

Cambridge Judge Business School

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Economies of Scale and Scope in Hospitals: An Empirical Study of Volume Spillovers

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Joint work with
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Existing and ongoing research

Patient routing and flow

- Gatekeepers at Work: An Empirical Analysis of a Maternity Unit, *Management Science (Forthcoming)*.
- Gatekeeping Under Uncertainty: An Empirical Study of Referral Errors in the Emergency Department, *Working paper*.

Hospital service redesign

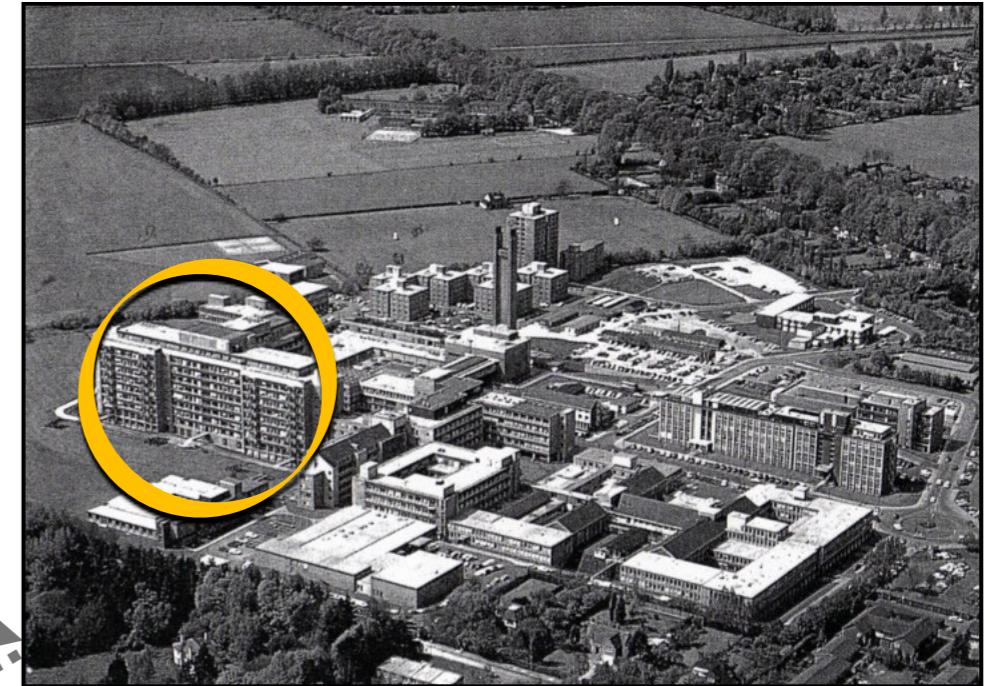
- Economies of Scale and Scope in Hospitals: An Empirical Study of Volume Spillovers, *Management Science (Under Revision)*.
- Fat-Tails in Patient Costs: Evidence and Implications for Tariff-Based Compensation Systems, *Work-in-progress*.

Hospitals have followed a path of growth



1964

Main
hospital
building



1983



2007



2016

Is this the most cost effective way of delivering care?



Do hospitals perform better at **scale**?
Should hospitals be offering such a **scope** of services?

Economies of scale and scope: industry specific

Scale

Economies

Production costs **reduce** with the volume of the **focal** activity

Theory: *Debreu (1959); Lancaster (1968); Mansfield (1970)*

Empirical evidence:

- *Banking (Saunders & Walker 1994);*
- *Electric power (Christensen & Greene 1976)*

Economies of scale and scope: industry specific

Scale

Scope

Economies

Production costs **reduce** with the volume of the **focal** activity

Theory: *Debreu (1959); Lancaster (1968); Mansfield (1970)*

Empirical evidence:

- *Banking (Saunders & Walker 1994);*
- *Electric power (Christensen & Greene 1976)*

Production costs **reduce** with the volume of **other** activities

Theory: *Teece (1980); Panzar & Willig (1981)*

Empirical evidence:

- *Advertising (Silk & Berndt 1993);*
- *Multi-industry (Villalonga 2004);*
- *Drug R&D (Henderson & Cockburn 1993)*

Economies of scale and scope: industry specific

Scale

Economies

Production costs **reduce** with the volume of the **focal** activity

Theory: Debreu (1959); Lancaster (1968); Mansfield (1970)

Empirical evidence:

- Banking (Saunders & Walker 1994);
- Electric power (Christensen & Greene 1976)

Diseconomies

Production costs **increase** with the volume of the **focal** activity

Theory: Coase (1937); Arrow (1974); Williamson (1975, 1985)

Empirical evidence:

- R&D (Zenger 1994);
- Private equity (Lopez-de-Silanes et al. 2012)

Scope

Production costs **reduce** with the volume of **other** activities

Theory: Teece (1980); Panzar & Willig (1981)

Empirical evidence:

- Advertising (Silk & Berndt 1993);
- Multi-industry (Villalonga 2004);
- Drug R&D (Henderson & Cockburn 1993)

Production costs **increase** with the volume of **other** activities

Theory: Skinner (1974); Heskett (1986)

Empirical evidence:

- Airlines (Tsikriktsis 2007);
- Automobile assembly (Fisher & Ittner 1999);
- Manufacturing plants (Brush & Karnani 1996; Schoar 2002)

Are there economies of scale and scope in healthcare?

Given the importance of economies of scale and scope [*in healthcare*] it is perhaps surprising that **so little is known about their extent and importance**. A systematic literature survey as part of this study revealed very little evidence (either positive or negative) about the issue. Many of the existing studies **focus on the “whole hospital”** rather than particular services and even those studies are often very **limited by poor data and methodologies**.

— “*Economies of scale and scope in healthcare markets*,” *Monitor* (2012).

The integrated general hospital



The fully integrated general hospital accommodates:

- Multiple **types** of urgency, e.g. **Emergencies** and **Electives**
- Multiple **service-lines**, e.g. *Orthopedics, Cardiology, Neurology,...*

The integrated general hospital



Benefits of the integrated model

Asset amortization

(e.g. Moore 1959; Panzar & Willig 1981)

Variation buffers

(e.g. Schuster et al. 2011; Freeman et al. 2016)

Meet diverse customer needs

(e.g. Bagozzi 1986; Cravens & Woodruff 1986)

The fully integrated general hospital accommodates:

- Multiple **types** of urgency, e.g. **Emergencies** and **Electives**
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The focused hospital model



Shouldice Hospital

The focused/specialist hospital treats a subset of patients, e.g.:

- with specific **types** of urgency, e.g. **Emergencies** or **Electives**
- in specific **service-lines**, e.g. *Orthopedics* or *Cardiology* or *Neurology*...

The focused hospital model



Shouldice Hospital

Benefits of the focused model

Organizational simplicity

(e.g. Argote 1982; Birtan 1988)

Learning and experience

(e.g. Pisano et al. 2001; KC & Staats 2012)

Development of specialized expertise

(e.g. Hopp & Lovejoy 2012; Argote 2013)

The focused/specialist hospital treats a subset of patients, e.g.:

- with specific **types** of urgency, e.g. **Emergencies** or **Electives**
- in specific **service-lines**, e.g. *Orthopedics* or *Cardiology* or *Neurology*...

Which model is more cost effective?

Integrated model



Focused model



- Asset amortization
- Variation buffers
- Meet diverse customer needs

- Organizational simplicity
- Learning and experience
- Specialized expertise

Do the benefits of pooling across patient **types** and/or **service-lines** in the integrated model outweigh the cost of reduced focus?

Research questions

Integrated model



Focused model



Do costs reduce with increased volume of patients:

[scale] of the same type and from the same service-line?

[type-scope] of the other type and from the same service-line?

[service-scope] of the same type and from the other service-lines?

[other-scope] of the other type and from the other service-lines?

Do effects depend on whether the focal patient type is **emergency** or **elective**?

Data

Condition level **cost** and inpatient **activity** data:

- ↳ For the **9** financial years from 2006/07 to 2014/15
 - ↳ For **130** acute hospital trusts operated by the NHS in England
 - ↳ Corresponding to **~105 million** inpatient admissions

Cost and volume data are reported in each year by each hospital,
broken down into one of

~2000 HRGs (treatment/conditions groups)

HRGs: Healthcare Resource Groups

HRGs: Patients within an HRG are clinically similar and require a relatively homogeneous bundle of resources for their treatment (*Fetter 1991*)

HA11A	Major Hip Procedures for Trauma, Category 2, with Major CC
HA11B	Major Hip Procedures for Trauma, Category 2, with Intermediate CC
HA11C	Major Hip Procedures for Trauma, Category 2, without CC
HA12B	Major Hip Procedures for Trauma, Category 1, with CC
HA12C	Major Hip Procedures for Trauma, Category 1, without CC
HA13A	Intermediate Hip Procedures for Trauma, with Major CC
HA13B	Intermediate Hip Procedures for Trauma, with Intermediate CC
HA13C	Intermediate Hip Procedures for Trauma, without CC

HRG assignment: Automated process, with each patient episode assigned to a unique HRG using information from discharge notes: (*DH 2013*)

- ICD-10 medical diagnosis codes
- OPCS procedure codes
- Contextual information, e.g. patient age and gender
- Any complications or comorbidities

Main data set

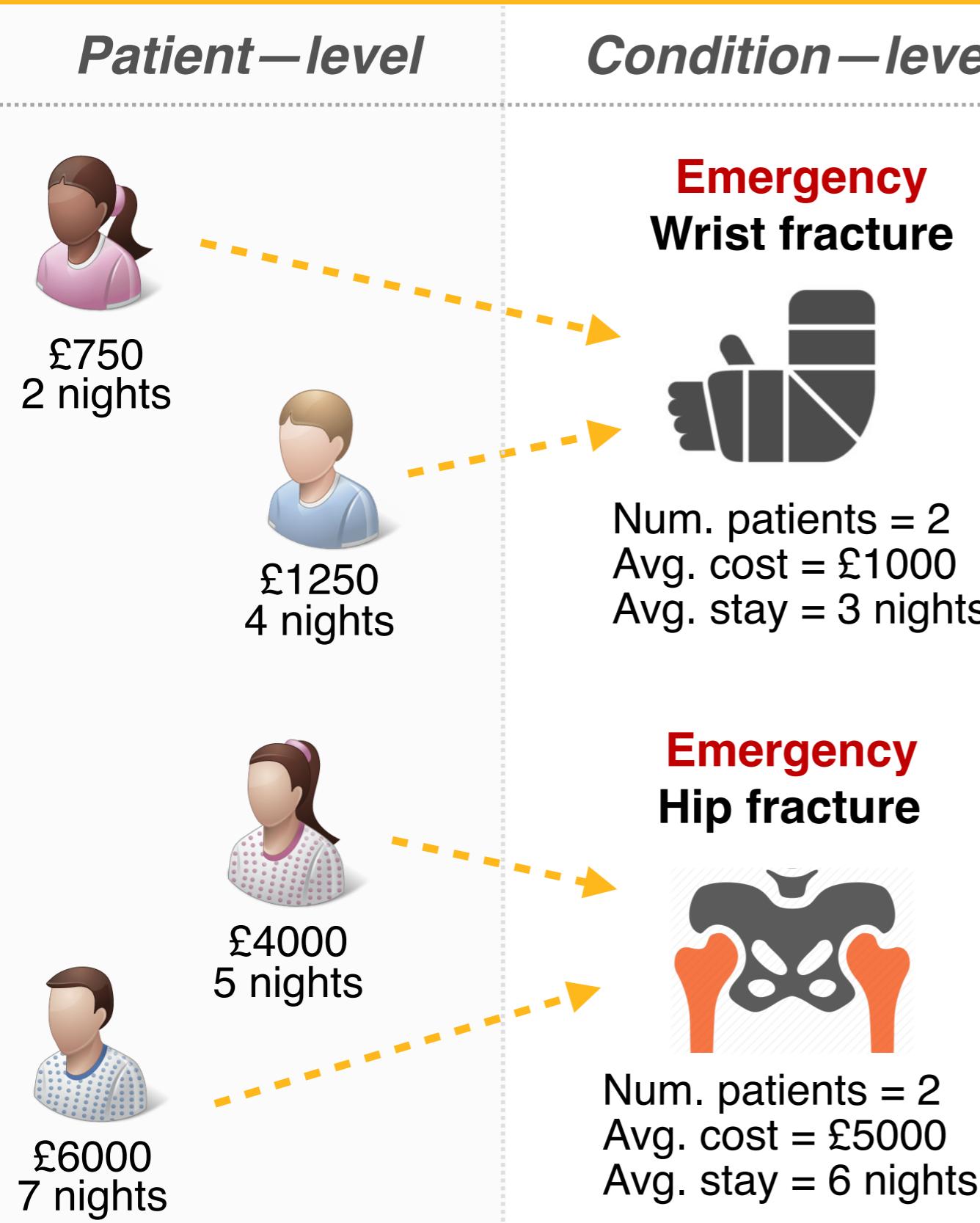


Each hospital in each year submits data to government, aggregated to the HRG level, containing:

- The **volume** of patients treated from each HRG
- The average **cost** of treating these patients
- The average length-of-stay (LOS) of these patients
- Reported separately for **electives** and **emergencies**

~7.2 million observations

Main data set

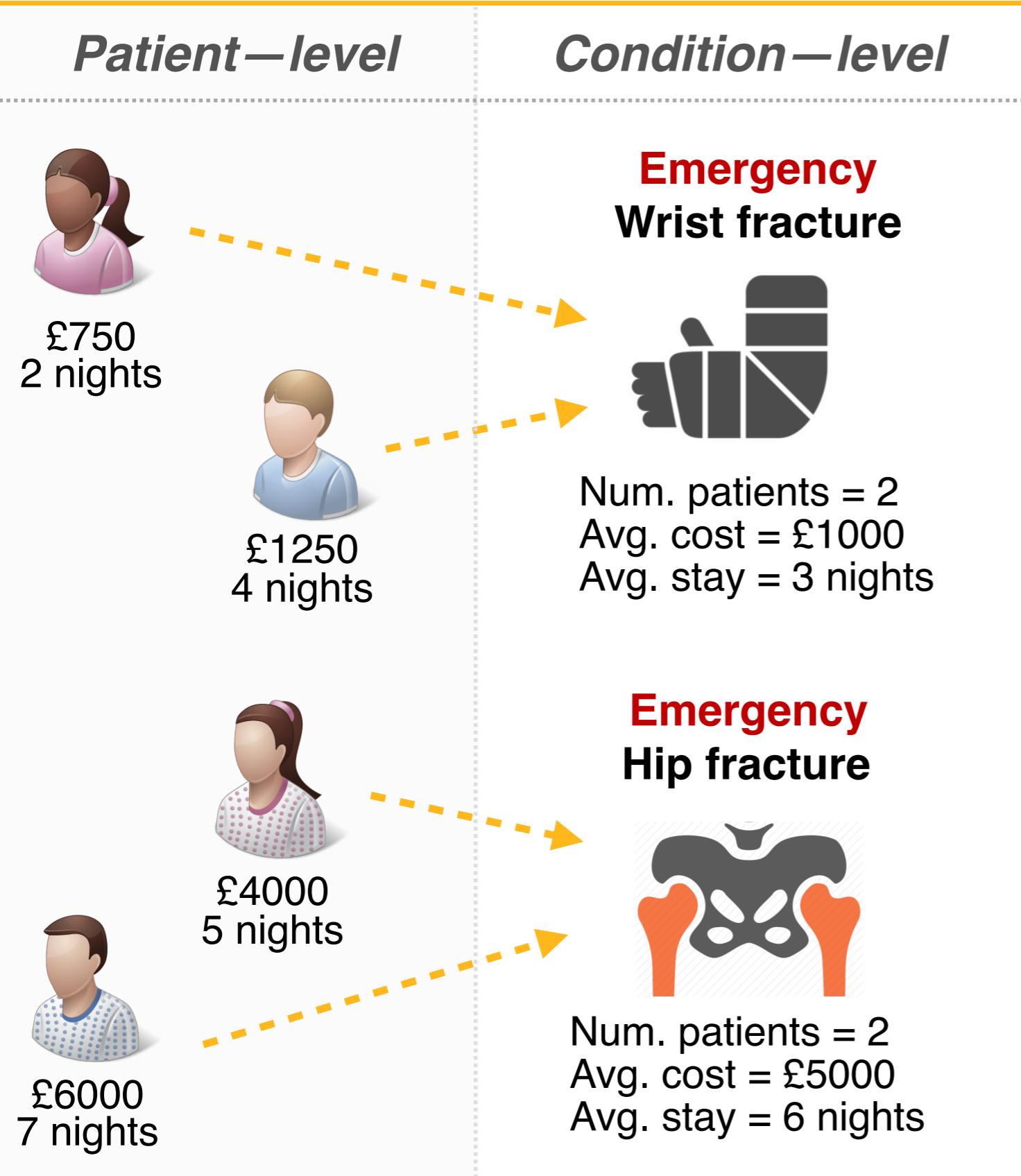


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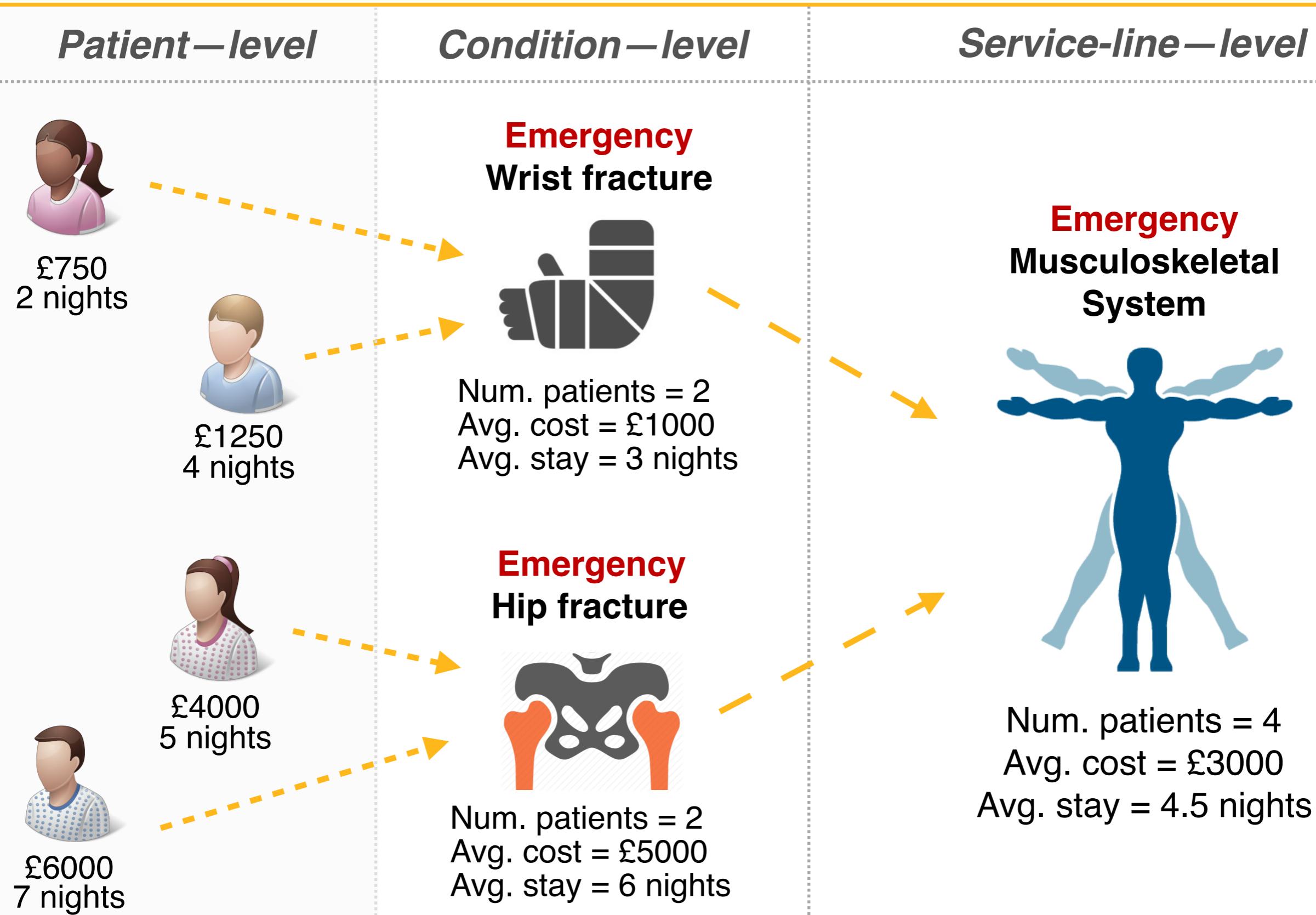
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~7.2 million observations

Aggregate condition-level data to the service-line level



Aggregate condition-level data to the service-line level



Service-lines: HRG chapters

14 service-lines

- Nervous System
- Eyes and Periorbita
- Mouth, Head, Neck and Ears
- Respiratory System
- Cardiac Surgery and Primary Cardiac Conditions
- Digestive System
- Hepatobiliary and Pancreatic System
- Musculoskeletal System
- Skin, Breasts and Burns
- Endocrine and Metabolic System
- Urinary Tract and Male Reproductive System
- Female Reproductive System
- Diseases of Childhood and Neonates
- Vascular System

HRG chapters correspond to major body systems or medical specialties

- Groups related conditions that are likely to share facilities, staff, and other resources.

Unit of analysis

In each of the **130** hospitals h

↳ in each of the **9** years t

↳ in each of the **14** service-lines s :

- **Volume** of elective inpatient admissions
- Average **cost** of treating those electives
- Average **length-of-stay** of those electives

- **Volume** of emergency inpatient admissions
- Average **cost** of treating those emergencies
- Average **length-of-stay** of those emergencies

**15,339
observations**

**15,354
observations**

Methods

We use

- Dependent variable: **Costs** – **emergency** and **elective**
 - Within service-line case-mix adjustment
 - Across service-line normalization
- Independent variables: **Volumes**
 - Four effects: scale, type-scope, service-scope, other-scope
 - Within-between volume decomposition (*Mundlak 1978*)
- Econometric model
 - Multi-level (hierarchical) model (*Gelman & Hill 2007*)

Methods

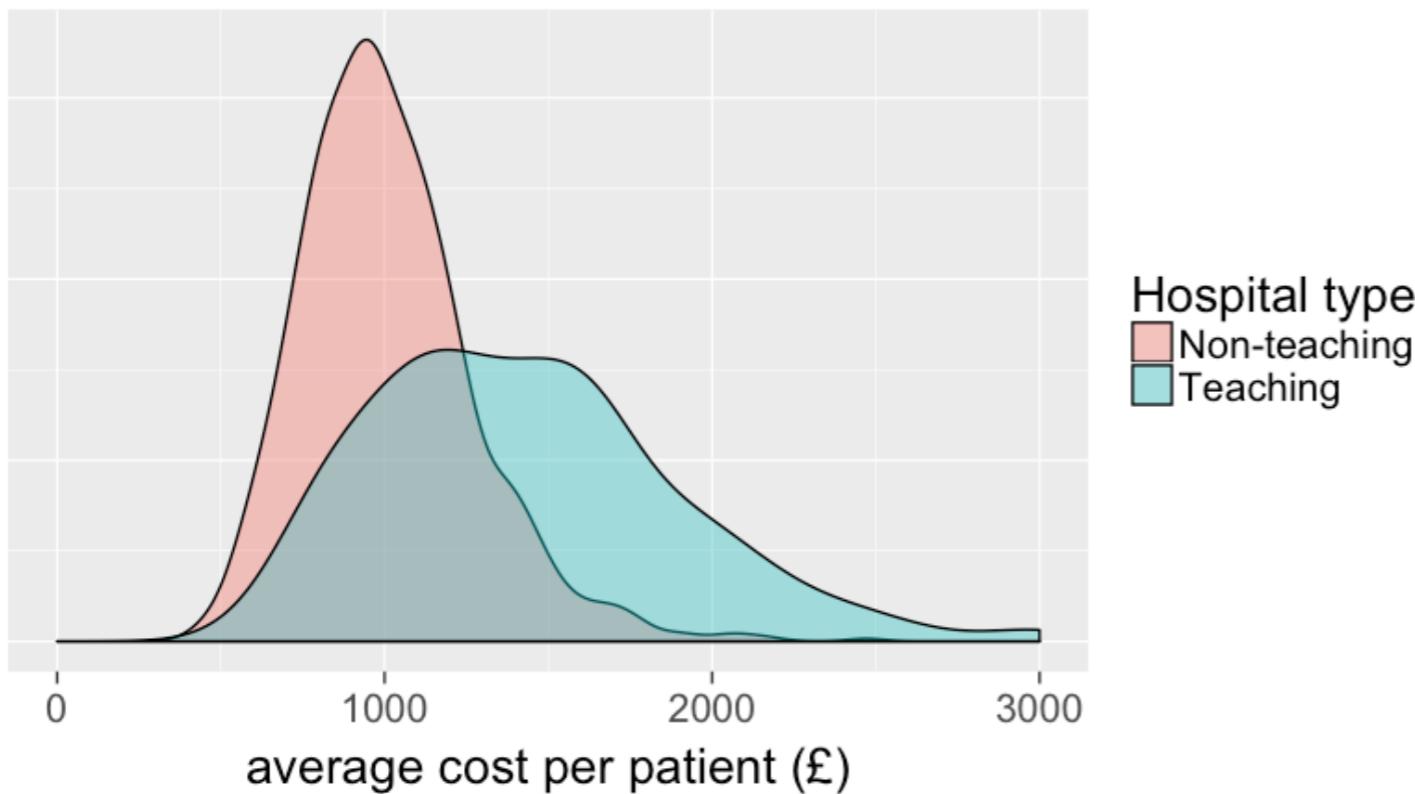
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Case-mix adjust costs to reduce estimation bias

- Costs confounded by case-mix variation across hospitals
- Granularity of data set (HRG-level) enables cost case-mix adjustment
 - ↳ Calculate cost of treating the same “average **elective**” and “average **emergency**” patient within a service-line s in each hospital h and year t

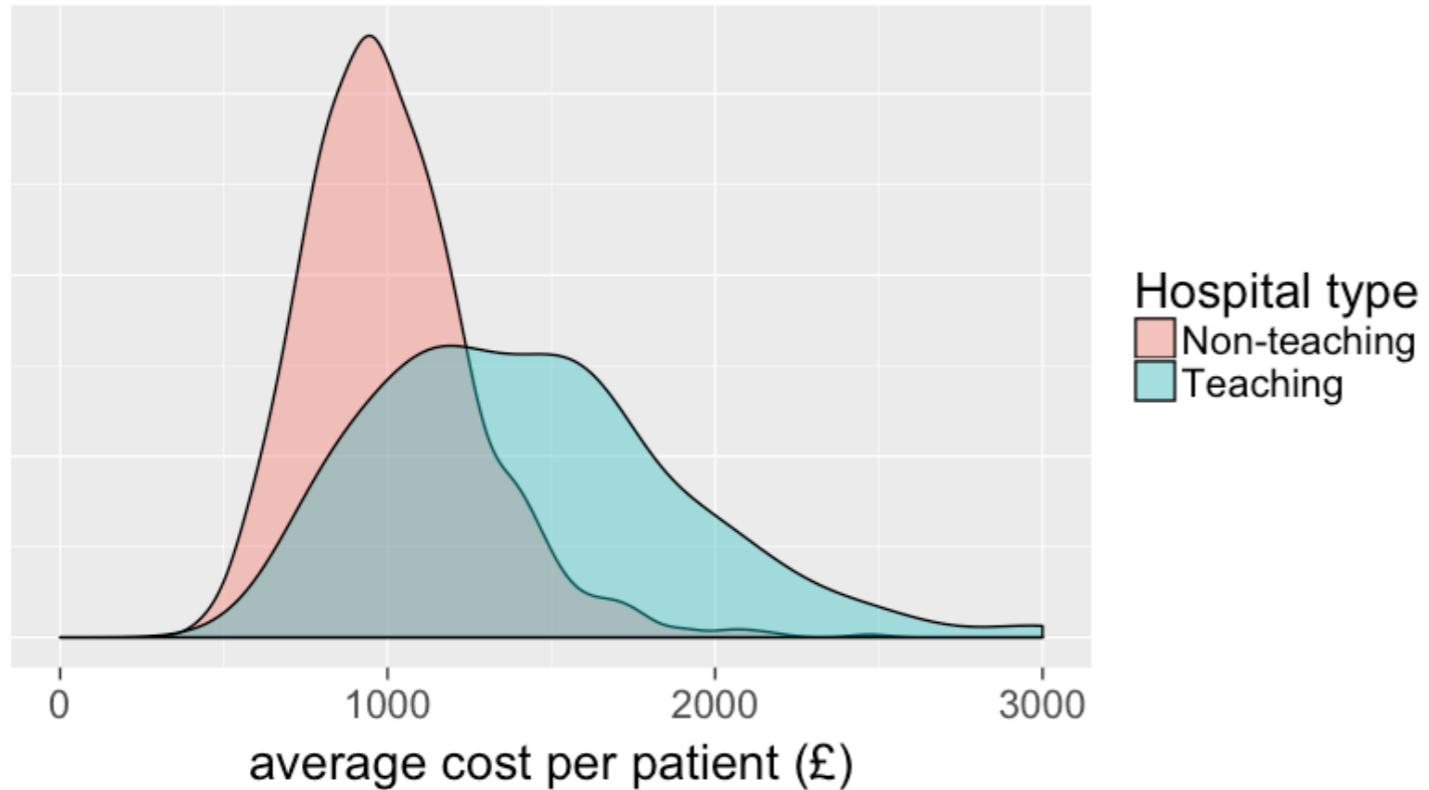
Average cost per patient,
emergency cardiac conditions



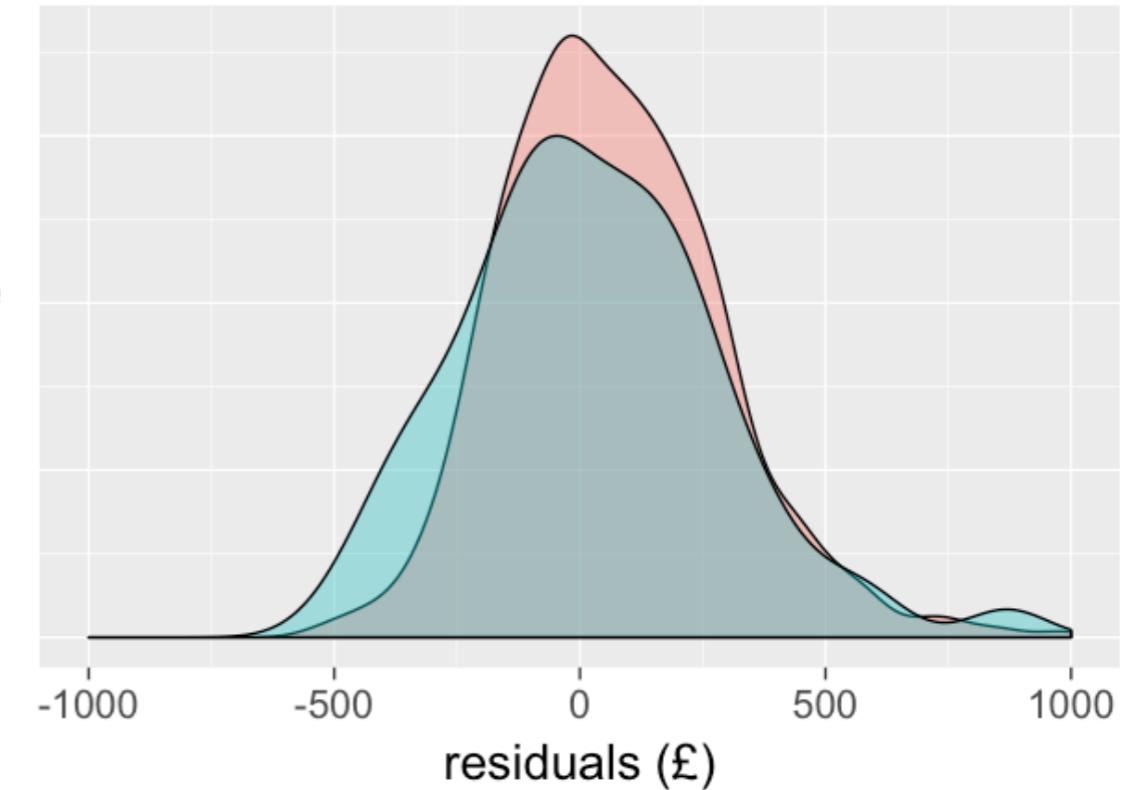
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Average cost per patient,
emergency cardiac conditions



after case-mix adjustment and
w/ hospital-type fixed effect



Methods

We use

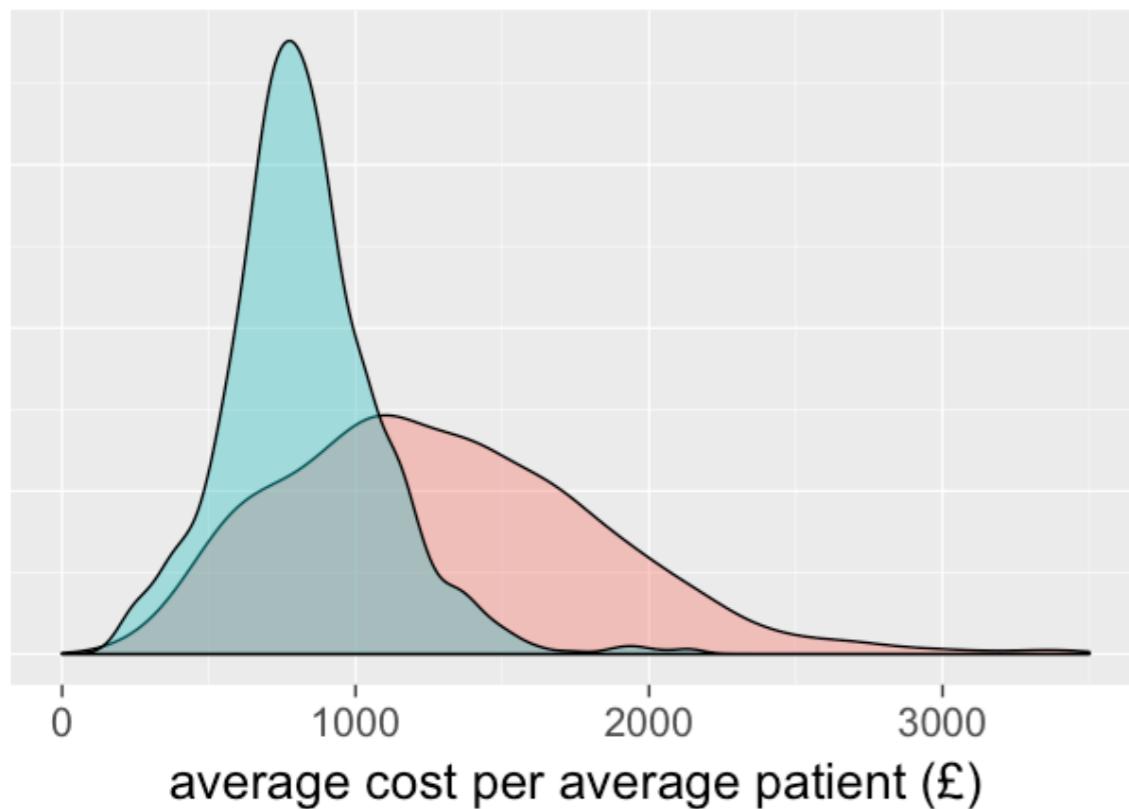
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Normalizing costs reduces across service-line heterogeneity

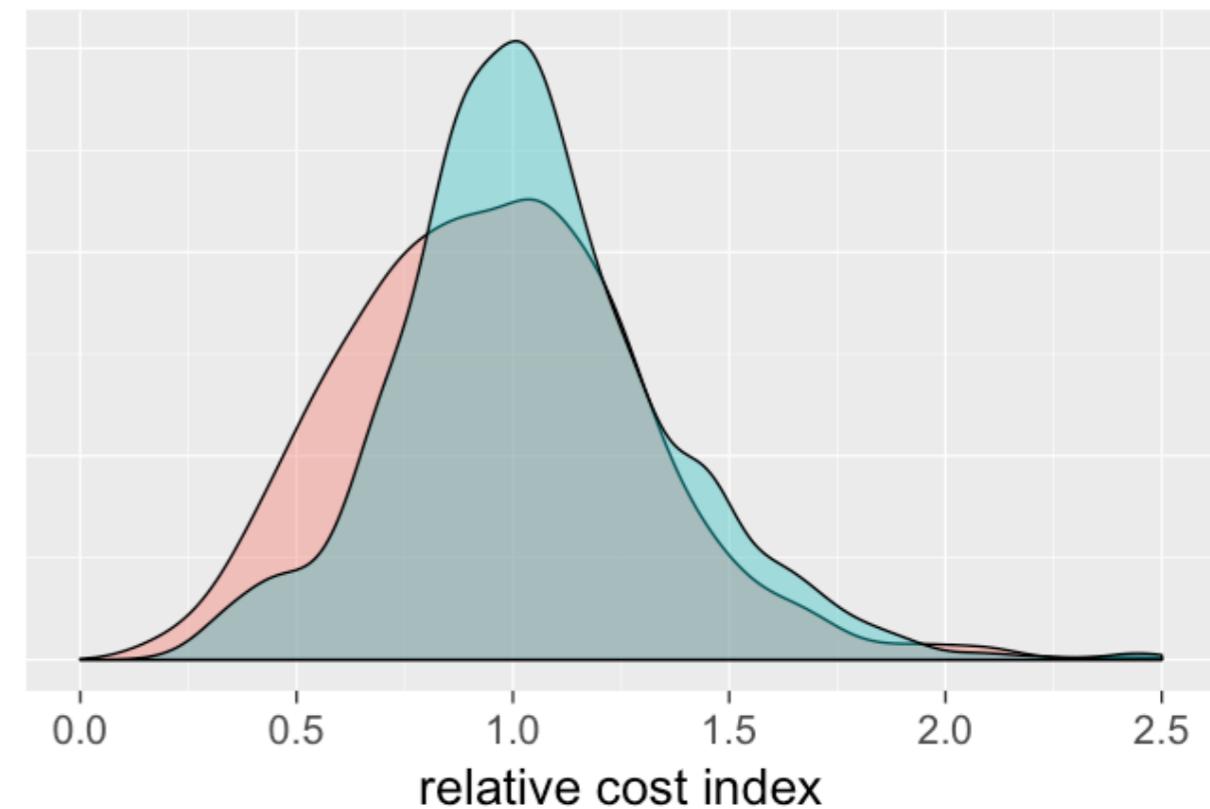
Average cost per patient higher in some service-lines than others

- ↪ Normalize costs by dividing by the across-hospital average cost of treating a patient of the same type and from the same service-line

Average cost per patient,
elective service-lines



after dividing by same service-line,
same-type average cost



Methods

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Volume measures

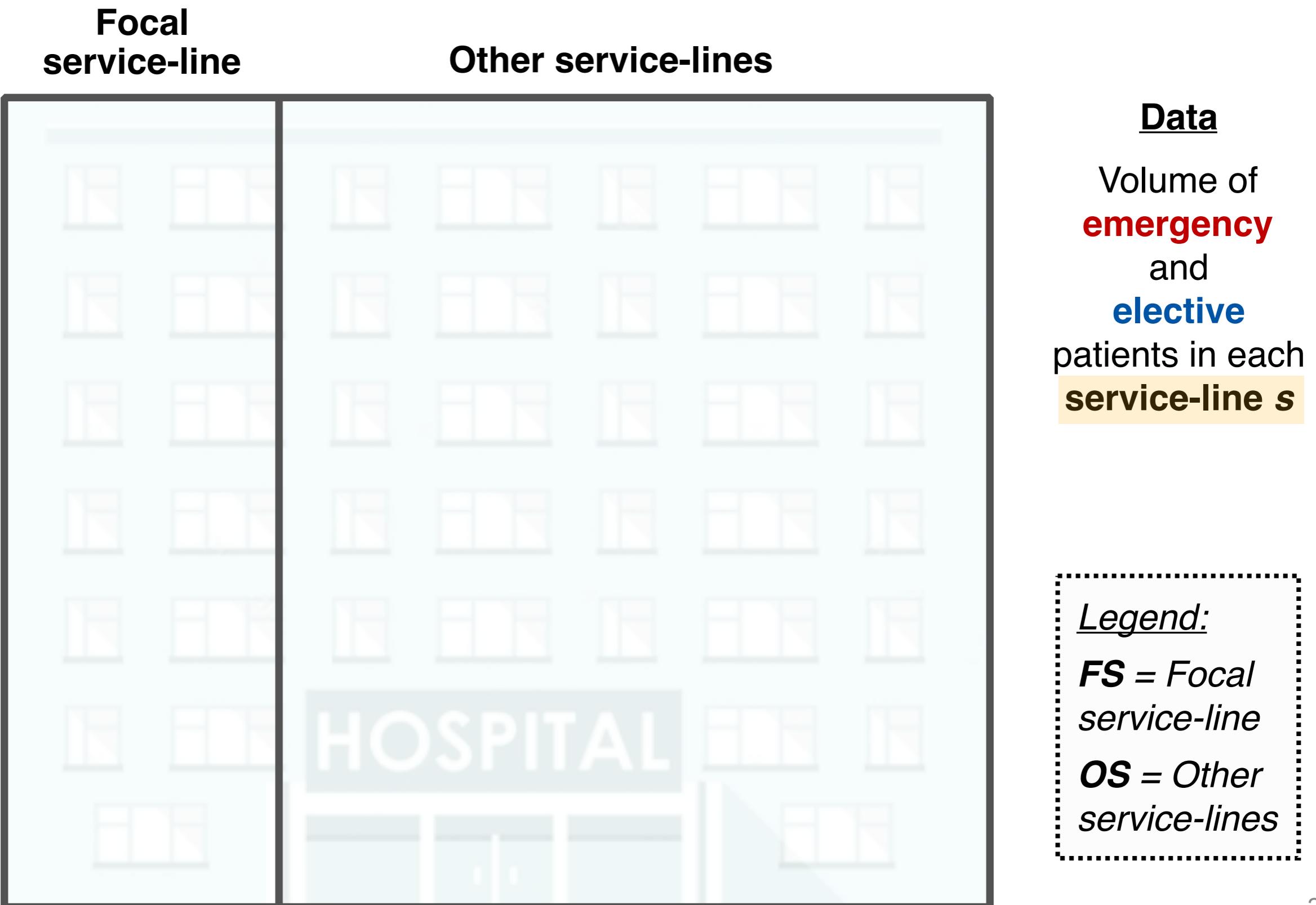


Data

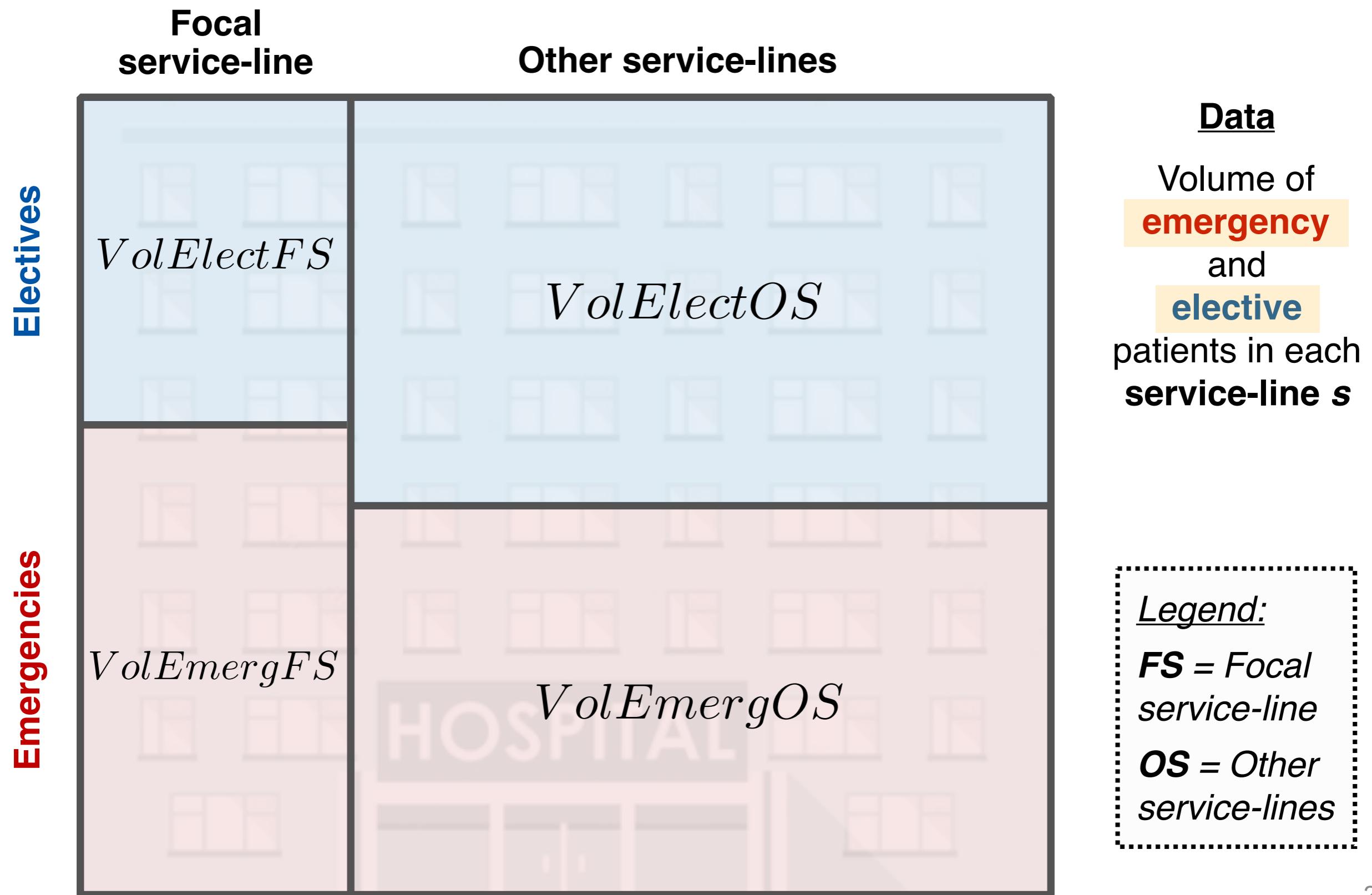
Volume of
emergency
and
elective
patients in each
service-line s

Legend:
FS = Focal
service-line
OS = Other
service-lines

Volume measures



Volume measures



Base model

$$\begin{aligned} EmergCost_{hst} = & \alpha_0 + \alpha_1 VolEmergFS_{hst} + \alpha_2 VolElectFS_{hst} + \\ & \alpha_3 VolEmergOS_{hst} + \alpha_4 VolElectOS_{hst} + \vec{\alpha}_5 Controls_{hst} + \delta_{hst} \end{aligned}$$

$$\begin{aligned} ElectCost_{hst} = & \beta_0 + \beta_1 VolElectFS_{hst} + \beta_2 VolEmergFS_{hst} + \\ & \beta_3 VolElectOS_{hst} + \beta_4 VolEmergOS_{hst} + \vec{\beta}_5 Controls_{hst} + \epsilon_{hst} \end{aligned}$$

where $\delta_{hst} \sim \mathcal{N}(0, \sigma_\delta^2)$ and $\epsilon_{hst} \sim \mathcal{N}(0, \sigma_\epsilon^2)$

Legend:
FS = Focal service-line
OS = Other service-lines

Base model

[scale] $EmergCost_{hst} = \alpha_0 + \alpha_1 VolEmergFS_{hst} + \alpha_2 VolElectFS_{hst} +$	[type-scope] $\alpha_3 VolEmergOS_{hst} + \alpha_4 VolElectOS_{hst} + \vec{\alpha}_5 Controls_{hst} + \delta_{hst}$
--	---

[service-scope]	[other-scope]
------------------------	----------------------

[scale] $ElectCost_{hst} = \beta_0 + \beta_1 VolElectFS_{hst} + \beta_2 VolEmergFS_{hst} +$	[type-scope] $\beta_3 VolElectOS_{hst} + \beta_4 VolEmergOS_{hst} + \vec{\beta}_5 Controls_{hst} + \epsilon_{hst}$
---	--

[service-scope]	[other-scope]
------------------------	----------------------

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Legend:

FS = Focal service-line

OS = Other service-lines

Methods

We use

- Dependent variable: **Costs** – **emergency** and **elective**
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Longitudinal versus cross-sectional effects

- For each of the four volume measures, observe 9 observations per hospital



e.g. volume of **emergency** orthopedics



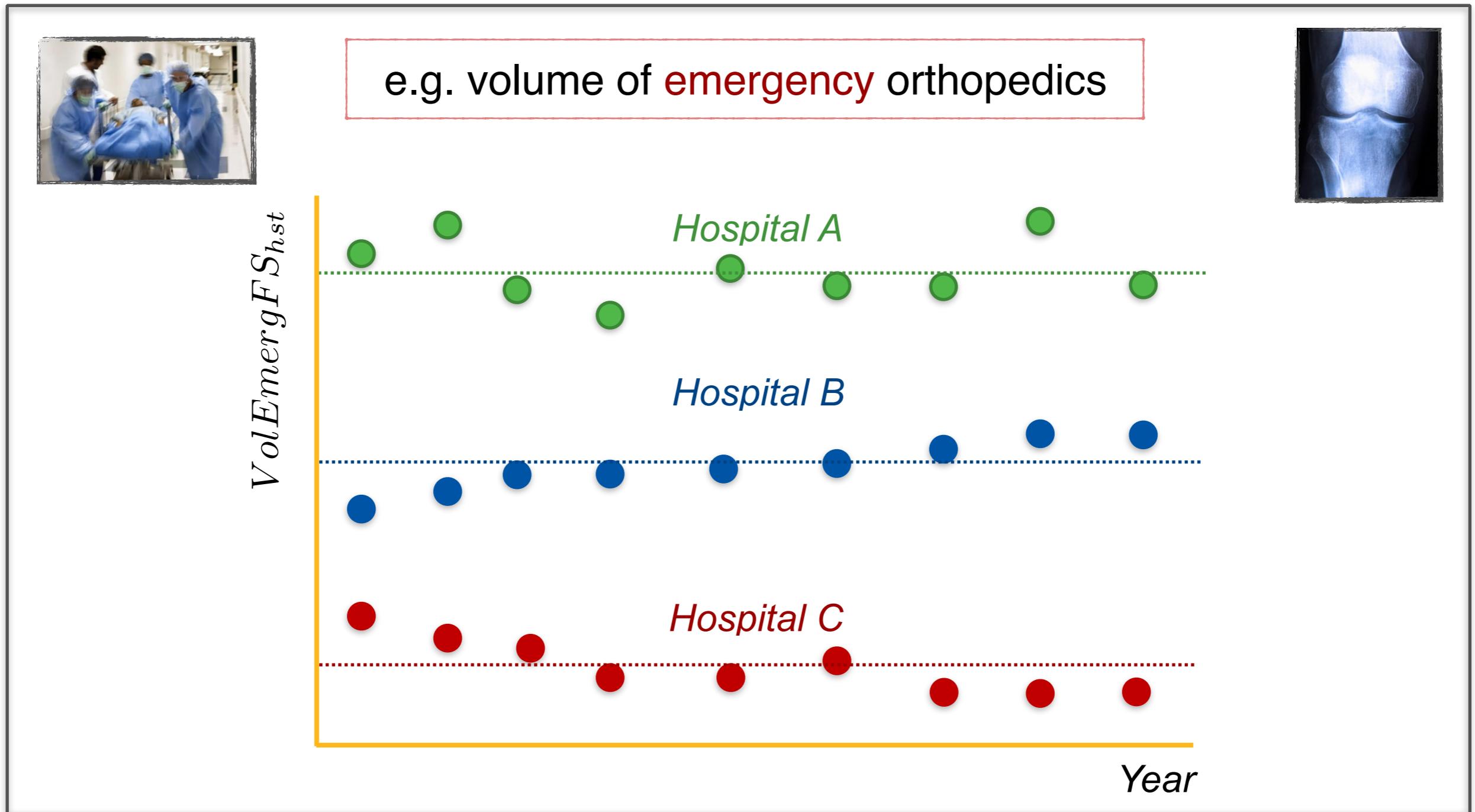
VolEmergFS_{hst}



Year

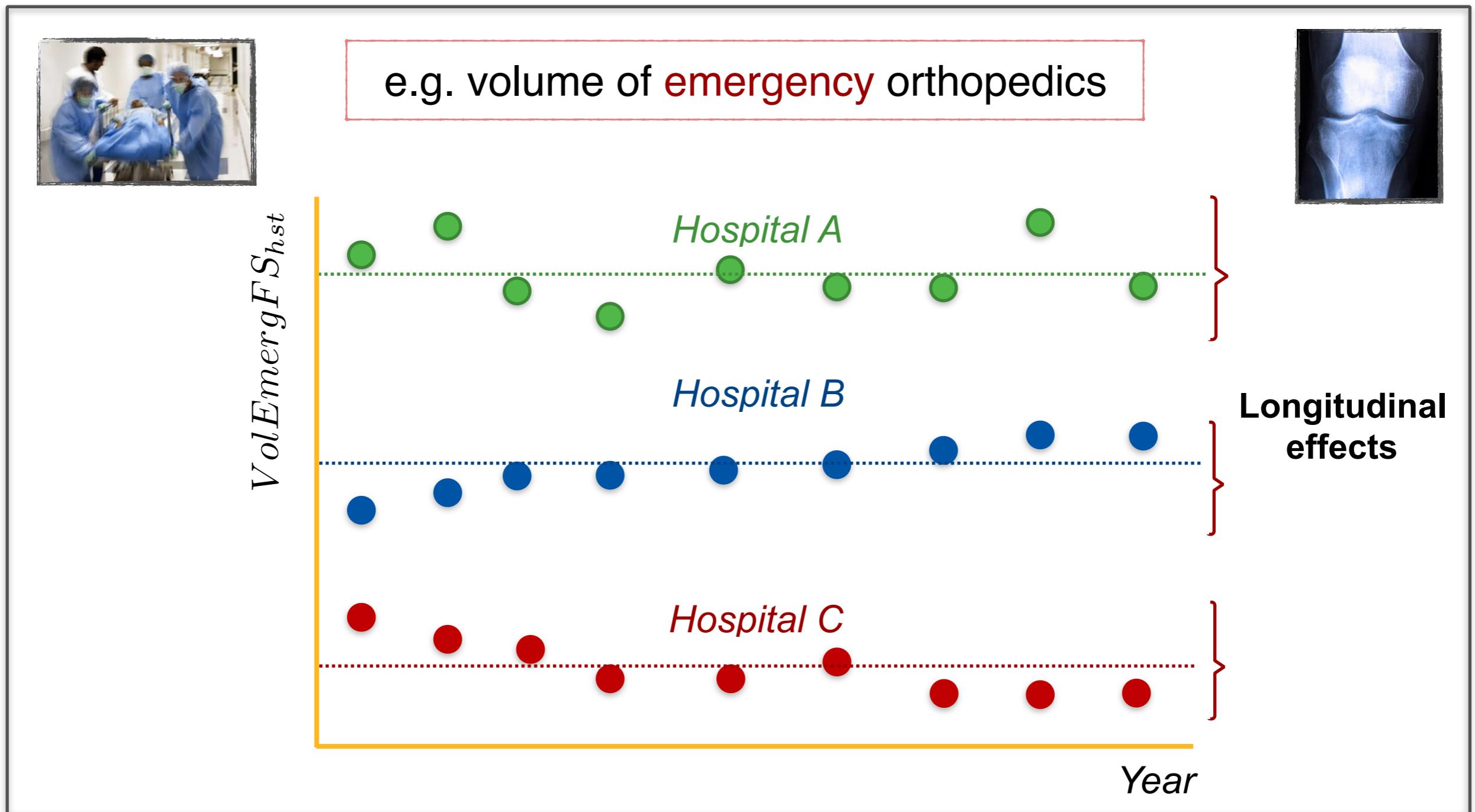
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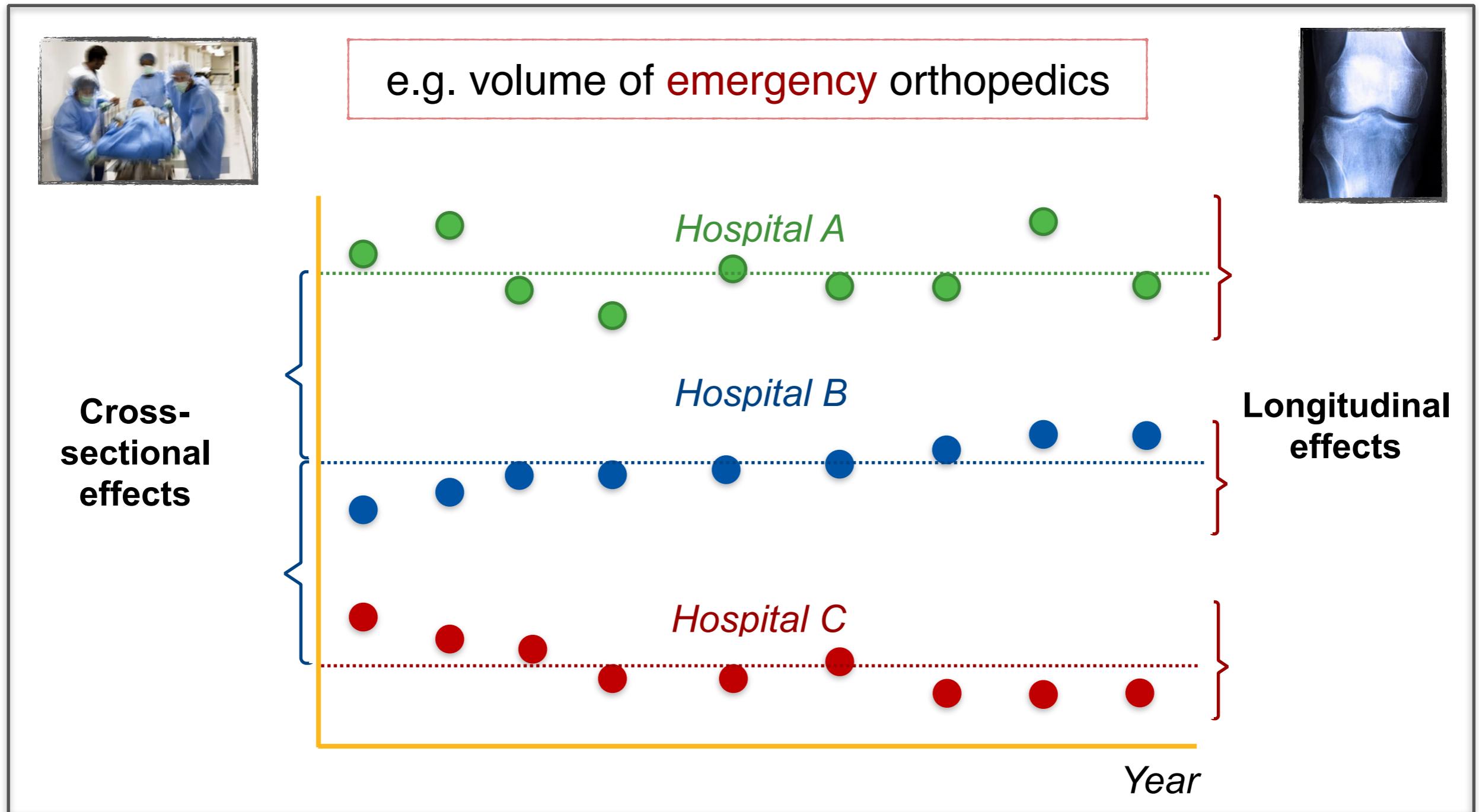
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Longitudinal versus cross-sectional effects

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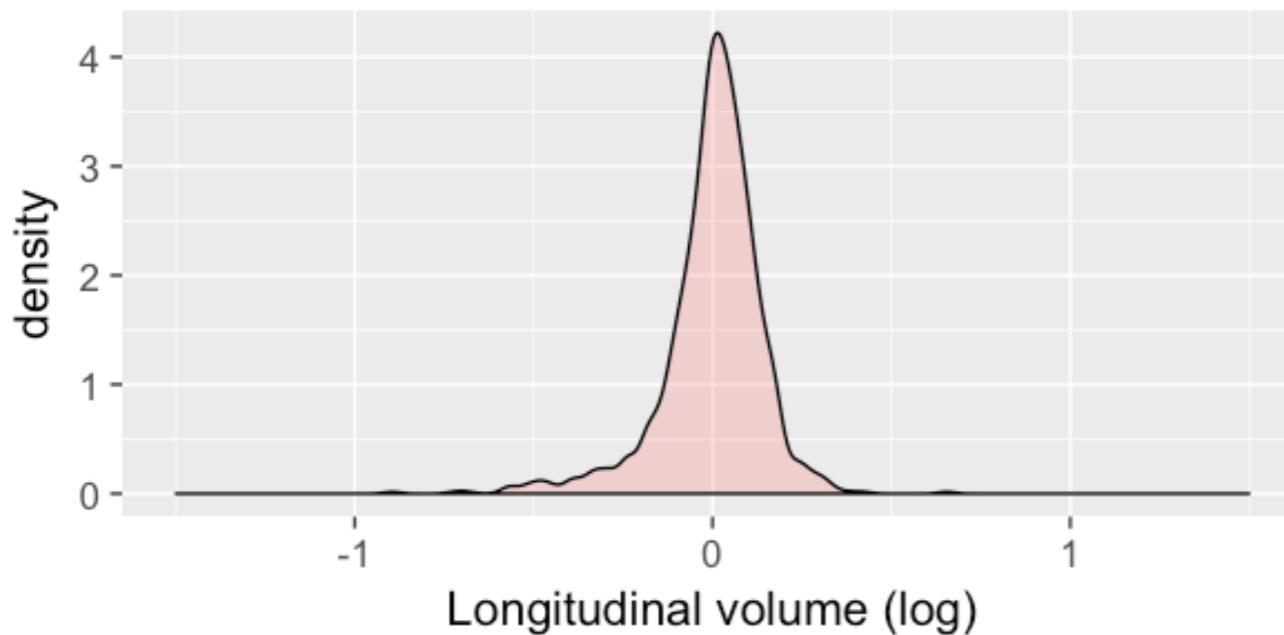


Volume decomposition

- Volume in hospital h , service-line s , year t : $VolEmergFS_{hst}$
- Average volume in hospital h , service-line s : $\mu(VolEmergFS)_{hs}$

Longitudinal volume

(Emergency orthopedics)



$$VolEmergFS_{hst} - \mu(VolEmergFS)_{hs}$$

- Captures change in utilization

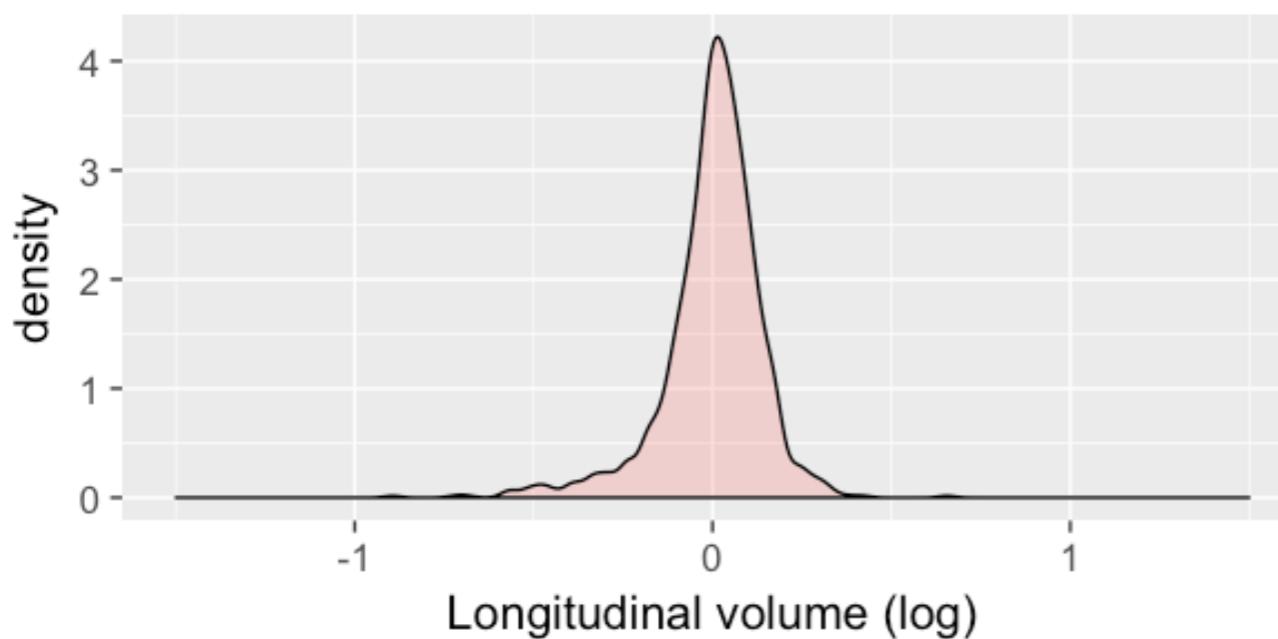
Volume decomposition

- Volume in hospital h , service-line s , year t :
- Average volume in hospital h , service-line s :

$$VolEmergFS_{hst}$$

$$\mu(VolEmergFS)_{hs}$$

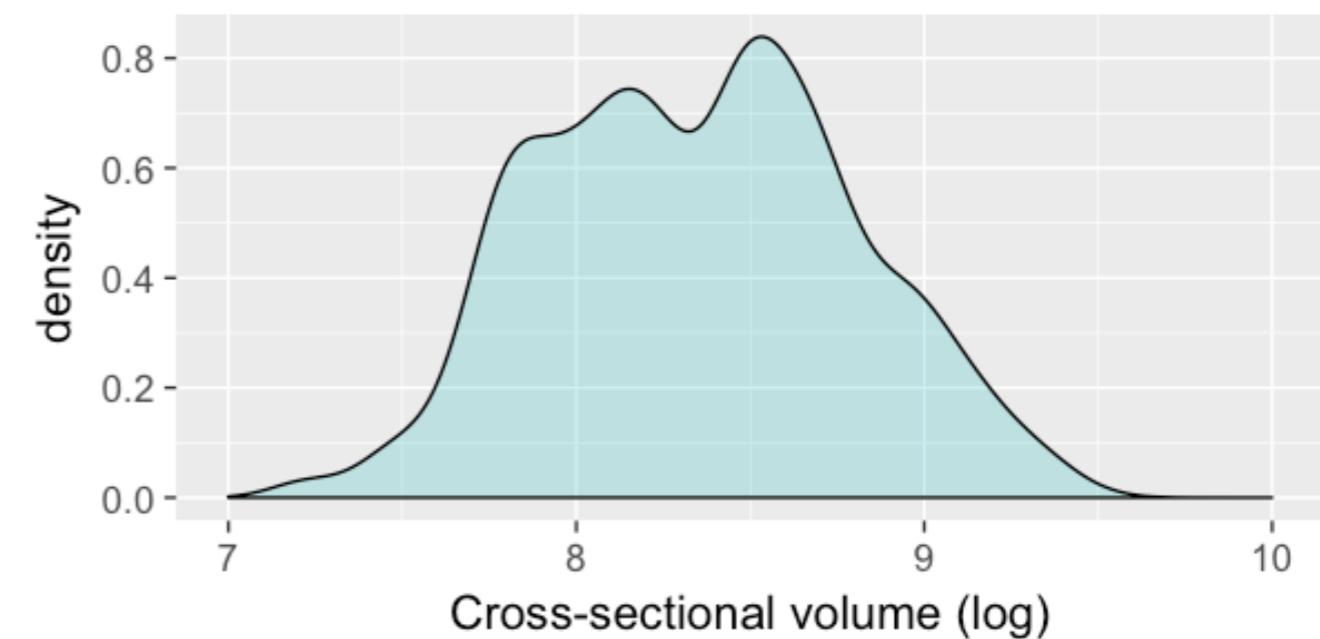
Longitudinal volume
(Emergency orthopedics)



$$VolEmergFS_{hst} - \mu(VolEmergFS)_{hs}$$

- Captures change in utilization

Cross-sectional volume
(Emergency orthopedics)



$$\mu(VolEmergFS)_{hs}$$

- Captures structural variation

Volume decomposition

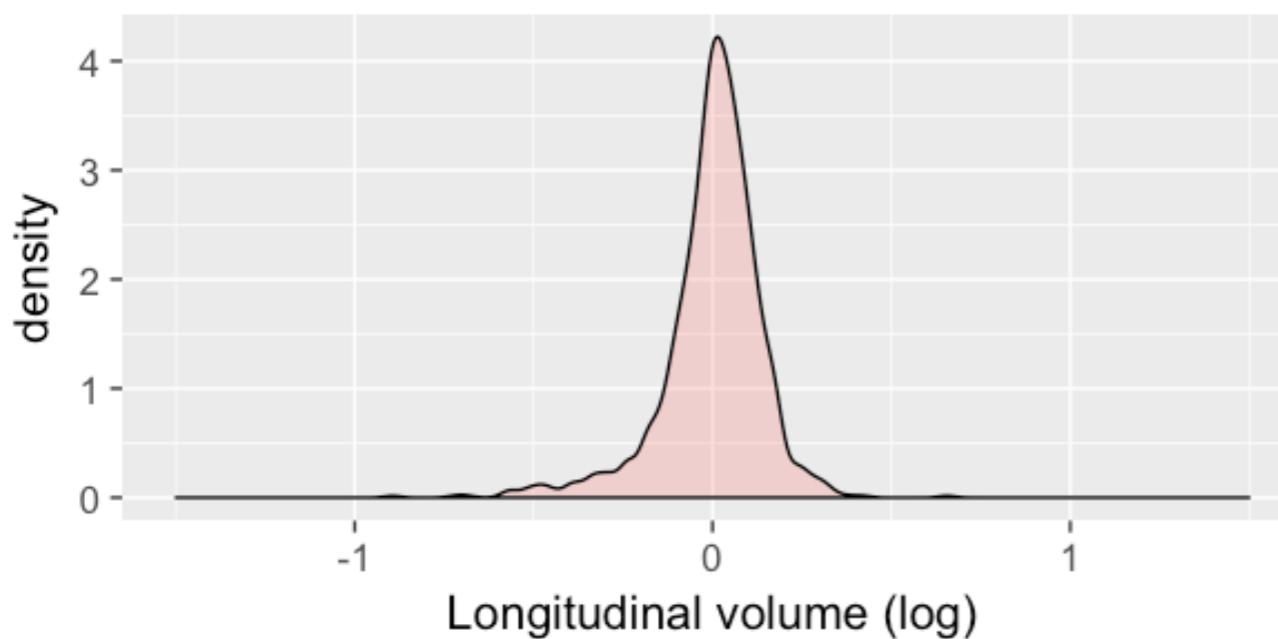
- Volume in hospital h , service-line s , year t :

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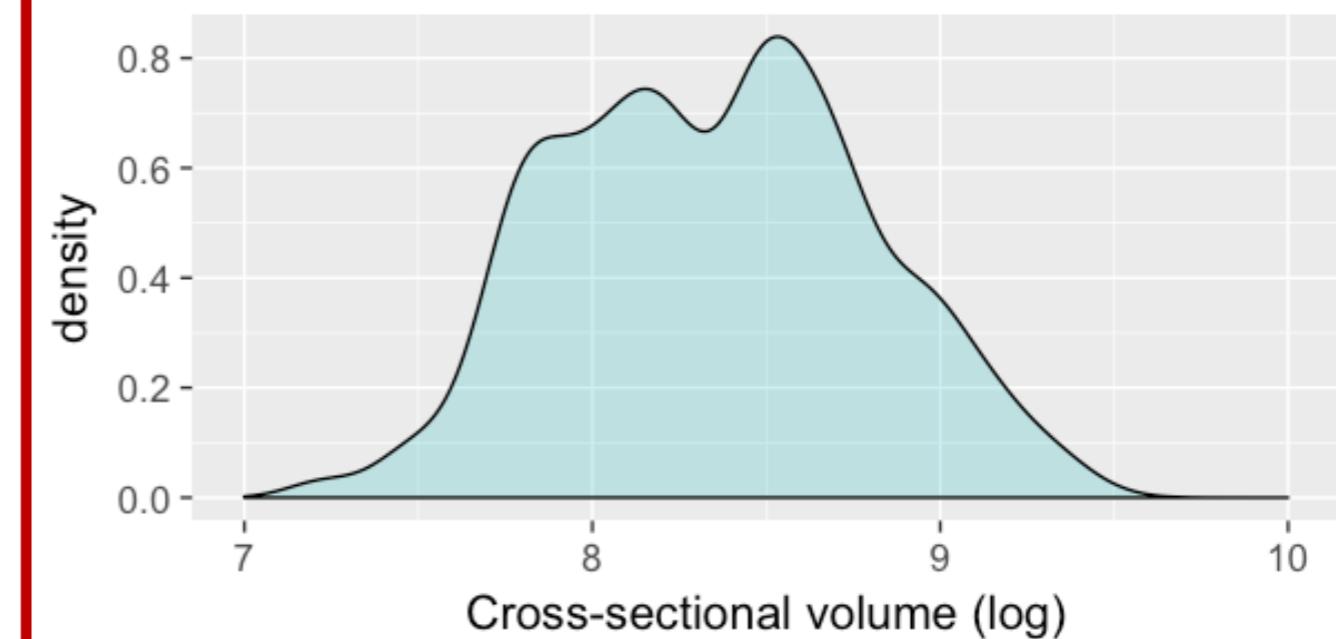
Longitudinal volume
(Emergency orthopedics)



$$VolEmergFS_{hst} - \mu(VolEmergFS)_{hs}$$

- Captures change in utilization

Cross-sectional volume
(Emergency orthopedics)



$$\mu(VolEmergFS)_{hs}$$

- Captures structural variation

Main effect of interest

Methods

We use

- Dependent variable: **Costs** – **emergency** and **elective**
 - ✓ - Within service-line case-mix adjustment
 - ✓ - Across service-line normalization
- Independent variables: **Volumes**
 - ✓ - Four effects: scale, type-scope, service-scope, other-scope
 - ✓ - Within-between volume decomposition (*Mundlak 1978*)
- Econometric model
 - Multi-level (hierarchical) model (*Gelman & Hill 2007*)

Multi-level (hierarchical) model

$$\begin{aligned}
 EmergCost_{hst} = & \alpha_{hs} + (Hosp)_h + (Service)_s + (Yr)_t + (HospYr)_{ht} + (ServiceYr)_{st} + \\
 & \gamma_1 VolEmergFS_{hst}^{Lgt} + \gamma_2 VolElectFS_{hst}^{Lgt} + \\
 & \gamma_3 VolEmergOS_{hst}^{Lgt} + \gamma_4 VolElectOS_{hst}^{Lgt} + \\
 & \vec{\alpha}_5 Controls_{hst} + \delta_{hst}
 \end{aligned}
 \quad [\text{controls}]$$

where

$$\begin{aligned}
 \alpha_{hs} = & \alpha_0 + \alpha_1 VolEmergFS_{hs}^{Cross} + \alpha_2 VolElectFS_{hs}^{Cross} + \\
 & \alpha_3 VolEmergOS_{hs}^{Cross} + \alpha_4 VolElectOS_{hs}^{Cross} + \nu_{hs}
 \end{aligned}$$

with

$$\begin{aligned}
 \delta_{hst} & \sim \mathcal{N}(0, \sigma_\delta^2) \\
 \nu_{hs} & \sim \mathcal{N}(0, \sigma_\nu^2)
 \end{aligned}$$

[scale]

[type-scope]

[service-scope]

[other-scope]

Legend:

FS = Focal service-line

OS = Other service-lines

Multi-level (hierarchical) model

[random intercept]

$$EmergCost_{hst} = \alpha_{hs} + (Hosp)_h + (Service)_s + (Yr)_t + (HospYr)_{ht} + (ServiceYr)_{st} + \gamma_1 VolEmergFS_{hst}^{Lgt} + \gamma_2 VolElectFS_{hst}^{Lgt} + \gamma_3 VolEmergOS_{hst}^{Lgt} + \gamma_4 VolElectOS_{hst}^{Lgt} + \vec{\alpha}_5 Controls_{hst} + \delta_{hst}$$

[controls]

[scale]

where

$$\alpha_{hs} = \alpha_0 + \alpha_1 VolEmergFS_{hs}^{Cross} + \alpha_2 VolElectFS_{hs}^{Cross} + \alpha_3 VolEmergOS_{hs}^{Cross} + \alpha_4 VolElectOS_{hs}^{Cross} + \nu_{hs}$$

[type-scope]

[service-scope]

with

$$\delta_{hst} \sim \mathcal{N}(0, \sigma_\delta^2)$$

$$\nu_{hs} \sim \mathcal{N}(0, \sigma_\nu^2)$$

[other-scope]

[]

Legend:

FS = Focal service-line

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Multi-level (hierarchical) model

[random intercept]

$$EmergCost_{hst} = \alpha_{hs} + (Hosp)_h + (Service)_s + (Yr)_t + (HospYr)_{ht} + (ServiceYr)_{st} + \gamma_1 VolEmergFS_{hst}^{Lgt} + \gamma_2 VolElectFS_{hst}^{Lgt} + \gamma_3 VolEmergOS_{hst}^{Lgt} + \gamma_4 VolElectOS_{hst}^{Lgt} + \vec{\alpha}_5 Controls_{hst} + \delta_{hst}$$

[controls]

[scale]

where

$$\alpha_{hs} = \alpha_0 + \alpha_1 VolEmergFS_{hs}^{Cross} + \alpha_2 VolElectFS_{hs}^{Cross} + \alpha_3 VolEmergOS_{hs}^{Cross} + \alpha_4 VolElectOS_{hs}^{Cross} + \nu_{hs}$$

[type-scope]

with

$$\delta_{hst} \sim \mathcal{N}(0, \sigma_\delta^2)$$

$$\nu_{hs} \sim \mathcal{N}(0, \sigma_\nu^2)$$

**Models correlation in cost over time
within the same hospital-service-line**

[service-scope]

[other-scope]

Legend:

FS = Focal service-line

OS = Other service-lines

Multi-level (hierarchical) model

[random intercept]

$$EmergCost_{hst} = \alpha_{hs} + (Hosp)_h + (Service)_s + (Yr)_t + (HospYr)_{ht} + (ServiceYr)_{st} + \gamma_1 VolEmergFS_{hst}^{Lgt} + \gamma_2 VolElectFS_{hst}^{Lgt} + \gamma_3 VolEmergOS_{hst}^{Lgt} + \gamma_4 VolElectOS_{hst}^{Lgt} + \vec{\alpha}_5 Controls_{hst} + \delta_{hst}$$

[controls]

[scale]

[type-scope]

where

$$\alpha_{hs} = \alpha_0 + \alpha_1 VolEmergFS_{hs}^{Cross} + \alpha_2 VolElectFS_{hs}^{Cross} + \alpha_3 VolEmergOS_{hs}^{Cross} + \alpha_4 VolElectOS_{hs}^{Cross} + \nu_{hs}$$

[service-scope]

[other-scope]

with

$$\delta_{hst} \sim \mathcal{N}(0, \sigma_\delta^2)$$

$$\nu_{hs} \sim \mathcal{N}(0, \sigma_\nu^2)$$

**Models correlation in cost over time
within the same hospital-service-line**

Legend:

FS = Focal service-line

OS = Other service-lines

- Adjustment: take $\ln()$ of the cost and volume effects to reduce skewness

Recap: research questions

Integrated model



Focused model



Do costs reduce with increased volume of patients:

[scale] of the same type and from the same service-line?

[type-scope] of the other type and from the same service-line?

[service-scope] of the same type and from the other service-lines?

[other-scope] of the other type and from the other service-lines?

Do effects depend on whether the focal patient type is **emergency** or **elective**?

Results: economies of scale

[scale]

Marginal effects at the mean:

- a 1,000 patient increase in the number of admissions p.a. to the “average” hospital results in an ~x% change in costs / length-of-stay

	Costs		Length-of-stay		“average” hospital
	Elective	Emergency	Elective	Emergency	
Cross-sectional effects					
Elect. vol. (focal SL)	−0.022***	0.008***	−0.008***	0.002*	2,640 p.a.
Emerg. vol. (focal SL)	0.002	−0.040***	0.007***	−0.027***	2,990 p.a.
Elect. vol. (other SLs)	0.001	0.004***	−0.000	0.002**	38,210 p.a.
Emerg. vol. (other SLs)	−0.000	−0.002**	0.000	−0.001†	51,540 p.a.
Model fit					
Observations	15,339	15,354	15,339	15,354	
Conditional R^2	0.513	0.623	0.463	0.739	

† $p < 0.10$; * $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$.

Results: economies of scope

[type-scope]

Marginal effects at the mean:

- a 1,000 patient increase in the number of admissions p.a. to the “average” hospital results in an ~x% change in costs / length-of-stay

	Costs		Length-of-stay		“average” hospital
	Elective	Emergency	Elective	Emergency	
Cross-sectional effects					
Elect. vol. (focal SL)	−0.022***	0.008***	−0.008***	0.002*	2,640 p.a.
Emerg. vol. (focal SL)	0.002	−0.040***	0.007***	−0.027***	2,990 p.a.
Elect. vol. (other SLs)	0.001	0.004***	−0.000	0.002**	38,210 p.a.
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Results: economies of scope

[service-scope]

Marginal effects at the mean:

- a 1,000 patient increase in the number of admissions p.a. to the “average” hospital results in an ~x% change in costs / length-of-stay

	Costs		Length-of-stay		“average” hospital
	Elective	Emergency	Elective	Emergency	
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Results: economies of scope

[other-scope]

Marginal effects at the mean:

- a 1,000 patient increase in the number of admissions p.a. to the “average” hospital results in an ~x% change in costs / length-of-stay

	Costs		Length-of-stay		“average” hospital
	Elective	Emergency	Elective	Emergency	
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Model fit					
Observations	15,339	15,354	15,339	15,354	
Conditional R^2	0.513	0.623	0.463	0.739	

† $p < 0.10$; * $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$.

Endogeneity concerns

- **Reverse causality:** more productive hospitals may be referred a higher volume of patients (or patients may self select)
 - Health services in the UK are free at the point of care ⇒ little incentive
 - Little evidence that patients or physicians exercise such choice, or even account for quality (Gaynor et al. 2004; Gowrisankaran et al. 2006)
 - *Recent survey: only half of patients in UK offered choice of hospital, 70% chose nearest provider (Dixon et al. 2010)*
 - Re-run analysis on geographically isolated hospitals (for which travel to another provider more inconvenient for patients): no reduction in effect size on this subsample
- **Endogenous service-line formation:** hospitals may choose to offer a subset of elective services, selecting only the most profitable.
 - If this were the case, lower volume hospitals would be more productive (we find the opposite)
 - Re-run analysis on only hospitals that treat >90% of HRGs, no change in results
- *Little concern for endogeneity associated with emergency volume effects, since emergency activity is largely exogenous*

Other robustness checks

- Cost accounting issues: repeated analysis using length of stay data
- Autocorrelated errors: no evidence
- Across service-line heterogeneity in scale and scope effects: consistent
- Non-linear volume effects: no evidence (*log-log* formulation already captures diminishing returns to scale/scope)
- Influence of cost outliers: cap extreme costs and re-estimate, consistent
- Rare conditions: re-estimate for set of most common conditions, consistent
- Outliers/Limited service: re-estimate for high volume hospitals (e.g. >.25 median)

Implications: which model is more cost effective?

Integrated model



Focused model



Implications: which model is more cost effective?

Emergencies

Found economies of **scale** and **scope** when pooling emergency care



Integrated model



Electives

Found economies of **scale** but not scope when pooling elective care



Focused model



Implications: which model is more cost effective?

Emergencies

Found economies of **scale** and **scope** when pooling emergency care



Integrated model



Electives

Found economies of **scale** but not scope when pooling elective care



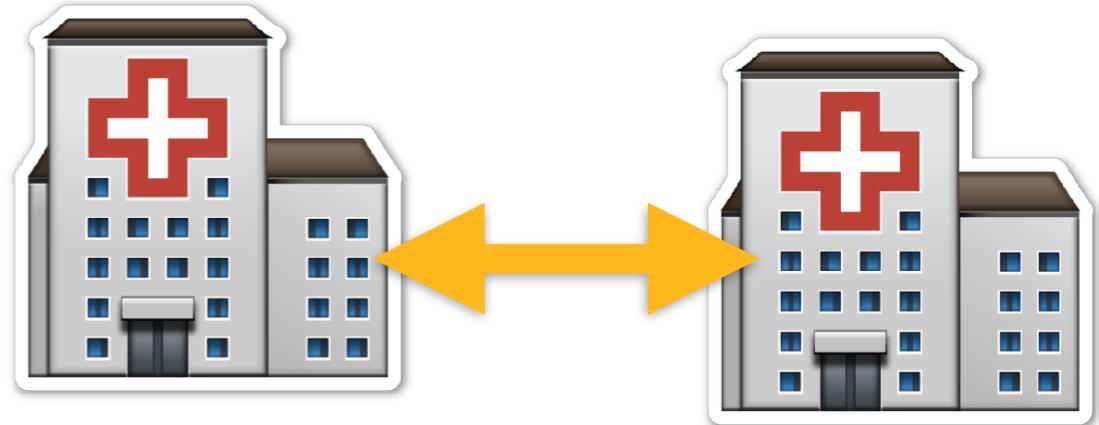
Focused model



- Empirical evidence suggests may also be quality benefits (e.g. Kuntz et al. 2016)

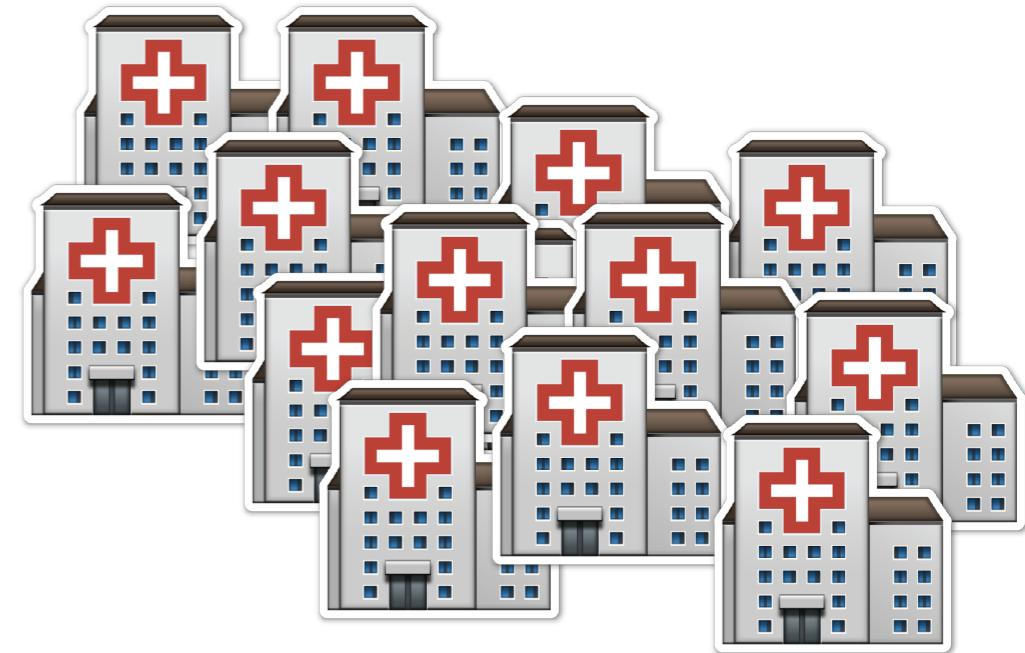
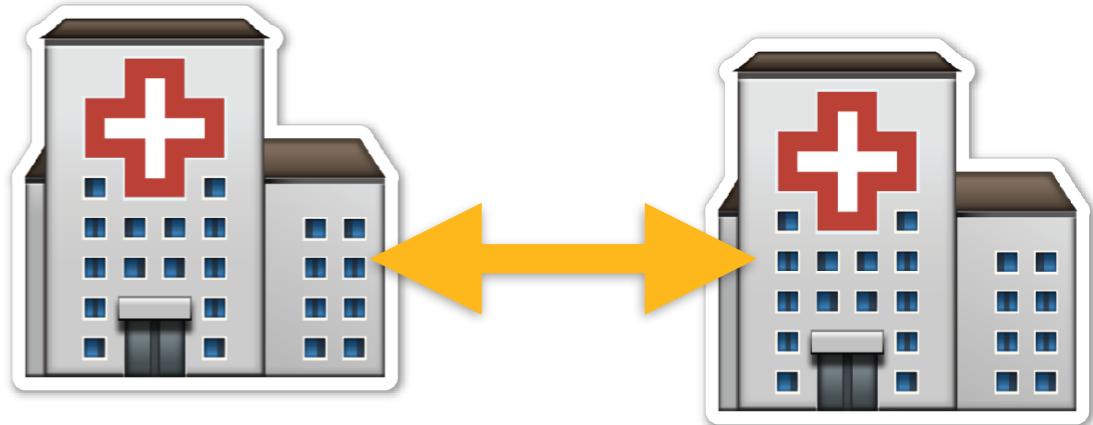
Counterfactual: Potential cost savings

- ▶ If pairs of hospitals in London divided elective service-lines then:
 - Cost reduction of ~4%, saving **£300m+** over sample period
 - Limits need for new capacity



Counterfactual: Potential cost savings

- ▶ If pairs of hospitals in London divided elective service-lines then:
 - Cost reduction of ~4%, saving **£300m+** over sample period
 - Limits need for new capacity
- ▶ Establishing one “focused” specialist hospital for each service-line:
 - Cost reduction of ~15%, saving nearly **£1.2bn** over sample period
 - Plus cost savings for the leftover emergency activity in other hospitals



Thank you!

Questions?

Appendix

Full results

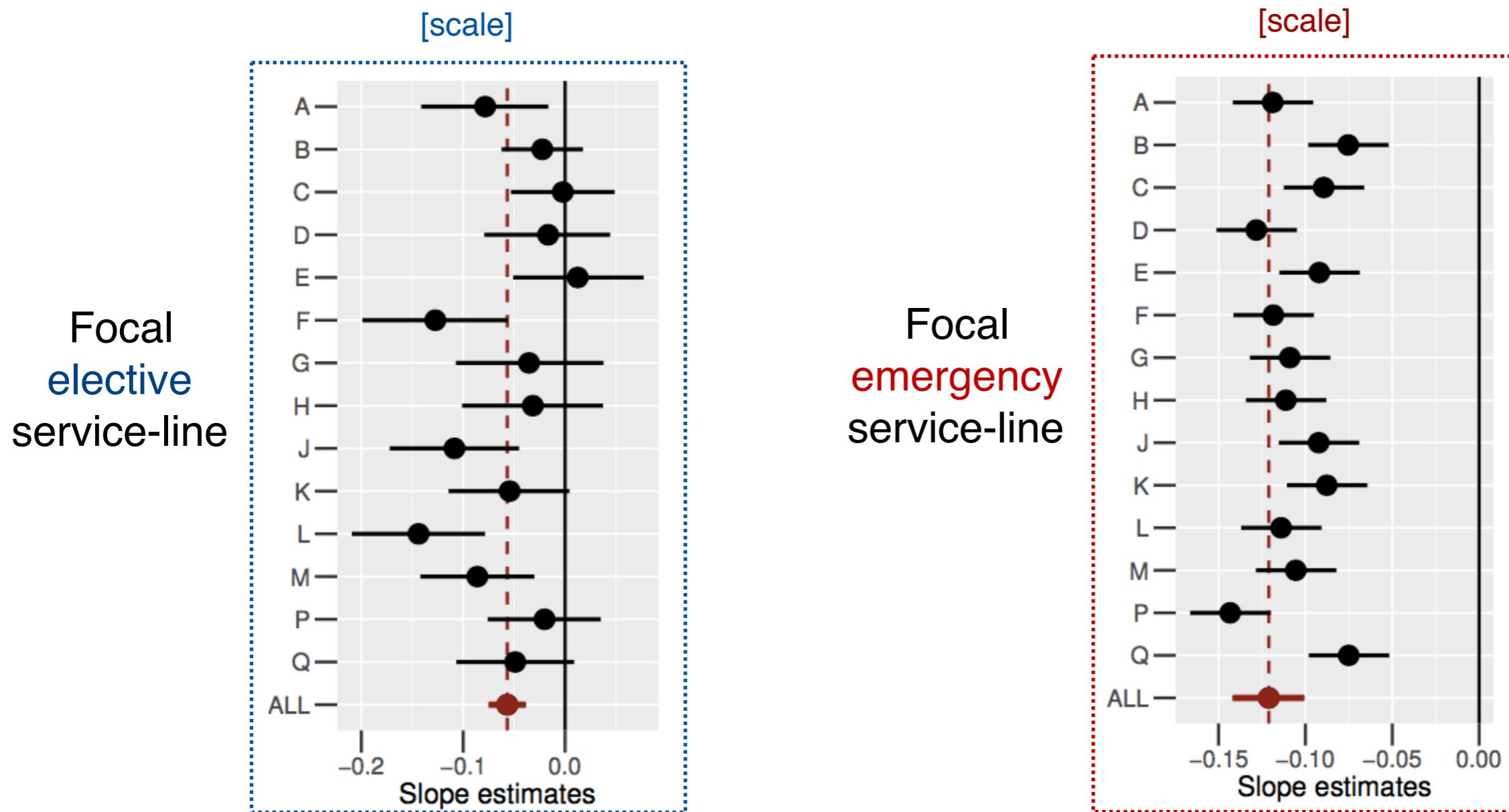
	Costs		LOS	
	Elective	Emergency	Elective	Emergency
Within-effects				
Elect. vol. (focal SL)	-0.117*** (0.007)	0.007 (0.004)	-0.062*** (0.003)	0.001 (0.003)
Emerg. vol. (focal SL)	-0.011 (0.012)	-0.162*** (0.008)	0.010† (0.006)	-0.083*** (0.005)
Elect. vol. (other SLs)	-0.129*** (0.031)	0.070* (0.029)	-0.039* (0.016)	0.114*** (0.027)
Emerg. vol. (other SLs)	0.049 (0.032)	-0.162*** (0.031)	0.027† (0.016)	-0.117*** (0.029)
Between-effects				
Elect. vol. (focal SL)	-0.057*** (0.009)	0.020*** (0.004)	-0.022*** (0.004)	0.006* (0.003)
Emerg. vol. (focal SL)	0.007 (0.014)	-0.121*** (0.011)	0.021*** (0.006)	-0.081*** (0.008)
Elect. vol. (other SLs)	0.043 (0.030)	0.135*** (0.028)	-0.005 (0.014)	0.069** (0.026)
Emerg. vol. (other SLs)	-0.008 (0.034)	-0.099** (0.031)	0.015 (0.015)	-0.052† (0.028)
Control structure				
Year	Y	Y	Y	Y
Service line	Y	Y	Y	Y
Hospital	0.072	0.076	0.031	0.073
Hospital:Service line	0.153	0.094	0.065	0.070
Hospital:Year	0.034	0.016	0.020	0.011
Service line:Year	0.080	0.088	0.041	0.092
Residual std. error	0.206	0.138	0.105	0.087
Model fit				
Observations	15,339	15,354	15,339	15,354
Marginal R^2	0.096	0.179	0.107	0.100
Conditional R^2	0.513	0.623	0.463	0.739
Bayesian inf. crit.	481.0	-11,166.4	-20,650.8	-23,870.5

Appendix

Service-line dependency

Service-line dependency of scale effects

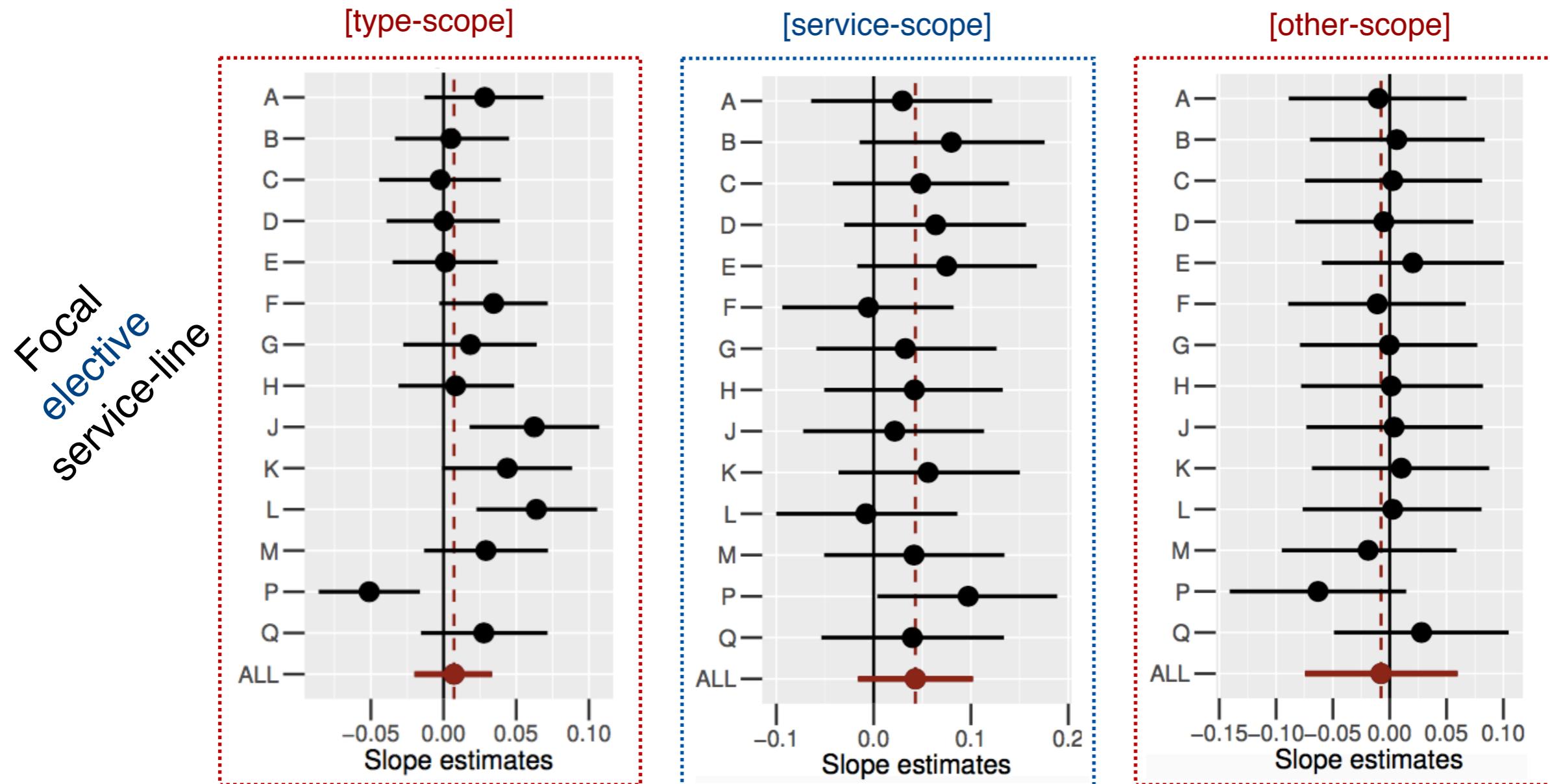
- Scale effects consistent in direction and similar in scale across service-lines



Note. A – nervous system; B – eyes and periorbita; C – mouth, head, neck, and ears; D – respiratory system; E – cardiac surgery and primary cardiac conditions; F – digestive system; G – hepatobiliary and pancreatic system; H – musculoskeletal system; J – skin, breast and burns; K – endocrine and metabolic system; L – urinary tract and male reproductive system; M – female reproductive system; P – diseases of childhood and neonates; Q – vascular system.

Electives: Service-line dependency of scope effects

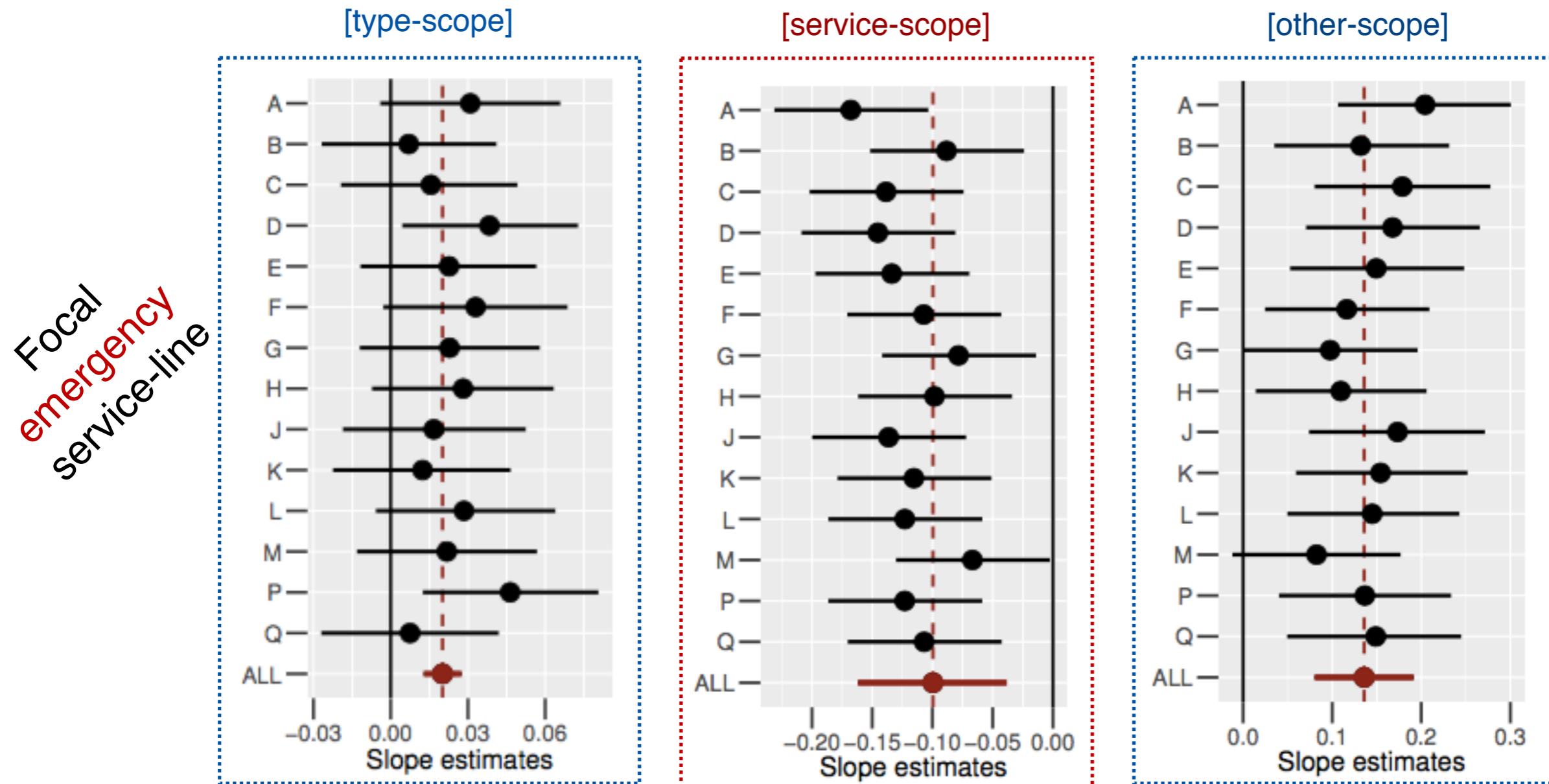
- Scope effects consistent in direction and similar in scale across service-lines



Note. A – nervous system; B – eyes and periorbita; C – mouth, head, neck, and ears; D – respiratory system; E – cardiac surgery and primary cardiac conditions; F – digestive system; G – hepatobiliary and pancreatic system; H – musculoskeletal system; J – skin, breast and burns; K – endocrine and metabolic system; L – urinary tract and male reproductive system; M – female reproductive system; P – diseases of childhood and neonates; Q – vascular system.

Emergencies: Service-line dependency of scope effects

- Scope effects consistent in direction and similar in scale across service-lines



Note. A – nervous system; B – eyes and periorbita; C – mouth, head, neck, and ears; D – respiratory system; E – cardiac surgery and primary cardiac conditions; F – digestive system; G – hepatobiliary and pancreatic system; H – musculoskeletal system; J – skin, breast and burns; K – endocrine and metabolic system; L – urinary tract and male reproductive system; M – female reproductive system; P – diseases of childhood and neonates; Q – vascular system.

Appendix

Multi-level modeling

Why a MLM?

MLM estimator

$$y_{it} = \alpha_i + \beta(x_{it} - \bar{x}_i) + \epsilon_{it} \quad \text{where} \quad \alpha_i = \alpha_0 + \gamma\bar{x}_i + \nu_i \quad \text{and} \quad \nu_i \sim \mathcal{N}(0, \sigma_\nu^2)$$

longitudinal effect

cross-sectional effect

Fixed effects estimator

$$\begin{aligned} y_{it} &= \alpha_i + \beta x_{it} + \epsilon_{it} \\ (y_{it} - \bar{y}_i) &= \beta(x_{it} - \bar{x}_i) + \epsilon_{it} \\ y_{it} &= \bar{y}_i + \beta(x_{it} - \bar{x}_i) + \epsilon_{it} \end{aligned}$$

longitudinal effect

Random effects estimator

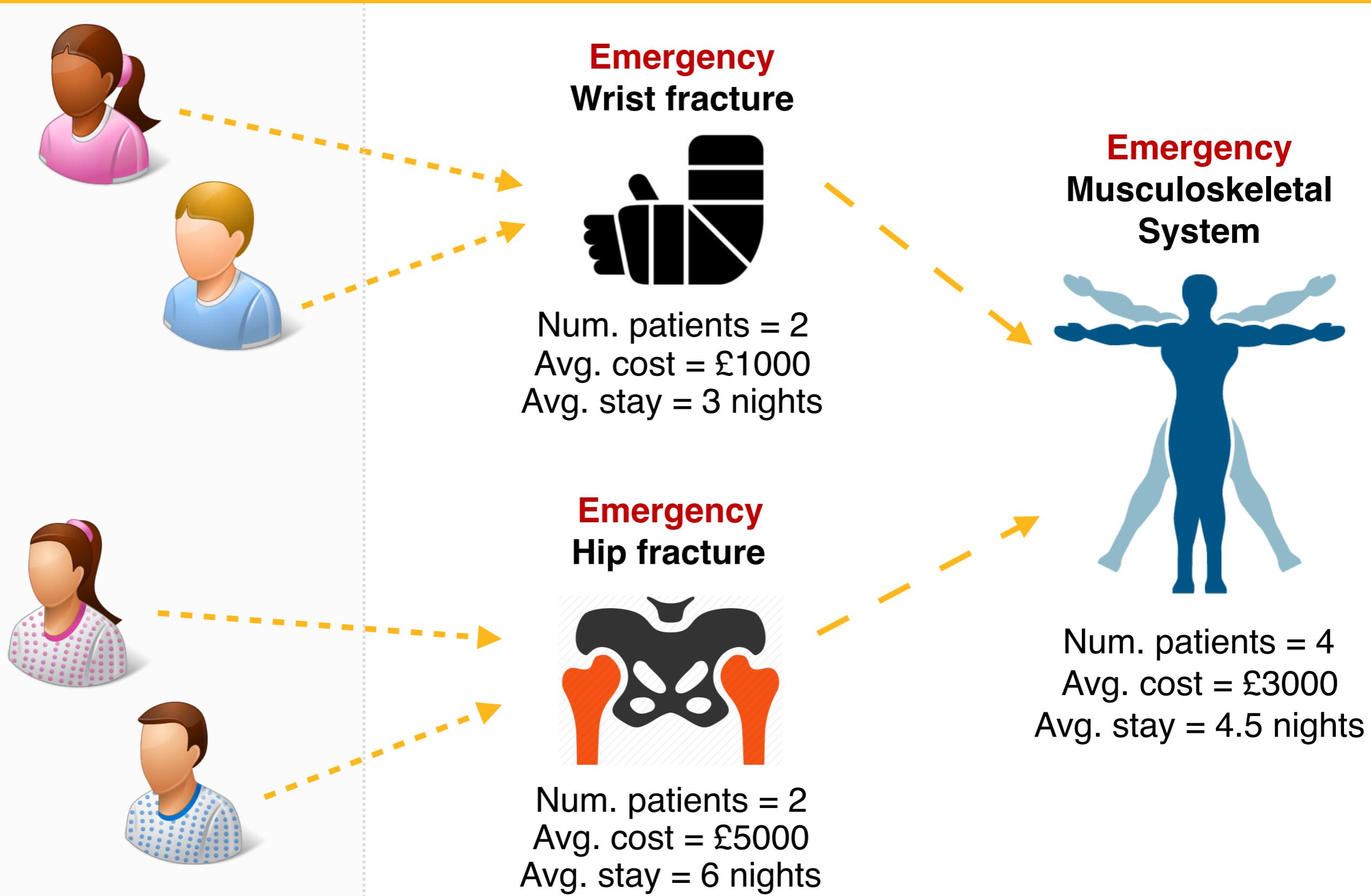
$$\begin{aligned} y_{it} &= \alpha_i + \beta x_{it} + \epsilon_{it} \\ \text{where } \alpha_i &= \alpha_0 + \nu_i \\ \text{and } \nu_i &\sim \mathcal{N}(0, \sigma_\nu^2) \end{aligned}$$

longitudinal & cross-sectional effect

Appendix

Case-mix adjustment

Example of data aggregation process



Within service-line case-mix confounding



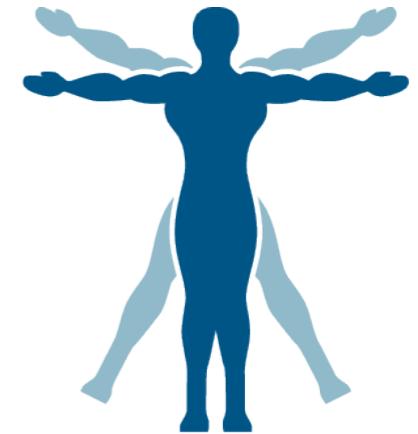
Hospital A



Num. patients = **2**
Avg. cost = £1000



Num. patients = **2**
Avg. cost = £5000



Num. patients = **4**
Avg. cost = **£3000**

Within service-line case-mix confounding



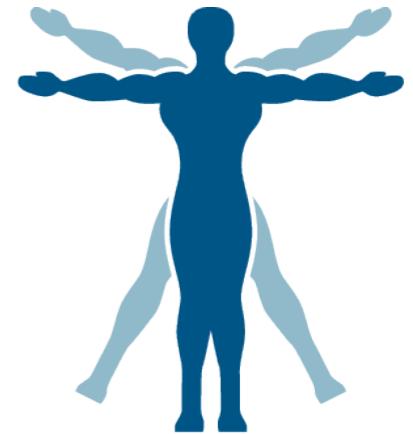
Hospital A



Num. patients = 2
Avg. cost = £1000



Num. patients = 2
Avg. cost = £5000



Num. patients = 4
Avg. cost = £3000



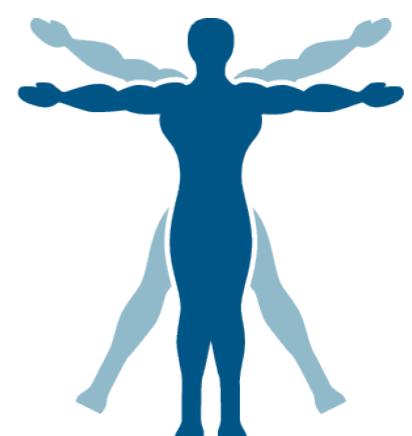
Hospital B



Num. patients = 1
Avg. cost = £1000



Num. patients = 3
Avg. cost = £5000



Num. patients = 4
Avg. cost = £4000

Within service-line case-mix confounding



Hospital A



Hospital B



Num. patients = 2
Avg. cost = £1000



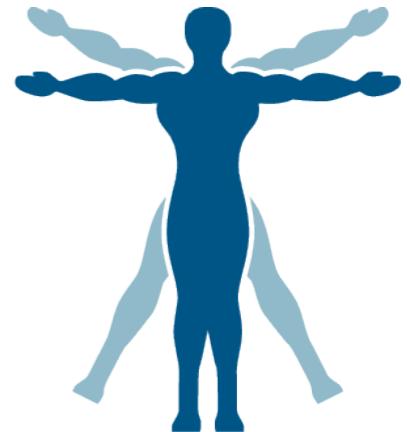
Avg. num. patients = 1.5



Avg. num. patients = 2.5



Num. patients = 3
Avg. cost = £5000



Num. patients = 4
Avg. cost = £3000



Num. patients = 4
Avg. cost = £4000

Cost of treating an “average” patient



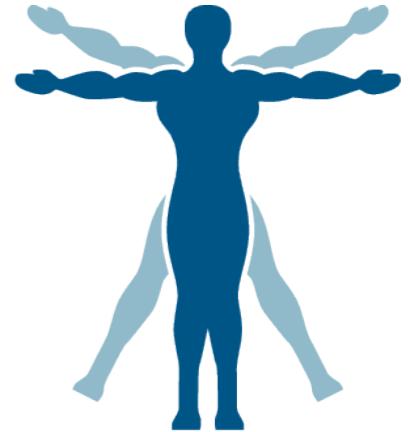
Hospital A



Avg. num. patients = **1.5**
Avg. cost = £1000



Avg. num. patients = **2.5**
Avg. cost = £5000



Num. patients = 4
Avg. cost = **£3500**



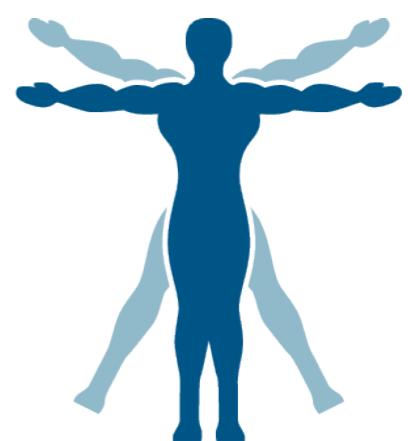
Hospital B



Avg. num. patients = **1.5**
Avg. cost = £1000



Avg. num. patients = **2.5**
Avg. cost = £5000



Num. patients = 4
Avg. cost = **£3500**

Cost of treating an “average” patient



Hospital A



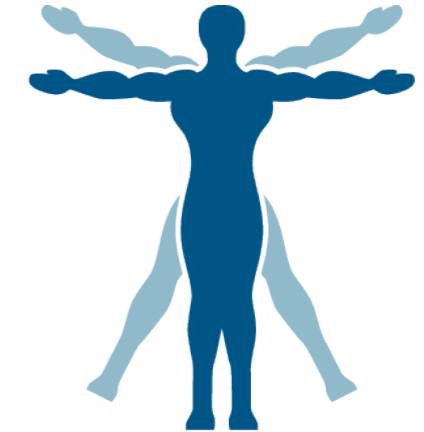
Avg. num. patients = **1.5**

Avg. cost = £1000



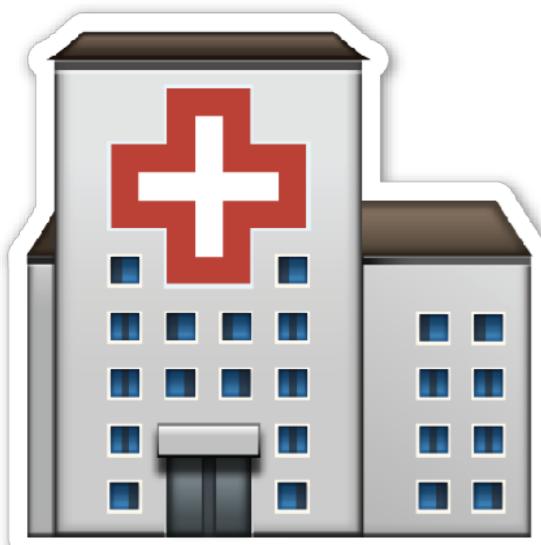
Avg. num. patients = **2.5**

Avg. cost = £5000



Num. patients = 4

Avg. cost = **£3500**



Hospital B



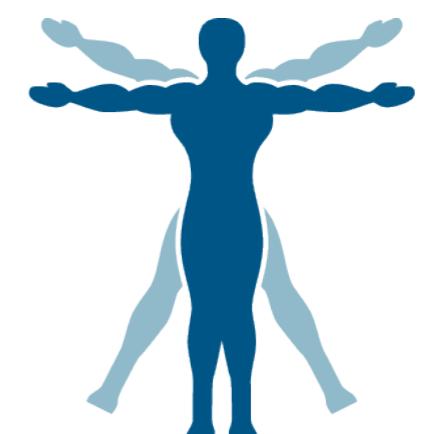
Avg. num. patients = **1.5**

Avg. cost = £1000



Avg. num. patients = **2.5**

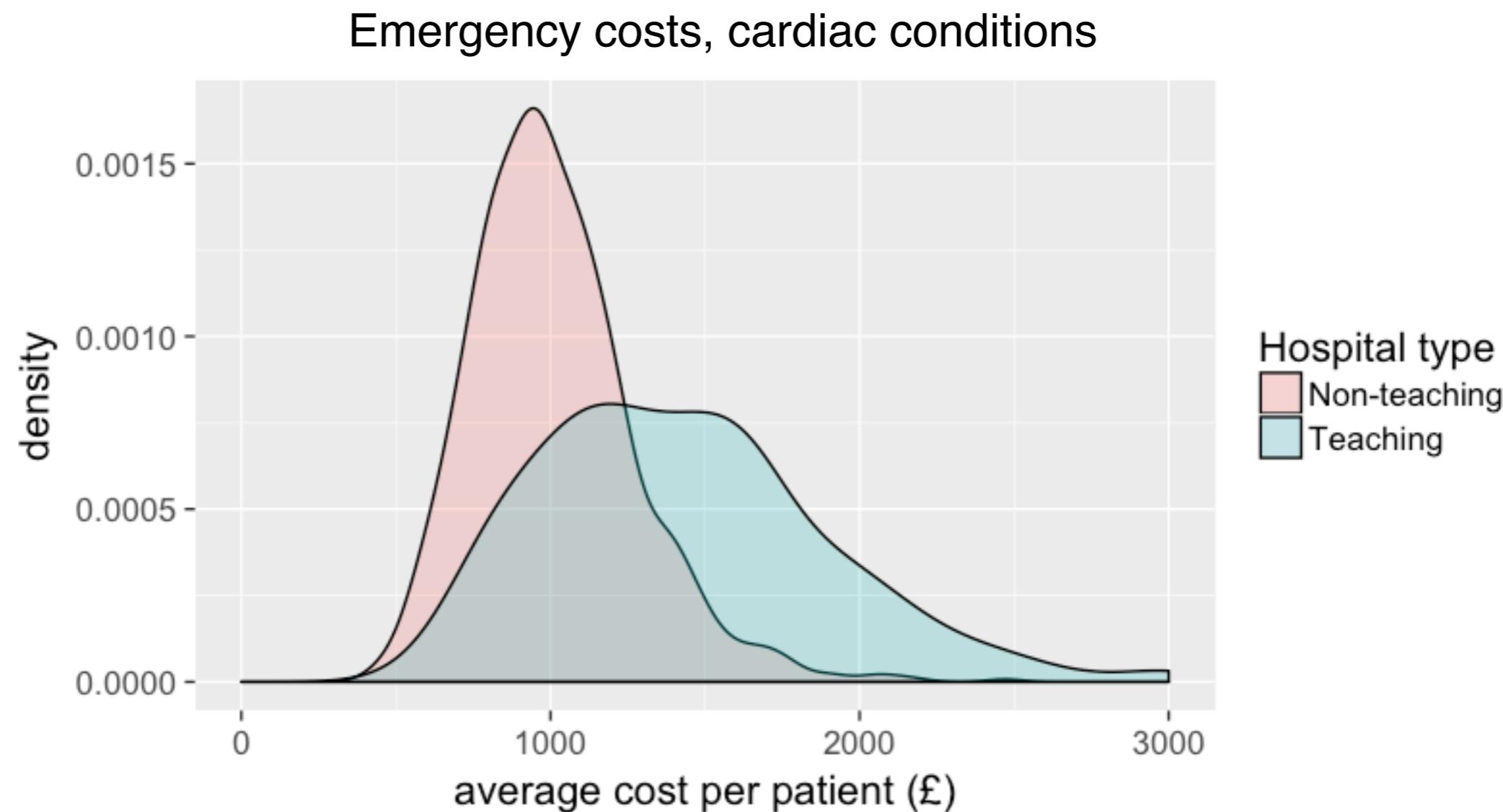
Avg. cost = £5000



Num. patients = 4

Avg. cost = **£3500**

Within service-line case-mix confounding in the data



Problem:

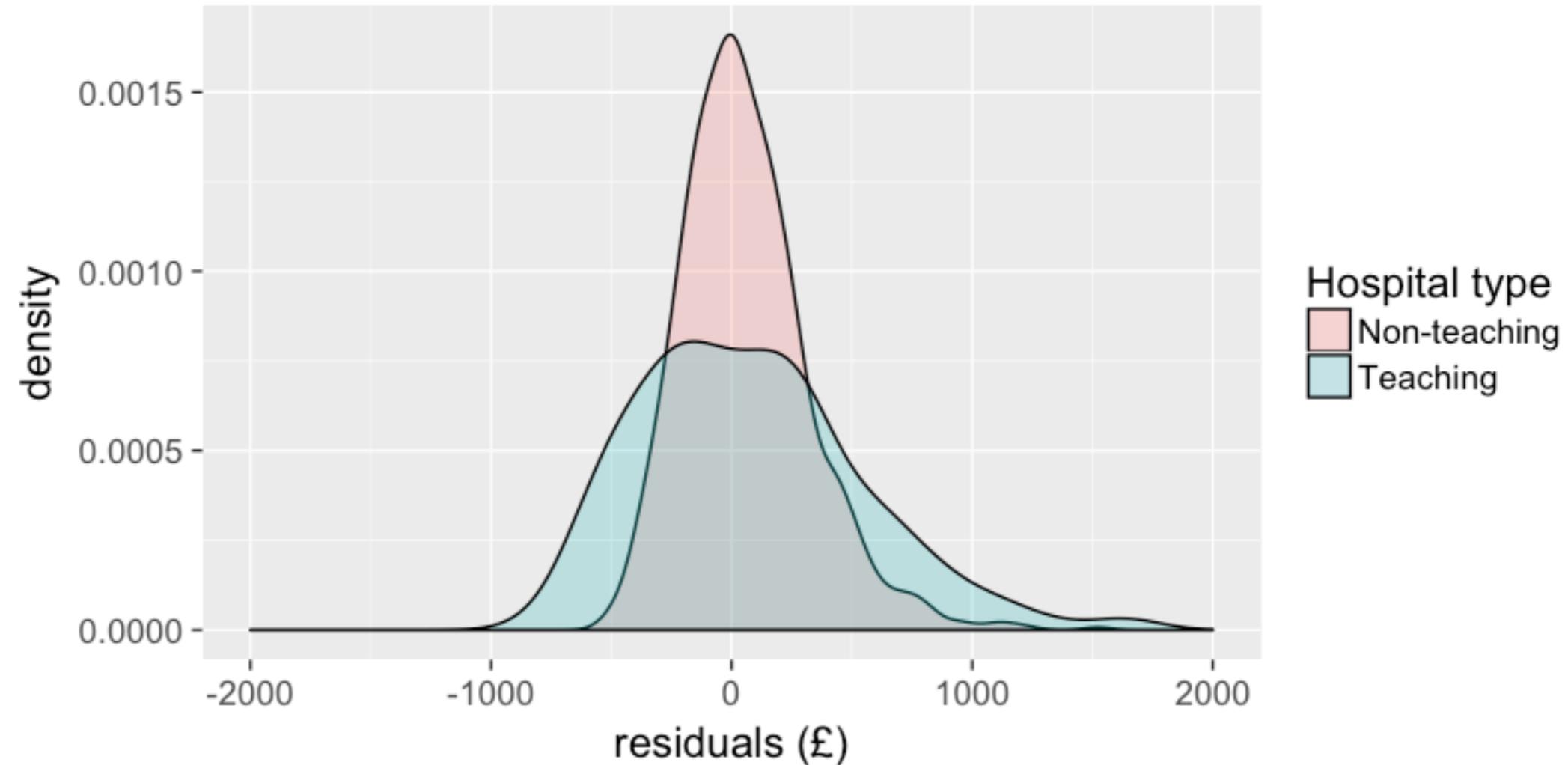
- Teaching hospitals treat more complex mix of patients → higher cost
- Teaching hospitals are also larger → higher volume

} spurious relationship

Solution?? Add a fixed-effect to control for average cost differences across hospitals?

Heteroskedastic errors

Emergency residuals, cardiac conditions — w/ hospital type fixed-effect



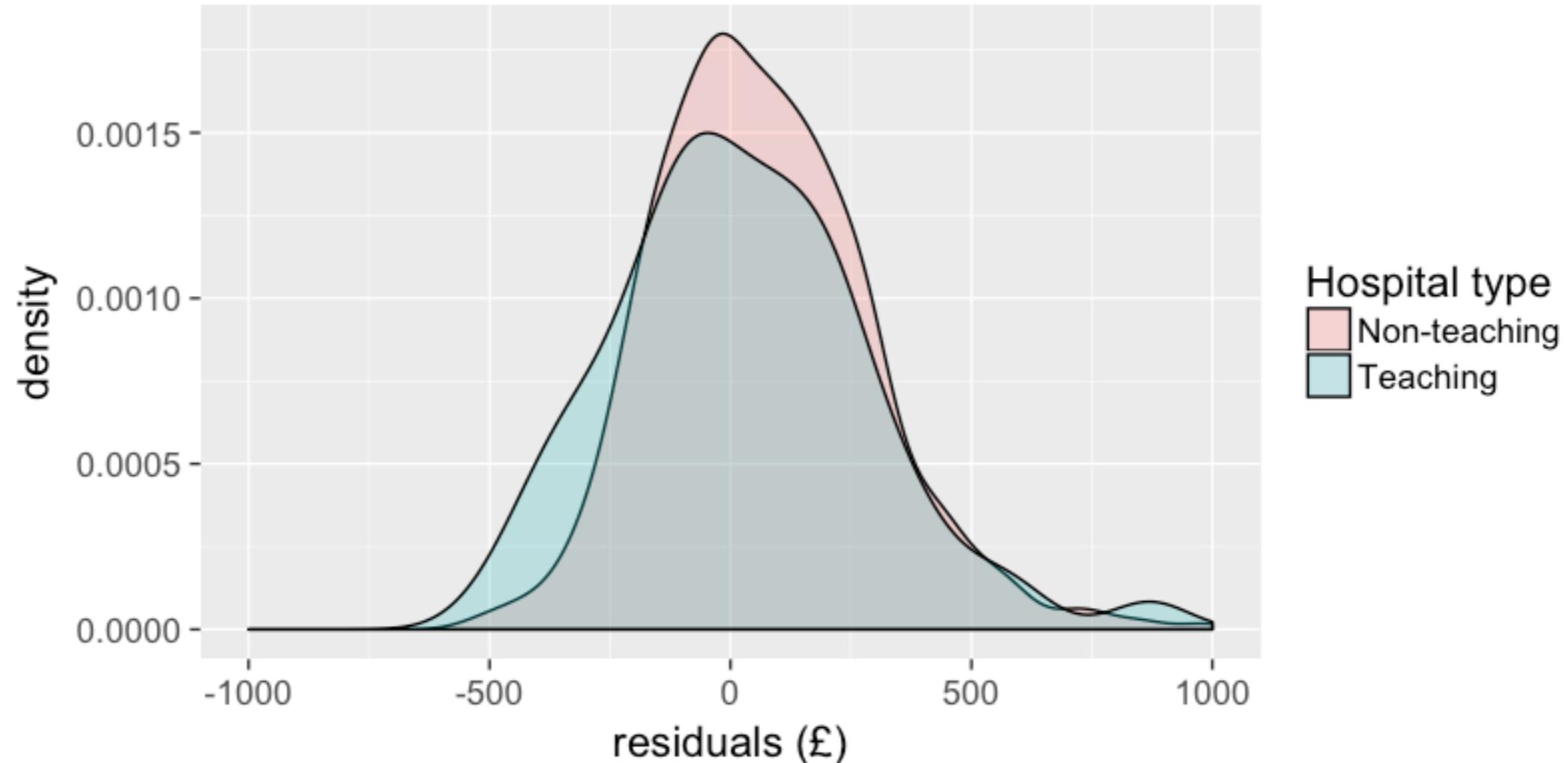
Problem:

- Errors (residuals) are heteroskedastic across hospital types → violation of IID assumption
- If error term is misspecified, can bias model coefficient estimates (*King & Roberts 2014*)

Solution: Case-mix adjust costs to remove within service-line heterogeneity

Homoskedastic errors after case-mix adjustment

Emergency residuals, cardiac conditions –
after case-mix adjustment and w/ hospital type fixed effects



⇒ compare hospitals based on the cost of treating an “average” patient within the specified service-line