Medical expenditures are rising faster than any other sector of the economy (Feldstein, 2001). More dollars are being spent on health care than ever before, yet health care providers are realizing lower profits. The explosion of medical spending in the 1960s led to constraint in the 1970s. As a result, clinicians, who are facing cutbacks in demand and reimbursement of their services, are looking for ways to cut overhead. Many are asking themselves, “Is supporting my professional organization worth the cost?” The issue is: cutting overhead by not supporting the very organization that is advocating for higher and broader reimbursement, ultimately will cost professionals more than they’ll save. The purpose of this commentary is to explore how declining reimbursement, changes in legislative policy, and the trend towards outcomes-based performance measures are effecting the occupational therapy profession, and how the American Occupational Therapy Association (AOTA), in turn, is mediating the impact.

Factors Affecting Declining Demand and Reimbursement

Several factors are associated with the decrease in demand and reimbursement for occupational therapy services. One factor is the abundant supply of health care professionals that became apparent in the 1980–1990s relative to federal health manpower legislation (Nurse Training Act, 1964–1965). For example, the number of active physicians increased by 77 per 100,000 members of the U.S. population between 1970 and 1990 (Klettke, 1987). The number of active internists was projected to increase 121% for the 20-year period 1978–1998, while the U.S. population was only expected to increase by 19% (Klettke). The number of occupational therapy graduates more than doubled during the 9-year period 1990–1999. The number of occupational therapy students taking their board exam nearly tripled during the 9-year period 1993–2001 (National Board for Certification in Occupational Therapy [NBCOT]). The number of occupational therapy schools nearly doubled during the 19-year period 1980–1999 (Centers for Disease Control and Prevention, 2001). As supply increases, demand and reimbursement decrease.

A second factor affecting demand and reimbursement was the explosion in health care costs resulting from the enactment of Medicare and Medicaid in 1965. Federal expenditures increased by nearly $300 billion during the first 23 years of Medicare. In 1965, 5.9% of the gross national product (GNP) was dedicated to medical care (Feldstein, 2001; Levit, Lazenby, Letch, & Cowan, 1989; Relman, 1991). Currently, 13.4% of the GNP goes to medical care, roughly a 250% increase just over 35 years. In 2011, the first baby boomers will begin using Medicare, further increasing demands. Meanwhile, Medicaid expenditures have also expanded. In response, states have tried to constrain expenditures by reducing eligibility. In the midst of inflation resulting from the Vietnam War and an increasing supply of health care professionals, the federal government enacted legislation (during the 1970–1980s) attempting to offset rising health care costs by limiting reimbursement.

The transition from the cost-based method to the Prospective Payment System (PPS)-method of reimbursement is the third factor associated with decreasing demand and reimbursement. Initially, Medicare used a cost-based method to pay hospitals, thus there was little incentive to control costs. In 1983 the PPS was introduced. Hospitals (and later physicians in 1989) were paid according to “fixed prices” per diagnosis-related groups (DRGs). Clinicians could no longer treat clients on an as-needed basis; prior approval and capitation were implemented.

Federal Legislation Affecting Demand and Reimbursement

For many, health care is based upon the values of beneficence, nonmaleficence, justice (Kanny, 1993), and the Oath of Hippocrates that focuses on the benefit for the patient above all else (Furrow, Greaney, Johnson, Jost, & Schwartz, 2001). These values are consistent with the Public-Interest Theory (Feldstein, 2001) where well-meaning legislators act according to what they believe is in the public’s best interest. The Public-Interest Theory is a consumer-driven theory grounded in humanitarian and justice values. Benefits and costs are weighed for the “good of society” (overall public benefit).

In contrast, according to the Self-Interest Theory (Feldstein, 2001; Furrow et al., 2001), individuals, voters, organized groups, and legislators act to serve their
own self-interest. Rather than viewing the health care dollar as being spent for the “good of society,” the expenditure is viewed as investment for gains in political support and power. Whereas helping others was once, according to the Public-Interest Theory, the foundation of health care, the foundation is now, according to the Self-Interest Theory, big business, and political support.

It is proposed then that whereas professional success once resulted from merit and good will when rendering services to others, professional success now occurs in the political arena. The players are organized groups, such as health maintenance organizations (HMOs), the American Medical Association (AMA), and AOTA, who can provide political support and in turn receive benefits that support their organization. The next paragraphs discuss legislation that AOTA jostles in the political arena, financed and supported by its members.

According to the Self-Interest Theory, health policies change over time when groups campaign to support or oppose legislation that serves or impedes their economic interests. Medical societies were the main organized groups of health providers until the 1960s, when the cost-based health care delivery system was structured primarily to benefit physicians. As Medicare expenditures increased, not only did those paying the increased costs (employers providing health care benefits and the government) begin to challenge this structure, other professional organizations such as nurses, occupational therapists, and psychologists began to compete with physicians. Health care began moving in the direction of market competition, leaving many health care professionals wondering whether medicine would become a business or remain a profession (Relman, 1991).

A review of the types of health care legislation renders the Self-Interest Theory even more convincing. Legislative benefits to the health care industry have affected entry into professions, training, certification, mechanisms for paying providers, which providers are to be included under public medical programs, and subsidies for medical education (in the form of institutional rather than individual student subsidies) (Feldstein, 2001).

“Producer” legislation affects how health care professionals are paid and the bylaws written within professional organizations (Feldstein, 2001). Producer legislation benefits providers by creating benefits for one group of health care practitioners at the expense of another. Justification for this legislative competition (who can do what task, entry into the profession, which provider should be reimbursed by public programs) is public protection.

There are five types of producer legislation (Feldstein, 2001). The first type is demand-increasing legislation that results in increased reimbursement (i.e., Medicare, government subsidization of health insurance especially for those unable to pay, and legislation that widens the professional roles by increasing the number of tasks they are allowed to perform and limiting what others such as aides and technicians can do). The second type secures the highest reimbursement by attempting to eliminate price competition and price discrimination. For example, price competition was limited by terming advertising and “fee-splitting” unethical behavior, and by prohibiting advertising in state practice acts. In a 1982 suit against the AMA, the U.S. Supreme Court ruled professional organizations could not penalize members for advertising, in fact advertising is now encouraged by the Federal Trade Commission (Relman, 1991). Price discrimination is defined as charging different patients or payers different prices for the same services, based on the client’s ability to pay. The third type is reducing the price or increasing the quantity of “complements,” or both. Complements are defined as professions that are “allied” or have close connections to physicians. Currently, the physician is no longer the sole entry point of service delivery. Increasingly, more health professionals are practicing independently of the physician. The fourth type is increasing the price and availability of services that substitute those of the association’s members (i.e., the American Nurses Association [ANA]) has successfully made it more difficult for foreign-trained nurses to enter the United States, and the ANA favored wage increases for licensed practical nurses (LPNs). Decreasing the disparity between LPN and RN wages diminished the demand for LPNs. The fifth type limits increases in supply by restricting entry. State licensure, a specified education lasting a minimum number of years (with that number and cost constantly increasing), and education in an approved institution all limit entry. Graduation from an approved (medical) school was enacted in 1906. Whenever standards are raised, the grandfather clause protects those already in practice, regardless of their abilities. If the licensure requirements were met by passing an exam, the knowledge could be acquired in a number of ways. Entry-level master’s and doctoral therapy programs can be viewed as barriers to entry, in that standards, cost, and number of years are being raised.

Quality and Outcomes

During the 1970s, a demand for increased efficiency resulted from soaring medical costs. During the 1980s a demand for quality was added, reflecting societal trend towards consumerism. Not only were payers confronted with uncontrollable health-related costs, the benefits of the services were unknown (Relman, 1988). The movement away from a health care system designed to benefit physicians toward a competitive medical market resulted not only in employers purchasing medical services from HMOs, but also employers pressuring HMOs to provide report cards, or information on medical outcomes. HMOs in turn forced medical groups to reexamine how medical care was provided. As HMO managers utilized centralized decision making, concentrating on doing the right things right, the medical field sought scientific evidence to support decentralized decision making where clinicians could determine service provision and resource expenditure. As managed care blurred the distinction between public health and clinical practice, an emphasis on a standard way of managing the care of patients with the same conditions occurred. Management would no longer allow clinicians to choose the right thing to do, or make decisions on an individual basis. Along with the consumerism movement came the demand for decisions that were made collectively and based on the best evidence available (MuirGray, 1997; Relman, 1988). In the midst of an
increasing supply of health care professionals, legislation to offset rising health care costs by limiting reimbursement, and a shift of power from the AMA to the consumer market, clinicians were being held accountable for the cost-effectiveness of their services. It is no wonder the changing values of the health care system instilled disillusion in many clinicians, including the author.

Resolution

Turning away from your professional organization, however, during such a time is analogous to passengers of a sinking ship shunning the life preserver intended to save them. Yet many professional organizations are facing declining membership. In 1980, when AOTA membership was required to be registered as an occupational therapist (prior to the formation of NBCOT), the 22,453 members of AOTA approximated 100% of the work force. In 2001, an estimated 49% of the occupational therapy work force maintained AOTA membership (C. Foster, AOTA, personal communication, September 4, 2002). Professional organizations, like individual professionals, are accommodating the shift of the health care dollar from benefi ciency to business. A challenging task for both, professional organizations must strive to help members understand these more complex goals. In turn, members must make an effort to understand the precipitating events so they can navigate the change.

Free Riders

When individuals organize to achieve a favorable gain, all individuals with that common interest share in any gain achieved whether or not they participate in the support of the organization. Consequently, individuals who do not share the cost of producing the benefits get a “free ride” (Feldstein, 2001). Free riders benefit from the investment others have made in political support. Knowledge of legislative measures taken to contain costs during the 1970s, the movement toward managed care and consumerism in the 1980s, and information provided by Feldstein on the Self-Interest Theory and legislative demands that organizations make on our behalf should convince professionals of the importance of their membership support.

Various organizations share a similar progression. Initially, unions and the AMA were small organizations. Members joined for the benefits a local society could provide. In a small group it is easier to monitor performance and members have a larger stake in the outcome because the benefits are distributed over a smaller group. Peer pressure to join can be exerted more effectively when local. As the size of the organizations grew and dues increased, the benefits became less apparent to members. Professional organizations began looking for alternate ways to attract members. As unions became more powerful, they sought a closed shop; all employees were required to join. Professional organizations unified. Membership at the national level was tied to membership at the state level. For example, at one time, a physician had to belong to the county organization to be allowed hospital privileges. Once physicians joined the county organization they automatically belonged to the national organization, the AMA. The local association remitted part of the dues to the AMA. As dues increased, these unified systems declined and AMA membership also declined. AMA then began selling private services to physicians at a discount, similar to the services AOTA offers to its members (e.g., credit cards, insurance). Another approach was to require the person desiring certification to join the organization. This, however, was declared illegal by the U.S. Supreme Court in 1978, and led to the formation of the NBCOT. It should be noted that AOTA and state occupational therapy organizations recently affiliated to emphasize communication and collaboration between the national level and state levels (Diffendal, 2002b). While the groups will remain financially independent of each other, this partnership hopes to improve the local visibility and perceived relevance of national efforts.

Increased visibility of national efforts and educating members as to the need for legislative support and may dispel members’ disillusionment in the changing health care system. Members need to understand what their professional organization is doing for them and the purpose of the organization’s actions. The perceived benefits must exceed the cost. The amount of dues that a member will pay depends upon how the practitioner values the benefits. The first step however is helping the membership realize the benefits.

An increasingly diverse membership poses yet another challenge for professional organizations: The more heterogeneous and multidisciplinary the membership, the more difficult representation becomes. Membership fees and the costs for continuing education associated with membership renewal are increasing while resources (employer reimbursement, time away from clients) are decreasing. Time and cost restraints can force members to make choices about which organizations they support. Of concern is the knowledge upon which professionals base their choice(s). For example, to what extent do professionals base their decision to join an organization on the organization’s ability to provide legislative support?

As an example, trends in reimbursement and practice have brought occupational and physical therapists together in the area of hand therapy. Legislation proposed in California, which would require occupational therapists who treat hands to be certified by the Hand Therapy Certification Commission, has been interpreted by some as a move toward a separate profession. Referrals are typically for “rehabilitation of the hand.” Whether an occupational or physical therapist treats the patient is dependent upon availability and the patient’s insurance coverage. A hand therapy CPT (Current Procedural Terminology—developed and owned by the AMA for accurate reporting of procedures and services, presently used for billing purposes) (AMA, 2003) code is being sought that will be accepted by insurers regardless of whether the treating therapist is an occupational or physical (Diffendal, 2002a). Who uses a CPT code is not an issue, but rather who is financing the approval of the new CPT code. Fortunately, AOTA and American Physical Therapy Association (APTA) are collaborating on such endeavors.

Another example is in the area of assistive technology (AT). Through a joint effort with the Rehabilitation Engineering &
Assistive Technology Society of North America (RESNA), AOTA and APTA, a new CPT code for AT assessment was approved. RESNA is an interdisciplinary association of people with a common interest in technology and disability that promotes research, product development, education, advocacy, and provision of technology. According to the Self-Interest Theory, however, more is at stake than a sharing of research, education, and practice. To be effective, the new concentrated interests groups must also have the resources to acquire legislative support. This poses a dilemma for health care professionals with varied interests, including an interest in AT. How many professional organizations should a professional be expected to support? When we make choices about the organizations we support, are we making informed decisions? At what point are the professional organizations working together, and at what point do they begin to compete with each other?

Conclusion

The enactment of Medicare and Medicaid in 1965 led to an explosion in U.S. health care expenditures. Investor-owned medical care businesses (mainly hospital chains), attracted by the opportunity for profit began to appear (Relman, 1988). Rising inflation in the 1960s (attributed to financing the Vietnam War) contributed to the inflation in the 1960s (attributed to financed Vietnam War) contributed to the health policy affects their careers will be more likely to support the organizations that best represent their interests. In addition, clinicians feel pressure to choose between supporting diverse interests within their individual professional organization, supporting similar interests of competing professional organizations, or just not supporting at all. As the number of competing professional interest groups increases, and temporal and fiscal resources decrease, decisions about organizational membership become increasingly more difficult. Professionals who choose not to support at all thus do not share the cost of producing the benefits, get a “free ride” (Feldstein, 2001).

Legislative events occurring over the past 40 years that have resulted in constraints on health care expenditures, emergence of a competitive medical market, health-dollar value shift, and evidence-based practice have prompted the need for clarification and perhaps redefinition of the relationship between health care professional organizations and their potential members.

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References


