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Perception versus Reality in the Era of the ACA

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Fear not! This is not another diatribe for or against the Affordable Care Act (Obamacare). This is intended to be a discussion about terminology of programmes/services in the everchanging healthcare environment, and the intended meaning as opposed to the perceived meaning.

The 1980s brought us the Health Maintenance Organization, or HMO. This programme was developed by the insurance industry to rein in spiralling costs. It was doomed to failure due to multiple flaws. There was a lack of ability to gather and share clinical information; it was driven entirely to control costs, without apparent concern for quality or outcomes; and, most importantly, the perception by the consumer was that it restricted choice. It was this perception, rather than the actual problems with the system, that caused it to fail. As a result, the term HMO is perceived as a bad idea.

In the late 1990s a new acronym arrived, the ACO, or Accountable Care Organization. This concept was based on a clinically integrated group of providers caring for patients based on quality and efficiency metrics, and taking responsibility for care as well as cost. This is not entirely dissimilar from the HMO model, except that a few tweaks were made in the compensation plan, and the ability to share data was improving. The concept gained little traction until it was made a centrepiece of the ACA. The government developed demonstration projects to highlight the potential benefits of ACOs, and all of a sudden, everyone wanted to be an ACO! Since there were no specific requirements to call oneself an ACO, the term has lost meaning, however the perception is still positive and therefore, it is still a popular term to use.

Please notice that the term compensation was used, not reimbursement. Reimbursement suggests repayment of a loan, while compensation suggests payment for services or labour. In reality, payment determinations for health services have created this “healthcare crisis”. Providers are paid “fee for service”, which means the more you do to someone, the more money you receive. No consideration is made for outcomes, appropriateness, or value. Hospitals are paid based on the number of admissions, not the health of their constituents. The payment system is entirely counterintuitive. Providers are paid to keep doing things TO patients, not for patients; and hospitals are paid to put people in the hospital, not keep them out, and healthy.

The most recent terminology to grace this discussion is Population Health Management. The concept is excellent – using disease-specific guidelines to minimise complications and improve outcomes. However, the perception of the terminology is that we are treating populations, not individuals.

Management suggests limiting choice. The public perception of the term is at odds with the intent of the concept. I propose we create new terminology that is descriptive of the intent: GLOBAL HEALTHCARE EXPERIENCE. If we use terminology that is clear and carries positive connotation, and we set guidelines and expectations for use of the terminology, our message will ring true and we can partner with the public to adapt to the changing climate and provide quality cost-effective care

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