PHMC pay disparities evidence

Our asks:

- Pay restoration for all public health doctors across the UK, with full funding of pay awards for all the relevant employers.
- All public health consultants and registrars across the UK to be employed on medical and dental terms and conditions where appropriate, regardless of employer.
- UK Health Security Agency (UKHSA), the DHSC's Office of Health Improvement and Disparities (OHID) and relevant parts of NHS England to be brought back into the NHS as part of a single, independent public health agency.
- Collective bargaining for public health consultants in English local authorities.
- As per previous ARM policy[1], redressing existing pay disparities between medical and non-medical public health specialists, both for consultants and registrars.

The evidence:

1. **There are not enough public health specialists in the UK,** despite rising demands and a need for pandemic surge capacity[2].

Current UK public health consultant numbers	Level recommended by FPH and BMA	Shortfall
Roughly 2000 headcount	30 whole time equivalent per million population	750+ consultants across UK

2. Double digit pay erosion has occurred since 2008 for public health specialists of all backgrounds, harming recruitment and retention. The loss of medical and dental terms by many doctors employed by local authorities has led to even further pay erosion.
    a. For advertised salaries, **there can be a £12,000 difference in annual pay** between a typical English local authority and other NHS organisations, such as Public Health Wales
    b. In our consultant pay ready reckoner, extreme disparities were seen over a 21-year career. For example, in Wales, **medical/dental terms and conditions (TCS) would pay out £100,000 less in cumulative basic pay than agenda for change** (AfC) whereas in England **it would pay out £200,000 more**. Basic **pay in England is generally less.**
    c. For registrars, **cumulative basic pay can be over £40,000 lower over the course of specialist training** for those working on AfC compared to medical/dental TCS.

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[1] See BMA policy book section, public health medicine: That this Meeting believes that when statutory registration of non-medical public health specialists has been introduced, and if it complies with current BMA policy and includes revalidation, all public health consultants, whether or not medically qualified working for Public Health England (PHE), the NHS or local authorities should be offered employment on the medical and dental health service consultant contract (2013).

[2] https://www.fph.org.uk/policy-advocacy/what-we-think/fph-policy-briefs/the-public-health-workforce/

3. We estimate **8-25% of current consultant posts are unfilled vacancies**[3]. The **number of GMC registrants is trending down** as doctors either retire (including early retirement) without replacement or leave the country, specialty and even the profession[4].

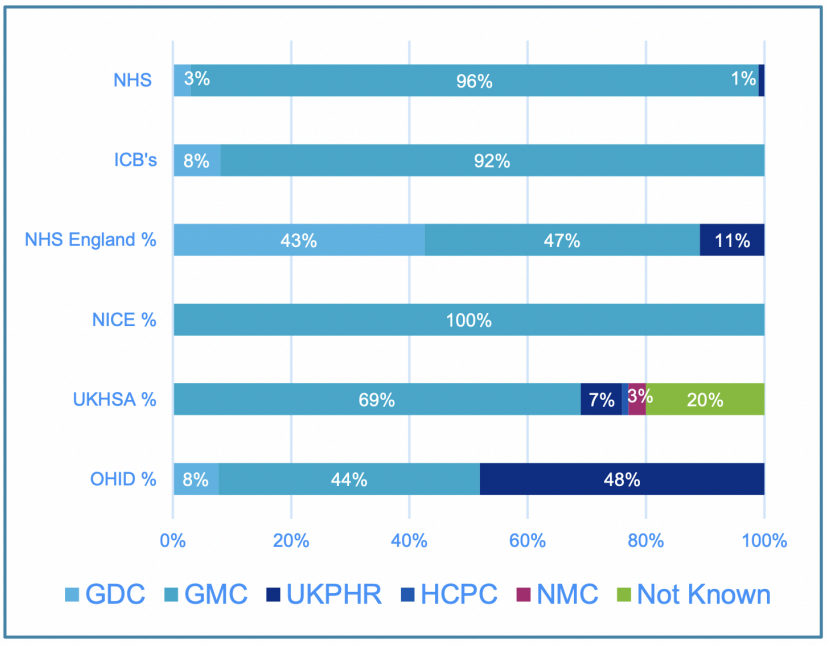
	2018	2019	2020	2021	2022	2018-22
Number on the GMC specialist register for public health medicine	1053	1016	1033	1014	977	-7%

4. Major pay disparities occur at registrar and consultant level depending on employer, professional background, and country[5]. These can be ten of thousands of pounds per year in basic pay.

5. Pay disparities drive serious workforce imbalances[6]. **This compromises the diversity of background and characteristics that is essential for public health** organisations to function well.

% by registration type working in English local authorities	2017	2019	2021	2022	% change 2017-2022
GMC public health specialists	30%	23%	23%	22%	-8%
GMC directors of public health	40%	27%	18%	16%	-24%
UKPHR/Other public health specialists	70%	73%	77%	78%	+8%
UKPHR/Other directors of public health	60%	69%	81%	83%	+23%

Public Health Specialists by registration type (%) for various bodies in 2022



[3] It is difficult to pinpoint the extent of vacancies, though we have been told that the Faculty of Public Health estimates a range of 8-25% unfilled consultant posts in this area. A 2022 BMA report also explores the shortfall of public health doctors against targets and explores the contributing factors to this – see bma-covid-review-report-4-28-july-2022.pdf

[4] https://www.gmc-uk.org/-/media/documents/workforce-report-2023-full-report_pdf-103569478.pdf

[5] This data comes from the Faculty of Public Health and publicly available pay scales at https://www.nhsemployers.org/topics/pay-pensions-and-reward . Analysis has been udnertaken by Dr Ellis Friedman and Dr Youssof Oskrochi

[6] https://www.hee.nhs.uk/sites/default/files/documents/2022%20Public%20Health%20Workforce%20Capacity%20Review%20.pdf

6. Pay disparities on the basis of contract can also **affect existing pay gaps, such as for gender and ethnicity, further compromising workforce diversity**. This can be shown by our summary below of FOI data from UKHSA for annual public health consultant salaries in 2023/24.

Pay Gap by protected characteristic	Mean pay gap in annual basic pay on Medical and Dental TCS	Mean pay gap in annual basic pay on Agenda for Change
Gender	£1586	£1872
Ethnicity	£1212	£2078
Disability status	£937	£475

7. Current funding arrangements do not adequately cover recent consultant pay offers for both academic and local public health in England, **failing to address this shortfall will lead to redundancies, further pay disparities, and limited opportunities for public health registrars**. All this will contribute to diminished public health services and in turn to greater strains on NHS services.

Public Health Medicine Committee
June 2024