An NHS Royal Commission

From fighting fires to lasting settlement

BY MAURICE SAATCHI

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About the author

Maurice Saatchi was Chairman of the Centre for Policy Studies from 2010 to 2020. He is the cofounder of Saatchi & Saatchi and M&C Saatchi, and author of 'Do Not Resuscitate' (ERIS, 2022). He is a former Governor of the London School of Economics and the author of numerous influential Centre for Policy Studies reports. He was elevated to the peerage in 1996. He served on the Conservative Front Bench in the House of Lords as Shadow Minister for the Treasury and the Cabinet Office between 1999 and 2003. He was Chairman of the Conservative Party from 2003-2005.

Editor's Note

This paper was originally published by the Centre for Policy Studies in February 2017, and attracted widespread support. Given the debate about the NHS in the wake of the pandemic, we are republishing both Lord Saatchi's original report calling for an NHS Royal Commission and his subsequent, more detailed report setting out its proposed remit.

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Contents

Summary 4

A Declaration of Interest 5

Alternative Facts 6

1. Introduction 13

2. Background 14

3. The Pessimist's Case 17

4. The Future-Proofer's Case 20

5. The Optimist's Case 25

6. Why a Royal Commission? 27

Conclusion 30

Summary

- A Royal Commission into the NHS should be set up to report on options for relieving growing pressures on the system and to ensure that its governance, care, operating, and funding models are fit-for-purpose in the 21st century.

- There is a wide range of perspectives on the current performance of the NHS, and varied confidence in its long-term future – from the pessimistic view that the system is in crisis, to the optimistic position that its only threats are meddling politicians. A Royal Commission offers significant benefits regardless of the position taken.

- A Royal Commission is an opportunity to help reverse a deterioration in some clinical outcomes, to identify and eliminate barriers to equal access, and to ensure that trusts are adequately funded to cope with current demand pressures. The solutions it arrives at could help to avert the kind of distress seen throughout the system over the 2016/17 winter.

- Future-proofing the NHS against the projected rise over the coming decades in demand from population ageing and growing prevalence in long-term conditions is an additional, huge and vital challenge. This will be compounded by the inflationary pressures of medical innovation on unit costs. The fiscal implications are significant, and a Commission is needed, not only to establish the funding envelope required, but also to find ways of alleviating pressure on the system. To sustain world-class healthcare over the next several decades, we need to think through the kind of NHS we want for the 21st Century.

- Even if the NHS were fully fit-for-purpose and able to withstand the coming pressures, a Royal Commission is a chance to determine innovations and efficiencies that could significantly improve the quality of care cost-effectively. The OECD has identified a number of options already, but a Royal Commission could look at how to implement best practice in a way that will see results for frontline services.

- While Royal Commissions do not have an unblemished record, they are hugely effective when set up to succeed. This means tightly defining its length and remit (the subject of the second of these papers on the NHS). The advantages though are immense, and include the 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.

A Declaration of Interest

The Access to Medical Treatments (Innovation) Act 2016 passed both Houses of Parliament at 4.11pm, and was sent to Buckingham Palace for Royal Assent. It was signed into UK law by HMQ at 8.11pm that evening, presumably in the middle of Her Majesty's dinner.

I introduced this legislation in the UK Parliament to advance medical innovation, and to save doctors and patients from the 'standard procedure' for cancer, usually leading to poor life quality followed by death. I had experienced, all too painfully, how even with the best will in the world and the best efforts of all concerned, the system could still fail its patients.

The Act was passed by the wishes of a grass-roots movement.

I made lifelong friends among the inspiring leaders of the Medical Profession, the Civil Service, the Press, and the Judiciary, especially the Judges, who saw better than anyone how the law could assist medical innovation, or at least not get in its way.

During this long medical and legislative process, I encountered two different kinds of people with two distinct cultures. Pessimists and Optimists, Realists and Idealists looked at each other as if they were creatures from another planet. Both were striving by their own best lights for the community.

I saw first-hand the glow of pride in the NHS slowly darken to ambivalence concern about the present and anxiety for the future.

That's why I produced this CPS pamphlet…

Alternative Facts

The NHS is the ultimate *Post-Truth* world – *Fake News* and *Alternative Facts*.

Here are a few of them…

1	All is well.	All is not well.
2	All is not well but it's under control.	The economic model is irreparably broken.
3	The NHS is in crisis.	Crisis? What crisis?
4	Health spending is rising.	Health spending as a percentage of GDP is falling.
5	Health spending is up on the previous Government.	Health spending per head of population is lowest in the G7.
6	Cancer treatment is improving. Cancer innovation is happening night and day.	Only 5.6% of the UK 'cancer incidence' are enrolled in clinical trials. 94.4% of us receive the 'standard treatment' – poor life quality followed by death. Slowest take-up of new drugs.
7	Cancer treatment is stuck in the past. Many treatments are the same as 40 years ago – medieval, degrading and ineffective.	We all have to die sometime.
8	Medical negligence litigation is a barrier to NHS innovation. Nearly £5bn paid out in claims over the last five years.	There is no fear of litigation in the medical profession.
9	The Tory Government will sell off the NHS, just like the trains, gas, electricity, etc. – giant monopolies or cartels who couldn't care less about us.	A fantasy. The Government is always 'putting patients first'.

10	Bad news for the NHS is good for the Tories. It 'rolls the pitch' for privatisation.	The NHS is 'safe in our hands'.
11	We don't want to be like the US – credit card at the ready.	As a percentage of GDP America spends nearly twice as much on healthcare as the UK.
12	Everyone should pay, or at least rich people.	We can't have 'means testing' as we are rolled into surgery.
13	Everyone should pay more tax to preserve the NHS.	We're paying enough tax. We're not paying any more.
14	'Free means free'. That is the basic principle to save people from financial distress in their hour of need.	The rich should pay for their own treatment.
15	When things go wrong, nobody is accountable.	New regulations encourage whistle blowers. We are learning lessons from errors of omission and commission in the past.
16	Doctors say this winter crisis is worse than ever.	The NHS treats over 1 million patients every 36 hours. A few problems are to be expected, no blame attached.
17	Labour wears its heart on its sleeve, but will do nothing in practice.	Labour created the NHS. Labour loves the NHS.
18	Conservatives love 'our NHS' more than Labour.	Tories only say that to avoid being called 'the nasty party'.
19	The Conservatives should do more to defend their 'brand image' on the NHS.	The NHS is an issue of high salience on which Labour has a high rating. The correct Conservative strategy is to shut up.
20	It's all-out war! Labour should attack 'the nasty party' at every turn.	Labour should concentrate on its economic management credentials.

21	Royal Commissions are a waste of time and money.	The NHS Royal Commission will have the power to subpoena witnesses, and require them to speak under oath. A false statement is perjury, punishable by imprisonment.
22	HMG has a health policy. It was in our Manifesto at the last General Election. We don't need to invent another one.	It isn't working.
23	The NHS is a national treasure. We all love the NHS.	The NHS is past its sell-by date.
24	We are not going to pay to see the doctor. They said 'free at the point of use'.	Get real!
25	Rationing new drugs by wealth is unacceptable. NICE is no longer 'fit for purpose'.	NICE is just doing its job. Grow up!
26	The NHS is 'rationing' operations, scans, procedures. The rich are in front of the queue.	Money means a better car, a bigger house and, in time, a longer life.
27	Morale is at an 'all-time low'.	They said that in 1948 when the NHS began.
28	Poor people are suffering most.	The poor 'asked for it'. They don't exercise, eat junk food, are overweight and smoke and drink too much.
29	We need massive public awareness campaigns like AIDS on obesity, alcohol, etc.	These campaigns cost taxpayers money and don't work. The money should be spent on 'the front line'.
30	We need legislation on sugar, alcohol, etc. Prevention is better than cure.	Law change is unnecessary and counter-productive. A culture change is required.
31	Overprescribing of antibiotics creates 'false hope' and only leads to drug 'resistance'.	Science will provide.

32	It's all the fault of the ageing population.	They paid their taxes all through their working lives. They deserve 'end of life' care.
33	It's all the big pharma drug rip-off.	NICE is negotiating hard to reduce prices of innovative drugs.
34	2000 doctors say the NHS 'hits new performance lows'.	The Department of Health says: 'the NHS is now carrying out record numbers of treatments, with more doctors and nurses providing safer, more personal care than ever before'.
35	Doctors are overworked and underpaid. They deserve better than constant carping and criticism.	Doctors are lazy and greedy. They will not give us a 7 day/24/7 service unless they are paid more. Top consultants are 'profiteering'.
36	We need more cancer innovation. There will be no cure for cancer until real doctors with real patients in real hospitals can attempt an innovation.	Innovation risks doing patients harm. Patients will be experimented on like mice and their bodies thrown out into the streets.
37	Cancer survival is improving.	UK cancer survival rates for some types are lower than in Croatia, Estonia and Latvia. Cancer rates are rising, not falling.
38	We are doing worse than the EU average on cancer.	These league tables overlook 'other factors'.
39	NHS spending is 'ring fenced'.	You need a Masters degree from Harvard Business School to know what that means.
40	The Internet is helping patients know more.	Amateur detectives are dangerous. Leave it to the experts.
41	It's all a question of money.	Money is not the problem. It's 'systemic'.
42	The NHS is a giant bureaucracy. Too many cooks.	The NHS is a proven system for managing a large complex organisation.

43	Cuts in mental health are the problem.	Mental health is now to be treated in 'parity' with physical health.
44	Immigration is the problem. Doctors don't speak English. Patients don't speak English.	The NHS depends on foreign doctors, nurses and staff.
45	'Health Tourism' is ripping off British taxpayers.	It is only small – under 1% of the NHS budget.
46	Immigrants are taking our hospital beds and clogging GP appointments and A&E.	Brexit will solve the immigration problem.
47	The NHS just cannot take any more change.	The NHS is very adaptable, has changed and can change.
48	Pharmacies can help relieve the burden on GPs and A&E.	Pharmacists are not properly qualified to provide safe care for patients.
49	With consent, our medical records should be shared for the benefit of scientific knowledge. Sharing data is important for national security.	Patients' data should not be shared with other Government departments, HMRC, police or the security services.
50	Same sex wards should be banned.	This is out of date in the LGBT 'trans' world.
51	Every clinician a researcher! Every willing patient a research patient! 1 million NHS patients a year is a unique national asset for science.	This kind of data 'trawling' and 'harvesting' is an intolerable invasion of privacy. Our 'data' will just be sold to the highest bidder.
52	One patient can change the world.	We want 'evidence-based' medicine, not anecdotes.
53	Brexit will boost the NHS by £350m a year.	Brexit will set back UK medical science and research for generations.
54	The NHS suffers because it is a political football.	The party war is good for the NHS. It's democracy.
55	The 'old folk' are 'bed-blockers'. That's why A&E is failing.	It's not their fault! There is no 'social care' in the community for them.

56	The NHS is a national treasure, like the crown jewels.	The NHS is a national relic, like Stonehenge.
57	We need more 'business disciplines' in the NHS.	The NHS is not a business. It is a social contract. The fake 'buyer's and seller's market' in the NHS is the cause of all the trouble.
58	We need an 'NHS Tax'. People would pay if they knew it was for the NHS.	Hypothecated taxes are dangerous because they are blind to economic cycles. The Treasury needs full control of tax revenue to manage the public finances.
59	We should copy the successful 'Social Insurance' models of other countries.	Cross-country comparisons are for the birds. There are too many other variables.
60	Politicians should get out of the NHS.	That is childish. Ultimately, they cannot and should not escape responsibility.
61	The NHS is a bloated bureaucracy of managers and pen-pushers. More should be spent on the front line.	It's not the structure. It's the culture.
62	Love of money is the root of all evil in the NHS.	It's not the money. It's the organisation.
63	It's an unfair postcode lottery.	The NHS is working hard to bring the mediocre and failing hospitals up to the level of the best.
64	A Royal Commission is just a talking shop for the great and good. Their Report will go on the shelf, in the bin or into the long grass.	Maybe. It depends on who is the Chairman. And who are the Members.
65	We should rely on the Government to solve the problem.	The NHS is a punch bag for rival politicians, who are only interested in their own careers and climbing the greasy pole. They have created stalemate and gridlock while people die.

66	NHS data is a source of cash for the NHS. People are used to having our personal history sold to advertisers, in return for free downloads. The same should apply to free treatment.	Nye Bevan would turn in his grave.
67	NHS Digital has been created to advance the dissemination of scientific knowledge and diffusion of best practice.	Facebook knows what kind of lettuce we like and what we had for breakfast. But NHS Digital may sell our most intimate private details.
68	There is too much waste in the NHS purchasing system for drugs and equipment.	Top level accounting professionals from the private sector have been brought in to advise HMG.
69	Doctors and nurses should run the NHS.	They have no idea about money.

‘If a hospital bedpan is dropped in a hospital corridor in Tredegar, the reverberations should echo around Whitehall’

Nye Bevan, Founder of the NHS (1948)

Original meaning:

‘When you are in trouble in the NHS, we will feel your pain in the corridors of power’

Current meaning:

‘The NHS is the Third Rail of politics – touch it and die’

1. Introduction

Today, the medical profession, Parliamentarians, civil servants, charities, patient groups, 'representative organisations' and Royal Colleges do not agree about whether there is a problem with the NHS; or, if there is a problem, what it is, or what might be the solution.

There is no national consensus on problem or solution, cause or cure, diagnosis or prognosis.

If you drop this CPS pamphlet it will fall to the ground.

Tomorrow, the sun will rise.

These statements can be made, perhaps without finality, but with a certain plausibility.

The same cannot be said about the NHS.

Whenever we speak about the NHS, error, doubt and uncertainty come to the fore; dearly admired and harshly condemned in equal measure. Loved by romantics. Denounced by realists.

Apparently, the NHS is so complex that it is beyond the judgement and understanding of the human mind to comprehend all its variables.

We the people cannot follow all the why's and wherefore's of what is going on – the deliberations of the 'Establishment Elite'.

It is time we had our say. This NHS Royal Commission will be a People's Commission.

2. Background

Over the recent 2016/17 winter, the NHS showed worrying signs of strain. Faced with an unexpected surge in A&E demand, almost a quarter of patients had to wait longer than the guaranteed maximum four hours to be seen. Critical cancer operations were cancelled, and in some hospitals the percentage of bed occupancy rose nearly ten points above the safe threshold.[1] The British Red Cross called the situation a 'humanitarian crisis' after reports emerged of patients dying in the corridors.[2]

There is little doubt that this acute pressure on the system was triggered by an unexpectedly large and sudden uptick in demand. Nor is there any doubt that the NHS benefits from some of the best-trained and hardest-working doctors and nurses in the world. Since 1948, it has provided genuinely world-class, equitable healthcare at relatively high levels of funding efficiency. It is no surprise then that despite its imperfections, the system enjoys overwhelming public approval.[3] Nigel Lawson famously described the NHS as the 'the closest thing the English have to a religion.'[4]

'The Office for Budget Responsibility estimates that the NHS will need an extra £88bn over the next fifty years to survive'

However, the 'winter crisis' occurred against a backdrop of mounting challenges. There is evidence of a deterioration in some clinical outcomes, and the OECD recently found that quality of care in the NHS was 'poor to mediocre' across a number of important areas, including cancer survival and stroke deaths.[5] Many in the NHS leadership are becoming increasingly concerned about the system's capacity to handle growing demand pressure. Last year, the head of the Royal College of Physicians said the NHS was 'underfunded, under-doctored, and overstretched.'[6]

These problems could get worse. The CEO of NHS England, Simon Stevens, has said that 2018 may be the 'toughest year' yet, with three-quarters of NHS acute hospitals already in deficit,[7] trusts struggling to meet their savings targets under the Five Year Forward View, and much of the pledged extra government funding back-ended to 2020/21.[8] The impact could be felt in frontline services.

1 NHS Improvement data, reported by BBC News, 10 January 2017.

2 *The Guardian*, 'NHS faces humanitarian crisis', 6 January 2017.

3 According to a 2013 Ipsos MORI Global Trends Survey, for example, public approval of the NHS's performance was higher in only one other country (out of 19 advanced economies included in the survey).

4 Nigel Lawson, *Memoirs of a Tory Radical*, Bantam Press, pg 613.

5 OECD, *Health at a Glance*, 2015.

6 Prof. Jane Dacre, Royal College of Physicians, 4 May 2016.

7 NHS Improvement, Quarterly performance of the provider sector, 30 June 2016

8 *The Independent,* 'NHS Chief Simon Stevens warns Theresa May', 11 January 2017.

Important though these problems are, they do not get close in scale to the question of how the NHS will continue to weather the projected demand growth and unit cost inflation under the triple pressures of population ageing, growth in long-term conditions, and costly medical innovation. The Office for Budget Responsibility estimates that the NHS will need an extra £88bn over the next fifty years to survive.[9]

This government should be applauded for recognising these challenges and being prepared to sacrifice the necessary political capital to make vital reforms. While investing an extra £10bn, the government has once again had to run the gauntlet of opportunistic accusations that it cannot be trusted with the NHS in order to deliver a 7-day GP service. Despite the dividends for patient choice and accessibility, overwhelming public support, and the potential to relieve A&E departments of the kind of pressure seen this last winter, the move has still faced long and bitter resistance.[10]

> **'While investing an extra £10bn, the government has once again had to run the gauntlet of opportunistic accusations that it cannot be trusted with the NHS in order to deliver a 7-day GP service'**

This paper argues that the next step should be to set up a Royal Commission to report on options for relieving these pressures on the NHS and for ensuring that its governance, care, operating, and funding models are fit-for-purpose in the 21st Century. As a constitutional mechanism, a Royal Commission is uniquely placed to draw attention to some of the enormous, long-term challenges that many members of the public, and Westminster, are not fully aware of. A Commission's investigatory powers, and capacity to provide evidenced-based review free from the constraints of the immediate political cycle, allow it to craft solutions that command the support of practitioners and politicians alike. When set up properly, its recommendations carry a unique legitimacy that could be essential to securing a lasting, bipartisan settlement on the NHS.

While Royal Commissions have fallen out of favour in recent years – only three have reported since 1990[11] – they can be hugely effective if their length and remit are well-defined. The unfocused recommendations of the 1976 Merrison Commission into the NHS, for example, stand in contrast to much more successful examples like the 1991 Royal Commission on Criminal Justice. The experience of smaller, public inquiries too suggests that past failures have tended overwhelmingly to be a result of poor set-up. In the second of these reports, we will look at how the Commission should be set up, including its length, composition, and possible remit.

There is now growing traction for the idea of deploying a Royal Commission to take on the task of finding solutions to the NHS's huge challenges. Former Secretary of State for Health, Lord Fowler, has come out publicly in favour of the idea,[12] as have former Health Secretaries, Stephen Dorrell and Alan Milburn, and former Health Minister, Norman Lamb.[13] The interest recently spurred the set-up of a Lords Select Committee, chaired by Lord Patel, on the Long-Term Sustainability of the NHS.

9 Office for Budget Responsibility, *Fiscal Sustainability Report,* January 2017.

10 YouGov, July 2015: 61% of the 2052 adults surveyed agreed that GP surgeries should be required to offer appointments seven days a week.

11 Down from an average of 5 per year in the nineteenth century according to analysis by the Institute for Government ('The Lost World of Royal Commissions').

12 Lord Fowler, 'Only a Royal Commission will get us talking sensibly about the NHS', *The Telegraph*, 16 December 2015.

13 BBC News, 'Cross-party review needed for health and care', 6 January 2016.

In preparation for this report, a wide range of experts, practitioners, and leaders across the NHS and Whitehall were consulted. The great majority voiced strong support for the proposal. While noting the importance of how the Commission's scope is defined, they each agreed – often from the perspective of their own specialism – that the NHS is facing challenges on a unique scale and the ordinary political processes may not be sufficient to find the lasting solutions.

Few public policy topics elicit as much passionate disagreement as the NHS. Perspectives on the acceptability of its current performance, and the confidence in its long-term future, vary enormously. To that end, this paper advances the argument for a Royal Commission from three pincer perspectives.

'The focus throughout is on NHS England. Although there are lessons to be learned throughout the UK, devolved control of the other healthcare systems makes it unwise to generalise too widely'

In the first section, we examine the Pessimist's case for a Royal Commission, exploring how a crisis – ongoing or imminent – in the NHS can only be relieved by generating the type of solutions that a Commission might offer. In the second section, we look at the Future-proofer's case; namely, that although the NHS may be fundamentally sound right now, there are big challenges looming in the coming decades. Finally, we look at the Optimist's argument: the rare position that the NHS is fit-for-purpose and future-proofed but could still benefit from the efficiencies and innovations that a Royal Commission could provide.

The focus throughout is on NHS England. Although there are lessons to be learned throughout the UK, devolved control of the other healthcare systems makes it unwise to generalise too widely.

3. The Pessimist's Case

The pessimistic case for a Royal Commission is that the NHS is either in, or on the brink of, a crisis; the signs of which are a deterioration in the quality of care, growing barriers to equal access, and the slide of many hospital trusts into the red. The fact that these problems interlock would make the need for wholesale review of the system all the more urgent.

A dramatic illustration of these difficulties came over the 2016/17 winter when a 4% increase in A&E attendance caused nearly a third of English hospital trusts to report the highest Operational Pressures Escalation Levels of 3 and 4, representing a call for urgent action to cope with escalating pressure.[14] A large number of hospitals were forced to cancel critical surgeries due to the lack of beds.[15] Although this was all triggered by a larger-than-expected surge in A&E demand, critics point out that a number of the most important indicators for quality of care had been quickly deteriorating beforehand.

> **'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 2014, the Commonwealth Fund had declared the NHS one of the best healthcare systems in the world.[16] Just under two years later, the OECD found serious concerns with quality of care in the NHS.[17] 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.[18] 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.[19] These are hardly non-critical indicators.

Behind the 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.[20] 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.[21]

14 Nuffield Trust, 6 January 2017, based on NHS England data for December 2016.

15 *The Independent*, 'Hospitals across UK cancelling urgent cancer operations', 15 January 2017.

16 The Commonwealth Fund, *Mirror, Mirror on the Wall: How the Performance of the US Health Care System Compares Internationally*, 18 June 2014.

17 OECD, *Health at a Glance*, 2015.

18 Euro Health Consumer Index, 2014

19 OECD, *Health at a Glance*, 2015.

20 The King's Fund, 2011.

21 Euro Health Consumer Index, 2014.

Nor is extra funding a silver bullet for these problems; changes are probably needed in the care model itself. For example, in recent years the government has pledged billions of pounds to ensure that mental health is given 'parity of esteem' with physical health (nearly £3bn since 2014 alone). The problem is that much of the funding isn't reaching frontline services,[22] many practitioners are inadequately trained to deal with severe mental illness, and there is still too little co-ordination between specialist mental health clinics, GP practices, and hospitals. People with severe mental illness continue to lose up to 20 years in life expectancy.[23]

While the healthcare system may still achieve outstanding results for a large share of its users, a disproportionately large burden of negative outcomes fall on the BME community, low-income earners, and disadvantaged postcodes. The unacceptable result, in part, is that a boy growing up in Blackpool, for example, has a life expectancy of just 75 while another born in Kensington could expect to live at least another decade.[24]

'At the end of 2015/16, 75% of NHS acute hospitals were in deficit, and many expect that the system will be unable to produce the £22bn in efficiency savings agreed under the Five Year Forward View'

To an extent this is a reflection of underlying unevenness in public health, with large discrepancies in the regional and income prevalence of chronic conditions like obesity, and unhealthy behaviours like smoking, before user contact is even made with the NHS. Certainly, the NHS has otherwise received plaudits for the relative absence of cost-related access barriers.[25] Nevertheless, it seems strange to draw such a sharp distinction between wider public health and the performance of the NHS.[26] Whether the NHS could be doing more to stop unhealthy behaviours before admission is precisely the kind of question a Royal Commission could look at.

However, there is also evidence of barriers to equality at the frontline. The Department of Health's own patient surveys have tended to reveal that minority ethnic groups have more dissatisfactory experiences with NHS services,[27] and there have been large, persistent variations by geography in the rate of elective hospital admission.[28]

Admirably, the current government has made the elimination of these barriers across society one of its top priorities, with all departments expected to focus on how existing services can be refined to improve inclusion and mobility for all British people. Clearly, what happens in the NHS will be integral to achieving that objective as poor health is so closely bound up in the cycle of income deprivation and inequality.[29]

Finally, many experts argue there are signs of serious financial distress throughout the system. At the end of 2015/16, 75% of NHS acute hospitals were in deficit,[30] and

22 The King's Fund (14 October 2016) found that 40 per cent of mental health trusts saw their income fall in 2015/16.

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

24 ONS, 2015.

25 The Commonwealth Fund, *Mirror, Mirror on the Wall: How the Performance of the US Health Care System Compares Internationally*, 18 June 2014.

26 OECD, *Health at a Glance*, 2015.

27 Department of Health, *Report on the self-reported experience of patients from black and minority ethnic groups*, June 2009.

28 The King's Fund, *Variations in Healthcare: The Good, the Bad and the Inexplicable*, 2011.

29 David Buck and Joni Jabbal, *Tackling Poverty: Making More of the NHS in England*, 2014.

30 NHS Improvement, Quarterly performance of the provider sector, 30 June 2016.

many expect that the system will be unable to produce the £22bn in efficiency savings agreed under the Five Year Forward View.[31] Even with the government's commitment of £10 billion in extra NHS expenditure, some argue that the system is going backwards in real financial terms under the cumulative impact of growing demand-side pressure and price inflation. Demand for treatment is growing at 3-4% p.a. (although patient contacts with GP practices increased by as much as 10% over 2016),[32] while medical innovation is simultaneously driving unit cost inflation at over 3% p.a.[33]

'Growth in real spending on the NHS has decelerated since 2010 under the constraints of fiscal consolidation. Although it is up from the 2010-2015 term, expenditure growth at 1.75% p.a. to 2020/21 is still less than half the long-run average of 3.6%'

Meanwhile, growth in real spending on the NHS has decelerated since 2010 under the constraints of fiscal consolidation. Although it is up from the 2010-2015 term, expenditure growth at 1.75% p.a. to 2020/21 is still less than half the long-run average of 3.6%. The 2010-2021 period will see the biggest drop in NHS spending as a share of GDP in any period since 1951,[34] and Simon Stevens has warned that we are now spending 30% less than countries such as Germany.[35]

Critics of the Five Year Forward View argue that its projected efficiencies were never realistic and that savings targets were bound to affect frontline services at some point. The reasoning is that expected efficiencies were based on the implementation of new care models to curb demand growth and cut unit cost inflation, but these models could not be funded while trusts were still trying to fix their deficits.[36] Trusts, they argue, have then tried to wrest themselves from the red by freezing workforces and cutting down hours, leaving hospitals vulnerable to failure when patient demand rises above baseline.

According to the OECD, the UK's ratio for doctors and nurses to patients is below average and the 'relatively low staffing levels' are having an impact on the capacity to deliver quality care.[37] Mr Stevens has also warned that 2018 will be especially tough because much of the pledged £10bn in extra government funds won't be delivered until the end of the decade.[38] So in the absence of a sudden jump in productivity growth,[39] many argue that trusts will have to continue making cuts and risk a further deterioration in clinical outcomes if they are to meet their targets.

The pessimist's case is, therefore, that a Royal Commission is urgently needed to solve these serious problems and to pull the NHS back from the brink. A Commission could identify options to fix the funding shortfall, alleviate the pressure on hospitals, eliminate barriers to access, and lift performance on critical care indicators. Inaction, however, could mean the NHS will simply go on from crisis to crisis.

31 The King's Fund, 2016.

32 The King's Fund, Quarterly Monitoring Report, November 2016.

33 NHS, Economic assumptions 2016/17 to 2020/21.

34 The King's Fund, 'NHS funding: squeezed as never before', 20 October 2015.

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

36 Sally Gainsbury, *Feeling the Crunch: NHS Finances to 2020*, Nuffield Trust.

37 OECD, *Health at a Glance*, 2015.

38 *The Independent,* 11 January 2017.

39 The Five Year Forward View estimated productivity improvements of 2-3 percent a year, higher than the 0.8 percent currently averaged.

4. The Future-Proofer's Case

The most common objection to the pessimistic perspective outlined above is that although the symptoms of dysfunction may be real – the wait-times, the bed shortages, the failure to lift survival rates – the government must not misdiagnose the underlying condition: lack of investment. Many in the NHS leadership argue that these failures could have been avoided if the system had been better funded.

For example, the President of the Royal College of Emergency Medicine linked hospitals' 'acute state of distress' over the winter to 'the background of chronic underfunding'.[40] The President of the Society for Acute Medicine expressed the views of many in the system when he said 'we are asking NHS staff to provide a world-class service but with third world levels of staffing.'[41]

> **'The fact that real annual growth in NHS spending could vary from nearly 6% on average under the Blair/Brown governments to just 0.9% under the Coalition shows how vital it is to achieve a bipartisan, generational settlement on these questions'**

Advocates for this position might balk at the idea of a Royal Commission. 'Why', they might argue, 'do we need a Royal Commission to tell us what we already know: that the system is underfunded?' This, however, is a short-sighted reaction.

If we accept the view that the current problems with the NHS stem in part from lack of funding, then we should be particularly careful to ensure that any funding solution devised won't prove to be a temporary fix. The fact that real annual growth in NHS spending could vary from nearly 6% on average under the Blair/Brown governments to just 0.9% under the Coalition shows how vital it is to achieve a bipartisan, generational settlement on these questions.[42]

Fixing any shortfall will also have ramifications beyond the NHS. Continuing to raise the NHS share of government expenditure to keep up with these pressures will place increased pressure on non-ringfenced services already hardest hit by post-2010 spending cuts (e.g. welfare) and increase the likelihood of negative health outcomes simply being passed on indirectly to taxpayers.

Most importantly though, many of those calling for increased investment fail to take into account just how large the funding gap may be if the NHS is to not just weather the next crisis but keep up with the escalation in demand projected for the coming decades. There are three challenges ahead, with enormous fiscal implications.

40 *The Guardian*, 'NHS on brink of winter crisis', 6 January 2017.

41 *The Independent*, 'Hospitals across UK cancelling urgent cancer operations', 15 January 2017.

42 The King's Fund, 'NHS funding: squeezed as never before', 20 October 2015.

The first is the impact of long-term demographic shifts that are still unfolding. Over the next quarter of a century, Britain's population is expected to grow by 10 million people.[43] While this ONS projection did not assume an end to free movement for EU nationals, it also reflected trends where there is no evidence of decline, including above-average birth rates for settled migrant communities and high levels of non-EU migration. The NHS was designed to serve a catchment the size of Britain's post-war population. Already under strain serving its 2016 user base, the NHS will have to do significantly more with less if it is to serve 15% more patients within a decade.

If the size of the NHS's user base has changed significantly since 1948, so too has its profile. A combination of the baby boomer generation maturing and advances in life expectancy have meant that over-65s now comprise nearly a fifth of the UK population – compared to just 11% when the NHS was created – and with a rise to 25% forecast by 2044. The British median age too has been consistently rising, from 34 years in 1974 to 40 years in 2014, its highest ever value.[44]

'Nearly 30% of patients in England now have a long-term condition and account for 70% of the total NHS spend'

The potential impact is alarming. The experts we consulted agreed that, without investment to match the growing number of geriatric patients, there will be a huge increase in the pressure on available bed spaces and a consequent deterioration in A&E wait-times as hospitals struggle to find alternative discharge options for their older patients. They also noted that one of the biggest concerns shared by GPs is the growing workload pressure created by chronic geriatric conditions such as dementia and arthritis.

Finding the funds to deal with this change is no easy task. An eighty-five year old man already costs the NHS nearly seven times more on average than a man in his late thirties.[45] Not only will significantly greater finance be therefore needed for geriatric care in the years to come, any funding solution will have to take into account the impact that an ageing population will have on the recruitment pool and tax base. More over-65s will mean that the NHS will find it increasingly difficult, and therefore more expensive, to maintain safe staff-to-patient ratios, while a smaller share of NHS users than ever will be contributing revenue to Treasury.

The new demand pressures are not purely demographic, however. The kinds of health outcomes that users expect of the NHS are also changing. Driven by a range of factors, including population ageing and unhealthy lifestyles, the diseases that the NHS deals with are increasingly chronic and long-term in nature. Conditions such as diabetes, asthma, heart disease, obesity, and cancer are costly to treat – in both time and resources – and the drain on NHS finances is only growing. Nearly 30% of patients in England now have a long-term condition and account for 70% of the total NHS spend.[46]

Once again, the solution cannot be a matter of just injecting more funds into the system. As a single-payer healthcare system, free at point of access, the NHS was

43 ONS, National Population Projections, 2015.

44 ONS, Overview of the UK population, 2016.

45 *The Guardian*, 'Ageing Britain', 1 February 2016.

46 House of Commons Health Committee, *Managing the care of people with long-term conditions*, 2014.

set up to address predominantly acute illnesses. Whether or not the current model, and the level of public funding that taxpayers can reasonably be expected to shoulder,[47] are properly designed to address the growing burden of chronic diseases requiring extensive out-of-hospital care and integrated, holistic treatment is a vital question for the Royal Commission to examine.

Indeed, the implications of this explosion in chronic diseases for the taxpayer are even more grave when we consider (as is rarely done) the costs that are passed onto the wider economy. Unlike acute illnesses, chronic conditions tend to place a huge strain on a wide range of public and private resources, including sick leave and unemployment benefits. Obesity, for example, is estimated to already cost the British economy as much as £57bn, or 3% of GDP.[48]

> **'Obesity, for example, is estimated to already cost the British economy as much as £57bn, or 3% of GDP'**

Compounding the problem, patients have developed increasingly consumerist expectations of the NHS. As the funding envelope for the NHS increases, and as the rest of the economy becomes increasingly digitalised and available 24/7, many taxpayers will come to expect a health service that better meets their work and lifestyle needs. There is already overwhelming support for GP surgeries being required to provide 7-day access, and for ensuring that hospitals must offer non-emergency services on the weekend.[49]

The cost implications will again be significant. Properly digitalising the NHS will require a significant upfront investment and a recognition that returns may take longer to accrue than the lifecycle of a single government. Unfortunately, the temptation with digitalisation is to limit upfront costs by cutting back on things that improve uptake, including promotional activities and provision for digital assistance. Worse still, there is a tendency to try to secure Treasury funds by projecting optimistic growth rates for digital uptake and then prematurely closing estates and retrenching staff before users have made the switch online.

The result is that most patient interactions with the NHS are still not available online, and where digital services do exist, the evidence for user uptake, satisfaction, and completion rates (how many people take an online journey from start to finish) is mixed. For example, the completion rate for online blood donation appointments – a relatively transactional service – still hasn't risen above 30%.[50]

Taking the NHS into the digital age will clearly require a considerable lift in resourcing. It is also going to demand a wider, more probing investigation into the plethora of complications that online service provision creates, including the implications for privacy and use of patients' data. It is therefore understandable that people are concerned about some of these challenges and that a Royal Commission could helpfully shine a public light on the case for adjusting some of our expectations around privacy and interrogate the risks involved.

47 Polling suggests that younger people are more likely to reject the idea of free healthcare for conditions that result from unhealthy behaviours (Public Perceptions of the NHS, Spring 2012, Ipsos MORI).

48 McKinsey, 'Obesity costs UK society $73 billion per year', 2015.

49 YouGov, July 2015: 61% of the 2052 adults surveyed agreed that GP surgeries should be required to offer appointments seven days a week.

50 GDS Dashboard, February 2016 – January 2017.

Buffeted by all these demand pressures, it will be a difficult task for the healthcare system to simultaneously meet the inflationary cost pressures of medical innovation. Upfront, the system will have to keep pace with the growing cost of developing and distributing new technologies and treatments, and then invest in education and training for the NHS workforce to ensure that productive use can be made of these innovations.

The NHS cannot afford to sit on its hands. Aside from the fact innovative treatments like immunotherapy have the potential to be game changers in dealing with many diseases, thanks to the internet patients are also increasingly literate about the types of treatment and drugs available to them outside the NHS and internationally. If the NHS does not keep pace with innovation, it could face mounting criticism of the kind increasingly seen in the press,[51] and a de facto two-tier healthcare system as more users switch to private insurance.

'The reforms needed to sustain the NHS against these changes affect almost every aspect of the system, including its governance, care, and operational models'

Moreover, investing in digital technologies has the potential to not only deliver superior clinical outcomes, but unleash huge savings for the NHS by promoting better public health outcomes and reducing the cost of detection. Examples of this type of initiative include smart cards to reward healthy living (some private health insurers already provide reward points for healthy food purchases) and blood monitoring implants. While the benefits of these emerging technologies could be enormous, they require investment with a long payback period.

These growing demand and cost pressures carry enormous fiscal implications. The Office for Budget Responsibility estimates that the government will need to increase NHS funding by £88bn over the next fifty years if it is to keep pace with the projected rate of demand growth.[52]

It is not just a question of investment though. The reforms needed to sustain the NHS against these changes affect almost every aspect of the system, including its governance, care, and operational models. For example, preparing the NHS for the kinds of rapid technological shifts that may be possible in the coming decades requires not just money, but radically rethinking how medical professionals are trained so that they can more quickly adopt new practices, and even switch specialties if a new technology displaces the need for their skill-set.

These challenges also raise questions about the purpose of the NHS in the 21st Century. Is the system meant to go on providing free treatment for all long-term conditions? Is it right that the share of national income that goes to healthcare should double to make that possible? Will taxpayers be willing to foot the bill for a 2% annual rise in NHS expenditure?[53] What services will they otherwise sacrifice to prevent the collapse of public finances?

51 See for example A.A. Gill's last article in *The Sunday Times*, December 11 2016.

52 Office for Budget Responsibility, *Fiscal Sustainability Report,* January 2017.

53 Ibid.

Because of these challenges that a coming down the road, those who argue that the NHS is in fundamentally 'good shape' and just needs more funding should therefore welcome a Royal Commission. The NHS will have to make significant adaptations

> **'The completion rate for online blood donation appointments – a relatively transactional service – still hasn't risen above 30%'**

to remain a financially sustainable, world-class care provider. A Royal Commission could look at just what adaptations are needed so that the NHS can thrive in the years to come.

5. The Optimist's Case

Many of those most influential in NHS policy-setting advocate a position on the NHS of 'please don't change very much'.[54] For example, in the lead-up the last General Election, Dr Mark Porter, Chairman of the BMA, was pressing the Labour Party to adopt just such a position.

Those advocating the more hands-off position tend to stress the world-class performance of the NHS, the strain that is placed on doctors and nurses by constant political meddling, and a belief in the ability of front-line staff and managers to continue raising standards if given the right tools and freedom. Nigel Edwards, Chief Executive of the Nuffield Trust, argues that it is more important to 'focus the attention of front-line staff and managers on the real business of healthcare' than to continue conducting a 'sterile debate about funding systems and reform'.[55]

'Frustrated by ever-shifting goalposts and the accumulating paperwork needed to comply with each new set of targets, NHS doctors are reporting historically low morale'

This position is understandable. The Commonwealth Fund recently ranked the UK the best of 11 countries examined for overall quality of care, access to treatment, and funding efficiency.[56] It's also true that the each new government's root-and-branch reform initiatives, however well-intentioned, have taken their toll. Frustrated by ever-shifting goalposts and the accumulating paperwork needed to comply with each new set of targets, NHS doctors are reporting historically low morale.[57]

Each new reform programme also generates a stormy political debate that adds to the perception, correct or not, by many NHS workers that they are being unfairly vilified. The impact on recruitment and retention for doctors and nurses is well-documented, but perhaps the most damaging by-product has been the talent crisis in management. One expert noted the precipitous decline in the prestige and respectability of NHS management, and questioned why 'anyone talented would want to sign up for such a career anymore'.

While it therefore may seem attractive to simply leave the NHS alone, all these concerns highlight why it is more critical than ever to find a generational settlement for the NHS that can at last end the disruptive cycle of piecemeal reform initiatives. Pursuing that settlement outside the political arena will also help to ensure that the

54 25 September 2013, 'BMA chair lobbies Labour to avoid another NHS reorganisation', Pulse Today.

55 *The Independent*, 24 August 2009.

56 The Commonwealth Fund, *Mirror, Mirror on the Wall: How the Performance of the US Health Care System Compares Internationally*, 18 June 2014.

57 BMA (2016) Morale and workload survey: half of the 1000 doctors surveyed reported low or very low morale.

hardworking frontline staff and management on which the NHS depends are treated with respect and trust, something which is vital the system is to retain its talent.

Even taking the rosiest view of the NHS – that it is still completely fit-for-purpose and future-proof – there is a strong argument to be made for using a Royal Commission to investigate how to deliver continued gains in productivity and clinical outcomes. However outstanding the NHS may be, there are ample opportunities to build on that success. Indeed, the OECD named the UK as one of the three countries that would most benefit from a series of proposed efficiencies identified across the healthcare operating model.[58]

> **'The increasing use of pharmacies for routine treatments like flu vaccinations is already paying dividends in reduced workload for GP surgeries'**

Some of the best-practice proposals highlighted by the OECD include greater consistency in the allocation of responsibilities across the governance model to avoid duplication and improve accountability; making comparable data on the allocation of spending across sub-sectors more available; reforming compensation by, for example, readjusting the balance between performance-related pay and set wages; and redirecting more investment to quality out-patient care in order to reduce costly hospital admissions for conditions such as asthma and cataract surgery.

The OECD also highlighted the benefits of creating more patient choice. While the debate over choice tends to get bogged down in controversies around privatisation, there are a number of simpler solutions that would offer patients a greater say over their medical care and means of accessing treatment. For example, this could include encouraging more people to make plans for end-of-life care, and better tailoring some care models to expand the range options available (e.g. enabling people to pick up hearing aid batteries from local community audiologists rather than requiring them to drive long distances to collect at NHS hospitals).

The benefits are not just greater patient satisfaction. More patient choice will also tend to alleviate pressure on the system. For example, actively encouraging patients to make more use of pharmacies for non-emergencies would go a long way to reducing unnecessary A&E admissions and limiting the kind of extraordinary pressures seen over last winter. The increasing use of pharmacies for routine treatments like flu vaccinations is already paying dividends in reduced workload for GP surgeries.

These efficiencies are estimated to be worth a further 3% of GDP. Remarkably, the OECD found that exploiting them would allow the NHS to improve health outcomes as much as over the previous decade without having to even increase investment. A Royal Commission could explore each of these options in depth, examining the case for implementation – including risks and challenges – and canvassing other possible efficiencies missed by the OECD.

Finally, regardless of ones confidence in the NHS, there is no denying that the political and economic landscape around British healthcare has shifted dramatically in the past year. A Royal Commission is a much-needed opportunity to respond to some of the new, unfamiliar challenges posed. Foremost among these changes is Britain's decision to leave the European Union. Whatever shape Brexit finally takes, there will be far-reaching implications for the NHS.

58 OECD, *Healthcare Systems: Getting More Value for Money*, 2010.

6. Why a Royal Commission

What impact will new barriers to EU free movement have on the NHS workforce? It is estimated that as much as 5% of the NHS workforce is composed of EU migrants, including 10% of registered doctors.[59] For a system already under strain, any deal that would limit EU migrant numbers (which seems almost certain to be the case) could pose challenges for NHS capacity if solutions aren't first found.

Brexit also presents some opportunities. If changes to free movement threaten to compound the system's talent retention challenge, the flipside is that the NHS's user base will shrink back in line with its original catchment, and a fall in health tourism could mean lower overall operating costs.[60] A Royal Commission could look at how best to maximise that opportunity. Moreover, it could provide guidance on how to ensure that these costs are not passed back indirectly to British tourists and expats via the loss of reciprocal access to free healthcare in the EU.

'Royal Commissions have fallen out of fashion. Only three have reported since 1990, and governments have repeatedly rebuffed calls to set up Commissions into topics such as national drugs policy'

There is also an opportunity for the NHS to benefit directly from the clawback in EU contributions. Any reduction in contributions is a chance to increase spending on the NHS; how much is reinvested, and where it is targeted, are important questions that a Royal Commission could assist with.

So, for the optimists, a Royal Commission could explore all these issues in parallel to the ongoing EU negotiations, with a view to having a full set of policy responses ready for implementation once a new deal is agreed. This would save much-needed time and ensure the least possible disruption to English healthcare. It could also go further and produce invaluable guidance on how NHS concerns and priorities should inform future trade negotiations outside the EEA.

However optimistic or pessimistic one is about its current performance, the looming challenges facing the NHS present a unique opportunity to think seriously about what kind of healthcare is expected in 21st Century Britain; and what steps need to be taken to get there. As we approach the NHS's 70th birthday, it would be reckless not to seek a full body check-up – the first in decades – if we want to guarantee another 70 years of world-class healthcare.[61]

59 NHS Electronic Staff Record, September 2015; List of Registered Medical Practitioners, General Medical Council, 2015.

60 Prederi, Quantitative Assessment of Visitor and Migrant use of the NHS In England: Exploring the data, 2013.

61 The last Royal Commission on the NHS reported in 1979. Its remit was limited to investigating the management of the financial and manpower resources of the NHS.

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 (there was an average of five a year in the 19th Century),[62] Royal Commissions have since fallen out of fashion. Only three have reported since 1990, and governments have repeatedly rebuffed calls to set up Commissions into topics such as national drugs policy.[63]

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.'[64] Indeed, the average lifespan of Commissions – from Warrant to report – is four years; long enough that the ultimate recommendations frequently depend on enactment by a new, hostile government. For example, the Pearson Commission was established by the Wilson Government in 1973 to investigate opportunities for tort reform but its central recommendation of a no-fault insurance scheme for road accidents was immediately shelved by the incoming Thatcher Government.

> **'The national apotheosis of a single-tier, free-at-the-point-of-use health service has made it almost impossible for political parties to talk about serious reforms'**

Another related concern is that Commissions have tended, by their nature, to lose sight of the political realities of the day, producing lengthy tomes with hundreds of recommendations that are dead on arrival. Despite enjoying initial bipartisan support, the Royal Commission on Long-term Care of the Elderly – set up in fulfilment of a Labour manifesto commitment at the 1997 general election – was rejected by the Blair Government for producing unrealistic, cost-blind recommendations.[65] It was over a decade before the Dilnot Report – which was closer to the view of two dissentient reports from the previous Commission – was accepted by the Coalition Government.

However, a Royal Commission could provide a much-needed circuit-breaker for serious NHS reform. One of the reasons this is necessary is that the NHS has increasingly become the political third rail for parties. The national apotheosis of a single-tier, free-at-point-of-use health service (vividly illustrated in Danny Boyle's Opening Ceremony for the 2012 Olympic Games) has made it almost impossible for political parties to talk about serious reforms.[66] This is the case even where there is arguably already a cross-party consensus in place.

While such reforms are unlikely to ever come without some political cost, the non-partisanship, authority, and expertise of a Royal Commission would go a long way toward detoxifying some of the best proposals for reform. Royal Commissions are uniquely trusted by the public for their independence and thoroughness – more than

62 'The Lost World of Royal Commissions', The Institute for Government.

63 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)

64 Despite the sentiment, Wilson established 10 Commissions in his time as Prime Minister, including the famous Kilbrandon Commission.

65 BBC, 'Government to reject free elderly care', 26 July 2000.

66 52% of the public say the NHS is what makes them most proud to be British, more than the armed forces (47%) or the Royal Family (33%) according to a 2014 Ipsos MORI poll. According to 2015 BSA Survey (25 February) 89% of adults in Great Britain support a national health system that is tax-funded, free at the point of use, that provides comprehensive care for all citizens.

any other kind of public inquiry – and sustainable policy change in the NHS depends on first securing that kind of legitimacy.[67]

In addition to public legitimacy, it is imperative that any substantive proposals for change enjoy as much cross-party support as possible. The challenges which the system is facing – whether it is an ageing population or the rising prevalence of chronic diseases – are likely to span generations, and therefore so too must the solutions. The lengthy gestation period of a Royal Commission, so often a source of criticism, may in this respect be a considerable strength because it would imperil any recommendations not devised with a view to a potential change in government. Chaired astutely, a Royal Commission would be best placed to find the kind of solutions that do not disappear with the first change in Downing Street.

> **'While the public seems worried about the future of the NHS, there is less evidence for widespread awareness of some of these specific challenges'**

Searching for common ground on an issue as politically vexed as the NHS, there is a risk that the Commission could fall between two stools (or three) and ultimately produce little by way of substantive recommendation. Whether this eventuates will depend on how the Commission is set up, and on the selection of its chair, but even the most anaemic Commission could still be hugely valuable in triggering long-term change.

One of the reasons why it is so difficult for governments to push necessary reforms through is because there is still too little public awareness for many of the thorniest problems confronting the NHS. Partly this is a consequence of the stifled political debate discussed above, but it is also because some of the most important issues – such as the fiscal impact of patients' increasingly consumerist expectations – are simply not as visible or readily felt as indicators like wait-times, for example. However, to secure public support for change the government must first convince people that the problem in fact exists. While the public seems worried about the future of the NHS,[68] there is less evidence for widespread awareness of some of these specific challenges.[69]

A Royal Commission provides an unparalleled national forum to discuss these problems and place a spotlight on the health of the system. While it may be tempting to opt for a shorter ad hoc inquiry, the immense investigatory powers of a Commission (e.g. summoning witnesses under oath, offering indemnities, seizing evidence) is also vital if the incentives that keep many NHS stakeholders from speaking out about their concerns are to be surmounted. There are still too many barriers for this to happen organically – as evidenced by the closed-shop culture identified in the 2010-2013 Francis Inquiry – but a Commission may be just the circuit-breaker needed.

67 Public polling consistently reveals an aversion to political involvement in decisions about the NHS. For example, a 2006 Ipsos MORI poll found that only 9% of the public thought MPs should play any party in decision-making about funding for treatments.

68 More people (40%) nominate the NHS as the one of the biggest challenges facing the country than any other issue, and concern has been consistently rising – up from only 12% in 2008 (September 2016 Economist/Ipsos MORI Issues Index).

69 2013 Ipsos MORI Global Trends Survey.

Conclusion

Regardless of one's perspective on the NHS – the pessimistic view that it is in, or on the brink of, crisis; a belief that the system is performing adequately but faces looming long-term challenges; or the optimistic position that the NHS will continue providing world-class healthcare if just left to its own devices by meddling politicians – a Royal Commission is the potential game-changer to meet and sustain it for decades to come.

Whereas piecemeal reforms may end up overwhelmed by the system's wider problems, or last only the lifetime of an individual government, 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 still ahead.

> **'The Saville Inquiry cost £195m, and the Francis Inquiry produced a 4,000-page report with 290 recommendations, five years after poor care at the Stafford Hospital was first exposed'**

The alternative of a shorter, cheaper, and more manageable public inquiry may also 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 4,000-page report with 290 recommendations, five years after poor care at the Stafford Hospital was first exposed. As with other inquiries, controlling the length and cost of a Commission is entirely in the gift of Parliament. Whether they succeed in driving changes on contentious issues invariably depends on the choice of Chair and how well-defined are the Commission's remit and lifespan.

The second of these reports on the NHS will focus on the latter two questions. For now, one suggestion that seems to deal with a particularly common objection to the use of Commissions – that they can run out of control, producing recommendations that are either inconsistent with their purpose or to which the government is hostile – is that the Royal Commission on the NHS should be invited to submit a range of options for implementation. 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.

Whether one is a pessimist or an optimist on the state of the current NHS, all should welcome the chance for a system-wide, thorough investigation of both the current and the future challenges, in a forum uniquely capable of leading public opinion and providing legitimacy for the hard policy decisions that lie ahead. The NHS simply cannot afford to miss this opportunity.

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