AS HEALTH DEVICES GO ONLINE, ARE WE READY FOR THE INTERNET OF BODIES? PAGE 8

Rebuilding America’s CIVIC INFRASTRUCTURE

The high price of INSULIN in the United States

Having REAL CONVERSATIONS about race and privilege
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<td>This online tool shows the effects that improving diet quality in the U.S. could have on health and economic outcomes, such as the prevalence of diet-related illness, health care spending, and labor force participation, over a 30-year period. The user can explore the effects of a dietary improvement on several outcomes, across different metrics and population subgroups.</td>
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<td>Last November, Oregon voters approved a ballot initiative legalizing use of psilocybin—the psychedelic component of “magic” mushrooms—in a therapeutic setting. Californians could soon face a similar choice. But drug policy experts at RAND warn that ballot initiatives are a poor way to set drug policy, especially for psychedelics.</td>
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The Price We Pay
An international comparison shows just how high U.S. insulin prices are

Mila Clarke Buckley needs insulin to manage a progressive form of autoimmune diabetes. When she and her husband briefly lost their health insurance a few years ago, she had to ration her supply so they could pay their bills. “It comes at a high cost,” she said, “and not just financially, but in terms of your life.”

America’s Civic Infrastructure
The Biden administration must rebuild trust in government

Research Briefly
An incarceration generation and more

The Q&A
Laura Bogart on trust and vaccines

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POINT OF VIEW
GIVING
Helping the next generation

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COVID-19 and the Digital Divide

Even months after the coronavirus shifted schools online, only half of the teachers in a RAND survey were confident their students all had home access to the internet. Their responses provide a stark look at the “digital divide” in America, and at how costly it has been for the most vulnerable students.

Only 30 percent of the teachers in the highest-poverty schools said all or nearly all of their students could get online from home. That was 53 percentage points lower than in schools with the lowest levels of poverty.

Teachers in schools with higher percentages of students of color were also much more likely to say some of their students couldn’t get online from home. So were teachers in towns and rural areas. The numbers varied greatly by state: In New York, more than half of the teachers in the highest-poverty schools said all or nearly all of their students could get online. In Louisiana, it was less than 10 percent.

The impact on student learning was clear. In schools where internet access was a widespread problem, just 6 percent of teachers said all or nearly all of their students were finishing their assignments.

The survey of nearly 6,000 public school teachers in late spring 2020 underscored the need for new strategies to help those families get across the digital divide. That could include providing free or discounted WiFi access, or providing incentives to internet providers to help families in need. Schools also need to do more to make sure their students can learn from home: Nearly 80 percent of the teachers in the survey said their schools had provided laptops to students. But only 45 percent had provided the mobile internet hot spots that many students would need to use them.

MORE AT www.rand.org/t/RRA134-3

Funding for this research was provided by the Bill & Melinda Gates Foundation, the Charles and Lynn Schusterman Family Foundation, and Overdeck Family Foundation.
Crime and Punishment

The United States has a greater share of its people living behind prison bars than any other country in the world. Experts often blame policies enacted in the 1990s for filling American prisons with low-level drug offenders and minor felons.

In a recent study, researchers started there but traced a different path to the overcrowded prisons of today. Those get-tough policies of the 1990s, they argue, made it much more likely that young people would be arrested, convicted, and marked for life as prior offenders. Even now, decades later, with the national mood turning against mass incarceration, those prior records keep pulling them back into the prison system.

That’s because sentencing guidelines require harsher penalties for anyone with a criminal record. People who were convicted of relatively minor offenses in the 1990s will always face a higher risk of going to prison if they get arrested again.

The researchers saw that in action when they looked at data for all state prisoners in North Carolina from 1972 to 2016. Those who came of age in the late 1980s and ’90s did indeed have higher conviction rates than those who were just a few years behind or ahead of them. And those convictions have followed them into middle age: They were still being sent to prison in their 40s at rates more typical of people in their 20s.

That helps explain why incarceration rates today are four times higher than they were in the 1960s, even though crime rates are roughly the same. It also suggests that efforts to reduce the prison population should focus more on that Generation X cohort. The generations that followed—the Millennials and Generation Z, who came of age after the crime-and-punishment 1990s—have much lower incarceration rates, more in line with those of their Baby Boomer grandparents.

MORE AT www.rand.org/t/EP68297

Bill of Health

The private health plans that cover most working Americans could save billions of dollars every year if they negotiated rates closer to what Medicare pays, a recent RAND study found.

Researchers looked at millions of claims paid by employer-sponsored health plans between 2016 and 2018, worth nearly $34 billion in all. Then they repriced every hospital stay, out-patient checkup, and other service using Medicare rates. They estimated that Medicare would have paid a little over $14 billion for the exact same services at the exact same hospitals.

That’s a difference of nearly $20 billion. Put another way: Employers and their private insurers paid 247 percent more than Medicare for the same health care. That could explain why health prices have been surging in the United States. Nearly 60 percent of non-elderly Americans get their health insurance from those plans.

Those higher prices didn’t necessarily mean higher-quality care. More than 90 percent of the hospitals with the lowest prices, relative to Medicare rates, received three or more stars on quality scales of 1 to 5.

Those less-expensive hospitals also tended to have the same safety ratings. That suggests there’s room for employers to negotiate better prices without sacrificing care.

The study also found wide differences in payment rates by state. Arkansas, Michigan, and Rhode Island paid rates closer to the Medicare rate. Florida, Tennessee, Alaska, West Virginia, and South Carolina paid much more.

The employer-sponsored insurance market has been described as “chaos behind a veil of secrecy.” RAND’s study was meant to give employers a look behind that veil, to provide them with the information they need to make better decisions for their employees. There are trade-offs here—nobody wants hospitals to run out of money—but the added transparency could help focus discussions on how to lower health costs for privately insured Americans.

MORE AT www.rand.org/t/RR4394
The rapid development of vaccines to fight COVID-19 has presented Americans with an urgent new question: Would you get one? Polls in the fall, before the vaccines were announced, suggested that many Americans had their doubts. And Black Americans, in particular, were especially likely to question whether a vaccine would be safe or effective.

Laura Bogart studies medical mistrust, especially in the Black community, as a senior behavioral scientist at RAND. Her research has shown how centuries of oppression and unethical medical experimentation became a barrier to effective treatment for Black Americans during the HIV epidemic. Her most recent paper laid out a model for how discrimination feeds mistrust and conspiracy beliefs at the individual level, becoming a direct impediment to care and treatment.

A social psychologist by training, Bogart specializes in working with communities to better understand and address health disparities, especially related to HIV. Her research has helped improve access to treatment for communities not just in the United States, but also in Botswana, South Africa, and Uganda.
Q: What made you start studying medical mistrust as a barrier to treatment?

A: I started working in the HIV field in the late 1990s, and new treatments were just coming out. I was talking to people in the community, social service staff, and they were telling me they were hearing a lot of mistrust. There were what people call conspiracy beliefs about the role of the government in allowing HIV to spread in Black communities, or deliberately withholding a cure. And staff at these agencies didn’t know how to respond, how to convince people to take these new treatments.

What drives that mistrust?
The important thing to recognize is that it’s rational; it’s understandable that people who have been discriminated against would put their guard up. It’s a survival mechanism. And any intervention really needs to acknowledge that as a first step. We know where people are coming from, we know discrimination is real—and so it makes sense that people who have been discriminated against might not trust national entities like the health care system.

How widespread is that kind of mistrust?
We’ve done two national surveys of Black Americans, one in 2002–03, and then one in 2016. Both found high levels of mistrust. Around 40 percent of the people in the 2016 survey said they think there’s a cure for HIV that’s being withheld from the poor, for example. Only around 18 percent thought the government usually tells the truth around health issues, and that was down from 37 percent in 2002–03.

I think we would probably find even worse results today. Health issues have become so politicized, especially now in the era of COVID-19. People think you have to believe one thing if you’re on one side of the political spectrum, and something else if you’re on the other.

What does that say about acceptance of a COVID-19 vaccine?
We need to better understand what people’s specific concerns are so we can design interventions that address their mistrust. I did a small study of 101 Black adults living with HIV about COVID-19 mistrust. We found that 60 percent said the government can’t be trusted to tell the truth about COVID-19. About half said they’re worried a vaccine might be harmful. A third said they wouldn’t want to take it—and that was back in May and June of 2020.

How can the health care system respond to that?
One lesson we’ve seen clearly with HIV is that you can’t do anything without working directly with the key stakeholders in a community. And any response needs to be tailored to the community; what works in L.A. might not work in New York. One thing that I think might come out of this is taking more of an approach like we do with HIV, which is to convene local community stakeholders to figure out what works for their community. For example, offering vaccinations in nonmedical settings—and those settings might vary depending on what settings are most trusted in the community.

How would you design an intervention for a COVID-19 vaccine?
When I first started working in this field, I would hear from people, ‘Oh, these HIV treatments are poison, I would never take them.’ And some health care providers would say, ‘Well, you have to take them; they work.’ What we know from psychology is that just telling someone to do something rarely works. They have to be convinced themselves, they have to be motivated themselves.

So we’ve developed interventions in which peer counselors are trained to use nonjudgmental, nonconfrontational forms of communication. They acknowledge mistrust, and the roots of mistrust, before introducing any new information about a medicine or treatment. We’ve developed and tested this kind of motivational interviewing strategy with HIV, and we’re hoping we can develop more provider training that we could expand to other conditions.

We’re also conducting a RAND-funded study with 200 Black participants on COVID-19 vaccine hesitancy. As part of the study, we’ve been convening a community stakeholder board to consider the results and help identify strategies and policies. The goal is to address COVID-19–related racial inequities, especially those related to a vaccine.
Putting America’s Civic Infrastructure on the Biden–Harris Agenda

By Michael D. Rich and Jennifer Kavanagh

President-elect Joe Biden has been clear about his agenda: control the pandemic, recover economic stability, advance racial equality, and confront climate change. To accomplish any of these, however, another pressing issue will have to be tackled. The Biden administration must begin rebuilding Americans’ trust in their government and public institutions.

Public trust is deeply intertwined with the reliance on facts and analysis as the basis for political discourse—and research finds that has been on the decline for about two decades, a problem we refer to as “truth decay.” Today, large numbers of Americans question the science behind vaccines, are skeptical of government-reported economic and crime statistics, and are more accepting of conspiracy theories such as the baseless one concerning QAnon.

Much like our bridges and roads, America’s civic infrastructure—the practices and policies that enable a nation to solve its communal problems—has been allowed to crumble. This has allowed truth decay to set in. Reconstructing this infrastructure will require concerted effort across many areas, starting with increasing government transparency, promoting expertise in the executive branch, assembling an inclusive administration, and investing in civic education.
Increase transparency

To demonstrate a true commitment to informing and working for the American people, elected leaders and their appointees need to clearly disclose government deliberations, plans, and actions—and then provide honest accounts of both successes and failures. This begins with comprehensive collection and sharing of data and continues with direct reporting to the public by senior officials. Where possible, these standards and reporting requirements should be codified and formalized to ensure they endure beyond the next four years.

Historical experience underscores the power of this type of transparent accountability for rebuilding trust. For example, the Church Committee hearings in the 1970s investigated domestic spying and covert plots by national intelligence agencies—and that accountability began the process of rebuilding public trust after its Watergate-era nadir.

Transparency also extends to interaction with the news media. Being more forthright and responsive to journalists and, wherever possible, treating the news media as a partner in the responsibility of informing the public also could—by leading through example—help restore confidence in the news media more generally.

Elevate experts

Perceived competence is central to public trust, so qualifications must be the deciding factor when the new administration identifies individuals to take on positions of national authority. Ensuring that appointees and agency heads are among the leaders in their fields—and that they assemble similarly qualified teams—would demonstrate a commitment to using facts and analysis as the foundation for tackling challenges facing the country.

History shows us that such an approach could work. In the early 1930s at the start of the Great Depression, federal economic policymakers ignored key pieces of evidence, and as a result the Depression got worse. As the crisis deepened, a reversal ensued. New government agencies were set up to collect and analyze data and launch evidence-based approaches for getting the economy restarted. Individuals with genuine expertise and training were brought in to develop and implement new policies. Over time, trust in government rose. The same approach could work today.

Rewarding expertise—and letting qualified individuals publicly explain the value of fact-based analysis—may also rebuild trust in other areas, such as science. Finally, an executive branch filled with the foremost experts might generate excitement among young people about serving their country through civil service employment.

Build a diverse administration

Research suggests that feelings of trust stem, in part, from feeling included and represented. As a result, ensuring that the next government “looks like America” will be crucial to a civic infrastructure project. Already, President-elect Biden has built diverse transition teams; that will be even more important to the construction of the future Cabinet and to appointing the thousands of staffers who will serve across the federal government. This commitment should extend to all levels of the administration, down to the internship programs that serve as feeders for future leaders. Furthermore, diversity should be conceived of in the broadest possible terms—race, gender, economic status, religion, sexual orientation, education, and experience.

Invest in civic education and development

Civic education and development activities can help children and adults better understand the foundations of democracy, how the government works, and what it provides. It can also bridge divides, creating a sense of belonging and responsibility among people of all generations.

In a 2019 survey, many teachers reported lacking resources and materials to effectively provide civics instruction to children—and our adult population has fewer and fewer common civic experiences or opportunities for civic development.

The new administration might set out to address this by funding student activities or coursework oriented toward encouraging civic responsibility. At the same time, it could convene a bipartisan commission to set standards for civic knowledge and understanding at various grade levels.

A national service requirement for young people could also be valuable in this respect, providing common experiences that break down societal barriers between citizens. Serving the country could also foster a sense of involvement that might bolster feelings of trust in a democratic system of self-governance.

Restoring trust won’t occur quickly, nor will progress follow a straight line. But the new administration can begin to repair the deep fissures in our society by explicitly and implicitly rehabilitating the nation’s civic infrastructure. The health of America’s participatory democracy depends on it.

A version of this commentary appeared in the Los Angeles Times in November 2020. Commentary gives RAND researchers a platform to convey insights based on their professional expertise and often on their peer-reviewed research and analysis.
Technology brings us unprecedented levels of convenience. Technology saves lives. And technology can track our every move.

By Doug Irving, Staff Writer

The “Internet of Things” gave us driverless cars, video doorbells, and smart refrigerators—everyday items made new with sensors and network connections. Up next: the “Internet of Bodies.” You’re about to find out just how personal your personal technology can get.

Think smart pills transmitting information from inside your body; smart beds that can track your heart rate and breathing; even smart clothes that can sense your body temperature—and adjust your smart thermostat accordingly. One team of doctors recently announced the development of “hardware and software for the long-term analysis of a user’s excreta”—a smart toilet.

There are dangers here, of course, as RAND researchers found when they explored the Internet of Bodies. Any device can be hacked, including one inside the human body; and we need to really think through the privacy and security implications of devices that live with us. But the researchers also highlighted the life-changing, life-saving potential of technologies that know us inside and out.

“There’s been a lot of work on how we need to regulate this new Internet of Bodies,” said Mary Lee, a mathematician at RAND who led the study. “We wanted to outline some of the benefits, too, that not too many people may have thought about. These technologies are just going to keep growing in popularity, so we need to get ahead of the policy issues and make sure we get that balance right.”
Artificial pancreases that can help diabetics manage their blood-sugar levels.

Digital pill with embedded sensors that record when the medication is taken. The pill has been successful at treating schizophrenia and some forms of bipolar disorder and depression—conditions for which patients’ adherence to treatment is critical to preventing relapse.

Eye implants to repair—or even enhance—vision.

Brain implants that allow amputees to control their prosthetic limbs.

Smart stents that can monitor themselves for blood clots.

A wristband designed to track and record workers’ locations and hand movements, used to gauge their productivity.

Smart clothes that can sense your body temperature—and adjust your smart thermostat accordingly.

Health tracker bracelets track steps, heart rate, sleep patterns, and other physical data, such as alcohol consumption.

Genetic testing kits can provide interesting ancestry information and even personalized insights on health and disease risks. But with little oversight, these services could unknowingly create challenges for individuals’ future descendants—long before they’ve even been conceived.

Newer cardiac pacemakers and implantable defibrillators can provide real-time and continuous information about a patient’s cardiac health. These devices can also regulate heart rates in patients whose hearts beat too fast or too slowly, and can help treat heart failure.

Systems that can detect and collect data on human emotions by analyzing facial expressions, voice intonations, and other audio and visual signals.

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The pill has been successful at treating schizophrenia and some forms of bipolar disorder and depression—conditions for which patients’ adherence to treatment is critical to preventing relapse.
Tamara Banbury has a faint blue bump on the back of her right hand, just above her thumb, like a grain of rice under her skin. It’s where her microchip is.

Banbury, a Ph.D. student in Ontario, Canada, is part of a small but growing movement of innovators and thrill-seekers trying to hack the human body with technology. She has two microchips embedded in her hands, in fact. The one in her left hand can store passwords, identification, even electronic train tickets. The one in her right? That one launches a video clip of singer Rick Astley performing his 1987 hit “Never Gonna Give You Up” when she waves it under a cell phone.

“We don’t want to be looking back 20 years from now and saying, ‘Wow, we really should have set the bar here on these technologies,’” said Banbury, whose Ph.D. research focuses on technology, culture, and people like her whom she describes as voluntary cyborgs. “That line has been crossed. We need to think about it. And we should be thinking about it now, while the stakes are small—such as, should I be able to play Rick Astley with a chip in my hand?”

Researchers at RAND struggled with how to define the Internet of Bodies. In the end, they took a broad view to help policymakers think through the challenges and opportunities. They included any device that collects health or biometric information, or—like Banbury’s chips—alters human function in some way. To make the list, a device also needed to transmit information over the internet, on its own or through another device like a cell phone.

Within that definition, you’ll find fitness trackers, electronic health records, even some employee badges. You’ll also find artificial pancreases that can help diabetics manage their blood-sugar levels; brain implants that allow amputees to control their prosthetic limbs; and smart stents that can monitor themselves for blood clots. Cochlear implants can already restore hearing; in the near future, eye implants could repair—or even enhance—vision.

The impact such technologies could have on the health care system is nothing short of revolutionary. Artificial pancreases and smart stents will surely keep more people alive; but the real breakthrough will be data. All of those devices tracking our health and behavior will provide a “treasure trove” of new information about what keeps people healthy, and what makes them sick, the researchers wrote.
That will advance our understanding of long-term population health and point the way toward more-effective public health interventions. It could help doctors spot signs of disease earlier, help hospitals provide better care and more precise treatments for their patients, and help the American health care system drive down costs. By one estimate, the improved care and efficiency of medical technology could save billions of dollars every year.

All of which makes the cautionary tale of Tony Schmidt especially important to keep in mind.

Chipping away at privacy

Schmidt, a computer technician in Texas, needs a continuous positive airway pressure—or CPAP—machine to sleep. Without it, he stops breathing hundreds of times a night. The morning after he registered it, he got a chirpy email from the manufacturer, congratulating him on his first night of good sleep.

“That’s how I realized it was transmitting my information,” said Schmidt, who quickly bought a new machine and shut off its internet connection. “I didn’t sign any piece of paper saying it was okay for my sleep information to go to anyone other than my doctor. It was very troublesome. It was sending this information to people I didn’t even know: ’He’s sleeping now.’”

Privacy intrusions like that are only part of the risk as more and more medical devices go online. Researchers have shown that they can hack into an insulin pump, for example, raising the possibility that they could make it deliver a fatal dose. Former vice president Dick Cheney was so concerned that someone could attack him through his pacemaker that he had its wireless capabilities disabled.

Even simple fitness trackers can expose sensitive information. A few years ago, a fitness app released a world map showing every run and walk it had tracked. Military analysts quickly realized the map was detailed enough to identify American and allied bases in places like Syria and Afghanistan. Foreign service members were the only people using a fitness app there, and so their movements around their bases stood out bright white against a black background.

Yet RAND’s researchers could find only a patchwork of regulations and consumer protections that might govern the Internet of Bodies and avert its potential harms. Some of the strongest attempts to establish some guardrails, in fact, came not from government agencies, but from nonprofit privacy and technology groups. The researchers couldn’t even determine who owns the data—You? Your doctor? The equipment manufacturer?—because the rules are different in every state.

Congress should consider establishing some national ground rules for data transparency and privacy protections, the researchers concluded. The government and industry should also develop a certification program, like the “Energy Star” program for household appliances, to help consumers gauge the security of different devices. Manufacturers need to build in security from the very start—and figure out how to patch vulnerabilities in a device that might already be in someone’s body.

“This is really our first cut at what policymakers and device makers and consumers can do to manage these risks,” RAND’s Lee said. “There are real medical benefits, but we have to address the risks to realize them. This study gives us a foundation to keep working on these questions for the future.”

Tamara Banbury also has her eye on the future, both in her professional life as a researcher and in her personal life as a voluntary cyborg. Pop culture always assumes that life in the future will be dominated by smart machines—as in The Jetsons, or as in The Terminator—“but we get there incrementally,” she said. “And so we need to start asking ourselves what steps we want to take. How do we make sure we’re going where we want to go? It’s doing little things like putting chips in our hands that helps us find our way.”

Her chips are no more sophisticated than the chip in your debit card. But she always gets the same questions when she tells people about them: Don’t they endanger her privacy and allow people to track her? “Oh, no no no,” she tells them. “We’ve already given up those privacy rights.” She holds up her cell phone: “They’ve got me with this.”
Drug companies charge more for insulin in the United States than in nearly three dozen other countries RAND researchers examined—and it’s not even close. The average list price for a unit of insulin in Canada was $12. Step across the border into America, and it’s $98.70.

Those differences help explain why insulin has become a symbol of the high cost of American health care. Its prices have shot up in recent years, for reasons that are opaque at best, with those who can least afford it often paying the most. Reining in those prices has become the rare political cause embraced by Democrats and Republicans alike.

“This isn’t just some academic question: ‘How do our prices compare with those in other countries?’” said Andrew Mulcahy, a senior policy researcher at RAND who specializes in health care economics and led the study. “It’s becoming a very practical question, because there are ideas out there to do something about it, and they can benefit from this kind of analysis.”
Diabetes is one of the most pervasive, deadly, and expensive diseases in the United States. More than 30 million people have it, and nearly a quarter of them use insulin to manage their symptoms and prevent life-threatening complications. Per-person spending on insulin, for those with employer-paid health insurance, doubled between 2012 and 2016.

The U.S. Department of Health and Human Services asked RAND to investigate how American insulin prices compare with those in other parts of the world. Researchers obtained list prices for all types of insulin from 33 countries in Europe, Asia, Australia, and the Americas. Plotted on a graph, the U.S. prices stand alone.

The average price in America, across all types of insulin, was more than ten times higher than the average for all of the other countries combined. In fact, the closest any country came to paying the $98.70 American average was the $21.48 average that Chile pays.

The differences were especially stark when the researchers looked at rapid-acting insulin, which makes up about a third of the U.S. market. Its average price in other countries was just over $8. In America, it was $119.

“It comes at a high cost, and not just financially, but in terms of your life,” said Mila Clarke Buckley, 30, whose autoimmune diabetes is slowly shutting down her pancreas. She runs a top-rated blog for fellow diabetics, “Hangry Woman,” from her home in Houston. She has more than 30,000 readers.

“It’s not like one day you can just stop taking insulin,” she said. “You really have to manage your life thinking, OK, this is my No. 1 priority, to be able to get this little pen of liquid so that I can live.”

The prices RAND used in its study—the list prices, set by drug manufacturers—were the most available for comparison across different countries. They’re a good starting point for understanding the true cost of insulin. In the cryptic world of drug-price setting, the list price is like an opening bid.

The companies that manage the drug formularies that you might see on your insurance plan then enter the picture. They negotiate discounts and rebates in a closed-door process that yields a...
Drug manufacturers compete for their business by offering generous discounts, which gives them every reason to set their initial prices high. Even if those discounts cut 50 percent from the price, RAND’s study noted, Americans would still be paying several times more for insulin than what people in other countries pay.

It’s hard to track the final prices that patients like Buckley actually pay at the pharmacy counter. Those who have insurance still have to cover deductibles and copays, which can be significant. Those who don’t have insurance can find themselves paying the full list price.

Drug companies have started to introduce lower-priced insulins and discount cards to help those struggling to pay. But nearly a third of the people who responded to an American Diabetes Association survey said they had postponed doctors’ appointments or put off paying bills to afford their insulin. A quarter had skipped a rent or mortgage payment.

Buckley has been there. When her husband lost his job a few years ago—and with it, their health insurance—she, too, found herself caught between paying their bills and paying for insulin. She paid the bills.

“It was an impossible choice, but we had nothing left to give,” she said. For several weeks, she watched her blood-sugar levels creep up as she rationed what little insulin she had, until her husband could find another job. “It was terrifying,” she said. “That’s why we need to really force this conversation to stay open. It’s important to live in a country where insulin is accessible and affordable and people don’t have to make choices to go without just so they can get their insulin.”

Several states have capped how much their residents can be asked to pay out of pocket for insulin. A few have filed lawsuits against the major drugmakers. At the federal level, policymakers have talked about—but not yet acted on—ideas to allow the importation of cheaper insulin, or to peg prices here to those in other countries. One proposal would cut back the middlemen so that list prices can more closely reflect the final pharmacy prices.

Rep. Earl “Buddy” Carter of Georgia offered a backhanded thank-you to industry executives during a 2019 hearing on the soaring price of insulin. “You have done something here today that we have been trying to do in Congress [for years],” he told them. “And that is to create bipartisanship.”

Researchers at RAND are now starting to look at how American prices for other prescription drugs compare with those in other countries. “We really need to have a better sense of just how much more we’re paying,” RAND’s Mulcahy said. “It’s not just insulin; it’s across the board. My hope is that this insulin report is the start of a long string of analyses doing this kind of international drug-price comparison.”

Mila Clarke Buckley knows her insulin costs will go up. The type of diabetes she has—latent autoimmune diabetes in adults, or LADA—is a progressive disease, breaking down her body’s ability to function without increasing doses of insulin. Sooner or later, she will become completely insulin dependent. She has a separate tab on her household budget for when that day comes: “Mila’s Diabetes Care.”

“It happened to me; it can happen to you any day,” she said. “That’s why we need to have this conversation, because the prices are astronomical, and it affects real lives. One day, I didn’t have diabetes, and the next day, I found out I did, and it changed my entire life.”
RAND Launches Center to Advance Racial Equity Policy

Against the backdrop of a pandemic inflicting disproportionate physical and economic pain on communities of color, and an overdue reckoning with America’s long history of systemic inequity and structural racism, the RAND Corporation is launching the RAND Center to Advance Racial Equity Policy.

The center, funded by an initial $1 million from donor contributions and RAND’s own resources, will support a growing portfolio of innovative, high-impact racial equity research and analysis at RAND, create a clearinghouse to help coordinate related efforts, and collaborate with organizations dedicated to advancing racial equity. Fundraising for the center is a priority in RAND’s recently launched Tomorrow Demands Today $400 million campaign.

“The evidence is clear regarding persistent racial inequities in the settings that define our daily lives—the neighborhood, the hospital, the classroom, and the U.S. criminal justice system,” said RAND’s president and CEO Michael D. Rich. “RAND has an obligation to address these problems, but it will not be enough to conduct more research. We will need to convert that research into action.”

RAND is undertaking a search for a director to lead the new center. The director will have a track record in racial equity systems and policy research and action, including engaging diverse stakeholder groups and conducting outreach in areas such as community-building and dissemination of research and analysis findings.

“We must examine where inequities intersect across systems and groups, represent voices that are too often left out of leadership on these topics, and integrate the structural contexts in which policies have been developed and applied sometimes with unintended consequences,” said Anita Chandra, vice president and director of RAND Social and Economic Well-Being.

RAND has undertaken research on the challenges presented by racial inequity across sectors, including how principals and teachers can better support students of color; how California can improve mental health outcomes for Latino and Black residents; how the military and public safety agencies can diversify their workforce; and how to estimate the economic impact of the pandemic on communities of color. The center will usher in a new phase of racial equity research and action that goes deeper into the policies that underlie systemic racism and what it will take to build future systems and policies that advance racial equity.

RAND’s commitment to objectivity and nonpartisanship should allow the organization to bring a wider range of stakeholder perspectives and policy solutions to address racial inequity. “We bring a perspective and history with decisionmakers that can support conversations about the policy options to dismantle systemic racism,” Chandra said.

RAND is adept at turning difficult concepts from fields such as sociology and economics that have informed the understanding of racial equity into policy action across public and private sectors—in other words, how to make sure racial equity is better integrated into government and civil society action.

“But we also recognize that the organization has not yet met its potential in racial equity policy research and the impact we can have,” Rich said. “The center is an important step to focus our efforts on this topic and take bigger steps to test, implement, and sustain policy solutions.”

The center’s initial blueprint was developed with input from RAND staff across the organization. The center is part of a larger commitment to advance diversity, equity, and inclusion in RAND’s internal operations and external engagement.
Welcome to parenting in a pandemic. COVID-19 has idled workplaces, closed day cares, and sent schooling online. With children at home and few jobs available, many parents have dropped out of the labor force altogether—the largest block of them being women.

Between August and September, four times as many women as men left the labor force (865,000 vs. 216,000), according to the U.S. Bureau of Labor Statistics, meaning they not only stopped working but also stopped looking for work. In fact, there were 2.2 million fewer women in the labor force in September 2020 than the year before. One reason is that the pandemic affected occupations that employ higher shares of women. Another is that child care still falls primarily to moms.

While job losses are to be expected in a recession, the fear is that this downturn’s unique need for caregiving will push some women out of the labor force altogether or make it harder to catch up. Experts predict that the gap in earnings between men and women—already about 18 cents on the dollar—will increase 5 points as a result of the recession.

“It likely will take years to recover from overall declines of this scale,” economist Kathryn A. Edwards said recently in a post on The RAND Blog. “Even when women’s labor force participation was growing at its fastest clip, it rarely increased more than a percentage point a year.”

In other words, even after vaccines arrive, the pandemic will continue to put pressure on women’s wallets.
Since World War II
women have increasingly joined the labor force.

It likely will take years to recover from overall declines of this scale.
Kathryn A. Edwards

The Toddler Tax
Parents of young children are most affected.

Change in Labor Force Participation Rates of Men and Women 18–55 Who Have Children in the Household, January–September 2020, by Number of Children

<table>
<thead>
<tr>
<th>Number of Children</th>
<th>Change in Men</th>
<th>Change in Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 child</td>
<td>-1.93</td>
<td>-1.39</td>
</tr>
<tr>
<td>2 children</td>
<td>-3.26</td>
<td>-3.82</td>
</tr>
<tr>
<td>3+ children</td>
<td>-2.35</td>
<td>-1.95</td>
</tr>
</tbody>
</table>

Source: Current Population Survey


<table>
<thead>
<tr>
<th>Age of Oldest Child</th>
<th>Change in Men</th>
<th>Change in Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–1 years old</td>
<td>-4.24</td>
<td>1.37</td>
</tr>
<tr>
<td>2–6 years old</td>
<td>-1.26</td>
<td>-1.26</td>
</tr>
<tr>
<td>7–12 years old</td>
<td>-1.77</td>
<td>-1.77</td>
</tr>
<tr>
<td>13–17 years old</td>
<td>-1.57</td>
<td>-1.57</td>
</tr>
</tbody>
</table>

Source: Current Population Survey

School Bust
Since COVID, individuals with children in their household have been dropping out of the labor force, especially as the new school year starts.

Change is relative to January 2020.

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David A. Thomas, president of Morehouse College, joined Susan Marquis, dean of the Pardee RAND Graduate School, for a video dialogue in June 2020 to discuss answers to the question posed by Martin Luther King Jr.’s last book, Where Do We Go from Here? The book, a series of essays on the progress and future of the civil rights movement, shares King’s vision of equality for the nation and challenges people of all races to work together to further the causes of social justice.

Thomas and Marquis discussed the commonalities between King’s vision for equity and equality in America and the goals of the new antiracism movement in the United States.

The dialogue took place in the context of recent civil unrest throughout the United States and the world in response to police brutality, racism, inequality, and inequity, and the call for a new Civil Rights agenda.

The killing of George Floyd in May 2020 made the world take notice of what it is like to live as a Black man in the United States.

“The thing that many people lose sight of is, as a Black person in America, [the recent deaths] are not news,” Thomas said. “I’m 64 years old. I can’t think of a year where there wasn’t some incident of that nature that happened. But we weren’t able to capture it on television, or on our telephones and then put it on TV.”
He also described the all-too-common fear among Black parents that his children would be racially profiled or hurt by police. "As a Black parent, you know what terrorism means every time you send your Black sons out on a date," he said. "I can remember my wife and I staying up to make sure our sons got home."

During the discussion, Thomas and Marquis were asked, "How do we address systemic racism and resulting institutional advantages when the typical person views change from a zero-sum perspective [where] 'if you gain, I lose'?" The problem, according to Thomas, needs to be approached in terms of both the society we’re in and the society we want to build.

"In the society we’re in, leadership matters, and privilege matters," he said. "From a leadership standpoint, it’s looking at what are the institutionalized policies, the assumptions we have in our organizations, that [result in] disparities between communities of color and predominantly white communities ... and beginning to attack those policies.

“When we think about it in terms of the future we want to build with young people, how do we get them engaged in understanding each other in a deep way?” Thomas continued. “[Young people today are] much more culturally integrated, but they’re not socially and emotionally integrated. How can we begin to convert that?”

When asked how Pardee RAND can help to break down these walls, Thomas said it’s especially important for minority students to be mentored and supported, because there are so few minority faculty members.

“When we hire deans, when we appoint department chairs, look at their record on mentoring students who don’t look like them. What’s their record on mentoring faculty who don’t look like them?” Thomas said. “That tells you a huge amount. Hire faculty whose research takes things like race into account.”

He explained, “Every great piece of research has an autobiographical element behind it. That’s even more so for students of color going into a Ph.D. program, and it’s usually harder to hide.”

If faculty members don’t appreciate that, Thomas said, minority students especially may find themselves doing work that doesn’t interest them intellectually.

"How a dean defines the intellectual terrain we’ve got to map also sends signals of value to who we need here," he said. "That has to do with what students we want, what faculty we want—and that’s where I would start."

Another participant asked how RAND and other predominantly white institutions could better support people of color.

"We have to be open to learning what we don’t know," Thomas said. "If you don’t have a lot of faculty of color, to learn what you need to know, you’ll have to learn it from your students. It’s about creating relationships, and trust, and engaging, and being honest. It’s a back and forth."

This is another reason why diversity is so important within all levels of an organization, he said. He returned to the topic of conversations, or lack thereof.

"A lot of people are having conversations that sound like, ‘Hey, tell me what it’s like to be Black.’ And the white people listen, but they don’t really engage. And the Black people leave, not trusting, because it’s not a real conversation,” he said. “Part of that stems from the fact that, often times, the people asking that question have never had a real conversation with a Black person about race. They’re afraid of talking about their racial experience. White people have a racial experience, too. Anybody who has a real Black friend, who they’re able to have deep conversations with, they’re able to talk about their white racial experience.”

Marquis asked Thomas what public policy has missed. Thomas responded with a question of his own: “What are some of the social dynamics that, if we can’t fix them, … are likely to threaten [society’s] existence? We know there are a few. One we’re living now: the issue of race. It’s pulling us apart. It is tightly linked with another, which is the income gap and wealth gap in our country. They have distinguishing dynamics, but they’re inextricably linked. Until income, wealth, and educational gaps are addressed, Thomas explained, Black families will not progress like their white counterparts.

"We’re in the midst of two viruses," Thomas said, referring to racism and COVID-19. "They require the same three things: leadership, relationship, and alignment. You’ve got to apply the same leadership you would apply to a problem that you think is important to an organization, to your business, to the issue of institutionalized racism. You have to build the relationships that will equip you as a leader to engage these issues. And you have to have leaders with relationships that help them create new forms of interaction and policies that will address the problem in the long term.

"It starts with asking, ‘How serious is the problem?’ If you believe the problem is serious, you are willing to rethink and inconvenience the organization, the country, or the state, wherever you’re exercising leadership, in ways that may initially feel uncomfortable, but you’re also willing to message why this will make us better, why this will make us healthier.”

A version of this article appeared on prgs.edu in June 2020.
Leaving a legacy: Gerald Parsky gives to make the world better for his children and grandchildren

Gerald Parsky has served under two presidents, advised three more, and helped the leaders of his home state of California handle such political hot plates as tax reform and public-pension funding. *Time* magazine described him as “one of official Washington’s brightest new Wunderkind” when he became assistant secretary of the treasury in 1974—at the age of 31.

His government service introduced him to RAND. He’s been a financial supporter for more than two decades, serves on the Board of Trustees, and recently included a substantial gift to RAND in his estate plans.

“I’m a big believer in free and open public policy debates,” he said, “and I believe very strongly that one’s views should be factually based. That’s what RAND research and analysis represents—quality and objectivity. Supporting an organization like RAND, with those core values and which will use philanthropic funds in accordance with the highest standards, is important to me.”

Parsky began his career as a lawyer on Wall Street, but was soon recruited to the Treasury Department. He created and led the office that allocated oil supplies to the states during the oil crisis of the early 1970s. His appointment as assistant secretary made him the youngest person to hold that position to that point in modern history. He oversaw the department’s international affairs and capital markets policy.

He returned to the private sector in 1977, first as a senior partner at a leading Los Angeles law firm, then as the founder and chairman of an investment firm, Aurora Capital Partners. But he never quite left the policy world. He served on advisory councils for presidents Ronald Reagan, George H.W. Bush, and George W. Bush. He also chaired the University of California Board of Regents, and chaired California commissions on economic and pension policy.

“If you’ve been fortunate, or if society has been good to you the way I think it has been good to me, you look for ways in which you can contribute time, effort, and resources as a way of giving back,” he said. “I feel very strongly about that.”

Parsky’s interest in RAND dates back to his days at Treasury. He’s been a financial supporter since the 1990s, and joined the board in 2015, “because of the breadth and quality of its members.” He still follows RAND’s research on international affairs, especially on how to approach China and improve relations with countries in the Middle East.

He sees his estate gift as a legacy, to make the world better for his children and grandchildren.

“I hope it helps the next generation of leadership at RAND make important contributions to our society,” he said, “to look at problems for which there isn’t a research sponsor but for which society would benefit from RAND’s capabilities.”

His gift comes during an unprecedented campaign at RAND to raise $400 million, of which $50 million will be from estate gifts like his. And Parsky, ever the investment expert, has some advice for others who would support such a campaign.

“Consider the quality of the organization; the public good that can come from advancing its mission; the quality of the people and the leadership; and that your contribution will make a difference. On all of those factors, RAND scores very high.”

For more information about giving, visit campaign.rand.org.
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