Facilities

HOSPITALS

Reliability and Validity in Hospital Case-Mix Measurement

Pettengill, Julian (Office of Research, Health Care Financing Administration) and Vertrees, James. RELIABILITY AND VALIDITY IN HOSPITAL CASE-MIX MEASUREMENT. Health Care Financing Review 4:101-128, December 1982.

Discussion of the “problem of measuring the expected cost of the mix of inpatient cases treated in a hospital (hospital case mix) and a general approach to its solution. The solution is based on a set of homogeneous groups of patients, defined by a patient classification system [DRGs], and a set of estimated relative cost weights corresponding to the patient categories. This approach is applied to develop a summary measure of the expected relative costliness of the mix of Medicare patients treated in 5,576 participating hospitals.

“The Medicare case-mix index is evaluated by estimating a hospital average cost function. This provides a direct test of the hypothesis that the relationship between Medicare case mix and Medicare cost per case is proportional. The cost function analysis also provides a means of simulating the effects of classification error on [the authors’] estimate of this relationship.” It is concluded that: “[T]he Medicare case-mix index provides a valid and generally accurate representation of the expected costliness of an individual hospital’s patient mix.” Tables. Figures. References.

Hospital Performance in Multihospital Systems: A Comparative Study of System and Independent Hospitals

Coyne, Joseph S. (Graduate Program in Health Services Management, University of California School of Public Health, Los Angeles). HOSPITAL PERFORMANCE IN MULTIHOSPITAL SYSTEMS: A COMPARATIVE STUDY OF SYSTEM AND INDEPENDENT HOSPITALS. Health Services Research 17:303-329, Winter 1982.

Hospital costs and productivity in multihospital systems versus those of independent hospitals are a major source of debate among health care providers and researchers. Previous studies have shown system hospitals perform better than independent hospitals. The evidence, however, has been limited to only a few nonprofit systems.
The Effects of Hospital Rate-Setting Programs on Volumes of Hospital Services: A Preliminary Analysis

Worthington, Nancy L. (Policy Analysis Inc., Brookline, Mass.) and Piro, Paula A. THE EFFECTS OF HOSPITAL RATE-SETTING PROGRAMS ON VOLUMES OF HOSPITAL SERVICES: A PRELIMINARY ANALYSIS. Health Care Financing Review 4:47-66, December 1982.

Report of a preliminary study of the effects of state rate-setting programs on the volume of hospital services, namely, admission rates, occupancy levels and average lengths of stay. "A volume response to rate-setting may be anticipated as a result of program effects on hospital costs or charges as well as on hospitals' behavioral incentives."

This report is "one of a series that has been prepared as part of the National Hospital Rate-Setting Study (NHRS), a large-scale evaluation of rate-setting programs funded by the Health Care Financing Administration. . . The NHRS was funded to evaluate the effects of such programs in nine states: Arizona, Connecticut, Maryland, Massachusetts, Minnesota, New Jersey, New York, Western Pennsylvania and Washington." This analysis uses data for samples of hospitals and counties in these states, some with and some without rate-setting programs, for the period 1969-78.

"The results of [the] analyses suggest that the dominant influences on utilization include market area characteristics, such as age, income and health status of the population, availability of nursing home beds and physicians, as well as other aspects of the county and state environment that were not directly measurable. However, the results also suggest
that rate regulation has affected certain volume measures. The principal conclusion...is that rate-setting programs have brought about an increase in hospital occupancy by increasing the average length of stay of patients...rather than by increasing the number of patients admitted...[Few] programs have had a measurable effect on admissions, measured either per bed or per capita."

The most strongly supported a priori hypotheses were those "about the effects of per diem-based systems. All three of the systems based on per diem produced an increase in average length of stay, and occupancy increased significantly in two of the three. There was far less evidence that the programs influenced the admission rate.

"Hospitals' responses to rate-setting in the states with charge-based systems conformed less well to [the] a priori predictions, although since there were relatively few significant findings among these programs it is difficult to assess the extent of conformity. The predominance of null findings for this group of programs may be a function of their lack of stringency...However, the absence of findings may support [the] hypothesis that the most pronounced effects of charge-based systems will be on intensity of care, rather than the more aggregate measures explored in this analysis. It is not possible, given available data, to evaluate that hypothesis..."

"The results also indicate that rate-setting does not have much effect on the rate at which people are hospitalized. This finding is not inconsistent with...prior expectations, which were that admission rates would either not change or that the net effect of the program could not be predicted in advance of the analysis. If admission policies have changed as a result of rate-setting, the changes have been too small to be measured by this analysis."

The Effects of Prospective Reimbursement Programs on Hospital Adoption and Service Sharing

Cromwell, Jerry (Health Economics Research, Inc.) and Kanak, James R. THE EFFECTS OF PROSPECTIVE REIMBURSEMENT PROGRAMS ON HOSPITAL ADOPTION AND SERVICE SHARING. Health Care Financing Review 4:67-88, December 1982.

Analysis of the cost-saving effects of prospective rate-setting (PR) programs on the diffusion of hospital services. "Data compiled from a sample of over 2,500 hospitals in 15 rate-setting and other states between 1969 and 1978 were used to determine PR's effect on both service adoption and sharing.

"Evidence indicates a consistent, retarding effect on all services for New York, the country's oldest, most stringent program. Several other
states, notably Minnesota, Maryland, New Jersey, Washington and Wisconsin showed retarding effects on costly rapidly diffusing services such as open-heart surgery, intensive care units (ICUs), and social work, as well as accelerating the phasing-out of redundant services, such as the premature nursery. . . [N]o consistent, significant effects on service sharing" were found. Tables. Figure. References.

Neighborhood Characteristics and Hospital Closures: A Comparison of the Public, Private and Voluntary Hospital Systems

McLafferty, Sara (Department of Geography, Columbia University). NEIGHBORHOOD CHARACTERISTICS AND HOSPITAL CLOSURES: A COMPARISON OF THE PUBLIC, PRIVATE AND VOLUNTARY HOSPITAL SYSTEMS. Social Science & Medicine 16:1667-1674 (No. 19), 1982.

Report of a study of the "neighborhood distribution of hospital closures in New York City between 1970 and 1981. Discriminant analysis procedures are used to compare the social, economic and health status characteristics of neighborhoods in which hospitals have closed with those of neighborhoods in which facilities have remained open. . . . During the study period, 1970-1981, 5 municipal, 17 voluntary and 17 proprietary hospitals closed, while only 2 new facilities were opened." This analysis is limited to short-term general hospitals.

Findings include: (1) "Closed facilities had significantly fewer beds and lower occupancy rates than their counterparts"; (2) "The neighborhoods experiencing hospital closure differ[ed] significantly from other neighborhoods in several important respects: they [had] a higher percentage [of Black residents], higher rates of infant mortality and higher rates of population decline. . . . Overall, the geographical pattern of hospital closures [had] a clear distributional impact, unfavorable to needy, minority neighborhoods"; and (3) "Closures of voluntary hospitals occurred most frequently in disadvantaged neighborhoods; whereas municipal and proprietary hospital closures showed no differential neighborhood impact. . . .

"Even if the pattern of hospital closures is an efficient way to lower health care costs while responding to population decline, it is doubtful whether closures will end the financial problems of urban hospitals. Although closures should lead to increased occupancy rates at remaining hospitals, those hospitals will also be called upon to provide increasing amounts of free care. The burden of caring for the uninsured shifts but does not disappear. This could mean more hospitals in financial trouble despite their higher occupancy rates—signs of a larger crisis in health care." Tables. Figure. References.
"A Poor Sort of Memory": Voluntary Hospitals and Government Before the Depression

Stevens, Rosemary (Department of History and Sociology of Science, University of Pennsylvania). "A POOR SORT OF MEMORY": VOLUNTARY HOSPITALS AND GOVERNMENT BEFORE THE DEPRESSION. Health and Society: Milbank Memorial Fund Quarterly 60:551-584, Fall 1982.

The appropriate relationship between government and voluntary hospitals has been debated for decades. Throughout most of the nineteenth century there was little distinction — or concern — as to what was appropriate for government and what for voluntary initiative; both were assumed to serve the public interest. Only well into the twentieth century did the source of capital displace societal purpose in redefining "publicness". Versions of history for political purposes have utility as myths that bear scant resemblance to the historical record. (Reprinted with permission from Health and Society: Milbank Memorial Fund Quarterly, Vol. 60 (No. 4), Fall 1982, copyright 1982 by the Milbank Memorial Fund and the Massachusetts Institute of Technology, One East 75th Street, New York, N.Y. 10021.)