

The Role of Commissioners in Health Service Provision: Lessons Learned from Primary Care Trusts (PCTs) England

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Abstract

It is the government's responsibility to reach policy outcomes. Since the needs of citizen vary, the government needs to improve the way it delivers public services. Monopolistic provision of public service by government becomes inadequate to fulfill the needs of the community. One of the ways pursued by the government is working with the third sector, through procurement and commissioning. National Health Services (NHS) in the UK is one of the examples of commissioning in the healthcare service. The role of commissioning has been done by Primary Care Trusts (PCTs) from 2002 until 2014. Since commissioning became the center of public health provision, the role of commissioners has become pivotal. Using systematic review, this study aims to examine the role of commissioners in health service provision in England. It can be concluded that commissioners (PCT) play an essential role in identifying the needs of the community. This early stage of planning relied on the knowledge, skills, and capacity of commissioners. Unfortunately, not every commissioner has the capability to perform the commissioning process. Therefore, a partnership with other stakeholders is critical to overcoming the limitations of resources, including the capacity, time, and funding. The other findings suggest that national policy by the central government has contributed to the success of commissioning. Results revealed that national targets often prevented commissioners from reaching the local targets, especially when resources were insufficient.

Keywords:

public-private partnership; commissioning; health services; primary care trust

Introduction

It is the government's responsibility to reach policy outcomes. In order to meet those policy objectives, governments have ways of pursuing them. Taxes, regulation, advertising, and marketing to change people's behavior are all examples of government effort to reach and meet their policy objectives. Since the needs of citizens vary, the government needs to improve the way they deliver public services. Monopolistic provision of public service by the government is inadequate to fulfill the needs of the community. One of the ways pursued by the

government is working with the third sector, through procurement and commissioning. From the third sector, government procures not only goods but also services. Although not always obvious, this public-private partnership (PPPs) has an important role in reaching policy outcomes. Procurement and commissioning contribute to reaching policy outcomes through the direct and indirect ways.

The cooperation between the public and private sector is increasing in many countries around the world. Happening in most areas of public service provision, this PPPs mechanism

is based on working arrangements system with a mutual commitment between stakeholders. When there are public-private partnerships, there are usually clear contracts (Bovaird, 2004, p. 199). Cabinet Office (2006, p. 7) defines commissioning as “the cycle of assessing the needs of people in an area, designing and then securing appropriate outcomes.” Meanwhile, Woodin (2006) defines it more as a proactive role that aims to plan, design, as well as implement the various services rather than purchasing services.

According to the Office of Government Commerce (2008), commissioning is defined as managerial activities rather than purchased goods, services or works from a third party. It can happen in areas such as education, social care, and health services provided by private or by voluntary sectors. As the principle of public procurement is value for money, effective procurement is essential to ensuring good public services to meet users’ needs. However, in order to fulfill the needs of community through commissioning, the commissioning process still need to meet the standards from the government.

One of the examples of commissioning in public service delivery is National Health Services (NHS) in the UK. The separation of responsibility on the planning and funding of health service provision is important to achieve the policy goals. Based on Wade (2011), separation of responsibility on planning and funding of health service delivery aims “to ensure that health services are planned and delivered in a way that meets the interest of patients and taxpayers rather than healthcare providers” (p. 35). It has to be done as an attempt for NHS to be more responsive in the cost control and demands of patients in order to create high-quality health services (Wade, 2011, p. 36).

Since NHS does not offer their services, they must be procured from external suppliers. The purchase is not only for goods but also

services from diverse cross-sector network suppliers (Allen et al., 2009). Buying services for external suppliers is certainly different from buying goods. As argued by Smeltzer & Ogden (2002), purchasing healthcare requires monitoring quality and assessing standard. It involves complex human relations that require the ability to plan, monitor and evaluate. This managerial function played by a third party is known as commissioning.

The official model of commissioning by NHS describes commissioners “as those who plan and fund services to meet local health care needs” (Shaw et al., 2013, p.6). It is completely different from services provision. Before replaced by Clinical Commissioning Group in 2013, the function of commissioning in NHS is played by Primary Care Trusts (PCTs) as a third party payer. Based on the Department of Health in McCafferty et al. (2012, p. 40), PCTs “were established in England in April 2002 and charged with undertaking the commissioning role.” The main responsibility of PCT is to assess the health needs of the local people and determine priorities according to the allocation of the resources (Allen et al., 2009, p. 6). PCTs as local commissioners have a responsibility to decide resources in many different activities in order to meet the goals of healthcare (Wade et al., 2006). It has to be done by managing contracts with diverse healthcare providers to meet health goals based on local needed.

Since commissioning is becoming central to health service provision, the effectiveness of NHS becomes important for its success. Therefore, as argued by Williams et al., (2012, p. 83), it is important to strengthen the capacity and the capability of the individuals as well as the organizations that are involved in the commissioning process. Basically, discussion about organizational and individual capacity in procurement is not only owned by the public sector. Based on Allen et al., (2009), procurement both in public and private sector requires personal knowledge of “wider system

and how decisions may impact upon wider structure” (p. 524).

Apart from capacity and capability, it is important for PCTs to develop a dynamic partnership with other stakeholders involved in commissioning. Working together will develop high quality and integrated services. As mentioned by Baxter et al., (2008), there are many different organizations involved in commissioning and service provision based on mix managerial and contractual system. This argument is supported by Shaw et al. (2013) who argued “managers and professional staff from provider organization and local authorities, clinicians and, to a lesser extent, patients and the third and independent sectors also played a role” (p. 6).

Since commissioning separates the function between purchaser and provider, Bovaird (2006) emphasized the ability to be sensitive to the requirements of each partner involved as well as the aims and priorities of the partnership. Partnership procurement and distributed commissioning are more complex than straightforward bureaucratic decision making. Transparency is required for the building of a relationship. Bovaird (2006) argued that strategies are needed for working together to formulate and agree formally on how to keep the partnership in line with strategy and policy. What is important from commissioning is it has to be done through innovation (Allen et al., 2009, p. 523). If this can be achieved, the lesson from commissioning will be beneficial for public service provision.

Research Aim

Using the case of NHS England, this research aims to examine the role of the commissioner in health service provision. Overall, it will try to answer the question, how do commissioners use their knowledge to assess local needs in order to improve health service provision. Primary Care Trusts (PCTs) as a third party had a responsibility to

manage health service provision that affects health service provision. Since PCTs have a responsibility to assess, prioritize, and decide on health service provision, the capacity of PCTs becomes important. It will also try to identify how commissioners build relationships with providers and involve public engagement in order to support their decision-making process.

The research question will examine commissioning in the planning stage. The author also acknowledges that the role of PCTs has been replaced by the Clinical Commissioning Group. Therefore, this research will only discuss the role of the commissioner in the frame of PCTs. Based on England’s experience of commissioning through NHS, this paper will contribute to knowledge related to the commissioning process. It might be useful to improve public service delivery in Indonesia by providing a broader perspective of public service provision through a partnership with the third sector.

Methods

Using systematic review, this research aims to provide a complete and systematic picture through a rigorous and transparent process. The systematic review is different from literature review since it applies “a replicable, scientific and transparent process” (Tranfield et al., 2003, p. 209). It aims to minimize the bias through “exhaustive literature searches of published and unpublished studies and by providing an audit trail of the reviewer decisions procedures and conclusions” (Tranfield et al., 2003, p. 209). This comprehensive search makes differences between the systematic review and traditional narrative review (Aveyard, 2010).

The research protocol is one of the most important steps in a systematic review. In the systematic review process, “once protocols are complete they are registered with the appropriate review-groups editors, such as the Cochrane Collaboration” (Tranfield et al., 2003, p. 215). If the research protocol

is satisfactory, “the review is published to encourage interested parties to contact the reviewers and to avoid duplication of studies” (Tranfield et al., 2003, p. 215).

This research implements a step by step systematic review according to protocol systems such as database and keywords, eligibility criteria, screening process, data extraction, form of critical appraisal, and analysis tool for the findings. To build a comprehensive search strategy, the first step that has to be done is deciding on the database and keywords. This research uses three databases such as MEDLINE, Applied Social Sciences Index and Abstracts (ASSIA), and Health Management Information Consortium (HMIC). The keywords are: (1) commissioners OR commissioner;(2) commissioning OR procurement;(3) health outcomes OR health outcome; (4) Primary Care Trusts;(5) England; (6) World Class Commissioning; (7) Strategic Commissioning; (8) (Commissioners OR commissioner) AND Primary Care Trusts AND England; (9) (Commissioning OR procurement) AND Primary Care Trusts AND England; (10) (Health outcomes OR health outcome) AND Primary Care Trusts AND England; (11) (Commissioners OR commissioner) AND (Commissioning OR procurement) AND (Health outcomes OR health outcome) AND Primary Care Trusts AND England; (12) World Class Commissioning AND Primary Care Trusts AND England; and (13) (Strategic AND Commissioning) AND Primary Care Trusts AND England.

The eligibility criteria refer to several principles such as:(1) studies conducted in England, UK; (2) based on qualitative research; and (3) published between years 2004-2014. Articles not written in English language and without abstract are not included. The review looked for articles discussing: (1) Strategic Management of PCTs England; (2) Process of the need assessment of community; (3) Commissioners knowledge and capacity; (4)

Relationship between commissioners and health provider; and (5) Public engagement in decision-making process.

From the database and keywords above, there are 2076 articles eligible as the first database. The first screening process included the titles and abstracts, narrowing the results down to 32 articles. From those 32 articles, eight articles have been chosen based on the full-text screening process as the main articles to answer the research questions. The data extraction sheet contains the title of review, the nature of the study, outcomes as well as the results. Since this research uses the qualitative approach as one of the eligibility criteria, each journal has been examined by the Critical Appraisal Skills Program (CASP), which contains ten questions that are designed to review qualitative journals. The results of the systematic review provided in this study are compiled by eight main journals to provide various information related to the role of commissioners in health service provision.

This research aims to examine the role of commissioners in health service provision through a systematic review. The registration process that should be done in a systematic review is not carried out in this research. The review of each journal as well as the critical appraisal has also been done solely by the author. Even though the implementation of the systematic review is not cohort in this research, this research will hopefully be suitable to enrich the implementation of a systematic review in social science.

Result and Discussion

Identifying the Needs of Community

Commissioning process is divided into five main stages of cycles such as: (1) need assessment, (2) planning, (3) contracting, (4) monitoring, and (5) revising phase. The needs assessment process contains activities such as “quantification of need based on epidemiological studies, census data, mortality and morbidity rates and other population data;

quantification of need based on health records of registered population/members; identification of evidence-based interventions, patient surveys and focus group; and professional and stakeholder views” (Woodin, 2006, p. 206).

This local needs assessment is essential for examining all possible resources that can be used to improve the health of the community. Commissioners play a role in identifying local resources that might be valuable and can be utilized to support the health of society (Shircore & Ladbury, 2009).

Research by Klee (2009) found that information from various resources is analyzed by the commissioners to gain an understanding of communities especially regarding health inequalities and access to services. Klee (2009) describes how the process of gathering information in each stage by the council and the PCTs is supported by the framework based on the view of local people and national policy, compounded by “measuring current performance” to identify improvement needed to meet the better outcomes. The importance of this framework has been emphasized by Williams et al. (2012). Williams et al. argue that the clarity about aims and objectives plays an important role on this stage of commissioning.

However, identifying the needs of the community and implementing them into a decision-making process is very challenging. Forecasting and whole-systems work requires skills and experiences to deal with the complex task of commissioning. Maybin et al. (2011) stated that excellent health services depend on the effectiveness of commissioners at the local level. In order to assess local needs and decide on the most appropriate response, the professional skills and knowledge of commissioners become pivotal especially to ensure transparency (Shircore & Ladbury, 2009, p. 286). McCafferty et al. (2012, p. 420) support the argument that the competencies of commissioners have a substantial impact on making the whole process more professional.

Unfortunately, research by Williams et al. (2012) has identified that the functions and competencies of commissioners remain under-specified (p. 85). This study found that not every commissioner understands the commissioning process very well. The weakness of commissioners is including “analyzing performance data, conducting cost-benefit analyses and option appraisals, and drawing up appropriate contracts to manage an external provider for service areas that previously had been delivered in-house” (Williams et al., 2012, p. 85). There are many problems and opportunities that depend on the skill of commissioner.

This claim has been supported by the findings from the case study of Telford and Wrekin Council that was assessed by Klee (2009).

“It became clear that commissioners did not have a framework to enable them to prioritize and so used personal judgment or responded to pressure from stakeholder groups. As a result, they felt overwhelmed by demand and ineffective in the impact that they could have.” (Klee, 2009, p. 31).

The lack of capacity not only happened in identifying the needs of the community. As argued by Orton et al. (2011), the commissioner cannot interpret and apply research evidence in the decision-making process. Orton et al. (2011) have revealed that the commissioners’ limited ability to utilize the sophisticated research evidence affects the effectiveness of the decision-making process. Findings related to the lack of capacity in implementing research are also found in Williams et al. (2012), which mentioned:

“Very often we’ve got some good data but we don’t really understand what it means so we need good analytical skills and we need a good understanding of the service-user

journey" (interview from Williams et al., 2012, p. 85)

The group of informants in Orton et al. (2011) discussed how capacity building is pivotal for decisionmakers to improve their ability in order to utilize "complex public health research evidence" (p. 5). It will affect the effectiveness of public service provision. Moreover, according to Orton et al.(2011), some informants emphasized the ability to understand research and how to implement it in the decision-making process. It should be part of training or even the job requirement and started at the earliest possible stage of planning (Orton et al., 2011, p. 5).

On the other hand, the lack of capacity to implement research evidence is not the only obstacle in the research area. It becomes more complicated since there is the lack of research evidence for the most effective approaches to delivering the intervention to society. The lack of research evidence has been strengthened by evidence provided by McCafferty et al. (2012). Participants in the study by McCafferty et al. (2012) emphasized that data from the national or local area was not always useful and applicable for the specific setting:

"Data is always typical in the NHS, we have so many nationally defined data sets that they never quite give us the information we want, they give us, you know, some information but it's never exactly what you're looking for"(ID1, PCT Executive, Site A – McCafferty et al., 2012, p. 43).

Shaw et al. (2013) also revealed the evidence related to the limitation of the data. Even though the commissioner put a very high value on available data to support in the decision-making process, it is challenging for commissioners to collect data that is compatible with their specific condition (Shaw et al., 2013). As argued by McCafferty et al. (2012), "inappropriate and poor quality data, a lack

of robust information systems and capacity to generate data and interpret knowledge were identified as considerable hurdles" (p. 43).

The limitation of the data also related to ethical reason. Based on public health specialist, "it was often impossible, or unethical, to generate this kind of evidence" (Orton et al., 2011, p.4).Without adequate evidence and measurement, the process of decision making becomes more complicated. To overcome this obstacle, Orton et al. (2011) found that some PCTs prefer to ask for collaboration with academician. Therefore, building a partnership with other stakeholders and setting collaborative standards among stakeholders is one of the options to deal with the limitation of data. The urgency of partnership in the commissioning process will be discussed further in the other part of the chapter.

The lack of capacity in the decision-making process is not the only barrier that needs to be tackled for successful commissioning. As mentioned by McCafferty et al. (2012), availability of resources such as time and money can be barriers to commissioning. The demands related to the time were often longer than the time available. It is challenging for the commissioner to make a decision and to distribute resources when they have insufficient time.

Time availability is even worse in scenarios where long-term condition services are being provided. Shaw et al. (2013) have revealed that long-term condition services require multiple years and involve various activities. It also requires "convening and coordinating service development across interest groups and supporting service implementation" (p. 5). Developing service for the long-term condition usually requires a longer time than other services. It is "complex and multifaceted, involving effort by a wide range of individuals and organization and taking place over long periods of time" (Shaw et al., 2013, p. 5).

On the other hand, Orton et al. (2011) described how commissioners often face

difficulties in setting priorities for health services. The preventive action is also necessary as an immediate medical intervention. Based on the research of Williams et al. (2012), the limitation of resources can be handled by building a partnership with other stakeholders. Williams et al. (2012) have emphasized relationship as incredibly important.

Public Engagement and other Stakeholder Involved

As mentioned in the discussion above, partnership plays an important role in overcoming the challenge of health service provision. The active partnership between commissioners and providers became fundamental for developing an approach to providing high-quality services (McCafferty et al., 2012; Shaw et al., 2013). Dickenson and Glasby (2008) in Klee (2009) stated that an effective partnership would lead to better health and social care. Through the partnership, stakeholders share willingness and vision to achieve common goals. There will be a commitment between actors to improve the well-being of local people (Klee, 2009, p. 30).

However, building a relationship with various stakeholders brings its own challenge. Different professional backgrounds lead to different interpretations of health outcomes. Commissioners and public health specialist have very different perspectives on identifying health outcomes (Baxter et al., 2008; Orton et al., 2011). The challenge goes further into negotiating each stakeholder's agenda and make priorities. It is compounded by cultural issues between various partners such as a lack of shared language and values (Klee, 2009).

Furthermore, Orton et al. (2011) have revealed that partner organization outside from NHS has a different audit system on the same targets and outcomes. This partnership is even perceived by the participant as being impossible due to the "imbalance of power between the PCT and acute providers," which

is further compounded by different objectives and competition between another (McCafferty et al., 2012, p. 43). Not only that, Klee (2009) has mentioned that in partnerships involving complex organizational boundaries there are also costs that need to be paid. The cost of partnership is expensive.

The different perspective between commissioners and public health specialists can be understood in a framework of government target. Managers from various organizations tend to understand the aims and objectives of each other rather than the target of clinicians. This is what causes the clinician's objectives to be sidelined.

"Strong government targets aimed at managers may augment the cultural differences between clinicians and managers, with clinicians becoming more reluctant to support managers as they feel their clinical freedom being reduced. Moreover, clinicians may simply have different objectives from managers, with these differences being highlighted by targets. Clinicians prioritize quality while senior managers are more concerned with organizational objectives" (Baxter et al., 2008, p. 123-124).

The differences between the organization in measuring outcomes as well as the different perspective between stakeholders cause difficulties in the commissioning process. Therefore, according to Orton et al. (2011), the power relationship between stakeholders will determine the process. The concrete example of differences between stakeholders can be seen in the study by Klee (2009). Klee (2009) has revealed that there are two different perspectives that have been used to decide on health service provision. The first perspective is based on a managerial aspect of commissioning. On the other hand, there is the paradigm of "putting people first" versus the needs of the community.

Another example has been shown by Orton et al. (2011). There are differences in paradigm to reduce health inequalities. Based on Orton et al. (2011), some commissioners “tended to prefer focussing on identifying and targeting intervention at those considered to be ‘high risk,’ ‘deprived,’ or ‘easy to miss’ rather than adopting more effective population-wide approaches. These targeted initiatives were considered to have a more immediate and noticeable impact at a local level” (p. 5).

However, behind all of the weakness of partnership, McCafferty et al. (2012) have revealed that this difference might bring a positive impact on the decision-making process. One of the key informants in McCafferty et al. (2012) argued that commissioners need to shift their focus more to process rather than the end. There is also an attempt by the commissioner to shift their perspective to balance the differences between stakeholders (Orton et al., 2011).

Moreover, based on research from McCafferty et al. (2012, p. 46), it is important to provide support in order to strengthen inter- and intra-organizational culture. Williams et al. (2012) have revealed that to be able to reach the effective performance on commissioning, the commissioners need to be collaborative and open to the providers. Commissioning will be more successful in open culture ways rather than “a highly distant and antagonistic relationship between commissioner and provider” (Williams et al., 2012, p. 86). Besides the trust, each of the stakeholders involved in the partnership needs to build intense communication and willingness to understand the value, language, and objectives between the organizations (Klee, 2009). This is what McCafferty et al. (2012) describes the difference between commissioning and contracting. In commissioning, there is no distance between commissioner and provider.

Since partnership plays an important role in ensuring the effectiveness of commissioning, leadership from commissioner becomes unavoidable. Based on Klee (2009), there is a

strong need for the leadership to establish a successful partnership between stakeholders. Leadership becomes substantial. As mentioned by Klee (2009, p. 32):

“The leadership from the Council and the PCT have enabled them to be clear about shared priorities and to direct their limited time and energy to improve specific outcomes. Poor alignment of targets and performance measures for health and social care is one of the main barriers to effective partnership working.”

From the explanation above, it can be concluded that partnership between stakeholders has its challenge and opportunity. The different perspective can be an obstacle in decision-making process whereas the various perspective brings own advantages that “offer valuable input at all levels in assessing, planning, commissioning, and delivering services” (Banks, 2010, p. 11).

Nevertheless, the effort to improving health outcomes is not only can be done through the partnership with providers. Klee (2009) emphasizes that public or patient involvement in the decision-making process is also significant. According to Klee (2009, p. 30), it is central for the Health and Well-being Strategy to have a clear focus and pay attention to what local communities opinion. This process will help the commissioner to identify priorities and make improvement for public service delivery (Klee, 2009).

Similar with Klee (2009), Banks (2010, p. 14) has argued that by involving and considering public opinion, the commissioner will be able to ensure that their decisions are suitable to meet the needs of the community. It will also contribute to improving health outcomes. Through public involvement, “people will take a shared responsibility in their own health, the health of others, and in the provision of improved, more efficient and

effective, value-for-money health services” (Banks, 2010, p. 14). Public engagement was seen as the most successful approach to make the best use of available resources (William et al., 2012).

As argued by Banks (2010, p. 10), involving the patient in the commissioning process is fundamental to improving health service provision. It is substantial to ensure that the needs and preferences of the patient are met. NHS organization has to ensure that patient and public have the opportunity to be involved in all aspects of redesigning care. Shaw et al. (2013) mentioned that input from the user is pivotal especially in the planning stages. Patient and public involvement in designing plan will ensure there will be a better standard for patients. Moreover, the patient will have better information related to the preferences. Thus, commissioners can invest more appropriately on behalf of the community. Public involvement is also important since people have different needs, knowledge, and experiences of health (Banks, 2010, p. 11). Discovering patient needs and experience is valuable to make improvements in health service delivery.

Similar to Banks (2010), Shircore and Ladbury (2009) also emphasize seeing the “public” as the participant as well as the generator for the process. It is crucial for the public to be involved in their health status, have control of their lives, have power and influence over their needs, and be treated as “a resource for their own benefit, rather than as a source of problems to be solved” (Shircore & Ladbury, 2009, p. 283).

On the other side, it has to be realized that public opinion is not always beneficial for decision making. Based on Vergel & Ferguson (2006, p. 150), difficulties occur when public demands are not covered by the central guidance. Practically, the challenge can be more extensive. It requires a common framework so that “decisions can be taken on fair and reasonable grounds” (Vergel & Ferguson, 2006,

p. 150). Moreover, commissioners have to deal with their limited budgets to deal with the pressure of the public as mentioned by Orton et al. (2011).

In cases where commissioners feel powerless to influence the decision-making process, national targets and policy from the central government contribute to strengthening the position of the commissioners. In this situation, national policy has been a support for commissioners (Gridley et al., 2012, p. 88). On the other hand, if the central government is too dominating, it also contributes to the destabilization of the commissioning process (McCafferty et al., 2012, p. 43).

Primarily, the central government has an essential role in commissioning through establishing national targets and national policy as a guide for commissioners. However, there are several challenges as mentioned by McCafferty et al. (2012, p. 44) such as “perverse political intensives; constant change; and policy misalignment.” The case study from McCafferty et al. (2012, p. 44) has revealed that healthcare organization “was highly politicized and thus beyond the control of the PCT.”

The Importance of Performance Management and External Factors

After all of the discussion above, there is another thing that has to be done by commissioners for effective commissioning: performance management. The lack of targets and the absence of reward and punishment make the staff members reluctant to provide their best performance. It affects performance organization and the process of service improvement (Gridley et al., 2012, p. 89–90). It can be concluded that the right program without reward and punishment tends not to bring any good results. On the other hand, the program with the clear target, reward, and punishment, has real results for health service improvement. Since the commissioning process involves various stakeholders, it has to be realized

that “incentives within organizations are as important as those between organizations” (Baxter et al., 2008, p. 125).

Besides the ability of commissioners to maintain and manage the commissioning process, there are several external factors that need to be concerned. This element has major influences on the commissioning process and is often out of control of the commissioners. First is the rapid change from central government. Based on McCafferty et al. (2012), the continual change in national policy was contributed to the negative impact on PCTs to maintain and focus on service improvement. The change is often rapid, inconsistent, and disruptive to the organizations’ working patterns.

Similar findings have been provided by Baxter et al. (2008), for some respondents, national targets tend to be a trap that consumes many resources and limits flexibility to pay attention to local issues. Furthermore, Baxter et al. (2008) argued that “government policy tending to focus on providing advice and information encouraging individuals to take more responsibility for their own health, whilst ignoring the need to complement this with addressing the entrenched structural inequalities that exist in society” (p. 2).

Conclusion

This research aims to examine the role of commissioners in health service provision. The separation between provider and purchaser in public service has been a feature in the UK for many years. One of the examples is the health service provision that is held by NHS. This separation between purchaser and provider is known as commissioning. In health service provision, the role of commissioning has been done by Primary Care Trusts (PCTs) from 2002 until 2014. Since commissioning became the center of public health provision, the role of commissioners has become more important.

This research has three main questions. First is the process of commissioners in identifying

the needs of the community. Identifying the needs of the community is the earliest step of the planning cycle in commissioning. Since PCTs have the responsibility to decide on behalf of the population, it is very important that commissioners examine the needs of the community in appropriate ways. Misidentification of the needs of the community will affect the health service improvement.

From this research, it can be concluded that the process of identifying needs of the community has been done through official documents such as epidemiological data, population data, census data and any others data related to the health records of population compounded by surveys and professionals as well as stakeholders’ view. In this process, the knowledge, skills, and capacity of commissioners have an organizational role in identifying and interpreting data, especially data based on research.

The premise of this research has emphasized that the capacity of the commissioner will be one of the key roles in the commissioning process, specifically in the planning stages. Findings of this study have established that the ability of commissioners is substantial in analyzing data, interpreting research, and implementing it in the commissioning process. Not every actor known as a commissioner understands what they need to do in the commissioning process. Moreover, much of the data available is inappropriate to address the specific condition that is faced by commissioners.

Based on the conditions above, developing partnerships with other stakeholders is critical. Through the partnership, the commissioner will be able to tackle the limitation of resources, including the capacity, time, and money. However, the partnership has its own challenge since organizations involved have their own interests, values, and perspectives. It can be handled by leadership from PCTs as the leader of the commissioning process. Open

culture and willingness to understand each other agenda also pivotal to ensure effective commissioning.

Since commissioners decide on behalf of the community, it is important for commissioners to consider public opinion. Through the opinions of the public and patients, commissioners have the opportunity to reveal the needs of the community more accurately. There is no one who can identify the needs of the community better than the community itself. All of the planning stages above need to be supported by performance management, through a clear target coupled with reward and punishment. National policy by the central government has also contributed to the successful commissioning to improve health outcomes. Findings revealed that national target was often burdening commissioners to reach the local target especially when the resource is insufficient.

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