REVIEW BODY ON ARMED FORCES PAY

SERVICE MEDICAL AND DENTAL OFFICERS

Supplement to Fourteenth Report
1985

Chairman:
SIR DAVID ORR

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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.

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SERVICE MEDICAL AND DENTAL OFFICERS

Introduction

1. The remuneration of combatant members of the armed forces is covered in our main report; we deal with that of Service medical and dental officers separately as their pay is related to the remuneration of General Medical Practitioners (GMPs) in the National Health Service (NHS). For this reason, we await the Government's decisions on the recommendations of the Review Body on Doctors' and Dentists' Remuneration (DDRB) before making our recommendations on the pay of medical and dental officers in the armed forces. This year the Government has deferred the implementation of the rates recommended by the DDRB until 1 June 1985. As in previous years, we have concluded that it is right for us to recommend rates of pay for medical and dental officers in the armed forces which reflect what will actually be paid to GMPs in the NHS. Accordingly, we recommend salary levels for implementation from 1 June 1985. Our recommendations also reflect our conclusions on the evidence we have received from the Ministry of Defence and the British Medical Association together with the British Dental Association.

Our approach

2. We think it important that our aims and approach in recommending levels of pay are well understood by Service personnel. It has been our practice to set out in some detail the basis for our recommendations, and we do so again.

3. It is clear that direct comparison with levels of remuneration in the NHS must be an important factor in assessing levels of pay which will facilitate recruitment and retention of medical and dental officers; but at the same time the pay structure which we recommend must meet the particular requirements of the armed forces. For a number of reasons, NHS patterns of remuneration cannot be directly transferred to the armed forces context. Remuneration structures within the NHS vary: that of NHS GMPs, for example, is very different from that of the NHS hospital doctor. The GMP is likely to earn more than a contemporary in the hospital service in the early part of a career, but the hospital doctor can expect to overtake the GMP as their careers progress. Deciding on a suitable analogue, to provide a basis for assessing levels of remuneration appropriate to the Services, is also made difficult by the fact that an armed forces' medical or dental career can involve differing types of duty (including periods spent on administrative duties) to an extent not normally found in the NHS.

4. A significant factor, which complicates direct comparison with the NHS, is that the salaries of Service medical and dental officers have to be compatible with the military rank structure. We have found that this structure can sometimes hinder the adjustment of pay levels to meet particular manning problems as there is no direct link between pay and professional expertise. We have raised these matters with the Ministry of Defence on a number of occasions but the normal system of progression by rank is considered by Services' management to be an important feature of the armed forces which they wish to retain. We accept, therefore, that the framework within which we have to work is that of pay progression linked to rank progression.

5. We aim to provide military salary levels which ensure that the earnings of a Service medical or dental officer over a 32-year career from Captain to Colonel will equate, after taking account of various factors indicated in the following paragraphs, to the average net remuneration of a GMP in the NHS over the same period. In the past, we have considered whether the GMP provided the most suitable analogue for our purpose. We have examined whether the use of more than one analogue might be more appropriate, in order to reflect the variety of duties which Service medical and dental officers might undertake and the fact that in the Services, just as in the NHS, there is a distinction between general practice and hospital work. We concluded, however, that the complexity and fundamental differences in NHS remuneration patterns for those different groups of medical personnel would make it very difficult to use a combination of them as the basis for a single Services' pay structure which could apply to both groups. It is clear to us that most medical and dental officers consider the GMP analogue to be an appropriate guide for the assessment of their salary levels. We have concluded, therefore, that this approach remains the most appropriate and have retained it as the basis for our considerations this year.

The assessment of the NHS analogue

6. In assessing an appropriate analogue figure from which to construct a suitable salary structure we need to ensure that the figure we use as a starting point properly reflects both the actual earnings of GMPs in the NHS and the differences in the employment circumstances between the NHS and the armed forces. We discuss below the adjustments made to account for these points.

7. ***Adjustments to the average net remuneration of GMPs.*** The average remuneration, net of practice expenses, for GMPs from 1 June 1985 is £23,440. As in previous years, we consider that this figure may be depressed by the inclusion of GMPs who give less than a full-time commitment to NHS work. Equally, it does not include additional income which GMPs receive from other official sources. We therefore increase the average net remuneration figure to take account of these factors.

8. Two other adjustments are made to allow for the differing circumstances of employment in the NHS and in the armed forces. Some responsibilities which are rewarded in the NHS through the GMP's average remuneration are the subject of specific payments to members of the armed forces. Consequently, a deduction is made from the analogue figure for the average value of the training grant, because Service doctors and dentists who provide training receive a separate additional payment. Similarly, the average net remuneration of GMPs includes payment for out-of-hours work, which in the armed forces is one of the considerations leading to the payment of the X factor.

9. The British Medical Association have asked us to consider an aspect of the gross income of GMPs which they argue should be taken into account in the assessment of the analogue figure. For the most part, Service doctors and dentists have no practice expenses equivalent to those incurred by NHS GMPs and for which allowance is made in the assessment of GMP average gross income. For this reason we have considered it appropriate to use the GMP

average net remuneration figure as the basis for assessing the salaries of doctors and dentists in the armed forces. We continue to believe this is the right approach. However, it has been put to us that GMPs in the NHS effectively receive reimbursement of professional expenses associated with medical defence body membership and of subscriptions to various professional bodies and colleges. Personnel in the Defence Medical Services are able to obtain tax relief on such expenses, but do not receive reimbursement of them. In this way they are at a disadvantage compared with GMPs in the NHS, although not with NHS hospital doctors who are also unable to claim reimbursement of these expenses. However, it would be very difficult to isolate the amount allowed for in the DDRB's estimate of average gross income for expenses of the sort mentioned by the British Medical Association, and to build into pay an element for reimbursement of expenses would be contrary to the normal approach in the armed forces, whereby expenses necessarily associated with a job are reimbursed through the allowances system. Reimbursement allowances are, of course, outside the scope of our remit. They fall to Services' management for consideration and in our view should continue to do so. We consider, however, that the Ministry of Defence should examine whether any reimbursement of necessary professional expenses is appropriate in the case of Service medical and dental officers.

10. ***Pensions and fringe benefits.*** In civilian life, overall remuneration generally comprises a package of benefits of which basic salary is only one component. Pensions and fringe benefits form other important elements and due consideration of their relative value in the NHS and the armed forces must form part of a comprehensive assessment of salary levels in the Services.

11. In 1981 we asked the Government Actuary to carry out a comparative evaluation of the armed forces and civilian pension schemes. A similar exercise was undertaken at the same time for medical and dental officers, in which a comparison was made with the benefits accruing from the contributory NHS pension scheme for GMPs. For combatant personnel, we concluded that a reduction of comparator earnings by 11 per cent would provide an appropriate reflection of the relative advantages of the armed forces scheme; and that a reduction of 10 per cent should apply in the case of medical and dental officers.

12. We have continued to apply these levels of adjustment since 1981 although, as we said in our last report, we have become increasingly inclined to the view that the structure of the Armed Forces Pension Scheme appears less well suited to the situation of medical and dental officers than to that of combatants. We have discussed this matter with both the British Medical Association and with the Ministry of Defence. There are two main areas of difficulty in the application of the Armed Forces Pension Scheme to medical and dental officers. First, there is the fact that the pensions of medical and dental officers are based on the appropriate (but lower) pensionable pay of combatants of the same rank and not on actual levels of pay. Secondly, criticism is often aimed at the fact that the adjustment of 10 per cent is applied to all medical and dental officers regardless of their actual length of service: the British Medical Association see this as too high for those who stay beyond the immediate pension point. We have explained in previous reports that both these points are taken into account in our judgment of the appropriate

average adjustment that should be made in assessing the analogue figure. The Government Actuary, in the advice he gave us, took account of the fact that pensions were not based on actual salary levels and this, together with the fact that personnel benefit to different degrees dependent on when they take their pension, weighed heavily in our consideration of the wide range of possible adjustments (5.9–17.7 per cent) that might have been made.

13. While we believe that the adjustment we make is fair, given the current arrangements, we consider that the particular circumstances of medical and dental officers are different from those of combatants and that there are good arguments for a different approach to pensions for the former. The Ministry of Defence are presently considering the issues involved and we welcome this. In addition, we have asked the Government Actuary if he will re-evaluate the Armed Forces Pension Scheme as part of our 1985–86 review and the position of medical and dental officers will be examined also. For this year, we consider that a 10 per cent adjustment for pension purposes remains appropriate.

14. The recommendations we make also reflect our judgment on the relative value of fringe benefits available to Service medical and dental officers and to GMPs in the NHS. Our approach to this has remained the same this year as previously.

Manning considerations

15. We have received detailed evidence on the manning position in the medical and dental branches from both the Ministry of Defence and the British Medical Association. A summary of the position is given in Appendix 2.

16. On the whole, the manning information shows a similar picture to that of recent years. There has been little change in the position in the dental branches. In the medical branches the position in both the Army and the Royal Air Force has improved over last year. In the Royal Navy, last year's surplus has moved to a small shortfall against establishment. However, there is a lower ceiling imposed on manning levels against which the Royal Navy continues to have a surplus of medical officers. Against this background, the Ministry of Defence have pointed out that the balance within the rank structure is out of line with the requirement and that there are shortfalls among consultants. These imbalances are often the result of the persistent problem of retaining experienced officers after completion of a short service commission or beyond the immediate pension point.

17. There are two aspects of the manning position—recruitment and retention—which need to be considered. Recruitment continues to be good. This reflects, perhaps, the generally attractive salaries available to medical and dental officers when compared with those in the NHS at this stage of a career. Furthermore, a short service commission allows medical and dental officers to take advantage of the excellent professional training provided in the armed forces without limiting the prospects of a future career in the NHS. This fact contributes to the difficulties which the Defence Medical Services continue to have in retaining personnel. While the situation is not appreciably worse than in recent years it continues to give cause for concern. We remain convinced,

however, that the reasons why experienced medical and dental officers choose to leave the Services are linked to other factors besides pay, such as the greater scope for professional development which a career in the NHS can offer. In addition, the structure of the present Armed Forces Pension Scheme, which offers an immediate pension at a point when a medical or dental officer's career opportunities in civilian life are very good as a result of Service training and experience, is bound to prove attractive to many. We continue to believe, therefore, that a solution to the retention problem is not to be found in pay alone and, as we concluded last year, we think it inappropriate to adjust the general analogue figure on this account.

The analogue

18. Our considerations in assessing the analogue figure are described above. We have concluded that the appropriate analogue figure for 1 June 1985, on which our recommended military salary structure, exclusive of the X factor, for medical and dental officers should be based is £21,830.

The X Factor

19. Since 1980, medical and dental officers have received the same level of X factor as combatants (10 per cent). We have retained the same approach this year, and this is reflected in our recommendations on military salary.

Structural considerations

20. We have already referred (paragraph 4) to the limitations which the need to maintain the military rank structure imposes on our assessment of medical and dental officers' pay. While we face similar difficulties when recommending levels of pay for combatant personnel, because of the need to retain a sensible incremental progression, they are more acute in the medical and dental context because the earnings profiles for members of these professions in civilian life vary greatly. We attempt, in making our recommendations, to provide a pay structure which is based, as far as possible, on the earnings of GMPs in the NHS but which also links incremental progression with rank advancement in a sensible way. For this purpose, we regard a full career as being 32 years, during which an officer might be expected to be promoted from Captain to Colonel. We spread the total earnings, based on the analogue figure, that a 32-year career would generate so as to provide an incremental pay structure. The X factor is then added.

21. This structure limits the scope for providing financial incentive to remain in the Services at career points where there are problems. There is, however, one key point where we think it is particularly important to try and include such an incentive. This is at or about the time of promotion to Major when personnel on a short service commission have to decide whether to transfer to a full career commission. Our approach has been to insert a higher-than-average increment between the Major 'on appointment' and 'after two years' rates. We have maintained this approach for this review although there is some evidence that increasing numbers of personnel are reaching this point whilst still on a short service commission. We intend to examine further during our next review whether this financial incentive is working and whether it is

appropriately placed. Incentive to transfer to a permanent commission is also provided in the form of the permanent commission grant (see paragraph 30). Retention of experienced officers at this point and further on in a career is something we know to be particularly worrying to the Ministry of Defence and the British Medical Association and to which we have given a great deal of thought in previous years and again this year. We have attempted to provide further incentive to remain in the Services by continuing this year to widen the differentials at the upper end of the structure.

Military salaries

22. ***Captain to Colonel.*** Our recommendations on the rates of military salary we consider appropriate for Service medical and dental officers from 1 June 1985, are in Table 1.

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 June 1985
		£
Colonel:	after 8 years	29,645
	6 years	29,047
	4 years	28,444
	2 years	27,846
	on appointment	27,244
Lieutenant Colonel:	after 8 years	26,641
	6 years	25,952
	4 years	25,262
	2 years	24,543
	on appointment	23,820
Major:	after 6 years	22,703
	4 years	21,984
	2 years	21,265
	on appointment	18,852
Captain:	after 4 years	17,232
	2 years	16,272
	on appointment	15,312

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

23. ***Brigadiers.*** In recommending a military salary for the medical and dental Brigadier we take into account the maximum of the scale for the medical Colonel, the salary of the Major General, and the salary of the combatant Brigadier. In the light of these considerations, we recommend a salary of £31,000 for the medical and dental Brigadier from 1 June 1985.

24. ***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 the first-year House Officer in the NHS, whose duties are identical, allowing for the average earnings at that stage 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 applied in respect of pensions, work in 'unsocial hours' and the X factor; and an appropriate amount is added to take account of the fact that NHS House Officers receive free accommodation in their first year. In the light of these considerations, we recommend a salary of £11,928 for PRMPs from 1 June 1985.

25. ***Cadets.*** In reaching our conclusions on appropriate rates of pay for medical and dental cadets we pay particular attention to the pay of PRMPs, the grant available to civilian medical and dental students, the pay of university cadets and the level of recruitment of medical and dental cadets. Taking account of these factors, we recommend the following rates of pay for medical and dental cadets from 1 June 1985:

	£ a year
On appointment	5,810
After 1 year	6,505
After 2 years	7,195

Medical and dental additional pay

26. ***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 or 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
(after 15 years)	4,500

As with the various forms of additional pay for the combatant ranks, the justification for medical and dental additional pay is related to recruitment and retention needs. In considering the levels of payment, we take account both of the basic remuneration of NHS hospital doctors and of the additional payments available to them in the form of Class A and B supplements and from distinction and meritorious service awards. Last year, in response to a proposal by the Ministry of Defence, who were concerned about the number of senior consultants leaving the Services before completion of a full career, we recommended the introduction of an 'after 15 years' increment in consultant pay. It is as yet too early to establish the effect of this extra increment on outflow, but we will continue to look closely at the manning information to establish whether the desired effect has been achieved. This year we have concluded that no change is necessary in the payments made to the most senior consultants but consider there is some evidence to justify an increase in the payments made to those at a more junior level. Consequently, we recommend an increase of £500 in the rates payable to

consultants 'on appointment' and 'after 5 years'. This gives the following rates of specialist, senior specialist and consultant pay from 1 June 1985:

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

27. ***Trainer allowance.*** The trainer allowance, which was introduced in 1981 as a payment for Service doctors who provide post-graduate training in general practice, is analogous to the training grant paid to GMPs in the NHS. It was increased significantly last year to its present level of £1,000. This year, we have received two proposals for changes to the allowance. First, the Ministry of Defence have proposed the introduction of a separate and higher rate of allowance for those trainers who are responsible for co-ordinating and administering the scheme—the Directors/Advisers and Associate/Command Advisers. Secondly, the British Medical Association have asked us to consider increasing the allowance by a further £250 a year.

28. The Ministry of Defence proposal to introduce a higher rate of trainer pay for Directors/Advisers has given us some difficulties. As part of the GP post-graduate training structure, there is a Director/Adviser for each of the Services who has overall responsibility for vocational training, advises the respective Director General and liaises with national organisations concerned with general practice. Other officers are appointed to assist them as Associate/Command Advisers. The Ministry of Defence have suggested to us that these advisory functions are similar to those performed by Regional Advisers in General Practice in the NHS who are paid, pro rata, on the maximum of the NHS consultant scale. While we remain to be convinced that the scale of the duties involved is in fact similar, a simple comparison of salaries of the relevant post holders shows that those in the armed forces do not compare badly. Another aspect of the Ministry of Defence case is that a higher allowance for these personnel would offer recognition of their status, provide an endorsement of the structure of GP training in the armed forces, and thereby encourage volunteers for the basic training duties. In our view, it is not the purpose of additional pay to provide recognition of status—the rank structure exists to do this. In strict manning terms there is no justification for the extra payment as all the posts concerned are currently filled and we doubt whether the possible appointment to such a post at some time in the future will provide an adequate extra inducement to personnel to volunteer for the basic GP trainer duties. We are, therefore, unable to agree to the Ministry of Defence proposal.

29. We have also considered the British Medical Association proposal for a further increase in the trainer allowance, which is based on their concern over a shortfall of personnel volunteering for trainer posts in the Army, but we feel that it would be premature to recommend another large increase this year before the substantial increase made last year has had a chance to take effect. We therefore recommend no change in the value of the trainer allowance this year.

Permanent commission grant

30. 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 currently stands at £4,000. We have explained that we intend to examine the efficacy and positioning of the large increment in the Major's scale during the next review. We shall include in that examination the value of the permanent commission grant. Consequently, we recommend no change in the level of the grant this year.

Costs and conclusions

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

Military salary	***£ million***
Brigadier	0.08
Captain to Colonel	1.44
PRMPs	0.04
Medical and dental cadets	0.05
Medical and dental additional pay	0.08
Total cost of increases in pay	1.69

Our recommendations will increase rates of military salary for individuals by between 4.9 per cent and 8.4 per cent. The cost for 1985–86 represents an increase of 4.9 per cent over the estimated paybill for the year at current rates (those which have applied since 1 November 1984). These estimates of costs are based on the manpower strengths of the medical and dental branches of the armed forces in 1985–86 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 June 1985.

DAVID ORR (*Chairman*)
MICHAEL BETT
DAVID HUDSON
JENNY HUGHES
PETER MATTHEWS
LEIF MILLS
TONY MORTON
J R SARGENT

OFFICE OF MANPOWER ECONOMICS
25 June 1985

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
Supplement to Thirteenth Report	Cmnd. 9301, July 1984
Fourteenth Report	Cmnd. 9526, June 1985

DEFENCE MEDICAL SERVICES: MANNING STATISTICS

Table 2.1

Manpower(*a*) establishments and strengths in the medical and dental branches at end-March 1982, 1983, 1984 and 1985

		Royal Navy				Army				Royal Air Force			
		1982	1983	1984	1985	1982	1983	1984	1985	1982	1983	1984	1985
Medical officers													
Establishment	No.	325	298	283	293(*d*)	563	573	596	619	410	400	392	398(*e*)
Strength	No.	299	286	291	287	494	502(*b*)	518	540	395(*c*)	373	368	377
Shortfall	No.	26	12	(8)	6(*d*)	69	71	78	79	15	27	24	21(*e*)
	%	8.0	4.0	(2.8)	2.0(*d*)	12.3	12.4	13.1	12.8	3.6	6.8	6.1	5.3(*e*)
Dental officers													
Establishment	No.	102(*c*)	96	92	86	194	195	195	197	107	107	106	109
Strength	No.	101(*c*)	100	92	90	181	194	196	195	116	108	109	109
Shortfall	No.	1	(4)	—	(4)	13	1	(1)	2	(9)	(1)	(3)	—
	%	1.0	(4.2)	—	(4.7)	6.7	0.5	(0.5)	1.0	(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.
(*d*) A manpower ceiling of 283 has been imposed for 1984–85 against which there is an overbearing of 4 (1.4 per cent)
(*e*) A manpower ceiling of 387 has been imposed for 1984–85 against which there is a shortfall of 10 (2.6 per cent)

Table 2.2

Number of pre-registration medical practitioners (PRMPs) and medical and dental cadets at end-March 1982, 1983, 1984 and 1985

	Royal Navy				Army				Royal Air Force			
	1982	1983	1984	1985	1982	1983	1984	1985	1982	1983	1984	1985
Medical cadets	52	35	33	26	74	81	94	98	50	41	26	35
PRMPs	18(*a*)	24	19	21	25	27	40	34	14	17	25	11
Dental cadets	7	5	6	5	11	10	—	9	4	2	1	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, 1981–82 to 1984–85

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									
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	10	8	110.0	30	33	110.0	10	8	80.0
Pre-registration		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	18	14	127.8	45	47	104.4	11	11	100.0
Pre-registration		2		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
1984–85									
Bursars	8	0	0.0	—	—	—	—	—	—
Cadets	22	12	90.9	33	36	109.1	25	20	80.0
Pre-registration		2		30	2	116.7	25	25	100.0
Direct entry		6			33		10	10	100.0
Total	30	20	66.7	63	71	112.7	60	55	91.7
Dental officers									
1981–82									
Cadets	4	2	100.0	5	5	100.0	2	2	100.0
Direct entry		2		33	20	60.6	—	—	—
Total	4	4	100.0	38	25	65.8	2	2	100.0
1982–83									
Cadets	6	3	83.3	6	6	100.0	—	—	—
Direct entry		2		24	24	100.0	—	1	—
Total	6	5	83.3	30	30	100.0	—	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
1984–85									
Cadets	2	2	100.0	5	4	80.0	1	0	0.0
Direct entry	3	3	100.0	11	11	100.0	9	9	100.0
Total	5	5	100.0	16	15	93.8	10	9	90.0

Table 2.4

Numbers who have left the Services, 1981–82 to 1984–85

	Royal Navy		Army		Royal Air Force(a)	
	Number	Percentage of strength at end of previous year	Number	Percentage of strength at end of previous year	Number	Percentage of strength at end of previous year
	No.	%	No.	%	No.	%
Medical Officers						
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
1984–85	29	10.0	50	9.7	26	7.1
Dental Officers						
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
1984–85	9	9.8	18	9.2	9	8.3

(a) Premature voluntary retirements in the Royal Air Force are controlled by quota.
(b) Excludes 2 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 Supplement.

Table 2.5

Conversions from short service to regular commissions, 1981–82 to 1984–85

	Royal Navy	Army	Royal Air Force
	No.	No.	No.
Medical Officers			
1981–82	8(a)	17	19
1982–83	18	15	8
1983–84	18	11	11
1984–85	7	30	14
Dental Officers			
1981–82	2	1	2
1982–83	2	6	1
1983–84	2	7	4
1984–85	1	6	2

(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 1984 and 1 November 1984

Rank		Military salary	
		From 1 April 1984	From 1 November 1984
		£	£
Brigadier		27,555	28,600
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
Pre-registration medical practitioner		11,016	11,271
Cadet:	after 2 years	6,695	6,855
	1 year	6,050	6,195
	on appointment	5,405	5,535

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

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