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Secondary Medical Services for Israel Defence Forces Career Personnel in an Age of National Compulsory Health Insurance[1]

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ABSTRACT

Background: IN JANUARY 1995, the Compulsory Health Insurance Law came into effect in Israel. The legislation was an egalitarian move that set forth that every resident of the State of Israel was entitled to health services according to a uniform "basket of service". Individuals were also given the right to choose the identity of their ser vice-provider. The law, however, does not apply to the Israel Defence Forces (IDF) soldiers. Soldiers receive health services from the IDF Medical Corps or civilian agents acting on its behalf. Career personnel pay a "health tax" to the state but they do not have the privilege of choosing their service provider as do other members of their family in accordance with the law.

Objectives: The objectives of the paper were:

- to investigate the subjective attitudes of career personnel towards the medical service they received from the medical corps or from outpatient clinics of contracted civilian hospitals; and
- to determine if career personnel are "discriminated" against with the medical services they receive.

Methods: The study population included 273 women and men serving as career personnel. The participants were chosen from among career personnel referred to three clinics who constitute 60% of all referrals for secondary medical services. All participants filled a questionnaire, which was analysed using SPSS.

Results: Results indicate that career personnel view themselves as less healthy than their conscript counterparts. There are bigger gaps between the expectations and actual treatment, especially with respect to sick leave and medical restrictions. There is also a lack of continuity of care and follow-up.

Conclusions: The law discriminates against career personnel compared to other residents of the state, and the con sequences are registered in lack of satisfaction among career personnel with the medical services they receive- even though these services are provided by highly professional physicians and cover a very broad basket of services.

Keywords: Israel Defence Forces (IDF), Secondary care, Satisfaction, Career personnel

INTRODUCTION

Since January 1995, a compulsory health insurance law has been in force in the State of Israel that stipulates that every resident of the state is entitled to health services by law, according to a fixed and defined 'basket of services'. Individuals have the right to choose the particular system (i.e. sick fund) that will provide them with medical services from among the service providers working with the sick fund of their choice.

The Compulsory Health Insurance law does not encompass Israel Defence Forces (IDF) service personnel, including career personnel. Clause 55 of the law stipulates that medical services for IDF solders will be given by the Medical Corps or by an agent acting on behalf of the Medical Corps.[1] The IDF Medical Corps operates a broad spectrum of medical services for all IDF personnel, draftees and career personnel, including secondary medical care. The secondary medical system operates in two configurations. The first is a comprehensive system, comprised of army

personnel in all medical specialties, which is located in a military camp and operates under the full responsibility of the army. The second is based on the hospital-based civilian secondary medical system, which operates under a contractual relationship between the Ministries of Defence and Health, and the public medical system designed to provide secondary medical services and hospitalisation within the framework of government-owned hospitals[2-4]. IDF personnel are referred to specialists by the primary medical system that serves as a gatekeeper to secondary medicines. It is a system designed to serve its clients. The client is part of the system and the client's character, subjective perceptions and satisfaction carry significant weight in the process of formulation and actualisation of health policy.

Career personnel are a special population. They are mobilised into the army like any soldier; they receive a medical profile and serve until their contract with the army is not renewed or they reach retirement at age 45 (whichever comes first). Unlike draftees who may change posts a few times in the course of two to four years of conscript service, in the course of twenty years' service and more, career personnel serve in a host of posts. Each unit has its own family medicine setup, often tied to a different secondary medicine ser vice-provider than the individual's previous post; moreover, at secondary medicine clinics, reserve-duty physicians usually change frequently'. In the course of their service, career personnel develop medical problems- some tied to the nature of their occupation, some the product of age common to civilians and persons in the military. Career personnel who remain in the army to the age of retirement leave the service at an age when they face the 'ramifications' of the natural aging process and have time to devote themselves more to personal needs, including a growing awareness of medical problems. The health professionals to whom army retirees turn are neither familiar with the client and the patient's past history, nor are they well acquainted with the military milieu where such patients have spent the better part of their lives.[8] Families of career personnel receive their medical care from the civilian system and upon demobilisation, career personnel generally join the medical framework where their family has been receiving their medical services all along.[7.9]

With the passage of the Compulsory Health Insurance Law in 1994 - a law that provides universal access to basic medical care in exchange for payment of a 'health tax' by all employed persons - IDF career personnel have been transformed into an 'underprivileged population' compared to their families and the public-at-large.[10.11] They are discriminated against in terms of freedom to choose their own service provider, the right to ongoing care and care at the hands of a family doctor familiar with the medical history of the entire family over time (the same physician whom the demobilised career person will ultimately turn to in most cases upon leaving the army).[8] Ironically, career personnel are required to pay part of the 'health tax' out-of-pocket although they do not enjoy all the benefits granted to civilians.[12]

This study examines the subjective perspectives of IDF career personnel vis-a-vis the secondary medical services they receive from the IDF Medical Corps and civilian agents acting on its behalf.

METHODS

The sample population was chosen from among IDF career personnel receiving secondary medical services from both medical service configurations: one, a military specialist clinic; the other, out-patient clinics of hospitals working under contract with the military system. The military clinics chosen for this study focus on secondary medical care at the large centre for specialist medicine located in the centre of the country and out patient clinics at three hospitals working under contract with the military. The participants were chosen from among career personnel, who constitute 60% of all referrals for secondary medical services, referred to three clinics that have a clear impact on the performance of career personnel in the field, in training units and rear units: orthopedics, dermatology and ophthalmology. The clinics were chosen in consultation with key decision-makers in the Medical Corps: The Chief Medical Officer, the commander of the Central Command clinic and the commander of the specialists' clinic complex. The commanders of the three specialist clinics chosen to represent the entire medical system-orthopedics, dermatology and ophthalmology - were also consulted.

The sample population was comprised of 273 men and women career personnel, 82.4% males and 17.6% females. Statistics show that overall, 87.4% of career personnel turned to IDF-operated specialists' clinics and 12.6% turned

to hospital outpatient clinics. The ratio among draftees turning to the two clinics was different- 60% to IDF-operated specialists' clinics and 40% to civilian hospital outpatient clinics. The preference for IDF-operated clinics among career personnel was clearly evident.

A questionnaire was drawn up. Career personnel were requested to fill out the questionnaire distributed after exiting the doctor's office. On-site staff at the clinics, familiar with the questionnaires, were responsible for distribution to respondents, answering any questions and collection of the completed questionnaires. During the three weeks during which the sample population was chosen, 20 career personnel were inter viewed following completion of the questionnaires. The subjects expressed great satisfaction with the survey, said they understood the questions and had taken their responses in all seriousness. The researchers maintained daily contact with those administering the questionnaires at the clinics and the commanders of the military clinics. At the end of the sampling process, all the questionnaires were collected- 273 among career personnel visiting military clinics and 30 among personnel visiting hospital outpatient clinics. Responses were processed using the SPSS program for creating cross tabs between various components and between the two medical service settings - military and civilian. Gaps in expectations between the reason for the visit, the treatment expected and the treatment received were measured. Three questions concerning expectations were asked: What was the reason for the visit? What was the care the client expected to receive? What treatment did the respondent actually receive?

RESULTS

Table 1: Care that career personnel expect to receive compared to care they actually received

Gap between reason for visit and desired care	Care Actually Received	Desired Care	Reason for Visit	Type of Medical Service
- Respondent wanted less	25.2%	29.6%	42.8%	Doctor's Examination
= Care Equal to Respondent's Expectations	35.2%	32.7%	34.6%	Continued Treatment /Check-up
+ Respondent Wanted more	0.6%	2.5%	0.6%	Medical Restrictions
+ Respondent Wanted more	7.5%	2.5%	0.6%	Sick Leave
+ Respondent Wanted more	1.3%	5%	3.1%	Referral to Medical Evaluation Committee

Examination of the gaps among career personnel between the reason for coming to the clinic and the results of the visit indicated that the majority cited that the reason for coming to the secondary medicine clinics was the need for a doctor's examination or continued care, but that the respondents received more than they expected. Only two-thirds of those who came for a doctor's examination cited that the reason for their visit was a doctor's examination (see Table 1). On the other hand, with regard to medical restrictions, sick leave and medical review boards, the respondents expected more than what they stated as the reason for their visit to the clinic on the questionnaire (Table 1). Similar behaviour was found among draftees in a prior study. For example, 0.6% of the career personnel cited that they had come to the clinic in order to receive a medical restriction. An identical percentage received medical restrictions, but a larger percentage (2.5%) said they expected to receive medical restrictions although they had not cited this as the reason for their visit.

Career personnel that visited medical installations (civilian and military) were also queried about the accessibility of the clinics, availability of service, organisation of the facility and its environment, and attitudes of service staff. There was no difference found between civilian and military clinics. Only 28.9% rated the accessibility and availability of service as "very good". 49% rated the organisation of the facility and its environment as "very good'. 36.4% ranked the attitude of service staff as polite, and that the doctors devoted sufficient time to the client and

provided adequate explanations. Here as well, measurements of degree of satisfaction among career personnel with overall service and secondary medical care were lower than among draftees. The majority of draftees described the environment in the various medical facilities in positive terms. Half the draftees had cited that the facilities were accessible and avail able and more than two-thirds cited the politeness of various service staff.

Career personnel viewed themselves as less healthy than draftees and, against the backdrop of greater options afforded their families and the absence of ongoing care or follow-up encountered for them selves, respondents demonstrated gaps between their expectations from medical care and the actual care received.[10]

DISCUSSION

The Compulsory Health Insurance Law does not ignore career personnel and stipulates that the law will not apply to those serving in the army; all army personnel shall receive health services from the Medical Corps or from agents acting on its behalf. Overnight, with passage of the law, the status of career personnel changed significantly in regard to receipt of health services. Career personnel, unlike draftees, pay the universal health tax paid by all workers through National Insurance but they cannot enjoy the freedom of choice in choosing their health service provider as other members of their family can. Career personnel receive medical services from a single vendor whose character is different from parallel health service providers in the civilian health system. For example, a person in the army can find him or herself receiving medical care for an eye problem each time from a different ophthalmologist due to the high turnover among reservists staffing the military clinics.

Although from an objective standpoint, members of the military enjoy medical care that is among the best and the most advanced in Israel, career personnel are not satisfied with the secondary medical services they receive from the IDF, whether provided within the framework of military clinics or at hospital out-patient clinics, against the backdrop of the Compulsory Health Insurance Law. In both cases, there are significant gaps between the care career personnel wanted to receive and the care they receive in practice. They would prefer to receive all their care from the civilian service where they feel they could exercise more control over the services they receive.

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