Department for Health and Social Care: NHS pension scheme: increased flexibility

1. The Royal College of General Practitioners welcomes the opportunity to respond to this consultation on increased flexibility for the NHS pension scheme.

2. The Royal College of General Practitioners (RCGP) is the largest membership organisation in the United Kingdom solely for GPs. Founded in 1952, it has over 53,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline. The RCGP is an independent professional body with expertise in patient-centred generalist clinical care.

3. The RCGP exists to encourage, foster and maintain the highest possible standards in general medical practice. This includes supporting the retention of a highly skilled and experienced workforce. However, the perverse incentives of the current pension taxation arrangements are leading clinicians to refuse additional work, reduce their hours or retire altogether.

4. For this reason, the RCGP broadly supports the principle of a more flexible NHS pension scheme, allowing members to control the rate at which they accrue benefits (a common feature of many private sector, defined contribution schemes). However, it is unlikely that even these proposals will fully address the problems faced, particularly by GP partners.

5. Furthermore, these proposals would not be as necessary, were it not for the unintended consequences of features of the wider pensions system. The RCGP
therefore encourages HM Treasury and others to undertake wider reforms to key aspects of the current system, including tapering and the calculation of deemed pension growth for defined benefit schemes.

6. Finally, these problems are not limited to the scheme as it operates in England and Wales. The RCGP would urge relevant bodies to bring forward parallel reforms in Scotland and Northern Ireland.

**Question 1**

**Who do you think pension flexibility should be available to?**

- NHS GPs and consultants who may be affected by the annual allowance tax charge
- Other NHS clinicians who may be affected by the annual allowance tax charge
- Non-clinicians in the NHS who may be affected by the annual allowance tax charge
- All members of the NHS workforce, regardless of their tax position
- Other group
- None of the above

**Please provide evidence to support your views.**

7. In responding to this consultation, the RCGP’s priority is to limit the impact of pension taxation on the healthcare workforce, particularly in a primary care setting. GPs and consultants are most likely to adjust their working patterns in order to avoid pension tax liabilities and are therefore most in need of more flexibility. However, the RCGP believes that it would be fairest to offer flexibility to all scheme members, in order to ensure that no one is penalised for undertaking additional work.

8. As outlined in the consultation documentation, in order to avoid pension liabilities, NHS staff are opting to reduce their hours or take early retirement. For example, 42% of GPs have reduced their hours to avoid or limit pension tax liability.¹ When the NHS is facing rising demand, particularly in primary care, this is clearly unsustainable.

9. This situation is most pronounced for senior clinicians, who are highly paid, and liable to have variable hours and incomes, but other staff may also be affected. Most GP practices are independent small businesses, meeting patient demand with a small team. This can mean that, at times of increased demand, it is not only GPs who must work extra hours, but also other clinical and administrative staff. Pay rates vary across general practice, but it is likely that senior staff who are not GPs – such as senior nurses or practice managers – may be at risk of significant pension liabilities.

10. For example, if a non-clinical staff member leaves the practice, a practice manager might take on additional hours in order to meet patient demand, temporarily increasing their income and leading to a significant one-off pension liability. In such a context, it seems very hard to justify creating a two-tier system in which some scheme members are afforded greater flexibility than others.

11. A two-tier system would also be complex to administer, with NHS Business Services Authority (BSA) having to confirm eligibility in every case, and could damage staff morale and working relationships. The alternative – offering flexibility to all members – has the added benefit of helping to encourage younger employees to remain in the scheme, allowing them to save for retirement at a rate which they feel is affordable, and making the scheme more financially sustainable over the longer term.

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Question 2

Do you think the proposal for a more tailored approach to pension accrual is flexible enough for senior clinicians to balance their income, pension growth and tax liability? Please set out the reasons for your answer.

12. The RCGP welcomes the proposal to allow scheme members to select from a range of contribution and accrual rates, set at 10% intervals. In lieu of system wide reform (which the RCGP would welcome, while recognising it is not within the gift of DHSC), such reforms represent an improvement, both on the status quo, and on the more limited reforms previously proposed.

13. Decile flexibility would allow scheme members to limit their liability to pension taxation, by reducing their accrued pension in a given year in order to avoid exceeding the annual allowance, or, over the longer term, to reduce the likelihood of exceeding the lifetime allowance. Staff would be able to maintain or increase working hours, without facing the perverse incentive of large, unexpected tax bills. The option to adjust contribution rates in year may also be valuable for some scheme members.

14. However, the RCGP is concerned that, even with this flexibility, GPs in particular may struggle to manage their tax liabilities, and that working fewer hours or taking early retirement may continue to represent more straightforward solutions.

15. As most GPs are self-employed, either as partners or locums, incomes can fluctuate significantly from year to year (a problem exacerbated by out-of-hours work). This can make it hard to predict likely pensionable income and liabilities. Furthermore, the self-assessment tax process means that the full extent of income and tax liabilities may not become clear until substantially after the end of the tax year. The option to ‘fine tune’ pension growth in year may therefore be of little value to GPs, unless it is accompanied by the provision of ‘live’ in-year NHS pension data.

16. The RCGP also believes that savings in employer contributions should be passed on to all employees who opt to reduce their pension savings, in the form of increased take home pay. GP partners effectively pay both employer and employee contributions, so will see the full benefit of reduced contributions and accrual rates in their take-home pay, and it would be fair for all other staff to accrue the same benefits.

17. Finally, the proposals would not be sufficient to discourage early retirement among older GPs who have reached the lifetime allowance threshold. If staff have already reached the lifetime allowance limit, even a 10% contribution rate could still result in significant liability. In that situation, early retirement may appear preferable to either remaining in the scheme with that liability or opting out of the scheme and thereby losing other benefits relating to ill health and death in service, which are significant parts of the scheme. Given that the aim of these reforms is to mitigate the implications of tax policy on the healthcare workforce, this is a significant gap in the proposals.
Question 3
If not, in what ways could the proposals be developed further?

18. Firstly, a new form of zero-accrual scheme membership (i.e. neither active, deferred or pensioner) should be offered. Members of this type would not accrue new pension benefits but would make a small payment to the scheme (of perhaps 1-2% of standard contribution rates) and would retain non-pension benefits relating to ill health or death in service (which are integral to this, and many other pension schemes). Contributions could be deducted at source but need not necessarily be exempt from income tax. This would reduce the incentive for members nearing retirement age, who have reached the lifetime allowance to take early retirement.

19. Secondly, a new system should facilitate NHS Employers to pass on ‘unused’ employer pension contributions to staff who have either reduced their contribution rate, or who have opted out of the scheme altogether. This would ensure that staff who opt to limit their tax liability when taking on extra work are not penalised by losing out on a part of their overall remuneration package.

20. Thirdly, to support GPs and other clinicians to better understand their pensions and the way these pensions interact with wider tax and income, NHS BSA should explore options to provide ‘live’ in-year data on the accrual of pension benefits.

21. Beyond that, HM Treasury and others should commit to system-wide to tapering and the calculation of deemed pension growth for defined benefit schemes, in order to improve the clarity and functionality of the pension system.

22. At present, tapering effectively penalises higher earning individuals from saving into a pension scheme, which is perverse and conflicts with the government’s objective to encourage people to save for retirement. Indeed, the tapering system can result in someone who takes on additional work seeing a net loss. Overall progressivity in the tax system can more easily and clearly be ensured through other means.

23. The method for calculating the value of accrued pension benefits against the annual allowance also causes problems in defined benefit schemes. Although the benefits an employee accrues over a given year is determined purely by that year’s income, the deemed pension growth against the annual allowance is determined in part by the change in contributions from one tax year to the next.

24. This methodology is also out of step with that used for calculating the value of benefits against the lifetime allowance. For the lifetime allowance, the value of accrued benefits is calculated simply by multiplying accrued annual benefits by a factor which represents the likely number of years over which someone will draw the pension (currently 16).

25. It would be clearer and easier for members of the NHS pension scheme (and other defined benefit schemes) to understand their annual allowance liability if the value of their pensions in a given year were similarly calculated based only on that year’s accrued benefits (in turn based on that year’s income) and would also mean that staff who took on extra hours in a given year were not disproportionately penalised.
**Question 4**

We’re proposing that large pay increases for high-earning staff should only be included in their pensionable income gradually. Do you agree or disagree with this proposal? Please set out the reasons for your answer.

26. Phasing the ‘pensionability’ of pay increases may be attractive to some high earning staff, including senior GPs, allowing them to take on new roles or increase working hours, without facing a significant annual allowance tax charge. It would, however, add further complications to what is already a complex proposal, and may not be the right choice for all scheme members. As such, the RCGP would welcome this proposal, if it were provided on an optional basis to scheme members but would have concerns regarding mandatory phasing for all members.

27. However, these proposals represent a stop gap reform. Phasing pensionable earnings would not be necessary, where it not for the problems inherent to the current method used for calculating the value of accrued benefits against the annual allowance. It would be more straightforward to simply reform the basis for calculating the value of accrued pension benefits, as outlined in our answer to question 3.

**Question 5**

Currently, the NHS Pension Scheme has a notional defined contribution pot (NDC) approach to Scheme Pays deductions. We’re proposing to replace this with the debit method. Do you agree or disagree with this proposal? Please set out the reasons for your answer.

28. The RCGP agrees with the proposal to move from the NDC system to the debit system for Scheme Pays deductions.

29. While the RCGP is not in a position to comment on the details of Scheme Pays, the BMA and others have raised concerns that Scheme Pays is not always a cost-effective option for GPs and other staff. The RCGP nonetheless believes that Scheme Pays can help some members manage their pension liabilities, and that the debit system provides greater clarity, allowing members to see the effect of current charges in “real time”, making it easier for them to manage pensions.

**Question 6**

What impact, if any, do you think the following will have on people with one or more protected characteristics:

- The proposal to target the flexibility to clinicians who have a reasonable prospect of an annual allowance tax charge
- The proposal to provide flexible accrual to clinicians who have a reasonable prospect of an annual allowance tax charge
- Other proposals in the consultation document e.g. phasing pensionable pay increases and/or commissioning a modeller to help individuals understand their tax liability and flexibility options
- Adopting the debit method for scheme pays
30. The RCGP is not aware of any specific implications of the proposed changes for people with one or more protected characteristics.

**Question 7**

*Are there any further equality considerations that the department should be aware of from groups outside the data set?*

31. As outlined above, the RCGP believes that changes are clearly necessary in order to counteract the perverse incentives of the current system, and thereby to preserve the current NHS workforce. However, wholesale reform of the taxation system to remove those perverse incentives would be fairer and more straightforward than the changes proposed in this consultation, which specifically target a sub-set of scheme members, and thereby create a two-tier scheme membership.

32. The RCGP also calls for equivalent reforms to be brought forward for the NHS pension schemes in Scotland, Northern Ireland and the Isle of Man.

33. The RCGP is not aware of any further equality considerations, relating to any protected groups.