Bob Bury: We need grown-up answers to crucial questions that still hang over future of the NHS

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IT'S all very well agreeing to write a personal view of the proposed NHS reforms, but they have become a bit of a moving target in recent days. After the U-turns and vaguely-worded amendments, it's difficult to know exactly what is now being proposed.

Initially, it was easy – there were two main strands, the first being the abolition of the Primary Care Trusts (PCTs) as commissioners of health care and their replacement by "consortia" composed largely of GPs. The second was the move to open up health care provision to the private sector in competition with established NHS facilities.

The initial negative response of most NHS staff to Andrew Lansley's proposals was due to the fact that, in the run-up to the election, we had welcomed David Cameron's promise that there would be no more top-down re-organisations of the health service.

So when one of his first announcements in office was the big-bang implementation of a completely untried restructuring of the NHS, we had every cause to feel aggrieved – no-one likes being lied to.

And when we got around to looking at what Mr Lansley was proposing, we discovered that we had every reason to be concerned. While more clinical involvement in the commissioning of services was welcome, the idea that all responsibility would pass from the PCTs to GPs raised more questions than it answered.

For a start, GPs already have a day job – providing care for their patients – and despite what you read in the Daily Mail, it tends to be a full-time job. So where would they suddenly find the time to take over the role of the PCTs?

And it wasn't just a question of time. The job of deciding what services to commission and then organising the necessary tendering, contracting and monitoring processes is a fairly complex one. It certainly isn't the job that doctors were trained for, so how would they acquire the necessary expertise?

The answer to both of those questions was the same – they wouldn't be doing it on their own – they would enjoy the services of administrators with experience in health care procurement. Suddenly it all became clear.

The staff made redundant by the abolition of the PCTs would be re-hired by the GP consortia to do the same job. Now, an idea will be occurring to you – an idea that would occur to anyone who wasn't a politician.

Why not leave the PCTs alone, but increase the amount of clinical input to the commissioning process? Why impose an expensive and unsettling revolution, when a process of evolution would achieve the same end?

The second strand of the reforms – to increase the role of the private sector in health care provision – was even more worrying than the proposed upheaval to the commissioning process.

Experience with private sector involvement in Leeds and elsewhere has taught us that commercial solutions are not necessarily cheaper, and that the quality of service is often sub-standard.

Even if this Government paid more attention to quality than its predecessor (which would not be difficult), increased public sector provision has the potential to increase the fragmentation of the service, which is one of the main issues we need to address in order to reduce costs and increase efficiency.

So, we weren't happy, but if you have been following recent events, you'd be expecting me to welcome the fact that many of our concerns have been addressed in the recent "listening exercise", at least where private sector involvement is concerned.

The role of Monitor – the Government's independent NHS regulator – has changed from that of ensuring increased efficiency (never mind the quality, feel the width) to, as David Cameron put it, "creating a genuine level playing field, so the best providers flourish and patients get a real choice".

Earlier this year, they also changed the initial intention that any willing provider would be invited to tender for services provided by the NHS, to any capable provider, thus implying some concern for quality.

That all sounds reassuring, but the fact that the Government needed to specify that Monitor would now "protect patient interests and not promote competition as an end in itself" shows that we were right to be concerned about their initial agenda. And as far as capable providers are concerned, it turns out that "capable" simply means

that the company concerned has to be registered with the Care Quality Commission, and therefore subject to its regulatory oversight. That's right – the CQC – the same outfit that was supposedly regulating that Bristol care home that featured onPanorama recently. Reassured? Me neither.

We will have to wait and see what happens, but I don't believe that very much has changed. The commissioning issue will no doubt be fudged, and we'll end up with de facto reconstituted PCTs with a bit more clinical input (from hospital doctors and nurses, as well as GPs).

The real agenda – the piecemeal privatisation of health care – will go ahead, perhaps slightly more slowly than would otherwise have been the case, and with more apparent heed being paid to quality.

And we have to remember why all of this is necessary – it is the pressing need to rein in health care expenditure at a time of financial crisis. Obviously, increased efficiency is one way to tackle the problem, but anyone who thinks there is £20bn of efficiency savings to be squeezed out of the NHS, and that greater involvement of the private sector is the way to deliver it, is deluded.

The area where we require increased plurality is in health care funding, not provision. We need a government with the courage to admit what nearly everyone else realises – that a service funded solely from taxation cannot meet the health care demands of the 21st century. We need to move to a model where taxation is supplemented by private insurance, and have a grown-up discussion which acknowledges that rationing of health care is an unavoidable reality. We can then decide what should be provided by the state, and what should be paid for by personal health insurance.

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