To note

Costs and Benefits Associated with Revalidation

Issue

1. An assessment of the direct and indirect costs and benefits associated with revalidation.

Recommendations

2. Council is invited to note:

   a. The costs associated with the revalidation process (paragraphs 6 to 24).

   b. The work done to identify the benefits arising from revalidation (paragraphs 25 to 26).

   c. The need to put in place, in advance of the introduction of revalidation, systems to allow Council to assess the effectiveness of the process (paragraphs 27 to 29).

Further information

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Background

4. We undertook to make available an assessment of the costs and benefits associated with revalidation.

5. As expected, it has proved easier to quantify the prospective costs than the benefits. This is partly because the benefits are hard to measure. It is also because revalidation is part of a wider drive to improve the quality of health care; and disentangling revalidation’s potential impact is complicated. For example, improving the quality of the medical practice would – over time – result in lower mortality and morbidity rates; and, beyond the short term, quality assurance measures could be expected to lead to a reduction in the number of resource-intensive cases where serious dysfunction has been unreported over many years. The weight to be attributed to revalidation, as opposed to other initiatives, is difficult to determine.

Discussion

6. The costs of revalidation need to be set in the broader context of the GMC’s finances as a whole, and seen against the upward pressures on the GMC’s expenditure that are independent of revalidation.

7. Paper 13a presents the report of the Finance and Establishment Committee on the GMC’s accounts for the year ended 31 December 2000. They show, for example, that expenditure in 2000, at £27.3 million, was £7.7 million higher than in 1999. This was despite efficiency and economy gains, which will realise ongoing reductions in overhead expenditure of more than £2 million pa. The upward pressures continue, and budgeted expenditure for 2001 is £36.2 million, a further increase of £8.9 million.

8. The main increases arise in Fitness to Practise, where costs rose by £5.2 million in 2000 and are budgeted to increase by a further £7.6 million in 2001.

9. Revalidation is one part of a broader range of developments, which include, for example, clinical governance, appraisal, the Clinical Standards Board in Scotland, and the National Clinical Assessments Authority. It seems inevitable, at least in the short term, that the pressures on fitness to practise will continue as the full impact of a range of quality assurance measures is felt.

10. Beyond the short term, the quality assurance measures could be expected to lead to a reduction in the number of resource-intensive cases, where serious dysfunction has been unreported over many years.

11. The long-term effect of successfully introducing revalidation should eventually be to reduce the number of cases referred to the GMC: currently dysfunctional doctors should have been identified and dealt with and future problems should be identified and dealt with before they merit a referral to the GMC.
12. There is no reliable means of forecasting the position over the next three or four years. And there is no obvious way of distinguishing the respective effects of individual developments. However, if the trend in fitness to practise costs continued, we could see expenditure increase by, say, £6.5 million (a doubling of referrals) or £13 million (a tripling of referrals).

**The costs to the GMC associated with the revalidation process**

13. Against this background, we have distinguished three effects for the GMC flowing from or associated with revalidation:¹

   a. The direct costs to the GMC associated with the introduction of revalidation.

   b. The costs incurred through the performance procedures in assessing doctors where revalidation has not been recommended and the doubts cannot be resolved in any other way, but whose performance proves to be satisfactory.

   d. The reduction in the number of ARF paying doctors on the Register.

The direct costs to the GMC associated with the introduction of revalidation

14. The calculations in *Annex A* suggest that the total costs of the revalidation procedures could be in the region of £7.85 million.² This costing includes the costs for the central registration process, the external quality assurance, the Evidence Committee and the revalidation groups.

15. The aim of the piloting is to design a system which is as light touch as is consistent with purpose. In particular the processes that are designed to complement other systems to help with the early identification of problems and to discriminate between dysfunctional doctors and their colleagues. When further results of piloting are available, Council will need to determine the details of the Revalidation Groups (for example, does every folder need to be seen by three people, can there be some pre-screening - the proposed legislative framework provides the flexibility to enable Council to take these decisions on the basis of further information).

The cost of dealing with doctors about whom there are doubts

16. For the purposes of these calculations, we have assumed that around 20% of the doctors about whom the revalidation process raises doubts and who go on to be assessed through the performance procedures will prove to be fit to practise. Their assessment will thus result in a direct cost to the GMC of, we estimate, around £1.3 million.

¹ The underpinning assumptions for all estimates are explained at Annex A.
² The assumptions in this paper are based on an average amount of 135 000 doctors going through the revalidation process.
17. The combined effects of direct costs and the cost of dealing with doctors about whom there are doubts might thus add, say, £9.2 million to the GMC’s expenditure, which would add about £68 to the ARF, given the current numbers on the Register.

The reduction in the number of ARF paying doctors on the Register

18. At present the register is a list of those who have at some time in the past obtained a primary medical qualification, registered with the GMC and who have not had that registration erased as a consequence of the fitness to practise procedures. At present there are 196 000 registered medical practitioners on the register. Of these 163 000 pay the ARF.  

19. Once revalidation is introduced the register will be a list of doctors who have demonstrated their fitness to practise. For the purposes of these calculations, we assumed that 135 000 doctors will stay on the register: this is based on a sample. A drop of this sort would mean a loss of income of £4.8 million. This would mean an additional increase to the ARF of £36. This increase would be partially offset by the fees paid by doctors on the Supplementary List.

20. A secondary effect is that the other costs of the GMC, that is other than revalidation, would be spread over, say, 135 000 doctors rather than 163 000 as at present. If that had been the case in 2000, the ARF would have been £205, not £170.

The implications in respect of doctors’ time

21. The Council has always recognised the importance of looking not just at the cost to the GMC itself but also to the wider implications of revalidation. This is particularly true in respect of the time doctors will need to spend participating in revalidation. In Annex A we have estimated these wider implications.

22. In doing this we have recognised the value to doctors and their employers of being able to rely as far as possible on existing and planned systems such as the arrangements for appraisal that are being introduced in the NHS. The more that the doctor can rely on such systems to deliver the underlying data for revalidation, the less additional time will need to be spent.

23. We believe that doctors who are having appraisal should be able to fulfil the requirements for revalidation by spending an additional hour a year on revalidation. Doctors who do not have appraisal will need more time. On the basis of the first stage of the piloting we believe that this might require an average of six hours a year.

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3 Doctors do not need to pay the ARF when they are over 65 years old or have a health exemption.
24. In addition we need to identify the resource implications of serving the revalidation process itself. We estimate that for the base line this will require 450 doctors to spend 26 days a year. This is equivalent to 59 full time doctors or 0.04 per cent of practising doctors.

**Recommendation:** To note the costs associated with the revalidation process.

**Benefits**

25. Two of the expected benefits of revalidation are the identification of currently dysfunctional doctors and the encouragement of the provision of early assistance to doctors who have problems which if not tackled might lead to a referral to the GMC. These have been described above. A third benefit is the behavioural changes that may result from revalidation. The Revalidation steering Group commissioned an evidence-based review on the benefits of revalidation in this respect from Professors Alistair McGuire and David Parkin of City University. The results of this analysis are in Annex B.

26. The results show in particular that behavioural changes introduced as a result of revalidation should result in:

   a. More effective and cost effective health care and therefore improved outcomes and wider availability.

   b. Reduced costs of implementing evidence based health care.

   c. Better patient-doctor communication.

   d. Improved trust and confidence in the doctor-patient relationship

**Recommendation:** To note the work done to identify the benefits arising from revalidation.

**Arrangements for monitoring the implementation and operation of revalidation**

27. Before revalidation starts Council will need to consider the detailed arrangements for the monitoring of the revalidation process. In particular Council will wish to be able to answer the question: how will we know whether revalidation has been successful? There are a number of strands to this question:

   a. Are the different elements of the revalidation process effective and cost effective?

   b. Does the system identify most of the doctors who are currently dysfunctional? Is there evidence that more is being done to help doctors deal with possible problems early, before they merit referral to the GMC?
c. How has the introduction of revalidation affected behaviour and therefore outcomes?

28. In Annex C Professors McGuire and Parkin have elaborated on these issues and have begun to identify possible methods for establishing a baseline from which to analyse changes as well considering how data might be collected during the actual operation of revalidation. In particular Professors McGuire and Parkin identified three sources of data:

   a. Data that might be collected from within the GMC: budgetary information and case through put.

   b. Data generated from the information submitted by the doctors participating in revalidation and as part of the external quality assurance process.

   c. Data collected in addition to that generated from the revalidation process: surveys.

29. Council will be invited to consider these issues further before revalidation is introduced. In particular Council will be asked to consider the desirability of establishing a set of base line data that would be derived from data collected from outside the process of revalidation before the revalidation process begins.

   **Recommendation**: To note the need to put in place, in advance of the introduction of revalidation, systems to allow Council to assess the effectiveness of the process.

**Resource implications**

30. This paper describes the resource implications of revalidation.