The Environment: Providing Opportunities for the Future

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Cost of Care

The cost of medical care in the United States has increased from $50 billion in 1965 to nearly $700 billion in 1990. By 1995, health care is projected to cost $1 trillion a year; by the year 2000, $1.5 trillion a year. These figures are important not for the actual cost of care, but rather, for the per capita expenditure for health care in the United States. Our real per capita expenditure in 1990 was $2,051; this represented 11.2% of the gross domestic product. Compare this figure with that of other countries with national health systems that provide care to all of their citizens. For example, in 1985, Canada's real per capita expenditure was $1,483; Germany's, $1,093; and the United Kingdom's, $758. The concern of most policymakers is that although the United States has the highest level of per capita expenditure, it reports the lowest level of satisfaction (Blendon, Leitman, Morrison, & Donelan, 1990). Except for Medicare and Medicaid, which serve the elderly and the poor, the United States does not have a national health care system. There are currently more than 37 million people without access to health care because no mechanism for payment exists (Congressional Research Service, 1988). When we look at who pays the health care bill, we gain some understanding as to why the health care system is changing so dramatically. The federal government currently pays for approximately 40% of the public's health care costs, the patient pays 25%, and the employer, through insurance mechanisms, pays approximately 32% (Letch, Levitt, & Waldo, 1988). The major increase in health care costs is affecting the gross domestic product and, thus, the net profits of U.S. corporations, which is prompting the control of health care costs that we see today. This trend will continue as more companies build systems to self-insure their employees in order to control costs. Occupational therapy is affected in that as industry contracts directly with health maintenance and preferred provider organizations, the assurance of inclusion of our services is difficult unless such services have been deemed primary and cost-effective.

Major Factors Contributing to the Changing Health Care System

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Companies will focus on keeping their employees healthy. We will see an increasing emphasis on health promotion and prevention in order to minimize the cost that companies have to pay in benefits for chronic diseases. Preventable conditions to be targeted include heart disease, cancer, stroke, injuries, AIDS, alcoholism, drug abuse, low birth weight, and inadequate immunization. People in industry believe that prevention pays off and that it is up to them to figure out how to put knowledge of prevention into practice (Data Watch, 1990). Occupational therapists must be challenged to help industry design strategies to prevent chronic conditions.

Besides the costs associated with chronic disease, industry is facing an increased number of injuries and illnesses in the workplace. In 1989, the occupational injury and illness rate was 78.7 days of missed work per 100 employees (U.S. Bureau of Labor Statistics, 1990). As industry tries to control its health care costs, preventive strategies can be directed toward the identification of risk factors within industrial sites to prevent such injuries as repetitive motion and lower back injuries. Important strategies for the resolution of industries’ problems can come from the unique occupational therapy body of knowledge. Occupational therapists assess factors that threaten or impair performance. In the workplace, these can range from biomechanical factors and movement to attitudes and perceptions of the employee. Possibly, the unique balance of the human being’s work and rest and the individual person’s movement may be keys to understanding repetitive motion disorders.

**Changing Demographics**

Life expectancy in the United States has increased substantially since 1900, from 47.3 years of age to 74.7 years of age (Magaziner, 1989). The United States currently has approximately 34.9 million persons aged 65 years and over. This will increase to 65.6 million persons by the year 2030 (American Association of Retired Persons, 1988). This demographic pattern is of serious concern not only to social security policy planners but also to health and social service planners. In the next 50 years, the number of older persons will increase faster than any other age group in proportion to the total population. We expect health expenditures to increase because per capita public spending for the elderly is 2 to 4 times higher than for the young (Simanis, 1990). Most persons needing long-term care will reside in the community, not in nursing homes. In light of these projections, we as occupational therapists must be concerned with community-based prevention at all levels. Projections indicate the need to provide medical care for a growing population of elderly persons. The increase in persons over 85 years of age will require more emphasis on long-term care. This care will need to occur in the community, not in the nursing home. Planning efforts must be focused on mechanisms that will make care available at the community level. This care will not be a biomedical intervention. Considerable effort in the areas of disability reduction and rehabilitation will be needed due to the large number of persons with chronic disease; such efforts must begin now (Magaziner, 1989). Occupational therapists are thus challenged to design cost-effective care systems that will support the elderly at community levels of care and that will support their independence and capacity to continue to engage in occupation.

The percentage of people in the United States who are limited in the activities in which they can engage continues to grow. For the population under 5 years of age, approximately 2% are restricted; from age 5 to 14 years, 5%; from age 15 to 44 years, 6%; and from age 45 to 64 years, approximately 17%. At age 65 to 74 years, 22% of the population experience limitations; at age 75 years, almost 25% of the population is limited in performing major activities (Magaziner, 1989). Most of the persons (17.7%) experiencing these limitations have an annual income of less than $13,000, which severely restricts their access to care (Data Watch, 1990). Persons across income levels need services to support their independence. Payment mechanisms will be designed in this decade to address these problems. Occupational therapists must work both on a political and a policy level to ensure that all persons have access to the services necessary to promote their performance.

The fastest growing population today is persons over the age of 85 years, which brings about a new phenomenon—middle-aged persons who have an older adult in their kinship network. In 1965, approximately 25% of persons over the age of 45 years had a surviving parent. By the early 1970s, 25% of persons in their late 50s had a surviving parent, as did those in their early 60s. Today, 10% of persons over the age of 65 years have a surviving parent. Currently, the average woman will spend 17 years of her life caring for a dependent child and 18 years caring for dependent parents (U.S. House of Representatives, Select Committee on Aging, 1987). Thus, women in the work force require resources that will provide them with necessary services as they struggle to support older parents in the community without compromising their jobs. Some innovative industries are beginning to address the needs of workers who care for parents. Occupational therapists can play a major role in designing wellness and maintenance-oriented services to assist industry in meeting the needs of workers who are managing older adults. By designing programs and methods by which to train community-based caregivers, we can help families as they help their older adults stay productive and functional.

Other changes in demographics relate to advances in technology that are making life possible for infants at risk. Children who enter life at risk are often managed initially in intensive care units. Babies of 26-weeks gestation are not an unusual occurrence in intensive care units. These babies require major services to ensure their ability to survive and develop. Occupational therapy’s expansion within local education systems was tremendous from the mid-1970s to the mid-1980s, due to the regulations required by the Education for All Handicapped Children Act (Public Law 94-142). The increase in this at-risk population of infants should support continued expansion in occupational therapy services, particularly because of the major role that the schools play in managing children of working parents. A primary societal problem will be to provide opportunities for children with special needs to grow into adults with opportunities for work. What is occupational therapy’s role in vocational readiness?

**Women in the Work Force**

One of the major influences that has forced an expanded and more comprehensive health care system has been the percentage of women participating in the work force. Since 1950, the number
of women in the work force has increased. The 1986 U.S. census showed that more than 70% of women are working during their prime childbearing years; more than 60% of women are in the work force until age 55 years, declining only to 45% between the ages of 55 and 64 years. Because most women are not in jobs with a great deal of flexibility, it is not often possible for them to leave their work to take their children or parents to outpatient therapy. To accommodate this problem, some hospitals now offer freestanding 24-hr medical health facilities designed to provide access to services at times when persons are available to take their family members for care. In this decade, there has been a decline in occupational therapy services within outpatient departments. That decline will continue because of women's working roles. If therapists wish to serve working women, one of two strategies can be used: Services can be provided in the evening and on weekends, or they can be provided in the schools or at day-care centers where children or older adults can reside during the day. As we design programs, we must keep the factor of working women in mind, because such programs, which cater to persons who can pay for services directly or through third-party payers, will not be used if they are not available at a time when they can be accessed.

Changing Disease Patterns
During this decade, we have seen a number of new medical conditions, many of which are associated with the technology employed in medicine, and we have seen an increase in societal problems. The number of strokes per year has increased to 600,000, and injuries number 2.3 million, including 177,000 spinal cord injuries. In the United States, as of January 1990, there were 118,000 persons with AIDS, 18.5 million persons who abuse alcohol, and an estimated 1 to 3 million cocaine users. Last year alone, 260,000 low-birth weight babies were born, 23,000 of whom died (Data Watch, 1990). These examples indicate that a large percentage of the population continues to require the intervention services of occupational therapists.

Yet some of our services must be directed toward prevention. We must also design and implement services that lead to cost-effective outcomes. Such outcomes can be achieved when persons attain a level of independence where they can be productive members of society. Occupational therapy programs that provide only a part of the service that a person needs and that do not lead to productive living are a cost-liability to the health care system as opposed to a cost-benefit. It is critical that occupational therapists' services be perceived by health care consumers as a cost-benefit.

Changing Payment Patterns
Since the 1980s, patterns of payment have been changing. Industry has been advised to cut health care costs by precertifying admissions, requiring second opinions, and improving employee awareness of health factors and stress prevention. Some industries determine what health care services their employees can obtain. They conduct utilization reviews and use case management. Many companies have increased their deductibles, so that the employee is responsible for paying for the first health dollar. They also have designed prescription drug reimbursement plans that include generic drugs. Greater emphasis has been placed on improved data analysis, which involves a review of the records of hospitalized patients to determine the necessity of services as well as the accuracy of documentation and billing. Many companies have established wellness and fitness programs, some using preemployment medical and work examinations. Some companies have actually reduced their health benefits, and many have required that the employee seek outpatient, rather than inpatient, care. Some companies have gone so far as to make in-house medical services available for their employees. All of these changes provide occupational therapists with the opportunity to design and implement treatment approaches that are cost-effective, not only in the provision of care but also in ensuring the appropriate outcome of care.

Embedded in these cost-containment strategies are some important ideas for assisting companies in decreasing health care costs. Data collection systems need to be designed that will provide the necessary information to insurance companies to demonstrate the clinical effectiveness and cost-effectiveness of our care. Additionally, programs need to be designed that ensure that persons have access to wellness and fitness programs. Occupational therapists have expertise in designing programs for persons with chronic disabilities that will ensure an improved level of performance and function. The changing patterns of payment for health care services relate directly to the changing system of health care provision, with industry playing a more active role than it used to in health care.

Clinical Effectiveness
The cost of medical care has prompted much of the development in clinical effectiveness. Health care providers are being asked to document the effectiveness of their services and demonstrate their efficiency. In December 1989, the Omnibus Budget Reconciliation Act (Public Law 101-239) led to the development of the National Center for Health Services Research and Health Care Technology Assessment as part of the U.S. Department of Health and Human Services. This legislation led to the development of the Agency of the Office of the Forum for Quality and Effectiveness in Health Care. This agency is responsible for developing, reviewing, and updating clinically relevant guidelines to assist health care practitioners in the prevention, diagnosis, treatment, and management of clinical conditions. The purpose of the clinical guidelines is to enhance the quality, appropriateness, and effectiveness of health care. We will see that as clinical guidelines are developed for major diseases and problem areas in medicine, the relevance and payment of such services will be tied to quality criteria (U.S. Department of Health and Human Services, Agency on Health Care Policy and Research, 1990). Scientifically based evidence is used to develop guidelines for the establishment of criteria.

As occupational therapists approach the future in health care provision, we will be required to participate in the development of practice guidelines. In fact, we are currently being given the opportunity to participate in the development of criteria; for example, note our contributions to the clinical criteria for the management of depression. To be involved in this process, we must demonstrate the effectiveness of our interventions. Other health care professionals are being asked to do the same thing. Medicine, physical therapy, speech pathology, and many other di-
We must join our colleagues in document-rect service providers have the opportunity to participate in building future practice patterns.

Most of the documentation for the effectiveness of medical care has been at the basic science or laboratory level. We must join our colleagues in documenting the benefits of our contributions. Many of the National Institutes of Health grants are beginning to build clinical measures of function as a criterion for their grants. A new Center for Rehabilitation Research is under development. Our researchers must be ready to contribute to this initiative. We must also educate our clinicians in methods of addressing the appropriateness of care, beginning with basic quality assurance and medical effectiveness methods. It is also critical that we prepare professionals to objectively demonstrate our body of knowledge at both basic science and applied science levels. Clinical effectiveness will, in the future, guide practice. Both standards of care and performance measures will directly affect service provision patterns and, therefore, the patient populations who can benefit from our services. We are fortunate in the way this legislation has been developed in that practice guidelines must be developed by a process that includes participation by representatives of the affected provider groups.

Creating the Future

As we look toward the future, it appears that there are major limitations to what we have traditionally done as occupational therapists. One can view change as limiting our opportunities for service provision or as an opportunity for occupational therapy to participate in solving many of the complex medical problems and related social problems associated with dysfunction. By preparing clinicians who have the capacity to address these problems, we can make a major contribution to medicine and health care. The changing emphasis in medicine on promoting effectiveness in the outcome of care is creating many opportunities for occupational therapy to make its own contribution to health care provision. We are becoming a primary service in health care because we focus on how people engage in occupation and we know how performance can be affected through appropriate treatment and use of resources.

Reilly (1962) asked the question, "Is occupational therapy a service vital and unique enough for medicine to support and society to reward?" (p. 1). Thirty years later we can say that we are recognized for our unique contribution. We are being rewarded for our contribution to medicine through inclusion in policy, through inclusion within payment systems, and through an unprecedented demand for our services. Reilly said that our profession has a "magnificent medical purpose" (p. 9). She went on to state that she did not know whether we would fulfill this purpose. I believe that the developments in the last 30 years have demonstrated our capacity to fulfill that purpose. Many of our contributions toward enhancement of our clients' performance have satisfied Reilly's mandate.

We are now at a crossroads in health care provision. It is a very turbulent time. What do we do now? What do we do next? I think that the main responsibility we have is to continue to answer, both in our practice and in our research, the questions about how a person influences the state of his or her health. By doing that, we will make a strong commitment to our future.

The future is ours if we generate knowledge about occupational performance in the medical and social science literature, if we provide services that promote independence in community living, if we are considered the experts in assessing and treating performance deficits; and if we work as part of interdisciplinary treatment and research teams addressing the performance needs of the persons we serve. We also must be included in state and national policies governing payment of services as well as managed care plans. We need talented administrators in key management positions, and we must recruit and train occupational therapy personnel to respond to these challenges. These projections require the actions of every occupational therapist as we function within our work, political, professional, and social environments.

Occupational therapy was conceived by a group of dedicated professionals who believed that performance was the most dependable and influential part of life. The original concept was that the human being was an organism that maintained and balanced itself in the world of reality (Meyer, 1922). Interestingly, these principles are now being recognized and discussed by many medical specialists. Let us make a commitment to make our work visible through our science and through our practice.

Let us make a commitment to face the realities and carry forward Reilly's (1962) challenge for our patients, for our profession, and for ourselves. If we do, we will move into the 21st century making a major contribution to the health and welfare of American society.

References


