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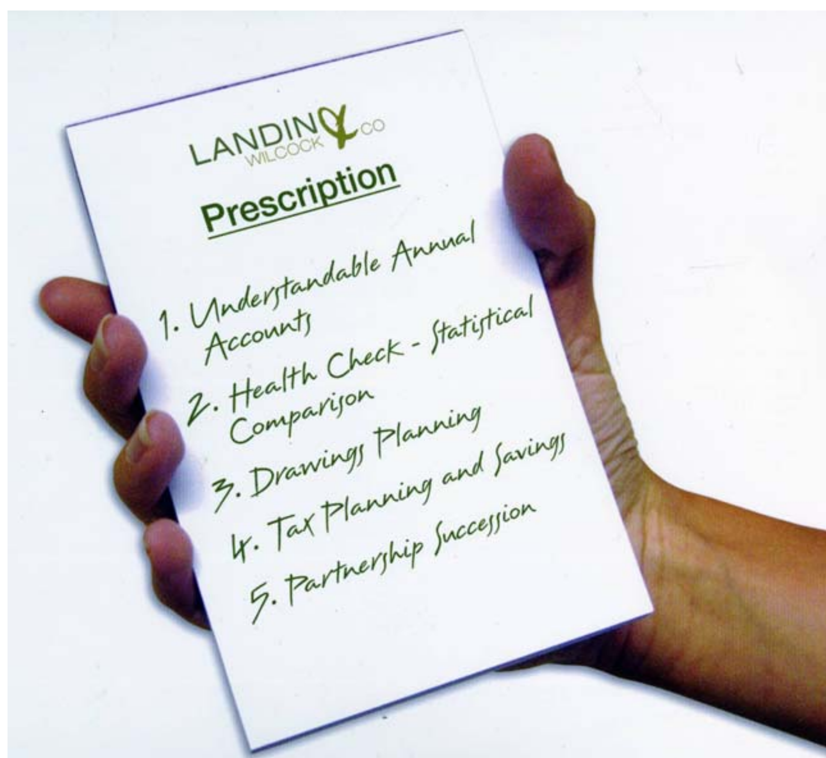
MEDICAL NEWS



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Pensions Update

Confused by the forthcoming NHS Pension scheme changes? You will be.

Let's **TRY** to keep it simple.

From 1 April 2008 there will be two schemes-the current NHS Pension scheme with updated rules and benefits (applying to anyone who is an active member on and before 1 April 2008) and the New NHS Pension Scheme (for anyone who joins on or after 1 April 2008).

So, what are the principal changes to the current scheme?

Firstly, and perhaps most importantly, the contribution rate! Instead of 6% on all annual FTE pensionable pay as it is now, tiered contribution rates apply from 1 April 2008. For those earning up to and including £19,165 the rate is 5% (a saving!) but between £19,166 and £63,146 it will be 6.5%, from £63,417 to £99,999 7.5% and for £100,000 plus 8.5%.

The "double whammy" for higher earners is the removal of the so called "earnings cap" which is currently £112,800. There will be no earnings limit for future service. In other words, you will pay 8.5% on your entire pensionable pay and not just 6% up to £112,800 as it is now.

(On the subject of contribution levels, please also note that employee contributions will be limited to 100% of pensionable pay from 1 April 2008 and not 15% as they are now (subject to a current tax year overall annual allowance of £225,000 and £1.6m fund limit).

Probably the most publicised change has been that to Added Years contracts. From 1 April members can purchase additional annual pension of up to £5,000 per annum but will NOT be able to buy Added Years anymore. So, time is very much of the essence if you have not as yet taken advice in this area!

However, it's not all bad news.

One of the more interesting changes is the ability from April onwards to give up part of your pension ("commutation") for an increased tax free lump sum up to 25% of the pension value. This will almost certainly be higher than the current 3 x annual pension currently allowable.
Advice will be needed as the additional cash would need to provide an investment return of 8.33% gross per annum linked to inflation to cover the lost income. This is because you exchange at a rate of £12 of lump sum for each £1 per annum of pension given up.

One significant change for "practitioners" is that all pensionable earnings from 1 April will be revalue by dynamising factors determined by changes in the Retail Prices Index (R.P.I.) plus 1.5%. Currently, dynamising factors are determined by changes in the Earnings of each practitioner profession.

Other less publicised changes include those to membership limits, flexibility of retirement, abatement, ill health retirement, survivor benefits and pensions on death in service, and child allowances. These can be summarised as follows (source: NHS Business Services Authority Pensions Division):

	NHS Pension Scheme (pr 08 terms)	**NHS Pension Scheme** (1 April 08 & after terms) Effective from 1 April 2008	**New NHS Pension Scheme** Effective from 1 April 2008
Membership limits	• From age 16 to 70 • 40 yrs at age 60 & 45 yrs overall	• From age 16 to 75 • Overall membership limit, for future service, of 45 yrs	• From age 16 to 75 • Overall membership limit of 45 yrs
Flexible retirement	• Pensionable re-employment if you retire on ill-health grounds, draw a pension and return to the NHS under age 50 • No pensionable re-employment after drawing a pension on any other grounds • Pension payable on retirement only	• Pensionable re-employment if you retire on ill-health grounds, draw a pension and return to the NHS under age 50 • Pension payable on retirement only[1] • Step down – voluntary pension protection where pay is reduced on taking a less demanding job	• If you retire on or after 1 April 2008 and before the choice exercise pensionable re-employment is available in the New Scheme after a break of 2 years • Pensionable re-employment on return to work after retirement and re-join the scheme • Draw down – taking part of pension whilst continuing in a less demanding NHS employment
Abatement Practice of reducing a pension if the combined amount of pension and salary in NHS re-employment exceeds the pre retirement level of pensionable pay	• Takes full pension into account • No abatement after age 60 or after 50 where pension is actuarially reduced on Voluntary Early Retirement (VER)	• Takes only part of the pension into account[2] • No abatement after age 60 or after 50 where pension is actuarially reduced on Voluntary Early Retirement	• Takes only part of the pension into account[3] • No abatement after age 65 or after 55 where pension is actuarially reduced on Voluntary Early Retirement

[1] *Deferred members who return to the NHS after 5 years will be able to draw their deferred pension at 60 while continuing in pensionable employment in the New Scheme*

[2] *Only takes into account any additional pension over and above what would have been paid had benefits been actuarially reduced in the same way as for VER*

3 *Only takes into account any additional pension over and above what would have been paid had benefits been actuarially reduced in the same way as for VER*

Ill health retirement	• Ill health retirement benefits up to 10 years extra service	• See separate review by NHS Employers and NHS Health Unions. Details at www.nhsemployers.org	• See separate review by NHS Employers and NHS Health Unions. Details at www.nhsemployers.org
Survivor benefits	• For legal spouse and registered civil partnerships from 2005 (backdated until 1988)[4] • Partners normally lose pension on re-marriage	• All qualifying partners[5] eligible for pension backdated to 1988[6] • All qualifying partners keep survivor pension even when re-marry or co-habit	• All qualifying partners[7] eligible for pension • All qualifying partners keep survivor pension even when re-marry or co-habit
Survivor pensions on death in service	• Initial widow/widower/civil partners(s) pension paid for 3 months or 6 months subject to dependent children	• Initial Partner Pension to be paid for 6 months in all cases	• Initial Partner Pension to be paid for 6 months in all cases
Child allowances	• Payable under the age of 17 and from 17 if still in full time education (beyond 23 if physically or mentally dependent)	• Payable to dependent children up to age 23 in all cases[8]	• Payable to dependent children up to age 23 in all cases[9]

[4] *All service for legal female spouses and from April 1988 for male spouses and civil partners. Civil partnership refers to same sex partners who have entered into a legal civil partnership*

[5] *Partners defined as someone who you are married to , have entered into a civil partnership with, or a partner you have nominated who you have an exclusive and long-term committed relationship with of at least two years in which you are financially dependent or inter-dependent*

[6] *All service for legal female spouses and from April 1988 for male spouses and civil partners. Civil partnership refers to same sex partners who have entered into a legal civil partnership*

[7] *Partners defined as someone who you are married to , have entered into a civil partnership with, or a partner you have nominated who you have an exclusive and long-term committed relationship with of at least two years in which you are financially dependent or inter-dependent*

[8] *This allowance will be payable indefinitely as long as the child, through physical or mental impairment, remains unable to earn a living and the condition existed at the member date of death*

[9] *This allowance will be payable indefinitely as long as the child, through physical or mental impairment, remains unable to earn a living and the condition existed at the member date of death*

There are some areas which are not changing.

For practitioners, the scheme will continue to be a Career Average Re-valued Earnings (CARE) arrangement with an accrual rate of 1.4%.

Death in service lump sum benefit remains at twice annual pensionable pay.

The two Money Purchase Additional Voluntary Contributions (MPAVCs) and Stakeholder Pension partners continue to be Standard Life and Prudential.

And, finally, what is so different about the new NHS Pension Scheme?

The major change is that normal pension age will be age 65 (minimum pension age 55) and accrual rate 1.87% for practitioners.

Like the updated version, there will be no “earnings limit”, the same tiered contribution rates, the facility to take 25% of the pot as tax-free cash, and, for practitioners, the same dynamisation treatment of pensionable earnings (see above for details).There is, it cannot be denied, improved flexibility on retirement.

Active members of the updated scheme will be offered the choice (from 1 July 2009 to 30 June 2010) of moving to the new scheme-which may suit some members’ retirement plans.

However, do you really want to retire at age 65?

When did they get rid of the Off Side Rule?

The Thirty Seventh report by the Review Body on Doctors' and Dentists' Remuneration is not something that many people would have on their "must read" list. While the publication of the DDRB report normally provokes some debate it is a bit like most refereeing decisions – you don't expect to find out that someone has changed the rules in the middle of the game. That, however, is exactly what has happened with this years report. It has highlighted that the final agreement of the 2006/7 GMS Contract Revisions had a clause buried in it that no-one really noticed at the time. To be precise paragraph 1.6 referred to the following:

> ***"It was agreed that future uplifts to the global sum should seek to reduce the reliance upon correction factor payments and, therefore, release an element of the correction factor envelope".***

A fairly bland paragraph, phrases like *"seek to reduce the reliance"* and *"release an element of"* did not ring too many alarm bells with readers when the changes were first seen. However the DDRB have taken that paragraph and applied a very hard line interpretation to it. The end result being that while they have agreed that the Global Sum should be increased by 2.7% for 2008-09 they have then said that any increase would then be deducted, **in full**, from the practices' correction factor.

It appears that this paragraph in the 2007 Revisions to the GMS Contract was included following the governments threat to change the Allocation Formula and get rid of the Correction Factor in one go. The GPC negotiators obviously felt that a more gradual reduction would be preferable – however it's a shame that they didn't feel the need to publicise the agreement of that particular point more widely at the time.

In practice this would mean for example that a three partner practice with a current Global Sum of £291,000 and a Correction Factor of £39,000 would see their Global Sum for 2008-09 increasing by £7,857 and their Correction Factor going down by £7,857! Their overall income from the combined Global Sum and Correction Factor of £330,000 would be unchanged. If the rate of uplift to the Global Sum remained at 2.7% per annum then this practice would not see any actual increase until 2011.

So where is this likely to go from here? One would speculate that once practices have woken up to the fact that the MPIG has been broken and that the correction factor will be recouped over time they will start to press to have the Allocation Formula revised and a wholesale revisit on practice funding carried out. There may also be an immediate knock on effect on PMS practices. At the moment PMS practices are expecting local negotiations to give them a 1.5% uplift for 2008-09, however at a time when perhaps 90% of GMS practices may not actually see an uplift that may not happen.

Finally to go back to the example quoted above, the practice in question is in a fairly deprived area (they do exist even in the south – I wouldn't leave my car there at night!). The practice list of 1,736 patients per partner are rather older than the national average, only 80.2% being under 65, and the partners earn approximately £78,000 profit a year from the NHS. Not exactly the sort of practice that might be regarded as being "unfairly" favoured by the presence of the correction factor!

Cash Flow Warning

A combination of two of the pension changes which occurred on 6 April 2008 can cause severe cash flow problems which must be heeded by practices. The two relevant changes are:-

- The increase in rate of the employee's superannuation contributions from 6% to a maximum of 8½%.
- The abolition of the earnings cap which for 2007/08 was £112,800.

The potential problem arises with a high earning GP who up to 5 April 2008 was capped for pension purposes. Let us assume that he or she has superannuable income of £150,000. In 2007/08 the contributions are:-

Employers at 14% on £112,800	=	15,792
Employees at 6% on £112,800	=	6,768
		22,560

If earnings remain constant in 2008/09, the contributions are:-

Employers at 14% on £150,000	=	21,000
Employees at 8.5% on £150,000	=	12,750
		33,750
Increase		£ 11,190

It is the practice who has to fund the increase of £11,190 even though this amount is charged to the individual partner. For such partners, drawings will probably have to be reduced, particularly bearing in mind a positive pay award is not at this moment in time in sight. Do not rely on PCTs making the appropriate monthly adjustments. You have been warned!

Topical Bits and Pieces

As so much is happening in the medical profession, we thought it appropriate to raise a number of issues that we have recently come across in practice which will be of interest to GPs.

PCT Mergers

There can be little doubt that restructuring of PCTs has caused confusion, delay, and error, and GPs are advised to be particularly attentive to all financial schedules emanating from their PCT. One AISMA member was confused to discover that a three partnered practice received £70,200 from QOF in 2006/07 compared to £63,300 in 2005/06 and yet the points achieved had fallen from 970 to 815 respectively. On further investigation it was discovered that the clinical domain elements of the 2005/06 QOF had been calculated at 520 points multiplied by £75 per point to arrive at £39,000. Of course the calculation should have been at the higher rate of approximately £125 per point for that year. There was therefore an underpayment of £26,000. On taking the matter up with the PCT the latter argued that they were not liable to repay the £26,000 as the PCT at the time no longer exists and 2005/06 finances had been "signed off". No doubt a friendly solicitor has now reminded the PCT of its common law obligations on merger and recovered the amount outstanding.

Practice Errors

Recently, a four partnered practice recruited a new practice manager. They also changed their accountants to an AISMA member at the same time. Between them they discovered that the previous practice manager had failed to submit forms FP10 to the PCT, being the claim for reimbursement of drugs purchased for personal administration. This had occurred for at least three years. In particular, the practice had failed to claim reimbursement for the cost of flu vaccinations for two years.

The new practice manager negotiated with the PCT in respect of these back claims and was met with a rejection on the grounds of clause 17.15 of the Statement of Financial Entitlements which states that payments are only payable if the contractor has:-

> "noted, counted and sent all prescriptions in respect of drugs or appliances in respect of which it wishes to claim reimbursement to the PPA, Bridge House, 152 Pilgrim Street, Newcastle upon Tyne, NE1 6SN, not later than the 5th of the month following the month to which the prescriptions relate".

Furthermore it was argued that PCTs do not have the facility to carry over funds from one year to the next. The AISMA accountant referred the practice to specialist solicitors and the BMA, and at the time of writing the matter is not yet resolved. It is worth pointing out that flu vaccinations are not administered by way of prescriptions and therefore clause 17.15 may not apply in this respect.
It is also worth pointing out that one PCT made an error in respect of contract pricing on all their practices within the PCT, in that in 2004/05 they double counted the amount of employer's superannuation to go into the

global lump sum. Of course, they felt they were at total liberty to claw this back in 2006/07 and 2007/08 once the error was discovered. Referring back to drug claims, GPs **are** reminded that the PPA reimburse drugs in accordance with their published tariff. This means a practice can pay more out for a drug than they get reimbursed. Practices are advised to impose a check on purchase and reimbursement prices and if it is found that they are in a loss situation, then write a script and send the patient to the local chemist.

PCT Errors

Probably due to the various mergers, it is noticeable that the number of financial clerical errors emanating from PCTs has been on the increase over the last year. Our latest experience involves the deduction of employer's and employees' superannuation contributions of a salaried GP from the practice's monthly contract sum. The PCT correctly deducted the salaried GP's contributions at the same point in the schedule as the GP partners. However, they then proceeded to deduct the same contributions again as a special item on the second page of the schedule. This double count resulted in a repayment to the practice of £7,000 after the accountants had made the discovery. The moral of the story is to ensure that each and every monthly schedule, whether PMS or GMS is checked in the practice. In particular, practices **must** ensure that there is a valid reason for any contract variances. Practices cannot assume that the PCT's schedules are accurate, as demonstrated by previous horror stories.

Seniority and Pension Certificates

The Exeter System employed by PCTs to account for monthly superannuation deductions, and annual shortfalls and excesses, is linked to the GP's entitlement to seniority. Entitlement to 100% seniority is based upon a GP having superannuable earnings of at least two thirds of the national average. Between one third and two thirds attracts only 60% of the seniority entitlements, and less than one third nothing at all. The difficulty relates to those GPs who have taken 24 hour retirement and returned to practice. One common belief is that they no longer have to complete a pension certificate as they are no longer liable to pay contributions. This might appear logical but what about their entitlement to seniority?

Indeed, some PCTs have expressed the view that as they have no superannuable income they have no right to any seniority at all. This has to be challenged. Of course they have superannuable income – it is just that they do not pay contributions on their superannuable income. Accordingly, pension certificates should be completed for **all** GPs in practice. For those who have taken 24 hour retirement, the certificate will disclose the superannuable income but the boxes for contributions thereon will show "nil". This at least ***should*** protect their seniority entitlement, provided of course the Exeter System can cope with a variance.

Accounting after 24 hour Retirement

Profit sharing following a 24 hour retirement can be a source of misunderstanding. What basically happens is:-

- A partner takes 24 hour retirement and draws his or her pension. The profit share on that day is zero.

- With the permission of the partners (which should be in writing), the partner returns to the practice and for 28 days performs no more than 16 hours per week at whatever profit share is agreed between the partners.

- Thereafter, a profit share is agreed normally by reference to the number of sessions undertaken.

A potential problem exists – given that this partner no longer contributes to the NHS pension scheme, what should he or she draw compared to other partners on the same sessions? What happens to the employer's contributions included in 2004/05 in the practice global lump sum whether GMS or PMS? The fact of the matter is that whatever was included in the global lump sum remains, so that no deduction is made if a partner retires and no addition is made if a partner joins. In other words, the PCT contribution to employer's superannuation contributions is ***fixed*** and does not vary – it is "lost" in the global sum for perpetuity. This clearly suggests that an individual partner cannot identify his or her employer's superannuation contributions within the global sum, rather that it is general practice funds. Accordingly, all of the partners will benefit from the 24 hour retirement as such although the retiring partner most of all. This is because the ***deduction*** of both the employer's and employees' superannuation contributions are ***charged*** to individual partners. No adjustment is therefore required to profit shares. However, the returning partner will not be charged with superannuation contributions so that his or her Capital or Current Account will be enhanced by not having this liability. It therefore follows that the drawings of this partner should be greater than that of a fellow partner on the same share by the amount the fellow partner is paying for both employer's and employees' superannuation contributions. Life certainly does not get any easier, but at the end of the day, the partners can agree whatever profit share they like.

Budget 2008

The following matters are of general relevance to GPs:-

1 Income Tax

	2009	2008	2007
	£	£	£
Personal Allowance	5,435	5,225	5,035
Taxable income at 10%	nil	2,230	2,150
Taxable income at 20%	36,000	nil	nil
Taxable income at 22%	nil	32,370	31,150
Higher rate, 40% on taxable income over	36,000	34,600	33,300

2 National Insurance

	2009	2008	2007
Class 2 weekly rate	2.30	2.20	2.10
Class 4 rate	8%	8%	8%
Annual lower limit	5,435	5,225	5,035
Annual upper limit	40,040	34,840	33,540
Excess over upper limit (Class 4)	1%	1%	1%

3 Other Matters

	2009	2008
	£	£
• Inheritance Tax nil rate band	312,000	300,000
• Main corporation tax rate	28%	30%
• Small companies corporation tax rate	21%	20%
• CGT annual exemption	9,600	9,200
• Capital Allowances:		
o First Year Allowance	nil	50%
o Annual Investment Allowance up to	£ 50,000	nil
o Writing down allowance	20%	25%
o Writing down allowance on certain fixtures integral to a building	10%	25%

Let us therefore consider what the impact of the tax changes are in the case of a GP earning £120,000 in the year to 5 April 2007, £115,000 in the year to 5 April 2008, and £115,000 again in the year to 5 April 2009. These figures are assumed to be before the deduction of employer's and employees' superannuation contributions.

	2009	2008	2007
	£	£	£
Earnings before tax	115,000	115,000	120,000
Superannuation	19,550	17,250	18,000
Personal Allowances	5,435	5,225	5,035
	24,985	22,475	23,035
Chargeable to tax	90,015	92,525	96,965
Income tax at 10%	nil	223	215
Income tax at 20%	7,200	nil	nil
Income tax at 22%	nil	7,121	6,853
Income tax at 40%	21,606	23,170	25,466
	28,806	30,514	32,534
Class 4 NIC	3,518	3,171	3,145
Class 2 NIC	120	114	109
	32,444	33,799	35,788
% Liability to Income net of superannuation	34 %	34.6%	35.1%

There are a number of interesting features arising from the above:-

- On the surface it appears that the overall burden is falling in percentage terms, but this hides the real truth.
- From 2007 to 2008 earnings fell and so there was a lesser burden in terms of income tax at 40%. This causes the apparent fall in the percentage burden.
- From 2008 to 2009 the tax burden falls by £1,355 but this is taken away by the increase in employees' superannuation contributions which will cost an extra £2,300 for some unknown dubious return in the future.
- Notice the hidden tax - the increase in Class 4 NI contributions which was hardly noticed by many commentators.
- Over the three years, the effective take home pay is as follows:-

  2009 - £ 63,006

  2008 - £ 63,951

  2007 - £ 66,212

The reality is that the tax burden does not get any easier. The shuffling of the numbers does not make a GP better off, but, of course, we all hear the political announcements in the media - we just have to remain sceptical.

Finally, we continue to be asked by those GPs who save to pay their own tax liabilities, how much of their income is set aside for the rainy day. As a rule of thumb guide only we hope that the following table assists you in making the appropriate savings for 2008/09.

Profits after personal expenses and employers' superannuation (£)	**Tax & Class 4 NIC Liability £**	**Saving required %**
170,000	57,682	34 %
160,000	53,922	34 %
150,000	50,162	34 %
140,000	46,402	33 %
130,000	42,642	33 %
120,000	38,882	33 %
110,000	35,122	32 %
100,000	31,362	32 %
90,000	27,562	31 %
80,000	23,762	30 %
70,000	19,962	29 %
60,000	16,150	27 %
50,000	12,310	25 %

Equalisation of Partnership Shares

We make no apology for returning to the subject of Partners' Capital or Current Accounts as many GPs still believe that they are "paper" entries under the province of the accountant and have no real meaning. The truth of the matter is that they are of fundamental importance in that at any point in time they represent a partner's share of the value of the practice. Accordingly, it is good practice to ensure that the balances on the Capital or Current Accounts are as close as possible to the relevant sharing ratios. Otherwise, there is a strong argument to support the charging of interest on Capital or Current Accounts so that no one partner is penalised for an exceptionally high balance which is effectively financing the partnership for no tangible return. Let us deal with the issue by using a simple but hypothetical example.

Let us assume that we have a practice of four partners who own the surgery premises equally but share profits (and losses) in the following ratio:-

Dr A	21.875%
Dr B	28.125%
Dr C	21.875%
Dr D	28.125%

At 31 March 2007, the surgery is valued at £800,000 and there is a loan outstanding of £745,000. The Property Capital Accounts correctly state each partner's share in the equity of £55,000 in the premises at £13,750. Thus the Property Capital Accounts represent each partner's share in the surgery premises at any point in time. It therefore follows that the Partners' Current Accounts represent each partner's share in all of the remaining assets and liabilities of the practice at any point in time. At 31 March 2007 the remaining assets and liabilities were as follows:-

	£	£
Fixtures, furniture, fittings, computers and equipment		32,782
Current Assets		
Stock of drugs	16,603	
Debtors and prepayments (amounts owing to the practice)	148,119	
Cash at bank and in hand	121,116	
	285,838	
Current Liabilities		
Creditors and accrued charges (amounts owed by the practice)	98,386	
Provision for income tax 2006/07	87,703	
	186,089	
Net Current Assets		99,749
Value of the practice (excluding surgery premises)		£ 132,531

The Partners' Current Accounts which represent the value of the practice (excluding surgery premises) were disclosed as follows:-

	£	£
Dr A	43,167	
Dr B	36,016	
Dr C	40,082	
Dr D	13,266	
		132,531

It now becomes clear that the above amounts do not reflect the profit sharing ratios stated above, and that the "ownership" of the practice value is not as intended. In particular, Dr A might ask why he or she is financing more of the net assets of the practice than the others without compensation in the form of interest.

Many GPs ask how these balances get so much out of line. There are several reasons for this, the most common being as follows:-

- One partner incurs tax at source on an outside appointment.
- If the practice pays the tax liabilities of the partners, these liabilities may vary greatly for a variety of reasons.
- Since 1 April 2004, the individual partners' superannuation contributions, both employers and employees, may vary significantly, particularly if one partner is engaged in substantial out of hours activities.
- The regular drawings may be incorrectly calculated by not properly taking account of prior shares and charges, and possibly seniority.
- Some partners may have taken out added years contracts which are not properly reflected in the regular drawings.
- Changes in sessions undertaken during the year.

Once Partners' Current Accounts get "out of line", corrective action needs to be taken, probably by way of equalisation drawings, which, in the above example was effected as follows. Dr D was a new partner who had not "bought" into the practice when joining.

It was agreed, with the agreement of Dr D, that this be corrected, and he arranged to take out a personal loan of £15,000 to inject into the practice. The practice manager further confirmed that there was £32,531 cash in the bank account that was not needed by the practice for working capital and could therefore be drawn by the partners. In total, we have therefore £47,531 to play with to effect an equalisation of the Partners' Current Accounts.

The method of equalisation is to recognise the start and end points. The start point must be the balances on Current Accounts at 31 March 2007 which are set out above. The end point must be the revised Partners' Current Accounts in profit sharing ratio, which, after paying out the surplus cash will be:-

	£	£
Dr A	21,875	
Dr B	28,125	
Dr C	21,875	
Dr D	28,125	
		100,000

Thus, to get from the start point to the end point the transactions must be as follows:-

	Dr A	**Dr B**	**Dr C**	**Dr D**	**Total**
	£	**£**	**£**	**£**	**£**
Balances a 31 March 2007	43,167	36,016	40,082	13,266	132,531
Capital introduced by Dr D	-	-	-	15,000	15,000
	43,167	36,016	40,082	28,266	147,531
Equalisation drawings	(21,292)	(7,891)	(18,207)	(141)	(47,531)
Revised Current Account Balances	21,875	28,125	21,875	28,125	100,000

The partners now own the value of the practice in profit sharing ratio. To maintain the equilibrium, such an equalisation should take place annually, and practices need to ensure they save to enable the transaction to be carried out.

Partners' Current Accounts represent real value and are therefore not a "paper" entry dreamed up by accountants. In fact, they form the basis of a pay out to a retiring partner, so that once equalised, Dr A would be entitled to £21,875 plus his equity in the surgery premises on leaving the practice. Again, it should be pointed out that the balances on Partners' Current Accounts represent ***all*** the assets and liabilities of the practice, not just the bank balance, which is why partners will never be able to draw down to nil - they need to leave behind sufficient to finance the practice, such as the furniture or the stock of drugs in the fridge and monies earned not yet received, often referred to as "working capital".

Salaried GP or Partner

It is not often that the job vacancies sections of the medical press make interesting reading, but at the present time they do indicate what is going on in the recruitment market place. About ten years ago the profession were delighted that they secured a flexible salaried option which enabled GPs to move around more freely, free them from the boring and strenuous task of "running" the business, and provide for more flexible hours and career breaks. However, pay differentials have recently been at the root of a shift in desire amongst GPs so that it is likely in the future there will be less salaried GPs and more GP performers and providers (i.e. equity owners).

The issue centres around the pay gap, whereby an equity partner might, on average, earn £40k or more before tax over and above the level of pay offered to a salaried GP. This has led some salaried GPs to believe they are being exploited in that they feel the burden of equity ownership for partnership is not worth £40k plus. Of course it is not possible to accurately value the burden of ownership, but judgement is often made on the basis of perception. In any case, what we are now finding is that more salaried GPs want to be equity partners, whereby practices would prefer to recruit salaried GPs, both for quite obvious reasons. Thus, the market place is becoming somewhat confused.

Practices are now realising that if they wish to retain a good quality salaried GP, then an offer of partnership must be forthcoming in the near future. Otherwise, the salaried GP will move on to another practice where, for the reasons outlined above, there is high demand. However, the offer of full equity partnership may not be financially viable to the practice. There is of course an alternative and that is to offer a partnership on a fixed share moving to full parity over a period of, say, three years. This ties the salaried GP to the practice as he or she will take on all responsibilities and liabilities under the Partnership Deed, whilst at the same time not cause too great a financial burden as we now demonstrate. Remember of course that the salaried GP is no longer employed by the practice but becomes a self employed partner.

Assume a practice is currently employing a full time salaried GP at an annual salary of £72,000 but wish to retain the services of this GP into the future. They do so by offering the inducement of partnership and full equity rights after a period of two years. Currently, the "take home" pay of the salaried GP is calculated as follows:

		£	£
Gross salary 2007/08			72,000
Less:	Superannuation at 6%	4,320	
	Income Tax deducted at source	18,486	
	Class 1 NIC deducted at source	3,146	
			25,952
Net "take home" earnings			46,048

So far as concerns the practice, the gross cost to the partners is calculated as follows:-

Gross salary (above)	72,000
Employer's superannuation at 14%	10,080
Employer's National Insurance contributions	7,426
	89,506

Thus, the on-cost to the practice is £17,506, which is a considerable burden.

Assume that the partners offer a "fixed share" of £80,000 after agreeing to incur the cost of the employer's superannuation contributions in the first year of partnership, an equivalent £90,000 in the second year of partnership, and full parity in the third year of partnership. The "take home" pay of the salaried GP in the first year is calculated as follows:-

	£	£
Gross Fixed Share		93,023
Less: Employer's superannuation contributions		13,023
		80,000
Less: Superannuation contributions	5,581	
Income Tax	21,182	
Class 2 and Class 4 NIC	3,065	
		29,828
Net "take home" earnings		50,172

Thus, the salaried GP is now £4,124 better off in terms of take home pay, that is £343.67 per month. To achieve this result, the cost to the practice is £93,023 which is only £3,517 more than the £89,506 it was previously costing them. On top of this, the partners obtain tax relief on this additional cost of £3,517, so that the net cost of achieving the above result is only £2,075 or £172.92 per month to be spread over all of the original partners. Overall, in terms of net pay, the practice has made the salaried GP £4,124 pa better off at a cost of £2,075 pa. (These calculations have been based on tax rates and allowances for the 2007/08 tax year for the purposes of illustration).

It follows that by using the "fixed share" approach combined by a parity "trip" to full equity status the financial considerations can be quite favourable. During the forthcoming months we anticipate that more and more practices will adopt the above approach so that at the end of the day there will be more partners and less salaried GPs.

After all, this is merely a return to the good old days of all the professions whereby new qualified professionals entered a practice on a salaried basis and worked their way up to an eventual goal, being the senior equity partner of a professional practice. Career paths will once again become clear. However, at the end of the day recruitment policy is always geared to the market place which is dictated by the traditional economic theories of supply, demand and price.

To retire or not to retire that is the question.

The very simple answer is that if you are aged over 60 then YES! Take the money and run!!.
However you **MUST** seek professional advice before doing so to ensure it is right for you.

A GP's pension is based upon their dynamised earnings which are, in effect, their lifetime earnings which are added together. As you are aware, the BMA are taking the Government to court over the dynamising figures.

When the new contract was set up, the dynamising figures were to be based upon the actual earnings of all the GP's in England and Wales. The Government made an estimate of what this would cost and they got those figures very wrong!

If you obtain a pension forecast from Fleetwood this is based upon the published figures not the final figures. Approximately 27% has been included and the Government are trying to cap it at 48%. The BMA and ourselves believe that the figures will be higher, which is why the BMA are taking legal action.

Let's look at an example of a GP who is 60 with annual earnings of £120,000. For the purpose of this example the current dynamised earnings are £3,500,000. The Pension is calculated at 1.4% of this "pot" and the lump sum is generally three times this amount. The pension would therefore be £49,000 with the tax free lump sum of £147,000

The dynamising figure for this year will be no more than 1. So the only increase to the dynamised earnings will be another years' income. On that basis, if you deferred retirement for 1 year the pension income paid to you as a result would increase by £1680 gross and the tax free lump sum by £5040 but, you would have lost the pension income of £49,000 and unless you live to a very ripe old age of around 90 you will never recoup that lost income.

You can of course take 24 hour retirement, as long as you stop working for 24 hours and don't work more than 16 hours for the next month you can continue to work in the NHS. It may be an idea to get your fellow partners to agree to let you back in as a partner in the practice and if they decline, well, you know who your friends are.

If you do take the pension now and the lump sum, then when the court case is concluded you will receive your extra dynamisation at that point, so there is no downside to retiring now.

Taking advantage of the 24 hour retirement and perhaps returning to work in a reduced capacity may be worth considering as there are a number of benefits such as getting your hands on your tax free cash.
If this is then invested wisely it can provide an additional source of income and save significant amounts of income tax but can also be used via appropriate wills to mitigate Inheritance Tax in future, but that is a conversation for another day.

Secondly, it may be to your advantage to ease yourself into retirement and get used gradually to having something you may not have experienced previously, free time.

Surgery Premises – Capital Gains Tax

The Finance Bill 2008 introduced significant changes to the Capital Gains Tax (CGT) regime, although at the time of writing this note, the legislation has not yet been confirmed by Parliament.

In his pre-budget report of 9 October 2007, the Chancellor referred to the following changes to apply from 6 April 2008:-

- The rate of CGT to be 18% for all gains.
- Capital Gains no longer to be taxed by reference to Income Tax rates and bands.
- Rebasing of cost to 31 March 1982 value to be compulsory for assets held at that date.
- Taper relief to be scrapped.
- Indexation relief no longer to be available.

It was apparent from an early stage that the above changes would detrimentally affect GPs who own part or all of their surgery premises. Prior to 6 April 2008, the maximum rate of tax suffered by GPs tended to be 10%, but with a combination of the above reliefs the effective rate was more than often well below 10%. The immediate reaction was to advise all those GPs who were approaching retirement to dispose of their share of the surgery premises before 6 April 2008.

Following the pre-budget report there was major clamour from the leaders of industry who saw the proposed changes as a disincentive to business in general. Fortunately, the Chancellor heard the outcry and announced further changes to reduce the apparent hardship on business. He proposed a new relief, the Entrepreneur's relief, which will be available in respect of gains made on the qualifying disposal of a business, or part of a business, involving the disposal of certain business assets. "A business" in terms of this relief will be any trade, profession or vocation, excluding property letting business, but including furnished holiday letting. The first £1 million of lifetime gains on qualifying business assets will be charged to CGT at an effective rate of 10%. Gains in excess of £1 million will be charged at the normal 18% rate. An individual will be able to make claims for relief on more than one occasion, up to a lifetime total of £1 million of gains qualifying for this type of relief.

The new entrepreneurs' relief would certainly seem to help GPs when they dispose of surgery premises, but there are certain aspects that require careful planning. For example,

- If a partner retires and continues to own a share in the surgery premises after retirement, he needs to dispose of his share within 3 years of his retirement if he wishes to claim the relief. If this time limit is exceeded the potential rate of tax on disposal moves from 10% to 18%.
- If the surgery premises are not included in the balance sheet of the practice but are held by a number of partners in a separate property partnership, who charge the practice a rent equal to the cost or notional rent, this should not affect the availability of the relief, provided the disposal is associated with a retirement from the practice.

If GPs are entitled to the entrepreneurs' relief, is this as good as the situation prior to 6 April 2008? This can best be answered by using a hypothetical example.

Let us assume that Dr A bought into his surgery premises on 1 April 1988 at a price of £60,000 and that he intends to retire in 2008 and dispose of his share of the surgery premises for £160,000. Is he worse off completing the transaction after 5 April 2008?

Old Rules		**£**	**£**
Proceeds – say, on, 31 March 2008		160,000	
Cost		(60,000)	
Unindexed Gain		100,000	
Indexation relief (162.6 – 105.8) x £60,000 / 105.8		(32,212)	
Indexed Gain		67,788	
Taper relief at 75%		(50,841)	
		16,947	
Annual Allowance 2007/08	(9,200)		
Gain Chargeable to CGT		7,747	
Tax at 40%			**£ 3,099**

New Rules	**£**	**£**
Proceeds – say, on, 30 April 2008	160,000	
Cost	(60,000)	
Entrepreneurs relief (4/9)	(44,444)	
	55,556	
Annual Allowances (assumed 2008/09)	(9,600)	
Gain chargeable to CGT	45,956	
Tax at 18%		**£8,272**

Additional tax to pay under the new rules **£5,173**

Based upon the legislation today before Parliament, the current conclusions are:-

- Whilst entrepreneurs' relief has helped there may still be additional tax to pay on disposals after 5 April 2008.
- The timing of the disposal of surgery premises or a share in surgery premises should be planned carefully in relation to a retirement.

We now await the final legalisation – watch this space!