HEALTH POLICY

The New Direction in Health Policy

Health policy in the United States is at a new juncture in its development. Policy choices can be made based on three decades of experience during which diverse policy goals were established in succession. Health policy is also at a point where occupational therapists can make substantial contributions. In recent legislation and other health policy, the patient's functional status and quality of life increasingly are considered as factors in assessments of the value of health care. This article describes this trend and the unique contribution that occupational therapy can make in today's health policy arena.

It must be noted that U.S. health policy is expressed in many different forms, and each policy position is influenced by a multitude of competing interests and political actions. Federal legislation is the most visible and well-known form of policy. Legislation, however, does not determine the entire structure and provision of service. Because much of health care is provided through the private sector, national-level health policy is also developed through (a) coverage policies of insurance companies, (b) actions by national professional associations, (c) programs provided by foundations, (d) insurance benefits provided by employers, and (e) objectives of health care coalitions. This array of independent policy forums explains, in part, why health policy is complex and sometimes contradictory. Nonetheless, overall policy trends can be discerned.

Over the past three decades, health policy goals have shifted from building the structure of the health care system (particularly to provide acute care) to improving access to care to containing health care costs. A brief review of policy objectives demonstrates these shifting priorities.

Prior to the 1960s, the emphasis of health policy legislation was on designing the structural components of the health care system, such as upgrading hospital buildings through the Hill-Burton legislation (Hospital Survey and Construction Act [Public Law 79-725]); accrediting the training programs of schools and health professions; increasing the number of health care professionals (e.g., through the Health Amendments Act of 1965 [Public Law 84-911]); and developing financing mechanisms (e.g., Blue Cross insurance plan [Anderson, 1975], Social Security Act of 1935 [Public Law 74-271]).

During the 1960s, the-era of the "grea socierty" (New York Times, 1964) programs, the government's objective shifted to more directly improving the health and welfare of the American people. Health policies were aimed at increasing access to health care. In the private sector, health insurance benefits were expanded; in the public sector, Medicare legislation was enacted (Social Security Amendments of 1965 [Public Law 89-97]). Health services proliferated, and a greater proportion of the population gained access to them.

The mid-1970s introduced another policy direction, one that focused on controlling the rising costs of health care and on defining and measuring the quality of care. Quality of care was addressed in 1972 through amendments to the Medicare and Medicaid legislation that established the Professional Standards Review Organizations (PSROs) (Social Security Amendments of 1972 [Public Law 92-603]). The purpose of the PSROs was to monitor the quality of health care and the utilization of services provided under the Medicare program. This was the first time that medical treatment came under scrutiny. The PSROs were succeeded in 1982 by the Professional Review Organizations (PROs), which continue to be Medicare's quality assurance program today. According to the Peer Review Improvement Act (Tax Equity and Fiscal Responsibility Act of 1982 [Public Law 97-248]), the driving force behind the review is to ensure that health care paid for through public funds is of high quality; however, the reviews have been criticized as being a cost-cutting measure that pays little attention to quality of care.

The 1980s were a period of retrenchment exemplified by the Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35), which essentially reduced federal spending for the provision of direct health services by 25%. The predominant concern behind this legislation was to reduce the yearly increase in health care costs. A popular strategy for contain-
ing costs was to apply free market economic principles to the health care system. As a result of this competitive approach, alternate service provision systems, such as health maintenance organizations (HMOs) and preferred provider organizations (PPOs), were rapidly created and are, today, the large managed care systems. To date, rising health care costs have proved difficult to control, and the assumptions underlying the free market economy do not seem to be applicable to the health care system.

Interest in the quality of care also extended into the 1980s, with private insurance companies, managed care systems, and utilization review companies following the government’s lead in conducting quality assurance reviews. Unfortunately, quality assurance was frequently used only as a mechanism to justify reductions in health care benefits. Close inspection revealed that many of the quality assurance programs were nothing more than utilization review programs.

As we enter the 1990s, cost containment continues to be a policy goal, but rather than using quality assurance as a guise for cutting costs, private businesses and the government are looking at the value of health care, especially as it relates to long-term care and the patient’s ability to function. Value implies that the outcomes of care are worth the cost. This is a subtle, but potentially significant, difference from earlier efforts to provide care at the lowest cost.

As value in health care becomes a major policy objective, a developing perception is that the ultimate value of health care lies in helping people to function in everyday life. Perhaps this perception was spurred by the increasing prevalence of chronic disease and disability and by activism for the rights of persons who are physically or mentally challenged. The preeminent strategy for examining the value of health care is outcomes research, and both public-sector and private-sector policies now support research in measuring the outcomes of care.

An example of this new policy direction is the recent creation of the Agency for Health Care Policy and Research (AHCPR), a federal agency under the Public Health Service, whose broad mission is to promote improvements in clinical practice and in the organization, provision, and financing of health care services. One of the AHCPR’s many specific responsibilities is to facilitate and administer funding for research on health care outcomes. More and more, outcome measures include functional assessments.

The increased focus specifically on functional assessment is notable in policy positions such as the conclusions of a 1989 Institute of Medicine conference, which pointed out the need for the Health Care Financing Administration to include a patient’s functional status and quality of life as part of its assessments (Institute of Medicine, 1989). Also, the National Study of Medical Care Outcomes, a longitudinal study presently being conducted by John Ware, PhD, examines functional status as one of many patient outcomes. This assessment includes activities of daily living and vocational, leisure, social, and role functioning. Awareness of and interest in functional ability are also demonstrated by the fact that the U.S. House of Representatives recently passed the Americans With Disabilities Act (HR 2273).

Occupational therapists have a long history of treating both mentally and physically challenged people and have acquired a thorough understanding of how chronic disease and disability affect a person’s ability to carry out activities of daily living and to fulfill a meaningful role in society. Occupational therapists also have developed numerous functional assessments and have applied them in clinical situations. Thus, they have an understanding of the problems involved in selecting valid and reliable approaches to assess a patient’s functioning and can bring these conceptual skills to the policy process.

In order to contribute their special expertise to the development of health policy, occupational therapists must be informed of policy issues and developments on many fronts in both the private and public sectors. Information can be found in publications that summarize pending health legislation and discuss the policy positions of health care coalitions and other groups.

Occupational therapists can enter the policy process by increasing their visibility and by participating in health care forums both outside of and within the occupational therapy profession. Many advocacy groups, such as the American Heart Association, the Arthritis Foundation, and the American Association of Retired Persons, are active in the health policy arena and welcome voluntary work and consultation from members of relevant health professions. Within the profession, occupational therapists can maintain contact with their professional associations to seek information about policy actions and to advocate their interests on policy issues. The American Occupational Therapy Association’s Legislative and Political Affairs Division publishes the “Federal Report,” which appears bi-monthly in OT Week and reports on pending legislation of specific concern to occupational therapists as well as on what actions are being taken to influence or promote that legislation.

Occupational therapists, as health care professionals, are not limited to health policy as it relates to long-term care and functional assessment. There are broader policy questions on ethics and the organization
and provision of services in which occupational therapists can participate. However, the present policy direction, which includes a conceptualization of issues related to patients' functional abilities, indicates a need for the unique contributions that occupational therapy has to offer.

References

Health Amendments Act of 1956 (Public Law 84-911), 42 USC § 242D.
Hospital Survey and Construction Act (Public Law 79-725), (1946), 42 USC § 291.
Social Security Act of 1935 (Public Law 74-271), 42 USC § 501 et seq.
Social Security Amendments of 1972 (Public Law 92-603), 42 USC § 1301.

HEALTH POLICY provides a forum for discussion of policy issues and ways to contribute to policy making and for the exchange of policy information. As was pointed out in this overview, policy comes in different forms from a variety of sources. Readers are encouraged to submit manuscripts analyzing or discussing policy issues or containing ideas for participation in the policy process. All manuscripts are subject to peer review. Submit three copies to Elaine Viseltear, Editor. Published articles reflect the opinion of the authors and are selected on the basis of interest to the profession and quality of the discussion.

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