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The Employment of Civilian Dentists in the Israel Defense Forces: A Public-Private Mix Case Study

Rachela Levy • Michael Wiener
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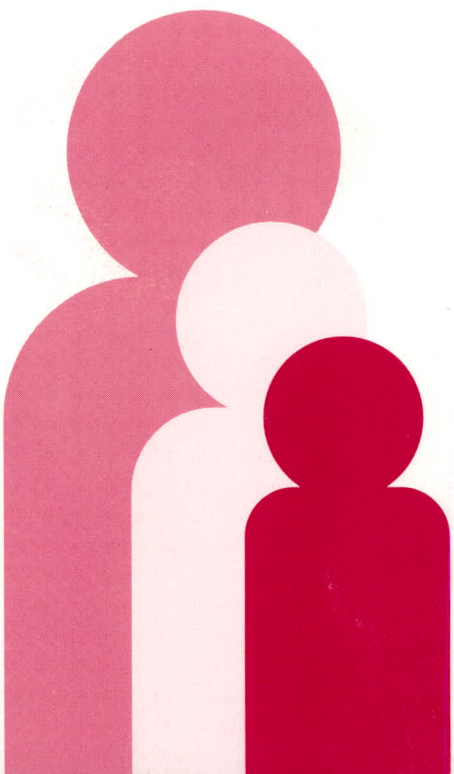
Reprint Series



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The Employment of Civilian Dentists in the Israel Defense Forces: A Public-Private Mix Case Study

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Abstract

This case study documents how the Dental Services of the Israel Defense Forces (IDF) successfully applied private sector practices to reimbursement and staffing in a special program designed to improve prosthodontic care for career army personnel. An innovative public-private synthesis enabled the IDF to reduce bottlenecks and increase productivity while securing high levels of employee and patient satisfaction. The success of the program can be attributed in part to the measures taken to adapt private sector practices to the culture and norms of the public sector, and to integrate the new program into the broader organizational framework of the IDF Medical Corps. The recruitment of appropriate types of manager at each stage of the organizational change cycle also played an important role in the program's success. The study is based on in-depth interviews with senior managers in the IDF Medical Corps, interviews with managers directly involved in implementing the program, IDF budget reports and productivity analyses, and a survey of career army dentists. The study will be of interest to managers of public health care systems worldwide who are looking to the private sector for innovative ways of improving efficiency.

The Employment of Civilian Dentists in the Israel Defence Forces

A Public-Private Mix Case Study

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Introduction: The Public-Private Mix in Health Care

Health care systems around the world are re-evaluating the roles of the public and private sectors in providing and financing health care. While in the past, debates on the public-private mix in health care tended to be dominated by extreme positions and ideological considerations, the debate has recently taken on a more pragmatic and empirical focus. Many policy analysts see a role for both the public and private sectors in health care. The challenge is to integrate the best of each sector into a coherent system[1].

The public-private mix issue also figures prominently in deliberations on Israeli health policy. Historically, public financing and provision have been the norm in Israel's health system. Recently, however, the roles of for-profit providers and out-of-pocket financing have grown substantially[2]. The 1990 report of the State Commission of Inquiry into the Israeli Health Care System (the Netanyahu Commission) reaffirmed the society's commitment to a primary public health care system. At the same time, it called for incorporating several practices and principles usually associated with the private sector within public institutions: e.g., enabling patients to choose their physician in return for an out-of-pocket payment (*Sharap*) in governmental and non-profit hospitals, personal contracts for hospital executives, requirements that budgets be determined by patient care revenues and decentralized management of health care institutions[3].

Given these trends, policymakers can benefit greatly from the study of past attempts to incorporate private sector practices in Israel's governmental and voluntary health-care organizations. One interesting hybrid, studied extensively by one of the authors, is the independent physician model in the General Sick Fund, which is operated by Israel's labour federation[4]. Also worthy of study are the special fee-for-service payments to second shift medical teams in government and General Sick Fund hospitals, the sponsorship of complementary insurance by sick funds, and the *Sharap* services in Jerusalem hospitals.

Objectives

Our objective was to analyse the development and impact of the "prosthodontics project", a quasi-private service which was introduced into the Israel Defence

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Forces (IDF) in 1988. We sought to identify the factors which accounted for the project's initiation, its successes and its failures. Particular attention was given to how public and private elements were interwoven in the programme's design and implementation. Our hope is that this case study will provide food for thought for those involved in planning the larger experiments in public-private integration currently under consideration.

Methods

We chose a case study approach. Data sources included:

(1) in-depth interviews of all past directors of the project, the current senior management of the IDF's dental service and the managers of the major commercial dental chains;

(2) analysis of the reports of relevant IDF Medical Corps' committees, budgetary reports and productivity analyses from the project, various published studies of Israel's dental care market;

(3) a satisfaction survey among all 23 dentists currently employed in the project.

The analysis is based primarily on the findings of a 1991 IDF review process.

Findings

The Setting: Israel's Dental Care System

Oral health status in Israel is poor in comparison with other developed countries[5]. The high prevalence of caries and other oral health problems is due, in part, to the lack of fluoride in the water supply serving most of the population. In addition, many Israelis face financial barriers in accessing dental care[6]. While most medical services are well covered by the basic benefits packages of Israel's sick funds, dental care is not covered and must be paid for "out-of-pocket". Approximately 85 per cent of dentists work in the private sector, typically on a fee-for-service basis. As a result, dental care accounts for 12 per cent of Israel's national health expenditure — a figure which is quite high by international standards[7].

In recent years, three important trends have begun to reshape the Israeli dental market. First, the proportion of the population covered by dental insurance has risen, and by 1991 it had reached 10 per cent[8]. Second, partly as a result of the massive wave of immigration from the former Soviet Union, the number of dentists rose by over 30 per cent between 1989 and 1991, leading to a marked decline in dental fees, in real terms[9]. Third, the market share of dental chains has been increasing, with some of these chains being operated by non-profit organizations, while others are operated by commercial firms. By 1991 these chains accounted for at least 400 dental chairs out of a national total of approximately 5,000.

Dental Care in the Israel Defence Forces

Conscription into the Israeli Defence Forces (IDF) is mandatory and almost universal for Israeli citizens. At age 18, males are conscripted for three years and females for two years. Reservists play a central role, with male citizens serving up to one month a year until age 51. The professional (career) IDF is relatively small in size.

The defined aim of the IDF dental services is "to preserve the dental/medical fitness of the soldier and to ensure his welfare". Soldiers on compulsory duty are entitled to basic restorative care, treatment related to injuries suffered in training or on the battlefield, and emergency first-aid treatment for acute conditions which would otherwise interfere with their service. As treatment in the IDF is free of charge, IDF dentists often find themselves treating conditions which have been neglected for many years.

Career military personnel are entitled to additional services such as periodontic and prosthodontic care, with the extent of coverage linked to duration of service. Certain services are also available at reduced rates for the families of career personnel or veterans.

The IDF's pattern of reliance primarily on reservists for manpower also holds true for IDF dentists. Israeli civilian dentists typically serve 30-35 days per year in reserve duty. The IDF allows a limited number of 18-year-olds to defer their service until completion of dental school, after which they must serve for a period of at least five years, primarily in dental clinics attached to the IDF's regional commands. Of their five years of service, three years are considered "basic" service — similar to other conscripts — and two years are considered "career" service. There is also a small number of career officers who serve mostly in senior management positions: commanders of major dental clinics in large bases, chief dental officers in the IDF's three regional commands, and staff officers in Medical Corps headquarters. In addition, career officers serve as dentists and department heads in the IDF's Dental Institute, a training/research/service facility which is a collaborative effort of the IDF Medical Corps and the Tel Aviv University Dental School.

The Prosthodontics Project

The project was initiated in 1988 in response to growing lists of career military personnel waiting for prosthodontic care. The project is staffed by 24 civilian dentists who work for the military as independent contractors. Almost all of these dentists work two to three six-hour shifts per week for the project and also work part-time in their own private practices or for large commercial dental chains. The project pays the dentists according to a formula which takes into account both how many hours the dentist works and his productivity.

The project is situated in a distinct wing of the IDF's Dental Institute at Tel Hashomer. It has its own cadre of IDF clerical personnel and dental assistants (mostly female recruits serving their compulsory service). The project is managed by a career IDF dentist who reports to the commander of the Dental Institute. The Dental Institute also houses the "prosthodontics department" whose staff is composed of (generally full time) career IDF dentists who are paid a monthly salary which is not related to productivity.

In 1991, as preparation for a planned redesign of the contract with the project dentists, the IDF Medical Corps undertook a review of the project's performance to date. The general finding was that the project has proven to be a success, and, in particular, waiting lists have been considerably shortened. At the same time, the need for various adjustments and mid-course corrections was identified.

Project Initiation

While career IDF personnel are legally entitled to prosthodontic care, in the late 1980s it became clear that the entitlement could not be realized on a timely basis. Waiting time had reached up to three years. In 1987, the branch of the military responsible for the welfare of the soldiers formally requested that the Medical Corps develop a plan for dealing with the long and growing queues.

A committee, consisting of representatives of the IDF's personnel, finance, and medical divisions, was established to explore options and present recommendations. The committee considered three major ways to secure the additional manpower needed for prosthodontic services: recruiting additional dentists into career military posts, using reserve duty dentists and employing civilian dentists on personal contracts. It was noted that it would be difficult significantly to expand the prosthodontics department even if qualified dentists could be found, owing to cutbacks in the number of IDF personnel positions and hiring/enlistment freezes. The use of reserve dentists was rejected because their productivity levels were relatively low; in addition, the high turnover of reserve dentists posed problems of continuity of care. The committee recommended that civilian dentists be employed as contractors on a trial basis. This approach was seen as a way around the IDF's enlistment freeze and a way to secure higher levels of productivity.

The decision to go ahead with the contract approach was adopted amid various concerns on the part of traditional elements within the dental service. In part, they feared that commercialization and fee-for-service dentistry would lead to a deterioration in quality. They also feared that the project would be able to demonstrate that high productivity levels were sustainable, thereby putting pressure on the rest of the IDF's dental service to work faster. In addition, the very notion of integrating private dentists and IDF dentists in this manner had few precedents and, therefore, a top-level decision was needed. Several high-level officers from the personnel branch became personally involved in pushing for this solution. Once the decision was made, all the interested parties co-operated and no specific measures were taken to obstruct the project's initiation and subsequent implementation.

Since its initiation, the project has had three directors. The first was an "entrepreneurial manager" — a manager who energetically pushes for change, sometimes even at the expense of formal processes[10]. A career IDF dentist, respected for both his technical and managerial skills, was recruited to launch the project and serve as its first director/manager. This dentist had already proven to be a successful innovator in his previous assignments in the IDF dental service. He began his task with a thorough study of the operations of the large commercial dental chains, a study from which he drew numerous ideas which influenced the programme's design. For example, as in the commercial dental chains, individual project dentists do not have full authority to determine treatment plans; initial intake assessments and final authorizations are the prerogative of the director. Similarly, the process by which patients are assigned to particular dentists, the formula for reimbursing dentists, and the system of penalties for patients who do not show up for appointments, all draw on the practices of the private sector chains.

At the same time, commercial practices were not adopted wholesale; they were adapted to the military setting, creating a synthesis of private dentistry and traditional IDF dentistry. For example, while compensation of dentists in the commercial chains was determined solely by the number of treatments they completed, the project's reimbursement formula also includes a salary component. It was felt — by the project's initiator and others in the IDF dental hierarchy — that incorporation of a salary component was necessary to reduce the incentive to sacrifice quality for quantity. In addition, it was felt that, given the high rate of down-time in the IDF Dental Institute for reasons beyond the control of the individual dentist (e.g., equipment failures and supply shortages), a basic hourly rate was necessary in order to be fair to the dentists. Finally, ensuring a basic rate was considered critical in attracting dentists to the new venture, as at that time it was unclear whether the project would be able to supply dentists with a steady stream of patients which would be large enough for the dentists to realize a satisfactory income from the fee-for-service component of their compensation package. However, the primary determinant of the income of project dentists remained the fee-for-service payments for treatments completed — in keeping with the project's principle objectives of increasing throughput and reducing queues.

Another critical decision early on in the programme's development was to establish a clear division of labour between the project and the prosthodontics department: the relatively simple cases were assigned to the project, while complex cases went to the department. This permitted each group to build on their assumed relative strengths: efficiency and speed in the case of the project; deliberateness and specialized expertise in the case of the department. An important by-product of the decision was that it limited competition and, hence, friction among the two units.

In addition to programme design, the project's first director placed great emphasis on issues of recruitment and human resource management. He hand-picked all 23 of the dentists to be employed in the programme, drawing them primarily from among dentists whom he had an opportunity to observe in the past, either as IDF reservists, or as IDF career dentists. In addition to the dentists' technical skill, the personnel selection process took into account their productivity levels, their degree of comfort with the idea of integrating public and private services, and the extent to which they were committed to the project's primary mission — the reduction of queues. Most of the project's dentists chose to work on a part-time basis because they were also working in private practice settings. This arrangement also benefited the project: the dentists brought to the project ideas and approaches from the private sector on a continuous basis.

The project dentists were then welded into a tight group with substantial *esprit de corps* and a strong group identity. Within the Dental Institute, they were apart from the mainstream, both organizationally and geographically. At the same time, the project drew on various service departments common to the Institute as a whole: supplies, maintenance, laboratories, etc.

After one-half year as the project commander, the project's initiator was promoted and transferred to another job within the IDF dental service. He was replaced by another career dentist, the "organizer" manager. This manager, who shared the philosophy of his predecessor, emphasized the building of the organization and effective working teams. Two-and-a-half years after the project's initiation, the "bureaucratic" manager arrived on the scene. His philosophy is more attuned to that of the IDF dental hierarchy than to that of the project's two previous commanders. This philosophy includes the belief that, when throughput increases, quality inevitably suffers. According to this view, while there may be a need for private sector "implants" such as the project to deal with specific problems — such as queues — the preferred model of the IDF's dental service is, and should remain, academic dentistry as practised in the rest of the Dental Institute. The new commander was also mandated to establish orderly operating procedures, in place of the free-wheeling style which had existed till then, and in general, to take steps to better assimilate the project into the Dental Institute mainstream. Predictably, all this has led to tensions between the project's dentists and its new commander.

Project Impact

The project has met its principal goals at reasonable cost. Prior to the initiation of the project, the typical waiting time for prosthodontic care was three years. The project has effectively eliminated queues; average waiting time is now less than one month. A small phone survey of patients treated in the project found high levels of satisfaction, particularly with the short waiting time and the personal interaction with the dentists. Project dentists complete, on average, three crown-equivalent per six-hour session, a rate similar to that which prevails in the private sector. In addition, the project succeeded in attracting and retaining dentists; of the 23 dentists currently working in the project today, almost all have been with it since its inception. These accomplishments were particularly important for the provision of prosthodontic care on a timely basis in the IDF, as during the same period many of the dentists in the prosthodontics department were sent to do rotations in other units of the dental service. (Interestingly, the rapid turnover in the prosthodontics department was one of the major reasons for the IDF's continued commitment to the project.)

The stability of project staff is understandable in the light of a recent survey of project dentists, which revealed that the project provides dentists with a number of benefits less readily available in their private practice work: interesting caseload, camaraderie, opportunities to exchange ideas with peers, office services to deal with administrative and financial tasks, opportunities to learn from specialists, supplemental income, and the opportunity to develop treatment plans without having to worry about the financial burden on the patient. In addition, most of the dentists are satisfied with the current reimbursement system and prefer it to either of two "purer" alternatives: straight salary or straight fee-for-service.

The full cost to the IDF of every crown-equivalent completed in the project is approximately NIS 460 (approximately US$180). This figure, which includes

manpower, supplies, capital depreciation, and overhead, is similar to the cost estimates which we received from private sector chains. In this regard, it should be noted that despite Israel's high inflation rates, the hourly and per treatment fees paid to the project's dentists have not been adjusted at all since the project's inception. Accordingly, in real terms, fees have declined substantially. This parallels developments in the private sector where fees have also fallen dramatically as a result of the growing surplus of dentists.

Unfortunately, no systematic data are available regarding the impact of the project on quality of care and duration of treatment. In general, the IDF Dental Service is just beginning to develop information systems to track these important parameters.

Discussion

The experience of the IDF's prosthodontics project demonstrates that it is possible to implement private sector elements successfully into health-care programmes which are predominantly "public" in nature. At least in some cases, the reservations of some of the key actors can be overcome. The case study described above suggests that some of the factors which may facilitate effective public-private mixing are as follows:

- The need to find a solution to a specific, pressing problem which the public sector alone has proven incapable of solving.
- The sponsorship of senior officers or managers.
- Adaptation, rather than wholesale adoption, of private sector practices.
- Charismatic and judicious programme management.
- Development of appropriate reimbursement systems for the professionals involved.

The case study also suggests that small private sector implants can have an impact on the broader public organization of which they are a part: productivity achievements in the project set an example for the Dental Institute as a whole. At the same time, such implants may remain more exposed to developments in the private sector than their parent organizations: the dentist surplus in the private sector lead to deterioration of real incomes in the project, but not in the rest of the IDF dental service.

The case study also demonstrates specific measures which can be used to control costs when introducing fee-for-service arrangements and other private sector elements into the public sector. Under fee-for-service reimbursement schemes, providers have a financial incentive to overtreat and to work rapidly, even at the expense of quality. The pivotal role of the project's director as a gatekeeper and his role in quality assurance may serve as a useful model for those developing public-private mixes in other settings.

The case study is consistent with the literature on organizational life cycles which highlights the need to bring in different types of managers at different stages in the organization's development. Each of the project's managers made a unique and timely contribution to this successful public-private mix.

While the case study presented above suggests a number of interesting hypotheses regarding public-private mixing in Israel, there are a number of reasons to be cautious about generalizing beyond this specific case study. To begin with, the project is limited in scope and this may well have been a factor which eased implementation. Attempts to introduce private elements into public health care programmes on a larger scale may be resisted, because they threaten the system's predominantly public nature and/or the system's view of itself as fundamentally public. Second, the project was implemented within the IDF, which is more hierarchical than the civilian setting and in which there are no unions — professional or otherwise. As underscored by recent attempts to introduce *Sharap* (quasi-private medical services) into Israeli public hospitals, unions can play an important role in resisting public-private mixing. Third, the project is a dental project and dentistry is one of the few medical services in Israel which is provided predominantly by the private sector. The private sector experience provided very useful models for the project's founders and (by setting a precedent) may also have legitimated the use of fee-for-service payment mechanisms for dentistry in the IDF. Finally, unlike most experiments in private health care provision, the project did not entail out-of-pocket payments for patients; all costs were covered by the IDF. As a result, concerns about equity and the potential creation of a two-class system of care (which afflict most public-private mixes) did not materialize.

Areas for Further Research

In light of the above-listed limitations, three avenues for building on this case study should be considered. First, if the IDF decides to make the project's services available to the families of career military personnel on a fee-for-service basis (as recently proposed), it will be important to continue monitoring the project for its equity and access implications. Second, it will be worthwhile to study the IDF's decision-making process regarding another current proposal: to reduce the size of the IDF's dental service drastically. According to this proposal, the IDF's need for dental care would be met primarily by private civilian dentists reimbursed via commercial insurance arrangements. Such a change would constitute public-private mixing on a large scale. Third, various attempts to mix the public and the private in Israel's civilian health care system should be documented. Generalizations about public-private mixing in Israel, such as those listed above, can only be confirmed or rejected on the basis of information from a range of institutional settings. Particular effort should be made to collect information on how changes in the public-private mix affect the quality of care.

Finally, as the prosthodontics project employs two groups of dentists (those who previously served as regular IDF dentists and those who did not), the project constitutes a useful setting for exploring the relationship between staffing patterns and performance in public-private mixes. In a future study, the authors plan to compare the productivity, job commitment and satisfaction levels of these two groups of dentists.

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ג'וינט־מכון ברוקדייל
לגרונטולוגיה והתפתחות אדם וחברה

רופאי שיניים אזרחיים בצבא ההגנה לישראל - שילוב הרפואה הפרטית והציבורית

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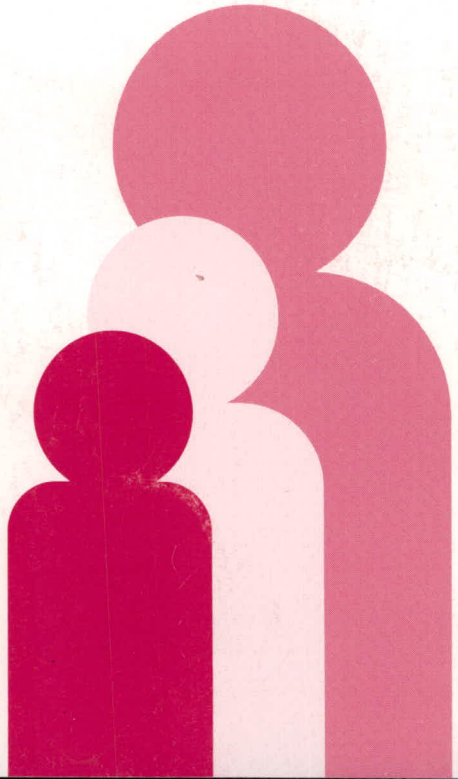

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ג'וינט – מכון ברוקדייל מהו?

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קבוצת חשיבה המחויבת לפרסום ממצאיה כדי לסייע לקובעי מדיניות ולספקי שירותים לתכנן וליישם תכניות רווחה.

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1 חיל הרפואה של צה"ל.

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תקציר

מאמר זה מתעד כיצד שירותי רפואת השיניים של צבא ההגנה לישראל יישמו בהצלחה נוהלי תיגמול ואיוש הנהוגים במגזר הפרטי במסגרת תכנית מיוחדת המיועדת לשפר את הטיפול השיקומי באנשי צבא קבע. מיזוג חדשני בין הרפואה הפרטית לציבורית איפשר לצה"ל לצמצם תורים ולהגביר את היעילות תוך הבטחת רמות שביעות-רצון גבוהות הן של המטפלים והן של המטופלים.

ניתן לייחס את הצלחתה של התכנית בחלקה לצעדים שננקטו כדי להתאים נהלים הנהוגים במגזר הפרטי לתרבות ולנורמות של המגזר הציבורי, ולשלב את התכנית החדשה במסגרת הארגונית הרחבה יותר של חיל הרפואה של צה"ל. גיוסם של מנהלים מהסוג המתאים בכל אחד משלבי השינוי הארגוני שיחק אף הוא תפקיד חשוב בהצלחת התכנית.

המחקר מבוסס על ראיונות עומק שנערכו עם קצינים בכירים בחיל הרפואה של צה"ל, על ראיונות עם קצינים המעורבים ישירות ביישום התכנית, על דו"חות תקציב של צה"ל וניתוחי פריון, ועל סקר של רופאי שיניים בצבא קבע.

יש במחקר משום עניין למנהלים במערכות בריאות ציבוריות ברחבי העולם הפונים אל המגזר הפרטי בחיפוש אחר דרכים חדשניות לשיפור יעילות.