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BMA Briefing – NHS Workforce and the Pension Taxation Crisis

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Overview

Since 2018, the BMA has argued that the Annual Allowance (AA) is completely unsuited to defined benefit schemes such as the NHS and called for the AA to scrapped in defined benefit schemes, something that had been supported by the Treasury's own advisers, the Office for Tax Simplification. However, the Government, did not agree and instead raised the taper thresholds to £200,000 and £240,000. The BMA was clear at the time, and ever since, that whilst this approach does mitigate some of the issues around the taper, it is not an effective solution, as the unfair interactions between pension taxation and the NHS pension scheme regulations remain – and crucially this does nothing to affect the punitive effects of the general annual allowance nor the lifetime allowance. Not only has **the raise in taper thresholds not fixed the problem but the situation has reached now reached a further crisis point** due to the combination of the levels of stress and burnout across the NHS, the McCloud judgement, the freezing of the lifetime allowance in 2021 and the rapid rise in inflation (Consumer Price Index, CPI) and a flaw in the Finance Act such that it is no longer operating as originally intended (i.e. measuring pension growth *above* inflation).

The current impact for punitive pension taxation – despite the increase in the taper

- Modelling from the BMA, as well as surveys from the Royal College of Physicians, suggests that, without decisive action from the government, more than **10% of the consultant and GP workforce are likely to retire by the end of 2022**. (these surveys were conducted before the recent rapid rise in inflation and the BMA believes this may now represent a very significant underestimate)
- A survey of BMA GP members which asked where GPs saw themselves professionally in the next three years found that **14.3% plan to take early retirement, and among those currently working as a GP partner, it was nearly 18%.**
- The 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.
- The freezing of the lifetime allowance (LTA) in 2021 was incredibly disappointing and served only to further exacerbate the problem. Our survey of over eight thousand doctors revealed 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 ; and 41% said they would be more likely to give up additional responsibilities.
- At the time of our survey CPI was 0.4%. It is now 9.1%, which is what the LTA is now reducing by each year. At the time it was assumed that inflation would stay stable at around 2%. We believe that if we were to re-run this survey the results would show a significant increase in those now intending to retire due to the impact of inflation, and its interaction with NHS pension policies.

Why the rise in CPI is turning a crisis into a disaster for the NHS

There are three major impacts of inflation. Firstly, for hospital doctors nearing retirement age with final salary schemes, the DHSC have suggested that despite CPI being likely to hit 10% by September 2022, the likely pay award for doctors is around 2%. This unprecedented gap between the level of

inflation and likely pay award risks significantly devaluing the pension of those member's aged 59 or above if they delay retirement even for a single year. This is compounded by the fact that there are no late retirement factors in the 1995 NHS pension scheme (the scheme that the vast majority of those staff approaching the age of 60 are in). **This means that for every year spent working beyond the age of 60, the level of annual pension that could have been received had they retired at the age of 60 is effectively lost**. In response to inaccurate information published by NHSEI that claimed that NHS staff would receive a higher pension if they delayed retirement, the BMA has produced a tool enabling hospital doctors aged 59 or above to model the impact on their own situation if they worked for an extra year. **This has demonstrated that a doctor may be well over £100,000 worse of if they retire at the age of 61 rather than age 60.**

The second pressing issue in relation to the current rates of CPI, is the fact that two different measures of inflation are used in the NHS pension scheme. This particularly impacts those on Career Averaged Revalued Earnings (CARE) Pension Schemes. As GPs are wholly within a CARE scheme, it has the biggest impact on this group of doctors. The current rules use a different CPI value for "opening" value (which is based on the rate of CPI measured in September LAST year), versus the revaluation/dynamisation of earnings built in the NHS pension scheme (based on the rate of CPI measured in September THIS year). When inflation was stable, and last year/this year CPI are similar, this doesn't present a major problem. However, when inflation changes rapidly, like it is now, it becomes a very significant problem for many. For example, CPI in September 2022 is likely to be ~10% and as per the scheme rules, the pension will be revalued by "inflation"+1.5% and therefore increased by ~11.5%. However, the opening value of the pension will only increase by 3.1% (September 2021 CPI). Therefore, even though the AA is only supposed to test pension growth "above inflation", this discrepancy caused by using two different measures of inflation will result in this purely inflationary growth being tested against the AA and for many this will use a significant proportion of the available AA or in some cases exceed it entirely, resulting in an additional tax charge simply as a result of inflation. This impact is compounded by the fact that the opposite scenario will occur next year if as predicted inflation returns to more "normal levels". Due to the fact that despite receiving a single pension, the 2015 scheme and the 1995/2008 schemes are considered different schemes, negative growth in one scheme cannot be offset against positive growth in another as negative growth is simply considered to be "zero". In addition, negative growth in the 1995/2008 scheme cannot be offset against either previous or future years. Consequently, even though if inflation falls again next year, the value of the 1995/2008 pension will fall in real terms, this fall is completely ignored. This effectively means that **GPs in particular will face additional AA tax bills of tens of thousands of pounds this year for "pseudogrowth", the majority of which will be lost next year but with no refund/reduction of the tax paid.**

An example in the latest BMJ article outlined a GP with median partner earnings of £115k (significantly below the £200k taper limit) receiving an AA charge of over £32k – due to this flaw in the finance act is incorrectly measuring growth above inflation. Further details of this issue are laid out here

Thirdly, the high levels of inflation have exacerbated the impact of the decision to freeze the Lifetime Allowance (LTA). This is likely to see over £100k real terms value removed from the LTA this year alone.

Why flexibility suggested by the Secretary of State and NHSEI won't work

We are disappointed to hear the suggestion from NHS Employers and the Secretary of State to the HSC that the solution to the outstanding pension taxation problem lies in the use **of pension flexibilities**. We are clear that taking an approach of introducing flexibilities, or 'tinkering' with the existing system, while ignoring its fundamental flaws will not resolve the situation, and the result is that senior NHS workers will leave the NHS in unprecedented numbers.

The government has conducted two prior consultations on pension flexibility over the last 4 years. The first "50:50" consultation was pulled and the second "decile flexibility" consultation was rejected by both members and the government. A third attempt to push flexibility as the solution will not only delay but will not solve the problem, leading to thousands more doctors retiring over the next year.

The option to "flexibly" contribute towards an NHS pension doesn't work for several reasons. Firstly, it adds another layer of incredible complexity to an already extremely complicated pension scheme and pension tax system. Secondly, scheme members will not know their own pension growth position during a given tax year and once a tax year has ended, there is no ability to retrospectively adjust your pension inputs, so any flexible options are not available. The complexity is such that you cannot predict your pension growth in advance, even with specialist advice and if trying to "guess" the level of accrual, it is very likely that the majority will over or under contribute. The penalties for guessing wrong are so severe and the complexity so high that most members simply won't be able to use this option. Furthermore, without recycling being available, flexibility (i.e., reducing how much you contribute towards your pension) is simply an overall pay cut.

BMA Solutions

Long term solution - Tax unregistered scheme

We are clear that in the long term**, the solution to this problem is a tax unregistered scheme for those impacted by pension taxation in the NHS.** When faced with similar recruitment and retention problems with the judiciary because of these taxes the UK Government introduced a tax unregistered scheme. This immediately addressed the issue and resulted in more judges being appointed. This is a fundamentally fair system, it ensures that the correct amount of tax is paid on pension growth, and as no tax relief is provided on employee pension contributions there is no requirement to subject scheme members to either the AA or LTA.

As NHS higher earners do not currently benefit from tax relief in the first place because of the contribution structure, extending such arrangements to the NHS would be particularly effective. 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. This would allow doctors to stop incurring large additional tax bills for undertaking more NHS work for their patients, and, crucially, it would do this by ensuring that higher earners in the NHS are paying the correct amount of tax.

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.

While the tax unregistered scheme is being introduced there are a number of other changes we recommend to mitigate in the short term against further NHS workforce loses:

1. **Amend the Finance Act**
   As outlined above, only growth above inflation should be tested against the AA. However, in this rapidly moving inflation environment, the Finance Act (Section 235) doesn't do this as two different values are used. Simply, amending Section 235 to ensure that the opening value is aligned with this year's CPI (not last year's), so the inflationary uplift of benefits is tested in the same year. This will ensure that only "growth" above inflation would be subject to testing against the AA as was clearly originally intended.

2. **Address the Issue around Negative Pension Input Amounts**

   As outlined above, although workers in the NHS will only receive one NHS pension, following the Public Sector Pension Reforms, many NHS staff are in both the 1995/2008 and 2015 pension schemes. Under the Finance, Act, these schemes are considered separately. Therefore, even though one scheme may have negative growth, this negative growth is not offset against positive growth in the other schemes. For example, if a member had £20,000 negative growth in the 1995/2008 scheme and £60,000 positive growth in the 2015 scheme, even though their combined Pension growth was £40,000 and within the standard annual allowance, the 1995/2008 is considered to be zero and instead the member is taxed on the £20,000 excess in the 2015 scheme. In addition, the negative growth in the 1995/2008 cannot be carried forward or backward to offset previous positive growth in those years.

3. **Repeat of the 2019/20 Annual Allowance compensation scheme**

   Given the urgent nature, and the significant impact on the impact of CPI on senior doctors and senior NHS staff, a repeat of this compensation scheme would stabilise the workforce and reduce the need for this group to consider retiring or reducing work over the next 12 months as it would prevent the penalty associated by being taxed on non-existent pension "pseudogrowth" that arises due to the anomalies within the Finance Act. It has been implemented rapidly in the past and is a fully operational solution that could be introduced immediately. However, it is essential that if this is utilised it covers all four nations across the UK.

4. **Recycling of Employer pension Contributions**

   The BMA is calling for Mandatory scheme level recycling of employers' pension contributions for those NHS workers who need to opt out of the scheme because of pension taxation. This is currently something which individual Trusts can choose to offer, but it is not mandated nationally by NHS Employers, leading to a postcode lottery for senior NHS workers. Our proposal would be cost neutral for the employer and fair to those working in the NHS. Most importantly, it could improve the retention of senior NHS staff at a time when they are needed the most. It is also an option supported by government with the Secretary of State, Sajid Javid MP commenting during his recent evidence session to the HSC that:

   "one thing that we did recently was publish guidance for NHS trusts, because they are ultimately the employers of these doctors, around flexibility—the option for them in many cases to give salary in lieu of pension contributions. Instead of an employer's pension contribution, they could offer the doctor the equivalent amount but in salary. Of course, it is taxed, but the doctor still gets that income. Some trusts are doing that. Other trusts are not, and that is why we issued guidance recently to make it clear that it is something that we, at the centre, are happy with. Ultimately, the trusts are the employers. We want to make sure that they understand that they have these flexibilities, and where that is happening, it is certainly helping."

   Given this central government support for recycling we are very concerned that the majority of Trusts are still not supporting its use to retain senior NHS workers, and of those that do offer recycling, they invariably are not paying the full value of employers' contributions to the employee. For that reason we believe it necessary to end the 'postcode lottery' approach to recycling and to mandated all trusts to offer scheme level recycling, for the full level of the employer contribution (less employers NI – and as such cost neutral to the tax payer).

The Association of Independent Specialist Medical Accountants have already written to HMT about this issue and have independently proposed many of these solutions. Their letter can be found here.