Written by **Michael Tennant** on June 4, 2010

Study Misused to Expedite ObamaCare Passage

"In selling the health care overhaul to Congress, the Obama administration cited a once obscure research group at Dartmouth College to claim that it could not only cut billions in wasteful health care spending but make people healthier by doing so," write Reed Abelson and Gardiner Harris in the New York Times.

White House Budget Director Peter Orszag claimed the study showed that "an estimated $700 billion a year spent on health care … does nothing to improve patient health, but subjects you and me to tests and procedures that aren't necessary and are potentially harmful — not to mention wasteful."

"Mr. Orszag," say Abelson and Harris, "even displayed maps produced by Dartmouth researchers that appeared to show where the waste in the system could be found. Beige meant hospitals and regions that offered good, efficient care; chocolate meant bad and inefficient." All the Obama administration had to do was to "trim the money Medicare pays to hospitals and doctors in the brown zones," according to Abelson and Harris, and the problem of wasteful healthcare spending would be solved.

Like so much else that passed for truth in the ObamaCare debate, Orszag's assertions turned out to be somewhat less than accurate. The Dartmouth study, known officially as the Dartmouth Atlas of Health Care, says nothing whatsoever about the quality of healthcare, nor does it even address regional differences in healthcare practice and economic conditions. As Abelson and Harris write, "For all anyone knows, patients could be dying in far greater numbers in hospitals in the beige regions than hospitals in the brown ones, and Dartmouth's maps would not pick up that difference. As any shopper knows, cheaper does not always mean better."

Indeed, the Dartmouth study method does seem a bit simplistic, at least as Abelson and Harris describe it: "Dartmouth researchers use data on how much hospitals have billed Medicare for patients with a chronic illness who were in their last six months or two years of life" and then compare the costs among hospitals to determine which ones are most efficient. They then conclude, as Dr. Elliott Fisher, one of the principal authors of the study said, "If everyone could operate like Oregon, Seattle or the Upper Midwest, there's huge savings."

"But," write Abelson and Harris, "the atlas's hospital rankings do not take into account care that prolongs or improves lives. If one hospital spends a lot on five patients and manages to keep four of them alive, while another spends less on each but all five die, the hospital that saved patients could rank lower because Dartmouth compares only costs before death."

Had the Dartmouth researchers and administration figures who cited them merely stood by their findings that some regions spend more than others on end-of-life healthcare, they would have been on solid ground. However, in their haste to assist the passage of ObamaCare, they went beyond the conclusions the data would support, actually making the case that higher healthcare spending correlated with lower-quality care. Abelson and Harris report:

> In just one example of this extrapolation, Dr. Fisher, in testimony before Congress last year, summarized his and others' work by asking, "Why are access and quality worse in high-spending

regions?"

And on Dartmouth's Web site, a question-and-answer section suggests that this interpretation is appropriate: "The evidence is that higher utilization does not extend life expectancy, and might be correlated with shorter life expectancy, compared with lower utilization. Therefore, sending people with chronic diseases to higher-efficiency, lower-utilization hospitals for their care could result in both lower spending and increased quality and length of life."

In fact, say Abelson and Harris, studies are inconclusive as to the link between spending and quality, and the Dartmouth researchers "acknowledged that there was no proven link between greater spending and worse health outcomes."

The Dartmouth research is not without value, but it should not have been used to suggest that healthcare spending can be slashed without regard to regional differences or the quality of care. Of course, if the United States had a truly free market in healthcare and Medicare and other unconstitutional government healthcare programs didn't exist, this would be moot because patients, not bureaucrats, would be making the decisions regarding how much, and what quality, healthcare they were willing and able to purchase (with an assist from charities for genuine hardship cases).

Ironically, in pushing a healthcare "reform" bill that was supposed to stick it to the insurance companies that allegedly put costs before quality, the Obama administration chose to use as a central part of its case for cost containment a study that, Abelson and Harris note, is now financed in large part by insurance companies who also like "the more-is-worse message" of the study. Then again, that same ostensibly stick-it-to-Big-Insurance bill also gave insurers a captive customer base.

Big Business long ago ceased being "America's most persecuted minority," as Ayn Rand once described it. Obama, like most Washington politicians, is a "corporatist," in Ron Paul's apt turn of phrase; and, says Paul, in "a corporatist state, government officials often act in collusion with their favored business interests to design polices that give those interests a monopoly position, to the detriment of both competitors and consumers."

Nothing better describes ObamaCare: a bill that was crafted at the behest of insurers, pharmaceutical companies, and other healthcare interests and eagerly signed into law by a President who received more campaign contributions from big pharmaceutical and healthcare companies than any other candidate in history. To put this one over on the American people some big lies had to be told. Only now, once the bill has become law, are we discovering the extent of those falsehoods.

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