

355-1357  
✓ I

PORTSMOUTH CENTRAL LIBRARY  
RESERVE  
STACK

PORTSMOUTH CENTRAL LIBRARY



**REVIEW BODY  
ON  
ARMED FORCES PAY**

**SERVICE MEDICAL AND DENTAL OFFICERS**

**Supplement to Eleventh Report  
1982**

**Chairman :  
SIR HAROLD ATCHERLEY**

*Presented to Parliament by the Prime Minister  
by Command of Her Majesty  
June 1982*

**LONDON  
HER MAJESTY'S STATIONERY OFFICE**

£2.55 net

Cmnd. 8573

## 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*)<sup>1</sup>

Dr Ewen M'Ewen CBE

Leif Mills

Sir John Read

J R Sargent

Air Chief Marshal Sir Ruthven Wade KCB DFC

The Secretariat is provided by the Office of Manpower Economics.

Dame Rosemary Murray DBE JP retired from the Review Body in June 1981.

M G Heron left the Review Body in April 1982 and was unable to take part in the later stages of this review.

---

<sup>1</sup> Also a member of the Review Body on Top Salaries.

# SERVICE MEDICAL AND DENTAL OFFICERS

## Introduction

1. In pay terms, medical and dental officers in the armed forces are a self-contained group. Their pay is related to the remuneration of general medical practitioners (GMPs) in the National Health Service (NHS) and we have to await the Government's decisions on the recommendations of the Review Body on Doctors' and Dentists' Remuneration (DDRB) before we can consider in detail the military salaries of Service medical and dental officers.

2. The Government has now announced its decision on the DDRB's recommendations for 1 April 1982 and has decided to introduce salary levels which maintain the abatement applied to DDRB recommendations last year. This means, in effect, that average net remuneration of GMPs in the NHS will increase by about 5·7 per cent with effect from 1 April 1982.

3. As was the case last year, we have had to consider whether to base our assessment of the military salaries appropriate for Service medical and dental officers on these reduced levels or on those recommended by the DDRB. We continue to take the view that our recommendations must be related to the actual levels of remuneration for GMPs which result from the Government's decision. As we said in the Supplement to our Tenth Report<sup>1</sup> (paragraph 3), our 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 with the necessary qualifications; and to meet this objective we need to consider actual levels of earnings among the comparators, not the levels that might have applied had circumstances been different.

4. We also have to take a number of other important factors into account in framing our recommendations. They include the appropriate level of the X factor; the adjustment to be made for pension benefits and for the comparative value of other elements within the total remuneration package; and relevant structural considerations. Above all, it remains our concern to recommend rates and a structure of pay that will enable the Services to meet their manning objectives. It is necessary, therefore, to look first at the current manning position.

## Manning

5. Each year, we receive detailed information from the Ministry of Defence on the manning of the medical and dental branches. The position for the year up to 31 March 1982 is set out in Appendix 1, which includes for comparison information for earlier years. The overall position for dental officers remains satisfactory. In the case of medical officers, the total number (1191) is about the same as this time last year, but with a slight reduction of the number in the Army. The overall shortfall from establishment has decreased over the year (from 114 to 107); but, as we have pointed out previously, it is difficult to make direct comparisons from year to year because establishment levels change frequently, and the small numbers involved can exaggerate the effect.

---

<sup>1</sup> A full list of previous reports is at Appendix 3.

Overall figures also mask shortages in certain specialist areas: in some cases these reflect a national shortage, compounded to some extent in the armed forces by the continuing effect of manning problems which developed when pay was not kept fully up to date.

6. The effect of such shortages can be mitigated for a time by employing civilian doctors. But it will take the Services some years to restore the level of experience that has been lost and a lasting improvement will depend upon satisfactory levels of both recruitment and retention. We have noted some encouraging signs. The number of medical cadets and pre-registration medical practitioners, who provide the main sources for replacing fully qualified doctors in the armed forces, has risen in each of the last three years, after a period of decline; and, once again, the number recruited in 1981-82 (98), although falling short of the target by about 11 per cent, exceeded the number who left (87). Nonetheless, it would be unwise to become complacent in the light of these figures. Satisfactory manning over the long run will depend upon a reasonable return of service being obtained from Service medical officers. There are still problems in this respect. Most medical officers enter the armed forces on an initial five year short service commission—which can be extended by up to three years in some cases—with an option, at management discretion, to convert to a permanent commission. Only about one-third of such officers who were eligible decided to convert in 1981-82; a further third extended their initial short service commission; and the remainder left to take up appointments outside the Services. A more important problem, of particular concern to management, arises from the number of experienced permanent commission officers who leave the Services as soon as they become eligible to receive an immediate pension—usually after 16 years' service: for example, in 1981-82 about 40 per cent of the permanent commission officers who left the Services did so before normal retirement age on an immediate pension. This loss of experienced personnel is a worrying aspect of the present situation: it underlines the difficulties that the Services face in retaining some of their more experienced and highly qualified specialist staff.

7. We have considered whether some change might be justified in our approach, to provide a greater incentive to medical officers to stay in the Services. We have decided against this for a number of reasons. It is important to recognise that there are limits to what can be achieved through the pay structure alone. Other considerations, such as how individual doctors see their opportunity for professional advancement, will affect the position, perhaps even to a greater extent.

8. Also, as we have noted in earlier reports, the way in which pay is linked directly to Service rank limits the extent to which the present pay structure for medical and dental officers can be used with flexibility to overcome specific manning difficulties. However, this rigid framework is now under review by management and, in the light of the results, we hope to examine next year the scope for introducing a more flexible and responsive approach. This does not imply that a rank structure is inappropriate for medical and dental officers. Our concern is rather with the automatic link that occurs at present between rank and pay, which greatly compounds the difficulties of devising a pay structure suitable to the circumstances of these professional groups.

9. A further limitation on the extent to which pay can remedy particular manning difficulties flows from the disincentives to retention inherent in the present arrangements. The ability to retire at a relatively young age with an immediate pension, and the level of gratuity that is payable—partly as a substitute for pension rights—at the end of a short service engagement, must be significant considerations when individual medical and dental officers are deciding whether to stay in the armed forces. This must be particularly so when there is relatively little difficulty in moving to a second and complementary career in the National Health Service. Some of these matters are also to be reviewed: for example, the Ministry of Defence is embarking upon a review of the Services pension scheme, including its application in the medical and dental branches. Such matters are primarily the concern of management but we record our close interest in them and will wish to examine possible pay implications of management deliberations in our next review.

10. Against this general background, we see no scope for a major change in our approach to determining medical and dental officers' pay for this review. We now look in detail at the issues that arise from the established basis.

### **The elements within remuneration**

11. The military salaries of medical and dental officers are based at present on the remuneration of GMPs in the NHS. Given the wide range of employment of Service medical and dental officers—in hospitals, general duties and administration—a single point of reference of this type has limitations. We indicated in the Supplement to our Tenth Report (paragraph 15) that we would examine whether a different basis of earnings comparison might prove more appropriate within a rank-related framework.

12. We last looked at this matter in 1980 and have done so again on this occasion. There are a number of options, as we explained in the Supplement to our Ninth Report (paragraph 5). For example, the military salaries of Service medical and dental officers could be based on the earnings of NHS hospital doctors and dentists instead of GMPs; or an attempt could be made to relate military salaries to the earnings of directly equivalent groups of doctors and dentists in the NHS. We have again concluded that, although an attractive case can be made for some of these possibilities, it would not be desirable to change the existing system at present. Our judgment has been influenced particularly by the practical consideration that any alternative is likely to be no less difficult to reconcile with the present rank-related pay structure for medical and dental officers. We consider that further examination of alternative bases of comparison should await the outcome of management's examination of the prospects for moving away from the rigid rank framework (paragraph 8). We shall return to the issue in a later review.

13. For the time being, therefore, our judgment of the appropriate levels of military salary for medical and dental officers remains based on the earnings of GMPs in the NHS. In the last two reviews we have extended the range of GMP earnings taken into account. Until 1980, military salaries were based solely on the average net remuneration (that is, remuneration net of practice expenses) which the recommendations of the DDRB were designed to produce. In 1980, however, we included the DDRB's estimate of average earnings from

other NHS and official sources, comprising income from contraceptive service fees, hospital work and other official sources, all of which was identified separately by the DDRB and not included in its assessment of average net remuneration. As a result of the Government's decision on this year's DDRB recommendations, it is estimated that NHS GMPs will receive, on average, an income of £19,385 from the sources we have identified—£18,990 from average net remuneration (which now incorporates contraceptive service fees) and £395 from hospital work and other official sources.

14. Last year, we introduced another modification to our approach by extending further the range of comparator earnings taken into account in forming our judgments. This was necessary to overcome certain drawbacks in an approach based on the average earnings of GMPs in the NHS. The average tends to be affected by those GMPs who do not devote themselves wholly to NHS patients (and who do not, therefore, provide a proper comparator for Service medical and dental officers). We were also concerned to take account of the full range of income available to GMPs from NHS sources, including the various services for which NHS patients are charged by their GMPs. We have adopted the same approach this year and, once again, in judging the appropriate level of comparator earnings have made allowance for the general range of income from NHS work that is available to the GMP, on the basis of such information as we have been able to obtain on the make-up and distribution of the total earnings of GMPs. The British Medical Association (BMA) have repeated the suggestion put forward last year that we should take greater account of the spread of actual earnings of GMPs and, by implication, should equate medical and dental officers with a higher point in this distribution. In our view the choice of the appropriate earnings levels must be a matter for broad judgment rather than precise measurement, with emphasis on the need to ensure that military salaries for doctors and dentists remain competitive. To this end, it is essential that all relevant remuneration of GMPs in the NHS is taken into account, and this we have sought to do.

15. The level of GMP earnings used for comparison is also adjusted to allow for the fact that Service medical officers who provide training in general practice now receive a separate trainer allowance. This makes it necessary to remove from GMP earnings data the element of income from the NHS training grant. Our recommendations again allow for this.

### **The X factor**

16. Since 1980, the X factor for medical and dental officers has been set at the same percentage level (10 per cent) as for combatant officers, but with an adjustment to avoid any element of double counting from the fact that the average net remuneration of the GMP in the NHS also includes an amount for 'out of hours' services (some £1,770 in the present year). Within the range of payments made to those GMPs who provide services at night and at weekends it is not possible to draw a clear distinction between items that represent payment for work actually undertaken in unsocial hours (an element recognised within the X factor), and those designed to compensate for the commitment to undertake such work. As in the last two reviews, we have applied our judgment in making an appropriate adjustment.

## Pensions and fringe benefits

17. In comparing total remuneration, it is necessary to assess the relative value of pension benefits and fringe benefits. Last year, following a detailed evaluation by the Government Actuary, we made a 10 per cent deduction from comparator pay in respect of pension benefits. We saw this as a reasonable reflection of the extent to which the pension benefits available to medical and dental officers—particularly early pension arrangements—exceeded those available to GMPs in the NHS. As in the case of combatant officers, this also involved judgment, from within a broad potential range indicated by the Government Actuary, of the extent to which early pensionability conferred a benefit or represented a compensation for career disruption. The BMA, whilst acknowledging the significant benefits of early pensionability, have argued that we overestimated them and, in making our adjustment last year, should have adopted a lower figure from the range given by the Government Actuary. However, as we indicated last year, we do not regard early pensionability as an automatic benefit for all members of the armed forces to whom it applies. Our view was that it could reasonably be considered to confer a benefit on those who volunteered to leave the armed forces early with an immediate pension. The adjustment introduced in our last review took account of information on the number of medical and dental officers falling into this category in recent years. We shall be giving further consideration in future reviews to this aspect of the pensions evaluation.

18. The BMA have raised two other points about our approach to the evaluation of pensions. They have expressed reservations as to whether it is equitable to apply a single adjustment across the board, particularly as the advantages of early pensionability diminish as a career progresses. We understand this reservation and share it to some extent, but there would be considerable difficulties in moving to a variable adjustment to reflect individual circumstances. We may also need to look at this question further when management has completed its examination of pension arrangements (paragraph 9).

19. The second point raised by the BMA echoed the concern we expressed last year about the fact that medical officers' pensions are based on the (lower) pensionable pay of a combatant officer of equivalent rank, rather than on their own salary. The Ministry of Defence will be looking at this point in their forthcoming review of Service pension arrangements. Clearly, however, if medical and dental officers' pensions were to be related more directly to their earnings, we should need to consider whether the resultant improvement in benefit affected the size of the adjustment to be made for pension purposes. At present, the fact that medical and dental officers' pensions are not directly 'earnings-related' reduces the overall value of the pensions package: this has been allowed for in the Government Actuary's evaluation and in our own assessment.

20. Pending the review by management, and any further developments in the light of the Scott Inquiry into the value of public service pensions<sup>1</sup>, we see no need to change the approach adopted to the assessment of pension benefits in our last review. Our recommendations again reflect a 10 per cent deduction for Service medical and dental officers.

---

<sup>1</sup> Inquiry into the Value of Pensions, Cmnd. 8147, February 1981.

21. Account must also be taken of the comparative value of any fringe benefits available to Service medical and dental officers and to GMPs in the NHS. We explained in our last report that as GMPs are self-employed independent contractors within the NHS they cannot, by definition, receive fringe benefits in the sense of non-cash benefits provided by an employer. The extent to which medical and dental officers derive any significant balance of advantage from benefits they share with their combatant colleagues is a matter for judgment. We have taken account of this aspect of remuneration in drawing our comparisons and in reaching our conclusions this year.

### **Structural considerations**

22. As already noted, the pay structure for medical and dental officers is governed at present by the pattern of ranks in the armed forces. The established basis for constructing military salaries is 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 GMPs in the NHS used for the purpose of comparison: the earnings of those who serve beyond 32 years, particularly if promoted to the rank of Brigadier or above, will exceed this average figure. The governing 32 year career progression entails a structure which is difficult to reconcile with the pay profile of the NHS general medical practitioner—or, indeed, with that of other possible NHS comparators. We hope that management will pay close attention to this problem when considering the possibility of removing or at least easing the existing direct link between rank and pay.

23. For this review we have considered whether any change of emphasis within the limits set by the existing structure might be desirable. We have given attention to two areas in particular. First, as in the last two reviews, we have considered the appropriate pay relationship between junior officers who serve on a short service commission and those who hold a permanent commission. Our aim is to provide, as far as is practicable, a pay structure sufficiently attractive to ensure that an adequate number of short service commission officers convert to a permanent commission, given the counter-vailing attractions of the (tax free) short service gratuity which is payable to those who leave the Services at the end of a short service commission. We hope that management will examine critically the disincentive effects of short service gratuities—which are in part a substitute for pension entitlements—as part of the general review of Service pension arrangements. The wider issue of providing incentives to retention, to which we referred in our Eleventh Report (paragraph 37), is also under review by the Ministry of Defence and is relevant here. For the time being, we propose to retain the framework we have adopted in the last two years, which provides a large increment between the ‘on appointment’ and ‘after two years’ points for the Major. This increment, when combined with a (taxable) permanent commission grant which is paid to those who convert, is designed to encourage young medical and dental officers to convert from a short service to a career commission. The permanent commission grant has remained at £3,000 for some years. Although we remain concerned that the level of the grant should not be set in direct competition with that of the short service gratuity, which is outside our remit, we consider an increase appropriate now in order to encourage a

higher rate of conversion from short service to permanent commissions. We recommend that the permanent commission grant should be increased to £4,000 with effect from 1 April 1982.

24. We have also considered this year whether, within the overall limits of the pay structure, it might be possible to provide increased incentives to retention for the more experienced officer. The levels of additional pay (paragraph 29) have an important bearing here, as they offer specific recognition for specialist skills and experience, but we see a case for some widening of differentials at the top of the pay structure (above the rank of Major) and our recommendations allow for this.

## Military salaries

### *Captain to Colonel*

25. 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 1982. The recommended structure is based on a 32 year career (paragraph 22) and our judgment that, in the light of the evidence and the considerations we have discussed, and after making the necessary adjustments, a 'comparator' remuneration figure of some £17,700 is appropriate this year. The levels of military salary which we have recommended are some 4.2 per cent to 7.1 per cent higher than the existing rates, introduced with effect from 1 April 1981 (Appendix 2): the higher increases are towards the top of the structure to provide an incentive to retention.

**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
		£
Colonel:	after 8 years	23,594
	6 years	23,196
	4 years	22,798
	2 years	22,400
	on appointment	22,002
Lieutenant Colonel:	after 8 years	21,564
	6 years	21,031
	4 years	20,502
	2 years	19,914
	on appointment	19,330
Major:	after 6 years	18,553
	4 years	17,969
	2 years	17,385
	on appointment	15,534
Captain:	after 4 years	14,220
	2 years	13,439
	on appointment	12,662

(a) Rounded to the nearest £.

## ***Brigadiers***

26. In considering the military salary appropriate to the medical and dental Brigadier we pay regard to the maximum of the scale for the medical and dental Colonel; to the salary of the Major General; and to the relationship with the salary of the combatant Brigadier. We consider that a salary of £24,450 is appropriate with effect from 1 April 1982, and we recommend accordingly.

## ***Pre-registration medical practitioners (PRMPs)***

27. As has been explained in previous reports, PRMPs in the armed forces are newly qualified doctors who are required to serve for one year before registration with the General Medical Council. Their duties are identical to those of house officers in NHS hospitals at the same career point, and the salary of the PRMP is based on the salary of a first year house officer plus average earnings at that level from Class A and B supplements. A 10 per cent X factor is applied but, to the extent that earnings from the A and B supplements include an element of compensation for work in 'unsocial hours', we make an adjustment to avoid double counting. We also make an adjustment for the better pension benefits in the armed forces, in line with that for medical and dental officers; and to allow for the fact that PRMPs pay for their Service accommodation, whereas it is normally provided free of charge for NHS house officers in their first year. In the light of these considerations, we recommend a salary of £9,150 for PRMPs from 1 April 1982.

## ***Cadets***

28. Service medical and dental cadets are currently paid on a three point pay scale reflecting our judgment of the appropriate relationships with the salary of a PRMP (the grade to which cadets are later appointed) and with the grants available to civilian medical and dental undergraduates. We recommend that the following rates of pay should apply with effect from 1 April 1982:

	£ a year
On appointment	4,950
After 1 year	5,525
After 2 years	6,100

## **Medical and dental additional pay**

### ***Specialist, senior specialist and consultant pay***

29. 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 pay are:

	£ a year
Specialist	225
Senior specialist	600
Consultant (on appointment)	1,700
(after 5 years)	2,025
(after 10 years)	2,550

These payments are intended to bring the pay of Service specialists and consultants into closer relationship with the remuneration in equivalent NHS appointments. This is necessary because the pay of Service doctors in hospital specialties is based on the remuneration of the GMP in the NHS which, although above that found in the NHS hospital specialties in the early stages of a career, tends to be lower than that attainable at a later stage by hospital specialists and consultants. Clearly, salaries must be reasonably competitive if Service hospitals are to be adequately manned. Pending the basic review of the relationship between rank and pay in the medical and dental branches (paragraph 8) and the possibility this might produce of relating Service pay more directly to earnings in the NHS, we see additional pay as continuing to have a vital retention purpose. In judging the levels now necessary, we have made a comparison of the remuneration of NHS and Service hospital doctors of equivalent status. In so doing, we have taken account of such factors as additions to the 'basic' remuneration of NHS hospital doctors (for example, through distinction and meritorious service awards) and the pension contribution made by NHS hospital doctors. On this basis, we conclude that some increase in all levels of medical additional pay is now required but particularly for those in receipt of consultant pay. We recommend that the following rates should apply from 1 April 1982:

	£ a year
Specialist	250
Senior specialist	650
Consultant (on appointment)	1,875
(after 5 years)	2,275
(after 10 years)	3,000

### *Trainer allowance*

30. Last year, we recommended the introduction of a new form of payment for those Service doctors who train postgraduates in general practice. This additional payment (currently £600) is similar in concept to the training grant paid in the NHS, in that it is designed to encourage qualified doctors to take on training duties, but the amount involved is less. This is because the NHS training grant incorporates elements for potential loss of earnings and for extra expenditure by the GMP trainer that do not apply to the (salaried) Service trainer. As explained in paragraph 15, the existence of this specific payment requires an adjustment to comparator earnings to remove the element for trainer grant which is included within the estimate of GMPs' average net remuneration. We consider that the allowance should now be increased and recommend that, with effect from 1 April 1982, it be set at a level of £675.

## Costs and conclusions

31. We estimate the additional costs of our recommendations to be:

Military salary	£ million
Brigadier	0·08
Captain to Colonel	1·34
PRMPs	0·03
Medical and dental cadets	0·05
Medical and dental additional pay	0·10
Permanent Commission Grant	0·06
	<hr/>
Total cost of increases in pay	1·66

The total cost of the increases in pay arising from our recommendations represents an increase of 5·8 per cent over the estimated paybill for 1982-83 at current rates. These estimates of costs are based on the manpower strengths of the medical and dental branches of the armed forces in 1982-83 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.

32. 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 1982. They are based on our established approach of relating the earnings of medical and dental officers to the remuneration of GMPs in the NHS. We shall re-examine in a later review the long-term suitability of this approach, in the light of management's examination of the possibility of a less direct link than at present between rank and pay. In forming our recommendations this year we have paid particular attention to the concern expressed to us about the need to encourage experienced officers to prolong their Service career. To this end, and within the limits of the present pay structure, we have sought to widen differentials to some extent and to give greater recognition, through increased rates of additional pay, to those with the greater skill and experience. We have also increased the level of the permanent commission grant. We believe that these measures should be of some assistance to the Services in their efforts to consolidate and strengthen manning in the medical and dental branches.

HAROLD ATCHERLEY (*Chairman*)

EWEN M'EWEN

LEIF MILLS

JOHN READ

J R SARGENT

RUTHVEN WADE

OFFICE OF MANPOWER ECONOMICS

9 June 1982

# APPENDIX 1

## DEFENCE MEDICAL SERVICES: MANNING STATISTICS

Table 1.1

Manpower establishments and strengths in the medical and dental branches at end-March 1979, 1980, 1981 and 1982

	Royal Navy				Army				Royal Air Force			
	1979	1980	1981	1982	1979	1980	1981	1982	1979	1980	1981	1982
	<b>Medical officers</b>											
Establishment	333(b)	333(b)	308	325	570	567	569	563	419	420	427	410
Strength(a)	282	277	294	299	485	490	501	494	404	401	395	398
Shortfall	51	56	14	26	85	77	68	69	15	19	32	12
%	15.3	16.8	4.5	8.0	14.9	13.6	12.0	12.3	3.6	4.5	7.5	3.0
<b>Dental officers(c)</b>												
Establishment	96	96	101	101	185	185	185	194	107	107	107	107
Strength(a)	92	98	102	102	172	168	167	181	107	106	109	116
Shortfall	4	(2)	(1)	(1)	13	17	18	13	0	1	(2)	(9)
%	4.2	(2.1)	(1.0)	(1.0)	7.0	9.2	9.7	6.7	—	0.9	(1.9)	(8.4)

(a) Excluding civilian medical practitioners, pre-registration medical practitioners and medical and dental cadets.

(b) Includes pre-registration medical practitioners.

(c) Army strengths at end-March 1979 and 1980 were revised in 1981. They, and the consequent shortfalls, therefore differ from the figures included in the 1980 and earlier Supplements.

Table 1.2

Number of pre-registration medical practitioners (PRMPs) and medical and dental cadets at end-March 1979, 1980, 1981 and 1982

	Royal Navy				Army				Royal Air Force			
	1979	1980	1981	1982	1979	1980	1981	1982	1979	1980	1981	1982
	<b>Medical cadets</b>											
PRMPs	66	70	59	52	89	87	74	74	55	53	42	50
Dental cadets	9	9	7	7	6	6	10	11	8	11	13	4

Table 1.3

## Recruitment of medical and dental officers, 1978-79 to 1981-82

Year and category	Royal Navy			Army			Royal Air Force		
	Target	Entry	Per cent achieved	Target	Entry	Per cent achieved	Target	Entry	Per cent achieved
<b>Medical officers</b>	No.	No.	%	No.	No.	%	No.	No.	%
<i>1978-79</i>									
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									
<b>Total</b>	40	26	65.0	60	31	51.7	54	16	29.6
<i>1979-80</i>									
Cadets	30	22	73.3	40	25	62.5	40	14	35.0
Pre-registration	} 20	{ 3 4	} 35.0	20	{ 5 16	} 105.0	56	{ 0 10	} 17.9
Direct entry									
<b>Total</b>	50	29	58.0	60	46	76.7	96	24	25.0
<i>1980-81</i>									
Cadets	30	30	100.0	40	36	90.0	35	25	71.4
Pre-registration	} 20	{ 4 9	} 65.0	20	{ 0 28	} 140.0	49	{ 1 18	} 38.8
Direct entry									
<b>Total</b>	50	43	86.0	60	64	106.7	84	44	52.4
<i>1981-82</i>									
Cadets	10	10	100.0	25	26	104.0	22	22	100.0
Pre-registration	} 13	{ 2 9	} 84.6	20	{ 0 13	} 65.0	20	{ 0 16	} 80.0
Direct entry									
<b>Total</b>	23	21	91.3	45	39	86.7	42	38	90.5
<b>Dental officers</b>									
<i>1978-79</i>									
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
<b>Total</b>	10	9	90.0	21	11	52.4	16	9	56.2
<i>1979-80</i>									
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
<b>Total</b>	10	7	70.0	21	15	71.4	13	11	84.6
<i>1980-81</i>									
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
<b>Total</b>	10	10	100.0	18	14	77.8	12	12	100.0
<i>1981-82</i>									
Cadets	} 4	{ 2 2	} 100.0	5	5	100.0	2	2	100.0
Direct entry									
<b>Total</b>	4	4	100.0	38	25	65.8	2	2	100.0

Table 1.4

## Numbers who have left the Services 1978-79 to 1981-82(a)

	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.	%
<b>Medical officers</b>						
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
1981-82	22	7.4	36	7.3	29	7.3
<b>Dental officers(c)</b>						
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
1981-82	5	4.9	11	6.1	4	3.4

(a) Excluding redundancies.

(b) Royal Air Force exits are controlled by quota.

(c) The Army figures for 1978-79 and 1979-80 were revised in 1981: they therefore differ from the figures included in the 1980 and earlier Supplements.

Table 1.5

## Conversions from short service to regular commissions, 1978-79 to 1981-82

	Royal Navy	Army	Royal Air Force
	No.	No.	No.
<b>Medical officers</b>			
1978-79	8	12	11
1979-80	31	15	16
1980-81	7	14	24
1981-82	5	17	19
<b>Dental officers(a)</b>			
1978-79	3	5	4
1979-80	1	11	5
1980-81	4	2	5
1981-82	2	1	2

(a) The Army figures for 1978-79 and 1979-80 were revised in 1981: they therefore differ from the figures included in the 1980 and earlier Supplements.

## APPENDIX 2

### Military salaries for medical and dental officers introduced with effect from 1 April 1981

Rank	Military salary <sup>(a)</sup>
Brigadier	£ 22,451
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
Pre-registration medical practitioner	8,687
Cadet:	
after 2 years	5,851
1 year	5,300
on appointment	4,749

(a) Rounded to the nearest £.

## APPENDIX 3

### 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