The public radio show about law and American life

Justice Talking
Radio Transcript

Is There a Right to Health Care? —Air Date: 3/17/08

With health care at the top of the domestic policy agenda and the presidential candidates stumping on the issue all across the nation, Justice Talking takes a look at how health care is being handled, from Massachusetts to California. Why has a program that was meant to provide medical care to people in Third-World countries found an increasing need to set up emergency clinics in the United States? We'll also ask whether health care should be seen as a right in this country.

MARGOT ADLER: From NPR, this is Justice Talking. I'm Margot Adler. On today's show: health care in America. It's been almost two years since Massachusetts reformed its health care system. And California just recently failed to pass comprehensive changes. As the country talks about health care reform, skeptics worry that restructuring the system won't make Americans healthier.

UNIDENTIFIED MALE: Remember that the goal of life isn't to have health insurance and the goal of life isn't to have health care. The goal in life we're talking about is to have health.

MARGOT ADLER: But most plans to reform health care forget about our teeth. We'll talk with a dentist who says our dental care is critical to our overall health. Coming up after the news.

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MARGOT ADLER: This is Justice Talking from the University of Pennsylvania's Annenberg Public Policy. I'm Margot Adler. Health care reform is a major priority for many Americans. Forty-seven million Americans have no health insurance. Added to that are millions more who are underinsured, leaving them with limited access to health care. Everyone agrees that without

significant changes the cost of health care will spiral out of control. The disagreements lie in how to restructure our ailing health care system. On today's show, we'll look at attempts at reform. One city that's working to guarantee access to health care is San Francisco. Last July, it launched Healthy San Francisco, a first of its kind program aimed at providing medical care to all of the city's 73,000 uninsured residents. Part of the ordinance requires employers to help pay for their employee's health care. The controversial provision has been litigated all the way to the U.S. Supreme Court, which declined to end the program. Zoe Corneli, in San Francisco, reports.

ZOE CORNELI: This is Maxine Hall Health Center, one of the clinics where uninsured San Franciscans can get the medical care they need. For now anyone who makes up to 300 percent of the federal poverty level can sign up. Program fees are based on income. [CONVERSATION IN BACKGROUND] Rachel Dorothy is here waiting for a doctor's appointment. She lost her health insurance when her husband left her. Because Dorothy lives below the poverty line, Healthy San Francisco provides her medical visits and prescriptions for free.

RACHEL DOROTHY: It's a blessing for me. You know what I'm saying? I mean it's great. I don't know what else ... how else to describe it because I knew I couldn't afford Kaiser.

ZOE CORNELI: The city provided health care to the uninsured before this program started, but Healthy San Francisco streamlines the registration system and changes the funding structure. So far more than 13,000 people have enrolled. Until now, much of the burden for caring for the uninsured has fallen to the taxpayers. Catherine James, medical director of Maxine Hall Health Center, says that's part of the motivation for the employer spending requirement.

ZOE CORNELI: The employer contributions will raise some money to help cover the program's two hundred million dollar annual budget. But Tangerine Brigham, deputy director of the San Francisco Department of Public Health, says the real reason for making businesses chip in is to prevent them from simply dumping their workers into the public system.

TANGERINE BRIGHAM: You could in fact get individuals who currently have employer-based insurance or privately-based insurance who (which is more expensive) ... Who decide, you know, I'm going to drop my employer-based or privately-purchased insurance and substitute it for a public program because it provides essentially the same services at less cost for me.

ZOE CORNELI: Kevin Westlye is executive director of the Golden Gate Restaurant Association, which filed the lawsuit against the city. He argues employers wouldn't do that.

KEVIN WESTLYE: I have not met a single business owner that says because I can get my employees clinic care for free I'm going to stop paying health insurance. And I'm going to go to my employees and say I'm going to ask you deal with a clinic system where you have to wait in line and go to general hospital for emergencies. I, I mean, how could a business owner look at an employee in the face and ask him to do that?

ZOE CORNELI: But historically most businesses haven't covered their part-time employees. The new rule forces them to cover everyone and that costs money. [CONVERSATION IN BACKGROUND] Palio d'Asti is an upscale Italian restaurant in San Francisco's financial

district. Chef/owner Dan Scherotter says along with worrying about the increased costs he doesn't think he should have to provide coverage for young, healthy part-timers who he says probably won't go to the doctor anyway.

DAN SCHEROTTER: And frankly when they go to use health care, they'll go to the pharmacy. They'll go to the emergency room or they'll buy chicken soup. You know, kind of like I did for years when I, before I had health insurance. I look at it and try to figure out, you know, where can I get the next $60,000 that I don't have? And I can't stick it to my customers because they're not going to pay $40 for a bowl of pasta. It's good but no pasta is that good.

ZOE CORNELI: The Golden Gate Restaurant Association says that financial pressure will likely put some San Francisco restaurants out of business in the coming years. Even though businesses have five different options to meet the spending requirement, the Restaurant Association argues any city regulation relating to employer benefits is against the law. The city disagrees, arguing the employer mandate is necessary to meet the need for health care in San Francisco. Neither the city nor the Restaurant Association is likely to accept a loss in the appeals hearing in April. So this case could be heard by the Supreme Court sometime next year. For Justice Talking, I'm Zoe Corneli in San Francisco.

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MARGOT ADLER: While San Francisco has taken matters into its own hands to provide health care to the uninsured, an effort at reform on the state level recently failed. California governor Arnold Schwarzenegger proposed sweeping changes to his state's health care system. But he couldn't secure the support of the legislature. There are about six and a half million uninsured in California. Just to put that into some perspective, that's more than the entire population of Massachusetts, the first state to have successfully passed comprehensive health care reform. The Massachusetts plan is almost two years old now. It expands Medicaid, provides a subsidy to low income residents, and mandates that most people buy coverage. The plan also created something called the Commonwealth Connector, which guides people through the new system. Here to talk with me about the Massachusetts plan is John Holahan. He's the director of the Health Policy Center at The Urban Institute. At this point, the Democratic presidential candidates have been debating individual mandates that require people to have health insurance. John, why are mandates so hotly debated?

JOHN HOLAHAN: The Massachusetts plan has overwhelming support within the state and now the mandate just went into effect and people are going to feel that for the first time at tax time and the penalty is pretty small. Next year it will be greater. And you could see more opposition to it. But most people are insured. People who are staying out are potentially free-riders in the sense that they won't have paid premiums. And if they get sick or have an accident would have to rely on the taxpayers to support their care when they've never really contributed when they were healthy. So I think by and large because of that I think people see the mandate as a, almost as an issue of, um, fairness.

MARGOT ADLER: Despite the fact that Massachusetts has this law on the books, I read that almost half of the state's uninsured still haven't gotten health insurance. Why not? Is this a failure of the law or of something else?

JOHN HOLAHAN: Well I think it's relatively new. I mean I think the statistics that we know right now are that about 300,000 people have come in to this, um, Connector, most of them below 300 percent of poverty. Uh, the state officials believe most of them have been uninsured. That would roughly leave another 300,000, let's say, or two hundred and some thousand, that are outside. But the mandate had not kicked in by the time that this data was made available. So this is how many people really came in voluntarily or with the potential threat of a, of a light penalty ...

MARGOT ADLER: Uh hmm.

JOHN HOLAHAN: ... in the first year. The really stronger penalty won't come in until the end of 2008 and by that time I suspect that more people will, will be covered.

MARGOT ADLER: I know it's still early but what's your read on the Massachusetts plan? Has it been a success so far?

JOHN HOLAHAN: Yeah, I think it's a success and given how many people that have already enrolled and how well accepted it seems to be among the population. So I think so far, so good. You know, two years from now I think we'll have a much better idea when the population has had time to adjust to it and the mandate will fully kick in and so on.

MARGOT ADLER: Let's talk about the issue of employer sponsored insurance. Uh, on the national level many Republicans want to migrate away from this sort of system in which people are covered through their jobs. Why? What do they see as the problem with people getting insurance through their employers?

JOHN HOLAHAN: I think that it's that the employer sponsored insurance that we have in this country is slowly eroding about a percentage point each year. In other words, it goes from 68 to 67 to 66 percent of the non-elderly population, sort of seems to go down in bad times and continues to go down in good times. And that, particularly for small firms, for firms with low wage workers, it seems to be unsustainable.

MARGOT ADLER: I know that the Urban Institute recently reported the decline that you spoke of, the decline of insurance from employers. And this is also coming at a time when the number of uninsured in the country is growing generally. So are these two trends related? Is the number of, uh, uninsured in the country growing because they're being dropped from the coverage by their employers? Or are these two things not related or there are other factors?

JOHN HOLAHAN: Oh, they're very related. And I think, you know, if employer coverage falls, and for example in the early part of this decade we had an expansion of coverage for children through Medicaid and the State Children's Health Insurance Program. And the increases in public coverage offset the declines in employer coverage and we had a reduction in the number

of uninsured kids for a while. And in the last of couple of years ... well, we didn't see it for adults, because public coverage didn't grow. But in the last couple of years, because of state economics circumstances the public coverage stopped growing. Employer coverage continued to decline and we had an increase in the uninsured even, say, between 2004 and 2006 when the economy was really quite strong.

MARGOT ADLER: Presidential hopefuls Clinton and Obama have paid close attention to what's happened in Massachusetts and California. How successful do you think either of them can be when it comes to passing some form of universal coverage?

JOHN HOLAHAN: I suspect it would take a while. I mean I think that the debate has been over this mandate but I think that would be the last thing that I would think they should try to implement. And I think it might be a hard sell but eventually, particularly if employer coverage continues to erode, I think you're going to need to go there. But even if it's, you know, if Senator Clinton gets elected I think that it still should be the last thing that's part of her plan and everything else ought to be working well before that's, uh, that's made part of the overall package. To get to universal coverage, if this is the alternative to a single-payer system, which I think it is, then you need the mandate at some point.

MARGOT ADLER: John Holahan is the director of the Health Policy Center at The Urban Institute. Thank you so much for coming on Justice Talking.

JOHN HOLAHAN: Thank you.

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MARGOT ADLER: Coming up on Justice Talking, while the presidential candidates have been busy putting forward their ideas for health care reform we'll ask an even bigger question. Should health care be a right? Most of the industrialized countries of the world besides the United States have said yes.

UNIDENTIFIED MALE: Many nations in the world have national health care and we see all the good things and all the bad things about it. The good thing is: is that most people get health care. The bad thing is: is that the health care that they get tends to be mediocre.

MARGOT ADLER: But not everyone agrees that medical care is compromised in a national health system.

UNIDENTIFIED MALE: They're all way ahead of us to an embarrassing degree. We're not in the first 10, the first 20. We're usually in the thirties in the countries of the world. So when we talk about quality of care I think we don't win any arguments over the other countries.

MARGOT ADLER: Stay with us.

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MARGOT ADLER: This is Justice Talking, the public radio show about law, justice, and American life. I'm Margot Adler. Today we're looking at health care reform, a major issue in this presidential campaign. Each candidate has weighed in with his or her plan to overhaul the system.

UNIDENTIFIED MALE: We've got the best health care in the world. It cost more than it should. We can either go one of two ways. We can let the government take it over. And it'll lower costs. Like, like they do in other countries. We will also sacrifice care.

UNIDENTIFIED MALE: The single most important element is does it cover everybody? Because if it doesn't everybody then I think whoever the candidate is should be made to explain what American they believe is not worthy of health care coverage.

UNIDENTIFIED MALE: Only 17 million Americans right now buy their own health insurance. If 50 million Americans were buying their own health insurance because it would be just as tax advantageous to do it that way, and we had health savings account ...

UNIDENTIFIED FEMALE: Because I believe if we don't have universal health care we will never provide prevention. I have the most aggressive measures to reduce costs and improve quality.

UNIDENTIFIED MALE: She would force in some fashion individuals to purchase health care. If it was not affordable she would still presumably force them to have it unless there is a hardship exemption as they've done in Massachusetts.

UNIDENTIFIED MALE: I don't think that there should be a mandate for every American to have health insurance but I'm not going to mandate that every American go to college. I feel the same way about health care. If it's affordable and available then it seems to me that the, again, it's a matter of choice amongst Americans.

MARGOT ADLER: Senators Obama and Clinton are both strong proponents of universal health care. Their disagreements lie in how to achieve that goal. But some say it's time to go further and make health care a right. Democratic Congressman Jesse Jackson, Jr. has proposed a constitutional amendment that would do just that. But what would it mean if health care were a right? Joining me to debate this are Russell Roberts and Dr. Quentin Young. Russ Roberts is a professor of economics at George Mason University and a research fellow at Stanford University's Hoover Institution. Quentin Young is a practicing internist and teaches preventive medicine and community health at the University of Illinois Medical Center. He is co-founder of Physicians for a National Health Program. Welcome both of you to Justice Talking.

QUENTIN YOUNG: Thank you.

RUSSELL ROBERTS: Good to be here.

MARGOT ADLER: Most people agree that our current health care system needs dramatic reform. Should health care be a right? I'd like you both to respond. Quentin, let's start with you.

QUENTIN YOUNG: Well, I emphatically believe, and have for almost all my professional life, that it is a right, that any other approach to the problem of health care is going to come a cropper. Now having said that, I don't mean remotely to imply it is ... recognizes the right or practices a right in this country. Other countries do operate on that principle. But in brief, I emphatically believe it's a right.

MARGOT ADLER: Russ, how about you?

RUSSELL ROBERTS: Well, for me it's not a matter of belief. It's a nice idea for everyone to have health care. It'd be even better if everyone had phenomenal health care. And it's a better world where no one ever gets sick and lives to 120. But that's not the real world. The real question is how we treat health care as a public policy issue in the real world depends on the incentives we face as consumers and as doctors and as bureaucrats. And I worry about how those incentives are structured. And when we talk about something is a right, we're basically moving away and ignoring those incentives. And we're going to move to a world where I think health care will be enjoyed by everyone but I worry at a very low level.

MARGOT ADLER: Uh hmm. So what about the idea that it might be in our national interest to make sure everyone gets adequate medical care?

RUSSELL ROBERTS: What does that mean "in our national interest?"

MARGOT ADLER: Well, essentially that it's good for our country.

RUSSELL ROBERTS: What does that mean "good for our country?" It'd be good for me to have more health care than I have now. It'd be good for you. Question is, how do we pay for it? And how do we make sure that the people who we worry don't get enough health care get it and the people who have plenty don't get more than that and throw ... waste resources. So I don't think there's any way you can talk about the nation's health care. As individuals we all have different incentives and different resources and we want to see people taken care of obviously. The question is, how do you do that in the most effective way possible?

MARGOT ADLER: Quentin, you want to respond?

QUENTIN YOUNG: I do. Uh, it is in the national interest to have good health status whether it's workers in the work force not missing time because they're ill or parents being able to be good parents because they're health is maintained. We have in this country a model, a flawed model, but much better than anything else we've got in the world of Medicare where in 1965, Congress passed and the President signed a bill that made everybody over 65 a beneficiary. And later, fully disabled people were added to the group. And this group has enjoyed this benefit happily while the rest of the systems were almost invariably bad.

MARGOT ADLER: Russ, I'm going to assume that you would say there's a problem with Medicare.

RUSSELL ROBERTS: Well, Medicare is, uh, pretty effective and also very expensive. The real question is what happens if we made it a model? It's always easy to take a little corner of the health care field and say, well, this is working well. Question is, would it work well if it were large? We often have this debate about health care as if it were a theoretical conversation. What might the world look like if we move to a world of, say, nationalized health care? Well, most, as Quentin points out, many nations in the world have national health care and we see all the good things and all the bad things about it. The good thing is: is that most people get health care. The bad thing is: is that the health care that they get tends to be mediocre.

MARGOT ADLER: Quentin, what ...

QUENTIN YOUNG: Let me comment ...

MARGOT ADLER: Oh, go on.

QUENTIN YOUNG: Yeah, I'd like to comment on the "little corner." Forty three million people enjoy Medicare. I don't buy the, uh, the erroneous view that America's singularly more innovative and that the rest of these nationalized systems are, you know, mediocre care as you put it. It's excellent care. The health standards in each of these countries by the usual ways we define health standards: life expectancy, freedom from preventable disease, infant mortality, maternal mortality. They're all way ahead of us to an embarrassing degree. We're not in the first 10, the first 20. We're usually in the thirties in the countries of the world. So when we talk about quality of care I think we don't win any arguments over the other countries.

MARGOT ADLER: I'd like you to talk a little bit about this whole question of innovation ...

RUSSELL ROBERTS: Yeah. Sure.

MARGOT ADLER: ... because one of the things that I've experienced is when I talk to my friends who've lived in Europe. And who have, you know, come back from, let's say, living a year in France or living a year in Germany, or even living a year in England. They'll say things like, ahh, it was just amazing! My, you know, my kid got glasses every six months. All the medical care was fabulous. And they usually have incredibly positive responses to it.

RUSSELL ROBERTS: Well, that could be. There are good things about it. Maybe your friends had good experiences. I'd like to talk about this question of innovation and the modalities that, that were mentioned. Other nations have better health care outcomes than we do. You don't want to use that as the only measure of the success of the system because obviously they have different baseline health care endowments and different populations, etc. We've have a much more diverse population than most countries. So let's look at what I meant by innovation which is the use of technology, the use of MRIs, the use of various imaging technologies, the use of pharmaceuticals, the use of biotech. All of those things, many of them come from the United States, biotech, biomedical industry. And they're not going to keep innovating if they can't

make a living, they can't make a profit, they can't make a high return. They are high risk activities. If the government got involved in the particular area that we're talking about we're going to have a very stodgy, un-innovative system because the political system will not stomach those costs and risks. They don't do it anywhere else. In Canada they don't do it. They don't do it in the U.K., the countries that I'm most familiar with. Their use of technology, their use of innovation, their production of technology and innovation is way behind ours. And if we start to emulate them we will become more like them.

MARGOT ADLER: Quentin, you want to respond?

QUENTIN YOUNG: Yes, of course. I, uh, I think the presumptions that government is bad and profit-making is good is hard to prove. In this country in particular we have enormous achievements by government in interventions or government activities that dwarf whatever profit-seeking, uh, improvements we could mention. I'll start out with the National Institutes of Health, by far the most successful way to fairly distribute research money and on its own accounts for America's superiority in biotech, a government function by definition. I'm a little less enthusiastic about the operation of the profit motive in the health care system. It has its place. The health care system, the record of profit-seeking, is a mess and a shame and unless we fix it, we will go down as a nation economically and health-wise.

MARGOT ADLER: I want to push you a little bit, Quentin, on one of these issues. Um, you say that health care should be a right but as I start thinking about that, I'm saying what part of health care should be a right? Just essential care? Who decides what's essential, what isn't? What about elective surgery? How do you go about deciding that?

QUENTIN YOUNG: I know how I would opt for deciding it, which is obviously the best way — joke. Uh, the point is there are standards. We have in the world of medicine, which I inhabit, we have a whole array of standards based on best practices, constant review of experience. We don't have enough of that. We're moving into that age and the technology helps us. But that's the answer to your question — what is, uh, the necessary and reasonable and appropriate? There are some things that are excluded by definition, by and large these plans do not pay first dollar for cosmetic entities and, uh, they don't allow you to get a drug because you want it nor should they. But you, it's not as hard to set standards as your question implies. I really feel comfortable about that.

MARGOT ADLER: Russ?

RUSSELL ROBERTS: Well, I think it's a lot harder to define standards when they move. If we want to say what the standard is today, yeah, it becomes fairly easy I suppose. There's still going to be a political fight as there is over anything the government does. And the decisions that the government makes are not done by experts. They're not done by good-hearted people. They're done by politicians and bureaucrats. And it's part of the sausage factory of special interests which some of it comes out pretty well and some of it comes out pretty ugly. Again, I don't have any problem with someone who argues that we should move toward and we get more egalitarian system, but it is not free. And we have to face the costs. The cost is, I believe, a more mediocre system. That might be a cost worth paying. Much of what we pay for in health

care right now isn't very effective. There's a lot of money wasted in the current system. There would be a lot of money wasted in a, in a government system but I think it would be a more static, less dynamic, and a tougher world for our great-grandchildren, or grandchildren, or maybe us.

MARGOT ADLER: I want to talk a little bit about employer-based health plans. People who have them love them. The numbers of people who have them are declining. Companies find them burdensome. I would imagine partly because they have to compete globally with European companies that don't have to shoulder such costs because the government takes it on. So I'd like you both to weigh in with the question whether it would be better for companies if they could get out of the health insurance business totally. You want to start, Quentin?

QUENTIN YOUNG: Of course that shouldn't be there and it is indeed making us non-competitive with many areas of production. And it's, it's a fluke. With this ... the history of this is worthy of mentioning. It happened during World War II when there was a wage price freeze because we were in a war economy. And in an effort to entice the workers which were in short supply with so many of our youth in the army that they, the companies, joined with unions in asking can we have perks that would let us compete better in the search for good workers. And the perks that were allowed included health care benefits. And the unions at that time, it was not possible to push for better wages under the law so they did push very hard and became very proud of these employment-based programs.

RUSSELL ROBERTS: It's very important in this debate, debate at large not our little debate, but the debate at large to remember that the goal of life isn't to have health insurance and the goal of life isn't to have health care. The goal in life we're talking about is to have health. And a lot of times people talk about it as if the health care crisis is a problem of health insurance. They are related obviously. If you're a person without health insurance, life is more anxious and it could be less healthy if things go wrong and you can't afford to pay for it. But it's important to remember at the same time that our obsession with health insurance and health coverage, especially at the governmental level, is one of the reasons we spend so much money on health care. In a world where government was not involved in the health care market, in a world where we were relying on our own choices which is what we do in many, many areas and things come out great. In the areas of food and shelter and many areas where we think, oh, they're crucial things just like health care, people make free choices. The outcomes are very, very good and the prices fall every year in real terms. Health care doesn't. And part of the reason for that, maybe the major reason, is because we subsidize it via the government. So to move farther in that, further in that direction, I think, would be to exacerbate and make this problem even worse.

MARGOT ADLER: What do each of you see as, as the best solution to our health care crisis? Uh, we'll start with you Quentin.

QUENTIN YOUNG: Well, I've already revealed my hidden agenda. I think it's obvious that we must move to a single payer national health insurance and take all the vast resources we have and make sure that everybody is in, nobody out. In contrast to the 47 million uninsured which doesn't mean you're out, it just means you're just malfunctioning. You go to ERs at a high cost instead of a private, a private physician for low cost. And that's just one of the areas that would

be mended. There's an equal number probably of people with poor insurance that comes into play whenever they have a serious illness. They'd be mended. And then we could address — I'm sure this will get Russ's rile, rage up — but we address the exorbitant profits for our pharmaceutical industries which are confiscatory in that they don't ... many people just can't afford them. Even though they need them. And that's, that's not a good society. So that's my answer and I hope we're moving toward it rapidly.

MARGOT ADLER: Best solution, Russ.

RUSSELL ROBERTS: Well, I have no rage [LAUGHTER] so I just, uh, try to keep my, keep my ire down.

QUENTIN YOUNG: I apologize.

RUSSELL ROBERTS: Pharmaceutical profits don't get me upset and taking them away won't get me upset. What would get me upset is removing the incentive for pharmaceutical companies to innovate which I think has been a great contributor to health. The cost of those profits if we eliminated them and made them zero the impact on our health care expenditures would be basically, uh, not even to, in the decimal point. It would just, it's a very small fraction of the money that we spend on health care and it happens to be a part that we spend that actually works surprisingly well. Not perfectly obviously. There are things that are not perfect. But if I were to move to an ideal system, my ideal system would solve what I think is the major problem with the current health care system. The major problem with the current health care system is the separation between the consumer and the payer. We've seen that system work elsewhere badly, uh, education is the best example. Free education which is a glorious idea leads to mediocrity. It's what we see in most public school systems in the inner cities and even in some cities. So when I look around and I see how that system works, it doesn't work particularly well. I think health care if we continue to move in that direction of free provision, having it financed by taxes, it would also not work very well, again, because the incentives are not there. So I want to move back to a world where people have the incentives both to provide good health care and to consume health care that is of value. And also the incentives to help people who are not able to afford health care and the incentives to make the world a better place over the next 10, 20, 50, and a 100 years. Our human creativity is our greatest gift. We will, I hope, continue to use it wisely. Providing free health care is a way in my experience and looking around at other areas to dampen that creativity. And so it comes at a cost.

MARGOT ADLER: Russell Roberts is an economics professor at George Mason University. Quentin Young is a doctor who co-founded Physicians for a National Health Program. I loved this discussion. Thank you for talking with me.

QUENTIN YOUNG: Thank you.

RUSSELL ROBERTS: Thank you.

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MARGOT ADLER: Massachusetts is on its way to making mental health care a right, at least for low income children. Pediatricians are now required to do mental health screenings of their Medicaid patients and some pediatricians are worried.

UNIDENTIFIED MALE: There's been more pressure on us as a professional group because we see kids in a first line fashion, um, to do more of that on our own. You know, we're at flu season so there are lots and lots of other kinds of problems that we're dealing with in pediatrics. And mental health is not, uh, something you can do quickly.

MARGOT ADLER: And we'll hear about a group that was created to provide free health care in the developing world. These days they're doing most of their work in rural America. Stay with us.

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MARGOT ADLER: Justice Talking has entered the blogosphere. Each day check out a new commentary from one of our contributors who cares passionately about law and justice issues. At JusticeTalking.org, you can also find forums where you can weigh in on the issues we cover on Justice Talking, like the environment, criminal justice, religious freedom, and elections. Continue the debate online with other Justice Talking listeners at JusticeTalking.org.

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MARGOT ADLER: This is Justice Talking, where we make the connection between law, justice and American life. I'm Margot Adler. So far on today's show we've focused on health care reform. But one aspect of health care, mental health care, is getting new attention. A bill to improve mental health parody is making its way through the halls of Congress. And in Massachusetts there's a new focus on mental health care for children. As of January 1st this year, all pediatricians in Massachusetts are required to screen their young Medicaid patients for mental health problems. A judge ordered the screenings after ruling that the State was failing its mentally ill children. Supporters hope screenings will identify troubled children at younger ages. But some worry the new efforts won't actually lead to more treatment for children who need it. Karen Brown reports.

UNIDENTIFIED MALE: D, Z, D, Z...

KAREN BROWN: This 14-year-old boy from Westfield, Massachusetts is flying through his annual physical at Holyoke Pediatric Associates. The eye chart, hearing, blood pressure, [SOUND OF BLOOD PRESSURE CHECK] and this year one more assessment.

UNIDENTIFIED FEMALE: Is he done with the questionnaire?

UNIDENTIFIED FEMALE: Oh yeah.

UNIDENTIFIED MALE: Yep.

UNIDENTIFIED FEMALE: Thank you much, and Dr. Brooks will be in. Okay?

UNIDENTIFIED FEMALE: Okay.

KAREN BROWN: The questionnaire is something all Massachusetts pediatricians must now give their Medicaid patients and many practices like this one give it to all patients. For teenagers, the form has 35 questions about their mood and behavior. This boy who asked not to be identified didn't mind filling it out. Although he did find some questions overly simplistic.

UNIDENTIFIED MALE: Two of the questions in particular: are you ever sad or are you ever angry? And I was thinking everybody's sometime sad and everybody's always sometimes angry. I think you should check "never" off the choices for that one.

KAREN BROWN: The boy's doctor, Betsy Brooks, had been concerned about his emotional health since his parents had recently divorced. After going over his questionnaire she decided he was doing fine. But she's going to keep a close watch. Brooks is a strong supporter of mental health screenings. She says they are the first step to moving mental health higher on the priority list for doctors and policy makers.

BETSY BROOKS: The idea of this is to make it a routine part of well child care. It's like your vision is checked. Your height is checked. Your weight is checked. And there is a check-in in growth and development. And that that check-in is more systematic than what we've been doing.

KAREN BROWN: While state and federal health officials have long recommended mental health screenings, Massachusetts is one of the first states to mandate them for Medicaid patients. The screenings came out of a 2005 lawsuit known as Rosie D. v. Romney. In the class action suit, a judge found the state of Massachusetts was failing to provide enough services for mentally ill children. The annual screen is the first remedy to come out of the judge's ruling. Pediatricians have to offer the questionnaire to all families, although families can decline it. Any child who scores high on the questionnaire is supposed to be examined further or sent to a psychiatrist.

UNIDENTIFIED MALE: Screening is proactive where you're, you're actually systematically trying to find out if kids have mental health problems. If you wait for people to complain you're kind of missing a lot of people.

KAREN BROWN: Barry Sarvet is a child psychiatrist at Bay State Medical Center in Springfield who's long pushed for mandatory screenings by pediatricians.

BARRY SARVET: Psychiatrists can't be proactive because we're specialists and we don't see people before they kind of get sick and have to be referred. Primary care doctors are really the only ones who can be proactive and who can identify kids before outcomes start happening.

KAREN BROWN: But there's a potential Catch-22. Some doctors are worried the screening will be too successful in finding new consumers of mental health care. Massachusetts, like most

states, has a critical shortage of child psychiatrists and long waiting lists for therapy. The Massachusetts Society for the Prevention of Cruelty to Children estimates that already 100,000 children a year don't get the mental health care they need. That's why the judge in the Rosie D. lawsuit also ordered the state to significantly expand services. But that could take years, and in the meantime pediatricians like David Norton are worried the screenings will simply create scores of anxious parents with nowhere to go.

DAVID NORTON: If there aren't resources then they might come back to us for help and I don't feel that we're really appropriately trained. Or at least I don't feel I am in carefully diagnosing more complicated developmental and/or behavioral mental health problems in children.

KAREN BROWN: Norton is a colleague of Dr. Brooks at Holyoke Pediatric Associates but unlike Brooks he doesn't think it's fair or even wise to ask pediatricians to fill in the gap in mental health services.

DAVID NORTON: There's been more pressure on us as a professional group because we see kids in a first line fashion, um, to do more of that on our own. And that involves more continuing education. It involves learning a lot about new medications. It involves close follow-up of kids. You know, we're at flu season so there are lots and lots of other kinds of problems that we're dealing with in pediatrics. And mental health is not, uh, something you can do quickly.

KAREN BROWN: But psychiatrist Barry Sarvet says pediatricians can do more than they think and help ease the system logjam. He says the most common mental health problems in children, depression and attention deficit disorder, have established treatment protocols that can be easily taught.

BARRY SARVET: Psychiatry has been balkanized, uh, as this, you know, mysterious specialty that can only be done by, you know, a bearded, uh, psychiatrist who, uh, has ways to read people's minds. But it's really not as mysterious a field.

KAREN BROWN: Some critics say screenings will lead to pathologizing normal child behavior and overuse of psychiatric drugs. But doctors like Betsy Brooks believe the contrary, that there will be less need for complicated mental health services, even medication, if you catch the problems early. [CHILD CRYING] She's even screening some infants and toddlers like this 18-month-old girl who is labeled high risk because her mother had allegedly used drugs while pregnant.

BETSY BROOKS: So, Cheyenne, I'm going to check you out. You're going to have all sorts of things ...

KAREN BROWN: But Brooks, like most health advocates, says the state will have to do more than mandate screenings if it really wants to help children. A bill in the Massachusetts legislature would require insurance companies to pay for more mental health services and help coordinate state agencies that handle child mental health. In the meantime, doctors like Barry Sarvet want medical schools to incorporate psychiatry better into pediatric training. That way

the next generation of primary care doctors might consider mental health a natural part of their practice. For Justice Talking, I'm Karen Brown.

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MARGOT ADLER: It's not just mental health care that is sometimes separated out of comprehensive health care. Dental care is often neglected as well. In fact, dental insurance is a separate benefit from health insurance. But there's one group of volunteers that ignores these bureaucratic distinctions when it comes to offering care. Remote Area Medical provides medical care and dental care for free in areas of the world with little access to health services. Although the program was created to serve people in the developing world, 60 percent of their work is now done in rural America, in Virginia, Kentucky, and Tennessee. Teams of volunteer medical personnel set up a temporary clinic for a couple of days, sometimes in a tent on a fairground, or in a gymnasium. But founder Stan Brock says it's harder to get volunteers for his sites in the U.S. than for clinics in far-off places like the Amazon or Haiti.

STAN BROCK: In the overseas arena I think there's a perceived adventure factor. But here in the United States, um, we do have a lot of difficulties in getting sufficient numbers of dentists and eye doctors and physicians to volunteer in their own backyard.

MARGOT ADLER: More than 1,000 people sometimes show up at these clinics.

STAN BROCK: So it's overwhelmingly adults and it is overwhelmingly the desire to get their teeth fixed because they're in agony with bad teeth. And to get their eyes fixed and to get themselves a pair of free eyeglasses from us so that they can, you know, attain a job or just able to read the newspaper for a change and that sort of thing. Because even though many of our patients are on Medicare, Medicaid, they do not cover dental work. And they do not cover vision care with eyeglasses. Now the profile of the patients that come to our clinics is very much that of people who really do need the rest of the health care services that we provide such as mammograms and pap smears and general medical treatment. But they're so anxious to get their teeth fixed.

MARGOT ADLER: Has your experience, um, given you some, some sense or insight of what you think should be done in the health care realm here in the States?

STAN BROCK: Oh, very, very much so, Margot. Um, the first thing that needs to be done and that is to allow doctors, nurses, dentists, veterinarians — because we have a very big veterinary program here at Remote Area Medical as well — to be able to freely cross state lines here in the United States to provide free care.

MARGOT ADLER: So you're not allowed to cross state lines?

STAN BROCK: No, no, no, absolutely not, and, uh ...

MARGOT ADLER: That means the doctors aren't or the organization isn't?

STAN BROCK: No, no, the doctors are.

MARGOT ADLER: Oh, because they're licensed in one, in one state and can't cross into another state in other words?

STAN BROCK: That's exactly right. I have an airline transport pilot's license and I'm able to fly anywhere I want to, uh, within, you know, legal limits. But, uh, if you're a doctor in state X and you want to go and volunteer your time in state Y, you're not allowed to do that. Back in 1995, we managed to get the forward-thinking Tennessee legislature to pass a law called The Volunteer Health Care Services Act. Which allows Remote Area Medical and indeed any, uh, charitable organization to bring in doctors and nurses, etc. from out of the state of Tennessee and prove that they are a doctor in good standing by just showing us a copy of their license. And they roll up their sleeves and go to work immediately. There's no delay and there's none of this preamble and hoops that you have to jump through. Now we tried to get the law changed in Kentucky and Virginia and, uh, we did indeed get them to, uh, pass legislation but they made it too difficult.

MARGOT ADLER: And one of the other things that you said, uh, you said you provide veterinary services. Do people come with their pets?

STAN BROCK: Oh yeah. We ... sometimes we'll hold a joint operation here where we have the medical teams in, uh, in one part of the camp, uh, and then we'll have the veterinary team in another part. And, uh, people will, you know, wait all night with their dogs and their cats and, uh, and they say, well, I want my teeth fixed as well. So we take over the pets and take them to the veterinary clinic for their, their procedures and we do the dentistry on the, on the mamas and papas and at the end of the whole procedure we reunite everybody, people with pets, and they go on home.

MARGOT ADLER: Stan Brock is the founder and director of Remote Area Medical. Thank you so much for speaking with me today.

STAN BROCK: It was a pleasure. Thank you very much.

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MARGOT ADLER: As Stan Brock mentioned, one of the most common reasons that people will travel for hours to come to a Remote Area Medical clinic is for dental care. Nearly one-third of Americans have no dental insurance. That works out to about one hundred million people. Burton Edelstein joins me now to talk about dental care in America, a subject that's been left out of the national debate over health care reform. He's a professor of dentistry and health policy at Columbia University. He also sits on the board of the Children's Dental Health Project which works to improve children's oral health and their access to dental care. Welcome to Justice Talking.

BURTON EDELSTEIN: Thank you.

MARGOT ADLER: I want to know why dental care is seen as separate from other medical care. They're both about your health, right?

BURTON EDELSTEIN: They're definitely both about health. Dental and medical parted ways right from the beginning of the professions in the United States, uh, so that dental evolved as its own independent profession and not incorporated within the medical care structures. And therefore has its own separate schools, has its own separate agencies and associations. And as a result dental and medical are often seen as uniquely different, just as mental health services are often not well integrated with medical services.

MARGOT ADLER: Talk about what the lack of attention to dental care means in the long run.

BURTON EDELSTEIN: Well, let's start with the short run if I could. In the short run, it often means pain and infection. And dental pain has been described by many as one of the most severe pains. It's very vocalized.

MARGOT ADLER: Excruciating. Excruciating. Let's be, be right out there with it. [LAUGHS]

BURTON EDELSTEIN: Very much the case. And that pain in children causes real distraction. But chronically the problem is more the relationship between the mouth and the rest of the body. Periodontal disease is an infection of the gum tissue. The gum tissue in area is about the same size as the palm. So if you could envision that your entire palm has an infection, you can imagine how that infection could seed into your blood stream and cause distant problems. So periodontal disease has been associated in various ways with poor birth outcomes, with exacerbation of diabetes, with cardiovascular difficulties, even with some kidney problems. And none of that is unexpected because if you had a chronic long-standing, significant infection anywhere the body being integrated across all of its parts would be impacted.

MARGOT ADLER: Hmm. So as you look at this and study this and are on various boards that deal with it, what kind of solutions do you see out there to begin to address the lack of dental health parity?

BURTON EDELSTEIN: We consider four areas of redress for the problem. The first is financing. The financing for dental care and Medicaid is very, very much lower than the financing for the rest of the population. And with inadequate financing there is inadequate access to the existing dental resources. The second is work force. How many dental providers are there out there? How are they distributed? What are their competencies? What are their availabilities to populations with the greatest needs? And the fourth is the one that's really the most critical. That is turning off the tap of the disease in the first place. Really focusing on prevention, disease management, and eradicating as much of the disease as possible so that we don't have to chase after the delivery system to try to address the needs that are pent up and built up in the population.

MARGOT ADLER: Um, earlier you talked about, um, dental and medical always being separate. But dental and medical have never been considered equal. So why, I can understand them being separate, but why has there been this inequality between dental and medical?

BURTON EDELSTEIN: It has in part to do with the understanding and appreciation by the public of dental services and the confusion between primary health services offered by dentists and cosmetic elective services. It has to do with the fact that many dental conditions are very chronic and they don't become acute and very painful until well into their advanced stages. So people just get by and get along with the dental problems. It has in part to do with policy makers understanding and appreciation of the issue. And politics being what it is with so many competing issues, unless there is some acute episode that brings attention and focus to a problem it's often a problem that is just let go.

MARGOT ADLER: Burton Edelstein is a professor of dentistry and health policy at Columbia University. Thank you so much for coming on our show.

BURTON EDELSTEIN: You're very welcome. Thank you.

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MARGOT ADLER: The presidential candidates have been telling us how they want to change our health care system. But what are your ideas? Tell us what you think at Justicetalking.org. You can post on our message boards, learn more about our guests, and sign up for our free podcast. And check out our blog where many of the nation's leading commentators give their views on law and American life. Thanks for listening. I hope you'll tune in next week. I'm Margot Adler.

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