Elizabeth Baratta
Bangor

Chairs Claxton and Meyer, honorable members of the Joint Standing Committee on Health and Human Services, and sponsoring representative Rachel Talbot Ross: my name is Beth Baratta. I live in Bangor and I am here today to testify in favor of LD 718. I would like to speak to my experiences as a family medicine physician in an outpatient primary care practice.

In my personal experience, I have noticed that there is a discrepancy in the health outcomes between people with more financial resources and those with fewer. This health inequity is the result of more than just money. If you don't have reliable and sufficient income, many things fall by the wayside. Your general level of education (and thus the number of employment opportunities) decreases and you are limited to jobs that do not always offer protected time off, insurance, and other benefits. These jobs are generally considered "unskilled" labor, despite the fact an average person off the street employed elsewhere cannot simply walk in and perform that same job to a high level. They are not often secure jobs either – being considered "unskilled" labor, there is a large pool of similarly "unqualified" individuals available to fill that job, perhaps more desperate for whatever income they can find and thus perhaps more susceptible to being abused in order to acquire and maintain that position. With these kinds of jobs, getting time off for doctor's appointments (or for your family's appointments) can be challenging, or even something that ends up getting you fired.

In addition, these jobs are more likely to be ones that put you in contact with toxic chemicals that threaten your health and well-being. I'm thinking specifically of laundry businesses, which use organic solvents and other solutions for dry cleaning that can wreak havoc on your liver, brain, and if you are a human with a uterus, do very real damage to a developing embryo, and places like nail salons, with volatile solutions that can be inhaled by employees which pose a similar threat to those who are pregnant. These businesses have disproportionate representation of immigrants and noncitizens in their employees and it puts their health at greater risk.

It is also expensive to maintain good health. It means both having access to and being able to buy high quality food. It means having vaccinations and screening procedures like colonoscopies, Pap smears, ultrasounds (for abdominal aortic aneurysms), or CT studies for lung cancer. It means regular dental visits. It means being able to get prescriptions and know how to take them. It means knowing when to see your PCP and when to appropriately seek a higher level of care, like going to the ED.

Without insurance, these are not affordable to a lower income population. Given the rising costs of healthcare, it is hard for a middle class population to afford these interventions out of pocket.

But most importantly, in my experience, having an established PCP plays a tremendous role in maintaining "good health". Yes, a PCP can order or perform those interventions I just mentioned and can prescribe medications. But medicine is more than that and so one of the functions I serve for my patients is facilitating their health literacy, something which is overall impaired in the poor and underinsured. People are not born understanding why you need to take ibuprofen with food or that you can prevent a lot of reflux by waiting several hours after your last meal before you go to sleep. I mean, I wasn't. That second thing I didn't even learn in medical school.

People can get their routine prescriptions from emergency rooms, if they must, and this is what a lot of patients without insurance do, but not only is that unnecessarily expensive, it's not what they are designed for. What ERs are best equipped for is triage and crisis intervention. Triage is a medical process where patients are sorted in order of priority according to their need for care and the likely benefit that care will provide. Their job is to find out if someone needs something done, emergently, and then facilitate that something – a specialist evaluation, a diagnostic test, an admission to the hospital.

Their job is not to spend time with patients to determine what their actual problem is. That's my job.

When I interact with patients, I have lots of objectives. I want to figure out what matters to them. I want to determine what medical interventions are my priority for them. I want to come up with a plan (in conjunction with the patient) that accomplishes what matters to them and allows for my medical priorities. I want to educate the patient about their bodies and answer their questions. I want to make a space for them to be heard. I want to reflect back at them what they are doing well and transform what they are struggling with into action or growth.

And because I will see my patients on more than one occasion, because we can have follow up appointments, because we can build a relationship, I can accomplish these objectives.

What people need is to understand their bodies, how they function, and when to worry and when to let themselves sit with discomfort and wait it out. What the uninsured have just have (extremely costly) access to someone who can tell them they don't have a heart attack, or need surgery for appendicitis. This is doing them a great disservice.