How cooperative military and civilian health provider (CHP) models can be optimised in forward areas of operation; what do CHPs need to know?

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Topic: Operational Health Support

Introductions

Militaries, governments, and intergovernmental agencies have increasingly contracted civilian health provider (CHP) companies for medical care in forward areas of operation (FAOs), rather than providing these services organically. This trend has been driven by institution-specific decision factors such as cost effectiveness, force-generation limitations, timeliness of deployment, risk mitigation, value for money and overall cost reduction. Regardless of decision-making pathways that result in cooperative military and CHP models being established, three key questions are frequently raised in forums of discussion between military professionals and CHPs: what is needed, why outsource, and how is it implemented? The clarity and depth of these answers are important factors for militaries and CHPs to optimise cooperative models in FAOs. This discussion reviews these questions, from the CHP's perspective, drawing from the authors' experience to identify key information that should be discussed.

Discussion

What is Needed?

Creating a cooperative healthcare model for a specific military is as variable as the individuals that compose the organization itself; that is to say, every military has a unique set of standards, operational expectations and norms, command and control structures and desired medical capabilities at different levels of the patient care pathway. This information is vital for a CHP to provide solutions tailored to the military's needs. With this information, a detailed enumeration of specific requirements of the CHP and a thorough assessment of the challenges in a specific FAO, the cooperative model established will have both the depth and technical specialization needed for optimised efficiency.

Why Outsource?

The decision pathway and, ultimately, the factors that result in a military's decision to outsource a specific capability to a CHP should translate into a proverbial mission statement for the selected provider. Understanding a Defence organization's strengths and weaknesses in the provision of healthcare empowers a CHP to supplement and compliment where needed, respectively. This is a paramount principle for creating efficient/effective models of cooperation, regardless of theatre of operation.

How Will the Model Be Implemented?

Implementation of an agreed cooperative healthcare model should fall within the expertise of the selected CHP. Defence organizations can expect a full assessment of mobilization and implementation challenges, with resulting solutions to meet them, from the CHP. Paralleling this will be explicit requirements for support from the military; e.g., importation of blood products into most FAOs is near-impossible for a CHP without falling under the military's logistics banner. Clearly identifying these responsibilities, and ensuring the CHPs capability in a specific FAO, will contribute to the model's immediate and long-term success.

Conclusion

Militaries and CHPs have unique areas of expertise that, when applied cooperatively, can create healthcare systems greater than the sum of their parts. Parts of achieving success for these models is extensive dialogue and a depth of mutual understanding to identify the military's needs in the context of its larger structure, understand its strengths and weakness, and provide clarity to a CHP's capability in implementing a healthcare model in a specific FAO. Specific attention to detail in these areas can empower both militaries and CHPs with knowledge required to optimise cooperative healthcare models in FAOs.