ROYAL LONDON POLICY PAPER 34

Finding the right medicine – how to fix the problems between doctors and their pension scheme

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Finding the right medicine – how to fix the problems between doctors and their pension scheme

1. Introduction – what is the problem

A. Pension Tax Relief – the basics

Contributions into pensions generally attract tax relief. This means that the money that goes into the pension is not taxed at the time it is earned. Instead, tax is paid when the pension is drawn out and usually a part of the pension pot can be withdrawn tax free.

Because this tax treatment is relatively generous, the government limits tax relief in two ways:

a) An 'annual allowance' (currently at a standard rate of £40,000) which limits the amount which can go into a pension pot each year with the benefit of tax relief, and

b) A 'lifetime allowance' (currently £1.055m) which limits the total value of pension wealth which can be built up whilst still benefiting from pension tax relief.

Where an individual has unused annual allowances, these can be carried forward for up to three financial years.

Those who exceed the Annual Allowance face a tax charge at their marginal income tax rate on any accruals above their Annual Allowance. Those who exceed the Lifetime Allowance pay tax on any excess at a rate of 55% where the money is taken as a lump sum and at 25% where the money is taken as a regular pension income.

It should be noted that it is not illegal or immoral to exceed annual or lifetime allowances. The tax charge is simply a way of the Exchequer clawing back the value of any tax relief granted in excess of the relevant limits. Indeed, there may be situations in which it is entirely rational to build up pension rights even if this incurs a tax charge. For example, because a large part of the pension rights built up in the NHS scheme (and most other public sector schemes) is paid for by an employer contribution, the extra pension built up – even after allowing for a tax charge – can still be greater than the amount that would be saved by opting out.[1]

[1] Royal London has produced a 'good with your money' guide which discusses situations in which exceeding lifetime or annual allowances might be the best strategy: https://www.royallondon.com/media/good-with-your-money-guides/why-saving-beyond-pension-tax-relief-limits-might-not-be-a-bad-idea/

For higher earners, a stricter regime applies to annual contributions and this is known as the 'tapered' annual allowance. This applies to people who both:

a) Have 'adjusted' income over £150,000 per year; 'adjusted income' is total taxable income plus the real growth in value of pension rights over the year AND

b) Have 'threshold' income over £110,000 per year; 'threshold' income is essentially total taxable income, but net of the value of any employee pension contributions.

Where an individual ticks both of those boxes, for every £2 of adjusted income that they receive above the £150,000 level, their annual allowance is reduced by £1. This means that those with an adjusted income of £210,000 have their annual allowance tapered down from £40,000 to £10,000, which is the lowest level to which tapering can reduce your annual allowance.

The tapered annual allowance was introduced for the financial year 2016/17. The ability to carry forward unused allowances from years before the taper was in force has so far helped to dampen down the impact of the taper. But in 2019/20 carry-forward will be from no earlier than 2016/17, when the taper was also in force. This will reduce the number of people with significant amounts of available unused annual allowance. As a result, the taper is likely to be much more of an issue from 2019/20 onwards.

B. Why is this a problem for doctors?

The NHS Pension Scheme has, in common with other public sector schemes, undergone major reform in recent years. Box 1 summarises the main features of the scheme and how it has changed in recent years.

Box 1. The NHS Pension Scheme

Since April 1st 2015, new joiners to the NHS are enrolled into a pension scheme where the amount of pension you are paid is based on your average salary over your NHS career within the scheme. Each year of service is revalued to take account of inflation and earnings growth at a rate of CPI + 1.5% per year. This type of arrangement is therefore known as a CARE scheme – as it is based on Career Average Revalued Earnings. Pension is payable at state pension age.

In the case of the NHS scheme, a pension is payable at 1/54th of career average salary for each year of service. Member contribution rates depend on full-time equivalent pensionable pay and range between 5% and 14.5%. The NHS as an employer contributes a standard 20.6%.

Prior to this there were two earlier versions of the NHS Pension Scheme – the 1995 Section and the 2008 Section. Both of these schemes operated on a 'final salary' basis. Those who were within ten years of their NHS Pension Scheme Normal Pension Age in April 2012 were able to remain in their 1995 or 2008 final salary scheme until they retired.

NHS Staff can easily have rights under one of these older sections as well as under the 2015 scheme. Given that it is possible in any given year to accrue new rights in more than one section, it can be especially difficult for NHS staff to work out how much of their annual allowance they have used up.

Another gap in the information available to NHS staff is future projections of their benefits under the 2015 scheme. The NHS has taken the view that because future earnings levels are not known, it would be speculative to estimate what future level of benefits today's NHS workers might be entitled to in the CARE scheme. But without such information it can be very hard for people to undertake sensible pension planning. The NHS Pension Scheme should start to present this information as soon as possible. This would also help members to see the true value of their pensions and might reduce opt out rates.

Many senior doctors earn enough money from their core hours plus additional shifts, to be potentially affected by the tapered annual allowance. In addition, because of the relative generosity of the NHS pension scheme, pension rights can be built up quite quickly, especially for those who experience a step up in pension rights because of a promotion. Paradoxically, in most cases overtime shifts are *not* pensionable. This means that by working more, a doctor can find he or she has built up no extra pension but – because of the operation of the tapered annual allowance – has reduced the amount of pension s/he can build up within the tax relief limits.

If all of these things were simple and well understood, many people would think that this is simply a case of high earners being limited on how much tax relief they can enjoy and would probably support the policy intention. However, in practice the rules are causing a lot of problems for senior doctors, with growing numbers reporting that they are considering working fewer hours or in some cases even leaving the profession because of tax relief limits. The main issues are as follows:

- Complexity – it can be extremely difficult to work out whether or not you have an annual allowance issue; this is true for any higher earner but may be particularly true for those in the NHS because:
    - They may have rights under different sections of the NHS pension scheme – for example, a final salary pension and a 'career average' pension; these rights are tested against the annual allowance, but a 'negative' accrual in one section cannot be set against a positive accrual in another;
    - The way that Defined Benefit pension rights are tested against the Annual Allowance is complex; the growth in rights over the year has to be adjusted to strip out any increases that simply keep pace with inflation and are then multiplied by 16 and added to any additional lump sum accrual before being tested;
    - Whether or not the tapered annual allowance applies depends not just on whether your 'adjusted' income is over £150k but whether your 'threshold income' is over £110k; these two measures are quite different, and adjusted income in particular is calculated in a very complicated way;

- Unpredictability – the way that the tapered annual allowance works is to use income for the current year to determine the size of the annual allowance for the current year; many NHS doctors work extra NHS shifts and may do private work and may have little idea what their income for the year is going to be until very late in the year; this makes it virtually impossible to know with confidence what their annual allowance will be for the year they are in; for example, NHS Trusts may put in extra resources towards the end of a financial year to try to meet waiting list targets which may mean more shifts are available late in the financial year; but a doctor who does a lot of extra work late in the year could suddenly find they have an annual allowance issue that they did not expect when they were making pension contributions earlier in the year;

- Cliff edges – although the tapered annual allowance results in a gradual reduction in annual allowance for each pound of adjusted income above £150k per year, the fact that the whole system 'switches on' abruptly for threshold income above £110k can create a violent cliff edge effect; those with threshold income a penny below £110k can effectively ignore the tapered annual allowance, but those a penny above can find themselves caught; for the latter group, not only does each extra pound attract income tax at 40p (and a loss of personal allowance equivalent to another 20p in the pound), but they can suddenly face a big drop in their annual allowance; for some people they can be worse off overall by working an extra shift if it makes the difference between being over or under the £110k threshold;

- Large lump sum bills – those who exceed the annual allowance can find that they are faced with large – and potentially unexpected – lump sum bills, running into many thousands of pounds; although there is a mechanism available for asking the scheme to pay those bills in the short term (see 'scheme pays explained' box), some doctors are unwilling to use this route and face a large short-term bill in respect of a pension they will not receive for many years;

C. What are doctors doing in response?

Whilst this is a highly technical area, concern over large or unexpected tax bills is having a real impact on the decisions of individual doctors. The issue was debated in Parliament in April 2019[2] and examples cited by MPs included:

- Several doctors being advised to take early retirement or considering taking early retirement to avoid lifetime allowance tax charges;
- Doctors reducing their hours to avoid annual allowance tax charges;
- A survey by the Hospital Consultants and Specialists Association in which more than 40% of the doctors questioned said that pension taxation changes had led them to change their plans and retire earlier than expected.
- Doctors being reluctant to take on additional roles such as teaching or research because resultant 'discretionary points', clinical excellence awards or paid senior roles can create tax issues.

Doctors who have contacted Royal London in the preparation of this report have mentioned:

- Problems in staffing Intensive Care Units as doctors are reluctant to take on additional shifts to cover for staff absence;
- Challenges for Trusts trying to cut waiting times – because 'waiting list initiatives' are often undertaken towards the end of a financial year, doctors can be reluctant to do additional work if they know they are already at, or near, a limit for pension tax relief;
- A breast cancer consultant who said that owing to concerns over tax bills she was allocating work to less senior staff than might otherwise have been used;

[2] See full transcript at: https://hansard.parliament.uk/commons/2019-04-02/debates/71E9792B-AD44-4938-9A2A-4A4E253D17BE/NHSPensionSchemeTaperedAnnualAllowance

Box: "Scheme pays" in the NHS Pension Scheme

Where someone gets a lump-sum bill because of a breach of the annual allowance, it does not necessarily mean that they will have disposable cash available to pay that bill. The bill has arisen because of a relatively large growth in their pension rights, but they may not be planning to access those pension rights for decades.

To help overcome this cashflow problem, the concept of 'scheme pays' was introduced. In all schemes some members have a statutory right to have the scheme pay their annual allowance tax charge, but in the NHS scheme there is a more comprehensive 'scheme pays offer. In essence, where someone has an annual allowance tax charge, they can ask the NHS pension scheme to pay the bill for them, in return for a reduction in the value of their pension at retirement[3].

On the face of it, this is a welcome concession and allows doctors to enjoy a big boost to their pension rights in a given year without having to find a large cash sum up front. In addition, whereas any tax bill would have to be met out of post-tax income, any reduction in pension at retirement resulting from a scheme pays arrangement will come from a doctor's pre-tax income and will therefore reduce the retired doctor's tax bill. This reduces the eventual impact of entering into a scheme pays arrangement.

The main downside of 'scheme pays' is that the amount borrowed is subject to interest – in the NHS scheme this is currently inflation plus 2.4%.[4] The amount borrowed will therefore grow rather rapidly and may be perceived to be taking a significant chunk out of the doctor's future pension, especially for younger doctors.

However, it is also the case that the doctor's accrued pension is being 'revalued' every year between now and retirement. Revaluation in the NHS pension scheme

[3] Note that when 'scheme pays' was first introduced it was not available to those whose adjusted income lay between £150,000 and £210,000 and who therefore had a partially tapered annual allowance. It was only available to those who had been tapered down to the minimum £10,000. This restriction has now been relaxed.

[4] For more detail on how scheme pays works in the NHS Pension Scheme, see: https://www.nhsemployers.org/your-workforce/pay-and-reward/pensions/nhs-pension-scheme/annual-and-lifetime-allowances#scheme%20pays

is by inflation plus 1.5 per cent. This means that *relative to the pension at retirement*, the deduction arising from scheme pays will be more modest than at first sight appears, especially as it comes out of pre-tax income.

A further advantage of 'scheme pays' is that it will reduce the amount of pension which is tested against the lifetime limit for tax relief. For doctors worried about hitting the £1.055m lifetime limit, it may make more sense to let annual allowance tax charges be debited against their final pension via scheme pays, giving them more headroom against the LTA, than pay such charges up front and have a larger pension at retirement.

2. Solutions #1 – adjustments to the NHS pension scheme

One way to reduce the issues raised in the previous section would be to make changes to the NHS pension scheme itself. Some of the issues described are not unique to the NHS – senior professionals in other areas such as local government or universities could face some of the same problems and those schemes have made changes to try to minimise the impact. In this section we consider whether changes to the NHS pension scheme or NHS employment practices could help to resolve the problem, before going to consider whether what is really needed is a change to the rules around pension tax relief.

A number of different solutions have been suggested to reduce the impact of this issue on NHS staff, in some cases building on similar changes that have been made in other schemes.

a) Reduced contributions for reduced pensions – 'fifty-fifty' options, 'hokey-cokey' pensions and the like

For those concerned about breaching the lifetime allowance or the annual allowance, building up pension more slowly could in principle help to reduce the risk of either.

One approach to this which has been adopted by the Local Government Pension Scheme has been to allow members to opt to accrue at half the normal rate for half the normal level of contributions. This is known as the 50-50 section.[5] If such an option was available in the NHS pension scheme this would have the additional advantage that lower-paid staff who are currently opting out on affordability grounds might instead opt for half pensions, which would give them better retirement outcomes.

As opposed to a simple 50:50 option, the BMA have made the case for a range of options (such as 10:10, 20:20 etc) depending on a doctor's individual situation in any given year. This could be accompanied by the ability to take any employer contribution thereby given up in the form of an increase to taxable pay in a way that could be cost-neutral to the taxpayer overall.[6]

In the absence of such a formal option within the NHS pension scheme, some doctors have gone for a 'DIY' version of reduced accrual, known colloquially as the 'hokey-cokey'

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[5] More information about the 50-50 section of the LGPS can be found here https://www.lgpsmember.org/arm/already-member-contsf.php. However, discussions at the LGPS Board suggest that take-up of the 50-50 option was relatively low – see http://lgpsboard.org/images/PDF/CMBDAMay2018/Item4_PaperB_5050awarenessproject.pdf

[6] At present, if doctors opt out of the NHS Pension scheme completely or for a large part of the year there can be a significant saving to the NHS employer, especially given the high rate of employer contributions in this scheme.

approach. Essentially this involves being a member of the scheme for (for example) one month and then opting out for the rest of the year, and then repeating the same process the next year. This ensures that annual accrual does not exceed the annual allowance but means that the right to a pension based on current salary levels is retained.

There is no doubt that a 50-50 option (or some variation) would give better paid NHS staff an alternative to turning down additional work altogether. There are however two situations where this option would not wholly alleviate the problem:

- Some NHS staff could still face a 'cliff-edge' at £110,000 of threshold income, albeit this would be reduced if accrual rates were lower;
- Those who received promotions could still see a 'spike' in their pension accrual; with limited ability to carry forward unused allowances from earlier years, this could still result in large lump sum tax bills;

Worse still, there are some cases where a 50-50 option could actually make matters worse. When threshold income is measured for tapered annual allowance purposes, it is measured after the deduction of employee pension contributions. Whilst it would be relatively unusual, it is possible to imagine a scenario where a doctor had threshold income slightly under £110,000 at current contribution levels. If they were to opt for 50-50 accrual this would reduce his/her pension contributions. This in turn would increase the level of threshold income and could take it over £110,000, potentially bringing the tapered allowance into play. This suggests that it would be important for anyone considering opting for 50-50 accrual to have access to financial advice to avoid unintended consequences of such a decision.

b) Caps on pensionable pay

An alternative way of reducing the risk of exceeding the annual allowance (or the tapered annual allowance) would be to give doctors the option to reduce the amount of their pay which generates pension rights.

This option has been offered to members of the Universities Superannuation Scheme (USS). It is known as the 'Voluntary Salary Cap' and enables members to specify that earnings above the cap will no longer be pensionable. Other benefits such as lump sum death benefits

remain pegged to the full pay level.[7] In this model, each individual can choose the cap level that works for them, subject to a scheme-wide floor.

A linked suggestion[8], but one which would apply equally to all members in a much more rigid way, has been an across-the-board cap on pensionable pay of £100,000. The significance of this threshold (other than being a rather round number) is that beyond this point a different 'taper' cuts in. For those earning between £100,000 and £125,000 per year, each extra pound of earnings triggers a reduction of 50p in the value of their personal allowance for income tax. As well as paying income tax at a marginal rate of 40p in the pound, the loss of personal allowance means a further deduction of 20p in the pound, creating a combined marginal income tax rate of 60p. It could be argued that if people in this income range already face such a high marginal withdrawal rate it is important to make sure that additional pension accrual does not make them even more at risk of working for little or no return. But it would not remove the risk of large and unexpected tax bills arising from the 'cliff edge' nature of the tapered annual allowance.

An across-the-board cap on pensionable pay might be attractive to NHS employers who would face lower employer pension contributions, but it would, of course, reduce the overall remuneration package available to senior clinicians. They might argue that it is unfair that their scheme has been singled out for such treatment when equally well paid employees in the civil service, local government or teaching profession were able to accrue pensions on much higher salaries. If an across-the-board cap were introduced on pensionable pay, doctors would undoubtedly expect offsetting changes to their overall remuneration package such as a salary supplement.

The alternative, of a voluntary salary cap, would have the advantage of enabling individuals to tailor their accrual to their individual tax position, though it would considerably increase the complexity of the scheme. As with other options, impartial financial advice would be needed before making such a choice.

c) 'Enhanced opt out'

For NHS staff who have a particular issue with the Lifetime Allowance and who are perhaps considering early retirement as a result, one option is simply to opt out of the NHS scheme altogether. However, if they do so they will lose some of the other valuable features of the

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[7] More information about the Voluntary Salary Cap in the Universities Superannuation Scheme can be found here: https://www.uss.co.uk/~/media/document-libraries/uss/member/factsheets/minifactsheet-4-voluntary-salary-cap.pdf?la=en

[8] See, for example, https://www.thetimes.co.uk/article/john-ralfe-time-for-a-triple-tax-bypass-to-get-hospital-doctors-off-the-critical-list-330vkjxf5

scheme, notably death-in-service benefits. Whilst they could, of course, simply buy life assurance instead, it is possible that some would fail to do so or would not buy the level of cover that they currently enjoy.

To avoid this risk, the Universities Superannuation Scheme has introduced an option for members known as 'enhanced opt-out'. Under this arrangement, members cease to accrue new pension rights but retain their death-in-service benefits. The member contribution rate falls from 8.8% to 2.5% and the employer contribution rate falls from 19.5% to 2.1%.[9]

The drastic measure of opting out of all pension benefits except death benefits may be worth considering for those with LTA issues, but those with Annual Allowance issues may not want to go this far as they should always be able to accrue £10,000 per year of additional benefits without being at risk of an Annual Allowance charge.

d) Cash / pension alternatives for tapered staff

In many private sector firms, senior employees are also at risk of facing tax charges if they build up pension rights in excess of their annual allowance. In response, many employers have offered employees the option of pension contributions up to the minimum tapered level of £10,000 and a (taxable) salary top-up in lieu of a more generous pension package.

This option would be most attractive to those who are tapered all the way down to a basic annual allowance of £10,000. It would be less attractive to those who are tapered down to a higher figure (eg £20,000) who would be missing out on a significant part of their potential pension accrual. One of the consequences of the complexity of the tapered annual allowance is that each individual has their own individual and complex calculation as to how much annual allowance they have and it would be impossible for employers at the start of a tax year to set the total pension contribution at the right figure for each individual employee. For this reason the approach in the private sector tends to be to offer the maximum 'safe' level of £10,000 and to replace the rest with a cash supplement.

Salary alternatives are not offered as of right across the NHS but individual NHS Trusts are understood to have made them available on a trust-by-trust basis. In this case, senior staff who opt out can have the employer contribution of over 20% of salary paid to them as (taxable) earnings instead.

A similar, but slightly different approach would be for the employer to offer Defined Benefit rights up to the £10,000 level and then to make contributions into a separate Defined

[9] More detail on 'enhanced opt-out' in the Universities Superannuation Scheme can be found at: https://www.uss.co.uk/~/media/document-libraries/uss/member/tax/enhanced-opt-out.pdf

Contribution (or 'pot of money') arrangement beyond this level. For those who have a reduced annual allowance but who are not reduced to the £10,000 level, this could enable them to build up more pension whilst staying within their overall AA limit. This would also give doctors a mix of pension provision in retirement comprising a meaningful defined benefit pension plus a 'pot of money' defined contribution arrangement which they can use more flexibly.

3. Solutions #2 – potential reforms to pension tax relief

Throughout this paper we have focused on the impact of pension tax relief limits on members of the NHS pension scheme. This is because it appears to be the case that those limits bite in particularly unsatisfactory ways on senior NHS staff. But the same limits apply to other pension schemes and can create some of the same problems, notably the complexity of the tapered annual allowance and some of the unwelcome cliff-edge effects. In this section we consider whether there is a case for wider reform of these limits.

a) Reform of the tapered annual allowance

If the tapered annual allowance is the main source of the problem, but if the government wishes to restrict pension tax relief to higher earners, one option might be to reform the tapering process.

One of the biggest complications arising from the way the system is currently designed is that the amount of money you can put in a pension with the benefit of tax relief in 2019/20 depends on your income in 2019/20. And many people will not know at the start of the year – or even towards the end of the year – what that income figure will be. Whether it is doctors who can put in extra shifts, self-employed people with unpredictable profits or workers who receive annual bonuses, income is often not predictable. It seems bizarre that such workers have to guess how much they can put in a pension based on a guess as to how much they will earn and are at risk of unexpected tax bills if they guess wrong.

A modest tweak to the tapered annual allowance system would be to make the income in the current year the determinant of the annual allowance in the following year. So, for example, someone with 'adjusted income' of £210,000 in 2019/20 would go into 2020/21 knowing for certain that their tapered annual allowance would be just £10,000. This would reduce the risk of unexpected tax bills and would assist in tax planning.

Even though such a change would be welcome, it would not address most of the fundamental issues that we have been considering. For example, there would still be a 'cliff edge' effect at £110,000 of 'threshold income', it would simply be that the resultant tapering would bite in the following tax year.

Beyond this, it is difficult to see how such a fundamentally flawed and complex system could be meaningfully reformed.

b) *Allow offsetting of 'negative' accrual against positive accrual*

As noted earlier, many NHS staff have rights under different versions of the NHS pension scheme. It is quite common for a member to have 'final salary' rights under the 1998 or 2005 scheme as well as 'career average' rights under the 2015 scheme. It might be assumed that when testing the annual accrual against the annual allowance, accruals under the two schemes would simply be added together. But this is not the case.

Those who were members of a final salary version of the scheme and who are now members of the 2015 scheme can no longer build up additional years of service in the final salary section. But their rights in the older scheme still change each year because the 'final salary' in question changes.

In recent years many NHS staff have had pay increases below the rate of inflation. Because annual allowances measure real terms pension growth, it is possible to have a 'negative accrual' in the old section in a year when the NHS professional had a below-inflation pay rise. But rather than set the negative accrual against the positive accrual in the 2015 section, the negative accrual is simply set to zero. In effect, this overstates the growth in the member's total pension benefits during the year.

A simple change would be to allow negative accruals in one section to be offset against positive accruals in another. This would help to dampen down any tax effect of service in the 2015 scheme.

c) *Abolition of the tapered annual allowance*

If the tapered annual allowance is the main problem, then abolition would seem to be the obvious solution. However, the Chancellor is already on record saying that the cost of pension tax relief is 'eye-wateringly expensive' and the Treasury is unlikely to want to make any changes that increase the overall cost of pension tax relief – especially ones which disproportionately benefit the highest earners.

On this basis, it seems realistic to suppose that if the tapered annual allowance were to be abolished outright, the Treasury would be looking to make other changes to recover the revenue foregone.

The most obvious, and simplest measure to take alongside abolishing the tapered annual allowance would be an across-the-board cut to the Annual Allowance for all. In recent years the AA was reduced from £50,000 to £40,000, and the Treasury might be tempted to make a further reduction to £35,000 or £30,000.

It is important to appreciate that although a flat £30,000 AA would be far cleaner and simpler than a £40,000 AA plus a taper, there would be gainers and losers from such a change, including amongst higher earning NHS staff.

For example, a consultant who received a pay rise could find that their annual accrual was well in excess of £30,000 and they could face a bigger tax bill than they would under the current system.

On balance, if the Treasury was insistent that the reformed system could cost no more overall than the current system then a simple lower annual allowance would probably be preferable to the current system but it would not entirely solve the problems we have been discussing in this paper.

d) Abolition of the lifetime allowance

The balance of this paper has focused very much on the impact of the Annual Allowance and the tapered Annual Allowance. But the Lifetime Allowance is also having an impact on senior doctors, and it is worth considering briefly the scope for reform here.

As well as annual limits on tax relief, there is a lifetime limit on the size of pot an individual can build up, beyond which tax charges apply. As noted earlier, it is not automatically the case that an individual should try to avoid going over the Lifetime Allowance. Even though they would then incur a tax charge they may find that the additional pension they accrue (funded in significant part by a generous employer contribution) outweighs the tax they would pay.

But even though breaching the LTA should not be a reason for someone to stop work, it does appear to be the case that senior clinicians have been retiring before 'normal' retirement age in significant numbers in recent years. In a recent House of Commons debate, the Department for Health and Social Care said that in each of the last three years around 400-500 hospital doctors and a somewhat larger number of GPs had left the profession. This is likely to be for a range of reasons, but tax considerations are thought to be one important contributory factor.

There is clearly a case for abolishing the LTA outright. It seems excessive to limit people on the amount that they can put in to a pension and to limit them on the amount they can build up. Where money is in a Defined Contribution pension arrangement, the mere fact of investment growth can lead a pension pot to exceed the LTA, and it seems odd to penalise people simply for investing their money well.

The Treasury's view however would be that some people have benefited from very generous pension arrangements, supported by tax relief, and that some limit is appropriate on the total amount of relief they can benefit from – beyond the limit on the amount that can be received in any given year.

As with the idea of abolishing the tapered annual allowance, if the LTA were to be abolished, the Treasury would be very likely to wish to recoup the lost tax revenue by restricting relief in some other way. This could lead to pressure for further reductions in the Annual Allowance which would cause problems for doctors (and others) earlier in their career.

There can be little doubt that there is a case for root-and-branch reform of pension tax relief. The current system has grown up incrementally and with increasing layers of complexity. But a government without a working majority is unlikely to introduce a major reform – such as giving the same rate of tax relief to all pension savers – which would create large numbers of politically toxic losers. Against this backdrop, the most we can hope for in the short-term would be incremental simplification of the system to tackle its worst features.

4. Conclusions

There is no doubt that senior clinicians receive salaries well in excess of those enjoyed by the large majority of the population, nor that the pension scheme to which they have access is one of the most generous in the land. But it also seems clear that if the government's attempts to limit the cost of pension tax relief have led to some doctors retiring early, others cutting back on the number of shifts they work, and many more spending a lot of time understanding the finer points of the tax system, then something has gone wrong.

In terms of potential solutions, this paper has identified two main approaches.

The first would be to make changes to the NHS pension scheme itself. The NHS pension scheme has been slower than some other public service pension schemes to offer its members options which could help to mitigate tax issues. These include setting up a 50-50 arrangement – or a range of more flexible options - to offer reduced pension for reduced contributions or the option of a voluntary cap on pensionable pay which could be tailored by the individual. In each case, doctors would be looking for any saving in employer contributions to be paid to them directly in the form of taxable pay.

In the absence of action by the scheme, NHS staff and their employers have been coming up with a number of 'DIY' work-arounds. These have included opting out of the scheme a few months into the year before opting back in again at the start of the next year, or simply offering cash in lieu of employer pension contributions to clinicians who have opted out altogether.

Whatever the government decides to do on pension tax relief, it would be desirable for the NHS scheme to offer members new flexibilities and to ensure that these were available across the NHS and not just on a trust-by-trust basis. A new 50-50 option could also benefit many lower paid workers who currently opt out of pension saving altogether because of affordability issues but who might be willing to remain in at a lower contribution rate.

But there can also be no doubt that these are all sticking plaster solutions to try to fix a fundamentally rotten system. The creation of the 'tapered annual allowance' in 2016/17 was one of the worst examples of unnecessary complexity in tax legislation in living memory. When doctors themselves say that some consultants have spent more time talking about pensions in the last six months than about patients, it is clear that a measure designed to cut tax relief costs for high earners has had unintended consequences.

It is clear that the revenue the Treasury generates by annual and lifetime limits on pension tax relief will be severely dented if the NHS has to spend large sums replacing staff who are either retiring or cutting back on their hours because of tax issues, to say nothing of the impact on patient care.

By far the cleanest solution to this problem would be to abolish the tapered annual allowance. It creates unwelcome cliff-edges in the tax system and makes taxation appear arbitrary and capricious to taxpayers in a way that is never desirable. And the Treasury needs to move quickly. In 2019/20, the tapered annual allowance will start to bite much harder as those who have been consistently high earners will no longer be able to carry forward significant amounts of unused allowance from earlier years before the taper was introduced. There is considerable evidence that doctors are already taking matters into their own hands with the result that patient care is already suffering. Even a reform which took effect in 2020/21 would mean serious damage was done during the current financial year. Despite the many other issues pressing in for the Treasury's attention, this is one that simply cannot wait.

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