The effects of cardiac specialty hospitals on the cost and quality of medical care

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Abstract

The recent rise of specialty hospitals – typically for-profit firms that are at least partially owned by physicians – has led to substantial debate about their effects on the cost and quality of care. Advocates of specialty hospitals claim they improve quality and lower cost; critics contend they concentrate on providing profitable procedures and attracting relatively healthy patients, leaving (predominantly nonprofit) general hospitals with a less-remunerative, sicker patient population. We find support for both sides of this debate. Markets experiencing entry by a cardiac specialty hospital have lower spending for cardiac care without significantly worse clinical outcomes. In markets with a specialty hospital, however, specialty hospitals tend to attract healthier patients and provide higher levels of intensive procedures than general hospitals.

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1. Introduction

The debate over the welfare implications of specialty hospitals – for-profit, physician-owned institutions that serve patients with a particular illness, such as cardiac disease – involves several issues of long-standing interest to economists. Opponents of specialty hospitals argue that they...
are a vehicle to disguise kickbacks to physicians for referrals, and that they thereby contribute to
the “medical arms race” of competition through the provision of medically unnecessary services.1
Opponents also argue that specialty hospitals “cherry pick” profitable services and healthy patients
from general hospitals. Specialty hospitals, for example, are less likely than general hospitals to
have emergency departments (US GAO, 2003b). In contrast, proponents argue that specialty
hospitals are “focused factories” that not only offer their own patients more efficient specialized
care but also lead neighboring general hospitals to become more responsive and up-to-date in
their practices.

These opposing views have been manifest in two distinct policy perspectives. If competition
from specialty hospitals has social benefits, then state regulators and public insurers such as
Medicare and Medicaid should allow, and perhaps even facilitate, their entry. If competition
from specialty hospitals has social costs, however, then policy makers should set regulations and
financial incentives to account for the negative external effects that specialty hospitals create. As
a result of this debate, the federal government imposed an 18-month moratorium in December
2003 on Medicare reimbursement for care at new specialty hospitals to allow for greater analysis
of their impact.

Despite both practical and academic interest in this question, we are not aware of any existing
research that has simultaneously estimated the effects of specialty hospital entry on health care
costs and patient health outcomes; without information on both costs and outcomes, conclusions
about welfare are necessarily speculative. In this paper, we assess empirically the two main
hypotheses about specialty hospitals. We focus on the treatment of elderly Medicare beneficiaries
with cardiac disease at single-specialty cardiac hospitals. Most of these hospitals are jointly owned
by for-profit chains and the local cardiologists and cardiac surgeons who practice at the facilities.

First, we estimate how the Medicare expenditures, treatments, and outcomes for patients in
geographic areas that experienced specialty hospital entry between 1996 and 1999 changed over
this period. If specialty hospital entry leads to lower expenditures and better outcomes, we would
conclude that it increases welfare. If it leads to higher expenditures and worse outcomes, we
would conclude that it decreases welfare. If it leads to lower expenditures and worse outcomes
(or higher expenditures and better outcomes), we would calculate the implied cost per life saved
of specialty hospital entry to determine its welfare effects.

Our approach provides an unbiased assessment of the effects of specialty hospitals even if
specialty hospitals select healthier patients for treatment, because it estimates the effect of specialty
hospital entry by the difference in all patients’ expenditures and outcomes – not just those for
patients at specialty hospitals – between entry and control geographic areas. It identifies the direct
plus any spillover effects of specialty hospitals. The consistency of these estimates depends on
the assumption that trends in the unobservable characteristics of patients and markets in entry
versus control areas are uncorrelated with the unobserved determinants of costs and outcomes.
We investigate the validity of this assumption in detail below.

Second, we examine how the expenditures, treatments, and outcomes of patients admitted to
a specialty hospital differ from those admitted to a general hospital in a 1999 cross-section of
geographic areas with an operating specialty hospital. In addition, we estimate the extent to which
differences in observable patient characteristics explain differences in the care of patients admitted
to a specialty versus a general hospital. Although these estimates can neither prove nor disprove

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1 The concept of competition among health care providers leading to higher levels service provision is noted by Joskow
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