

Dr. Lee:

Dr. Duncan, the Chair of our department, asked me to take a look at your study of hospital costs, because I have done some work in that area in the past and also I'm familiar with the AHCA hospital data.

I realize that you don't put everything into your presentation that you have looked at in the process, so I wondered if you have considered:

- Including some measure of how input prices differ regionally?
Differences in input prices, especially wages, would be expected to result in differing costs. We know, for example, that Medicare adjusts hospital DRG rates to reflect differences in both labor and non-labor inputs. Salaries and wages per FTE is a possible measure, as is capital-related expenses per bed. Or, county-level data also are available to reflect the general level of wages.
- For payer mix, using % Medicare admissions (or patient-days) and % Medicaid admissions?
We might expect payer mix to affect costs and revenues. If government hospitals have different payer mixes, in general, than private hospitals, the government variable may be measuring this difference, at least in part, rather than the "pure" effect of public ownership.
- Including the number of beds as a measure of size?
Particularly for costs, previous studies have found evidence of scale effects.
- Using operating expenses per adjusted admission rather than patient expenses per adjusted admission?
Given that the cost of caring for a given patient includes operating costs such as housekeeping, utilities, etc., operating expense may be a more inclusive measure of the "costs of government-operated hospitals," especially since there is reason to believe that hospital accounting systems often do not reliably allocate costs between patient and other operating expense categories.