

The Dartmouth Atlas of Health Care study: Shoddy science in support of health care cuts

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The Obama White House and its media backers defend the administration's cost-cutting health care overhaul, with all its dire implications for broad layers of the population, with the claim that the scheme is based on objective scientific research.

Leading the charge has been the *New York Times*, which has berated a skeptical US population for not accepting the supposedly incontrovertible scientific evidence that slashing Medicare, the government program for seniors, and reducing the availability of more expensive tests, drugs and procedures to ordinary people will improve the quality of their care while dramatically reducing costs.

In numerous editorials and articles, the newspaper has blamed runaway health care costs not on insurance companies making record profits and a for-profit system dominated by giant drug companies and hospital chains, but on doctors and hospitals that order "excessive" tests and treatments. It asserts that the Obama plan is based on scientific research, and suggests that people who oppose it are simply being irrational and backward.

Since the most expensive treatments are not *always* the best treatments, the liberal supporters of the Obama plan assert, high-cost hospitals and doctors should be penalized and the entire system should be loaded with financial incentives to ration care—except, of course, to the rich, who will continue to enjoy the best care money can buy.

Most prominent among the studies cited by such backers of Obama's health care overhaul is the Dartmouth Atlas of Health Care, which is published by Dartmouth Medical School's Institute for Health Policy and Clinical Practice. The Dartmouth Atlas website asserts that at a time "when there seem to be too many questions and too few answers about how to repair a broken system, the [Dartmouth Institute for Health Policy and Clinical Practice] offers a science-based, methodological approach to analyzing and proposing solutions that can and will work."

The Dartmouth Atlas research "has become phenomenally influential on Capitol Hill since it was popularized by Peter R. Orszag, as the director of the Congressional Budget Office and then as President Obama's budget director," the *New York Times* wrote last June.

In a September 2008 speech at Stanford University, Orszag stated that the government is "building off of much of the work the Dartmouth folks have done," asserting there is "little evidence that extra spending gets us anything in terms of reduced mortality rates or higher quality."

In fact, the underlying methodology of the Dartmouth studies is, at best, highly questionable from a scientific standpoint, and, as an examination of the Dartmouth Atlas shows, the conclusions the Dartmouth researchers draw from the data they collected are built into the premises they employ. There is a vocal and growing body of opinion within the health care and medical communities that insists the Dartmouth Atlas studies are examples of shoddy science driven by an underlying and reactionary political agenda.

While it has come to prominence of late, the Dartmouth group has long been an advocate of health care rationing. The Dartmouth Atlas April

2008 publication, "Tracking Patients with Severe Chronic Illness," provides the key "scientific" rationale for Obama's proposed health care cost reductions—in the range of 30 percent for both Medicare and other government health programs and for the private sector. The June 2009 *Times* article says that Orszag estimates that total US health care costs can be reduced by \$700 billion a year without any decline in the quality of care for the American people.

The April 2008 study, headed up by Dr. John Wennberg, examined Medicare spending during the last two years of life for individuals who died between 2001 and 2005. It found that health care for these patients delivered in different regions and by different hospitals involved significantly differing amounts of treatment. From this, the Atlas concluded that those institutions with higher costs were guilty of providing unnecessary and excessive treatment.

The study argued that since there were no differences in patient outcome—all subjects died—variations in spending between high-cost and low-cost regions and hospitals could not be justified.

"By looking at care delivered during fixed intervals of time prior to death," states the study's Executive Summary, "we can say with assurance that the prognosis of all the patients is identical: all were dead after the interval of observation."

This is a crude example of circular reasoning. According to the Dartmouth Atlas, all the patients in the study died. Ergo: those hospitals that spent more were wasting money.

To be blunt—that such arguments can be credited as "science" is an astounding testament to the degradation of official thought and intellectual life in contemporary America. Pardon us, if we point out—all of the patients died because only those patients who died over the two-year period were included in the study!

How does the banal and entirely predictable fact that some hospitals spent more on their patients than others warrant the conclusion that there was no difference in the quality of care? Or, for that matter, any conclusion other than the fact that some spent more than others. Because, the Dartmouth researchers claim, they all died.

One is almost embarrassed to point out the absurdity of this line of argument. Since there was no attempt to determine which hospitals had a better survival rate for the Medicare patients, or to measure any other indicator of the quality of life of the patients, the Dartmouth data can legitimately yield no conclusions about the relationship between cost and quality of care.

Moreover, and no less crucial, the Dartmouth study ignores real-life socio-economic and demographic factors among the different patient populations that obviously play a huge role in determining the cost of medical care. As many critics of the Dartmouth studies have correctly pointed out, poverty matters! Hospitals in large cities that treat many people from impoverished neighborhoods, as well as those in poor rural areas, are obviously going to face higher costs than hospitals in mainly upper-class areas, whose patient pools are wealthier and healthier.

Further, the study claims that a major portion of the “unwarranted” variation in spending is the result of what the researchers call “supply-sensitive” care—that is, the availability of health care resources, such as the number of specialists per capita. In other words, a major problem in the health care system that needs to be addressed is the general availability of more expensive and sophisticated forms of care, including new tests, devices, drugs and procedures arising from advances in medical technology.

The implications of this line of argument are as sweeping as they are reactionary: new technology and methods are “unnecessarily” increasing health care costs because they are available to ordinary people, and their widespread availability creates an incentive to use them on the general population. The truly Malthusian and misanthropic premises of this argument—and the entire line of the Dartmouth studies—emerge quite clearly.

Ordinary people are being given too high a level of care, they are living too long, and they are costing the ruling class too much! The Atlas study points to the “increasing recognition that some chronically ill and dying Americans are receiving too much care.”

This is clearly an argument for rationing health care and depriving masses of people of more sophisticated and expensive treatments, which should be reserved for the wealthy.

The principal conclusion drawn by the Dartmouth study is that lower-spending institutions should be the benchmark to be emulated, by financially incentivizing facilities and practitioners to provide a decreased amount of care. Toward this end, the study holds up as a model the Mayo Clinic in Rochester, Minnesota, and denigrates as a prime example of “excessive” care the UCLA Medical Center in Los Angeles.

“Data from the Atlas can therefore be used,” says the study, “to estimate the savings that could be achieved if, for example, UCLA met the utilization provided by the Mayo Clinic.” The study ignores the fact that the Mayo Clinic is located in a suburban and upper-income area, while UCLA is an inner-city hospital in one of the largest metropolitan areas and services poor, working class and minority populations.

“One group of winners in this scenario would be payers,” such as insurance companies, says Dartmouth. The “winner” in this scenario would indeed be the for-profit health care industry, and the “loser” the American people.

There is, of course, waste and inefficiency in the US health care system. Waste is inherent in a corporate-dominated, for-profit system in which health care is subordinated in the accumulation of private wealth and subject to the anarchy of the capitalist market. It is one expression of the contradiction between the development of science and technology and the profit system.

Responding to the Dartmouth attack, the UCLA Health System, including six California teaching hospitals, produced a counter-study in which the dead were counted—but so were the living.

As a result, the California investigators found that the “hospitals that used more resources had lower mortality rates.” They went on to say that “our findings suggest that focusing only on expired patients may lead to different ranking of hospitals with regard to resource use.... Assessing hospital efficiency requires that we consider outputs as well as inputs, that is, health outcomes as well as resource use.” (See accompanying interview with Dr. Michael Ong, lead author of the California study.)

One critic of the Dartmouth Atlas, Dr. Peter B. Bach of Memorial Sloan-Kettering Cancer Center in New York, published an analysis of the study in the February 18, 2010, issue of the *New England Journal of Medicine*. Entitled “A Map to Bad Policy—Hospital Efficiency Measures in the Dartmouth Atlas,” the article stated, “Because the Atlas is so influential, their rankings [of hospitals] could have broad effects on policy.... Given their potentially far-reaching implications, it is concerning that the rankings are unsound, both conceptually and methodologically.”

Bach asserts that the “Atlas efficiency rankings consider only costs (i.e., resources consumed),” rather than “weighing both resources consumed and [patient] outcome,” and might be used in the withholding of care from the seriously ill.

“We are about to embark on a huge transformation of our health care system,” Dr. Bach told the *New York Times*. “If we start with a bunch of flawed measures, it will be as devastating as putting in the wrong coordinates before a moon shot.”

Senior researchers at the Johns Hopkins School of Public Health concluded that at least half of the differences in end-of-life-care costs discovered by the Dartmouth group are the result of “socio-economic factors,” such as poverty.

Testifying before Congress on April 1, 2009, Dr. Robert Berenson of the Urban Institute in Washington DC, asserted, “Our preliminary findings cast doubt on both the magnitude of the geographic spending variations and the source of the variations that the Dartmouth researchers found. Analysis of spending for individual patients who live in different geographic areas suggests that variations in individual characteristics, especially patient’s underlying health status and a range of socio-economic factors, including income and the presence of supplemental insurance, account for almost all of the explainable variation. In our analysis, local provider supply—the number of hospital beds and physicians per capita—did not explain the Medicare or total health cost of individual patients.”

One of the most persistent critics of the Dartmouth group has been Dr. Richard Cooper, a professor of medicine at the University of Pennsylvania and former dean of the Medical College of Wisconsin. He spoke with the *World Socialist Web Site* about the major fallacies of the Dartmouth study and their political implications. (See accompanying interview).

In a separate conversation, Dr. Cooper brought out what he termed a conflict of interest between Dr. Wennberg’s commercial affiliations and the research over which he presides.

“In *Health Affairs* in 2007,” Dr. Cooper said, “Dr. Wennberg cited a financial interest in Health Dialog, a commercial provider of care management services. Also in 2007, his son David Wennberg stated that he is the president and chief operating officer of Health Dialog Analytic Solutions, a subsidiary of Health Dialog. The pending Senate health care reform bill contains a section that calls for value-based purchasing, introduced by Senator Maria Cantwell, a member of the Senate Finance Committee, chaired by Max Baucus, who both received campaign contributions from employees of Health Dialog, according to Watchdog.net.

“The privately-held corporation has a contract from the British National Health Service to develop risk-stratification tools for use by providers in England.”

Health Dialog describes itself as a firm that “helps physician groups, health plans and self-insured employers improve health care quality while reducing overall costs.”

A press release for the Dartmouth Atlas study acknowledges that it was funded by the Robert Wood Johnson Foundation in partnership with a “funding consortium” that included the foundations of mega health insurance companies WellPoint, Aetna and UnitedHealth Group.

Dr. Wennberg’s office did not reply to questions on the study submitted by the *World Socialist Web Site*.



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