

# **Better is Possible: An Advocacy Action Plan from the Oregon Chapter of the American College of Physicians**

**October 2020**

**The American health care system is in crisis.** Even in the best of times, our health care system is fragmented, inefficient, and costly, failing to serve patients well. Now, with the country facing the worst pandemic in a century, the system's brokenness is intensified. Millions are out of work and uninsured, exposing the flaws of a system dominated by job-based health insurance coverage. Frontline physicians and other health care professionals struggle to get supplies needed to keep them safe. Primary care physicians face serious financial trouble due to a payment delivery system that fails to ensure solvency or promote high value care. At the same time, the United States is experiencing a national reckoning on racial injustice and discrimination. Health inequities are exacerbated. Racial and ethnic minority groups are at higher risk of being affected by [COVID-19](#) according to the Centers for Disease Control and Prevention. They also comprise a majority of the essential workforce in food and agriculture, and industrial, commercial, and residential facilities and [services](#), where remote working and social distancing is difficult. Despite all this, **the Oregon Chapter of the American College of Physicians (ACP) believes better is possible.**

In January 2020, ACP released its new vision for a better, fairer, higher quality and less costly health care system. ACP's policy prescription lays out how to achieve universal coverage with improved access to care, reduce per capita health care costs and spending growth, reform clinician compensation and reduce systemwide complexity.

**Oregon needs reform.** In our state 7.1% of the population was uninsured in [2018](#), a rate that has likely increased during the COVID-19 [pandemic](#). Nationally, about 3 million adults lost job-based health insurance coverage and 2 million became uninsured between late April and early July [2020](#).

Health care costs too much. Per capita health spending for Oregon was \$8,044 in 2014, the last year data was [available](#). U.S. health care spending is expected to grow at a faster rate than the economy as a [whole](#).

Racial and ethnic health disparities persist. Black, Hispanic, and American Indian/Alaska Native Oregonians are more likely to report being in fair or poor health compared to white [Oregonians](#). Racial and ethnic disparities for COVID-19 case and death rates are likely to exist in Oregon according to The COVID Tracking [Project](#).

Access to primary care is insufficient. 895,684 million Oregonians live in a Primary Care Health Professional Shortage Area and may have difficulty finding a primary care physician to care for them.

**ACP has a new vision for America's health care system**, one where everyone has coverage for and access to the care they need, at a cost they and the country can afford.

- ACP envisions a health system where coverage is universal, comprehensive, and affordable, and not dependent on a person's job and employment status, where they reside, their health status, or income. Universal coverage could be achieved by either: (A) a public option/public choice model, which would offer everyone the choice of enrolling in publicly-financed coverage or a private insurance plan that meets federal benefits standards, or (B) a single payer model, where everyone would be enrolled in a publicly-financed and administered plan with little or no role for private insurance. Each option has advantages and disadvantages that need to be carefully weighed, and under each, financing and payments to physicians and hospitals would need to be sufficient to ensure access. Effective cost controls would need to be in place.
- ACP envisions a health system that ameliorates social factors that contribute to poor and inequitable health (social drivers/determinants); overcomes barriers to care for vulnerable and underserved populations; and ensures that no person is discriminated against based on characteristics of personal identity, including but not limited to race, ethnicity, religion, gender or gender identity, sex or sexual orientation, or national origin.
- ACP envisions a health care system where payment and delivery systems put the interests of patients first, by supporting physicians and their care teams in delivering high-value and patient-centered care.
- ACP envisions a health care system where spending is redirected from unnecessary administrative costs to funding health care coverage and research, public health, and interventions to address social determinants of health.
- ACP envisions a health care system where clinicians and hospitals deliver high-value and evidence-based care within available resources, as determined through a process that prioritizes and allocates funding and resources with the engagement of the public and physicians.
- ACP envisions a health care system where primary care is supported with a greater investment of resources; where payment levels between complex cognitive care and procedural care are equitable; and where payment systems support the value that internal medicine specialists offer to patients in the diagnosis, treatment, and management of team-based care, from preventive health to complex illness.
- ACP envisions a health care system where financial incentives are aligned to achieve better patient outcomes, lower costs, and reduce inequities in health care.
- ACP envisions a health care system where patients and physicians are freed of inefficient administrative and billing tasks, documentation requirements are simplified, payments and

charges are more transparent and predictable, and delivery systems are redesigned to make it easier for patients to navigate and receive needed care conveniently and effectively.

- ACP envisions a health care system where value-based payment programs incentivize collaboration among clinical care team–based members and use only appropriately attributed, evidence-based, and patient-centered measures.
- ACP envisions a health care system where health information technologies enhance the patient–physician relationship, facilitate communication across the care continuum, and support improvements in patient care.

**Better is Possible.** The COVID-19 pandemic has underscored the need to fix our broken system, in Oregon and nationwide. Our nation’s pandemic response would have been more effective had these recommendations been in place. No one would have lost health insurance because they lost a job. No one would have been unable to afford testing, treatment, hospitalizations, and medications. Policies would have been in place to ensure no one is discriminated against based on race, ethnicity, gender, gender identity, sex, sexual orientation, and other personal characteristics. Physicians would have been freed of unnecessary administrative, billing, and reporting requirements—and not just on a temporary emergency basis. The U.S. would have invested in understanding and ameliorating social determinants—like the ones contributing to higher mortality from COVID-19 for underserved groups. Public health would have been prioritized and major health threats, including environmental health and climate change, would have been addressed. Social drivers of health that contribute to higher mortality rates from COVID-19 for underserved populations would have been better understood, and policies would have been in place to mitigate them. Physicians would not have been at such risk of losing revenue because they no longer would be paid based on volume (FFS) but on value. Primary care physicians would have been paid more, and the value of primary care supported—especially important during a pandemic.

The Oregon Chapter of ACP invites policymakers and stakeholders to partner with us to build a better, fairer, simpler, and less costly health care system.

ACP’s specific recommendations can be found at the Annals of Internal Medicine [website](#).