The Honorable John Lawn, Chair
Joint Committee on Health Care Financing
State House, Room 236
Boston, MA 02133

The Honorable Cindy Friedman, Chair
Joint Committee on Health Care Financing
State House, Room 313
Boston, MA 02133

Re: Testimony regarding An Act to Advance Health Equity (H.1250/S.799)

Honorable Chairs and Members of the Joint Committee:

Thank you for the opportunity to submit testimony regarding An Act to Advance Health Equity (H.1250/S.799). I applaud Massachusetts lawmakers for their work to make the state a national leader in health equity, as it has done in health care reform and in so many areas in health care. Continuing to look for ways to improve and ensure the health of all its residents is both a laudable goal, and a moral responsibility.

My name is Joseph R. Betancourt, M.D., M.P.H. It is a privilege and honor to provide commentary on this issue, as health equity is my life's work. This issue is personal to me, given I'm originally from Puerto Rico, and my lived experience has given me a unique window on the challenges faced by minority and vulnerable communities. I have worked on this topic across the nation and have also served on a variety of advisory boards and committees at the Massachusetts state level on the topic of disparities and health equity over the course of the past 20 years. I have been at Massachusetts General Hospital (MGH) for 22 years, as a primary care doctor and formerly as Senior Vice President for Equity and Community Health, overseeing the organization's diversity, equity, inclusion, and community health portfolio. This included its Center for Diversity and Inclusion, Disparities Solutions Center, Center for Community Health Improvement, as well as centers focused on gun violence prevention, community health innovation, immigrant health, and global health. I also led the Mass General Brigham system's COVID Equity and Community Health response and served as founder and director of MGH's Disparities Solutions Center.

While I continue to see patients at MGH, I am now President of the Commonwealth Fund, where I lead a portfolio of national and international independent research and grantmaking to promote a high-performing, equitable health care system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable, including people of color, people with low income, and those who are uninsured.

The Commonwealth Fund's 2021 Scorecard of State Health Performance noted that profound racial and ethnic disparities in health and well-being have long been the norm in the United States. Black and American Indian/Alaska Native (AIAN) people live fewer years, on average, than white people. They are also more likely to die from treatable conditions; more likely to die during or after pregnancy and to suffer serious pregnancy-related complications; and more likely to lose children in infancy. Black and AIAN people are also at higher risk for many chronic health conditions, from diabetes to hypertension. Decades of policy choices made by federal, state, and local leaders have led to structural economic suppression, unequal educational access, and residential segregation, all of which have contributed in their own ways to

worse health outcomes for many people of color. Predictably, the COVID-19 pandemic only made things worse.

Issues around cost, affordability, and access to care contribute to these inequities. Black, Latinx/Hispanic, and AIAN populations are less likely to have health insurance, more likely to face cost-related barriers to getting care, and more likely to incur medical debt. It is also less common for individuals from these groups to have a usual source of care or to regularly receive preventive services like vaccinations. In addition, many people of color contend with interpersonal racism and discrimination when dealing with clinicians and more often receive lower-value or suboptimal care.

While these issues are vast and complex, our research at the Commonwealth Fund shows a number of ways policymakers could begin to tackle them. These include addressing the drivers of health; ensuring quality data are available to monitor the progress of efforts intended to advance health equity; bolstering primary care; diversifying the health care workforce; and ensuring access to telehealth.

Drivers of Health (DoH) and Health Equity Data: There is no health without social context. Throughout my career as a doctor and researcher, I've seen that all the science and technology in the world are worth nothing if we aren't able to address the specific social context within a community. The DoH—which include stable, affordable housing; healthy food; reliable income; and interpersonal safety, among others—account for 80 percent of health outcomes and have a disproportionate impact on communities of color. A growing body of evidence has also established that addressing DoH can improve health outcomes more cost-effectively and equitably than medical interventions alone. Therefore, it is important that policymakers look for opportunities to address DoH. The Fund collaborated with CDC Director Mandy Cohen—then the Secretary of the North Carolina Department of Health and Human Services—on a report on seven strategies that can help states establish scalable, sustainable integration of DOH.

Equally important is the capability to measure DoH, which equips providers with data to identify and address unmet needs and allows policymakers and payers to account for DoH in payment models. Without measurement, the social factors promoting or inhibiting health are invisible, and providers are left on their own to identify and address unmet needs, policymakers and payers are unable to develop models that create financial incentives to address the root causes of poor health, and communities are hamstrung in efforts to mobilize resources needed to build the workforce and partnerships necessary. Furthermore, while the quality and availability of general race and ethnicity data in our health care systems vary widely, the data are essential for seeing where disparities exist and how they persist throughout the continuum of care. Efforts to improve race and ethnicity data and act on it could improve health equity in Massachusetts.

Workforce Diversity and Primary Care: Research shows that a diverse and representative health care workforce improves patients' access to care, their perceptions of the care they receive, and their health outcomes, especially for patients of color. When Black patients are treated by Black doctors, they are more satisfied with their health care, more likely to have received the preventive care they needed in the past year, and are more likely to agree to recommended care like blood tests and flu shots. Other studies have

documented measurable gains in access, quality, and health outcomes when patients' health care teams mirror their personal characteristics and thereby foster relationships that engender respect, empathy, and trust.

We also know that physicians of color are more likely to build their careers in medically underserved communities—places that often have lower concentrations of primary care providers. Primary care is another critical component of the health equity discussion: While there is a well-established association of robust primary care with better, more equitable health outcomes, the proportion of health care dollars going to primary care is shrinking. Intentional policy efforts to strengthen pipelines into the health professions for people of color and to increase investment in primary care could positively impact health equity.

Telehealth: A recent Fund report noted that that telehealth technologies can increase access to care by reducing barriers to in-person visits and allowing patients to match with linguistically and culturally appropriate providers who may be geographically distant but can provide them with person-centered care. Technologies can create linkages to clinician extenders (e.g., care coordinators who can help with health care needs in place of a physician) and to services that may not be available on site (e.g., behavioral health specialists). These technologies expand the capacity of the primary care and behavioral health workforce to provide quality behavioral health care to larger numbers of people across diverse geographies. It is also worth noting that it is popular among providers; our findings from the 2022 Commonwealth Fund International Health Policy Survey of Primary Care Physicians on telehealth showed 82 percent of primary care physicians in the U.S. felt telehealth improved the timeliness of care they delivered to patients, and 80 percent said it allowed their practice to offset potential financial losses related to the COVID-19 pandemic "to a great extent" or "to some extent."

Too often in the U.S., race and ethnicity are correlated with access to health care, quality of care, health outcomes, and overall well-being. This is a legacy of structural, institutional, and individual racism that predated the country's founding and that has persisted to the present day, in large part through federal and state policy. By pursuing new policies that center racial and ethnic equity, Massachusetts can ensure that its health care system fulfills its mission to serve all its citizens.

Please feel welcome to contact me at jbetancourt@cmwf.org with any questions. Thank you.

Sincerely,

Joseph R. Betancourt
President
The Commonwealth Fund

Cc: Members, Joint Committee on Health Care Financing