

## The British Medical Association's response to the NHS Pension Scheme regulations – consultation

April 2021



## FOREWORD

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 health care and a healthy population. It is an association providing members with excellent individual services and support throughout their lives.

Most BMA members are members of the NHS Pension Schemes. This is a response from the BMA to the proposed changes to the NHS Pension Scheme regulations, consulting on a draft statutory instrument entitled The National Health Service Pension Schemes and Injury Benefits (Amendment) Regulations 2021.

## RESPONSE TO CONSULTATION

### **Question 1: Do you agree or disagree that the proposed amendments to the NHS Pension Scheme Regulations and the Injury Benefit Scheme Regulations should be made?**

We agree that the concerned NHS Pension Scheme Regulations and the Injury Benefit Scheme Regulations require amending. However, we cannot agree that the Government's proposed amendments properly deal with the issue of equality as it alleges, principally in relation to the NHS Pension Scheme Regulations 2015 ("the 2015 Scheme").

### **Question 2: Please provide details as to your answer**

Whilst we welcome the Government's acknowledgment that change is required to ensure equality, we would question why the Government has persisted in its reference to excluding pre-6th April 1988 pensionable service, and the limitation imposed of 4<sup>th</sup> December 2005. No such reference or restriction is placed on a widow's or female surviving partner's pension within the 1995 Regulations and so we question why the Government is treating widowers and male surviving partners differently.

As drafted, the proposed amendments do not provide equality but continue with the existing inequality and discrimination.

The 1995 Scheme provides that:

- a. A widow's pension under reg G1 is based upon all of the male member's service;
- b. A widower's pension under reg G7 is based on all of the female member's service from 6 April 1998 (excluding any service prior to this date);
- c. A survivor's pension for a male civil partner of a female member is based on all of the female member's service since 6 April 1988 (excluding any service prior to this date), see regs A4(5A) and G7; and
- d. A survivor's pension for a female civil partner or widow of a female member is now<sup>1</sup> based on all of the female member's service, see reg G10.

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<sup>1</sup> NHS Pension Schemes, AVC and Injury Benefits (Amendment) Regulations 2019, 2019 No 418.

This means that the male survivor of a female member (either her widower or surviving civil partner) would have a lower pension than the female survivor of an otherwise comparable female member (if she had pre-6 April 1988 service).

We would draw the Government's attention to the following extract from the consent order in *Goodwin v SoS for Education* [2020]:

*2.1 By providing for a survivor's pension which is less favourable for a widower or surviving male civil partner of the Claimant than for a widow or surviving female civil partner of a female scheme member, regulations 94 and 96 of, and Schedules 8 and 9 to, the Teachers' Pensions Regulations 2010 (as amended) ('the 2010 Regulations') directly discriminate because of sexual orientation and thereby result in a breach of the non-discrimination rule in section 61(1) to the Equality Act 2010.*

*2.2 Pursuant to section 61(3) of the Equality Act 2010, the 2010 Regulations shall have effect so that a widower or surviving male civil partner of the Claimant shall be entitled to the same pension as he would if he were a widow or surviving female civil partner of the Claimant.*

Following *Goodwin*, the Chief Secretary to the Treasury made the following statement in relation to survivors' benefits in public sector pension schemes:

*"The Government have concluded that changes are required to the Teachers' Pension Scheme to address the discrimination. The Government believe that this difference in treatment will also need to be remedied in those other public service pension schemes, where the husband or male civil partner of a female scheme member is in similar circumstances.*

*Departments responsible for the Administration of affected schemes will consult on and take forward changes as soon as possible. Schemes will notify their members of changes and any actions they need to take."*

As noted above, it is welcome that the Government believes that the difference in treatment must be remedied. However, we must question how it sets out that the proposed amendments deal with this.

This principle, i.e. that all pensionable service should be considered and that benefits should be provided regardless of the date of death, should apply to:

1. Any female member (in service, deferral or in receipt of a pension under the NHS 1995 Scheme), and
2. Any male survivor where the female member of the NHS 1995 Scheme died on or after 5 December 2005 (as there could be no comparator of the female member with any better rights before that date).

**Question 3: Do you think any changes are needed to ensure the proposed amendments deliver the policy objectives set out in the consultation document?**

Yes.

**Question 4: Please provide details as to your answer**

For the reasons provided in response to Q2 above, we do not consider that the proposed changes provide equal treatment.

The Government must take the following steps:

- Remove any restrictions relating to pre-6<sup>th</sup> April 1988 pensionable service. Any survivor of any member (be that a widow, widower, surviving civil-partner or surviving scheme partner) should receive that same benefit, based on all the member's pensionable service.
- Remove any restrictions in relation to a female member who dies on or after 5<sup>th</sup> December 2005 leaving a male survivor. There is no such restriction where a female member dies on or after 5<sup>th</sup> December 2005 leaving a female survivor and this principle must also apply where a female member leaves a male survivor.

We trust that the Government will appreciate that any failure to deal with these issues will expose them to the risk of further litigation, which the BMA will have no option but to consider in order to ensure that its members and their families are treated equally. There are already substantial constraints on the public purse without the Government having to defend unnecessary litigation, which can be resolved sensibly at this early stage.

**Question 5: In relation to chapter 6, are there any further considerations and evidence that you think the department should take into account when assessing any equality issues arising as a result of the proposed changes, and in particular whether there may be any potential impact on people who share a protected characteristic (age, disability, gender re-assignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex (gender) or sexual orientation).**

We fully support the overarching aim of this consultation to address equality issues within the NHS pension scheme. We, however, feel strongly that there are other outstanding equality issues that need to be urgently addressed in addition to those outlined in the consultation.

One of these include the issue of 'pseudo-growth'. Pseudo-growth occurs when there is a temporary rise in pensionable pay, e.g. through taking on a fixed term management position or receiving a national clinical excellence award that is subsequently not renewed. The vast majority of consultants retain a final salary link in the 1995/2008 pension schemes. Consequently, when they receive a pay rise as a result of receiving a pensionable management responsibility payment or a national clinical excellence award, this can result in large in-year pension growth and trigger a large annual allowance tax charge. However, if the doctor's pay falls again pre-retirement, because of the way their pension is calculated, they may not receive the increased pension benefit on which they have paid AA tax.

This leads to an equality issue with respect to those younger consultants who take on management roles or receive a national clinical excellence award for example. This is because they are less likely to hold these awards close to retirement and consequently are more at risk of their final pension not being based on the higher level of pay. Indeed, if these payments cease but their pensionable pay increases again in the future (e.g. as a result of incremental pay progression) they may face additional AA charges again in the future, even if their overall pension pay has not exceeded its previous value.

### Example of the impact of pseudo growth

Consultant E was appointed to the consultant grade in 2008. They had a pensionable Level 6 CEA and accrued 18 years in the 1995 pension scheme. They had £50,000 of non-pensionable income but following an unexpected tax charge of £20,176 in 2017/18, they reduced their additional sessions, retaining £30,000 of non-pensionable income.

However due to the demands of a struggling service, Consultant E took on a management role which attracted a £20,000 pensionable responsibility allowance in February 2020. This increase in pensionable pay generated a calculated pension input amount of £126,855, (£81,312 in the 1995 final salary scheme and £45,544 in the 2015 scheme). This resulted in a tax bill of £52,585. If Consultant E was able to continue in the management role until retirement and is likely used 'scheme pays' to pay the annual allowance tax bill, they could expect a pension of £62,353 if they retired aged 60.

However, these roles are usually for a fixed term and given the demands it is unlikely that this role is held until retirement. If the role is given up after 3 years (in 2023), Consultant E will lose the pension benefit relating to the 1995 final salary pension. However, the large tax bill that this generated and has been paid using scheme pays is an irrevocable decision and this will continue to accrue interest until retirement. As a result, Consultant E could expect to receive a pension of £57,072. This is over £5,000 lower than they would receive had they retained the management role until retirement. However, had they not taken on the management role at all, their pension would have been over £3,000 higher at £60,557.

Consequently, the cumulative effects of pseudo-growth and the scheme pays loan have meant that the consultant has lost more in total income by doing the management role than they could expect to receive in 'take-home' pay.

This is an extremely unfair anomaly within the pension scheme that is affecting many senior clinicians, and therefore must be addressed urgently. This could be done by automatically extending the pay protection arrangements. This would be best done by protecting the temporary rise in pay separately to the value of basic pay in order to not disadvantage those who take on these roles or receive national excellence awards. For example, if a consultant received a bronze clinical excellence award after 7 years in post, their basic pensionable pay would be £92,372 and the value of the CEA would be £36,192. If they subsequently failed to renew their CEA after 5 years, their total pensionable pay would be £98,477 (pay point 6) plus £36,192 i.e. £134,669 (not taking into account any pay uplifts).

However, simply protecting pensionable pay at this level would not be equitable as this individual could reasonably expect that the remaining pay increments on the consultant contract, coupled with pay uplifts over a further 20 years of consultant practice would take their basic pay alone above this level. This in effect means they have not received any pensionable benefit from being awarded a CEA and potentially paid more in AAA tax compared to a consultant who had not received this award. In contrast, an older consultant on the top pay point would be fully protected if any protection was applied only to total pensionable pay. We believe the government must address the equality issue that relates to pseudo-growth by not

only protecting pensionable pay but by offering protection relating to the pensionable pay rise (particularly that on which AA tax has been paid) independently of the value of future basic pay.

It is also worth highlighting that the current system is particularly inadequate for GPs who transitioned into the 2015 scheme. Under the 2015 scheme, contribution rates for GPs are ‘annualised’. This means that the amount they earn in a year is divided by the total number of days worked, and then multiplied by 365. This is an unfair system that results in many sessional GPs paying the top tier (14.5%) of pension contributions, even if their actual pensionable pay is far below the relevant threshold compared to a GP who worked full time.

We therefore believe that the process of annualisation of pay is inequitable and that, within a CARE pension scheme, contributions should be commensurate to earnings at the end of each financial year. It is also our view that this regulation is inherently discriminatory, as workforce trends show that women are more likely to work part-time than men, which in turn means that this regulation disadvantages women more than their male colleagues.

A similar issue applies for less than full time workers employed in the officer scheme. In the 1995/2008 final salary scheme, contributions for LTFT workers were based on whole-time equivalent pay. There was some rationale for this as the final pension was also based on whole time equivalent pay. However, in the 2015 pension scheme, contribution rates have continued to be based on whole-time equivalent pay even though the pension accrued is based on actual pensionable pay. Again, this is unfair and results in LTFT workers paying more for the same amount of pension than a full time colleague.

**Table 1. Relative costs for 3 different NHS workers purchasing approximately the same amount of pension.**

	Laura, GP Locum (working 1 day a week for 42 weeks a year)	Fran, FY2, (LTFT 60%)	Peter, Porter (full- time) Band 3
Actual Pensionable salary	£21,000	£20,620	£21,142.00
Income used for calculation	£182,500 (annualised)	£34,368 (FTE)	£21,142.00
Tiered rate	14.5%	9.3%	5.6%
Employee contributions	£3,045	£1,918	£1,184

This demonstrates that the annualised GP and the LTFT FY2 pay significantly more in employee contributions despite accruing the same amount of pension in the 2015 CARE scheme compared to a full time Agenda for Change worker with a similar level of actual pensionable pay.

For sessional GPs, we expect that, as a result of the McCloud consultation response, many members will revert to their legacy scheme for the duration of the remedy period (2015-2022) and therefore, should expect excess contributions to be refunded. Going forward though, we have sought assurances that, in the reformed scheme post-2022, all contribution rates will be based on actual rather than annualised or whole-time equivalent pay. However, a number of sessional GPs, e.g. those who commenced after the 1<sup>st</sup> April 2012, will not be offered the option

to revert to the legacy schemes for the remedy period and as such will have overpaid in terms of employee pension contributions. This is unfair and we believe these excess contributions should also be refunded.

It must also be recognised that the current system of pensions taxation in the NHS can result in the same pensions savings in effect being taxed multiple times. This is because higher earners pay more for their pension due to the current tiered contribution rates, meaning that the majority of senior consultants and GPs will pay contribution rates of 14.5% - a rate almost twice as much a year in contributions for a similar pension as civil servants. Despite this, they are also subject to further taxation if they exceed the annual allowance and again if they exceed the lifetime allowance.

A key rationale for this tiering was to offset the effect of higher rate tax relief which members of a career averaged revalued earnings pension scheme receive. This regulation more than achieves this and indeed means that many higher rate taxpayers will pay more for the same amount of pension as a basic rate taxpayer.

We believe that a flatter contribution rate structure would help to address some of the unfairness experienced by higher earners, ensuring greater mutuality within the scheme. We do, however, recognise that the target yield of 9.8% in the NHS pension scheme is too high and needs to be reviewed, but do not believe that this should be a barrier to introducing a flatter structure that means all members of the scheme are paying a fair level of tax.

In addition, due to the way the annual allowance regulations work, most senior doctors still face a tax cliff edge. This means that if their taxable income is just over the income threshold, even by as little as £1, it would result in an AA charge. Although the changes announced at the March 2020 Budget have mitigated this problem to some extent, if the level of the threshold remains fixed, more and more people will be affected by this over time as inflationary rises in pay are applied.

Indeed, given the desperate need for doctors to take on yet more additional work to reduce the backlog post COVID, this is still an area for concern. For doctors who cross the tax cliff and for those affected by pseudo-growth, the result is paying high levels of taxation, which is often for no additional pensionable benefit or at a level that far exceeds any additional income. Not only is this punitive and unfair, we believe this is discriminatory to those in the public sector as it is far too complicated to assess pension growth and pension growth cannot be controlled independently of the value of pay. Therefore, solutions such as removing the annual allowance in a defined benefit schemes or making a similar 'tax unregistered' pension scheme as has been offered to the judiciary, must be explored.

We note that there is also a significant gender pension gap within the NHS, meaning that there is a difference in pension income for female doctor's pensions relative to their male counterparts. We appreciate that this is primarily the result of a greater proportion of women working less than full time compared to their male counterparts. However, we believe that the government could help to address this by allowing those working less than full time to re-purchase lost pension provision at rates that are at least as favorable to the pension accrued whilst working full time. Previously, the option to purchase added years offered such a solution but this was closed in 2008. Whilst it is possible to purchase additional pension in the 2015 scheme, this is far less generous than the added years scheme and less valuable than 2015 accrued pension as it is no longer revalued in the same way.

On a more general point, it is also worth noting the review into the Gender Pay Gap in Medicine. The report identifies that there are a multitude of reasons causing the GPG, but we felt it important to raise this matter in response to this consultation as it is intrinsically linked to the gender pension gap.

The BMA is making every effort to address the causes of inequality in medicine and ensure that policy and pay decision making properly considers the diversity of the medical workforce, and therefore welcomes the opportunity to raise these issues in this forum.