al Commission on Space report is the 1950s painting which illustrates a concept of a space station developed by von Braun. Von Braun, Krafft Ehricke, and other members of the German rocket team made possible the 1961 decision by President John Kennedy to "land a man on the Moon and return him safely to Earth."

As the 20th anniversary of the first lunar landing in July 1989 was approaching, Paine was again raising the question of long-range goals for the space program. Three months before, he testified before the House Subcommittee on Space Science and Applications of the Committee on Science and Technology. "NASA is a mission-oriented agency in desperate need of a challenging mission. In pursuit of exciting goals NASA has flourished; without long-range objectives, it has languished," he began.

Paine pointed out that "arid areas of Earth, like the American Southwest, the Middle East, and central Australia, are potential beneficiaries of space biosphere research," repeating his plan to overturn the doctrine of Parson Thomas Malthus.

"The settlement of Mars will double the land area available to humanity," Paine pointed out. He told the congressmen that the "arid areas of Earth, like the American Southwest, the Middle East, and central Australia, are potential beneficiaries of space biosphere research," repeating his plan to overturn the doctrine of Parson Thomas Malthus. Three months later, President George Bush pronounced from the steps of the National Air and Space Museum that the nation would implement, in outline, the program that Paine and others had worked two years to produce.

Paine parried for years with this writer about the state of the economy. It could not be as bad as presented in *EIR*, he argued. A Kennedy Democrat committed to both developing the frontiers of science and technology and raising the standard of living for the U.S. and world population, Paine was always optimistic that the economy was not in a depression, and that rationality would prevail. Yet, it is the current spiraling economic collapse more than anything else which has stymied the long-range program President Bush announced nearly three years ago.

If this nation starts down a different economic path, one similar in concept to that taken by President Kennedy, humanity will have a chance to "pioneer the space frontier." If that path is taken, a large share of the credit should be given to the visionaries who preceded him, and to Tom Paine.

Minnesota 'Health means corporatist

by Steve Parsons

Politicians and medical reformers toasted each other in April for enacting the Minnesota HealthRight bill into law. HealthRight has received rave reviews from the media and the so-called biomedical ethicists. Endorsed by a large bipartisan legislative majority, insurance companies, physicians, and consumer groups—albeit with various caveats—it is indeed the most sweeping health reform legislation ever enacted, going far beyond the widely trumpeted Oregon Plan.

The law purports to provide the basis for expanding health care services in the state, particularly in rural areas, while providing low-cost basic health insurance for the uninsured. Its "glories," as ethicist Arthur Caplan calls them, are "that it mandates data collection on outcomes and practices, and the prices incurred for those outcomes; that the health commissioner will be able to take steps on regulating reimbursement to providers; that it has conflict-of-interest prohibitions; that it limits malpractice actions by setting practice parameters that, if adhered to, are absolute defenses; and that it moves insurance companies to community rating."

These "glories" actually augur the fascist regimentation of health care. Far from enhancing health care, the law is designed to police the administration and dispensation of health care, leading to enforced rationing of medical treatment, and ultimately to euthanasia, for those deemed either too unfit or too "cost-inefficient" to live. As such, it is an integral feature of an economy no longer able to sustain its population in the deepening depression.

Down the primrose path

Larded with 182 pages of small-print legalese, the legislation was crafted by a select group of seven politicians, led by ultra-liberals Rep. Paul Ogren and Sen. Linda Berlin. The real architects, however, were two expert "facilitators," the aforementioned Caplan of the Center for Biomedical Ethics at the University of Minnesota, and Dr. Steven Miles, a geriatric specialist and steering committee member of the Minnesota Network for Institutional Ethics Committees. The legislators cloistered themselves for weeks working out the details, guided at crucial points by Caplan and Miles. The self-described "Gang of Seven" paraded it as a series of

Right' plan cost-cutting

revolutionary, yet practical, steps for simultaneously protecting the uninsured and lowering the spiraling costs that have incurred the wrath of voters.

Contrary to media characterizations that HealthRight focuses on subsidizing medical insurance for lower-income families, HealthRight insurance coverage will still be unaffordable for many families—premiums can be as high as $300 per month—while its benefits are skimpy. For example, HealthRight's maximum inpatient coverage is only $10,000 per person annually—an amount that can be reached in a couple of hospital days.

Caplan readily admits that the insurance coverage is "scrawny" and expensive. "We aren't implementing the Canadian sytem in this state. It's not a revolution in catastrophic health coverage. The state of Minnesota can't pay for catastrophic coverage; it can't be done. This is just a bare-bones policy that does cover much of basic primary and preventive care. The primary aim of the law is structural reform aimed at *cost-containment*."

Cost-containment policing

The key measure in the HealthRight law is the establishment of several commissions and agencies, the most important being the Minnesota Health Care Commission. This is to be comprised of 25 appointees from business, labor, government, and "consumers"—in other words, a corporatist board that will effectively have total control over health care policy and regulation of hospitals and doctors.

The commission is mandated to establish limits on the growth of health care spending, both public and private, and specifically to cut the current rate of growth by 10% annually. If those limits are not met, it is empowered to recommend sanctions against providers that would include restricting use of certain "expensive" technologies and procedures, regardless of the ability of either patients or providers to pay for them.

The language of this section is studded with policing recommendations. For example, as the Minnesota Medical Association points out, the commission is charged with considering "methods that could be used to monitor compliance with the limits . . . methods for avoiding, preventing, or recovering spending in excess of the approved rate of growth . . . methods of imposing mandatory requirements such as practice parameters, hospital admissions protocols . . . methods of preventing unfair health care practices." The commission is urged to set up "permanent regional coordinating boards to ensure community involvement" to enforce the cuts.

Big Brother is watching

Central to this policing strategy is the establishment of a ubiquitous data collection agency that will force physicians and hospitals to turn over every scrap of information on their patients and practices, and will target "treatment outcomes" and costs. Disciplinary action is threatened for non-compliance, including sanctions by licensing boards.

This data collection will be complemented by a "Practice Parameter Advisory Committee" under the commissioner of health, which will specify recommended physician and hospital procedures. This is doubly pernicious. Physicians who are found to have complied with such procedures are automatically immune from malpractice suits. This not only creates a potential loophole for otherwise incompetent practitioners who might technically comply with the parameters; it would virtually prohibit conscientious doctors from altering accepted practices in efforts to help their patients, thus eliminating more effective, if more expensive, medical procedures.

Even before the commission is appointed, the law mandates that *all* providers must report major capital expenditures to the commissioner. This is the first step toward rationing "expensive" technologies; penalties for exceeding quotas will be decided later.

The law extends "anti-kickback" statutes on Medicare to all providers, and permits the commissioner to develop even harsher regulations. These "anti-kickback" regulations ultimately can be employed to prevent thousands of physicians and practitioners from using expensive high-technology equipment or sending patients to facilities that have such equipment, lest they be charged with kickback fraud. Needless to say, this will help "contain costs"—at the expense of lives.

Caplan cheerfully admitted to *EIR* that these cost-containment measures necessarily lead to a rationing regimen far beyond what Oregon is trying to implement. "Of course it's rationing. The difference is that Oregon is rationing *without* the data; we're rationing *with* the data.

"Oregon targets the poor on Medicaid with rationing. Our choices apply to everyone, whether they have money and insurance or not. In Minnesota, the aim is to share the burden of rationing among everyone."

"Other states and Congress should take a cue from Minnesota," Caplan and Miles told the *Baltimore Sun*, "by swallowing the politically bitter medicine of cost-containment."