Title: Statutory Regulation of Non-Medical Public Health Specialists **IA No:** 8054 **Lead department or agency:** Department of Health **Other departments or agencies:**	**Impact Assessment (IA)**
	Date: 16/01/2015
	Stage: Final
	Source of intervention: Domestic
	Type of measure: Secondary legislation
	Contact for enquiries: Alison Ross

Summary: Intervention and Options

RPC Opinion: EANCB Validated

Cost of Preferred (or more likely) Option				
Total Net Present Value	**Business Net Present Value**	**Net cost to business per year** (EANCB on 2009 prices)	**In scope of One-In, Two-Out?**	**Measure qualifies as**
£107,000	-£13,800	£739	Yes	IN

What is the problem under consideration? Why is government intervention necessary?

Around 50% of public health specialists are 'non-medical' public health specialists (NMPHSs). Unlike medical PHSs, their practice is not subject to statutory regulation although their job does not usually differ from that of medical PHSs. NMPHSs are invited to register voluntarily with the UK Public Health Register as a way of demonstrating their competence and fitness to practice. Although there is no evidence that NMPHSs have yet acted in a manner which has put the public and their health in danger, the risk of this happening currently exists. While the scale of this intervention is relatively small, Government intervention would provide more consistent and rigorous public protection than the current system.

What are the policy objectives and the intended effects?

The policy objective is to extend the public protection that currently applies to specialists from a medical or dental background to NMPHSs; to ensure a consistent approach to regulation and standard setting; and to realise cost savings from increased efficiency of back office functions. The intended effect of the policy is that all practising NMPHSs will be registered with a statuory regulator. This will increase efficiency and reduce the risks of inconsistent approaches to preventing disease, protecting and improving general health, promoting healthy lifestyles and improving healthcare services.

What policy options have been considered, including any alternatives to regulation? Please justify preferred option (further details in Evidence Base)

Two options have been shortlisted in this IA (others are considered in Appendix 2):
Option 1: Do Nothing. Continue with a mixture of training, voluntary and statutory regulation across the profession

Option 2: Require all non-medical public health specialists to register with a statutory regulator. This is the preferred option because it delivers the policy objective, removes inconsistency in the industry and delivers a net benefit.

Will the policy be reviewed? It will be reviewed. **If applicable, set review date:** 07/2019

Does implementation go beyond minimum EU requirements?			N/A		
Are any of these organisations in scope? If Micros not exempted set out reason in Evidence Base.	**Micro** Yes	**< 20** Yes	**Small** Yes	**Medium** Yes	**Large** Yes
What is the CO_2 equivalent change in greenhouse gas emissions? (Million tonnes CO_2 equivalent)			**Traded:** N/A	**Non-traded:** N/A	

I have read the Impact Assessment and I am satisfied that (a) it represents a fair and reasonable view of the expected costs, benefits and impact of the policy, and (b) that the benefits justify the costs.

Signed by the responsible Minister: Daniel Poulter Date: 16/01/2015

Summary: Analysis & Evidence

Policy Option 2

Description: Require Non-Medical Public Health Specialists to register with the HCPC

FULL ECONOMIC ASSESSMENT

Price Base Year 2014	PV Base Year 2014	Time Period Years 20	Net Benefit (Present Value (PV)) (£m)		
			Low: -	**High:** -	**Best Estimate:** 0.107

COSTS (£m)	**Total Transition** (Constant Price)	Years	**Average Annual** (excl. Transition) (Constant Price)	**Total Cost** (Present Value)
Low	-	2	-	**-**
High	-		-	**-**
Best Estimate	1.400		0.041	**1.980**

Description and scale of key monetised costs by 'main affected groups'

The Health and Care Professions Council will incur transitional costs. The Department of Health will fund the transition costs of HCPC which are estimated at £350,000 (IT installation and other set-up costs) plus opportunity costs. NMPHSs' fees are estimated at about £40,000 per year.

Other key non-monetised costs by 'main affected groups'

None identified.

BENEFITS (£m)	**Total Transition** (Constant Price)	Years	**Average Annual** (excl. Transition) (Constant Price)	**Total Benefit** (Present Value)
Low	-		-	**-**
High	-		-	**-**
Best Estimate	0		0.152	**2.087**

Description and scale of key monetised benefits by 'main affected groups'

A benefit of £152,000 per year will be gained by NMPHSs – through savings on annual registration fees due to the difference between UKPHR's annual fee of £295 and the HCPC's annual fee of £80.

Other key non-monetised benefits by 'main affected groups'

Potentially less risk of malpractice - by ensuring statutory registration, the risk of ill-equiped persons making decisions with wide-spread ramifications on public health is reduced.
Public reassurance in non-medical public health specialists – a statutory register of non-medical public health specialists could reassure the public that specialists are of a sufficient standard, and that their decisions are well informed and valid.

Key assumptions/sensitivities/risks | **Discount rate (%)** 3.5%

1) There are 10 non-medical public health specialists operating in the private sector.
2) All the NMPHSs currently registered with UKPHR will leave the register and the UKPHR reduces its costs in line with its reduced income.

BUSINESS ASSESSMENT (Option 1)

Direct impact on business (Equivalent Annual) £m:			In scope of OITO?	Measure qualifies as
Costs: £0.00	**Benefits:** £0.00	**Net:** -£0.00	Yes	IN

Evidence Base (for summary sheets)

Rationale for intervention and intended effects

1. Public health was originally a medical or dental specialty with specialists subject to statutory regulation by either the General Medical Council (GMC) or General Dental Council (GDC). In around 2002, access to the national specialty training programme was extended to professionals from other related backgrounds such as environmental health, nursing or microbiology and public health became a multidisciplinary specialty.

2. Around 50% of public health specialists (about 516 individuals[1]) are now from a non-medical or non-dental background and their public health practice is not subject to statutory regulation. These 'non-medical' public health specialists (NMPHS) are invited to register voluntarily with the UK Public Health Register (UKPHR; a registered charity and non-for-profit company limited by guarantee) as a way of demonstrating their competence and fitness to practise.

3. The job role of non-medically qualified public health specialists does not usually differ from those with a medical or dental background – however, they do differ in their initial qualification and the fact that they are not subject to ongoing statutory regulation.

4. Public health specialists must take action to promote healthy lifestyles, prevent disease, protect and improve general health and improve healthcare services. Although there is currently no evidence that non-medical public health specialists have yet acted in a manner which has put the public and their health in danger, the risk of this happening currently exists.

5. As reported by the Scally Review of the Regulation of Public Health Professionals[2] "there may be instances where professional probity is lacking or there may be instances of malfeasance in office or misconduct. Non-technical skills (both cognitive and social) are important in the work environment; issues such as an inability to engage in team-working or poor ability to communicate about risk may be raised as a cause for concern. Public health specialists may, along with the rest of the population, suffer from behavioural difficulties (other than misconduct) and from physical or mental health problems (including substance misuse). Again, the public must have confidence that there are trustworthy mechanisms in place within a health profession for dealing with concerns about behavioural matters. (Page 21)"

6. The Scally Review[2] continues: "Two core public health functions where there are risks from poor professional practice are health protection and evidence-based resource allocation. The health protection function includes the management of a wide range of communicable diseases and environmental hazards in addition to their surveillance at a population level… The resource allocation function within public health includes allocation of resources for specialist treatments and commissioning public and personal health service developments. If evidence is inaccurately assessed, there is a potential risk of mortality or morbidity to the individual patient who requires specialist treatment; or risk of increased levels of disability, morbidity or mortality in a population if incorrect choices are made about intervention programmes. (Page 22)"

7. In order to build greater consistency and cohesion across this key leadership group for public health, the Department of Health is proposing that NMPHS should have the same competences and reach the same professional standards as medical and dental public health specialists. They should demonstrate this by fulfilling the requirements for, and registering with, a statutory regulator if they wish to use the title 'Public Health Specialist'. Statutory regulation enables specific actions to be taken when professional misconduct or incompetence are identified and proven. These include the ability to place conditions on an individual's practice, and the ability to de-register someone. These powers strengthen incentives to gain and maintain high levels of competence.

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[1] Source: Communication with UKPHR

[2] Source: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216095/dh_122237.pdf

8. The scale of the intervention is relatively small but Government intervention is necessary to provide a more consistent and rigorous level of public protection than the current, voluntary, scheme.

Consultation

9. The Department ran a public consultation on the proposed changes for statutory regulation of public health specialists[3]. It ran from 4th September to 14th November 2014 and received 168 responses. Respondees were generally content with the technical side of the regulations, including the main stakeholder organisations such as the Faculty of Public Health, Public Health England, British Medical Association, Chartered Institute of Environmental Health and the Local Government Association. No new arguments had been put forward to suggest that the HCPC were not best placed to regulate public health specialists from non-medical and non-dental backgrounds. There is one amendment to the proposal from the consultation in that NMPHSs that are currently registered with a statutory regulator as well as the UKPHR (e.g. an NMPHS from a nursing background) will not be required to register with the HCPC, although they will be able to if they choose.

10. One question in the consultation asked about potential impacts on business arising from the regulations – this is replicated in Appendix 3.

Policy Objective

11. The policy objective is to extend the public protection that currently applies to specialists from a medical or dental background to NMPHS and ensure a consistent approach to regulation and standard setting, as well as realise cost savings from increased efficiency of back office functions. The intended effect of the policy is that all non-medical public health specialists should register with a statutory regulator.

12. For brevity purposes, this document uses the acronym NMPHS to refer to any public health specialist that is not registered with any statutory regulator, not just specialists from a strict medical background.

13. The Regulatory Triage Assessment for the policy was submitted to the Regulatory Policy Committee and it was confirmed as a low cost regulatory proposal (reference RPC14-FT-DH-2099). In line with the RPC comments a sensitivity analysis of the chosen option has been provided in Appendix 1.

Options considered

14. The Scally Review[2] considered 6 options. These are explored further in Appendix 2. The option to require public health specialists to register with the HCPC was found to be the most efficient and most appropriate, given the time and expenses that would be incurred in creating a possible new statutory regulator when there is already a possible option fit for purpose. The HCPC can exploit economies of scale; as of 31st March 2014 the HCPC had regulated 322,000 individuals, across 16 professions[4]. Furthermore, a statutory register would reassure the public that all public health specialists are competent to practise. If a registrant does not meet prescribed standards, HCPC can take action which can include stopping them from practising.

15. The proposed regulation would therefore require those who wish to use the title “Public Health Specialist” to register with the HCPC if they are not already registered with the GMC, GDC, Nursing and Midwifery Council (NMC) or General Pharmaceutical Council (GPhC). The regulation will not prevent anyone from registering with other organisations, including those with which they are currently registered.

Options shortlisted

16. Two options are shortlisted for more consideration:
    a. Option 1: Do Nothing.

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[3] https://www.gov.uk/government/consultations/public-health-specialists-regulation

[4] Source: HCPC Annual Report 2014 http://www.hcpc-uk.org/assets/documents/10004777Annualreport2014.pdf

b. Option 2: Require public health specialists to register with the HCPC unless already registered with the General Medical Council, General Dental Council, Nursing and Midwifery Council or the General Pharmaceutical Council.

Costs and benefits of Option 1

17. The costs and benefits of Option 1 are defined as zero. This is the counterfactual against which Option 2 is appraised.

Costs and benefits of Option 2

Appraisal overview

18. The table below sets out an overview of the costs and benefits, and explains which are direct costs on the private sector, and which are indirect impacts and wider economic impacts. The treatment of the Equivalent Annual Net Cost to Business (for One-in, Two-out purposes) is covered separate to this analysis.

	Impact		CBA (Green Book) treatment	EANCB treatment (direct private costs)
1	HCPC	Transitional costs of gearing up for registering NMPHSs (to be subsidised by DH)	Cost included	Public sector cost
2	HCPC	Ongoing costs of registering NMPHSs (to be covered by fees paid)	Cost passed through to NMPHSs, and included as fees paid	Public sector cost (but see "private NMPHSs" below)
3	DH	Funding of HCPC transitional costs	Cost included (under HCPC above)	Public sector cost
4	NMPHSs: public sector	Obliged to register with HCPC; may cease to use UKPHR	Both cost and saving included	Public sector cost
5	NMPHSs: private sector	Obliged to register with HCPC; may cease to use UKPHR	Both cost and saving included	Cost of registering with HCPC included (saving not included; see UKPHR below)
6	UKPHR	NMPHSs may choose not to register with UKPHR	In principle, include any reduction in producer surplus / profit	Indirect impact (contingent on changed behaviour of NMPHSs)
7	General public	Health risks reduced compared with inconsistent voluntary approach to regulation	Included but not monetised	Not a business impact

Table 1: Table of impacts from Option 2

Costs

Impacts 1 and 3: HCPC Transitional costs

19. The Health and Care Professions Council will incur transitional costs from setting up the function of regulating non-medical public health specialists. The HCPC intends to cover the costs of the register through fees on a cost-neutral basis. The Department of Health will fund the transition costs of HCPC which are estimated at £350,000 in total. This is due to be split £110,000 in the 2014/15 financial year, and £240,000 in 2015/16. The money DH transfers to the HCPC covers IT installation and other set-up costs. In addition, the HCPC will incur costs and gain revenue from expanding its remit to non-medical public health specialists.

20. DH Impact Assessment guidance requires the consideration of opportunity costs when appraising options where DH finances are being spent. An alternative use of the £350,000 would be to spend the money on NHS resources. The £350,000 could be used to produce 23.3 QALYs[5]. DH IA guidance also states that society generally values a QALY at £60,000 each, meaning the 23.3 QALYs above have a societal value of £1.4million. It is this £1.4million that is included as a cost in this analysis to ensure the money being spent represents value for money.

Impact 2: HCPC fees

[5] Recent research finds that the NHS can 'produce' Quality Adjusted Life Years at a cost of £15,000 each.

21. Second, non-medical public health specialists will have to pay one-off registration fees, and annual fees, to the HCPC. The fees set by HCPC are £80 per year plus an additional £56 in the first year for additional scrutiny[6]. The HCPC have confirmed that they would be able to register public health specialists from non-medical and non-dental backgrounds for these fees.

22. There are approximately 1,100 practising public health specialists in the UK, around half of whom are medical or dental and registered with the General Medical/Dental Council. The other half, numbering 516 NMPHSs, are registered with the UK Public Health Register[7]. Requiring all of those registered with UKPHR to register with the HCPC creates a one-time cost of £28,896 followed by £41,280 per year. Public health specialists from a medical, dental, nursing or pharmaceutical background would not need to register with the HCPC so there are no impacts on them.

23. Some of the 516 individuals covered in paragraph 22 will have a nursing or pharmaceutical background, however we do not have an estimate for how many individuals this is. These individuals would not need to pay HCPC fees, so it follows that the estimated cost of registration above will be an overestimate of the true costs.

Impact 6: UKPHR running costs

24. The proposed regulation will not prevent NMPHSs from registering with the UKPHR. However, contingent upon NMPHSs changing their current practice and ceasing to register with the UKPHR, it is (conservatively) assumed that all currently registered NMPHSs might cancel their registration with UKPHR and in future only register with the HCPC. As 87% of UKPHR's current registrants are NMPHSs[8], we expect UKPHR could lose a substantial income stream. However, in these circumstances, the UKPHR would also no longer incur the costs of registering NMPHSs. The UKPHR received £136,000 in fees in 2012/13 and has outgoings around £270,000 per year[9]. As a not-for-profit company limited by guarantee, there are no shareholders and no profits as such. Our central assumption is that there will continue to be zero producer surplus or profit on UKPHR activities.

25. Our assumption would be that the UKPHR could face a fall in registrants and fees of 87% – i.e. income down by £118,000 per year[10] – but that it would also incur a reduction in costs of £118,000. Therefore, the change in profit of UKPHR will be zero and will not be included in the table of overall costs and benefits. This assumption is tested in Appendix 1.

<u>**Benefits**</u>

Impacts 4 & 5: HCPC fees

26. The UKPHR currently charges an initial £300 registration fee followed by annual fees of £295 per year. Switching to HCPC will save each person £295 per year in the long run and the entire sector £152,220 per year from annual fees. Those NMPHSs that are already registered with a statutory regulator will save the entire cost of the UKPHR fee.

Impact 7: Benefits to the public

27. There are two main benefits to the public. Neither of these have been monetised.

<u>Potentially less risk of malpractice</u>

28. Public health is about improving the health of large groups of people, rather than treating individual patients. Public health specialists strive to realise ways of making communities and environments healthier. Public health specialists must look at the big picture and take action to promote healthy lifestyles, prevent disease, protect and improve general health and improve healthcare services.

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[6] Source: HCPC website, www.hcpc-uk.org

[7] Source: Personal communication with UKPHR.

[8] Source: Personal communication with UKPHR

[9] Source: UKPHR Annual Accounts. UKPHR received around £140,000 from DH core funding and other project funding.

[10] Calculated as 87% of £136,000.

29. Although non-medical public health specialists interact with the public directly only in certain circumstances (e.g. an outbreak), the decisions they make could have wide-spread ramifications. For example, it could be possible to have a non-medically qualified Director of Public Health providing poor advice to the local authority that could result in negative physical or mental health impacts on individuals.

30. It is important to note that there is currently no evidence that non-medically qualified public health specialists have yet acted in a manner which has put the public or their health at risk. The policy is therefore a proactive measure. By ensuring statutory registration, the risk of persons ill-equipped to make such decisions being in a position to do so is reduced. If a registrant does not meet prescribed standards, HCPC can take action which can include stopping them from practising.

<u>Public reassurance in non-medical public health specialists</u>

31. A statutory register of non-medical public health specialists could reassure the public that specialists are of a sufficient standard, and that their decisions are well informed and valid. This could potentially help increase traction of initiatives requiring public engagement, such as voluntary vaccination schemes, or voluntary preventive care.

<u>Summary of costs and benefits</u>

32. The table below presents the total costs and benefits of the scheme. In line with HMT Green Book guidance and DH Impact Assessment guidance:
    a. all future costs and benefits have been discounted at a rate of 3.5% per annum, with the exception of:
        i. QALYs, which are discounted at the utility discount rate of 1.5% per annum
    b. inflation is removed from the estimates.

33. The table below presents undiscounted impacts, assessed over a 20 year time horizon.

COSTS		**Year**			
Description	**On whom?**	**0**	**1**	**2 - 19**	**TOTAL**
Setting up IT system	HCPC/DH	£110,000	£240,000	£0	**£350,000**
Setting up IT system - opportunity costs		£330,000	£720,000	£0	**£1,050,000**
HCPC Scrutiny fee	Public Sector NMPHSs	£0	£28,224	£0	**£28,224**
HCPC Scrutiny fee	Private Sector NMPHSs	£0	£672	£0	**£672**
HCPC Annual cost of registration	Public Sector NMPHSs	£0	£40,320	£40,320	**£766,080**
HCPC Annual cost of registration	Private Sector NMPHSs	£0	£960	£960	**£18,240**
UKPHR - lost income	UKPHR	£0	£0	£0	**£0**
BENEFITS					
Description	**On whom?**	**0**	**1**	**2**	
UKPHR - saved costs	UKPHR	£0	£0	£0	**£0**
Saved registration costs	Public Sector NMPHSs	£0	£148,680	£148,680	**£2,824,920**
Saved registration costs	Private Sector NMPHSs	£0	£3,540	£3,540	**£67,260**
SUMMARY					
TOTAL COSTS		**£440,000**	**£1,030,176**	**£41,280**	**£2,213,216**
TOTAL BENEFITS		**£0**	**£152,220**	**£152,220**	**£2,892,180**
NET BENEFIT		**-£440,000**	**-£877,956**	**£110,940**	**£678,964**
DISCOUNTED TOTAL COSTS					**£1,979,674**
DISCOUNTED TOTAL BENEFITS					**£2,086,911**
DISCOUNTED NET BENEFIT					**£107,238**

Table 2: Summary of costs and benefits for Option 2

34. Under Option 2 the policy generates a net benefit of £107,000 discounted over twenty years. The first two years of the policy generate a net loss from the consideration of opportunity costs on the £350,000 transition cost. However, continued savings in future years to registrants results in a net benefit over the full time horizon.

Assumptions

35. The following are the central case assumptions:
    - All of the NMPHSs currently registered with UKPHR will choose to leave that register after the policy is implemented. As a result the UKPHR will likely reduce its costs in line with its reduced function.
    - The net turnover of NMPHSs is zero, that is, we assume a constant number of public health specialists in future years.

36. The first assumption is tested in Appendix 1.

One-In, Two-Out and Equivalent Annual Net Cost to Business estimate

37. For the purposes of One In, Two Out, the following impacts should be recorded:
    - Impacts 1 and 3: Out of scope – public sector. The transfer of funds from DH to HCPC does not affect the private sector.
    - Impacts 2 and 4: Out of scope – public sector. The transfer of funds from public sector NMPHSs to the HCPC does not affect the private sector.
    - Impact 5: In scope. There is a direct private sector cost depending on the number of NMPHSs that work in the private sector. This is the cost of registration and scrutiny fees that private sector NMPHSs incur by registering with HCPC. The possible benefits, i.e. savings, are considered indirect, as they are contingent on changed behaviour by NMPHSs.
    - Impact 6: Out of scope – indirect effect. The UKPHR is a not-for-profit company limited by guarantee. For OITO this would therefore count as a private sector business. The regulations would not prevent NMPHSs registering with UKPHR. Any decision by NMPHSs not to register with UKPHR would be a voluntary one, not one prescribed in the regulations. This is why this is an indirect effect.
    - Impact 7: Out of scope – public sector. These benefits fall on the general public and have no [direct] impact on businesses.

38. An estimate for the EANCB covering only Impact 5 is set out below.

<u>Private sector impact</u>

39. A survey of Public Health Specialists was conducted by the Centre for Workforce Intelligence (CfWI) in November 2013[11]. Extensive efforts were made to ensure that all practising PHSs had an opportunity to participate. The survey was promoted in a variety of ways including via direct email to members of the Faculty of Public Health (FPH) and registrants of the UK Public Health Register (UKPHR), and a range of "cascade" communications, including:

- Newsletters from the UKPHR to their registrants;
- Social media updates and communications from PHE, e.g. Twitter and Friday emails from PHE chief executive;
- Bi-monthly newsletter from HEE;
- Word of mouth from commissioners and those involved in survey development;
- CfWI social media updates.

40. A total of 574 consultants and specialists responses were used in the overall survey analysis. Given there were approximately 1,100 public health consultants and specialists in September 2012 (according to the Health and Social Care Information Centre[12]) the CfWI has assumed that the response rate was just over half (52%).

41. Of the 574 respondents, 53% were registered with the General Medical Council (GMC), 46% with UKPHR and 3% registered with the General Dental Council (GDC). None were unregistered. All in the field of public health believe that this is because there are no such unregistered practising PHSs.

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[11] Source: Centre for Workforce Intelligence, http://www.cfwi.org.uk/publications/the-cfwi-public-health-consultant-and-specialist-staff-survey-2013

[12] Source: Health and Social Care Information Centre, Hospital and Community Health Services (HCHS) Workforce Statistics in England, Medical and Dental Staff 2002-2012, as at 30 September 2012. http://www.hscic.gov.uk/catalogue/PUB10394/nhs-staf-2012-medi-dent-detl-tab.xls

42. Given the above efforts and intelligence, and the high proportion of PHSs surveyed, we are therefore confident that the survey is reasonably representative of all PHSs who are currently practising.

43. Additional analysis from the CfWI found 28 respondents out of 574 responses (3.7%) worked either in the private sector, independent or voluntary sectors (collectively referred to hereafter as "private sector PHSs")[13]. Further, 6 of these 28 respondents were registered solely with UKPHR, that is, only 6 out of 28 respondents who stated they work independently or in the private/voluntary sector were non-medical public health specialists. The remaining 22 were registered with either the General Medical Council or General Dental Council and therefore out of scope of the EANCB.

44. In the survey the proportion who were private sector non-medical PHSs and within scope was 1.05% (6/574). Applying this proportion to the population of 1100 PHSs we believe there are probably 12 non-medical public health specialists working in the private/independent/voluntary sector. (This implies that of the 516 NMPHSs registered with the UKPHR, almost 2% would be in the private sector.) This assumption is tested in the Appendix 1.

45. We asked in the consultation a question on whether an estimate of 10 private sector non-medical public health specialists felt reasonable (the excerpt from the consultation is in Appendix 3). Of the 168 responses, around half did not comment or did not know whether this was reasonable. One quarter felt the number was an underestimate, whereas the remaining quarter felt the estimate was reasonable. One response quoted a survey by the British Medical Association which found 10 out of 238 non-medical public health specialists worked in the private or independent sectors[14]. This gives a proportion of 4.2%, however the survey did not ask whether the respondents were registered with UKPHR. This means this proportion will likely be an overestimate. Applying this proportion to the 1100 PHSs used earlier gives an upper estimate of 46 private sector non-medical public health specialists.

46. The direct cost to each private sector public health specialist from Option 2 is £80 per year plus £56 in the first year for additional scrutiny. Over a 20 year horizon this gives a total undiscounted cost of £1,656 per person. Applying the EANCB calculator (to deflate prices to 2009 levels and set 2010 as the present value base year[15]) to this cost profile gives an EANCB of £62 per person.

47. Multiplying the EANCB per person by the estimated 12 private sector NMPHSs gives an EANCB estimate of £739. As a sensitivity if we used the estimate of 46 non-medical public health specialists from above this gives an EANCB of £2,932. Since EANCB estimates are rounded to the nearest £10,000, this means our EANCB estimate for Option 2 is £0.

Sensitivity analysis

48. For sensitivity analysis, we considered what would be the upper limit of the number of private sector NMPHSs required such that the EANCB remains £0. Our calculations found that the upper limit is 81, or 7.4% of the public health specialist population. We received no evidence to suggest the number of private sector NMPHSs will be in this region.

49. In addition, we calculated the confidence interval of the proportions mentioned above. The CfWI proportion of 1.05% has a 99% confidence interval of 0.29% - 1.80%, whereas the BMA estimate of 4.2% has a 99% confidence interval of 1.24% - 7.17%. When applied to the 1,100 estimate of all public health specialists, gives a range of 3 – 20 and 14 – 79 private sector non-medical public health specialists respectively. These ranges are below the upper limit of 81 to guarantee an EANCB of £0.

Conclusion, implementation and evaluation

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[13] The CfWI report gives 29 responses [on page 42 of their report], but these responses refer to 28 people.

[14] Source: Public Health Survey, British Medical Association, http://bma.org.uk/publichealthsurvey

[15] Link: https://www.gov.uk/government/publications/impact-assessment-calculator--3

50. Appraisal of the monetised costs and benefits of Option 2 reveals a Net Present Value of +£107,000 over twenty years. The opportunity costs for the use of DH money coupled with two years of transition costs are outweighed by long term savings to non-medical public health registrants themselves.

51. There are two benefits that have not been monetised that should also be included in the appraisal: the potential reduced risk from malpractice of NMPHSs and public reassurance in NMPHSs. These have not been monetised but we believe that the benefits afforded by this would strengthen the overall case for Option 2.

52. On this basis, the preferred option is Option 2. It achieves the policy objectives and does not have a significant direct impact on business.

	Option 1	**Option 2**
Total Net Present Value	£0	+£107,000
Net cost to business per year (EANCB), 2009 prices	£0	+£0

Table 3: NPV and EANCB for Option 2

53. It is anticipated that the legislative process will allow the HCPC to open its register by the end of 2015. HCPC will be able to monitor the accuracy of the impacts described above through its registration processes. Better Regulation Guidance by BIS advises a timespan of 3-5 years for an evaluation, which this policy will be subject to.

Appendix 1: Sensitivity analysis

The UKPHR incurs a loss (i.e. it cannot reduce its cost base)

54. We have assumed in the main analysis that the UKPHR will be able to reduce its cost base if NMPHSs cancel their registration with them. We relax this assumption in this section. Relaxing this assumption has an impact on the profile of costs in Option 2, equal to an increase of £118,000 per year. The table below presents the overall (undiscounted) profile in this scenario.

SUMMARY	Year 0	Year 1	Year 2-19	TOTAL
TOTAL COSTS	£440,000	£1,148,496	£159,600	£4,461,296
TOTAL BENEFITS	£0	£152,220	£152,220	£2,892,180
NET BENEFIT	-£440,000	-£996,276	-£7,380	-£1,569,116

Table 4: Summary of undiscounted costs and benefits when UKPHR assumption relaxed

55. After discounting the net benefit under this scenario is -£1.51m over twenty years. It is our belief that the loss of income coupled with a rigid cost base is not sustainable for UKPHR. We would expect UKPHR to find ways to find cost savings if NMPHSs cancel their registration with them. On this basis, we do not believe this scenario will materialise.

Appendix 2: Options considered in the Scally Review of the Regulation of Public Health Professionals, November 2010[2].

1. Mixture, depending on training, of statutory and voluntary self-regulation (status quo)
   This option would operate within employing organisations, whereas individuals can choose to leave roles and bypass organisational systems or move from local government to the NHS or vice versa. This would require the use of multiple routes of influence, and organisational compliance, to improve accountability and standards.

2. Fellowship Model
   Standards are policed by professional bodies rather than statutory regulators, potentially lowering compliance costs. This would allow for a consolidation of bodies within public health, and result in a stronger Faculty. This option may provide little above the level of cover and assurance that the UKPHR currently gives, and would require the functions of the UKPHR to be present within the Faculty of Public Health. It would therefore be unlikely to represent a cost improvement when compared with the current system.

3. Chartered Status
   This option uses existing bodies and expertise in public health. If applied to a group that is not currently regulated, the formation of the quasi-regulatory machinery needed to operate the system would require standards and regulatory requirements to be applied to that group for the first time. If applied to non-medically qualified public health specialists, this option could be expected to incur approximately the same running costs as the current UKPHR and would need to be structured so as to make it a self-financing body; some transitional funding might be necessary for the administrative costs of amendment of an existing charter.

4. Conferring upon the UKPHR the status of a statutory regulator
   The UKPHR already has expertise in the registration of public health professionals, and minimal disruption to the profession would be involved in this option. The creation of a new statutory regulator would have significant administrative costs, as well as parliamentary costs to a greater or lesser extent (depending on the legislative vehicle).

5. The General Medical Council registering public health specialists
   This would not require the creation of a new body and would promote efficiency of back office functions. It would allow the public health specialist workforce to be regulated by the fewest number of regulatory bodies. Changes to the GMC remit have to be agreed by Parliament and may well be contentious. Any change would be subject to the timetable required by secondary legislation.

6. The HCPC registering public health specialists
   The HPC has a proven track record of taking on the regulation of new professions, having done so in recent years with Operating Department Practitioners and Practitioner Psychologists. The HCPC has generic procedures in place for handling conduct, health and other issues for a wide range of professions, which means their framework is very flexible and adaptable to the integration of a new profession. Regulation of the public health specialist workforce would sit across three main regulators; therefore, strong ongoing coordination across regulators, and a strengthened role for the Faculty of Public Health, would be required to promote consistent approaches to the workforce.

Appendix 3: Consultation chapter on impacts of proposal on business

Chapter 4. The costs and benefits of the proposed order[1]

4.1. An economic assessment of the impact of the proposed policy has not been prepared as the order regulates the title 'public health specialist' (or whatever title is decided upon), rather than the activities that public health specialists engage in. In creating a protected title, the order would only affect those who currently call themselves 'public health specialists'. Therefore, the impact on business only applies if there was a self-employed contractor who was called 'Public Health Specialist'.

4.2. A survey by the Centre for Workforce Intelligence[2][6] of public health specialists found that of the 574 respondents, 21 (3.7%) worked in either the private sector or the independent (self-employed) sector. Further, 5 of these 21 respondents were registered solely with UKPHR, that is, only 5 out of 21 respondents that stated they work independently or in the private sector were non-medical public health specialists. The remaining 16 were registered with the General Medical Council and therefore out of scope.

4.3. Applying these proportions we believe there are potentially 10 non-medical public health specialists working in the private sector (including independent, self-employed persons.) The impact on business is sufficiently small that an economic assessment is not necessary. This position has been discussed and agreed with the Regulatory Policy Committee.

Q10. Is our estimate of the numbers of non-medical public health specialists working in the independent or private sector reasonable?

1 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/362507/Public_Health_Specialist_Con_inc_additional_Questions.pdf

2 http://www.cfwi.org.uk/publications/the-cfwi-public-health-consultant-and-specialist-staff-survey-2013