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A Review of Pay Comparability for Doctors and Dentists

A report for the Review Body for Doctors' and Dentists' Remuneration

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Foreword

This project has been undertaken at a time of considerable change and challenge for the medical and dental workforces. The NHS continues to face significant pressures relating to recruitment, retention, and workforce motivation, amplified by the cumulative effects of high inflation, industrial action, and sustained workload demands.

The previous review of the pay comparator methodology was completed in 2017. Since then, developments in training and career pathways mean an updated review is required to consider whether the comparator professions and data sources used previously remain appropriate. The distinct nature of medical and dental careers presents particular challenges for identifying appropriate external benchmarks, and this work therefore seeks to provide a robust, transparent framework for evaluating comparability with other professions.

The aim of this report is to support the DDRB in its remit to make evidence-based recommendations on remuneration, balancing fairness for NHS professionals with broader public sector pay considerations.

Comparing medical and dental roles with occupations in the wider labour market is inherently complex, as these roles have no exact equivalents. The methodology has therefore been designed to be systematic, transparent and grounded in structured professional judgement, drawing on stakeholder views, job evaluation principles and the most reliable data sources available. While no comparison exercise can be perfect, the approach provides a consistent and balanced framework to support the DDRB's deliberations.

Incomes Data Research

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Acknowledgements

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Executive summary

- This report looks at how the pay of doctors and dentists compares with pay for other professions in the UK. It was commissioned by the Review Body on Doctors' and Dentists' Remuneration (DDRB) as part of its remit to consider developments in doctors' and dentists' earnings relative to those for comparator professions.

- Our approach combined a review of existing evidence, interviews with key stakeholders, and a structured evaluation of medical and dental roles. We developed a new framework for selecting comparator professions based on five clearly defined characteristics, covering the level of training and professional regulation required; responsibility for independent, high-stakes decision-making; the nature of work schedules; physical, cognitive and emotional demands; and opportunities for career progression. Pay data were then collected and analysed for doctors, dentists, and a range of appropriate comparator professions.

- The review of existing literature showed a lack of academic literature on methods of pay determination and comparability. Many studies rely on job evaluation (JE) to identify appropriate pay comparators, particularly in the private sector, and most signal the importance of considering more than just basic pay.

- Semi-structured interviews with stakeholders representing Government departments, employer bodies, pay experts, pay review body members and trade unions revealed that, while stakeholders had some differing views, in the main they consider using comparator professions as a helpful but imperfect approach. A major problem, however, is the data that underpins the comparisons: official average earnings data (from the Annual Survey of Hours and Earnings, ASHE) is for occupational classifications that are too broad, while data from other sources is often incomplete or unavailable entirely.

- Within the UK, stakeholders did not consider that doctors' and dentists' roles vary sufficiently enough by devolved administration – in terms of job content and responsibility – to warrant separate benchmarking.

- International comparisons are widely seen as important, given that UK-trained doctors move abroad to countries such as Australia, New Zealand, Canada, and Ireland (although not necessarily permanently and decisions are affected by a variety of factors, not just pay). However, adjusting for different healthcare systems, pay structures, and living costs is complex. A minority of stakeholders feel these international comparisons do not offer

sufficient value and suggest focusing instead on understanding why doctors leave and the significance of the issue.

- Our review of doctor and dentist roles identified 17 benchmark roles across hospital practice, general practice and dentistry and included two doctor roles not previously evaluated – post-foundation locally employed doctors (LEDs) and specialists (senior SAS doctors) – and two salaried dental roles.

- We developed a comparator assessment framework for assessing the suitability of potential comparator professions. The framework is structured around five core job characteristics, selected for their relevance to clinical roles and their applicability to other professions. These were: training and professional standards; high-stakes decision-making; work schedules; physical, cognitive and emotional demands; and career progression.

- The comparator assessments identified 'best-fit' external professions that align with the core characteristics in the framework; they are not intended to identify alternative career paths for doctors or dentists.

- Only one profession – Veterinary Surgeon – achieved a close match for both doctors and dentists, and solicitors were identified as a close match for dentists. Most of the other selected professions were assessed as partial matches, indicating that these roles generally share some but not all of the core characteristics.

- Across hospital practice, general practice and dentistry, the benchmarking shows a mixed picture, with relative pay positions varying by career stage, comparator group and pay measure (basic pay, total earnings and total remuneration). The inclusion of NHS pension value materially improves the relative position of doctors and dentists, meaning total remuneration generally benchmarks more favourably than basic pay alone.

- Hospital doctors' pay comparisons vary by career stage and pay measure. At foundation level, basic pay for FY1 doctors sits below most comparators and improves for FY2, while the relative position strengthens once total earnings and total remuneration are considered, reflecting the contribution of additional payments and pension value. A similar pattern is seen for core trainees and specialty registrars, where basic pay tends to sit below comparators, but total earnings narrow the gap, and total remuneration places these roles above several comparators. Among specialty and specialist doctors, pay benchmarks above comparators across basic pay, earnings and total remuneration.

For consultants, basic pay remains below many professional comparators, but total earnings and total remuneration place consultants closer to, and in some cases above, comparator roles.

- Pay comparisons for general practice also vary by role and available earnings measures. For GP specialty trainees, benchmarking is limited to basic pay, which sits above comparators, reflecting the GP training premium. For salaried GPs, comparisons based on earnings and total remuneration show a weaker relative position, with pay below most comparators on these measures. In contrast, GP partners show the strongest relative position, with total earnings benchmarking above all comparator professions, reflecting the higher earnings potential associated with the partnership model.

- Pay comparisons for dentists are more constrained by data availability, particularly for salaried roles, but the available evidence suggests a varied picture across roles and pay measures. For foundation dentists, basic pay sits broadly in line with comparators. Among salaried dentists, basic pay for Band A and Band B roles benchmarks above comparators, though earnings comparisons are limited. For self-employed dentists, associate dentist earnings sit below comparators, while providing-performer dentists are broadly in line with comparator professions. Earnings comparisons should be interpreted with caution, as available data are reported on a headcount rather than FTE basis.[1]

- International pay comparisons are feasible but would require a separate, in-depth study, as meaningful cross-country analysis is complex and depends on robust data, agreed parameters, and careful consideration of differences in healthcare systems, workforce structures, and pay mechanisms. If pursued, further work should focus on key destination countries for UK doctors (Australia, New Zealand, Canada and Ireland) and we would recommend using Purchasing Power Parity (PPP) as the preferred basis for comparison, as it adjusts for cost-of-living differences between countries, which helps make salaries more comparable.

- However, despite these complexities, this review did find robust examples of international pay comparisons being conducted for doctors and consultants, with one particularly relevant study, commissioned by Public Service Pay Commission (Ireland),

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[1]For the purposes of this report, NHS dentists are grouped as associate dentists and contractor dentists. Contractor dentists hold NHS dental contracts, while associates are performer-only dentists.

which could provide a useful methodology reference for the DDRB's international pay comparisons.

1. Introduction

This report presents the findings from a review of the pay comparability methodology used by the Review Body on Doctors' and Dentists' Remuneration (DDRB). The work was undertaken by Incomes Data Research (IDR), following a commission to review and develop the DDRB's approach to pay comparability for doctors and dentists. The project encompassed stakeholder engagement, role evaluation, the identification and assessment of comparator professions, and the development of a benchmarking methodology.

The DDRB provides independent advice to the four UK governments on pay for doctors and dentists working in the National Health Service (NHS) and Health and Social Care (HSC) in Northern Ireland. In line with its terms of reference, the DDRB considers developments in doctors' and dentists' earnings alongside broader labour market trends, including pay in comparator professions. Pay comparability is therefore an important element of its evidence base, informing decisions on fair and appropriate remuneration while balancing recruitment, retention, workforce motivation, and the wider NHS context.

The purpose of this review was to update, strengthen, and modernise the DDRB's pay comparability approach. The key objectives of this work were to:

- assess whether the current list of benchmark roles was appropriate, identify any additional roles to include, and understand how doctor and dentist roles, training and career paths have changed since 2017
- develop an updated methodology for evaluating and selecting comparators
- establish a robust and replicable framework for future pay comparisons.

This work builds on the last comprehensive review undertaken by the Institute for Employment Studies (IES) in 2017. That review highlighted both the uniqueness of medical and dental careers and the difficulty of matching them closely with external roles, as well as the need for practical, clearly defined comparator criteria. It also cautioned against stretching comparability too far or relying on detailed job descriptions that do not translate well across professions.

2. Research methods

This chapter sets out the methods used to carry out the research. Our main objectives were to understand current trends in pay comparability methods and approaches, gather views from stakeholders on the current approach to pay comparisons for doctors and dentists, identify key medical and dental roles for comparison, and develop an updated methodology for evaluating and selecting professional comparators. We also aimed to identify suitable market data to support pay comparisons and to develop a new methodology for conducting those comparisons. The overall aim was to create a robust and replicable framework for future pay comparisons.

2.1.   Overview of the research approach

We used a variety of research methods and analytical techniques, combining both qualitative and quantitative approaches. These included an evidence review, semi-structured interviews, job evaluation, the development of a mechanism for identifying professional comparators, and quantitative benchmarking. To help structure the work, we divided the analysis into six phases:

1. **Foundation research** – Reviewing existing evidence and engaging with stakeholders to inform the development of the new pay comparability approach.
2. **Doctor and dentist role evaluations** – Evaluating the roles of doctors and dentists to support comparator identification and inform the framework for assessing comparator suitability.
3. **Development of comparator assessment framework –** Defining the criteria and mechanism for evaluating comparator suitability.
4. **Identification of comparator professions** – Selecting and assessing suitable comparator professions based on clearly defined criteria.
5. **Sourcing and assessment of salary data** – Collecting and assessing pay and reward data for the identified comparator professions.
6. **Pay comparisons** – Analysing and comparing remuneration across the selected roles.

Further detail on each of these phases is provided in the remainder of this chapter.

2.2.   Foundation research

The first part of the project focused on building a robust evidence base through a combination of a rapid evidence assessment and engagement with key stakeholders. The aims were to identify recent developments in pay comparability practices that could inform our approach, ensure that the list of benchmark doctor and dentist roles properly reflects current medical and dental career paths, and gather views on how the current pay comparison methodology could be improved. Insights from the foundation research helped shape later stages of the project, ensuring that the final methodology and pay comparisons took account of up-to-date evidence and stakeholder views.

2.2.1.   Rapid evidence assessment

As part of the foundation research we undertook a rapid evidence assessment (REA) to build on and update the previous two literature reviews on pay determination and comparability methodologies, which were conducted for the Armed Forces Pay Review Body (AFPRB) in 2016 and the Review Body on Doctors' and Dentists' Remuneration (DDRB) in 2017.[2] The aim of this review was to identify recent evidence and trends in relation to:

- how pay comparisons are conducted across the public and private sectors, including approaches used for other public sector groups and professions
- alternative methods for conducting pay comparisons for doctors and dentists, which could inform later project phases, including consideration of international pay comparisons
- examples, experts or case studies which could be examined or interviewed in more depth to inform the project objectives.

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[2]Brown et al (2016) A Review of Pay Comparability Methodologies: Armed Forces Pay Review Body (AFPRB), Institute for Employment Studies, October 2016; Brown et al (2017) Office of Manpower Economics: Review of DDRB Pay Comparability Methodology: Final Report, Institute for Employment Studies, July 2017. AFPRB have commissioned more recent research on pay comparability, see: Pay comparability for medical and dental officers in the armed forces, however, this report did not include a review of the literature.

To identify the relevant evidence, three complementary search strategies were used:

1. targeted website searches of prominent relevant public and private institutions, including governmental and intergovernmental organisations, professional bodies, trade unions, think tanks, and consultancies
2. advanced Google searches to find wider relevant non-academic and practitioner literature
3. searches of academic databases (SAGE Journals, JSTOR, Core.ac.uk and Google Scholar) using appropriate search terms.

All searches were conducted in March 2025. The inclusion criteria were as follows: relevance to the research aims; English-language publications from 2017 onwards to capture new evidence published after the previous review; full text access availability; and literature possessing a solid scientific basis, eg findings based on quantitative analysis, case studies, literature reviews and/or surveys with acceptable samples.

As with the previous evidence reviews, we found relatively little academic literature on the topic. Across the three search strategies, based on an initial screening of titles and abstracts, we obtained an initial selection of 97 documents. Full text screening reduced the final selection of evidence to 33 papers (including web pages).[3] The main findings relevant to our review were extracted and summarised into key themes, which are presented in Chapter 3.

2.2.2.   Stakeholder interviews

As part of the foundation research we also conducted 14 semi-structured interviews with stakeholders representing government departments, employer bodies, pay experts, pay review body members, and trade unions (see Table 2.2.2-1). These were conducted between 14 March and 7 May 2025, and aimed to gather relevant information and views from stakeholders on:

- the current approach to pay comparability
- how the current methodology could be updated or improved

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[3]IDR added some additional references to expand or further explain elements of the discussion.

- the roles to be assessed and possible comparators

- pay data sources

- conducting regional and international comparisons.

The discussions were guided by topics agreed in advance with the Office for the Pay Review Bodies (OPRB). The OPRB provides secretariat support for the pay review bodies, including the DDRB. Interview questions are provided in Appendix 1.

Table 2.2.2-1 Stakeholders interviewed

Stakeholder	Type
Academic expert in labour markets and pay determination	Pay expert
British Dental Association (BDA)	Trade union
British Medical Association (BMA)	Trade union
Department for Health and Social Care (DHSC)	Government
Independent reward consultant	Pay expert
NHS Employers	Employer
NHS England	Employer
Northern Ireland Government	Government
Office of the Pay Review Bodies/DDRB Secretariat	Pay expert
Review Body on Doctors' and Dentists' Remuneration (DDRB)	Pay review body member
Scottish Government	Government
Welsh Government	Government

Note: the OPRB stakeholder group was represented through interviews with two individuals (a senior statistician and a remuneration specialist). The DDRB stakeholder group was represented through interviews with two review body members.

Chapter 4 presents the interview findings, organised by theme, and provides a summary of the key insights.

2.3. Doctor and dentist role evaluations

In this phase, we carried out detailed job evaluations of the benchmark doctor and dentist roles to establish their relative sizes. The findings from these evaluations helped us to develop a structured framework for identifying and assessing suitable comparator

professions, ensuring that any external pay comparisons are based on a well-grounded understanding of what these jobs involve and the demands they place on postholders.

Role evaluations were undertaken using the IDR Job Evaluation Scheme, an analytical, equality-proofed framework designed to assess all types of work – from operational to specialist and managerial roles – to evaluate the doctor and dentist roles across seven key factors, as defined in the following table.

Table 2.3-1 IDR Job Evaluation Scheme factors

Factor	What this factor measures
Knowledge and skills	The level of specialist, technical, administrative, operational or professional knowledge and how it is applied to the role, plus other relevant skills, training and experience needed to carry out the role at an effective level
Thinking and creativity	The requirement in the job to collect, consider and analyse information, to diagnose problems and resolve operational issues, to apply initiative and creativity in developing workable solutions (taking into account the degree to which these issues are routine or unexpected) and to develop plans, policies, strategies or new ways of working
Communications	The requirement for both verbal and written communications and the development of interpersonal relationships, including working effectively with colleagues outside the immediate working group, customers, and representatives of all external organisations, dealing with difficult and sensitive issues in a caring manner, and influencing and persuading individuals and groups both internally and externally
Freedom to act	The requirement in the role to take independent action, taking account of the level of supervision, instruction and guidance provided and the existence of procedures, policies and guidelines
Resources	Responsibility for monitoring or managing resources or equipment in the role including staff, temporary employees and contractors, budgets, income and cash, other tangible assets and facilities, and other less direct resources such as pupils, patients, service users etc
Service delivery	Considers the contribution of the role to the services or products provided by a team, department or organisation, taking into account colleagues, customers or service users, and the timescale of the impact
Context	The nature of the work environment and the demands on the jobholder, taking into account the level of concentration and intensity, pressure of workload and deadlines, the level of physical and emotional demands involved, exposure to threatening behaviour or abuse, and nature of the working conditions

Source: IDR Job Evaluation Scheme, Incomes Data Research (IDR). For client use only.

Across our work for clients, we have used the scheme to evaluate a broad range of roles and have also developed an understanding of how the levels in our scheme relate to those in other major job evaluation frameworks, including those used by the NHS and other consultancies that have undertaken pay comparability work for the DDRB previously.

Evaluations were carried out through a desk-based process and drew on a range of evidence sources as follows:

- NHS Trust job advertisements and person specifications
- guides on NHS training and education pathways
- previous job evaluation outcomes for doctor and dentist roles
- additional information gathered from stakeholders, providing insights into job content and career structures.

The outcomes of our evaluations, along with how they compare to previous role evaluations of doctors and dentists, are presented in Chapter 5.

2.4.   Development of comparator assessment framework

In this phase, we determined the criteria and mechanism for assessing the suitability of comparator professions. Unlike standard benchmarking approaches that rely solely on job size or evaluation scores to identify comparators, the comparator assessment framework was designed to reflect the key characteristics of medical and dental roles. The 2017 IES review followed a similar approach, considering qualifications, training and career paths; technical skills and competencies; and responsibilities and risks.[4]

Our comparator assessment framework is structured around five core job characteristics, selected for their relevance to clinical roles and their applicability to other professional occupations. The selection of these characteristics was informed by our experience of assessing medical and dental roles in both NHS and non-NHS contexts, evidence gathered through the role evaluation process undertaken for this study, and feedback from key stakeholders, which included the trade unions.

Although some stakeholders identified job security as a distinguishing feature of medical and dental employment, this was not included as a criterion. Job security is shaped by labour market conditions, rather than by the intrinsic nature or demands of the work itself, so including it could distort the purpose of the comparator scoring, which is to assess job

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[4]See Table 7.1, IES (2017).

equivalence. By contrast, career structure and progression opportunity was retained, as this captures the extent to which advancement to senior or top-tier roles is available or constrained by structural limits.

We recognise that comparator professions may have distinctive features that do not apply to medical or dental roles, such as commercial or compliance requirements. Because these characteristics are distinct to those professions and are less relevant for assessing equivalence with doctors and dentists, they were excluded from the framework. The five key job characteristics used in our comparator assessment framework are outlined in the following table.

Table 2.4-1 IDR comparator assessment framework

Characteristic	What it measures	Why it matters
Training and professional standards	Level of education, training requirements, and need for professional registration or licensing	Doctors and dentists complete long, formally regulated training; comparator professions should demonstrate similarly rigorous preparation and/or recognised professional standards
High-stakes decision-making	Responsibility for high-stakes decisions and independence of those decisions	Doctors and dentists make complex, high-stakes decisions with significant consequences; comparator professions should show similar responsibility and autonomy in professional judgement
Work schedule	Extent of antisocial or unpredictable hours and opportunity for rest or recovery	Doctors and dentists frequently work irregular or extended hours, including nights and on-call duties with limited rest. Comparator professions should demonstrate similarly demanding work patterns
Physical, cognitive and emotional demands	Physical and cognitive demands and exposure to traumatic, distressing, or emotionally challenging situations	Doctor and dentist roles are both physically and cognitively demanding and are frequently exposed to trauma, and distress, which places sustained emotional demands on them. Comparator professions should show similar physical, cognitive or emotional demands
Career progression	Extent to which individuals within the profession can progress to senior or top-tier roles	Medical and dental careers typically offer open progression to senior positions once qualification and experience standards are met. Comparator professions should show similar opportunities for career advancement

Note: developed by Incomes Data Research (IDR).

2.5.   Identification of comparator professions

The first stage in this phase involved identifying a long list of potential comparator professions. This identification was informed by:

- professions used in the existing methodology and suggested comparators from previous pay comparability studies
- discussions with stakeholders in the early stages of the project
- our own recommendations, based on our salary benchmarking and job evaluation experience, and our knowledge of medical and dental careers, as well as those of relevant professions in the wider labour market.

Initial screening process

The long list of professions was screened against our initial inclusion criteria to determine which should proceed to full assessment. The initial inclusion criteria were designed to reflect the core characteristics of medical and dental roles and to support the identification of comparator professions that are meaningfully comparable in terms of training, responsibility and career structure. The choice of criteria was informed by evidence gathered through stakeholder engagement and the development of the comparator framework, as well as our broader professional experience of identifying relevant comparators for undertaking benchmarking exercises.

Professions were required to meet four core inclusion criteria – degree-level entry; formal training requirements; structured career pathways; and high levels of responsibility and autonomous decision-making – to be taken forward for full assessment.[5] Opportunities for self-employment were considered as a supplementary factor, reflecting the relevance of practice ownership models in general practice and dentistry, but did not determine inclusion or exclusion as a potential comparator. Below we provide an example of the initial screening process for potential comparator professions.

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[5]A structured career pathway refers to a clearly defined route through which professionals progress, and is typically characterised by prescribed training requirements, professional examinations or accreditation, and a recognised hierarchy of roles.

Table 2.5-1 Example of the initial screening process for potential comparator professions

Comparator profession	Requires a degree? (mandatory)	Requires formal training? (mandatory)	Offers a structured career pathway? (mandatory)	Involves high levels of responsibility/ autonomous decision-making? (mandatory)	Opportunities for self-employment? (non-mandatory)	Meets initial criteria?
Accountant	Yes	Yes	Yes	Yes	Yes	✓
Police Officer	No	Yes	Yes	Yes	No	✗

Note: developed by Incomes Data Research (IDR).

We compiled information on comparator roles and career paths through desk-based research. Each profession that met the initial criteria was then assessed using the previously outlined comparator assessment framework.

Comparator assessment framework

Recognising that these assessments involve specific judgements, we developed a framework to systematically assess comparability with doctors and dentists using the five core characteristics within the IDR comparator assessment framework set out in 2.4-1. Comparator professions were assessed using a set of structured Yes/No questions as follows.

1. Training and professional regulation
    *   Does the comparator profession require a comparable level and length of education and professional preparation? (Yes/No)
    *   Does the comparator profession have to meet a required skill standard to be able to practise? (Yes/No)
2. High-stakes decision-making
    *   Does the comparator profession involve 'high-stakes' decision-making?[6] (Yes/No)
    *   If yes, are 'high-stakes' decisions made autonomously? (Yes/No)

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[6]'High-stakes' decisions are considered to be those which have significant consequences and impact and may have to be made under pressure.

3. Work schedule

- Does the comparator role involve anti-social hours, on-call duties, or frequently scheduled or unscheduled out-of-hours working? (Yes/No)
- Does the role offer limited opportunities for breaks or rest? (Yes/No)

4. **Physical, cognitive and emotional demands**

- Is the role physically or cognitively demanding in a way that makes it a potential comparator to doctors or dentists?[7] (Yes/No)
- Does the role face emotional demands, such as responding to emergency situations, and/or dealing with traumatic events or very sensitive issues? (Yes/No)

5. Career progression

- Does the comparator profession entail a structured career path with several clear steps for advancement? (Yes/No)
- Is progression to senior or top-tier roles largely unrestricted by formal quotas or post availability? (Yes/No)

Scoring approach

Each 'Yes' response was assigned one point and a 'No' response assigned zero points, giving a maximum possible score of 10 points across the five characteristics. The total scores were calculated and used to determine the strength of each match.

Table 2.5-2 Comparability score ranges and interpretation

Score range	Assessment outcome	Description
8-10 points	Close match	High comparable, with strong alignment across most or all key job characteristics
5-7 points	Partial match	Some similarities, but differs in one or more key job characteristic
0-4 points	Limited match	Limited comparability, with substantial differences in key job characteristics

Note: developed by Incomes Data Research (IDR).

Internal workshops were held to discuss and peer-review the assessment outcomes before sharing them with the OPRB for feedback. A sense-checking process was also undertaken,

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[7]'Demanding' refers to professions that require sustained cognitive effort, complex decision-making, or responsibility for others' health, safety, or significant outcomes, and/or regular physical effort, including fine motor skills, manual precision, or physically intensive tasks.

with adjustments made where needed before finalising the list of comparator professions used in the pay comparisons. Outcomes from our assessments are presented in Chapter 6.

2.6.   Sourcing and assessing salary data

We collected, reviewed and collated salary data from a range of sources for use in the benchmarking analysis. For doctors and dentists, pay information was sourced from nationally recognised datasets including NHS Digital publications and other official sources covering basic pay, allowances and pension contributions.

For comparator professions, data sources include commercial salary surveys, publicly available reward information, and data provided directly by employers and professional bodies. This also included a bespoke data collection exercise for pharmacists, where IDR constructed a dataset through direct engagement with major community pharmacy employers.

Each source was assessed for relevance, coverage, and alignment with the job sizes established through the role evaluation stage. Particular attention was given to the definition of pay used in each dataset – such as whether figures reflected basic salary, total earnings, or total reward – as these vary across sources and affect comparability. Full details of data sources for each profession, definitions of pay, and the limitations and caveats associated with these datasets are provided in the technical notes (Appendix 3).

2.7.   Pay comparisons

Chapter 7 presents the pay comparisons between doctors and dentists and the selected comparator professions. This analysis compares remuneration at equivalent job sizes and levels of seniority. Wherever possible, the pay comparisons examine three measures: basic salary; total earnings (including allowances); and total reward (including pensions).[8]

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[8]For DDRB (and other public sector roles) in defined benefit schemes, pension values are calculated as the difference between the employer pension contribution rate and the employee pension contribution rate. For comparator roles, typically in defined contribution schemes, the value of pension, was the median employer pension contribution. See Tables A3.2-4 in Appendix 3 for pay definitions.

To provide a more representative picture than averages alone, the analysis focuses on the 25th to 75th percentile range – that is, the lower and upper quartiles, also known as the interquartile range – which captures the typical spread of salaries. Where percentile data was not available, basic pay ranges were used, supplemented with allowances where appropriate.

Pay levels for comparator professions can vary across local labour markets and UK nations. However, due to data availability and to provide consistency, this study uses UK-wide averages for external professions and England-only pay data for doctors and dentists.

3. Rapid evidence assessment

This REA builds upon and updates two earlier evidence reviews on pay determination and comparability methodologies conducted in 2017 for the Review Body on Doctors' and Dentists' Remuneration (DDRB), and in 2016 for the Armed Forces Pay Review Body (AFPRB).[9, 10]

Our review sought to identify recent evidence and trends in relation to:

- how pay comparisons are conducted across the public and private sectors, including approaches used for other public sector groups and professions
- alternative methods of determining pay for doctors and dentists which could inform later project phases, including the conduct of international pay comparisons
- examples, experts or case studies that could be examined in more depth to inform the project objectives.

The final selection of evidence was limited to 33 papers (including web pages), plus some additional references from IDR to expand or further explain elements of the discussion.[11] As with the previous evidence reviews, we found little academic literature on this topic. Indeed, Armstrong & Brown (2017) noted the lack of academic evidence on pay comparability methodology and, similarly, more recently, Glind et al (2025) noted the 'dearth of recent research on job evaluation (JE) methods' (2025:39), an important underpinning of pay determination, with research in JE having declined since 2010 (ibid.).

3.1.   Key findings

- There has been increased emphasis on achieving equal pay, internal equity, and pay transparency, which has reinforced the importance of robust job evaluation (JE) as a foundation for pay determination. Many of the pay comparability studies identified in this

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[9]Brown et al (2017) Office of Manpower Economics: Review of DDRB Pay Comparability Methodology: Final Report, Institute for Employment Studies, July 2017.

[10]Brown et al (2016) A Review of Pay Comparability Methodologies: Armed Forces' Pay Review Body (AFPRB), Institute for Employment Studies, October 2016. (*The subsequent IDR (2022) work did not include an evidence review.)*

[11]References for this chapter can be found at Appendix 4.

review relied on JE to identify appropriate pay comparators, particularly in the private sector where market alignment remains a key reward priority.

- Since 2017, several bespoke pay comparability studies have been commissioned to support the work of the other PRBs and provide benchmarking for their remit groups. These studies often face similar challenges in identifying direct comparators where roles have distinctive working conditions, leading to the use of a 'best fit' approach. This typically involves JE to match roles based on core skills, knowledge and responsibilities, and some studies also profile occupations against additional factors such as work context and work style.

- In most other professions, pay comparability is undertaken by benchmarking average salaries *within* the profession, rather than across occupations. Benchmarking is commonly carried out through member surveys conducted by professional bodies or employer associations, or by reference to proprietary occupation-specific salary surveys published by consultancies or recruitment agencies. These surveys facilitate job matching based on broader classifications such as job title, job level, job function, contract nature, specialism, years of experience, sector, region, firm size or turnover level. Such approaches are feasible in multi-employer labour markets but are less readily applicable in settings dominated by a single employer. Nevertheless, these surveys provide useful data sources on pay for comparator professions to doctors and dentists.

- In terms of alternative means of conducting pay comparisons, the review identified:

  o a study that used the CAMSIS (Cambridge Social Interaction and Stratification) scale to undertake pay comparisons. CAMSIS is a social stratification scale, hosted at the University of Stirling, which attempts to measure social standing based on occupation using Office for National Statistics (ONS) data. The study highlighted the importance of 'occupational prestige' as a key factor influencing pay comparison (Georgellis et al, 2019) and the CAMSIS scale may therefore be a potentially relevant tool to help identify comparator occupations for doctors and dentists.

  o another study devised a new benchmark measure of 'outside pay', in the context of teachers. Annual Survey of Hours and Earnings (ASHE) data was analysed to examine the occupational choices and earnings for teachers who left teaching (Worth & McLean, 2022). However, there was no evidence from regression modelling that this new measure was more predictive of teacher attrition than the current measure of

teachers' pay compared to other professional graduate occupations. While the usefulness of the new benchmark of 'outside pay' may be limited, the concept of the 'outside option', for graduates deciding whether or not to enter the medical profession, may be of interest.

- There is evidence of pay comparisons being conducted at three distinct levels of analysis: basic pay; total cash (fixed and variable pay); and total reward. The literature signals the importance of considering total reward in pay comparisons. Information on wider earnings, including private practice income, is of clear interest in the context of the DDRB's remit. However, there are significant practical challenges in undertaking robust total reward analysis for doctors and dentists. In particular, comprehensive and consistent data on private practice earnings – especially for consultants – and on total earnings across the devolved nations are limited. There are also limitations in respect of data (under certain headings) for potential comparators.

- A study was identified that provides a methodology for the measurement of total reward for the occupations under the remits of the PRBs (Danzer and Dolton, 2012, cited in Dolton et al, 2019). Dolton et al (2019) used this methodology to examine the value of total reward in occupations under the remit of the PRBs and compared this with the total reward of private sector counterparts. In their calculations of total reward, the authors considered current earnings, pensions, hours of work, paid holidays, employer-provided health insurance, the likelihood of unemployment and the lifetime pattern of pension contributions by employers. It excluded other benefits such as company cars, private medical insurance, and stock options, due to a lack of available data on the value of these allowances. We note that this is a significant limitation to any total reward analysis at this level as these are substantial elements of the remuneration package of some of the private sector comparator professions.

- The DDRB's revised terms of reference for 2025-26 require it to consider international comparators in making its recommendations. This evidence review found that conducting international comparisons can provide useful insights, especially when differences in pay across countries can act as a 'push' or 'pull' factor in relation to the migration of doctors (OECD/European Commission, 2024), but only if the relevant differences between countries can be adjusted and accounted for.

- The challenges of conducting international pay comparisons for medical practitioners include the following: medical practitioners' earnings come from different sources and are based on different payment mechanisms; differences in the availability of robust earnings data; differences across countries in regard to workforce definitions, qualification requirements, hierarchies, distribution of responsibilities, career paths, time taken to progress through grades and pay ranges, and employment terms and conditions; doctor speciality can influence earnings levels; and pay is linked to the particular social, administrative and economic context of each country.

- However, despite these complexities, this review did find robust examples of international pay comparisons being conducted for doctors and consultants, with one particularly relevant study, commissioned by the Public Service Pay Commission (Ireland), which could provide a useful methodology reference for the DDRB's international pay comparisons.

3.2.   Current trends in pay comparison methodology

In their 2017 review of pay comparability methodology, Brown et al noted a trend towards more traditional job evaluation methods being combined with simpler external market- and survey-based approaches in both the private sector and parts of the public sector.[12] Concerns around demonstrating equal pay and achieving internal equity mean formal job evaluation methods remain common as a support for pay determination, with Armstrong & Brown observing that the use of JE 'is increasing in the UK, not least because of the pressures to achieve equal pay' (2023:179). Glind et al (2025) noted that the recent 'EU directive and the US legislation on pay transparency both highlight the use of job evaluation as an instrument for equal and fair pay and for decreasing existing pay inequalities' (Glind et al, 2025:25).

The recent EU directive on pay transparency[13] may support the use of formal job evaluation and although the UK is no longer part of the EU, the directive will impact organisations with

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[12]Job evaluation (JE) is a systematic process for deciding on the relative worth or size of jobs within an organisation (Armstrong & Brown, 2019). Factor-based JE schemes, as the name suggests, allow jobs to be compared on the basis of common factors. As such, they can provide a basis for pay determination.

[13]The EU Pay Transparency Directive is due to be implemented by EU member states by 7 June 2026. It includes requirements around mandatory gender pay gap reporting; joint pay assessments;

business operations in Europe and will perhaps raise expectations of pay transparency in the UK (Faragher, 2024) beyond the current gender pay and CEO pay ratio reporting requirements. The CIPD reported that employees, particularly millennials (those born between 1981 and 1996), are increasingly being more transparent about pay, sharing their terms and conditions on sites such as Glassdoor, and on social media platforms (CIPD, 2019).

The pay transparency laws in the United States (which vary across states but generally require employers to disclose salary ranges and benefits to job candidates) also seem to have boosted the use of market rates for pay determination purposes, with employers turning to market data for a number of purposes including: setting the pay of new recruits (54% of organisations); guiding salary negotiations (53%); setting ranges for specific job titles (90%); and setting the salary for job adverts (41%) (Cullen et al, 2023). 'Extreme market pricing', whereby organisations rely solely on comparisons with external market rates for pay determination, is the most common method of valuing jobs in the United States, but it is also found in the UK, particularly among small and medium-sized organisations (Armstrong & Brown, 2019).

A survey of the use of job evaluation by e-reward found that the three main purposes of job evaluation among respondent organisations were to: manage internal job relativities (88%); compare internal pay levels with market rates (76%); and provide a basis for the design and maintenance of a rational and defensible pay structure (69%) (e-reward, 2017). However, only about half (49%) of European organisations in the private sector use a formal JE scheme (Cordis, 2023: cited in Glind et al, 2025), yet almost all public sector organisations do so (Glind et al, 2025). UK survey data from Incomes Data Research shows that analytical or 'points factor' JE approaches remain prevalent in the UK, used by 63% of respondents (Heffernan, 2023). However, a trend has been to 'consign point factor schemes into a more subsidiary or supporting role' (Armstrong & Brown, 2017:153) with an increasing reliance on less time-intensive JE methods such as non-analytical matching or levelling techniques (Glind et al, 2025; Armstrong & Brown, 2017).

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prohibition of pay secrecy clauses; pay transparency at the point of recruitment; and transparency on pay policy, pay setting and pay progression (Clifford Chance, 2024).

While the 'ability to pay' remains the most important factor in setting salaries in private sector organisations (CIPD, 2019), market alignment is an important reward priority in the private sector (PwC, 2023). The use of market rates is more common in the private sector (22% of HR professionals state that this in conjunction with JE is the most important factor in setting salaries), compared to the public sector (16%, falling to 7% for market rates without JE) (CIPD, 2019). Linked to this, there has been an increasing use of job family-based approaches in the UK, which allow organisations to set pay at different levels within the same grade to reflect market pay differences between occupations (Brown, 2018). Although the private sector is the most likely to use job families (52%, compared to 24% in the public sector (CIPD, 2019), job family approaches are being adopted in the public sector. For example, the Civil Service has implemented pay scales for digital and data roles and commercial specialists, which allow for higher pay and bonus potential to better align with the private sector (Trendall, 2024). This is linked to an increasing demand for greater flexibility and customisation of reward (CIPD, 2019).

Armstrong & Brown (2017), however, cited words of caution from the CIPD about the reliability of market rates, noting that: 'Although the concept of a market rate for a job is common, there's no such thing as an accurate single rate of pay for a job or role, and rates may vary within the same occupation and in the same location. It's important for employers to consider carefully how to interpret the data collected and where the organization wants to position its salary and total remuneration levels in relation to the market' (CIPD, 2017; cited in Armstrong & Brown, 2017:156).

Similarly, Armstrong & Brown (2019) subsequently advised that establishing the market rate for a job is a matter of judgement rather than certainty, noting: 'All too many managers and senior executives – and, indeed, many employees – commonly believe that it is not only possible, but relatively easy, to establish a 'correct' rate for any given job, in any industry, in any location, for any age or experience level, preferably to the nearest pound. But ...different corporate values, variations in the 'pay stance' adopted by organisations (where they want their pay levels to be in relation to market rates), perceptions of the contribution of each job to the effectiveness of the organisation, and the experience and performance of the

individuals holding the jobs all impact on the remuneration paid to people in apparently similar positions' (Armstrong & Brown, 2019: 170).

Babcock, Xianghong & Lowenstein (cited in Armstrong & Brown, 2017) also highlight the issues with market pay comparisons, including the risks of inaccurate job matching and that the choice of pay comparators can often carry the risk of 'self-serving bias', with Findley et al noting that the choice of comparators significantly affects the outcome (cited in Armstrong & Brown, 2017). Indeed, last year, the retailer Next lost a six-year equal pay claim after a tribunal ruled that it should not have relied on market rates when determining employees' pay, due to market rates reflecting historical attitudes of 'men's' and 'women's' work and was therefore discriminatory (Wyatt, 2024). There is also no certainty that a pay structure aligned to the market will always prevent recruitment or retention issues.

Importantly, Armstrong & Brown (2019) state that most organisations try to focus on what is right for them, pursuing a policy of best fit rather than best practice, and recognising the importance of market pricing but not to the detriment of internal equity considerations.

Overall, Armstrong & Brown (2017) conclude that the broad trend in job evaluation methodology is for 'adaptation rather than revolution, for simplification rather than complexity' (2017:157) and more recently, Glind et al (2025) noted in their scoping review of the JE literature, that a multitude of organisations, including public sector employers, and HR professionals are seeking innovation and solutions to the 'pitfalls' in the job evaluation process. In particular, they are demanding less bureaucracy and greater flexibility in JE methodology. The latest edition of Armstrong and Brown's handbook notes, significantly, that the competing claims of external competitiveness and internal equity may be hard to reconcile in practice (Armstrong and Brown, 2024:179).

3.3.   Pay comparability in the public sector

While only the Armed Forces and Prison Service Pay Review Bodies (in addition to the DDRB) have requirements in their standard terms of reference to undertake pay comparisons, other pay review bodies have done so to inform their recommendations. The DDRB's revised terms

of reference from 2025-26 also require it to consider international comparators in making its recommendations (DDRB, 2024), which we consider in Section 3.8.

The AFPRB is required to ensure that Armed Forces pay levels remain broadly comparable with those in civilian life, ensuring pay remains consistent with pay levels of other public-sector workforces (especially given the Armed Forces cannot participate in collective bargaining or industrial action) and broadly comparable with the private sector (AFPRB, 2025). Indeed, some members of the Armed Forces that work alongside civilian contractors and some personnel, in specialist trade groups (eg cyber and engineering), are very aware of the reward packages available to individuals with similar skills outside of defence (eg in the private sector or overseas) (AFPRB, 2025). Similarly, Defence Medical Services (DMS) MODOs' work is 'interwoven with the NHS', (AFPRB, 2024:60), with pay comparisons drawn between NHS doctors and dentists and DMS personnel (AFPRB, 2025).

The Prison Service Pay Review Body (PSPRB) is required to consider 'the competitiveness of the Prison Service in England and Wales with the private sector, and any differences in terms and conditions of employment between the public and private sectors, taking account of the broad employment package including relative job security' (PSPRB, 2025:iv).

Currently, the DDRB conducts pay comparability using three core measures: how earnings have evolved relative to the pay distribution across the UK economy, using Annual Survey of Hours and Earnings (ASHE) data; changes in real-terms pay over time, using the Consumer Prices Index (CPI); and pay compared to that in comparator professions, based on job evaluation methods, to enable like-for-like comparisons as far as possible.[14] This was supplemented in 2025 by a broad job levelling and market assessment using Willis Towers Watson (WTW), pending results of this review. Variations of these methodologies are used by the other PRBs, with the methods applied by the other PRBs discussed below.

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[14]Brown et al, 2017 matched medical and dental roles to actuarial, legal, finance/accounting, pharmaceutical, academic and veterinary roles.

3.3.1. Broad comparisons using ONS earnings data

Both the AFPRB and the Police Remuneration Review Body (PRRB) use the Average Weekly Earnings (AWE) series and pay settlements implemented across the public and private sectors to monitor pay movements. In addition, the AFPRB uses ASHE data to analyse the position of the main pay scales, including the X-Factor, in the distribution of earnings of those in full-time employment across the wider economy (AFPRB, 2025:17). Non-pay related benefits are not considered in the AFPRB pay comparability analysis. Similarly, the PRRB uses ASHE data to compare police officer (constables and sergeants) median full-time gross annual earnings against three comparator groups: the whole economy; associate professional occupations (this group includes police officers) and professional occupations (typically graduate professions) (PRRB, 2025).[15],[16] The Prison Service Pay Review Body (PSPRB) also compares gross annual earnings against the percentile distribution of economy-wide earnings, using ASHE data (PSPRB, 2025).

The School Teachers' Review Body (STRB) considers how teachers' relative pay compares to other occupations, using ASHE data on full-time median gross annual earnings for the whole economy, wider public sector and for other 'professional occupations' in England (STRB, 2025).

The NHS Pay Review Body has also consistently used ASHE to compare full-time earnings in the human health and social work activities sector with those for employees in the whole economy, public and private sectors and in certain broad occupational groups (NHSPRB, 2025).[17]

The Review Body on Senior Salaries (SSRB) focuses on comparisons at the top of the earnings distribution in both the public and private sectors, rather than making specific occupational

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[15]Using the Police Earnings Census at the Home Office.

[16]The review body's analysis only focuses on constables and sergeants, to the exclusion of the inspecting, superintending and chief officer ranks. This is due to smaller sample sizes for the latter group, which introduces higher uncertainty into the earnings estimates (Police Remuneration Review Body, 2025).

[17]These include professional occupations; associate professional and technical occupations; administrative and secretarial occupations; skilled trades occupations; caring, leisure and other service occupations (NHSPRB, 2025).

comparisons. The SSRB consider ASHE data on relative earnings growth at the 90th and 95th percentiles of the earnings distribution for both the public and private sectors (SSRB, 2025).

3.3.2. Graduate and starting salary comparisons

The AFPRB, PRRB and STRB have conducted comparisons of graduate starting pay using survey data from organisations such as The Institute of Student Employers, High Fliers, Prospects and IDR (AFPRB, 2025; STRB, 2025; PRRB, 2024). The AFPRB also compares Armed Forces starting salaries with those for other public sector occupations, which may or may not require a university degree, (AFPRB, 2025) and the PRRB has compared police constable degree apprenticeship salaries with other degree apprenticeships at commencement and completion of the qualification, using GOV.UK and IDR data (PRRB, 2024)

The NHSPRB conducts pay comparisons using the Longitudinal Education Outcomes (LEO) dataset, published by the Department for Education. The LEO covers graduate earnings by subject for first-degree higher education (HE) graduates at one, three, five and 10 years after graduation. The NHSPRB focuses on graduates in nursing and midwifery; medical sciences; pharmacology, toxicology and pharmacy; allied health subjects; and health and social care. The data utilised also includes the earnings of graduates employed in areas unrelated to their degree subject but it is not adjusted for geography, age or other factors. This data also only measures earnings and does not include the elements of wider reward, which are particularly relevant to medical staff (DHSC, 2024).[18]

3.3.3. Comparisons with comparator occupations

Since 2017, several bespoke pay comparability studies have been commissioned to support the work of the other PRBs and provide benchmarking for their remit groups. As part of these studies, suitable comparators have had to be identified for roles where distinctive working conditions mean it is difficult to identify direct comparators and therefore as a result a 'best

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[18]Total reward refers to the combination of financial and non-financial elements of remuneration, including pay, pensions and other benefits in kind. While the literature emphasises the importance of considering total reward in pay comparisons, there is no consensus on how total reward should be defined or measured, and approaches vary widely across studies. Further discussion of total reward concepts and evidence is provided in Section 3.7.

fit' approach has been used, often supported by job evaluation methodology, to ensure comparisons are made on the basis of the same or similar levels of responsibility and skill.

For example, in 2019, the Office of Manpower Economics (OME) commissioned IDR to conduct a pay comparability exercise for operational Prison Service staff, on behalf of the PSPRB.[19] This provided pay comparisons with other occupations judged to be suitable comparators. As in Brown et al (2017), comparators were identified through a job evaluation methodology. This included: interviews with key stakeholders; a review of job descriptions; job evaluation of the roles against IDR's own JE scheme which identified core characteristics of Prison Service roles; the identification of a large pool of potential comparators in the wider labour market and collation of comparator job descriptions; and assessment of the extent to which comparator jobs served as a good fit based on the core job characteristics. A scoring mechanism was devised based on the level of match (low, medium, or high), with the highest scoring roles considered the most appropriate comparators. Finally, pay comparisons were conducted with the most appropriate comparators, examining the relative position of Prison Service staff on basic pay, including any location allowances, and basic pay plus unsocial hours pay (IDR, 2019a). The latest PSPRB report includes an updated comparator analysis based on the IDR approach, examining base pay including unsocial hours payments for Band 3 staff, against the pay of the comparators identified by IDR (PSPRB, 2025).

In 2021, a pay comparability exercise was commissioned by the OME, on behalf of the AFPRB, for Defence Medical Services (DMS) Medical and Dental Officers (MODOs). The approach also utilised job evaluation methodology for assessing the suitability of different civilian jobs as comparators for General Medical Practitioners (GMPs) and General Dental Practitioners (GDPs), with roles assessed against job factors designed to reflect the core underlying skills and features of the military roles.

These factors were determined using information from key stakeholder interviews and desk reviews of supporting documents (IDR, 2022). The job factors used in the assessment of comparators is shown in the following figure.

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[19]The Office of Manpower Economics (OME) was renamed the Office for the Pay Review Bodies (OPRB) in 2024.

Figure 3.3.3-1 Job factors used in the assessment of job comparators for MODOs

Clinical skills and experience
This factor considers the level and breadth of professional knowledge required and its application to the role, as well as the level of training and experience required to perform the role effectively.
Rationale – the above factor aims to reflect what we have learnt about the level of skills, qualifications, training, and experience required to practice in the military, as well as reflecting any specialities.

Management of resources
This factor considers the extent of management responsibilities in respect of controlling or directing staff (including contractors), budgets, medical equipment and supplies (including medicines), and other tangible/physical assets.
Rationale – the above factor aims to reflect responsibility for resources.

Communications
This factor considers the communication skills required with both the immediate and wider working groups, including the level of interaction, influence and persuasion and difficult/sensitive nature of the topic.
Rationale – this factor aims to capture communications/liaison with patients, colleagues and also commanders relating to health/fitness reports and/or deployability.

Service delivery
This factor considers the effect of the role on the services delivered, accountability for results and contribution to overall organisational strategic goals.
Rationale – this factor aims to capture the impact of the role on both patients/service users and the wider DMS strategic aim for occupational health and fitness to deploy.

Risk management and governance
This factor considers the management of clinical risks and governance (including audit of other professionals' practice), operational risks and financial risks.
Rationale – this factor aims to reflect risk management and level of governance required. It encompasses both clinical and non-clinical risk and governance.

Decision-making and accountability
This factor considers the level of decision-making, use of judgement, and accountability of the role, including the level of independent action.
Rationale – this factor aims to reflect lone and autonomous judgements and the impact of decisions made on both personnel and the Service.

Source: IDR, 2022

Job evaluation methodology was also used to help consider the competitiveness of teachers' pay in 2024. The STPRB commissioned Willis Towers Watson (WTW) to undertake benchmarking of primary and secondary teacher and leadership roles against pay data for jobs of comparable size, scope and complexity.[20] WTW used a job levelling methodology and grading system to compare 36 different roles to other roles of a similar size in terms of required skills, experience and accountabilities.

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[20] WTW (2024) OME – School Teachers' Review Body Teacher Job Levelling - Final. Willis Towers Watson. March 2024.

The 2025 STRB report stated: 'Benchmarking is a useful way to provide insights to the important central question of how competitive current pay is… Benchmarking relies on finding an objective way to compare roles which, whilst different, share important characteristics in terms of size and scope. Whilst the outputs should be treated with care, and are based on a sample, it does provide a useful alternative lens to examine the competitiveness of pay. This type of exercise is standard practice in the private sector' (STRB, 2025:10).

A key challenge in pay comparability is finding benchmarks for the distinct aspects of some occupations. Indeed, the AFPRB acknowledge that finding direct civilian equivalents for some military occupations is difficult (AFPRB, 2024). The experience in other English-speaking countries is relevant here. For example, the RAND National Security Research Division (NSRD) in the United States has conducted military-to-civilian occupational matching using an occupational questionnaire (the Occupational Information Network (O*NET)). Its latest study focused on US Navy, Marine Corps and Airforce occupations, with the aim of improving the transition for service members into civilian employment (Wenger et al, 2023). By breaking down the elements of selected military occupations such as knowledge, skills, abilities, work activities, work context, and work styles, and profiling the same data for civilian jobs using O*NET data, it algorithmically matched military occupations to civilian occupations and created 'an apples-to-apples comparison' (Wenger et al, 2023:v).

In the UK, there have been discussions on designating a portion of existing police officer pay as a 'P-Factor', reflecting the distinct elements of police officers' responsibilities, obligations and terms and conditions, which are shared by very few other workers in the public sector and private sector, building on the original X-factor addition for the Armed Forces. The PRRB has raised concerns on the methodology, which the NPCC has attempted to address but there is no consensus among policing parties on the way that it should be used in conjunction with benchmarking, and the PRRB suggested the unique aspects of policing should be explored in a comprehensive review of remuneration (PRRB, 2024).

Following a different approach, the PRRB has compared police pay with the occupations from which police officers most commonly join the police service. It found most officers join from

the following SOC occupational groups: welfare and housing associate professionals; caring personal service occupations; sales assistants and retail cashiers; administrative occupations (including administrative occupations in government and related organisations); community and civil enforcement occupations; and customer service occupations. It then compared constable salaries with the quartiles and mean of the earnings distributions for these occupations (PRRB, 2024). We would comment that this is a highly unusual approach that departs from the usual principles involved in comparability exercises, given that it relies on a group of 'comparators' from whom the recruiting body has few/no difficulties in attracting staff, and that do not constitute an issue in respect of retention. As such we would suggest it is less relevant than other examples.

3.4.   Pay comparability in other professions

As identified in Brown et al, 2017, pay levels for other professional occupations are typically informed by the benchmarking of average salaries within the relevant profession, rather than looking outside of the occupation. This benchmarking is typically undertaken through:

- annual member surveys hosted by professional bodies, with benchmarking typically conducted against factors such as years of post-qualification experience (PQE), job level, specialism, region, practice size (relevant to accountants, veterinary professionals, lawyers) (ICAEW, 2018; Law Society, 2025; SPVS, 2024), responsibility level, and job function, or by
- reference to proprietary occupation-specific salary surveys published by recruitment agencies (ICAEW, 2018) and large consultancies (eg Willis Towers Watson, Korn Ferry, Deloitte etc) (relevant to actuarial, finance and pharmaceutical roles). These surveys facilitate job matching based on broader classifications such as job titles, hierarchy levels, sector, region, organisation size or turnover level.

These surveys are useful sources of pay data for the DDRB comparator professions. Some professional bodies set minimum wage expectations, for example, Royal Institute of British Architects (RIBA) Chartered Practices are required to pay at least the Real Living Wage, as defined by the Living Wage Foundation (RIBA, 2024), to all staff, including apprentices and architectural assistants. RIBA recently conducted a survey of practice employees on

remuneration and working hours, with the findings indicating that while most practices pay the Real Living Wage for all staff, based on contracted hours, many staff in their early careers do not receive the Real Living Wage once additional hours worked are included (RIBA, 2024).

The Law Society recommends a minimum salary for trainee solicitors and Solicitors Qualifying Exam (SQE) candidates in London and outside of London, following the removal in 2014 of the regulatory minimum salary set by the Solicitors Regulation Authority (The Law Society, 2024). [21] This rate is reviewed annually, with the Consumer Price Index (CPI) used to calculate each year's rise in the recommended minimum salary (ibid.). However, lawyers' earnings are generally dependent on factors such as practice area; sector (lawyers in commerce and industry tend to earn more than those in government or private practice); stage of career; size of employer; and geographical location (The Law Society, 2025).

Salaries of first- and second-year trainee lawyers and newly qualified lawyers within the largest UK law firms are often compared across firms. Recent reporting indicates that some large UK law firms have moved away from advertising single 'spot rate' salaries for newly qualified (NQ) lawyers towards publishing headline maximum potential remuneration packages, combining base pay with variable elements such as bonuses. This shift may represent an attempt by employers here to gain more control over starting pay and prevent 'leapfrogging'.

Industry sources suggest that, at the upper end of the London market, advertised maximum potential NQ remuneration has reached £180,000 per annum (The Lawyer, 2024). This is consistent with wider market reporting: the *Financial Times* has reported NQ salaries of £150,000 at Slaughter and May, and Clifford Chance reports on its website that newly qualified lawyers are paid £150,000. However, such figures reflect the highest-paying firms and provide limited transparency on typical or average earnings for newly qualified lawyers.

Similar to the findings of Brown et al, 2017, this review found little evidence of comparator professions looking outside of their own professional areas to conduct pay comparisons.

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[21]Currently the rates are set at: £27,418pa in London and £24,320pa outside London (The Law Society, 2024).

However, we did find minor evidence of a comparator profession following with interest developments in the medical career pathway. The Royal College of Veterinary Surgeons (RCVS) Education Committee highlighted the new NHS apprenticeships for medical doctors, implemented from September 2023, with the suggestion that the RCVS could explore the potential for a similar veterinary apprenticeship (RCVS, 2023).

3.5.   Alternative methods of conducting pay comparisons

Within the academic literature, we identified a novel approach to undertaking pay comparisons, albeit through the lens of determining 'pay satisfaction', which can be defined as a person's feelings about the adequacy of their pay (Armstrong & Brown, 2019), which are often based upon the comparisons they make between their own pay and that of others (ibid.). Georgellis et al (2019) compared occupations by considering the similarity of the 'prestige' of the occupation. Occupational prestige is based on how society perceives different occupations, and is typically linked to factors such as education, income level and societal contribution. The authors used the CAMSIS (Cambridge Social Interaction and Stratification) scale, which is a social stratification scale, hosted at the University of Stirling, that attempts to measure social standing based on occupation using Office for National Statistics (ONS) data. [22] It uses occupational groups as its basic units since 'occupation is still the single most significant and convenient indicator of someone's location in the overall structure of advantage and disadvantage, as well as a major source of social identity' (Lambert and Prandy, 2018).

Georgellis et al (2019) provided a relevant example within their paper, stating that: 'Although doctors and lawyers represent different professions and different industrial classification codes, the CAMSIS scale classifies them as being similar professions in terms of relative prestige. For this reason, we seek to probe for the first time how similarity in terms of occupational prestige affects pay comparison and pay satisfaction' (Georgellis et al, 2019:580).

The authors hypothesised that the more similar the prestige of others' occupations, the greater the tendency is to compare pay; that the pay of others in similarly prestigious

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[22]See: https://www.camsis.stir.ac.uk/

occupations has a negative impact on pay satisfaction; and that the negative effect of comparison is stronger in higher-prestige occupations than in lower-prestige occupations. They conducted two studies. Study 1 used an experimental vignette methodology with 200 participants in the USA and Study 2 applied an empirical approach using 18 waves of the British Household Panel Survey (the basis for the more recent Understanding Society survey). The authors' hypotheses were confirmed across the two studies and highlighted 'the importance of occupational prestige as a main factor influencing pay comparison' (Georgellis et al, 2019:578). The CAMSIS scale may therefore be a potentially relevant tool for the DDRB to help identify comparator occupations for doctors and dentists.

We also identified a study by the National Foundation for Educational Research (NFER) which created a new benchmark measure for teachers' pay. The authors (Worth & McLean, 2022) questioned whether pay levels for other comparator professions represent a valid benchmark for teachers' pay. The study notes that teacher pay is often benchmarked to earnings for other professional, graduate occupations, which makes sense for understanding teacher recruitment. However, it argues that this makes less sense for addressing the retention of teachers, due to the findings of a longitudinal analysis of the occupations into which teachers who left teaching in the state sector in England moved (Worth and McLean, 2022). The analysis indicated that the majority of teachers who leave teaching do not move into professional or managerial occupations, but instead, the wider education and childcare sector.[23] It found that most entered jobs below professional or managerial level. Only about 2% of teachers moved into a different professional occupation immediately, and only 3% were working in a different professional occupation 10 years after leaving. Therefore, the authors devised a new benchmark, which measures what a teacher who left for another job (termed 'outside pay') typically earned and how this changed over time. ASHE data was analysed to examine the occupational choices and earnings for teachers who left teaching over the last 30 years. The study found that on average, the earnings of early-career teachers who left state-sector teaching tended to be higher in the first year after leaving than in their

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[23]Including being a teacher outside of schools (eg tutors), or in the private sector, or working in further or higher education, and in childcare related occupations or as teaching assistants (Worth and McLean, 2022).

last year of teaching.[24] However, comparison of the earnings trajectories of teachers who left with teachers (with similar characteristics) who stayed in teaching for 10 continuous years found that leavers had lower subsequent earnings growth than teachers who stayed .[25]

The analyses, however, concluded that there was limited evidence that the new measure of 'outside pay' was superior to using professional pay as a benchmark, with the measure of outside pay having a similar profile over time to professional pay (ibid:3), with both pay measures suggesting that teacher pay has become less competitive to other options over the last decade. In addition, there was no evidence from regression modelling that the new measure was more predictive of teacher attrition than a measure of teacher pay relative to professional pay.

The authors stated: 'These results also do not provide a strong reason to abandon making comparisons between teacher pay and professional pay in order to understand the likely impacts of relative competitiveness on attrition. Not only is benchmarking teacher pay to professional occupations likely more useful for analysing recruitment (versus retention), the larger sample sizes available for professionals makes it a useful benchmark to derive from a number of different datasets' (Worth & McLean, 2022:66).

While the usefulness of the new benchmark of 'outside pay' may be limited, the concept of the 'outside option', for graduates deciding whether or not to enter the medical profession, may be of interest to the DDRB.

3.6.   Public and private sector pay comparisons

Marcinkowski et al (2024) acknowledge that 'to determine specific levels for public sector pay grades in reference to relevant market comparators, it is important not to rely on a simple comparison of average salaries in the public and private sector' (Marcinkowski et al 2024:90), with comparisons instead needing to account for education and skills levels for similar jobs. The authors discuss the work of the Public Service Pay Commission in Ireland,

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[24]Earnings for leavers were about 7 per cent higher in real terms in their new job than in their last year of teaching (Worth & McLean, 2022).

[25]Teachers with similar characteristics who stayed in teaching for 10 years had about 6 per cent higher earnings, around three percentage points higher than teachers who left (Worth & McLean, 2022).

established in 2016 as a temporary independent body to analyse the wage system. The Commission's predecessor, the Public Service Benchmarking Body, had used a job evaluation methodology to analyse public service remuneration, however, the body received criticism for the lack of transparency and clarity in its methods (Marcinkowski et al, 2024). Its findings were used as the basis for a series of reductions in public sector workers' pay, following the economic crisis of 2009/10. In response to the perceived shortcomings in the methodology underpinning these pay cuts, the Public Service Pay Commission was established. Marcinkowski et al (2024) state that this Commission used a more robust and varied methodology to compare the pay levels of public service grades with pay for jobs of similar size and complexity in the private sector through regression analysis of household survey data and administrative salary data. 'It aimed to compare wages across sectors by accounting for a comprehensive set of worker characteristics and also implemented job evaluations to enhance the fairness and accuracy of public and private sector pay comparisons' (Marcinkowski et al, 2024:93).

Similarly, we also identified studies conducted by the ONS (2020) and, separately, the Institute for Fiscal Studies (O'Brien, 2022) which controlled for worker characteristics in their comparisons of public and private sector pay for similarly skilled occupational groups, using ASHE and Labour Force Survey (LFS) data and regression analysis.

In the ONS study, the main factors considered as influencing earnings were: employer and employee pension contributions (pensions being a significant proportion of employee remuneration, especially in the public sector); age (used as a proxy for experience); sex; skills/occupation group (the 2010 Standard Occupational Classification used in ASHE is grouped into four broad skill levels, which consider qualification levels, training, skills and tasks undertaken); organisational size and working patterns; and other factors.[26] The study presents, amongst other analyses, public and private comparisons for each of four categories of occupations, by organisation size and by industry grouping. The study found that on

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[26]For example, geographic factors such as local labour market conditions and cost of living; job tenure, often used as a proxy for organisation-specific experience; contract type eg permanent, temporary, full-time or part-time; benefits-in-kind such as a company car or company-paid health insurance; and union membership, however the latter was not used in the ONS analysis as ASHE does not hold that variable. (ONS, 2020).

average, employees in the public sector received a larger total remuneration package than their counterparts in the private sector in almost every occupation grouping regardless of company size; however, high-skilled private sector employees in the knowledge-intensive services were found to have had higher earnings on average than their counterparts in the public sector (ONS, 2020).

These studies highlight the importance of consideration of different employee and employer characteristics in pay comparisons, as direct comparisons of average earnings between the sectors do 'not give a full picture of the difference for similar workers' (O'Brien, 2022:3).

3.7. Total reward comparisons

Armstrong & Brown define 'total reward' as 'the combination of financial and non-financial rewards made available to employees' (2019:15). Dolton et al (2019) state that 'any debate about remuneration should include pay and pensions and all other forms of benefits in kind'. However, there is no consensus on how total reward should be calculated (Dolton et al, 2019), nor exactly what elements should be included (ibid.). Indeed, within the literature, although we identified a number of 'total reward' comparisons, these varied between total cash (fixed pay and variable pay) comparisons on the one hand and more comprehensive total reward analyses on the other. In our view, only the latter can properly be regarded as representing 'total reward' analyses. The differences are significant for recruitment and retention since, for example, remuneration in the public sector involves a greater deferred pay component than the private sector (O'Brien, 2022), perhaps in a period, characterised by a higher cost of living, when non-deferred pay (total cash) may be increasingly important to employees (ibid).

The Department of Health and Social Care (DHSC) has reiterated in its written evidence for the DDRB for the 2026-27 pay round that pay makes up only one part of the overall reward package. DHSC emphasises that a range of enhanced financial and non-financial benefits – including pensions, annual leave, parental leave and opportunities for learning, development and career progression – impact the motivation, recruitment and retention of NHS doctors and dentists (DHSC, 2025). Indeed, Dolton et al (2019) noted the PRBs' efforts to include

the value of pension benefits and other conditions of employment in their comparisons of public sector pay with private sector counterparts.

Figure 3.7-1 Different elements of wider reward package in the NHS

Source: Government Actuary's Department for the DHSC, 2024, reproduced under the terms of the Open Government Licence v3.0.

In its submissions to the DDRB, the DHSC has focused its basic pay and total cash comparisons. In its most recent evidence, DHSC presents two measures of average earnings in the hospital and community health sector in England: total earnings per person (including basic pay, additional activity and, for consultants, clinical impact awards); and total basic pay per full-time equivalent (FTE).

DHSC also commissions the Government Actuary's Department to measure the value of the total reward package for a range of medical roles in the NHS. The most recently published figures indicate that total reward increases with seniority, and across all the doctor roles included in the analysis, at least 34% of their total reward consists of non-basic pay (DHSC, 2025).

In addition to the complexities of calculating total reward, Palmer et al (2023) note that data limitations impact the robustness of total earnings analyses for doctors. For example, the authors state that only one in eight NHS employers possessed accurate data on how much private practice work their consultants were undertaking outside of the NHS (albeit an

outdated survey conducted in 2013), which suggests that data on the wider earnings of NHS doctors is potentially limited. The authors also cite research from 2010, which found that private practice accounted for, on average, almost a third of consultants' total earnings, with significant variations by specialty (Palmer et al, 2023). Palmer et al also note the differences in total pay across the UK (NHS pay is set by the devolved administrations), stating that there is no 'readily available data' on hospital doctors' overall earnings (including non-basic pay) outside of England. The authors therefore conducted a comparison between basic salaries for doctors and consultants in England, Scotland, Wales and Northern Ireland. They found that, for example, resident doctors entering their sixth year of specialty training in England have basic pay of £63,152 a year, whereas their equivalents in Northern Ireland are paid £50,903 (with the potential to increase to £60,260, depending on the length of the training programme) (Palmer et al, 2023).

Figure 3.7-2 Value of the total reward package for NHS doctors
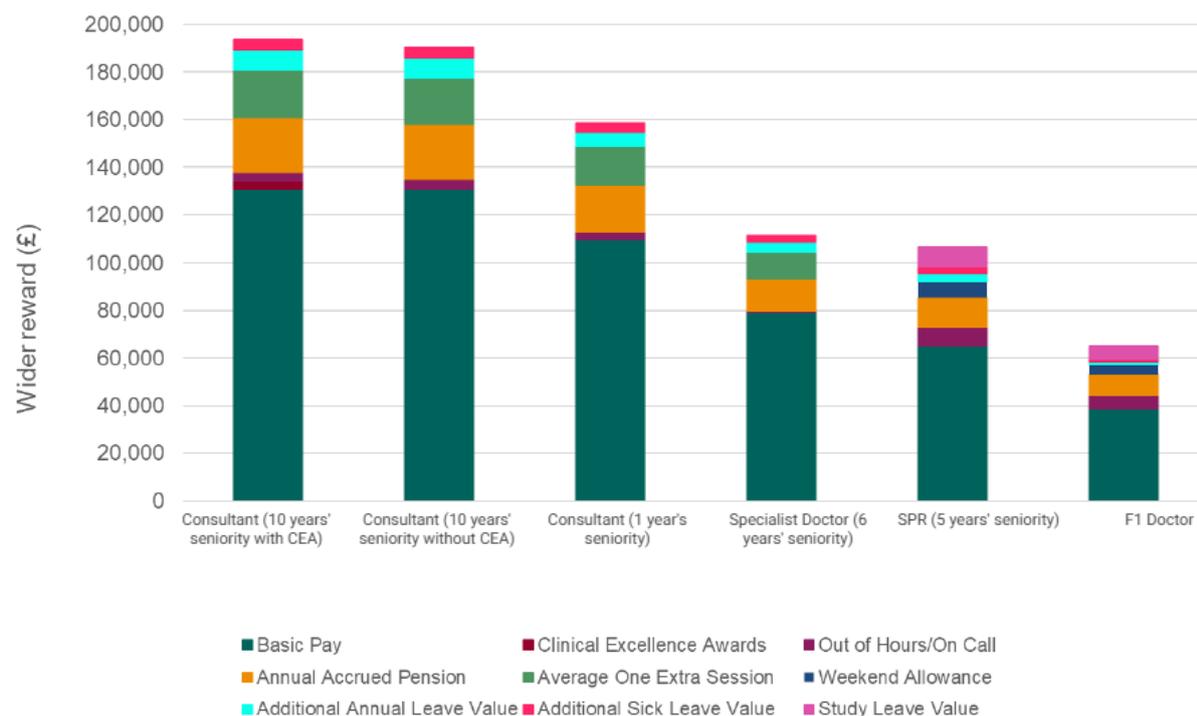
Source: Government Actuary's Department for the DHSC, 2025, reproduced under the terms of the Open Government Licence v3.0.

In 2012, Danzer and Dolton compared the whole public sector with the whole private sector, in terms of the complete remuneration package including lifetime earnings and pensions (cited in Dolton et al, 2019). This 2012 study provides a conceptual method for the measurement of total reward for the occupations under the remits of the PRBs and in a more

recent study, Dolton et al (2019) used this methodology to examine the value of total reward in occupations under the remit of the PRBs and compared this, where possible, with the total reward of private sector counterparts.[27]

For the purposes of Dolton et al's study, total reward is defined as 'the total financial benefits and "in kind" compensation, evaluated in money terms over the life cycle for a representative worker. This will include conditions of work that can be evaluated in money terms and all direct financial remuneration both now and deferred as pension payments in the future' (2019:7).

The relevant lessons from this study are as follows:

- the authors used ASHE, the Labour Force Survey (LFS), the English Longitudinal Survey of Ageing (ELSA), and the British Household Panel Survey (BHPS) combined with Understanding Society (US), to inform the study. These datasets provided age-earnings profiles, employer and employee pension contributions, employees' hours worked and data on risk of unemployment

- in their calculations of total reward, the authors considered: current earnings; pensions; hours of work; paid holidays; employer-provided health insurance; the likelihood of unemployment; and the lifetime pattern of pension contributions by employers

- importantly, the authors noted that they were unable to include other benefits such as company cars, private medical insurance, and stock options, due to a lack of any available data on the value of these allowances. We note that this is a significant limitation in total reward analysis as these will constitute important elements of the remuneration package of some of the private sector comparator professions, especially for high-paid employees

- in order to compare total reward packages across sectors, the authors limited the initial analysis to men and women with higher education qualifications due to: a higher proportion of lower-qualified employees not having occupational pension schemes at the time; previous analysis showing that public sector earnings are greater than comparable private sector earnings over the life cycle among employees with fewer educational

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[27]With the exception of public sector GPs and general dental practitioners, who are not included in the LFS and ASHE national data sets (Dolton et al, 2019).

qualifications; and lastly because reward comparisons among the highly educated have been the main focus of the media

- the study concluded that:
    - remuneration comparisons should be based on the principles of total reward, which take into account the value of pensions, different working conditions relating to working hours, holidays and the probability of unemployment
    - total reward principles and methods can be used to compare reward for jobs across sectors – both for jobs that are directly comparable, eg NHS nurses and private nurses and state school teachers and private school teachers, and within and between occupations
    - it recommended that the PRBs use the total reward methodology detailed in the study as part of their assessment of remuneration conditions for their remit groups (Dolton et al, 2019). However, we would advise caution due to the exclusion of key private sector benefits that could not be included due to data limitations
    - the total reward methodology used in this study could be used to robustly evaluate the Accumulated Lifetime TR (ALTR) for GPs and General Dental Practitioners using HMRC data, if it could be made available (Dolton et al, 2019).[28]

3.8.   International pay comparisons

The Organisation for Economic Co-Operation and Development (OECD) includes a review of the remuneration of doctors across European countries in its annual 'Health at a Glance' report including comparisons of wages for specialists and general practitioners against the average wage of all full-time employees in the country (OECD/European Commission, 2024). However, the wider literature highlights that such international pay comparisons need to be treated with caution (Palmer et al, 2023; DHSC, 2024) due to the methodological assumptions that are required (PSPC: Ireland, 2018) and the inherent technical complexities (ibid.).

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[28]'The ALTR concept evaluates the discounted cumulative value of all real earnings and the financial value of all accrued pension rights and non-pecuniary benefits each year as a person ages' (Dolton et al, 2019:8).

In Ireland, the Review Body on Higher Remuneration in the Public Sector has expressed reservations about the use of international pay comparisons due to the differences across countries which question the validity of the comparisons (PSPC: Ireland, 2018). However, conducting such comparisons can provide useful insights, especially when differences in pay across countries can act as a 'push' or 'pull' factor in relation to the migration of doctors (OECD/European Commission, 2024), if the relevant differences can be adjusted and accounted for (PSPC: Ireland, 2018).

The differences and the complexities of conducting international pay comparisons for medical practitioners, which were highlighted in the literature, are summarised below:

- earnings come from different sources and are based on different payment mechanisms eg capitation, fee-for-service (FFS) payments and/or salary, other financial benefits eg bonuses (Quentin et al, 2018) and differing employment status (self-employed versus salaried) (DHSC, 2024). The OECD/European Commission highlight complexities in the latter as some salaried doctors also have private practices and some self-employed doctors receive part of their remuneration through a salary (OECD, European Commission, 2024)

- differences exist across countries in regard to workforce definitions, qualification requirements (DHSC, 2024; PSPC: Ireland, 2018), grade hierarchies and the distribution of responsibilities among specialists (Quentin et al, 2018). For example, in England and the USA, fully-qualified specialists in hospitals work as consultants (England) or attending physicians (USA), while in Germany, France, Sweden and Switzerland, there are several hierarchical levels of hospital-based specialists (Quentin et al, 2018)

- there are international differences in career paths and the time taken to progress through grades and pay ranges (PSPC: Ireland, 2018)

- specialty can have an important influence on earnings levels in some countries. For example, in the USA and Sweden, where salaries are based on individual negotiations, the specialty can significantly determine income (Quentin et al, 2018). Destatis (2023, cited in OECD/European Commission, 2024) also found that in Germany, ophthalmologists and radiologists received on average at least twice the income of paediatricians, neurologists and psychiatrists

- there is wide variation across countries in employment terms and conditions, including pensions and working hours (Palmer et al, 2023; Quentin et al, 2018)

- pay is linked to the particular social, administrative and economic context of each country and 'at a minimum gross remuneration rates need to be adjusted for relevant differentials in income tax, social insurance, and purchasing power' (PSPC: Ireland, 2018:34). Indeed, there are different methods to compare earnings between countries, including by adjusting for exchange rates or in relation to the costs of goods (purchasing power) or by multiples of average earnings in the country (Palmer et al, 2023). We would recommend that using the OECD Purchasing Power Parity (PPP) Indices is the most useful approach, however, as the DDRB state, 'even adjusting for purchasing power may not make up for all the cost-of-living differences in a country such as housing, education or healthcare costs' (DDRB, 2025:208)

- there are differences in the availability of reliable earnings data. For example, data is available on earnings for salaried doctors in England, but data is only available for self-employed doctors in the USA and Australia, whose earnings are typically higher (Palmer et al, 2023). The OECD/European Commission (2024) also note that data limitations can result in underestimation of remuneration in some countries, particularly relating to:

  o exclusion/omission of overtime payments, bonuses and other additional payments for some comparator roles in some countries' data

  o exclusion/omission of incomes from private practices for salaried doctors in some countries

  o data only relating to public sector employees in some countries (who often earn less than those working in the private sector)

  o exclusion/omission of informal payments, which may be common in certain countries (OECD/ European Commission, 2024).

Figure 3.8-1 International comparisons of specialist doctors' pay
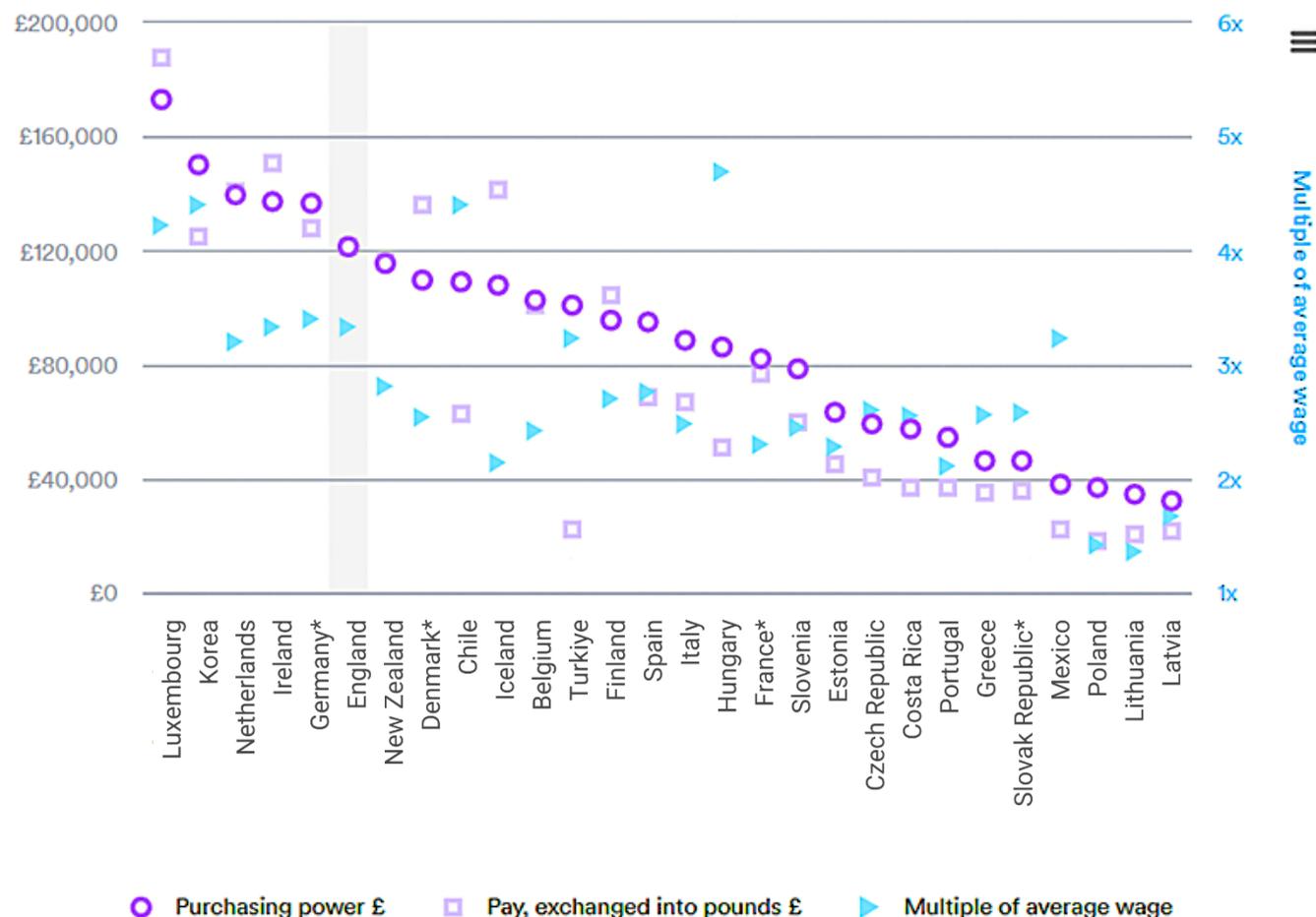
Note: some countries include GP salaries within their data, however these typically account for a small proportion of the total doctors included.

Source: Palmer, W., Rolewicz, L. and Dodsworth, E. (2023), *Exploring the earnings of NHS doctors in England*. Nuffield Trust analysis of OECD data. Reproduced with permission.

An example of an international comparison of doctors' pay is that conducted by Treacy Consulting and Willis Towers Watson (TC/WTW) in 2018. This work was commissioned by the former Public Service Pay Commission (Ireland) to undertake international comparisons of total reward (including basic salary and benefits including pension, allowances, overtime and bonuses) and standard contracted full-time working hours for roles in the UK, Australia, USA and Canada that were judged to be equivalent to Senior House Officer (SHO) and Hospital Consultant in the health service in Ireland (PSPC, 2018), with these countries identified as key destinations for doctors emigrating from Ireland. The comparative analysis did not consist of a comprehensive job evaluation exercise of international comparators (with this deemed too large in scale for the timelines of the Commission); rather it considered 'the

competitiveness of pay and certain conditions of employment (eg annual leave) vis-à vis other countries' (PSPC, 2018:35).

Key methodology observations from this research include:

- a 'host' location in each country was selected as a comparator where there was access to relevant robust publicly available data (the North Central region in the USA; Ontario and British Columbia in Canada; Victoria in Australia; and England (excluding London) in the UK) (PSPC, 2018)[29]

- due to variations in qualifications, career paths and time taken to progress through grades and pay ranges, like-for-like role comparisons were not possible. Therefore TC/WTW reviewed the qualification requirements for the relevant grades and identified specific grades at early career points for Non-Consultant Hospital Doctors (NCSD) (the comparator guide for Senior House Officer) and Consultants to provide comparators for total reward in each of the countries. In addition, a later career point was identified for NCHDs to reflect pay progression in each of the countries. However, due to the differences in career paths across countries this data could not be presented as a primary comparator point

- for all 'host' locations, apart from the USA, the data reflected the relevant collective agreements in place for the role. Collective agreements, employee handbooks and contracts were used to determine the allowances and benefits applicable to each grade. Where there was more localised determination of pay (eg Canada), TC/WTW used not-for-profit and private sector data from employer-based surveys

- all gross pay data was adjusted by OECD Purchasing Power Parity (PPP) indices and converted to Euros[30]

- the allowances and benefits, in addition to basic pay, included in the analysis were (where available):
  - flexible working arrangements
  - unsocial hours payments

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[29]The North Central region includes Wisconsin, South Dakota, Ohio, North Dakota, Nebraska, Missouri, Minnesota, Michigan, Kansas, Iowa, Indiana, Illinois (TC/WTW, 2018).
[30]PPPs are the rates of currency conversion that equalise the purchasing power of different currencies by eliminating the differences in price levels between countries (TC/WTW, 2018).

- o overtime
- o standby allowances and call-out pay
- o annual leave and public holidays
- o maternity leave
- o other leave
- o pension benefits
- o other benefits.

Figures 3.8-2 and 3.8-3 overleaf provide a useful summary of the research methodology applied to the matching for Non-Consultant Hospital Doctors and Hospital Consultants, including the rationale for the selection of the 'host' locations; the primary data sources used for the comparisons; and the grades selected as comparators in each country.

The reference in figure 3.8-3 to a 'new consultant contract expected 2018' reflects the timing of the original work. The consultant contract framework in England was established in 2003 and has been amended repeatedly since, with versions incorporating changes up to 2018 and further updates agreed and implemented between 2023 and 2025. While this covers negotiations and staged changes over several years, it did not constitute a single new contract process, and none of the amendments altered the formal entry qualifications or core role requirements for consultants; the methodological approach therefore remains relevant.

Figure 3.8-2 Research methodology for Non-Consultant Hospital Doctors (comparators for Senior House Officer)

	United Kingdom	Australia	United States	Canada
Host locations (rationale for selection)	**Scotland, Wales and Northern Ireland** • A traditional incremental pay structure applies across these regions. No significant differentials. **England** • Since 2016, England in a different pay model to rest of UK. • Identified accessible public data.	**Victoria region** • Minimal regional differentials within Australia. • Melbourne is a high population density location. • Identified accessible public data.	**North Central with National references** • Three quality sources of data. • Mobile workforce evident from prevalence of relocation allowances. • Robust WTW survey data.	**Ontario and British Columbia** • The determination of pay and benefits is largely determined at a provincial / local level in Canada. • Both locations identified as provinces with largest populations of Irish trained physicians, Ontario (651) and British Columbia (223). • Areas of high population density. • Identified accessible public data.
Primary Data Source(s)	NHS public-sector/not-for-profit pay template. Accessible information on career paths and roles. Data points: • NHS Agreements: Scotland, Wales (01.04.17) Northern Ireland (01.04.17) England (01.04.2017). Reporting: Pay scales.	Victoria public-sector pay structures. Accessible information on career paths and roles. Data points: • Victoria Public Health Sector – Doctors in Training Enterprise Agreement 2018–2021. Reporting: Pay scales.	Selected primary and secondary survey data sources. Comparator survey job capsules and accessible information on career paths and roles. Data points: • WTW 2017, Compensation Survey Report and WTW 2017, Health Care Compensation Survey Report. • Medscape Physician Compensation Report, 2017. • Merrit Hawkins 2017, Review of Physician and Advanced Practitioner Recruiting Incentives. • Bureau of Labor Statistics (US Department of Labor). Reporting: 25th, 50th, 75th percentiles	Collective Agreements. Accessible information on career paths and roles. Data points: • British Columbia (BC) - Resident Doctor of BC Agreement with Health Employers Association of BC, 2014 – 2019. • Ontario – Professional Association of Residents of Ontario agreement with Hospitals of Ontario 2016-2020. Reporting: Pay scales.
Comparator guides for: Registrar/Specialist Registrar levels and SHO	Specialist Registrar (SpR)/ /Specialty Registrar(StR) Foundation Yr2 (Entry).	Registrar. Hospital Medical Officer (Y1).	Fellows. Resident Doctor (Y2).	No feasible match. Resident Doctors (Y2).

Treacy Consulting   Willis Towers Watson   20

Source: Treacy Consulting/Willis Towers Watson, 2018. Reproduced with permission.

Figure 3.8-3 Research methodology for Hospital Consultants

	United Kingdom	Australia	United States	Canada
Host locations (rationale for selection)	**England, Scotland, Wales and Northern Ireland** • Review of 2003 agreement • New Consultant Contact. under negotiation, expected in Autumn 2018. • Identified accessible public data.	**Victoria region** • Minimal regional differentials within Australia. • Melbourne is a high population density location. • Identified accessible public data.	**National data** • Three quality sources of data. • Mobile workforce evident from prevalence of relocation allowances. • Robust WTW survey data.	**Ontario and British Columbia** • The determination of pay and benefits is largely determined at a provincial / local level in Canada. • Both locations identified as provinces with largest populations of Irish trained physicians, Ontario (651) and British Columbia (223). • Areas of high population density. • Identified accessible public data.
Primary Data Source(s)	NHS public sector/not-for-profit pay template. Accessible information on career paths and roles. Data points: • NHS Agreements 2003 – Effective 2016,17 and 18. Reporting: Pay scales.	Victoria public-sector pay structures. Accessible information on career paths and roles. Data points: • Victoria Public Health Sector – Doctors in Training Enterprise Agreement, 2018–2021. Reporting: Pay scales.	Selected primary and secondary survey data. Comparator survey job capsules. Data points: • WTW 2017 Health Care Compensation Survey Report. • Medscape Physician Compensation Report, 2017. • Merrit Hawkins 2017 Review of Physician and Advanced Practitioner Recruiting Incentives. • Bureau of Labor Statistics (US Department of Labor). Reporting: 25th, 50th, 75th percentiles.	Selected secondary survey data. Accessible information on career paths and roles. Data points: National Physician Database Canadian Institute for Health Information. Reporting:40th, 50th, 60th percentiles
Comparator guide for: Consultant - Contract A	Consultant.	Medical Specialist.	Attending Physician.	Medical Specialist. Surgical Specialities.

Treacy Consulting   Willis Towers Watson   2

Source: Treacy Consulting/Willis Towers Watson, 2018. Reproduced with permission.

4. Stakeholder research

This chapter summarises the views of key stakeholders on a range of issues related to conducting pay comparability assessments for medical and dental roles. The findings are drawn from semi-structured interviews, which explored perceptions of the current methodology, views on the appropriateness of the roles being assessed, and suggestions for suitable comparator professions.

Discussions also covered how pay comparability should be measured – including consideration of total reward beyond basic pay – the availability and reliability of pay data sources, and the feasibility of regional and international comparisons. These insights provide valuable context for evaluating and refining the comparability framework, drawing on the practical experience and expertise of those closely involved in workforce planning, pay policy, and representation.

4.1.   Summary

- Although few outright object to the current methodology used by the DDRB for pay comparability, it was last reviewed in 2017, and many stakeholders believe it is due for an update. There is a strong call for greater transparency and more opportunities for stakeholders to shape how the methodology operates.

- Using comparator professions is considered a helpful but imperfect approach. Common comparators include private sector roles in law, finance, and similar fields, but some stakeholders suggest adding more core public sector roles, such as civil servants, to balance the current emphasis on private sector jobs. However, an alternative view challenges the very idea of comparators, arguing that no other profession fully mirrors the complexity and demands of being a doctor.

- Within the UK, stakeholders did not think the doctors' and dentists' roles vary sufficiently enough by devolved administration – in terms of job content and responsibility – to warrant separate benchmarking.

- A major problem is the quality of the data that underpins the comparisons. The most commonly used dataset, ASHE, is considered too broad and does not capture important aspects such as private or self-employed income. Other data sources are often incomplete – for example, while certain roles or broad sectors are well covered,

information on some roles, such as actuaries or pharmaceutical roles, is often patchy or unreliable. These limitations make it difficult to draw fair and accurate comparisons.

- There were some important differences between the stakeholders when it came to the issues involved in comparisons, and what factors to include or exclude (see summary of relevant section below).

- International comparisons are widely seen as important, given that UK-trained doctors move abroad to countries such as Australia, New Zealand, Canada, and Ireland (although not necessarily permanently and decisions are affected by a variety of factors, not just pay). However, adjusting for different healthcare systems, pay structures, and living costs is complex. A minority of stakeholders feel these international comparisons do not offer much value and suggest focusing instead on understanding why doctors leave and how significant the issue is.

- Other issues including burnout, shifting career aspirations and a preference for part-time and flexible work are changing what doctors want from their jobs.

4.1.1. Key findings: views on the current methodology

- Most stakeholders expressed no fundamental objections to the current pay comparability methodology. While some had limited familiarity with its technical detail, there was general agreement that the structure is sound, and the list of anchor roles is broadly appropriate.

- Several interviewees noted practical difficulties in applying the current DDRB methodology – for example, accurately distinguishing between experience levels within a given role (eg junior vs. senior consultants) or reflecting the five-year development period that typically follows consultant certification. Some questioned whether splitting closely related roles (such as Foundation Years 1 and 2) yields meaningful comparative insights.

- Stakeholders highlighted the importance of better reflecting the full diversity of medical career paths – including doctors who bypass core training, the varied experience of locally employed doctors, and differences between salaried and self-employed professionals.

- There was support for expanding the pool of comparator professions to include groups such as academics, architects, and vets. Some felt this would provide a fuller picture of

equivalent responsibilities and career paths, while also addressing stakeholder expectations that have evolved since the last methodological review in 2017.

- Many stakeholders advocated for greater use of international benchmarks – particularly in light of global mobility and UK doctors relocating to countries like Australia, Canada, and the US. Others emphasised the need to account for the UK's unique labour market conditions, especially given the NHS's role as a monopsony employer. This was seen as a limitation for relying solely on market comparisons without careful justification.

- Several stakeholders emphasised the importance of greater transparency in how comparator roles are chosen, how pay data is analysed, and how changes are communicated. There was also strong support for regular updates to the methodology to reflect shifts in the health workforce and labour market conditions.

- Stakeholders pointed to several developments that could potentially inform future methodology updates, for example by taking into account demographic changes in the workforce (eg increased gender diversity), changing career aspirations (eg reduced interest in private practice or ownership), growing concerns around burnout and mental health, and the increasing importance of the NHS/private sector divide.

4.1.2. Key findings: comparator professions

- There was general agreement that existing comparator professions are broadly appropriate, with common mentions including legal, finance, actuarial, academic, veterinary, and pharmaceutical roles. However, many stakeholders stressed the need for greater specificity within these groups (eg City vs. high-street lawyers; senior vs. junior finance roles).

- There were calls for more nuanced and structured comparisons, with emphasis on matching not just levels, but also:
  - required training length and intensity
  - qualifications and certification requirements
  - level of decision-making, autonomy, and responsibility
  - career trajectory and likelihood of progression

- Some stakeholders argued that comparators should not be drawn from elite roles (eg top barristers; CEOs) unless they represent a likely and attainable career path. Instead, the focus should be on professions attracting individuals of similar calibre (eg high-achieving

graduates) with comparable entry requirements and progression likelihood. Medicine offers more structured and assured progression than many professions.

- Difficulties were noted in comparing public and private sector roles, due to significant differences in pay visibility, security, and employment conditions. Some felt private-sector comparators can distort findings unless carefully contextualised.

- There was support for including high-level public sector roles (eg senior NHS executives, senior civil servants, senior public health roles) to better reflect shared constraints such as transparency, pay caps, and public accountability.

- Doubts were raised about the use of self-employed comparators, especially for employed doctors and dentists. Stakeholders questioned comparisons with high-earning self-employed professionals, citing differences in income stability, benefits, and risk exposure.

- Stakeholders said that some comparator professions lack reliable data, particularly actuaries, architects, and private GPs, making them difficult to include consistently. Alternatives like data scientists or life sciences PhD roles were suggested to supplement gaps.

- The emotional and psychological burden of medical roles was seen as unique, making comparisons with other high-status professions (eg law, banking) incomplete. Suggestions included comparisons with senior armed forces or fire service roles due to similar emotional demands.

- Stakeholders emphasised early-career comparators for trainees, pointing to the value of benchmarking graduate and postgraduate earnings, especially among professions that attract similarly high-achieving individuals (eg law, finance, software engineering, consultancy).

- Job security and predictability of career progression were noted as key features of medical careers, and important factors to reflect in comparator analysis. Unlike many professions, consultants are rarely made redundant and training paths are clearer.

4.1.3.   Key findings: alternative careers and career paths

- Several stakeholders emphasise that once individuals commit to studying medicine, switching into a different profession is relatively rare. The more relevant question for

comparability they suggest is therefore what similarly high-achieving individuals choose instead of medicine.

- A minority of stakeholders (notably the independent consultant and some DDRB members) note that if doctors do leave for alternative careers, this usually happens early in the career, typically around or shortly after completing training (rather than established doctors leaving medicine mid-career). Suggested alternative careers include finance, consulting, software/data roles, engineering, and AI-related fields.

- Survey data from the BMA's NHS Leavers Survey indicates most leavers move to similar roles or remain in the medical/dental field, with a minority moving into non-medical roles, formal study, or leaving the workforce entirely (reported by stakeholders to be relatively rare).[31]

- Overseas moves (eg to Australia, New Zealand, the Republic of Ireland) are noted but not perceived as large-scale, with many returning. These moves are often driven by personal/lifestyle factors rather than direct pay comparisons.

- A growing number of professionals seek flexibility rather than a career change, with part-time working, career breaks, or diversified portfolios seen as more attractive than rigid linear progression.

- There are concerns about return on public investment in training, particularly if doctors leave for private sector or overseas roles. Stakeholders highlighted the public cost of medical education and questioned the sustainability of losing trained professionals.

4.1.4. Key findings: issues in pay comparability

- Stakeholders expressed a strong consensus for pay comparisons to go beyond basic pay and include elements which might not be available in other professions, such as:
  - overtime, shift pay, and unsocial hours payments
  - private income (eg private practice, waiting list initiatives)
  - NHS pension value (noted as generous but difficult to benchmark)
  - leave entitlements, job security, flexible working arrangements
  - career certainty and structured progression to senior roles.

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[31]BMA NHS Leavers Survey, as reported in the BMA's evidence submission to the DDRB 2025/26 pay round.

- Straight pay comparisons across professions can be misleading as public sector pay is visible, whereas private practice or self-employed income is not consistently captured.

- There are notable differences in working conditions, risk exposure, and benefits between doctors and self-employed or private-sector professionals. The job security, pension provision, and protections offered in the NHS are seen as unique advantages. However, private professionals may benefit from other perks (eg bonuses, private health insurance, remote working) not available in public sector roles.

- Many stakeholders highlighted the intensity and complexity of doctors' roles — including moral responsibility, decision-making consequences, litigation risk, long hours, and personal accountability. These burdens often exceed those in comparator professions and are hard to quantify in pay benchmarking.

- Unlike in many other professions, doctors typically follow a structured and predictable career path, with high certainty of progression and limited redundancy risk. This makes long-term planning more viable and should be reflected in comparability assessments.

- Comparability must account for the significant educational and experiential investment required in medicine and dentistry. The breadth and intensity of responsibility, and the level of autonomy in clinical decision-making, were cited as core differentiators from other professions.

- Many pointed to the lack of robust, standardised data on private sector pay, especially in private healthcare. Other issues included incomplete datasets for locally employed doctors, self-employed earnings, and untracked private income. There were calls for coordinated national data systems and improved access to tax, payroll, and employment records, or for investment in specialist data sources and collaboration with industry bodies to improve insight.

- NHS pensions are widely recognised as generous but inflexible. Their defined-benefit nature sets them apart from private sector schemes, but they are often undervalued in public debate and hard to compare directly.

- Several respondents raised issues about how GP earnings are reported — specifically the blending of employed and self-employed income, temporary Covid payments, and the lag in published data (typically two years behind). These factors were seen as barriers to accurate, like-for-like comparison and a source of misunderstanding in public and policy debates.

- One stakeholder argued that comparability cannot adequately account for the full scope of the medical profession's complexity, responsibility, and context. Instead, they suggested focusing on other benchmarks such as vacancy rates, labour market demand, and retention indicators.

4.1.5.   Key findings: regional and international comparisons

- Most interviewees felt that there were no differences in doctors' and dentists' job roles between the different nations/administrations of the UK. However, one stakeholder cautioned that this position needs proper evidence-based validation.

- Only two stakeholders perceived there to be differences in doctors' roles between the four UK nations; one in particular in reference to the role of consultants. However, further supporting details were not provided.

- In reference to international comparators, it was recognised by most stakeholders that international comparisons are challenging.

- The OECD was referenced by some stakeholders as being a source of data and expertise for international comparisons. In addition, the General Medical Council's evidence-based research on the international migration of medical practitioners was cited as a useful reference and information source.[32]

- Most stakeholders agreed that the focus of international comparisons should be on Australia, Canada, New Zealand and Ireland, with a minority adding the Gulf States.

- Variations between countries were raised as issues in conducting international pay comparisons, including key differences such as variations in the cost of living; different types of healthcare systems (including public vs private); and different payment systems. Study budgets available in some countries for doctors in training could be considered in pay comparisons.

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[32]For example, see: Identifying Groups of Migrating Doctors Research, General Medical Council, November 2023; Understanding doctors' migrate from the UK, Shift Insight Limited, 2022; Completing the Picture Survey, A collaboration between the General Medical Council (GMC), Health Education England (HEE), Department of Health (Northern Ireland), NHS Education for Scotland (NES) and Health Education and Improvement Wales (HEIW).

5. Evaluation and analysis of doctor and dentist roles

This chapter outlines the evaluation and analysis of the roles covered by the DDRB. It provides an overview of the career pathways for doctors and dentists, identifies the key benchmark roles used in our pay comparability analysis, and presents the results of the job evaluations undertaken for these roles.

5.1. Career pathways

The NHS can offer unusually structured and clearly defined career progression for both doctors and dentists, with each stage of training and professional development mapped out from entry into the profession through to senior specialist or leadership roles. These pathways are underpinned by formal qualifications, professional registrations, and nationally recognised training frameworks.

5.1.1. Doctor career pathways

The medical career pathway in England begins with a medical degree (MBBS/MBChB), typically lasting five years (or four-six years depending on the course). After graduation, doctors complete a two-year Foundation Programme (Foundation Year 1 (FY1) and Foundation Year 2 (FY2)). This programme provides supervised clinical practice across various hospital and community settings and leads to full registration with the General Medical Council (GMC). Following the foundation stage, doctors progress into core or specialty training:[33]

- Core Training (CT1-CT3) or Internal Medicine/Core Surgical Training (two-three years) for hospital-based specialties
- General Practice Specialty Training (GPST/ST1-ST3) (three years), which combines hospital rotations and general practice placements for a pathway to general practice.

To advance to higher specialty training, doctors that have completed core training must complete membership exams for the Royal College of Physicians (MRCP) or Royal College of

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[33]It should be noted that an increasing number of doctors take time out between stages of formal training, either by choice or due to competition for training places. During these periods, doctors commonly work in locally employed doctor (LED) roles or other non-training posts.

Surgeons (MRCS). Higher Specialty Training (ST3-ST8) then follows, lasting four-six years depending on the specialty, culminating in a Certificate of Completion of Training (CCT) and inclusion on the specialist register.

Figure 5.1.1-1 NHS doctor career pathways (England)
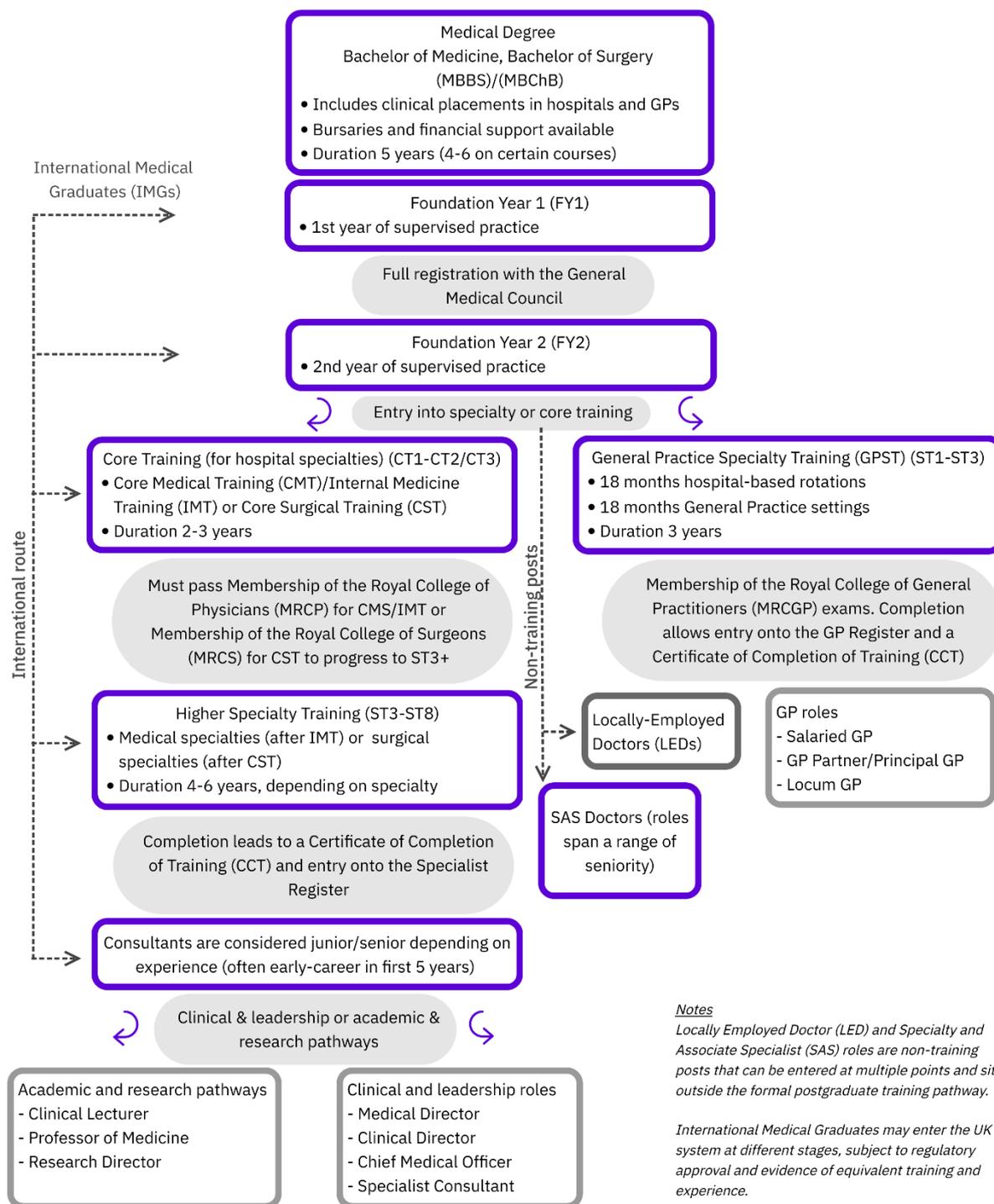
Note: developed by Incomes Data Research (IDR). For client use only.

Post-training, doctors can become consultants (or GPs if on the GPST pathway) and can pursue leadership roles (eg clinical director, medical director) or academic careers (eg clinical lecturer, professor). An alternative route, for SAS (Specialty and Associate Specialist) doctors, offers experienced doctors a non-training pathway with senior responsibilities.

International Medical Graduates (IMGs) may join the NHS at different stages depending on their previous experience and qualifications, typically after obtaining GMC registration. Many IMGs begin as Locally Employed Doctors (LEDs), who are not in formal training programmes but work in NHS hospitals to gain UK experience before entering training or pursuing other roles, and LEDs are employed locally at different stages depending on their previous experience and qualifications.

5.1.2. Dental career pathways

The dental career pathway begins with a Bachelor of Dental Surgery (BDS) degree, typically lasting five years. Following graduation and full registration with the General Dental Council (GDC), new dentists who wish to deliver NHS services must complete Dental Foundation Training (DFT), a one-year supervised programme designed to develop core clinical skills in general practice settings.

After DFT, dentists can progress into one of three main routes (in order of most common):

- general dental practice roles – such as associate dentists or contractor dentists
- community and public dental practice roles – including salaried dentist Band A and Band B positions
- core training for hospital specialties (DCT1-DCT3) – a three-year programme providing experience across hospital dental services.

For those pursuing specialist careers, Specialty Training (ST1–ST6+) follows, lasting three to five years depending on the specialty (eg orthodontics, oral surgery, dental public health). Completion of this pathway leads to the Certificate of Completion of Specialist Training (CCST) and entry onto the GDC's Specialist List. Specialist roles include hospital-based

positions such as orthodontists, oral surgeons, dental public health specialists, and consultants.

Figure 5.1.2-1 NHS dental career pathways (England)
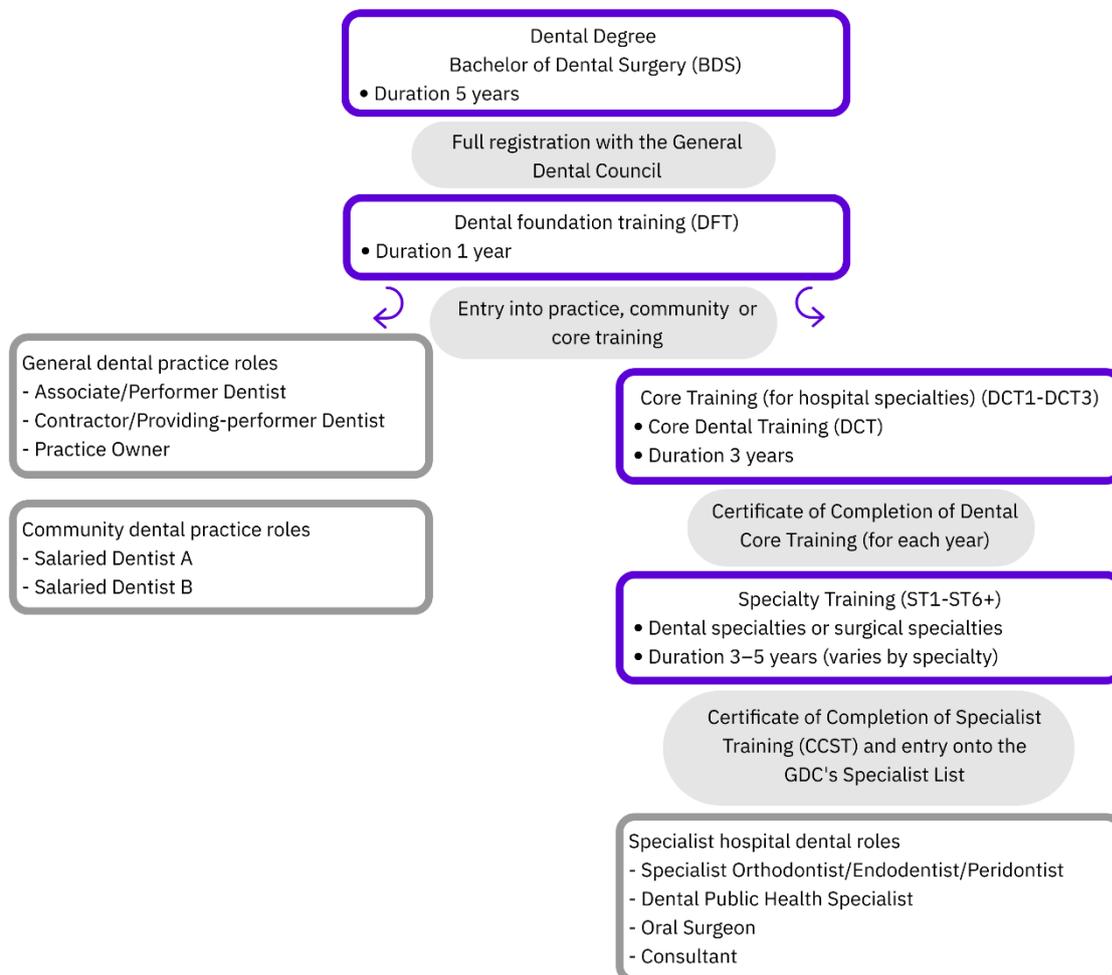
Note: developed by Incomes Data Research (IDR). For client use only.

5.2.   Benchmark roles

Using information from the NHS career pathways for doctors and dentists in England, we identified the key roles and levels within NHS medicine and dentistry to serve as benchmark roles for the pay comparability analysis. In total, we identified 17 benchmark roles. These are designed to capture the main stages of doctor and dentist careers across hospital medicine and general practice, while ensuring the full DDRB remit group is represented.

Table 5.2-1 IDR's benchmark roles – hospital doctors

Job role	Description
Hospital doctors and consultants	
Foundation Year 1 (FY1)	The first year after medical school, where newly qualified doctors undertake structured rotations under close supervision. They are primarily involved in delivering routine patient care while developing clinical and communication skills within defined frameworks. Doctors rotate across hospital specialties, focusing on developing practical clinical skills and professionalism
Foundation Year 2 (FY2)	The second year of foundation training. FY2 doctors take on broader clinical responsibilities and have more autonomy in patient care. They continue to rotate through various specialties to build experience. Doctors have more autonomy and responsibility in clinical care
Core Trainee (CT1)	Doctors at the start of core training for specialties (eg medicine, surgery, psychiatry), after completing foundation training. They provide professional services with greater independence, applying specialist knowledge in chosen fields while continuing to receive structured training. Doctors begin to specialise and work more independently in their chosen field
Specialty Registrar (ST3)	Doctors in the first year of higher specialty training. At this stage, they start to work with greater autonomy, managing more complex cases while remaining under consultant supervision. They support more junior trainees as they develop specialist competence
Locally Employed Doctor (Post-Foundation)	Doctors in non-training posts, often employed to fill workforce gaps. They provide independent clinical care within defined protocols, contributing to service delivery in hospitals
Specialty Doctor	Experienced non-consultant hospital doctors (SAS) who provide specialist clinical care, working with significant autonomy but outside formal specialty training. They work independently with a defined clinical focus
Specialist (Senior SAS Doctor)	Senior SAS doctors with leadership responsibilities, including managing complex cases and supervising junior staff. They bring deep experience and specialist expertise in their field
Consultant – Newly Qualified	Doctors who have completed specialty training and received their Certificate of Completion of Training (CCT). They hold full responsibility for patient care in their specialty and may lead teams
Consultant – Experienced	Senior consultants with over ten years of experience, providing authoritative expertise and leadership and often contributing to strategic decisions within their specialty or organisation

Note: developed by Incomes Data Research (IDR).

Table 5.2-2 IDR's benchmark roles – general practitioners (GPs)

Job role	Description
General Practitioners (GPs)	
GP Specialty Trainee (GPST1)	Doctors in the first year of GP specialty training. They manage patient care in primary settings with increasing autonomy while under the guidance of senior GPs. GP specialty training combines hospital-based rotations (18 months) and general practice placements (18 months) to build GP-specific skills
Salaried GP	Qualified GPs employed under a contract with a practice or NHS organisation. They work independently, providing primary care to patients and contributing to the delivery of GP services
Partner/Principal GP	Senior GPs who hold NHS contracts, often as practice owners or co-owners. They combine clinical practice with leadership, business management, and decision-making for the practice

Note: developed by Incomes Data Research (IDR).

Table 5.2-3 IDR's benchmark roles – general dental practitioners (GDPs)

Job role	Description
General Dental Practitioners (GDPs)	
Foundation Dentist/Vocational Dental Practitioner	The first year after dental school (Dental Foundation Training, DFT), where newly qualified dentists provide dental care under supervision while developing clinical and patient management skills
Associate (Performer) Dentist	General dental practitioners working under a contract, typically in general dental practice, delivering routine NHS dental care independently
Contractor (Principal/Providing-Performer) Dentist	Dentists who lead or own a dental practice, combining clinical work with practice management and business responsibilities
Salaried Dentist Band A	Salaried NHS dentists working in community dental services, delivering routine dental care to diverse patient groups
Salaried Dentist Band B	Senior salaried NHS dentists in community dental services, managing more complex dental cases and taking on additional leadership or supervisory roles

Note: developed by Incomes Data Research (IDR).

Table 5.2-4 The DDRB remit group – NHS doctors and dentists, 2024

Source: Office for the Pay Review Bodies

5.3.   Role evaluations

We used the IDR Job Evaluation Scheme to assess the relative size of 17 benchmark doctor and dentist roles. The 2025 evaluations included two doctor roles not previously evaluated – post-foundation Locally Employed Doctors (LEDs) and Specialists (senior SAS doctors) – and two salaried dentist roles.

For each role, factor scores were combined to produce a total points score, which in turn corresponds to an IDR job level. The IDR job levels reflect the relative job size, based on the breadth of responsibilities, required expertise, and demands, as measured by the seven factors in the IDR Job Evaluation Scheme. The IDR role evaluations outcomes, which show the hierarchy of roles within hospital doctor, GP and dentist populations, are provided in Table 5.3-1. Descriptors for each IDR job level are set out in Appendix 5.

Our assessment of the job size for the Specialist Registrar (ST3) roles indicates a lower Hay reference level than that proposed by IES in 2017, but is consistent with the level proposed by PA Consulting in 2008. This difference reflects a deliberate methodological choice to evaluate the Specialist Registrar role at the point of entry to higher specialty training.

The Specialist Registrar role spans several job levels over the course of training, with autonomy, responsibility and leadership expectations increasing substantially as trainees progress. Evaluating the role at entry (ST3), where autonomy is more limited, avoids conflating multiple job sizes within a single role and supports more consistent benchmarking, as external market data are typically segmented by job level rather than by multi-year training pathways. In addition, the majority of the role documentation we reviewed for the job evaluation related to the ST3 entry point.

The duration of hospital specialty training varies by specialty, but doctors entering at ST3 typically spend around five years (ST3-ST7/ST8) in training before becoming eligible for consultant appointment. Registrars further along this pathway are therefore likely to attain higher job evaluation scores, reflecting increased clinical competence, autonomy and leadership responsibilities.

It should also be noted that high-street dentists and GPs may sit at a higher job level depending on their particular practice setting. For example, contractor or practice-owning dentists and GP partners may have additional business, leadership and service management responsibilities beyond those of employed dentists or salaried GPs. However, for consistency with the overall approach to job evaluation and to support comparability with market data – typically segmented by job level – these roles have been assessed at their entry level, recognising that job size may increase in more complex or senior practice settings.

Table 5.3-1 IDR role evaluation outcomes 2025

IDR Job Level (points range for level)			Hospital doctors	GPs	GDPs
	9	1,251-1,500	Experienced Consultant* New Consultant (1,265)	GP Partner (1,290)	
	8	1,001-1,250	Specialist (1,145)	Salaried GP (1,055)	Contractor Dentist (1,250) Salaried Dentist B (1,055)
	7	801-1,000	Specialty Doctor (980) ST3 Registrar (955) LED (Post-FY2) (815)		Salaried Dentist A (860) Associate Dentist (845)
	6	721-800	CT1 Doctor (790) FY2 Doctor (750)	GP Specialty Trainee (785)	
	5	621-720	FY1 Doctor (670)		Foundation Dentist (710)

*The experienced consultant role has been slotted in and has not been evaluated using the IDR JE Scheme, as the job descriptions and supporting information reflect the standard scope of the role as a newly qualified consultant.

Note: developed by Incomes Data Research (IDR). For client use only.

6. Comparators

This chapter summarises the outcomes of the comparability assessments and presents the professions judged to offer the closest alignment with the core characteristics of medical and dental roles.

6.1.   Initial screening of professions

The first step involved identifying the professions that should proceed for full assessment from the longlist, and we did this by screening them against our initial inclusion criteria – namely degree-level entry, formal training requirements, structured career pathways, and roles involving significant responsibility and/or autonomous decision-making. We also considered opportunities for self-employment where relevant, particularly in relation to general practice and dental practice ownership models. The full long list of professions considered, including those that did not meet the initial screening criteria and the reasons for their exclusion, is set out in Appendix 2.

6.2.   Comparability assessment outcomes

The comparability assessments are based on the understanding that doctor and dentist roles are distinct from other professions. The aim of this exercise is not to identify roles that doctors or dentists might move into – indeed, we do not have data on career transitions – but to determine 'best-fit' external professions that align most closely with the core job characteristics used in our assessment framework.

The table below presents the assessment outcomes for both doctors and dentists. The scores are derived from the 10-point framework described in Chapter 2, where higher values correspond to a stronger degree of alignment. Scores of 8-10 represent a close match, 5-7 a partial match and 0-4 a limited match.

Table 6.2-1 Comparability assessment outcomes

Comparator profession	Dentist	Doctor
Academic	Limited (3)	Limited (2)
Accountant	Partial (5)	Limited (4)
Actuary	Partial (5)	Partial (6)
Architect	Partial (6)	Partial (5)
Barrister	Partial (6)	Partial (7)
Chartered Surveyor	Partial (7)	Partial (6)
Engineer	Limited (4)	Limited (4)
Graduate schemes	Limited (4)	Limited (4)
Nurse	Partial (6)	Partial (6)
Optometrist	Limited (4)	Limited (3)
Pharmacist (community)	Partial (7)	Partial (6)
Social Worker	Partial (6)	Partial (6)
Solicitor (criminal/family practice)	Close (8)	Partial (7)
Teacher	Partial (6)	Partial (5)
Veterinary Surgeon	Close (10)	Close (9)

Note: Scores of 8-10 represent a close match, 5-7 a partial match and 0-4 a limited match. Developed by Incomes Data Research (IDR).

Only one profession – Veterinary Surgeon – achieved a *close match* for both doctors and dentists, reflecting the strong parallels in clinical training, autonomous high-stakes decision-making, physical and emotional demands, and structured career paths. Solicitors achieved a *close match* for dentists, while most of the other selected professions were assessed as *partial matches*, indicating that these roles generally share some but not all of the core characteristics in our comparability framework.

The assessments presented in this chapter identify professions that offer the closest alignment with our comparability framework. Whether a profession is taken forward into the subsequent benchmarking and pay comparison analysis depends additionally on the availability, quality and comparability of suitable pay data. This is considered in the following chapter.

7. Pay comparisons

This chapter presents pay comparisons for doctors and dentists, benchmarked against a subset of the comparator professions identified in Chapter 6, and outlines key considerations relevant to the interpretation of international pay comparisons for doctors and dentists.

While eleven professions were assessed as conceptual comparators based on either partial or close alignment with the core characteristics of medical and dental roles, the analysis in this chapter focuses on those professions and role levels for which it was feasible to undertake robust pay comparisons, taking account of data availability, quality and job-level alignment. Several comparator professions – most notably actuaries, barristers, chartered surveyors and social workers – were not taken forward into the pay comparison analysis because suitable pay data were not available. If robust and comparable earnings data were available, these professions would have been included alongside the other comparator groups in the benchmarking analysis.

In addition, even where data were available, not all comparator professions were benchmarked against every doctor or dentist role. Matches were identified on a role-by-role basis, reflecting differences in career structure, scope of practice and the availability of comparable job-level data. As a result, some potential comparisons are not presented where no sufficiently robust match could be identified.

Where data are available, comparisons are presented using basic pay, total earnings and total reward (including pension values).[34] However, not all data sources provide information on all three measures, and data availability varies across professions.[35] If consistent data were available across all comparator professions, the analysis would present comparisons across all three measures for each profession. In practice, the analysis relies on the most comparable measures available in each dataset. The charts present the interquartile range (25th to 75th percentile) or, where necessary, the available pay range to illustrate the distribution of earnings. Comparator professions are ordered in ascending order based on the

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[34]Pension values are calculated as the difference between the employer pension contribution rate and the employee pension contribution rate.
[35]The technical notes in Appendix 3 provide a full audit of data sources.

median of the relevant pay measure, with doctor or dentist pay shown at the top of each chart as a reference point. For ease of interpretation, basic pay is shown in purple, total earnings in green, and total reward in blue.

Pay levels for comparator professions can vary across local labour markets and UK nations. However, due to data availability and to provide consistency, this study uses UK-wide averages for external professions and England-only pay data for doctors and dentists.

7.1.   Doctors' pay comparisons

Tables 7.1-1 and 7.1-2 show the professional comparator role matches used for doctors' pay benchmarking. These matches are drawn from the conceptual comparators identified in Chapter 6 but include only those professions and job levels for which robust pay comparisons were feasible. As a result, not all professions provide suitable comparators, and some cells are therefore shown as 'no match'.

IDR reference levels represent job-size bands rather than exact point matches. Roles mapped to the same level may therefore sit at different points within the points range for the level (see job evaluation scores in Table 5.3-1).

Table 7.1-1 Comparator role matches used for hospital doctors' pay comparisons

Medical role	IDR job level	Finance & accounting, legal and pharma (R&D) roles	Architect	Nurse	Community Pharmacist	Teacher	Veterinary Surgeon
FY1	5	14	No match	No match	Newly Qualified Pharmacist*	No match	Vet, <1 year qualified
FY2	6	15	No match	Nurse (Band 6) (non-HCAS)	Newly Qualified Pharmacist*	Teacher (MPR), M1-M6, Eng exc. London	Vet, 1 year qualified
Core Trainee (CT1)	6	16	Private Practice Architect I, up to 5 years' experience, London	Nurse (Band 7) (non-HCAS)	Pharmacist	Teacher (MPR), M1-M6, Eng exc. London	Vet, 2 years qualified
Specialty Registrar†	7	17	Private Practice Architect II, 6 or more years' experience, London	No match	Pharmacist	Teacher (UPR), U1-U3, Eng exc. London	Vet, 4 years qualified
Specialty Doctor	7	17	Private Practice Associate, London	No match	Pharmacy Manager**	Deputy Head-teacher, Leadership band 4, Eng exc. London	Vet, 5 years qualified
Specialist	8	19	Private Practice Associate, London	No match	Pharmacy Manager/ Senior Pharmacy Manager**	Deputy Head-teacher, Leadership band 4, Eng exc. London	Vet, 10-<15 years qualified
Consultant	9	20	Principals in Partnership II, 20 or more years' experience, London	No match	No match	Head-teacher, Leadership band 7, Eng exc. London	Vet, 20+ years qualified

*Most employers do not differentiate by role and recruit to the minimum of the pay range.
**Pharmacy managers are qualified pharmacists with management responsibilities.
†The role was evaluated at the entry point (ST3), while the earnings data reflect all specialty registrars across multiple training years. As a result, reported earnings may appear overstated relative to market comparators.
Notes: details are provided only for comparators taken forward to the pay comparison stage. Data were not available for all comparator professions identified; see Table A3.4 in Appendix 3 for details. Community pharmacists were identified as a comparator profession, and we collected data from a small number of large pharmacy multiples, reflecting the limited number of major employers in the sector. A wider pharmaceutical sector salary survey from Korn Ferry is also used as a supplementary benchmark.
Source: developed by Incomes Data Research (IDR).

Table 7.1-2 Comparator role matches used for general practice doctors' pay comparisons

Medical role	IDR job level	Finance & accounting, legal and pharma (R&D) roles	Architect	Nurse	Community Pharmacist	Teacher	Veterinary Surgeon
GP Specialist Trainee (GPST1)	6	16	Private Practice Architect I, up to 5 years' experience, London	No match	Pharmacist	Teacher (MPR), M1-M6, Eng exc. London	Vet, 3 years qualified
Salaried GP	8	18	Private Practice Associate, London	No match	Pharmacy Manager**	Deputy Head-teacher, Leadership band 4, Eng exc. London	Vet, 7 years qualified
Partner/ Principal GP	9	20	Principals in Partnership I, under 20 years' experience, London	No match	No match	No match	Vet, 10-<15 years qualified

*Most employers do not differentiate by role and recruit to the minimum of the pay range.
**Pharmacy managers are qualified pharmacists with management responsibilities.
Notes: details are provided only for comparators taken forward to the pay comparison stage. Data were not available for all comparator professions identified; see Table A3.4 in Appendix 3 for details. Community pharmacists were identified as a comparator profession, and we collected data from a small number of large pharmacy multiples, reflecting the limited number of major employers in the sector. A wider pharmaceutical sector salary survey from Korn Ferry is also used as a supplementary benchmark.
Source: developed by Incomes Data Research (IDR).

7.1.1.   Foundation doctors

NHS Digital does not produce the distribution of earnings for foundation dentists as it does for other grades. This is because doctors only spend one year in each grade (FY1 and FY2), and very few complete the full year within the April-March reporting period. Therefore, comparisons are based solely on the basic spot rate of pay for each grade.[36]

The basic spot rate for FY1 doctors is below the median for comparators in legal, finance and accounting, and pharmaceutical R&D, and is well below the range for newly qualified pharmacists. The relative position of pay for FY1 doctors slightly improves when we compare total earnings, with total earnings above the median for comparators in legal and finance and accounting but remains below median total earnings for comparators in pharmaceuticals

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[36]Appendix 3 sets out details of the data used in the pay comparisons.

R&D and well below earnings for newly qualified pharmacists. Once pension values are included, FY1 doctors sit above the median for veterinary comparators, at the upper quartile for comparators in legal and accounting, around the median for pharmaceutical R&D roles, but remain below total reward for newly qualified pharmacists (Figures 7.1.1-1 to 7.1.1-3).

Figure 7.1.1-1 Interquartile range of basic pay: FY1 doctors and comparator professions 2025

Figure 7.1.1-2 Interquartile range of total earnings: FY1 doctors and comparator professions 2025

Figure 7.1.1-3 Interquartile range of total reward: FY1 doctors and comparator professions 2025

Note: some comparators are not shown due to limited data; see Table A3.4, Appendix 3.
Source(s) (all charts): DDRB (2025)/NHS Staff Earnings estimates; Korn Ferry market surveys; IDR; NHS Employers/NHS Staff Earnings estimates; Society of Practising Veterinary Surgeons (SPVS)

The basic spot rate for FY2 doctors is above median basic pay for comparators in teaching, nursing and pharmaceutical R&D, around the lower quartile to median for legal and accounting comparators, and below the range for newly qualified pharmacists. FY2 doctors'

relative position improves when total earnings are considered. Including pension values further improves the relative position: on a total reward basis, FY2 doctors sit above all comparator professions shown (Figures 7.1.1-4 to 7.1.1-6).

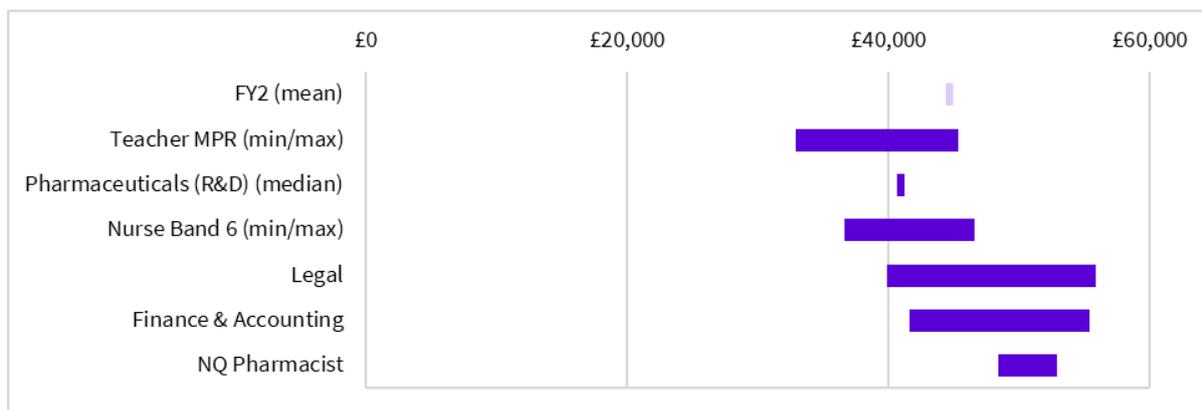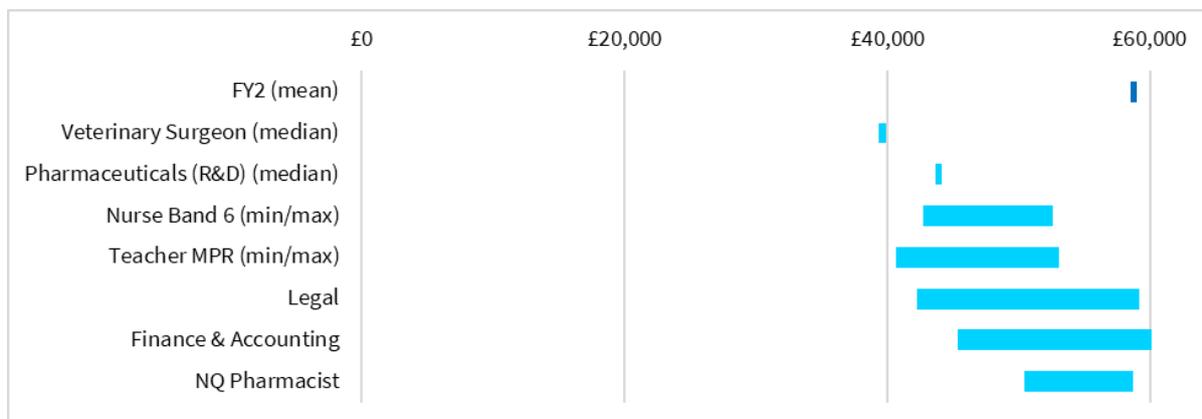**Figure 7.1.1-4 Interquartile range of basic pay: FY2 doctors and comparator professions 2025**

Figure 7.1.1-5 Interquartile range of total earnings: FY2 doctors and comparator professions 2025

Figure 7.1.1-6 Interquartile range of total reward: FY2 doctors and comparator professions 2025

Note: some comparators are not shown due to limited data; see Table A3.4, Appendix 3.
Source(s) (all charts): DDRB (2025)/NHS Staff Earnings estimates; Korn Ferry market surveys; IDR; NHS Employers/NHS Staff Earnings estimates; STRB (2025); Society of Practising Veterinary Surgeons (SPVS)

7.1.2.   Core trainee doctors and specialty registrars

The charts in Figures 7.1.2-1 to 7.1.2-3 compare the interquartile range (IQR) of pay for CT1 doctors with a range of comparator professions across three measures: basic pay, total earnings and total reward. Taken together, they show how the relative position of CT1 doctors improves as additional elements of remuneration are considered, although differences remain compared to higher-paying professions.

The interquartile range of basic pay for CT1 doctors sits above teachers on the main pay scale but below all other comparators. Other professions, particularly in legal, finance and accounting, community pharmacy and pharmaceutical R&D, show both higher and wider pay ranges. When total earnings are considered (Figure 7.1.2-2), the relative position of CT1 doctors improves, placing them above architects and the pay range for Band 7 nurses, though their range remains narrower than for most other comparators, and below those observed for legal, finance and accounting, pharmacy and pharmaceutical R&D roles.

Total reward comparisons (Figure 7.1.2-3), which include the value of pensions, place CT1 doctors above vets, architects, teachers and nurses; however, the interquartile range remains narrower and below that for comparators in legal, finance and accounting, community pharmacy and pharmaceutical R&D (Figures 7.1.2-1 to 7.1.2-3).

Figure 7.1.2-1 Interquartile range of basic pay: core trainee doctors (CT1) and comparator professions 2025

Figure 7.1.2-2 Interquartile range of total earnings: core trainee doctors (CT1) and comparator professions 2025
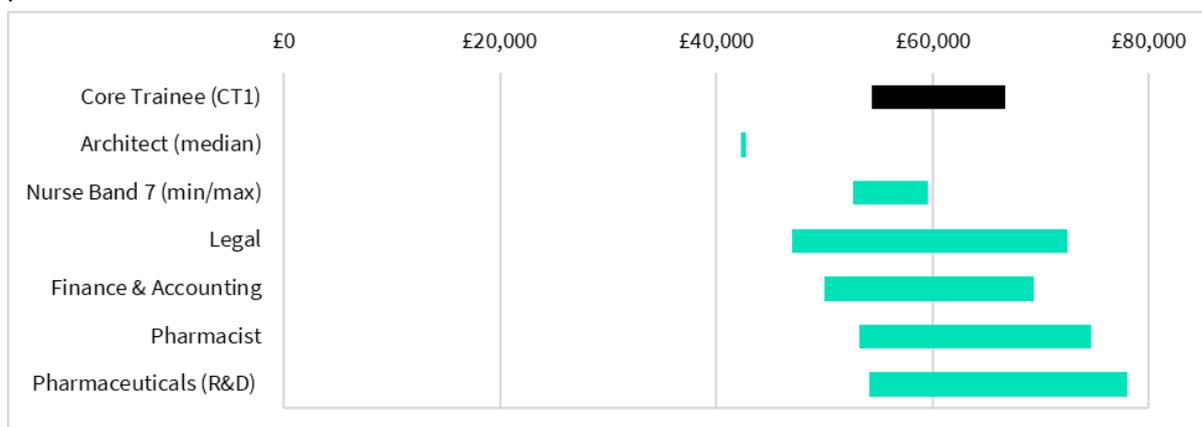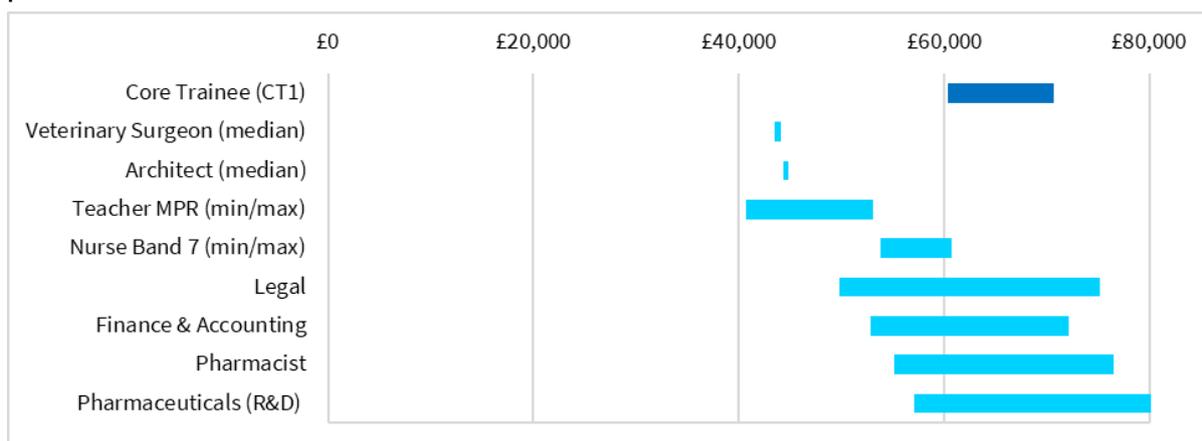

Figure 7.1.2-3 Interquartile range of total reward: core trainee doctors (CT1) and comparator professions 2025

Note: some comparators are not shown due to limited data; see Table A3.4, Appendix 3.
Source(s) (all charts): DDRB (2025)/NHS Staff Earnings estimates; Korn Ferry market surveys; IDR; NHS Employers/NHS Staff Earnings estimates; STRB (2025); Architects Earnings; SPVS

Our job evaluation and identification of comparator professions for Specialty Registrar are based on the role at entry to higher specialty training (ST3). However, NHS earnings data are not available by training year and instead reflect earnings for all specialty registrars combined. As responsibility and job size increase over the course of training (see Section 5.3), the earnings distribution therefore includes doctors whose roles may correspond to higher job levels than the ST3 benchmark. This may overstate earnings for ST3 relative to market comparators.

The interquartile range of basic pay for specialty registrars lies below that for all professional comparators, except teachers, where only the minimum and maximum of the upper pay range are shown and the upper quartile for specialty registrars exceeds the maximum for teachers. Total earnings improve the relative position for specialty registrars. The interquartile range of total earnings sits above that for comparators in legal, architecture and community pharmacy, but remains below that for finance and accounting and pharmaceutical R&D comparators. Comparisons based on total reward show a broadly similar pattern to total earnings (Figures 7.1.2-4 to 7.1.2-6).

Figure 7.1.2-4 Interquartile range of basic pay: specialty registrars and comparator professions 2025
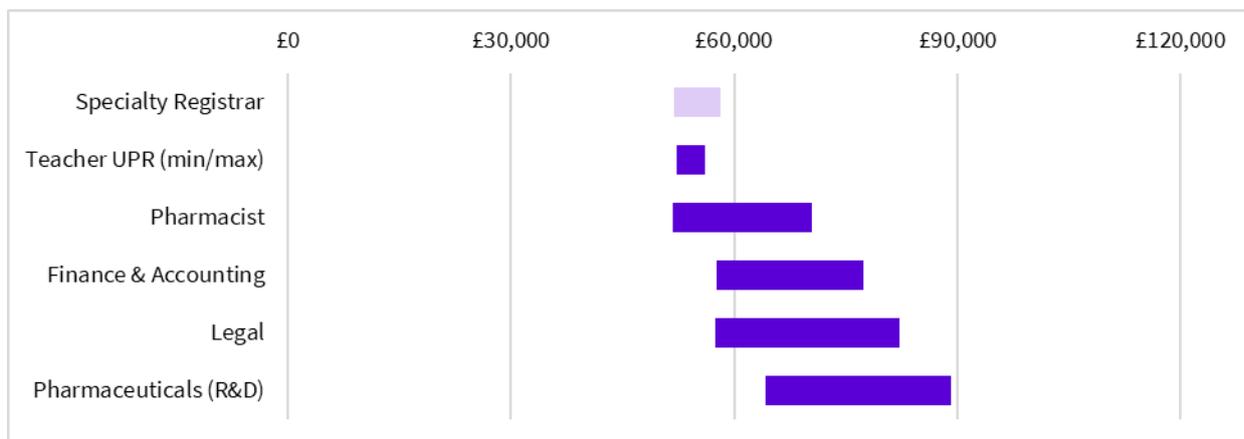

Figure 7.1.2-5 Interquartile range of total earnings: specialty registrars (ST3) and comparator professions 2025
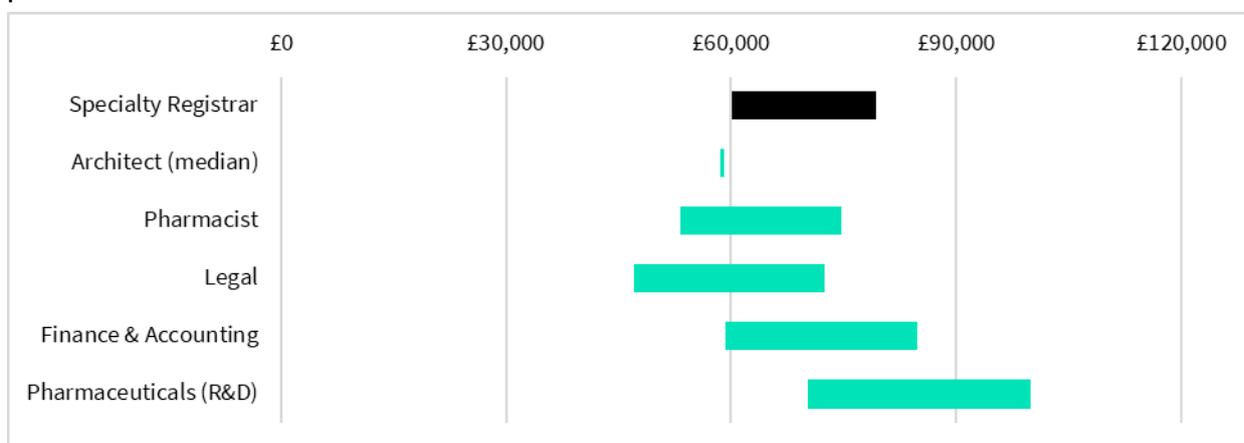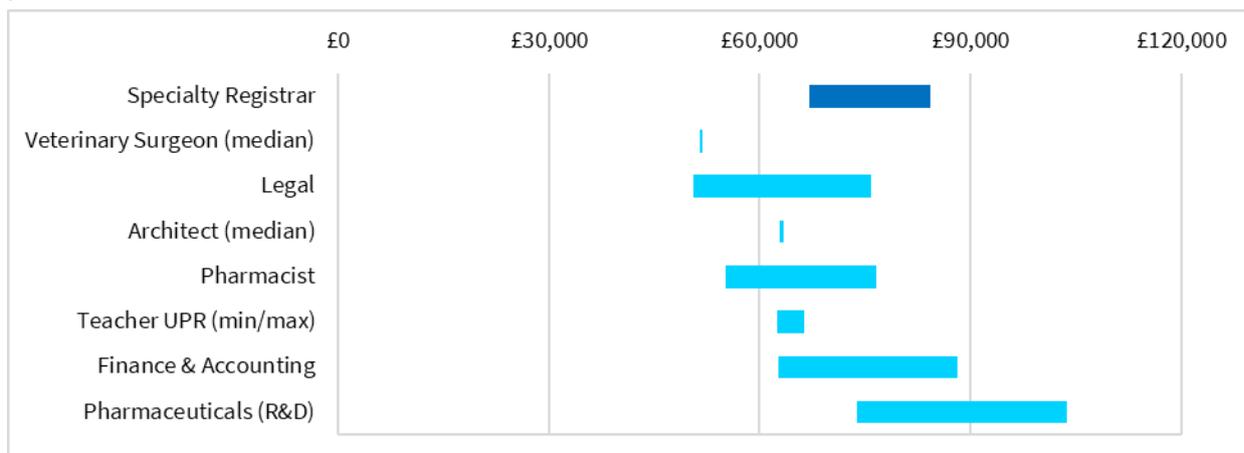

Figure 7.1.2-6 Interquartile range of total reward: specialty registrars (ST3) and comparator professions 2025

Note: some comparators are not shown due to limited data; see Table A3.4, Appendix 3.

Source(s) (all charts): DDRB (2025)/NHS Staff Earnings estimates; Korn Ferry market surveys; IDR; NHS Employers/NHS Staff Earnings estimates; STRB (2025); Architects Earnings; SPVS

7.1.3. Specialty and Associate Specialist (SAS) doctors

The interquartile range of basic pay for specialty doctors sits above that for comparators in community pharmacy, finance and accounting, and legal, and is both narrower and slightly below that for comparators in pharmaceutical R&D and teaching. Total earnings span a much wider range and sit above those for all comparator professions. The interquartile range for total reward is also wider than that for most comparator professions and sits above the majority of comparators, though it remains below the upper end of the range for the highest-paid roles (Figures 7.1.3-1 to 7.1.3-3).

The interquartile range of basic pay for specialists sits above that for comparators in community pharmacy, finance and accounting, and teaching, but below that for comparators in pharmaceutical R&D and legal. Total earnings span a wider range than most comparators and sit above all comparator professions, except those in pharmaceutical R&D. While the interquartile range of total reward is slightly narrower, the relative pay position for specialists is broadly the same as when total earnings are compared (Figures 7.1.3-4 to 7.1.3-6).

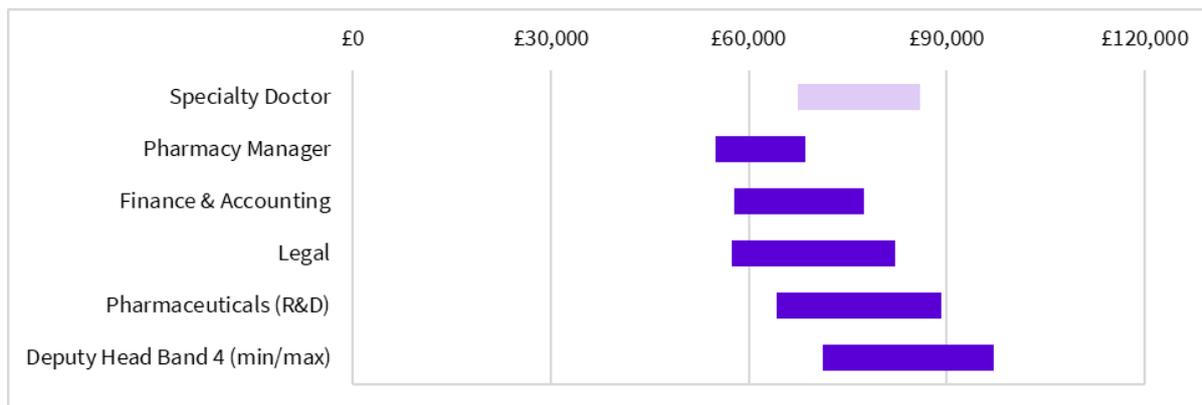**Figure 7.1.3-1 Interquartile range of basic pay: specialty doctors and comparator professions 2025**

Figure 7.1.3-2 Interquartile range of total earnings: specialty doctors and comparator professions 2025
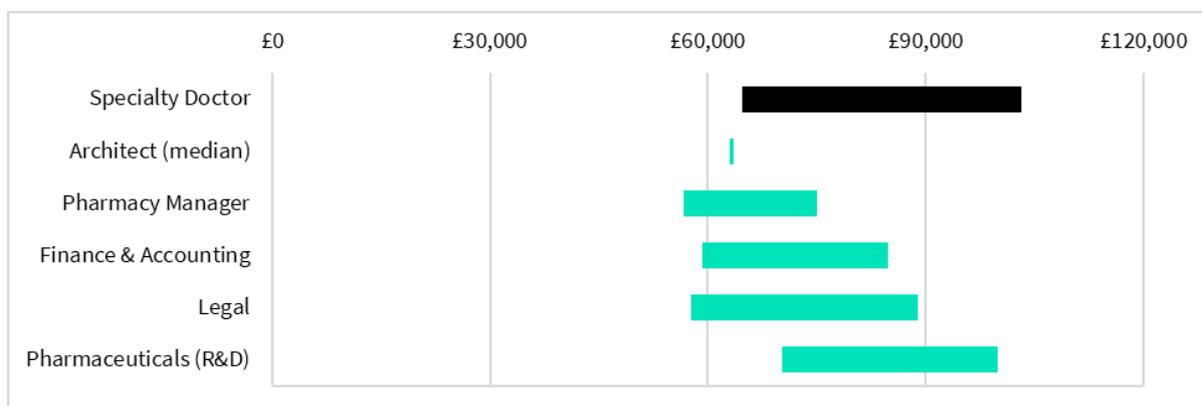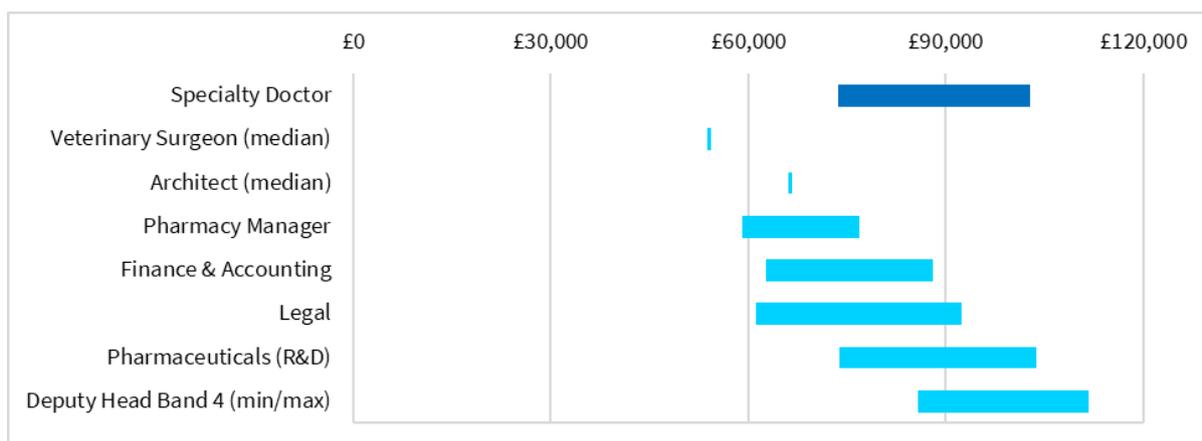

Figure 7.1.3-3 Interquartile range of total reward: specialty doctors and comparator professions 2025

Note: some comparators are not shown due to limited data; see Table A3.4, Appendix 3.
Source(s) (all charts): DDRB (2025)/NHS Staff Earnings estimates; Korn Ferry market surveys; IDR; NHS Employers/NHS Staff Earnings estimates; STRB (2025); Architects Earnings; SPVS

Figure 7.1.3-4 Interquartile range of basic pay: specialists and comparator professions 2025
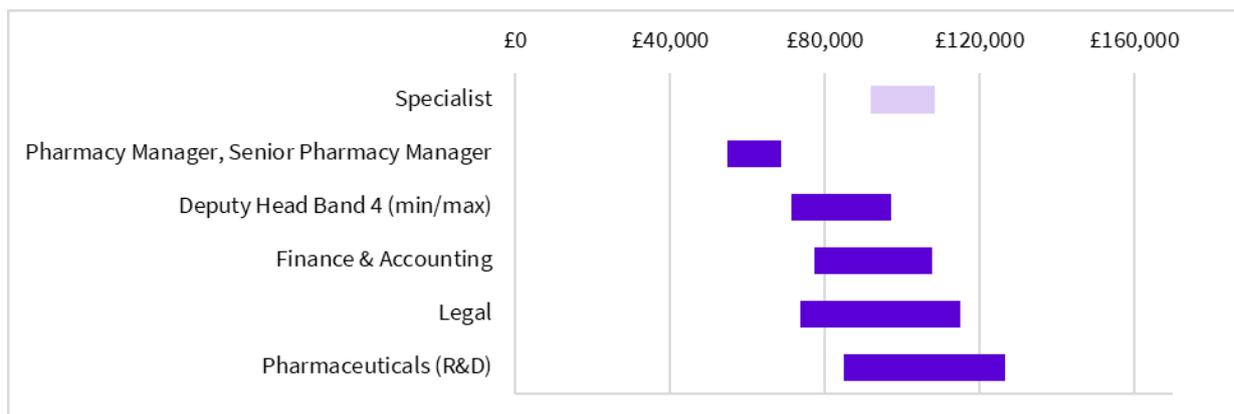

Figure 7.1.3-5 Interquartile range of total earnings: specialists and comparator professions 2025

Figure 7.1.3-6 Interquartile range of total reward: specialists and comparator professions 2025

Notes: some comparators are not shown due to limited data; see Table A3.4, Appendix 3. The lower quartile basic pay for specialists is higher than total earnings because basic pay is measured on a full-time equivalent (FTE) basis, while earnings are reported per headcount.
Source(s) (all charts): DDRB (2025)/NHS Staff Earnings estimates; Korn Ferry market surveys; IDR; NHS Employers/NHS Staff Earnings estimates; STRB (2025); Architects Earnings; SPVS

7.1.4.   Consultants

The interquartile pay range for consultants is much narrower and also sits below that for comparators. Consultants' total earnings sit above the median for architects and pharma R&D, above the interquartile range for finance/accounting, and below the upper quartile for legal comparators. Total reward is above the median for vets, architects and pharma R&D, above the range for accounting and teaching, but below the upper quartile for legal roles.

Figure 7.1.4-1 Interquartile ranges for basic pay: consultants and comparator professions 2025

Figure 7.1.4-2 Interquartile ranges for total earnings: consultants and comparator professions 2025
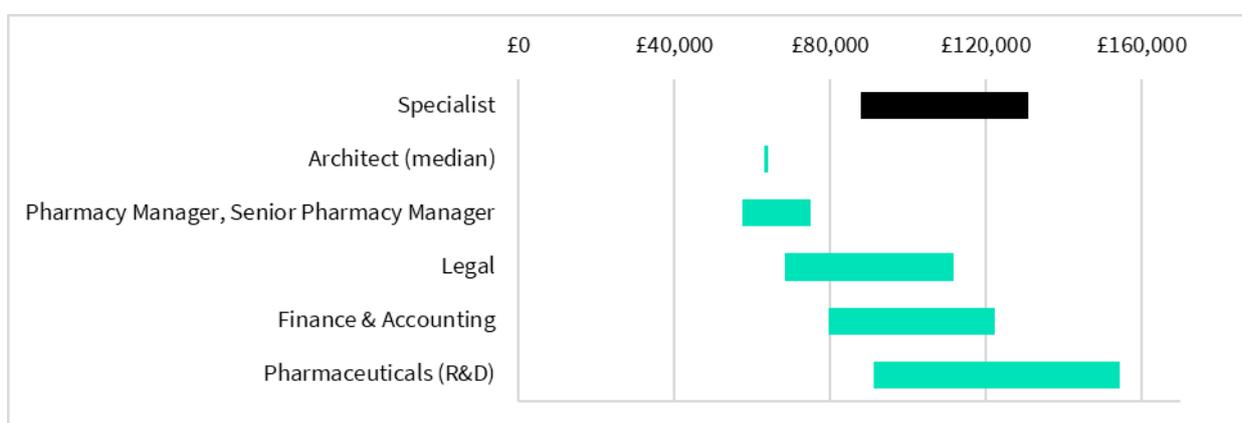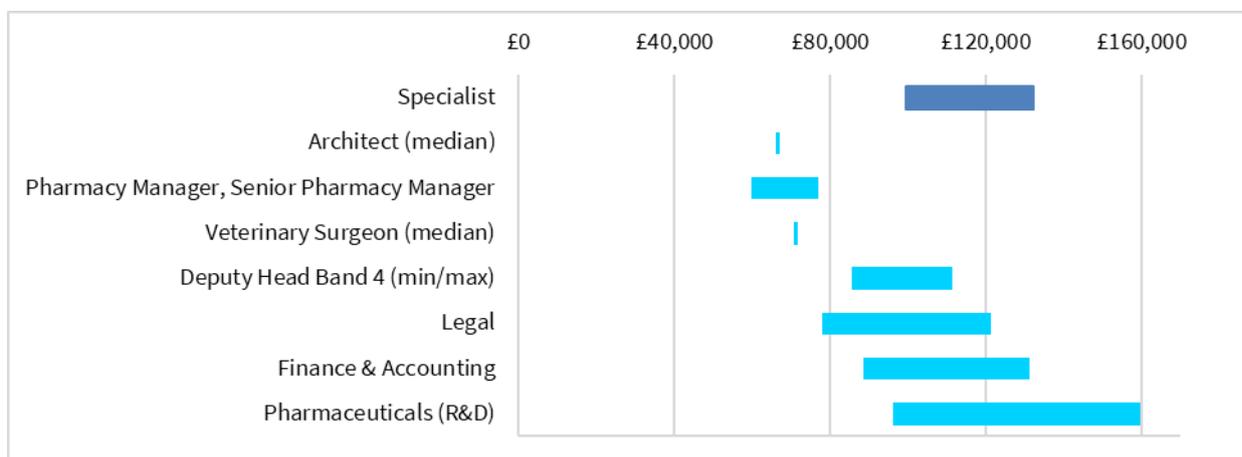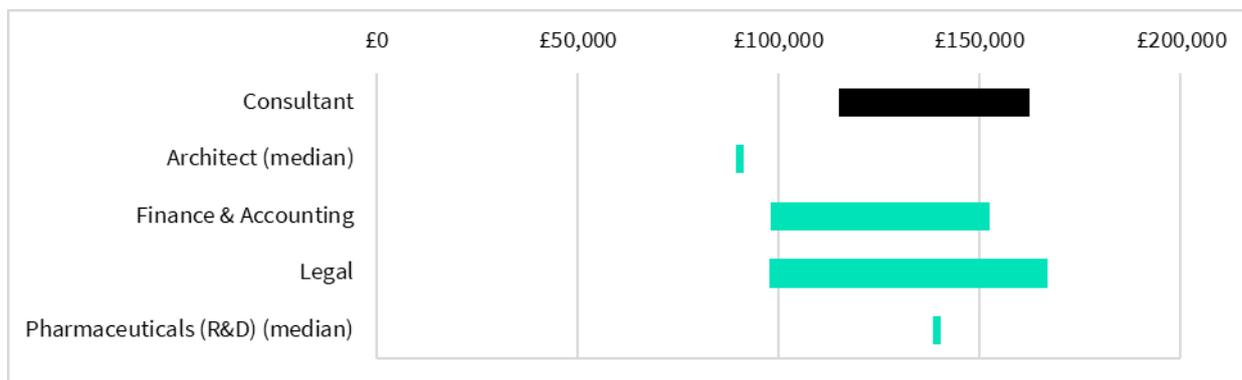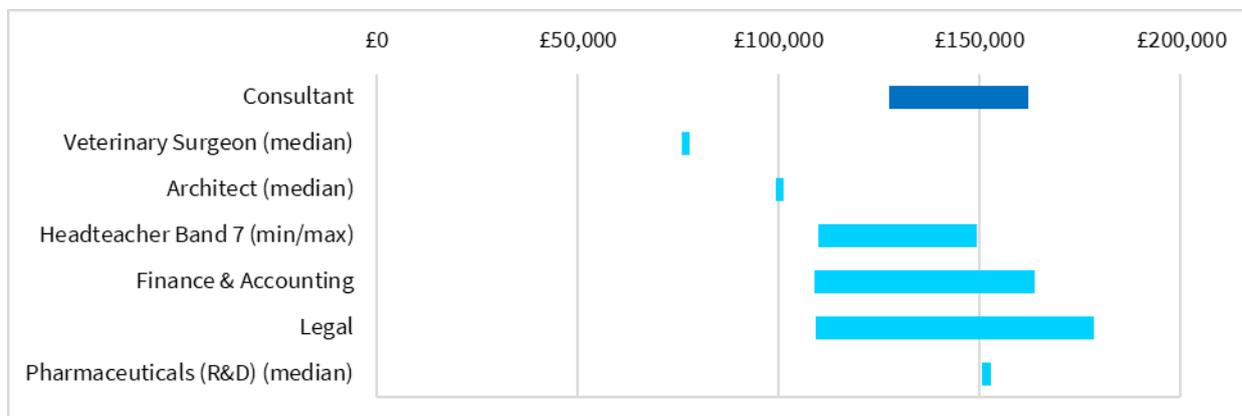

Figure 7.1.4-3 Interquartile ranges for total reward: consultants and comparator professions 2025

Notes: some comparators are not shown due to limited data; see Table A3.4, Appendix 3.
Source(s) (all charts): DDRB (2025)/NHS Staff Earnings estimates; Korn Ferry market surveys; IDR; NHS Employers/NHS Staff Earnings estimates; STRB (2025); Architects Earnings; SPVS

7.1.5.   General practice

NHS Digital does not produce percentile earnings for GP specialist trainees as it does for other grades, and therefore the analysis here focuses on basic pay only. The basic pay spot rate for GPST1 (including the flexible pay premium for general practice) is above the pay range for teaching comparators and above the median for pharmaceutical comparators. It sits at the upper quartile of the range for finance and accounting comparators, and towards the upper quartile for both pharmacist and legal comparators (Figure 7.1.5-1).

Comparisons for salaried and partner GPs can be made only on the basis of total earnings, as NHS Digital's GP Earnings and Expenses data (2023/24) is the sole source available. This dataset reports employment income before tax (covering both direct employment and self-employment). The income figures are presented on a headcount basis, without adjusting for hours worked, and are therefore likely to be lower than full-time equivalent (FTE) estimates.[37]

Subject to the limitations of the available data, the analysis indicates that the interquartile range of total earnings for salaried GPs is wider than that for most comparator professions and sits above the median total earnings for architects and above the interquartile range of total earnings for pharmacy managers. The upper end of the range falls towards the upper quartile of earnings for deputy headteachers and accounting comparators, and around the median of the range for comparators in pharmaceuticals and legal. When average total earnings for directly employed GPs are adjusted to a full-time equivalent (FTE), total earnings for salaried GPs sit above most comparators and towards the upper quartile of total earnings for comparators in pharmaceuticals and legal. (Figure 7.1.5-2). Comparisons based on total reward, which includes pensions values, show a similar pattern. (Figure 7.1.5-3).

Total earnings for partner GPs have a substantially wider interquartile range than those of the comparator professions and sit above all comparators across the range, reflecting the stronger earnings potential associated with the partnership model (Figure 7.1.5-4).

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[37]NHS England estimates show that the number of FTE salaried GPs in September 2022 was 0.631 of the headcount number of salaried GPs (unchanged from a year earlier). Para 4.99, DDRB (2025).

Figure 7.1.5-1 Interquartile range of basic pay: GP trainees (GPST1) and comparator professions 2025
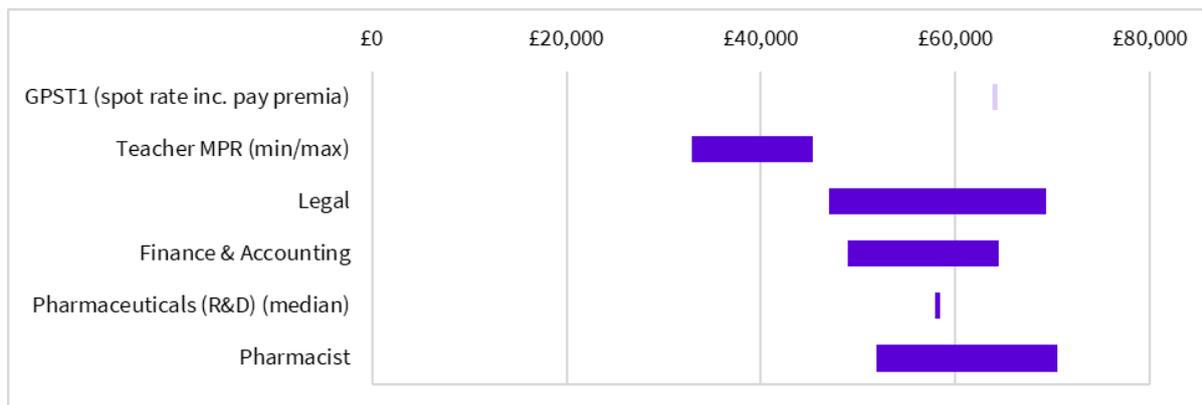

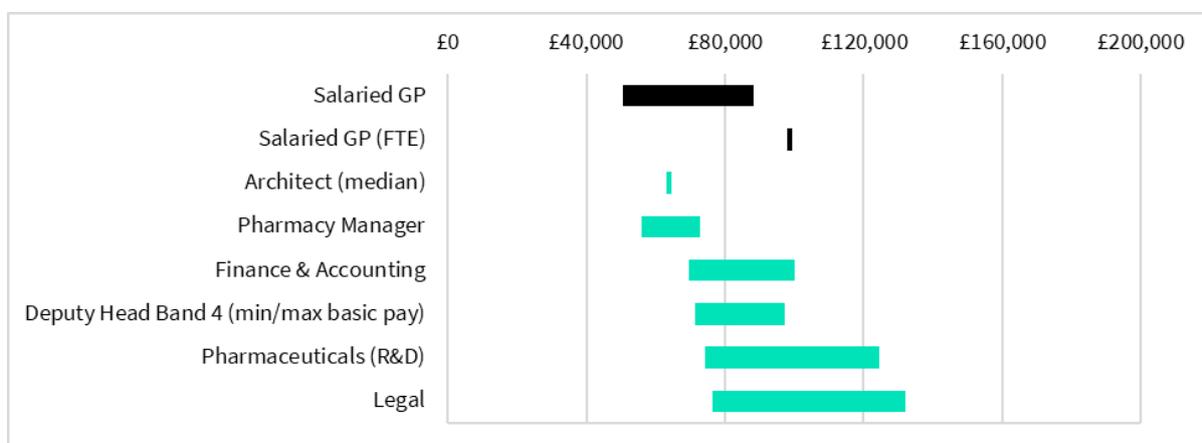Figure 7.1.5-2 Interquartile range of total earnings: salaried GPs and comparator professions 2025

Figure 7.1.5-3 Interquartile range of total reward: salaried GPs and comparator professions 2025
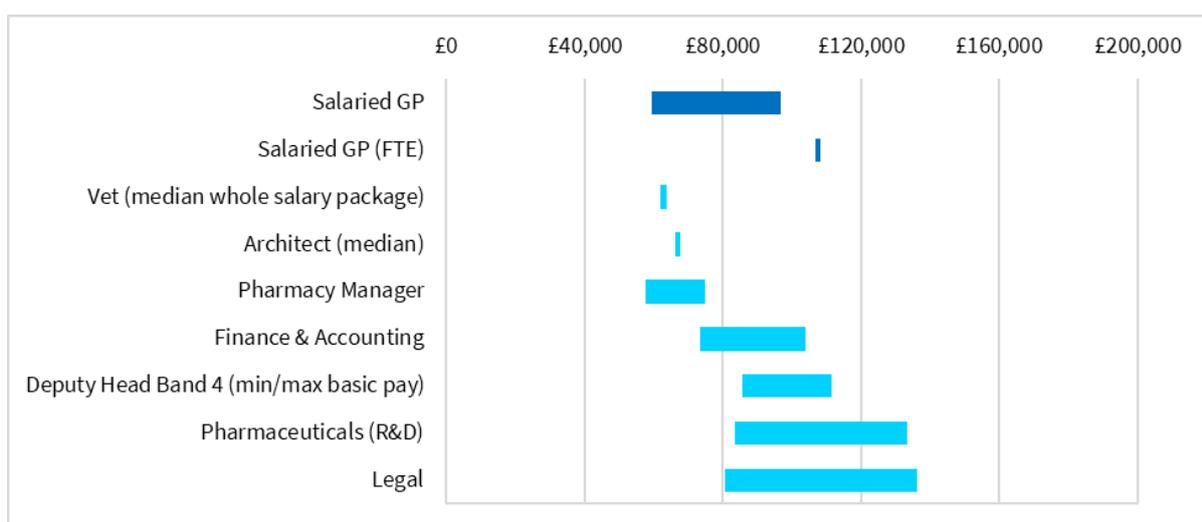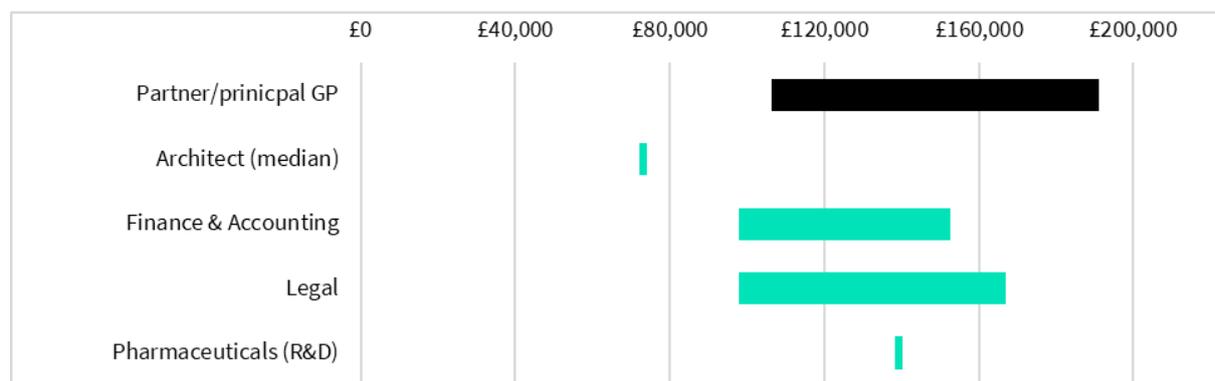
Figure 7.1.5-4 Interquartile range of total earnings: partner/principal GPs and comparator professions 2025

Notes: some comparators are not shown due to limited data; see Table A3.4, Appendix 3. NHS Digital reports GP earnings on a headcount rather than a full-time equivalent (FTE) basis. Figures 7.1.5-2 and 7.1.5-3 include an illustrative estimate of earnings for FTE salaried GPs. This is calculated by adjusting average earnings for directly employed GPs using NHS England's Sept 2022 estimate of working hours. Source(s) (all charts): DDRB (2025); Korn Ferry market surveys; IDR; NHS Employers/NHS Staff Earnings estimates; STRB (2025); Architects Earnings; SPVS

7.2.   Dentists' pay comparisons

Table 7.2-1 sets out the comparator role matches used in the pay benchmarking analysis for dentists. These matches draw on the conceptual comparators identified in Chapter 6 but reflect only those professions and job levels for which it was feasible to undertake robust pay comparisons, taking account of data availability, role comparability and job-level alignment. Not all conceptual comparator professions were suitable for benchmarking against every dentist role. As a result, some cells are shown as 'no match', indicating that no sufficiently robust comparator role was identified for benchmarking purposes at that level.

Pay comparisons for dentists are challenging because the available data on dental earnings is limited. The main source of pay data for general dental practitioners is the Dental Earnings and Expenses Estimates, based on anonymised HMRC tax records. Like the earnings figures for Salaried GPs, these figures are reported per dentist rather than on a full-time equivalent (FTE) basis, such that they appear lower than if adjusted for hours worked. For foundation and employed dentists (Salaried A and B), no earnings data is published, so comparisons rely on basic salary ranges alone. Despite these limitations, the pay comparisons provide useful insights, and the results vary by role.[38]

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[38]Appendix 3 sets out details of the data used in the pay comparisons.

Because comparisons for dentists are limited – basic pay for foundation and salaried roles, and total earnings for associates and contractors, rather than across basic pay, total earnings and total reward – we have included veterinary surgeon comparators in all charts. Available data for veterinary surgeons reflects the median whole salary package (ie total reward). Ideally, this would only be used in total reward comparisons, as we have done for doctors; however, no comparable total reward data is currently available for dentists. The pension element of the salary package for vets is likely to be relatively small.

Table 7.2-1 Comparator role matches used for dentists' pay comparisons

Dental role	IDR job level	Finance & accounting, legal and pharma (R&D) roles	Architect	Nurse	Community Pharmacist	Teacher	Veterinary Surgeon
Foundation Dentist/ Vocational Dental Practitioner	5	14	No match	No match	Newly Qualified Pharmacist*	No match	Vet, 1 year qualified
Associate Dentist	7	17	Private Practice Architect II, 6 or more years' experience, London	No match	Pharmacist	No match	Vet, 4 years qualified
Salaried Dentist Band A	7	17	Private Practice Architect II, 6 or more years' experience, London	No match	Pharmacist	Teacher (UPR), U1-U3, Eng exc. London	Vet, 4 years qualified
Salaried Dentist Band B	8	18	Private Practice Associate, London	No match	Pharmacy Manager**	Deputy Head-teacher, Leadership band 4, Eng exc. London	Vet, 7 years qualified
Contractor Dentist	8	19	Principals in Partnership I, under 20 years' experience, London	No match	No match	No match	Vet, 15-<20 years qualified†

*Most employers do not differentiate by role and recruit to the minimum of the pay range. **Pharmacy managers are qualified pharmacists with management responsibilities. †2025 pay comparisons use 10-15yrs qualified as 15-<20yrs is a lower salary which we have assumed is a sampling effect.
Notes: details are provided only for comparators taken forward to the pay comparison stage. Data were not available for all comparator professions identified; see Table A3.4 in Appendix 3 for details. Community pharmacists were identified as a comparator profession, and we collected data from a small number of large pharmacy multiples, reflecting the limited number of major employers in the sector. A wider pharmaceutical sector salary survey from Korn Ferry is also used as a supplementary benchmark.
Source: developed by Incomes Data Research (IDR).

7.2.1. Foundation and salaried dentists

The basic spot rate salary for foundation dentists is above the median whole salary package for veterinary surgeons, above basic median pay for comparators in pharmaceuticals, finance and accounting, and legal, and below basic pay for newly qualified pharmacists (Figure 7.2.1-1).

The basic pay range for Salaried Dentist A is wider than the interquartile range for comparators. At the median, basic pay is higher than that for teachers and pharmacists and median whole salary package for veterinary surgeons but lower than that for comparators in pharmaceuticals, finance and accounting and law (Figure 7.2.1-2).

The basic pay range for Salaried Dentist B is narrower – sometimes much narrower – than the interquartile range for comparator professions. At the median, pay is above that for all comparators. The maximum of the pay range is above the upper quartile of the range for pharmacy managers and finance and accounting comparators but lower than the upper quartile of the range for deputy headteachers, pharmaceutical R&D and legal roles (Figure 7.2.1-3).

Figure 7.2.1-1 Interquartile range of basic pay: foundation dentists and comparator professions 2025

Figure 7.2.1-2 Interquartile range of basic pay: salaried dentists A and comparator professions 2025
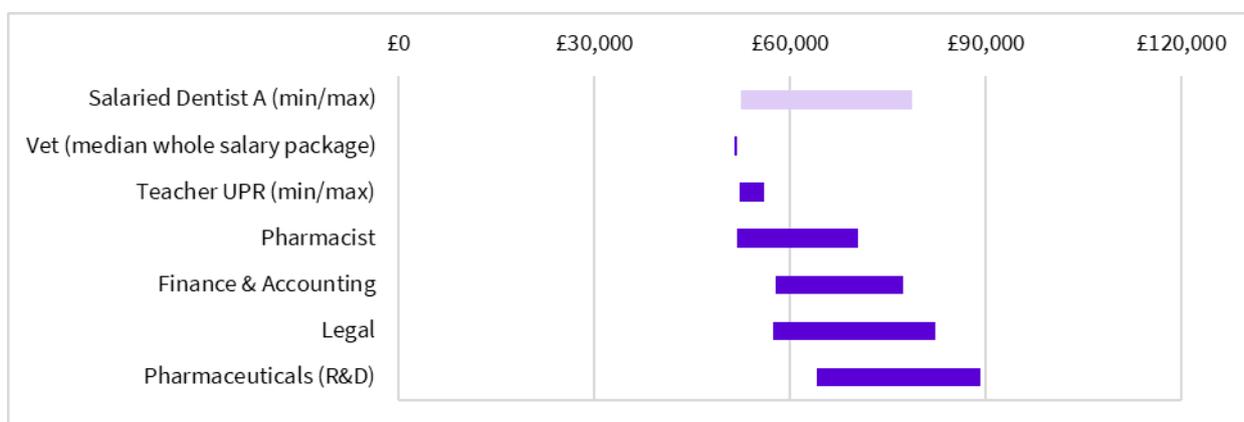

Figure 7.2.1-3 Interquartile range of basic pay: salaried dentists B and comparator professions 2025

Notes: some comparators are not shown due to limited data; see Table A3.4, Appendix 3.
Sources (all charts): DDRB (2025); Korn Ferry market surveys; IDR; NHS Employers; STRB (2025); SPVS

7.2.2. Associate and contractor dentists

Median total earnings for associate dentists are broadly in line with those for veterinary surgeons (note only available data is for whole salary package) and architects, while the interquartile range of total earnings sits around the lower quartile for most comparator professions and falls below the range for pharmaceutical comparators. These estimates are reported per dentist rather than per full-time equivalent (FTE), and no data are available on working hours; as a result, the figures are likely to be lower than equivalent full-time earnings (Figure 7.2.2-1).

Figure 7.2.2-1 Interquartile range of total earnings: associate dentists and comparator professions

The interquartile range of earnings for contractor dentists is much wider than for other professions, indicating greater variation. Their median total earnings are also higher than those for architects and veterinary surgeons, and exceed median earnings in legal, finance and accounting, and pharmaceutical research and development (Figure 7.2.1-2).

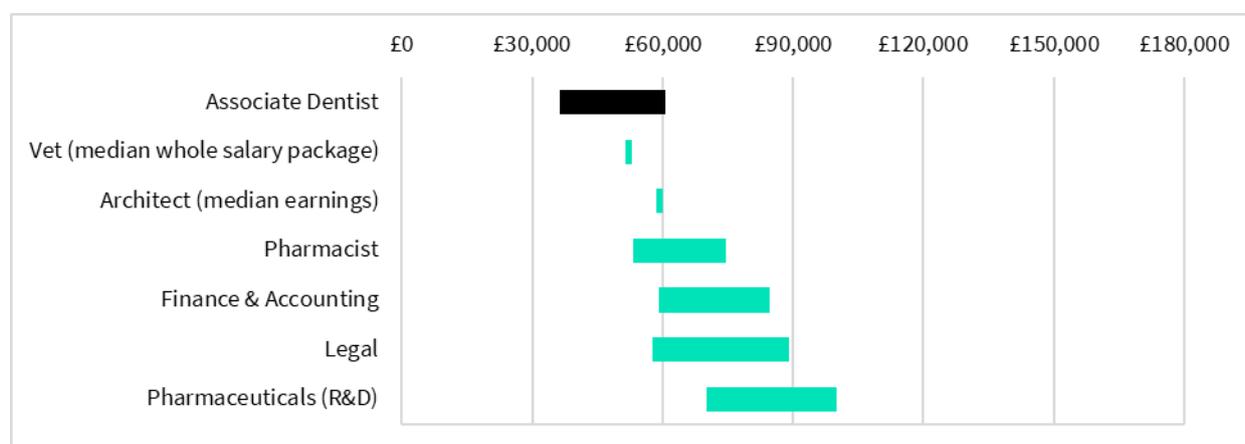**Figure 7.2.2-2 Interquartile range of total earnings: contractor dentists and comparator professions**
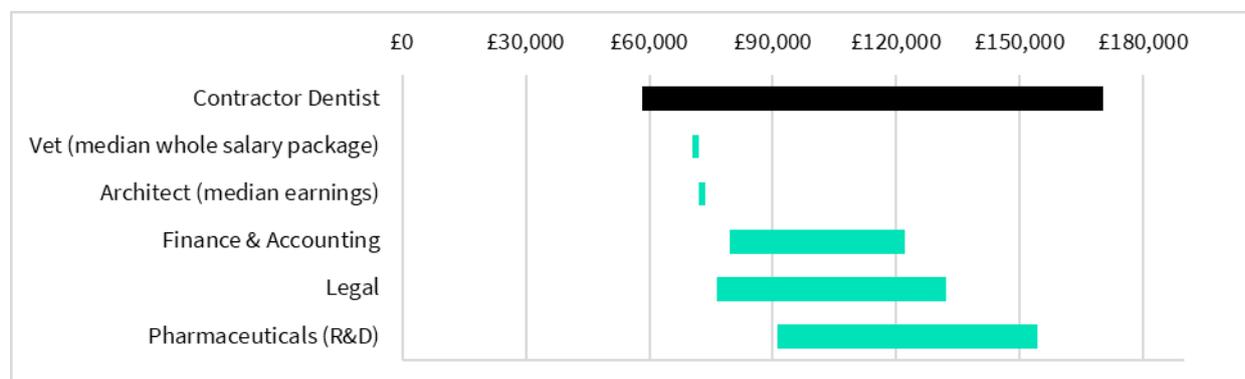
Notes: some comparators are not shown due to limited data; see Table A3.4, Appendix 3.
Sources (all charts): Dental Earnings and Estimates 2023/24; Korn Ferry market surveys; IDR; Architects Earnings; SPVS

7.3.   International context

Uniquely among the pay review bodies, the DDRB's revised terms of reference from 2025-26 require it to consider international comparators in making its recommendations. Our review explored the literature evidence and stakeholder views in relation to international pay comparisons. Both highlighted the perceived importance of such comparisons, due to doctors relocating overseas, but they also pointed towards the intricacies of comparing doctors' pay internationally. The considerations here relate to doctors only since there is no academic evidence on international pay comparisons for dentists, in large part because it is not as significant an issue.

While we found that some bodies have attempted international pay comparisons (OECD; Ireland's Public Service Pay Commission), our review highlighted the complex methodological assumptions (PSPC: Ireland, 2018) that are inherent in conducting these comparisons (see Section 3.8) and that any results need to be interpreted with caution (Palmer et al, 2023; DHSC, 2024). Our key messages for the DDRB in relation to considering international comparators are as follows:

- any exploration of international comparators should focus on the common destination countries for UK doctors including Australia, New Zealand, Canada, and Ireland, as these are the countries most frequently cited by stakeholders as destinations for international mobility and emigration
- the task of conducting robust international pay comparisons should not be underestimated and could be complex, resource-intensive and potentially costly
- differences between countries such as: the availability of robust earnings data; different healthcare systems and payment mechanisms; workforce definitions; qualification requirements; workforce hierarchies; distribution of responsibilities; career paths; time taken to progress through grades and pay ranges; employment terms and conditions; earnings differences between specialties; and the social, administrative and economic context of each country will need to be taken into account in any analysis
- there is no single methodological approach which determines how international comparisons should be conducted. Precise 'like-for-like' comparisons will not be possible due to variations across countries and therefore stringent parameters will need

to be discussed and agreed ahead of any related work to ensure there is value in the outputs

- in addition, there are different methods for comparing earnings between countries including by adjusting for exchange rates or in relation to the costs of goods (purchasing power) or by multiples of average earnings in each country (Palmer et al, 2023). We would, however, recommend that the OECD Purchasing Power Parity (PPP) indices are the most useful approach, as they adjust for cost-of-living differences between countries, which helps make salaries more comparable

- it may be advisable for the DDRB to commission separate, detailed work to assess the feasibility of conducting international pay comparisons, including the methods required and the availability of suitable data. Any in-depth study would also need to consider differences between healthcare systems to determine whether meaningful comparisons can be made.

Appendices

Appendix 1 – Stakeholder interview guide

Appendix 2 – Long list of professions considered at the initial screening stage

Appendix 3 – Technical notes

Appendix 4 – References for evidence review

Appendix 5 – IDR Job Levels Matrix

Appendix 1 – Stakeholder interview guide

Introduction

- *Study aims (including reminder that last review was conducted in 2017)*
- *Content of discussion*
- *Confidentiality*

A. Current approach to pay comparability

1. What is your overall view of the current methodology?
   - *What are its key strengths and weaknesses?*
   - *What might need to change?*

B. Medical and dental roles

2. Is the proposed list of roles appropriate? [see table]
   - *Should any additional roles be considered? Which ones? And why?*
   - *What have been the main changes in doctor and dentist roles, training and/or career paths that we need to take account of since 2017?*

C. Comparator selection

3. What are the main factors we need to reflect when making external comparisons?
   - *How do we decide which external roles are valid comparators given the distinctiveness of medical and dental roles (eg workload, patient complexity, working conditions etc)?*

4. How appropriate are the current comparator professions (eg actuarial, legal, finance/accounting, pharmaceutical, academic, veterinary)?
   - *Should additional professions be considered, and/or should some existing comparators be removed? And why?*
   - *What professions or sectors do you consider most relevant in benchmarking salaries for doctors/dentists? And why?*
   - *What other NHS or broader public sector roles would be useful comparators?*

5. Are alternative careers becoming more attractive? Which ones?

6. What are medical and dental professionals leaving to do – alternative careers, overseas roles, etc?

D. **Measuring pay comparability**

7. What additional elements of total reward (beyond basic pay) should be considered in pay comparability assessments?

    - *How important are these extra elements in the comparisons?*

8. What sources of pay and reward data should we use for benchmarking?

    - *And how about in private healthcare?*

9. What challenges do you think we will face in obtaining reliable comparator data, and how can they be mitigated?

E. **UK and international comparisons**

10. Are there differences between England, Scotland, Wales and Northern Ireland that affect the job roles and pay comparability?

11. How should international comparisons be approached, given challenges in data availability and role variations?

    - *Which countries or health systems provide the most relevant international benchmarks? Why?*

    - *Are some international comparisons more useful or valid than others?*

12. What experts might we be able to speak to about changes to the methodology, assessing comparator roles, pay data sources or other information we need?

Appendix 2 – List of professions considered at initial screening

This appendix sets out the long list of professions considered during the initial stage of comparator selection.

Professions on the long list were screened to identify those suitable for full assessment against our initial inclusion criteria. These criteria covered degree-level entry, formal training and accreditation requirements, structured career pathways, and roles involving significant responsibility and/or autonomous decision-making. Opportunities for self-employment were also considered where relevant, particularly in relation to general practice and dental practice ownership models.

Below summarises the professions considered and indicates whether each met the initial inclusion criteria. Professions that did not meet the criteria were excluded from further analysis of their relevance as comparators for doctors and dentists.

Table A2.1 Outcome against initial inclusion criteria for professions considered

Profession	Outcome against initial inclusion criteria
Academic (university teaching and research)	Met
Accountant	Met
Actuary	Met
Air Traffic Controller	Did not meet
Airline Pilot	Did not meet
Architect	Met
Banking, finance and technology professionals	Did not meet
Barrister	Met
Chartered Surveyor	Met
Engineer	Met
Graduate schemes	Did not meet*
Judge	Met†
Military Officer	Met†
Medical Officers and Dental Officers (MODOs)	Met†
NHS Medical Director	Met†
Nurse	Met
Optometrist	Met
Pharmacist (community)	Met
Physician Associate	Did not meet
Police Officer	Did not meet
Private healthcare practitioners	Met†
Probation Officer	Did not meet
Social Worker	Met
Solicitor (criminal and family practice)	Met
Teacher	Met
Veterinary Surgeon	Met

Notes on inclusion and exclusion decisions

*****Graduate schemes** did not meet all initial inclusion criteria, as most graduate programmes are not part of a professionalised or nationally accredited career pathway. However, they were assessed as a comparator group for foundation-level doctors and dentists, reflecting their degree-entry requirements and structured early-career training and development. Graduates were subsequently rated as a limited comparator and not taken forward to the pay comparisons.

†**Judges, military officers, Medical Officers and Dental Officers (MODOs), NHS medical directors, and private healthcare practitioners** were assessed as meeting the initial inclusion criteria but were not taken forward for comparator analysis for other reasons, as set out below.

Professions excluded at the initial screening stage

The professions set out below were excluded from further assessment because they did not meet one or more of the initial inclusion criteria. Exclusion reflected the absence of a mandatory criterion. In most cases, the key issue was the absence of a mandatory degree requirement. The rationale for exclusion in each case is summarised below.

Air traffic controllers (ATCs)

ATCs were excluded because the profession does not require degree-level entry and therefore does not meet the academic threshold set in the inclusion criteria. Although the role is highly regulated and involves significant responsibility, ATCs do not follow a nationally accredited professional career pathway comparable to doctors and dentists. In addition, the structure of the profession makes self-employment impractical.

Airline pilots

Airline pilots were excluded because, although the profession is highly regulated, it does not generally require degree-level entry. In addition, the scope of the role is narrower and focuses primarily on operational performance rather than the broader clinical, managerial, and leadership responsibilities typical of consultant and senior medical roles. This is consistent with the findings of the 2017 IES review, which excluded pilots on the basis of limited job and skill comparability.

Banking, finance, technology professionals (eg IT, cybersecurity, software development)[39]

These professions were excluded due to the absence of nationally recognised or externally regulated career pathways. Training and progression vary widely by employer, with no consistent or accredited professional framework(s), and degree-level entry is not universally required.

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[39] Korn Ferry pay data for the 'Finance and Accounting' job family is used to inform the pay comparisons for the accountancy profession.

Military officers

Military officers operate within a uniquely governed environment subject to military law and command hierarchies, which limits comparability to civilian regulated professions. In addition, not all roles have a mandatory degree-entry requirement.

Physician Associates (PAs)

PAs were excluded because they do not meet several core inclusion criteria. They undertake substantially shorter training than doctors, work under medical supervision, and do not have an autonomous scope of practice. They are not currently a fully regulated profession and cannot prescribe independently. The PA role also has a limited career structure, with limited opportunities for career development to senior levels. As such, PAs were not considered suitable comparators for doctors and dentists.

Police officers

Police officers were excluded because the profession does not consistently require degree-level entry and therefore does not meet the academic threshold set in the inclusion criteria. Although police officer roles involve some high-stakes decision-making and operate within a regulated framework, progression is largely determined by local force structures rather than a nationally standardised or accredited professional career pathway. In addition, policing does not provide a self-employment route.

Probation officers

Probation officers were excluded due to the absence of a consistent degree-level entry requirement and a nationally standardised career structure. In addition, the role does not typically involve the level of autonomous responsibility specified in the inclusion criteria, and probation officers cannot work on a self-employed basis.

Professions meeting the initial criteria but not taken forward

A small number of professions were assessed as meeting the initial inclusion criteria but were not taken forward for comparator assessment for other reasons.

Judges

Judges were excluded because the judiciary is an appointed profession rather than a structured, open career pathway, limiting comparability with professions characterised by standardised entry, training and progression routes.

Medical and Dental Officers (MODOs)

Medical Officers and Dental Officers (MODOs) were excluded because they operate within a uniquely governed environment subject to military law and command hierarchies. In addition, MODOs represent alternative or additional employment for doctors and dentists within medicine and dentistry rather than a distinct comparator profession. Their pay is also relative to NHS pay structures, meaning they do not operate within an independent labour market.

Private healthcare practitioners

Private healthcare practitioners were excluded because they represent alternative or additional employment for doctors and dentists rather than a separate comparator profession.

NHS medical directors

NHS medical directors were excluded as these roles are commonly held by senior consultants and therefore do not represent a distinct profession for comparator purposes.

Appendix 3 – Technical notes

This appendix summarises the data sources used in pay comparisons, the pay definitions applied, and the recommended anchor points for benchmarking.

Doctors and dentists

Doctors

Doctor pay data were drawn primarily from administrative sources published by NHS Digital and from the DDRB's 2025 report. Basic pay is based on nationally agreed spot rates or pay scales, while total earnings are derived from mean annual earnings per person reported for NHS staff groups in England over a 12-month period. Total reward estimates incorporate employer pension contributions net of employee contributions, using contribution rates applicable to each role and grade.

Dentists

Dentist pay data were drawn primarily from the DDRB's 2025 report and from published Dental Earnings and Expenses Estimates. Basic pay for foundation and salaried dentist roles is based on nationally agreed spot rates from pay scales. For associate and contractor dentists, earnings data are reported as median income before tax for all dentists in England and are presented on a headcount basis rather than a full-time equivalent (FTE) basis; as a result, these figures are likely to be lower than comparable FTE earnings.

Table A3.1 Definitions of pay for hospital doctors

Medical role	Source	Effective date of pay data	Basic pay	Total earnings	Total reward
Foundation Year 1 (FY1)	DDRB 2025 report/NHS Digital	2025/12-month period April 2024 to March 2025	Spot rate basic pay from scales in Appendix B DDRB 2025 report	Mean Annual Earnings per person by Staff Group, in NHS Trusts and other core organisations in England 12mnths ending March 2025	Total earnings + employer pension contribution rate of 23.7% minus 9.8% employee contribution
Foundation Year 2 (FY2)	DDRB 2025 report/NHS Digital	2025/12-month period April 2024 to March 2025	Spot rate basic pay from scales in Appendix B DDRB 2025 report	Mean Annual Earnings per person by Staff Group, in NHS Trusts and other core organisations in England 12mnths ending March 2025	Total earnings + employer pension contribution rate of 23.7% minus 9.8% employee contribution
Core Trainee	NHS Digital (data request for PRBs)	2025/12-month period April 2024 to March 2025	Basic pay per FTE in a 12-month period	Earnings is the amount paid to an individual in a 12-month period, regardless of the contracted FTE	Total earnings + employer pension contribution rate of 23.7% minus 9.8% employee contribution
Specialty Registrar	NHS Digital (data request for PRBs)	2025/12-month period April 2024 to March 2025	Basic pay per FTE in a 12-month period	Earnings is the amount paid to an individual in a 12-month period, regardless of the contracted FTE	Total earnings + employer pension contribution rate of 23.7% minus 10.7% employee contribution
Specialty Doctor	NHS Digital (data request for PRBs)	2025/12-month period April 2024 to March 2025	Basic pay per FTE in a 12-month period	Earnings is the amount paid to an individual in a 12-month period, regardless of the contracted FTE	Total earnings + employer pension contribution rate of 23.7% minus 12.5% employee contribution
Specialist	NHS Digital (data request for PRBs)	2025/12-month period April 2024 to March 2025	Basic pay per FTE in a 12-month period	Earnings is the amount paid to an individual in a 12-month period, regardless of the contracted FTE	Total earnings + employer pension contribution rate of 23.7% minus 12.5% employee contribution
Consultant	NHS Digital (data request for PRBs)	2025/12-month period April 2024 to March 2025	Basic pay per FTE in a 12-month period	Earnings is the amount paid to an individual in a 12 month period, regardless of the contracted FTE	Total earnings + employer pension contribution rate of 23.7% minus 12.5% employee contribution

Note: earnings data for specialty registrar is not available by training year, therefore earnings are for all specialty registrars.

Table A3.2 Definitions of pay for GPs

Medical role	Source	Effective date of pay data	Basic pay	Total earnings	Total reward
GP Specialist Trainee (GPST1)	DDRB 2025 report	2025	Spot rate basic pay from scales. Core/run-through training (yrs 1-2) plus £11,118 premium for General Practice	No available	Not available
Salaried GP	GP Earnings and Expenses Estimates	2023/2024	Not available	Employment income before tax (direct and self-employment) (all, England) (headcount basis)	Total earnings + employer pension contribution rate of 23.7% minus 10.7% employee contribution
Salaried GP (FTE)	GP Earnings and Expenses Estimates	2023/2024	Not available	Employment income before tax (direct employment) (all, England) adjusted to FTE*	Total earnings + employer pension contribution rate of 23.7% minus 10.7% employee contribution
Partner/Principal GP	GP Earnings and Expenses Estimates	2023/2024	Not available	Employment income before tax (all, England) (headcount basis)	Not available

*Pre-tax income estimates are reported on a headcount basis and do not account for hours worked. NHS England estimates that, as of September 2022, FTE salaried GPs represented 0.631 of headcount. This ratio is used to adjust average pre-tax employment income to approximate full-time earnings for salaried GPs.

Table A3.3 Definitions of pay for dentists

Dental role	Source	Effective date of pay data	Basic pay	Total earnings	Total reward
Foundation Dentist/ Vocational Dental Practitioner	DDRB 2025 report	2025	Spot rate basic pay from scales	Not available	Not available
Associate Dentist	Dental Earnings and Estimates	2023/24	Not available	Median income before tax (all dentists, England). Earnings for GDP earnings are on a headcount basis, and therefore lower than if on a FTE basis	Not available
Salaried Dentist Band A	DDRB 2025 report	2025	Spot rate basic pay from scales	Not available	Not available
Salaried Dentist Band B	DDRB 2025 report	2025	Spot rate basic pay from scales	Not available	Not available
Contractor Dentist	Dental Earnings and Estimates	2023/24	Not available	Median income before tax (all dentists, England). Earnings for GDP earnings are on a headcount basis, and therefore lower than if on a FTE basis)	Not available

Comparator professions

Accountants, solicitors and the pharmaceutical industry

Pay data for these professions is represented by data for legal, finance and accounting, and pharmaceutical (R&D) functions within Korn Ferry market surveys, segmented by job level and function, with matches determined according to job size through job evaluation. These aim to reflect earnings for solicitors, accountants, and the pharmaceutical industry.

The Korn Ferry market surveys provide robust, independently collected pay data across a wide range of functions, including legal, finance and accounting, and pharmaceutical roles. Coverage varied by sector, pay measure and job level. For finance and accounting roles, between approximately 3,000 and 4,700 incumbents were represented at each level, drawn from around 350 to 440 organisations. Legal roles were represented by between around 300 and 1,500 incumbents per level, drawn from approximately 100 to 140 organisations. Coverage for pharmaceutical research and development roles was smaller, ranging from around 10 to 600 incumbents per level, drawn from approximately 4 to 14 organisations.

Matches are based on job size determined through job evaluation, ensuring comparability across organisations. The dataset covers both base salary and total earnings (including variable pay and allowances), offering a reliable benchmark for these functions. As Korn Ferry operates its surveys on a continuing basis, the data is expected to remain available for future benchmarking exercises.

Architects

Salary data for architects is from the Architects Earnings 2025 edition, published by The Fees Bureau (a division of Mirza & Nacey Research). The information is based on a survey of architects and the 2024 survey received 1,396 returns. It provides data on median earnings and median value of remuneration packages. As the survey is undertaken annually, it is expected to remain available, however the DDRB will need to purchase the data and obtain agreement to include selected data in their report. It should also be noted that the data relates to self-reported earnings by architects.

Nurses

Pay for nursing is based on the April 2025 Agenda for Change pay scales (non-HCAS) for base salary. Estimates of additional earnings from shift work were drawn from the NHS Staff Earnings Estimates (March 2025), while the value of employer pension contributions was calculated using the standard NHS contribution rate of 23.7% minus employee pension contribution rate based on earnings. These sources provide a robust and comprehensive picture of nursing pay across the NHS. As they are maintained and published on a regular basis, the data is expected to remain reliably available for use in future benchmarking exercises.

Pharmacists

The pharmacist dataset was constructed by IDR in July 2025 through direct engagement with community pharmacies (both high street and supermarket) who agreed to share pay data on the basis that the findings would be aggregated and shared back with them, providing useful benchmarking information. Both of the major high street pharmacy chains were invited to contribute; Superdrug supplied data, while Boots did not [note: LloydsPharmacy now operates solely online]. Among the four major supermarkets with in-store pharmacies, Asda and Tesco participated.

In addition, IDR accessed the union-negotiated minimum rates at Boots, as agreed with the Pharmacists' Defence Association (PDA), and drew on in-house data for other pharmacy multiples. The Royal Pharmaceutical Society (RPS) confirmed that it does not collect or publish pharmacy pay data.

The pharmacy dataset is based on a combination of pharmacist-reported pay data, contributions from major employers (Superdrug, Asda and Tesco), union-negotiated minimum rates at Boots, and IDR's in-house holdings for other multiples. This mix provides a robust and representative picture of community pharmacy pay, although coverage is not absolute as Boots did not contribute. The dataset can therefore be regarded as reliable for pay benchmarking. While it is not routinely available, similar data could be collected in future years, and there is potential for an annual pharmacy pay survey to be established to support DDRB benchmarking work.

Teachers

The pay comparisons draw on data from the published basic pay ranges for teachers in England excluding London and fringe. Total earnings data is not available for teachers. The value of employer pension contributions was calculated using the standard NHS contribution rate of 23.7% minus employee pension contribution rate based on earnings.

Veterinary Surgeons

Veterinary pay data was kindly provided by the Society of Practising Veterinary Surgeons (SPVS). The SPVS salary survey is widely regarded as the benchmark source for veterinary pay in the UK. It is based on a large sample of practising vets and reports on the whole salary package, including allowances and benefits, making it more comprehensive than many alternative sources. While it is self-reported and therefore subject to some response bias, it remains the most reliable and widely used dataset for veterinary pay benchmarking. The survey is conducted annually and is likely to remain available for use in future pay benchmarking exercises.

Table A3.4 Definitions of pay for comparator professions

Comparator profession	Source	Effective date of pay data	Basic pay	Total earnings	Total reward
Accountant	Korn Ferry, Finance & Accounting	2025	Base salary (25th/50th/75th percentile)	Total earnings is the sum of base salary and variable pay and total allowances. (25th/50th/75th percentile)	Total earnings + 5% IDR median DC scheme employer contribution (or 10% for the most senior roles equivalent to GP Partner, Principal Dentist and Consultant)
Actuary	No data	-	-	-	-
Architect	Architects Earnings	2024	Not available	Median earnings	Median package including benefit: the value of the remuneration package calculated by adding the value of any benefits received to the earnings
Barrister	No data	-	-	-	-
Chartered Surveyor	No data	-	-	-	-
Nurse	NHS Employers/NHS Digital	2025	Pay ranges (min/max)	Basic pay + estimates of additional earnings from shift work were drawn from the NHS Staff Earnings Estimates	Total earnings + employer contribution rate of 23.7% minus 9.8% employee contributions
Pharmacist (community)	IDR bespoke data collection	2025	Basic pay	Total earnings	Total earnings + median employer DC pension contribution
Pharmaceutical R&D	Korn Ferry, Pharmaceutical (R&D)	2025	Base salary (25th/50th/75th percentile)	Total Earnings is the sum of Base Salary and Variable Pay and Total Allowances.	Total earnings + 5% IDR median DC scheme employer contribution (or 10% for the most senior roles equivalent to GP Partner, Principal Dentist and Consultant)
Social Worker	No data	-	-	-	-
Solicitor	Korn Ferry, Legal	2025	Base salary (25th/50th/75th percentile)	Total Earnings is the sum of Base Salary and Variable Pay and Total Allowances.	Total earnings + 5% IDR median DC scheme employer contribution (or 10% for the most senior roles equivalent to GP Partner, Principal Dentist and Consultant)
Teacher	STRB	2025	Pay ranges (min/max)	Not available	Basic pay + employer contribution rate of 28.68% minus 8.9% for teachers on the main pay scale, 9.9% for teachers on the upper pay scale and 11.7% for leadership roles
Veterinary Surgeon	Society of Practising Veterinary Surgeons (SPVS)	2025	Not available	Not available	Whole salary package: dividends, performance-related pay, accommodation, car, CPD, subscriptions, pension contribution

Appendix 4 – Rapid evidence assessment (REA) references

Armstrong, M. & Brown, D. (2024) Armstrong's handbook of reward management practice: Improving performance through reward, 7th ed., Kogan Page, London, 2024

Armstrong, M. & Brown, D. (2019) Armstrong's handbook of reward management practice: Improving performance through reward, 6th ed., Kogan Page, London, 2019

Armstrong, M., & Brown, D. (2017). Job evaluation versus market pricing: Competing or combining methods of pay determination? Compensation & Benefits Review, 49(3), 153-160

Armed Forces' Pay Review Body/AFPRB (2025) Armed Forces' Pay Review Body Fifty-Fourth Report 2025. May 2025

Armed Forces' Pay Review Body/AFPRB (2024) Armed Forces' Pay Review Body Fifty-Third Report 2024. May 2024

Brown, D. (2018) Fairness, flexibility and affordability: What are the lessons from recent pay and reward approaches and trends in the UK? Institute for Employment Studies, February 2018

CIPD (2019) Reward management: Focus on pay. Chartered Institute for Personnel and Development: London. February 2019

CIPD (2024) Job evaluation and market pricing. Factsheet. Chartered Institute of Personnel and Development. London. 5 June 2024

CIPD (2025) Strategic reward and total reward. Factsheet. Chartered Institute of Personnel and Development: London. 14 February 2025

Cullen, Z.B., Li, S., Perez-Truglia, R., Schaefer, A., Weiss, B. (2023) Why Your Organization Should Use Salary Benchmarking, Harvard Business Review, 10 October 2023

Clifford Chance (2024) The EU Pay Transparency Directive: Countdown to implementation, Clifford Chance, November 2024

DDRB (2025) Review Body on Doctors' and Dentists' Remuneration Fifty Third Report – 2025, Review Body on Doctors' and Dentists' Remuneration, May 2025

DHSC (2025) The Department of Health and Social Care's written evidence to the Review Body on Doctors' and Dentists' Remuneration for the pay round 2026 to 2027. Department of Health and Social Care. October 2025

DHSC (2024) The Department of Health and Social Care's written evidence to the Review Body on Doctors' and Dentists' Remuneration for the pay round 2025 to 2026. Department of Health and Social Care. December 2024

Dolton, P.J., Samek, L., She, P., (2019) Total Reward and Pensions in the UK by Occupation in the Public and Private Sectors. A Report for the Office of Manpower Economics. University of Sussex and National Institute of Economic and Social Research

E-reward (2017) Job evaluation in the UK: Provisional findings from E-reward survey. E-reward (Online)

Faragher, J. (2024) EU pay transparency directive: should UK employers prepare? Personnel Today, 17 May 2024

Georgellis, Y., Garcia, S.M., Gregoriou, A. and Ozbilgin, M. (2019), Pay Referents and Satisfaction with Pay: Does Occupational Proximity Matter? British Journal of Management, 30: 578-592

Glind, I. van de, Mulder, R., Akkerman, A., van der Biezen, M., Bootsma, J., Finnema, E., Heerma van Voss, L., Mouter, N., van Rooij, J., & van de Ven, G. (2025). Mapping the Literature on Job Evaluation: A Scoping Review. Compensation & Benefits Review, 57(1), 24-46

Heffernan K (2023) Job evaluation remains valued tool for ensuring equal pay and designing grading structures, Incomes Data Research, June 2023

ICAEW (2018) Salary surveys. The Institute of Chartered Accountants in England and Wales, 14 March 2025

IDR (2019) A review of school teachers' pay in England compared with other graduate professions – A report for NASUWT. Incomes Data Research, December 2019

IDR (2019a) Prison Staff Pay Comparability. A report for the Office of Manpower Economics, Incomes Data Research. November 2019

IDR (2022) Pay comparability study for MODOs. Incomes Data Research, August 2022

O'Brien, L. (2022) Remuneration in the public and private sector. Institute for Fiscal Studies, 2022

Lambert, P.S. and Prandy, K. (2018) CAMSIS project webpages: Cambridge Social Interaction and Stratification Scales, Retrieved 14 March 2025 from http://www.camsis.stir.ac.uk

Marcinkowski L, Butnaru A and Rabrenović A (2024), Salary systems in public administration and their reforms: Guidance for SIGMA partners, SIGMA Papers, No. 71, OECD Publishing, Paris

NHS Pay Review Body/NHSPRB (2025) NHS Pay Review Body Thirty-Eighth Report 2025. May 2025

OECD/European Commission (2024) Health at a Glance: Europe 2024: State of Health in the EU Cycle, OECD Publishing, Paris

ONS (2020) Public and private sector earnings: 2019. Office for National Statistics, 23 September 2020

Palmer W, Rolewicz L and Dodsworth E (2023) Exploring the earnings of NHS doctors in England. Explainer, Nuffield Trust

Police Remuneration Review Body/PRRB (2025) Police Remuneration Review Body Eleventh Report England and Wales 2025. August 2025

Police Remuneration Review Body/PRRB (2024) Police Remuneration Review Body Eleventh Report England and Wales 2025. July 2024

Prison Service Pay Review Body/PSPRB (2025) Prison Service Pay Review Body Twenty-Fourth Report on England and Wales 2025. May 2025

Public Service Pay Commission (Ireland)/PSPC (2018) Report of the Public Service Pay Commission: Recruitment and Retention Module 1. Public Service Pay Commission, August 2018

PwC (2023) 2023/24 All Employee Reward Intelligence Survey. PwC UK. 22 November 2023

Quentin W, Geissler A, Wittenbecher F, Ballinger G, Berenson R, Bloor K, Forgione D.A, Köpf P, Kroneman M, Serden L, Suarez R, van Manen J W, Busse R, (2018) Paying hospital specialists: Experiences and lessons from eight high-income countries, Health Policy, Volume 122, Issue 5, 2018: 473-484

RIBA (2024) Workplace Wellbeing Practice Note, Royal Institute of British Architects, 13 November 2024

RCVS (2023) Education Committee agenda and papers. Royal College of Veterinary Surgeons, 12 September 2023

School Teachers' Review Body (2025) School Teachers' Review Body Thirty-Fifth Report 2025. May 2025.

SPVS (2024) 2024 Salary Survey. The Society for Practising Veterinary Surgeons, 2024

Trendall, S. (2024) Ministers mull boost to digital pay framework 'to meet market trends', Civil Service World. 30 April 2024

The Lawyer (2024) Trainee and newly qualified solicitor salaries, The Lawyer, 1 November 2024

The Law Society (2024) Recommended minimum salary for trainee solicitors and SQE candidates, The Law Society, 30 July 2024

The Law Society (2025) How much do solicitors earn? The Law Society, 28 January 2025

Treacy Consulting/Willis Towers Watson (TC/WTW) (2018) Pay and benefits for Nurses, Non-Consultant Hospital Doctors and Consultants – International Data. Public Service Pay Commission, June 2018

Wenger J B, Hastings Roer E, Wong J P (2023) Military-to-Civilian Occupational Matching. Using the O*NET to Provide Match Recommendations for the U.S. Navy, Marine Corps, and Air Force. RAND Corporation, 2023

Worth, J. and McLean, D. (2022) What teachers do next after leaving and its implications for pay-setting. Slough: NFER

WTW (2024) OME – School Teachers' Review Body Teacher Job Levelling – Final. Willis Towers Watson. March 2024

Wyatt, H (2024) Next loses equal pay tribunal after basing pay on market rates, HR Magazine, 28 August 2024

Appendix 5 – IDR job levels matrix

IDR job level	Description
Administrative, manual and support	
1	Work requires basic literacy and numeracy skills and the ability to perform a few straightforward and short-term tasks to instructions under immediate supervision. Previous experience is not necessary
2	Work requires developed literacy and numeracy skills and the ability to perform some routine tasks within procedures that may include keyboard and practical skills and initial contact with customers. Some previous experience is required
Secretarial/craft	
3	Work requires specific administrative, practical, craft or technical skills gained by previous experience and qualifications to carry out a range of less routine work and to provide specialist support, and could include closer contact with the public/customers
4	Work requires broad and deep administrative, technical or craft skills and experience to carry out a wider range of activities including staff supervision, undertaking specialist routines and procedures and providing some advice
Vocational/supervisory	
5	Work requires detailed experience and possibly some level of vocational qualification to be able to oversee the operation of an important procedure or to provide specialist advice and services, involving applied knowledge of internal systems and procedures
6	Work requires a vocational qualification and sufficient relevant specialist experience to be able to manage a section or operate with self-contained expertise in a specialist discipline or activity
Professional and managerial	
7	Work is concerned with the provision of professional services and requires an experienced and qualified professional to provide expertise and advice and operate independently. Also includes operational managers responsible for service delivery
8	Work requires deep professional experience and qualifications in a specific discipline to be able to carry out a range of specialist technical or scientific activities, which may include the management of a team or services. May also include specialist management roles responsible for delivery of a major service

Senior management		
9	Senior managerial roles involved in managing an important activity or providing authoritative expertise, also contributing to the organisation as a whole through significant experience	
Director		
10a	Very senior executive roles in private or public sector organisations with substantial experience in, and leadership of, a specialist function, including some input to the organisation's overall strategy, but not normally a member of a company board	
10b	Member of a company board or an executive/senior management team in public sector organisations, with overall functional responsibility and input to the strategy of the wider organisation, through deep and broad experience	
Chief executive		
11	The most senior posts in an organisation responsible for setting the overall direction, strategy, financial success, and performance achievement requiring substantial business pre-eminence	

Source: IDR Job Evaluation Scheme, Incomes Data Research.

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