The increased interest in administrative issues reflects the changing climate facing the profession of occupational therapy in the mid-1980s. The effect of the changing medical delivery system on the profession is evidenced through the development of home health organizations (HMOs), diagnostic-related group (DRG) systems, and other federal and state-regulated systems. To ensure survival, the practice of occupational therapy will become more community based and less dependent on the hospital setting.

In preparing for this session, I reviewed previous conference programs to determine what subjects occupational therapists were interested in and what changes in trends were apparent. I also reviewed the minutes and President's address from the 1975 Representative Assembly to compare the profession's current interests with the interests of 10 years ago. I found that in just the last few years supply and demand has changed conference program content dramatically. For example, in 1979, 11 preconference institutes were scheduled, two of which, on nonpractice subjects, were cancelled (1). In 1980, six of the 12 preconference institutes scheduled were cancelled because of lack of advanced registration (2). These six institutes also dealt with nonpractice subjects. This indicates that in 1979 and 1980 only the practice institutes survived.

In 1985, 29 preconference institutes were scheduled (3). Of these, 55% dealt with practice issues, 38% with administrative issues, and 7% with research. Not one preconference institute on administration survived in 1980; yet 38% of all the institutes scheduled in 1985 dealt with administration. This is a noteworthy change in the profession's interest and awareness. It suggests that we are recognizing the importance of administration and administrative issues to the profession's progress, growth, and existence.

The preconference institutes on topics of administration for 1985 deal with automation, productivity, microcomputers, data use in treatment and the political arenas, the development of private practice models, and the meeting of standards. All these administrative issues also affect practice both now and in the future.

This trend toward heavy concentration on practice issues extends beyond the preconference institutes to the 1985 conference pro-
gram itself, for about 65% of the program topics relate to practice. The subject matter in the 1985 practice sessions is extremely varied, quite innovative, and challenging. Eleven percent of the conference sessions deal with different administrative concerns, including financial issues, private practice, and computer application. About 5% deal with educational issues, 16% with research, and the remaining 3% are general in nature.

It is not surprising that more than 60% of the sessions at conference deal with practice, because most members of the American Occupational Therapy Association (AOTA) work in different areas of practice, whereas a relatively small percentage is in administration and education, and the conference is designed to reflect the interest of the members. However, it is encouraging to see the increasing number of administrative sessions and the obvious interest in subjects that affect practice, including those that are clearly administrative in nature.

The 1975 Representative Assembly Minutes (4) and President Jerry Johnson’s address to the Delegate Assembly in that year (5) indicate that our profession was in the midst of a radical and traumatic revolution—formerly a maintenance organization we can now respond to the needs of our members, support their personal agendas, and cause change through self-directed and self-initiated activity. The plan laid out in 1975 called for creative action to respond not only to the needs of our individual members but also to the needs of consumers. Because of our competent performance, the payoff for the profession was changed from job security to reimbursement for our services. Our profession needed to support licensure, a recognized certification process, and to make a strong continuing effort on the part of the AOTA; we have done both.

In 1975, our profession was envisioned to function in three major environments—the medical, educational, and community environments. We are functioning in all three of those environments today; however, those environments have changed from what they were, or were perceived to be, in 1975. Today, these environments are influenced by the escalating cost of health care. That cost is affecting not only the delivery of occupational therapy in the health care arena but also the delivery of occupational therapy services in the community, the schools or any other place where our services are needed.

**Five Issues in the Revolution of Health Care**

I see five major issues confronting our profession that are part of the revolution in the delivery of health care and other services:

- the Diagnostic-Related Group (DRG) system or the Prospective Payment System (resulting in fiscal problems and an occupancy crisis for hospitals);
- the change in the way that health care is being delivered, the proliferation of health maintenance organizations (HMOs), the resulting loss of physician income, and the loss of physician control over patient care;
- the growth in home health care (the glamour industry) and an impending reversal as that pendulum supporting home health care swings back;
- the aggressive entry of industry into the health care arena and its resulting control of health care; and
- the danger of occupational therapy losing its identity and position in the public schools as educators struggle to maintain control by involving as many of themselves in the educational system as possible.

**Impact of DRGs**

In 1984, AOTA conducted a survey on the impact of medical Prospective Payment Systems (6) on occupational therapy. Although the study will be reported elsewhere, I would like to refer to some of its findings here. The study was carried out to determine a) the potential impact that the pricing system (DRGs) might have on the delivery of occupational therapy services and b) the possibility of changes caused by this new payment system, which became effective in 1983. Of the 2,800 questionnaires sent out to hospital occupational therapy departments, 39.8% were returned. Respondents added comments indicating that patients were being discharged sooner and sicker, that patients were being referred to rehabilitation units prematurely, and that rehabilitation units had waiting lists. Also, there were significant increases in referrals to outpatient occupational therapy, early referrals to occupational therapy, paper work, computerized record keeping, and quality assurance processes.

We know that the occupancy rate of hospitals is on a dramatic decline and that some hospitals have closed because of this. Interestingly, for-profit hospitals are able to maintain their occupancy rate and in fact show a profit at about 45% occupancy rate, whereas nonprofit hospitals must maintain a much higher rate of occupancy (60% or better) to maintain a sound fiscal status. While Medicare is refining this prospec-
tive payment system, Medicaid is adopting a similar system throughout the country, and private insurance carriers are imitating the government and its payment system through hospitals, physicians, and other health care providers.

Physicians and hospital administrators are well aware of the strong possibility that all third-party payers will adopt some sort of prospective payment system in the near future and are therefore making every attempt to avoid such an action by demonstrating ahead of time that prudent practices can be voluntarily enforced by cutting health care costs and unnecessary hospital utilization. As prospective payment systems become more prevalent, our own profession will move away from the acute care hospital settings to provide additional care in the community and other arenas.

Increase in HMOs

The second major change in the delivery of health care is the nationwide increase in HMOs; this increase affects the private primary care physician and specialists in the community as well as the utilization of occupational therapy and other community-based services. There are two basic kinds of HMOs: One employs salaried physicians who work for the HMO, and the other is a membership organization with participating community-based physicians who treat HMO patients in their own offices. In both cases, a pool of funds is set up by designating a certain percentage of each subscriber’s dues for that purpose. The physician specialist and the other health care professionals (e.g., the physical therapists and occupational therapists) are paid for their services out of this pool. At the end of the year, the physicians in either kind of HMO benefit financially by dividing up the pool’s remaining funds (i.e., money not spent for purchasing special care). This incentive system is an obvious effort to cut costs by curtailing unnecessary referrals to specialists and other health care organizations. Fees paid to outside physicians will be cut. Primary care physicians need not be concerned about a loss in income; specialists, however, may lose an estimated 30% to 50% of their income because of this practice. At the same time that referrals are being controlled by HMOs in an effort to cut health care costs, physicians are losing control of their patients and their care. We have been concerned that occupational therapy be included in the services covered by HMOs. We also need to be concerned about the fact that in those HMOs that do cover occupational therapy, physicians are motivated not to make referrals for the service. We need a nationwide study on the rate of referrals for occupational therapy from HMO physicians as compared with other community-based physicians. This study needs to be done right away.

Growth in Home Health Care

The most glamorous and fastest growing health delivery system today is home health care. Competition in the home health care field is so keen that even the organizations representing the home health care agencies are competing against each other. A 600% increase in money spent on home health care has been projected to occur between 1980 and 1990. On the surface it would seem that the level of growth might mean increased levels of prosperity for Home Health Agencies, but indications from the Home Health Agencies involved are that not only competition in general, but expected intervention from the government in terms of capping reimbursement for home health may mean just the opposite (?).

Possibly an increasing number of services will be delivered by fewer agencies, exacerbating the problem of a two-tier medical system. As health care becomes more product-oriented and less patient-oriented, problems of access, management, and quality appear less frequently in the public dialogue. Traditionally, these have been the issues under discussion by the private, nonprofit sector. When for-profit providers are included into the home health market, we can expect to see the focus shift to for-profit issues, such as “products” and “profits,” with less attention given to measuring satisfaction.

As agencies feel the pressures of competition, their philosophies begin to resemble the traditional philosophy of business. Should health care be considered an economic issue? Should opposition be mounted to protect the service orientation and philosophy of the private, nonprofit sector? For consumers, the question is whether they are entitled to health care only if they can afford it or whether they have a right to quality health care even if they cannot afford it. Home health agencies are in the unique position of being at the forefront of change in the medical system and therefore could help sway the outcome of these questions. However, this requires a new approach; instead of trying to assure the survival of particular agencies it will be necessary to ponder the survival of a particular type of service system.

Some practitioners are concerned that increased home health and availability of home health agencies will cause an increased burden on Medicare/Medicaid, Blue Cross/Blue Shield, and the private health insurance companies.
who pay for home health services. These reimbursers fear that any savings due to reduced hospital utilization could be offset by large numbers of patients currently managing on their own at home who would use any new services, such as Homemakers and Home Health Aids, just because these benefits would be covered by their insurance. According to Rogatz (8), home health care should not be seen only as a cost-saving measure "but rather as a vital component of the broad spectrum of institutional-based, ambulatory and community-based services, which an enlightened society must make available to its members" (p 43).

Although the home health agency industry is projected to grow through 1990, current signs suggest that the growth will not continue. States are attempting to control the increase in home health agencies by imposing standards, demanding that certificates of need be obtained before new home health agencies are started, and imposing licensure. Congress proposes that payments to home health agencies be frozen as one measure to curb the rate of increase in health care costs. These are concrete efforts to control the growth of an industry that is perceived by some to only generate additional costs in the total health care system.

Entry of Industry

The fourth major change in health care delivery is the aggressive entry of industries, the largest of which is the insurance industry, into the health care arena. Insurance companies now own some HMOs, a large durable medical equipment firm, and some home health agencies. Dr. G. Gail Stephens (9), a member of the Department of Family Practice at the University of Alabama, Birmingham, recently described this change very well.

There can be little doubt that the most significant happening in American medicine now is its headlong rush into complete industrialization. After decades of waiting in the wings until the last professional resistance to corporate practice has crumbled, business is having its way with the ownership and delivery of medical services. The reasons are legion—high costs, mal distribution, unremitting demands, failure in government programs, professional exploration, etc.—but certainly one of the most important is profit, the opportunities for which are alluring and well nigh irresistible. One might be forgiven, however, for wondering whether the takeover of medicine by industry will be any more beneficial for the general public than similar takeovers of farming, auto manufacturing, education and newspaper publishing have been. Will a new day dawn in which every citizen will have equal access to proper medical care at a reasonable cost or will this utopian vision prove once more to be a mirage? (p 189).

Stephens draws a correlation between the food supermarket of today and a medical supermarket of the future. He analyzes the controlled cost in the well stocked food supermarket of today; the homogenization of merchandise (a supermarket in Ohio will offer the same items and brands as one in Arizona, regardless of customer preference); and the difference between food and nutrition as a business of the food supermarket. He describes the human dimensions or the lack of human dimensions in the supermarket, the infrequent presence of the manager, the TV monitors, the clerks, the stockpersons, the checkers—all impersonal because they do not interact with the customer. Stephens muses that if our medical services are to be delivered in such a supermarket fashion once the medical industry is indeed fully grown and operated according to business principles, then the medical industry will have characteristics similar to those of other businesses: absentee ownership, the profit motive, impersonality, strong cost control measures, appeal to a mass market, advertising, and caveat emptor (a business principle meaning that without a warranty buyers take the risk of quality upon themselves). The delivery of medical services in a supermarket atmosphere will certainly be a change for us. If a doctor will be involved and if he is to pay attention to our individual and humanistic needs, we will surely have to safeguard such a personalized design. The same is true of other services, including occupational therapy, which we now take for granted and which may become rare, unprofitable commodities that cannot be mass-produced and circulated in a cost-effective supermarket way.

Occupational Therapy in Public Schools

The fifth and final sign of revolution is the changing role of the occupational therapist in the public school system as a result of the mandates of Public Law 94-142. Several years after the implementation of the right of Education for All Handicapped Children Act, occupational therapists continue to be employed in the public school system as teachers, are still supervised by teachers, and have their work or job description defined by teachers. There is a fine line between giving the candy store away and working as a consultant or partner with the educator. If teachers can pick the brain of the occupational therapist and take what they can to satisfy the letter of the
services. Occupational therapists are developing programs that are developing so called "transdisciplinary treatments," meaning that the occupational and physical therapists tell the teacher what to do or write out a treatment plan to be carried out by the teacher. In so doing they are writing occupational therapy right out of the IEP and instead include the components of previously written occupational therapy treatment plans described as the responsibilities of teachers or aides.

Five years ago we were making real inroads into the public schools and developing a strong practice arena. Five years from now occupational therapy may well be as rare within the public school system as it was when we were relegated to the relatively few schools for the orthopedically handicapped and their programs. We must protect the role of the occupational therapist in the educational system.

Outlook for the Future

There are a number of things that won't be possible if the assumptions described in the five issues just discussed are correct. Health care costs cannot continue to increase. "Freeze" has been a popular word in Washington for some time. Congress talks of freezing the budget. A freeze was imposed to reduce Medicare/Medicaid reimbursement of physicians. Physician fees were frozen. One study showed that doctors reacted to reduction of fees and reimbursement by increasing the number and complexity of services for beneficiaries, thus maintaining program cost (10). For example, California physicians increased services to Medicare patients by 8% to 15% under the new defunct economic stabilization program, which limited annual reimbursement increases. When those controls were lifted, services billed by general practitioners declined by 9% and prices increased by 23%. Findings further show that doctors are less likely to treat public program patients when reimbursement is restricted. When changes in the Medicare program in Colorado gave physicians outside Denver a windfall rate increase but raised doctors' rates in the cities by less than 5%, the number of Medicare patients declined sharply. Furthermore, in California the likelihood of Medicaid participation by primary care physicians was found to increase by 11% when reimbursement levels rose. The question is, will a freeze affect the total cost of health care?

A number of suggestions have been made about how to hold down the cost of health care, including rationing, curbing the cost of health care technology, having limited access to certain health care programs, and developing strong prevention programs. Strong consideration is being given to freezing payments to various components of the health care system, including hospitals, nursing facilities, and home health agencies. The freeze on physician fees would be continued.

We are well aware of the changing posture in the health care delivery system and knowledgeable about how some of these changes will affect us as individuals and as a profession. What matters is not whom we know or even what we know, but where we go and how far we go from this point in our professional development.

Occupational therapy has clearly established its role in three areas of practice—the medical arena, community practice, and the educational programs of handicapped children. However, we have no guarantees that occupational therapy will continue in these areas of practice. As a profession we have never had promises or guarantees, only opportunities. A promise is grounds for expectations, usually of success, improvement, and excellence. A guarantee is an assurance of the fulfillment of a condition, it is like a contract in which one person undertakes to secure another in the possession or enjoyment of something. An opportunity, on the other hand, is a favorable set of circumstances, a good chance for advancement or progress.
We have the opportunity to demonstrate the unique, long-range cost-effectiveness of occupational therapy and to return to some of the arguments and demonstrations that were developed forty years ago as rehabilitation was emerging as a professional entity and we in the rehabilitation field had to demonstrate not only to the government but also to private insurance carriers that rehabilitation services, including occupational therapy services, were indeed cost-effective as well as beneficial to the patient. Our profession is ahead of many others in the development of a quality assurance system, in the work that has been carried out to validate the effectiveness of our treatment programs, and in our research programs. We need to continue to build on the strong foundations that have been laid in these areas. However, as we build, we must be cautious of what we build. We must build bridges, not walls. We do not need a barrier intended to prevent escape or intrusion or to mark a boundary; we need a time, place, or means of connection—a bridge. Franklin D. Roosevelt (11) once said, “It has always seemed to me that the best symbol of common sense was a bridge.” We need our bridge as a symbol of common sense to connect our profession with the issues that are greatly affecting the delivery of all health care and the delivery of occupational therapy services in other arenas of practice.

REFERENCES
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