

become increasingly Republican, voting for the GOP in the last four presidential elections. The district, which curves north to south on the east side of Nashville, includes 15 counties, many of which lie in the rural heart of what was considered Democratic Middle Tennessee.

No longer. Black won all 15 counties in 2010, beating her Democratic opponent by nearly 38 percentage points. That sort of swing should have been big news, but the race went largely unnoticed by the national press. Black says her constituents' vote just makes sense.

"I think that the people's values and my values have matched," Black says.

It's a trend discernible in conservative districts across the country, says Larry Sabato of the University of Virginia: From Georgia to Idaho, conservative voters are trading conservative Democrats for Republicans. "We should change the letters from 'D' and 'R' to 'L' and 'C,'" Sabato says. "We have a liberal party and a conservative party, two parties that are so distinct ideologically that voters know what they're getting."

In the Sixth District of Tennessee (still one of nine states without a personal income tax), voters knew they were getting more than a Republican. In the state general assembly, Black gained a reputation as a quick study and a wonk, notably during her service on the finance, ways, and means committee in the senate. "Looking at budgets, looking at tax issues, all of that came through that committee," Black said.

"I have told Diane for years that she should come to Congress," says her friend Marsha Blackburn. "Diane understands how to get things accomplished."

Black tells me she won because people knew her record. "The reason why I was able to carry all those counties," she says, "is that they had an opportunity to see me and knew what I had done in the past."

And if Diane Black's past is any indication of her future, it's unlikely Congress will be passing dubious tax or spending hikes without a fight. ♦

# About Those Death Panels . . .

The very real threat of government health care rationing. BY WESLEY J. SMITH

When Sarah Palin warned that Obamacare could lead to medical rationing and "death panels," supporters were outraged. Alarmism! they roared. A lie! Right-wing propaganda! Alas for supporters of the Patient Protection and Affordable Care Act, Palin's provocative sound bite was at least partly grounded in reality—which is why the term entered the political lexicon.

Now, however, some are seeking to wield the term against conservatives. Case in point: The Arizona legislature recently cut its Medicaid budget because the state is in dire financial straits—a move approved by the Obama administration. When the cuts led to canceling Medicaid coverage for organ transplant surgeries, and a potential organ recipient died, death panel claims suddenly became all the fashion. For example, CBS's *HealthWatch* opined:

There is a certain irony here. During last year's federal battle over President Obama's health care legislation, some Republicans claimed his program promoted "death panels" which they seemed to suggest would involve government bureaucrats deciding who lives and who dies. The health care bill did include language which paid doctors to offer end-of-life counseling. That was eventually removed. Facing a tough budget situation, however, Arizona has instituted what critics say is much closer to these so-called "death panels" than anything that ever appeared in the federal government's health care legislation.

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Similarly, *New York Times* liberal columnist Gail Collins raged:

Republicans kept ranting about how "Obamacare" would put the federal government between you and your doctor and try to save money by prohibiting said doctor from using the best treatments and procedures. All this came to mind when I was talking to Flor Felix, whose husband, Francisco, a 32-year-old truck driver with four kids, was denied a liver transplant because the Arizona Legislature had yanked funds for it out of a state Medicaid program.

But these and other similar columns and editorials miss the point: The Arizona Medicaid story was not grounded in conservative heartlessness or hypocrisy. It resulted from a single-payer health care system crashing into a budgetary brick wall. The real lesson here is that "single payer" and "death panels" go together like "See's" and "candy."

Oregon, a decidedly liberal state, provides an unequivocal example. In 1993, the Clinton administration gave permission to the Oregon Health Plan, the state's Medicaid program, to introduce rationing. The system involves a treatment schedule that lists 649 potentially covered procedures. The state pegs the number of procedures the state will cover to the available funds. Patients requiring procedures above the cutoff line are out of luck.

As of October 2010, only the first 502 treatments were covered. But even that low number doesn't tell the full story of rationing in Oregon. The Oregon Health Plan also rations covered procedures under certain circumstances. Chemotherapy, for instance, is not provided if it is deemed to have a

5 percent or less chance of extending the patient's life for five years, meaning that a patient whose life might be extended a year or two with chemo may not receive it.

Worse, even though it is not a formally ranked procedure, assisted suicide is covered under state law. Thus, when two recurrent cancer patients were rationed out of receiving potentially life-extending chemotherapy in 2008, an administrator wrote a letter assuring them that the state *would* pay for the costs associated with their assisted suicides. Talk about a death panel!

As state Medicaid budgets become increasingly strained, some within the medical establishment are promoting formal rationing systems. Thus, the Wisconsin Medical Society recently argued that the state's Medical Assistance program should be "allocated" and "prioritized" by creating a "ranked order" of coverage. "The goal is health," the association stated, "rather than health services or health insurance," a potentially alarming prospect for those with serious—and expensive to treat—illnesses and disabilities.

Looking abroad, one should note

that rationing is routine in single-payer health systems. Canada's Medicare allocates services primarily by time, forcing patients to wait weeks, or even months, to receive urgent diagnostic screenings and surgeries. A recent study by the free-market Fraser Institute found that the median wait for surgeries in Canada has grown to 18.2 weeks—141 percent longer than in 1993.

Britain's National Health Service (NHS) best illustrates the connection between stringent health care rationing and single-payer funding. Until very recently, the National Institute for Clinical and Health Excellence (NICE) determined what procedures—and which patients—would be covered by the NHS. (The new government in Britain is replacing NICE rationing with decisions made by general practitioners, creating the potential for conflicts of interest between physicians and their patients.)

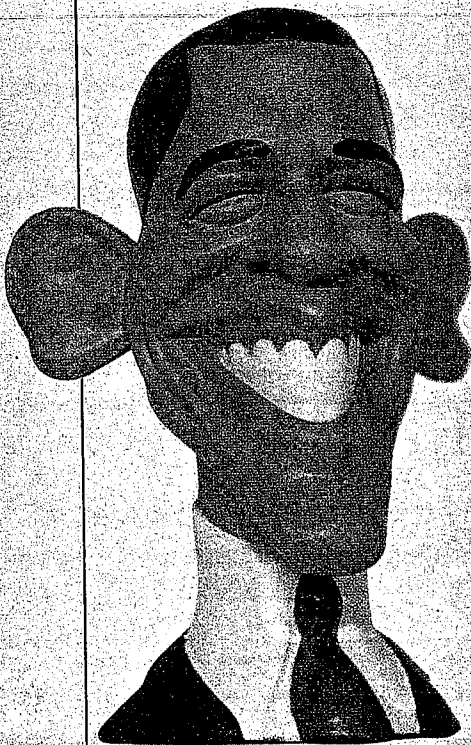
In its heyday, NICE followed a complicated quality-of-life/cost-benefit formula to ration care, using a unit of measurement called the "quality adjusted life year," or QALY. Briefly, the process of determining whether a given treatment would be covered

involved determining how much time a procedure might give a patient, then subtracting for low quality of life. The resulting QALY estimate was then analyzed to determine whether the predicted benefit was worth the projected cost. Some Obamacare supporters—including the *New England Journal of Medicine*—want the United States to adopt a QALY system, raising the prospect of bringing the worst aspects of single-payer rationing to federally controlled private health insurance markets.

Our current private system certainly has serious problems that need addressing. But no private insurance company would dare unilaterally deny a previously qualified patient life-saving surgery, as Arizona did. Only government can get away with something like that.

Indeed, if insurance companies fail to pay for covered care, they risk juries awarding tens of millions in punitive damages against them in "bad faith" lawsuits—and there are plenty of trial lawyers eager to bring such cases. At the same time, government regulators of private systems are much more likely to side with patients than insurance companies, a benefit of the doubt likely to be reversed in single-payer or federally bureaucratized plans. Potential loss of market share serves to keep private carriers on the up and up—particularly in markets with robust competition, which is why expanding health insurance markets is an urgent agenda item for those seeking to replace Obamacare.

As the nation continues to debate health care reform, we should keep in mind that many Obamacare supporters see the Affordable Care Act as merely a first step on the road to a national single-payer plan. Those who oppose such a centralized system should stress that avoiding death-panel medicine in a time of strained budgets requires that we eschew both single-payer financing and federalized bureaucratic control. They should also promote cost-containment innovations, such as price competition at the source of services, and reforms that enable hard-to-insure people and workers with low wages to gain broader access to coverage or inexpensive care. ♦



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