Available online at www.sciencedirect.com
SCIENCE @ DIRECT®
ELSEVIER
Journal of Health Economics 25 (2006) 702–721
JOURNAL OF HEALTH ECONOMICS
www.elsevier.com/locate/econbase

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

Jason R. Barro[a,d], Robert S. Huckman[b,d], Daniel P. Kessler[c,d,*]

[a] *Bain and Company, USA*
[b] *Harvard University, USA*
[c] *Stanford University, Graduate School of Business, and Hoover Institution, Stanford, CA 94305-5015, USA*
[d] *NBER, USA*

Received 10 March 2005; received in revised form 28 October 2005; accepted 2 November 2005
Available online 6 December 2005

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.
© 2005 Elsevier B.V. All rights reserved.

JEL classification: I1

Keywords: Health economics

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

* Corresponding author.
E-mail address: fkessler@dk.stanford.edu (D.P. Kessler).

0167-6296/$ – see front matter © 2005 Elsevier B.V. All rights reserved.
doi:10.1016/j.jhealeco.2005.11.001

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

[1] The concept of competition among health care providers leading to higher levels service provision is noted by Joskow (1980), Held and Pauly (1983), and Robinson and Luft (1985).

دریافت فوری ← متن کامل مقاله

ISIArticles
مرجع مقالات تخصصی ایران

- ✓ امکان دانلود نسخه تمام متن مقالات انگلیسی
- ✓ امکان دانلود نسخه ترجمه شده مقالات
- ✓ پذیرش سفارش ترجمه تخصصی
- ✓ امکان جستجو در آرشیو جامعی از صدها موضوع و هزاران مقاله
- ✓ امکان دانلود رایگان ۲ صفحه اول هر مقاله
- ✓ امکان پرداخت اینترنتی با کلیه کارت های عضو شتاب
- ✓ دانلود فوری مقاله پس از پرداخت آنلاین
- ✓ پشتیبانی کامل خرید با بهره مندی از سیستم هوشمند رهگیری سفارشات