PROSPERITY INSTITUTE

Unleash the doctors!

How tax and pension reform can immediately increase NHS workforce capacity

Introduction

This is the first of a series of healthcare reform policy pamphlets from the Prosperity Institute which will be published in 2026 and 2027. They follow on from our polling *The Health of the NHS*, published in February 2026, and *A Healthcare Platform for an Incoming Government*, the outline of our overall policy platform published in September 2026.

This pamphlet recommends a series of supply-side reforms which would increase NHS capacity. **By improving the fiscal incentives facing clinicians, more NHS capacity can be delivered to patients rapidly.** This will reduce waiting times, improve health outcomes, and help encourage a less distortionary tax system which has penalised the NHS's most experienced and productive clinicians.

The policy problem

Multiple barriers currently deter productive workers from undertaking additional work in Britain. This is true throughout the economy but is especially problematic within healthcare and the NHS specifically, given the political salience of healthcare in the country.

There are three major fiscal barriers which currently cause significant supply-side constraints in the NHS, especially among hospital consultants and general practitioners:

- The tapering of the income tax personal allowance above £100,000, which creates a 62 per cent marginal-rate band (60 per cent income tax plus 2 per cent employee NIC).
- The pension annual allowance, which allows only £60,000 tax-free total pension input, tapered down to £10,000 for those with threshold income above £200,000 and adjusted income above £260,000.
- IR35 restrictions, which restrict medical staff from taking on extra off payroll shifts through private companies by taxing them and the hospital as if they were on payroll.

The effect of these policies is that there are fewer doctors at work in the NHS than there otherwise could be. Many choose to work part-time or not to take on overtime because there is simply no financial incentive for them to do so, no matter how committed they are to their vocation. As noted below, the current pension annual allowance regulations alone lead to 77 per cent of consultants taking on less overtime.

The consequences of this are obvious: waiting times and lists are longer as there is less capacity to be shared among patients; those staff who are working operate under worse conditions; and health outcomes worsen because of problems which are not treated or picked up in time.

Political economy

As detailed below, it is proven that these policies deter senior NHS staff from taking on extra work. This is one of the most direct contributors to backlogs and waiting lists, and Britain's resultant worsening health outcomes and cratering satisfaction with the NHS.

This policy pamphlet makes a case for reforming these policies based on their **supply-side benefits to the senior NHS workforce**, which would in turn have a significant effect on key metrics such as backlogs, waiting times, and health outcomes.

The wider questions of tax and pension reform, particularly around the £100,000 tax cliff, are increasing in political salience all the time. Fiscal drag and frozen tax thresholds have brought far more British people—not just the health service—into this painful tax trap. This conversation will continue to develop at the national level and the wider political economy of tax reform will be a major consideration for future governments. **We have not sought to model wider effects of our proposals and do not suggest that consultants and GPs are the main consideration in these matters.** Our focus is solely on the supply-side benefits to the NHS from these reforms.

Main recommendations

To remove these disincentives and to release many of the NHS' most productive staff into more work, we propose the following:

- **Remove the effective marginal income-tax rate due to tapered withdrawal of the standard personal allowance between £100,000 and £125,140.**
- **Reform the £60,000 pension annual allowance** through either total abolition or abolishing the taper and indexing the threshold to inflation.
- **Simplify, reduce, or abolish IR35 rules.**

1. Remove the income tax personal allowance taper

Main points

- Withdrawal of the personal allowance above £100,000 creates high marginal tax rates that discourage NHS consultants from taking on additional work.
- Removing the personal allowance taper would improve incentives for senior NHS clinicians, releasing additional healthcare capacity.

Current policy

In 2026–27, the £12,570 personal allowance is withdrawn by £1 for every £2 of adjusted net income above £100,000, disappearing entirely at £125,140. For employment income in England, Wales and Northern Ireland, this creates an effective marginal income tax rate of 60 per cent across this band, or **62 per cent including employee National Insurance, leaving 38p from each additional £1 earned before other deductions.** Above £125,140, the combined marginal rate falls to 47 per cent. In Scotland, the corresponding rates are 69.5 per cent within the taper and 50 per cent above it.

Separately, if either parent's adjusted net income exceeds £100,000, **eligibility for Tax-Free Childcare and England's working-parent funded childcare is lost**, creating a genuine cliff edge that can leave affected families worse off after a pay rise.

Evidence of disincentive effect

In March 2025, the BMA recommended in its submission to the comprehensive spending review that various financial disincentives be tackled. Among other recommendations, they proposed indexing the personal allowance to inflation.[1] The threshold has been set at £100,000 since 2010; if it had increased in line with inflation, it would be around £166,400 in 2026.[2] The BMA restated the disincentive effect of the taper in written evidence to Parliament in April 2025, especially when combined with the total withdrawal of 30 hours free childcare when one parent earns over £100,000.[3] The 2026 report from the Review Body on Doctors' and Dentists' Remuneration reported that the HCSA said that "the steep marginal tax rate of 60 per cent between £100,000 and £125,140, and the loss of free childcare… forced many consultants to reduce hours or decline additional responsibilities."[4]

The 3.5 per cent pay award increase agreed in March 2026 for resident doctors and dentists; specialty, specialist and associate specialist doctors and dentists; consultants; and salaried GPs places the NHS consultant pay scale in England (2003 contract)

[1] BMA, "Funding Priorities for the Health and Care Sector: The BMA's submission to Phase 2 of the Comprehensive Spending Review, Spring 2025", 7th February 2025, 3-4. (link)
[2] Inflation calculation based on Consumer Prices Index.
[3] BMA, "Written evidence submitted by British Medical Association", April 2025, NWT0008. (link)
[4] Review Body on Doctors' and Dentists' Remuneration, Fifty-Fourth Report – 2026 (London: UK Government, March 2026), 62. (link)

between £113,565 and £150,570.[5] Therefore, all pay grades are above £100,000, which has been the case since 2024. Thus, a newly appointed consultant would only be able to keep 38p for every additional pound earned above £100,000. **This value reduces to 29p if the individual must repay student loans under the Plan 2 type.** Given the consistent recent testimony of the BMA, we can presume that, with a static tax threshold at £100,000 and a growing proportion of doctors having Plan 2 student loans, the disincentives will continue and possibly worsen.

If the Government is serious about incentivising some of the most experienced and productive people in the health service to maximise their efforts and care for British patients, it should look to the tax system which has become a deterrent against work.

Benefits of removal

It is estimated that the personal allowance taper generated £4.7bn in 2022–23.[6]. We estimate that currently—with approximately 2.06 million taxpayers losing some or all of their personal allowance according to HMRC—the static upfront cost to the Treasury of restoring the full allowance would be between £7.2bn and £9.2bn a year. **Accounting for behavioural responses, we estimate this amount would reduce to £4.1bn to £8.5bn, with a central estimate of £6.7bn.**

We will not propose an alternative to the tapered removal of the personal allowance other than to say it would need to come from wider redesign of income tax thresholds, bands, and rates. This could include lowering the 45 per cent threshold from £125,140 to £100,000 to mitigate some lost revenue whilst still reducing the size of the tax cliff.

However, the benefit for senior NHS clinicians is obvious as every full-time NHS consultant in England earns above £100,000. NHS clinicians account for approximately 3.5 per cent of those who would benefit from remove the taper—approximately 73,000 people, currently generating around £240m in tax revenue via the taper.

There are not precise figures for the scale of work not taken up by consultants specifically due to the personal allowance taper (which does not exist in isolation from the other policies discussed in this pamphlet). However, given that both the BMA and the HCSA have testified that "many" consultants are disincentivised, it can be assumed that it is a significant amount which would, if unleashed, bring much-needed relief to a failing NHS.

[5] NHS Employers, "Doctor's and dentists' pay award announcement 2026", 26 March 2026 (link); BMA, "Pay scales for consultants in England", 14 August 2026 (link).
[6] RSM, "The true cost of the personal allowance stealth tax", 20 March 2024. (link)

2. Reform the pension annual allowance

Main points

- The pension annual allowance and its taper expose clinicians to complex, unpredictable tax charges that discourage overtime and additional sessions.
- Full abolition would offer the greatest clarity, but much of its fiscal cost would benefit savers outside the NHS, and lower contribution relief limits would provide only a partial offset. Abolishing the taper and indexing the allowance offers a narrower alternative with a stronger estimated benefit–cost ratio.

Current policy

Currently, pension contributions mainly attract income tax relief, with most given through net pay arrangements and employer contributions. To mitigate this cost there is a maximum annual allowance (AA): £60,000 total pension input (employee + employer + relief), tapered down to £10,000 for those with threshold income above £200,000 and adjusted income above £260,000. **For NHS staff in a defined benefit (DB) scheme, the AA is assessed through pension input amount (i.e. the annual growth in promised benefits), rather than actual contributions.** Due to how growth is calculated, a pay rise could cause an unexpected increase in this amount. An excess triggers an AA charge, effectively clawing back relief at the individual's marginal rate.

The allowance is tapered for higher earners when their threshold income exceeds £200,000, and their adjusted income is more than £260,000. The standard allowance is reduced by £1 for every £2 of excess adjusted income until it hits a floor of £10,000.

Evidence of disincentive effect

Current policy creates a significant trap for medical consultants in that most waiting-list and extra-session pay cannot be included in a consultant's pension. Therefore, it increases threshold income and does not add to pension benefits. **Crossing the £200,000 income threshold can trigger a disproportionate tax charge.** In extreme cases, a £2 increase in extra income can incur a tax of £6,750, and the taper can increase the charge by up to £22,500.

Furthermore, the charge is assessed and paid through the self-assessment mechanism and frequently results in large five-figure sums being owed, which are complex to calculate, 18 months after the salary is paid. This has disincentivised many clinicians from undertaking additional work to prevent the threshold being breached.

In March 2025, the current government said there was no evidence that the pension allowance regime "constrains the activity of the consultant workforce in aggregate".[7] However, a 2024 BMA poll reported that 71 per cent of all respondents to its member survey "indicated that if there were no further reforms to the tapered AA following the

[7] UK Parliament, "Written Question 40602: Pension Tax Allowance," 24 March 2025, answered March 27, 2025. (link)

general election, this will prevent or limit their ability to take on additional overtime. Amongst consultant respondents, this proportion rose to 77.1%."[8]

Following a lack of reform, the BMA conducted another snap survey in February 2025. Over 5,000 GPs and consultants were surveyed and out of the consultants **21 per cent had reduced regular overtime, 16 per cent had gone part-time and 24 per cent had cut ad-hoc/waiting list initiative sessions.**

This issue is worsened by administrative delays. **Clinicians are forced to decide whether to take on extra work before knowing their pension input.** The same BMA survey revealed that 45 per cent of respondents said they did not know whether they would be liable for an annual allowance charge in the 2024–25 financial year. This uncertainty was in part due to NHSBSA delays in releasing pension savings statements.

Benefits of reform

The high levels of disincentive due to the annual allowance restrictions are obvious. Clinicians suffer often from a clear lack of financial incentive, either from a clear assessment of how much they add to their pension or the uncertainty of the current system.

The likely benefits of reform are equally obvious. After their February 2025 poll, the BMA estimated that loss from clinicians disengaging due to current pension policy was **equivalent to losing 5,400 consultants and 4 million GP partner appointments in England alone.**[9] Twenty-three percent of GP partners had reduced their regular workload, averaging 1.7 sessions per week. These numbers represent the very real gains for NHS capacity which could be made by supply-side reform.

There are different options open to policymakers for reform.

- Full and immediate abolition of the AA charge
- Sequential abolition: first remove the taper, then raise the AA threshold to a figure higher than £60,000, then abolish completely
- Abolish only the taper

Immediate abolition would have the benefit of clarity for clinicians and would swiftly introduce supply-side workforce improvements which would increase NHS capacity. Sequential and partial reform would have the benefit of impacting less suddenly on the Treasury but would obviously release less capacity and may still leave clinicians uncertain of their tax liabilities.

Scrapping the AA charge entirely would remove the cap on total inputs (beyond the earnings limit), allowing higher earners with significant employer contributions or

[8] BMA, "Funding Priorities", 15.
[9] British Medical Association. *BMA Briefing – The Impact of Punitive Pensions Taxation on the NHS*. March 2025. (link)

carry-forward to put in more and claim full relief without penalty. As NHS clinicians using a defined benefit scheme have their accruals set by scheme rules, abolition would see their charges removed rather than prompt more saving. Additional savings would mostly be derived from company directors and defined contribution savers.

A trade-off? Funding AA abolition by lowering the pension relief limit

Political economy of high-earner pension reform

It is the view of the Prosperity Institute that Britain should strive for far lower taxes and a far simpler tax regime for all. In a forthcoming tax reform project, we will outline our vision for this in more detail.

However, the question in view here is **how fiscal reform can incentivise key NHS staff into more work**, rather than that of overall tax simplification and reduction. We recognise that, despite public appetite for NHS reform reaching new heights (as confirmed in our own polling), the sensitive political economy of NHS-related reform and the dire state of the public finances will require trade-offs.[10]

As such, it is worth considering whether AA reform could be delivered with cost neutrality via changes elsewhere. This could be approached either through a cost-neutral reform that does not fall on the clinicians it is designed to support, or a reform whose net cost is justified to the public by its benefit to the NHS.

Current **AA charges raise approximately £300m per year.**[11] This would be the static cost to the Treasury before any behavioural effect of increasing healthcare capacity through the abolition of the AA. These behavioural effects include tax paid through Scheme Pays (£164m) and excess savings through Self-Assessment (£672m).

This lost AA revenue could be partly offset by reducing the tax-free amount which can be paid into pension funds, which is currently 100 per cent of salary and excludes employer contributions.

The limit currently applies only to a small number of people contributing more than 70 per cent of their earnings. A 70 per cent limit will only raise approximately £100m a year which is equivalent to 8 per cent of the central cost of full abolition.

While the immediate, direct beneficiaries of these policies are ultimately a small number of individuals, the AA reform has the benefit of releasing NHS capacity, allowing more patients to be treated in more quickly.

There is no simple, official figure for this exact policy trade-off, as it would require detailed HMRC microdata modelling of contribution distributions, marginal tax rates,

[10] 59 per cent of the public support reforming the NHS over simply increasing its funding, according to our polling published in February 2026. See Prosperity Institute, *The Health of the NHS: The National Mood on Healthcare in Britain's New Politics* (London: Prosperity Institute, 2026), 12. (link)

[11] HM Revenue & Customs, *Private Pension Statistics*, Table 6: *Registered Pension Schemes Cost of Tax Relief*, July 2026. (link)

and behavioural responses. However, a reasoned estimate is possible based on available statistics.

Basic cost of AA abolition

The current personal/employee relief limit is up to 100 per cent of earnings (or £3,600 minimum). This only applies to individual contributions and excludes employer contributions (including those made through salary sacrifice).

The full dynamic effect needs to be considered. Without the AA, some high earners would increase contributions further (up to their full earnings limit), generating additional upfront relief costing the Treasury more (we estimate approximately £0.3–£4bn per year, depending on behaviour, with a central estimate of £0.9bn). High earners (Higher and Additional Rate taxpayers) drive most of this. This trend comes mainly from company directors and defined contribution savers, as NHS clinicians cannot increase their pension growth in this manner.

The short-term net extra cost to the Exchequer from scrapping the AA entirely (including behavioural uplift) is likely in the range of £0.6–£4.5bn, **with a central estimate of £1.2bn annually in the short term**, concentrated among a small number of high contributors (around 23,000–50,000 people exceeding the AA). HMRC figures show that in 2024-25, 30,440 individuals reported that their pension contributions exceeded their annual allowance.[12] Incentives to "over-save" would be severely hampered if unused pension funds become subject to inheritance tax (IHT) in April 2027 as planned, thereby making this upper end less likely. To compare, the OBR estimated the cost of raising AA from £40,000 to £60,000 in 2023 as £270m a year. [13]

What earnings cap reduction would offset AA abolition?

To achieve revenue neutrality in abolishing the AA (i.e. no net loss to the Treasury**),** the pension relief limit of 100 per cent of earnings could be lowered. As this cap applies to individual contributors, lowering it would restrict relief mainly to a small cohort of high contributors.

In 2024–25, income tax relief on individual contributions was £12.9bn.[14] Most of this relief goes to basic/higher-rate taxpayers with moderate pension contributions well below that of 100 per cent of earnings who will be unaffected by the lower cap.

Below, we have estimated approximately the potential tax revenue from lowering the relief cap to different levels:

[12] HM Revenue & Customs, "Private Pension Statistics Commentary: July 2026," GOV.UK, July 30, 2026. (link).
[13] HM Treasury, "Spring Budget 2023: Costing Document" (London: HM Treasury, March 2023). (link)
[14] HM Revenue & Customs, *Private Pension Statistics*, Table 6.

Relief cap	Estimated annual revenue	Central estimate	Share of £1.2bn central cost of full AA abolition
80 per cent	£20m–£90m	£45m	2–8 per cent
70 per cent	£50m–£190m	£100m	4–16 per cent
60 per cent	£100m–£390m	£190m	8–32 per cent
50 per cent	£160m-£650m	£320m	13–54 per cent

As is clear, even a 50 per cent cap only raises around a quarter of the £1.2bn cost of full AA abolition.

However, this is not precise. Actual modelling (e.g., by OBR/IFS/HMRC) would depend on:

- Exact distribution of contributions relative to earnings.
- Marginal rates of those affected.
- How many people increase contributions post-AA scrapping.
- Interaction with employer contributions and salary sacrifice.

Cost neutrality cannot be achieved by reducing the cap on individual contributions alone. Our modelling shows that fully abolishing the annual allowance would require a broader package. This could include capping pension tax relief for additional-rate taxpayers at 40 per cent, alongside a 70 per cent contributions cap that includes employer contributions.

What if employer contributions are included?

An additional change could be to include employer contributions in the reduced cap. Currently they are outside it.

A large number of public sector employees benefit from substantial employer contributions in excess of 20 per cent of salary. This includes the clinical workforce this policy is aimed at incentivising. By including employer contributions in the cap, the policy may be seen as fairer, with public sector employees contributing more at source in exchange for abolition of the AA.

Were the pension relief limit reduced to 70 per cent, our analysis shows that including employer contributions would not push the workers targeted by the proposal over that limit. An NHS consultant's combined member (12.5 per cent) and employer (23.7 per cent) contributions amount to 36.2 per cent of pensionable pay. Even when measured on pension input amount, a typical consultant is at 38 per cent. However, because members with large one-off pay increases can approach 60 per cent, **there would need to be a smoothening rule (e.g. three-year averaging) for any cap tested on defined benefit pensions.**

We estimate that including employer contributions would raise the total tax revenue from the 70 per cent relief limit to approximately £460m, most of which would come from company-owner directors who tend to make large employer contributions in contrast to small salaries from NHS staff.

In addition, GP partners pay employer contributions for pensions from their global sum income. However, reducing the tax-free allowance to 70 per cent and including employer contributions should not cause GPs to breach the new lower limit as their combined contributions are approximately 36.2 per cent of NHS pensionable profit.

Overall, we are proposing a broader tax base with tax simplification. **The key to pension reform is to reduce complexity to make it user-friendly and generate good will from clinicians.** However, there is a risk here of creating a system that is too complex and uncertain, deterring workers from taking advantage of it.

Partial offset acceptable within broader political economy and spending reductions

Our above estimates have shown that the full cost of AA abolition could likely not be covered even by reducing the pension relief limit to as low 50 per cent. Even including employer contributions within a 70 per cent limit would raise only around 38 per cent of the cost. **A partial offset is the best that could be achieved.**

However, this is a policy considered as a trade-off, potentially justifiable in a political economy in which the government is seeking ways to release NHS capacity quickly and cost effectively.

Furthermore, if a future government were committed to a broad programme of reduced public spending, then achieving only a partial offset of full AA abolition may well be a fully acceptable policy trade-off.

An alternative: Abolish the AA taper and index the threshold

A narrower reform of abolishing only the tapered annual allowance (central cost of approximately £270m) could be entirely funded by capping pension tax relief at 40 per cent on personal and salary-sacrifice contributions made by current additional-rate taxpayers. This would raise £340m—enough to fund abolishing the tapered AA. Extended to all contributions (including employer contributions), this would raise approximately £710m.

Were the taper to be abolished, **the AA threshold should be simultaneously indexed to inflation**, to avoid swiftly losing the incentive benefits for NHS staff via fiscal drag. The threshold has been static since 2023–24. Had it risen with inflation, it would now be approximately £66,100.[15]

Due to a lower cap on individual contributions only affecting a minority of savers, this would not function as a broad-based trade-off. Rather, the burden would fall primarily

[15] Calculated based on Consumer Price Index.

on other high earners and high savers. For authoritative costing, an official dynamic analysis from HMRC or the OBR would be needed if such a policy were to be instigated.

Our Cost-Benefit Analysis strongly supports this framing for abolishing the tapered Annual Allowance, **with a central Benefit Cost Ratio (BCR) of 1.9. Conversely, fully abolishing the AA falls below 1 (at 0.7).** This is because the majority of its cost benefits savers outside the NHS.

3. Simplify, reduce, or abolish IR35 rules

Main points

- IR35 can reduce doctors' take-home pay from additional work through limited companies while creating administrative burdens and uncertainty over tax status.
- Simplifying, reducing, or abolishing IR35 could make additional clinical work more attractive and release NHS capacity.

Current policy

IR35, Britain's current off-payroll working (OPW) rules, require individuals providing services through an intermediary, usually their own limited company, to pay broadly the same income tax and National Insurance as employees where they would be employees if engaged directly. The good intent of IR35 is supposedly to prevent tax disparity between workers doing the same work. However, in practice, at least in the NHS, the rules deter an increase in the supply of services due to the heavy tax burden being a counter incentive, as well as stifling innovation and entrepreneurship.

Responsibility for determining this status rests with public-sector clients following reforms in April 2017, and medium and large private-sector clients following the April 2021 extension. For small private-sector clients, it remains with the worker's intermediary. Where the reformed rules apply, the deemed employer, usually the client or fee-paying agency, deducts income tax and employee National Insurance and pays employer National Insurance, without this tax treatment itself conferring employment rights.

There is no general healthcare exemption: NHS trusts must assess locum and additional clinical engagements through intermediaries case by case, considering the actual contractual terms and working arrangements, including control and requirements for personal service, rather than automatically treating all doctors as inside IR35. The same principles apply in private healthcare, subject to the client-size distinction.

Evidence of disincentive effect

IR35 rules commonly reduce take-home pay for doctors undertaking locum or additional work such as extra sessions, waiting-list initiatives, or weekend clinics through limited companies while also creating administrative friction. Similar problems have been identified in other sectors of the economy, such as software engineering or logistics, which involve a large proportion of contractors.

Since the public sector rules took effect in 2017 and the private sector extension in 2021, end clients (e.g. NHS trusts, larger GP or dental groups, or agencies) bear primary responsibility for status determinations. Blanket "inside IR35" approaches are a frequent complaint, even though HMRC guidance rejects them as failing the "reasonable care" requirement. Clinical roles often score poorly on substitution and control tests under tools such as CEST.

The BMA's guidance on how IR35 affects doctors explains that intermediary arrangements trigger employment status tax and NIC treatment (without full employment rights) and notes the removal of the 5 per cent notional expenses allowance in many cases.[16] It has historically criticised chaotic implementation and welcomed the NHS's earlier U-turn away from blanket approaches that would have "significantly penalised" locums. Specialist medical accountancy firms (such as LOYALS, Acctek, Sterling Finance, and Sigma Chartered) have documented the financial impact. **On a typical £90,000 contract, inside versus outside status can reduce take-home pay by £10,000–£14,000.** Restricted expenses and pension interactions further diminish the attractiveness of additional work.

These effects are reflected in case law, reporting, and operational practice. The long-running *George Mantides Ltd v HMRC* case (a locum urologist working via a personal service company at two NHS hospitals) illustrates the uncertainty for clinicians.[17] The Upper Tribunal's April 2025 decision confirmed one engagement as inside IR35 after applying updated mutuality-of-obligation principles, underscoring the difficulty of arguing outside status for hospital locum work. Older reporting (for example from Contractor Calculator) described locums being deterred from NHS shifts, moving to private sector "outside" contracts, or leaving altogether, with some trusts struggling to fill posts.[18] NHS England guidance on insourcing requires trusts to consider off-payroll rules, and agencies note that inside determinations lead to PAYE-style deductions by the fee payer.

Sources consistently link the material reduction in net pay, blanket determinations, administrative burdens, and restricted expenses to doctors declining extra sessions or shifting activity away from the NHS, contributing to capacity pressures.

Benefits of reform

Of the £1.2bn each year the 2017 and 2021 off-payroll (IR35) reforms generate in additional tax revenue (based on HM Treasury £6.19bn costing of their repeal in 2022), we estimate that approximately £120m is through healthcare services. Currently Reform UK wishes to abolish IR35 and the Conservatives are planning to reform it by simplification.

Both abolition and simplification of IR35 would be welcome improvements. With the NHS specifically in view, one approach could be to **exclude medical services under the Standard Industrial Classification (SIC) codes 86210 and 86220 from IR35 rules.** This would mitigate the risk of additional work carried out through limited company and incentivise additional activity. The exemptions should be based on worker's professional registrations (HCPC, GMC, or NMC) to avoid gaming the

[16] British Medical Association. "How IR35 Affects Doctors." Accessed 23 October 2026. (link)
[17] *George Mantides Ltd v. The Commissioners for His Majesty's Revenue and Customs*, [2025] UKUT 00124 (TCC), April 7, 2025. (link)
[18] Dave Chaplin, "NHS Locum Doctors Avoid IR35 by Being Lured to the Private Sector," *ContractorCalculator*, 18 May 2017 (link); Dave Chaplin, "NHS Survey: Patient Care Services in Crisis as IR35 Reforms Take Their Toll," *ContractorCalculator*, 9 November 2017 (link).

exemptions. Also, if the intention is to deliver benefit to the NHS, the engager should be a provider delivering NHS-funded care or an NHS body and **should only apply to NHS-funded sessions.**

Specific data on IR35's disincentive effects on hours or sessions worked is not available. However, given the consistent testimony of clinicians about the disincentives of current IR35 rules, these proposals are very likely to release additional capacity into the NHS.

Assessing success

The success of these reforms should be measured based on capacity rather than through productivity—that is, on the number of additional hours and sessions created, rather than output per hour or session. These reforms will release additional capacity rather than making existing capacity more productive.

Of course, this capacity must then translate into increased performance and better outcomes within the NHS, and so these too should be measured.

The most important of these metrics is the size of the waiting list for planned surgery. Labour arrived in 2024 with a clear promise: restore the NHS standard so that no patient waits longer than 18 weeks from referral for consultant-led treatment of non-urgent conditions, achieved by March 2029. More than two years on, the pledge is unravelling. The elective waiting list stood at 7.37 million pathways in August 2026, with little change since 2024. The additional capacity created by these reforms will help drive the waiting list down by releasing more doctors for appointments, diagnostic checks, and operations.

Other measures tracked in future assessments should include:

- Additional programmed activities and waiting-list sessions.
- A&E waiting times.
- Staff retention and working patterns, including early retirements among GP partners and consultants as well as rates of part-time working.
- Completed treatment pathways.
- Reduced spending on temporary staff, replaced by increased use of overtime, insourcing, and outsourcing.

Many more supply-side policies can be advanced to improve NHS workforce capacity in the long term, and the Prosperity Institute will be developing such policies throughout 2026–27.

However, with NHS performance, health outcomes, and public satisfaction in a state of constant decline, it is incumbent upon any government which takes seriously the health of the nation and the public finances to ask how it can free up existing capacity currently not in use.

Although they have wider implications across the economy, **the reforms proposed in this paper would deliver significant capacity from the first day of the next tax year.** It is unforgivable to have the NHS's most highly qualified staff ready and waiting to do work but sat idle because of our punitive fiscal policy.

It is time to unleash the doctors.