Looking Ahead

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The Roosevelt Institute at Cornell University is a student-run policy institute that generates, advocates, and lobbies for progressive policy ideas and initiatives in local, university, state, and national government. Members write for our campus policy journals, complete advocacy and education projects in the local community, host research discussions with professors, write policy and political blogs, and organize campus political debates and policy seminars.

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Letter from the Director

Dear Readers,

We are proud to present to you the fifth installment of *Looking Ahead: The Cornell Roosevelt Policy Journal* from the Center for Healthcare Policy. I have the unique pleasure of presenting policy proposals from an array of different policy genres.

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 the effects of e-cigarettes, to the benefits of the HPV vaccine for men and women. We look forward to sharing our work, please enjoy!

Sincerely,

Noah Rubin
Policy Analysis and Management '16 (HumEc)
Director, Center for Healthcare Policy

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Tobacco Regulation: The Effects of E-Cigarettes

John Lemp, Major: Industrial and Labor Relations (ILR), 2015, Email: jrl264@cornell.edu

The federal government should regulate electronic cigarettes like other tobacco products, in order to ensure the safety of e-cigarette users. Further, there should be regulations regarding the selling and advertising of e-cigarettes.

History:

An alternative to tobacco products, namely traditional cigarettes, that has become increasingly popular since its U.S. introduction in 2007 is the electronic cigarette, commonly referred to as the e-cigarette. The rise in the usage of e-cigarettes can be attributed to several factors including the belief that e-cigarettes aid regular smokers in the smoking cessation process, are healthier to smoke, and are generally viewed as easier to use. E-cigarettes are battery-powered devices that are equipped with a heating element, which in turn vaporizes a solution. In many instances, the solution present in e-cigarettes contains nicotine, the addictive component of tobacco. Therefore, although many perceive inhaling the vapor of e-cigarettes as healthier than traditional tobacco smoke, it nonetheless has an addictive element.

Key Facts:

- 14% of American high school students smoked in 2012. This number is down from 15.8% in 2011 and 28% in 2000.
- Nearly 90% of U.S. smokers began smoking by the age of 18. Smoking remains the leading cause of preventable disease and death in the United States.
- There are more than 250 brands of e-cigarettes available to consumers. An estimated 4 million Americans use e-cigarettes.

The use of electronic cigarettes is becoming increasingly ubiquitous, not just in the United States, but around the world. E-cigarette manufacturers advertise and sell their products over the Internet, which leads to a substantially larger target market of potential users in the United States. These manufacturers sell the actual e-cigarettes online and all relevant accessories, such as spare cartridges and batteries. E-cigarettes also do not emit second hand smoke, since the user is inhaling vapor, and the manufacturers of these products sell this as a plus when advertising e-cigarettes. However, a factor limiting the use of electronic cigarettes is their price -- e-cigarettes are relatively expensive. A typical starter kit, which contains the e-cigarette device, a battery and several cartridges, can cost anywhere from $60 to $150. A pack of five cartridges (each cartridge is equal to about a pack of cigarettes, depending on how much a person smokes) goes for about $10.

E-cigarette companies claim that their products are entirely distinct from traditional tobacco cigarettes and thus do not want e-cigarettes to be regulated in the same manner. However, a number of states have begun to treat e-cigarettes just like any other tobacco product, and have begun regulation and taxation efforts. Several states that took up e-cigarette legislation have already moved to tax them in specific ways. Minnesota, which defines e-cigarettes as another tobacco product, requires them to be subject to a tax equal to 95 percent of their wholesale price, making the taxes paid on an e-cigarette in Minnesota greater than the taxes on a pack of regular cigarettes. Only time will tell how effective these taxation efforts are, but if effective, these state-based systems of regulation have the potential to serve as a great model for e-cigarette legislation at the federal level.

The debate over the safety of e-cigarettes and whether or not the Food and Drug Administration (FDA) should regulate them has intensified in recent months. Additionally, more research findings are coming to light regarding e-cigarette usage. The Center for Disease Control and Prevention released research findings on November 14, 2013 of the 2012 National Youth Tobacco Survey. According to the survey, there has been a decline in the use of traditional cigarettes by middle and high school students. Yet the study, which surveyed 6th through 12th-graders, found a notable increase in those who have used hookahs, also known as waterpipes, and e-cigarettes -- both of which are not federally regulated and taxed as are cigarettes. Last year, about 5.4% of high school students said they used hookahs at least once a month, up from 4.1% in 2011, and 2.8% tried e-cigarettes, up from 1.5%. These survey results clearly demonstrate an increasing trend in the use of e-cigarettes. But the lack of federal regulations and FDA oversight of e-cigarette manufacturers is certainly a cause for concern.

Analysis:

While effective legislation passed by the U.S. Congress and enforced by the FDA should increase the oversight of the electronic cigarette industry, e-cigarette users need to be aware of the health dangers of using nicotine products. Although a number of scientific studies have been published revealing that e-cigarette use is safer than traditional tobacco smoking, there are still dangers to using this type of product. Another major concern that needs to be addressed is the advertising and marketing of e-cigarettes to the nation's youth. With new legislation to regulate e-cigarette advertising, there would be a level of uniformity among tobacco product regulations. Further, the imposition of effective e-cigarette regulation would address the concerns of various stakeholders, including law enforcement officials, public health officials, educators, and our nation's parents.

Talking Points:

- As e-cigarette usage increases, the time is now for effective federal legislation regulating the production, sale, and advertising of electronic cigarettes.
- Public health officials, researchers and professors, and FDA officials support the regulation of e-cigarettes to protect the health of consumers who use e-cigarettes.
- Regulation is especially needed regarding the advertising of electronic cigarettes, as e-cigarette manufacturers include teenagers in their target market of consumers. This is problematic because studies show that e-cigarette use often leads to traditional tobacco smoking among American teenagers.

Right now, the usage of e-cigarettes is in jeopardy, as the FDA has threatened to ban them from entering the United States if there are no regulations in place in the very near future. This solution, however, would display significant backlash and infringe upon the civil liberties of e-cigarette users and manufacturers, who have been legally using and selling these products in the United States since 2007. The wiser, more practical solution would be for the U.S. Congress to enact e-cigarette regulation legislation as soon as possible, in order to advance consumer protection and prevent American children from being exposed to tobacco product advertising.

Next Steps:

With legislative gridlock having become the norm on Capitol Hill, it is unlikely that effective, efficient e-cigarette regulation legislation will be passed by the end of 2013. However, the Food and Drug Administration, law enforcement officials, and public health officials are pressuring Congress to begin discussing this important issue. The time is now for a means of regulating both the production and advertising of electronic cigarettes. Perhaps, legislation at the state level will serve as a way of increasing the visibility of this issue at the federal level. The regulation of e-cigarettes at the national level will create a sense of uniformity regarding tobacco production and advertising standards.

Other than effective federal legislation regulating e-cigarettes, there needs to be better advocacy and education programs about tobacco use in our nation's schools. Many are unaware that e-cigarettes, widely viewed as a substitute for traditional cigarettes, often serve as teenagers' first experiences with smoking in the present-day. In many instances, teenagers start smoking traditional cigarettes, understood and accepted to be "the real thing", after using e-cigarettes. The dangers of smoking tobacco are well known and discussed in our nation's schools, but students need to be informed that e-cigarettes, though safer to use, can lead to more dangerous and destructive smoking behavior in the future.

Endnotes:

[1] "10 Facts about E-Cigarettes." Last modified on 12 November 2013. http://health.howstuffworks.com/wellness/smoking-cessation/10-facts-about-e-cigarettes16.htm

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Reducing Gender Gap in Military: Allowing Therapeutic Abortions

Elaine Jaworski, Major: Policy Analysis & Management, 2014, Email: emj43@cornell.edu

Pass legislation allowing military women to receive the same abortion care as those living in the United States in order to reduce unwanted pregnancies and provide rights for our military women.

History:

Currently military women and military dependents are restricted from basic abortion options because of the TRICARE health insurance. Military women are only allowed access to an abortion in a military hospital if the abortion is a result of incest, rape, or her life is endangered. In March of 2013 the Military Access to Reproductive Care and Health (MARCH) Act was introduced, sponsored by Louise Slaughter, with 64 cosponsors, which would allow military women to use personal funds to obtain a therapeutic or elective abortion in military facilities.[7] This act was referred to a committee on March 21, 2013 and no movement has been made since. Women in the U.S. military have an unintended pregnancy rate 50% higher than that of the general U.S. population; with 11% of active-duty military women having an unintended pregnancy in 2012.[6] These high rates of unintended pregnancies are a result of military culture. Military women are raped at much higher rates than the U.S. population, with very few being reported. It is estimated that 26,000 service members were sexually harassed in 2012 with under 3,000 reported.[2] Also military women have a lower level of contraceptive use than the average female women in the U.S. with health insurance. This is caused by two reasons; first many women do not anticipate having sex while on active-duty and so do not seek contraceptives. Second, because sex is prohibited in many instances while in active duty, very few women are consulted on contraceptives before deployment by their physician.[6] The Good Neighbor Policy is one reason why many object to allowing abortions in the military. The Good Neighbor Policy, initiated by Nixon, is part of the military's philosophy to follow the laws of the land in which the military operates. This often means a stricter regulation on abortions.[11]

Key Facts:

- Over half of our women deployed are in countries where elective abortions are banned.5
- 28% of women experience rape in the military.10
- 4% of unintended pregnancies are reported as the result of rape in the military.4

Analysis:

Women in the U.S. military are guaranteed health care, yet they have higher rates of unintended pregnancies than the U.S. population. Currently their health care is restraining them from treatment while on active duty that they would otherwise have in the United States. Reproductive rights in the military can no longer be ignored as the number of women enlisted continues to rise. In 2010 there were 213,000 women in active duty.[9] Sixty-five percent of military pregnancies are estimated to be unintended while the U.S. population's estimate sits at 43%.[3] These high levels of pregnancies put women at risk for dangerous activity while in active duty. Although estimates are not clear, anecdotal evidence suggests that many women try to rid themselves of pregnancies in unsafe manners, in order to avoid criticism and potential repercussions. This could involve self-abortion or seeking medical care outside of the U.S. base in countries like Afghanistan and Iran, where treatment is unsafe.8 In cases where the woman reports her pregnancy, she will have to take an immediate leave, leading to excess costs on the military and lost work for the female, even in cases where she would prefer to abort the fetus. In this past year, 900 women took a leave for this reason. While 40% of unintended pregnancies end in abortion for U.S. women, military women on active duty are not given access to this same treatment.5 Once home, these women can decide to have an abortion, however, the risk of complications due to an abortion increase with time and thus this ban is adding to the risk for these women.[4]

The Good Neighbor Policy is reasonable to follow in terms of drinking age and less drastic measures to respect the communities the military is operating in, however it is not appropriate when considering a woman's access to reproductive care. The expense of an unintended pregnancy does not only take it's toll on the female but also on troop readiness. Women in the U.S. that become pregnant cannot be deployed and women that become pregnant overseas must be evacuated immediately. This adds large expenses to the military, as women become less reliable during active duty.[6]

Next Steps:

Abortion is the last resort for unintended pregnancies. However, until contraceptive use increases in the military and rape decreases, abortion is an absolutely necessary treatment for women in active duty. These women should not be forced to lose basic reproductive rights, otherwise available to them as U.S. citizens, while on active-duty for the U.S. military. This is an injustice to our service women and must be changed. Congress should immediately act on the MARCH Act and vote to allow abortions on U.S. military bases for women who pay for their elective abortions. Alongside this bill the military should take active steps to increase contraceptive education and use among military women in order to reduce the need for abortions in the future.

Talking Points:

- Women in active duty deserve to have the same medical rights as women at home in the United States.
- Women in the military experience higher rates of rape and lower rates of contraceptive use due to military culture. [6]
- Women in the military experience unintended pregnancies at rates 50% higher than the U.S. general population.6

Endnotes:

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[3] "Ending the Rape, Sexual Assault, and Sexual Harassment Crisis," Service Women's Action Network, accessed November 10, 2013, http://servicewomen.org/our-work/policy/.

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[5] "Facts on Induced Abortion in the United States," Guttmacher Institute, October 2013, http://www.guttmacher.org/pubs/fb_induced_abortion.html.

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[8] "With the Majority of Military Pregnancies Unintended, Abortion Issue Raised Again in Congress Cont.," U.S. Medicine, the Voice of Federal Medicine, July 2011, http://www.usmedicine.com/womenshealth/with-the-majority-of-military-pregnancies-unintended-abortion-issue-raised-again-in-congress.html?page=2#.UoEN8ZTwJO-.

[9] Anne Sadler, Brenda Booth, Brian Cook, " Factors Associated with Women's Risk of Rape in the Military Environment," American Journal of Industrial Medicine, 43 (2003): 262-273 accessed November 18, 2013.

[10] Jamie Wilson, "Congress Moves to Require Military Hospitals to Provide Abortion Services," The Brenner Brief, April 28, 2013, http://www.thebrennerbrief.com/2013/04/28/congress-moves-to-require-military-hospitals-to-provide-abortion-services/.

Promoting Effective Coordination of Care: Accountable Care Organizations

Phil Susser, Major: Policy Analysis and Management, 2016, Email: pss226@cornell.edu

Programs that provide incentives for providers to invest in Health Information Technology could promote greater development of Accountable Care Organizations.

History:

Accountable Care Organizations (ACO) are groups of health providers that voluntarily join forces in assuming responsibility for the health outcomes of their patients in order to collectively reap financial rewards for increased efficiency. They are meant to increase the coordination of care amongst providers and avoid unnecessary and frivolous duplication of services. In a recent Congressional Budget Office (CBO) report, programs with more direct physician communication with care managers, a core feature of ACOs, resulted in a 7% decline in hospital readmissions and a 6% decline in overall costs for Medicare beneficiaries, coming out to a savings of $500 per beneficiary. While some may feel that ACOs may destroy competition in healthcare markets – by eliminating private practices through the consolidation of care - and raise costs through the formation of monopolies, many professionals have cited that these programs significantly reduce health care spending. This reduction comes through elimination of unnecessary emergency room visits by providing better follow up care for patients. The formation of ACOs was made more attractive for providers under the Affordable Care Act (ACA), with the implementation of both the Shared Savings Program (SSP) and the Pioneer Program. These two programs reward ACOs serving Medicare fee-for-service beneficiaries for providing care at a level of efficiency above a benchmark set through per capita expenditures over the past three years. Through the SSP, providers can choose two different methods of payment from Medicare: the first method only rewards the ACO for shared savings. The second shares both savings and losses with Medicare, with the upside of a higher rate of return on savings - clearly the riskier alternative. The proclivity of hospitals and health care providers toward forming ACOs will affect future savings for Medicare – an important goal with the baby boomer generation entering Medicare eligibility age – as well as the coordination of care and overall health of the population. Upon its inception on January 1 2011, 250 ACOs have formed, the majority of which (223) coming from the SSP, since there are fewer eligibility requirements for this program. Identifying what is holding providers back from forming ACOs and providing incentives for their formation will be important policy endeavors.

Key Facts:

- Programs with more direct physician communication with care managers can result in $500 savings per Medicare beneficiary annually.
- Upon its inception on January 1 2011, 250 Accountable Care Organizations (ACO) have formed.
- Health Information Technology (HIT) has the potential to save the US $78 billion annually.
- In 2010, 17% of doctors and 8-10% of hospitals used electronic health care records.

Analysis:

There is currently no relationship between a US region's rate of Medicare spending and their likelihood of forming an ACO. However, in areas with greater integration of providers, there was a greater likelihood of ACO formation. Thus, a key barrier influencing the formation of ACOs is the prevalence of small, independent health care providers. Fewer than 15% of US physicians are a part of integrated health care systems. A series of incentives, meant to promote the integration of providers can be an affective tool to indirectly encourage the formation of ACOs. Providing greater incentive for doctors, especially those in private practice, to invest in health information technology (HIT) systems is a policy that could promote greater integration of hospital groups, leading to greater ACO formation. In 2010, 17% of doctors and 8-10% of hospitals used electronic health care records. The CBO estimated that HIT has the potential to save the US $78 billion annually. Government subsidies for small, independent providers for an electronic records system could therefore be effective in both improving efficiency and promoting integration of provider networks.

Next Steps:

Investing in HIT can be a helpful way to both improve health care infrastructure and motivate providers to integrate and form ACOs. Currently, there are Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs in place, which provide incentive payments to providers that demonstrate meaningful use of EHR technology. Increasing the transparency of these programs to hospitals and particularly providers as well as reducing the stigma that many providers have – many feel that it will disrupt normal business practices - with this technology are important. Since hospitals are more likely to implement EHR than individual providers, creating a separate program that targets and provides greater incentives for providers could be an effective approach. Additionally, a program that identified and targeted areas with low ACO implementation and provided information to these areas about the potential shared savings they could achieve with Medicare for improved efficiency, as well as the existing EHR incentive programs could go a long way in increasing ACO adaptation.

Talking Points:

- ACO formation is linked to an areas prevalence of integrated health care systems.
- Health information technology (HIT) can increase the integration of providers and improve efficiency and communication in the provision of care.
- Especially in areas unlikely to form ACOs - with small providers - increasing the transparency of current government programs, as well as increasing the incentive to use HIT can promote ACO implementation.

Endnotes:

[1] http://www.ncpa.org/pdfs/st327.pdf
[2] http://online.wsj.com/news/articles/SB10001424127887323884304578326424211839236
[3] http://healthcare-exchange.com/2012/10/23/looking-for-proof-that-acos-will-work-it-already-exists/
[4] http://content.healthaffairs.org/content/30/1/161.full?sid=bf705846-2800-4b76-81ce-4c06f65e67ad
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[10] http://www.rwjf.org/content/dam/farm/reports/reports/2013/rwjf406758

Enforcing Quieter Hospital Standards to Promote Better Healing

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Current elevated noise levels in hospital environments are not conducive to optimizing the patient and provider healthcare experience. Enforcing reduced noise levels in hospitals is a cost-effective way to foster better healing and recovery.

History:

The World Health Organization recommends noise levels in hospitals to be 30 decibels or less, however a study analyzing noise changes in an urban-level emergency department in the US found that sound peaked to a range between 94-117 decibels.1 Patients rated the primary cause of unnecessary noise as coming from staff conversations in hallways, followed by noises caused by alarms and machines. Louder hospitals resulted in increased patient stress levels even when they were asleep, longer recovery periods and worse patient outcomes.4 Patients also viewed their healthcare experiences more positively when in a quiet hospital environment and experienced shorter hospital stays.6 The impact of noise also prevents nurses and doctors from fulfilling their duties as healthcare providers and leads to difficulties in concentrating, reducing stress, and communicating with colleagues and/or patients.3,5 While noise resulting from daily hospital operations may be unavoidable, several products and practices exist to help minimize the amount of noise output.2

Key Facts:

- The WHO recommends 30 decibel noise limit in hospitals; surveys have shown that these levels are more than twice that
- Doctors and patients are better able to work and communicate in quieter environments
- Noise causes stress; patients have shorter recovery times and better health outcomes when in quieter hospitals

Analysis:

Peace and quiet has long been understood as crucial to the healing process. It is clear that a quieter healthcare environment would be conducive to a better workplace for healthcare providers to practice and communicate in, and foster better health outcomes and faster recovery times for patients.4 Faster recovery times would allow hospitals to reduce operating costs, take on more patients and therefore experience a boost in revenue—any costs incurred by maintaining a quiet environment would be offset by this increased revenue.4 Establishing a quieter environment in hospitals would require simple behavioral changes, possible implementation of noise-reducing products and practices, and enforcement of recommended noise levels.

Next Steps:

As indicated by one study, a primary cause of unnecessary noise results from conversations between nurses and doctors in hallways. By holding conversations in decentralized areas that are more separated from patient rooms, lowering voices, and communicating via email whenever possible, healthcare providers can streamline communications without disturbing resting patients. Noise-re
ducing practices would be helpful in implementing—for example, some healthcare technology devices are being developed with the intention of cutting down on unnecessary machine beeping and alarms, and situating louder patients farther away from other patients. When building new hospitals, it would also be beneficial to incorporate materials and designs that dampen and separate noise as early in the planning stages as possible. A key component of ensuring that hospital noise levels are maintained at the appropriate 30 decibel level as recommended by the WHO would be to assign a task force to specifically evaluate these noise levels and to award compliant hospitals with a higher overall rating and an additional financial incentive.

Talking Points:

- A solution must incorporate behavioral, enforcement and possibly quiet implementation components
- While hospitals have autonomy to decide how to best change behavior and practices, a task force should be developed to assess noise levels in hospitals and enforce WHO recommended noise levels
- Compliant hospitals will be awarded with a cash incentive in addition to the financial benefits of higher inpatient flow due to faster patient recovery

Endnotes:

[1] Tijunelis, MA, E Fitzsullivan, and SO Henderson. "Noise in the ED." American Journal of Emergency Medicine. No. 3 (2005): 332-5. Richardson et al. "Development and implementation of a noise reduction intervention programme: a pre and post audit of three hospital wards." Journal of Clinical Nursing. No. 18 (2009): 3316-24.

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Patient Navigators: Enhancing the Patient Experience

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In order to provide patients with the appropriate knowledge and tools to successfully navigate the medical process, patient navigator programs should become more commonplace in medical institutions.

History:

Although medical treatment has improved tremendously in the last century, disparities in health outcomes are still prevalent. Racial and ethnic minorities, as well as low income patients suffer less favorable health outcomes than other patients1. Major causes of these disparities are economic, cultural, behavioral, and systematic barriers that cause these patients to receive adequate medical treatment. Patients who experience greater health disparities are often likely to receive not only lower quality health care, but they are also more likely to receive health care less frequently2. This is because these patients are much less likely to have insurance coverage, deterring them from seeking out necessary medical treatment. Additionally, racial and low-income patients are less likely to be aware of available services. They often feel uncomfortable with their providers, receive discrimination, and/or language translators are not available. Furthermore, these populations often cannot afford the long waiting times and their health care providers do not have offices in convenient locations. As a result of these complications, racial minorities and low income patients are much less likely to receive the health care they need. In order to address these health disparities, medical providers should have patient navigator programs to help patients receive adequate care.

Key Facts:

- Racial and ethnic minorities, as well as, patients from low socio-economic backgrounds have poorer outcomes than other populations1
- Patient Navigator Programs have been linked to improved health outcomes in disadvantaged populations5
- Each patient navigator adds, on average, an additional $150,000 in revenue6

Analysis:

A patient navigator is a person who provides support and guidance, both logistically and emotionally, to patients from disadvantaged populations4. A patient navigator can help to explain complex diagnoses, help to overcome barriers, and help to coordinate health care visits. More specific functions include arranging for transportation to appointments, arranging childcare during appointments, identifying culturally sensitive health care providers, helping to arrange for an interpreter, and helping to coordinate medical care among multiple health care facilities, among other functions. The services patient navigators are able to provide racial minorities and low income patients aids in the mitigation of delays in care and increases transparency during the treatment process.

Researchers have found the availability of a patient navigator has been associated with an increase the number of racial and economic minorities using health care services5. One study found that the use of patient navigation was correlated with a 31% increase in breast cancer survival rates6. It was also found that patient navigation reduces the number of no-show and cancellation rates, which saves money in cancellation fees. Not only did the revenue generated by a patient navigator program pay for itself in less than a year, but each full-time patient navigator increased hospital revenue by $150,000. Therefore, patient navigator programs are both effective at improving health status of disadvantaged populations and economically beneficial to medical providers. It would be advantageous to make these programs available in all medical institutions, especially in health care facilities that serve high populations of racial minorities and low-income families.

Next Steps:

In order to improve health disparities among racial minorities and those from low-income backgrounds, it is necessary to make patient navigator programs essential functions in all medical facilities. To achieve this, all health care providers who accept Medicare and Medicaid should be required to incorporate patient navigator programs into their business model. Existing patient navigator programs should be profiled and shared with

health care providers who do not currently have them. The size of the patient navigator program should be proportionate to the number of hospital users who use these government programs, as these patients belong to the target population of lowest health outcomes. Making patient navigator programs a component of the health care experience will have an enormous positive impact on health disparities among racial minorities and low income patients.

Talking Points:

- Patient navigator programs have been shown to improve the medical care of many users in a short time frame
- Patient navigators decrease fees associated with cancellations and no shows that are common among disadvantaged population. They also increase hospital revenue, making them self-sustaining programs
- Improving the health of these patients will allow them to be more productive members of society

Endnotes:

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Reframing the HPV Vaccine: Not Just a "Cervical Cancer Shot"

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The HPV vaccine, though recommended to both females and males in the US, is currently advertised by the CDC as a "cervical cancer vaccine." This language obscures the benefits males receive from HPV vaccination and frames the vaccine as a female-only shot. The CDC should move beyond this image of the HPV vaccine by including male cancers and genital warts in their advertising campaigns. Not only will this protect males from genital warts and HPV-associated cancers, but, due to herd immunity, it will further decrease these diseases among females as well.

History:

Human papillomavirus (HPV) is the most common sexually transmitted disease in the United States, contributing to more than 6 million new infections annually. It is estimated that 50% of sexually active men and women will get HPV at some point in their lives. Though cervical cancer is the disease most commonly associated with HPV, the virus can also cause oral, anal, vulvar, vaginal and penile cancers, as well as genital warts. Though men are at lower risk than women for developing an HPV-related cancer, they represent nearly 25% of cancer cases associated with HPV. The four most common strains of HPV are strains 6, 11, 16, and 18. HPV strains 6 and 11 account for over 90% of genital warts cases, whereas strains 6 and 11 are related to 70% of cervical cancer cases.

Key Facts:

- Human papillomavirus (HPV) is the most common sexually transmitted disease in the US and is a principal cause of cervical cancer.
- Though the CDC's Advisory Committee on Immunization Practices (ACIP) has recommended the vaccine to female adolescents since 2006, only 34.8% of females received the full three-dose course in 2011. ACIP issued a recommendation for males to receive the vaccine in 2011.
- In countries where the HPV vaccine is advertised to both males and females, rates of genital warts and HPV-associated cancers have fallen rapidly.

Currently, there are two HPV vaccinations available in the US: Gardasil and Cervarix. Gardasil was the first to be approved for females by the FDA in 2006 and was later approved for use in males in 2009. Gardasil protects against HPV strains 6, 11, 16, and 18, and therefore protects against both genital warts and HPV-associated cancers. Cervarix, on the other hand, protects only against HPV strains 16 and 18, and thus can only be administered to females and does not protect against genital warts.

The federal Advisory Committee on Immunization Practices (ACIP) recommended the use of the HPV vaccine for females aged 11-12 in 2006, and that girls and women aged 13-26 receive "catch-up" vaccinations. In 2009, ACIP extended their recommendation to include boys age 11-12, with "catch-up" vaccinations for boys and men age 13-21. The vaccine is recommended for "permissive use" for men age 22-26.

Analysis:

Though the vaccine is now recommended for both males and females, HPV vaccination advertising and outreach in the US continues to focus on cervical cancer. Indeed, the Center for Disease Control (CDC) has developed advertising campaigns promoting HPV as the "cervical cancer shot." In part, this campaign has emphasized cervical cancer prevention over protection versus genital warts due to the polemics of HPV as a sexually transmitted disease. As long as the HPV vaccine was associated with sexual activity, public health officials feared, conservative parents would decline vaccinating their daughters, putting them at future risk for cervical cancer. Their fears proved to be well warranted. Indeed, one study found that among parents who decided not to vaccinate their daughters, over 30% claimed this was because the vaccine was not needed or because their daughters were not sexually active.

However, while emphasizing the HPV vaccine as a "cervical cancer shot" may help overcome public resistance to vaccinating young girls, this strategy has proved to be a disservice to US males. Indeed, though the FDA finally approved the Gardasil for use in boys in 2011, a full five years after it was approved for use in girls, male vaccination rates remain woefully low. In 2011, only 8.3% of adolescent males had received one dose of the HPV vaccine, compared to 53% of females. Even worse, only 1.3% had received the full three-dose course, compared

to 34.8% of females. As a result, males in the US remain at risk for contracting HPV-related genital warts and cancers.

Countries that have directed HPV vaccine advertising towards both males and females have seen dramatic falls in the rates of all HPV-associated cancers and cases of genital warts. Australia, for example, was the first to implement a nation-wide school HPV vaccination program. The program offers the vaccine to both male and female school children for free, and is advertised through a series of school posters, comic books, videos, and pamphlets. In one study documenting the five-year period following the program implementation, cases of genital warts decreased by 92.6% for females under the age of 21 and by 81.8% in males under the age of 21. The authors concluded that in addition to protecting men against genital warts, inclusion of males in the vaccination program also helped decrease genital warts among females due to herd immunity, the indirect protection that unvaccinated people enjoy as a result of reduced exposure to infection.

Talking Points:

- Gardasil, the first vaccine against HPV, was introduced in the US in 2006. Since its introduction, HPV infection among female adolescents has decreased by 53%.
- Since 2010, increases in HPV vaccination rates among US females have stagnated. HPV vaccination rates among males remain below 10%.
- Under the Affordable Care Act, vaccines are considered a preventative service and therefore their coverage is mandated in all insurance plans without co-pay.

Next Steps:

The CDC should rework its HPV vaccine communications campaign to include genital warts and male-associated HPV cancers. Not only will this increase awareness of how males can benefit from the HPV vaccine, but it will also help further drive down female rates of HPV infection through the protections of herd immunity. Such actions would represent important steps towards eliminating HPV-associated cancers and genital warts in the US.

End Notes:

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Meet the Healthcare Policy Center

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John Lemp is a junior majoring in Industrial and La bor Relations and minoring in Business, Economics, and English. John would like to work in consulting or finance upon graduation, but his ultimate goal is to start a non-profit organization or become actively involved in politics. His primary policy interests include health care and entitlement reform, financial institutions, and international relations.

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Noah Rubin is a sophomore majoring in Policy Analysis and Management, with possible minors in Computer Science and Mathematics. When Noah is not editing blog posts or policy proposals for the Roosevelt Institute, he enjoys dabbling in computer programming, playing basketball, and hanging with his fraternity brothers in Delta Chi. He hopes to make great strides in the neuroscience of decision-making as an undergrad, and to one day work to bridge the gap that he sees between neuroscience and policy.

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