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Pointmaker

A ROYAL COMMISSION ON THE NHS

THE REMIT

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SUMMARY

- There is wide cross-party support for establishing a Royal Commission to consider and secure the long-term future of the NHS.
- Such a Commission would be an opportunity to find common ground on some of the major challenges facing the NHS.
- The recent history of the NHS – with multiple attempts at major structural changes over the last 30 years – illustrates the difficulty of enacting significant reform through traditional political means.
- Whatever one's view of the current state of the NHS, it is clear that the *status quo* will not hold indefinitely.
- A Royal Commission should examine the structure, funding and sustainability of the NHS in England as a whole. The aim should be to produce a blueprint that delivers the best possible health outcomes over the coming decades at the lowest cost. This menu of recommendations would be fully costed.
- The remit would be clear that the NHS's founding principles would remain intact: this would not be "privatisation by stealth".
- The Royal Commission would also be tasked with investigating a range of other issues, including the gap between health outcomes between rich and poor, and between Britain and other countries; the ageing population; the pace and cost of medical innovation; the need to integrate social and long-term care with health care; the case for and against greater private sector involvement in the delivery of health care; the tensions between patients' privacy and better use of health data; and potential additional sources of revenue for the NHS to complement general taxation.
- It would have the power to compel testimony from those within the health service (including testimony under oath), to investigate front-line conditions at its discretion, and to offer protection to potential whistleblowers.
- The Royal Commission would be not just cross-party but above party. At its heart would be the interests of patients and citizens – especially the most vulnerable and disenfranchised patients, who are least well-served by the current system.

1. INTRODUCTION

Over the past 30 years, the NHS has experienced an extraordinary number of attempted or actual structural reforms. The internal market, GP contracts, GP fund-holding, Primary Care Trusts, Regional Health Authorities, Strategic Health Authorities, practice-based commissioning, Clinical Commissioning Groups, Commissioning support units, the Healthcare Commission, the NHS Commissioning Board, the Commission for Healthcare Improvement, local control over services (as in Manchester), centralised organisation and regulators (such as Monitor, the Care Quality Commission, the NHS Trust Development Authority and Public Health England), the Five Year Forward View, the Ten Year Plan for Health and Care: these and many other reforms have been introduced; or introduced and then abolished; or introduced and then abolished and then re-introduced.

This extraordinary range of reforms indicates more than the usual political hyperactivity: no other department has been through as many structural reform programmes. Rather, it suggests an awareness that the NHS is in need of reform – but that there has been little lasting political agreement over its appropriate nature.

In a recent paper for the Centre for Policy Studies, one of the present authors set out the case for a cross-party Royal Commission on the future of the NHS.[1] The argument was that the health service is coming under increasing demographic and financial strain: the Office for Budget Responsibility estimates that on current trends, it will need an extra £88 billion over the next 50 years.[2] In order to future-proof the NHS against an ageing population, the rise in long-term conditions, and the inflationary pressures of medical innovation, the service will need more than just more money. Yet the public has lost faith in the ability of politicians to deliver reform.

There is near-universal support in Britain for the NHS model: according to the British Social Attitudes Survey, 89% of adults support a national health system that is tax-funded, free at the point of use and provides comprehensive care for all citizens.[3] Yet within this framework, there is enormous scope for discussion and argument.

What is the best balance between local and national commissioning of services? If prices are to be set, who should do this? Should price competition be allowed? Is there a tension between promoting co-operation, networking and integration and maintaining competition? In which services is competition appropriate and inappropriate? Is "the postcode lottery" in the delivery of services to be condemned as providing unequal outcomes or praised for enabling local variation? What should be the role of the patient as a commissioner of services? Or the GP? How should private operators – including pharmacists, dentists and high-street opticians – operate alongside the NHS?

The CPS's call for a cross-party Royal Commission to address these and other issues has gained significant support.[4] This paper seeks to put the flesh on the bones, and set out how the proposal would work in practice.

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[1] Lord Saatchi, *An NHS Royal Commission: from fighting fires to lasting settlement*, Centre for Policy Studies, 2017

[2] Office for Budget Responsibility, *Fiscal Sustainability Report*, January 2017

[3] NatCen/Health Foundation polling for BSA, February 2015

[4] Among those who have expressed their support for such an initiative are former Health Secretaries including Baroness Bottomley, Stephen Dorrell, Lord Fowler and Lord Milburn, alongside numerous politicians, newspapers and policy experts

2. THE CASE FOR A ROYAL COMMISSION

Whatever their attitudes on the current performance of the NHS, most people accept that the organisation faces new challenges in the years ahead. A Royal Commission is an opportunity to find common ground on some of the most serious problems the NHS is facing today, as well as the challenges and opportunities that lie ahead. It can provide the best format to move beyond short-term fixes in order to understand the systemic problems facing the NHS and to derive an overarching, long-term way forward.

While it would only apply to the NHS in England, it is to be hoped that the devolved institutions in Scotland, Wales and Northern Ireland would find much of use in its recommendations.

A Royal Commission may seem an unlikely means of providing this much-needed review. Although once a popular constitutional mechanism to develop public policy outside the partisan gridlock of Westminster, they have fallen out of fashion: only three have reported since 1990, and governments have repeatedly rebuffed calls to set up Commissions on topics such as drugs policy.[5]

This slide into constitutional obscurity was due to two recurring concerns. The first, best captured by Harold Wilson, was that they "take minutes and waste years", especially if there is a change of government in the interim.[6]

The second is that Commissions have tended to lose sight of the political realities, producing lengthy tomes with hundreds of recommendations that are dead on arrival. The Royal Commission on Long-term Care of the Elderly, set up after the 1997 general election, was rejected by the Labour Party for producing unrealistic, cost-blind recommendations.[7]

Yet both of these objections can be answered. Given the current political situation, a Royal Commission appears the only way of getting any kind of consensus behind significant reform to the NHS. The Commission could be asked to report within a given time period, and to take account of existing plans for NHS reform, in particular Simon Stevens' Five Year Forward View. The Commission's proceedings would also inform and educate the public about the problems the NHS faces, in a way that goes beyond partisan point-scoring.

The second objection has to do with the Commission's remit. Given the challenges the NHS faces, it is likely that any recommendations the Commission has will be of use. But our recommendation is that the Royal Commission should be invited to submit a series of options for implementing its central ideas, each of them fully costed.

This menu-style approach would allow the Commission to canvass a handful of more politically difficult proposals, while ensuring that any government – despite potential changes in party or disposition to risk – would still have much to usefully implement.

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[5] In 2012 the Cameron Government rejected a recommendation from the Home Affairs Select Committee to set up a Royal Commission into drugs policy. The Prime Minister said his preference was for maintaining existing policies and not investing in a "very, very long-term Royal Commission" (*The Guardian*, 10 December)

[6] Despite the sentiment, Wilson established 10 Commissions in his time as Prime Minister, including the famous Kilbrandon Commission

[7] BBC, 'Government to reject free elderly care', 26 July 2000

The alternative of a shorter, cheaper, and more manageable public inquiry may seem attractive at first sight. However, there is little evidence to suggest that there is anything about such inquiries, per se, that makes them any of those things. The Saville Inquiry cost £195m, and the Francis Inquiry produced a 4000-page report with 290 recommendations, five years after poor care at the Stafford Hospital was first exposed.

The other advantage of a Royal Commission is that they have the power to subpoena witnesses and demand documents and evidence. This makes them uniquely framed to investigate holistically, draw conclusions and make recommendations that will make the NHS sustainable for the long term.

This could be strengthened by forcing witnesses to testify under oath, with the threat of a perjury conviction hanging over those who were not scrupulously honest. The Commissioners should also have the ability to inspect all aspects of the NHS frontline, as they saw fit.

It follows that the remit of the commission should be comprehensive, with the coercive power to call witnesses to testify under oath, the ability to request evidence and investigate conditions across the NHS, and guaranteed protection for whistleblowers who provided information that those in authority might prefer to hide.

In particular, a Royal Commission should start and end with the principle that a new NHS must be co-built with patients, the users – all of us – rather than with patients as an add-on. The patient voice must be central to the process.

3. THE COMMISSION'S FRAMEWORK

A Royal Commission should exploit its ability to secure the bipartisan support needed to embed lasting changes, to detoxify reforms that otherwise may be too politically dangerous to pursue, and to deploy its unique investigatory power to establish what reforms are needed to ensure that we have a world-class, 21st century, health system.

What does the patient need and want? How should resources be organised to achieve best outcomes for individual patients and for society as a whole? How can and should tensions between the individual and wider society be resolved and managed? How should the patient be empowered and the patient voice be encouraged and heard?

As mentioned above, structure has clearly been a key area of political contention and therefore one that must be considered by a Royal Commission. Removed from the tactical and ideological political processes that have bedevilled many of the recent reforms, a Royal Commission can look at the issues coolly and dispassionately.

The overall priorities of the Royal Commission should therefore be as follows:

- To evaluate how to produce the best possible outcomes for patients at the lowest possible cost. This will include not only examining the current state of NHS provision, but how we can structure its incentives to focus on preventative care and the patient's overall health experience.

- To ensure that the NHS model that it suggests is sustainable over a period of decades, in terms of finance, staffing, infrastructure and leaving sufficient flexibility to respond to new developments and technologies.

- To evaluate the organisational and geographical structure of the NHS, particularly in terms of the balance between primary, secondary and tertiary care, and the concentration of NHS resources, and how they will need to change in future. And to examine the linkages between the NHS and other services, including social care.

- To suggest where the NHS can improve its operating model to provide services more cheaply, drawing on the suggestions made by the OECD for improving British healthcare in line with other countries' experience.

- To examine the question of funding, including revenue sources beyond taxation. The aim should be to produce a solution that is affordable and sustainable without ceding control of the NHS to commercial interests.

- The ultimate aim of the Royal Commission should be to produce a blueprint for an NHS that is genuinely world-class, with the patient at its heart.

4. FAIRNESS AND THE PATIENT

Within these overarching themes, there are many specific issues which a Royal Commission should address. The first is the issue of unfairness that is unfortunately prevalent in the current NHS. A recent statistical bulletin from the ONS showed that if you live in an upmarket area you will on average have 19 more *healthy* years of life than if you are born in a more deprived areas. A boy growing up in Blackpool has an overall life expectancy of just 75 while a boy born in Kensington can expect to live for at least an extra decade.[8]

How can fairness be improved in regards to the economically and socially disadvantaged? To what degree does ill-health cause poverty or to what degree does poverty cause ill-health?[9] How much are the poorer outcomes for the less well-off due to "lifestyle choices" or to difficult living conditions? Or does the system – unintentionally – favour, to some degree, the better off?

A Royal Commission should therefore seek to understand and address how those on lower incomes tend to suffer worse health outcomes compared with those on higher incomes.

5. OUTCOMES

The UK now sits in the middle order or lower tail of European countries for A&E wait-times, cancer survival rates, decrease of stroke deaths, and infant mortality. In 2015, it was ranked 19th of 31 countries for stroke deaths, 20th of 23 countries for both breast and bowel cancer survival, and 21st of 23 for cervical cancer survival. It was in the bottom third of countries for heart attack deaths, and our closest peers for survival following a cancer diagnosis are Chile and Poland.[10]

Behind these indicators are a range of policy and institutional problems that critics have identified, including late diagnosis, inadequate screening, lack of coordination, understaffing, age bias, and weaknesses in out-of-hospital care.[11] The result is a failure to keep pace with other healthcare systems, as evidenced by the growing gap with other countries on lung cancer survival rates.[12]

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[8] ONS, *Health state life expectancies by Index of Multiple Deprivation (IMD): England, 2013 to 2015,* released 22 March 2017

[9] See for example Joseph Rowntree Foundation, *How Does Money Influence Health?*, 2014

[10] OECD, *Health at a Glance*, 2015

[11] The King's Fund, 2011

[12] Euro Health Consumer Index, 2014

Mental health provision must also be considered, including as a chronic, public health issue which causes, and can be caused by, poverty. People with severe mental illness continue to lose up to 20 years in life expectancy.[13]

The Royal Commission should therefore consider how outcomes be improved to at least match those in other developed countries. It should, as part of this, consider the degree to which this is a question of funding, or whether are there systemic issues which reduce the effectiveness of treatment, despite the best efforts of NHS staff. It should also consider how can mental health services be given the priority they deserve. Why, when the government has pledged billions of extra pounds to ensure that mental health is given "parity of esteem" with physical health (nearly £3 billion since 2014 alone), has so little reached frontline services?[14]

6. AN AGEING POPULATION

Although the number of older people in the UK is growing rapidly, the proportion of very old people in the population is rising even faster. With 10 million people over the age of 65 at present, by 2050 this number will have almost doubled, to 19 million. The number of people aged 80 years and over is projected to double (from 3 million to 6 million) even sooner, by 2030, and will reach 8 million by 2050.[15]

The higher proportion of very old people in the population is likely to increase the funding pressure on the NHS: according to the Department of Health, an 85-year-old man already costs the NHS nearly seven times more on average than a man in his late thirties, and around three times more than someone between the ages of 65 and 74.[16]

With an increasing elderly population, what is the best way of delivering effective services to the elderly, particularly for those diseases which they are most vulnerable to (mental health issues, dementia, physical frailty etc)? How can this be achieved affordably? A Royal Commission should set out the challenges which the rapidly ageing population will pose and provide a clear way forward for best meeting them.

7. PREVENTION

It has been widely accepted for some time that the need to prevent illness is increasing. However, in England alone, almost one in five adults smoke, a third of men and half of women do not meet recommended levels of physical activity, and almost two-thirds of adults are overweight or obese.[17] The range of problems which can be moderated by more effective preventive care is wide: cancer, osteoporosis, obesity, diabetes, strokes, heart disease etc.

What more can be done to discourage unhealthy behaviours? What is the most appropriate way for the state to encourage individuals to take more control over their "lifestyle choices"? Where should the line be drawn between state promotion of healthy living and "nanny statism"? What is the best way of rewarding effective preventive care?

[13] Royal College of Psychiatrists and the Academy of Medical Royal Colleges, *Improving the physical health of adults with severe mental illness: essential actions*, 2016

[14] The King's Fund (14 October 2016) found that 40% of mental health trusts saw their income fall in 2015/16

[15] Economist Intelligence Unit, *Preventive Care and healthy ageing: a global perspective*, 2012

[16] *The Guardian*, 'Ageing Britain', 1 February 2016

[17] Mahiben Maruthappu, *Delivering Triple Prevention: a Health System Responsibility*, 11 March 2016, NHS England website

A Royal Commission should examine the potential for medium- and long-term savings from an improved system of preventive care while also providing clarity on the appropriate level of involvement by the state in encouraging healthy living.

8. SOCIAL CARE

One of the greatest challenges for the future of the NHS is that healthcare and social care are delivered and financed through different systems. State healthcare is provided to all free of charge while social services are means-tested. This dual system can lead to inequalities, split incentives, duplication of services or confusion as to whether individuals should be receiving care from nurses or social workers.

The Royal Commission should therefore consider whether health and social care should be fully amalgamated. It should also evaluate what level of local control over social or health care is best, and what the funding implications are of merging two differently funded systems.

The furore over the Conservative Party's social care plans in its 2017 manifesto (and its subsequent reversal) indicates the political sensitivity of this subject. A Royal Commission could provide a less heated forum in which these issues could be addressed.

9. FUNDING

The British population is increasing in number and age. And its health problems are becoming more complex. More Britons are developing more chronic diseases earlier and living longer with a greater prevalence of co-morbidities, which increase the complexity and cost of treatment.

There are already signs of serious financial distress throughout the system. At the end of 2015/16, 75% of NHS acute hospitals were in deficit,[18] and many expect that the system will be unable to produce the £22bn in efficiency savings agreed under the Five Year Forward View.[19]

Even with the government's commitment of £10 billion in extra NHS expenditure in 2016, and a further £2.8 billion over three years in the 2017 Budget, some argue that the system is going backwards in real financial terms under the cumulative impact of demand-side pressure and price inflation. Demand for treatment is growing at 3% to 4% p.a.,[20] while medical innovation is simultaneously driving unit cost inflation at over 3% p.a.[21] Simon Stevens, Chief Executive of NHS England, has warned that the UK is now spending 30% less than countries such as Germany.[22]

As a result, delivery of care can no longer be restricted to simple NHS settings predominantly designed to manage acute health needs. Those with chronic diseases and co-morbidities, specially but not exclusively the elderly, are treated and managed in a wider public health domain that spills beyond the traditional NHS estate. Others agents – families, local authorities, the emergency services, employers – have an interest, obligations and statutory duties towards the patient that have direct and indirect cost implications.

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[18] NHS Improvement, Quarterly performance of the provider sector, 30 June 2016

[19] The King's Fund, 2016

[20] The King's Fund, *Quarterly Monitoring Report*, November 2016

[21] NHS, *Economic assumptions 2016/17 to 2020/21*

[22] *The Independent*, 'NHS chief Simon Stevens warns Theresa May that 2018 will be 'the toughest year' as spending falls', 11 January 2017

Over recent years, the commercial sector has played a greater role in the delivery of health services to patients – sometimes with great success. Yet this area is fraught with political tension, with many decrying the "privatisation" of health care while others applaud the greater efficiency of private treatment provided under the NHS umbrella.

In addition, the cost of medical innovation is rising across the world. The development and application of new treatments can cost more money, compared to the use of standard treatments. It is true that this is not always the case. For example new treatments for mass, chronic diseases like diabetes may ultimately drive down long-term costs if health outcomes are improved and complications which would otherwise themselves need costly medical intervention (for example, kidney dialysis) can be avoided or at least delayed. In this case innovations may be cost effective as well as increasing quality of life for the patient.

However, health budget rationing is a fact of life. Stories in the media around the denial of an expensive new cancer drug for one patient, which if approved would deny cheaper treatments to the many, are common. It is the utilitarian argument – that it is morally superior to service the many rather than the few.

There are therefore many questions for a Royal Commission to examine. Who should control health budgets? What is the "right" level of spending on the NHS? How should priorities be formulated and money apportioned? Is there any role for some form of patient co-payments? Within this, should there be a one-size-fits-all approach, controlled centrally, or should local solutions be sought which potentially deliver bespoke services tailored to demographic needs? How should the NHS be funded and to what extent should commercial, for-profit businesses provide healthcare within an NHS setting?

A Royal Commission should therefore investigate funding in the widest possible context and derive an all-encompassing and sustainable financial model (including the considering the role of the private sector in the provision of healthcare and the question of how to pay for social care for the elderly and vulnerable). Its fundamental principle should be that the NHS will remain a public institution run for the benefit of the public – but that the ever-increasing demands of the health service cannot be met from general taxation without bankrupting the state. The Commission should therefore investigate alternative, additional sources of revenue for the NHS which are affordable and sustainable without ceding control of the health service to commercial interests.

10. DATA SHARING AND PRIVACY

Data, including individual health records, are currently not widely shared between hospitals, researchers, care homes and other health and academic institutions.

The NHS has, in theory, access to a huge data bank, which could generate new diagnostic tools and treatment options as well as offering a new income generation for the NHS. But taking the NHS fully into the digital age will require great clarity on the role and responsibilities of the largest organisation in the UK.

On the one hand, the unitary nature of the NHS means that it could have access to an extraordinary database of patient outcomes: medical records could be shared for the benefit of scientific knowledge. On the other hand, there are, often legitimate, concerns on patient confidentiality and use of patients' data, with

some feeling that data 'trawling' and 'harvesting' is an intolerable invasion of privacy.

In a world of big data, consideration should also be given to how patients are 'trained' or educated to manage chronic health conditions and, crucially, how the data they capture can and should be fed back into the NHS-research machine to drive better outcomes for patients. Furthermore, thought should be given to how, if at all, patients can be used as a resource to doctors and other patients to share learning and data laterally, among their peers.

Whose data is it? Should patient data be sold to commercial organisations? Is data sharing a huge opportunity or a great challenge? Can security of patient data ever be realistically guaranteed?

A Royal Commission should shine a public light on the case for adjusting some of our expectations around privacy and interrogate the risks involved. It should seek to investigate and resolve the tensions over collecting and using patient data, including the question of selling data to commercial parties.

11. CONCLUSION

There is a risk in attempting to compose the remit of a Royal Commission into the NHS by means of a list. Rather like the disjointed results of a 'join-the-dots' picture, the whole can be subsumed and destroyed by a section-by-section approach. However neutral the language, any remit that offers a simple list of targets to be considered tends to tacitly imply a pre-cooked set of assumptions as to what the problems are – and what the likely solutions might be.

It is vital, therefore, to approach the Royal Commission boldly – and with a sense of purpose and conviction that problems will be identified and solutions found. But at the same time it is equally important – existentially so – that no assumptions are made before evidence is heard.

This speaks not only to the quality of the process of a Royal Commission and the meaningfulness of its conclusions and recommendations, it speaks also to the perception of the Commission by stakeholders – patients, the medical establishment, academics, the media and politicians. The NHS is a polarising force that is often used to define wider political positioning. If the Royal Commission is perceived to have an agenda from the outset and to be biased in one way or another, it will fail before it starts.

Above all, the Royal Commission must stand above party. It is certainly possible that some eminent former politicians will be involved in its operations. But it must be led by figures who stand outside of politics.

Equally, while the Royal Commission must represent all the NHS stakeholders, it cannot be dominated by them. Representatives of the medical professions will of course have a vital role, but at the heart of the process must be patients and citizens who, alongside experts and professionals, must provide the inspiration for its deliberations.

A Royal Commission can and must rise above the political fray and, once established, must steadfastly defend its independence. Its mandate should not be to produce piecemeal, tactical, individual fixes, but a blueprint to keep the NHS healthy for decades to come – perhaps even for another 70 years. Above all, a Royal Commission must keep in its mind's eye those who are least well-served by the current system: the most vulnerable, marginalised and economically and socially disenfranchised. It is they who suffer the most when the NHS fails or falters, and they who will benefit most from the improvements to its operations that a Royal Commission can bring.

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