribution rates that were payable prior to that point. For doctors and other higher earners in the NHS, these changes resulted in them paying significantly more for their pensions than other public sector employees earning similar salaries with a top employee contribution tier of 14.5%. This results in doctors paying almost 3 times more for a similar pension in employee contributions compared to senior civil servants. The NHSPS also compares unfavourably with schemes for teachers, local authority staff, police and parliamentarians.

4.3 This unfairness is compounded by the earnings thresholds that determine pension tiers not being indexed link. The amounts have stayed rigidly in place in spite of rising inflation and costs that have superseded rises in salaries for doctors. These non-indexed thresholds therefore actively promote a greater number of people each year into these bands. This increases the costs of being in the pension scheme, particularly as the contribution tier is applied to the total value of pensionable pay rather than a banded system (where the increased costs are only applied to pay above the threshold). This coupled with the fact that doctors have been penalised with below inflation pay rises over the last 12 years, has severely adversely impacted the value of the NHS pension scheme. This problem is heightened for those who work part time or for sessional GPs as their employee contribution tiers is based on the whole time equivalent or annualised pay which means that these groups pay more per £1 of pension than their full-time colleagues.

4.4 Indeed, when considering the aforementioned 'surplus', which triggered the cost control mechanism by way of a floor breach, we can infer that the NHSPS was affordable following the jointly agreed 2008 reforms and that the further increase of employee contributions, also by 3.2%, was not required from an affordability perspective.

4.5 Further to this, we would highlight that the current model of contribution rates is grossly unfair on the highest earners. Their contribution rates have remained at the same level of 14.5%, despite the NHS pension Scheme Advisory Board reaching the consensus view that the removal of the top two tiers would be advisable in dealing with the 'floor' breach within the pension scheme. This unfairness has been compounded given the fact that the majority of scheme members are now in the 2015 career averaged revalued earnings scheme and the remainder will move to this scheme post 1 April 2022. This essentially

removes the justification for tiered contribution rates as each member should in effect pay the same amount per £1 of pension.

5. Pension taxation in the NHS pension scheme

5.1 There is a significant interaction between the NHS pension scheme rules and the current system of pension taxation that have resulted in a number of perverse scenarios and in many cases made ongoing membership of the pension scheme unaffordable for some members. This interaction has been responsible for a large number of doctors being forced to reduce their pensionable pay (by reducing their hours working for the NHS), opting out of the scheme, or taking voluntary early retirement. This problem has been acknowledged by the Government, who were forced to take immediate action by introducing the annual allowance compensation scheme in 2019 and announced changes in the March 2020 budget to mitigate a growing workforce crisis. Despite these measures, the problems still remain and have been exacerbated by the decision to freeze the lifetime allowance thresholds in the 2021 budget.

5.2 The fundamental problem is that both the annual allowance (AA) and lifetime allowance (LTA) are trying to claw back the benefits of higher rate tax relief but higher earners in the NHS do not benefit from higher rate tax relief in the first place. This is because the tiered contribution structure described above already accounts for higher rate tax relief and in fact the tiering is so steep that it more than removes this tax relief in its entirety. Despite this, doctors and other higher paid workers in the NHS are still subject to both the AA and LTA, as well as income tax on their pension once they have received it. This means that in effect the same 'pension earnings' are in fact taxed multiple times with the effects compounded as a result.

5.3 A further problem is that the calculation of pension growth is exceedingly complicated and pension growth cannot be controlled independently of pay. This means that members within the NHS pension scheme cannot easily plan to stay within the AA and even calculating their LTA is becoming increasingly complicated. This means that in many cases doctors are inadvertently hit with unexpected and punitive tax charges that not only decrease the value of the scheme but often makes ongoing membership unaffordable.

5.4 The BMA has recently commissioned an actuary to consider the impact of the AA and LTA on member contributions and benefit outcomes in relation to the 2015 NHSPS, as well as the contribution tax rate structure. We would be happy to share this with you on a confidential basis, however, for the purposes of this evidence, which is likely to be made publicly available, we have provided a brief summary of our findings.

5.5 The modelling compared 6 different NHS workers who all started work in August 2020 and calculates the relative cost of their pension until state pension age. This modelling includes the changes made at the 2020 budget that raised the threshold income to £200,000. The doctor is a foundation year 1 doctor, following a relatively typical career and progressing to a consultant. We found that the net cost of the employee contributions after income tax alone is 8.52%. This is a far higher than the cost of lower paid workers, despite being in the 2015 CARE scheme.

5.6 We also found that the tiered contribution structure more than simply removes the benefit of higher rate tax relief. If a doctor is subject to AA and the LTA (frozen until 2026), they incur a further 12.24% and 32.08% rise respectively to the cost of being in the pension scheme. The combination of these 3 factors means that the doctor is paying 52.84% of their lifetime pensionable earnings for their pension, compared to 13.06% for the lower paid workers. This means that doctors pay in many cases ten times more per £1 of their pension than other NHS workers.

5.7 For clarity, all consultants and GPs, as well as many SAS doctors, will incur significant additional tax bills as a result of exceeding the standard AA, which remains at £40,000. A small increase in pensionable pay can

result in a doctor breaching the standard AA, leading to punitive tax bills. These pay increases are typically out of the control of the doctor and may be as a consequence of incremental pay progression, or even a cost of living pay increase. In some cases, the cost of living pay rise alone can result in an additional AA tax bill and leave the doctor financially worse off after receiving a 'pay rise'.

6. What does this mean for the scheme in terms of affordability

6.1 As a consequence of these points, many doctors are choosing to either retire early or reduce their working hours, with many surveys evidencing this is the case:

- a BMA survey indicated that two-thirds of doctors over 55, and one in eight aged between 35 and 54 are considering retiring within three years[3].
- A survey from the Royal College of Physicians and Surgeons of Glasgow revealed that 45% of those surveyed decided to retire at a younger age than previously planned, with 86% of them citing pension concerns as one of their reasons for this decision[4].
- 53% of surgeons in Wales have been advised (e.g. by an accountant or financial adviser) to work fewer hours in the NHS[5].

6.2 This is before the impact of the recent decisions by Government to freeze the LTA, by removing it from indexation current level until 2026.[6] We, therefore, surveyed over 8,000 members to understand what the impact of this announcement would have on their retirement plans and work patterns as a direct result of the freeze in the LTA:

- 72% of respondents stated that they would retire earlier.
- 61% stated that they would reduce their hours.
- 40% stated they would give up additional roles.

6.3 These are doctors at the higher end of the pay scale who are already contributing significant amounts to the NHSPS. Without their contributions, there is a clear risk to the financial sustainability of the scheme should they not be incentivised to continue working or paying into their NHS pension.

6.4 If the Committee therefore wish to deal appropriately with maintaining the affordability scheme, we ask you to consider how to ensure the scheme can retain those higher earners within the NHSPS. We have already seen the average retirement age fall 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 since 2008. Without significant changes, this will only be further exacerbated in the coming years.

7. Resolving punitive pension taxation whilst maintaining affordability of the scheme

7.1 The BMA asks the Committee to recommend the UK Government to undertake a review of pension taxation and to reconsider the appropriateness of tiered pension contributions in a CARE pension scheme. Options we have considered which we believe will mitigate against the above issues include:

- A combination of a fairer tiering structure, as well as the removal of the AA in defined benefit schemes such as the NHS Pension Schemes, together with reversing the decision not to index the LTA.
- Introduction of a tax unregistered scheme with no tax relief on pension contributions and therefore no assessment against the AA and LTA.

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[3] https://questionnaires.bma.org.uk/news/payingtowork/index.html
[4] https://www.rcplondon.ac.uk/news/pension-tax-driving-half-doctors-retire-early
[5] RCS Survey on the NHS Pension Scheme, Royal College of Surgeons
[6] https://www.bma.org.uk/bma-media-centre/freeze-on-pension-lifetime-allowance-would-have-serious-impact-on-medical-workforce-warns-bma

- Mandatory scheme level recycling of employers' pension contributions for those NHS workers who need to opt out of the scheme because of pension taxation.

7.2 We note that the Government announcement for the reformed pension scheme for the judiciary. The judges are another large group of public sectors workers impacted by pensions taxation. They were reported to have had very similar issues with recruitment and retention to the NHS, as a result of the 2015 pension changes. Consequently, the Government has recently determined that the reformed judges pension scheme will be tax unregistered. In addition, the employee contribution rate for judges will be reduced to 4.26% (with no tax relief) compared to a contribution rate of up to 14.5% for doctors (8.7% net of income tax relief) with an accrual of 1/40th, (NHS 1/80th in the 1995 scheme and 1/54th in the 2015 scheme). This pension growth will not be subject to testing against the AA or LTA. Early indications are that this has already started to reverse the recruitment and retention difficulties in the judiciary.

7.3 This therefore demonstrates that the Government has a willingness to explore such solutions in the public sector, and we strongly believe that the introduction of a similar tax unregistered defined benefit pension schemes across the UK for those affected in the NHS, to mitigate the current punitive pension taxation system would ensure that the scheme remains sustainable.

7.4 It is also worth emphasising that the Office of Tax Simplification (OTS) has agreed with the BMA's position in that there is no justification for applying both an AA and LTA to pension growth, stating that 'given the policy aim of limiting the overall amount of pensions savings tax relief available to any one individual, applying both the AA and LTA charges to pensions may be unnecessary'.

April 2021