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Contents

Preface v

Reviewers vii

CHAPTER 1 Public Policy and Therapists 1

CHAPTER 2 Access and Cost of Health
Care 15

CHAPTER 3 Quality of Health Care 33

CHAPTER 4 Public Policies Addressing Social
Disablement 47

CHAPTER 5 Effecting Policy Change: Therapist
as Advocate 71

CHAPTER 6 Fundamentals of Insurance 95

CHAPTER 7 Private Insurance and Therapy
Practice 109

CHAPTER 8 Medicare 127

CHAPTER 9 Medicaid, Military/Veterans
Medical Insurance, and Indian
Health Service 157

CHAPTER 10 The Acute Medical Care
System 173

CHAPTER 11 The Post-Acute Health Care
System 189

CHAPTER 12 Special Education and Mental
Health Systems 209

CHAPTER 13 Global and Population
Health 229

Appendix A Resources on Policies Addressing
Social Disablement 241

Appendix B Advocacy Resources 242

Glossary 244

Index 249

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Preface to the Third Edition

Since the second edition was published in 2008, health policy has significantly changed.

The enactment of the Patient Protection and Affordable Care Act of 2010 (PPACA) in March 2010 (followed by its legal affirmation by the United States Supreme Court in June 2012 and a political re-affirmation by the reelection of President Obama in November 2012) is the largest regulatory overhaul of the United States health care system since the enactment of Medicare and Medicaid in 1965. The effects of the PPACA will be played out over several years, if not decades. In the years to come, this law is sure to affect the practice of all health care providers, including occupational therapists and physical therapists. In addition, a number of changes have occurred to other important public policies affecting therapist practice, for instance, in Medicare. Cumulatively, these developments have prompted this new edition of our textbook.

The central purpose of the book remains unchanged from the first edition published in 2003. We have striven to produce a comprehensive introduction to the policies and systems where occupational therapists, physical therapists, and therapist assistants find their work and provide their care. In doing so, we have made several changes in response to the users and reviewers of the book. We are very grateful to those persons who gave their time, expertise, and constructive criticism to help us improve this edition. The changes are as follows:

- The book has been increased from twelve to thirteen chapters. In this edition, we created a new chapter on global and population health. The global health content provides an international perspective on the health care systems of several industrialized nations. We have moved the public health content into this chapter and emphasized its relationship to population health. We view population health as a growing area of importance for occupational therapists and physical therapists in our evolving health care system.
- The advocacy chapter has moved from the end of the book to a position after the principles of health and public policy chapters. We believe that public policy advocacy skills need to have a stronger emphasis in occupational therapist and physical therapist entry-level curricula. We hope that this change will help students develop stronger policy analysis and advocacy skills by placing this content closer to the content that explains principles of policy. We encourage the use of the advocacy skills material to understand the reimbursement policy and systems chapters that follow this chapter.
- We welcome two new contributors (Creighton colleagues) to this edition of the textbook. Anna Domina OTD and Katherine Young OTD wrote a new chapter on special education and the mental health care systems. We are grateful for their participation and believe this chapter offers a significant, positive contribution to this edition. We also thank Yolanda Griffiths OTD for her assistance with this chapter.
- Several of the chapters on reimbursement policy (Chapters 6–9) had significant updates to reflect the statutory changes from the PPACA. As a result, we moved the content on casualty insurance, workers' compensation, and long-term care insurance to the private insurance chapter (Chapter 7). The Medicare chapter was rewritten to better explain the reimbursement strategies to their different benefits.
- All chapters have had content and emphasis updates and revisions that reflect changes in policy and the health care system since the second edition. We have tried to emphasize application to therapy practice.
- Key terms for each chapter are updated and defined in the Glossary. We have tried to be sensitive to the appropriate use of “patient” and “client” terminology when writing the narrative.

Increasingly, the challenge has been to make the book a comprehensive introduction to health policy and the health care system experienced by physical therapists and occupational therapists without making it too specific or overwhelming in detail. This has been challenging with all of the regulatory changes of the past few years and in recognition that many students have had little, if any, public policy or business background prior to encountering this content. There are outside resources that instructors will include that are not in this textbook and we recognize that there are portions of the book that will be excluded for one or more reasons. Given that a number of changes due to the PPACA have not yet occurred or are not widespread (e.g., health insurance exchanges or accountable care organizations), we expect that other resources will be accessed by instructors to provide students an appropriate education in these policy areas. Even as we conclude this edition, the Congress and president are considering Medicare and Medicaid reforms that may affect the content presented in this edition. For these still-to-be-determined changes, we have done our best to introduce concepts so as developments do occur the student will be able to recognize and understand the new policy or system landscape. We hope that we have been successful in meeting our primary goal to provide a strong foundation for a health services course in the therapy disciplines, apart from the traditional administration or management course. We offer this textbook as a tool to assist students and instructors in this endeavor.

We recognize and thank Mark Cohen, John Goucher, and the people of Pearson Education for their ongoing support of this project. A special thanks to Melissa Kerian and Anandakrishnan Natarajan for their patience, expert guidance, and editorial work as we have completed this edition. To our families, we offer our deepest thanks and love for their partnership with us on this book.

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Public Policy and Therapists

CHAPTER OBJECTIVES

At the conclusion of this chapter, the reader will be able to:

- 1 Explain the interaction between policy, systems, and everyday practice in occupational therapy and physical therapy.
- 2 Define power and describe how policy is used to create and distribute power in a society.
- 3 Compare and contrast the uses of private policy and public policy as a method to effect social change.
- 4 Discuss the experience of disablement using the medical disablement, social disability, and universalism models.
- 5 Differentiate medical care and human services systems as components of the health care system for persons with disabilities.

KEY WORDS

Biomedical Model
Disablement
Distributive Justice
Dualism
Health Services
Marginalization
Social Disability
Universalism

CASE EXAMPLE

Susan is a 22-year-old single woman who works full time in a low-wage job as a hotel housekeeper. Her employer does not offer health insurance to employees. Susan does not qualify for any public insurance program. Susan is among the 46 million Americans without health insurance. She does not have a regular health care provider.

Susan lives with her grandmother, Sarah, who is age 70. Sarah worked for many years at a local factory and has been retired for the last five years. She receives a small pension and a Social Security payment each month. Sarah has health insurance through the Medicare program. Her low monthly income qualifies her to receive assistance from the Medicaid program for her Medicare deductibles. This benefit is important since last year Sarah had surgery and was

hospitalized. Sarah did not pay for any out-of-pocket costs for her surgery.

Susan's mother, Ann, was injured in a motor vehicle accident three years ago and is unable to find work in her community. Since then, she has lost her job and has spent most of her life savings on medical expenses and monthly bills. She is waiting for a decision on her application for permanent disability status from Social Security. This would permit her to qualify for health insurance through Medicare and a disability benefit. She would like to work, but she has had difficulty finding vocational training options in her small community to help her learn new skills.

Case Example Question:

1. What are reasons for the differences in access to health care for Susan, Ann, and Sarah?

Introduction

Policies and systems are established to improve the lives of people and the overall community. This book is about an important and complex set of policies and systems in the United States: **health services**. Health services include the organization, financing, and operational delivery of medical care and certain human services to persons who experience disease, illness, injury, and **disablement**. We are most interested in the health services that affect disablement because this book is intended for physical therapists and occupational therapists. Specifically, we are going to explore the policies that support and direct therapy care as well as the systems that organize these services. It is our intent that as you become better informed about health services, you will become a better advocate for your patients and profession in order to improve existing policies and systems.

This chapter will introduce broad concepts regarding the development and implementation of health services affecting both occupational therapy and physical therapy. While our two professions are different, we are often similarly affected by policy. The next two chapters will introduce and explore the three foundational principles of health care policy: access, cost, and quality. Chapter 4 discusses public policies designed to address social disablement (i.e., marginalization and discrimination against persons experiencing disability). In Chapter 5, we present information about advocacy or how you can understand and potentially change the policies that we are going to discuss in this book. As you will learn, these policies have profound effects on the financing and organization of health care, including therapy services. First, we begin in this chapter by discussing the social structures that generate the policy and systems affecting therapists and persons with disabling conditions. Second, we will discuss different theoretical models of disablement and how they can explain different policies and systems.

We begin this chapter by introducing and discussing the issue of power as it affects health services. Specifically, we will discuss how power is distributed in American society through two policy-creating mechanisms: government (public) and private enterprise. Next, we will study different viewpoints about what it means to experience disablement. One's perspective on disablement affects the type of policy that is created and how its effectiveness is evaluated. Third, we will integrate the concepts of a medical care system and human services system into our discussion. All of these systems affect the organization of health services for persons who are experiencing temporary or permanent disablement. We will conclude the chapter with a historical review of the development of the U.S. health care system in the 20th century and discuss the future of health care delivery in the 21st century.

Policy and Power

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act of 2010 (PPACA). This executive action culminated a year of congressional deliberation and debate about the structure and function of the U.S. health care system. The PPACA achieved reform of the private insurance and public insurance programs and incentivizes changes in the U.S. health care system when prior attempts at reform (e.g., President Truman's and President Clinton's initiatives to create a national health care system) had failed. The success of the PPACA, in light of the failures of prior national leaders to achieve health care reform, illustrates the interplay between history, policy, and power. These reforms matter to occupational therapists, physical therapists, and the patients that seek our services. As we will discuss in this book, access to health care is affected by insurance status and cost. Policy incentives create social and economic forces that affect the ability of therapists to create or expand therapy practices.

The lack of uniformity in health services in the United States can be traced to our system of policy **dualism** (see Table 1-1). Both the government and private enterprise are involved in the financing, organization, and delivery of health services, including occupational and physical therapy. While the PPACA changed the market for health insurance in the United States, its effects were controversial, primarily because it affected the balance of power between these two social forces. The sources of power for these two forms of health services policy-making are the core documents of our republic and the dominant economic system, free market capitalism. Physical and occupational therapy services are shaped by each source of power.

As noted in Table 1-1, health services originate from two sources of *power* in the United States: public and private. The allocation of resources and the organizational ability of government and the free enterprise system create the foundation for health services in the United States. As we will discuss in later chapters, government uses its taxing and regulatory authority to create access to medical and rehabilitation services, and, in some cases, to provide them to persons in need. Health services are also large economic enterprises (see Chapter 2). Both not-for-profit and for-profit enterprises have privately invested in the delivery and financing of health care, including therapy services. The generation of profit from this investment creates economic power that influences the health services system. The tension and interplay between private policy and public policy affecting health services are dynamic and political.

Table 1-1 Dualism and American Health Services Policy

	Government	Free Enterprise
Source of power	Constitution	Capitalistic markets
Role	Financing	Financing
	Regulation	Organization and delivery
	Organization and delivery	

While policy is often affected by government decisions and economic investment, effective and fair health services policy must consider those who are powerless. The lives of many persons who experience disablement are characterized by poverty, unemployment, lack of adequate housing and transportation, impaired access to medical care services, and barriers to equal social and economic opportunity in the broader society. Policies reflect the distribution of power in the decision-making process and the values and ethics of the broader society. Just policy considers the life and circumstances of the powerless and creates opportunities for empowerment and advancement for all persons in the society (Banja and DeJong 2000; Purtilo 1995).

In summary, policies are expressions of power that allocate and organize resources to address identified needs in a society. As we will discuss later, systems are established that respond to policy decisions. Just policies affirm the human rights of those who are powerless and provide a pathway for advancement. In the next section, we will discuss in more detail the sources of power that drive health services: government and private enterprise, as well as moral/ethical principles.

Sources of Power

Government

In the United States, the power of the government is established in the Constitution and other core documents. The United States was founded in a revolt against the authority of central government, based on the idea of promoting individual liberty. In general, the American democratic republic is a system of limited and distributed government. The American system distributes power among three branches: executive, legislative, and judicial. Government authority is further divided between the national government and the states. Laws enacted by legislative bodies require executive approval and are reviewable by the courts. All of these decisions are reported, analyzed, and commented upon by a free press to the governed citizenry. American citizens have a right to address their government, and public policymakers are held responsible for their decisions by election on a regular basis. As a result, government power is expected to be used cautiously, for understood reasons, and only when necessary.

When it does act, government power is coercive (Weiner and Vining 1992). Government has the power to unilaterally ascertain, restrict, permit, or direct resources of private individuals and organizations. Through the establishment and enforcement of laws and regulations, government can force behavior change on individuals and organizations that may not agree with the policy or that would not implement the same policy on their own. We also need to recognize the important role of government in establishing the “playing field” for private enterprise. Laws are government policies that establish private property and regulate markets that help to create the conditions that allow competition and the efficient, effective allocation of economic resources, including health services. When and under what circumstances can government use this power?

We can summarize two reasons for government action: failure of the private market to work as expected and a consensus among the governed populace for government action (Weiner and Vining 1992). In certain circumstances, private markets are perceived to be ineffective in meeting individual or community needs. For example, government provides the resources and ensures that roads and bridges are available to meet the transportation needs of society. It is accepted that it would be ineffective for each individual or community to privately organize and maintain a system of roads and bridges that permit people to work, shop, trade, or use recreational resources. It is a government responsibility to perform this responsibility. Government action is also expected to address concerns raised by the will of the people. For example, the Americans with Disabilities Act of 1990 (see Chapter 4) was enacted to improve the civil rights of all Americans with disabilities and reflected the social consciousness that this was the “right thing to do.” It would be very difficult, if not impossible, for civil rights to be achieved in all communities unless government power was used.

POLITICAL PROCESS The will of the people is exercised through the political process at all levels of government. Chapter 5 will introduce you to the principles and application of advocacy related to the political process. It is useful now, however, to discuss the

Table 1-2 Political Perspectives on the Role of Government in Health Care

	Libertarian	Egalitarian
Source of responsibility	Individual	Society
Health care	Earned reward	Prerequisite for work
Treatment of poor	Private charity	Government programs

Source: Based on Long, M.J. Social Values and the Medical Care System. In *The Medical Care System: A Conceptual Model*. Health Administration Press, Ann Arbor, 1994, p. 23–40.

political process as it relates to the distribution of power. It is within the political process that priorities are determined and actions taken or not taken by government to address societal concerns.

Political power derives from electoral activity, position, and the power of persuasion. Elections determine the representatives who will make decisions regarding policy. Elections reflect a perspective on the proper role of government in solving societal issues, (e.g., health care problems). In Table 1-2, two contrasting political perspectives on the role of government are presented. A libertarian perspective views the primacy of the individual and freedom from government intervention as important. Health care is viewed as an earned reward for work, and persons who have difficulty receiving health care are best served by private charity. In contrast, egalitarian philosophy emphasizes the society (its rules, attitudes, and barriers) as the source of societal problems. Government action is encouraged from this perspective to improve overall freedom. Health care is looked upon as a prerequisite for work and government programs as the solution to improve the health care system. While not presented in this table, Long (1994) also discussed a *utilitarian* perspective on health care that emphasizes the greatest good for the greatest number of people. This viewpoint is the foundation for many public health initiatives (see Chapter 13) that improve health by ensuring clean water or proper vaccinations against communicable disease. Elections determine a dominant perspective; although, in our political debates, it is common to hear views that blend both perspectives. Policymakers have decision-making power by virtue of their position, whether elected or appointed by an elected official. Persuasion is commonly demonstrated by the influence of interest groups, which is expressed through lobbying on legislative matters. This system is carried over to regulators who develop regulations concerning medical care policy.

Active Learning Exercise

Reflect upon your personal political philosophy. Would you describe yourself as a libertarian or egalitarian or somewhere in between? Think about the issue of providing mandatory, national health insurance for all Americans. To what extent does the social issue affirm or change your perspective?

Private Enterprise

Private enterprise creates power by the investment of capital and the organizational ability of individuals and institutions that create systems each day to exchange economic resources in a marketplace. The American system of capitalism provides opportunities for individual success and allows unsuccessful enterprises to fail. In this economic system, private enterprises accept the risk of failure, create strategy, innovate, and implement services that meet the needs of consumers. People who successfully do this have a proprietary advantage, a form of economic power. This proprietary advantage creates business activity, initiates competition, allocates economic resources efficiently, and creates wealth.

Decisions that meet the demands of the marketplace in an efficient manner result in rewards to the owner of the resources, that is, a profit. Profits are used to pay creditors, create new investment, and provide for the personal well-being of the owners (Helfert 1997). Profits create economic power. Investment and the incentive to invest provide the economic resources to build hospitals and clinics, hire therapists, educate the next generation of providers, and deliver critical medical care services to the ill or injured.

The generation of economic resources also finances the government. Individuals and businesses pay taxes that support governmental action. While government and private sources of power are different, we must recognize that they are symbiotic and, at times, complementary. This relationship fuels the reality of interest group politics, the necessary advocacy of specialized, private groups for governmental action, and political action committees, groups that privately finance the candidates for government office who support their perspectives. The American Physical Therapy Association (APTA) and the American Occupational Therapy Association (AOTA) have long recognized this reality at all levels of government and expend considerable time and resources to involve members in the political process.

Ethics and Values

Complex societies, like the United States, are always changing. Changing economic conditions, emergence of new threats to the public health or welfare, and developing technologies alter the lives of persons. These changes often mean that existing social structures or policies are inadequate for the present or emerging circumstances. For a society to be well ordered and functioning to permit maximum quality of life for its citizens, the policies or social contracts of persons within the society must be just. The principal focus of ethics is often on individual duty and responsibility as a professional to one's patient. However, social policy also reflects ethical values. The key concept for thinking about and determining the ethics of social policy is **distributive justice**. One of the purposes of this book is to help you understand health policy and be able to reflect upon the rules, regulations, and systems that you work in, so that you can understand their effect on your practice and advocate for a more just society. In Chapter 5, we will explain the specific skills to be an effective advocate. In this section, we are going to think about ethical principles from three important philosophers about social policy in their worlds: Aristotle, John Rawls, and Michael Long. From their ideas and reflections, we can ascertain some principles upon which to think about the fairness and equity of the world in which we live and work.

For policy to be just, Aristotle (as summarized by Denier [2007], pp. 18–19) stated that social goods should be shared in a community “as far as it complies with the principle of equality of geometrical proportion. This means that justice demands to *treat equals equally and unequals unequally*”. Aristotle understood that distributive justice requires policy whose outcome or effect is not equivalent for all persons. As described by Denier, the dilemma is that a definition or standard of the meaning of “equals” or “unequals” is often difficult to determine. She describes four Aristotelian criteria or descriptors of persons that could be used to evaluate the distributive justice implications of social policy in this paradigm: personal needs, contributions to the society, status, and assignment by merit. Aristotle believed that assignment by merit was the best justification for unequal distribution of social goods. While there is no consensus understanding of ethical social policy, Aristotelian theory establishes the ethical framework for a social response that is customizable to the attributes and needs of individual persons. How does this framework support the ethics of social policy for persons with disabilities or in need of therapy services?

As we have already indicated, many people experience disenfranchisement from the mainstream of society. Socioeconomic disadvantage, discrimination, and isolation from opportunities affect the lives of people who are “different” from the majority in the community. Persons with disabilities have historically experienced these circumstances (Banja 1997). Policies that affect everyone, including the powerless, should be fair and equitable. Laws and private policies reflect the basic values and ethics of the society and must be considered along with economic power and government authority in any debate on health

services. John Rawls was a very influential 20th-century American philosopher on the subject of social justice, social policy, and social institutions. In *A Theory for Justice* (1999), Rawls identifies two principles for creating or determining just social policies and institutions:

1. Each person has an equal right to a fully adequate scheme of basic liberties that is compatible with a similar scheme of liberties for all (Equal Liberty Principle).
2. Social and economic inequalities are to satisfy two conditions. First, they must be attached to offices and positions open to all under conditions of fair equality of opportunity, and, second, they must be to the greatest benefit of the least-advantaged members of society (Difference Principle).

In Rawls's perspective, the first principle should be the first priority, and the Difference Principle has secondary priority. Both principles have priority over other considerations, for instance, welfare or efficiency in determining the ethics of social policy. Rawls did not specifically identify health care, but he did identify wealth and income as basic liberties in his first principle. "Rawlsian" theory is useful because it clarifies and expands upon Aristotle's ideas about the justice of inequalities in a society. Just social policies and structures permit all persons to have access to social goods based on equality of opportunity, and the "greatest benefit" is given to persons who are disadvantaged or marginalized.

Long (1994) describes four values that form the ethical base for health policy in the United States: freedom, equality, rewards, and treatment of the poor. Table 1-3 outlines the four principles and provides an example of a contemporary health services policy issue that is an application of the principles developed by Long. Freedom is a social construct that describes our relationship to one another and our ability to make and act upon individual decisions. Related to the ethical principle of autonomy, the ability to make choices about health care and have access to services are examples of policy matters related to the principle of freedom. Should people have the freedom to choose their health care provider without limitations from a managed care plan? Related to the ethical principle of beneficence, the principle of equality defines the sharing and disbursement of rewards and responsibilities in society. Who is entitled to receive health care services? How will health care services be distributed to people? The large number of Americans without health care insurance (prior to the PPACA) demonstrated that we do not have a system that guarantees equal access to health care (see Chapter 2).

The principle of rewards addresses this question: Is health care a basic right, or is it payment for contributions to the greater social good? Our core government documents do not define health care as a basic right of citizenship. A universal, national health insurance plan for all Americans has not been enacted. However, we have some laws (e.g., a right to emergency care) that create a legal expectation that all persons are eligible for a level of health care. Finally, according to Long (1994), health care policy must address the issue of the powerless and the poor. Treatment of the poor is an issue of social justice. A civil and just society will have policies and systems that provide for the care and treatment of all people, not only the economically advantaged or socially elite. Government intervention in health care has often been predicated on meeting the needs of historically disadvantaged groups (see Chapters 7 and 8).

Table 1-3 Ethical Considerations of Health Services Policy

Ethical Principle	Contemporary Issue
1. Freedom	Medicare therapy cap
2. Equality	Uninsured Americans
3. Rewards	Universal or employment-based health insurance
4. Treatment of the poor	Medicaid program changes

Based on M. Long, *The Medical Care System: A Conceptual Model* (1994).

In summary, health services are affected by competing and complementary sources of power in society: government and private enterprise. To be workable, social policy, including health care policy, must be perceived as meeting moral and ethical values in the society. This is a dynamic and changing situation that is created by multiple stakeholders making decisions each day. The PPACA of 2010 changed the social structure of health care in the United States in an attempt to improve access and reduce the number of persons without health insurance. Health care in the United States is political, and the decisions made in private enterprises and government affect the experience of disablement for millions of Americans. Let us now turn our attention to the experience of disablement and discuss how changing perspectives on this issue have affected the development of health services for persons with disabilities.

Experience of Disablement

The special interest of this book is how policy and systems affect people with disabilities and the people who care for them. Physical therapy and occupational therapy exist as professions to serve a societal need to treat people with disabilities. The incidence and prevalence of temporary and permanent disablement create a human and social need for assistance, new opportunities for independence, and community.

The experience of disablement creates foundational paradigms for the understanding of what needs to be done and the organization of rehabilitation health services. Disablement is experienced as a biomedical problem, an economic challenge, and a socio-political issue. Disablement is a major social problem. The size and prevalence of disablement mean that solutions require the involvement of major social institutions.

Disablement is common to the human experience and has existed throughout human history. It is only in the last 150 years, however, as Western society has industrialized, that formal attempts have been made to define disablement and to develop a major, organized, social response beyond the family unit. In the United States, a fundamental principle for defining and determining this social response is the individual's ability or inability to work (Alston 1997; Kennedy and Minkler 1998). The inability of a person to work jeopardizes the ability of the person and family unit to be self-sustaining. As a result, a broader social response is needed to provide the individual and family unit with support. At odds with this idea is the societal expectation that everyone capable of self-support and work will do so. Society can ill afford a policy that provides generous benefits to individuals and family units that are capable of working for self-support.

Ability to work as an establishing principle for defining disablement creates three new questions for policymakers: Who can work or not work? What types of services are needed by people who cannot work? What can society afford to provide to those who are unable to support themselves and their social unit? The first two questions have been addressed to medical care providers. The third question is a matter of continuing contention within and between private and public policymakers.

Answers to these questions are affected by the prevailing definition of the disablement experience. The basic characteristics of three major perspectives of disablement are summarized in Table 1-4. Historically, the **biomedical model** has been the dominant model of thinking about disablement in the United States. The social disability model has arisen in complement to and, in some cases, opposition to the biomedical model. Universalism challenges the notion that disablement is a special or separate policy issue. All three models affect the organization and delivery of therapy services to persons with disability in the United States.

Biomedical Model

In order to determine eligibility for benefits, policymakers have turned to health care providers to determine the type and extent of disablement. Since the late 19th century, medical doctors have been granted power to determine and certify who is disabled and who, within the guidelines of the policy, can receive benefits. This policy decision resulted in the "medicalization" of disablement (Craddock 1996a; Williams 1991). As the scientific rationale for medical practice grew exponentially in the 20th century, disablement became increasingly viewed as a biomedical problem.

Table 1-4 Disablement Models

	Medical Rehabilitation	Social Disability	Universalism
Source of disablement	Person	Social attitudes and policies	Both
Experience of disablement	Structure and function of body	Discrimination and isolation	All persons have potential
Response	Medical care	Human services	Integrated system

The focus of the biomedical model is to explain the patient's experience by understanding the source of the problem in terms of basic science and cellular pathology. This perspective emphasizes the role of the physician. The expansion of science and the acceptance of the biomedical model fostered a sophisticated and expensive medical care system with an emphasis on the identification and cure of pathology. Disablement was understood as a problem of medical pathology.

The biomedical model has limits, however, in its ability to explain disablement. Disablement is not "curable." Disablement often begins at the point where medical practice has limited effectiveness to eliminate disease or reverse injury. The manifestations of the pathology are not acute. Instead, they are usually chronic. A definition of disablement and the ultimate determination of success in treating disablement go beyond the terms used in treating acute illness, that is, morbidity and mortality. By the mid-1960s and thereafter, with the emergence of the Nagi model (Nagi 1965), new biomedical models emerged to explain the experience of disablement.

These models of "medical disablement" broaden our understanding of the manifestations of disease and injury. Impairments, functional limitations, and disability defined the organ/tissue, whole person, and societal role effects of chronic illness and disablement (Brandt and Pope 1997). The philosophy of medical disablement supports policies that develop systems to address these concerns. Physical therapy and occupational therapy services that improve function and address pain, weakness, contracture, and similar problems, can be defined as "medically necessary" and, therefore, are reimbursed through medical care insurance. This policy supports the provision of necessary services for those who are recovering from recent or recurring illness or injury.

The definition of "medical necessity" also limits independent therapist action and direct access to therapy services by the public. Many insurance plans, including public plans, require physician certification of therapy services in order for persons with disablement to access therapy care. We will discuss these issues in depth in Chapters 6–9. The medicalization of therapy services has also organized complex systems that employ therapists within the medical care system, typically dominated by physicians. We will explore this system in detail in Chapters 10 and 11. In summary, the medicalization of disablement has made it possible for many people to receive therapy services funded through medical care insurance. The dominance of the medical model, however, has also limited direct access to rehabilitation therapy care for persons with medically stable disabling conditions. While providing many employment opportunities, the medical rehabilitation model also constrains the distribution of therapists to the medical care system.

While the medical disablement model broadens the understanding of disablement to include more than pathology, the focus of the disablement experience remains on the individual. This conceptualization reinforces the importance of the patient-provider relationship to the exclusion of broader societal influences on the experience of disablement. As a result, some theorists reject the biomedical model as an inadequate explanation of disablement. Since medicine has limits to its effectiveness in treating chronic and disabling conditions, they argue, improvements in lifestyle and the barriers that affect people with disabling conditions must be addressed by different mechanisms.