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Yes, But Is It Health Insurance?

by Lee Wenzel

The problems of access, quality, and cost inherent in the current healthcare delivery system are a direct result of using the insurance framework or paradigm for a set of services that mostly do not conform to being an insurable risk. We blame insurance companies when we should blame insurance itself. There is a strategic misalignment between the inherent nature of the form of finance, that being insurance, and the inherent nature of health and more narrowly, even most medical services. These strategic problems will not be resolved by tactical maneuvers and adaptations. Fortunately, insurance is only one of eight paradigms available in our toolbox for forms of finance governing all financial transactions. The strategic task is to open the toolbox and design a viable way to finance healthcare.

The purpose of this article is to make explicit the implicit abandonment of insurance implied in the recently enacted national healthcare legislation. When everyone can obtain coverage and premiums are not related to risk, that is no longer insurance. To the extent that the concepts of insurance guide implementation, the system might well implode for lack of outcomes and uncontrollable costs. Reform is to move into alternative forms or paradigms.

Clean up our language

We need an accurate use of terms and a solid and logical conceptual base before economic science and business expertise can bring to bear alternatives and data to design and implement a viable system. Health insurance is an oxymoron that desperately needs elucidation if we are to design an adequate system to finance medical and broader healthcare services.

To take the first term, the *health* in health insurance usually refers only and primarily to medical services under the control of physicians. Health clubs obviously provide health services or they wouldn't be called health clubs, but most health club revenue does not come from health insurance. Nursing homes and custodial care provide healthcare services, but have only minimal financing from what we refer to as health insurance. Instead they are mostly financed by procurement (people buying directly), Medicaid (an entitlement, not insurance), Medicare for a short time (also an entitlement and not insurance), and increasingly long-term care insurance.

One would think that health insurance would provide financial compensation for the financial risks attendant to loss of health. In addition to paying for required medical services, this would include inability to work (disability), chronic and long-term nursing and healthcare services, and of course the ultimate loss of health which is death.

An entitlement plan that had financial liability for situations when a cure is not

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available, such as for ALS or Alzheimer's, would provide necessary ongoing care and have financial incentives to invest in critical research. Our insurance system has provider incentives for expensive treatments, if approved by the claims process, but no incentives for medical research.

The nature of insurance makes insurance most appropriate for medical cure in contrast to health care. Health services are broader than medical services. In addition, services oriented to care, rather than cure, generally do not conform to being an insurable risk.

What makes this matter of being an insurable risk so important is that the paradigm rules. Systems built on the principals of insurance tilt towards paying for insurable services and tend to deny or limit uninsurable services. This tilt happens despite the best intentions of providers, consumers, and public policy.

The good news is that most medical insurance plans and companies long ago abandoned medical insurance. They function mostly as third-party administrators (TPAs) and do not underwrite risk. The bad news is that even as we have shifted mostly from insurance to entitlements, we still call it insurance and apply many of the concepts and principles that are ill-suited to financing healthcare services.

An insurable risk

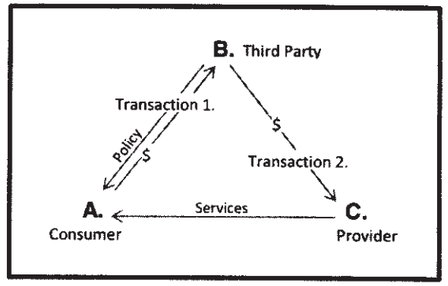
And what is an insurable risk? Think about insurance. Insurance is a way to have the money we need when improbable catastrophes occur. Using the laws of large numbers, a premium is charged when the policy is sold based on the probability of the undesirable event and the amount of money needed should that happen. Insurance is always for undesirable events and to compensate for a loss.

Insurance is always a conditional contract. If this happens, then that is what will be paid or provided. For insurance to work there has to be an objective and legally definable basis for a claim and for the consequent benefits or obligations of the insurance provider.

Third-party transactions

To understand how this works, one must dissect the dynamics of any third-party payment design.

As shown in the accompanying diagram, the first transaction between parties A & B is the purchase of a policy. In exchange for a premium, a contractual guarantee is made to pay for or provide "medically necessary" services that are usually limited by a specified list. As it has evolved, the second transaction is usually between parties B &C. In



order to fulfill its contractual obligations to A, the third party B buys services from C, the provider, which are delivered to A, the consumer. The consumer could submit a claim to B and receive payment which is then sent to C, although that is rarely done in practice as it creates uncertainties for the provider and more bookkeeping and work for the consumer. The provision of services by C for A is not an economic transaction in itself, but a consequence and the completion of the other two transactions.

These two transactions are in very different markets. Transaction One (A to B) is insurance. Transaction Two (B to C) is procurement.

Note that the consumer is not buying healthcare or medical services. The consumer is buying coverage for the possibility of being eligible for services. In practice, the services are purchased by the third party who becomes the provider's customer. The incentives for the consumer are to pay as little for coverage and get as much as possible from the provider or plan. The incentives for the third party are to collect as much in premium as possible and pay out in claims as little as possible. One lucrative way to do this is to make the policy commitments to the consumer as vague or buried as possible, or deny the providers' judgment as to necessity. This is particularly easy to do in areas such as need for psychotherapy. The incentives for party C, the provider, are to provide the maximum volume of services and at the highest price that the third party will tolerate. Of course there are other tactics in how B treats C such as those related to claim denial, difficulties in filing claims, or timeliness of payments.

Note from the diagram that a third party payment preempts a financial transaction between the consumer and the provider. As a consumer I'm left out of weighing cost-to-benefits and excluded from service considerations and decisions based on cost. What about deductions and copayments? Deductions and copayments are not insurance; they are exemptions from insurance. They define risk that is not covered. The result is that the consumer's health and welfare are dependent upon the negotiations between these two other parties, the third party payer and the provider, each with their own financial incentives.

In this tripartite arrangement, who decides medical necessity and the services I should receive under the terms of the policy? If the services are indeed medically necessary, then I shouldn't be asked about my insurance when I go to the clinic or hospital. By definition, I need necessary services and should get them regardless of who is paying or how much is paid. If the services are contingent upon who is paying and how much, then they are contingent services and not medically necessary services.

The original meaning of a professional service is that because of the nature of the services and the technical knowledge and trustworthiness of the provider, the provider decides what I need and what I will pay. The professional has a fiduciary responsibility for the economic transaction to be in my best interest. Under this meaning of professional, every bankruptcy from medical costs is prima fascia evidence of non-professional conduct.

More about insurable risk

Insurance pushes to take medical providers out of the diagnosis process. The consumer or a technician could feed the objective data into a computer which contains algorithms to determine the diagnosis, the course of treatment, and automatically send prescriptions to the pharmacist. Doctors are only needed for interventions requiring specialized skills, such as surgeons. Insurance doesn't support the importance of personal relationships for most chronic health conditions. The insurance problem with chronic conditions is that they begin so gradually that it is difficult to determine eligibility for a claim. Moreover, they are often not cured.

Some naïve people argue that insurance should cover prevention as a way to avoid costly acute interventions. Such arguments fail to understand the pervasive influence of the financial paradigm, and how prevention is antithetical to insurance. Insurance pays for claims and loss, not prevention. Things that are preventable should be managed and prevented, not insured. Insurance is for events over which we do not have control.

In a similar naïve vein, some argue for outcomes-based medicine. Insurance is based on compliance and is indifferent to outcomes. Ask any life insurance company about the outcomes of the claims they have paid and they would be hard pressed to provide any data beyond the timeliness and accuracy of sending checks.

Professionals are paid independent of outcome. Doctors are paid whether their treatments work or not. Indeed, mortality amongst doctors' patients is one hundred percent, although we still pay in hopes of postponing the event.

Any serious move towards outcomes in healthcare is paddling upstream if insurance is the finance paradigm.

Why insurance?

So why is our society fixated on medical insurance? The most obvious reason is that insurance provides the cash flow when services are needed. However, there are lots of other ways to accomplish the same thing. The function of insurance is for cost not to be an issue should the catastrophe occur. Since insurance is designed precisely to remove the cost issue, why are we surprised when health insurance costs move up without apparent constraint?

Ignorance insurance?

The arbitrariness of using the insurance paradigm to finance medical and health services can be revealed by a hypothetical proposal to use insurance to fund education. We could insure against ignorance, since learning is essential to individual career advancement, and if we don't get rid of ignorance our economy is going down the tubes! The way it would work is that education professionals could do assessments in their private clinics, and then refer to the institutions where they have staffing privileges (schools, as opposed to hospitals). Claims could also be based on standardized tests, such as those done for No Child Left Behind. Claims could then be submitted for each educational intervention, whether it was tutoring, web-based instruction, or classroom instruction. Defining the interventions very specifically and for brief discrete time periods could produce more claims and more income. The insurance could be purchased by individuals, families, corporations, or any other public or private entity. The third party administrators would love all the new business, and a lot more teachers would be making $200,000 a year. A lot of people and organizations would be relieved to have the focus shift away from outcomes and towards instruction delivered. You say it is different from health care? How and why?

Insurance claims, whether for ignorance, illness, or injury, are for what we want to get rid of, not for learning and health which we desire. Insurance implements an avoidant rather than a goal-oriented endeavor. The shift from obsessing about illness, aches, and pains to enjoying positive health practices is a challenge for more than a small minority of hypochondriacs. Insurance puts the providers' and consumers' focus in the wrong direction.

So what are the alternatives to health insurance?

There are eight alternative paradigms that govern

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economic transactions. Each has its own language and dynamics and is more or less appropriate for different situations. Economists talk about rational economics as if there is only one rational way to make an economic decision. In reality what is rational is configured and determined by the specific paradigm. I will review possible applications for healthcare financing.

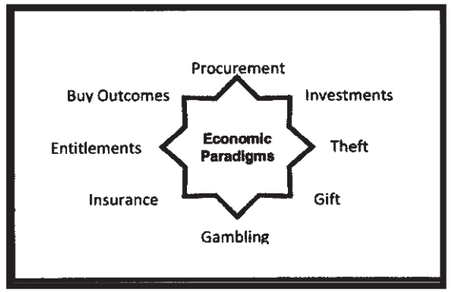
1. Entitlement

The most common alternative to insurance is entitlement. If an employer offers a health plan to its employees, and all employees pay the same fee (technically not a premium), the employees have an entitlement plan and not health insurance. Insurance always has individual underwriting where the premium is adjusted to the statistically calculated risk of benefits or claim payment. The employer may have an insurance plan to cover the cost liabilities attendant to the offered entitlement plan. We then have a significant private or employer form of socialism.

In contrast to insurance, for an entitlement the cost to the specific individual is unrelated to the entitled benefits. Entitlements are often goal- or service-oriented, and may or may not be contingent upon a loss, such as is the function of insurance. So we are entitled to go to the library and drive on most public roads. We buy a membership to a health club, or any other association, and are then entitled to the benefits of that membership. I buy an online subscription and pay the same whether I use the subscription or not. Our earliest and most primal economic experiences are with entitlements, as most of us are born into families where we are provided with food, clothing, housing, and a whole host of entitlements.

There can be limits to entitlements or forms of rationing according to rules, although entitlements work best in situations where there is a natural satiation—such as the public library. To avoid stigma, a third or so of a population must perceive a service or program as something they will or potentially might use. While entitlements provide security, as does insurance, excessive entitlements inhibit the motivation to conserve scarce entitlement resources. Since the demand for medical and health care services is highly elastic, any entitlement system needs some form of rationing just as every family rations who gets what and when. Don't be alarmed. The rationing of scarce resources is a primary function of all economic transactions. It just happens differently under different economic paradigms.

The biggest challenge in designing an entitlement plan is how to balance a rights-based system and leave room for judgment and discretion in determining access and availability of services. This dichotomy between rights and needs is sometimes referred to as the hard versus soft. To illustrate the contrast, retirement benefits under Social Security are a right while social work and children's rights activists argued successfully that caseworkers should provide services and use their discretion in determining eligibility for financial help to needy children and their



families. The result some seventy-five years later is that I make a good living and collect Social Security without social stigma, while many poor, hungry children and their parents in our country collect limited benefits accompanied by considerable stigma, or receive no benefits at all.

Any entitlement program based strictly on rules or rights is going to tilt towards acute cure medicine, to the neglect of chronic healthcare where the determination of need requires individual judgment and flexibility.

Isaac Rubinow was the brains behind Social Security, our first significant entitlement program. Rubinow was not only the pioneer in actuary science, but a pioneer in understanding the psychology and sociology of how people and peoples handle and mishandle their needs for economic security. In 1917 he was employed by the American Medical Society, speaking to large groups around the country promoting national health insurance. He wrote in a weekly magazine that we were within six months of making such insurance a reality. Of course health insurance at that time would be more like disability insurance today, and the window of opportunity closed with World War I. Rubinow was writing books in the 1920s about the reasons why people were not financially prepared for disability or old age, and the same remains largely true today. It is interesting that while many bemoan big government and deficits, only a few people advocate dismantling Social Security or refuse on principle to take the checks.

Personally, I see little reason for employers to be involved in medical or health plans apart from workplace safety and health promotion. The annual rotation in and out of plans is particularly destructive of any longer-term investment in an individual's health. The expenses detract from the employer's world competitiveness, too many people are self-employed or don't have an employer, and few employers have the expertise or motivation to design and implement state-of-the-art health plans.

2. Insurance

A second paradigm, which I would rather see, is large group health plans, perhaps with geographic boundaries like large school districts. The primary alternative to the tensions and dysfunctions of any third party payment system as outlined above is to merge parties B & C and make it an entitlement instead of insurance. This may have been the intent of Health Maintenance Organizations (HMOs), although for the most part they have not escaped the linguistics and baggage of the insurance paradigm. The model holds promise if some of the insurance mentality could be monitored and removed, if incentives could be controlled by controls on things like executive compensation and what happens to profits (or fund balances in the case of nonprofits), if adverse selection and annual membership rotations were limited, and if the boundaries between medical and broader health services could be appropriately managed. One move in that direction might be financial responsibility for total outcomes such as disability, long-term care, and death

3. Procurement

A third paradigm is procurement, the way we go to a store and buy something because we would rather have the object than the money. Veterinary services are mostly purchased by procurement, and it seems to work. Procurement could be supplemented by a large deductible or sliding copayment for catastrophic costs. Leaving off the psychological and political realities, financially it makes sense for anyone with financial means enough to retire or aspire to retire without a pension to buy a $10,000 or $20,000 deductible medical plan and purchase the balance of needed medical services. However, this option makes sense only if there were a fair and open market and providers were prohibited from having under-the-table preferred provider rates.

4. Purchase of outcomes

A fourth paradigm is the purchase of outcomes, rather than the components to accomplish the outcomes as in procurement. I can purchase the outcome of a roofing job for our house, or I can purchase the shingles and labor.

Last summer I went to a pain clinic for a pain in my hamstring that prevented me from running. After an MRI and two epidurals, the pain was still there. When I stopped taking the statin medication, the pain went away. If compensation was based on outcomes, the doctor might have told me to discontinue the statin and I could have saved myself the discomfort—and Medicare—the costs of the MRI and epidurals.

5. Charity

A fifth paradigm is charity. Many of our major medical institutions still carry the legacy names from charities that were part of their founding. Many churches have nurses delivering health services that are largely charitable. Research organizations devoted to specific disorders are often funded as charitable organizations. Whether charity is adequate to provide the continuity and advances in science that we need is perhaps questionable.

6. Theft

The flip side of charity is theft, in that the recipient rather than the giver is the primary decision maker for the transaction. Medical services are frequently funded by unpaid bills, a form of theft.

7. Gambling

A large proportion of health and even medical interventions are done without a solid probability that they will be efficacious. Even where we do have the benefits of good research, many interventions are a gamble. The odds might be seventy percent that it will work, or even ten percent, but given the alternatives, we take the gamble. Insurance systems pay or provide what is specified in the policy. An entitlement program might provide services based on a ratio of probabilities to cost. For example, should a procedure costing $500,000 be supplied when the probabilities of extending life up to six months are ten percent? Or are those resources better deployed in a children's health program that improves health status by ten percent for a thousand children? These are gambling decisions in that they are not just about compensating for loss, but about odds to achieve goals. Honeywell pioneered an employee organ transplant benefit that selected providers on a national level for each organ transplant and then only paid based on patient survival. The provider then had to set rates based on probabilities and take the gamble.

8. Investments

The final paradigm, investments, is when we buy something not to use it or benefit directly, but to have it produce income or increase in value for a consequent sale. We often refer to health promotion as an investment in our health. Endowments and foundations can produce a significant source of revenue for healthcare services.

What's wrong with calling it health insurance?

Calling it insurance perpetrates the illusion that my health is beyond my control. I'm passive and need to be (a) patient. My health is determined by the doctor who

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"treats" me. My health must be a matter of fate, since the purpose of insurance is to provide financial protection for improbable and uncontrollable events. Health promotion programs are undermined by the implicit premises of the insurance paradigm.

Insurance pays what is required by contract and is not responsible for achieving specific outcomes. Outcomes are discredited. Outcomes-based medicine is contrary to the financial incentives and framework of the primary funding mechanism.

Conclusion

In summary, we need more strategic thinking to lay a solid foundation for how medical and health services should be financed. Instead of blaming insurance companies for adhering to the principles of insurance, we need to examine the applicability of insurance. The paradigm of insurance has significant negative implications for providers, consumer, and payers. Yet, it is the paradigm which then frames all the other choices. We need to think creatively about how to frame a system based primarily on entitlements and procurement.

While a relatively small number of individual medical insurance policies exist in the United States, most of what passes for health insurance is in reality a medical entitlement plan. An important step towards creating a workable delivery system is to not call insurance that which isn't insurance. This means precision in not using many insurance-related words and concepts, such as premiums, risk, claims, and underwriting. Journalists, politicians, and legislative authors need to be more precise in their use of language. When I check in at a clinic, they might ask about my medical plan and not mention the word *insurance*. The term *insurance* should not be used for what is not insurance. The term *health* should not be used to refer only to medical services. The use of language defines the discourse and the framework for how people think, what they expect, and how they decide.

The people designing administrative rules and mechanisms to implement healthcare reform need to be clear as to the paradigms being deployed. If it is entitlement rather than insurance, then abandon the insurance language and principles. The effectiveness of programs, to say nothing of their efficiencies, is going to be dependent upon a level of implementation below the radar of political euphemisms.

Remember, the paradigm rules.

In the 1980s, Lee Wenzel, then working for Toro, designed alernatives to medical coverage. He is now all-but-dissertation for a PH.D.in the area of alternatives to medical coverage. He is also a registered investment advisor with his own company, Wenzel Analytics.

The ACLU in Minnesota

The January 30 meeting of the MISF featured Charles Samuelson, Executive Director of the Minnesota American Civil Liberties Union.

Samuelson addressed his remarks to the case of Near vs. Minnesota, which he called "the greatest case in the history of the ACLU in Minnesota," even though the court action took place in 1931, long before the ACLU in Minnesota was founded. The case overturned a Minnesota "gag" law enjoining papers from printing scandalous or libelous material.

In 1927, Jay Near and Howard Guilford printed a newspaper, *The Saturday Press*, accusing the police chief of Minneapolis of graft. They also targeted Floyd Olson (a future governor) and members of the grand jury of Hennepin County. Olson, then the Hennepin County Attorney, filed a complaint against Guilford and Near alleging that they were violating the Public Nuisance Law by "publishing…a scandalous and defamatory newspaper."

Guilford was gunned down and hospitalized by some of the people he had defamed, but Near went on to publish eight more issues of *The Saturday Press* between September 24 and November 19, 1927. Then on November 22, Judge Matthais Baldwin issued an injunction against Near, saying that the state had the right to prohibit the publication of "scandalous material" that might disturb the peace. Near protested that the injunction was a violation of the freedom of the press.

Near and Guilford appealed but were turned down and effectively barred from printing any newspaper. On a second appeal, the State Supreme court said that it would allow them to print a newspaper "so long as it was in harmony with the public welfare."

Near then appealed to the Supreme Court of the United States. In 1931 the U.S. Supreme Court (by a 5 to 4 decision) ruled that gag laws are unconstitutional. Under the Fourteenth Amendment, state laws must follow the US Constitution, which states that the press must not be restrained. Furthermore, one cannot restrain a publication in advance of its printing. Except in times of war or national security, government cannot determine what may be printed. As Chief Justice Charles Hughes put it, "…the fact that liberty of press may be abused does not make any less necessary the immunity of the press from prior restraint…a more serious evil would result if officials could determine which stories can be published…"

Near vs. Minnesota has been cited in several important decisions: most notably when the government tried to suppress the publication of the Pentagon papers in 1971 and in the case of *New York Times* vs. Sullivan, which limits the grounds on which a public official can sue for libel.

Samuelson concluded his remarks with some reflections on the importance of freedom of the press. To him, the U.S. exists in a state of creative tension. "The only time that we have had real concord was from 1941-1969, [when we] were a vast sea of conformity and bowling clubs." "Our government requires conflict because ideas that were on the fringe are now mainstream." "The Constitution requires open ideas. We don't have an orthodoxy in this country. We operate on chaos theory but it has worked pretty well."

Forgotten Churches

It has often been said at the dedication of church buildings that "man builds for time but God builds for eternity." Contrariwise, an old hymn by Isaac Watts indicates something quite different for time and space: "Time like an ever-rolling stream/ Soon bears us all away;/ We fly forgotten, as a dream/ Dies at the op'ning day."

In an illustrated talk on February 27, 2010, entitled "Forgotten Churches of Southeast Minnesota," Nancy Luther Powell suggested both aspects of survival and ephemerality. That is, she showed some churches that have experienced longevity, if not eternity. Such a structure was the family church of former Governor Quie in Valley Grove, just outside of Northfield. The original building was erected in 1862; and the current structure is being restored, expecting, one assumes, to last into an indefinite future.

Powell also showed many examples of church structures that time has borne away. One was a picture of a grove of trees where once stood a church: no building, no records, and, because of a barrier, no access. Powell didn't express regret at the loss of such churches merely from a sense of nostalgia. Rather, she indicated that the presence of churches (or their loss) reveals something important about the health (or lack thereof) of a community. History, she noted, disappears when a church (or a town) disappears.

She cited one kind of such social record: the presence of church cemeteries. Powell indicated that one could learn something about the devastation and duration of certain illnesses by tracking the numbers and death dates of children in church cemeteries. Some stories connected to churches, she noted, are just plain intriguing. For example, a certain Rev. Wright from a congregation in Saratoga took out after horse thieves one day in 1855. His dead body was found a few days later, just one mystery among many in the history of ecclesiastical communities.

In places where many churches once stood there are now just empty fields, testimony of a lost way of life. She showed a picture of a steeple in someone's backyard. It was standing proudly erect but devoid of a building on which to stand. Some churches, Powell noted, have taken on new life and identity as gift shops, coffee houses, art centers, or residences. One church, just south of the border in Iowa, looked fairly intact when looked at frontally. But by going around to the side it was possible to see how the bricks of the church are being filched, doubtless used for other purposes. It is a process of deconstruction similar to what has happened to many European structures in the past.

One feels a sense of poignancy at what is being lost or, at the very least, is being transformed. Who were those people standing in the church yard for a family or parish portrait? Whatever happened to that community of believers that has seemingly become extinct? What survives of those groups and churches? How is the landscape of Minnesota life and history reconfigured when churches, or towns, or newspapers, or schools disappear?

Powell, by her own admission, is always excited when she sees a church still standing in the countryside; but she grieves when she sees so many disappear or falling apart. She fears the loss of living history and good stories as well. She wistfully noted how many ministers' wives often stayed on – in cemeteries – when the minister was called to move on. The gravestone of one such spouse outside a Quaker Baptist Church reads:

> May you live your life for Jesus
> And meet her in that heavenly home.

One assumes the *her* refers to the woman resting under that headstone. Many churches are now just empty fields, Powell noted in closing; they are testimonies of a lost way of life. After all, time like an ever-rolling stream will bear us all away. But, thankfully, some churches and communities do survive and remain as testimonies to the perdurance of life and hope.

Robert Brusic

African-American CCC Boys

Barbara Sommer was the featured speaker at the MISF meeting Saturday, March 27. Her topic was: "African Americans and the Civilian Conservation Corps in Minnesota."

Sommer reminded us that the Great Depression was a time of world-wide hardship and unemployment. In 1933, between one-in-three and one-in-four Minnesotans were out of work; and, among young men, one out of two was unemployed. The Civilian Conservation Corps (CCC) was established March 31, 1933, to relieve unemployment and restore natural resources. (It was abolished June 20, 1942, and its funding ended June 30, 1943.)

The CCC was one of President Franklin D. Roosevelt's "alphabet" programs, established during his first 100 days in office. The CCC is now recognized as the most important conservation program in U.S. history.

Minnesota conservation work followed federal guidelines. The work was directed by state officials, including Forest Director Grover Conzet and Parks Director Harold Lathrop. It focused on forest work, state park development, and soil conservation. Forest conservation included planting 124,000,000 trees in Minnesota's parks and forests. The CCC worked in twelve state parks: Camden, Flandrau, Fort Ridgeley, Gooseberry Falls, Itasca, Jay Cooke, Lake Bemidji, Monson Lake, St. Croix, Scenic, Sibley, and Whitewater.

The CCC was open to unemployed men ages 19 to 25. Participants in the program were called enrollees or "boys." Over 77,000 people participated in the CCC in Minnesota. Enrollees were paid $30 a month. Of this, $25 was sent to designated dependents, while the enrollees kept $5 each month. (The dependent's pay would translate into about $400 today.)

Enrollees served for six-month enrollment periods and were eligible to re-enlist at least once. A company of 200 enrollees was assigned to each camp. Minnesota had close to 150,000 CCC camps. Each camp had a specified work program in a forest, state park, or area needing soil conservation.

The first CCC Company in Minnesota was formed at Fort Snelling on April 5, 1933. The first CCC Camp was probably Gegoka on McDougall Lake in the Superior National Forest. It was established on May 7, 1933. Army officers oversaw camp construction and administration. When enrollees were not at work on conservation projects, they were under the jurisdiction of the Army.

The CCC legislation included a non-discrimination amendment, called the DePriest Amendment after its author, Oscar DePriest [R-IL], the only African-American member of Congress at the time. The DePriest Amendment specified that enrollees were to be accepted "without regard to race, creed, or color." The U.S. Army was segregated at the time and fought carrying out the full intent of this amendment.

Nationally, about 10% of CCC enrollees were African American. Most of them lived and worked in segregated camps in the southern states. In 1933, two companies of African-American enrollees were sent to Minnesota. They were assigned to CCC Camps in northern Minnesota, near Tofte and Grand Rapids, to do tree planting and other forest conservation work. Enrollees at the Tofte camp also put in stonework along Highway 61.

But the move of African-American CCC companies to rural areas in the northern states met with criticism. CCC Director Robert Fechner abandoned the policy after about a year. In 1934, the two African-American companies in Minnesota were transferred to southern states. And after this time no more out-of-state African-American companies were sent to Minnesota.

During the first years of the CCC, young men from Minnesota's African-American communities also served in the state's camps. Between five and twenty-five of them served in the state's CCC Camps during each six-month enrollment period. They were assigned to forest camps—three to ten of them per 200-man company—near Ely and along the North Shore of Lake Superior. These camps were called mixed camps by the U.S. Army.

Segregation in these camps was enforced by the Army. But, according to their oral histories, Minnesota's African-American enrollees were not segregated on work crews or for sports activities. In 1936, Army officials began efforts to remove Minnesota's African-American enrollees from the state. These orders were challenged by Charles Washington, executive director of the Twin Cities' Urban League. For two years, Washington and other leaders of Minnesota's African-American communities held the Army off. At one point, Washington wrote to Fechner that the Army's actions were a "violation of the spirit of the entire program."

Cecil Newman, editor of the Twin Cities' African-American newspapers, wrote about the Army's "subtle effort to do away with mixed camps." Headlines in these papers said: "We Don't Want Our Boys Sent South." In 1937, Washington and Newman organized protests. Governor Elmer A. Benson and Senators Henrik Shipstead and Ernest Lundeen urged that "something be done at once" to help Minnesota's African-American enrollees. Even this support did not stop the Army from doing away with Minnesota's mixed camps. In September 1938, Army officials put Minnesota's twelve African-American enrollees on a train and sent them south.

An editorial in the Twin Cities' African-American newspapers said Army officials sent "our boys into states which subscribe completely to the Jim Crow Tradition." Leaders vowed to continue the fight for Minnesota enrollees. But, from 1938 on, these enrollees had to serve in all-African-American companies in southern states if they wanted to be in the CCC. Most of them served in Arkansas, Missouri, and Kansas. In 1940, Clarence M. Mitchell, Jr., executive secretary of the St. Paul Urban League, described the Army's ongoing actions as "gross discrimination against Negroes" in Minnesota. Sommers concluded that the actions of Washington, Newman, and others—although not successful in allowing young African-American Minnesotans to serve in Minnesota's CCC camps after 1938—are now seen as part of the civil rights movement in the state.

Barbara Sommer is a Minnesota native; she has been an oral historian for thirty years and has taught oral history at the University of Nebraska-Lincoln and Nebraska Wesleyan University.

Phil Dahlen

Islam 101

Dr. Irshad Jafri gave an illustrated lecture on the topic of Islam to the MISF meeting on April 24. Jafri, a practicing Muslim, is a medical doctor at Regions Hospital and teaches at the University of Minnesota.

Jafri began his talk by greeting his audience with the traditional Muslim salutation of "Peace be upon you." He then went on to explain that Islam is a complete way of life that seeks peace through submission to God. Islam is not based on race, ethnicity, or gender. In response to questions, he explained that Islamic women are individuals in their own right, that they can own property, and are entitled to participate in community and state affairs. They are not, however, allowed to lead prayers.

Muhammad (570-632), the founder of Islam, is considered to be the last of the prophets. When Muhammed was 40 years old, the angel Gabriel began to reveal the Koran to him. (Therefore the Muslim calendar and the Muslim state begin at 622 C.E.) Today there are 1.5 billion Muslims in the world (one fifth of the world's population) with 7 million in the United States.

Islam is a montheistic religion, with a belief in a single god, Allah. According to Islam we are all children of Abraham. Jesus is one of the great prophets, but he is not the Son of God, nor was he crucified. Muslims reject original sin and await the Second Coming.

Muslims have six important beliefs. First, they believe in One God (Allah). Second, they believe in angels, beings who do God's bidding and record people's actions. Third, they believe in prophets who are chosen by God and who preach monotheism. (In the Koran the Scripture is completed; there will be no more prophets.)

Fourth, rhey believe in Divine Scriptures, which include the Koran, the Gospel, the Torah, the Psalms, and the Scrolls. The Koran (the Recitation) has been preserved in its original language for 1400 years. Fifth, another belief of Islam is the Day of Judgment. On the Day of Judgment, the world will end, people will rise, good people will go to Paradise and bad people will be in Hell.

Sixth, Muslims believe in the Divine Decree: that God in his wisdom has ordained all things in creation. For a Muslim, nothing happens against the will of God: everything has a meaningful purpose.

In addiiton to the six beliefs, there are Five Pillars, which translate to things that a practicing Muslim must do in his lifetime. The Five Pillars of Muslim belief are

(1)The Testimony of Faith that there is no God but Allah and Muhammad is his messenger.

(2) A Muslim must pray five times daily: predawn, noon, mid-afternoon, sunset, and nighttime.

(3) Muslims must give alms: a practicing Muslim must give away 2.5% of any wealth he holds for a year.

(4) A Muslim must fast during Ramadan: Ramadan lasts for 30 days and fasting is expected from healthy adults during daylight hours.

(5) Good Muslims are expected, if possible, to make a pilgrimage (hajj) to Mecca once in their lifetimes. About 3,000,000 make this pilgrimage annually. Jafri had been to Mecca and concluded his talk with pictures of the Ka'bah, which is the house of God in Mecca.

In response to audience questions about Sunnis vs. Shiites, Jafri, who is a Sunni, said that the divisions in Islam have been fanned by external politics. As far he was concerned, Sunni versus Shia is a non-issue, but he added, "People who want to divide will find a way to divide." But Islam, to repeat, is a way of life that seeks peace.

The Idea of God

The MISF meeting on May 29 (Memorial Day Weekend) feaured a DVD of an intereview with Robert Wright and Bill Moyers. Wright is the author of *The Evolution of God: God and Morality*.

Wright's point of view, which he laid out in response to questions by Moyers, is that God changes whether he exists or not. In effect Wright suspects that God emerges from human nature.

In part the idea of God has come about to explain why bad things happen or why good things happen, since the human mind is simply not designed to perceive truth beyond this world. The answers that we seek from God are part of the natural evolution of the idea of God.

Wright is not sure whether he believes in God, but he does place credence in moral truth beyond human conception and that believing in a personal God is a way to align oneself "with the moral compass of the universe."

The interview turned to war and religious conflicts between believers. Wright sees religious conflicts as human secular conflicts and feels that is dangerous to emphasize religious differences. He feel that humanity makes choices to avoid belligerence and that tolerance will emerge in a globablized world. All religions have adaptive capacities that draw on interdependence with one another. These capacities lead toward unity.

A lively discussion followed the showing of the DVD. A couple of points from the discussion were that getting information is no longer the realm of the specialist so that shamans and priests no longer have the influence they once had as the connection to a mysterious source of information. The second point was that looking for a single religious formula may not be the way to go: our environment—which includes language, art, and ideas about God—is very complex. Single answers, whether religious or otherwise, are not viable.

NonConformity: A Radical Christian View

The June 26 meeting of the MISF featured a talk by George Sawyer, a theological scholar and Minneapolis business owner. Sawyer's presentation focused on the radical aspects of Anabaptist theology in historical context. Sawyer began by contrasting his concept of radical religion with more colloquial understandings. He asked the audience to make associations with the terms "radical" and "fundamentalist" Christianity or Islam. Eliciting these associations was important to his presentation in that his understanding of "radical Christianity" is a form of Christianity that is emphatically nonviolent and nonconformist. Contemporary Anabaptist religious communities include the traditional peace churches such as Mennonites, the Amish, and Hutterites.

Sawyer described the historical development of Anabaptist theology and communities during the European religious conflicts of fifteenth- and sixteenth-century Europe, particularly in Germany and Switzerland. Anabaptist communities arose in reaction to perceived corruption in both Protestant and Catholic churches. Anabaptist theology was political as well as spiritual. The term "anabaptism" means "re-baptism," and refers to the belief that baptism into the Christian faith, and thus into a Christian community, is based on a profession of faith in the salvation of Christ, which is made as an adult.

Within the Roman Catholic and Protestant churches, "credobaptism" was considered a heresy punishable by death. Moreover, because there was no division between church and state, infant baptism was the spiritual-political method of incorporating individuals into the body politic. To deny the efficacy of infant baptism in favor of adult spiritual decision was to deny the authority of the state. Even more radically, adult baptism incorporated individuals into a community not under the authority of the religious and political power of the church and state, but under the authority of the Holy Scriptures and the Holy Spirit. Therefore, Anabaptist communities developed a practice of "non-participation" with political authorities, including their refusal to participate in military action and armed conflict.

Time did not allow Sawyer to describe the historical development of the various Anabaptist groups such as the Mennonites and the Amish. However, we did have time to discuss how these contemporary communities embody the radical aspects of Anabaptism. All Anabaptists are pacifists, and, in the U.S. are exempt from military service on the basis of religious belief. The Amish present the most visible examples of radical separatism and non-participation, living in relatively self-contained communities, eschewing modern dress and technology, and not participating in state programs such as Social Security. However, it was noted that most contemporary Mennonites, including Sawyer himself, do not live in separate communities and do participate in community and political life.

Maria Swora

Editor's Note

The cowboy wore an impeccable white shirt, a tan 10-gallon hat, and a red tie. He sat easily on his pale gold horse and barely moved a muscle, except to loop his lariat, as he rode. He was in charge of escorting bulls out of the ring at the State Fair rodeo after the bulls had thrown the youthful cowboys—all of whom failed to stay on the bucking steer for the required eight seconds. The cowboy rarely had to rope a steer to drag him back to the pen; he just said "Hike, Hike" and rode patiently toward the bull, and the bull went where he belonged. The confident cowboy was clearly in charge.

oOo

When the editorial committee—David Juncker, Kathie Frank, and I—met in January to decide the theme for this issue, the earthquake in Haiti has just taken place and the effects of the market meltdown were still in the news everyday. Survival seemed a relevant topic, and we set about trying to drum up articles. I am not sure now whether we hoped for articles on how to survive in hard economic times or whether we hoped for inspiring stories about living through a natural catastrophe. In hindsight, it is pretty clear that I at least was looking for someone, like the cowboy on the pale gold horse, who was completely confident that he/she had some if not all the answers. And would tell them to us in about 1500 words.

As it turns out, no one had an answer and no articles about "survival" ever came forth. One author, Bob Brusic, did cast his report of Nancy Powell's talk into a survival mode, but that is all the attention that was paid to the theme.

I am, therefore, grateful to Lee Wenzel for allowing us to excerpt and print his article on health insurance. Mandated health insurance, whatever your opinion, has been a persistently surviving idea in American politics (at least since 1917). Wenzel will be addressing this topic at the October meeting, so you will have an opportunity then to respond to him.

Then, as I reflected on the talks that MISF sponsored this past season, all reported in this issue, I realized that the talks were about the survival of ideas, or perhaps one should say, about how ideas survive. The head of the ACLU talked about the survival of freedom of the press; Dr.. Irshad Jafri talked about Islam and Allah; our DVD meeting in May addressed the growth and survival of the idea of God; and George Sawyer addressed the evolution of radical Anabaptists into the Amish and the Mennonites. Only Barbara Sommer had the responsibility to discuss what seems an idea that should not survive—racial prejudice in Minnesota. Unfortunately, bad ideas persist in spite of our concerns and opinions.

So this issue of PT is about survival, just not in the form in which I thought it would be. I am grateful to the writers who stepped in to provide coverage of our meetings: Robert Brusic, Phil Dahlen, and Maria Swora.

I do not know yet what topic we will pick for the next issue, though I doubt it will be cowboys and bull dogging. Nonetheless, if somone out there knows a confidant cowboy who can rope some of the answers, do let me hear from you as soon as possible.

Lucy Brusic <lucy@brusic.net>

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Upcoming meetings

The Minnesota Independent Scholars' Forum announces a fall series of monthly meetings featuring speakers from the local community. These meetings take place the last Saturday of the month at Hosmer Library, 4th avenue at 36th Street in Minneapolis. They begin at 10 A.M., with the talk at 10:30. Admission is free and everyone is welcome.

Saturday, September 25, Joe Imholte, director of special exhibits at the Science Museum of Minnesota, will discuss the Dead Sea Scrolls and the Dead Sea Scrolls exhibit at the museum.

In addition, on **Saturday, October 9,** MISF will sponsor a group tour of the Dead Sea Scrolls exhibit if enough people have signed up by October 6. If you are interested please contact Curt Hillstrom for further information. <curthillstrom@hotmail.com> We need to have 15 people.

Saturday, October 30, Lee Wenzel will discuss "Is Health Insurable?" To prepare, see the lead article in this issue of PT.

Saturday, November 27, "The 2010 Elections: Review and Analysis" MISF will have a speaker, to be announced, who will help us take stock of the elections.

We look forward to seeing you and your friends at these meetings.

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