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 1964 [Public Law 84–911]); and developing financing mechanisms (e.g., the Blue Cross insurance plan [Anderson, 1975], Social Security Act of 1935 [Public Law 74–271]).

During the 1960s, the era of the "great society" (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-
“Occupational therapists can enter the policy process by increasing their visibility and by participating in health care forums both outside of and within their profession.”
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 79–725), 42 USC § 301 et seq.


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