The impact of reimbursement systems on occupational therapy practice in Canada and the United States of America

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Key words
- Health manpower, occupational therapy
- Professional practice
- Professional issues

Abstract
Different funding and cost-control mechanisms in Canada and the United States of America (USA) have a powerful influence on occupational therapy practice in each country. Canada’s public health insurance system emphasizes access to health care services based on medical need. Costs are controlled at the provincial government level by limiting the capacity of facilities and personnel. Occupational therapists in publicly-funded settings have considerable professional autonomy to use occupational therapy theoretical models and to be client-centred. The measurement of outcomes is not always required and the interventions of individual occupational therapists are infrequently scrutinized. The USA has no universal, publicly-funded, comprehensive health insurance. Health care policies are driven by financial priorities and cost control occurs at the service delivery level. Insurance companies define the scope of occupational therapy practice by identifying what services they will pay for and they scrutinize occupational therapy interventions. The emphasis on effectiveness and efficiency leads to critical examination of interventions by therapists. Canadian occupational therapists can learn much from their colleagues in the USA in this area.

Résumé
One might predict that the practice of occupational therapy would be very similar in Canada and the United States of America (USA). After all, these countries are located on the same continent, there is considerable travel and communication between the countries, and numerous therapists from each country practise in the adjacent nation. However, though the two countries are similar in terms of language and level of economic development, they are dissimilar in political institutions, cultures and values (Lipset, 1987). Social, political, economic and cultural forces have shaped, and continue to shape, health care systems and occupational therapy in each country. The purpose of this paper is to illustrate the powerful influence of different funding and reimbursement systems and cost-control mechanisms on practice in each country. The paper examines the ways in which different funding and cost-control systems in the two countries affect the demand for and location of services, client access to occupational therapy, emphasis on efficiency and effectiveness and the use of theory and documentation. Understanding the effects of funding-imposed opportunities and constraints on practice will help therapists view their services within a larger environmental framework and equip them to critically examine forces which shape their practice.

This article is based primarily on literature. A literature search revealed numerous articles on the effect of reimbursement on occupational therapy practice in the USA, but little on this topic in Canada. Therefore, literature on funding systems in general in Canada was used. We supplemented the literature search with personal experiences as therapists in the two countries and interviews with four occupational therapists who were knowledgeable about health care systems in each country.

Ideologies and their impact on health care systems

Two nations, not one, emerged from the American Revolution and the central political ideologies of the countries differ. Canada is a country of counter-revolution. It struggled to preserve an established source of legitimacy; the government deriving its right to rule from a monarchy linked to the church (Lipset, 1987). Canadian values regarding the importance of collectivism and the value of government intervention, as well as its parliamentary system and the existence of a social democratic third party led to the development, in the 1960s, of publicly funded and administered hospital and physician services (Evans, 2000). Since the health care system is primarily funded by taxes, it results in redistribution of wealth from the rich to the poor and from the well to the sick. Canada's health care system is an expression of the equality of all citizens in the event of disease and of community commitment to help people when they are ill or disabled. This approach to funding has equalized access to health care services to a large extent. The principles underlying the Canada Health Act are accessibility, universality, comprehensiveness, portability and public administration (Canada, 1984). Since health care is a provincial responsibility, the provinces administer the public health insurance programs and are required to meet national standards in order to receive federal funds.

The USA is a country born of revolution. Most Americans are resistant to a high degree of government intervention, and prefer local, rather than national control. Individual rights and responsibilities are emphasized. It is commonly believed that strength of character and hard work will lead to success and that failure results from individual shortcomings (Lipset, 1987). These factors have influenced the development and funding of its health care system. In the USA, efforts to establish national health insurance, both after the Second World War and more recently, floundered for several reasons including an individualistic ideology, distrust of government intervention, as well as opposition from physicians and insurance companies (Maioni, 1995). The USA does not have a comprehensive national health insurance system. It has a two-tiered system that operates on the assumption that the regulated market can provide adequately for the health needs of the majority, supplemented by a publicly funded system for the minority who are poor, elderly or disabled. The first level of care is excellent for affluent and well-insured people. For the most part, insurance is made available as a benefit of employers. However, millions of people have no health insurance and others lack adequate health insurance. Medicare and Medicaid constitute the second level of care. Medicare is a federally funded insurance program for those aged 65 and over. It also covers those with disabilities receiving social security. Medicaid is a public assistance program that uses federal, state and local money to provide health care for the poor (Evans 2000; Maioni, 1995).

Forms of organization of hospitals, education of personnel and accreditation systems are very similar in Canada and the USA. The major differences in the health care systems of these two countries can be attributed to the effects of different funding systems (Evans, 2000). These funding systems are, in turn, associated with different cost-control mechanisms.

In Canada, the Canada Health Act identifies what services are eligible for public insurance. Provincial governments control costs by constraining the capacity of facilities and the availability of personnel. Ceilings are established for expenditures on physician services as well as hospital and community services. The assumption is that, under these conditions, health care providers will choose to
provide the services that are essential (Evans, 2000). However, there is little questioning about why health professionals do what they do and little evidence that the services provided are effective.

There are no global (federal or state) cost-controls in the USA. A multitude of agencies fund health care services. Many exist to make profits and available services may be increased if this is likely to increase profits. Cost-control occurs at the service delivery level. Insurers are concerned about making profits and therefore want to fund only care that is appropriate and effective. They therefore scrutinize documentation of treatment. The USA is consequently more advanced than Canada in terms of examining treatment efficiency and effectiveness.

**Service demands and locations**

In both countries, the development and location of occupational therapy services have been shaped by the social, economic and political environment. Legislation and reimbursement mechanisms have influenced where occupational therapy is practiced and how various specialty areas developed (Struthers & Schell, 1991). In the early part of the 20th century, Canadian occupational therapy services were developed in response to worker's compensation legislation and veteran's programs (Crichton & Jongbloed, 1998). Public health insurance, developed in the 1960s, covered physician and hospital-based services. Hospitals were not required to offer occupational therapy services, but many did. Until 1977, the provinces received federal funds for these two types of services only; there was, thus, little incentive to develop community-based services. Consequently, for many years, occupational therapy was primarily hospital-based (Jongbloed & Crichton, 1990).

The Established Programs Financing Act of 1977 changed this by allowing provincial governments to use federal funding in any way they wished (Evans, 2000). This fostered the development of community and home-based care and occupational therapy positions in these areas increased. In 1995, the Established Programs Financing Act merged transfers for health and post-secondary education with the Canada Assistance Plan transfers for social assistance into the new Canada Health and Social Transfer (CHST) (Armstrong & Armstrong, 1996).

Provincial governments fund community agencies that plan and deliver services, including occupational therapy services. Opportunities for occupational therapists to practise in the private sector exist largely because of the way in which the disability income system in Canada is structured (Jongbloed, 1998). Over the last 80 years, various income programs have been added incrementally to existing programs. Currently, the income which a person with disability receives depends on the cause of the disability.

If the disability occurred at work, the person is covered by Worker's Compensation. If the person became disabled through a motor vehicle accident, motor vehicle insurance may provide some coverage. People with disabilities related to mental illness, intellectual impairments of diseases such as multiple sclerosis are not covered by motor vehicle insurance or worker's compensation legislation. If unable to continue working, they may be able to claim Canada Pension Plan disability benefits or private disability insurance. However, many people with disabilities depend on social assistance for income (Riou & Muszynski, 1992). Insurance agencies and lawyers employ occupational therapists, usually on a contract basis, to assess the functional abilities of people injured in car accidents or with disabilities that impair their ability to work. The percentage of occupational therapists working in private practice rose from 4% to 18% between 1989 and 1998 (Canadian Association of Occupational Therapists [CAOT], 1998).

- **Financial priorities drive health care policy and case management principles in the USA.**

In the USA, occupational therapy involvement in Medicare commenced in 1965 because Part A of the Medicare legislation provided compulsory hospital insurance for those aged 65 and older and occupational therapy was a covered service. Because occupational therapy was not included in Part B coverage in 1965, outpatient and private practice occupational therapy in the USA did not flourish as a result of this legislation at that time. Later, Part B coverage fostered the development of occupational therapy services in long-term care, outpatient and rehabilitation settings. In the recent past, Medicare established reimbursement incentives to those who provided rehabilitation in settings other than hospitals. This caused a rapid growth in skilled nursing facilities (SNFs) and home health care services, both of which employ occupational therapists. Many long-term care centres modified their service provision priorities to take advantage of a lucrative SNF rehabilitation market. The Balanced Budget Act of 1997 reduced funding available for occupational therapy through Medicare. Annual Medicare reimbursement for occupational therapy was limited to $1500 per patient. Since Medicare was a major source of payment for occupational therapy, this reduction decreased the demand for occupational therapy significantly (von Zweck, 1999).
However, in 1999, health provider and patient advocacy groups succeeded in obtaining a two year repeal of this Act while a new payment system was developed (Advance, 1999).

The effect of reimbursement on occupational services in the USA and Canada is evident in the areas of children and mental health. Approximately 20% of all occupational therapists in the USA work with children because of the provisions of the Education for All Handicapped Children Act of 1975 (Struthers & Schell, 1991). On the other hand, it is estimated that fewer than 5% of therapists in the USA work in hospital based psychiatric settings (American Occupational Therapy Association, 1990). In comparison, approximately 11% of Canadian therapists work with children, while 15-25% work in the area of mental health (CAOT, 1998).

Client access

Access to services is closely linked to payment mechanisms. Provincial governments control costs by setting global spending limits related to the payment of physicians or hospital and community services. The volume of publicly-funded occupational therapy services provided in a particular area depends on factors such as the volume of services historically provided in that setting and the ability of rehabilitation managers to lobby for services. The agency's mandate and its caseload management practices determine caseload. The primary limiting factor is the staff/client ratio, which influences how much time staff can spend with clients.

In some provinces, such as British Columbia, each intermediate care facility receives a global budget for all professional services, which means that the provision of additional occupational therapy services is associated with a reduction in nursing services. Consequently, little occupational therapy intervention occurs in these settings (BC Ministry of Health, 1998). In some provinces, residents of intermediate care institutions would likely receive less occupational therapy than those in nursing homes in the USA.

Pediatric occupational therapy services are limited in comparison to those in the USA. In the province of British Columbia, for example, the Ministry of Children and Families funds pediatric early intervention programs (EIP). This funding is allocated to specific regional health boards and then again to each EIP agency. Since EIP funding is so low, caseloads range between 40 to 150 children per therapist. This varies from region to region and as a result, children are seen on a consultative, needs and diagnostic basis. Wait lists range from 1 month to 2 years and some children consequently never receive the early intervention services of an occupational therapist. Since occupational therapists in private practice are funded primarily by insurance companies and lawyers, clients with automobile or private insurance coverage have better access to occupational therapy in private practice settings.

In Canada, the emphasis has been creating and maintaining access to the health care system.

In the USA, since there is no comprehensive policy to provide for the health care needs of US citizens, health care contracts are managed and provided by corporations and insurance companies who increase their return on investments by emphasizing the use of the least skilled provider and fragmentation of tasks (Armstrong & Armstrong, 1996). Access to occupational therapy depends on whether the client is employed, is 65 or over, or is poor. Those who are employed full time, as well as their families, will likely have health insurance through their employers, though coverage varies among insurance companies. People entitled to the benefits of Medicare and Medicaid receive limited occupational therapy services. Clinicians struggle to provide useful services in the limited time they have with these clients. There are, however, millions of citizens without health insurance who have no access to medical or occupational therapy services.

Emphasis on efficiency and effectiveness

Financial priorities drive health care policy and case management principles in the USA. The focus on functional goals is linked to cost containment. The main mission of most health provider agencies is to provide quality, cost-effective care and administrators focus on predicting costs and managing resources (Kulla & Muillenburg, 1999). Understanding the links between the cost of service and outcomes is important for managing financial resources. Large insurance companies like Blue Cross provide coverage for private health employment-based coverage and manage funds from public programs such as Medicaid and Medicare. Friedson (1990) argues that a small group of public and private third-party payers has reduced the economic and political power of the health professions in the USA. They mediate the relationship between the health professional and the patient by imposing restrictive rules.

Reimbursement for occupational therapy in the USA occurs only after the therapist has proven that his/her
intervention has made a difference. A USA provider sets wages for occupational therapists and operates the organization without knowing how much reimbursement it will receive. Only if reimbursement is greater than expected will wages and benefits increase. Such a system creates incentives to provide efficient occupational therapy services and ensures that health care agencies and therapists are accountable. Inefficient and unproductive occupational therapists in the USA may lose their jobs.

Managed care is used by private health care purchasers in the USA, as well as by Medicaid and Medicare. During the 1990s, efforts to contain costs resulted in increased use of managed care, which aims to make economic considerations central aspects of the decision-making process. This includes the formation of networks of providers, including occupational therapists, along the care continuum, e.g., Health Maintenance Organizations and capitated reimbursement, which refers to a prospectively determined payment system (per client, per admission, etc.). Thus, an agency might be paid a particular sum to provide health care services to a group of people for a specific period such as 3 years (Landry & Knox, 1996; Thorpe, 1997). Under managed care, providers will not profit unless costs are constrained. Managed care has a significant impact on occupational therapy practice. The reduced number of therapy sessions motivates therapists to carefully examine what they are doing, to do efficient evaluations and to work quickly. Since patients are discharged as soon as possible, treatment moves into the home and focuses on function. Family members and occupational therapy assistants assume more responsibility for intervention (Walker, 2000).

In Canada, the emphasis has been creating and maintaining access to the health care system. Few mechanisms to ensure effective and efficient use of resources have been established. Costs are controlled by limiting capacity such as funds for a region or for physicians. It is assumed that health care providers will allocate resources to the greatest needs. However, the system is under-managed and little attention is paid to efficiency and effectiveness. Lomas and Barer (1986) point out that efficient use of health care resources requires that attention be paid to the governance of professionals as well as the organization of health care delivery. In the first part of the 20th century, provincial governments viewed professionals as the only people able to judge professional competence. Professional organizations were given, and retain, the power to establish and enforce standards of practice. This ensures protection of individual patients but establishes no mechanism for the protection of public interest, e.g. ensuring that resources are used efficiently.

There is considerable discussion about evidence-based practice in Canada. The goal of evidence-based practice is that individuals will use research evidence and clinical reasoning to make treatment decisions which optimize client outcomes (von Zweck, 1999; Law & Baum, 1998). Some departments are using evidence-based practice to guide interventions and to support arguments regarding the benefits of occupational therapy services to funders. However, barriers at the individual and system level reduce the use of evidence-based practice. Barriers at the system level include lack of administrative support and lack of structured time for therapists to integrate research findings into practice. Barriers at the individual level include lack of ability to transfer research findings into practice and lack of time (Baum, 1998). Unlike the American system, where insurance companies scrutinize the nature, number and effectiveness of occupational therapy interventions, there is little scrutiny of treatment provided by occupational therapists. Since outcomes are not systematically measured, it is not known if interventions are effective or efficient.

Use of theory and determination of treatment priorities
Models of practice reflect the values and philosophies of the profession and help therapists to understand the occupational performance problems of clients. They emphasize collaboration between the occupational therapist and the client to design treatment that is valued by the client. In both countries, use of occupational therapy models in practice is constrained to some extent by the dominance of the use of the medical model in the health care system. With the support of the federal department of health, occupational therapists across Canada developed national guidelines for practice (Department of National Health & Welfare & CAOT, 1983). This led to the development of the Canadian Model of Occupational Performance (CMOP), which is a client-centred framework used by many therapists as a conceptual framework to guide practice (CAOT, 1997). This occurs in the context of a publicly-funded health care system, in which therapists have considerable autonomy. Occupational therapists who are reimbursed by insurance companies must focus on providing the intervention and information which the insurance company requires.

In the USA, certain people and universities have become renowned for the development of occupational therapy theory, such as occupational science at the University of Southern California and the Model of Human Occupation (Kielhofner, 1995). However, reimbursement systems shape practice more powerfully than theory. Reimbursement systems reward use of the medical model (Howard, 1991) and make the use of theory and a client-centred approach less feasible than in Canada (Van Leit, 1995). In some settings, therapists are pressured to shift the
focus from occupation and occupational performance to the performance components of occupation. They emphasize the effects of deficits on functional performance, analyze what components of function are necessary for each task, and promote the development of components that lead to successful performance (Woodson, 1995). As it is easier to demonstrate improvement in feeding or dressing than in psychosocial skills or management of leisure time, performance components in activities of daily living are emphasized. However, there is no evidence that improvement in a performance component, such as strength, is the most effective approach to improving particular functional skills such as dressing and eating (Mathiowetz, 1992).

Reimbursement systems shape practice more powerfully than theory.

Institutions such as nursing homes, which are funded by Medicare, must comply with federal regulations that stipulate that reimbursed services must be given only to those likely to show functional improvement in a specific time period (Thomasen, 1996). Education agencies in the USA introduced a billing structure for school-based occupational therapy services for children with disabilities who were eligible for Medicaid. However, Medicaid was intended for medically-related, not educationally-related occupational therapy services. This forces service providers to use a medical model and potentially limits the therapist’s ability to provide services to children who are not eligible for Medicaid and yet require occupational therapy (Royeen, Duncan, Crabtree, Richards & Clark, 2000).

Many therapists in the USA use the Functional Independence Measure (FIM) (Guide, 1993) because it is sensitive to functional gains, which must be demonstrated to funders. The FIM identifies a hierarchy of functions (body function, skill function, task function, activity function and occupational function) which can be measured. The FIM measures skill and task function, but it measures nothing at the occupational function level (Packer, 1998). Assessments have the potential to guide practice. Most standardized functional assessments do not inform the therapist about volitional aspects of task performance, and so volitional issues are not incorporated into the treatment (Fisher, 1992).

Whether a client’s goals are given priority in the USA as much as they are in Canada is debatable. In the USA system a client’s goals and motivations may be undervalued if they do not match reimbursement criteria. A study of occupational therapy in managed care environment indicates that many therapists feel that their theoretical and professional knowledge is irrelevant in their setting because treatment and reimbursement principles differ so much (Walker, 2000). Occupational therapists are caught between their role as advocate for the client and as agent for the Health Maintenance Organization (Fuchs, 1997). Respecting client’s needs and wants has been a cornerstone of occupational therapy in both countries because it is central to the client’s motivation. A reimbursement system which specifies that only certain, specific, functional outcomes are valid treatment goals inhibits client-centred practice.

Documentation

In the USA, the main purpose of documentation is to ensure reimbursement according to specific criteria. Framing occupational therapy goals and outcomes in a particular language makes it reimbursable (Howard, 1991). Reimbursement guidelines require measurable, objective descriptions of functional change. Documentation that includes FIM scores and functional, objective description will typically produce more reliable reimbursement than subjective measures and descriptions. Though narrative and life history methods enable practitioners to understand the complexity of a client’s life and occupations, the trend toward managed care and the need to demonstrate effectiveness of interventions has forced therapists to abandon the use of these methods (Burke & Kern, 1996). A heavy emphasis on providing treatment that is reported only in functional, objective terms, however, may limit the quality of the occupational therapy. It may also reduce the opportunity to treat the whole person, since without serious consideration of subjective, qualitative information, valuable insights into client motivation may be lost (Hammell, Carpenter, Dyck, 1999).

In long-term care (LTC) settings, reimbursement for rehabilitation services also depends upon effective and timely completion of another functional status measure, the minimum data set (MDS). It is a detailed assessment that documents a resident’s functioning and the level of care he or she needs. It must be done at admission and at the 5th, 7th, 14th and every 30th day thereafter or reimbursement will not occur. Documentation in SNF and LTC environments that is used for reimbursement is sent to fee payers immediately, typically with an on-line system. The MDS is sent directly to Medicare, while documentation of weekly summaries, discharges and progress reports may sometimes be sent to a third party biller before they themselves submit it to Medicare for reimbursement. MDS and treatment records must all match up to prove that the client
is receiving the amount of services indicated in their assessment. If functional levels, treatment categories and the amounts billed do not add up correctly, Medicare will not pay the service provider the amount he/she has billed. Admitting clients for SNF and LTC services requires many complex considerations because of the stringent reimbursement criteria.

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Since the guidelines established by third-party payers are so narrowly focused, how do therapists obtain services for their patients, especially when improvement is uncertain? Third party payers do not directly observe patient treatment and consequently rely on patient records. Because records are social constructs (Friedson, 1990), they can be used to achieve the goals of the record-maker. It is likely that some occupational therapists use their knowledge of rules of various third-party payers to obtain services, which their patients need (Uli & Wood, 1995). If a client has a limited number of treatment days available, the therapist may document changes in such a way that it appears to the fee payer that the patient is making steady progress. This is most common with clients who may progress much faster or slower than the norm, or with those who experience plateaus during crucial documentation reporting phases. If the occupational therapist were to document the real functional improvements to Medicare, the person might be discharged without the opportunity to make as much progress as possible. By including the vocabulary of the rules of the insurance agency in the health record of the patient, the therapist can create a description of treatment and its outcomes that has an increased likelihood of surviving the scrutiny of the fiscal review process (Uli & Wood, 1995). In this way, many occupational therapists in the USA may have one set of clinical reasoning and documentation skills to help them guide therapy, and another set to present to fee payers.

In Canada, provincial regulatory colleges have standards of practice related to the management of client records. Regulations relate to such issues as collection, confidentiality and use of personal information by the therapist (College of Occupational Therapists of British Columbia, 2000). However, there are no national standardized requirements related to charting. There is thus considerable variation in the charting formats used among institutions and departments. Therapists themselves use documentation to articulate and communicate goals and to track progress. Those working in publicly-funded settings are required to document the amount of time they spend on direct and indirect treatment; but this provides no information about assessment, intervention and outcome.

Occupational therapists in both countries may choose a particular activity to achieve a therapeutic goal, recognizing that this activity is an excellent medium for improving cognitive and physical skills. However, the documentation in each country differs and can be best explained with a hypothetical example. A Canadian occupational therapist may document a client with a stroke attempting to paint as, "Client able to paint a picture with non-dominant hand if given guidance from the therapist and is happy with the results." In the USA, occupational therapists are required to break the task down into a more detailed objective account, e.g. "Patient able to maintain trunk in normal alignment to assume seated position for 10 minutes if given 25% tactile neurodevelopment technique cues in order to perform a fine motor task with non-affected extremity. Patient required 60% assistance for organizing of equipment and sequencing, and 25% hand-over-hand assistance distally to carry out the visuo-motor components of the task." In the USA, an occupational therapist may identify the physical, cognitive and perceptual components of the activity, and the level of assistance required for each. The Canadian example reported on the client's affect regarding the performance. This would not be needed in the USA record unless the client's affect was crucial to reaching higher levels of independence. Were the American example to lack objective detail and not show improvement from previous treatment sessions, then payment for that session might be denied. In Canada, this documentation difference would not affect reimbursement. Documentation in the USA is informative and measurable, and might tell more about a client's level of function than most occupational therapy documentation in Canada.

The lack of consistent and objective occupational therapy documentation methods in Canada limits communication among health professionals. The focus on objective detail in the USA enhances teamwork and interdisciplinary communication. Since "all team members need to work together to avoid financial penalties for service over-utilization or the potential for poor clinical outcomes, team members must understand their own and other's defined roles and responsibilities so they can understand how their functions affect clinical outcomes and reimbursement" (Kulla & Muillenburg, 1999, p. 49). Efficiency and effectiveness of service provision rely heavily on clear interdisciplinary communication, and thus managers attempt to educate American health professionals about reimbursement issues and the importance of using
particular terminology and formats in communication. Education is extended to physicians, consumers, discharge planners, referral sources, and vendors since all need to understand reimbursement issues and how to maximize services for clients. Clear and consistent documentation enhances interdisciplinary communication. The FIM is used by a majority of American medical rehabilitation providers and the use of this common language fosters interdisciplinary communication (American Medical Rehabilitation Provider's Association, 1999).

The American documentation process enhances occupational therapists’ critical thinking skills. Since funding in the USA is tightly managed, a therapist must be sure that what he/she is doing is making a difference. Occupational therapists require strong skills to assess, analyze, create treatment plans, document effectively and maintain a competitive set of skills in order to compete in a system that is driven by accountability (Walker, 2000). Occupational therapists in the USA are under pressure to perform well because if they do not, their clients may lose coverage. Some people state that such a tightly managed system may rush the therapy process and hinder effective progress.

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One might argue that occupational therapists in Canada do not have to develop critical thinking skills as much in the USA. In the Canadian system, an occupational therapist’s actions or documentation are not directly, nor frequently, scrutinized by the fee payer. It is possible that occupational therapy services may not be meeting public needs because the system does not require consistent, quantifiable documentation methods. In comparison to the USA, there is less opportunity for the occupational therapy profession in Canada to measure growth because little of what Canadian occupational therapists do is measured. The therapist’s actions are reviewed by the charge occupational therapist and occupational therapy services as a whole may be examined by a hospital administrator, but a therapist’s assessments and interventions are not scrutinized on a case by case basis as occurs in the USA.

In some settings in the USA, therapists spend up to 45% of their time on documentation issues and therefore have less time for focused client intervention (Walker, 2000). In contrast, SNF medicare guidelines specify that documentation of assessments, discharges, patient conferences and progress notes are not considered direct treatments and only direct treatment units are billable. As a result, time spent on billable tasks is a focus of rehabilitation management. Many managers and hospital systems demand high productivity from their occupational therapists in order to make profits, and in non-profit institutions, to balance their budgets. Most agencies require that therapists spend 80% to 100% of their time on the job doing productive or billable tasks (Howard, 1991).

**Limitations**

This paper analyzed some of the forces that have constructed occupational therapy in the USA and Canada. It is based primarily on literature, supplemented by personal knowledge and experience of the two health care systems and interviews with a limited number of therapists in each country. It is not based on a survey of occupational therapy practice in each country. In addition, factors outside the health care system, such as income, education, employment and social support that have a large impact on occupational performance, were not examined in this paper.

**Conclusions**

Health policies are influenced by assumptions underlying the social, cultural and political history of a nation. Canada’s public health insurance system, which is universally accessible, grew out of strong beliefs in collectivism and the value of government intervention. Occupational therapy services are publicly funded and occupational therapy has remained a service oriented profession, focusing on client care, rather than on the bottom line. There is considerable freedom to use theoretical models to guide treatment and engage in client centered practice. Insurance companies and lawyers fund approximately 20% of occupational therapy services and these agencies exert considerable control over the timing, content and documentation of services.

In the USA, distrust of the state and an individualistic ideology have resulted in a two-tiered system with private insurance for some, public insurance for the poor and elderly and no insurance for others. Reimbursement mechanisms affect the location of occupational therapy services and client access to services. Health care is largely a product in a free market economy. Buyers search for the cheapest, high quality option. There is tension between the needs of third party payers to control costs and of health professionals to provide the most appropriate care for the patient (Horner, 1998). Occupational therapists are forced
to function simultaneously as part of a profit making business and as health care providers with responsibilities for clients’ health. The central goal of making profits leads to an emphasis on effectiveness, efficiency and documentation and allows less room for the therapist to engage in client centred practice and use theoretical models.

Occupational therapists in Canada have much to learn from their colleagues in the USA. Concerns about rising health care costs have led to increased attention to treatment effectiveness and evidence based practice in Canada. Canadian therapists can benefit from the considerable experience of therapists in the USA in terms of examining, demonstrating and documenting treatment effectiveness and efficiency. An increasing percentage of Canadian occupational therapists is being reimbursed by third party payers, but this percentage is much lower than in the USA. The experiences of occupational therapists in the USA regarding balancing the demands of third party agencies with responsibilities for enhancing the occupational performance of their clients can serve as lessons for Canadian therapists involved in, or embarking on a career in private practice.

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