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REVIEW BODY
ON
ARMED FORCES PAY

SERVICE MEDICAL AND DENTAL OFFICERS

Supplement to Thirteenth Report
1984

Chairman:
SIR DAVID ORR

Presented to Parliament by the Prime Minister
by Command of Her Majesty
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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 David Orr MC (*Chairman*)[1]

Michael Bett

Sir Richard Cave MC

David Hudson

Jenny Hughes[2]

Leif Mills

J R Sargent

Air Chief Marshal Sir Ruthven Wade KCB DFC

The Secretariat is provided by the Office of Manpower Economics.

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

[2]Also a member of the Review Body for Nursing Staff, Midwives, Health Visitors and Professions Allied to Medicine.

SERVICE MEDICAL AND DENTAL OFFICERS

Introduction

1. In assessing the salaries appropriate to Service medical and dental officers, we take as a starting point the remuneration of the General Medical Practitioner (GMP) in the National Health Service (NHS) which is the subject of recommendations each year by the Review Body on Doctors' and Dentists' Remuneration (DDRB). The Government's decisions on the DDRB recommendations for 1 April 1984 have now been announced. This year, as last, the Government has decided to stage the implementation of the recommended levels with an increase of 3 per cent applying from 1 April 1984 and the full recommended levels from 1 November 1984. When, in previous years, the Government has varied or staged the DDRB recommendations we have concluded that we should reflect the actual levels in payment in the recommendations we make for medical and dental officers. We consider this to be the appropriate course of action again this year. Our recommendations therefore reflect the effect of the decisions made by the Government, together with the conclusions we have reached on particular matters which have been put before us this year by the Ministry of Defence (MOD) and the British Medical Association (BMA) together with the British Dental Association (BDA).

Our approach

2. As we have done in our main report, covering combatant personnel, we think it important to explain in some detail the basis on which we form our recommendations. This view is reinforced because our discussions with Service doctors and dentists, in the course of visits we have made to military units, suggest that there is a measure of misunderstanding of our aims and approach.

3. Although we are able, in assessing appropriate levels of pay for medical and dental officers, to look across to the NHS, we also have to recommend a pay structure which meets the particular circumstances of the armed forces. The pattern of remuneration in the NHS is in any case complex. Earnings at particular stages of a medical career, and the profile of earnings over a career, can vary significantly between different branches of the profession. For example, a GMP is likely to be earning more than his colleagues in the hospital service in the early part of a career, but later the hospital doctor, as a consultant, may well earn more than his contemporaries in general practice. Since medical and dental officers in the armed forces undertake the full range of work found within the NHS, as well as filling administrative appointments which have no equivalent among NHS doctors and dentists, the choice of an appropriate analogue for the purpose of making earnings comparisons is not easy. Moreover, within the Services the pay of doctors and dentists has to be accommodated to the rank structure, with appropriate differentials and increments.

4. We pointed last year to the desirability of examining the scope for introducing more flexibility into the pay structure for medical and dental officers, to recognise advancement in professional terms as distinct from advancement through the rank structure. The rigidity of the current

arrangements reduces the flexibility for adjusting the pay structure to meet particular manning problems, and it is difficult to provide adequate reward in all cases for professional excellence (and incentive to remain in the Services) when increases in pay are tied in the main to time promotion through the rank system. Services' management have made it clear to us that they are firmly opposed to any alteration of the normal system of progression by rank. We must, therefore, accept this principle and it follows that the pay structure derived from the GMP analogue has to be fitted into the given structure of ranks, with the constraints that this imposes on differentials and on the possibilities for a more flexible relationship between professional achievement, pay and rank progression.

5. The approach we have adopted is to aim to ensure that, after appropriate adjustments, the career earnings for medical and dental officers over a period of 32 years, from Captain to Colonel, broadly equate to the intended average net remuneration of a GMP in the NHS as recommended by the Doctors' and Dentists' Review Body. In last year's Supplement (paragraph 3), we indicated our intention to consider further whether this continued to provide the most suitable analogue. In their evidence to us the MOD have argued for continuing to use the GMP analogue. They have told us that medical and dental officers have confidence in this as a general approach although they might question particular aspects of its application. The BMA endorse this view. We agree that comparison with the GMP offers the most suitable approach if the pay structure is to be based on a single analogue. The alternative would be to pay Service doctors and dentists variously as if they were in the NHS and working either in general practice or in the hospital service or in administration. However, as we have explained, the earnings profiles of the two medical and dental streams in the NHS are different and it would be difficult to combine them in a way which would provide a practical structure sensitive to the requirements of the armed forces. We have concluded, therefore, that the current approach, using the remuneration of the GMP in the NHS as a guide, should remain.

The assessment of the NHS analogue

6. There are two main aspects to our assessment of an appropriate analogue figure from which we can develop a suitable salary structure for Service medical and dental officers. First, we have to satisfy ourselves that we have a realistic estimate of the average remuneration received by GMPs in the NHS and, second, we need to take account of the different circumstances of employment as between the NHS and the armed forces. In this way we produce an adjusted analogue figure which we can be satisfied is appropriate for use in the armed forces context.

7. *NHS earnings.* In assessing the remuneration of GMPs in the NHS we take as our starting point the level of average annual net remuneration which the fees and allowances recommended by the DDRB are intended to generate. From 1 November 1984 this is £22,070. We increase this figure by an amount which we judge sufficient to take account of the extent to which it reflects the inclusion of GMPs who do not devote themselves full time to the NHS. We add a further sum for the estimated average

amount of additional income which GMPs receive from other 'official sources', including NHS hospital work, not covered by the average net remuneration figure which the DDRB recommends.

8. During our visits to Service units, medical officers have suggested to us a variety of figures as the 'typical' earnings of a GMP in the NHS. Without exception, the figures quoted have been substantially in excess of the DDRB's intended average net remuneration figure. Both the MOD and the BMA have also told us that Service doctors consider our analogue figure, even allowing for the adjustments we make, to understate significantly the potential earnings in NHS general practice. It is clear to us, however, that much of the anecdotal evidence offered by Service doctors does not allow for the fact that many of the payments which GMPs receive for items of service, together with the basic practice allowance and capitation fees, include an amount for the reimbursement of practice expenses. Before taking account of the Government's decisions the DDRB estimated that average expenses for 1984–85 would amount to some £10,830 which, together with the recommended average net income of £22,070, would have produced average gross income in the year of £32,900. As Service doctors and dentists have no expenses of the sort covered by the NHS general practice fee scale, it would be inappropriate to use anything other than the net figure in our calculations.

9. We have considered carefully the point that has been put to us that we do not take sufficient account of the actual earnings of GMPs in the NHS. While the intended average net remuneration figure will tend to understate the total net earnings of full-time GMPs in the NHS for the reasons we have indicated, it is difficult to be precise about the extent to which it does so. The degree to which the average net remuneration figure should be increased to make some allowance for this understatement is therefore a matter of judgment. It is relevant to note that the latest available data show the average NHS list size, on which average net remuneration is based, to be 2,107 while, so far as a direct comparison can be drawn, it appears that the average list size for general practice in the armed forces is distinctly less than that. Despite this, we think it right to make some increase to the average net remuneration figure. We also recognise that GMPs in the NHS are more readily able to increase their earnings through hospital and other 'official' work and from private practice. We provide in our calculations for the average earnings from hospital and other 'official' work. As for GMP earnings from private practice, we explained in the Supplement to our Ninth Report that they vary widely and that the opportunity to undertake such work is by no means uniform across the country. It is doubtful whether, taking general practice as a whole, average income from this source is significant. Nonetheless, the upward adjustment we make to compensate for the effect of part-timers on average net remuneration is to some extent a compensation for the inability to take on private practice, as it is likely that the GMPs who work less than full-time for the NHS will include among them those who are giving more time to private practice. We are satisfied that the approach we adopt, using average net remuneration for the GMP, with the adjustments we have described, provides a realistic basis for determining the salary levels for medical and dental officers.

10. ***Other elements in remuneration.*** As we have mentioned, we also have to take account of the differences in circumstances and conditions of employment between the armed forces and the NHS. This entails adjusting the overall remuneration figure we have arrived at on the basis described above in order to remove from it elements which are paid for separately in the Services, but which are included in the average net remuneration figure for GMPs in the NHS; to take account of differences in pensions and fringe benefits between the armed forces and the NHS; and to take account of manning considerations.

11. The intended average net remuneration figure recommended by the DDRB contains two elements which are recognised separately in the medical and dental officers' pay system: payments for out-of-hours work and the grant paid to those NHS GMPs who provide training in general practice. In the armed forces, the X factor (which applies equally to medical and dental officers as to combatant officers) contains an element which recognises the degree to which work in unsocial hours is a concomitant of Service life. It would be inappropriate to recognise this element both in the basic comparison of remuneration and in the X factor. Consequently, we make a compensating adjustment to the 'comparator' earnings figure to avoid such double counting. Similarly, those doctors in the armed forces who provide training in general practice receive a separate allowance, and we therefore reduce 'comparator' earnings by the average value of the NHS training grant.

12. ***Pensions and fringe benefits.*** As part of our approach to the determination of armed forces pay as a whole, we consider it vital that pay comparisons with civilian life are drawn on a basis which takes account of total remuneration. Pensions and fringe benefits are important elements and can play a significant part in attracting and retaining personnel in all walks of life. We adjust our remuneration comparisons to recognise the relative value of the armed forces scheme as compared with civilian pension schemes. For this purpose, we asked the Government Actuary in 1981 to carry out a comparative evaluation of the scheme. In the case of combatants, the Government Actuary suggested that an adjustment in the range 7·1 per cent to 17·6 per cent would be appropriate for officers to recognise the better benefits of the non-contributory armed forces pension scheme (in particular, the facilities for an early pension from age 38 or after 16 years' service and inflation proofing from age 55—much earlier than in other public service schemes). The range of potential adjustment recognised in part the degree to which the early pensionability arrangements could be regarded either as a pure benefit or as a compensation for a frequently short career. In considering where to pitch our judgment within this range, we examined the extent to which personnel volunteered to leave the Services on early pension, and we concluded that a deduction of 11 per cent from comparator earnings provided an appropriate adjustment in the case of combatants.

13. A separate evaluation was carried out at the same time for medical and dental officers in which a comparison was made directly with the benefits accruing from the contributory NHS pension scheme. As with combatants, the Government Actuary took account of the more advantageous benefits which accrue from the armed forces scheme, and also of the fact

that the pensions of medical and dental officers are based on the appropriate (and lower) pensionable pay of combatants in the same rank and not on their own actual level of pay. In this case the Government Actuary suggested that an appropriate adjustment to comparator pay to recognise the greater pension benefits available to medical and dental officers would fall in the range 5·9 per cent to 17·7 per cent (on the same basis as applied to the evaluation for combatants). We also applied the same test as we had for the combatant evaluation and concluded that an appropriate adjustment for medical and dental officers would be 10 per cent. The fact that medical and dental officers' pensions are not based on their actual salaries had already been taken into account in the Government Actuary's evaluation and there was therefore no need for us to make any separate allowance for it.

14. It has often been put to us, both by individual Service doctors and dentists and by the BMA, that the pensions arrangements for medical and dental officers provide a disincentive to remaining in the Services because the 10 per cent adjustment is too high and pensions are not based on actual salaries. We too have pointed out in previous Supplements that the rules of the armed forces pension scheme, particularly those relating to early pensionability, can provide an incentive to leave. The content and application of the pensions scheme are not within our remit but are matters entirely for the MOD and the Treasury. We have, however, discussed with Services' management the way in which the regulations apply to medical and dental officers and the MOD have this year submitted to us evidence on the possibility of relating pensions benefits to actual earnings. The MOD have concluded that the average medical and dental officer would not benefit from this to any marked degree and that, in any case, such a move would run contrary to the underlying principle that all servicemen of the same rank and length of service should receive the same pension. It is worth explaining the reasons for the conclusion that there would be no overall benefit to the medical and dental officer in basing pensions on actual earnings. This rests on the assumption that the adjustment we make to comparator earnings for pensions purposes would have to be increased from the present 10 per cent. As we have indicated, the fact the pensions are not currently based on actual earnings was taken fully into account by the Government Actuary in his evaluation. Any change to the pension arrangements which improved the benefits to medical and dental officers would need to be evaluated afresh and, if significant, would be likely to necessitate an increase in the adjustment and, consequently, to involve a relative decrease in the resultant levels of military salary.

15. While recognising the validity of this point, we remain concerned that the structure of the armed forces pension scheme, however appropriate it may be to the situation of combatants, is less well suited to that of medical and dental officers. It could well be that a more fundamental change in the scheme, which would not only base pensions on actual earnings but remove the availability of an early pension on present lines, would be beneficial. In this way the positive incentive to leave after 16 years' service would be removed, or at least lessened; and the consequent reduction in the overall benefit available from the scheme could well act to reduce the size of the adjustment necessary to comparator remuneration.

16. Under present arrangements, we do not accept the view of the BMA that the 10 per cent adjustment for pensions purposes is too high. Our judgment in this matter is based on the full evaluation carried out by the Government Actuary and takes account, as we have said, of the number who voluntarily take the benefit of early pensionability. The BMA have argued that this approach penalises those who stay on beyond the immediate pension point. As we pointed out last year, it is virtually impossible to devise a system of pension adjustment which takes into account the wide variety of possible career choices that are available to medical and dental officers. It is common pensions practice that participants pay an equal rate of 'contribution' irrespective of the benefits that any individual might derive in practice. The availability of an early pension is a distinct benefit and it is proper that it should be taken into account in valuing the total remuneration package available to medical and dental officers. We have therefore concluded that a 10 per cent adjustment for pensions purposes remains appropriate this year.

17. We have also maintained the same approach as in recent years to the fringe benefits available to Service medical and dental officers. The recommendations we make reflect our judgment on this matter.

18. ***Manning considerations.*** As usual, the MOD have provided us with detailed manning information showing the position in the medical and dental branches as at 31 March 1984. This information is summarised in Appendix 2. Similar manning information was also supplied by the BMA.

19. As in previous years, the position in the dental branches is good with a general surplus of dental officers over requirement. In the medical branches, the overall position has improved in the Royal Navy (where there is now a surplus of medical officers) and in the RAF. The picture is not so good in the Army where strength has increased but the establishment has increased even more. Recruitment to the medical branches has been particularly healthy with both the Royal Navy and the Army recruiting more than their target. The RAF did not meet their target for 1983–84 but their overall performance is not noticeably worse than in recent years. Numbers leaving the medical branch in 1983–84 were lower in both the Royal Navy and RAF than in the previous year and about the same in the Army. The majority left on completion of a short service or medium career commission but about one third left on premature voluntary retirement (PVR). The PVR rate is slightly lower than in the previous year but has been running at a fairly constant level over the last five years or so.

20. On the whole, the manning information shows a not very different picture from that presented in recent years. The shortfall of medical officers (94) against establishment is lower than it was last year (110). The surplus of dental officers (4) is exactly the same as last year. The MOD continue to be concerned about the loss of medical officers at the end of short service commissions and at the immediate pension point. While this concern is understandable, we do not see it as appropriate to attempt to compensate for this through any adjustment to the analogue. The nature of existing Service arrangements at both these points is such that some medical officers are bound to see it as attractive to leave. The end of a short service

commission allows a medical officer who is considering a career in general practice to contemplate a move into the NHS which is likely to offer, at that stage, higher remuneration. Similarly, those on the immediate pension point can also take their chance in the NHS knowing that they will receive a pension (worth, possibly, in excess of £5,000 a year plus a considerable lump sum) together with the prospect of further career opportunities. Any adjustment to the general analogue figure, which could not otherwise be justified, would prove a rather blunt instrument to deal with the outflow at the particular points mentioned and we have concluded that such an adjustment would not be appropriate.

21. ***The analogue.*** Taking account of the considerations outlined above, we have concluded that it is appropriate to base our recommended military salary structure from 1 November 1984 for medical and dental officers, before the inclusion of X factor, on an analogue figure of £20,600.

The X factor

22. In 1980, we changed the approach we had previously adopted to the X factor for medical and dental officers so that they received the same rate as combatants (10 per cent) but had an adjustment made in the calculation of the analogue figure so as to remove the element in comparator earnings for work in unsocial hours (see paragraph 11 above). We have maintained this approach for the current year and our recommendations on military salary reflect this.

Structural considerations

23. We have mentioned above that our approach is based on providing career earnings for medical and dental officers, after appropriate adjustments, which broadly equate to those available in the NHS. The degree to which we are able to achieve this is governed by the strict principle of time and rank (rather than professional) advancement which underlies the medical and dental officer structure. We have to provide, as far as possible, a pay structure which allows a sensible incremental progression but which is based on comparison with the earnings of GMPs in the NHS, which are not forced into an incremental straightjacket. In these circumstances, we take a full career as being 32 years, during which an individual could normally expect to be promoted from Captain to Colonel, and we spread over that period the earnings which would be generated from the analogue figure. The X factor is then added. As will be immediately clear, such a rigid framework allows little scope for major structural changes to reflect particular difficulties at any one point in the pay scale.

24. This year we have maintained our approach to providing within the structure some incentive for medical and dental officers to transfer from a short service to a full career commission. A decision on this matter is normally made at or about the time of promotion to Major and we have continued to provide a higher than average increment between the Major 'on appointment' and 'after two years' rates. It is our hope that this, together with the permanent commission grant (see paragraph 37), will provide a degree of counterbalance to the attractions of the tax-free short

service gratuity which, as we have remarked before, must act as an incentive to leave the Services at that point. We have also given further thought this year to the question of providing greater incentives at the upper end of the structure. Because of the way in which the pay structure is devised, there is a limit to what can be done in any one year. However, we continue to consider it important to widen differentials at the upper end of the structure and our recommendations allow for this.

25. The MOD have asked us to consider this year a proposal to extend the incremental scale at the Surgeon Commander (Lieutenant Colonel) level to provide additional increments for certain RN medical personnel who are 'overzoned' for promotion to Surgeon Captain. The justification put forward for this is that promotion prospects at this level in the Royal Navy are significantly below those in the Army and the RAF and that the situation has become worse as a result of manpower cuts following the 1981 Defence Review. The Royal Navy argue that these personnel are now unable to achieve the total career earnings which the pay structure is designed to provide.

26. This proposal causes us some difficulty. First, we would be reluctant to recommend any variation to meet a problem in one Service—this is particularly so when there is evidence that non-specialist medical and dental officers in the Army and RAF also have a less than 100 per cent chance of promotion to Colonel or equivalent level. Secondly, it is in our view wrong to award a level of pay for a job at a certain rank simply in order to compensate for lack of promotion opportunities. It may be that we shall have to reconsider our view of what it would be reasonable to take as a full career in the medical and dental branches if this sort of problem becomes more widespread but, until we have evidence that significant numbers of personnel are disadvantaged under the current arrangements, we can see no justification for modifying our approach or the existing structure on this account.

Military salaries

27. ***Captain to Colonel.*** We recommend in Table 1 the rates of military salary that we consider appropriate for Service medical and dental officers from 1 April 1984 and from 1 November 1984, taking into account the staging of the DDRB recommendations.

28. ***Brigadiers.*** In recommending the military salary appropriate to the medical and dental Brigadier we consider the maximum of the scale for the medical and dental Colonel; the salary of the Major General; and the salary of the combatant Brigadier. Bearing these considerations in mind we recommend a salary of £27,555 for the medical and dental Brigadier with effect from 1 April 1984 and of £28,600 with effect from 1 November 1984.

29. ***Pre-registration medical practitioners (PRMPs).*** PRMPs in the armed forces are newly qualified doctors who are required to serve for one year before registration with the General Medical Council. The salary we recommend for them is based on that of a first year House Officer in the NHS, whose duties are identical, taking into account also the average

Table 1

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

Rank		Military salary	
		From 1 April 1984	From 1 November 1984
		£	£
Colonel:	after 8 years	26,557	27,711
	6 years	26,108	27,196
	4 years	25,660	26,682
	2 years	25,214	26,163
	on appointment	24,765	25,649
Lieutenant Colonel:	after 8 years	24,283	25,138
	6 years	23,685	24,499
	4 years	23,086	23,856
	2 years	22,426	23,178
	on appointment	21,772	22,499
Major:	after 6 years	20,893	21,535
	4 years	20,232	20,856
	2 years	19,575	20,174
	on appointment	17,491	17,896
Captain:	after 4 years	16,009	16,378
	2 years	15,137	15,472
	on appointment	14,257	14,564

(*a*) Annual salaries are derived from daily rates in whole pence and rounded to the nearest £.

earnings in the NHS from Class A and B supplements which are paid for contracted hours beyond the standard week. Identical percentage adjustments to those made for other medical and dental officers are made in respect of pensions, work in 'unsocial hours' and the X factor, and an amount is added to take account of the fact that NHS House Officers receive free accommodation in their first year. On this basis we recommend a salary of £11,016 for PRMPs from 1 April 1984 and of £11,271 from 1 November 1984.

30. ***Cadets.*** Since 1979 we have recommended rates of pay for medical and dental cadets with particular reference to the pay of PRMPs, although last year we did not incorporate into our comparison the significant increase awarded to PRMPs to reflect the increase in NHS earnings from Class A supplements. We have also borne in mind, when reaching our conclusions, the level of recruitment of medical and dental cadets; the grant available to civilian medical and dental students; and the pay of university cadets in the armed forces. Taking account of all these factors, we recommend the following rates of pay for medical and dental cadets from 1 April 1984 and from 1 November 1984:

	1 April 1984	1 November 1984
	£ a year	£ a year
On appointment	5,405	5,535
After 1 year	6,050	6,195
After 2 years	6,695	6,855

Medical and dental additional pay

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

	£ a year
Specialist	250
Senior specialist	650
Consultant (on appointment)	2,000
(after 5 years)	2,500
(after 10 years)	3,500

32. We adopt a similar approach to medical and dental additional pay as to combatant additional pay. In both cases the justification for the payments is to aid recruitment or retention and each year we consider whether the levels of additional pay awarded are sufficient in this context. In order to do so we make comparisons between the average earnings potentially available to hospital specialists in the NHS and those of medical and dental officers. While the main Services' medical and dental officer pay scale compares well with the basic NHS hospital pay scale, account also needs to be taken of extra income which is possible in the NHS from Class A and B supplements, payments for domiciliary visits, and the value of the various distinction and meritorious service awards for which NHS consultants are eligible.

33. This year, we have also considered a proposal from the MOD that an extra incremental point (after 15 years) should be added to the consultant additional pay scale. They have suggested that the value of this extra point should be set at £4,500. In considering this proposal, as well as bearing in mind comparisons with average earnings potentially available in the NHS hospital stream, we have noted the concern the MOD has expressed over the number of senior consultants who leave the Services before completion of a full career. We recognise the importance of retaining the skills and experience of consultants in the armed forces medical services and have concluded that an extra increment as proposed is justified. Otherwise, we are satisfied that the current rates of additional pay remain adequate. Consequently, we recommend the following rates of specialist, senior specialist and consultant pay from 1 April 1984:

	£ a year
Specialist	250
Senior specialist	650
Consultant (on appointment)	2,000
(after 5 years)	2,500
(after 10 years)	3,500
(after 15 years)	4,500

We do not consider it appropriate to 'stage' the additional increment on the consultants' scale as this represents a new payment.

34. The MOD have also put before us a proposal concerning the rules for continuity of medical and dental additional pay. Following the 1981 Defence Review, the number of clinical consultant posts at Surgeon Captain level in the Royal Navy has been reduced, with the result that a greater proportion of posts at this level will now be in administration. Under the present arrangements, a clinician who is transferred to administrative duties is able to retain specialist or consultant pay for one tour but loses it thereafter unless returned to clinical duties. The MOD have argued that the organisational change at Surgeon Captain level means that more people will now lose their consultant pay and that the current rules should be changed to allow the retention of additional pay as long as an individual remains liable to return to clinical duties. They have also proposed that the additional pay should be retained on a 'mark time' basis on promotion to Surgeon Rear Admiral.

35. This proposal causes us two difficulties. First, it appears to relate only to a problem in the Royal Navy and, as with the proposal for over-zoned Surgeon Commanders (paragraphs 25–26), we would find it difficult to accept a change in overall rules to meet particular circumstances in only one Service. Our second difficulty is with the concept of liability to return to the duties which attract the payment. The MOD proposal would allow this liability to be completely open-ended although they recognise the possibility that in some cases personnel could be retained in administrative posts until retirement. We cannot agree that such personnel should retain indefinitely payments specifically designed to ease manning problems when there remains a strong possibility that they will not return to the duties for which the payment is made. Consequently, we do not accept the proposal the MOD has put forward. However, we recognise that there may be occasions when it is in the interest of the Services to require personnel to stay in posts which do not normally attract additional pay for a longer period than the rules are designed to cover. While we do not consider it necessary to change the general rule that additional pay is retained for one tour away from clinical duties we recommend that there should be discretion, subject to appropriate procedures of approval, to extend the period of retention by one further tour (ie for no more than a total of two tours) when it is clear that an individual will be returning to the duties which qualify for the payment. This recommendation applies to all three Services. As a consequence of this recommendation, we see no need for a change to the rules governing the payment of additional pay at the Surgeon Rear Admiral or equivalent level.

36. ***Trainer Allowance.*** In 1981, we introduced the trainer allowance as a payment for those Service doctors who provide training in general practice. On the advice of the MOD, we set the level of allowance with reference to the value of senior specialist pay, but last year broke that link and increased the allowance to £700 a year. This is considerably below the level of the training grant in the NHS, which is paid for exactly the same reason, but includes a significant element to recognise the potential loss of earnings to a GMP in the NHS and additional expenses, which are not relevant in the Services' context. The MOD have suggested to us that the value of the trainer allowance should be increased again this year and have proposed a

level of £1,000. They have emphasised the importance of GP trainers to the Defence Medical Services not only to ensure appropriate standards but as an important element in atracting recruits. We accept this and recommend the level of trainer allowance be increased to £1,000: again, we consider this should be implemented with effect from 1 April 1984.

Permanent commission grant

37. The permanent commission grant is intended, when combined with the large increment between the 'on appointment' and 'after two years' points on the Major scale, to encourage a sufficient number of medical and dental officers to convert from a short service to a permanent commission. The grant was last increased in 1982 when it was raised significantly from £3,000 to £4,000. We have considered carefully whether a further increase is needed this year but have concluded that it is not.

Costs and conclusions

38. We estimate that the additional costs of our recommendations are:

	£ million
Military salary	
Brigadier	0·05
Captain to Colonel	1·28
PRMPs	0·04
Medical and dental cadets	0·05
Medical and dental additional pay	0·06
Total cost of increases in pay	1·48

39. The total cost of the increase in pay arising from our recommendations represents an increase of 4·6 per cent over the estimated paybill for 1984–85 at current rates (those which have applied since 1 January 1984). These estimates of costs are based on the manpower strengths of the medical and dental branches of the armed forces in 1984–85 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. We consider the levels of military salary that we have recommended to be appropriate for implementation with effect from 1 April 1984 and 1 November 1984 as indicated.

DAVID ORR *(Chairman)*
MICHAEL BETT
RICHARD CAVE
DAVID HUDSON
JENNY HUGHES
LEIF MILLS
J R SARGENT
RUTHVEN WADE

OFFICE OF MANPOWER ECONOMICS
29 June 1984

APPENDIX 1

PREVIOUS REPORTS OF THE REVIEW BODY ON ARMED FORCES PAY

First Report	Cmnd. 4954, April 1972
Second Report	Cmnd. 5336, June 1973
Supplement to Second Report	Cmnd. 5450, October 1973
Third Report	Cmnd. 5631, May 1974
Supplement to Third Report	Cmnd. 5729, September 1974
Second Supplement to Third Report	Cmnd. 5853, January 1975
Fourth Report	Cmnd. 6063, May 1975
Supplement to Fourth Report	Cmnd. 6146, July 1975
Second Supplement to Fourth Report	Cmnd. 6420, March 1976
Fifth Report	Cmnd. 6470, May 1976
Supplement to Fifth Report	Cmnd. 6515, July 1976
Sixth Report	Cmnd. 6801, April 1977
Seventh Report	Cmnd. 7177, April 1978
Supplement to Seventh Report	Cmnd. 7288, December 1978
Eighth Report, 1979	
Supplement to Eighth Report	Cmnd. 7603, June 1979
Second Supplement to Eighth Report	Cmnd. 7770, November 1979
Ninth Report	Cmnd. 7899, May 1980
Supplement to Ninth Report...	Cmnd. 7956, July 1980
Tenth Report	Cmnd. 8241, May 1981
Supplement to Tenth Report...	Cmnd. 8322, July 1981
Eleventh Report	Cmnd. 8549, May 1982
Supplement to Eleventh Report	Cmnd. 8573, June 1982
Twelfth Report...	Cmnd. 8880, May 1983
Supplement to Twelfth Report	Cmnd. 8950, July 1983
Thirteenth Report	Cmnd. 9255, June 1984

APPENDIX 2

DEFENCE MEDICAL SERVICES: MANNING STATISTICS

Table 2.1

Manpower(a) establishments and strengths in the medical and dental branches at end-March 1981, 1982, 1983 and 1984

		Royal Navy				Army				Royal Air Force			
		1981	1982	1983	1984	1981	1982	1983	1984	1981	1982	1983	1984
Medical officers													
Establishment	No.	308	325	298	283	569	563	573	596	427	410	400	392
Strength	No.	294	299	286	291	501	494	502(b)	518	395	395(c)	373	368
Shortfall	No.	14	26	12	(8)	68	69	71	78	32	15	27	24
	%	4·5	8·0	4·0	(2·8)	12·0	12·3	12·4	13·1	7·5	3·6	6·8	6·1
Dental officers													
Establishment	No.	101	102(c)	96	92	185	194	195	195	107	107	107	106
Strength	No.	102	101(c)	100	92	167	181	194	196	109	116	108	109
Shortfall	No.	(1)	1	(4)	—	18	13	1	(1)	(2)	(9)	(1)	(3)
	%	(1·0)	1·0	(4·2)	—	9·7	6·7	0·5	(0·5)	(1·9)	(8·4)	(0·9)	(2·8)

(a) Civilian medical practitioners, pre-registration medical practitioners and medical and dental cadets are excluded; ranks above Brigadier (or equivalent) are included.

(b) Revised by MOD in 1984; it, and the consequent shortfall, therefore differs from the figure included in the 1983 Supplement.

(c) Revised by MOD in 1983; it, and the consequent shortfall, therefore differs from the figure included in the 1982 Supplement.

Table 2.2

Number of pre-registration medical practitioners (PRMPs) and medical and dental cadets at end-March 1981, 1982, 1983 and 1984

	Royal Navy				Army				Royal Air Force			
	1981	1982	1983	1984	1981	1982	1983	1984	1981	1982	1983	1984
Medical cadets	59	52	35	33	74	74	81	94	42	50	41	26
PRMPs	17	18(a)	24	19	16	25	27	40	17	14	17	25
Dental cadets	7	7	5	6	10	11	10	—	13	4	2	1

(a) Revised by MOD in 1983: it therefore differs from the figure included in the 1982 Supplement.

Table 2.3

Recruitment of medical and dental officers, 1980–81 to 1983–84

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									
1980–81									
Cadets	30	30	100·0	40	36	90·0	35	25	71·4
Pre-registration	20	4	65·0	20	0	140·0	49	1	38·8
Direct entry		9			28			18	
Total	50	43	86·0	60	64	106·7	84	44	52·4
1981–82									
Cadets	10	10	100·0	25	26	104·0	22	22	100·0
Pre-registration	13	2	84·6	20	0	65·0	20	0	80·0
Direct entry		9			13			16	
Total	23	21	91·3	45	39	86·7	42	38	90·5
1982–83									
Bursars	12	9	75·0	—	—	—	—	—	—
Cadets		8		30	33	110·0	10	8	80·0
Pre-registration	10	0	110·0	30	2	103·3	14	14	100·0
Direct entry		3			29		12	12	100·0
Total	22	20	90·9	60	64	106·7	36	34	94·4
1983–84									
Bursars	10	8	80·0	—	—	—	—	—	—
Cadets		14		45	47	104·4	11	11	100·0
Pre-registration	18	2	127·8	35	7	105·7	18	18	100·0
Direct entry		7			30		15	11	73·3
Total	28	31	110·7	80	84	105·0	44	40	90·9
Dental officers									
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
1981–82									
Cadets	4	2	100·0	5	5	100·0	2	2	100·0
Direct entry		2		33	20	60·6	0	0	—
Total	4	4	100·0	38	25	65·8	2	2	100·0
1982–83									
Cadets	6	3	83·3	6	6	100·0	0	0	—
Direct entry		2		24	24	100·0	0	1	—
Total	6	5	83·3	30	30	100·0	0	1	—
1983–84									
Cadets	6	3	100·0	5	5	100·0	—	—	—
Direct entry		3		7	7	100·0	4	4	100·0
Total	6	6	100·0	12	12	100·0	4	4	100·0

Table 2.4

Numbers who have left the Services, 1980–81 to 1983–84

	Royal Navy	Percentage of strength at end of previous year	Army	Percentage of strength at end of previous year	Royal Air Force(*a*)	Percentage of strength at end of previous year
	No.	%	No.	%	No.	%
Medical Officers						
1980–81(*c*)	13	4·7	37	7·6	43	10·7
1981–82(*c*)	22	7·5	36	7·2	29	7·3
1982–83	34	11·4	40	8·1	48	12·2
1983–84	25	8·7	41	8·2	34	9·1
Dental Officers						
1980–81(*c*)	6	6·1	13	7·7	7	6·6
1981–82(*c*)	5	4·9	11	6·6	4	3·7
1982–83	6(*b*)	5·9	18	9·9	11	9·5
1983–84	13	13·0	9	4·6	5	4·6

(*a*) Premature voluntary retirements in the Royal Air Force are controlled by quota.

(*b*) Excludes two redundancies.

(*c*) Percentages of strength have been rebased on strengths at the end of the previous year (rather than the end of the current year): they therefore differ from the figures included in the 1982 and earlier Supplements.

Table 2.5

Conversions from short service to regular commissions, 1980–81 to 1983–84

	Royal Navy	Army	Royal Air Force
	No.	No.	No.
Medical Officers			
1980–81	7	14	24
1981–82	8(*a*)	17	19
1982–83	18	15	8
1983–84	18	11	11
Dental Officers			
1980–81	4	2	5
1981–82	2	1	2
1982–83	2	6	1
1983–84	2	7	4

(*a*) Revised by MOD in 1983: it therefore differs from the figure included in the 1982 Supplement.

APPENDIX 3

Military salaries(*a*) for medical and dental officers introduced with effect from 1 April 1983 and 1 January 1984

Rank		1 April 1983	1 January 1984
		£	£
Brigadier		26,099	26,751
Colonel:	after 8 years	25,148	25,785
	6 years	24,723	25,349
	4 years	24,299	24,914
	2 years	23,874	24,478
	on appointment	23,450	24,043
Lieutenant Colonel:	after 8 years	22,988	23,578
	6 years	22,421	22,996
	4 years	21,854	22,414
	2 years	21,228	21,773
	on appointment	20,606	21,136
Major:	after 6 years	19,775	20,284
	4 years	19,153	19,643
	2 years	18,531	19,006
	on appointment	16,558	16,982
Captain:	after 4 years	15,156	15,544
	2 years	14,325	14,695
	on appointment	13,494	13,842
Pre-registration medical practitioner		10,464	10,695
Cadet:	after 2 years	6,500	6,500
	1 year	5,874	5,874
	on appointment	5,248	5,248

(*a*) Rounded to the nearest £.

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