

# Critical Analysis of a Public Policy: An Occupational Therapist's Experience With the Patient Bill of Rights

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### KEY WORDS

- managed care
- patient protection legislation
- reflective thinking

In addition to their daily responsibilities toward clients, I believe that occupational therapy practitioners have a larger responsibility to the American society as professionals and citizens. This responsibility involves being informed about public policy related to the profession of occupational therapy and advocating for legislation that benefits clients. A key means for understanding public policy is using a critical analysis approach. Using critical analysis will be presented in this paper with the Patient Bill of Rights (S. 1052, 2001 & H.R. 2563, 2001) as an exemplar for this strategy. This bill proposed over the past few years focuses on providing patients with strengthened rights, such as access to information and an appeal process with managed care organizations.

In addition, a primary concept presented in this paper is that public policy represents values of the larger society (Shapiro, 1999). For example, Medicare, which developed in the 1960s, represented the value of access, or meeting the health care needs of all elders. Considering values with public policy while making judgments is part of an individual's and a profession's responsibility. Public policy analysis also involves understanding the history behind the current legislation, including the conflicts and compromises that finally produce legislation.

I formed these thoughts and questions while doing a 3-month rotation for my professional doctorate degree as a participant observer working with the American Occupational Therapy Association's (AOTA's) government relations division learning about public policy. The first section of this paper presents a framework for using critical thinking with policy analysis. The second section introduces the impor-

tance of considering values with policy analysis. The third section presents a critical analysis of the value issues related to the Patient Bill of Rights in context of its history.

### Using Critical Thinking With Policy Analysis

Critical thinking involves being "purposeful, reasonable, and goal directed" (Halpern, 1996, p. 33). Furthermore, a critical thinking attitude is described as being willing to plan, be flexible with thinking, persistent, willing to self-correct, attentive to thinking processes, and seeking of agreement (Halpern). Critical thinking can be applied to micro or personal day-to-day issues, such as thinking about patients in clinical practice. It can also be applied to broader macro or societal issues, such as thinking about the impact of health care related policy. Typically, occupational therapy authors discuss a form of critical thinking called clinical reasoning in the micro world of practice (Mattingly & Fleming, 1994).

Critically thinking about macro policy issues can help invest people in societal concerns and make them feel more connected with a rapidly changing society. Critical thinking may make people more likely to participate in political activity. Furthermore, citizens who challenge policymakers by calling for accountability, who are skeptical about media coverage, or who want to hear different viewpoints are critical thinkers (Brookfield, 1987). The four components of critical thinking proposed by Brookfield are presented here to illustrate one way to analyze a bill or political issue critically.

### *Identifying and Challenging Assumptions*

Critical thinking about a public policy involves first identifying key issues based on a sound knowledge foundation about a bill. It includes understanding the context of an issue (Brookfield, 1987) through learning the historical framework behind the development and progression of the bill. Challenging assumptions also involves critically reading or listening to viewpoints about the legislation to consider opposing and supporting arguments (Halpern, 1996). It entails thinking beyond one's current life experiences to consider other's viewpoints, including their motivation and special interests. Brookfield defines this as "contextual awareness" (p. 16). Contextual awareness can be very difficult as people's values and beliefs are formed by their own life experience. One can compare the concept of contextual awareness to clinical situations when therapy practitioners attempt to understand the meaning of disability in a patient's life by considering the patient's values and belief systems. When using critical analysis with public policy, consideration is also made about what may be missing from a bill and ultimately what the bill is trying to accomplish. Without critical analysis one can easily be swayed by a persuasive account devoid of substance.

Practitioners can reflect about the following questions to better understand how to identify and challenge assumptions about public policy: Why did this bill develop in the first place? Why should I be interested in this bill? Who stands to gain and who stands to lose with this bill? What are the assumptions behind the key arguments for and against parts of the legislation? What is missing from the current health care bill and why has it been excluded? Thus, by considering these critical analysis questions therapy practitioners can begin to think more broadly about policy issues.

### *Understanding the Societal Context in Which Information Is Presented*

Occupational therapy practitioners are taught to consider the social context of their patients on a micro level (Kielhofner, 1992). For example, they attend to family and culture. Understanding the societal context from which a bill develops takes

this process in a broader direction. Therapists need to critically think about why a bill developed in the first place, what societal problem(s) the bill is trying to correct, and what societal values it reflects. For example, with the Patient Bill of Rights, therapy practitioners might relate to the development of the bill because of experiencing patient denials for reimbursement from managed care organizations. When considering the societal context of a bill practitioners may contemplate how it addresses societal values, such as fair access to health care.

Practitioners can reflect upon the following questions to better understand the societal context in which information is presented with public policy: In what societal context was this public policy formed? How is this bill of value to society? Why is this bill being considered now and not earlier? What and whose societal values does it reflect? Thus, with these critical analysis questions therapists can apply skills they already have related to the patient context to the societal context.

### *Imagining and Exploring Alternatives*

Imagining and exploring alternatives with public policy is not unlike some of the clinical reasoning processes that practitioners use in treatment with patients (Mattingly & Fleming, 1994). For example, with conditional reasoning therapy practitioners consider the person's life before an incident, as well as his or her current status, and possible future status. Similarly when analyzing a bill, one needs to understand what led to the development of the bill, its current status, and future implications, if passed. To explore alternatives, one also should consider what would realistically happen with the bill if not passed, or if other bills would achieve the same goals. Even with the best intent, public policies can become quickly dated once instituted as they represent the needs of society at the time they were passed. For example, some may argue that Medicare legislation instituted during the 1960s became outdated with the growth of the elderly population and the societal change from fee-for-service insurance predominance to managed care. It is for that reason that public policy often continues to be amended.

Practitioners can reflect upon the following questions to better understand how to imagine and explore alternatives of public policy: What will happen in 5 (or 10) years if a particular version of a health care bill is passed, or not passed? What alternative bills accomplish the same or similar purposes as this bill? Thus, similar to considering a patient's future with a disability, a future orientation adds to the depth of understanding about a bill.

### *Reflective Skepticism*

Reflective skeptics recognize that there are no specific truths and that alternatives exist for any fixed idea (Brookfield, 1987). Reflective skepticism occurs in clinical practice when therapists question the diagnoses of a patient, or the appropriateness of an ordered treatment. With policy issues, reflective skeptics are aware that there are many varying perspectives and that no one bill or single viewpoint about it is the only answer. One might find upon analysis some positive aspects in opposing legislation. For example, I found more inclusive language in one section of a bill that was not supported by the AOTA. Or, one can see some validity to concerns on the opposing side.

Reflections on the following questions are helpful to gain an understanding of reflective skepticism with public policy: Why is this bill being introduced now? Why has this bill not passed during previous years? Who are the legislators and special interest groups that support this bill and why? Who are the legislators and special interest groups that do not support this bill and why? Can I argue the opposing viewpoint with this bill? Why are certain items included in the bill and other items excluded? What are the valid points in the opposing perspective? What values are not being expressed or challenged with the legislation? Thus, these questions help practitioners reflect more in depth about all perspectives with public policy.

## **The Importance of Understanding Values With Public Policy Critical Analysis**

Thinking critically about any policy involves considering values. It would be remiss with any critical analysis of public

policy to ignore values because public policy analysis does not develop in a “moral vacuum” (Harrington, 1996, p. 373), but rather represents inquiry into competing societal values (Shapiro, 1999; Weimer & Vining, 1992). Kielhofner (1992) defines values as “an individual’s internal images concerning what is good or right” (p. 157). Values can also be considered more broadly in terms of what is embraced by the majority in a society. Values can be moral ones, such as what one considers to be good or right or nonmoral ones, such as economic values (Aroskar, 1993). In the following discussion the influence of American values on the historical development of the Patient Bill of Rights is addressed.

## History of the Patient Bill of Rights

Understanding legislative history helps one develop a broader perspective about current legislation and encourages critical analysis. Ultimately, with historical evaluation one should consider the societal context. Historical analysis allows one to identify and challenge assumptions as one analyzes changes in public policy over time. It also enables one to examine the values related to the legislation. This section presents a brief history of managed care and the Patient Bill of Rights legislation interspersed with value issues.

The roots of the Patient Bill of Rights legislation can be traced to two legislative acts in the 1970s, the Health Maintenance Organization (HMO) Act (Pub. L. 93–222, 1973) and Employee Retirement Income Security Act (ERISA) (Pub. L. 93–406, 1974). The HMO Act developed as a solution for the escalating costs in the health care market, partially due to the dominance of the fee-for-service insurance model (Misocky, 1998). A less future focused law, ERISA was based on the fee-for-service health care market of the 1970s, a market with minimal self-insured health care plans. The purposes of ERISA were to create consistent national management of employee benefit administration and to encourage the expansion of private insurers by releasing them from state laws (Noble & Brennan, 1999). By the 1980s managed care became very imbedded in the health care market as employers recognized the

cost savings from managed care (Gage, 1998). With ERISA, self-insured plans grew. However, ERISA became outdated (Soriano & Feder, 1999) because it protected the self-insured health care plans from state law, allowing them not to be legally accountable. If consumers wanted to sue their HMOs it could only be done in federal court with damages based on the cost of denied care (Soriano & Feder, 1999).

Although the original intent of managed care was positive, it created a different system altogether. From its inception, managed care practices laid the groundwork for a conflict between the business values of the managed care organizations and the traditional health care provider’s trusting relationship with patients (Annas, 1998; Cadette, 1998). As managed care rapidly grew to dominate the health care market it changed the power structure of how health care was delivered. This change included health care costs managed by the insurance agencies, and overseeing the medical and financial decisions of physicians and other health care professionals (Regan, 1997). Working with health maintenance organizations, physician “gatekeepers” became economic managers with financial incentives to economize care. Every time these gatekeepers did not refer patients to specialists, such as to occupational therapy practitioners, it resulted in profit for the gatekeeper and ultimately the insurance company. Thus, because of these economic restrictions physicians lost control of their decision making and feared losing the patient–health provider relationship (Cadette, 1998; Regan, 1997; Thomasma, 1996). Furthermore, therapy practitioners also felt constraints with time limitations for patient care based on the plan’s guidelines and at the same time that they were receiving fewer referrals.

Overall, from the 1980s and beyond with a strong emphasis throughout the early 1990s during the health care reform discussion (Regan, 1997), a general discontent grew about the managed care system. Physicians were dissatisfied by the decision-making constraints placed on them by utilization review, financial incentives not to refer patients to specialists, and “gag” clauses that limited open communication about treatment options (Cadette,

1998; Levinsky, 1996; Misocky, 1998). Specialists, such as occupational therapy practitioners, were frustrated because of constraints leading to lack of access to patients, and concerns about quality of care because of time limitations. They also worried that managed care did not blend with the profession’s value of supporting occupation (Fisher, 1997; Lohman & Brown, 1997).

Underlying this dissatisfaction were concerns that certain American values, such as self-determination, the right to choose, freedom of speech, and the right for justice were being impeded by the managed care organizations (De Ville, 1999; Misocky, 1998). Overall, Americans perceived lack of control in their ability to choose their plans, see specialists, and to be informed clearly and honestly about health care options because of gag regulations. In addition there was no accountability in many managed care organizations because of ERISA protections. Essentially, the American public did not trust the business and health care combination (Regan, 1997). However, managed care insurance was preferred by businesses as it was less costly.

Since 1994 there have been various state legislative bills and a trend of several unsuccessful federal legislative attempts to address these concerns. The state piecemeal attempts at legislation have generally focused on access, quality of care, due process protections for patients and physicians, provisions for participation in managed care organizations, expanded patient liability, and better access to medical information for patients (De Ville, 1999; Regan, 1997; Waxman, & Dallek, 1998). An analysis of why the federal attempts have been unsuccessful is beyond the scope of this paper. However, a discussion about certain key historical elements helps to build a framework to critically think about current patient protection bills. These historical elements include the vision of the Patient Access to Responsible Care Alliance (PARCA) coalition, which facilitated the development of the original patients protection legislation (Phillips, 1998), the value-driven influence of the Advisory Commission on Consumer Protection and Quality in the Health Care Industry (Wakefield, 1997), and the AOTA focus on

anti-discrimination in legislative language (Rome, 2000).

The history of the PARCA coalition illustrates how the critical thinking process, particularly imagining and exploring alternatives, helped with the development of patient protection legislation. The PARCA coalition consisted of a group of health care representatives from specialty organizations such as the American Chiropractic Association, the American Association of Nurse Anesthetists, and the AOTA. This coalition concerned itself with patient and provider protections, which were lacking in managed care organizations because of the ERISA law (Phillips, 1998). As discussed, patients were negatively affected, such as not having access to specialists. So, PARCA developed a vision about improving anti-discrimination language, access to specialists, due process, external review, anti-gag provisions, and information sharing (K. Pontzer, personal communication, July 17, 2001). This vision was included in the PARCA bill of 1997, a bill that the PARCA coalition along with other coalitions helped to push forward over a 3-year time period (Phillips, 1998). Although the PARCA bill did not become a law, it has been a model for future patient protection legislation and many of the ideals of the PARCA coalition have remained.

The history of the Advisory Commission on Consumer Protection and Quality in the Health Care Industry, appointed by President Clinton in 1997, illustrates how values were a strong part of patient protection legislation. This commission developed recommendations, many of which were used in the PARCA bill. This value-driven commission, which included participants from all sides of the debate, based their recommendations on the following four core principles: "(1) all consumers are created equal, (2) costs matter, (3) each right will improve the quality of care, and (4) elements of the current health care system that work should be preserved" (Wakefield, 1997, p. 315). Over the years many of the recommendations of the commission have remained in legislation, such as information disclosure, access to emergency room, nondiscrimination, and an appeal process. However, other recommendations have been lost from subsequent bills

such as consumers taking responsibility for a healthy lifestyle and respect for consumers from all members of the health industry.

Finally, the history of the AOTA's involvement with patient protection legislation (Rome, 2000) illustrates the critical thinking process used to choose a policy focus that meets the needs of its members. This history illustrates how AOTA's organizational focus ultimately shaped legislative language. AOTA has been involved with managed care legislation for many years. Consistent through all of the managed care legislation has been AOTA's support of anti-discrimination legislation, including access to specialists and the inclusion of comprehensive services. The anti-discrimination language used in many versions of patient protection legislation was developed by AOTA in 1993. It states that:

Health plans are prohibited, when selecting among providers of health services for membership in the provider network, from discriminating against any health professional on the basis of the type, class or category of health professional. In selection of health care providers, provider networks shall have a sufficient number and range of health professionals, specialties, and practice settings to provide adequate access to the comprehensive benefit package. Selection criteria to be used by provider networks shall include the number capacity and geographic distribution of health professionals within the designated service area. (Rome, 2000)

The question remains why the political advocates in the government affairs division at AOTA chose anti-discrimination and comprehensive services as areas to focus on with patient protection legislation. According to the Director of the Federal Affairs Group for the AOTA Christina Metzler (personal communication, June 17, 2001), "We listed key areas of concern about MCOs and then thought about what areas were currently of concern to members and what areas in the future would remain or develop to be a concern." Thus, similar to the critical thinking process used in the other two examples, members of the government affairs division at the AOTA methodically and strategically imagined and explored alternatives as they developed an organizational focus for patient protection policy.

As this review of the history for the patient protection legislation illustrates, using critical analysis skills allows one to consider issues more in depth. When critically examining the history of a health care policy one can consider the following questions: What issues and values led to the development of a public policy rather than a market-based solution? What has been eliminated or added from the bill(s) over time and why? How has the history of the legislation influenced occupational therapy practice? Thus, thinking critically about the history of a bill enables therapy practitioners to have a better overall picture to provide the context for considering current issues.

## Conclusion

In conclusion, at first glance, understanding public policy may seem quite complicated. Yet, as illustrated in this paper with the example of the Patient Bill of Rights, a key to understanding any public policy is approaching it by using critical analysis. Developing critical analysis skills helps one get a handle on the intricacies of public policy. As Brookfield (1987) suggests, one should commit to a cause such as a public policy in an informed manner after a period of reflective analysis.▲

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