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Whatever their philosophical bias, few policymakers would argue the importance of adequate information describing differences among health care providers in quality, cost, and availability of services. In particular, such information is widely viewed as essential to improving the quality of health through consumer choice. Thus, advocates of many points of view have pressed for the development of new mechanisms for collecting and disseminating comparative data about health services.

The uses of comparative provider information, however, have rarely been subject to empirical test. No one knows very much about how consumers and their agents respond to such information or how such responses influence provider behavior in turn. This DataWatch reports the results of a “natural experiment” in the impact of public release of provider-specific quality data.

The HCFA “Death List”

In 1985 and 1986, the Health Care Financing Administration (HCFA) analyzed Medicare data as part of an effort to refine and better target peer review organization (PRO) and administrative oversight of Medicare providers. The analyses involved constructing multivariate models to predict hospital-specific mortality rates for Medicare patients discharged in 1984 and comparing those predicted rates with actual rates. Those comparisons identified 269 hospitals as “outliers,” approximately half of which had higher-than-predicted mortality, and half lower. Additional analyses, less widely reported, applied the same methodology to nine specific diagnosis-related groups (DRGs).1

Hospitals from the metropolitan New York City area were overrepresented among the 269 “outlier” hospitals. Twenty-five (9.3 percent) were...
from New York City, and twenty (7.4 percent) were from surrounding New York and New Jersey counties. Of the New York City hospitals cited, two-thirds had higher-than-expected death rates, and one-third had lower-than-expected rates.²

HCFA disseminated the data March 12, 1986, through a press conference and press release. Release of the HCFA data, dubbed the “death list” by journalists and health professionals alike, received wide media attention in New York City and nationwide.³

Methods

All New York City general acute care hospitals were classified into one of three mutually exclusive categories based on the HCFA data: hospitals with higher-than-expected mortality rates; hospitals with mortality rates as expected; and hospitals with lower-than-expected mortality rates. Seventy New York City hospitals were included, of which fourteen were in the higher-than-expected group, forty-seven in the as-expected group, and nine in the lower-than-expected group. Nine hospitals were excluded from the study—one children’s hospital and eight general acute care hospitals for which data were unavailable.

Occupancy rates for the three groups of hospitals for the five calendar quarters preceding (prerelease period) and the three calendar quarters following (postrelease period) the publication of the list were compared and tested (one-way ANOVA). The hypothesis tested by this natural experiment made the following predictions regarding change in occupancy after release of the “death list”: occupancy in hospitals with higher-than-expected death rates would decline; occupancy in hospitals with as-expected death rates would not change; and occupancy in hospitals with lower-than-expected death rates would rise.

Findings

There was no significant difference in occupancy rates between the two study periods among the three groups of hospitals (F=1.046, p=.357, df=2.67). Average occupancy for all hospitals did not differ substantially across the two periods (Exhibit 1). Occupancy rate changes between the two periods for hospitals with higher-than-expected and lower-than-expected mortality rates not only were statistically insignificant, but they also were in the opposite direction from that hypothesized. Occupancy for hospitals with expected mortality rates declined by less than one percentage point. Occupancy rates of medical/surgical beds alone followed a similar pattern, as did occupancy for voluntary hospitals only.

All three groups of hospitals experienced less fluctuation during the study period than one might expect given normal seasonal and other
Exhibit 1
Occupancy Rates In New York City Hospitals Before And After Announcement Of “Death List”

<table>
<thead>
<tr>
<th>Hospital group</th>
<th>Before</th>
<th>After</th>
</tr>
</thead>
<tbody>
<tr>
<td>All hospitals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Higher mortality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expected mortality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lower mortality</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: New York State Department of Health

variation. Disaggregation of the data by hospital auspices or type of inpatient service did not yield any differences in variation from aggregated data.

Consumer Reaction

The experience in New York City following the release of the HCFA “death list” fails to disprove the null hypothesis: public identification of particular hospitals as having unusually high mortality rates will not discourage consumers (be they patients or physicians who admit patients) from continuing to use those hospitals, nor will public identification of hospitals as having abnormally low death rates attract consumers. Indeed, the absence of any discernable behavioral effect is especially dramatic.

These results do not, of course, definitely disprove the assumption that consumers will in fact respond to comparative provider information. To begin with, the health care system in New York, being highly regulated, lacks many of the characteristics of other, less regulated, health care systems. Hospital payment rates still are regulated by state government, and certificate-of-need regulation still is quite comprehensive. Market penetration of prepaid and managed-care plans still is relatively limited, although higher than in the average US. metropolitan area. In addition, both academic medical centers and religiously
affiliated hospitals occupy a more dominant role in the New York City health care system than in many other communities.4

Perhaps as a result, hospitals in New York City also have occupancy rates significantly higher than in most other parts of the U.S.5 All other things being equal, one would expect more dramatic swings in utilization patterns in areas of greater slack capacity. Moreover, high utilization rates may have reduced incentives for New York City hospitals to engage as energetically in the marketing of their services as hospitals in other communities. It may be worthwhile replicating this study in communities that have lower overall occupancy rates or that more closely approximate a competitive health care marketplace. It also must be acknowledged that this version of the HCFA “death list” itself was seriously flawed methodologically and that its release was accompanied by a variety of caveats and disclaimers.6 Hence, this “death list” may have had such limited impact because consumers understood that it simply was not a useful indicator of quality of care. Another, more refined, “death list” was released in December 1987.

Nonetheless, it is also possible that the basic assumptions behind information strategies are simply wrong. Consumer choice of hospitals probably has far more to do with preferences for and by physicians, tradition, convenience, and word of mouth—not to mention sheer randomness—than with objective information about hospitals. This is not to say that consumers are certain to accept passively efforts by physicians, employers, insurers, and others to impose choices of providers based on such information. Market-based theories of health care may have, once again, simply run afoul of the realities.

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NOTES

5. Ibid.