Defense Report
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Military Medical Care—How We Got Where We Are

Recent Congressional testimony by the Surgeons General of the three military departments painted a gloomy picture of military medical care and confirmed what active duty and retired personnel have learned through frustrating exposure to the military "health care" system.

The key element of the military health care crisis is the shortage of physicians. At this moment the Army alone is shy of its authorized number of doctors by more than 700—a catastrophic shortfall in terms of that service's ability to provide mandated care to active duty troops and promised care to dependents and retirees. The Army has expanded the duties of its nurses and replaced the surgeons assigned to combat battalions with "physicians assistants" trained to hold sick calls and treat minor illnesses but it has still been forced to close some treatment facilities and to reduce the capabilities of others. More and more families and retirees are being forced to find care in the civilian medical community at greater cost to themselves and disparate expenditure from the subsidized Civilian Health and Medical Program for the Uniformed Services (CHAMPUS).

The basic reason for the military doctor shortage is that civilian practice is almost always more lucrative and is free from many of the factors that set military service apart from civilian life. Also, according to the Surgeons General, the fluctuating nature of attitudes toward military medicine by political leaders makes it impossible for them to promise a young doctor the continuity of income and specialty programs that will be attractive.

One of the most difficult points they have to make to cost-cutters on Capitol Hill and in the Office of Management and Budget is that no doctor wants to practice medicine with a patient environment composed solely of men and women in the prime of life. In order to remain "whole doctors" they must also treat the very young and the very old. The physician structure of the military medical services is designed to provide that range of care and, at the same time, to establish a core of trained military physicians for a mobilization situation.

The uncertainty about income is typified by recent congressional action to extend a doctor incentive bonus for just one year. The military doctors who now receive that bonus are not sure they will continue to get it beyond that short-term extension.

The worst part of all this is that the cost-cutters are not saving money. They are causing more to be spent by increased reliance on CHAMPUS and by growing turnover in the military medical ranks. It is time that Congress and the Administration take a hard look at what the military health care system should be, then make it permanent and predictable.