Dear Ms Hales

Mandatory Gender Pay Gap Reporting – Public Sector Employers

The British Medical Association (BMA) is an apolitical professional association and independent trade union, representing doctors and medical students from all branches of medicine across the UK and supporting them to deliver the highest standards of patient care. We have a membership of over 170,000, which continues to grow every year.

The Association welcomes the opportunity to respond to the consultation on Mandatory Gender Pay Gap Reporting – Public Sector Employers. Please find enclosed the BMA’s submission.

The BMA’s response centres around four key areas:
1) The wider context of the GPG (Gender Pay Gap) across the medical workforce
2) The criteria for public sector organisation for GPG reporting
3) The methodology by which the GPG should be calculated under the regulations and
4) Issues relating to the publication of the GPG by public sector organisations

We hope that our submission is useful – please do not hesitate to contact us for more information if required.

Yours sincerely

Raj Jethwa
Acting director of policy
The BMA welcomes the commitment by the GEO (Government Equalities Office) to monitor and address the GPG (gender pay gap) amongst public sector organisations. This is particularly relevant to the medical workforce, where the GPG has grown significantly in recent years¹.

We have divided our response into four sections:

1) Introductory comments on the wider context of the GPG across the medical workforce
2) Criteria for GPG reporting;
3) Methodology by which the GPG is calculated under the regulations; and
4) The publication of the GPG by public sector organisations.

1. Introductory comments

The BMA is wholly committed to the aim of “eliminating the GPG in a generation” whilst recognising the scale of this ambition.

The size of the pay gap in medicine has long been acknowledged as a problem. In 2004 male doctors earned 21% more than their female colleagues. By 2013 they earned 40% more².

The issues underlying the GPG are well-documented. Barriers to women progressing include: pregnancy and maternity leave, as well as provision of childcare; the lack of high ranking female role-models or mentors; and conscious and unconscious bias in medical organisational culture³.⁴

¹ Rimmer A. (2016) Five facts about the gender pay gap in UK medicine, BMJ Careers, 12 July 2016 careers.bmj.com/careers/advice/Five_facts_about_the_gender_pay_gap
In her presentation to a 2015 King’s Fund summit *Advancing women in medicine* Chief Medical Officer Dame Sally Davies highlighted “*the perception that a career path is too difficult because of male dominated work culture, unsocial hours, [and] lack of opportunities for part time work*”5.

Cohort studies have repeatedly shown that in the face of demanding family responsibilities, women are more likely to change career paths, and less likely to work in the specialties they aspired towards as medical students6. Studies have also found that women in part time training posts progress more slowly through training and fewer become consultants, particularly in surgical specialties7. A 2013 survey found that only 40% of female part-time consultants who responded reported taking on additional roles compared to 86% of male respondents. Only 37% of respondents (88% of whom were women) reported that they currently had a mentor8. Similar issues have also been identified for women in medical academia roles9.

Recent evidence suggests that there is some change particularly amongst those starting out in their medical careers. 55% of medical students are women – a rate which has remained steady over the last five years,10 and part time and flexible working are becoming more common for trainees11.

Despite this progress, there is still a long way to go. GPG reporting has the potential to be a valuable information resource for public sector organisations to highlight this issue. However, other measures will also be required, including initiatives to facilitate women’s leadership,

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5 Dame Sally Davies: what can organisations do to improve women’s ability to achieve their potential? The King’s Fund, 15 January 2015 kingsfund.org.uk/audio-video/dame-sally-davies-what-can-organisations-do-improve-womens-ability-achieve-their
6 Taylor K et al *Career destinations, job satisfaction and views of the UK medical qualifiers of 1977.* JRSM 2008;101:191-200
7 Taylor et al 2009
8 Academy of Medical Royal Colleges Flexible Careers Committee (2013) results of the flexibility and equality survey 2012 aagbi.org/sites/default/files/RESULTS%20OF%20THE%20FLEXIBILITY%20AND%20EQUALITY%20SURVEY%202012%20AoMRC%20Gibb.pdf
9 Wellcome Trust (2013) Report reveals issues that might turn women away from academic scienceReport reveals issues that might turn women away from academic science 26 September 2016 wellcome.ac.uk/press-release/report-reveals-issues-might-turn-women-away-academic-science
11 BMA (2015)
training and support such as mentoring and developing role models, and increased flexible working opportunities.

In July 2016, the Secretary of State for Health announced an independent review of how the gender pay gap can be eliminated in medicine\textsuperscript{12}. The BMA recommends that the result of this review is taken into account when considering the development of the GPG reporting regulations as part of a wider programme of work to eliminate the GPG in the medical workforce.

2. Criteria for gender pay gap reporting

**Scope of guidelines: application to public organisations employing 250 staff**

The BMA advocates that the threshold of organisations covered by the GPG regulations should be lowered to 150 or more staff to cover the majority of staff working in public sector organisations in the NHS and social care.

This would bring the regulations into line with the public sector equality duty requiring public authorities with over 150 employees to publish annual information about their workforce.

The BMA notes that both Scotland and Wales have introduced similar regulations: Wales requires public sector organisations employing 150 staff to publish their GPG; and Scotland recently changed their regulations to include any public authorities employing 20 staff or more.

**CCGs (clinical commissioning groups)**

The BMA welcomes the proposed inclusion of CCGs within the scope of the GPG reporting regulations. They are becoming increasingly significant employers of NHS staff, particularly doctors (including public health doctors and consultants).

However, the BMA notes that the median headcount of CCGs is 33 FTE (full time equivalent) staff\textsuperscript{13} and so, most CCGs will be exempt from GPG reporting. If a lower threshold of 150 employees were adopted as the BMA proposes, several CCGs would come within the GPG regulations. These include: Dorset CCG (229 FTE staff); and Cambridgeshire and Peterborough CCG (228 FTE staff).


\textsuperscript{13} Williams, D. (2013) Revealed: the 100-fold variation in CCG workforce size | Health Service Journal, hsj.co.uk/topics/workforce/revealed-the-100-fold-variation-in-ccg-workforce-size/5059624.article
Many more CCGs may fall into the 150 staff threshold in the future with plans for merging a number of CCGs under discussion\textsuperscript{14}.

**GP practices**
The BMA notes that the consultation does not include GP practices, a major provider of NHS services. They are classified as private sector organisations and therefore employers by the Office for National Statistics, so would presumably be included in the GPG reporting regulations covering the private and voluntary sectors.

There are substantive GPG issues in general practice\textsuperscript{15}. GP partners are largely male whereas an increasing majority of salaried GPs, employed by practices, are female. The BMA would welcome the opportunity to explore with the GEO how smaller, yet crucial employers such as GP practices and CCGs could be encouraged to adopt GPG reporting mechanisms to reduce the GPG.

**Proposed timetable**
We agree the timetable laid out in the proposal is proportionate and realistic. The process underpinning GPG reporting is unlikely to be completed at a faster pace.

It will be important that the schedule outlined (i.e. public authorities to capture the data in 2017 and then publish the data within 12 months, no later than April 2018) is strictly adhered to as any delay will set back analysis of the GPG.

The proposed ‘snapshot’ approach to GPG reporting will be subject to considerable fluctuation. As such, the BMA suggests a full scale national/sectoral analysis will only be possible after studying the trends over a longer-term period – e.g. five years. A full analysis of the UK GPG will be possible from 2023.

The BMA considers that it is important that organisations make the best use of lead-in time ahead of the regulations coming into force to fully prepare, understand their GPG and take steps to address any issues.

\textsuperscript{14} Williams D. (2016) Exclusive: Three commissioners consider merger to form biggest CCG, Health Service Journal hsj.co.uk/topics/service-design/exclusive-three-commissioners-consider-merger-to-form-biggest-ccg/7005612.article

\textsuperscript{15} Medical Women’s Federation (2015) Written evidence submitted by Medical Women’s Federation | House of Commons, para. 3 data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/women-and-equalities-committee/gender-pay-gap/written/25606.html
Reporting of sectoral GPGs

The division of GPG reporting on a sectoral basis will provide a valuable insight into the GPG at the health, social care and social security level.

The BMA recommends also including GPG data at a sub-sectoral level. For example, ‘Health’ would be a sub-sector within ‘Health, social care and social security’. This would have a number of benefits, including:

- enabling a comparison of the average GPG figure across health organisations;
- enabling a comparison across all hospital trusts, all foundation trusts and CCGs (the issues affecting the GPG vary widely in primary care and hospital settings); and
- in education, exposing GPG issues for medical academics.

Overall, this analysis would provide a more accurate and relevant analysis of the GPG within sectors, as opposed to comparing every sector to the national average. This is crucial when looking at the doctor workforce.

As referred to our introductory comments, arrangements for flexible working or maternity/parental leave disproportionately affect women doctors’ ability to secure stable career progression and income (especially among women doctors in training). A national GPG average would not account for these gendered issues. These issues would only become visible when looking at: an average across the sector and sub-sectors; and the inclusion of a detailed narrative explaining the underlying calculations.

3. Methodology

Proposed method of assessing hourly rate of pay

The BMA acknowledges that the use of the median gross hourly earnings (excluding overtime) is a standard and widely used method of collecting GPG information. However using the gross hourly pay rate as the dependent variable for the GPG data analysis is problematic.

Looking at the hourly pay rate among the doctor workforce from a ‘snapshot’ approach does not accurately account for out-of-hours work, or the accurate FTE levels among doctors in clinical roles. This is especially important for doctors working LTFT (less than full time), the vast majority of whom are women.
In relation to junior doctors, for example, over 80% of LTFT junior doctors are women\(^\text{16}\). The most common reason for working LTFT is to care for children\(^\text{17}\). LTFT doctors with children are often restricted in the number of out of hours/unsociable hours work they can do. In practice, LTFT doctors commonly work more their contracted hours\(^\text{18}\). A 2013 survey of LTFT workers found that on average, junior doctors worked 3.3 unpaid hours a week\(^\text{19}\).

In relation to consultants, in 2015, 32% of women consultants in England worked part time, compared to just 12% of men\(^\text{20}\). According to a 2013 study, LTFT consultants estimated that they worked on average, six unpaid hours per week.

The BMA is concerned that an hourly rate will mask these differences and the GPG will, as a result, be less accurate.

In addition to the issues regarding LTFT roles, there are specific issues arising from the manner in which doctors are paid that will mean the hourly rate of pay will not provide the most reliable GPG data. Set out below are the issues relating to junior doctors and consultants.

**Junior doctors**

**Junior doctors’ current pay**

- Basic salary;
- Various supplements which are amalgamated into a ‘banding payment’ – includes out of hours work, on call duty and varies according to hours and speciality.

**BMA concerns**

16 General Medical Council (GMC) National Training Survey (NTS) results 2012-14
http://careers.bmj.com/careers/advice/Trainees%E2%80%99_tales_of_less_than_full_time_training

18 BMA (2015) Less than full time guidance


20 Health and Social Care Information Centre (HSCIC) (2015) NHS Hospital and Community Health Services (HCHS): Medical staff only by gender, grade and working pattern, in NHS Trusts and CCGs in England, as at 30 September 2015, headcount (unpublished)
There is a substantial variation in the pay rate between medical specialities. This particularly impacts junior doctors as they tend to cover more out of hours work (i.e. unsocial hours which can attract a higher rate of pay) and because they can rotate between different jobs and between different specialties in a given year. As such there is variation in the pay an individual junior doctor gets at different stages throughout the year, and also amongst junior doctors as a group, compared to higher grade doctors, for example for staff grade, specialty and associate specialist doctors.

This means that a GPG report, produced on the basis of a ‘snapshot’ hourly rate, will be unable to reflect this annual variation and will be inaccurate.

Consultants

Consultants’ current pay (2003 contract)
- Basic pay (at 8 pay points over 19 years);
- On call availability supplements (based on rota contribution, as a percentage of basic pay);
- Additional PAs (Programmed Activities - 10% of basic salary);
- Clinical Excellence Awards – incentive payments that reward outstanding work or research (see below; could not be captured by hourly rate);
- WLI (Waiting List Initiative payments): extra contractual work negotiated upon individually;
- Additional payments, such as London Weighting or Recruitment Retention Premiums (again, discretionary and hard to reflect in an hourly rate).

BMA concerns

One of the key concerns is the impact of extra-contractual pay on consultants’ overall salaries and that the GPG reporting will be unable to control for this, and consequently be inaccurate.

WLIs
Consultants can undertake WLIs (see above) at rates that they negotiate with their employer. These largely take place on evenings and weekends, which could disadvantage those with caring responsibilities, predominantly women. There are concerns that NHS data held on these payments is not very robust and therefore might not allow for an accurate picture of total pay.

On call payments
The use of on call availability supplements means there is no way of knowing exactly how many hours of work are actually undertaken during an on call period.
In addition, there are categories of on call work (categories A and B) with one requiring immediate return to work and the other being conducted largely over the phone. Someone who works a ‘high frequency’ of category B work receives a 3% supplement, which is the same as someone who works a ‘low frequency’ on category A. It may therefore be impossible for NHS data to adequately separate these payments from the respective commitments and give an accurate picture relating to pay.

**Premium** time
Under the consultant contract, a working week is divided into blocks of four hours called PAs (Programmed Activities). In premium time (any time outside of Monday to Friday, 7am to 7pm) a PA only lasts for 3 hours. Alternatively, a consultant can choose to continue working four hour PAs in premium time but at an enhanced pay of time and a third. Whilst the overall amount spent on premium time is known, the precise breakdown in terms of premium hours worked by a consultant, and therefore individual pay, is far less clear.

**Exclusions**

**Overtime pay**
The consultation suggests excluding overtime pay from the regulations. In many medical careers, but particularly for junior doctors facing financial pressures at the start of their career, overtime work is routine. Many doctors work extra/locum shifts to pay off debts incurred e.g. on exams, regulatory fees and professional indemnity insurance\(^{21}\). Excluding overtime from the GPG data will impact on its accuracy.

**Non-contractual pay**
The following are examples of doctor’ earnings outside of their contractual pay. They are more frequently taken up by male doctors and therefore should be included within the GPG reporting. If they are not included, the GPG may appear to be narrower than it actually is.

- Many doctors undertake research projects or secondments in academic medicine in addition to their clinical duties. In doing so they can develop their careers, as well as keeping up-to-date with new treatments, technologies and approaches, and gaining significant additional income.

  The undertaking of medical research has gendered implications. Doctors who engage in research activities are often compelled to work unsociable hours outside of their clinical placement, which already poses difficulty in maintaining a stable work-life balance, especially for women doctors with families. The Royal College of Physicians found that

healthmatters.org.uk/blog/what-is-the-junior-doctors-dispute-really-about/
women were less likely than men to engage in research in addition to their regular clinical duties, with only 29% doing so compared with 43% of men\textsuperscript{22}.

- **Clinical excellence awards** of between £2,957 and £75,796 at the highest (platinum) level are given to consultants who contribute most towards the delivery of safe and high quality care to patients and to the continuous improvement of NHS services. These awards are available to doctors who contribute to academic medicine. In 2014 a fifth (270) of the 1404 doctors who applied for a clinical excellence award were women. Of 300 awards given out, 15\% (46) went to women and 85\% went to men\textsuperscript{23}.

\textit{Expenses and salary sacrifice schemes}

Expenses and salary sacrifice schemes are excluded from the proposed GPG regulations. The consultation does not explain the rationale for excluding salary sacrifice schemes, however given that these schemes are used to provide benefits such as childcare vouchers, the exclusions appears to be gender-neutral and helpful in terms of providing an accurate GPG. The BMA would welcome confirmation that this is the case.

The draft regulations also exclude expenses which would appear to disregard childcare costs additional to childcare vouchers and the costs of respite and care for older, sick and disabled relatives. As a result, GPG reporting would not account for significant expenses which reduce the actual take-home pay for many LTFT doctors.

The BMA suggests that the hourly wage should take account of recorded data from payroll departments on childcare costs/vouchers and out-of-pocket expenses incurred in caring duties, including both respite care and childcare costs.

**Quartiles**

The BMA does not in principle object to the use of quartiles as a measurement tool. The BMA is concerned that the amalgamation of the entire workforce (e.g. of a hospital or foundation trust), based on an hourly pay calculation that does not incorporate large elements of doctors’ remuneration, into one set of quartiles will not produce an accurate reflection of the GPG. As a result, the data will be of limited use.

\textsuperscript{22} Limb M. (2016) Medical research lags behind in gender equality, say researchers, BMJ Careers 15 March 2016, \url{careers.bmj.com/careers/advice/Medical_research_lags_behind_in_gender_equality_say_researchers}

\textsuperscript{23} Rimmer A. Five facts about the gender pay gap in UK medicine, BMJ Careers, 12 July 2016 \url{bmj.com/content/354/bmj.i3878}
LTFT doctors may take extended periods of time away from work to go on maternity leave, shared parental leave, or to care for a sick or disabled relative or dependant. The effect of being away from their work has long term effects on their career which need to be recognised in GPG reporting.

Women who take career breaks miss out on vital elements of training and, on their return to their training post must catch up whilst continuing to undertake their training. The proposed new junior doctors’ contract goes some way to address this but remains an impediment to LTFT doctors’ careers. This is borne out by the declining proportions of LTFT trainees at more senior grades: only 8% at ST7 and 2% at ST8\(^24\) (the grades below consultant), compared to 22% at ST3 level, indicating the perpetuation of a ‘part time pay penalty’ in medicine. These issues will not be identified in whole-workforce quartiles, even after several years.

Studies on doctors’ pay have successfully reflected the complex factors underpinning the GPG. For example, the BMA conducted a survey of men and women doctors’ pay in 2009. It found that in general, female doctors earned 18% less than male doctors, equating to a raw pay gap of £15,245. By controlling for factors such as part time working, maternity leave, and fewer years of experience, the BMA found a “true” gender pay gap among consultants of 5.6%, equating to £5,500 a year, and among trainees of 4.1%, equating to £2,000 a year\(^25\). Because of the difficulties in using an hourly pay calculation that does not control for maternity leave and stage of career, the BMA suggests that division by career group within each public sector organisation would be a more useful alternative to quartiles. This would provide a more accurate view of GPG issues for women selecting and pursuing certain career paths as opposed to a purely income-defined analysis. Furthermore it would more accurately reflect the career concessions and decisions that women doctors make. This division would also facilitate a more useful disaggregation of the workforce amongst non-NHS public sector organisations in which doctor’s work – e.g. community care facilities, public health units, medical academics in universities, police forces and the armed forces, and prisons.

4. Publication of GPG reports

The BMA believes the GPG reporting could be a useful tool to assist public sector employers address GPGs. It will need to be considered alongside other resources - including studies on the gendered issues associated with part time working and flexible working initiatives designed to tackle the GPGs.

\(^{24}\) BMA (2015)
The BMA recommends that to ensure maximum benefit is derived from the data and it is subject to appropriate scrutiny that:

- the GPG data is disseminated by each organisation and across sectors;
- The data is published at a national level accompanied by narrative explanation (see below) and in a format that is easily accessible to all employees and the public;
- it is published annually and presented to Parliament by the Minister of Equalities.

**Narrative accompanying the report**

The BMA strongly advocates that a narrative to accompany the GPG reporting should be included in the regulations. Without this information, the GPG data could be misleading. Even if the GPG reports include a breakdown by career group, as the BMA has proposed, an explanation of what constitutes LTFT employees, a discussion of how pay and career grades are affected by caring for children and/or sick and disabled adults should be included.

If the regulations are not amended to include the detailed breakdown that the BMA proposes the narrative will need to be extremely detailed to help people navigate the data. The BMA suggests that under the health, social care and social security sector, an explanation of how the calculation about doctors’ pay is reached would need to include information about:

- which professions are included in each quartile;
- the reasons behind gaps in quartiles;
- an explanation of the pay structure, including basic pay and supplements, out of hours work, and other awards for all grades of doctors; and
- part time working: including the specific arrangements for junior doctors - what constitutes LTFT, the impact of childcare, caring responsibilities, parental leave.

This narrative will be critical for example, to avoid creating adverse incentives – e.g. for female prospective and current medical students and trainees to opt for or avoid particular specialities because of the GPG.