The development of a health policy for the Army

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This paper describes the development of the Army Health Policy (AHP), which is a key component of the Army Human Resources Strategy (AHRS). The work on the AHP provided an opportunity for a fundamental review of the delivery of health support to the Army. The AHP will provide the strategic framework by which the Army will ensure the health of its workforce and, where appropriate, their dependants. The methodology used for this work may be a useful model for the development of a health policy for occupational populations.

Key words: Army; development; policy.

INTRODUCTION

People are the Army's principal resource. Many successful commanders have acknowledged that medical treatment services have a limited influence on the overall health of their troops. Field Marshall Viscount Montgomery wrote in the introduction to the Official History of the Army Medical Services in World War 2:

The men of 21 Army Group were fully immunised and fully trained; their morale was at its highest; they were well clothed and well fed; hygiene, both personal and unit, was exceptionally good; welfare services were well organised. The exhilarating effect of success also played its part in reducing the rates of sickness. Commanders in the field must realise that the medical state of an Army is not dependent on the doctors alone.1

The 1990s saw an unprecedented level of commitment of the Armed Forces worldwide at the same time as manpower levels reached the century's lowest level. It is therefore of paramount importance that the best use is made of the human resources within the Armed Forces. Within the Army, an Army Human Resources Strategy (AHRS) has been developed to guide human resource management. The overall aim of the AHRS is 'to provide the strategic framework within which coherent and effective HR policies can be actioned in order to better deliver the human element of fighting power'. Three core functions have been identified as obtain (to attract, acquire and prepare the trained soldier), retain (to provide the soldier with a rewarding career which meets the Army's needs) and sustain (to sustain an environment in which individuals will be willing to commit themselves).

The Army Health Policy (AHP) has evolved as an integral component of the AHRS. At the outset, it was considered that the development of the AHP should define the core objectives for health within the Army. Therefore the AHP should reflect trends in the delivery of health outside the Army and should recognize the major causes of ill-health within the Army. The aim of this paper is to describe the development of the Army Health Policy and to outline the proposed implementation plan as a model for health service development.

BACKGROUND

The importance of health to the Army

The Army is a large employer that has high demands for health within its workforce. It requires personnel who are physically fit and psychologically robust. Individuals must be able to be deployed anywhere in the world and fight in high intensity combat. Historically, the wastage caused by sickness and injury has been enormous. Between September 1939 and August 1945 more than 450,000 soldiers died or were discharged from the Army as a result of disease or accidental injury. This compared with about 100,000 killed in action and less than 40,000 discharged as a result of wounds. Ill-health continues to impact on operational capability. In 1997 the rate of
hospital admission was 79.4 per 1000 personnel, and the rate of death in-service was 0.8 per 1000. In addition, there was a further loss of manpower of approximately 4.5 days per person per year resulting from minor illness treated at unit level. This apparently small figure nonetheless amounts to some 450,000 person-days lost across the Army. Between 1993 and 1998, the proportion of soldiers not fully fit rose from 5.6% to 7.5%, whilst for officers, the number rose slightly from 3.0% to 3.2%. The cost of failing to deliver an effective health policy lies not only in reducing military capability through avoidable loss of manpower, but also in the human costs of disablement and demands for health care.

External influences

The government has developed a new strategic framework for the National Health Service (NHS) which is described in the White Paper The New NHS: Modern, Dependable and the Green Paper Our Healthier Nation. The Green Paper sets out proposals to improve people’s living conditions, with particular emphasis on promoting healthy workplaces. This has two aims: the first to improve the overall health of the workforce, and the second to ensure that people are protected from the harm that certain jobs can cause their health.

The government is actively promoting occupational health beyond the Department of Health. The Health & Safety Commission is developing a 10-year strategy for occupational health. This supports the existing Health & Safety Executive’s largest ever campaign ‘Good Health is Good Business’. The government chose health and safety as one of the themes of its Presidency of the European Council of Ministers. The AHP will reflect these developments, with the Army Medical Services (AMS) playing a strong role as the advocate of soldiers’ health.

Army organizational structures and cultures

Commanders are responsible for the health of their personnel and for the provision of resources to achieve this. As the principal personnel manager for the Army, the Adjutant General (AG) has ultimate responsibility for the health of the Army. The Director General of the Army Medical Services and his policy-making staff, within the Army Medical Directorate (AMD), have two functions: to advise on health policy for the Army and to deliver the required organizational structure to provide medical support to land-based, military operations. AMD issues policy guidance to commanders and their medical advisers on standards and procedures for the medical care of military personnel. The Army Health Unit takes the lead in developing health policy for the Army.

The Army aims to provide an integrated, comprehensive primary care and occupational health service for its personnel. The medical agencies, the Defence Secondary Care Agency, the Defence Dental Agency, the Medical Supplies Agency and the Defence Medical Training Organisation provide the remainder of the military health care functions. The formation of these agencies has created a ‘purchaser–provider’ split.

Therefore the AHP should include models for managing these contractual arrangements for the delivery of health services. Overall, there is a clear requirement for a strategy for health for the Army which reflects external developments, uses the existing management cultures in the Army, and provides a clear organizational vision for the future.

DEVELOPMENT

Overview

The AHP was placed within the ‘sustain’ collection of objectives of the AHRS but there was acknowledgement of the contribution of health to ‘obtain’ and ‘retain’. The AHP has been developed through a series of well-defined stages. These are summarized in Box 1. The first step in the development of the AHP was to ensure that there was a collective ownership of the AHP within the AMS. The necessity for consensus required an identification of stakeholders, both formal and informal. A series of working teams were identified. A secretariat provided guidance, administrative support and liaison to the AHP working groups. An AMD team reviewed all versions of the policy papers. The external AMS team met to define the boundaries and scope of the project and finally to prioritize and approve the policy objectives. The wider Army management structure was involved via the AHRS working groups.

The scope and definition of the aim

The work started with a review of the AHRS to provide the background for the work on the AHP. A definition of health was chosen, based on the World Health Organization definition, to represent the holistic requirements of the AHP: ‘The ability to perform military duties unimpeded by physical, psychological and social problems’. It was felt that the aim of the AHP should logically describe how health supports military capability. The aim of the AHP is therefore:

- to ensure that Army personnel are fit for role in accordance with readiness criteria through the promotion of health, the prevention of ill-health and the provision of treatment and rehabilitation services.

BOX 1. Stages in the development of the army health policy

- Identification of stakeholders
- Outlining the scope and defining the aim
- Identifying policy objectives
- Developing enabling objectives
- Prioritizing enabling objectives
- Formalizing the policy
- Implementing the policy
- Communication
- Evaluation
Identifying policy objectives

The NHS long term strategic aims were used as a starting model as they were considered to be sufficiently broad and generic to form the basis of a similar set of strategic aims for the AHP. These are shown in Box 2. An additional aim was added at the outset ‘to optimize performance based on an assessment of the individual and the demands of the job’ to reflect the crucial role of occupational health as part of Army health. The exact wording was to be refined to reflect the requirements of the Army. It was agreed that this level of policy statement would become the policy objectives of the AHP.

Developing enabling objectives

The identification of the true meaning and resource requirement of each of the policy objectives was the key to the development of the AHP. Thus each of the policy objectives of the AHP would need to be supported by further work. The hierarchy of policies and objectives shown in Fig. 1 would be the basis of the actual AHP. The enabling objectives would provide the actual detail that delivered the AHP.

The creation of the enabling objectives was achieved in two stages. A working group was convened and divided into small teams. The teams were asked to examine the meaning of each word in each policy objective and to freely associate any task that might naturally fall out. The work was then summarized and refined using military management techniques. This enabled the unstructured methodology adopted in the first phase to be converted into the military management language. The process identified approximately 50 individual tasks that were required within the AHP. When these were consolidated it was clear that there was substantial overlap and it was possible for many of them to be combined. An initial draft of this summary of tasks was presented to the internal AMD team. These were rigorously examined and teased out to produce the final listing of enabling objectives against the policy objectives.

Prioritizing enabling objectives

The next stage was to rank the enabling objectives in priority order, recognizing that it would be extremely unlikely that the whole policy would be funded concurrently. In addition, it was clear that some of the enabling objectives were dependent on others. It was felt that there should be a formal prioritization exercise to ensure that the final order of the enabling objectives represented a consensus view. This was planned as a two stage Delphi process. This process is a formal voting system designed to ensure consensus of views amongst an expert panel.

The first stage in the prioritization exercise was the issue of a list of the enabling objectives in random order to the working group to allocate priorities. The results of this first trawl were presented to initiate discussion. The following criteria for allocating priorities were chosen: cultural, obtain, retain, sustain, and logic. These were also placed in rank order and a table set up to provide arithmetical weighting for each criterion. Finally the prioritization exercise was run for a second time with each enabling objective being considered against the effect on each criterion in turn.

Formalizing the policy

It was felt that the AHP should be subjected to some form of quality assurance to ensure that no key area had been omitted. The method chosen was to compare the AHP with the developing Health & Safety Commission ‘National Strategy for Occupational Health’. This reconciliation demonstrated that the AHP would deliver all the current aims of the lead body for occupational health in the UK. As discussed earlier, the AHP was developed from the existing NHS strategy for public health. Therefore implementation of the AHP would also deliver the required components of a strategy for public health within the Army. Once AMD had completed its work, all of the components of the AHP were approved by the AHRS Working Group and incorporated into the main, capping document.

THE ARMY HEALTH POLICY

Content

The Army Health Policy is composed of three elements: three doctrinal principles, five policy objectives, and 12 enabling objectives. The first principle is a summary of factors that determine health. These have been examined
in the publication Independent Inquiry into Inequalities in Health commissioned by the Department of Health.\textsuperscript{12} The model of health used by this inquiry has been modified for the Army and is shown in Fig. 2. The Independent Inquiry into Inequalities in Health sets the external context in which the Army should work. It recommended the following areas for action in people of working age: improving the quality of jobs, reducing psychosocial work hazards, preventing suicide, promoting healthier lifestyles, promoting sexual health, encouraging physical exercise, reducing tobacco smoking, and reducing alcohol-related harm. The AHP will need to collate existing Army policies within these areas into an overarching plan to promote health. For the Army this can be summarized into three areas of responsibility: the individual, the chain of command and the AMS. Thus health is the concern of many professional groups, not only doctors and the paramedical professions. The Army Health Policy must reach these target audiences.

There are two overarching descriptions of the activities involved in the promotion and maintenance of military health. The first, the chain of care, summarizes the functions involved in delivering health. The second, the health management cycle, summarizes the actions required to manage health.

The chain of care is shown in Fig. 3. It is enclosed by a box that represents the population at risk for whom the Army has responsibility. The profile of the population at risk is a major determinant of the resources required. This population is primarily Army personnel but may include dependants, veterans, civilians, Joint and Combined Forces and, on operations, prisoners of war and indigenous populations. The Army Health Policy will define the nature and extent of responsibility for the full population at risk. For Army personnel the demand for health services is shaped by the application of medical standards for recruitment, employment, deployment and retention.

The hierarchy shows the order of each function. The relative proportions reflect the ideal distribution between functions. The chain begins with the prevention of challenges to health. If prevention fails and health is compromised, priority is given to saving life, then to restoring function, promoting healing and finally to rehabilitation. The contribution of the chain of command to health is shown in white and that of the Army Medical Services is shaded.

The importance of the prevention of ill-health is invariably emphasized in post-operational reports. The chain of care emphasizes this is a collective responsibility. Military personnel are able to make an initial contribution to saving life by providing effective first aid.\textsuperscript{13} The functions, 'save life, restore function and promote healing' are principally the responsibility of treatment services. The Army Health Policy will examine the boundary of responsibilities for each organization involved in the provision of treatment in order to deliver holistic health care. Rehabilitation is the process of returning sick or injured personnel to work or civilian
The health management cycle summarizes the executive functions required to implement an Army Health Policy. The process is shown in Fig. 4 and begins with the investigation, analysis and interpretation of measures of health. This may also involve research to determine appropriate interventions to improve health. No single measure is likely to represent a complete summary of health but the existing measures discussed earlier may form the basis for an effective integration of information. Formulation is the process of interpreting the evidence and initiating action to address issues. Mandate and educate uniquely describe the delivery of the resources to effect changes in the health of the target audiences. The hierarchical nature of military command should enable health to be mandated through policy, matched with resources and direction given to ensure action. Education aims to ensure that the behaviour of individuals is changed to improve health. This is the activity of health promotion. Evaluation of the effectiveness of health policies is the final element of the cycle. This measures performance against set targets and links to ‘investigate’ for further action in the next revolution of the cycle.

The policy and enabling objectives developed out of the work on the AHP are listed in Box 3. As described earlier, these objectives provide the framework for the implementation of the Army Health Policy.

**Communication**

The identification of stakeholders has been identified in an earlier section. This was essentially a communication plan for internal policy development. The principal objective for the AHP within the AHRS is ‘to develop, promulgate and implement the Army Health Policy’. This will be achieved through an external communication plan delivered as part of the enabling objective ‘promote the ethos and culture of health’.

**Evaluation**

The mechanisms required to evaluate the effectiveness of the AHP will be identified through the enabling objective ‘develop a model for the management of resources to deliver health’. The enabling objectives ‘define and set targets from 1 April 2000’ and ‘establish an effective intelligence and information system for managing resources and clinical practice’ will ensure that the chain of command is informed of the health of their workforce and owns the responsibility to maintain this health.

A number of existing systems could be used to provide measures of health outcomes including the J97 primary care surveillance system and the surveillance of medical fitness, medical discharges and deaths provided by the Defence Analytical Services Agency. Measures of clinical activity could include attendance rates in primary and secondary care, hospital admission rates, drug prescribing rates and investigation rates. Measures of general health could include body mass index, smoking and physical performance. Much of this data is already captured, the key is to integrate the information to provide an overall measure of military health.
CONCLUSIONS

This report has described the development of the objectives for the Army Health Policy. Implementation of the AHP will provide a coherent mechanism to maximize the health of the Army. Initial work used models developed within the NHS to identify the strategic framework within which the AHP would evolve. Brainstorming techniques used both an unstructured approach and a formal, military approach to ensure that correct enabling objectives were created. The Delphi process ensured that the priority afforded to each objective was owned by all relevant professional groups. Although there is still a considerable amount of work yet to be done, the development of the objectives of the AHP provides a robust foundation for further work.

Existing pressures on manpower within the Army are exacerbated by the loss of personnel through sickness and injury. Health support, for which commanders at all levels have responsibility, should be provided for soldiers (and their dependants, where appropriate) to a standard which recognizes the demands placed upon them by their employment. Emphasis should be on the proactive aspects of health delivery, and should not rely on the purely reactive response to injury or illness. Implementation of the Army Health Policy will maximize the potential for good health amongst Army personnel and therefore minimize the impact of ill-health on military capability. This process is presented as a model for the development of a strategy for a health service for a defined occupational group.

REFERENCES