

The impact of punitive pension taxation rules on doctors and the delivery of NHS services



Executive summary: BMA briefing on the impact of punitive pension taxation rules on doctors and the delivery of NHS services

The problem

The NHS is in crisis with the waiting times figures and A&E performance the worst on record. A significant cause of this is the workforce shortage that has resulted from the ill-conceived pension taxation system and is effectively forcing senior clinicians to reduce the work they do for the NHS. The value of the annual and lifetime allowances were progressively reduced by successive governments and in 2016 the government introduced tapering of the annual allowance. While primarily intended to prevent tax avoidance in the private sector, the impact of these changes on the public sector, and the NHS in particular have been catastrophic. It has been acknowledged that these impacts were not fully assessed prior to the introduction of the changes and the effects in the NHS have been compounded by separate changes to the NHS pension scheme.

Over the last two years the BMA has issued repeated warnings to governments across the four nations of the UK that the current system of unfair and punitive pension taxation must be urgently reformed to avoid negatively impacting patients. This reform has not happened, and the NHS is now feeling the consequences. Waiting times for cancer and routine care are at record highs, A&E performance is the worst since records began, and 11 million patients are experiencing waiting times for GP appointments of over three weeks as doctors continue to be forced to reduce their work and, in many cases, stop working entirely to avoid huge and disproportionate tax bills.

The fundamental problem is that the annual allowance is entirely unsuited to a defined benefit scheme such as the NHS pension scheme. This is because in-year pension growth is based on the level of pensionable pay and cannot be controlled by the employee. This causes significant problems as staff may incur very large tax bills if they have even a modest rise in their pensionable pay that may occur at the time of promotion, commencement of a leadership roles, receipt of an excellence award or even a cost of living pay rise. Some doctors have even received large tax bills because they have become seriously ill, forcing them to retire on ill-health grounds with an 'enhancement' to their pension. The taper results in a further problem for doctors as there is an effective 'tax cliff' whereby people can incur additional tax bills of up to £13,500 if they cross the threshold by as little as £1. These doctors are effectively paying to go to work.

Key stats

- 31% of doctors, surveyed by the BMA, have already reduced the number of hours spent caring for patients because of actual or potential pension taxation charges
- 37% of doctors who have not already reduced their hours plan to do so in the next 12 months
- Waiting times for cancer and routine care are the longest on record
- A&E performance is the worst since records began

The solution

While the pension taxation problem is complex, the solution is simple. **We are calling for the removal of the annual allowance in defined benefit pension schemes, such as the NHS scheme.** We are not alone in calling for this, the Government's own advisory body, the Office of Tax Simplification has also suggested this as a solution. This is the only option that resolves this issue completely as it allows doctors and other public sector employees to work without fear of large unexpected tax bills. It is also a fair solution and is not (as has been suggested in the media) a 'windfall' for doctors. In the NHS, tax relief is already severely limited by both the lifetime allowance and the tiered employee contribution rates.

As well as being the most effective solution, it is also the cheapest for the Government and the tax payer and will cost significantly less than the recent suggestion of raising threshold income to £150,000. This latter proposal will not solve the current pensions crisis as all of the problems with the annual allowance remain. Employees within the public sector will still potentially face large tax bills if they are promoted, take on leadership roles or have relatively modest rises in their pensionable pay, even if their earnings are well below £150,000. In some cases, they will pay tax on theoretical growth that they never actually receive; for example their pay falls pre-retirement. For those doctors with earnings above threshold income, they will still be forced to reduce the work they do for the NHS in order to mitigate their tax bills. Many of these doctors are leaders in their field, making significant contributions to the NHS, research or education but under this proposal will be the ones forced to cut back their activity. The BMA are not alone in their view that this is not the solution the NHS needs. The IFS (Institute for Fiscal Studies) has been clear that simply raising the annual allowance threshold will *'not remove the problem'*.

Scrapping the annual allowance in defined benefit schemes and scrapping the lifetime allowance in defined contribution schemes, as suggested by the Office of Tax Simplification is not only the fairest and most effective solution for the NHS and the tax payer but is the cheapest solution for the Government.

Scrapping the annual allowance in defined benefit schemes will:

- **provide the best value for money solution to the taxpayer.** Initial modelling shows this option is cheaper than the alternatives of either removing the taper across all schemes or increasing the annual allowance threshold
- **safeguards against future inflation**, meaning that unlike the alternative of raising the annual allowance threshold, this option has longevity and this situation will not be rerepeated as wages rise through inflation over the coming years
- **will completely solve the issues within the public sector** who are unfairly hit by the unintended consequences of ill-thought-out tax changes and will allow NHS staff to do the work that patients need without fear of large unexpected tax bills
- **provides an equitable solution for all staff groups affected by the current punitive taxation rules.**

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Key facts

- **31% of doctors, surveyed by the BMA, have already reduced the number of hours spent caring for patients because of actual or potential pension taxation charges**
- **37% of doctors who have not already reduced their hours plan to do so in the next 12 months**
- **A&E performance are the worst since records began and 11 million patients are experiencing waiting times for GP appointments of over three weeks¹**

Background

The BMA has issued repeated warnings to governments across the four nations of the UK that unless the current system of unfair and punitive pension taxation is urgently reformed, that the impact on the NHS and patients will be catastrophic. Unfortunately, these fears are being realised. A BMA report released in November 2019,² showed that patients are already being affected. Waiting times for cancer and routine care are at record highs, A&E performance is the worst since records began, and 11 million patients are experiencing waiting times for GP appointments of over three weeks as senior doctors are forced to reduce their work and, in many cases, stop working entirely to avoid huge and disproportionate tax bills.

This performance is clearly directly related to the current system of pension taxation that is forcing senior doctors to reduce their working commitments. Without swift, fundamental taxation reform the situation will only continue to deteriorate.

The most recent BMA survey of more than 6,000 doctors from hospitals and general practice across England, Wales and Northern Ireland revealed that:

- 42 per cent of GPs have already reduced the number of hours spent caring for patients because of actual or potential pension taxation charges
- a further 34 per cent of GPs are planning to reduce their hours.
- 30 per cent of hospital consultants have already reduced their hours
- when it comes to planning to reduce their hours, a further 40% of consultants told the BMA that was their intention³
- data from an earlier Scottish survey had similarly concerning findings.⁴

Surveys from both the BMA and NHS Employers have demonstrated that as well as those doctors who have already reduced their working commitments, half of doctors plan to retire early, with the majority citing pensions taxation as the reason.

Issues and recommendations

- Although the annual allowance is effective in limiting tax relief in defined contribution schemes, it is unnecessary and entirely unsuitable in defined benefit schemes such as the NHS, as tax relief is already limited via tiered contribution rates and the lifetime allowance. The current system results in repeated taxation of pension growth and is having a devastating impact on workforce capacity within the NHS.
 - **The BMA calls for the removal of the annual allowance, and taper, in defined benefit schemes, such as the NHS.** This recommendation is supported by findings from the Government's own advisory body the OTS (Office of Tax Simplification).⁵

1 BMA Pension Survey, Aug 2019, <https://www.bma.org.uk/features/payingtowork/>

2 BMA NHS Pressures, Nov 2019,

<https://www.bma.org.uk/collective-voice/influence/key-negotiations/nhs-pressures>

3 BMA Pension Survey, Aug 2019, <https://www.bma.org.uk/features/payingtowork/>

4 BMA Scotland Pensions Survey, June 2019,

<https://www.bma.org.uk/news/2019/june/pensions-tax-devasting-the-profession-finds-survey>

5 Office of Tax Simplification, Taxation and Life Events: Simplifying tax for individuals, October 2019. P.48

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/838130/Taxation_and_life_events_Oct_2019.pdf

- The current value and mechanism of the lifetime allowance is driving early retirement and further exacerbating the current workforce crisis.
 - The BMA is clear that that any solutions to address the issues caused by the annual allowance must not further worsen the impact that the lifetime allowance is already having in forcing people to retire early. Indeed, **the BMA calls on the Government to do everything possible in order to retain our most experienced doctors that are affected by the lifetime allowance at a time when the NHS is under significant pressure.**
- Due to the complexities of calculating pension growth, pension flexibilities such as those suggested in the recent NHS consultation will not solve the current problem and the only solution remains fundamental tax reform suggested above. Even with tax reform, there **remains a role for the recycling of the full value of employer’s pension contributions** for those who require to ‘opt-out’ of the pension scheme. This is cost neutral to the NHS and is commonplace in other sectors. Indeed, in private sector defined contribution schemes, the annual allowance charge is only rarely paid, as remuneration is easily adjusted to divert excess pension investment (including employers’ contributions) into pay. Recycling of employer’s pension contributions simply extends this provision to those working in the public sector.
- The recent emergency mitigations put in place by NHS England and NHS Wales, outline the urgent need for pension taxation reform.⁶
 - **The BMA calls on the UK Government to announce definitive pension taxation reform as outlined above at the earliest opportunity in the new parliament and to implement these reforms for the start of the next tax year.**

Why is the pension taxation system causing this problem?

The annual allowance was introduced in 2010 primarily to limit tax relief on pension contributions in defined contribution schemes. Successive governments have reduced the value of both the annual and lifetime allowances. In 2016 the Government introduced tapering of the annual allowance for those with ‘adjusted incomes’ of more than £150,000. The impact of the taper on the NHS and public sector defined benefit schemes was not considered in any detail prior to its introduction and even HM Treasury have conceded that the impacts of this were not appreciated at the time. In addition, separate changes made to the NHS pension scheme introduced in 2015 have led to a ‘perfect storm’ in which pension growth is subjected to multiple levels of taxation and indeed the same pension growth can be taxed repeatedly. This has led to a situation in which senior clinicians and other NHS staff can effectively **be paying to go to work or receive a higher pension by reducing their hours and working part time.**

The annual allowance is fundamentally unsuitable for defined benefit schemes such as the NHS pension scheme and the BMA is calling for it to be removed completely from these schemes. This would also by definition remove the taper. This approach echoes recommendations from the OTS, an independent body that advise HM Treasury. The reasons for this are outlined in the following paragraphs.

Inability to control growth

In defined benefit schemes, it is impossible for employees to control in-year pension growth. Pension growth is directly linked to the value of pensionable pay, in particular to increases in pensionable pay. Any increases in pensionable pay are then effectively multiplied by a factor of 16 or 19, which is the multiplier the Treasury uses as an estimation of eventual pension pot growth. Therefore even very small increases in pensionable pay can then exceed the annual allowance and result in a tax charge. This can cause some very perverse situations. For example, for many, the cost of living increase applied to pay in 2019-20, will result in them incurring an additional tax charge and therefore being financially worse off as a result of a ‘pay-rise’.

⁶ Statement from the Secretary of State on the Clinician Pension Tax Scheme, December 2019. <https://www.gov.uk/government/publications/statement-from-the-secretary-of-state-on-the-clinician-pension-tax-scheme>

Financially punished for pay rises

As pension growth is linked to pensionable pay, the annual allowance causes significant problems if there is a large rise in pensionable pay. This may arise if senior clinicians are promoted, receive a pay increment, take on management or leadership roles or receive clinical excellence awards. This has resulted in senior clinicians no longer applying for leadership positions or striving for excellence awards, which include a financial settlement. The situation is further compounded by the fact that these roles and awards are often time limited. As such there may be large theoretical 'pseudo-growth' at the time pensionable pay rises but when it falls, as these roles are given up, the value of the notional 'pension pot' falls. **This may result in senior clinicians incurring five figure tax charges on 'pension growth' that they ultimately never receive.** To compound matters if they subsequently see their pensionable pay rise again, they are taxed once again on this 'pension growth', even though they are simply recovering towards the pension on which they were already taxed.

Unique impact on Defence Medical Services

The annual allowance is not only a problem within the NHS but is an issue in other defined benefit schemes including in the armed forces. In the military pension, which is non-contributory but is earned like any other, DMS (Defence Medical Services) doctors' salaries were reduced when their pay scales were set to take into account the value of employee contributions and they now face the same problem as NHS doctors with regard to the impact of the annual allowance and taper. Given the nature of the role played by DMS doctors, opting out of the pension scheme and losing death in service and ill-health retirement benefits is not a realistic option for them, particularly as the value of the employee and employer contributions are not currently accessible to service personnel.

The annual allowance can have a significant impact on military personnel at the time of promotions and upon receipt of taxable allowances such as the Long Separation Allowance. This is not just an issue for doctors and senior officers. Annual allowance tax letters have been sent to thousands of junior service personnel, even non-commissioned officers. The system punishes those whose pensions rise quickly, with large bills being experienced by officers promoting quickly and by those who have commissioned from the ranks. The MOD has identified this as a profound threat to morale and retention. The introduction of pension flexibilities, such as recycling of employer contributions, will do nothing to support our vital military personnel and highlights the need for complete removal of the annual allowance from all defined benefit schemes. Reform of the annual allowance taper will ease but not solve the situation for senior officers and medical officers; only the tax reform we are proposing will resolve this issue for ordinary members of the Services.

Impact on UK research and innovation

Clinical academics usually divide their time between NHS and university commitments in relatively equal proportions. When these doctors, reduce their hours, or are forced to leave the profession, due to tax charges, the impact is felt both by patients in a clinical setting but also on an academic level, reducing the amount of time these specialist senior clinicians can work on what is often ground-breaking research. These tax policies are acting as a disincentive for medical academics to become entrepreneurs in research and stifling innovation. This is particularly important as we move closer towards Brexit. Clinical academics play an invaluable role in attracting investment and industry to the UK, and at this time of transition it becomes more important than ever to addressing punitive taxes, which could limit or prevent clinical academics ongoing and future contribution to UK research.

Impact on other sectors

Although due to a unique set of circumstances, senior clinicians are affected more severely and in larger numbers, the annual allowance affects many other public sector workers. Indeed, for many it is the standard annual allowance rather than the taper that is the problem. For example, senior nurses, allied health professionals and non-clinical NHS managers may receive large annual allowance tax bills at the time of a promotion. Other public sector workers including police officers, firefighters and head teachers may also be impacted and this merely reinforces the assertion that the annual allowance is completely unsuitable for defined benefit schemes.

Inadequate information to manage or calculate pension growth

Calculation of pension growth in defined benefit schemes is extremely complicated and the pensions agencies in each nation only provide information about pension growth after the end of the tax year. For NHS staff in secondary care, pension statements are typically received at least six months after the end of the tax year but for doctors in primary care the situation is even worse and accurate figures may only be available two or three years after the end of the tax year. **This makes it virtually impossible for doctors and other senior NHS staff to predict their pension growth within a given tax year** and they cannot do anything to manage their pension growth after the tax year has ended. Furthermore, the pensions agencies only routinely send pension savings statements to those whose pension growth has exceeded the standard annual allowance and staff who may have a lower annual allowance as a result of tapering can incur an unexpected tax charge. In England and Wales, the NHSBSA (NHS Business Services Authority) has also been routinely failing in its statutory requirement to provide pensions statements on time and as evidenced by NHS Employer's surveys, which show satisfaction with NHSBSA's service is extremely low.⁷

Ineffective taxes

When it comes to defined benefits schemes the annual allowance and taper are not effective taxes for HM Treasury, as tax receipts from the annual allowance will start to fall as more people understand the issues or are afraid they may impact upon them. In addition, **the lost income tax receipts from reduced work and the costs to the NHS from re-provisioning services from the private sector will far outweigh any revenue generated from these taxes.** The latest available government figures for the 2017-18 tax year, suggest that the total value of pension contributions exceeding the annual allowance reported from self-assessment was £812 million.⁸ This would generate tax receipts in the region of £365 million if taxed at the highest rate of 45% across all sectors. This amount will be dwarfed by the cost of re-providing NHS services via the private sector, including the increased use of locums, and lost income tax receipts as doctors reduce the work they do for the NHS.

The annual allowance effectively implements a double income tax. This is because the annual allowance is first charged at the prevailing rate of income tax on contributions above the allowance and income tax is then charged again when the pension is paid out. This taxation system was designed as a deterrent,⁹ which it succeeded in. A survey of FTSE 100 companies showed that 93% had adjusted the remuneration of employees affected by pension taxation so that they could avoid the charges.¹⁰ We believe that it is wrong to impose such an onerous taxation regime on those working in the public sector when, unlike those in the private sector, they cannot avoid the charges.

It has been suggested that these taxes are necessary to limit tax relief – this is not the case. In the NHS pension scheme, tax relief is already significantly limited. There are also 'tiered' contribution rates with higher earners paying 14.5% compared to lower earners paying 5%. Tiered contribution rates were brought in to specifically offset the benefit of higher rate tax relief and indeed in the current 2015 CARE (career averaged revalued) pension scheme more than offsets higher rate tax relief on employee contributions. Most significantly, there is also lifetime allowance that sets an absolute limit of tax relief that can be obtained. There is no justification for applying both an annual allowance and a lifetime allowance to pension growth, something that the OTS also noted. The OTS stated 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. One*

7 NHS Staff Survey results 2018, <https://www.nhsstaffsurveys.com/Page/1064/Latest-Results/2018-Results/>

8 Pensions Annual Allowance Statistics Official Statistics, September 2019. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/833861/Table_7_Personal_Pensions_Annual-Allowance_Statistics.pdf

9 HM Treasury / Inland revenue, Simplifying the taxation of pensions: increasing choice and flexibility for all, Dec 2002 https://webarchive.nationalarchives.gov.uk/20100104174903/http://www.hmrc.gov.uk/consult_new/pensions_consult.pdf

10 LCP, How is the tapered annual allowance impacting pensions?, LCP FTSE 100 pensions tax survey, May 2017 <https://insight.lcp.uk.com/acton/attachment/20628/f-057e/1/-/-/-/1/LCP%20FTSE100%20pension%20tax%20survey%202017.pdf>

possibility would be for the AA to apply in relation to [defined contribution] DC schemes and the LTA in relation to DB schemes.'

The taper

The problems with the annual allowance have been compounded by the introduction of the taper. The way tapering of the annual allowance operates is that the available annual allowance reduces by £1 for every £2 that the 'adjusted income' is over £150,000. HM Treasury and HMRC have repeatedly stated that tapering only impacts people with **earnings** of over £150,000. However, this is incorrect and in defined benefit schemes this has created a 'tax cliff' at the threshold income of £110,000. Indeed, the OTS commented that **'The rules are complex and widely misunderstood. HMRC's guidance is unclear and open to interpretation'**.¹¹ As a result of this cliff edge, senior clinicians and other senior staff in defined benefit schemes may face additional tax charges of up to £13,500 if they exceed the threshold income by even £1. Others may face effective tax charges of greater than 100%. This results in some senior clinicians effectively **paying to go to work**. Although there is the option of paying these charges from the pension pot via 'scheme pays', this effectively generates a loan against your final pension that attracts a relatively high rate of interest. For younger members, this can result in the scheme pays loan rising significantly until the point of retirement. Once this is deducted it reduces the amount of pension that becomes payable. **BMA modelling has shown that for a typical consultant in their early 40s, they can halve the amount of clinical care they provide, reduce their pension contributions by 30% and yet obtain a higher pension.** As a result of this many doctors are taking the only option available to them, which is to reduce their hours and refuse to take on additional shifts or leadership roles.

Effect of multiple pension schemes

The introduction of the 2015 NHS pension scheme has exacerbated the problem for doctors. The 2015 pension scheme is a career averaged revalued earnings scheme, however, the majority of senior clinicians also retain their accrued benefits in the 1995 or 2008 final pension salary schemes. Despite there being only one NHS pension, from an employee perspective, the annual allowance is calculated separately for the two schemes. However, negative growth in the final salary scheme is unfairly rounded up to zero and not offset against positive growth in the 2015 scheme. In addition, the notional pension pot in the 2015 pension scheme is revalued by a rate of CPI plus 1.5%. This results in annual increasing pension growth that effectively prevents the build-up of 'carry forward' of any unused annual allowance. **The effect of these technical issues is significant for those younger clinicians who were forcibly transitioned to the 2015 pension scheme paying 10 times the amount of tax compared to older clinicians who were offered protection and able to remain within the 1995 pension scheme.** This is despite those older clinicians receiving a higher pension and tax-free lump sum. Secondly, the average taxable earnings of senior clinicians are close to the £110,000. A small rise in earning could push them over the tax cliff that exists around the threshold income. This means that for many senior clinicians there is little margin for error and a small increase in non-pensionable pay could tip them over the tax cliff and generate large tax bills. Finally, the majority of senior clinicians do regular overtime and have comparatively high proportion of their pay that is non-pensionable. The impact of non-pensionable pay on the taper is significant.

Solutions

While the pension issue is a very complex one, we believe the solution is entirely straightforward. There is a clear need for taxation reform, with removal of the annual allowance, and taper, in defined benefit schemes. This solution will work for all doctors regardless of whether they are treating families in the NHS, training the next generation of doctors in universities, or supporting our Armed Forces in the field. In addition, it will provide a solution for all NHS staff and other public sector workers affected by these punitive taxes.

¹¹ Office of Tax Simplification, Taxation and Life Events: Simplifying tax for individuals, October 2019. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/838130/Taxation_and_life_events_Oct_2019.pdf

This conclusion was also reached by the OTS, it is fundamentally fair and achieves the aim of limiting pension taxation relief in a way that can be managed effectively by members of both defined benefit and defined contribution schemes. Indeed, for those in defined contribution schemes, whose pension input is limited by the annual allowance, it does not make sense to have a lifetime allowance as the final value of their pension is typically determined by investment growth, which they do not control, and the policy penalises those who save for a pension early, which cannot be the Government's intention.

We are aware that other options have been discussed but firmly believe that they will not solve the problem and the majority will be more expensive for HM Treasury. These are discussed below:

1. Increasing the threshold income to £150,000

There have been recent media reports that increasing the threshold income is HM Treasury's preferred solution. However, the BMA and the IFS believe that this will categorically not solve the problem. In addition we believe that this is a more expensive proposition for the Government than scrapping the annual allowance in defined benefit schemes and scrapping the lifetime allowance in defined contribution schemes. In addition to being more costly, there are a number of other problems with this proposal. Firstly all of the issues with retaining the annual allowance remain. This means that many people, even those with earnings far below the £150k threshold income will incur large tax bills for breaching the standard annual allowance. This can occur in a number of different circumstances in which there is a modest rise in pensionable pay and is not limited to clinicians. Similarly, clinicians can exceed the standard annual allowance and incur tax bills if they take on leadership roles, receive excellence awards or even if they receive a cost of living pay rise. This proposal does nothing to mitigate against these issues and will effectively deter people from accepting important leadership roles or striving for excellence. This is especially the case as these additional payments may not be held until retirement and as a result, tax will have been paid on theoretical pension growth that is ultimately never received.

A further problem with this proposal is that the 'tax cliff' at the level of the threshold income not only remains but is potentially made even steeper. Unless there is an increase in the adjusted income threshold, crossing the threshold income level of £150k brings with it the certainty that you will incur a large tax bill. Indeed, the amount of tax payable in this circumstance is no lower than it would have been for that individual had the threshold income level remained at £110,000. Due to the complexities involved in managing pension growth, this means that that a significant number of doctors will still need to limit their earnings to remain below the threshold income level. The simplest way to do this is to reduce the work they do for the NHS. Although this may potentially affect fewer people, those that remain impacted are the most experienced doctors who are often leaders in their field. A proposal that limits the work of these doctors is not in the best interests of patients or the NHS.

It is also important to note that this proposal is undoubtedly more expensive for HM Treasury than the suggestion from the OTS of removing the annual allowance (but retaining a lifetime allowance in defined benefit schemes) and removing the lifetime allowance (but retaining the annual allowance) in defined contribution schemes. The annual allowance is not an effective tax for HM Treasury as people will alter their behaviours to mitigate against an annual allowance tax charge. In the public sector not only will this result in decreased income tax receipts as people reduce the work they do but receipts from exceeding the annual allowance will also fall as there will be less impact from tapering. By increasing the threshold for all workers, those in the private sector will receive the greatest benefit as many more can increase the amount of tax free savings into a pension. There are five times as many private sector employees than there are in the public sector and a higher number in the private sector have earnings in the range of £100-£150k. As a result, not only is it less effective a solution for the NHS but this proposal is more expensive to implement

than scrapping the annual allowance in defined benefit schemes. The NHS is suffering a workforce crisis and needs a correct, lasting solution. Only scrapping the annual allowance in defined benefit schemes achieves this.

2. Scrapping of the tapered annual allowance

This would remove the 'cliff edge' and prevent the situation in which senior clinicians are paying to go to work or where they may receive a higher pension by reducing their hours. However senior clinicians may still receive annual allowance tax bills at the time of pensionable pay rises such as the time they receive a pay increment or take on a leadership role. Furthermore, the problem of 'pseudo-growth' remains and people may pay tax bills relating to a temporary rise in the notional value of their pension. The retention of an annual allowance will continue to have a significant impact on doctors in the military who may have significant in-year pension growth at the time of a promotion. Finally, this is also likely to be a more expensive option for HM Treasury than the OTS recommendation as all those in the private sector whose remuneration was adjusted to avoid the annual allowance charge go back to sheltering the full £40,000 a year from income tax.

3. Pension flexibilities

The recent Department for Health and Social Care consultation suggested pension flexibilities.¹² The BMA had suggested the option of full flexibility in order to provide some control for pension growth. However, we first requested this in early 2019 as an emergency mitigation while pension tax reform was implemented. The BMA has been clear that this is not a long-term solution particularly as calculating pension growth is so complex. In reality, clinicians will have neither the time nor the inclination to utilise this and will instead continue to reduce their hours. However, there will still be occasions when for reasons of pension taxation, clinicians may need to opt out of the pension scheme. If this is necessary, it is essential that there is the option to retain the full value of the employer's pension contributions. This is commonplace in other sectors and even the chancellor has described this as a 'regular' approach.

4. The lifetime allowance

As outlined, the BMA supports the OTS recommendation of scrapping the annual allowance (but retaining the lifetime allowance) in defined benefit schemes and scrapping the lifetime allowance (but retaining the annual allowance) in defined contribution schemes. However, the current value of the lifetime allowance has been significantly reduced by successive governments and is a potent driver for early retirement amongst senior clinicians. HM Treasury need to be mindful of this and ensure that any solutions to address issues caused by the annual allowance do not adversely impact the lifetime allowance. In addition, ways of retaining the most experienced doctors at a time when the NHS is under significant pressure should be explored.

¹² Department of Health and Social Care, NHS Pension Scheme: increased flexibility, September 2019, <https://www.gov.uk/government/consultations/nhs-pension-scheme-increased-flexibility#history>

Conclusion

There is irrefutable evidence that the current system of pension taxation is having a severe impact on capacity within the NHS. The recent NHS performance figures are already the worst on record and will continue to deteriorate until this issue is finally resolved.

While short-term measures such as moves to support recycling for those forced to opt out of the NHS pension scheme, or the recent time-limited scheme initiated by NHS England offer some relief, they fall far short of resolving the problem.

It is now past the point where we can afford any more short-term sticking plasters. **The only viable solution is a Treasury led reform to remove the annual allowance and taper in defined benefit schemes. The BMA calls on the UK Government to announce definitive pension taxation reform at the earliest possible opportunity and to implement these reforms for the start of the next tax year.**

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