**An idea labeled "un-American"**

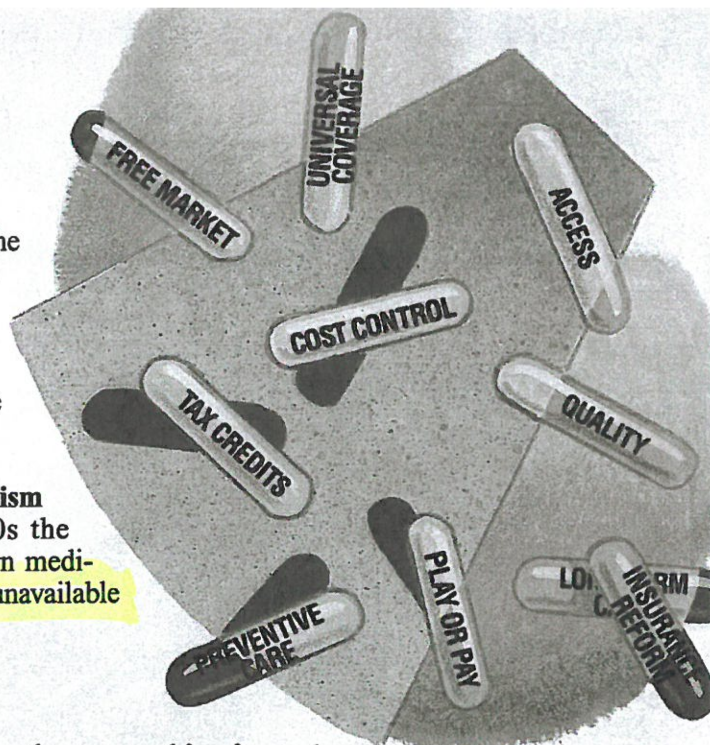
Let's begin in 1912. Teddy Roosevelt, running for President against Woodrow Wilson, endorsed the Progressive Party platform that pledged "protection against the hazards of sickness . . . through the adoption of a system of social insurance adapted to American use." Wilson won, however, and the issue disappeared from the Washington scene for a time.

Later in the decade when other Progressive reformers introduced legislation to encourage a state-run insurance system, state medical societies and the American Federation of Labor opposed it. But the most devastating blow to health insurance was the charge that it was "un-American." It was argued that Bismarck had invented it in Germany and thus it was a foreign import. This position proved so effective that labeling health insurance "alien" has had appeal—even to this day—to all those who take a stand against it.

**The first step: Social Security**

We next move to the 1930s, the decade of the Great Depression, when Americans turned to Franklin Delano Roosevelt to solve the nation's problems. It was a calamitous era with numerous crises.

This time Washington responded. Many of the protections we now take for granted—Social Security, unemployment insurance, the Federal Deposit Insurance Corporation—were born during F.D.R.'s Administration. It was a time when we were less cynical, when we had faith in government, when we believed Washington could make a positive difference, and when, with leadership, it did so.




Roosevelt also envisioned a program to deal with "the major hazards and vicissitudes of life which cannot be wholly eliminated in this manmade world of ours." Although his Cabinet-level Committee on Economic Security didn't dispute the need for health insurance, it decided not to recommend that medical benefits accompany Social Security. The Committee feared that such inclusion would jeopardize Social Security's chances of being enacted.

To many, that assessment was correct. The sentence in the Social Security bill calling for "further study" of public health insurance was stricken unanimously by the Ways and Means Committee. Reason: The Administration was convinced "that little line was responsible for so many letters to members of Congress that the entire Social Security program seemed endangered." This was a time when Secretary of Labor Frances Perkins, testifying on behalf of Social Security, was asked, "Won't you agree that there is just a teeny-weeny bit of socialism in your plan?" Little wonder Roosevelt submitted his proposal noting that he was "not at this time recommending the adoption of so-called health insurance."

F.D.R. was powerful, but so were the forces of organized medicine and Republican opponents, joined by conservative Southern Democrats. As was the case two decades earlier, public education about health-care-reform issues was woefully lacking. Given the absence of public involvement and understanding, no effective citizens' organization ever sprang up to counter any of the opposing lobbyists' claims.

Although Roosevelt later pledged in 1944 to support "the right to adequate medical care and the opportunity to achieve and enjoy good health," World War II absorbed most of his attention. The battle over health insurance paled by comparison to all the real-life battles that were raging overseas.

**The fear of socialism**

By the late 1940s the benefits of modern medicine had become unavailable to those Americans whose employers did not provide comprehensive health insurance as a fringe benefit to their workers and to those who did not have the funds to purchase private coverage. New President Harry Truman decided it was time to address this remaining gap by renewing the fight for universal health insurance.

## 'Socialized medicine' had forced its way into our vocabulary

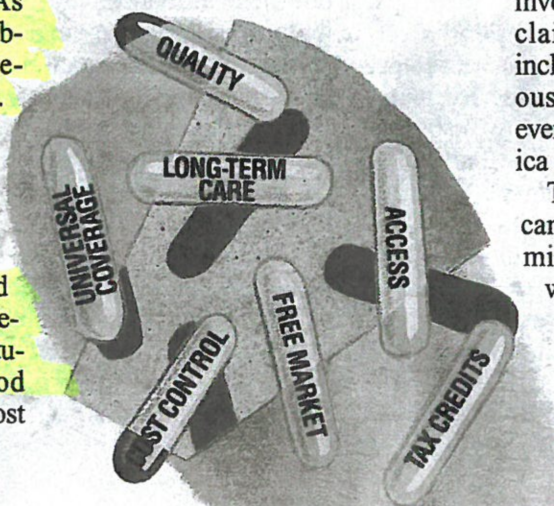
On September 6, 1945, he sent a message to Congress outlining a proposed economic bill of rights for every American citizen. Echoing Franklin Roosevelt, he also spoke of "the right to adequate medical care, the opportunity to achieve and enjoy good health . . . and the right to adequate protection from the economic fears of . . . sickness." People would continue to get health-care as before—with one difference: Receipt of services "would not depend on how much they can afford to pay."

It was a hard and harsh fight. Opponents used an argument that would be invoked (unsuccessfully) a decade later against Medicare: Instead of one universal program covering *all* Americans, offer limited federal assistance to state programs that help the poor and needy.

The American Medical Association mounted an expensive and effective campaign against Truman. It invoked the fear of communism by claiming that reform's supporters included "the President, all who seriously believe in a socialistic state, every left-wing organization in America [and] the Communist Party."

Truman fought back: "The American people are the most insurance-minded people in the world. They will not be frightened off from health insurance because some people have misnamed it 'socialized medicine.' "

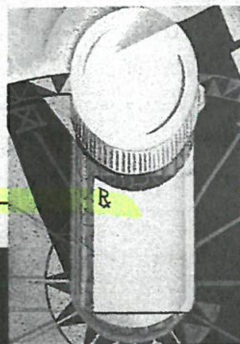
He was wrong.



Harry Truman left office in 1953 having fought, and lost, one of the most bruising battles in history on behalf of comprehensive health-care reform. The term "socialized medicine," used in a pejorative rather than an analytical sense, had forced its way into our political vocabulary. It has not only maintained its presence there ever since, but its image and power have persevered.

**The miracle of Medicare**

The defeat of Truman's proposal led its supporters to change their strategy. Instead of trying to sell the concept of insuring everyone, emphasis was shifted to protecting only the aged. In a way, this made more sense because the elderly were the ones in greatest need. Since Social Security beneficiaries were older they had greater medical needs; since they were retired they lacked the advantages of group enrollment through employment. As their health-insurance costs rose, more of them lost their private coverage.



So government was once again called on to respond. And this time it did—soon after the 1964 election.

*continued on page 30*

# The SIX *keystones of reform*

*America has learned many lessons during its struggle to enact comprehensive health-care reform. But six maxims stand out from the rest. No foundation for universal health-care reform will hold up unless the following building blocks are in place:*

**1 The debate must be issue-oriented.** Because health-care reform is so complex, it needs thoughtful analysis of the pros and cons of the various proposals. What it doesn't need is emotional rhetoric, stereotypical labeling, and stigmatized slogans such as "socialized medicine" that solve nothing and simply squelch debate.

**2 Proposals must be simple and understandable.** Americans want to know how a plan relates to them. We understand the *basics* of Social Security (even if we don't understand the benefit formula) and we know generally how Medicare works (even if we don't fathom how DRGs are computed). In 1965 all Medicare advocates needed to know was "it will put the equivalent of a Blue Cross card into the wallet of every older American."

**3 Reform must address all problems.** It's not enough to guarantee insurance only for those without it. Health-care reform must also control costs. It must calm our fear of losing insurance if we lose or change jobs. It must promise that our premiums and out-of-pocket costs won't skyrocket if our employers cut back coverage. It must remove the possibility that "pre-existing conditions" or a sudden, serious illness will ever again affect us or our children. And finally, it must end our subjugation to forms and waste and fraud.

**4 Coverage must be universal.** The strength of Social Security and Medicare is that all of us are or hope to be beneficiaries. We have a stake in these programs and the way they work. The weakness of welfare and Medicaid is that, because few of us will or hope to be recipients, we think of them as being for someone else and have little interest in their adequacy or effectiveness.

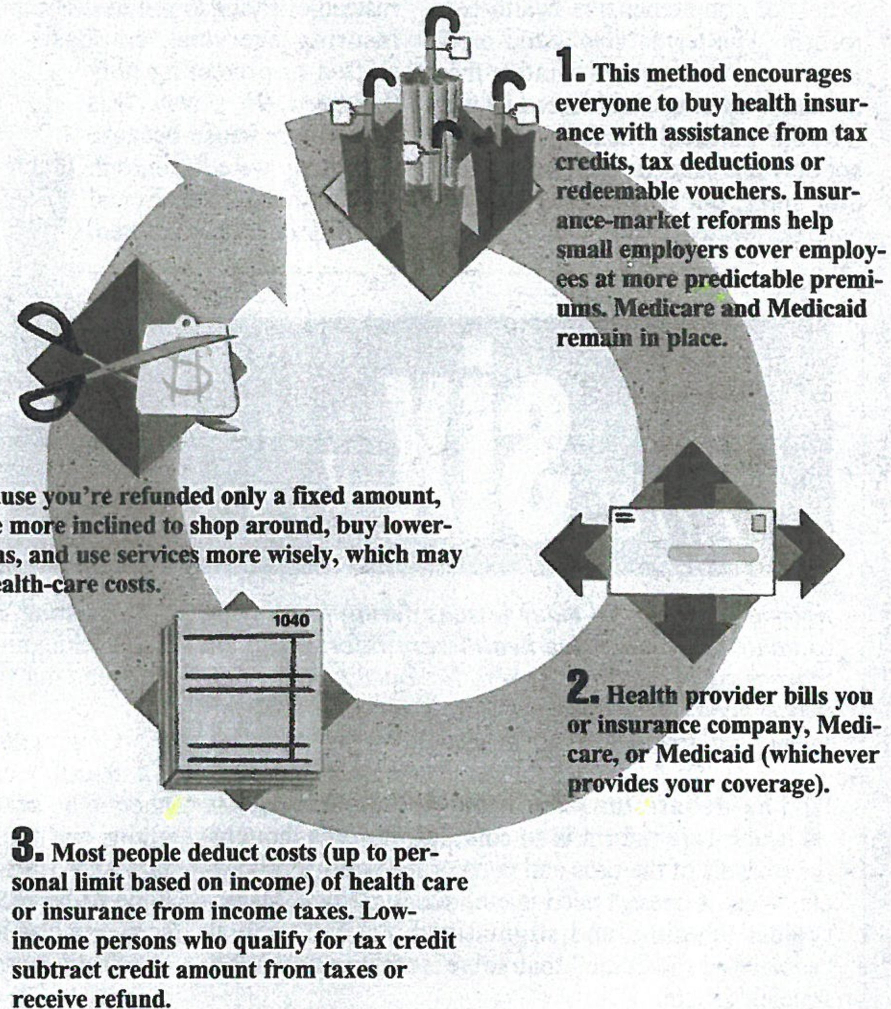
**5 The campaign must involve and educate the public.** The history of health-care reform and Medicare proves that legislation won't happen just because a small group of politicians think it's necessary. Without understanding, organization and pressure by the public, Congress will feel little need to reach consensus any time soon.

**6 The President must lead.** Many current health-care-reform proposals, if passed, would greatly disrupt various industries and areas of our society. As a result, Congress and the President will face resistance from many citizens, corporations and special-interest groups. We need a President, therefore, who will ensure that people who don't "get their way" don't block action. It's inconceivable that a social program of the scope required could pass without the President teaching, mediating, leading. —*R.F.*

# Private-market approach

*After decades of tinkering and bickering over health-care reform, three major approaches to financing have emerged*

Under this approach, also known as "tax credit/voucher," some people get health insurance from their employers or buy it themselves. Government tax credits/vouchers and deductions make such purchases easier for low-income persons. Insurance-market reforms also stabilize premiums for small firms. Those who are self-employed receive a 100 percent tax deduction. Others receive coverage from Medicare or Medicaid, although most current proposals expand Medicaid to give coverage to all the poor.




**1. This method encourages everyone to buy health insurance with assistance from tax credits, tax deductions or redeemable vouchers. Insurance-market reforms help small employers cover employees at more predictable premiums. Medicare and Medicaid remain in place.**

**2. Health provider bills you or insurance company, Medicare, or Medicaid (whichever provides your coverage).**

**3. Most people deduct costs (up to personal limit based on income) of health care or insurance from income taxes. Low-income persons who qualify for tax credit subtract credit amount from taxes or receive refund.**

**4. Because you're refunded only a fixed amount, you'll be more inclined to shop around, buy lower-cost plans, and use services more wisely, which may lower health-care costs.**

## PROS

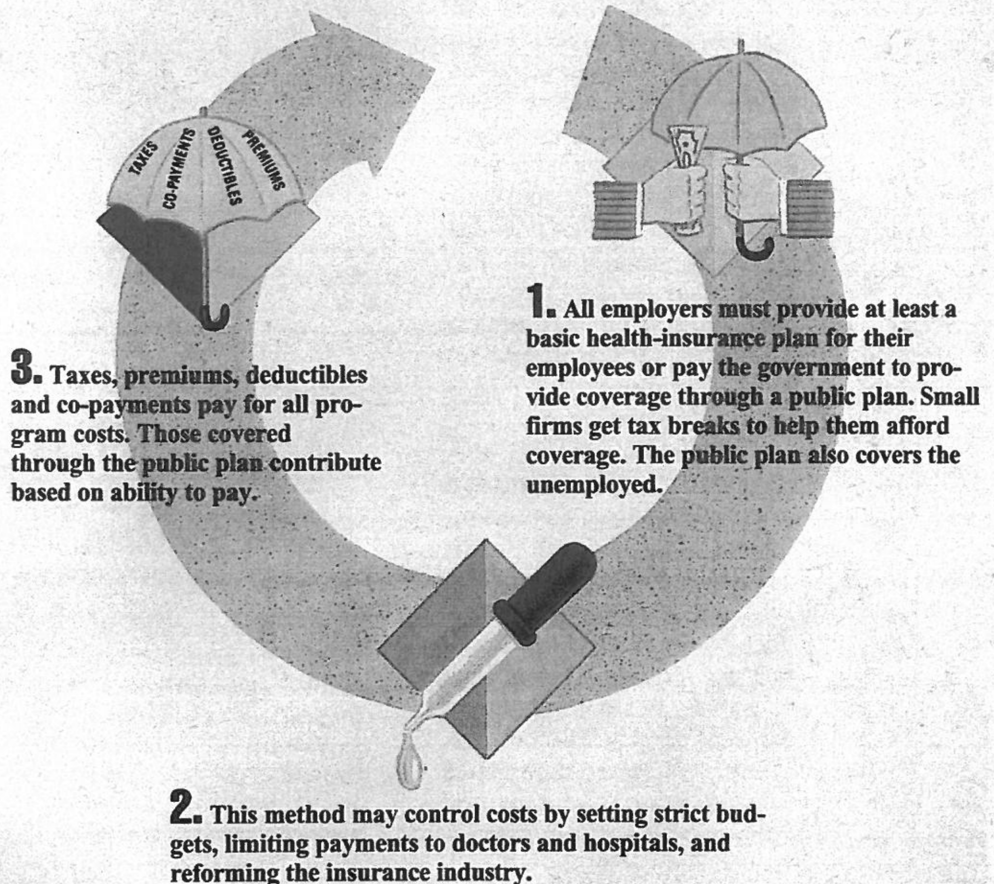
- Provides greater health-care access for some groups of people.
- Builds on, rather than replacing, current system.
- Eliminates exclusions for pre-existing conditions.
- Promotes managed-care concept (HMOs, PPOs, etc.), which sets fees and budgets to control costs.
- Gives people incentive to price-shop for insurance and medical care, improving individual choice and reducing personal costs.
- Stimulates competition among insurance companies, improving quality and reducing costs.
- Maintains private market-based approach.
- Increases government involvement and regulation, but at significantly lower degree than either of the other two approaches.

## CONS

- Doesn't mandate coverage for everyone.
- Requires consumers to have a sophisticated knowledge of insurance plans.
- Relies primarily on questionable cost-control strategies already in place.
- Opens door wider to fraud and false advertising by health-insurance companies.
- May require much greater government regulation to monitor insurance marketing practices.
- Doesn't address administrative waste.
- Would require increased taxes or cuts in benefits.
- Continues two-tier medical system in which those who can afford it have greater coverage, while low-income people receive minimum coverage.
- Lacks long-term-care coverage.

# Employer-based approach

Under this approach, also known as "play or pay," everyone receives health insurance from either the employer or the government. Employers must "play" by providing insurance, or "pay" a tax to provide coverage through a public plan. Reforms make health insurance more affordable for small businesses. Preventive care, pre- and postnatal care, and additional benefits for low-income individuals are generally included. Medicare remains for older Americans and the disabled, and it includes people of all ages and incomes in some proposals. Long-term care is usually provided for as part of a separate social-insurance program.




## PROS

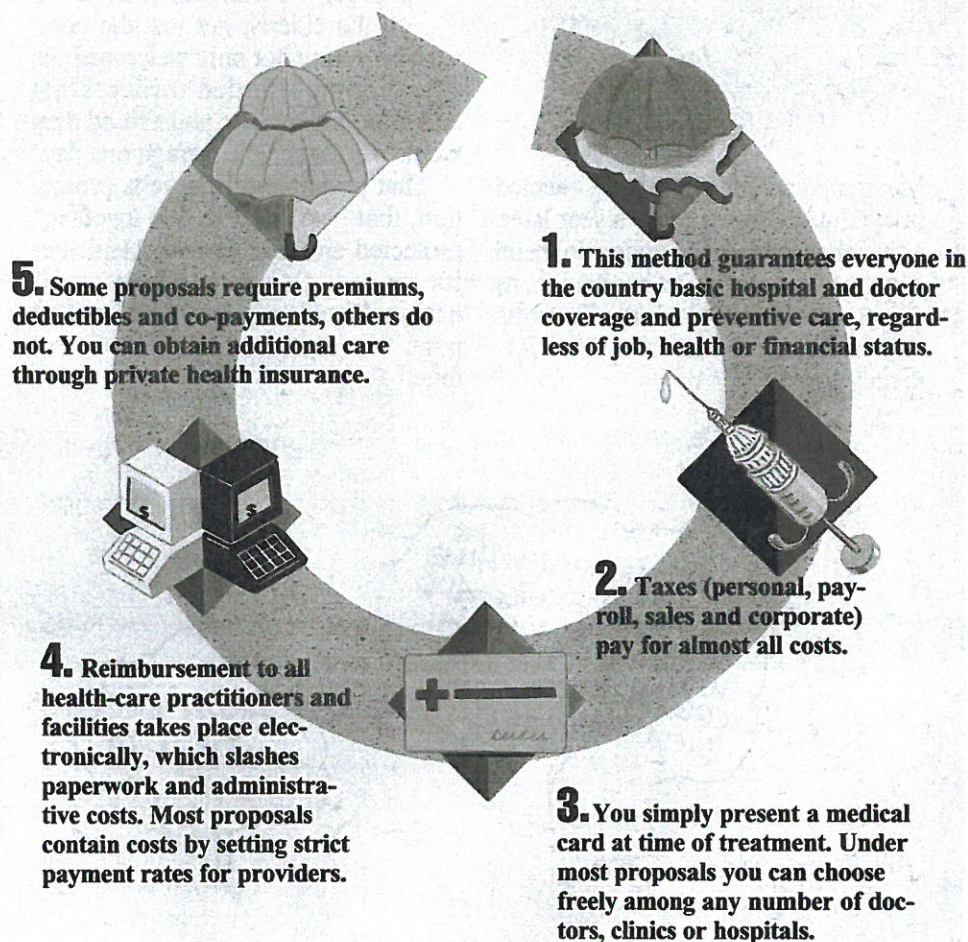
- Provides coverage for everyone.
- Builds on, rather than replacing, current system.
- Eliminates exclusions for pre-existing conditions.
- Enables the government and private insurers to eliminate cost-shifting by health-care providers.
- Reduces out-of-pocket costs substantially for many groups of people.
- Shows good potential for cost containment.
- Maintains competition among private-market insurance companies.
- Spreads risk (and cost) across entire population.

## CONS

- May offer no real incentive for some employers to "play" because tax route may be cheaper (depending on level of employer tax), which could shift millions of employed people into government pool.
- Requires small businesses to pay, through either health insurance ("play") or more taxes ("pay").
- Enables some insurance companies to continue to operate, which means at least some of their administrative costs (e.g., advertising) also continue.
- Increases taxes, although by much less than necessary for government-based approach.

# Government-based approach

Under this approach, also known as "single payer" or "national health insurance," the government becomes the sole payer for all health-care services. Everyone receives access to guaranteed basic hospital and doctor coverage. Preventive care, pre- and post-natal care, and additional benefits for low-income individuals are generally included. Some plans include long-term care. Some proposals replace Medicare, Medicaid and all private insurance plans with a national health trust fund paid for through taxes. Others expand the Medicare program to include all ages, eliminating the need for Medicaid or private insurance. Employers no longer have to provide insurance to employees, although they are required to contribute financially to the new program for their employees' coverage. Health-insurance companies play no more than a limited role, providing only supplemental insurance.

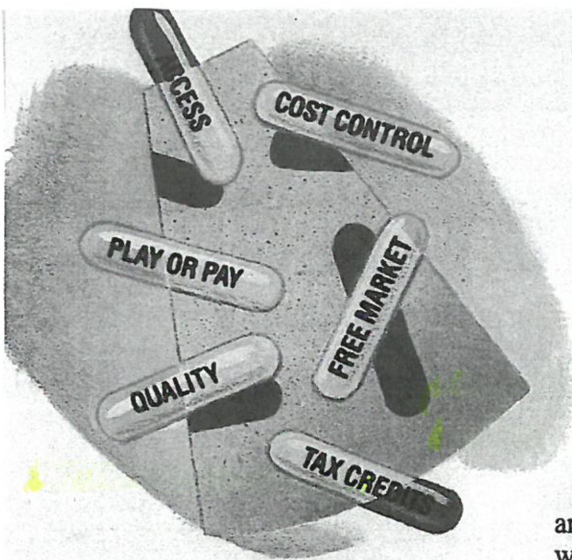



## PROS

- Guarantees access to care for all individuals.
- Eliminates exclusions for pre-existing conditions.
- Reduces or eliminates many out-of-pocket costs.
- Controls costs by setting payment rates or limits on health-care spending.
- Controls administrative costs and makes system simpler by eliminating or minimizing paperwork.
- Removes employers' responsibility to provide health insurance, though they continue to pay for coverage through taxes.
- Greatly reduces insurance companies' role, thus lowering administrative costs.
- Spreads risk (and cost) across entire population.
- Ensures coverage if people lose or change jobs.

## CONS

- Increases taxes substantially.
- Puts government in charge of whole system, which could lead to budgetary constraints affecting choice, quality, use of new technologies, and, in turn, to waiting lists and shortages..
- Reduces competition, which traditionally has been source of innovation and new technologies in health-care arena.
- Significantly curbs need for private insurance coverage, resulting in thousands of lost jobs throughout insurance industry.
- Could allow political and ideological biases more power to influence scientific decisions, curtail experimentation and limit coverage.




Medicare and Medicaid were enacted in 1965 and implemented a year later, after what President Lyndon Johnson described, according to one source, as "the largest management effort this nation had undertaken since the Normandy invasion."

It's important to recall that although Medicare was a successful alternative to insuring people of all ages, its proponents nevertheless lauded those universal aspects it sustained: It involved *all* the elderly, not just the poor. The young not only welcomed the protection afforded their parents and grandparents but understood they would also receive coverage one day.

That principle of umbrella protection, that "we're all in this together," protected and popularized Medicare. Its success also gave advocates of national health insurance renewed hope that their dream was still very much alive.

**The debate picks up**

It was President Richard Nixon who started the health-care ball rolling again when he stated, "We face a massive crisis in [health] . . . a breakdown in our medical-care system. Things do not have to be this way. We can change these conditions—indeed we must change them—if we are to fulfill our promise as a nation. Good health care should be readily available to all our citizens."

In 1971 extensive hearings on health-care insurance were held before the House Ways and Means Committee. In 1972 Medicare was extended to cover the disabled. In 1974 the Administration's support of the Comprehensive Health Insurance Program seemed to ensure that America's health-care-financing mechanisms would be restructured. By July of that year 22 different health-care-reform bills had been introduced to the Congress.

Although important differences among the various measures caused some concern, legislators from both parties and all important national organizations supported action. For the first time in decades experts were truly optimistic that sweeping legislation was close at hand.

Once again, the optimists were wrong. In the end unbridgeable differences prevented the divergent parties from reaching agreement. The reasons were many: Some wanted to wait until after the next election when support for their favorite approach would be greater. Others were so convinced of their own rightness that they preferred inaction to compromise. Still others believed the problems were the business of the states, not the federal government.

Eventually the complexity of the myriad proposals and problems confused the electorate and dissolved their support. To make matters worse, public priorities changed. National attention soon switched to Watergate and to inflation. When asked about

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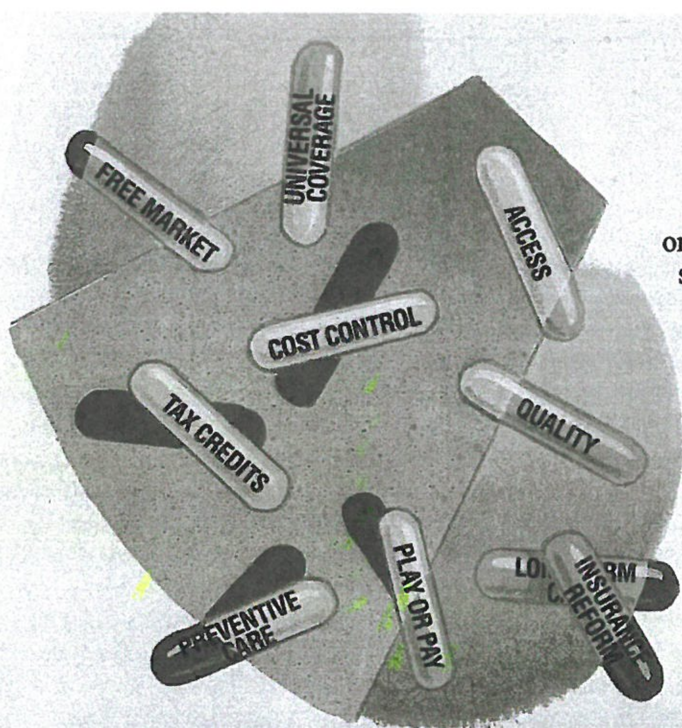



health-care reform, the policymakers just shook their heads, saying the issue would have to wait until the inflationary spiral had been contained.

Furthermore, a real conflict had arisen among adherents of two different and powerful schools of thought: one endorsing comprehensive change ("You don't leap over a chasm in two steps"), the other an incremental approach ("You must proceed one step at a time").

Clearly the issue of comprehensive health-care reform had become more complex. No longer was it enough simply to argue that health care should be a right rather than a privilege. Now proponents were forced to consider complicated issues such as quality, access, cost, rationing, malpractice, administration, paperwork, technology, billing, et al.

In recent times the debate has taken place in an even more hostile environment: President Ronald Reagan made it clear he wanted market competition rather than government intervention. Paramount during his two terms was concern about the deficit, which negated all major domestic-policy innovations and new social initiatives.

**Has the time finally arrived?**

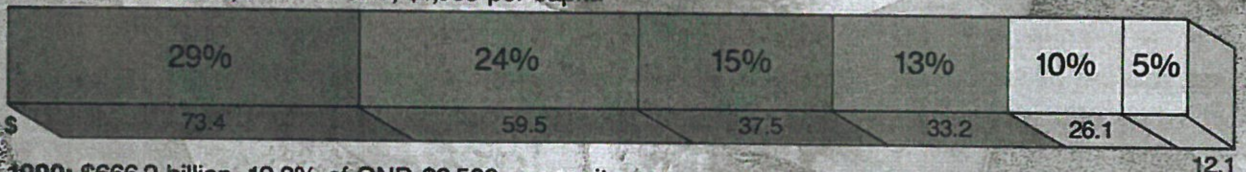
Today our health-care system has grown even larger and more complicated, and the disaffection of large parts of the electorate with Washington has intensified. This hardly seems to bode well for any major or forthcoming legislative breakthrough.

Nevertheless, experts almost unanimously agree that America is close to or already experiencing a health-care catastrophe. Very soon, analysts predict, the various interested parties, providers, payers and patients will have no choice but to come to the table to negotiate and compromise all their myriad differences.

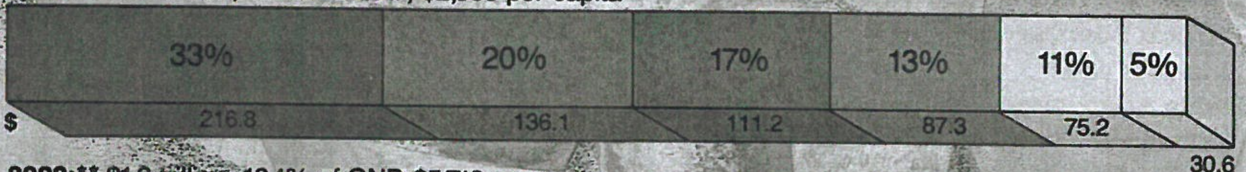
## What our health care costs *

*in billions of dollars*

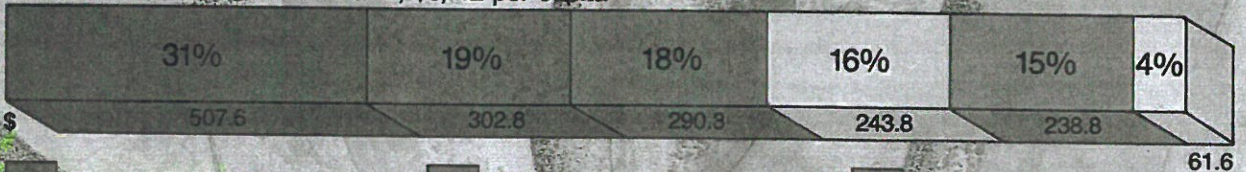
**1980:** $250.1 billion, 9.2% of GNP, $1,063 per capita




**1990:** $666.2 billion, 12.2% of GNP, $2,566 per capita




**2000:**** $1.6 trillion, 16.4% of GNP, $5,712 per capita

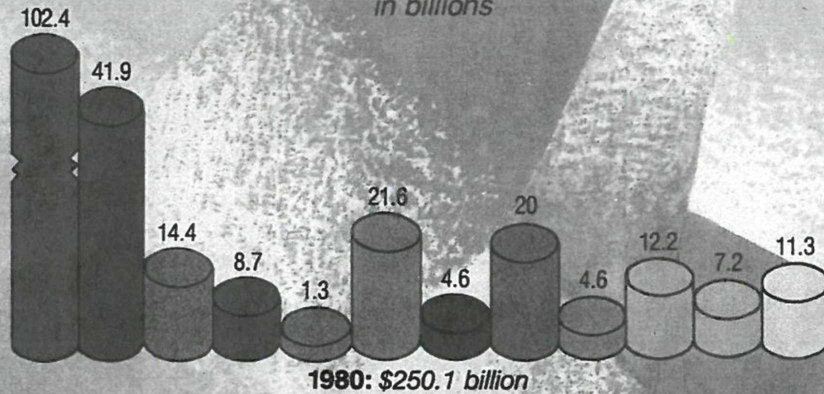


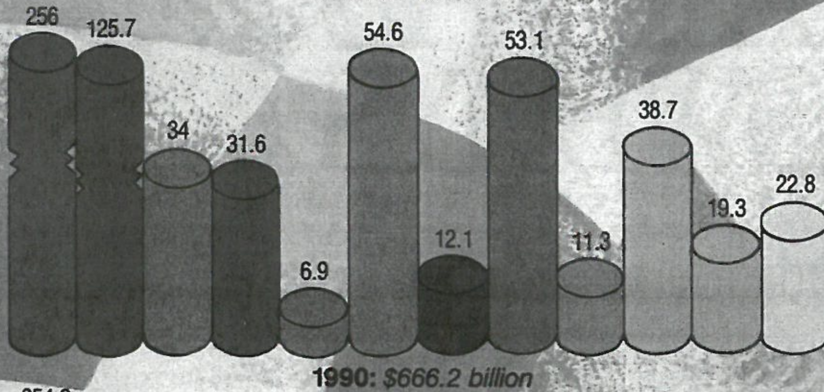

Private health insurance
Medicare
Out-of-pocket payments
State/local governments
Medicaid
Other private spending

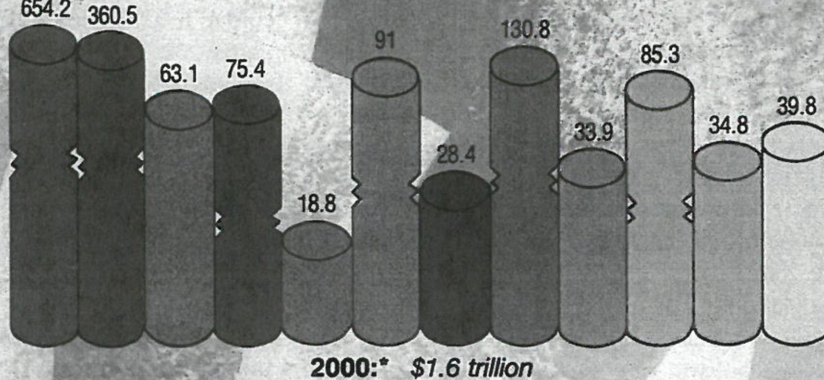
*Dollar amounts will not equal total, nor percentages equal 100, because of rounding

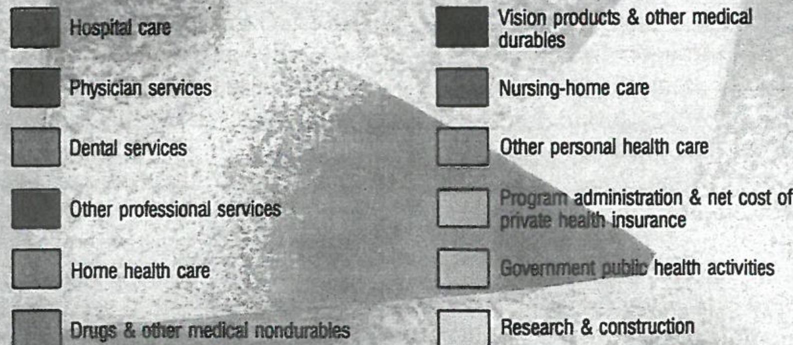
**Projected expenditures   Source: Health Care Financing Administration

## Where our health dollars go




*Projected

*Source:* Health Care Financing Administration

Why so much certainty this time? Is this the real thing or just a replay of earlier errors that also predicted imminent change?

The renewed sense of optimism and resolve rests primarily on two factors. (1) We're better able to apply lessons learned from past health-reform failures as well as successes such as Medicare. (2) Former adversaries are finally more willing to cooperate (for example, business, which traditionally opposes any form of government intervention, and labor, which traditionally negotiates for higher wages irrespective of the economic climate; today both sides recognize the common enemy—health-care costs—and are uniting to take up the fight against it).

This time, as with Medicare earlier, the need for change is bubbling up from everyone simultaneously:

Frightened and vocal middle-class Americans no longer want rhetoric, they demand assurance that they'll continue to receive access to adequate health-care coverage for themselves and their families.

Employers, ravaged by increasing health-care premiums and unwilling to cut wages, want ways to decrease the cost of employee health care, which would free more funds for research and development.

The government wants to reduce the deficit by containing the inflationary increases in Medicare and Medicaid costs, which would free more funds for other domestic concerns.

And doctors and hospitals want to replace intrusions into their clinical decisions with more effective ways to control costs.

What's new in 1992? What's new is everyone is unhappy and our health-care system is coming apart. Harry Truman said it almost 50 years ago: "We are a rich nation and can afford many things. But ill health is one thing we cannot afford."

What's really new is that we're now closer than ever before to acting on that statement. ■

By Melanie Johnston

# CANVAS COWBOYS

## Western artists ride the range of color

Jeanne Kinoshita is giddy with excitement. She and her husband, Gil, have traveled to the Phoenix Art Museum from California to bag what amounts to big game in the world of cowboy art—a painting, any painting, by Howard Terpning.

This is the annual Cowboy Artists of America Show and Sale, an event that takes on the electrified atmosphere of a prize-bull auction because buyers are determined not by who can write the biggest check, but by whose name gets drawn from the locked boxes into which hopeful collectors have slipped their bid cards.

By the luck of the draw, Gil's name is drawn second. The Kinoshitas are tantalizingly close to taking home Terpning's *Digging In at Sappa Creek*, at $185,000 the most expensive work in the show.

*Melanie Johnston is a Southwest freelance writer and a regular contributor to **Arizona Highways**.*

Clutching a glass of champagne, Jeanne stares at the group, looking for any sign of movement. If Doug Erion, whose name was drawn first, does not come forward, the painting will be theirs. Howard Terpning, behind the crowd, fields handshakes from admirers while keeping one eye on the activity before his canvas.

The Kinoshitas' crossed fingers notwithstanding, Erion at last saunters up to sign the papers. Jeanne Kinoshita affects a Shirley Temple pout. The couple vow to try again next year.

In an era when many artists can only dream of turning collectors away, many of the 24 members of the Cowboy Artists of America (CAA) have to do just that. Founded in a Sedona, Arizona, tavern in 1965, the CAA was conceived as a kind of fraternal trade association. Artists gathered twice a year, once to mount an inspirational trail ride in the frontier tradition, again to showcase their work in a communal sale and exhibit. Over the years the "CA" brand, which only members may sign next to their names, has become a bankable commodity. "It means you get more for your work than you used to," jokes co-founder Joe Beeler.

Richard Nilsen, art critic for *The Arizona Republic*, is one holdout who fails to see artistic value in the genre. Equating it with "motel art," Nilsen says CAA members' work lacks the bite and edge necessary to qualify as art. "A real artist works beyond the scope of his talent, not comfortably within it," he says.

Susan McGarry, editor-in-chief of *Southwest Art* and a champion of cowboy art, says such dissenting opinions don't diminish the pleasure many people derive from the work. "Art is not a mass item," she insists. "It shouldn't appeal to everyone."

Many cowboy artists have traveled circuitous paths before becoming celebrities in the Western art scene. The following five portraits reveal the interesting diversity of the Cowboy Artists of America.