



¹ Cicely Saunders Institute, King's College London

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In a healthcare system under increasing pressure, can a palliative care commission drive meaningful change?

Irene J Higginson,¹ Natalie Ramjeeawon¹

In November 2024, the *Terminally Ill Adults (End of Life) Bill* was passed in the UK House of Commons by a majority of 330 to 275. One key consensus in the debates surrounding the bill was that while palliative care in the UK can be excellent, its provision and funding are often inconsistent, inadequate, and must be improved. In response, a commission on palliative care has been established by Rachael Maskell MP to drive improvements in palliative and end-of-life care in the UK. More recently the Expert Panel of the parliamentary Health and Social Care Committee has announced it is undertaking an independent evaluation of the state of palliative care in England.

The 1946 NHS Act established a health service focused on improving physical and mental health and treating illness. This wording led many to assume that palliative care, which puts the person and their concerns before their illness, was excluded. It was not until the 2022 *Health and Care Act* that palliative care, along with care after illness, was introduced as a requirement.

Despite the UK's pioneering role, the provision, quality, and outcomes of palliative care remains inconsistent. Many people, along with their families who provide crucial support, miss out on quality care. A review of local health strategies found that some omitted palliative care entirely, while others mentioned it without concrete plans.¹ Some strategies had plans for care coordination, but key needs like timely access and 24/7 services were lacking.

A 2023 national survey of bereaved relatives revealed significant gaps: nearly one in five people had no GP contact in their final three months, only 29% received home palliative care, and just 19% had hospital-based support. In their last week, 35% suffered severe pain, and 40% experienced overwhelming breathlessness.² Many informal (unpaid) carers, such as family members, provided intensive support, through direct assistance, care co-ordination and emergency response, at substantial personal cost including to their health and finances.²

Health systems worldwide face mounting pressures—workforce shortages, rising demand, and fiscal constraints—while managing increasing numbers of adults and children with complex, life-limiting illnesses. The NHS is in serious trouble, both in hospital and community services.³ These pressures are expected to grow, with increased complex illnesses.⁴ In this context, how can a commission or an expert panel's findings drive meaningful change?

Palliative care is a vital, cost-effective component of modern healthcare systems. Meta-analyses and empirical studies consistently find that palliative care

delivers multiple benefits: it enhances quality of life, emotional wellbeing, and symptom management for individuals. It costs about the same or less for the healthcare system and society compared with usual services.^{5,6} Multidisciplinary, multicomponent, and multi-setting services have the greatest benefits.⁷

Cost savings are larger for people with more comorbidities, and when consultations are offered earlier.⁸ A recent study in Ireland found that timely hospital-based palliative care shortened stays by nearly two days, saving an estimated €1,820 per admission, whereas later referrals did not reduce costs.⁹

Trials in the UK have shown that community-based earlier short term integrated palliative and supportive care reduces symptom distress for older people with chronic noncancer conditions compared with usual care.¹⁰ Short term integrated palliative and respiratory care offered over six weeks improved quality of life and survival for people who were severely affected by breathlessness and chronic respiratory conditions.¹¹ Economic modelling identified cost-savings, which were highest when services were individually tailored.¹²

Therefore, palliative care can significantly contribute to the new government's three shifts for the future NHS, especially moving care from hospitals to communities and prevention.

Challenges remain, including the misconception that palliative care is only for the end-of-life. While end-of-life care ensures comfort in a person's final stages,¹³ palliative care is broader. It can also offer early support to manage symptoms and improve quality of life. The misunderstanding or lack of knowledge about this delays timely care that could alleviate distress, improve outcomes, and provide greater cost-effectiveness. Indeed, modern palliative care will often include physiotherapy support to help people manage symptoms.

Palliative care's holistic approach—addressing physical, psychological, social, and spiritual needs—benefits both patients and care givers, particularly those with chronic conditions who frequently rely on NHS services. Meta-ethnography finds that to provide care effectively at home, it is vital to ensure patients, and their care givers feel safe. This requires competent care (i.e. skilled teams) to be present when needed, around the clock.¹⁴ By providing comprehensive, continuous care, palliative services can reduce emergency admissions, improve outcomes, and enable more people to stay in the community.

And there are opportunities to improve care more. Frugal innovation—with cost-effective person-centred

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approaches—could improve symptom management and patient outcomes further. Interventions could be scaled by enhancing self-management of symptoms using web-based technology.¹⁵ Digital technologies integrated with appropriate outcome assessments¹⁶ could help provide early warnings when symptoms are tipping, prompting preventive action.

The question is however: will this commission drive real change, or is it merely sticking plaster, holding back a tide of unmet need? Both the commission and the expert panel have the potential to set in train bold, systemic actions to change policy, challenge entrenched barriers, and galvanise investment in palliative care. Their findings could steer government commitments, strengthen accountability, lead to better monitoring of outcomes, and integrate palliative care into mainstream health strategies. They might also push for better workforce planning and education, support for informal carers, and research into innovation and scalable models of care. Crucially, both must confront the pressing issues of untimely access to skilled palliative care and the persistent inequalities—ensuring that no community or group is left behind. Yet, there is a risk that their conclusions pull in different directions—fragmenting efforts rather than reinforcing them. To be truly transformative, their work must align, not compete, and drive early action rather than just debate. Otherwise, they risk being another set of well intentioned reports that gather dust. The challenge is to close the gaps.

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- 1 Chambers RL, Pask S, Higginson IJ, Barclay S, Murtagh FEM, Sleeman KE. Inclusion of palliative and end of life care in health strategies aimed at integrated care: a documentary analysis [version 2; peer review: 2 approved][version 2; peer review: 2 approved] [published Online First: 2023/03/30]. *AMRC Open Res* 2023;4:. doi: 10.12688/amrcopenres.13079.2. pmid: 36987529
- 2 Johansson T, Pask SJG, et al. *Time to care: Findings from a nationally representative survey of experiences at the end of life in England and Wales. Research report.* Marie Curie, 2024, <https://www.mariecurie.org.uk/document/experiences-at-the-end-of-life-in-england-and-wales>.
- 3 Darzi A. Independent investigation of the National Health Service in England. London: UK Government 2024: <https://assets.publishing.service.gov.uk/media/66f42ae630536cb92748271f/Lord-Darzi-Independent-Investigation-of-the-National-Health-Service-in-England-Updated-25-September.pdf>. (accessed 10/2/25)
- 4 Higginson IJ, Shand J, Robert G, et al. Reimagining Health and Care to Tackle the Rising Tide of Inequity, Multimorbidity, and Complex Conditions. *Catalyst non-issue content* 2024;5(5) doi: 10.1056/CAT.24.0266
- 5 Gomes B, Calanzani N, Curiale V, McCrone P, Higginson IJ. Effectiveness and cost-effectiveness of home palliative care services for adults with advanced illness and their caregivers. *Cochrane Database Syst Rev* 2013;2013:CD007760. doi: 10.1002/14651858.CD007760.pub2. pmid: 23744578
- 6 Bajwah S, Oluyase AO, Yi D, et al. The effectiveness and cost-effectiveness of hospital-based specialist palliative care for adults with advanced illness and their caregivers. *Cochrane Database Syst Rev* 2020;9:CD012780. doi: 10.1002/14651858.CD012780.pub2. pmid: 32996586
- 7 Johnson MJ, Rutterford L, Sunny A, et al. Benefits of specialist palliative care by identifying active ingredients of service composition, structure, and delivery model: A systematic review with meta-analysis and meta-regression[published Online First: 2024/08/02]. *PLoS Med* 2024;21:e1004436. doi: 10.1371/journal.pmed.1004436. pmid: 39093900
- 8 May P, Garrido MM, Cassel JB, et al. Palliative Care Teams' Cost-Saving Effect Is Larger For Cancer Patients With Higher Numbers Of Comorbidities. *Health Aff (Millwood)* 2016;35:. doi: 10.1377/hlthaff.2015.0752. pmid: 26733700
- 9 Matthews S, Hurley E, Johnston BM, et al. Does a palliative medicine service reduce hospital length of stay and costs in adults with a life-limiting illness?-a difference-in-differences evaluation of service expansion in Ireland. *Ann Palliat Med* 2024;13:. doi: 10.21037/apm-23-479. pmid: 39108246
- 10 Evans CJ, Bone AE, Yi D, et al. Community-based short-term integrated palliative and supportive care reduces symptom distress for older people with chronic noncancer conditions compared with usual care: A randomised controlled single-blind mixed method trial[published Online First: 2021/06/20]. *Int J Nurs Stud* 2021;120:103978. doi: 10.1016/j.nurstu.2021.103978. pmid: 34146843
- 11 Higginson IJ, Bausewein C, Reilly CC, et al. An integrated palliative and respiratory care service for patients with advanced disease and refractory breathlessness: a randomised controlled trial. *Lancet Respir Med* 2014;2:. doi: 10.1016/S2213-2600(14)70226-7. pmid: 25465642

- 12 Yi D, Reilly CC, Wei G, Higginson IJ OPTBreathe collaborators. Optimising breathlessness triggered services for older people with advanced diseases: a multicentre economic study (OPTBreathe)[published Online First: 2022/08/16]. *Thorax* 2023;78:. doi: 10.1136/thoraxjnl-2021-218251. pmid: 35970540
- 13 NICE. Care of dying adults in the last days of life. 2015. <https://www.nice.org.uk/guidance/ng31/resources/care-of-dying-adults-in-the-last-days-of-life-pdf-1837387324357> (accessed 10/2/25)
- 14 Sarmento VP, Gysels M, Higginson IJ, et al. Home palliative care works: but how? A meta-ethnography of the experiences of patients and family caregivers. *BMJ Support Palliat Care* 2017;7(4):O. doi: 10.1136/bmjspcare-2016-001141
- 15 Reilly CC, Maddocks M, Chalder T, Bristowe K, Higginson IJ. A randomised, controlled, feasibility trial of an online, self-guided breathlessness supportive intervention (SELF-BREATHE) for individuals with chronic breathlessness due to advanced disease[published Online First: 2023/04/15]. *ERJ Open Res* 2023;9:00508-2022. doi: 10.1183/23120541.00508-2022. pmid: 37057089
- 16 Murtagh FE, Ramsenthaler C, Firth A, et al. A brief, patient- and proxy-reported outcome measure in advanced illness: Validity, reliability and responsiveness of the Integrated Palliative care Outcome Scale (IPOS). *Palliat Med* 2019;33:. doi: 10.1177/0269216319854264. pmid: 31185804