Looking Ahead

The Cornell Roosevelt Institute Policy Journal

Center for Healthcare Policy

Issue No. 4, Spring 2013

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The Roosevelt Institute at Cornell University is a student-run think tank that generates and promotes progressive policy initiatives and that seeks to inform and inspire public policy debate in the Cornell and greater-Ithaca communities. Members write for our *Looking Ahead* journals, craft blog posts on important current events, organize political debates, host speaker series, and coordinate advocacy and education projects. The Cornell Roosevelt Institute is one of over eighty chapters in the larger Roosevelt Institute Campus Network.

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Letter from the Policy Director

Dear Readers,

As you know, now is an exciting time for the United States healthcare system. As more and more gears of the Affordable Care Act begin to turn, Americans will witness extraordinary changes to the "iron-triangle" of healthcare. Still, the consequences of these changes on quality of care, cost of care, and *even* access to care largely remain a mystery. Will Medicare pay-for-performance initiatives, public health programs, comparative effectiveness reporting, and the push for information technology actually improve the quality of care? Will preventative healthcare programs and the newly chartered Independent Payment Advisory board actually lower costs? Will the expansion of health insurance actually expand access to care in the face of a severe physician shortage and lower reimbursement rates? Healthcare enthusiasts look forward to following these questions closely in the upcoming years.

I am very pleased to present the second issue of *Looking Ahead: The Cornell Roosevelt Institute Policy Journal* from the Center for Healthcare Policy. The analysts have spent many hours carefully crafting proposals that compliment the goals of the current reform initiative - improved quality, reduced costs, and expanded access. Topics touch on a variety of issues, from measures to combat the American obesity epidemic and tighter regulations on food and medicine, to reforming payment methods. We look forward to sharing our work, and we hope that you enjoy!

Sincerely,

Noah Rubin
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Creating a National Standard for Health Information Technology

By Kaylin Greene '15, Major: Policy Analysis and Management (HumEc), Email: kag283@cornell.edu

The government should standardize code used by competing health information technology (HIT) systems and the institutional use of electronic health records (EHR) so that healthcare providers can deliver more efficient and cost-effective patient care.

Background:

Key Facts:

- 2013 is the year that the Affordable Care Act has designated to begin enacting penalties against physicians who do not use electronic health records.[2]
- Many HIT certification organizations exist,[3] but healthcare providers and systems manufacturers face issues regarding conflicting compliance standards which ultimately detracts from the goal of delivering good patient care.
- If a government standard for interoperability existed, healthcare providers would be better able to access patient information entered in several different systems (for example, for lab test results and other doctors) in order to better serve their patients.[4]

Electronic health records (EHR) are being increasingly incorporated into health systems nationwide, with 54% of all physicians having adopted an electronic health record system in 2011 and another 25% planning to purchase one soon thereafter.[1] Healthcare information systems are also a component in the recent healthcare reform legislation. Medicare is using 2013 as a benchmark for future penalties against physicians that do not use EHR.[2] As a result, the health information technology (HIT) industry has grown into hundreds of companies that offer systems and technology services to healthcare providers. While this is good for market competition, interoperability and compatibility between systems is an issue.[3] Several certification organizations exist, but the differences in each certification's standards make it difficult for HIT companies to build systems that adhere to these standards—which are often subject to the technology standards of the company that has the largest share of the market. This also makes it difficult for systems to communicate effectively—a hindrance which leads to difficulty in ensuring quality patient care.[4]

Analysis:

Talking Points:

- A cost-benefit analysis revealed that the "estimated net benefit from using an electronic medical record for a 5-year period was $86,400" for each primary care provier.[6]
- Physicians who do participate in the Medicare or Medicaid EHR Incentive Program can earn up to $44,000 - $63,750.[7]
- "Almost 50% of patients report that information necessary to their care was not available when needed,[8]" but with proper communication between electronic health record systems, this issue can easily be resolved.

Because there are many players involved in each level of healthcare, and because the Affordable Care Act will begin to penalize health providers that do not meet meaningful use standards, the certification of health information technology should be the responsibility of the government, rather than of private organizations. Many HIT professionals recommend developing a central, national healthcare database that can be accessed by each system independently.[5] While this could be an effective solution, the most effective way to aggregate the data would be to simply create a government standard code that all HIT systems must follow, and then collect data from there. In order to ensure that this government standard is met, the government itself should create the code that will be implemented into each system without depending on private accreditation organizations or on any one HIT company. This code should focus on interoperability and inter-system communication, especially for information such as personal patient information, health history, current diagnoses, prescriptions, insurance providers and healthcare providers. In order to maintain market competition, each system should be given the technical freedom to adapt to each healthcare provider's unique needs.

Next Steps:

As patients and as taxpayers, every citizen in the United States benefits from a healthcare system that delivers cost-effective, high-quality care. State and federal health codes exist, which can be expanded on to incorporate further developments in HIT. Healthcare providers, policymakers and insurance companies are also interested in investing in systems that are cost-effective and efficient.

The responsibility of ensuring that HIT systems are practically compatible should be regulated by government standards and frequently quality-checked by healthcare administrators and IT personnel. Furthermore, it is the responsibility of the patient community at large to give feedback to their healthcare providers in order to better tailor each system to meet unique community needs. In order to achieve an ideal, universally -accessible and interoperable healthcare information system, the federal government should take steps to enact laws that set standards for HIT coding. Furthermore, in order to ensure that standards are properly met, standardization code must be created by the government for use by companies that provide healthcare IT systems. A special commission for the writing of this code should be created—composed of HIT professionals, healthcare policy analysts, and persons with practical experience as hospital/ healthcare administrators that understand efficient workflow. Patient and healthcare provider input should also be surveyed and incorporated into the project to best meet the population's needs. In order to safeguard the success of HIT companies that already exist, there should be financial incentives and tax breaks for companies and providers who agree to adopt the new government coding standard.

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Reducing Performance-Enhancing Drug Use by High School Athletes

By John Lemp '15, Major Industrial and Labor Relations (ILR), Email: jrl264@cornell.edu

The federal government should pass legislation that requires the implementation of random drug testing programs for high school athletes. This policy would provide for greater fairness and continuity between collegiate and high school athletics and prevent the mental and physical side effects of performance-enhancing drug use.

Background:

Key Facts:

- According to the High School Athletics Participation Survey, 55.5 percent of high school students play at least one sport.
- Approximately 7.6 million students participated in interscholastic athletics during the 2010-2011 academic year, according to a 2011 survey by the National Federation of State High School Associations.
- The epidemic of performance enhancing drug use has spread from professional leagues to high school interscholastic athletics.
- Illinois, New Jersey, and Texas currently have performance-enhancing drug testing policies for high school athletes in place.

According to a 2011 survey by the National Federation of State High School Associations, approximately 7.6 million students participated in interscholastic athletics during the 2010-2011 academic year. The High School Athletics Participation Survey also estimates that 55.5 percent of high school students play at least one sport. Participation in interscholastic athletics is a great mechanism for adolescents and young adults to engage in physical activity, build self-confidence and self-esteem, reduce stress, and form friendships. Furthermore, interscholastic sporting events build a spirit of camaraderie within local communities and provide a means for local citizens to take an active role in the development and education of students. The life lessons learned from participation in sports are invaluable -- the importance of teamwork, dedication, and commitment, as well as honesty and integrity. However, the integrity and honesty inherent to sports has been compromised due to increased performance-enhancing drug usage. Cheating and gaining unfair competitive advantages plague not only professional and collegiate sports, but high school interscholastic sports as well, which diminishes the role of honesty and integrity in athletics.

anything grown and sold in the same state. Whole Foods considers this to be anything grown within a 200 mile radius or a 7 hour drive of the store. And Seattle's PCC natural Markets considers this to be anything grown from Washington, Oregon and S. British Columbia.

Analysis:

Talking Points:

- The use of anabolic steroids in the United States for cosmetic, non-medical reasons is illegal, which pushes the steroid industry into the black market. As a result, these steroids pose significant health risks to users since they are neither regulated nor tested by the Food and Drug Administration.
- Coaches, school district officials, and administrators need to ensure that their athletic programs maintain high levels of honesty, integrity, and sportsmanship.

While productive legislation passed by the U.S. Congress and enforced by the National Federation of State High School Associations should greatly reduce the number of high school student athletes using performance-enhancing drugs, more action needs to be taken by high school administrators, teachers, and coaches. Educators need to emphasize that performance-enhancing drug use is extremely dangerous, especially for adolescents and young adults, as their brains and bodies are not fully developed. Performance-enhancing drug use by high school-aged athletes, particularly anabolic steroid intake, leads to inhibited growth and development in teenagers. Moreover, the use of anabolic steroids in the United States for cosmetic, non-medical reasons is illegal, which pushes the steroid industry into the black market. As a result, these steroids pose significant health risks to users since they are neither regulated nor tested by the Food and Drug Administration.

Coaches, athletic directors, and school administrators also have the responsibility to advocate for fair competition and maintaining high levels of honesty, integrity, and sportsmanship in high school athletics. In high schools across the American South, sports like football raise tremendous amounts of revenue for local school districts. High school sporting events also prove to be a healthy means of competition between public and private high schools in similar areas, which exposes students to a more diverse range of peers. In a progressive, 21st Century society, diversity and inclusivity should be a priority, especially in the education system. Yet, coaches, school district officials, and administrators need to ensure that their athletic programs maintain high levels of honesty, integrity, and sportsmanship.

There are two ways a school district's athletic department can protect the health and safety of high school student athletes while holding honesty and integrity as the highest values. First of all, the enforcement of a nationwide performance-enhancing drug testing program by the National Federation of State High School Associations will require a school's athletic director to make sure their school is in compliance with all rules and procedures. Second, the initial implementation of the plan will serve as an opportunity to educate students about the dangers of performance-enhancing drug use and advocate for student mental and physical health. Interscholastic athletics serve as a large source of revenue for many school districts, and the compliance to the policies established by the nationwide drug-testing program, will ensure that these activities will be able to continue far into the future.

Next Steps:

The states of Illinois, New Jersey, and Texas have all passed legislation and made significant progress regarding prevention of performance enhancing drug use by high school student athletes. However, a federal policy that can be enforced by the National Federation of State High School Associations is imperative for this matter. Such a policy would allow for a uniform and standardized approach to protecting the physical and mental health of high school student athletes. Furthermore, this would hold student athletes to higher levels of accountability and responsibility. Participation in sports has the ability to teach an individual numerous life lessons. Since sports have such a profound impact on American culture and society, it is important that American citizens learn of the importance of honesty, integrity, and persistence, instead of always trying to take the easy way out.

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From Fee-For-Service to Bundled Payments

By Oriseloka Onumonu '15, Major: Policy Analysis & Management (HumEc), Email: oko2@cornell.edu

The typical fee-for-service model has proven not to be the most cost efficient method of healthcare delivery. When looking at the costs and benefits of both a fee-for-service and a bundled payment system, it is clear that the bundled payments method is far superior.

Background:

Key Facts:

1. Since the passing of the Affordable Care Act, the Center for Medicaid and Medicare Services has developed a $963 million dollar pilot pay-for-performance program which awards $850 million in bonuses to the nation's 3,000 highest-achieving acute care facilities based on quality standards and measurements of care.
2. As a part of the Affordable Care Act of 2010, the Center for Medicare will implement bundled payment pilot programs (7).

A substantial portion of government spending associated with health care is devoted to the Medicare system. Medicare is a national insurance entitlement program that citizens become automatically eligible for when they reach age 65, structured similarly to conventional private insurance. The program represents a significant proportion of government expenditures—3.8% of total spending in 2010 (34)—and is integrated within many aspects of the U.S. healthcare system. This places it in a unique position to serve as an exemplary model of reform. Since Medicare has the potential to become a precedent for efficient and high quality insurance, it could lead to beneficial reformative state action, and could be followed by private healthcare providers. For this reason it is valuable to look at Medicare as more than just a government funded insurance program for the elderly. It is a beacon of potential for responsible reform that the United States is in dire need of in order to become economically stable, and to reach healthcare quality reflective of its high international status. The spike in Medicare expenses partially stems from the aging population and the growing prevalence of chronic diseases; nevertheless, many costs are accumulated due to the structure of care and over-use of expensive technology (5). In the United States healthcare spending is often determined by quantity of care rather than quality and efficiency. Doctors prescribe surgeries, medications, and tests while preventive medicine or lifestyle recommendations are given less serious attention. This may be due to the common practice of paying physicians in a "fee-for-service" system, which incentivizes running as many expensive procedures as possible.

Even if doctors believe less care might have superior or equal outcomes, many increase the quantity of services out of fear of being sued for medical malpractice (5). The purpose of this policy memo is to examine a proposed alternative to this method of compensation for doctors. Instead of paying for quantity of care, bundled payment systems provide a single, capped payment for all procedures required to treat a particular condition, spanning across various physicians and settings (19). This type of system may have the potential to increase quality and reduce the costs of the healthcare in this country.

Analysis:

Talking Points:

1. In a small-scale study by Casale et al. in the Geisinger Health System in Pennsylvania, which compared 117 patients in a bundled payment program with 137 patients from the year before the program's implementation, hospital costs declined by 5% and readmission rates fell by 8.5% (6). The hospital's average duration of stay was lowered by 16% (6).
2. A Casale et al. study saw physician adherence to best treatment practices reach a high of 100% and only lower to 86% across the two year span, compared to a low adherence of 59% before the bundle payment program (6).

Studies have proven that a bundled payment system does have the potential to lower healthcare costs and increase quality. Hackbarth et al. claims this method could initially lower steep Medicare expenditures for significant, yet common surgeries, such as cardiac bypass, and chronic hospitalizations covered by Part A, which account for 40% of national Medicare spending or $500 billion annually (19, 8). Medicare would fund the provider, composed of the hospital and its related employees, with one payment equal to the sum of expected fees for all Medicare-covered services used. Since one-time payment would have to be divided among physicians involved, and does not cover excess services, it would incentivize containment of costs, increased coordination between physicians, and creativity to organize efficient care (19). Bundled payments have the ability to level health care spending for specific medical cases, which currently has considerable variation among hospitals (19, A9). The Medicare Payment Advisory Commission (MedPAC) recognized that readmissions are a particular problem—18% of Medicare hospitalizations end in readmission within 30 days of discharge, costing $15 million with $12 million spent on possibly *preventable* readmissions (33). By promoting the use of only necessary, cost-effective services, a bundled payment could also increase the quality of care, cut unneeded post-acute care, and reduce readmissions (2). In the Medicare Bundled Payment Demonstration Project studied by Cromwell et al., the four hospitals involved experienced considerable cost reductions, specifically for episodes of coronary artery bypass grafting (CABG).

During the first two years, Cromwell et al. reported a 15.5% decrease in costs, accounting to $17.2 million in savings for the hospitals (2). 85-93% of those savings were from cost cutting for inpatient care. Wynn et al.'s analysis also found Medicare saved $52.3 million during the whole length of the demonstration, and Cromwell et al. calculated that three of the four hospitals' average total costs per episode dropped between 2-23% (2).

However, there are some negative aspects associated with a bundled payments system. Beneficiaries may have less time with each physician and also have fewer choices of physicians if the care's payment is bundled to a certain provider. Maximizing the quantity of bundled payments received incentivizes hospitals that accept a higher quantity of patients, which could consequently promote volume of admissions over quality of care, a negative effect similar to fee-for-service (33). The quality of care could also be adversely affected by this bundle payment system. The quality of care provided could fall if physicians perform low levels of service to stay within the Medicare quota. Providers also could manipulate bundled payments by delaying physician services until after the billing period, to then charge Medicare for the same service twice, adding to costs (33). If physicians are not freed from responsibility for especially high-cost patients that require care over the cap, they could also avoid accepting them. One more offsetting behavior associated with a bundled payment system is in an effort to receive higher bundled payments, providers could too change how they code the severity for inpatient care and exaggerate patients' sickness levels, which would presumably improve quality but exacerbate our healthcare spending problems.

Next Steps:

Moving forward I believe that the United States of America should fully implement a bundled payments system. Studies shown that this system is able to be effective on a micro scale and I believe that these results are duplicable on a macro scale as well. Although there are several negative aspects associated with a bundled payment system, much of this is just random and has not been duplicated in multiple studies.

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Combating Food Deserts through Incentivizing Local Businesses

By Timothy McGraw '16, Major: Industrial and Labor Relations (ILR), Email: tam248@cornell.edu

Governments should incentivize local businesses to sell healthy foods in areas that normally lack access to such foods.

Background:

Key Facts:

- Areas without access to healthy and fresh foods are called "food deserts"
- 23 million Americans live in these food deserts, which are overwhelmingly in inner-city and extreme rural areas
- The Federal Government has begun subsidizing big-box retailers to fill the void in these areas

Over 23 million Americans have little or no access to the fresh and affordable foods necessary to maintain a healthy diet. These Americans live in locations known as "food deserts," which are areas without access to fresh and healthy foods, particularly produce, usually characterized by their distance to grocery stores per capita. This compounded with low incomes that typically accompany such areas, means healthy food is extremely difficult to come by. People in food deserts typically have access to the cheap processed foods available at convenience stores and fast food restaurants, and have significantly higher rates of both diabetes and obesity.

The United States Department of Agriculture (USDA) recently visualized the problem with the Food Access Research Map, which used census data to find neighborhoods with limited access to the large grocery stores and markets that offer fresh foods. Unsurprisingly, the USDA found food desertification most acute in impoverished inner city and extreme rural regions, and especially problematic in majority-minority areas. The USDA, alongside leading advocates such as Michelle Obama, have ramped up efforts to combat the problem of food desertification through ensuring access to affordable and fresh foods. In 2010, Congress passed the Child Nutrition Act, which mandated healthier school lunches, and recently advocates have been pushing to include healthy food provisions in the food stamp program.

The USDA is trying to address the issue by recruiting large retailers to fill the gap, with the Obama Administration recently devoting $400 million towards attracting these retailers. Such a move, along with public pressure, has encouraged retailers to make their food products healthier. Wal-Mart, the nation's largest supplier of groceries, recently announced an initiative to improve the nutrition of its food, including a 10 percent reduction in added sugar in its products.

Analysis:

Talking Points:

- Incentivizing local businesses to sell healthy foods and local produce in place of cheap processed foods would positively impact the community more than expanding the footprint of big-box retailers
- Increasing access to healthy foods could significantly reduce obesity and improve health quality

In focusing their efforts on big-box retailers, the USDA and Congress overlook the positive impact that local retailers and small convenience stores could have. It is impossible to fill the entire healthy food void, especially in rural areas, using large retail corporations. These stores often bring their own problems, such as depressing local business. Rather, legislation should focus on more local solutions. Convenience stores sell cheap processed foods because it is profitable to do so – a 7/11 will make more profit by giving shelf space to Doritos than bananas or local produce. Incentives for businesses to stock their shelves with nutritious foods would make it worthwhile for Mom-and-Pop groceries and convenience stores to offer healthy alternatives. This could be done through subsidies or tax cuts to food retailers in USDA categorized food deserts, and could significantly reduce the problem of access while empowering local businesses. The profits from such a program would be more beneficial to the community than profits going to a large corporation.

Next Steps:

Incentivizing local businesses to sell fresh and healthy foods would be best enacted at the state and local level. Major cities in particular would benefit from incentivizing local businesses to provide healthy alternatives far more than the proposed method of incentivizing large retailers to move in to food deserts. Local governments could promote pilot programs in certain neighborhoods to measure the impact of such a program. Further, a portion of the $400 million set aside by Congress for tackling the food desert issue should be redirected to local governments to enact this subsidy program. Adopting such a program could successfully eliminate many food deserts and provide millions with access to healthy foods, significantly reducing obesity and healthcare costs.

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Reducing the Incidence of Osteoarthritis by Practicing More Effective Surgical Techniques

By Layla Hood '14, Major: Biological Sciences (CALS), Email: lmh229@cornell.edu

Physicians should use surgical methods that restore natural anatomical ACL flexion and weight-bearing activity in order to slow the onset of osteoarthritis among patients.

Background:

Key Facts:

- Almost half of patients who suffer an ACL injury undergo surgery to repair the damage[1]
- Joint degeneration associated with ACL reconstruction has been linked to the acceleration of the onset of OA[2]
- Surgical techniques that are able to mimic the native anatomical placement of the ACL result in less joint degeneration[2,6]
- Patients with OA spend twice on medical care annually than those without[5]

The anterior cruciate ligament (ACL) is one of the most commonly injured ligaments in the human body. It is reported that more than 200,000 ACL injuries occur each year.[1] Of these injuries, almost half require surgery.[1] Researchers have noted a high incidence of joint degeneration following the reconstruction of the ACL.[2] This joint degeneration has been linked to the acceleration in the development of osteoarthritis (OA).[2]

Osteoarthritis, the most common form of arthritis resulting from the degradation of protective cartilage separating the bones, affects millions of people around the world.[3] Those who suffer from OA experience joint pain, joint tenderness, joint stiffness, loss of joint flexibility, joint grating sensations, and bone spurs around the affected joint.[3] There is no known cure for OA and the affliction becomes more severe with time.[3] It has been reported that OA is one of the leading contributors to physical disability worldwide.[4] Although it is more common among the aging population, injuries to joints as a result of physical activity and obesity have been recognized as a primary factor for the development of OA.[5]

Analysis:

A common surgical option for ACL repair is a graft placement. Researchers at Duke University compared graft placement techniques and locations and determined that techniques in which the graft placement could be placed closest to the native ACL location achieved more natural flexion and weight-bearing activity.[2,6] However, many surgeons are comfortable using only one technique for ACL reconstruction, many of which

do not mimic native anatomical ACL placement. Researchers believe that abnormal knee motion following surgery contributes to joint dysfunction, and thus accelerates the onset of OA. The implication of these findings is enormous in slowing the onset of OA in those with ACL injuries.

Talking Points:

- Exclusively practicing techniques that restore proper knee kinematics and result in less joint degeneration will increase the accuracy of such techniques
- OA affects millions of people annually; reducing the onset of OA will lessen not only the economic burden but also the physical pain that accompanies it

It has been estimated that the total cost of OA is approximately $89.1 billion.[5] Patients with OA spend almost double on the cost of healthcare than patients without OA.[5] As the degenerative ailment worsens, the costs also increase.[5] Not only are there the direct costs of medical care associated with OA, but also indirect costs. These indirect costs include lost wages, home care, child care, and home remodeling, which result from the inability to function given the disabling pain associated with OA.[5] Since there is no known cure, physicians have been working to slow the onset of OA.

Next Steps:

Osteoarthritis takes a huge toll both physically and economically on those who are affected. Because new research links unnatural placement to the acceleration in the onset of OA, it becomes pertinent to practice surgical techniques that most accurately mimic natural ACL placement and knee kinematics. Medical professionals performing ACL reconstruction surgeries should move toward exclusively practicing techniques that achieve anatomical graft placement in order to reduce joint degeneration. Medical schools should move to teach these reconstruction methods that are more effective to medical students in order maintain natural ACL functionality. By reducing joint degeneration, the onset of OA will be delayed, sparing patients from paying thousands of dollars in medical care costs and lost wages, as well as from the pain associated with the degenerative ailment.

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CPR Training in Public High Schools

By Emily Shearer '14, Majors: Biology and Government (A&S), Email: ejs288@cornell.edu

State legislation requiring all public high schools to include CPR instruction in their curriculum would increase the number of citizens able to perform effective bystander CPR appreciably, saving thousands of American lives annually.

Background:

Key Facts:

- Almost 383,000 out-of-hospital cardiac arrests occur annually in the US.
- Nationwide, less than 10% of people who go into cardiac arrest outside the hospital setting survive.
- Effective bystander CPR provided immediately after cardiac arrest can quadruple a victim's chance of survival, but only 15-30% of victims receives such care.

Heart disease currently ranks as the number one cause of death in the United States. Highly prevalent in the adult population, heart disease contributes to over 400,000 cardiac arrests nationwide each year. However, despite advances in cardiac-pulmonary resuscitation (CPR), the chances of survival for out-of-hospital cardiac events, which account for over four fifths of cardiac arrests, remain below 10% nationally. One major reason these survival rates remains so low is that over 70% of Americans are either not trained or are not comfortable with their skills in CPR.

Early CPR is one of the strongest predictors of survival in victims experiencing sudden cardiac arrest. In the absence of CPR, survival rates for cardiac victims drop precipitously within four to six minutes after arrest, a time period that can often exceed the time it takes for local ambulances to respond. A victim's chance of survival can be increased from 9.5% to 40.1% if they are given effective CPR in the interim. However, bystander CPR takes place in the US in only an estimated 15-30% of cardiac events.

Analysis:

Studies have shown that people who have viewed CPR instructional videos are significantly more likely to attempt bystander CPR than those who have not. Moreover, Hands-Only CPR, which can be done by any individual, has been shown to be just as effective as CPR with breaths. As a result, the American Heart Association recommends Hands-Only CPR training for American citizens.

Some cities have proactively taken steps to increase CPR proficiency within their populations. In Seattle, Washington, fire agencies have been training citizens to deal with

sudden cardiac arrest through their training program Medic II since 1971. Today, Medic II has reached over 771,000 residents and CPR is initiated in 58% of sudden cardiac arrests before ambulance arrival. EMS agencies in Boston, Massachusetts have developed a similar citizen-training program, Medic One, which provides CPR instruction to individuals, churches, or any other group who requests it. As a result of these efforts, Seattle and Boston currently rank first and second in the US for highest cardiac arrest survival rates, at a whopping 45% and 40%, respectively.

Talking Points:

- Actions taken within the first six minutes of a cardiac arrest are critical in determining the victim's chance of survival, a time period that often exceeds ambulance response time.
- Bystander CPR can help the victim's heart stay in ventricular fibrillation until an AED can be located or an ambulance arrives.
- American cities with the highest percentages of their populations trained in CPR have the lowest cardiac arrest death rates.

Next Steps:

The increases in survival rates for cardiac victims in Boston and Seattle suggests training citizens in CPR is worth the time and effort. Given the prevalence of cardiac-related deaths in the US, however, states should begin to look even beyond municipal EMS agencies in training their citizens in bystander CPR. Perhaps the most efficient way to teach citizens is to include CPR training in public school curriculum. Five states already have such laws on their books and two more states, Washington and Texas, are considering similar legislation currently. Passing legislation to ensure CPR training in public high schools would ensure a dramatic expansion in the percentage of the population qualified in life-saving skills at a relatively low cost.

Because chest compression CPR is relatively simple (classes can be as short as 30 minutes), including instruction in a physical education or health class curriculum would not drastically affect current lesson plans. Ideally, schools would require physical education or health teachers to become certified in CPR instruction (for example, through a short day course taught by an American Heart Association or American Red Cross CPR instructor). This way, schools would not have to bring in outside resources each year, but could instead rely on their existing faculties. Each school would need to make a one-time investment in training videos and CPR dummies, which could be accomplished by allocation of state education funds to each district. These funds in turn could come from federal grants financed by higher sin taxes on items that contribute to heart disease, such as high-fat animal products or tobacco. Preferably, instruction would take place during students' freshman year with shorter refresher courses taught annually thereafter, as retention of CPR knowledge is generally poor if not repeated and can decrease as early as six weeks after a class is taken. Classes should also include information about the state's policy on Good Samaritan Laws, which offer pro-

tection to bystanders performing CPR in the most states. Knowledge of Good Samaritan Laws should encourage students to use their new skills, as studies have found fear of being sued to be one reason why bystanders hesitate from intervening in cardiac arrests. Courses should also emphasize that impact CPR can have on saving lives, as similar studies have found this to be a significant motivator in bystander CPR.

By increasing the percentage of their population proficient in CPR, such laws would begin to change the horrific survival rate of cardiac arrest victims nationwide, in a simple and relatively inexpensive scheme.

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Taxing Unhealthy Foods to Reduce Obesity Rates in the United States

By Philip Susser '16, Major: Policy Analysis and Management (HumEc), Email: pss226@cornell.edu

State governments should offer monetary incentives to restaurants for reducing average portion sizes by up to 25 percent.

Background:

Key Facts:

- Obesity levels in the United States have reached staggering numbers. In 2012, 34% of Americans were obese.
- Obesity makes up 21% of all medical expenditures in the United States
- Obesity has indirect costs that are often not considered, such as the number of sick days an individual takes and lower wages.
- Some consider taxing obese individuals at a higher rate than healthy individuals to address high obesity related spending. Others suggest taxing unhealthy foods.

An adult with a BMI of over 30 is considered obese (10). Rates of obesity in the United States have reached staggering numbers, affecting an overwhelmingly large proportion of the population. The economic and social costs of obesity have made it a public concern; methods to slow down this epidemic are continuing to be explored. In 2012, it was reported by the U.S Centers for Disease Control and Prevention that close to 34% of Americans were obese (5). Obesity has many health consequences, resulting in tremendous health costs in the United States. Cardiovascular disease, sleep apnea, hypertension, type 2 diabetes, stroke, and cancer have all been linked to obesity, leading to an estimated annual health care cost of $150 billion (1, 4). This accounts for close to 21% of all medical spending (3). While direct costs, or outpatient and inpatient health care resulting from obesity are often cited, many indirect costs that substantially affect Americans are often neglected. Such costs include are lost labor as a result of an increased number of sick days, lower wages for obese individuals, and higher life insurance premiums for employers that cover more obese workers (3). Indeed, the morbidly obese are 118% more likely to miss work than healthy individuals, resulting in an estimated annual cost of $4.3 billion (2). If obesity, a preventable condition, can be lowered within the US, it could substantially decrease health care costs - other indirect costs - and result in an overall healthier population.

Some people question if it is fair that in a publicly funded health care system, those who choose to engage in riskier health behaviors gain more from coverage at the expense of healthier individuals. People have proposed taxing individuals who are obese at a higher rate than those who are healthy (4). This would hold people more accountable for their health decisions and promote healthier eating behaviors. Others have

proposed a similar policy to smoking – creating a "sin" tax which would tax unhealthy foods to dis-incentivize people to purchase them.

Analysis:

Talking Points:

- Creating a tax on unhealthy foods, indexed to their health contents could discourage the consumption of foods that lead to adverse health outcomes.
- Indexing the tax to the health contents of food would evenly distribute the negative costs of unhealthy foods and drinks evenly across different food industries.
- The food tax must be substantial – nearly 20% - to significantly influence the purchase of unhealthy foods.

Taxing the obese population at higher rates would surely create motives for healthier eating habits and more exercise. However, although the Center for Disease Control found in 2010 that most obese adults do not have lower income, taxing individuals at a higher rate through obesity would decrease disposable income and may create increased their demand for cheaper and unhealthier foods (6). A tax on unhealthy foods with high fat content, with revenue channeled towards subsidizing healthier foods could create the proper incentive for healthier eating habits. A caveat to this approach, on the other hand, is the difficulty in distinguishing between "healthy" and "unhealthy" foods (5). For example, avocados are high in fat content, but have other nutritional value. Therefore, an index must be created that considers all aspects of a food; the tax on that food would be indexed relative its contents. This sort of an index would distribute the costs of unhealthy foods evenly across different food industries. Rather than singling out the sugary beverage industry like New York City has through their soda ban, this index would affect all companies in a similar fashion. Furthermore, it would directly address the offsetting behaviors that result from the taxation of one unhealthy good. An individual would no longer be able to navigate through food taxes by switching consumption to whichever unhealthy, cheap good remained untaxed. Finally, it would create incentive for companies to improve the health content of their product in order to decrease tax rates.

The tax would need to be substantial in order to effectively reduce obesity rates. It has been found that a food tax must be around 20% of the product's price in order to have a substantial effect on population health (7). An 18% tax on pizza and soda was found to have the power to have the average American lose 5 pounds per year and reduce daily calorie intake by 56 calories (8, 11).

Unhealthy eating habits can be viewed similarly to smoking; both are personal decisions with negative health consequences. The tax approach to smoking has been quite successful – the mean state excise tax for cigarettes was $1.46 in 2011 - reducing smoking rates to less than 20% (8, 9). If the national, state, and local governments follow suit in their approach to obesity, they may achieve similar success.

Next Steps:

High tax rates on unhealthy foods have much potential. Although there are many facets to the obesity epidemic, such as sedentary lifestyles and overconsumption of food, a high level, indexed tax could be a proper step in a movement towards lower incidence of obesity in the United States.

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Improving Prescription Drug Use: Ban Product Specific Advertisements

By Elaine Jaworski '14, Major: Pre-Med, Policy Analysis & Management (HumEc), Email: emj43@cornell.edu

Congress should ban product-specific advertisements for prescription drugs to reduce the negative effects of direct-to-consumer advertising (DTCA) while maintaining their positive effects.

Background:

Key Facts:

- Physicians filled 69% of prescriptions they believed to be inappropriate for their patients.[6]
- Pharmaceutical companies spent $4.3 billion on DTCA in 2010.[2]
- Thirty-three percent of physicians feel discussing a DTCA with patients improves the doctor-patient relationship.[6]

The 1962 Kefauver Harris Amendment was the first major law that enforced regulations on advertisement of pharmaceutical drugs.[5] The amendment required advertisements to provide a fair balance of benefits and risks, a brief summary of contraindications, and to not be false or misleading. The FDA's interpretation of this vague law prevented pharmaceutical companies from including both the condition being treated and the brand name of the drug in one advertisement. However, this interpretation changed in 1997 to allow more freedom in advertising and both the name and the condition could then be mentioned together.[5] Since this revision spending by pharmaceutical companies has increased drastically on DTCA, reaching $4.3 billion in 2010, and patients are seeking specific prescriptions more often. [2]

Analysis:

Physicians are aware of this drug-seeking practice by patients, who have minimal health education, reporting that 49 percent of patients visit the office seeking treatments inappropriate for them after viewing a DTCA. Still, Physicians filled 69 percent of these prescriptions they believed to be inappropriate. Thirty-nine percent of physicians felt that DTCA decreased the time efficiency of the office visit.[6] Often because physicians had to spend time explaining why advertisements lead their patients to the wrong conclusions.

Talking Points

- Brand specific advertisements do not increase the consumption of only a specific drug, but rather the advertisement increases the prescription drug market for that entire class of drugs.[1]
- In a randomized control trial proper care was most often given to patients that discussed a general DTCA with their physicians, in comparison to a drug specific DTCA and no DTCA.[3]

These negative effects come from the advertisements mentioning a specific drug, causing tension between a physicians' professional advice and what a patients want. Patients are convinced certain drugs are superior and become focused on obtaining only that drug, rather than taking the advice of their physician. If DTCA were still legal, but restricted from mentioning a brand and only allowed to mention the availability of treatments for certain conditions, these problems would be eliminated.

DTCA has many positive effects that the U.S. benefits from making stricter regulation, rather than a complete banning of DTCA, a more favorable policy approach. DTCA improves overall health by informing and educating the public on new treatments and encouraging patients to become more involved in their own health and visit the doctor. The benefits of education and increased attention to health will still be present under the proposed policy. Patients will still be encouraged to see their doctor, but specific drug seeking behavior will decline. Instead patients will rely on their physician to choose the right medication and on advertisements to let them know options are available. In a randomized control trial patients who mentioned a general DTCA in a doctors visit were treated with the most consistent acceptable quality of care when compared to mentioning no DTCA or a drug-specific DTCA.[3] The proposed policy balances the positive informative benefits of DTCA while reducing the negative consequences of brand specific advertising.

Patients and physicians will benefit from this policy— overall health, patient-physician relationships and efficiency at physician visits will improve. Pharmaceutical companies may lose sales if the overall market for pharmaceuticals decrease due to an overall reduction in patients seeking drugs, however studies show that brand specific advertisements do not increase the consumption of that drug in comparison to others, but rather they increase the entire market for that class of drug.[1] Therefore, pharmaceutical companies should not be concerned that restricting advertisements will have a great effect on their market share.

Next Steps:

Congress should pass a bill clearly outlawing brand-specific, direct-to-consumer advertisements. After passing the bill, the FDA should increase funds to regulate and enforce the new law. Current enforcement of DTCA is inadequate.[1] Funding could come from an increased application fee for pharmaceutical drugs seeking FDA approval. The negative effects of the current DTCA practices can be improved through a simple measure taken by Congress; this should be recognized and acted on to improve the overall health of the nation.

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The Show Must Go On: Reforming Medical Malpractice Tort Law

By Trevor Ward '14, Major: Policy Analysis & Management (HumEc), Email: tmw78@cornell.edu

The US Department of Justice is urged to work with the Department of Health and Human Services and the American Medical Association to reform medical malpractice laws in order to ensure a more efficient healthcare system.

Background:

Key Facts:

1. There is a 4:1 ratio for all injuries of medical malpractice that go unreported compared to those that do get reported.
2. In 2011, the United States came in third place for the proportion of GDP invested into healthcare.
3. Medication errors by themselves account for an estimate 7,000 deaths per year

Hospitals are typically considered to be a place that corrects the many injuries filed under *tort litigation.* With recent statistics explaining the extent of deaths due medical malpractice, it seems like this consideration may be backwards. Due to the high amounts of deaths due to medical malpractice in the United States, there has been a great deal of worry over the tort laws pertaining to the medical industry. As it stands, medical malpractice is the leading cause of accidental death in the United States, with an estimated number of up to 200,000 fatalities due to accidents, and up to 120,000 of these claims due to *negligence.* This staggering number of deaths would signal that there would be a flooding of malpractice claims in the courts, but that is not the case. Only 2.9% of malpractice victims file suit against their doctors, with only one tenth of these victims ever winning their court case.

To illustrate the issues with medical malpractice, consider a typical interaction of a terminally ill Medicare/Medicaid patient. As soon as the patient comes into the hospital, she must provide the caregivers with proof of health insurance, and the provider must do the same. Given that both the caregivers and the patient are insured, there is a divide created in incentives. On one hand, the doctor knows that he will only bear a fraction of his accidents because of his malpractice insurance, and he knows that his rate will not fluctuate greatly with any of her injuries. While on the other hand, the patient has incentive to accept as much care as possible, because she knows that she will only bear a fraction of the total cost due to her insurance, at the cost of being exposed to more medical risk from unnecessary procedures.

With medical costs making up 17.9 percent of the United States' GDP (15.9 trillion dollars), and with at least 2.4 percent of that value (68 billion dollars) attributed to medical malpractice, it is clear that if these costs were contained and practices reformed, there is the potential for massive amounts of life and cost savings.

Analysis:

Talking Points:

1. Medical malpractice cases reached an all time high of 17 per 100 doctors in the 1980's, but have since decreased dramatically.
2. By July 2004, two-thirds of states passed tort reforms aimed to reduce medical malpractice lawsuits, but there was no benefit to safety.

The causes of medical malpractice are vast, stretching from pharmaceutical errors to surgical incompetence. Doctors must purchase comprehensive insurance plans to protect them from these errors. However, these insurance plans have created inefficient system of incentives. Currently, there are both deficient and excessive incentives to provide care, but not take medical malpractice into account.

To explain in more detail, in the aforementioned case of the doctor, he knows his insurance will make him only bear a fraction of the cost due to injuries inflicted on his patients, which can lead to a deficient standard of care to be provided. Since he will only be liable for a fraction of his injuries caused, he can afford to perform with suboptimal precautions. This deficient lack of precaution leads to the fundamental error within the aforementioned case of the patient's care. Since insurance reduces the proportion of pay required by the patient, they desire more care than necessary. Moreover, doctors have incentive to provide more care to make more revenue, but at the same time they also partake in what is called "defensive medicine." Defensive medicine is when a doctor provides too much care for patients in order to "demonstrate that they have done everything possible to prevent harm." It is the intersection of deficient incentives for precaution and excessive incentives to provide care that increases the amount of medical malpractice cases.

The current state of tort law has no clear solution for this problem, and state laws are adding to the problem. Modern medical malpractice lawsuits are based on whether the incident that occurred was a simple mistake or if was caused by gross negligence. Then, the courts allocate damages and liability on a case-by-case basis. In any case, the amount of liability and damages caused is based on the extent of the medical practitioners actions. In addition to mixed incentives, states are passing 'caps,' or limits, on

how much a medical malpractice suit can charge a doctor. The entire purpose for liability and damages are to hold injurers accountable for their wrongdoings. By placing caps on these legal ramifications, courts are essentially giving doctors even more incentive to invest in less precaution.

Next Steps:

Finding a solution to this medical malpractice issue can save money for many Americans, as well as saving the lives of many more. To avoid worsening this problem, it is imperative that the Federal Justice System work with the American Medical Association and Bureau of Health and Human Services to help create a system that incentivizes the most beneficial amount and precaution needed for medical practitioners in the United States. With over $60 billion being spent on medical malpractice lawsuits, there is the potential to save millions of dollars and lives through medical malpractice tort reform.

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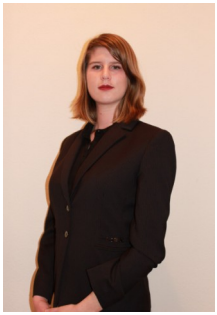
Meet the Center for Healthcare Policy!



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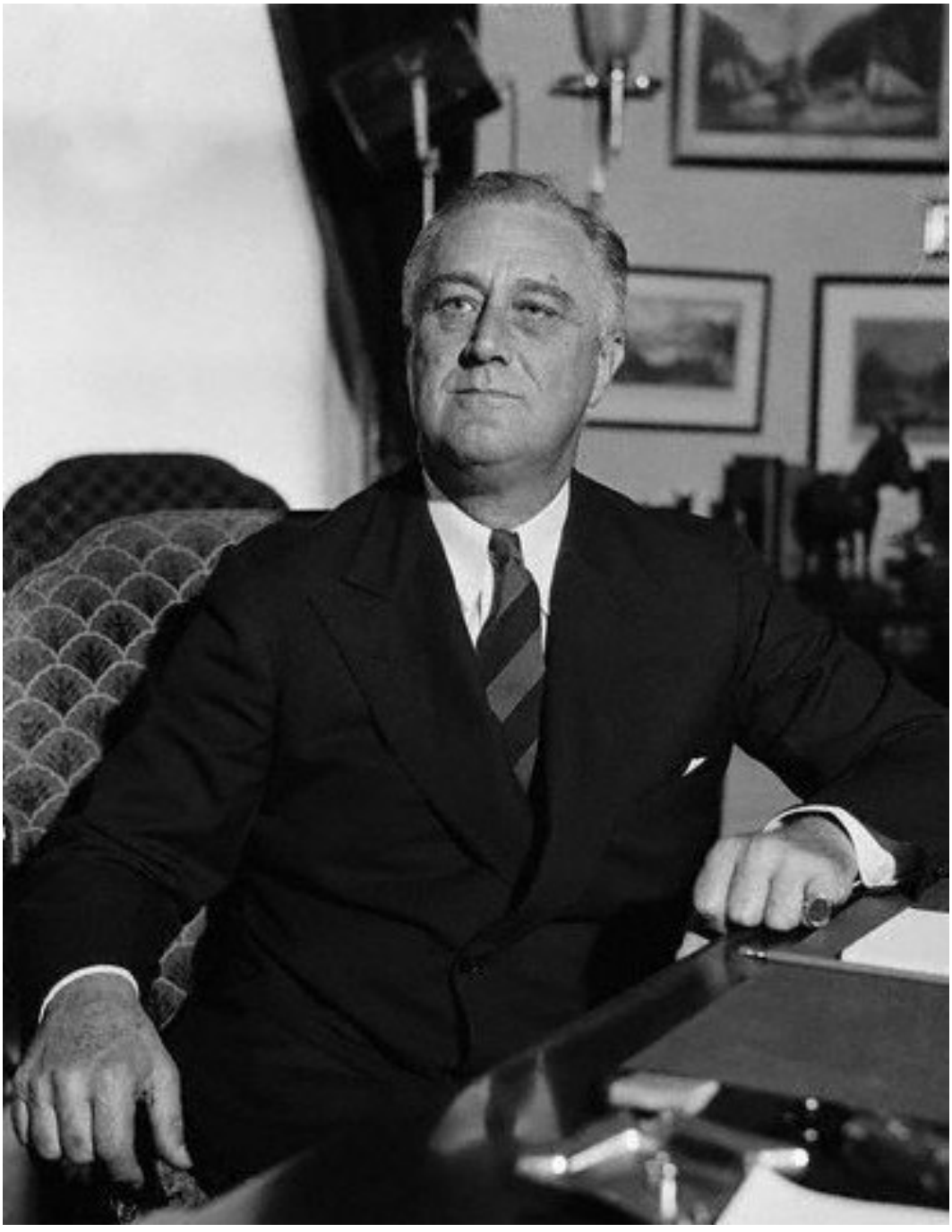

"Neither the American people, nor their government, intends to socialize medical practice any more than they plan to socialize industry."
-Franklin Delano Roosevelt

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