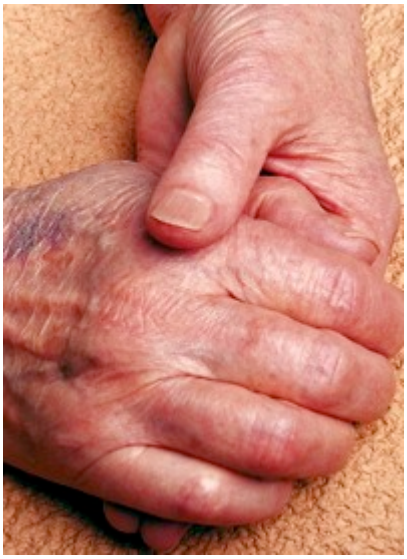
# The Truth About Obama's "Death Panels" And Rationing



President Barack Obama has been counterattacking against critics of his healthcare plan in recent days, cherry-picking the most outlandish "fishy" claims about his program.

Among the most hotly contested claims are some critics' claims that section 1233 of the House version of Obamacare would institute "death panels" that require end-of-life counseling and possibly euthanasia. During the August 11 "Town Hall" meeting, Obama tried to dispel this "rumor":

> The rumor that's been circulating a lot lately is this idea that somehow the House of Representatives voted for "death panels" that will basically pull the plug on grandma because we've decided that we don't — it's too expensive to let her live anymore.... Somehow it's gotten spun into this idea of "death panels." I am not in favor of that.



The "rumor" was most famously circulated by former GOP Vice Presidential Nominee Sarah Palin, who claimed, "The America I know and love is not one in which my parents or my baby with Down Syndrome will have to stand in front of Obama's 'death panel' so his bureaucrats can decide, based on a subjective judgment of their 'level of productivity in society' whether they are worthy of health care.... Such a system is downright evil."

Palin issued a rebuttal on her Facebook page on August 12 to Obama's remarks, without reusing the "death panel" language. Among the sources she cited was an August 8 op-ed by *Washington Post* Editorial Board Member Charles Lane. Lane noted that the provision in the House bill did not quite amount to a "death panel," but found that the truth was a bit more complicated than calling the whole thing a "rumor":

> Though not mandatory, as some on the right have claimed, the consultations envisioned in Section 1233 aren't quite "purely voluntary," as Rep. Sander M. Levin (D-Mich.) asserts. To me, "purely voluntary" means "not unless the patient requests one." Section 1233, however, lets doctors initiate the chat and gives them an incentive — money — to do so. Indeed, that's an incentive to insist.
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> Patients may refuse without penalty, but many will bow to white-coated authority. Once they're in the meeting, the bill does permit "formulation" of a plug-pulling order right then and there. So

> when Rep. Earl Blumenauer (D-Ore.) denies that Section 1233 would "place senior citizens in situations where they feel pressured to sign end-of-life directives that they would not otherwise sign," I don't think he's being realistic.

Viewed from the standpoint of Obama's claim that the purpose of national healthcare plan is to cut costs, the provision in the House bill could take a more sinister turn down the road. Obama claims, "What I've said is, our top priority has to be to control costs. And that means not just tinkering around the edges. It doesn't mean just lopping off reimbursements for doctors in any given year because we're trying to fix our budget. It means that we look at the kinds of incentives that exist, what our delivery system is like, why it is that some communities are spending 30 percent less than other communities but getting better health care outcomes, and figuring out how can we make sure that everybody is benefiting from lower costs and better quality by improving practices."

Such claims strike at the heart of the concern about government rationing. But Obama counters by claiming that Americans are already suffering under the rationing of care:

> Right now insurance companies are rationing care. They are basically telling you what's covered and what's not. They're telling you: We'll cover this drug, but we won't cover that drug; you can have this procedure, or, you can't have that procedure. So why is it that people would prefer having insurance companies make those decisions, rather than medical experts and doctors figuring out what are good deals for care and providing that information to you as a consumer and your doctor so you can make the decisions?

But Obama's statement is basically an apples and oranges proposition. The refutation of his statement can be found by looking at healthcare procedures in countries that already have government-run healthcare. In an August 12 interview on Fox News Channel, British Member of the European Parliament Daniel Hanaan explained how the British National Health Service has tried to enforce its rationing decisions when a patient needing care goes outside of the country to get privately paid, life-saving breast cancer treatment:

> If you then try and purchase your own treatment outside of the national health service, they will cut off the treatment you were getting from the NHS because they have this bias against the private sector. Now, to be fair, there was such an outcry about that that some of that has now been modified. But you get a good picture of the mentality there.

The response to Obama's claim that insurance companies are making decisions about what kind of treatments Americans can have is refuted by the above. Insurance companies only decide what kinds of treatments they are willing to pay for, but governments can — and often do — go a step further and punish patients who go outside of the official system to get the privately paid care they need. Americans can always decide to go outside of what the insurance companies are willing to pay and take on the debt for themselves — care to patients is generally given to Americans before payment is discussed. And British citizens can once again come to America today for quality breast cancer treatment without suffering government sanctions, but where will Americans be able to go if the last vestige of quality private care turns to a government-run system?

It's just that reflexively vindictive nature of government, when paired with the government's obvious need to control costs, that will inflict ever-greater pressure on patients who cost the government more money. A national healthcare system will inevitably include greater incentives for diminished end-of-life care, as well as punishments for politically incorrect "risky" or "costly" lifestyle choices. Smokers, the

overweight, and other more costly lifestyle choices will first face the voluntary "preventative" care that Obama is talking. But if the government's "customers" fail to heed the carrot, eventually the government will need to create a stick, either to control costs or — as was the case with the British NHS — to avoid political embarrassment.

These government policies would be fostered not only by bean-counting government bureaucrats, but also by the greed and envy of citizens turning on their neighbors asking: why should so-and-so's lifestyle choices be paid for by the rest of us, who are able to keep our weight under control/don't smoke?

British MEP Daniel Hanaan summed up this scenario succinctly:

> The idea that this, of all countries, could put into the power of a state bureaucracy decisions over what kind of medical treatment you can get, literally whether you can live or die, is deeply un-American.

Even foreigners can see that self-evident truth. And from the uproar at congressional town meetings, a substantial proportion of Americans see this truth as well.