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REVIEW BODY ON ARMED FORCES PAY

SERVICE MEDICAL AND DENTAL OFFICERS

Supplement to Tenth Report
1981

Chairman:
SIR HAROLD ATCHERLEY

Presented to Parliament by the Prime Minister
by Command of Her Majesty
July 1981

LONDON
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Cmnd. 8322

REVIEW BODY ON ARMED FORCES PAY

The Review Body on Armed Forces Pay was appointed in September 1971 to advise the Prime Minister on the pay and allowances of members of Naval, Military and Air Forces of the Crown and of any women's service administered by the Defence Council.

The members of the Review Body are:

Sir Harold Atcherley (*Chairman*)[1]

M G Heron

Dr Ewen M'Ewen CBE

Leif Mills

Dame Rosemary Murray DBE JP

Sir John Read

J R Sargent

Air Chief Marshal Sir Ruthven Wade KCB DFC

The Secretariat is provided by the Office of Manpower Economics.

Baroness Sharples left the Review Body in June 1981 and was unable to take part in the later stages of this review.

M G Heron was appointed to the Review Body by the Prime Minister in April 1981.

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[1] Also a member of the Review Body on Top Salaries.

SERVICE MEDICAL AND DENTAL OFFICERS

Introduction

1. Service medical and dental officers are dealt with separately from the generality of members of the armed forces, covered by our main report, as their pay is related to the remuneration of general medical practitioners (GMPs) in the National Health Service (NHS). Consequently, we have to await the Government's decisions on the recommendations of the Review Body on Doctors' and Dentists' Remuneration (DDRB) for general medical practitioners before we can consider in detail the pay of Service medical and dental officers.

2. This year, the Government has decided not to implement in full the DDRB's recommendations. Instead, it has announced that increases for NHS doctors and dentists will be made within an overall average of 6 per cent. Following consultation with the medical and dental professions, revised rates of payment have now been introduced for GMPs in the NHS to conform with this decision, with effect from 1 April 1981.

3. The Government's decision has implications for our consideration of medical and dental remuneration in the armed forces. We have had to consider whether to base our recommendations on the resultant reduced salary levels, against the background of the Government's commitment—which applied equally to our main recommendations this year—to maintain the pay of members of the armed forces at levels fully comparable with those of their civilian counterparts. We take the view that our recommendations for medical and dental officers this year must be based on the actual levels of remuneration of GMPs that have been implemented as a result of the Government's decision. Our underlying objective is to maintain military salaries at levels that broadly recognise earnings for equivalent work elsewhere, so that the Services can recruit and retain sufficient doctors and dentists of the necessary calibre. To meet this objective, it is necessary to have regard to the actual levels of earnings in the comparator area not to levels that might have applied had circumstances been different.

4. We recognise that there have been occasions in the recent past when, by analogy with the treatment of combatant officers, medical and dental officers in the armed forces have received preferential treatment compared with the GMP in the NHS. However, these cases arose largely as a result of the way in which the introduction of fully up to date rates was phased under the pay restraint measures then in operation, and we do not see them as offering a precedent now. The fully up to date NHS rates indicated by the DDRB had on those occasions been accepted by the Government as being appropriate in principle, and the effect of the Government's decisions was that medical and dental officers in the armed forces received their fully up to date rates of pay at an earlier stage than GMPs in the NHS: the point at issue was only the timing of their implementation. The situation now is different as there is no commitment by the Government to implement in full the latest DDRB recommendations. Accordingly, it is the actual levels of payment of the GMP in the NHS, as affected by the Government's decision,

which forms the basis for our judgment of the levels of military salary appropriate to Service medical and dental officers at 1 April 1981.

5. Concern has been expressed to us that medical and dental officers should not be treated less favourably this year than their combatant colleagues. We see a distinction between the treatment by Government of our recommendations, under the terms of its general commitment on armed forces pay, and the part played by NHS levels of remuneration as a primary factor that we take into account in reaching those recommendations. The level of remuneration of the NHS general medical practitioner is an important element in our judgment and should be viewed as the counterpart in the medical and dental context of the evidence we obtain on 'outside' levels of remuneration when framing recommendations on military salaries for other members of the armed forces. In both cases the purpose of comparisons is to provide information on current actual levels of remuneration, as part of the total evidence that we take into account. In basing our recommendations this year on actual levels of remuneration in the comparator group we have treated medical and dental officers in the same way as their combatant colleagues—although clearly the different bases of comparison involved may lead to different levels of increase in salary (as has often been the case in the past).

6. There are a number of other general considerations that we have to take into account when determining an appropriate salary structure for Service medical and dental officers. They include the level of the X factor that is appropriate in this context; the adjustment to be made for pension purposes and for the comparative value of any other elements within the total remuneration package; and relevant structural considerations. We have also considered a proposal for the introduction of a new form of additional pay (a trainer allowance) that has a bearing on the elements in GMP remuneration that we take into account. In exercising judgment on these issues we must above all have regard to the ability of the Services to attract and retain sufficient suitably qualified doctors and dentists and we look first at the latest manning position in some detail.

General considerations

The manning situation

7. We have received detailed information on the manning of the medical and dental branches of the armed forces for the year up to 31 March 1981. This is set out in Appendix 1, which includes comparative information for earlier years. The position overall for dental officers continues to be satisfactory: the main manning difficulties remain in the medical branches. However, the general improvement in manning that began to develop in the previous year has been maintained. The total number of medical and dental officers has increased although the position varies in the individual Services. There are still significant shortfalls of medical officers from establishment. These are less than in recent years, although direct comparison is complicated by regular changes in the establishment levels and the small numbers involved can exaggerate the effect. To a limited extent, also, the effects of shortfalls in uniformed manpower are mitigated by the practice of employing civilian

doctors in areas of particular shortage. Nonetheless, as we noted last year,[1] it will take some time to make good the serious shortfalls that occurred during the period when pay in the armed forces was not kept fully up to date, and when many of the more experienced Service doctors and dentists were leaving to take up more lucrative posts elsewhere.

8. A lasting improvement in manning can be achieved only through a combination of better recruitment and retention. The latest manning information, while needing to be interpreted with caution, offers encouraging indications in this respect. The number of Pre-Registration Medical Practitioners and medical cadets in the armed forces is higher in each Service than at the end of the previous year and, although only the Army were able to meet their target in full, there has been marked improvement in recruitment from all sources. Most significantly, this has had the effect that the number of medical officers joining the armed forces during the year (151) significantly exceeded the numbers leaving (93). This continues the trend that began to develop last year and is in contrast to the tendency of recent years for the numbers leaving to have been well in excess of those joining. The improvement in the proportion of short service commission officers converting to a permanent commission to which we referred last year has also been maintained, and we take this as another hopeful sign of an improvement in the overall manning position. However, there is no room for complacency: these improvements are occurring against a recessionary background which might be affecting the willingness of individuals to change employment, particularly at more junior levels. Moreover, there are still serious manning difficulties as a result of the shortages that have developed in recent years, particularly in those areas where specialist skills are required, and the Services still find it difficult to retain some of their most experienced and highly qualified specialist staff. It is against this background that we now discuss the issues affecting medical and dental officers' pay in more detail.

The elements within remuneration

9. The military salaries of medical and dental officers are related to the average net remuneration of the GMP in the NHS—that is, the average level of remuneration for all GMPs working in the NHS which the range of fees and allowances covered by DDRB recommendations is intended to produce, after allowing for practice expenses. Last year we extended the range of earnings taken into account for the purposes of comparison by including average earnings of GMPs in the NHS from contraceptive service fees, hospital work and other official sources that were not included in the DDRB's assessment of average net remuneration. As a result of the Government's decision on this year's recommendations by the DDRB, it is estimated that general medical practitioners will receive, on average, an income of £18,435 from these sources—some £17,970 from average net remuneration (which now incorporates contraceptive service fees) and £465 from the other NHS and official sources that we included in our assessment last year. These figures provide the starting point for our remuneration comparisons.

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[1] Review Body on Armed Forces Pay, Supplement to Ninth Report 1980, Cmnd. 7956, July 1980 (paragraph 9).

10. In discussion with serving officers in the course of visits in the last year, the suggestion was made that certain other elements within GMP remuneration should form part of the earnings comparison. The BMA have also covered this point in their evidence for this review. They contend that these items relate to other services provided for NHS patients, over and above the additional items we included last year, for which the GMP receives additional remuneration but which we have not taken into account in comparing earnings. These include charges levied on NHS patients for immunisation or for the provision of sickness certificates in some circumstances; and the potential additional income of those GMPs who engage in part-time occupational health work as occupational physicians, particularly since the introduction of the Health and Safety at Work Act. It has been suggested to us that the failure to take income from such sources fully into account widens the differences in pay between Service medical officers and general medical practitioners, and means that earnings comparisons are not being properly applied. We recognise that, if military salaries for medical and dental officers are to be competitive, it is important that all relevant remuneration of GMPs in the NHS is taken into account. It was for this reason that we included last year[1] the average income from those payments from NHS and official sources which, although not forming part of average net remuneration in the strict sense in which this is defined by the DDRB, were nonetheless quantified separately in that Review Body's reports. The difficulty with the additional items now identified is that there is no equivalent authoritative and up-to-date indication of how significant a part they form of the average earnings of GMPs.

11. Because of the difficulty of assessment, it has been suggested that, instead of basing our remuneration comparisons on the average level of earnings of GMPs, we should adopt a higher point in the earnings distribution. It has been put to us that this would also serve to overcome another criticism—that we are wrong to base our comparisons on the average remuneration of GMPs in the NHS because the average will be depressed by those who, although employed in the NHS, are not engaged fully or on a whole time basis in NHS practice.

12. We have indicated in the past the objections to abandoning a system of earnings comparison based on the average level of earnings in the comparator group.[2] Quite apart from the lack of firm and authoritative information on the overall distribution of earnings, such a course would run counter to the general approach that we adopt when assessing military salaries elsewhere in the armed forces. There is also the practical difficulty that, although Inland Revenue statistics provide some indication of the distribution of earnings of GMPs, they are retrospective and include income derived from private practice (in the sense of primary health care) which, as we have explained before, we do not consider to be appropriate in this context.

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[1] Review Body on Armed Forces Pay, Supplement to Ninth Report 1980, Cmnd. 7956, July 1980 (paragraphs 13–15).

[2] *ibid* (paragraph 12).

13. Nonetheless, we accept that the present approach undervalues the full range of income available to GMPs from NHS sources (for example, by ignoring items of service for which NHS patients are increasingly being charged by their GMP) and that average income from NHS sources will tend to be depressed by those GMPs who, for one reason or another, do not devote themselves whole time to NHS patients (and with whom Service medical and dental officers should not be compared). Accordingly, we have taken account of the full range of potential income obtained by the GMP in respect of NHS patients, on the basis of such information as is available on the make-up and distribution of the total earnings of GMPs. We have made some allowance for these considerations in judging the level of comparator earnings we should take into account as the basis for our recommendations.

14. The problems of assessing the appropriate range and composition of earnings to take into account for the purposes of comparison have served to highlight the shortcomings of using the earnings of GMPs as the basis of the structure from Captain to Colonel.[1] We looked at this question in some detail last year[2] when we concluded that, for the time being at least, the earnings of the general medical practitioner continued to provide the most appropriate single standard for this purpose. However, we still see some difficulties in this approach—which we intend to examine further—as the potential range of earnings involved is very wide given that it is based on the payment of fees and allowances for the provision of specific services, the incidence and nature of which can vary considerably from practice to practice and between areas. It also needs to be borne in mind, when seeking to set levels of earnings that are broadly comparable, that the GMP is self-employed for tax purposes whereas Service medical and dental officers are subject to PAYE. This difference in tax treatment complicates direct comparisons between the groups (paragraph 25).

15. The existing approach produces one other major difficulty—the need to relate a pay structure for medical and dental officers to the armed forces rank structure. At present, this is achieved by basing military salaries on the principle that, over a 32-year career from Captain to Colonel and before addition of the X factor, the average annual earnings of a Service doctor or dentist will equal the level of remuneration of general medical practitioners in the NHS that is adopted for the purposes of comparison. We noted last year[3] the difficulty of reconciling the pattern of career earnings for the NHS GMP—which tend to reach a high plateau at a relatively early stage—with that required by the progressive rank-related pay system in the armed forces. We invited the Ministry of Defence to reconsider the merits of the direct link between rank and pay in the medical and dental context. Having done so, they have reaffirmed their view that the management arguments in favour of the current arrangements outweigh other considerations which might support the separation of pay from rank. Nonetheless, there remains the serious

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[1] References to Army ranks relate also to equivalent ranks in the other Services, where the context allows.

[2] Review Body on Armed Forces Pay, Supplement to Ninth Report 1980, Cmnd. 7956, July 1980 (paragraphs 7–15).

[3] *ibid* (paragraph 6).

problem of reconciling the pay profile of the NHS general medical practitioner with the structure necessary to fit the rank pattern and progression seen as essential by management. We intend to look again at whether some other approach to earnings comparison might prove more appropriate within a rank-related framework.

The X factor

16. In the course of the last review, we modified the X factor for Service medical and dental officers by embodying within their military salaries the same level of X factor (10 per cent) as is paid to combatant officers. This increase of 3¾ percentage points had the effect of building into medical and dental officers' remuneration an element of payment for work in unsocial hours that had first been brought into combatant officers' salaries in 1974, under the terms of the Pay Code in operation at the time. For the reasons we outlined last year, the change necessitated an adjustment to allow for any equivalent payments for work in unsocial hours that might be built into comparator earnings. This approach, which applies equally to combatant officers, seeks to avoid the possibility of double counting: the average net remuneration of the GMP in the NHS, which provides in this context the basis for pay comparisons, includes an amount for the provision of out of hours services and some part of this had to be excluded from the remuneration comparison.

17. Various payments for out of hours responsibilities are made to GMPs: a supplementary practice allowance; a supplementary capitation fee for each patient in excess of 1,000 on a list; and a fee for each visit requested and made between 11.00 pm and 7.00 am. Within these various payments (averaging some £1,700 in the current year) it is not possible to distinguish precisely between the element that represents payment for work actually undertaken in unsocial hours (although night visit fees clearly fall into this category) and that designed to compensate for the commitment to undertake such work. As was the case last year, we have applied our judgment in making an appropriate adjustment to comparator earnings for this purpose: we are satisfied that it is sufficient to avoid double counting in respect of payment for work in unsocial hours.

Adjustment for pension benefits

18. As part of the process of comparing total remuneration, it is necessary to assess the relative value of pension benefits. The terms of the evaluation available to us last year—based only on a whole career comparison—did not permit us to assess the relative benefit arising from the provision for medical and dental officers in the armed forces to retire at a comparatively early age with an immediate pension. Bearing in mind also that the Government Actuary was undertaking this year (for the first time) a comparative evaluation of the pension benefits applying to the generality of members of the armed forces and those of their comparators elsewhere, we commissioned for this review a comparative evaluation, by the Government Actuary, of the superannuation benefits available to medical and dental officers in the armed forces and those available to GMPs in the NHS: his report is at Appendix 2.

19. The Government Actuary's evaluation assumes three notional careers as a basis for comparison. One envisages retirement at the earliest point in an armed forces career at which medical and dental officers can retire with an immediate pension: this helps to provide a basis for assessing the value of the early retirement provisions of the armed forces scheme. The other specimen careers illustrate the value of the pensions arrangements to those medical and dental officers who stay on to pursue a full career in the armed forces.

20. In some important respects, the evaluation of medical and dental officers' pension arrangements presents fewer problems than that undertaken for other members of the armed forces. There is only one pay comparator—the GMP in the NHS—and this comparator is subject to broadly similar pension arrangements, including the provisions for inflation-proofing of any accrued benefits. Furthermore, because of the facility enabling a GMP to leave the NHS without any loss of accrued benefits, the Government Actuary was able to compare directly the armed forces career with a civilian career up to the same age. Any further superannuation benefits attaching to service in the NHS following an armed forces career are similar to those attaching to the comparable period of service of the GMP with a full working life in the NHS; and such benefits may be left out of the comparison. This position contrasts with that in the evaluation of the pensions arrangements for the generality of members of the armed forces[1] where the provisions for those who retire early from comparator schemes are less generous than those applying under the armed forces (or NHS) scheme, particularly with regard to the inflation-proofing of any accrued benefits. As a general rule, those comparator schemes are not designed to allow for early withdrawal and the value of accrued benefits is not preserved; it was not appropriate, therefore, to evaluate the superannuation benefits attaching to equivalent periods of employment—as this would not have compared like with like. Consequently, in order to identify the value of all the benefits associated with armed forces arrangements, it was necessary to undertake a full career comparison—including any benefits earned during a 'second career' in comparator employment by retired servicemen.

21. The Government Actuary has indicated a potential range of adjustment to comparator pay of 5·9 per cent to 17·7 per cent to allow for the balance of benefit in favour of medical and dental officers. These figures take account of the 6 per cent contribution made by GMPs in the NHS for their pension benefits (the armed forces scheme is non-contributory) and reflect the benefit associated with early pensionability under the armed forces scheme, including inflation-proofing from age 55. The precise adjustment to be made depends upon the extent to which early pensionability is deemed to confer a benefit on medical and dental officers or to represent a compensation for career disruption. Similar considerations applied in this regard to the evaluation for other members of the armed forces and, as for them, we take the view that early pensionability can be considered to confer a benefit on those who volunteer to leave the armed forces early with an immediate pension. As a guide

[1] Review Body on Armed Forces Pay, Tenth Report 1981, Cmnd. 8241, May 1981 (paragraphs 12–18 and Appendix 1).

to judgment, we have obtained information from the Ministry of Defence on the numbers falling into this category in recent years and their ages on leaving, enabling an interpolation to be made within the range indicated by the Government Actuary: on this basis we consider it appropriate to deduct 10 per cent from comparator pay for pension purposes.

22. We view this as a reasonable adjustment in recognition of those benefits available to medical and dental officers in the armed forces—essentially the provisions for early pensionability—that exceed the benefits available to GMPs in the NHS. It allows for the GMP's contribution rate (6 per cent) and for the effect on the Government Actuary's calculations of the differences between the increases in the military salaries for combatant officers resulting from implementation of the recommendations in our main report and those recommended in this supplement for medical and dental officers. The Government Actuary draws attention to this factor in paragraph 13 of his report (Appendix 2).

23. There is one sense, however, in which Service medical and dental officers are at a disadvantage compared to GMPs. Their pensions are based on the (lower) pensionable pay of a combatant officer of equivalent rank, rather than on their actual earnings as medical or dental officers. The Government Actuary has taken account of this feature of the arrangements in his evaluation (it reduces the value of the benefits associated with early pensionability in the armed forces), but we consider that the Ministry of Defence should examine whether it should be maintained. We know from our visits to Service units that it is a source of some resentment among serving medical and dental officers, for reasons which we can well understand. This is especially evident among those with more experience and longer service and may contribute to individual judgments about whether to stay in the armed forces for a full career, or to leave early and take up a post in NHS practice so that the pension benefit earned during the latter part of a career may be assessed on a higher salary base. Any change to this effect would increase the value of the pensions package which we would need to take into account in comparing remuneration.

24. As with the pensions evaluation for combatant officers, the Government Actuary has indicated in his report the effect on his calculations of adopting different underlying economic assumptions, in line with the upper and lower limits suggested by the Scott Inquiry.[1] We have not formed any judgment on this point in advance of the results of the Government's consideration of the Scott report.

Fringe benefits

25. We also need to take account of the relative value of any fringe benefits available to Service medical and dental officers compared with those available to GMPs in the NHS. GMPs are self-employed independent contractors within the NHS. Their income from the NHS is composed of allowances and fees (which, where appropriate, include an element of reimbursement

[1] Inquiry into the Value of Pensions, Cmnd. 8147, February 1981.

of expenses) together with direct payments for certain costs actually incurred in their practices. By definition, therefore, GMPs receive no fringe benefits in the sense of non-cash benefits supplied by the employer. The argument has been put to us on visits that GMPs derive a benefit from the fact that their self-employed status enables them to claim tax remission on certain business expenses. For example, if a GMP buys a car for use in his practice, he can depreciate its value at 25 per cent a year and set the sum depreciated against tax along with any interest charges on borrowed capital. Running costs can also be set against tax. However, the amounts which can be set against tax are those parts of capital and running costs incurred which are attributable to business use, the proportion of such use being agreed with the Inland Revenue. GMPs have to finance their private motoring, therefore, out of their own resources in the same way as Service medical officers. This applies equally to other expenses for which tax remission costs can be claimed on the proportion agreed for business use. It seems to us, therefore, that the arguments advanced are not conclusive, and that GMPs do not in general receive any comparative advantage from their self-employed tax status that it would be appropriate for us to take into account.

26. On the other hand, Service medical and dental officers, in common with other officers in the armed forces, receive a number of benefits over and above the military salary. We gave an indication of the range of benefits involved in our main report.[1] But we also drew attention to difficulties in assessing and quantifying fringe benefits that we considered needed further examination before a judgment could be reached on where any balance of advantage might lie. Against this background, we have made no adjustment this year for any balance of advantage deriving from fringe benefits available to medical and dental officers. We may need to return to this issue in a subsequent review in the light of further examination of the issues involved.

Structural considerations

27. We have already described in general terms (paragraph 15) how the military salaries of medical and dental officers are related to the level of remuneration of the GMP for the purposes of earnings comparisons and structured to reflect the progressive pattern necessary in the context of the military rank structure. This provides an overall framework within which we must exercise our judgment about appropriate rates of pay.

28. We have given further consideration this year to a question affecting one particular part of the overall structure. This concerns the pay relativities between Captain and Major in the medical and dental branches, which raises the question of the appropriate pay relationships between junior officers who serve on a short service commission, and those who hold a permanent commission. We explained the underlying difficulties in detail in the Supplement to our Ninth Report.[2] Virtually all medical and dental officers in the armed forces are now recruited initially on a short service commission of five years

[1] Review Body on Armed Forces Pay, Tenth Report 1981, Cmnd. 8241, May 1981 (paragraphs 19–22).

[2] Review Body on Armed Forces Pay, Supplement to Ninth Report 1980, Cmnd. 7956, July 1980 (paragraphs 25–31).

(although a limited extension to the period of the commission is possible, in certain circumstances). Medical and dental officers who leave the armed forces at the end of a short service commission are eligible for a tax free gratuity based on the retired pay of a combatant Major. However, a significant proportion of short service commission officers need to be retained in the armed forces for a longer period, by converting to a permanent commission either during or at the end of their short service commission. To provide an inducement to conversion a permanent commission grant is offered (at present £3,000, subject to tax). We drew attention last year to the potential conflict of policy inherent in these arrangements. The short service gratuity is paid under the terms of the Services Pensions Codes and is therefore outside our terms of reference. It is intended to make the prospect of a short service commission attractive to recruits but is much more valuable than the permanent commission grant. Consequently, it must to some extent undermine the value of the permanent commission grant as an inducement to retention. Both the Ministry of Defence and the BMA have consistently argued that we should increase the level of the permanent commission grant to make it more competitive with the short service gratuity. The Ministry of Defence consider that a permanent commission grant of £6,000 would be appropriate (double the existing level, set in 1975).

29. We said last year[1] that we would be reluctant to increase the level of the permanent commission grant, as we were not convinced that it would be appropriate to perpetuate this competition between payments, particularly as we had no direct influence on the level of the short service gratuity. We concluded that it would not be appropriate to increase the permanent commission grant: instead, we retained the grant at its existing level and revised the pay structure to provide a significant increment between the 'on appointment' and 'after 2 years' points in the Major scale. We considered that such an increment, when combined with the permanent commission grant, should offer an attractive prospect to those interested in a permanent commission in the medical and dental branches, notwithstanding the attraction of the short service gratuity. The incremental point selected was judged to be the most appropriate as it was the earliest point at which a reward for converting to a permanent commission could be offered from which officers on a short service commission would not normally benefit because, in most cases, they could not complete sufficient service: and we saw the point selected as being sufficiently close to the point at which individuals were likely to be taking decisions about whether or not to convert to a permanent commission to offer a worthwhile incentive. We also urged the Ministry of Defence and the Civil Service Department to examine the reasons for a change in policy that had taken effect in 1978 whereby the relative value of the short service gratuity for medical and dental officers had been increased by linking it in all cases to the retired pay of a combatant Major (irrespective of the rank attained by an individual at the end of a short service commission). This compounded the difficulties of providing a realistic incentive to retention at the end of a short service commission, and we questioned whether it was

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[1] Review Body on Armed Forces Pay, Supplement to Ninth Report 1980, Cmnd. 7956, July 1980 (paragraph 29).

right that short service commission medical and dental officers, who by definition had not entered into a long term commitment to the armed forces, should in most cases be able to reach the rank of Major during their commission and in all cases have their gratuity linked to the retired pay of a combatant Major.

30. The Ministry of Defence take the view that short service commissions fulfil an important management function in enabling the numbers taken on permanent commission to be controlled, and it has been the normal practice for some time to recruit medical and dental officers on short service commissions initially so that their suitability for a longer career in the armed forces can be judged. The availability of short service commissions is also considered to be vital if recruitment is to be maintained, as it is held that young doctors and dentists would not be prepared to commit themselves at the outset to a longer period of engagement in the armed forces: in this sense, the gratuity paid at the end of a short service commission is viewed as a necessary aid to recruitment. The Ministry of Defence have advanced a number of arguments to explain why the short service gratuity for medical and dental officers is linked to the retired pay of a Major, whereas that for other short service commission officers is linked to the retired pay of a Captain. They point out that medical and dental officers have traditionally had an advantage over other officers in terms of both gratuity and promotion arrangements; and have commented that the relative improvement in the short service gratuity that was introduced in 1978 was designed simply to restore this position. The advantages enjoyed by short service medical and dental officers are seen as a reasonable recognition of the fact that they are relatively older on recruitment than their combatant equivalents (because of the duration of prior medical training) and as a means of attracting sufficient recruits with the necessary professional qualifications. The Ministry of Defence accordingly wish to retain the present arrangements for the recruitment and employment of young medical and dental officers, and see the short service gratuity and the permanent commission grant as being complementary aids to manning rather than in competition with one another.

31. While acknowledging the management arguments, we continue to have doubts on a number of points. We find it difficult to accept that, in practice, the short service gratuity and permanent commission grant are complementary and not in competition. They are available to young officers at about the same career point: the short service gratuity offers an incentive to leave the armed forces to those who, as a general rule, have skills that can be readily transferred to civil life, and the permanent commission grant seeks to persuade them to stay on in the armed forces. To this extent, they are pulling in different directions and we remain reluctant to increase the permanent commission grant simply to set it at a more competitive level in relation to the short service gratuity (even though from one point of view the gratuity may be regarded as representing compensation for the fact that short service commissions do not attract any pension entitlement). Our doubts are reinforced by the fact that the proportion of short service commission officers converting to a permanent commission is now much higher than in the recent past.

Against this background, the case for a substantial increase in the cash incentive to conversion must be open to question. Finally, we would be reluctant to introduce any change in this area until the Ministry of Defence have completed their review of the provision of incentives to retention in the armed forces as a whole: it is important that the review should examine whether those features that encourage individuals to leave the armed forces—such as short service gratuities and the provisions for early pensionability—remain appropriate.

32. We conclude, therefore, that for the time being the level of the permanent commission grant should not be increased and that we should continue to seek to provide a sufficient incentive to conversion in the medical and dental pay structure by combining it once again with a large increment in the pay scale for Majors. We believe this approach will continue to offer an attractive prospect to those interested in a permanent commission in the medical and dental branches of the armed forces, notwithstanding the counter attractions of the short service gratuity. We recognise that there could be a case for placing the extended increment at a slightly earlier point in the pay structure. It has been suggested that this would, in many cases, bring that part of the incentive to convert nearer the point of decision. However, as we have said, our prime concern is to ensure that as far as possible the large increment is available only to those who elect to undertake a permanent commission in the armed forces. Short of a radical change in the method by which junior officers are paid, we see this as the most appropriate approach.

33. Our attention has been drawn to a side effect of the change that was introduced last year in the pay scale for Majors, following our recommendation for an extended increment between the 'on appointment' and 'after 2 years' points in the scale. One consequence of this change was a relatively small increase in salary at the 'on appointment' rate of pay for Majors, and it has been suggested that Majors in the reserve forces have thereby been put at a disadvantage because their pay is based on the 'on appointment' rate for regular officers (but with a reduced X factor), with no incremental scale. We accept that our recommendations did lead last year to a relative deterioration in the pay of certain reserve officers. However, this will have had only a marginal impact on income levels (reserve officers are paid a daily rate of pay for days spent in training or on operations) and we do not consider this sufficient to warrant any special adjustment now, or to call for any change in our basic approach to the provision of incentives to encourage young regular officers to convert to a permanent commission. This view is shared by the Ministry of Defence, who have also pointed out that the pay of reserve officers is not necessarily based on the 'on appointment' rate for regular officers. Unless a medical reserve officer had previous reckonable service in the regular forces, his first appointment would be made in the rank of Captain and pay would be assessed at the 'on appointment' rate (which would be retained until promotion to the rank of Major where the 'on appointment' rate would again apply). However, those with previous reckonable service may be appointed in the rank or on the appropriate step of the pay scale for which they are qualified. Thus, a medical officer with 7 years' reckonable service in the regular forces would be eligible for immediate promotion to

Major and would receive the rate of pay applicable to 2 years' service in the rank of Major.

G P trainers in the armed forces

34. In our last review[1] we considered a proposal for a new form of additional pay to provide a degree of acknowledgement of the responsibilities carried by those Service medical officers who undertook training of postgraduates in general practice. It was pointed out to us that such training was now a general requirement in the armed forces, as in the NHS: previously it had applied only to those pursuing hospital specialties. An analogy was drawn with the grant payable to GMPs in the NHS who undertake training under the trainee practitioner scheme (which has been increased to £2,870 from 1 April 1981). We indicated last year, however, that we saw important differences between the NHS grant and the suggested allowance. The former is intended to compensate the GMP who takes on a trainee for extra responsibility, for additional expenses (arising, for example, from the need to take on extra anciliary staff) and for the potential loss of earnings (in a system where remuneration is derived, in part at least, from fees and allowances for services performed) during the periods necessarily spent with a trainee. We took the view that it would in any event be appropriate only to compensate the Service medical officer for any additional responsibilities involved in a training function; and we noted that general compensation existed to the extent that averaged payments of the trainer grant are included in the estimate of GMPs' remuneration upon which the military salaries of Service medical and dental officers are based. Against this background, we saw no case for the introduction of an allowance in the form proposed.

35. The Ministry of Defence and the BMA have both asked us to re-examine our decision in this review. They have pointed out that the Services are striving to increase the professionalism and status of their general medical practitioners (general duties medical officers) who form the largest group of Service medical officers. The high reputation of the Services' training scheme in general practice has been represented to us as an important reason why many young doctors are attracted initially to a commission in the medical services; and our attention has also been drawn to the fact that vocational training has now become mandatory for all new entrants to NHS general practice, and that the Services will therefore be obliged to continue to provide training opportunities that are at least as good as those applying in civilian vocational training schemes if they are to attract recruits of the requisite calibre. The Services have also drawn attention to a continuing difficulty in attracting sufficient numbers of experienced general duties medical officers to take on the extra responsibility of training postgraduates. It is on these grounds that we have been asked to reconsider the proposal.

36. As a general proposition, we judge the case for additional pay on manning grounds. We are concerned that the Services appear to be having some difficulty in attracting sufficient volunteers to undertake responsibilities for

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[1] Review Body on Armed Forces Pay, Supplement to Ninth Report 1980, Cmnd. 7956, July 1980 (paragraph 42).

training postgraduates in general practice, and acknowledge that comparable levels of vocational training in this respect will have to be offered if the armed forces are to attract sufficient recruits of the right standard. In the light of these problems, we conclude that an allowance of £600 a year should now be introduced, as proposed by the Ministry of Defence, to be paid to medical officers for periods during which they are engaged in the training of postgraduates in general practice. We recommend accordingly. This amount is significantly lower than the training grant available to GMPs in the NHS, but we see this as a reasonable reflection of the fact that Service medical officers do not require compensation for the potential loss of earnings or for the additional expenses that the NHS training grant is intended in part to recognise. As a consequence of this recommendation, the element for trainer grant that is included within the estimate of GMP's remuneration upon which we base our recommendations will need to be removed. Our recommendations allow for this.

Military salaries

Captain to Colonel

37. We recommend in Table 1 the rates of military salary that we consider appropriate for Service medical and dental officers (Captain to Colonel) from 1 April 1981. This military salary structure is based on a 32-year career (paragraph 15) and a figure of some £16,750 which we judge to be appropriate in the light of all the evidence that we have taken into account and the considerations that we have described. The existing rates of pay, introduced with effect from 1 April 1980, are at Appendix 3.

Table 1

Recommended military salaries inclusive of the X factor for Service medical and dental officers from Captain to Colonel (annual rates [a])

Rank		Military salary
		£
Colonel:	after 8 years	22,028
	6 years	21,696
	4 years	21,360
	2 years	21,024
	on appointment	20,688
Lieutenant Colonel:	after 8 years	20,334
	6 years	19,834
	4 years	19,330
	2 years	18,787
	on appointment	18,232
Major:	after 6 years	17,681
	4 years	17,129
	2 years	16,575
	on appointment	14,826
Captain:	after 4 years	13,629
	2 years	12,892
	on appointment	12,154

[a] Rounded to the nearest £.

Brigadiers

38. In considering the military salary appropriate to the medical or dental Brigadier, we need to have regard to the maximum of the scale for the medical or dental Colonel, to the salary of the Major General and to the relationship with the salary of the combatant Brigadier. We note that the Government has not yet reached a decision on the salary level for Major Generals in the medical and dental branches, as part of its consideration of this year's report of the Review Body on Top Salaries. We consider that a salary for the medical and dental Brigadier of £22,450 from 1 April 1981 is appropriate, and we recommend accordingly.

Pre-registration medical practitioners (PRMPs)

39. Pre-registration medical practitioners in the Services are newly qualified doctors who are required to serve for one year (as the equivalent of NHS house officers in National Health Service hospitals) before registration with the General Medical Council. Their duties are identical to those of NHS house officers at the same career point and they often work alongside them in NHS hospitals; but they receive Service pay and allowances from which the appropriate charge for single Service accommodation is deducted. On completion of the pre-registration year, they are promoted to Captain and enter the standard Service pay structure for medical and dental officers (Table 1). In the light of these considerations, the salary of the PRMP in the armed forces is based on the salary of a first year house officer in the NHS plus average earnings at that level from Class A and B supplements. To the extent that the average level of Class A and B supplements received by the NHS house officer includes an element for payment for work undertaken in 'unsocial hours', we have made an adjustment to avoid double counting following our decision to increase the X factor for medical and dental officers to 10 per cent. We have also made an adjustment for pension purposes, in line with that for medical and dental officers, and have allowed for the fact that, unlike PRMPs, house officers in their first year are provided with accommodation free of charge. On the basis of these considerations, we recommend a salary of £8,687 for PRMPs from 1 April 1981.

Cadets

40. In the second Supplement to our Eighth Report, we recommended a three point pay scale for medical and dental cadets. Through this scale we sought to establish appropriate relationships with the PRMP's military salary, which we considered to provide the most appropriate reference point with the general military salary structure for medical and dental officers. We also had regard to the potential earnings of civilian medical and dental undergraduates. The same considerations have guided our judgments this year and we recommend that the following rates of pay for medical and dental cadets should be introduced with effect from 1 April 1981:

	£ a year
On appointment	4,750
After 1 year	5,300
After 2 years	5,850

Medical and dental additional pay

Specialist, senior specialist and consultant pay

41. Medical and dental officers up to and including Major General or equivalent are eligible for certain forms of additional pay. Those in relevant appointments are eligible for specialist, senior specialist and consultant pay. The present rates of payment are as follows:

	£ a year
Specialist	225
Senior specialist	600
Consultant (on appointment)	1,600
(after 5 years)	1,900
(after 10 years)	2,400

42. These rates of pay are intended to go some way towards levelling up the pay of Service specialists and consultants with the remuneration for equivalent appointments in the NHS. In this sense they serve a retention purpose: as we noted last year,[1] the loss of such highly qualified and experienced officers would have serious consequences for the Services' ability both to treat patients and to provide the postgraduate training necessary to encourage the recruitment and retention of specialists. Although we view such manning arguments as a legitimate justification for additional pay in the armed forces generally, it must be borne in mind that the need for these particular forms of additional pay arises because the pay of Service doctors in hospital specialties is based on the remuneration of the general medical practitioner and not on that of the equivalent appointments in NHS hospitals. This is one of the aspects that we shall need to consider in our review next year of the approach to earnings comparisons in this area (paragraph 15). For the present, however, we have continued to base our judgments of the appropriate levels for specialist, senior specialist and consultant pay on a comparison of the remuneration of NHS and Service hospital doctors of equivalent status. Again, for the reasons we have explained, we have taken the actual level of remuneration in the NHS that will result from the Government's decision on the recommendations of the Review Body on Doctors' and Dentists' Remuneration, rather than the levels recommended by that Review Body. We have also taken account of such factors as the level and incidence of medical additional pay; additions to 'basic' remuneration of NHS hospital doctors (for example, the distinction and meritorious service awards which form a significant addition to the basic remuneration of those consultants who hold them); and the pensions contribution made by NHS hospital doctors. On this basis, we see no case for an increase in specialist or senior specialist pay at present: the remuneration of Service doctors at these levels compares well with those of equivalent status in the NHS. However, the comparisons are less favourable at more senior levels and we recommend that the value of consultant pay should be increased to the following levels with effect from 1 April 1981:

	£ a year
On appointment	1,700
After 5 years	2,025
After 10 years	2,550

[1] Review Body on Armed Forces Pay, Supplement to Ninth Report 1980, Cmnd. 7956, July 1980 (paragraph 38).

These increases will broadly maintain the value of consultant pay relative to medical military salaries and we consider them to be reasonable in the light of the remuneration comparisons we have undertaken.

43. It has been put to us that the value of consultant pay should be preserved automatically each year, in line with movements in the military salary, and in common with other major forms of additional pay. We do not accept this proposition. So long as the military salary of Service consultants is determined primarily by reference to the remuneration of GMPs in the NHS, our objective must be to recommend rates of consultant pay that have regard to the earnings of consultants in the NHS. An automatic formula is not appropriate for this purpose. We shall look again at the question of medical additional pay in our next review, in the light of both our further examination of the approach to determining the pay of medical and dental officers, and the results of the examination by the Ministry of Defence of the provision of incentives to retention in the armed forces.

Diploma pay

44. Last year we recommended that diploma pay should be abolished. It was an additional payment for the possession of certain qualifications for which medical officers below the rank of Colonel were eligible if they were not in receipt of specialist, senior specialist or consultant pay. We took the view that the possession of a qualification in a specialist subject did not provide sufficient justification for additional pay, particularly as the practice did not apply in other specialist branches of the Services or in the National Health Service, and it was on these grounds that we recommended abolition.

45. We have been asked by the BMA to consider the re-introduction of diploma pay for any qualifications considered necessary to the efficient operation of the medical services, as distinct from those gained for personal advancement. We understand that the Ministry of Defence intend to submit evidence on this issue for the next review and we shall look at the question in more detail in the light of that evidence. There is one point, however, that we should clarify now. In recommending last year that diploma pay should be abolished, we left the case for reserved rights for those already in receipt of the payment to be considered by management. Although we have occasionally made specific recommendations on this point in the past, it is a matter that we normally regard as being for management to consider. In the case of diploma pay, reserved rights were not introduced, and payment was withdrawn from those receiving it. It has been suggested that the resultant instability in pay, rather than the abolition of diploma pay as such, may have adversely affected morale; but this is a matter that properly falls to management to consider.

Costs and conclusions

46. We estimate the additional costs[1] of our recommendations to be:

Military salary (all Services)	£ million
Brigadier	0·044
Captain to Colonel	1·595
PRMPs	0·033
Medical and dental cadets	0·062
Medical and dental additional pay (all Services)	0·065
Total cost of increases in pay	1·799

The total cost of the increases in pay arising from our recommendations represents an increase of 7·0 per cent over the estimated paybill for 1981–82 at current rates.

47. We consider the levels of salary for Service medical and dental officers that we have recommended in this report to be appropriate for implementation now with effect from 1 April 1981. In framing these recommendations, we have taken account of the remuneration of general medical practitioners in the NHS, who provide the established comparator group, having regard to the effects on their earnings of the Government's decisions on the recommendations of the Review Body on Doctors' and Dentists' Remuneration. As part of the process of comparison we have enlarged, to a limited extent, the range of comparator earnings that we take into account to reflect the full range of income of the NHS general medical practitioner from NHS patients and sources. We consider this to provide a more appropriate basis for comparison. We have also sought to take account of other relevant elements in the remuneration package—and this has involved, as with our main report covering combatant officers, a detailed evaluation of relative pensions benefits. Although higher than in previous years, the adjustment that we have in consequence made for pension purposes is, in our view, appropriate to take account of the benefits associated with the armed forces pension scheme. In certain respects, particularly the benefits associated with early pensionability, the armed forces scheme is superior to that which applies to NHS GMPs. For the future, we intend to look again at whether the GMP in the NHS provides the most appropriate comparator for our purposes, given the difficulties of reconciling the earnings pattern of the GMP with the progressive rank-related structure which applies in the armed forces and to which management remains committed. We have also pointed to certain problems in determining the full range of comparator income under our present approach. We intend to look again at these issues in our next review of medical and dental officers' pay

[1] Based on the manpower strengths of the medical and dental branches of the armed forces in 1981–82 as forecast by the Ministry of Defence for budgetary purposes. To the extent that strengths differ in practice the costs of implementing the recommendations will also differ.

in the light of our underlying objective to ensure that, to the extent that pay is a relevant factor, the medical and dental branches of the armed forces are adequately manned.

HAROLD ATCHERLEY (*Chairman*)

M G HERON

EWEN M'EWEN

LEIF MILLS

ROSEMARY MURRAY

JOHN READ

J R SARGENT

RUTHVEN WADE

OFFICE OF MANPOWER ECONOMICS
14 July 1981

APPENDIX 1

DEFENCE MEDICAL SERVICES: MANNING STATISTICS

Table 1.1

Manpower establishments and strengths in the medical and dental branches at end-March 1978, 1979, 1980 and 1981

		Royal Navy				Army				Royal Air Force			
		1978	1979	1980	1981	1978	1979	1980	1981	1978	1979	1980	1981
Medical officers													
Establishment	No.	345[b]	333[b]	333[b]	308	586	570	567	569	431	419	420	427
Strength[a]	No.	284	282	277	294	504	485	490	501	411	404	401	395
Shortfall	No.	61	51	56	14	82	85	77	68	20	15	19	32
	%	17·7	15·3	16·8	4·5	14·0	14·9	13·6	12·0	4·6	3·6	4·5	7·5
Dental officers[c]													
Establishment	No.	93	96	96	101	181	185	185	185	107	107	107	107
Strength[a]	No.	90	92	98	102	170	172	168	167	111	107	106	109
Shortfall	No.	3	4	(2)	(1)	11	13	17	18	(4)	0	1	(2)
	%	3·2	4·2	(2·1)	(1·0)	6·1	7·0	9·2	9·7	(3·7)	—	0·9	(1·9)

[a] Excluding civilian medical practitioners, pre-registration medical practitioners and medical and dental cadets.

[b] Includes pre-registration medical practitioners.

[c] The Army strengths at end-March 1979 and 1980 have been revised. They, and the consequent shortfalls, therefore differ from the figures included in previous Supplements.

Table 1.2

Number of pre-registration medical practitioners (PRMPs) and medical and dental cadets at end-March 1978, 1979, 1980 and 1981

	Royal Navy				Army				Royal Air Force			
	1978	1979	1980	1981	1978	1979	1980	1981	1978	1979	1980	1981
Medical cadets	66	66	70	59	99	89	87	74	64	55	53	42
PRMPs				17				16				17
Dental cadets	8	9	9	7	9	6	6	10	5	8	11	13

Table 1.3

Recruitment of medical and dental officers, 1977–78 to 1980–81

Year and category	Royal Navy			Army			Royal Air Force		
	Target	Entry	Per cent achieved	Target	Entry	Per cent achieved	Target	Entry	Per cent achieved
	No.	No.	%	No.	No.	%	No.	No.	%
Medical officers									
1977–78									
Cadets	25	7	28·0	40	18	45·0	36	16	44·4
Pre-registration	15	2	33·3		—		—	—	—
Direct entry		3		20	8	40·0	4	—	0·0
Total	40	12	30·0	60	26	43·3	40	16	40·0
1978–79									
Cadets	25	19	76·0	40	18	45·0	30	12	40·0
Pre-registration	15	7	46·7	20	13	65·0	24	4	16·7
Direct entry									
Total	40	26	65·0	60	31	51·7	54	16	29·6
1979–80									
Cadets	30	22	73·3	40	25	62·5	40	14	35·0
Pre-registration	20	3	35·0	20	5	105·0	56	—	17·9
Direct entry		4			16			10	
Total	50	29	58·0	60	46	76·7	96	24	25·0
1980–81									
Cadets	30	30	100·0	40	36	90·0	35	25	71·4
Pre-registration	20	4	65·0	20	—	140·0	49	1	38·8
Direct entry		9			28			18	
Total	50	43	86·0	60	64	106·7	84	44	52·4
Dental officers									
1977–78									
Cadets	5	5	100·0	6	6	100·0	4	4	100·0
Direct entry	5	2	40·0	18	11	61·1	4	4	100·0
Total	10	7	70·0	24	17	70·8	8	8	100·0
1978–79									
Cadets	5	6	120·0	10	4	40·0	10	5	50·0
Direct entry	5	3	60·0	11	7	63·6	6	4	66·7
Total	10	10	90·0	21	11	52·4	16	9	56·2
1979–80									
Cadets	5	5	100·0	10	5	50·0	10	9	90·0
Direct entry	5	2	40·0	11	10	90·9	3	2	66·7
Total	10	7	70·0	21	15	71·4	13	11	84·6
1980–81									
Cadets	5	4	80·0	8	8	100·0	4	4	100·0
Direct entry	5	6	120·0	10	6	60·0	8	8	100·0
Total	10	10	100·0	18	14	77·8	12	12	100·0

Table 1.4

Numbers who have left[a] the Services 1977–78 to 1980–81

	Royal Navy	Percentage of strength for that year	Army	Percentage of strength for that year	Royal Air Force[b]	Percentage of strength for that year
	No.	%	No.	%	No.	%
Medical officers						
1977–78	30	10·5	41	8·1	44	10·7
1978–79	25	8·9	45	9·3	35	8·7
1979–80	27	9·7	45	9·2	32	8·0
1980–81	13	4·4	37	7·4	43	10·9
Dental officers[c]						
1977–78	9	10·0	19	11·2	7	6·3
1978–79	8	8·7	17	9·9	11	10·3
1979–80	4	4·1	13	7·7	10	9·4
1980–81	6	5·9	13	7·8	7	6·4

[a] Excluding redundancies.

[b] Royal Air Force exits are controlled by quota.

[c] The Army figures for 1977–78 to 1979–80 have been revised: they therefore differ from the figures included in previous Supplements.

Table 1.5

Conversions from short service to regular commissions, 1977–78 to 1980–81

	Royal Navy	Army	Royal Air Force
	No.	No.	No.
Medical officers			
1977–78	4	8	9
1978–79	8	12	11
1979–80	31	15	16
1980–81	7	14	24
Dental officers[a]			
1977–78	3	6	3
1978–79	3	5	4
1979–80	1	11	5
1980–81	4	2	5

[a] The Army figures for 1978–79 and 1979–80 have been revised: they therefore differ from the figures included in previous Supplements.

APPENDIX 2

REVIEW BODY ON ARMED FORCES PAY SERVICE MEDICAL AND DENTAL OFFICERS

EVALUATION OF SUPERANNUATION BENEFITS

Report by the Government Actuary

1. In my report on the evaluation of superannuation benefits which was published as Appendix 1 to the Tenth Report, 1981 (Cmnd. 8241) of the Review Body on Armed Forces Pay, I compared the value of superannuation benefits available to members of the armed forces with that of the benefits of their comparators elsewhere. This report provides the separate advice relating to medical and dental officers in the armed forces as mentioned in the opening paragraph of my earlier report. In the remainder of this report, my earlier report is referred to as "my principal report".

2. I have been asked to compare the value of the superannuation benefits available to medical and dental officers under the Armed Forces Pension Scheme with that of the benefits available to general medical practitioners under the National Health Service Superannuation Scheme. The main provisions of the Armed Forces Pension Scheme have been summarised in Annex 1 to my principal report; and the main provisions of the National Health Service Superannuation Scheme, as they apply to doctors and dentists, have been summarised in Annex 1 to my report constituting Appendix D to the 1981 Report of the Review Body on Doctors' and Dentists' Remuneration (Cmnd. 8239). For the purposes of this comparison I have been asked to consider the following three theoretical careers for medical and dental officers:

- Career A: An officer commissioned at age 25 who progresses through the military medical scale in 32 years retiring as a Colonel at age 57.
- Career B: As for Career A except that the officer remains in post for a further 2 years thereby obtaining a maximum pension after 34 years' service retiring as a Colonel at age 59.
- Career C: An officer commissioned at age 25 who retires as a Lieutenant Colonel at age 41 after having served 16 years—the minimum required for entitlement to an immediate pension based on the pension entitlement of a combatant officer of equivalent rank.

I have been asked further to assume that the comparable civilian general medical practitioner has the theoretical career of retiring after earning the average net remuneration that the Doctors and Dentists Review Body recommendations were designed to produce i.e. £16,290 per annum from April 1980 plus income from other superannuable NHS and official sources of £1,160 per annum (from April 1980).

3. In Section 3 of my principal report I discussed the nature of the comparison made when comparing the superannuation benefits available to members

of the armed forces with those of their comparators elsewhere. Because the Armed Forces Pension Scheme is designed to provide benefits at an early age after a career covering only part of the working lifetime of the individual, it was considered inappropriate to compare the superannuation benefits accruing during an average armed forces career with those accruing during the much longer average career in comparator employment. Instead, the benefits accruing over a whole working life were allowed for; on the one hand those arising from a career in the armed forces followed by some civilian employment after retirement from the armed forces, and on the other hand those arising from a wholly civilian career. An alternative approach, *viz.*, that of comparing the superannuation benefits accruing during a career in the armed forces with those accruing over the same period in comparator employment, was not pursued because most of the comparator pension schemes are not designed with significant retirement at these relatively young ages in mind; accrued benefits are not only related to the salary at the time of such premature retirement but they are deferred to the normal retirement age of 60 or 65 in most cases, and often with no protection against inflation. In the case of Service medical and dental officers, however, this objection does not arise because there is only one comparator, namely the general medical practitioner covered by the NHS Superannuation Scheme, and he can leave this scheme at relatively young ages with preserved pension rights which are protected against inflation under the Pensions (Increase) Acts. Thus for Service medical and dental officers the comparison made is between:

(i) the value of the Armed Forces Pension Scheme benefits accruing to a medical or dental officer during a career in the armed forces; and

(ii) the value of the National Health Service Superannuation Scheme benefits accruing to a general medical practitioner during the same period in the National Health Service.

The effect of alternative comparisons is discussed in paragraph 15.

4. Another way of looking at this is to say that a medical officer who retires early from the armed forces is likely to spend the rest of his working life in civilian medical posts which will carry pension rights as good as he would have obtained at that age if he had had a wholly civilian medical career. To the extent that this is true, a comparison between the value of the superannuation benefits accruing during the later part of the working life to someone who had a Service medical career and the corresponding value for someone who had a wholly civilian career would show that they were not dissimilar; thus they would cancel out in the comparison. On this basis the part of life after a medical officer has retired from the armed forces can be left out of account in the comparisons and we need only consider the value of the superannuation benefits accruing during the period spent in the armed forces and during the equivalent period for general medical practitioners.

5. In each case the value of the superannuation benefits is expressed as the contribution rate (as a level percentage of pay) required to provide those benefits. The underlying actuarial assumptions regarding the yield on investments and the rates of increase in prices and earnings are identical to those stated in paragraph 4.2 of my principal report. Thus I have assumed that,

over the long term, the yields on investments (including capital appreciation as well as interest) will on average exceed increases in the general level of earnings by 1 per cent per annum and increases in prices by 2½ per cent per annum; and that the rate of increase in prices will average 7 per cent per annum. For the rest of the basis for the calculations (such as mortality before and after retirement), the assumptions have been based on the experience of general medical practitioners as shown by NHS Scheme data, such data being far more extensive than the data on Service medical and dental officers.

6. Table 1 shows the value of the Armed Forces Pension Scheme benefits to medical and dental officers on each of the three specimen careers described in paragraph 2. As in my principal report, the figures shown are on the two extreme approaches of (i) allowing fully for all benefits payable from the Armed Forces Pension Scheme and (ii) excluding that part of the pension (other than invaliding pension) payable over the period to age 60.

Table 1

Value of the superannuation benefits of the Armed Forces Pension Scheme to medical and dental officers

	Percentage of armed forces pay		
	Career A (Retirement age 57)	Career B (Retirement age 59)	Career C (Retirement age 41)
(i) Allowing fully for all benefits payable from the Armed Forces Pension Scheme	24·3	22·6	31·0
(ii) Excluding that part of the pension (other than invaliding pension) payable over the period to age 60	21·3	21·6	16·6

7. In my principal report (paragraph 4.5), officers retiring with an immediate pension (other than an invaliding pension) were assumed to do so at an average age of about 46½, i.e. after 24½ years' service. The value of their superannuation benefits (from paragraph 5.3) was estimated at 34·1 per cent of pay (allowing fully for all benefits) or 23·8 per cent of pay (excluding that part of the pension payable over the period to age 60). For all three specimen careers the value of benefits shown in Table 1 is lower than the corresponding figures of 34·1 per cent and 23·8 per cent. The main reason for this is that although medical and dental officers have a higher level of salary than combatant officers of the same rank, their superannuation benefits are calculated on the same rate of pay as for other officers and are thus lower when expressed as a proportion of salary. It should be noted that if the present relationship between pensionable pay and actual pay is disturbed by different awards, as a result of the current Review, to combatant officers on the one hand and to medical and dental officers on the other, then the value of superannuation benefits (as a percentage of pay) would be changed from the figures given above. This possible effect is discussed in paragraph 13.

8. Table 2 shows the value to general medical practitioners of the National Health Service Superannuation Scheme benefits accruing over periods identical to those of the three specimen careers described in paragraph 2 for Service medical and dental officers. Thus the figure shown against Career A, for example, includes the value of the deferred pension benefits available to a general medical practitioner who leaves the NHS Superannuation Scheme at age 57; his deferred pension and lump sum (which come into payment at age 60, or on prior death in the case of the lump sum) are protected against inflation under the Pensions (Increase) Acts as, also, is any contingent widow's pension.

Table 2

Value of the superannuation benefits of the National Health Service Superannuation Scheme to general medical practitioners

Percentage of National Health Service pay		
Career A (Retirement age 57)	Career B (Retirement age 59)	Career C (Retirement age 41)
19·7	20·5	13·8

9. The figures in Table 2 show that, for each of the three civilian careers, the value of the NHS superannuation benefits is a lower proportion of the doctor's pay than is the case with the corresponding Service career, even though the benefits of the latter are to some extent depressed on account of the feature mentioned in paragraph 7. This reflects, in part, the promotional career and salary progression assumed for the armed forces doctor compared with the flat, or constant, earnings assumed throughout the general medical practitioner's career.

10. The superiority of the superannuation benefits to Service medical and dental officers must now be expressed in the form of a deduction from the pay of general medical practitioners. This conversion process is very similar to that set out in Table 2 of my principal report; in this process allowance has to be made for the fact that the Armed Forces Pension Scheme is non-contributory whereas the National Health Service Superannuation Scheme is contributory. The appropriate deductions for each of the specimen careers are summarised in Table 3; by way of example the derivation of one of the figures is discussed in more detail in the next paragraph.

Table 3

Deduction from general medical practitioner pay to allow for the excess of the value of the superannuation benefits to medical and dental officers over those available to general medical practitioners

	Percentage of National Health Service pay		
	Career A (Retirement age 57)	Career B (Retirement age 59)	Career C (Retirement age 41)
(i) Allowing fully for all benefits payable from the Armed Forces Pension Scheme	8·5	6·6	17·7
(ii) Excluding that part of the pension (other than invaliding pension) payable over the period to age 60	6·2	5·9	7·5

11. If we consider Career A, the corresponding general medical practitioner has superannuation benefits whose value (from Table 2) is £19·7 for each £100 of his pay. Allowing for the 6 per cent superannuation contribution that he has to pay, his net pay package of pay and superannuation benefits is £113·7 per £100 pay. Similarly the Service medical officer has superannuation benefits whose value, allowing fully for all benefits, (from Table 1) is £24·3 thus giving a net pay package of £124·3 for each £100 of his pay. By simple proportion, the level of armed forces pay that will give the same net pay package as the £113·7 for the general medical practitioner is £100 × 113·7 ÷ 124·3, or £91·5 for each £100 of general medical practitioner pay. Thus to arrive at the pay for the medical or dental officer the appropriate deduction from general medical practitioner pay is 8·5 per cent of that pay as shown in the first line of Table 3.

12. The figures in Table 3 show the appropriate deductions to be made from general medical practitioner pay to reflect the difference in the superannuation benefits of medical and dental officers compared with those available to general medical practitioners under the National Health Service Superannuation Scheme. The figures have been presented on two alternative assumptions about the Armed Forces Pension Scheme benefits to be allowed for and for the three specimen careers that I was asked to assume.

13. As mentioned in paragraph 7, the superannuation benefits for medical and dental officers are the same as those for combatant officers of equivalent rank. If, as a result of the current Review, the percentage awards granted to medical and dental officers differ from those granted to combatant officers, then the value of the superannuation benefits of the Armed Forces Pension Scheme to medical and dental officers will differ from the figures shown in Table 1 (which are based on the relative levels of pay and pension in force from April 1980). The percentage deductions from general medical practitioner pay shown in Table 3 would also need to be revised. As an indication of the magnitude of the effect of this feature, for each 6 percentage points that the pay award for medical and dental officers differs from that for combatant officers, the percentage deductions from general medical practitioner pay shown in Table 3 would change by about 1 percentage point. If the percentage pay award for medical and dental officers is lower than for combatant officers, then the percentage deductions from general medical practitioner pay shown in Table 3 would need to be increased and vice versa. Further calculations could be carried out if required.

14. In Section 6 of my principal report I discussed how my calculations would have been affected if I had adopted different economic assumptions in line with the upper and lower limits suggested by the Inquiry into the Value of Pensions chaired by Sir Bernard Scott (Cmnd. 8147). In the case of medical and dental officers, the figures summarised in Table 3 would be much less sensitive to changes in the underlying economic assumptions than the corresponding figures shown in my principal report. This is because both the medical officer and his civilian counterpart have pension benefits that are protected against inflation so that any change in the underlying economic assumptions would affect the value of the superannuation benefits available

to each by not very dissimilar amounts. For that reason detailed calculations on alternative economic assumptions have not been carried out but they could, if necessary, be done.

15. The comparison approach described in paragraph 3 is not the only approach that could have been adopted. For example, in the case of specimen Careers A and B it could be argued that by the time the officers retire from the forces at the assumed ages of 57 and 59 respectively, they can be considered to have completed their working life and so their armed forces superannuation benefits should be compared with those acquired by a general medical practitioner after a complete working life in the National Health Service. The value of the lifetime superannuation benefits to a general medical practitioner depends on his assumed age of retirement. If retirement is assumed at the minimum age of 60 then the value of the superannuation benefits to an individual starting his career at age 25 is about 20·9 per cent of pay on the basis assumed; with retirement assumed nearer age 65, as is the case in practice, the value of the benefits is about 18·6 per cent of pay. These figures for the value of the NHS Superannuation benefits could then be compared with those shown in Table 1 for the value of the armed forces benefits for Careers A and B which would lead to deductions from general medical practitioner pay not vastly different from the figures shown in Table 3. The disadvantage of this kind of approach though is that it would be inappropriate for Career C (because the individual leaving the armed forces at age 41 cannot usually be considered to have completed his working life) and it is advisable to adopt the same kind of comparison whatever the assumed specimen career. For this reason the approach described in paragraph 3 is preferred.

EDWARD JOHNSTON

Government Actuary's Department
London

20 May 1981

APPENDIX 3

Military salaries[a] for medical and dental officers introduced with effect from 1 April 1980

Rank		Military salary
		£
Brigadier		20,998
Colonel:	after 8 years	20,582
	6 years	20,272
	4 years	19,958
	2 years	19,644
	on appointment	19,330
Lieutenant Colonel:	after 8 years	19,016
	6 years	18,549
	4 years	18,078
	2 years	17,556
	on appointment	17,038
Major:	after 6 years	16,524
	4 years	16,005
	2 years	15,491
	on appointment	13,855
Captain:	after 4 years	12,735
	2 years	12,049
	on appointment	11,359
Pre-registration medical practitioner		8,143
Cadet:	after 2 years	5,449
	1 year	4,949
	on appointment	4,449

[a] Rounded to the nearest £.

Printed in England for Her Majesty's Stationery Office by Bemrose Specialist Print, Derby

Dd 154696 C20 7/81