Health Services Market Testing – the Experience of the Community Services Review Team in British Forces Germany

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SUMMARY: During 1993-1995 the health services in British Forces Germany were subjected to a market testing process by which the primary, community and acute health services for the British Servicemen and women, their families and attached civilian staff, a population of 70,000, were put out to competitive tender with the then current provider, the Defence Medical Services, as one tenderer for the contract. This paper outlines the methodology developed by the Health Alliance Community Services Review team in formulating a successful bid. It is considered that the process outlined could be of value to those involved in future market tests, commissioning projects and performance improvement programmes.

Introduction

Following the publication of "Competing for Quality"(1) and a predicted reduction of the population of the former British Army of the Rhine to a total of 70,000, it was decided during 1993 that the Defence Medical Services in Germany were to be subject to market forces as part of a large market testing project with the formation of a purchaser/provider split. Previous commissioning projects within the National Health Service have concentrated on particular aspects of a health service, namely primary health care, community care or acute care, but none have encompassed the full range of primary, community and acute services. Similarly none has tried to provide a British style of service in a foreign country. A MEDLINE search has provided only one reference to a British Service being provided in Germany(2). Table 1 specifies the services which were subject to market testing. Approximately fifty organisations, including the Health Alliance (an amalgam of the Army and RAF medical services, the Soldiers, Sailors and Airmen's Family's Association (SSAFA), Guy's and St Thomas's Hospital Trust and West Lambeth

Community Trust) initially indicated an interest in providing the health service in British Forces Germany. A short list of three bids (including the Health Alliance) was drawn up in the autumn of 1994. The process was competitive with each potential provider required to respond to a comprehensive Statement of Requirements (SOR) contained within an Invitation to Tender developed in British Forces Germany, in terms of specific details of how each element of the service would be provided at each location, track record in the area concerned and price(3). In addition the SOR specified the retention of certain military posts in certain locations, such as military general practitioners, required for military duties. The aim of this paper is to describe the process by which the members of the Health Alliance Community Services Review team reviewed the provision of care and the methodology that was employed in planning and proposing a successful submission.

Multidisciplinary Approach

British Forces Germany (BFG) is characterised by having a patient base of a small town (70,000) spread over

an area equivalent to that of Scotland. There are six main Army and two Royal Air Force population centres. These have populations of 5000 people or over, but there are several locations with approximately 2,500 people and some with as few as 300. These populations are located from the German/Dutch border north-eastwards to close to the former border with the German Democratic Republic. Table 1 emphasises the large number of community disciplines that were required to be provided in BFG. A core team was formed consisting of an experienced general practitioner and health visitor, both of whom had worked for many years in a Service environment and especially in Germany. This core team was supplemented by a senior midwife to provide specific midwifery advice. Regular input was provided from nominated senior staff in the Professions Allied to Medicine, for example Speech and Language Therapy, Pharmacy and Physiotherapy. Dental colleagues reviewed the provision of community dentistry in a manner similar to the medical services.

The team recognised early on that the provision of the various disciplines in the twenty three Army medical centres in BFG had many strengths such as accessibility, 24 hour nurse and general practitioner provision to form "Primary Care Centres", access to bedding facilities in some medical centres and an in-depth understanding of the military culture and the problem of operating in a foreign country. It was similarly recognised that in order to meet the Statement of Requirement for the market testing process that some enhancements would be needed. These were specifically in the areas of community midwifery, pharmacy, physiotherapy and the greater procurement of Information Technology. Formal SWOT (Strengths, Weaknesses, Opportunities and Threats) analyses were performed with other members of the Health Alliance team to focus on specific areas of the health service.

The Primary and Community review team fully understood that the requirements of each population centre could well be different, both in terms of the potential needs of the patient but also the staff. In order to ascertain these needs a formal survey preceded by a completion of a questionnaire by each medical centre was undertaken. The aims of the survey are outlined in Table 2 and apply to the whole Primary Health Care Team. Each medical centre was visited at least once and in some cases many times. Each visit was structured with specific members of the review team responsible for gathering elements of the information required. Each visit lasted a whole day with further visits arranged as required. This data was collated into a central database. The visits were important both for the gathering of information, but also to give updates on the process, which often appeared threatening to many members of staff. Staff were given opportunities to ask questions in an informal setting and as necessary any concerns were represented centrally. This was felt to be vital to improve the knowledge and

engender involvement and commitment, although this was not always successful. During the later stages of the project, within the bounds of commercial confidentiality information was given by the visiting team on the progress of the review and the process in general.

Table 1.

Overview of Services to be Provided in British Forces Germany

Primary Care

General Medical Practitioner (less those provided by the Royal Air Force)
General Dental Practitioner including orthodontics (less those provided by the Royal Air Force)
Practice Nurse including in certain centres 24 hour cover
Physiotherapy
Speech and Language Therapy
Health Service for Schools
Pharmacy support
Administrative and managerial support

Community Nursing

Health Visitor
Community Midwifery
Community Psychiatric Nursing

Acute Services

Full range of Secondary Health Services in keeping with a district general hospital
Emergency Medical Care

Transport Services

Staff transport
Emergency transport both British and German

Pharmaceutical and Other Medical Supplies

Table 2

Aims of the Primary and Community Service Review

General

Confirm patient base, quartering and school dispersion
Ascertain any clinical needs specific to the locality
Ascertain other service needs, for example provision of airfare cover
Confirm staffing levels in each discipline
Confirm extent of Information Technology provision
Ascertain building works requested or required

Patients

Speak to Commands and Staff in each location and request their views on the service provided, both good and bad.
Question patients on the views of the service provided in each medical centre, both good and bad.
To all provide information on the market testing process

Staff

To provide information on the market testing process
To request co-operation whilst planning the submission
Staff to outline the difficulties in providing the service and possible provide solutions
Staff to outline areas of excellence
To advise on the current service, where this was requested
Within commercial confidentiality guidelines, provide information on the future structure of the service, as this became

Formation of the Submission

With the data collected from the medical centres and in concert with that provided with the Statement of Requirement staffing requirements were developed from the "bottom up" using mathematically derived drivers for staffing. The drivers were derived either from NHS practice, if available, or alternatively from within a military setting. As an example due to the higher than average (when compared with the NHS) consulting rate and the requirement for Health Visitors to have a proactive role in Health Promotion and be involved with the Health Service for Schools, a ratio of one Health Visitor to 250 families with children under the age of 5 was recommended. This ratio compares with the UK national average of 307 families per Health Visitor(4). In all cases were the needs of each population, geographical isolation and the requirement for cross cover during leave and other absences taken into account. Table 3 outlines in broad terms the main and subsidiary drivers for the provision of staff.

The published literature was examined (5, 6, 7, 8) where available, and advice gathered on staffing levels. Due to the higher than NHS consultation rate(8) a doctor/patient ratio of 1:1500 for general practitioner principals was recommended and 1:1000 for general practitioner trainers or clinical directors. The clinical lead in each of the Professions Allied to Medicine in BFG and senior community psychiatric, paediatric and SSAFA community nursing advice was sought. In addition visits to BFG were arranged for members of the Royal College of Midwives, West Lambeth Community Services Trust and Guy's and St Thomas's Hospital Trust to provide independent views and provide advice, where required. The views of other professional bodies and the British Medical Association were also sought. In some cases the advice given was contrary to the view taken by the Health

Alliance core team as there were occasionally differences between those with an intimate knowledge of operating in Germany and those from outside organisations. These differences included the future management of the service as well as staffing numbers. In all cases these differences were discussed openly and any variations in opinion resolved, albeit that sometimes the discussions were long and heated.

The management structure and the methods of provision of each element of the service were derived with the future community services using NHS "Neighbourhood Management" as a model to ensure that management was as flat as possible, but at the same time had the potential to respond to local needs(9). The final solution outlined a Primary and Community Services Director, aided by a general manager responsible for a group of practices of all the primary and community services outlined in Table 1. In depth discussions and debates on the potential ways in which the clinical services could be delivered occurred using the SWOT analyses performed earlier, the SOR and the data derived from the formal review as a baseline. Full details of the provision of each element of the service in each specific location were provided in the final submission.

An Information Systems strategy was developed by means of interviewing specific members of the Primary Community and Hospital services and investigating systems available on the market. The results of this strategy have been published elsewhere(10).

Financial models were built as the staffing tables were constructed. These initially compared the predicted future cost with what was then the current, with the aim that a new service would produce a saving, or alternatively be financially neutral, as Market Testing a service is presumed to produce a saving of 15% (R Wilcox personal communication). These aims were not met. Each

Table 3

Main and Subsidiary Drivers for Primary and Community Staffing Numbers in each location

Speciality	Main Driver	Subsidiary Driver
General Medical Practitioner Practice Nurse	Doctor/Patient ratio Provision of 24 hour nursing service	Requirement for GP training Requirement to staff branch surgeries
Physiotherapy	Predicted military patients caseload	Predicted civilian patients workload
Speech and Language Therapy	Speech and Language Therapist/ population ratio	Predicted number of children with special needs
Health Visitor	Health Visitor/number of families with children under five years ratio	Requirement for Schools Health service input
Community Psychiatric Nursing	CPN/population ratio	Requirements for specific military input
Midwifery Administrative/ Management Support	Predicted Caseload Number of clinical staff to be supported	24 hour service Requirement for management of a group of practices

post was formally reviewed twice, both within the Health Alliance Community Services team (which included West Lambeth Community Services Trust) and the Health Alliance "star chamber", a senior review panel. The recommended drivers for each mathematical model were also examined.

Once the initial staffing models were derived a matrix approach was applied to each post and each location to provide the extra staff and non-staff costs. For example for each post provision was made for training, travel, subsistence and recruitment and for every location the purchase of information technology, stationery and diagnostic services. The figures from these matrices were added to the staffing models and then included within the overall Health Alliance submission.

Conclusion

The Health Service Market Test provided an opportunity for a whole "mini health service" to be reviewed, for in-depth analysis to take place and for new staffing numbers to be derived anew. Similarly it provided opportunities for changes in some working practices and where required for recommendations on performance improvement be instituted to meet the needs of the population of BFG and the changed health service. Initiatives both within the Services and the wider National Health Service, for example General Practitioner Total Purchasing initiatives require that the provision of health be assessed on a regular basis. This paper has described the methodology employed in planning, reviewing and ultimately bidding and being successful for the community health services in British Forces Germany.

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