Several rapid changes are taking place in U.S. health care, many of which were introduced by government and the private insurance industry. One change is the movement from fee-for-service to a managed care system of reimbursement.

By managed care system I mean an insurance plan that incorporates the features of selective contracting with providers, financial incentives for subscribers to use the network providers, and utilization review of service, designed to control medical cost. This is in contrast to traditional fee-for-service insurance, which reimburses charges to any provider selected by the patient for any service rendered (within the allowable benefit structure). With the introduction of the contract-based reimbursement, health planning for subscribers has become possible for the first time. The network provider structure and the utilization review process allow for a more precise needs assessment and the development of special services.

Some insurance companies are reserving the term managed care to refer to a system with an even greater level of structure, organization, and service coordination. Such a system is achieved through mechanisms such as aggressive case management of severe illnesses and regional planning for expensive tertiary services. The incentives for subscribers to use the network provider system (and corresponding penalties for out-of-network services) are even more severe than those under the preferred provider organizations. The third-party carrier becomes the operator of a closed delivery system.

Within the health care industry, this changeover from a fee-for-service to a managed care system is viewed as a transfer of power from physicians and hospitals to business and the insurance industry.

Increasing pressures have newly developed in two areas of health care: First, consumers want health care demystified and expect more sensitive responses to their perceived health care needs. Second, payers, especially employers and government, are more price-conscious, demanding lower costs and greater efficiency.

Cost containment through competition is the political theme for 1988 and beyond. The other political issue in health care is financial protection against catastrophic events for an increasing elderly population. Medicare will now cover long-term catastrophic illness through an extra 4-dollars-a-month assessment from each Medicare recipient. This insurance would pay for all hospital-related costs of more than $2,000 a year.

Congressional mandates to balance the budget and the fact that over one tenth of the gross national product is attributable to health care costs will be major forces in establishing future health care policies. Brian Riles, staff director of Ways and Means for the Subcommittee on Health in the U.S. House of Representatives, has stated that by the year 2000, people will be treated by systems of care and the systems will set the margin of pay.

A third change in health care is that health policy will become national in focus. Changes occurring now are shaping the future health care system. Physicians, hospitals, health maintenance organizations, preferred provider organizations, and insurers are all developing vertically and horizontally integrated systems to respond to and capitalize on the demand for more organized, sensitive, and efficient care and service. These systems have one thing in common: tight fiscal controls. This has already resulted in fewer inpatient resources and a demand for more outpatient services. It has also resulted in a multitiered health care system and in restricted coverage for the poor.

Another approach being taken to control costs is through legislation. In 1987 the U.S. Health Program Act was introduced and carried over into 1988, which would provide for basic health protection as well as for protection from catastrophic illnesses for

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This bill is designed to control health care costs, maintain health care quality for all providers and patients, and ensure financial access to health care. The cost containment provisions of the bill should be watched carefully. All health care providers would be paid prospectively on a capitation basis, with payment developed in consultation with the providers. Once the payments are established, increases will be limited to per capita gross national product. This will also apply to the providers of occupational therapy services. Other bills similar to this will be introduced in the next few years.

The meaning of these changes to occupational therapists

Occupational therapists are caught between the pressures of patients’ demands for quality care and the drive to contain costs. The desires of our patients to receive the best care are consistent with our reasons for entering the profession (the desire to help others) and with our training. This stimulates us to do the most for patients. Simultaneously, hospital administrators and payers are telling us to cut costs. This translates into a demand to do less for patients, and it creates professional and emotional conflict. The challenge is to provide the most for less, not simply to provide less.

Historically, the reimbursement method for occupational therapy has driven its delivery system. For example, before the passage of the Education for All Handicapped Children Act of 1975, 11% of occupational therapists worked in the school system. By 1982, the percentage increased to 18.3%. The move to managed care delivery systems provides an opportunity for occupational therapists to focus on both patients’ and payers’ needs. We must listen to what the insurance industry is asking us to do and make sure to address the industry’s needs. Insurers and payers want to include in their plans benefits that promote wellness, provide appropriate care, reduce hospital days, treat patients at the lowest level of care appropriate, return patients to the healthiest state and the most functional level possible, and keep patients satisfied and served. Since occupational therapists offer these services, we should be in demand. But we must educate the industry to the fact that occupational therapy treatment regimens make individuals more functionally independent and therefore less dependent on the health care system.

We must explain that attainment of the highest functional level for the elderly means greater capability of self-care, social interaction, and avocational pursuits, all relevant to human dignity. We must clarify that higher functioning directly relates to decreasing the probability of greater and more frequent medical problems that arise from isolation, depression, and sedentary states.

We must also explain that achieving the highest possible functional level for those of working age means an earlier return to work and the greatest possible productivity. Our goals need to be understood by the insurance providers; they are important for workers’ compensation as well as for the private insurance industry.

Issues That the Profession Must Address

If we can succeed in educating the managed health care industry about occupational therapy’s role, we should be welcomed with open arms. But are we ready? Do we have enough human resources? Do we know the difference between skilled treatment and care? Does our level of education prepare us to be generalists?

Human Resources.

Occupational therapists are a scarcity now and are going to be in greater demand in the future. If we cannot fill positions in the managed care system, other disciplines that say they do what we do will be hired. In addition to declining human resources, we must address our inequitable distribution. Blue Cross of California recently became the Home Health Intermediary for Region IX, which consists of the western states Hawaii and Alaska. For the past year, Blue Cross representatives, myself included, have traveled through the western region states, providing orientation workshops to new home health agencies (welcoming new agencies to Blue Cross of California). After finishing my presentations on occupational therapy and home care, I have been besieged by nurses and administrators from home health agencies in rural Nevada, eastern Oregon, and rural eastern Washington who wanted to know where they can get occupational therapists.

Skilled Treatment Versus Care.

In her 1987 Eleanor Clarke Slagle lecture, Claudia Allen noted that we should take into treatment only those patients whose conditions we can treat and improve and should recognize that patients have limitations and that there are things we cannot change. In a sense, this issue of treatment versus care, which I will discuss later in more depth, is going to make us tough-minded. We are going to have to define professional boundaries because resources are in fact scarce. The issue gets down to techniques that require the unique skills, knowledge, and judgment of an occupational therapist versus techniques that require general skills that could...
be offered by other skilled people or by less skilled people.

**Level of Education.** In a managed care system, one of the stated goals is that those of us who have physician-equivalency practices in our area of expertise will become primary referral sources. This is a cost-effective approach. If occupational therapists do become primary referral sources (Blue Cross of California is changing language to accomplish that), will we be able to meet the new and emerging demands that will be made on us? The issue is not whether we have a bachelor's or master's degree or whether we enter at a bachelor's or master's level, but how prepared we are when we enter. A different type of judgment is required when a patient has not been screened before we have to do the intake. To identify problems that should be forwarded to a physician we have to have broad knowledge and skills.

**Editor's Note.** Part 2 of this article, which discusses ways to sharpen our professional image and business acumen and how to organize for survival, will be published in the October issue of this journal.