Managed Care: Opportunities and Challenges for Occupational Therapy in the Emerging Systems of the 21st Century

This article examines current changes and trends in managed health care in the United States and the implications they may have for occupational therapy in the longer term. The movement toward managed care has its origins in concern for cost containment, so it is helpful to review that issue before considering the relationship between trends in managed care, as we see it today, and occupational therapy's historical and philosophical approach. Finally, what this present relationship implies for the future of occupational therapy will be explored.

The Evolution of Managed Care in the United States

American medical care has often been called the finest in the world, a distinction claimed at high cost. Today, the United States pays more in health care costs, which are figured as a percentage of the gross national product, than any other industrialized nation. The enabling legislation for Medicare and Medicaid in the 1960s signaled the beginning of this upward spiraling of health care expenditures. That legislation provided for government reimbursement of medical expenses incurred by Americans aged 65 years and over and by the poor. Underlying the legislation was a philosophical belief in reasonable access to health care for all Americans, regardless of means. But Medicare and Medicaid's generous fee-for-service provisions for reimbursing cost of care resulted in a series of legislative efforts to control the runaway costs of the system in the 1970s and 1980s.

These escalating costs were also burdensome to the private sector. Traditional insurance plans of the 1960s were fee-for-service plans like Medicare and Medicaid, which reimbursed policyholders for the cost of services covered by the plan. Later, such repayment or "indemnity" plans permitted policyholders to assign their benefits directly to health care providers and thereby avoid many out-of-pocket expenditures. Holders of indemnity plan policies had a full choice of providers. To contain costs, these plans depended on a mix of subscribers, with premiums paid by younger and healthier subscribers to offset costs incurred by older or less healthy policyholders.

Health care providers responded to private insurance plans and federal Medicare and Medicaid programs by setting reimbursable fees high enough to cover costs of nonreimbursed care. Patients were cared for; providers were paid; and insurers, both federal and private, were being pinched. As cost of services rose sharply in the early 1970s, insurers implemented measures to maintain premiums at affordable levels. Traditional insurance plans thus became "managed" indemnity plans, where management took various forms of control such as requirements for prehospitalization certification or the need for second opinions and continued utilization review to avoid unnecessary hospitalization.

More recently, preferred provider organizations (PPOs) and health maintenance organizations (HMOs) have emerged as popular delivery models. PPOs are networks of providers and facilities with whom insurance companies negotiate fixed, discounted fees in exchange for a large volume of patient referrals. In the 1980s, PPOs were the most rapidly growing segment of the health care market. HMOs (which actually began in the 1940s), and their variants (such as independent practice...
as comprehensiveness operations, benefit package and the integration of health care delivery and insuring components. These staff or group plans operate on the theory that physicians and providers, as business partners paid in advance for their services, will assume partial responsibility for cost-effective diagnostic and treatment decisions, thus helping to contain costs (Iglehart, 1992). Nearly two thirds of privately insured Americans are now in one or the other type of plan. In both types, insurers attempt to control costs by limiting the consumer’s choices of covered services (Weiner & de Lissvoy, 1993).

Today’s Cost-Conscious Health Care Environment

While the federal government considers revisions to policies governing its traditional fee-for-service Medicare and Medicaid plans and the insurance industry forges ventures with providers for cost-conscious care, service delivery in the private sector is also undergoing changes designed to reduce costs and improve efficiency. The adjustments that characterize the health care delivery system include hospital closings, mergers, reductions of personnel, and aggressive marketing—all aimed at ensuring that reimbursements for services exceed the costs of providing them. These changes take place under the rubric of managed care, which has become an unfortunate euphemism for cost containment.

True managed care systems generally seek to contain or reduce costs, assure clinical quality, and foster patient satisfaction by addressing five functional areas: administration, hospital care, primary care, specialty care, and ancillary services (Moore, 1993). Cost containment strategies usually focus on reducing administrative costs (which typically comprise 10%-20% of budgets), lowering hospitalization costs through shorter lengths of stay (hospital care accounts for about one third of expenditures), controlling ancillary costs (i.e., tests, equipment, drugs), and using primary care providers as gatekeepers to limit unnecessary use of costly specialists (including nonmedical providers). In the view of some consumers, the zeal to contain or reduce costs overshadows concern for clinical quality and patient satisfaction. In response to complaints by consumer groups, several states have introduced legislation to mandate minimum levels of coverage, for example, coverage of at least 2 days in hospital for a woman who has given birth. Private providers will need to work hard to address public dissatisfaction and perceptions of compromised quality to maintain market shares sufficient to sustain profitability.

Anticipating the Future

In a study that sought to determine likely scenarios for health care in the early part of the next century, Clement Bezold (1992) found general agreement among five other futurists who based their predictions on current trends. The futurists anticipated that efforts to control costs through managed care initiatives will continue, as will emphasis on outcomes and the use of cost-effective strategies to influence health care decision making. They forecasted that knowledge gained through better understanding of disease processes will lead to improved paradigms for anticipating and managing illness. A final prediction concerned changes in cultural attitudes and values that shape health care demands. Bezold’s study suggested that we can expect a greater acceptance of death and concern for quality of life in contrast to the heroic lifesaving efforts and extension of life at any cost philosophies that influence current health care practices. Other trends indicate that prevention of disease and injury will assume greater importance, along with concern for access to care and possible tensions resulting from ethical questions surrounding the use of such scientific technologies as genetic engineering (Goldsmith, 1992a, 1992b). These futurists anticipated that consumers will demand greater involvement in decision making regarding their health care services and will accept a role in influencing their own health and providing care for themselves and other family members in the home.

Occupational Therapy’s Strengths and the Future of Managed Care

Occupational therapy professionals should find this overview encouraging, noting particularly how the anticipated trends in the health care environment of the future align with traditional practice goals and values of their field. The occupational therapy profession should not lose sight of its ability to shape those changes by emphasizing its long-standing values, beliefs, and practices.

Four of occupational therapy’s professional values historically embodied in its practices are particularly consistent with trends in managed care: (a) its collaborative model of service delivery, (b) its emphasis on quality of life, (c) its belief in the importance of promoting health and preventing illness and injury, and (d) its strong moral foundation for guiding treatment decisions. Consider first the profession’s belief in planning and providing care in partnership with the consumer. This client-centered approach gives occupational therapy a personal focus and makes it relevant (Christiansen, 1991). In Canada, occupational therapy has demonstrated consistent leadership in promoting and institutionalizing this value through widely adopted intervention guidelines for client-centered practice (Canadian Association of Occupational Therapists, 1995). Recently, Gage and Polatajko (1995) have suggested that the operative metaphor is “client driven” because the appropriate “image of practice is one where the professional looks to the client to be an active participant, without abdicating professional responsibility” (p. 117). Personal approach and relevancy (major indices of patient satisfaction) are consistent with current trends toward consumer empowerment in health care (see Gage, 1995).

As a profession born of concern for the reciprocal relationship between...
doing and health, occupational therapy emphasized quality of life long before the expression gained currency in popular discourse. Englehardt (1977) noted this relationship when he claimed that "people are healthy or diseased in terms of the activities or functions open to them or denied them" (p. 667). Persons with spinal cord injury seldom care about the level of their lesion. Their paralysis is experienced through its impact on their typical daily routines. In discussing their conditions, they want to know whether they will be able to play the piano, ride a horse, or go fly fishing. By identifying and addressing the myriad consequences of health problems from the perspective of those affected, occupational therapy gets to the heart of quality of life.

Moreover, occupational therapy's emphasis on quality of life acknowledges the meaning that persons attach to their daily pursuits (Christiansen, Clark, Kiilhofner, & Rogers, 1995). Doing is more than physical activity. One's choice of activity expresses personal identity, and the rituals and experiences of living provide insight and guidance (Bruner, 1990). According to Englehardt (1983), occupational therapy has a special role in preserving this intangible and exceedingly important spiritual dimension of daily life. The cultural reawakening that seems to be occurring in North American society, with renewed emphasis on personal values and meaning, underscores the importance of this contribution to quality of life.

Occupational therapy has long recognized the importance of prevention and wellness programs, viewing lifestyle as integral to health and well-being. Contributors to health extend beyond the person to good environmental design and safe workplace practices. Though the medical community is aware that lifestyle and environment account for much of the variation in health experienced by the population, the health care system has given inadequate attention to behavioral approaches to intervention. Here, occupational therapy has much to offer. No other profession has a longer history of promoting wellness through education and advocacy of lifestyles that provide the activity, nutrition, rest, challenge, and personal fulfillment healthy persons need. In addition, occupational therapy's experience and comfort with the complexities of systems thinking, its knowledge of functional performance in a daily living context, and its growing body of knowledge relating occupation to health and well-being provide the basis for a vital and pivotal role for therapists of the future, possibly expanding to include case management (Van Deusen, 1995).

Finally, occupational therapy has a foundation in ethical decision making to draw on (Bing, 1981) when managed care's cost-containment measures clash with societal responsibilities. Consistent with its traditional (if not occasionally romanticized) values, occupational therapy must strongly advocate for those who are neglected because their economic, cultural, or employment status renders them ineligible for insurance or social assistance programs with health benefits. One need only consider the plight of the many homeless persons with mental illness to appreciate the danger in the current climate of social intolerance and cutbacks affecting mental health services. Advocacy for ethical decision making is not only historically consistent for the profession. It is simply the right thing to do.

Avoiding Pitfalls

These rich traditions and values can serve occupational therapy well in the health care system toward which current trends in managed care point. Yet, its practitioners must also consider some directions within the profession that might reduce its perceived attractiveness as managed care evolves. I believe that the education and research aspects of the discipline warrant greater attention in this regard than the area of clinical practice.

The current educational trend toward increased specialization within the discipline could well be at cross-purposes with a need for greater flexibility and versatility among health care providers of the next century. Preparing generalist practitioners may be the more prudent course. If state governments continue their attempts to improve access and reduce costs by deregulating health care (a likely eventuality), individual consumers and organizations will enjoy more provider options. Given a deregulated environment, the more specialized practitioner will be at greater risk than his or her counterpart who is able and willing to perform various roles and collaborate easily with others. The latter will be in demand by the public and provider organizations (Shugars, O'Neil, & Bader, 1991). Well-prepared practitioners, I think, will be ready to serve in the home and community as well as in the office or clinic; they will be able to deliver preventive and health promotion services as well as therapeutic and management interventions. Above all, competent graduates will be those who can function as members of interdisciplinary teams in providing optimal patient care while avoiding unnecessary duplication of services (Bulger, 1993; Greenlick, 1995; Larson, Osterweis, & Rubin, 1991).

The principal research caveat, as I see it, relates to outcomes research. Achieving the best results means achieving desired outcomes with a high level of user satisfaction. The perceived need for documentation of desired outcomes has led many to call for efficacy and outcome studies since the early 1980s (cf., Christiansen, 1983). Although such efforts are in demand, the profession must be wary of expecting too much from profession-sponsored efficacy studies, which may be viewed as biased and self-serving and thus discounted by the scientific community. Furthermore, the process of identifying outcomes for study is a highly value-laden activity, and the conduct of studies can be both difficult and expensive (Fuhler, 1995). Professional credibility can be built on satisfactory outcomes as defined and experienced by the recipients of services. To the extent that occupational therapists set relevant goals cooperatively with
their patients as well as enlist the motivation of their patients in achieving those goals, satisfactory outcomes are more likely to result. Certainly, successful approaches must be documented and best practices identified wherever possible. However, traditional studies of groups may not always provide useful information that works in individual circumstances (see Ottenbacher, 1995).

Summary

Overall, occupational therapy seems reasonably well situated to prosper in a cost-conscious environment of the future. But the profession's standing in the next century will depend on its ability to build on its strengths and assist in cost containment by avoiding unnecessary or duplicative services and by fostering versatility through the education of generalists. Above all, the profession must recognize that patients will measure quality in terms of results and satisfaction related to the impact of their health on their everyday lives. ▲

Acknowledgments

I thank Faith Lagay and Lisa Potts for their helpful assistance in the completion of this article.

References


Ottenbacher, K. J. (1995). Why rehabilitation research does not work (as well as we think it should). Archives of Physical Medicine and Rehabilitation, 76, 123–129.

