Funding priorities for the health and care sector: BMA's submission to the Spring Statement 2023

About the BMA. The British Medical Association (BMA) is a professional association and trade union representing and negotiating on behalf of all doctors and medical students in the UK. It is a leading voice advocating for outstanding healthcare and a healthy population.

This submission sets out the BMA's funding priorities over the next financial year and beyond. The UK's health and social care systems are in crisis. Services are underfunded, understaffed and over capacity, and therefore unable to cope with demand. Our key priorities are ensuring there are safe staffing levels in the health system, through expansion and retention of the existing workforce. This will require addressing through boosting pay and fixing pensions. We also call for increased investment in capital to ensure there are sufficient beds and other infrastructure to meet demand, and that worrying trends in declining population health are reversed so that demand is reduced - including through the adequate funding of the public health function.

Due to health being a devolved matter, the specific calls for investment set out below are England-focussed. However, many of the issues highlighted are just as pressing in the devolved nations, and we would expect to see any increases in health funding mirrored for the devolved nations through the Barnett formula.

The primary issue facing the NHS is insufficient and undervalued staff. The long-awaited long-term workforce plan must be fully funded, and include measures to improve retention through increasing pay, and reforming NHS pensions.

Recruitment and retention of staff is a significant issue, if the NHS expects to provide a decent quality of care to its patients. There are currently over 9,000 known FTE (full-time equivalent) medical vacancies in the secondary care workforce[i], whilst GP vacancies are not even collected and published. In England, there are less than 3 doctors per 1,000 patients, whereas OECD comparator EU nations average 3.7 doctors per 1,000 patients. To bring England's doctor/population ratio in line with OECD comparator EU nations of 3.7, we estimate an additional 47,600 FTE doctors are needed (this includes the current 9,000 vacant posts)[ii]. In General Practice, despite patient numbers rising, the total GP workforce has seen little growth since 2015, with the fully qualified GP workforce contracting over that time. As of November 2022, there are now the equivalent of 1,973 fewer fully qualified full-time GPs than there were in 2015[iii].

A combination of both below inflationary pay uplifts and the consequent negative impact on pensions is significantly reducing the pull factors in recruiting medical staff. Across each branch of practice, doctors have seen their pay continue to fall since 2008/09 relative to inflation. This has a dual effect on both the recruitment and retention of doctors. Firstly, with significant debts accrued in the training of doctors, a profession with a reduced salary and overall renumeration package

[i] https://digital.nhs.uk/data-and-information/publications/statistical/nhs-vacancies-survey
[ii] https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/workforce/nhs-medical-staffing-data-analysis
[iii] https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/pressures-in-general-practice

becomes far less attractive at a time where we require more doctors to support the NHS. Secondly, the reduction in pay has a particularly significant impact on those senior doctors with legacy final salary pension benefits. The impact of pay restraint has resulted in huge losses to the lifetime remuneration of all doctors, but those with legacy scheme benefits in particular (the most senior doctors). They are in effect through continuing to work for the NHS losing value in their pension every year. This will inevitably lead to further retirements and a vital loss to the NHS of senior, experienced doctors. Doctor's early retirements tripled between 2008/09 and 2020/21[iv]. A BMA survey in the Autumn of 2022 of nearly 8,000 doctors indicated that nearly half (44%) of hospital consultant respondents in England plan to leave, or take a break from working in the NHS, over the next year – directly because of more than a decade of pay erosion and punitive pension taxation arrangements[v]. These issues must be addressed immediately: waiting to see whether all these doctors will in fact leave the system will be too late, given the length of time it takes to train up new doctors, and the inefficiencies of high turnover.

A shortage of staff produces a vicious cycle: staff experience chronic stress, which encourages high turnover and absence, which in turn increases pressure on existing staff. For the most recent year of data we have (September 2021 – August 2022), doctor sickness in England was on average 2.09%. For doctors, this is 68,135 FTE days lost to sickness in August 2022 alone[vi]. This is much higher than a decade earlier, September 2011 – August 2012, when doctor sickness was on average 1.23%.

Plans to address backlogs and tackle long waits for care rely on there being sufficient staff to enact them. The elective care recovery plan relies on hundreds of new diagnostic hubs and surgical hubs[vii]. These will require staffing, and with high levels of vacancies already existing in the system, it is difficult to see how this will be possible without attracting more doctors.

To boost recruitment and retention doctors pay must rise and the Government must immediately reform the unfair pensions taxation system. Over 10,000 doctors gave up their licence to practice last year[viii]. 89.7% of doctors who have already left the NHS to work abroad blame dissatisfaction with pay in the UK[ix]. Countries such as Australia are actively recruiting UK doctors. Meanwhile international recruitment of doctors to come work in the UK is at risk. The UK heavily relies on international doctors who make an important contribution to the NHS. Nearly one in three doctors working in the UK were trained abroad[x], but an international doctor shortage suggests it will become increasingly difficult to recruit abroad[xi]. It is a false economy to not renumerate staff appropriately, as the costs involved in recruiting and training new doctors comes with a significant price tag.

[iv] https://www.bmj.com/content/373/bmj.n1594

[v] https://www.bma.org.uk/bma-media-centre/catastrophic-crisis-facing-nhs-as-nearly-half-of-hospital-consultants-plan-to-leave-in-next-year-warns-bma

[vi] https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates

[vii] https://www.england.nhs.uk/2022/02/nhs-publishes-electives-recovery-plan-to-boost-capacity-and-give-power-to-patients/

[viii] https://www.gmc-uk.org/news/news-archive/action-needed-to-stop-senseless-waste-of-nhs-talent---gmc-chief-warns#:~:text='Last%20year%2C%20nearly%2010%2C000%20doctors,new%20opportunities%20and%20adventure%20abroad.

[ix] https://onlinelibrary.wiley.com/doi/full/10.1002/hsr2.419

[x] https://stats.oecd.org/Index.aspx?DataSetCode=HEALTH_WFMI

[xi] https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(22)00532-3/fulltext

Doctors are calling for full pay restoration, back to 2008/09 levels. This will ensure the UK remains competitive in terms of doctor compensation. Pay awards for doctors have been below inflation since 2008. Our calculations show that pay awards for junior doctors in England from 2008/09 to 2021/22 have delivered a real terms (RPI) pay cut of 26.1%. To achieve pay restoration by reversing this cut, would require a 35.3% pay uplift. For junior doctors, we estimate this will cost £1.65 billion in gross cost in the current financial year, to the NHS budget. This includes the full cost of wage increases, including additional employer costs of National Insurance and pension contributions. But over a third of that will be returned to the Treasury in the form of higher tax receipts, giving an actual net cost of £1.03 billion[xii]. Pay restoration should be provided to junior doctors this year and from the next year pay should rise in line with inflation.

Pensions represent a crucial part of the overall renumeration for doctors. Yet pensions taxation is having a major impact on retention. A recent BMA survey found that 16% of doctors intend to take voluntary early retirement in response to multi-year pay erosion and pension taxation arrangements. We welcome the government's desire to find solutions to this issue, and we support many aspects of the recent consultation on proposed amendments to the scheme regulations. In particular, we support partial retirement which will aid senior consultants to keep working as much as they wish to and are able to. We are in full support of pensionable re-employment for the 1995 scheme members. However, there are still many issues, which we describe below.

A particularly unfair situation relates to the issue of Negative Pension Input Amounts. This is an issue because most senior consultants are members of two separate but connected pension schemes, considered separately for tax purposes. Therefore, if you have negative growth in one scheme (e.g. the 1995/2008 scheme), this negative growth is rounded up to zero and can neither be offset against positive growth in the 2015 scheme or carried forward or backwards within the same scheme. Whilst the Government has proposed changes that would mitigate this issue, they do not wholly remove it from future years, and represent only a sticking plaster rather than a comprehensive solution that is necessitated. This is due to these proposals not addressing what would happen in the case of 'negative growth' in one scheme being in effect zeroed off rather than this 'negative growth' being taken into account in addressing the actual value of the scheme, and these proposals therefore represent at best partial support to doctors. The Government must urgently correct this anomaly in the Finance Act so that 'negative growth' in one scheme can either be offset against growth in another or carried forward or backwards into other tax years.

The time has come for genuine comprehensive solutions and a radical overhaul of the way the NHS Pension Scheme is taxed, alongside immediate increases to doctor's pay, rather than small tweaks to a system that is failing to provide value and retain doctors. We recognise and appreciate that the Government has been active in providing mitigations to a number of issues, with the proposed 'encouragement' of recycling policies and the introduction of partial retirement. However, these are solutions that work around the surface of a pension scheme that requires substantive reforms. These approaches, alongside Government proposals around 'flexibilities' and exchanging a portion of the NHS pension and receiving a portion of the employers pension contribution, as discussed in the House of Lords by Lord Markham on the 11th Jan 2023), do not fix the heart of the issue, with steep falls in the overall take home renumeration package for senior doctors due to the punitive taxation system alongside the issues around pay and inflation. If the Government is to be able to retain

[xii] https://www.bma.org.uk/media/6665/junior-doctor-pay-restoration-costing-analysis-methodology-v1.pdf

doctors within the NHS, it must implement substantive changes, as highlighted by the BMA, that can protect senior doctors from unfair taxation and can incentivise them to remain within the NHS.

In the long-term, the BMA has repeatedly and consistently argued that a solution similar to the one implemented for judges should be introduced for doctors and other higher earners in the NHS. It is extremely unfair that through the annual allowance and the lifetime allowance, that together claw back the income tax relief on pensions contributions twice over. We propose that the tax unregistered scheme is a separate, opt in scheme that members can choose to move across to once it is clear that the pension taxation rules are having a negative impact on their ability to work more or pushing them towards early retirement. Such a solution would significantly aid retention, with a BMA survey suggesting that 77% of respondents would delay their retirement if this was implemented. We will continue to engage with the Treasury on how such a scheme or similar could be implemented. (See appendix for modelling that suggests such a scheme could in fact be a net benefit to the Treasury).

In addition to the retention of existing staff, the pipeline of new staff must be developed. We welcome the upcoming NHS Workforce Plan and the inclusion of independently assure workforce modelling, but it is vital that it is fully funded. There should be a significant expansion in medical school places rather than penalties for medical schools taking the initiative to increase medical school places to help start tackling the crisis. But this must be matched with sufficient clinical placements, foundation programme places and corresponding specialty and, crucially, GP training places, working closely with the devolved nations. This is necessary to ensure a high-quality experience for medical trainees and to ensure that they are able to deliver high quality care. The staff/educator workforce, particularly medical academics, in medical schools and NHS providers also needs to expand significantly to deliver the necessary increased teaching, education and supervision workload. A flexible return to work programme for educators is urgently needed to bolster that workforce. Failing to guarantee access to the Foundation Programme and, later on, speciality/GP training places and continuing professional development for staff grade, associate specialist and specialty doctors would contradict efforts to address medical workforce shortages.

Historical underfunding has led to a lack of resilience in the health system, and the UK's health systems are now under unprecedented pressure from high demand and cost pressures.

Prior to the pandemic, the UK's health system experienced a decade of underfunding. The Health Foundation has found that day to day spending on healthcare between 2010 and 2019 was 18% below the EU14 average, and if UK spending per person had matched the EU14 average, then the UK would have spent £40 bn per year more on average each year between 2010 and 2019. As a result, there has been insufficient investment in infrastructure, and insufficient investment in staff through pay freezes and sub-inflationary pay awards.

Recent funding injections are insufficient. Although the most recent fiscal event (Autumn 2022) allocated £3.3 billion in additional funding in both 2023/24 and 2024/25, bringing the total DHSC budget to £182 billion and £184.5 billion in real terms[xiii], respectively, this additional cash injection still means the DHSC faces real terms cuts to its budget compared to commitments made in October 2021, and funding growth is still lower than the historical average. Even with the additional money in the autumn statement, the budget is still lower than it would have been if the commitments had

[xiii] https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/funding/health-funding-data-analysis

been honoured[xiv]. And even with the additional money the average growth of the DHSC's budget between 2019/20 and 2024/25 is due to be equivalent to 2.9%, lower than the historic average of 3.6% growth[xv].

Failure to invest properly in the health system is a false economy, leading to the need for costly expenditure and last-minute budget top ups. Due to a lack of investment in staffing, over the past five years, the NHS has spent a combined total of £4.6 billion on agency doctors. There is evidence that agency spend is increasing, with a total of over £9 billion spent on agency and bank staff in England in the last year (2021/22)[xvi]. Meanwhile, due to a lack of capital investment and support for social care, significant additional last-minute investment has been required in England this winter alone to ensure there are places to discharge patients in need of care safely and to free up beds.

Health in the UK is in decline, and poor health is impacting the economy. Healthy life expectancy has fallen for both males and females at birth in 2018 to 2020 compared to 2011 to 2013[xvii]. And the number of people out of the labour market because of long-term sickness has been rising in recent years, with the number economically inactive due to sickness rising from 2 million people in spring 2019 to about 2.5 million in summer 2022[xviii]. Worryingly, long-term sickness rose faster among younger age groups, with a 42% increase in those aged 25-34 out of the workforce due to long-term sickness. The number of new disability benefit claimants also doubled between December 2021 and December 2022[xix]. Tackling this would support economic growth and post-pandemic recovery. Meanwhile, analysis shows that growth in healthcare investment has a clear relationship with economic growth. They found that for each £1 spent per head on the NHS, there is a corresponding return on investment of £4[xx].

Investment is needed to ensure the backlog of poor, inefficient and high-risk infrastructure (estates and technology) is tackled with sufficient capital funding

The quality and capacity of healthcare estates has a direct impact on the health, safety and wellbeing of staff and patients. Healthcare facilities in poor condition present great risk to staff and patient safety, and both create and exacerbate negative working conditions. In a recent BMA survey, 43% of respondents reported that the physical condition of the building in which they work has a negative or significantly negative impact on patient care[xxi]. One of the most visible consequences of underinvestment in healthcare estates are spiralling hospital maintenance backlogs, which show the

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[xiv] https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/funding/health-funding-data-analysis

[xv] https://ifs.org.uk/publications/nhs-funding-resources-and-treatment-volumes

[xvi] https://www.nursingtimes.net/news/workforce/nhs-agency-spend-up-20-in-england-amid-workforce-gaps-14-11-2022/

[xvii] https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/healthstatelifeexpectanciesuk/2018to2020

[xviii] https://www.ons.gov.uk/employmentandlabourmarket/peoplenotinwork/economicinactivity/articles/halfamillionmorepeopleareoutofthelabourforcebecauseoflongtermsickness/2022-11-10

[xix] https://ifs.org.uk/sites/default/files/2022-12/The-number-of-new-disability-claimants-has-doubled-in-a-year-IFS-report-R233.pdf

[xx] https://www.nhsconfed.org/system/files/2022-10/Health-investing-and-economic-growth-analysis.pdf

[xxi] https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/the-future/building-the-future-healthcare-infrastructure-reports/estates-infrastructure

extent of investment needed to ensure all hospitals meet even the most basic standards. The size of the maintenance backlog in England alone is £10.2 billion, and this year's total capital investment amounts to less than 14% of the total cost of the backlog. Meanwhile, our analysis has found that insufficient space in GP practices is hindering doctors training and preventing the recruitment of additional staff[xxii].

At minimum, the BMA is calling for next year's capital investment to be protected in real terms. The capital budget for health is currently set to decrease by 6% next year (2023/24), but further funding should be provided to ensure that this is not the case, meaning the capital budget should be increased by at least £0.7 billion. We also note that from 2025/26 onwards, the total capital spending envelope for all departments is set to be held flat in cash terms. The BMA is calling for the health department's budget to be protected in real terms.

General practice and public health must also be sufficiently funded to ensure that people are supported to stay well and to ultimately reduce demand on the system.

The pressure on General Practice is enormous. General Practice is feeling the pressure from all sides; enormous patient demand, falling numbers of GPs and now the impact of inflation as well are destabilising practices' finances[xxiii]. The backlog of unmet need and delayed elective care, together with winter pressures, is leading to unprecedented demands on a shrinking workforce[xxiv]. Inflation is hitting practices hard through increased staffing costs and energy costs. Other expenses are also increasing across the board. As the BMA works with ministers, DHSC and NHSE on more support for hard pressed providers to improve patient access, we re-emphasise the need to ensure access and staff numbers do not continue to diminish in general practice because providers cannot cope with inflationary cost pressures. It is also vital that General Practice is recognised as a vulnerable industry and energy support for the sector maintained into 2023/24.

COVID-19 has demonstrated the importance of public health services and how they help to reduce pressure on the NHS, through the health protection function, by addressing inequalities at local level and by ensuring healthcare services meet the needs of populations. Yet public health services remain significantly underfunded. Compared to 2015/16, the public health grant has been significantly cut. This has led directly to the reduction in public health services[xxv]. In addition to this, while the pandemic has shown how vital both ongoing and surge health protection capacity is at local level, there is now the unrealistic expectation that this will be maintained, yet the additional local resource for this function (the Outbreak Containment Fund) is being withdrawn.

We should be seeking to restore the public health grant to adequate levels rather than maintaining the low and unambitious level of public health funding of the past few years. The Health Foundation estimates that in order to restore the grant to its real-terms value and meet increasing cost pressures and demand, the grant should be £4.7 billion by 2024/25. The Outbreak Containment Fund should also be restored.

Health Protection and improvement are crucial areas that should also remain appropriately resourced at central and regional level. it is vital that there is sufficient funding for the UK Health

[xxii] https://www.bma.org.uk/media/6579/bma-infrastructure-1-report-brick-by-brick-estates-dec-2022.pdf
[xxiii] https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/pressures-in-general-practice-data-analysis
[xxiv] https://committees.parliament.uk/publications/9266/documents/160332/default/
[xxv] https://www.nao.org.uk/report/financial-sustainability-of-local-authorities-2018/

Security Agency (UKHSA), along with the Office for Health Improvement and Disparities (OHID), to allow these organisations to appropriately monitor and mitigate significant threats to health and to continue to provide screening and immunisation and other vital public health services. Together, the UKHSA and OHID should have an operating budget exceeding the prior Public Health England operating budget, to reflect the essential need for these functions.

Appendix: A tax unregistered pension scheme for doctors: technical note accompanying in-year cash flow model

May 2022

Executive summary

This note provides a technical overview of a model to look at the in-year cash implications for public funds of a tax unregistered pension scheme for high-earning doctors. It was developed in order to consider the viability of such a scheme.

It has sought to demonstrate the viability of such a scheme in terms of the net benefit this could provide to the Treasury and wider NHS through the retention of senior clinicians. At a time where the NHS is emerging from the pandemic with a significant waiting list, the need to retain our senior doctors both from a practical and financial perspective has never been greater. As can be demonstrated by a modelling tool we have recently published which allows members to understand the impact on the value of their pension by remaining in the NHS for a further year from April 2022, a significant number of doctors will be forced to retire as a result of the current system to avoid in effect having to pay to remain working within the NHS.

We believe a tax unregistered scheme can fix this issue. Under a range of retirement and early retirement scenarios, the net impact on the public purse if the scheme was introduced this financial year would be in the range of £30 million to £410 million gained. Even under the most conservative assumptions that we have made, it would still have a significant net beneficial impact for the Treasury, in direct taxes received from doctors remaining in work, reduced locum payments and reduced pension payments.

We have, in this technical note, sought to provide a useful overview and an introduction to our modelling and how have come to these conclusions. Our intention would be to hold a further meeting whereby we could directly run through the modelling with yourself and colleagues, thereby ensuring a shared understanding as to our assumptions, basis of our conclusions and the facilitation of further dialogue around the proposed solution.

Background

BMA members and the BMA Pension Committee have identified that doctors are being taxed excessively on their pensions, leading to increased incentives to retire early. This has implications for the achievement of manifesto commitments (6,000 more GPs by 2024) as well as other policy commitments (reducing the elective care backlog).

Some doctors are exceeding the limits on both the lifetime allowance and the annual allowance through the way these mechanisms interact with the defined benefit structure of the NHS pensions scheme. This means they are not only losing out on income tax relief on their pensions contributions, but are in fact being taxed twice on the same income source. This is incentivising doctors at the height of their careers to leave the profession.

The BMA has developed some initial modelling to consider the implications of one potential solution – a tax unregistered pension section or scheme for the NHS, similar to the offer for judges.

This model looks at one specific potential implementation of a tax unregistered scheme, simulating the impact on the public purse in the following (2022/23) financial year, to demonstrate what the

costs and benefits would be to the Treasury in terms of tax revenue, to the Department of Health in terms of reduction in costly locum cover, and to the NHS pension scheme in terms of the balance of contributions.

Overview of the model

Although there are a potential range of ways a tax unregistered scheme could work, the model considers the following implementation as an appropriate method:

- This would be a separate section of the current scheme or a new scheme[xxvi] that doctors would have the option to move into once certain conditions are met. Conditions conserved were – upon first breach of annual allowance/lifetime allowance; when a particular threshold of income reached, eg. £100,000; or to allow as an option for all doctors at any point they choose. This model considers the threshold income option, using £100,000 for modelling purposes.
- Those utilising the scheme/section would no longer enjoy tax relief on their pension contributions. But they would also not be subject to annual allowance charges or lifetime allowance charges on any contributions to the new scheme/section. The contribution rate would be at least 8.1% of pensionable earnings, which is the contribution rate for the highest earners from October 2022, net of income tax relief (13.5% net of 40%).
- Benefits in prior section(s) would be preserved and could be accessed at retirement along with additional pension accrued under the tax unregistered scheme/section.

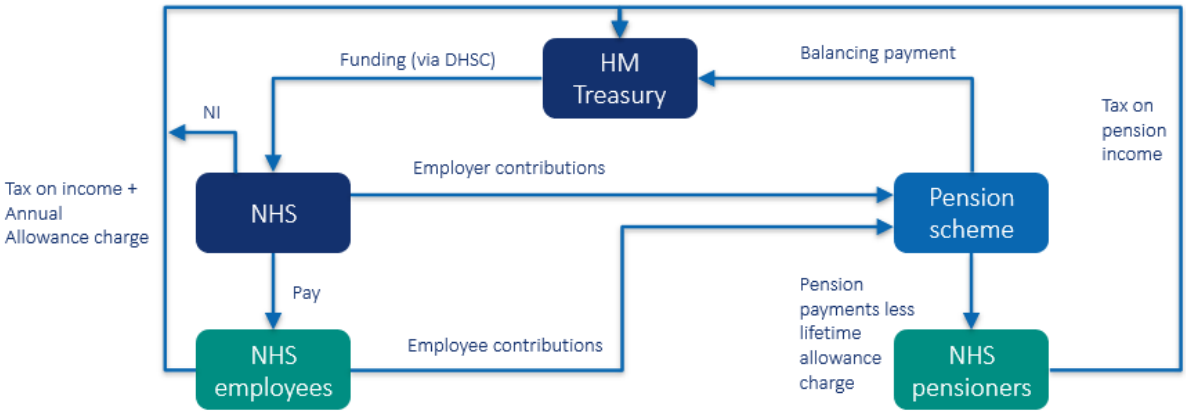
The model compares the impact of a tax-unregistered scheme, as described above, with a business-as-usual scheme (ie. NHS pension scheme maintained as is currently planned for 2022/23). The model uses a cohort-based approach, simulating the fraction of each age group who retire, work part time, or work full time under each of the two schemes (tax-unregistered and baseline schemes). I have considered a range of different scenarios for doctors following each of these pathways, further detailed below.

Figure 1 below shows how cash flows are modelled, between HM Treasury; the NHS; the NHS pension scheme; NHS current employees and NHS pensioners. Pay-as-you-go public service pensions, of which the NHS pension scheme is one, are paid for by staff through employee contributions, and taxpayers, through employer contributions and a balancing payment[xxvii] from HM Treasury. The flows in the below diagram are aggregated up in the model to show:

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

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

[xxvi] Whether this is a separate section of the same scheme or a separate scheme depends on legal advice.
[xxvii] Currently the Treasury retains an annual surplus from the NHS pension scheme in the form of a balancing payment worth £3.8 billion in 2020/21. However, contributions are set based on the present value of future benefits earnt, and so if fewer contributions are received due to people retiring early or leaving the scheme, the scheme may no longer be considered stable.



Source: adapted from NAO (2021) Public service pensions

Scenarios modelled

Under the business-as-usual scheme, we model three pathways: a) retire and cease work; b) retire and return at part time rate (50%); c) work full time. Similarly, within a tax unregistered scheme, a doctor can either: a) retire and cease work; b) work part time (80%); c) work full time. It is expected that under a tax unregistered scheme, fewer doctors will retire early and cease working altogether, and that those that choose to work part time, may work longer hours. However, the extent of part time working under each scenario can easily be changed in the model.

Scenarios for retirement pathways were generated based on expected retirement and early retirement pathways. We used linear projections of expected early retirements and retirements based on data from 2015/16 up to 2020/21. We then considered different scenarios based on this for the tax unregistered and business as usual schemes. GP and consultants have different pathways because linear projections for GPs mean that very few aged 60 to 64 are likely to be working full time. The rationale for each scenario was as follows:

Scenario 1	High retirement (150% rate) and reducing working hours (125% rate for 65 and over, 133% rate for 64 and under) under business as usual; higher retirement and reduced working hours (120% rate for both) the tax unregistered scheme due to burnt-out workforce.
Scenario 2	High retirement and reduction of working hours under business as usual as in Scenario 1; lower retirement rates and reducing working hours rates (80% rate for both) under the tax unregistered scheme.
Scenario 3	Slightly higher retirement (120% rate) and reducing working hours (110% rate) under business as usual but tax unregistered schemes at linear baseline projection.
Scenario 4	As scenario two, but variation in age (retiring later)
Scenario 5	Linear retirement and reduction of working hours under business as usual and 90% retirement rates under tax unregistered scheme

Further scenarios could certainly be modelled.

Further key assumptions

There are a range of different assumptions used in the modelling, many of which can be adjusted to look at the impact of results.

- **Cohorts**. We have focussed only on consultants and GP partners over the age of 55. They are considered in three groups, ages 55 – 59, 60 – 64, and 65 and over. GPs and consultants are modelled separately and aggregated up. We have used linear forecasting to estimate the total number of consultants and GP partners in April 2022, and disaggregated by age according to the most up to date data for each group.
    - **Consultants pay**. We have based pay on 2021/22 pay scales and assumed that in 2022/23 there will be a 2% pay increase. This is based upon the DHSC recommendation to the DDRB. We have used a 3% on call consultant rate, which is pensionable and an additional non-basic additional pay of 30% which is non-pensionable. This is in line with NHS Staff Earnings Estimates mean annual non-basic pay for all consultants. For consultants, we have modelled 30% on notch 7 and 70% on notch 8 as this reflects the Pensions Committee's estimate for the distribution for consultants aged 55 and over. We have also included some estimates of Local Clinical Excellence Awards, which if awarded prior to 2018 are still pensionable. Data on LCEAs are only publicly available from 2012 and before, which shows 20% roughly exceed a level 5 LCEA which is the level at which we have determined annual allowance to be breached. We have therefore assumed that 20% of consultants at each notch have a level 5 or above LCEA.
    - **GP partner pay**. For GP partners, the most up to date earnings data is from 2019/20. We have used earnings data and uprated by GP partner earning increase averages over the last five years (on average a 4.1% increase). This gives the earnings distributions for 2022/23, and in the absence of other data, we have assumed the distribution of earnings are the same for each age cohort.
- **Locum costs.** We have modelled locum costs by using the capped costs prescribed by the DHSC for locums, assuming 50% hours covered are antisocial, based on experiences of the committee. We have used the same uplift between consultant regular pay and locum capped costs for consultants, for GPs.
- **Pension sections.** Doctors have a range of different pension scheme memberships under the 1995, 2008 and 2015 sections. The modelling assumes that all doctors would accrue pension up to 2022/23 under the 1995 section and beyond that under the 2015 section if they continue to work. This is for simplicity given the variation but we believe represents the majority of doctors.

Results

As of April 2022 (the start of this financial year), assuming linear projections there would be 5,053 GP partners (11% of GP workforce) and 12,185 consultants over the age of 55 (9% of the medical hospital workforce).

Under our scenarios above, we project the following numbers retiring or moving to part-time at each age cohort:

Doctor type	Age band	Scenario	Retire - baseline	LFTF - baseline	Keep working - baseline	Retire - tax unregistered	LFTF - tax unregistered	Keep working -

								tax unregistered
Consultant	65 and over	1	648	923	116	519	886	283
Consultant	60 to 64	1	1513	1327	684	1210	1198	1116
Consultant	55 to 59	1	570	1840	4564	456	1660	4858
Consultant	65 and over	2	648	923	116	346	591	751
Consultant	60 to 64	2	1513	1327	684	807	798	1919
Consultant	55 to 59	2	570	1840	4564	304	1107	5563
Consultant	65 and over	3	519	812	357	432	738	517
Consultant	60 to 64	3	1210	1098	1216	1009	998	1517
Consultant	55 to 59	3	456	1522	4996	380	1383	5210
Consultant	65 and over	4	648	923	116	432	738	517
Consultant	60 to 64	4	1311	1098	1115	1009	998	1517
Consultant	55 to 59	4	418	1383	5172	380	1383	5210
Consultant	65 and over	5	432	738	517	389	664	634
Consultant	60 to 64	5	1009	998	1517	908	898	1718
Consultant	55 to 59	5	380	1383	5210	342	1245	5387
GP	65 and over	1	236	471	190	202	514	181
GP	60 to 64	1	550	331	346	393	331	504
GP	55 to 59	1	678	564	1685	581	615	1731
GP	65 and over	2	236	471	190	135	343	420
GP	60 to 64	2	550	331	346	314	265	648
GP	55 to 59	2	678	564	1685	388	410	2130
GP	65 and over	3	202	471	224	168	428	300
GP	60 to 64	3	472	364	392	393	331	504
GP	55 to 59	3	581	564	1782	485	513	1931
GP	65 and over	4	253	514	130	168	428	300
GP	60 to 64	4	511	364	352	393	331	504
GP	55 to 59	4	533	513	1882	485	513	1931
GP	65 and over	5	168	428	300	152	386	360
GP	60 to 64	5	393	331	504	354	298	576
GP	55 to 59	5	485	513	1931	436	461	2030

This leads to the following set of savings for the public purse. We recognise that savings are not always to the same funding streams, and transferring funds may be a challenge, but note that overall, even under our most conservative scenario (scenario 5), there is a net positive to the Treasury in terms of direct taxes of over £120 million in 2022/23 received due to more people continuing to work (see graph below). This is because the revenue received in income tax outweighs the lost revenue from annual allowance/lifetime allowance charges.

	Scenario 1	Scenario 2	Scenario 3	Scenario 4	Scenario 5

	High retirement under baseline and tax unregistered schemes due to burntout workforce	Slightly higher retirement than linear under baseline scheme due to end of 1995 section, but under tax unregistered more people stay in the workforce, working part time	High retirement under baseline scheme but tax unregistered schemes at linear projection	As scenario two, but variation in age (retiring later)	Linear retirement under baseline and 90% retirement rates under tax unregistered scheme
NET IMPACT ON TREASURY	£ 189,923,780	£ 412,978,384	£ 111,955,197	£ 184,114,454	£ 31,496,604
LTA tax received	-£ 3,402,632	-£ 7,467,338	-£ 2,296,305	-£ 4,028,967	-£ 1,148,152
Annual allowance tax received	-£ 9,142,161	-£ 9,142,161	-£ 9,972,680	-£ 9,825,335	-£ 11,338,739
Income tax/NI received from staff	£ 208,275,049	£ 302,599,732	£ 196,825,569	£ 204,851,913	£ 182,285,445
Income tax/NI/other tax received from locums	-£ 64,917,117	-£ 122,182,074	-£ 51,830,830	-£ 61,215,468	-£ 37,122,674
NI received from employer (see NHS) - staff	£ 51,870,102	£ 88,463,258	£ 43,344,229	£ 48,164,140	£ 34,462,788
NI received from employer - locum	-£ 64,090,089	-£ 94,796,950	-£ 53,799,506	-£ 58,750,545	-£ 43,578,092
DIRECT TAX RECEIVED, TREASURY	£ 118,593,151	£ 157,474,468	£ 122,270,479	£ 119,195,738	£ 123,560,575
Staff pay - gross including employee pension contributions	£ 344,651,837	£ 587,795,732	£ 288,001,523	£ 320,027,507	£ 228,988,621
Pension contributions (employers) for staff, NHS	£ 112,466,554	£ 189,993,190	£ 121,651,203	£ 127,125,129	£ 121,528,584
Locum pay + additional costs associated, gross, including NI and pension contributions	-£ 483,482,482	-£ 745,068,499	-£ 409,018,040	-£ 454,935,156	-£ 330,009,530
TOTAL NHS COST	£ 26,364,090	-£ 32,720,423	-£ 634,687	£ 7,782,520	-£ 20,507,676
Pension contributions, staff and locums	-£ 140,366,133	-£ 129,796,993	-£ 136,571,173	-£ 137,849,409	-£ 135,001,584
Pension payments to current pensioners (excluding lifetime allowance tax charge)	-£ 43,399,020	-£ 97,838,858	-£ 29,658,516	-£ 45,553,726	-£ 14,829,258
Lump sum	-£ 141,933,650	-£ 320,182,475	-£ 97,232,061	-£ 149,431,879	-£ 48,616,031
TOTAL PENSION SCHEME	£ 44,966,538	£ 288,224,339	-£ 9,680,595	£ 57,136,196	-£ 71,556,295