



Europe Economics

Assessing Efficiency and Efficacy Gains in Health Professional Regulation Report for the General Optical Council

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Executive Summary

The General Optical Council (GOC) wished to explore the topic of shared functions within the context of the healthcare professional regulators in the UK and, in particular, the extent to which some sharing options would be effective and cost-efficient whilst protecting patient health and safety. Europe Economics, an independent consultancy which specialises in economic regulation and the application of economics to public and business policy issues undertook this work.

Our starting point was the development of a conceptual framework for assessing the costs, benefits and risks of various sharing options, ranging from the sharing of certain functions whilst retaining the independence of the regulators, through to a full merger option. This framework identifies the main functions of the regulators and their key organisational features which could be impacted by the sharing of these functions.

We then linked how changes to these key features could affect patient outcomes. We considered outcomes to include the broad quality of care provided by healthcare professionals, and the cost and uptake of care, and describe the links through which patient outcomes may be affected. The diagram below summarises our conceptual framework.

Figure 1: Mapping regulatory functions through to patient outcomes



We used the existing literature on public sector and private sector mergers and the joint sharing of functions to establish a preliminary evidence base to underpin the conceptual model. Our analysis of this evidence base finds that the case for economies of scale in a merger of some or all of the extant health professional regulators is still to be fully made. Whilst some economies of scale are likely realisable at some level, at least with respect to the smallest three regulators, it is not possible to rule out the possibility of diseconomies of

scale if one simply merged these regulators together. In this context, we investigated three potential sharing options between healthcare professional regulators, namely:

- **Option 1.** Independent regulators with limited sharing of functions.
- **Option 2.** Independent regulators with more extensive sharing of functions.
- **Option 3.** Full merger of independent regulators.

Our analysis of the various sharing and merger options suggests that the costs, benefits and risks do differ substantively across the sharing and merger options that we consider.

- In Option 1 — maintaining the independence of each regulator with limited sharing of functions — the sharing of back office and support functions would be likely to generate synergies and cost savings. There are various examples of such sharing arrangements, and savings, across public sector organisations. This level of sharing would be unlikely to result in a notable loss of profession-specific specialisation or increased operational complexity, and thus the risks and impacts on patient outcomes should be low. We find that the sharing of the registration function between regulators is different to other shared services, however. To realise scale (scope) efficiencies such a system would need to be consistent across all professions, which would entail the integration of a range of profession-specific features and/or a significant increase in operational complexity and cost.
- Under Option 2 — maintaining the independence of each regulator but with more extensive sharing of functions — we find that this would potentially be subject to risks arising from a loss of specialisation and increased complexity, however, this would depend on the exact nature of the sharing and the degree of integration. Particular areas of risk and uncertainty are likely to be in education and training and standards and guidance, as well as overall IT and systems integration.
- The third option of the full merger of the regulatory bodies would increase the risks associated with increased operational complexity in particular, as well as additional risks relating to leadership and governance and a loss of innovation.

The main drivers of risks to patient outcomes as a result of moving away from the current status quo appear to be increased operational complexity and a loss of profession-related specialisation. The evidence we have examined suggests that these would increase with greater sharing, such that increased scope for efficiencies goes hand in hand with increased risk, with the greatest risks present in the merger option.

The potential for cost savings is mainly accessible through the two sharing options. Whilst in the long-term a full merger could secure additional cost savings, this is far from a given — and indeed, this option involves substantially heightened risks in both scope and scale.

In the case of the health professional regulators, whilst there may be synergies at the operational level, the regulation of each profession entails a level of specialisation and independence that may not facilitate or necessitate interdependence. The case for patient outcomes to benefit from a fully merged regulator are not obvious, over and above the

sharing of best practice or operational elements which could be achieved from a less-integrated sharing approach.

Given these doubts, and with the focus upon patient outcomes, a cautious approach to accessing any potential economies of scale is merited. This could entail the exploration of sharing back-office and support functions, possibly with an external body (say acting as honest broker) to overcome any coordination problems amongst the regulators.

1 Introduction

The General Optical Council (GOC) wished to explore the topic of shared functions within the context of the healthcare professional regulators in the UK and, in particular, the extent to which some sharing options would be effective and cost-efficient whilst protecting patient health and safety. Europe Economics undertook this work, and this is our report to the GOC, presenting a review of the potential impacts of different hypothetical options for sharing.

Europe Economics is an independent consultancy which specialises in economic regulation, competition policy, and the application of economics and econometrics to public and business policy issues. We advise a wide range of clients, including national regulators and government departments, EU institutions (such as the European Commission and the European Parliament) and private companies and industry bodies.

1.1 Background and focus of the work

At present, there are nine statutory regulators of healthcare professionals in the UK.¹ At a high-level, all of these bodies have a common set of objectives, with a particular focus on patient safety and protection, yet there are differences in founding legislation, standards and approach. Some of the nine organisations regulating health professionals regulate a single profession while others regulate several occupations within a particular healthcare setting. Similarly, whilst most regulators are required to register only healthcare professionals some register both professionals and businesses; only the GOC regulates students. There are very significant differences in scale. The NMC has nearly 700,000 registrants, while some others are relatively small (e.g. the GCC with around 3,100).²

Recently, the Professional Standards Authority (PSA) has set out proposals for a transformation of the regulation of health and care professionals towards a more shared approach to providing the various regulatory functions and standards as well as fitness to practise. This report provides a high-level review of the potential costs, benefits and risks around consolidating regulators (or at least some of the functions within those regulators). In undertaking this work we:

- Developed a conceptual framework for analysing the impacts associated with different sharing options (which is described in Chapter 2).

¹ The statutory regulators of healthcare professionals are the following: General Chiropractic Council (GCC); General Dental Council (GDC); General Medical Council (GMC); General Optical Council (GOC); General Osteopathic Council (GOsC); General Pharmaceutical Council (GPhC); Health and Care Professions Council (HCPC); Nursing and Midwifery Council (NMC) and Pharmaceutical Society of Northern Ireland (PSNI).

² Professional Standard Authority for Health and Social Care. Annual Report and accounts and performance review 2015-2016.

- Analysed a body of academic and non-academic literature relating to public sector organisations.

The report particularly draws on the UK's past experience of public sector mergers and examples of regulators retaining independence but sharing some assets and/or functions. Our review is described in Chapter 3, with our conclusions in Chapter 4.

2 Conceptual Framework

In this section we set out our conceptual framework for understanding the role and functions of health professional regulators. From this starting point we elaborate how these could be affected by possible options for combining the work of regulators or sharing some of these functions. This represents our theoretical basis for analysing the corresponding benefits, costs and impacts on patient outcomes.

2.1 Main functions of healthcare regulators

Regulatory bodies are generally characterised by a set of core regulatory functions. In a health care context, the responsibilities of health professional regulators can be divided into the following core regulatory functions.³

- **Registration.** In order for a health professional or social worker to practise legally in the UK, they must be registered with the relevant regulator. The regulators only register those professionals who meet the defined standards. The regulator is required to keep an up-to-date register of all the professionals it has registered. The register should include a record of any action taken against a registrant that limits their entitlement to practise.
- **Standards and guidance.** All of the regulators are responsible for publishing and promoting standards of competence and conduct. These are standards for safe and effective practice that every health professional and social worker has to meet to become registered, as well as to maintain their registration. They set out the quality of care that patients and service users should expect to receive. Regulators also publish additional guidance to address specific or specialist issues that complement the regulators' standards of competence and conduct.
- **Education and training.** The regulator has a role in ensuring that students (where applicable) and trainees obtain the required skills and knowledge to be safe and effective. They also need to ensure that registrants remain up-to-date with evolving practices and continue to develop as professionals. As part of this work, the regulators can also approve educational programmes which students must complete in order to be registered.
- **Fitness to Practise (FTP).** Members of the public, employers and the regulators themselves can raise a concern about a registered health professional's (or social worker's) conduct that calls into question their fitness to practise on ethical and / or competence grounds. The regulators are required to take action under their FTP procedures where there are such concerns. This can lead to a variety of outcomes

³ PSA (2016) "The Performance Review Standards".

including no further action, a professional being prevented from practicing or restrictions being imposed on their practice.

Besides these regulatory functions, there are various business and support functions that are part of the day-to-day affairs of the regulatory bodies, but not necessarily part of the regulatory process. Included in business functions are activities such as procurement, back-office, IT, finance, accounting, facilities management, support staff, and other general administration facets.

2.2 Organisational features

There is a number of features that influence a regulator's ability to carry out its regulatory and non-regulatory functions. These range from a regulator's cost structure and operational complexity to its level of specialisation and ability to innovate.

We have developed the following list of features from the literature around regulatory management, drawing out those which we feel most applicable in the context of the possible consolidation of healthcare professional regulators' functions.

- **Cost efficiency.** Insofar as regulators' costs are recovered from the registrants, the overall level of cost incurred by regulators will be passed onto its registrants. The more cost-efficient a regulator is (i.e. meeting its objectives in the least costly way), the more proportional the costs to registrants, all else being equal. If a merged regulator can reduce its unit costs (or at least constrain the growth of costs) compared to individual regulators, then registrants would benefit.
- **Specialisation.** Specialisation here refers to the creation of separate, specialised regulators, each focussing on a specific segment (or in our case, profession).⁴ It is associated with the growing role of expertise in regulation and the existence of multiple regulators: according to Rommel and Verhoest, specialisation is necessary so that regulators have the sufficient sophistication to effectively regulate specific segments.⁵ The effects of specialisation might include the knowledgeable development and implementation of targeted regulation and guidelines, anticipated changes in risk within the profession, closer rapport with registrants and more effective data collection.⁶ On the other hand, the concept of specialisation can also apply *within* organisations and may work in the opposite direction. Larger, more centralised organisations may be able to

⁴ Specialisation is discussed in the literature around regulatory proliferation and competition. See Rommel and Verhoest (2008) for a summary of such literature.

⁵ Rommel, Matthys, Verhoest (2011) "Regulatory agencies and multi-actor regulatory governance: A method to study regulatory fragmentation, specialization, coordination and centralization?"

⁶ For example, Rommel and Verhoest (2008) cite Laffont and Martimort (1999) that a fragmented and decentralised regulatory arrangement may be able to collect more easily relevant information from the registrants at different levels, than a centralised one. See Laffont, J.-J. & Martimort, D. (1999) "Separation of regulators against collusive behaviour". RAND Journal of Economics, 30, 232-262.

achieve efficiencies by having individuals focus on fewer, larger tasks compared to smaller regulators in which an individual may be required to undertake a range of different tasks.⁷

- **Innovation.** This refers to the ability of regulators to enhance their regulatory performance through innovative approaches to regulation and, according to the literature, is influenced by benchmarking. The larger the number of relevant regulators, the greater the scope for benchmarking between them, whereby regulators share best practice, learn from each other's mistakes and seek to outdo each other.⁸ Sharing options that reduce the number of regulators or the number of separate regulatory functions will reduce the scope for benchmarking and innovation.
- **Operational complexity.** The complexity of a regulator will have an impact on its effectiveness, and will need to be managed. Operational complexity can arise for reasons such as the proliferation of services being delivered, unclear staff reporting structures, and unresolved legacy issues (e.g. the size, breadth and interoperability of IT systems). It can have consequences for the ability of the regulator to respond quickly to changes in the profession (e.g. risks), and communication between individuals and departments (for example, the ability to learn from past harm). Increases in operational complexity following the merging or sharing of functions could undermine the effectiveness of the regulator if not properly anticipated and managed.⁹
- **Leadership and governance.** Strong leadership and governance are important in regulators to ensure that their objectives and duties are effectively carried out. For example, in their International Public Sector Governance Framework, CIPFA¹⁰ and IFAC¹¹ maintain that effective governance in the public sector encourages better decision making and the efficient use of resources. Effective governance can improve management, leading to more effective implementation of the chosen interventions, better service delivery, and, ultimately, better outcomes.

2.3 Impact on patient outcomes

The ultimate goal of a healthcare regulator is to influence patient outcomes, by promoting good practice and reducing bad. Therefore we need to consider how a regulator's organisational features will impact on patient outcomes. This could be either direct or indirect (for example through impacts on the registered professionals).

⁷ For example, Audit Scotland found evidence from mergers that regulators were better able to streamline processes after merging by more efficiently deploying staff. Audit Scotland (2012) "Learning the lessons of public body mergers: review of recent mergers".

⁸ Rommel, J and Verhoest, K (2008) "Proliferation and specialisation of regulatory bodies in Belgium".

⁹ For example, and IBM Business Services report describes the underlying operational and systems complexity that is very often underestimated during corporate mergers. Such operational challenges — for example, integrating core processes, are difficult to understand and quantify ahead of the merger as they are often hidden deep within the systems and infrastructure of the merging companies. They may also be of little interest to the board, investors and the market and thus are overlooked until after the merger when the operational challenges become apparent. IMB (2006) "Business Service Report".

¹⁰ Chartered Institute of Public Finance and Accountancy.

¹¹ International Federation of Accountants.

As patient outcomes vary widely depending on the healthcare profession concerned we have taken a high-level view and consider outcomes to include the broad quality of care provided by healthcare professionals, and the cost and uptake of care. Mechanisms through which patient outcomes may be affected include:

- **Cost of healthcare and patient prices (direct impacts).** Sustained changes in regulators' operating costs will be passed through to registrants in the form of higher or lower registration fees. In the context of other types of cost (salaries, property costs etc.) incurred by healthcare professionals, registration costs are relatively trivial for most healthcare professionals. Even so, they may in turn affect the business models of some registrants and/or the costs of delivering healthcare.¹² We discuss the sustainability of the profession discretely below. Impacts on patient prices resulting from the merger or sharing options discussed in this paper look likely to negligible at worst (depending on the profession, there may not even be a relationship with any costs directly borne by patients). On the other hand, higher registration fees could be translated into demands for increased pay, which in turn could affect the public purse.
- **Monitoring and safeguarding.** The ability of regulators to safeguard patients from healthcare professionals who are unfit to practise has a clear impact on patient outcomes by avoiding potential harm (including sub-optimal outcomes) caused by these professionals. Safeguarding is linked to the fitness to practise (FTP) functions and registration procedures, whereby unfit professionals are identified and prevented from practicing. The monitoring capacity of regulators, through for example continuous professional development (CPD) requirements, also contributes to the identification of risky professionals. Changes in the operational complexity of regulators, or their capacity for specialisation and good leadership, may impact on the monitoring and safeguarding capacity of regulators and thus patient outcomes.
- **Professional quality assurance and development.** In addition to the more immediate intervention implied by the FTP and registration processes, regulators are involved in the continuous quality assurance and development of the professionals they regulate. This includes ensuring that registrants demonstrate that they are up to date and fit to practice; being aware of changes and emerging risks in the profession and ensuring that guidelines and education/ CPD reflect these; and ensuring educational bodies meet the required standards. This will influence the quality of care provided by healthcare professionals and in turn patient outcomes. Various sharing options may impact on the organisational features of regulators which may in turn affect the professional development and quality assurance they provide. For example, a loss in specialisation may result in developments and risks within a professional group being overlooked and not adequately reflected in the regulator's CPD requirements.

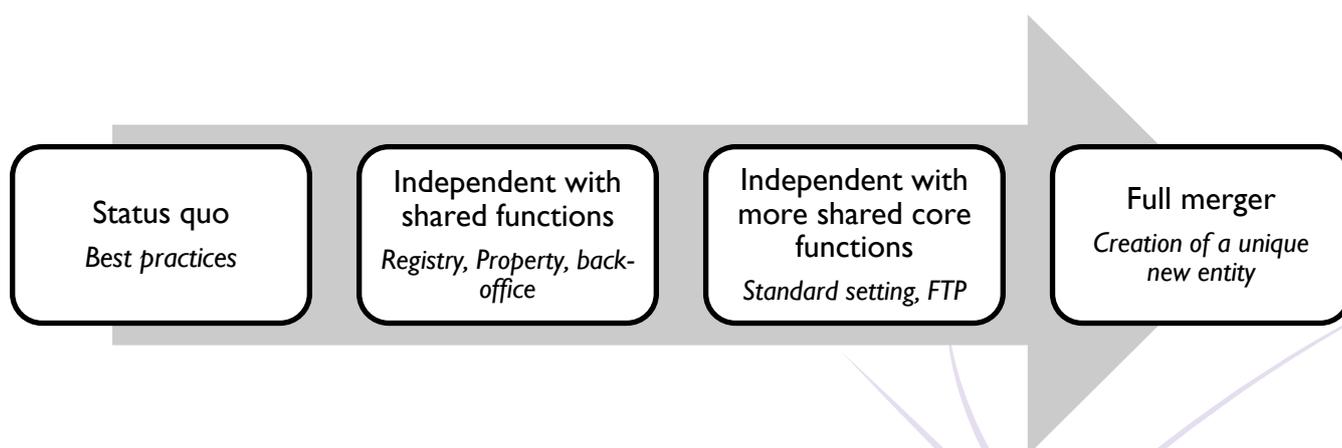
¹² The Centre for Health Service Economics and Organisation states that pay restraint for some healthcare professionals (particularly those operating in the NHS) may have limited registrants' ability to pay fees for registration and renewal — i.e. the latter fees are sufficiently consequential that paying them is non-trivial in businesses made marginal by increases in other costs. CHSEO (2012) "Cost-efficiency review of the health professional regulators."

- **Sustainability of the profession.** Regulators have a role in the sustainability of the professions they regulate through the cost and time burdens placed on them (for example stemming from fees and compliance requirements), the disciplinary burden, and the perception of the profession by the public. For example, high registration costs, or mismanaged disciplinary procedures, could jeopardise registrants' ability to run their practices thereby impacting on patient access to care. Cost and time burdens could impact on patient outcomes if they result in overwork among professionals. An effective registration and removals procedure may improve patient trust in the profession and increase uptake of care (i.e. through a regulatory badging effect). A regulator's role regarding the sustainability of the profession could be affected by impacts to its key features as a result of sharing options, thus leading to indirect impacts on patient outcomes.

2.4 Options for sharing

The organisational features described in 2.2 above could be affected by organisational change, in this instance the extent to which regulatory functions are shared across the different regulatory bodies. In this section we outline a set of illustrative sharing options. These differ according to the type of shared function (e.g. core versus non-core regulatory functions) as well as the degree of "consolidation" between functions. More specifically, we have developed four staging posts on the continuum between the status quo (i.e. a regulator sharing best practices with its peers) and a monolithic regulator combining a remit for multiple professions. This is illustrated in the diagram below.

Figure 2.1: The continuum of options for sharing



- **Status quo.** The "status quo" refers to the current state of the world, i.e. the existence of nine regulators working fully independently and sharing mainly best practices.
- **Independent regulators with limited sharing of regulatory functions (Option I).** Moving forward from the status-quo, regulators could consolidate non-core (i.e. business and support and back office) functions, and have a degree of sharing of assets (e.g. property). This option could extend to the sharing of the maintenance of a shared, public register of appropriately qualified health and care practitioners.

- **Independent regulators with more extensive sharing of regulatory functions (or merge of some parts) (Option 2).** Beyond sharing such business-related functions, a further shift across the spectrum of options could involve the setting up of common standards that all registrants must meet and the investigation of allegations that registrants do not meet the standards (or at least some of the support work “behind the scenes” for this — whilst retaining regulatory independence).
- **Full merger (Option 3).** This would be a single regulator covering all or some of the regulated profession.

2.5 Summary of conceptual framework

The different sharing options would have an impact on regulators’ key features as described in Section 2.2, such as cost over-runs or cost-efficiencies, changes in innovation and specialisation, changes in operational complexity, or impacts on leadership and governance. These in turn would have some impact on patient outcomes through the mechanisms described in Section 2.3.

A schematic representation of our conceptual framework is provided by Figure 2.2 below.

Figure 2.2: Mapping functions through to patient outcomes



Below is an illustrative example (excluding any evidence) of how the conceptual framework could be read across.

- **FUNCTIONS.** A sharing option entails the merging of Standards and Guidance (1) and FTP administrative procedures (4).
- **ORGANISATIONAL FEATURES.** This option is likely to lead to overall cost savings due to the streamlining of the FTP procedures, thus improving the cost efficiency of the regulators. (Although there could also be significant transitional costs). However, the merger of the standards and guidance function reduces the overall scope for

specialisation and the extent to which standards and guidelines can be targeted to the different professions.

- **LINKS TO PATIENT OUTCOMES.** There is a number of potential relevant mechanisms here:
 - The improved cost efficiency may improve the sustainability of the profession and reduce the cost of providing healthcare (A) and (D).
 - The loss of specialisation could imply that the setting of standards and guidelines is less responsive to emerging risks in the various professions and the quality of care provided to patients may decline (C).
 - The effectiveness of the FTP procedures would likely remain the same and therefore the monitoring and safeguarding role of the regulator would be unaffected (B).

Overall, the possible types of patient outcomes involved would vary according to the degree of consolidation as well as the type of functions involved in the sharing. In the next section we analyse the costs, benefits and risks for the various sharing options.

3 Review of the Impacts of Sharing Options

3.1 Introduction

In this chapter we provide a review of the impacts of various sharing function approaches as outlined in our conceptual framework. We discuss the expected changes in the organisational features resulting from consolidation and the corresponding costs and efficiency gains as well as potential impacts on patient outcomes.

In general terms, benefits, costs and risks resulting from a consolidation processes can be grouped into short-term (i.e. transitional) and long-term categories.

More specifically, benefits can be classified as:

- Cost efficiencies achieved. This refers to costs reductions stemming from, for example, employing fewer staff as well as the opportunity to streamline processes, and share services and contracts within organisations. Cost efficiencies are typically the most readily observed and measureable benefits.
- Benefits to patients. These encompass improved health outcomes as discussed in Section 2.3 and include direct benefits such as better patient safeguarding (e.g. through FTP and registration functions) as well as indirect benefits through improving the quality of the registered professionals.
- Benefits to consumers. Patients as consumers may benefit from sharing options in terms of the cost of healthcare, choice and satisfaction.

We note that not all merger or sharing examples are likely to realise all categories of benefits.

Sharing options give rise to two broad categories of cost:

- One-off costs of the actual sharing/merger. These would include staff costs (e.g. staff relocation, training, pay and pension consolidation, voluntary redundancies); property costs (removal costs, service contracts, acquiring new premises); IT costs (notably integrating IT systems); and other corporate costs (management planning time, adviser and consultancy costs, interim parallel management structures).
- Ongoing or long-term costs. These might include higher operating costs stemming from increased operational complexity, or lower costs due to being able to access increased cost efficiency through scale effects or through innovation in processes.

The risks associated with sharing options consist of potential negative impacts on the key organisational features of the regulatory bodies concerned and negative impacts on patient outcomes.

A large driver of the net costs of the sharing options is the potential for scale and scope efficiencies. Before turning to our analysis of the sharing options, we need to first consider the likely extent of such efficiencies present in health regulation — or rather, the regulation of multiple healthcare professions.

3.1.1 Overview of regulators' costs and revenues

The table below presents a summary of statistics for the nine regulators taken from their annual accounts.

Table 3.1: Regulators' costs and revenues

Regulator	Number of Employees (000s)	Number of Registrants	Revenues (£millions)	Costs (£millions)	Of which staff costs (£millions)
Pharmaceutical Society of Northern Ireland (PSNI)	13	2,303	1.15	1.12	0.60
General Chiropractic Council (GCC)	13.5	3,109	2.37	2.48	0.90
General Osteopathic Council (GOsC)	24	5,102	2.71	2.73	1.20
General Optical Council (GOC)	49	29,162	6.81	6.47	2.87
General Pharmaceutical Council (GPhC)	224	75,264	21.39	22.06	10.45
General Dental Council (GDC)	320	108,209	45.95	46.69	18.54
General Medical Council (GMC)	1,082	273,700	99.26	101.20	58.31
Health and Care Professions Council (HCPC)	228	350,980	28.31	28.29	10.54
Nursing and Midwifery Council (NMC)	613	692,550	80.27	76.34	33.79
Total	2566.5	1,540,379	£288.3	£287.4	£137.2

Note: The GOC's reported revenues in 2015 include a gain from the sale of a Harley Street property. This has been excluded from the above analysis.

Source: 2015 Regulatory Accounts of the nine regulators.

3.1.2 How accessible are economies of scale or scope in the regulation of health professionals?

Economies of scale are exhibited when the average cost of output declines as output increases. This can mean that smaller participants are at a cost disadvantage compared to larger rivals. Such economies may only be exhibited within a given output range, and there has typically been found to be a minimum efficient scale beyond which the beneficial impact on average cost of additional scale weakens considerably.

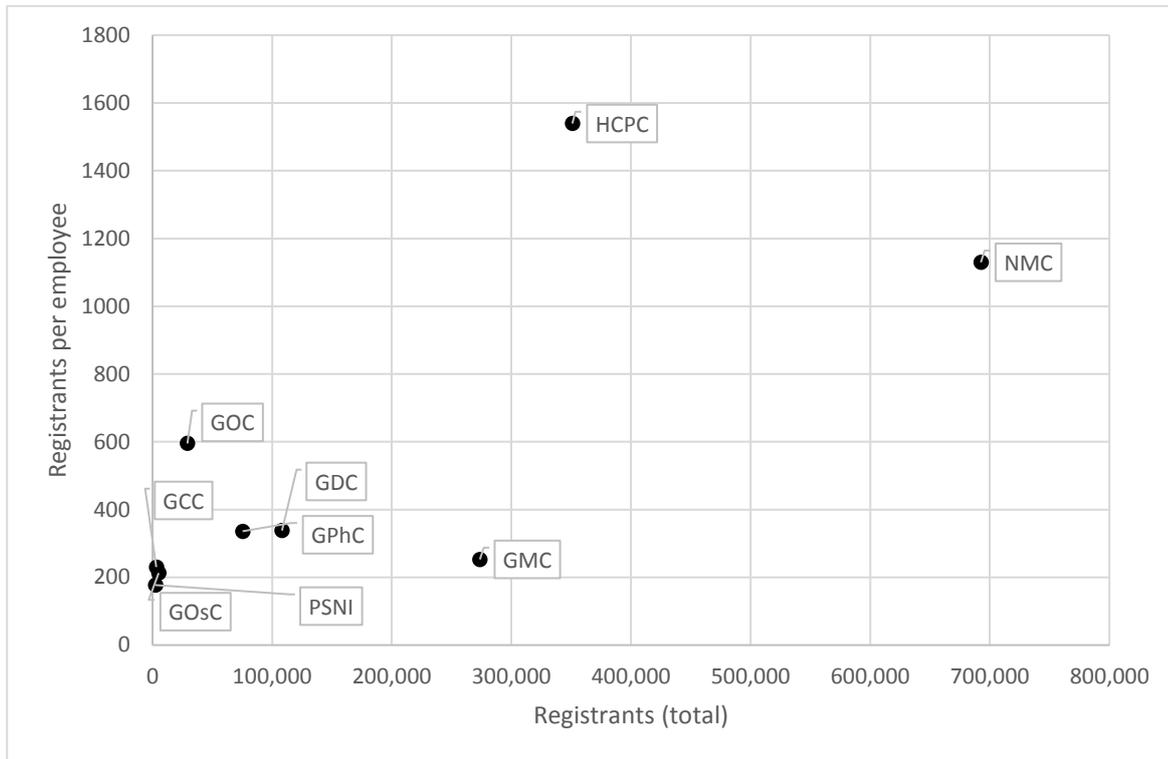
Economies of scale relate to unit-cost savings achieved through increasing production of a given good or service; “economies of scope” is where savings are achieved when the production of a *variety* of goods or services increases.¹³

It is worth pausing to consider whether the regulation of health professionals can be considered as a single ‘service’ or whether it is more differentiated — and in turn, if there is such differentiation, whether it means that each profession needs to be considered discretely or whether there are aspects of regulation that are sufficiently common that they can be considered jointly across some (or perhaps even all) of the regulators. The Health and Care Professions Council (HCPC) regulates multiple health professions, and given that it does this at relatively low cost, *prima facie* this is highly suggestive that it is achieving economies of scale and/ or scope within its own operations. However, it does not automatically follow that the regulators of other health professions have equivalence to each other and would achieve such economies if merged.

There is significant scope to compare oranges with lemons here (due to the differences between the regulators based on the professionals being regulated being qualitatively different). This thought can be captured simply below where we present data on the number of registrants per employee at each of the health professional regulators, and also on the total costs incurred per registrant — both assessed against the total number of registrants. As can be seen, the HCPC and NMC are notably distanced from the other regulators.

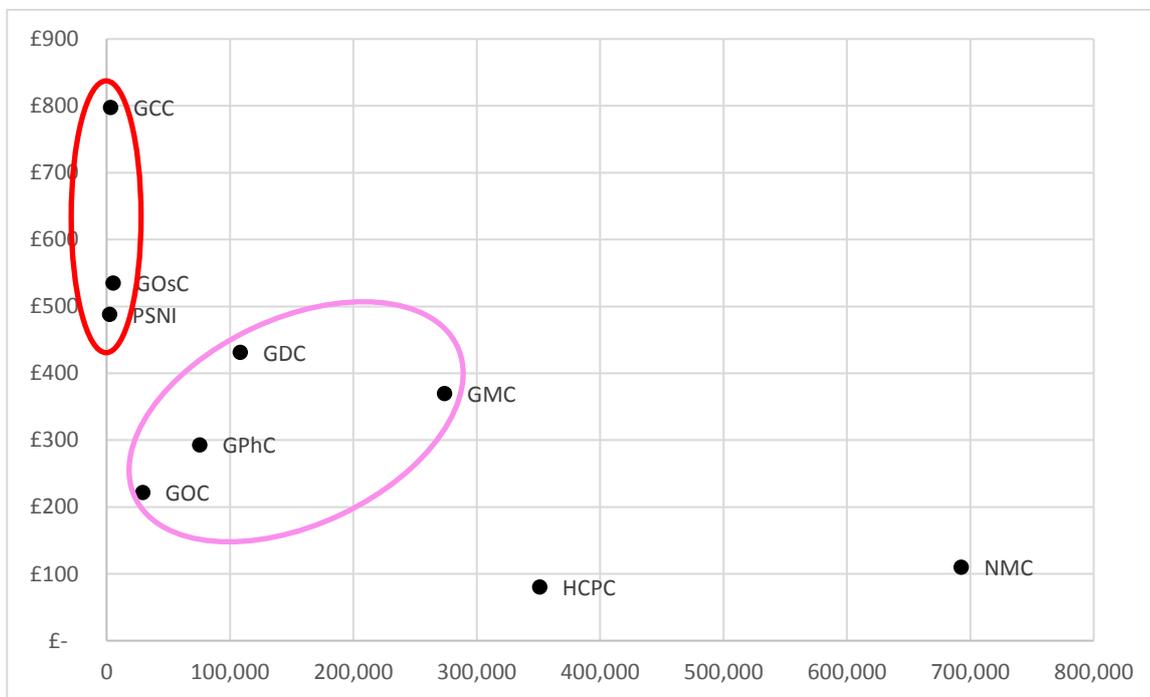
¹³ Economies of scope are generally defined in terms of the relative total cost of combined production in one firm compared to separate production in two or more.

Figure 3.1: Registrants per employee assessed against aggregate registrant numbers



Source: Europe Economics' analysis of regulators' annual reports.

Figure 3.2: Total costs per registrant assessed against aggregate registrant numbers



Source: Europe Economics' analysis of regulators' latest annual reports.

The Centre for Health Service Economics & Organisation (CHSEO),¹⁴ however, argues that there is such equivalence between regulators, and further indicates that most scale economies are realised once a regulator achieves a registrant base of 100–200,000. Inter alia, this suggests that the HCPC and the GMC should be able to experience comparable efficiency levels — indeed, given that the HCPC is regulating multiple professions, it might be reasonable to expect it to be less able to access such economies relative to the GMC despite having a marginally larger registrant base. Instead, current overall costs per registrant and the individual functional unit-costs calculated by the CHSEO in 2012 are all multiples higher at the GMC. This could signal markedly superior organisational efficiency at the HCPC — or equally, inferior organisational efficiency at the GMC and thus scope for efficiency savings to be made. Equally, we believe this could simply indicate that these health professional regulators have fundamental dissimilarities which drive their costs and which undermine the evidence presented by the CHSEO for demonstrating the scale efficiencies accessible.

Our base hypothesis is that much of the regulatory activity is sufficiently different that inferences drawn around scale without reference to such differences are uninformative. Further, in such a small sample, this is likely to be further distorted by the experiences of individual regulators. In other words, if the apparent cost advantage of the HCPC and of the NMC is influenced by scale but also significantly by other factors, then the estimates of scale gains will be flawed. We do not consider the CHSEO's conclusion that doubling the registrant base achieves a 19 per cent reduction in unit operating costs to be meaningful.

Whilst the CHSEO recognises that the 'tasks' faced by each regulator differ, its analysis of the 'scale-adjusted' unit cost of particular tasks (or functions) is — for understandable reasons — qualitative and hence likely non-linear.¹⁵ Even if it is a fair reflection of the situation, it is at best ordinal in nature (i.e. it says $X > Y$, but does not tell you by how much). So whilst this analysis is more meaningful than simply assessing apparent scale efficiencies without reference to differences in the complexity or difficulty of the regulatory functions being undertaken, it still does not demonstrate the existence of scale efficiencies across the whole experiential range of the regulators.

An alternative interpretation of these data would be that:

- A registrant base below 10,000 (i.e. the GCC, GOsC and the PSNI) are likely below an efficient scale, i.e. some diseconomies of scale are apparent and consequently some economies of scale or scope might be realisable involving these three (not necessarily by simply combining the three together).

¹⁴ CHSEO (2012) "Cost-efficiency review of the health professional regulators", Chapter 5. The CHSEO 2012 report attempts to analyse the potential for cost savings through improved statutory regulation of healthcare professionals. The report includes a comparison of unit operating costs across a core set of six regulatory functions to comment on efficiency savings through economies of scale and scale-adjusted efficiency, as well as an estimation of compliance costs imposed by regulators on third parties to determine whether regulators operate efficiently merely by shifting costs onto others.

¹⁵ CHSEO (2012) "Cost-efficiency review of the health professional regulators", Chapter 5.

- The HCPC and the NMC are sufficiently qualitatively different that they should not enter into the same analysis as the other regulators without adjustment for such differences, if at all. We do not consider the CHSEO’s approach adequately accounts for such quality differences, and its conclusions around scale are therefore flawed.
- The residual group — the GDC, GOC, GMC and the GPhC — do not display any clear signs of scale effects pre-adjusted for quality differences, and since such an adjustment is too imprecise to rely on, the only reasonable inference is that the existence of scale effects within in this group is unproven — and, indeed, one cannot rule out the possibility of diseconomies of scale if the likes of the GOC/ GDC/ GMC were merged together.

We now turn to our analysis of the three main options for sharing between healthcare regulators as set out in Section 2.4, namely:

- Option 1. Independent regulators with limited sharing of functions.
- Option 2. Independent regulators with more extensive sharing of functions.
- Option 3. Full merger.

3.2 Option 1. Independent regulators with limited sharing of functions

Under this option of sharing we consider the possibility of sharing mainly business and support functions, including a degree of property sharing, as well as the registration function.

3.2.1 Description of sharing arrangements

The **sharing of business and support functions** in this option would be with the aim of accessing purchasing economies (e.g. through bulk-buying standard goods or services) and also of reducing fixed costs in aggregate. In this context, we consider the following back-office business functions: human resources, IT, accounting, finance, and support staff in general. For example, the health professional regulators could move towards centralised systems for recruitment, training, performance evaluation, payroll, employee relation and development. Alternatively, regulators could share financial management processes or these could be managed by one regulator on behalf of all (e.g. after having been identified as having best practice in that area), or managed by an external organisation.

The **sharing of property and assets** would not involve the consolidation of the property “portfolio” held across all of the regulatory bodies. Instead, regulators would retain existing ownership structures alongside the coordination of advertising and utilising spare capacity. This would be particularly relevant for FTP hearings, as the demand for such space can be much more volatile than the more quotidian activities at the regulators. At one level, such sharing could involve an agreement to share space (i.e. the regulators would share a room booking system) to coordinate needs. Taking the concept further, one could envisage a shared, dedicated FTP facility somewhere in the UK.

Registration is one of the core business-related regulatory functions that could be potentially shared. As a result, the process of registering all professionals would be centralised, with a single IT system and database, and a core set of employees and manager(s).

3.2.2 Benefits of Option 1 — independent regulators with limited sharing of functions

The centralisation of purchasing activities could capture economies of scale in purchasing prices and process costs by replacing individual purchases with regulator-wide framework agreements. Benefits would be achieved through the formalisation of purchasing processes and channels, e.g. e-procurement, and the reduction in supplier base, developed by the central purchasing unit. As an example of the potential benefits, NHS England has been encouraged to realise efficiencies through centralised procurement and greater aggregation.¹⁶ Measures to reduce waste and running costs, improve procurement, etc. were expected to access efficiency gains of £150m in 2013-14, £550m in 2014-15 and £800m in 2015-16.¹⁷ Similarly, in 2011 The National Audit Office had identified the potential for £500 million savings in the NHS alone.¹⁸ Bearing in mind some of these figures include savings in clinical services, not simply procurement savings, purchasing savings are unlikely to exceed 0.5–0.8 per cent across the entire NHS budget¹⁹ (and presumably a much higher proportion of non-payroll costs). It is not clear that an equivalent gain would be accessible through enhancing procurement activity at the healthcare professional regulators — even combined total costs are below £290 million per annum, of which spending on support activities is only about 10 per cent of the total.²⁰

Further benefits from consolidating back office functions may be realisable in the form of contract rationalisation, for example through an outsourced partnership to reduce IT costs or legal procurement.

Scale economies would also likely be realisable through the sharing of support functions such as IT, accounting and other support staff. This would depend on the extent to which these functions are currently outsourced among the regulators (the idea being that outsourcing is already achieving scale economies). There is a number of examples of sharing arrangements in the UK government which all cite net cost savings. These are summarised in the table below. We note that the savings are driven by the contexts and details of the various sharing

¹⁶ Department of Health (2013) “Better Procurement Better Value Better Care: A Procurement Development Programme for the NHS”.

¹⁷ The four initiatives were the following: delivering immediate efficiency and productivity gains; improve data, information and transparency including the adoption of GSI coding standards; action to demonstrate ways in which the NHS can improve outcomes for patients at lower costs through clinical procurement review partnerships; a longer term programme to improve leadership and capability through the creation of a new ‘centre of procurement development’ to support the delivery of world-class procurement throughout the NHS and develop improved trust level leadership, including the role of nonexecutive directors.

¹⁸ NAO (2011) “The procurement of consumables by NHS acute and Foundation trusts”.

¹⁹ Based on an estimate of the NHS budget compared to the cost savings cited.

²⁰ Based upon analysis of the regulators’ latest available annual reports.

examples and as such do not provide unqualified support for similar savings in the context of the healthcare regulators; however, the precedent for sharing functions and clear potential for net savings is illuminating.

Table 3.2: Summary of past public body functional sharing

Organisation	Type of Shared Services	Benefits (cost savings)	Costs of sharing
Cambridgeshire and Northamptonshire County Councils – LGSS21	Back office, professional services, some front-line such as social care financial assessments. LGSS governed by a Joint Agreement - all staff remain employees of their respective County Councils.	£9.5 million (Year 1+2) £3.79m from budget of £83 mil (Year 1) = 4.5%. £1.8m from IT. £0.93m from reduced property costs.	35% of savings
Procurement Lincolnshire²²	Single function shared service for local authorities in county, providing strategic procurement advice.	£5million (Year 1+2) £9m (over 3 years) from procurement budget of £194m per year = 1.5% per year	18% of savings
Ministry of Justice, National Offenders Management Service, Home Office²³	Human resources	Home Office: £13m per annum vs £8.9bn budget in 2010 = 0.15% Ministry of Justice: £20m per annum vs £9.4bn budget in 2010 = 0.21%	NA
Financial Shared Services Centers in UK and Ireland (FSSC)²⁴	Establishment of 'accounting shops', bringing staff involved in financial activities to a single location for general ledger accounting, accounts payable/ receivable, treasury, payroll, cash management, inventory etc.	Headcount reduction 21% Cost reduction 26%	NA
MyPay (Ireland)²⁵	Shared Service Center for all local government payroll and superannuation, currently 17 local authorities, estimated all local authorities using MyPay by 2017	448,495 payments made in 2015, estimated annual savings of £4.34 million (44% of operational budget)	NA
Procurement (Ireland)²⁶	Procuring Minor Works and Plant Hire for the entire public service	£2.73m per annum	£2.5m annual costs

²¹ Local Government Association (2012) “Services Shared: Cost Spared?”

²² Local Government Association (2012) “Services Shared: Cost Spared?”

²³ Cabinet Office (2011) “Government Shared Services — a Strategic Vision”

²⁴ Cacciaguidi-Fahy et al., ACCA (2002) “Financial Shared Services Centres: Opportunities and Challenges for the Accounting Profession”.

²⁵ National Oversight and Audit Commission (NOAC) (2016) "Local Government Shared Services Project".

²⁶ NOAC (2016) "Local Government Shared Services Project".

Organisation	Type of Shared Services	Benefits (cost savings)	Costs of sharing
NHS Shared Business Services²⁷	Procurement, finance and accounting services on a voluntary basis to 415 NHS organisations	Net savings of £250 million over 11 years, NHS bodies save at least 20% of existing costs when they join Shared Business Services	Breakeven after 5 years in 2008/09
Prison Service Shared Services²⁸	Modern integrated IT system, procurement, financial services, HR for 128 Prison Service establishments at a single site in Newport	£120 million over 9 years, gross staff savings of £52m = 32% original staff costs of £66m	Breakeven after 5 years in 2008/09

Notes: NA = Not available.

Source: Europe Economics' desk-top research.

Greater integration of IT systems could lead to the creation of “common portals” where information from all the regulatory bodies could be made available in a streamlined fashion. In CHRE (2009), for instance, the GOC provides an example of this kind suggesting the possibility of normalising similar data releases, for example annual reports, across the regulators.²⁹ Along the same lines, the Department for Business, Innovation and Skills suggests that one of the main potential benefits to having such a common approach would be to facilitate the sharing of information and data between regulators and across regulatory functions, thereby enabling more accurate targeting of regulatory activities to where they are most needed, in particular to where the risks are greatest.³⁰ We note that whilst such information sharing would not necessarily require a formal sharing option as described here, it can nevertheless be considered a benefit of such an arrangement.

Sharing property would have the benefit of smoothing out ‘lumpy’ demand from individual regulators, in particular with regard to FTP hearings. Depending on the terms of such an agreement, regulators could share their own spare property space at a reduced rate compared to accessing the private market, potentially with fewer administrative costs or waiting times. For this to be effective some agreement would need to be reached to balance the demands and contributions of regulators with differing levels of spare property to avoid potential ‘free-riding’. In accessing property from the private market (as opposed to internal sharing), the sharing of a dedicated venue would potentially free up space, but would only result in immediate cost savings to the extent that temporary accommodation was being used at present — or the space freed up within longer-term property tenures was sufficient in scale and in nature to permit sub-letting. Otherwise, such gains would be limited to some future date when some realignment of property scale was possible.

The benefits of a consolidated registration function would be cost savings due to scale economies. To the extent that the registration process can be automated, a single IT system could be created and managed centrally, along with a central administrative team. There is

²⁷ National Audit Office (2007) “Improving Corporate Functions Using Shared Services”.

²⁸ National Audit Office (2007) “Improving Corporate Functions Using Shared Services”.

²⁹ Council for Healthcare Regulatory Excellence (2009) “Shared functions”.

³⁰ BIS (2013) “What is the Value in Regulators Sharing Information?”

likely to be scope for labour specialisation as described in Section 2.2, with employees focused solely on the registration function. In addition, a system of that size would most likely warrant the employment of a dedicated IT maintenance team which could improve efficiency in relation to the identification and solution of problems.

3.2.3 Costs and risks of Option 1 — independent regulators with limited sharing of functions

The costs associated with sharing business support functions as described here would be largely transitional costs, such as terminating existing purchasing contracts and coordinating and negotiating new contracts that met the needs of all regulators. This option might also entail ongoing costs for example around the monitoring of the regulator-wide contracts. The alignment of IT and financial systems from predecessor organisations is a delicate process. Some of the main risks relate to the possibility of transferring — or increasing access to — considerable amounts of sensitive data, with a potential for private data to be lost or to be acquired for unscrupulous uses.

The one-off costs of consolidating a registration function across all regulators could be substantial. It is likely that the best way forward would be to build a system from scratch rather than attempting to integrate multiple existing systems. Such an IT project would be costly and subject to the ‘standard’ risks associated with such projects relating to changing specification and overruns.

Further, the potential for such economies should not be over-stated: registration is not simply a data-processing function. Decision-making by the Registrar is necessary around sensitive cases (e.g. a potential registrant’s past convictions, and the treatment of any shortfall in CPD/CET or, for example, the highly complex task of assessing registration applications from outside the UK). There is a degree of subjectivity in these judgements making them unsuitable for a simple algorithm. Likewise, decisions will vary by profession. There may thus be limited scope to reduce the number of people involved in the registrations process.

In addition, the registration function is intimately linked with other regulatory functions and cycles such as CPD/CET, FTP, auditing, appeals etc. Each of these will dictate specific times and circumstances under which registrants are added to or removed from the register and will vary from regulator to regulator. In order for real efficiencies to be achieved issues such as the criteria for the removal or reinstatement of registrants, the number of warnings a registrant may have before being removed, the existence of cohorts with different renewal phases and so on would need to be standardised across regulators, which would imply a far more detailed level of sharing than intended by this option.

3.2.4 Impact on patient outcomes associated with Option 1 — independent regulators with limited sharing of functions

The nature of the business and support functions which we have envisaged being shared under this option are not likely to impact directly on patient safety outcomes to any notable degree. The costs savings would likely be passed on to registrants in reduced fees, helping the sustainability of the industry and professionals. (The immediate pass-through to patients in reduced service charges would seem much less likely, e.g. due to menu costs — the costs related to changing fees or prices, even where there is a direct link with prices paid by the patient).

One potential risk to patient outcomes is that registry unification might be accompanied by a loss of specialisation in relation to each profession's needs. In particular, the potentially very specific enquiries raised by registrants (for example stemming from impacts from other functions which would remain separate across regulators) would not be handled effectively from employees/call centre staffed by individuals without specific domain knowledge.

A lack of specialised knowledge might also have an impact on the very sensible process of checking carried out by each regulator in order to ensure that only those who are fit to practice are registered, including revalidation and CPD checks. This may increase the risk that professionals who ought to be placed under surveillance (and set on a pathway that ultimately could result in removal from a register) slip through the cracks, with the risk to patient outcomes.

There is also the potential for enormous operational complexity of a unified registration system, particularly if other functions remain independent across the regulators. This could lead to transitional problems (e.g. registration backlogs) which in turn might impact on the sustainability of the profession, for example if a professional's indemnity insurance were not valid until they were registered.

The diagram below summarises how this sharing option may affect the relevant organisation features of regulators and in turn the possible impact on the patient outcome mechanisms.

Figure 3.3: Summary of the impact of Option 1 (independent regulators with limited sharing of functions) on patient outcomes



Note: Text in bold is most relevant to this option.

3.3 Option 2. Independent regulators with more extensive sharing of functions

This second option for sharing would involve additionally consolidating aspects of core regulatory functions such as standards and guidance, FTP, and education. This type of consolidation would involve more extensively shared functions but without impacting on the regulators' status, legislative framework, fees and funding structure, i.e. they would maintain independent. In this scenario, we envisage regulators retaining separate management for each function — along with the associated profession-specific expertise embodied within these managers — but with some pooled resources and infrastructure. To the extent that profession-specific expertise is held at lower-levels within the regulators, consolidation at these levels may involve a loss of expertise and a more generalist approach.

3.3.1 Description of sharing arrangements

The sharing of **business and support functions** would attempt to access additional purchasing economies and to further reduce fixed costs. In particular this could involve a greater degree of sharing of locations, say shared security and facility management (e.g. front-desk reception, cleaning services).

Such a sharing approach to facility management and security would likely require the regulators to share at least some of the same permanent location(s) so to be able to have the same security and cleaning personnel. However, it could also relate to shared contracts with security service providers and shared security policy.

Standards and guidance. Standards of competence and conduct reflect up-to-date practice and legislation, while guidance helps registrants apply the standards to specialist or specific issues. A shared approach to standards could entail a set of common professional standards agreed by consensus between regulators to apply to all registrants. Besides the codification of such a common set of standards, it is likely that profession- or occupation-specific standards would need to be separately taken into account.

Education and training. There is currently a wide range of practices and approaches across the regulators in how they quality assure training and higher education courses. This is largely because the different occupations require different types and levels of education, which has changed over time. However, the PSA considers that the current arrangements for the regulation of undergraduate and other pre-registration training tend towards duplication of regulatory responsibilities between professional regulators and other regulators in education, resulting in unnecessary expense.³¹

A sharing option could entail coordination among the regulators in their interaction with higher education institutes (HEIs) and other training providers. This could establish a consistent approach to the allocation of responsibilities between training providers and regulators. However, we note that our options entail sharing between healthcare professional regulators, not including other bodies (e.g. education and clinical organisations) which is where arguably the most overlap exists. Any benefits therefore of reducing duplication cited by the PSA are unlikely to be realised.

Education and training also incorporates continuing professional development (CPD) and continuing education and training (CET) of professionals. Regulators' responsibilities in this area include setting CPD/CET requirements, the quality assurance of CPD/CET providers, recording and monitoring registrants' CDP/CET attainment (including the auditing of portfolios and submissions), and remedial/disciplinary actions in cases of non-compliance. A shared approach could entail a common CDP/CET portal and IT system, as well as shared support staff undertaking audit and registrant communication.

Fitness to Practise is a key function of health professional regulators being directly related to the protection of the health, safety and well-being of patients. In particular, it assures the public that action is taken against those professionals whose fitness to practise is impaired (not able to continue practising or practising unrestricted).

A consolidation of FTP could entail a common approach to investigation, prosecution, and adjudication as well as further harmonisation in sanctions. The PSA for example believes that regulators should continue to move towards shorter, less costly and more consensual ways to close cases. This would particularly involve the promotion of further co-operation with employers to achieve local resolution at an earlier stage where possible (without requiring the regulator's intervention).

³¹ PSA (2016) "Regulation rethought".

3.3.2 Benefits of Option 2 — independent regulators with more extensive sharing of regulatory functions

In terms of the **sharing of property**, the benefits would include reduced rent payments (or similarly reduced capital held as property), and savings on facilities management costs (e.g. property maintenance, energy costs, security costs). These would be seen in the longer-term, allowing for current rental contracts to run to term and for the divestment of property. In the CHRE review, for example, regulators saw some potential in sharing existing facilities, particularly those outside of London and in the devolved countries.³² Any associated savings need not be experienced evenly by the individual regulators: each has a different situation now (e.g. one may be enjoying a peppercorn rental, another could own the freehold, etc.). We return to this thought below, at 3.3.3.

The benefits of a common set of **standards and guidance**. In order to avoid the significant risk of a loss of specialisation, profession-specific standards and guidance would most likely need to sit alongside the common set. This would reduce the scope of any scale efficiencies. Indeed, the whole sharing option described here could be one of net cost resulting from the increased coordination in setting common standards, and no reduction in existing standards and guidance resources among the regulators. However, benefits could stem from a coordinated approach to external standards (i.e. from outside any of the nine regulators) if this reduced duplication and confusion in standards from other regulatory / supervisory bodies. For example, a report for the Health Foundation highlights the plethora of standards and guidelines, from national bodies including professional regulators and NICE,³³ employers (including the NHS) and professional associations. This is thought to create confusion among professionals and negatively impact patient outcomes. They quote: “their [clinical guidelines] extraordinary and uncoordinated proliferation in the NHS confuses staff, causes inefficiencies and delay, and is becoming a threat to patient safety.”³⁴ Any rationalisation of such external standards could lead to an improvement in professional practice.

The benefits of a shared approach to **education and training** are likely to be limited. Some cost savings arising from more streamlined processes and a reduction in regulatory duplication may be realisable for HEIs and other training providers as a result of a more coordinated approach by regulators to quality assurance. Cost savings from scale economies may be realisable from a shared CPD/CET infrastructure, as well as shared support staff for audit and communication with registrants. However, given the very different risk profiles of the professions in question and the associated range in CPD/CET requirements, any further integration of this function (e.g. coordinated CPD/CET requirements) is unlikely under this option.

A common approach to FTP could result in cost savings and improved productivity due to more streamlined processes and scale economies (e.g. due to increased scope for

³² Council for Healthcare Regulatory Excellence (2009) “Shared functions”.

³³ National Institute for Clinical Excellence.

³⁴ Health Foundation (2013) “Asymmetry of influence: the role of regulators in patient safety”.

specialisation). As an example of such streamlining, the creation of the Care Inspectorate in Scotland from three other bodies resulted in swifter processes to produce care service inspection reports. This was due to the fact that the larger organisation was able to establish new dedicated sub-teams (e.g. dealing with complaints and registration activity) allowing the inspection teams to focus on inspection and enforcement activity.³⁵ A similar impact could be envisaged here, whereby the increased volume of cases across all regulators could permit the creation of more streamlined processes for investigation, including specialist teams. Similarly, more streamlined adjudication processes could realise cost savings such as reduced legal costs and regulators' time.

3.3.3 Costs and risks of Option 2 — independent regulators with more extensive sharing of functions

The extended sharing of property would result in some one-off, transitional costs — at least relocation costs and, if the consolidation was accelerated, then costs related to selling properties or rental agreement termination. Such property costs are an element of all mergers, with their scale of course related to the extent of the consolidation. As examples, mergers of UK government departments have incurred property-related costs ranging from 0.4 per cent of administrative budgets (where merging departments were accommodated in an existing department's building) to 14 per cent (equalling £10 million, where a new building was needed for the newly created department).³⁶ These costs would apply to a full merger situation or to a sharing option where property was extensively shared.

The costs associated with having a shared set of standards and guidance should be fairly contained. Time from management and professional experts would be required across the regulators to draw up and agree on the standards. Time would also need to be spent engaging with other relevant standards bodies in order to consolidate external standards.

The most notable additional costs associated with sharing of the education and training function would stem from creating an integrated CPD/CET system across all regulators. This is likely to be very complex given the diversity among regulators in relation to CPD cycles, deadlines and grace periods, the nature of requirements to be logged and checked (e.g. completed journal articles, conference attendance, practical exercises, and portfolio assessments). The risk of cost overrun here could be high (as mentioned in Section 3.2.3, IT cost overruns can be significant among public sector organisations).

A **shared FTP function** would entail some transitional costs, most likely staff costs if FTP departments are to be rationalised (e.g. voluntary release costs and levelling up pay rates). A risk associated with a more centralised FTP function could be that investigations and information gathering is less efficient. This could be due to a loss in profession-specific

³⁵ Audit Scotland (2012) "Learning the lessons of public body mergers: review of recent mergers".

³⁶ For example, the creation of DIUS and DECC required new accommodation for their staff (800 and 1,000 respectively), costing an estimated £10 million each. Institute for Government (2012) "Making and breaking Whitehall departments".

expertise or a loss in geographic diversity. As an example of the latter, Marine Scotland reported making more efficient use of locally based staff to monitor grants awarded through the European Fisheries Fund, compared to staff based centrally in Edinburgh having to travel widely to undertake the investigations.³⁷ Regulatory proliferation literature also maintains that a fragmented, decentralised regulatory arrangement may be able to collect more easily relevant information from the registrants and markets at different levels, than a centralised one.³⁸ Individual, specialist regulators may be best placed to have a high-quality relationship with their regulated professionals.³⁹

In addition, data gathered from FTP records can be an important source of information for risk assessment within professions, which in turn can influence regulatory policy and the content of education and training. For this to be useful a fairly granular level of data needs to be recorded such that FTP cases can be disaggregated by characteristics of the registrant (e.g. length of time spent in training, CPD records, years of time since qualification etc.) and most importantly specific areas of practice which will naturally vary by healthcare profession. Designing a system that would capture this level of detail for all professions may be very complex, and certain details may be overlooked which would impede the regulators' ability to study and address risk. If the sharing option is limited to sharing a common *approach* to FTP processes (i.e. agreeing on best practice but retaining autonomy in carrying out the activities) then such costs and risk would not apply.

3.3.4 Impact on patient outcomes associated with Option 2 — independent regulators with more extensive sharing of functions

The increased codification of standards could realise patient benefits by increasing the ability of patients to appreciate what to expect of a more diverse range of health professionals (i.e. because the same conduct standards would apply). A shared set of standards could also reduce confusion among registrants, making them more likely to heed the standards and pay attention to them in their work. To the extent that valuable standards are not being adhered to in the current situation due to confusion, this change could be expected to improve patient outcomes.

Regulators' roles in monitoring and safeguarding, and professional quality assurance and development may be undermined with the sharing of the education and training function. The greatest concerns would be either an overly complex, or else simpler but less specialised, CPD/CET monitoring system which may result in non-compliant registrants being overlooked, or in CPD/CET requirements that are not as tailored to each profession as they are currently. Any changes to CPD/CET (e.g. based on a regulators' response to emerging risks in a profession) would be much more complex and costly to implement which

³⁷ Audit Scotland (2012) "Learning the lessons of public body mergers. Review of recent mergers".

³⁸ Laffont, J.-J. & Martimort, D. (1999) "Separation of regulators against collusive behaviour" *RAND Journal of Economics*, 30, 232-262.

³⁹ Oliver Quick (2011) "A scoping study on the effects of health professional regulation on those regulated".

would reduce the responsiveness of the regulators. These risks could mean registrants are less able to respond to increased risk in their profession, or that registrants who are not up to date are able to continue practising, both of which would have negative implications for patient outcomes.

FTP investigations and data gathering could be more time-consuming due to centralisation and loss of specialisation. This may link to negative patient outcomes if important information is missed or delayed by impeding the regulators’ monitoring and safeguarding role. It may also affect the sustainability of the profession if the FTP process becomes lengthier, due to uncertainty and cost for the registrant (particularly if their practice is suspended during investigation). On the other hand, to the extent that a common approach to FTP streamlined the hearings and investigations process and led to swifter resolution of cases, this could have a positive impact on the profession by reducing employment uncertainty and its associated costs.

Regulators’ monitoring and safeguarding role would also be undermined if a shared FTP IT system was not detailed enough to allow for profession-specific risk assessment activity. This in turn could impact on the extent to which regulators can adapt to changes in risk and influence the professional development of registrants, thus undermining patient outcomes.

The diagram below summarises the ways in which the sharing of functions may ultimately impact on patient outcomes, by affecting the key organisational features of regulators. This is the cumulative effect of both sharing options discussed to this point. The degree of sharing in this example assumes that regulators would retain to a large extent profession-specific autonomy (of course, in practice a wide variety of sharing choices would be conceivable). Any loss of specialisation and increased operational complexity would largely relate to systems and infrastructure, rather than to decision structures.

Figure 3.4: Summary of the impact of Option 2 (independent regulators with more extensive sharing of functions) on patient outcomes



Note: Text in bold is most relevant to this option.

3.4 Option 3. Full merger of the regulatory bodies

The third option we consider would be a full merger. Here, the considerations identified above in relation to the first two sharing options would be aggregated to a certain extent, but with some of the positive and negative effects likely to be different and possibly larger in magnitude. The full consolidation option could involve all nine regulators or only some of them (e.g. all bar the HCPC).

3.4.1 Description of sharing arrangements

In a full merger scenario, the regulators would be combined including at an executive level, with all subsequent management levels and functions also fully merged. In particular, over and above the previous sharing option, this would entail:

- A single property portfolio, with common facility management and security.
- Fully shared business and support services including human resources, and fuller integration of administrative staff, IT, financial management etc.
- A unified approach to developing standards and guidance including a core set of common standards and other profession-specific standards.
- A single registration function (as in the previous options), with aligned processes for removals, renewals, and appeals.
- A unified approach to education and training, including CPD/CET.
- A single FTP function including a common approach to investigations, adjudications and prosecutions as in the previous function, as well as full integration of employees and processes.

3.4.2 Benefits of Option 3 — Full merger of the regulatory bodies

The incremental gains of a full merger over and above the other sharing options could include further purchasing economies as all departments are consolidated. A single property portfolio would enable a greater alignment of space to the needs of the single regulator, and improved forward planning to minimise demand mismatches and underutilised space.

The consolidation of duplicated senior executive and management functions could be a significant source of ongoing cost savings (albeit taking into account associated costs, as discussed below). Further employee consolidation at lower levels would also be likely as economies of scale are realised, leading to further cost savings. (There would be less potential for staff reductions in tasks that are closely linked to the volume of registrants.)

A full merger option would enable greater operational integration and thereby may realise greater scale economies. As discussed above, the integration of functions such as registration and CDP/CET is greatly influenced by the overall approach of the regulator, and thus a full

merger would enable greater operational integration along with strategic and managerial integration.

In terms of a merged CPD/CET function, the HCPC's model for CPD provides an example such an approach. The HCPC sets six high-level standards for CPD that all registrants must meet (e.g. maintain a continuous, up-to-date and accurate record of their CPD activities; demonstrate that their CPD activities are a mixture of learning activities etc.) and registrants decide for themselves what their CPD should consist of. The HCPC does not make any input requirements (e.g. minimum number of hours), does not stipulate any particular types of activities, and does not approve any CPD activities or schemes. There is no infrastructure to record registrants' CPD activities). Registrants are responsible for keeping their own CPD record, and the HCPC monitors this by means of an audit process (a sample of registrants from each profession is audited, and each audit team contains at least one assessor from the relevant profession).⁴⁰ This model is therefore resource-light and only audit costs are incurred. It is also generic enough to apply across all the regulated professions.

The significant increase in size of the merged regulator could create scope for increased specialisation within functions or departments. For example, in a small organisation some individuals may need to work across a range of functions or activities, whereas in a larger organisation the volume of work within one activity would be sufficient to provide them with a single focus. An example of this was found in the creation of the Care Inspectorate in Scotland.⁴¹ The Care Inspectorate reported that it improved the speed at which its care service inspection reports are produced by streamlining processes and more efficiently deploying its staff. The new Care Inspectorate established two new national teams to deal with complaints and care service registration activity. This allowed inspection teams to focus on inspection and enforcement activity. This resulted in a notable improvement in performance compared to the previous year before the merger.⁴² Within our merger option, the streamlining of processes and increased specialisation among staff may also lead to increased productivity and time savings.

Examples of mergers and consolidations in public sector organisations show that cost savings from staff reductions are often the largest source of benefit. For example, in a review of four recent public sector mergers in Scotland, Audit Scotland reported that for all mergers staff-related net savings were expected.⁴³

⁴⁰ HCPC (2014) "CPD and your registration" http://www.hpc-uk.org/assets/documents/10001314cpd_and_your_registration.pdf.

⁴¹ The Care Inspectorate was created in 2011 from the merging of the Social Work Inspection Agency, most of the Care Commission and some functions of HM Inspectorate of Education.

⁴² From April to December 2011, the Care Inspectorate issued 85 per cent of draft inspection reports within 20 working days — exceeding the target of 80 per cent (this compares to 67 per cent in the Care Commission the previous year). In the same period, it published 96 per cent of final inspection reports within 13 weeks, compared to 82 per cent the previous year. Source: Audit Scotland (2012) "Learning the lessons of public body mergers. Review of recent mergers".

⁴³ Audit Scotland (2012) "Learning the lessons of public body mergers. Review of recent mergers".

Although a direct comparison of mergers is not possible, given the range of baselines, approaches and complexity, we present here some anecdotal evidence from past mergers for illustrative purposes. These tend to show net savings, largely stemming from reductions in staff costs. The creation of the Care Inspectorate in Scotland (from the merging of the Social Work Inspection Agency, most of the Care Commission and some functions of HM Inspectorate of Education) incurred estimated costs and savings of £5.6million and £6.2 million respectively over the first four years after consolidation. This translates to 16 and 18 percent of its first year's operating budget for 2011/12 (approximately four per cent per year).⁴⁴

Table 3.3: Costs and savings for other mergers examined in the Audit Scotland report

Organisation	Operating budget (2011/12) £million	Estimated costs of merger (aggregated over first 4/5 years) £million	Estimated savings of merger (aggregated over first 4/5 years) £million
Skills Development Scotland (new non-departmental public body)	181	20	77
Marine Scotland (became part of the Scottish Government)	51	1	4.3
Creative Scotland (new non-departmental public body)	75	3.3	4.9
Care Inspectorate (new non-departmental public body)	35	5.6	6.2

Source: Audit Scotland (2012).

A consistent finding from reviews of public sector mergers is that costs and savings are not adequately attributed and recorded by the organisations (for example, many costs are absorbed into daily running costs, and benefits are not adequately accounted for going forward).⁴⁵ It is therefore difficult to construct a definitive picture of the total costs and savings brought about by mergers.

In addition to more streamlined functions and potential efficiencies, the further consolidation of a regulatory approach implied by a full merger may create simpler outcomes and better

⁴⁴ This assumes that the operating budget remained constant for the time over which the costs and savings were estimated.

⁴⁵ For example, the NAO highlights the difficulty of separating reorganisation costs from the costs of ongoing business: National Audit Office. "Reorganising central government" March 2010. Similarly, Audit Scotland found that for all the mergers it examined, costs were underestimated and savings and efficiencies inadequately measured: Audit Scotland (2012) "Learning the lessons of public body mergers. Review of recent mergers". The IFG review of UK government department reorganisations also found that cost estimates are usually too conservative, and that benefits, being more intangible and accruing over the longer term, often not measured at all: Institute for Government (2012) "Making and breaking Whitehall departments".

public service delivery. This could entail for example a consistent approach / framework to calculating risk in order to determine the level of regulation each profession warrants.

Whilst the degree of profession-related specialisation in a fully merged regulator may decline (as discussed later), the increased distance from individual professions may bring benefits in terms of limiting the scope for “regulatory capture” whereby the regulator is unduly influenced by registrants and professional bodies. For example, in the creation of DEFRA⁴⁶ from a number of departments including the Ministry of Agriculture, Fisheries and Food (MAFF), the MAFF image of an agriculturally ‘captured’ department was largely eliminated and DEFRA maintained a much better balance of its regulatory duties across the range of sectors under its remit.⁴⁷

A further potential benefit of the merger option would be through enabling a more flexible workforce, which could benefit patient outcomes.⁴⁸ For example, effective regulation can be made harder if there are “boundary disputes” between different professions, e.g. due to one professional group seeking to undertake an activity previously seen as its own reserve by another profession. In this sense, a merged entity could internalise such disputes, perhaps leading to readier resolution. It is not clear, however, the extent to which such disputes are present or likely, to become present, between professions currently regulated by separate bodies — i.e. a boundary dispute is likelier between, say, dental nurses and dental hygienists (both currently regulated by the GDC) than between dental nurses and someone outside the GDC’s remit.

Benefits of public sector mergers over and above any cost savings appear most immediate when there is a clear logic to the merger in terms of uniting complementary functions. For example, the creation of DWP⁴⁹ was regarded as one of the most beneficial government reorganisations because it united the functions of the social security system with employment services, linking unemployment benefits to job-seeking services, and both with the pension service. There was a clear administrative and functional rationale for the merger, and each function depended on and influenced the other.⁵⁰

3.4.3 Costs and risks of Option 3 — full merger of the regulatory bodies

There are likely to be significant transitional costs of moving to a full merger scenario. Table 3.3 above illustrates the magnitude of costs for a selection of mergers. The rationalising of property and assets may incur greater transitional costs relative to a case where regulators retain individual independence. A merged entity may impatient in achieving the goal of becoming established (e.g. with respect to the consolidation of its property portfolio), incurring greater costs/lower returns associated with contract termination and asset

⁴⁶ Department for the Environment, Food and Agriculture.

⁴⁷ Institute for Government (2012) “Making and breaking Whitehall departments”.

⁴⁸ For example, this was part of the rationale behind setting up the Australian Health Practitioner Regulation Agency.

⁴⁹ Department for Work and Pensions.

⁵⁰ Institute for Government (2012) “Making and breaking Whitehall departments”.

divestment. Managing any merger is a crucial step that includes assessments of the initiative in terms of value for money as well as the development of robust costs and savings estimates of the consolidation procedures, with regular review of these as necessary as the merger proceeds. For example, the review of Ofcom's creation found that the transition team needed substantive property expertise to apply due diligence and cost analysis of location options, acquire new premises and to dispose of legacy assets.⁵¹

The greater integration of regulatory approach enabled by a full merger, as described in 3.3.2 above, could reduce the additional complexity and cost of creating integrated systems, i.e. instead of designing a system to meet all the different needs of the respective regulators, a more streamlined approach could be taken and a single, "one-size-fits-all" system designed. For example, an option for a shared approach to CPD could use the HCPC as a model, whereby CPD management is light-touch and limited to a set of standards and guidelines, and an audit process. This would be far simpler and less costly than an integrated infrastructure described in the sharing option above.

However, this approach does lose the profession-specific CPD/CET requirements that a number of other regulators have in place. These requirements seek to address specific risks within the profession: for example the GOC has a requirement for CET points to be gathered from a range of activities, and a range of specific optometry competencies, with at least some points acquired through peer review.⁵² The loss of this would undermine the value of CPD/CET in keeping registrants up to date for the specific contexts of their professions, and could have negative impacts on patient outcomes.

In addition to the one-off costs associated with integrating specific functions such as CPD/CET and registration, IT costs associated with full integration of all systems and processes are likely to be substantial in a full merger option. The Institute for Government (IFG) reports IT investment and integration costs of around £3 million for merging UK departments. It is likely that the investment and integration required in bringing together eight or nine healthcare profession regulators would be much higher. In its review of its own merger, Ofcom warns that the challenge of implementing new IT infrastructure in a new building or location should not be underestimated, particularly whilst also supporting legacy business-as-usual activities through the transition.⁵³ The risk of IT overspend is great, based on experiences of other public sector IT investment. For example, a report for the UK government in 2009 suggested that there was scope for efficiency savings in UK IT expenditure of up to 20 per cent, equivalent to €3.6 billion per year.⁵⁴

Evidence from a number of merger reviews highlights the cost-related risks associated with timing and planning. Insufficient time to plan can result in higher transitional costs relating

⁵¹ Ofcom (2006) "A case study on public sector mergers and regulatory structures".

⁵² See for example the GOC's requirements for optometrists CET: https://www.optical.org/en/Education/CET/cet-requirements-for-registrants.cfm#General_principles. Requirements based on risks associated with isolated practice and specific competency areas.

⁵³ Ofcom (2006) "A case study on public sector mergers and regulatory structures".

⁵⁴ HM Treasury (2009) "Operational Efficiency Programme Final Report".

to, among other things, property divestment, staff release and IT integration. For example, the Scottish Government estimated early release costs for the new Care Inspectorate of around £1.5 million. However, after the late appointment of its chief executive, there was insufficient time to finalise the staff structure and issue the required notice to staff, resulting in almost £0.5 million of unanticipated payments in lieu of notice to staff who left under the scheme.⁵⁵ On a related note, merger reviews also highlight the risks associated with overly politically-motivated mergers, in particular that this can lead to mergers being rushed and ill-planned, leading to higher costs and longer lead times before the new organisation is effective.⁵⁶

Real-world experience of mergers of public sector organisations show that staff changes (e.g. restructuring workforces), are often among the most important drivers of one-off costs. A full merger of the healthcare professional regulators would necessitate far greater workforce reorganisation over and above a less-intensive sharing option. Costs could include voluntary release and early retirement, as well as levelling up pay grades. In two examples of government reorganisations, costs associated with differential pay settlements were significant and represented a large proportion of one-off and ongoing costs.⁵⁷

One source of such diseconomies could be influence costs.⁵⁸ These can result from the misallocation of resources due to the lobbying efforts of particular managers (and also the time wasted on such lobbying). In an enlarged regulatory body, it is plausible that those managers dealing with particular professions could gain increased influence (because of the numbers of the registrants, or the sum of fees). Alternatively, there could be an increased lobbying effort by those involved in the regulation of the professions with the least members.

The merger option has the greatest scope for generating diseconomies of scale or scope. These may stem from the substantial increase in size and operational complexity of the new regulator compared to the other sharing options, or the status quo. This is evident from other mergers, for example lessons from Ofcom's merger show that a newly merged organisation is likely to be larger and more complex than its predecessors.⁵⁹ A study into private-sector merger success found that organisations struggle with the complexity of integrating legacy systems and processes, and that this is a key factor in limiting the success of mergers.⁶⁰

The literature on industrial organisation also points to the link between organisation size and operational complexity, and the resulting negative effects. When an organisation grows, its complexity increases with more committees, departments, and managers, making

⁵⁵ Audit Scotland (2012) "Learning the lessons of public body mergers. Review of recent mergers".

⁵⁶ Institute for Government (2012) "Making and breaking Whitehall departments".

⁵⁷ The Institute for Government estimates a one-lump sum of £15 million for DEFRA and £140 million for DWP, representing nine and two per cent of administrative budgets respectively. However, this doesn't account for the net cost over the future of the organisations, which would be much greater.

⁵⁸ Milgrom, P. and J. Roberts "Bargaining costs, influence costs and the organisation of economic activity" in Alt, J. and Shepsle, K. (eds.) (1990) "Perspectives on Positive Personal Economy".

⁵⁹ Ofcom (2006) "A case study on public sector mergers and regulatory structures".

⁶⁰ Genpact (2016) "Enabling M&A Success with Effective Post-merger Integration Support".

communication in the firm more difficult. Increases in the size of management can lead to more indecisive management. Large organisations are often characterised by inertia and rigidity, with managers increasingly “insulated from reality” and distant from operations.⁶¹ This all has the effect of rendering the organisation less able to respond and adapt to changes in the market or regulatory environment.⁶²

A full merger would also have a significant impact on leadership and governance. The senior management would be responsible for a large and complex organisation, needing to account for profession-specific needs whilst maintaining a common structure. There would be added complexities arising from individuals from differing regulators needing to work together. Inadequate leadership would impose significant additional risks to the new organisation. A ministerial report into the mismanagement of the Health Professions Council of South Africa (HPCSA) found that among the many reasons for its failure was its structure, citing the huge challenges for a CEO/Registrar to manage 12 Professional Boards that represent at least 27 professions and the Council. (There were at least 52 meetings per year with one Board meeting per week. Every Board had various committees that had broad agendas — and they needed to meet at least four times per year.) Furthermore, decision-making was difficult because of conflicts of interest among different professional groups.⁶³ This is an extreme example (in that the organisation failed), but illustrates the leadership risks associated with large and complex structures.

A further leadership / managerial risk stems from a potential loss of specialisation — as identified above, the main incremental source of cost savings over and above the sharing options are likely to be achieved by reducing managerial costs through redundancy, voluntary severance and early retirement. As previously, this could come at the loss of some specialist knowledge, which could increase the risk of regulatory arbitrage, as the regulated “exploit” a lack of such knowledge in the new entity — i.e. this would act as a countervailing tendency to the potential benefit described above of reducing regulatory capture.

There could also be a loss of human asset specificity, i.e. specialist knowledge: someone who is effective in one set of routines and processes may be markedly less effective in a transformed context (and those scale economies accessible only in a merged entity are likely predicated on such a transformation). This is over and above the loss of professional specialisation, which we discuss further in the following section.

A further challenge would relate to registrant fees. In broad terms, there are two choices: evolution from current registrant fee levels, or a new unitary fee. The HCPC currently

⁶¹ Canback, S (2002) “Managerial Diseconomies of Scale” Henley Management College; and Crozier, M (1964) “The Bureaucratic Phenomenon.” Chicago: University of Chicago Press.

⁶² See for example Graves, D. (1981), “Individual Reactions to a Merger of Two Small Firms of Brokers in the Reinsurance Industry: A Total Population Survey”. *Journal of Management Studies*, Vol. 18, No. 1, p. 89–113; and Delens, G. (2005) “Fusies en overnames in de verzekeringssector (Mergers and Acquisitions in the Insurance Sector”, Ghent University).

⁶³ Ministerial Task Team of South Africa (2015) “Report of the Ministerial Task Team (MTT) to Investigate Allegations of Administrative Irregularities, Mismanagement and Poor Governance at the Health Professions Council of South Africa (HPCSA)”.

applies the latter approach, with the implication being that there is at least some element of cross-subsidy between the affected professions. Such cross-subsidisation has risks. One unintended consequence could be that it reinforces agency costs, e.g. those managing the regulation of the smaller-scale professions could be less concerned with efficiency compared to the status quo — in the knowledge that excessive costs incurred would be borne largely by other professions. It could also raise equity issues. On the other hand, without any such cross-subsidy particular professions may struggle to finance unexpected costs, e.g. their full share of any transitional costs in moving to a merged body.

In the case of evolution from current fee levels, some mechanisms for the allocation of cost would need to be set up. Attempts to influence such an exercise would likely be a chronic feature of such a merged entity. This might be especially difficult in dealing with property consolidation.

3.4.4 Impact on patient outcomes associated with Option 3 — full merger of the regulatory bodies

One of the major risks of a full merger of core regulatory functions relates to the loss of profession-specific specialisation. As discussed above, in order to realise scale and scope efficiencies, particularly in relation to the consolidation of staff and IT and other systems, a high level of integration would be necessary. There is a significant risk that systems would be too generic and that profession-specific knowledge among individuals would be lost. This would impact on all functions. We have already described the potential impact of a generic approach to CPD/CET, i.e. that it would not be sufficiently targeted to address profession-specific risks.⁶⁴ Similar risks would also be inherent in a common approach to standards and guidance. For example, in a review of the education of children's social workers, Sir Martin Narey noted that the standards applied to social workers by the HCPC are far too generic to adequately capture what children's social workers should know, and that in general social work sits very oddly with the other professions the HCPC regulates. Narey raises the concern that there is limited expertise in children's social work in the HCPC either in the executive or in the body's governance.⁶⁵ This illustrates the potential risk associated with a combined regulator.⁶⁶

Loss of profession-specific specialisation would also impact on the regulator's role in professional quality and assurance, and could mean that professionals are not as up-to-date on risks or correct practices as they would be under either the sharing options or the status

⁶⁴ For example, through research and individual experts individual regulators know the best (and most proportionate) way to ensure that registrants keep up to date, such as through rigorous portfolio assessments (like the GMC) or lighter touch tailored CET (like the GOC).

⁶⁵ Narey, Sir Martin (2014) "Making the education of social workers consistently effective".

⁶⁶ In addition, CHRE (2009) noted that among the regulators interviewed there was a sense that the profession-specific knowledge provided by the current regulatory regime could be lost, and the expertise provided to registrants and the public would not necessarily find its way into a shared scheme between regulators.

quo. This may negatively impact patient outcomes, or at least act as an impediment to quality improvements. This in turn might impact on the sustainability of the profession.

A loss of specialisation may also impact the regulator's role in monitoring and safeguarding, which would negatively impact patient outcomes. As described above, decisions relating to FTP and the register, as well as the monitoring of CPD/CET, all demand a degree of subjectivity and it may be the case that instances of risky behaviour or incompetence are overlooked.

With regulators undertaking functions together, the lack of individuality could negate the possibility for change and growth as a profession develops. Merging functions may ultimately limit the single regulator's ability to adapt to new dynamics in the professions, i.e. to innovate. A loss of innovation may also arise from the reduction in benchmarking possibilities, whereby separate regulators can compare best practice and seek to improve on each other. This may negatively impact patient outcomes through limiting the professional development and safeguarding roles of the regulator.

Increased operational complexity is another key source of risk to patient outcomes, in addition to cost-related scale diseconomies. A significantly larger organisation may be less responsive to developments in professions or in the wider regulatory landscape which may limit the regulator's role in professional quality assurance. Any system-related problems would be far more complex and would affect a far wider range of professionals compared to other sharing options — for example registration backlogs or, more seriously, FTP backlogs. An additional, associated risk in a single regulator would be if responsibility became more diffused and hence ceased to be clearly owned in some instances. If responsibility for oversight and remedy for quality and safety was more diffused then again patient outcomes could be negatively affected.

Related to increased operational complexity, any negative impacts on leadership and governance from a full merger could pose a risk to patient outcomes by affecting the monitoring and safeguarding and professional quality assurance roles of the regulator.

Most notably, the Francis Report condemned the failure of leadership and governance in its review of the failures of the Mid Staffs hospital foundation trust. In particular, the report drew attention to the reorganisation and mergers of the West Midlands strategic health authorities (SHAs):

“there is little doubt that the demands of reorganisation and the limited staff and other resources available seriously restricted the ability of the SHA to perform an effective role in performance management.”⁶⁷

The transition to a new body would itself represent a significant distraction from business-as-usual, i.e. the regulation of healthcare professionals, for the body's management. The transition to the Australian Health Practitioner Regulation Agency seems to have led to an

⁶⁷ Francis, R (2013) “Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry”.

effective reduction in the supervision of international medical graduates and delays in the health complaints process.⁶⁸ These types of reduced functioning — even if only temporary — could affect patient outcomes (e.g. by maintaining a professional on the registry when he should have been removed).

As with the sharing options, any incremental costs or savings could be passed on to registrants in terms of reduced fees. This might help the sustainability of the various professions.

Figure 3.5: Summary of the impact of Option 3 (full merger) on patient outcomes



Note: Text in bold is most relevant to this option.

3.5 Conclusions

This report investigates three potential sharing options between healthcare professional regulators, namely:

- Option 1. Independent regulators with limited sharing of functions.
- Option 2. Independent regulators with more extensive sharing of functions.
- Option 3. Full merger.

We used the existing literature on public sector and private sector mergers and the joint sharing of functions to establish a preliminary evidence base to underpin the development of a conceptual framework for assessing the costs, benefits and risks of the sharing options. Our framework identifies the main functions of the regulators (which form the basis of the sharing options), and the key organisational features of the regulators which may be impacted by the sharing options. We then described how changes to these key features may affect patient outcomes. In this final step we have taken a high-level view of patient outcomes,

⁶⁸ State of Victoria Legislative Council, Legal and Social Issues Legislation Committee (2014) "Inquiry into the Performance of the Australian Health Practitioner Regulation Agency".

given the wide variation across the healthcare professions concerned. The outcomes considered include the broad quality of care provided by healthcare professionals, and the cost and uptake of care, and describe the links through which patient outcomes may be affected. The diagram below summarises our conceptual framework.

Figure 3.6: Mapping functions through to patient outcomes



We have described above how the case for economies of scale in a merger of some or all of the nine extant health professional regulators is still to be made. Whilst some economies of scale are likely realisable at some level, it is not possible to rule out the possibility of diseconomies of scale if you simply merge these regulators together.

Indeed our analysis of various sharing and merger options suggests that the costs, benefits and risks do differ substantively across the sharing and merger options that we consider.

- In Option 1 (maintaining the independence of each regulator with limited sharing of functions), the sharing of back office and support functions would be likely to generate synergies and cost savings. We have described various examples of such sharing arrangements, and savings, across public sector organisations. This level of sharing is unlikely to result in a notable loss of specialisation or increased operational complexity, and thus the risks and impacts on patient outcomes should be low. We find that the additional sharing of the registration function between regulators would be different to other shared services, however. To realise scale (scope) efficiencies such a system would need to be consistent across all professions, which would entail the integration of a range of profession-specific features and/or a significant increase in operational complexity and cost.
- Under Options 2 (maintaining the independent of each regulator but with more extensive sharing of functions) we find that this would also potentially be subject to risks arising from a loss of specialisation and increased complexity, however, this would depend on the exact nature of the sharing and the degree of integration. Particular areas of risk and

uncertainty are likely to be in education and training and standards and guidance, as well as overall IT and systems integration.

- The third option of the full merger of the regulatory bodies would increase the risks associated with increased operational complexity in particular, as well as additional risks relating to leadership and governance and a loss of innovation.

The main drivers of risks to patient outcomes as a result of moving away from the current status quo appear to be increased operational complexity and a loss of profession-related specialisation. The evidence we have examined suggests that these would increase with greater sharing, such that increased scope for efficiencies goes hand in hand with increased risk, with the greatest risks present in the merger option.

The potential for cost savings is mainly accessible through the two sharing options. Whilst in the long-term a full merger could secure additional cost savings, this is far from a given — and indeed, this option involves substantially heightened risks in both scope and scale.

In the case of the health professional regulators, whilst there may be synergies at the operational level, the regulation of each profession entails a level of specialisation and independence that may not facilitate or necessitate interdependence. The case for benefits to patient outcomes to benefit from a fully merged regulator are not obvious, over and above the sharing of best practice or operational elements which could be achieved from a less-integrated sharing approach.

Given these doubts, and with the focus upon patient outcomes, a cautious approach to accessing any potential economies of scale is merited. This could entail the exploration of sharing back-office and support functions, possibly with an external body (say acting as honest broker) to overcome any coordination problems amongst the regulators.