EXPOSURE TO TRAUMA

PATIENT REVIEWS of health care providers

Americans living PAYCHECK TO PAYCHECK

A CHAMPION for children, and practitioners
Russia’s Hostile Measures in Europe
Researchers assess the range and limits of Russian tools of influence, European countries’ abilities to resist or respond, and, ultimately, these states’ vulnerabilities to hostile measures.
MORE AT www.rand.org/t/RR1793

A Crisis of Unintended Consequences
The pain medicine OxyContin was reformulated in 2010 to make it more difficult to crush or dissolve. But this had unintended consequences, including a rise in hepatitis C infections as drug abusers switched from taking OxyContin to injecting heroin.
MORE AT www.rand.org/b190220

Accountability in Cyberspace
Several recent cyber incidents with geopolitical implications have received high-profile press coverage. Identifying the responsible parties behind malicious cyber incidents is a necessary prerequisite for holding these actors accountable, but there are many challenges that accompany cyber attribution.
MORE AT www.rand.org/v190114

Consolidation of Political Power in China Under Xi Jinping
In February 2019, senior international defense research analyst Timothy R. Heath testified before the U.S.–China Economic and Security Review Commission on how the concentration of political power in China affects Chinese military and domestic security forces.
MORE AT www.rand.org/t/CT503

Four Problems on the Korean Peninsula
This toolkit provides visualizations illuminating four Korea-related problems: North Korea’s nuclear arsenal, North Korean artillery systems, evacuating South Korean population centers, and securing North Korean nuclear weapons and facilities.
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RAND WINS GRANT TO
Improve Landslide Warning

The National Science Foundation awarded RAND a $2.1 million grant to develop and demonstrate a novel approach to landslide warnings in Sitka, Alaska, where three people died in a 2015 slide.

Researchers are using new, inexpensive sensors to monitor slope conditions around the coastal town of 9,000 residents. They also have enlisted the help of local “citizen scientists” to collect field data with an innovative app-based system.

A central question the team is trying to answer with the community is how to most effectively communicate risk without overburdening residents with false alarms. The project will help communities around the world better anticipate and prepare for landslides, which are difficult to predict because they are infrequent and depend on specific soil, rain, and wind conditions.

The RAND-led team includes the Sitka Sound Science Center, the University of Southern California, the University of Oregon, and the Sitka Tribe of Alaska. It is being led by Ryan Andrew Brown, codirector of the Center for Qualitative and Mixed Methods at RAND, and Robert Lempert, director of the Frederick S. Pardee Center for Longer Range Global Policy and the Future Human Condition.

Lempert and other RAND researchers made earlier trips to Sitka under a yearlong planning grant from the National Science Foundation’s “Smart and Connected” communities program. They held public discussions with the Sitka community about how to communicate often-imperfect landslide risk information.

Now that funding for the full project has been approved, the researchers will undertake three to four years of collaborative work in Sitka with geoscientists, computer scientists, engineers, and education experts to improve the safety of people living with landslide risks.
RAND has been selected to help oversee a philanthropic fund that will support high-quality research on issues related to gun violence.

The National Collaborative on Gun Violence Research is a creation of Houston-based Arnold Ventures, which has pledged $20 million to the effort and will seek an additional $30 million from other philanthropic groups.

“Over the next five years, the collaborative will fund projects on a range of topics concerning gun policy and gun violence reduction,” said Andrew Morral, the collaborative’s director. “These projects will be selected to provide information needed by policymakers to create fair and effective strategies for reducing gun violence.”

“Understandably, gun violence is a deeply emotional issue. But arguing about the proper response will not solve the problem. Our goal is to provide objective information to guide a rational, fact-based response to a national crisis,” said Laura Arnold, cochair of Arnold Ventures. “We need data, not politics or emotion, to drive our decisions.”

The National Collaborative on Gun Violence Research will oversee the selection of research topics and dissemination of key research findings to a wide variety of audiences.

RAND was chosen to help administer the National Collaborative on Gun Violence Research based on RAND’s deep technical knowledge of gun policy science and its ongoing Gun Policy in America initiative, a philanthropically funded RAND Venture designed to establish a shared set of facts on gun policy that will improve public discussions and support the development of fair and effective policies.

The center is designed to be a national resource, fostering innovative and high-quality research in opioid policy science.

The opioid crisis is a dynamic public health threat. Opioid use disorders affect an estimated nine out of every 1,000 Americans. The estimated economic burden of opioid abuse and overdose is staggering—nearly $500 billion annually, more than the government spends on health care for the poor each year. Successfully combating the crisis demands collaborative efforts to address the challenges to our public health, health care, public safety, law enforcement, and criminal justice systems.

The National Institute on Drug Abuse funded the RAND Opioid Policy Tools and Information Center to develop reliable data, rigorous methods, and policy tools to inform evidence-based opioid policy. The center will assess the opioid crisis as it continues to evolve, describe the policies being implemented to address it, identify the impact of alternative strategies taken by the state and federal government, and suggest policy approaches that have yet to be tried together as comprehensive strategies for improving public health and public safety.

The center is designed to be a national resource, fostering innovative and high-quality research in opioid policy science, and developing and disseminating methods, tools, and information to the research community, policymakers, and other stakeholders.

In addition to this new government-funded center, a new philanthropically funded RAND Venture called Stemming the Tide of the Opioid Crisis was launched in 2018. This venture will be the first to rigorously model the comprehensive opioid ecosystem and to delineate for decisionmakers how decisions and outcomes in one sphere reverberate across so many others.
Heroin and other opioids kill tens of thousands of Americans every year, a death toll approaching that of AIDS at its peak. It’s time to consider unconventional ideas to address the epidemic, researchers argued in a series of reports—including studying prescription heroin.

Their research found strong clinical evidence from Canada and Europe that “heroin-assisted treatment” can stabilize people’s lives and help them reduce their use of illicit and impure street drugs. It’s typically used only for people who have been using heroin for years and have previously tried other treatments for opioid use disorder.

It usually involves giving patients injectable, pharmaceutical-grade heroin under medical supervision in a clinic. Evidence from randomized control trials indicates that it can help longtime users who have not been able to stop with methadone or other front-line treatments. There is also some evidence that heroin-assisted treatment may be more effective than oral methadone in reducing criminal activity and illicit use of benzodiazepines, and improving the physical and mental health of users.

Increasing access to medications like methadone and buprenorphine must remain a priority in treatment for opioid use disorder. But given the severity of the opioid crisis and evidence from other countries, the researchers concluded that the U.S. should conduct a clinical trial of heroin-assisted treatment. Information from the trial would help determine whether the approach should be expanded.

It’s not a silver bullet, and it won’t solve the opioid crisis. But it might provide another option to help those for whom other treatments have not worked. “The horrific death toll wrought by opioids should drive true innovation,” the researchers wrote, “not just extension of best practice.”

MORE AT
www.rand.org/t/RR2693

This project was launched by RAND Ventures, a program for investing in important but underfunded policy issues that is made possible by unrestricted gifts from philanthropic supporters.
Alternative Health Care Payment Models

New ways of paying for doctor visits and other health services could lower costs while improving patient outcomes. But a recent study found those alternative payment models can be confusing and paperwork intensive, detracting from the business of keeping people well.

Medicaid and private insurers have experimented with a growing number of new payment models in recent years. Some offer bonuses for good performance. Others provide lump-sum payments to treat a patient for a given time period or procedure, rather than individual payments for every appointment and service.

Researchers partnered with the American Medical Association to interview dozens of practice leaders and front-line physicians. They found that the new payment models have generated an increasing volume of “nonclinical activity”—in other words, paperwork. The new models are often complicated, demand more data, and can be subject to errors, they found.

Physicians overwhelmingly supported new payment models that incentivized improvements in patient care. They were disengaged and skeptical when the new models seemed to have no impact on patient care—even when they stood to receive financial bonuses from them.

What is needed is a more stable and predictable pathway for health care providers to introduce new methods of payment, the researchers wrote. Those methods also need to be simpler, and to keep the focus on patient care. One way to encourage that: Involve the physicians themselves in designing new payment models.
Dionne Barnes-Proby works to improve the lives and well-being of young people in need. She’s a social policy researcher at RAND whose recent studies have examined juvenile justice, the foster care system, and workforce development programs for people with criminal records. She recently managed a national evaluation of programs for children and women exposed to violence.
**Q** You started your career as a social worker and foster care case manager. What drew you to those fields?

**A** My passion, really, is to help adolescents and young adults. It really developed when I was in high school. I was raised by an amazing single mom who had to work multiple jobs, in a community where there was limited access to social capital. I was part of an integration program, so I was bused about an hour and a half to school. There were few of us minorities at the school, and I felt like we were not really supported. They didn’t talk to us about postsecondary education; we weren’t told about taking the SATs. I remember being told by a counselor that I shouldn’t even apply to colleges because I likely wouldn’t get in.

That developed a passion in me for helping to prevent young people from having to go through that experience. Helping them to navigate these various systems—education, housing, employment—with which they would need to engage to ultimately be successful and overcome the challenges that folks like myself and my peers had to struggle with.

**What brought you over to research?**

I wanted to effect change on a broader scale. I wanted to be a practitioner at the table of policymakers, bringing the voice of the clients and the practitioners to the conversation, so that policies would reflect an understanding of the needs of the populations they’re intended to improve. The practitioners are the ones who are responsible for implementing those policies, so I really wanted to make sure that their voices and their concerns were taken into consideration.

**Was there any experience that convinced you of the need for that?**

I just remember feeling like, ‘Who wrote these policies?’ … this overwhelming sense of frustration with policy after policy, where you just become this cog in the wheel of doing what you’re told, even though you don’t think it will result in the best outcomes. My sense was that policymakers did not always know what we have to deal with on the ground.

I characterized myself at the time, and kind of still do, as an infiltrator. I wanted to infiltrate the research and policy space and provide that voice of those who are unheard and yet are directly impacted by policies that are being written.

**I wanted to infiltrate the research and policy space and provide that voice of those who are unheard and yet are directly impacted by policies that are being written.**

**What are you working on now?**

I’ve been working on workforce development programs for folks who have been involved in the justice system—primarily adults, but I just wrote a proposal to evaluate programs serving youth who have been on probation or at risk of involvement. That’s the area of research I’m most interested in, really—system-involved youth and young adults. That can mean the justice system or, given my social work background, the child welfare system. Just trying to improve the outcomes and well-being of those populations that are really struggling.
Help for Traumatized Kids

By Doug Irving, Staff Writer

She was six years old when her baby brother died in his sleep. She remembers her aunt shaking her awake, the ambulance outside, her mother crying downstairs—and a thought that has haunted her ever since. Could she have done something to save her brother?

She gives her name as Rebecca, but that’s not her real name. It’s still hard for her to talk about this, and she wants some privacy. She’s 16 years old now, a student leader at her school in New Orleans, a member of the marching band, still scarred by the loss of her brother. “Sometimes I just break down,” she says, “and I find myself in a place I don’t want to be.”

Rebecca is part of a school program, developed at RAND, to help children exposed to trauma confront and subdue their stress and anxiety. It grew out of the street violence of South Los Angeles in the 1990s and has since helped children from Newtown, Conn., to Fukushima, Japan. Researchers are now tailoring it for children whose lives were upended by the hurricanes that devastated Puerto Rico.

“It made me feel like I have somebody to talk to,” Rebecca says. “It made me realize everything is not as hard as you think it is. You’ve just got to sit there and really talk it over with yourself.”
Exposure to trauma, research has shown, is more the rule for children than the exception. One study found that nearly two-thirds of children had experienced or witnessed violence, crime, or abuse in the past year. Another estimated that more than a third had endured a physical assault. Many more live through natural disasters, witness violence in their communities or, like Rebecca, suffer a traumatic loss.

Those childhood traumas have been linked to poorer academic performance, decreased reading ability, and lower high school graduation rates, as well as mental and physical health problems later in life. And yet the effects of trauma—including post-traumatic stress disorder (PTSD), anxiety, and depression—often go undiagnosed in children.

“These are kids who are just sitting in math class, and then when we ask them about trauma exposure and symptoms, it turns out that they have both,” said Lisa Jaycox, a senior behavioral scientist at RAND. “Quite a large number do, many more than you’d think. They’re still in school. They’re just suffering in silence.”

A novel intervention

In the 1990s, South Los Angeles was an epicenter of childhood trauma. Crisis teams working in the hardest-hit schools would ask children if they had seen gang assaults, shootings, or death. “Every single kid said yes,” said Marleen Wong, then the director of mental health services for Los Angeles schools. “Every single kid.”

Wong knew a researcher at RAND named Bradley Stein. Over lunch one day, she issued him a challenge: What can we do about this? They started jotting ideas down on a napkin.

Over the next several years, Stein and Jaycox on the RAND side, working with Wong and her team on the school side and some researchers from UCLA, put together one of the first programs for children exposed to trauma. They called it CBITS, for Cognitive Behavioral Intervention for Trauma in Schools.

It would be delivered in the schools themselves, by staff psychologists or social workers, so that children wouldn’t need to find a ride to a therapist’s office. It would be rigorous, backed by research, open to evaluation. And it would work in real schools, with real students. The school officials made sure of that—pointing out, for example, that every session had to take no more than 45 minutes, so kids could get to their next class.

CBITS aims to catch children before they develop signs of clinical PTSD or anxiety—while they’re still sitting in math class, suffering in silence. It teaches them to process their traumas and challenge their distressing thoughts. A program manual describes trauma as standing at the edge of a cliff. Spend enough time there, and you can learn to relax and feel comfortable, even though you recognize there’s still a cliff there.

The program had its first test run with immigrant children in Los Angeles schools who spoke Russian, Spanish, Armenian, and Korean. Some had fled civil wars in their home countries. The program helped, and so in 2001–2002 the district expanded it to two middle schools, for any student who needed it. Three-quarters of the students who enrolled said they had witnessed or experienced violence involving a knife or gun.

The program significantly lowered PTSD and depression scores in the children who went through it, compared with a wait-listed group who had not yet.

In another study, researchers offered either CBITS or traditional clinical therapy to children who had survived Hurricane Katrina. More than 90 percent of the children in school-based CBITS finished the program, with marked improvement in PTSD and depression symptoms. Only 15 percent of those who had to go to clinics did.
“It turns out that, even though it’s painful, people do want to talk about what happened to them,” Jaycox said. “They do want to share it, and they do want to get support for it.”

**Expanding the reach of CBITS**

Rebecca wasn’t so sure at first. The memory of that night her brother died was never far from the surface—the helpless feeling of not knowing how to comfort her mom, the awful fear that she could have done something to save him. She kept to herself in the first CBITS group sessions she attended, listening to other students share their stories.

But then she realized they were there for each other, shoulders to lean on. She wrote about her trauma in poems and stories, and realized she could shape the narrative however she wanted. She learned to relax her muscles whenever she came up to the cliff.

“It was a place where everybody could just talk,” she says. “Everybody was like a family up in there. It made me realize that I’m a teenager who really went through something, but I can still get out in the world.”

Over the years, the researchers have adapted CBITS to work with youth in foster care, special education, and faith-based settings. They have spun off two new programs based on CBITS, one aimed at younger children, another designed to be led by teachers or other school staffers without clinical training. They recently released an updated manual for the core CBITS program. The National Child Traumatic Stress Network and the National Institutes of Health have sponsored their work.

RAND and its partners make the program manuals and training materials available for free at cbitsprogram.org. It’s hard to say how many schools have used the program, but around 2,000 clinicians attend formal training sessions every year.

The communities they come from read like an almanac of crisis and disaster. Houston, after Hurricane Harvey swept through in 2017. Sonoma County, Calif., after wildfires burned whole neighborhoods to the ground. Las Vegas, after the deadliest mass shooting in modern U.S. history. New Orleans, Newtown, South Korea, Japan. Soon, Puerto Rico.

“I wish this was research that would no longer be needed,” said Stein, now a senior physician policy researcher at RAND. “I would love to be put out of this line of business. If this was no longer a need, that would be fantastic.

“But we’re not there. And sadly, it doesn’t look like we’re any closer than we were two decades ago. When these things happen, and you have children exposed to trauma and violence, at least we can be ready to meet their needs and help them through it.”

CBITS aims to catch children before they develop signs of clinical PTSD or anxiety—while they’re still sitting in math class, suffering in silence.
Steven Martino studies health care quality at RAND, and he knows the power of a good story. Those two facts help explain a project he’s been working on that could make the American health care system a little more responsive to the patients it serves.

Martino and his research partners have developed a more effective and reliable way for patients to provide narrative feedback about the care they receive. They were inspired by consumer websites like Amazon, where people post comments by the thousands on everything from books to blenders.

Done right, they realized, short but detailed reviews could help health care providers better understand the patient experience, the good and the bad, in the patient’s own words.
Perin did a thorough evaluation and recommended a treatment plan and several options and suggestions for follow-up exercises. I don’t feel like she suggested I was treated with respect. The office was also nice and everything went very efficiently. I was kept about 10 minutes waiting in the exam room. I felt like the doctor spent a lot of time hearing about my condition. She...
Building a better review

Dozens of websites already allow patients to rate and review their doctors. The problem is that there’s no way to know who’s writing those reviews or why, or whether their experiences are at all typical. One study even identified several reviews that appeared to have been written by the doctors themselves. (“Every anonymous review I’ve written on myself has been glowing,” said one.)

But users clearly value those reviews. Nearly a quarter of the people in one survey had run their doctor’s name through one of those sites before making an appointment. Martino and colleagues, from RAND and collaborating institutions, decided to build a better review—to put some science behind the anecdotes.

“The power of narratives is that they convey emotion, they engage people at an emotional level,” Martino said. “They’re vivid, they convey detailed information, and they stick with people.”

Martino’s team developed a set of questions to guide patients through providing a short but detailed review of their care. They asked what patients expected from their doctor, what happened during their appointment, what they liked and disliked about the experience, and how they related to their doctor. It took around five minutes to complete.

And it worked. The researchers gave the questions to hundreds of patients, then went back and interviewed many of them to see how well their answers to the questions captured their full experience as conveyed in the interview. They found that those five-minute reviews covered a surprising amount of ground. They were especially good at conveying how patients felt about their doctor’s communication style, their interactions with the front desk, and the coordination of their care.

Challenges and opportunities

“People have been gathering reviews for years, but no one was testing how well their methods work,” said Mark Schlesinger, a professor of public health at Yale University and member of the research team. “No one had asked the question, ’Are we doing this well?’”

The researchers envisioned a consumer website like Amazon that would show people narrative reviews alongside numerical information about doctor quality.

But here, they hit a problem. When they tested how such a website would perform with patients, they found that reading reviews actually led to worse decisions. They used a mock-up of a patient-choice website designed to mimic real-world sites, down to the colorful graphics and snappy name, SelectMD. They could vary how much information they provided on the site, from higher-level star ratings to a full complement of detailed ratings and reviews. When they asked users to pick the doctor they would want to go see, those who saw reviews along with numerical ratings picked a lower-performing doctor more than half the time.

That happened even when the website highlighted links between the numerical information and the reviews. It happened even when the site gave users a sense for how typical any given comment was. In fact, when reviews were in the picture, the only thing that saved users from making bad choices was having a navigator on hand to help them make sense of it all.

“We kept getting this effect where the narratives were outweighing the numerical information,” Martino said. “We know people are very engaged by narrative information. They weigh it to a very large extent in their decisions. But we found that if consumers pay too much attention to narrative information, they lose something important in their evaluation of these doctors, hospitals, and health care providers.”

The researchers decided to turn their attention to a different audience.

For years, doctors and hospitals have relied on numerical data and star ratings to assess how well they’re meeting patient expectations. Rigorous, reliable reviews would let them supplement those quality measures with patient voices.

The survey questions could provide the data: “In the last six months, how often did this provider spend enough time with you? Never-sometimes-usually-often.” But the reviews could add some depth, from the patient’s perspective: “Even though I was the doctor’s last appointment and we were already running a little late, she still took extra time to address some things I was concerned about and made sure I understood what she was doing and why.”

Those reviews, in short, could help providers better understand not just where they could improve, but how,
said Rick Evans, a senior vice president and the chief experience officer for NewYork–Presbyterian, an academic health care delivery network. The network is one of two, with UCLA, that has started collecting patient reviews using the researchers’ five-minute protocol.

Evans calls them “de-mystifiers.”

“Put yourself in a doctor’s position,” Evans said. “When you show a doctor a low rating, inevitably, the question is, ‘Well, what does that mean?’ These deeper comments can give them a sense of what that score means, and where they can improve.”

The researchers are now building a digital dashboard to help NewYork–Presbyterian and other providers navigate the reviews they get back and identify any areas for improvement. Data scientists at RAND are also working on algorithms that could go through the reviews and code them by keyword and topic.

The U.S. Agency for Healthcare Research and Quality now includes the review protocol as a supplement to its flagship patient survey, the Consumer Assessment of Healthcare Providers and Systems.

The researchers have not given up on finding a way to keep reviews from drowning out other performance measures. “We have powerful tendencies to be unduly persuaded by evocative commentary, and those are hard to work against,” Martino said.

He sees that in himself, every time he scrolls through those one-star product reviews on Amazon. “I like to think that I do it more carefully because I’ve been studying this phenomenon for so long now,” he said. “But it’s hard not to think that maybe I’ll be the one person who the negative thing happens to. That part of your brain that should recognize the rarity of it shuts off for a moment. The comments become the story, even though I know it’s not the whole story.”

Researchers found that these five questions produced patient reviews of health care providers that were balanced, reasonably complete, meaningful, and representative of the patient’s actual experience.

1. What are the most important things that you look for in a health care provider and his or her staff?

2. When you think about the things that are most important to you, how do your provider and his or her staff measure up?

3. Now we’d like to focus on anything that has gone well in your experiences with your provider and his or her staff over the past 12 months. Please explain what happened, how it happened, and how it felt to you.

4. Next, we’d like to focus on any experiences with your provider and his or her staff that you wish had gone differently over the past 12 months. Please explain what happened, how it happened, and how it felt to you.

5. Please describe how you and your provider relate to and interact with each other.


Associations of CAHPS Composites with Global Ratings of the Doctor Vary by Medicare Beneficiaries’ Health Status is available for free download at www.rand.org/t/EP67694
What the Government Shutdown Revealed About the Fragility of American Life
The 35-day government shutdown that began in December 2018 uncovered many stories of hardship suffered by the families of employees who were either furloughed or had to work without pay. But two interrelated statistics are telling: Four out of 10 adults cannot cover an unexpected expenditure of $400 without selling something or borrowing. And a staggering 78 percent of American workers live paycheck to paycheck.

These pieces of information are worrisome in the long run. They highlight the lack of resilience many American families suffer from when they encounter unexpected events, or experience “shocks,” in economic parlance. The recent government shutdown was only one example of an unexpected occurrence that was beyond the control of those affected. Families are also buffeted by many more shocks on a routine, less-publicized basis: job change and loss, illness, needed home and auto repairs, and damage caused by weather events, to name just a few. Having enough discretionary income is an important aspect of being in the middle class. Increasingly, commentators have been worried about the health of the American middle class based on the difficulty households have in affording housing and health care. One could add the inability of many families to deal with shocks and living paycheck to paycheck to this list of concerns. These difficulties...
belie the notion that America is a nation with a thriving middle class. The middle class is often considered to be one of the engines that spur economic growth, and when this large group of consumers is in trouble, that engine could sputter and slow the economy as a whole in the long run.

The lack of sufficient discretionary income in American families does not augur well for saving, especially for retirement. There are two facets to the non-saving behavior implied by the statistics mentioned above. One is the inability of the poorest families, who can barely meet their living expenses, to save. One in three Americans has saved less than $5,000 for retirement and will have to rely on a Social Security system that is bound to become strained by an aging population. However, it is unlikely that all 80 percent of paycheck-to-paycheck families in the country live in poverty. Instead, they have likely become accustomed to spending habits that eat into their savings. On average, Americans have saved a meager $84,821 for retirement.

What can be done? Poverty and middle-class status are based on preset levels of income. For instance, the poverty guideline used by the U.S. Department of Health and Human Services for eligibility of certain federal programs is $25,100 for a family of four. There are no official qualifications for middle-class status, but one study concludes that the median middle class household earned $78,442 in 2016. However, the shutdown experience highlights the need to regularly measure and report on the ability of families to respond to shocks to understand how resilient these families are when faced with uncertainty. It might be worth considering whether eligibility for safety-net programs should go beyond the level of income and take into account income volatility.

The median American family has been losing ground for decades, and policy responses to address this situation are going to be complex and difficult, but are much needed. Policymakers could focus on the training needs of workers who have lost out to the forces of technological change and globalization. The ever-widening income disparities could also be tackled, especially by improving access to quality education and health. An entire rethinking of education and training might have to be undertaken to make workers resilient to uncertainty and technological change. “Nudging” families with disposable income to increase their saving, for both rainy-day funds and retirement, could provide them relief from living paycheck to paycheck.

A second shutdown in February was averted, but the financial fragility of the American family seems set to continue. ■

A version of this commentary originally appeared on RealClearPolicy in February 2019. Commentary gives RAND researchers a platform to convey insights based on their professional expertise and often on their peer-reviewed research and analysis.
Recognized as one of the architects of the Affordable Care Act, Ezekiel J. Emanuel wrote the book on highly effective medical organizations, and has influenced approaches to health care costs, bioethics, end-of-life care, and more. He currently serves as the vice provost for global initiatives at the University of Pennsylvania and chair of the Department of Medical Ethics and Health Policy. In 2018, Emanuel delivered the Albert P. Williams Lecture on Health Policy at RAND, where he offered a framework for thinking about drug pricing.

On crunching the numbers
In 2016, we spent $10,300 per person in the United States on health care. That’s a huge amount of money—and 30 percent larger than the next-highest country. How much does the U.S. spend on prescription drugs? Well, 17 percent of those dollars—which amounts to 3 percent of the total GDP—just goes to drugs. That’s a huge amount of money just for drugs.

The whole world spends about $1 trillion on drugs, and roughly half of that is spent in the U.S. We’re less than 5 percent of the world’s population, and yet we pay 50 percent of drug costs.

The key issue in all this spending on drugs is not the number of drugs in the U.S. We are not an outlier in terms of the number of drugs per person. I recently calculated that if you take the health care costs in the United States, which are $10,300 per person, and you look at the next series of very high-cost countries—Switzerland, Norway—that delta between our costs and their costs, a third of that difference is drug prices. That swamps any other costs: It’s much more than the number of MRIs or CT scans, it’s much more than doctors’ salaries. So drug prices are a very substantial portion of the delta.

On research and development
If you ask the drug company executives why we have high drug prices, they’ll say drug development is risky. Ninety percent of drugs that enter human clinical trials fail. That is true. But as Silicon Valley has taught us, it’s very important to know when you’ll fail. Failing early is very cheap. And that’s true in the drug business, too.

On exploitation
We don’t talk about the fair price of a car, or fair prices of restaurant meals, or fair prices for smartphones. But we do think there should be fair prices for drugs. That’s because drugs prolong or improve our quality of life, or at least decrease our side effects. Like food and housing, many but not all drugs are basic goods necessary to lead a decent life.

Excessively high prices for basic necessities such as drugs are unjust because they represent a type of price gouging—exploitation.

On solving the problem
The federal government gives drug companies a monopoly through patents and FDA marketing exclusivity. And what do companies do with a monopoly? Both economic theory and lots of empirical data say that when you give a company a monopoly, they’re going to raise prices until raising the prices reduces their margin.

What do we do in monopoly situations? We regulate. Every other country in the world regulates drug prices, typically through some formal process of negotiation. Only we don’t.

Drug prices are excessive and unjust, and R&D costs don’t explain the high drug prices in the U.S. We still have a lot of work to do to get those drug prices under control.

Excessively high prices for basic necessities such as drugs are unjust because they represent a type of price gouging—exploitation.

If someone’s drowning in a lake, and you come out and say, “I’m willing to save you, but you just have to pay me $100,000,” it’s called exploitation. How different is that from when someone is dying of cancer, and we say, “I’m willing to save you—but that will be $140,000, please?”

Founded in memory of Al Williams, a distinguished researcher and leader of health policy research at RAND, the Albert P. Williams Lecture on Health Policy was established through the generosity of Williams’s friends and former colleagues to commemorate his legacy. Today, the Williams Lecture provides a forum for leading voices in health policy to share cutting-edge ideas and insights, giving ongoing life to Williams’s commitment to improving health and health care for all of us.
A philanthropic gift from Schmidt Futures is fueling research that will have an impact on displaced people throughout the world.

RAND researchers are looking into how technology—from cell phones to biometric screeners—could improve the lives of the world’s 69 million refugees, internally displaced people, and asylum seekers. The project is being funded by a charitable foundation that aims to solve world problems with the inventive zeal of a Silicon Valley startup.

Schmidt Futures, founded by former Google CEO Eric Schmidt and his wife, long-time conservationist Wendy Schmidt, calls itself a venture fund for public benefit. It describes its mission with three bullet points: advance society through technology, inspire scientific breakthroughs, and promote prosperity.

Schmidt Futures came to RAND with a challenge. It was looking for investments that could help move the needle on big public-policy problems, and it was open to ideas. More than two dozen research teams within RAND made proposals; the refugee project stood out.

“Technology comes up every time we work on refugee issues—there could be better ways of addressing problems if technology were deployed in different ways,” said Shelly Culbertson, a senior policy researcher who is coleading the project. “The technological solutions that do exist are often fragmented, one-off solutions. They’re not woven through humanitarian governance structures. So we’re hoping to develop a road map for what that could look like.”

Culbertson has spent several years working to help displaced people in places like Syria and Iraq, suggesting better ways to provide them with education, jobs, and humanitarian assistance. She teamed up with Jim Dimarogonas, a senior engineer and specialist in information technology, who himself came to the U.S. after his family fled the 1967 military coup in Greece. Several generations of his family had also fled persecution and conflict.

Dimarogonas and Culbertson knew that technology can play an outsized role in the lives of people far from home and family. It’s a connection to loved ones, a source of job leads, even a way to learn the language of a new country.

A recent United Nations survey found that refugees often think their phone and internet access is almost as important to their safety and security as food, shelter, and water. But nobody had stepped back to assess the technological needs of refugees around the world, or how technological advances could help responding agencies and the refugees themselves. For example, one agency is distributing aid to refugees in Jordan at ATM machines with biometric identification. Another has created an online tracking tool that documented the displacement of Iraqi civilians in real time. But innovations like those have too often been piecemeal, with no overarching strategy to get them to more people in more places.

The researchers are interviewing policymakers involved in refugee work in the Middle East, Africa, Europe, the United States, and South America. They also plan to conduct focus groups with refugees, possibly in Ethiopia, Colombia, Jordan, Greece, and the United States.

Their research will lay out a plan for investing in technology on a global scale to better help displaced people.

Schmidt Futures has been critical to the work, Culbertson said—and not just as the sponsor. “Just having somebody pose the question at the right time and the right place, I think, was key to sparking ideas about what we could do,” she said.
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