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Project on Commissioning for Secondary and Primary Health Care in Turkey

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Abstract

The commissioning of health services is emphasis of primary care led national health services through primary care groups. Commissioning includes assessing need, setting priorities, allocating resources, and influencing providers, involving patients and public Clinical commissioning groups (CCGs) are responsible for the majority of the National Health Service (NHS) budget, controlling around £69 billion in 2015. NHS England is responsible for commissioning primary care and specialized health care services in secondary care. The aim of this study is identifying knowledge of physicians, nurses and health manager of primary and secondary health care setting about clinical health commissioning in Turkey. Family practice centers and secondary care centers were chosen randomly in Edirne province. Qualitative and quantitative method were used. The results indicate that providers believe CCGs have the potential to improve quality in primary care. There is statistically difference between health professionals and their CCGs knowledge. Physicians have higher scale points than others.

Keywords

Clinical Commissioning Groups • Clinical Health Commissioning• Primary Healthcare • Secondary Healthcare • Health Professional

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Beginning of the 1990s, public policy analysts have been drawing attention to the rise of the ‘contract state’ or ‘contractual governance’. These terms are new in the literature of public management. This is a management technique from the private into the public sector by using market forces such as competition and contract as a way of increasing efficiency and choice in the delivery of public services. The introduction of ‘managerialism’ in healthcare sector and hospitals began in the early 1980s. This was followed in the early 1990s by the introduction of the ‘quasi’ or ‘internal’ market between purchaser and provider. Markets rather than bureaucracies are more likely is needed in order achieve efficiency, re organization and sustainability of health services. The new hospital management system shares realignment between management and medicine. The way of this, it is not challenging with the doctors’ rights in order to control them. It is creating a space for management rather then. The formal organizational structure involves a “physician leader” and “hospital manager” with equal and overlapping responsibilities for the functioning of treatment center. Medical leadership is top management support for widespread organizational change. The power of consultants in the hospital and their ability to promote or inhibit change in health care is important (Moran et al., 2017).

The commissioning of health services is emphasis of primary care led national health services through primary care groups. Commissioning includes assessing need, setting priorities, allocating resources, and influencing providers, involving patients and public. The commissioning of health services is Health Commissioning Project in United Kingdom is about getting the best possible health outcomes for the health of local population managed by primary care centers (GP surgery), by assessing local needs, deciding priorities and strategies, and then buying services on behalf of the population from providers such as hospitals, clinics, community health bodies, etc (Cafaggi, 2005; NHS, 2014).

The organizations commissioning health services in England has changed during April 2013. Clinical commissioning groups (CCGs) are responsible for the majority of the National Health Service (NHS) budget, controlling around £69 billion in 2015/16. NHS England is responsible for commissioning primary care (£12 billion) and specialized health care services in secondary care (£15 billion). As of April 2015, in most parts of the country NHS England shares primary and secondary health care responsibilities with CCGs through commissioning arrangements. Commissioning support units provide a range of services to CCGs and NHS England to help to manage health care and health cost together. CCGs must work with the new local authority Health and Wellbeing Boards and Strategic Clinical Networks that were established in 2012 in order to give efficient, locally sensitive and customer-focused service to CCGs (NHS Commissioning Board, 2012; McDermott et al, 2016).

Beginning of the spring 2013, NHS is in in new comprehensive system of Clinical Commissioning Groups (CCG), called NHS Commissioning Board. These groups are responsible for commissioning of primary health services. Every local GP practices have joined up with other health professionals in a Clinical Commissioning Group, which is responsible for "commissioning" - planning, designing and paying for NHS services. This system includes planned and emergency hospital care, rehabilitation, primary care, and mental health and learning disability services. Figure 1 (Wistow & Callaghan, 2011; NHS Kingston Clinical Commissioning Group).

Figure 1
Accountable Health Care Organizations via CCG

First, Accountable Health Care Organizations by using CCG are ready to organize a whole system of health care for a large population via clinical health commissioning. Taken fully, this effectively means that the CCG becomes a monitoring panel that judges the achievement of health care outcomes. Second, according new demands of young generation the need to 'transform' systems of health care have led to frustration for health staff and patients. General practitioners (GPs) nowadays are managers of primary and secondary health care demands of patients. The health needs of a community is detected, the responsibility is taken for providing that suitable services are available which meet these needs, and the engagement for the connected health outcomes is founded. Currently, primarily non-clinical managers in primary care trusts (PCTs) with little clinical data performed commissioning activities such as planning (assessment and evaluation), purchasing (identifying and negotiating) and monitoring health services. In response to that, the recent reform transferred commissioning duties over to GPs, nurses and other healthcare professionals who represent a range of both provider and purchasing relation. The range of the health staff involved as well as the difficulty of the tasks demands a composite approach to commissioning than produce earlier. GP leaders are seen as network leaders within their healthcare service environment with CCGs being the core of change activity. Illustration upon this theory, we were able to obtain single insights of the emerging leadership activities of GPs and their efforts to set up best practices as well as to develop new health clinical services ordered to the needs of their population. We believe that this approach will disseminate light on the emerging forms and functions of improving commissioning presence and will offer a fresh feeling on clinical leadership in healthcare networks (National Voices, 2017; Graham et al., 2015).

Method

Integration of family practice centers to secondary care hospitals could help to manage primary and secondary care by a cost effective way. This study aimed to identify knowledge of physicians, nurses and health manager of primary and secondary health care setting about clinical health commissioning.

Family practice centers and secondary care hospitals were chosen randomly from the national health care system database of Edirne. The first and second phases of survey visit was conducted between 2016 June and March. The interviews were audio recorded and were less than one hour in duration. Results from both phases of the survey were organized into a database for analysis.

The study has been also used qualitative data collection techniques by semi-structured interviews. Two groups consisted of six health professionals that were made for collecting qualitative data. The respondents were consisting of health professionals like physician, manager, and nurse. A phenomenological theoretical structure was used to empower the determination of experience and it is meaning in a specific time and place. We looked at the personal experience - the meaning and decisions of the participating trainees when coordinating their load. The data was gathered via semi-structured in-depth interviews.

A phenomenological theoretical framework was used enabling the determination of experience and its meaning in a specific time and place. This method was chosen for its inductive nature, providing valuable insight into various perspectives of the study participants. The data was gathered via semi-structured in-depth interviews.

The following research question was asked:

1. "What does mean Clinical Health Commissioning"?
2. "Did you hear about CCGs"?
3. "Is it Possible to do it in Turkey"
4. "Please explain why is possible or not possible to do it"

Hypotheses

In summary, we can generate two hypotheses regarding the conditions, under which the different measures.

H1: There is difference between Clinical Health Commissioning knowledge and socio demographics variables.

H0: There is not difference between Clinical Health Commissioning knowledge and socio demographics variables.

H2: There is difference between Clinical Health Commissioning knowledge and health professionals

H0: There is not difference between Clinical Health Commissioning knowledge and health professionals

Results

Barriers to integration were unawareness about health commissioning business models and lack of coordination across secondary and primary care health services, uncertainty about the adequacy of new health care transition systems that could be managed by effective health commissioning services. Main outcome measures awareness of clinical health commissioning members and health care stakeholders from their healthcare network; clarifying the role of primary care by analyzing strengths and areas for development of collaborative management of relationship between primary and secondary care. One hundred twenty-three codes were identified in the first analysis, which were then reduced and gathered

by similarities into codes of higher rank and then grouped into 9 themes and into 3 categories. The identified themes were the following: types of commissioning, hear about health commissioning, consequences of health commissioning.

A: No, I think it's all down to the strength of the GPs who are involved in primary care. CCG health care is clear yet. But I think it has not got, you know, any potential.
B: So, in theory CCG is not possible to in Turkey. Nobody believes in referral chain in Turkey. ...Even patients and public consensus.
C: Well CCG is a different relationship, I think if I speak in general terms, management and modernization of public health. CCGs effectively works in partnership, and it helps in the development of local policy and strategy.
D: We do not have a lot of time building up local relationships in the localities, and bringing people in from elsewhere just isn't the same.
E: we need a performance system they don't have the ability to interpret what that intelligence says,

The 10-item sustainable development Clinical Health Commissioning Index fared much better, with N = 83. Chronbach α values is 0.90 for both and relatively good average item-total correlations of 0.76 and 0.89. Average item-total correlations of 0.73.Pearson Product-Moment Correlations among Clinical as shown table 1.

Table 1
Health Commissioning Index socio demographic variables, age, experience, profession

		Clinical Health Commissioning Index
Age (year)		r: 0.91 ; p=0.000
Experience (year)		r: 0.85 ; p=0.001
Profession	Physician	28 ±1.5
	Nurse	24 ±1.2
	Manager	29±2.1

There is statistically difference between health professionals and their CCGs knowledge. Physicians are CCGs knowledge's points are 28 ±1.5; nurses CCGs knowledge's points are 24 ±1.2. Manager's points are 29 ± 2.1. According to Anova test p=0.001.

Conclusion

Health commissioning services via health integration with primary and secondary care may offer a cost effective and safe form of care for chronic disease management to family medical physicians. Interventions are needed to reduce uncertainty about the implementation commissioning processes and to ensure integrated health service models of primary care. This study provides evidence about the attitudes and beliefs of those currently undertaking formal roles within CCGs.

Responders clearly shared clinical knowledge to improve health commissioning. They also believed that CCGs have the potential to improve quality in primary care, although this will depend crucially on the ability of CCGs to engage their members. There is no a priori reason as to why CCGs should be better than PCTs at engaging the public with the need to close services, and it is at least plausible that those with detailed knowledge of patients' wishes are less likely to take the risk of engaging in difficult service reconfigurations.

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