RESOLUTION 44-19

Title: Support Availability of Public Transit Systems

Introduced by: Brent Oldham for the Medical Student Section

Original Author: Fiona Clowney

Referred to: Reference Committee D

House Action: **APPROVED**

Whereas, existing AMA policy states that "climate changes will create conditions that affect public health, with disproportionate impacts on vulnerable populations, including children, the elderly, and the poor" (H-135.938), and supports "maximum feasible reduction of all forms of air pollution" (H-135.998), and

Whereas, a shift from personal car use to public transport use can cause a six-fold decrease in greenhouse gas emissions[1], and

Whereas, the Lancet Commission on Pollution and Health has concluded that pollution can be controlled by switching to an economy that relies on public transport and discourages private car use in cities[2], and

Whereas, cities whose citizens utilize their public transit networks, averaging 50 or more transit trips per year, have half the average fatalities from traffic compared to cities with an average of 20 transit trips per year[3], and

Whereas, a study that modeled the potential health effects of switching 40 percent of private vehicle transport to alternative transport in a 1.1-million-person metropolitan area showed that per year 508 deaths were prevented due to increased physical activity, 21 deaths were prevented by avoiding traffic fatalities, and 13 deaths were prevented due to improved air conditions[4], and

Whereas, the implementation of a new transit system has been shown to generate new physical activity and decrease body mass indexes among new users[5], and

Whereas, in addition to improving air quality and reducing negative effects on the environment, public transport can increase health care access for underserved populations and geographical areas[6,7,8,9,10], and

Whereas, rural cancer patients who lack a car are often unable to access their radiation and chemotherapy treatments in neighboring towns and cities[6], and

Whereas, 78 percent of people with disabilities have challenges accessing transportation for health care services[7], and public transportation improves the quality of life and independence of young adults with disabilities[8], and

Whereas, ride share programs such as Uber are not legally required to adhere to Americans With Disabilities Act guidelines, which eliminates yet another mode of transportation for people with disabilities[9], and

Whereas, use of public transport by the elderly is associated with decreased depressive symptoms, reduced feelings of loneliness, increased contact with friends and children, and increased volunteering[10]; therefore be it

RESOLVED: That MSMS supports and shall advocate for the establishment, expansion, and continued maintenance of affordable, reliable public transport networks in Michigan to improve public health outcomes; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to advocate for the establishment, expansion, and continued maintenance of affordable, reliable public transport networks in to improve public health outcomes.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $25,000 or more as this resolution requires legislative advocacy.

Relevant MSMS Policy:

Air and Water Pollution
Reasonable and scientific study should be directed toward the sensible control of the major problems of air and water pollution, whether it is the dusts and wastes of industry, the products of combustion of gasoline or oil (automobiles), the combustion products of home heating and burning equipment, or of smoking tobacco. (Prior to 1990)
– Edited 1998
– Reaffirmed (Res02-16)

Air Pollution and EPA Clean Power Plan Policies
MSMS supports:

- The Environmental Protection Agency's authority to promulgate rules to regulate and control greenhouse gas emissions in the United States;
- Increased physician participation in regional and state decision-making regarding air pollution across the United States;
- State legislation and regulations that meaningfully reduce power plant emissions of carbon dioxide and nitrogen oxide;
- Efforts to limit carbon dioxide emissions through the reduction of the burning of coal in the state's power generating plants, efforts to improve the efficiency of power plants, and continued development of alternative renewable energy sources; and,
- National enactment of the U.S. Environmental Protection Agency's Clean Power Plan and the implementation of the Plan's policies in Michigan.

(Res77-16)

Climate Change
MSMS supports the American Medical Association policy, Global Climate Change and Human Health (H-135.938). (Res77-16)

Policy Statement of Environmental Pollution
MSMS supports efforts to improve environmental health. MSMS supports all agencies charged with the control of environmental pollution. (Prior to 1990)
– Edited 1998
– Reaffirmed (Res35-05A)
– Reaffirmed (Res02-16)

Support of Healthy Lifestyle
MSMS supports a healthy lifestyle related to nutrition and exercise and the avoidance of alcohol and tobacco. (Res36-93A)
– Reaffirmed (Res34-14)

Provide Transportation for the Alcohol Impaired Driver
MSMS supports the availability of year round safe transportation home for intoxicated persons. (Res35-95A)

Relevant AMA Policy:

Global Climate Change and Human Health H-135.938
Our AMA: 1. Supports the findings of the Intergovernmental Panel on Climate Change's fourth assessment report and concurs with the scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes will create conditions that affect public health, with disproportionate impacts on vulnerable populations, including children, the elderly, and the poor. 2. Supports educating the medical community on the potential adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies. 3. (a) Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes. 4. Encourages physicians to assist in educating patients and the public on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability. 5. Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that the AMA's Center for Public Health Preparedness and Disaster Response assist in this effort. 6. Supports epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment.

AMA Position on Air Pollution H-135.998
Our AMA urges that: (1) Maximum feasible reduction of all forms of air pollution, including particulates, gases, toxicants, irritants, smog formers, and other biologically and chemically active pollutants, should be sought by all responsible parties. (2) Community control programs should be implemented wherever air pollution produces widespread environmental effects or physiological responses, particularly if these are accompanied by a significant incidence of chronic respiratory diseases in the affected community. (3) Prevention programs should be implemented in areas where the above conditions can be predicted from population and industrial trends. (4) Governmental control programs should be implemented primarily at those local, regional, or state levels which have jurisdiction over the respective sources of air pollution and the population and areas immediately affected, and which possess the resources to bring about equitable and effective control.

Exercise and Physical Fitness H-470.997
The AMA encourages all physicians to utilize the health potentialities of exercise for their patients as a most important part of health promotion and rehabilitation, and urges state and local medical societies to emphasize through all available channels the need for physical activity for all age groups and both sexes. The AMA encourages other organizations and agencies to join with the Association in promoting physical fitness through all appropriate means.

Promotion of Exercise H-470.991
1. Our AMA: (A) supports the promotion of exercise, particularly exercise of significant cardiovascular benefit; and (B) encourages physicians to prescribe exercise to their patients and to shape programs to meet each patient's capabilities and level of interest. 2. Our AMA supports National Bike to Work Day and encourages active transportation whenever possible.

8.11 Health Promotion and Preventive Care
Medicine and public health share an ethical foundation stemming from the essential and direct role that health plays in human flourishing. While a physician's role tends to focus on diagnosing and treating illness once it occurs, physicians also have a professional commitment to prevent disease and promote health and well-being for their patients and the community.

The clinical encounter provides an opportunity for the physician to engage the patient in the process of health promotion. Effective elements of this process may include educating and motivating patients regarding healthy lifestyle, helping patients by assessing their needs, preferences, and readiness for change and recommending appropriate preventive care measures. Implementing effective health promotion practices is consistent with physicians' duties to patients and also with their responsibilities as stewards of health care resources.

While primary care physicians are typically the patient's main source for health promotion and disease prevention, specialists can play an important role, particularly when the specialist has a close or long-standing relationship with the patient or when recommended action is particularly relevant for the condition that the specialist is treating.

Additionally, while all physicians must balance a commitment to individual patients with the health of the public, physicians who work solely or primarily in a public health capacity should uphold accepted standards of medical professionalism by implementing policies that appropriately balance individual liberties with the social goals of public health policies.

Health promotion should be a collaborative, patient-centered process that promotes trust and recognizes patients' self-directed roles and responsibilities in maintaining health. In keeping with their professional commitment to the health of patients and the public, physicians should:
(a) Keep current with preventive care guidelines that apply to their patients and ensure that the interventions they recommend are well supported by the best available evidence.
(b) Educate patients about relevant modifiable risk factors.
(c) Recommend and encourage patients to have appropriate vaccinations and screenings.
(d) Encourage an open dialogue regarding circumstances that may make it difficult to manage chronic conditions or maintain a healthy lifestyle, such as transportation, work and home environments, and social support systems.
(e) Collaborate with the patient to develop recommendations that are most likely to be effective.
(f) When appropriate, delegate health promotion activities to other professionals or other resources available in the community who can help counsel and educate patients.
(g) Consider the health of the community when treating their own patients and identify and notify public health authorities if and when they notice patterns in patient health that may indicate a health risk for others.
(h) Recognize that modeling health behaviors can help patients make changes in their own lives. Collectively, physicians should:
(i) Promote training in health promotion and disease prevention during medical school, residency and in continuing medical education.
(j) Advocate for healthier schools, workplaces and communities.
(k) Create or promote healthier work and training environments for physicians.
(l) Advocate for community resources designed to promote health and provide access to preventive services.
(m) Support research to improve the evidence for disease prevention and health promotion.

11.1.4 Financial Barriers to Health Care Access
Health care is a fundamental human good because it affects our opportunity to pursue life goals, reduces our pain and suffering, helps prevent premature loss of life, and provides information needed to plan for our lives. As professionals, physicians individually and collectively have an ethical responsibility to ensure that all persons have access to needed care regardless of their economic means.

In view of this obligation,
(a) Individual physicians should:
(i) take steps to promote access to care for individual patients, such as providing pro bono care in their office or through freestanding facilities or government programs that provide health care for the poor, or, when permissible, waiving insurance copayments in individual cases of hardship. Physicians in the poorest communities should be able to turn for assistance to colleagues in more prosperous communities.
(ii) help patients obtain needed care through public or charitable programs when patients cannot do so themselves.
(b) Physicians, individually and collectively through their professional organizations and institutions, should participate in the political process as advocates for patients (or support those who do) so as to diminish financial obstacles to access health care.
(c) The medical profession must work to ensure that societal decisions about the distribution of health resources safeguard the interests of all patients and promote access to health services.
(d) All stakeholders in health care, including physicians, health facilities, health insurers, professional medical societies, and public policymakers must work together to ensure sufficient access to appropriate health care for all people.

Monitoring Medicaid Managed Care H-290.985
As managed care plans increasingly become the source of care for Medicaid beneficiaries, the AMA advocates the same policies for the conduct of Medicaid managed care that the AMA advocates for private sector managed care plans. In addition, the AMA advocates that the following criteria be used in federal and/or state oversight and evaluation of managed care plans serving Medicaid beneficiaries, and insists upon their use by the Federation in monitoring the implementation of managed care for Medicaid beneficiaries: (1) Adequate and timely public disclosure of pending implementation of managed care under a state program, so as to allow meaningful public comment. (2) Phased implementation to ensure availability of an adequate, sufficiently capitalized managed care infrastructure and an orderly transition for beneficiaries and providers. (3) Geographic dispersion and accessibility of participating physicians and other providers. (4) Education of beneficiaries regarding appropriate use of services, including the emergency

department. (5) Availability of off-hours, walk-in primary care. (6) Coverage for clinically effective preventive services. (7) Responsiveness to cultural, language and transportation barriers to access. (8) In programs where more than one plan is available, beneficiary freedom to choose his/her plan, enforcement of standards for marketing/enrollment practices, and clear and comparable disclosure of plan benefits and limitations including financial incentives on providers. (9) Beneficiary freedom to choose and retain a given primary physician within the plan, and to request a change in physicians when dissatisfied. (10) Significant participating physician involvement and influence in plan medical policies, including development and conduct of quality assurance, credentialing and utilization review programs. (11) Ability of plan participating physicians to determine how many beneficiaries and the type of medical problems they will care for under the program. (12) Adequate identification of plan beneficiaries and plan treatment restrictions to out-of-plan physicians and other providers. (13) Intensive case management for high utilizers and realistic financial disincentives for beneficiary misuse of services. (14) Treatment authorization requirements and referral protocols that promote continuity rather than fragment the process of care. (15) Preservation of private right of action for physicians and other providers and beneficiaries. (16) Ongoing evaluation and public reporting of patient outcomes, patient satisfaction and service utilization. (17) Full disclosure of plan physician and other provider selection criteria, and concerted efforts to qualify and enroll traditional community physicians and other existing providers in the plan. (18) Absence of gag rules. (19) Fairness in procedures for selection and deselection. (20) Realistic payment levels based on costs of care and predicted utilization levels. (21) Payment arrangements that do not expose practitioners to excessive financial risk for their own or referral services, and that tie any financial incentives to performance of the physician group over significant time periods rather than to individual treatment decisions. (22) Our AMA urges CMS to direct those state Medicaid agencies with Medicaid managed care programs to disseminate data and other relevant information to the state medical associations in their respective states on a timely and regular basis.

Non-Emergency Patient Transportation Systems H-130.954

Our AMA: (1) supports the education of physicians, first responders, and the public about the costs associated with inappropriate use of emergency patient transportation systems; and (2) encourages the development of non-emergency patient transportation systems that are affordable to the patient, thereby ensuring cost effective and accessible health care for all patients.

---

[1] Chester, M. and Cano, A. Time-based life-cycle assessment for environmental policymaking: Greenhouse gas reduction goals and public transit. Transportation Research. 2016;43:49-58.

[2] Landrigan, P. et al. The Lancet Commision on Pollution and Health. The Lancet Commissions. 2018;391(10119):462-512.

[3] Litman, T. Safer Than You Think. Victoria Transport Policy Institute. July 24, 2018.

[4] Xia, T. et al. Traffic-Related Air Pollution and Health Co-benefits of Alternative Transport in Adelaide, South Australia. Environ Int. 2015;74:281-90.

[5] MacDonald, J. et al. The Effect Of Light Rail Transit on Body Mass Index and Physical Activity. American Journal of Preventive Medicine. 2010;39::2:105-112.

[6] Charlton, M. et al. Challenges of Rural Cancer Care in the United States. Oncology. 2015:29(9)

[7] Kurichi, J. et al. Perceived Barriers to Healthcare and Receipt of Recommended Medical Care Among Elderly Medicare Beneficiaries. Arch Gerontol Geriatr. 2017;72:45-51.

[8] Lindsay, S. and Lamptey, D. Pedestrian Navigation and Public Transit Training Interventions for Youth with Disabilities: A Systematic Review. Disabil Rehabil. 2018;9:1-15.

[9] Mapelli, E. Inadequate Accessibility: Why Uber Should Be a Public Accommodation Under the Americans With Disabilities Act. Am Univ Law Rev. 2018;67(6):1947-87.

[10] Reinhard, E. et al. Public Transport Policy, Social Engagement and Mental Health in Older Age: A Quasi-Experimental Evaluation of Free Bus Passes in England. J Epidemiol Community Health. 2018;72(5):361-368.