Hospital Rankings and Health Equity

For more than 30 years, rankings published by US News & World Report and other organizations have measured various facets of hospital performance. Of the 6 domains of quality identified in the landmark 2001 report Crossing the Quality Chasm,3 domains—safety, efficacy, efficiency, timeliness, and patient-centeredness—have been addressed to varying degrees in hospital rankings. Major rankings, however, largely have not examined the sixth crucial domain of quality: equity.

This must now change. Recent developments support an emerging consensus. Health care experts have issued calls for hospital rankings that use measures of health equity, and approaches have been demonstrated by organizations including the Lown Institute and IBM Watson. Correcting inequities that plague the US health care system will require purposeful measurement.

On July 26, 2022, US News & World Report published new and updated health equity measures for hospitals featured on the publication’s website.2 This Viewpoint summarizes why and how US News & World Report has approached evaluating and publicly reporting hospital performance in various aspects of health equity and describes several novel equity measures published under the aegis of its “Best Hospitals” rankings program.

Like other elements of US News & World Report’s public reporting program, the health equity measure portfolio could be expected to expand and evolve.

Development of Health Equity Measures

Each equity measure was developed under a framework comprising 3 domains: access, outcomes, and social determinants of health. Analogous to the domains of the Donabedian model of quality, these represent areas in which hospitals have opportunities to promote equitable health. Measures in the access domain evaluate the extent to which vulnerable patient populations residing in the hospital’s community are able to make use of various health care services. The outcomes domain refers to whether the results of care differ between certain groups of patients. The social determinants of health domain examines ways in which hospitals address social conditions that create and exacerbate health inequities.

Measures in each domain have been published on US News & World Report’s online profiles of eligible hospitals; in the future, potentially as early as 2023, a composite index will combine these into a summary score. Once completed, the composite index may serve as a standalone ranking or may be incorporated into existing US News & World Report rankings.

Access

Studies have highlighted substantial differences in patient demographic characteristics among hospitals located in the same community. For example, Black patients disproportionately receive care in hospitals with lower volume, lower quality, and fewer advanced treatments available.3 Similarly, patients with lower income or Medicaid insurance coverage may have difficulty accessing care due to barriers such as transportation or fewer clinicians accepting Medicaid,4 among others. While some observers may be tempted to attribute this pattern of segregation to patient choice or external factors alone, the extent to which hospitals’ policies and practices may cause or perpetuate them warrants further investigation.

To investigate racial and ethnic disparities in access, a team of US News & World Report analysts evaluated how closely each hospital’s population of patients with Medicare undergoing typically elective procedures reflect the demographics of Medicare beneficiaries residing in the surrounding community. Measures examined the representation of Asian American and Pacific Islander, Black, Hispanic, Native American, and all non-White patients. Separately, to investigate access to inpatient care for patients with Medicaid insurance regardless of race or ethnicity, Medicare cost reports data were used to compare, for each hospital, the proportion of inpatients insured by Medicaid vs the proportion of community residents insured by Medicaid. The analysis controlled for certain hospital and community factors.

Outcomes

Previous studies that investigated outcome disparities found that Black patients were more likely to experience higher readmission rates compared with White patients after undergoing certain procedures, such as coronary artery bypass graft surgery or lumbar spinal fusion surgery.5,6 The factors driving these disparities are believed to vary widely. For instance, a study of women who underwent hysterectomy found that Black women were more likely to be treated by surgeons who performed low volumes of these procedures.7 This same study found that patients operated on by surgeons with low procedure volume were at an increased risk of mortality and complications. Another study found that insurance coverage differences accounted for about half of the observed disparity in survival rates between Black and White patients with colorectal cancer.8

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To investigate outcome disparities, hospital-level differences in the risk of 30-day unplanned readmission between visits for Black patients and White patients following coronary artery bypass graft surgery, knee replacement procedures, and spinal fusion surgery were examined for hospitals that treated at least 12 patients of each race within the study period. The model specification was consistent with modeling performed in the Best Hospitals analyses, included covariates such as age and comorbidities, and adjusted for certain social, economic, and environmental factors that could potentially confound the relationship between race and readmission. These included a proxy for the social vulnerability of the patient, determined by the Centers for Disease Control and Prevention’s county-level Social Vulnerability Index data, and the percentage of the hospital’s patient population that was represented by Black patients.

**Social Determinants of Health**

For uninsured individuals, the inability to pay for health care often manifests as delayed care focused on emergency department services, overall significantly lower utilization than insured individuals, and higher resulting morbidity and mortality. Even though hospital charity care can significantly alleviate individuals’ inability to pay, financial assistance policies and amounts distributed can vary widely even between hospitals in the same community. Additionally, nonprofit hospitals are obligated by law to devote a portion of expenditures toward Community Benefit activities, which include charity care, to meet the requirements of their tax-exempt status. Prior research has noted that hospital choices in the construction of their financial assistance policies can have a large influence on the amount of financial assistance, including charity care received by patients.

To investigate differences among hospitals’ contributions toward charity care for uninsured individuals, Medicare cost reports data were used to examine the relative alignment of a hospital’s proportion of costs spent on uninsured charity care to its community’s proportion of uninsured individuals. This measure examines whether a hospital’s uninsured charity care costs are significantly above or below what would be expected after controlling for hospital and community factors.

**Limitations and Future Directions**

The current analysis examining hospital rankings for equity has several limitations. First, Hospital Service Areas (HSAs) were used to define hospital communities; however, in some instances, the HSA might not most accurately represent the population that a hospital serves. The HSA was selected as the geographic unit because of its widespread use in health services research, its feasibility to be merged with the available data, and its applicability nationwide. Second, the observational data used in this analysis may have included unmeasured confounding factors that limit the ability to derive causal inferences for any disparities that may be observed. Third, due to the complex and multifactorial nature of health disparities in the US, there may be important aspects of health equity in which disparities exist but are not addressed by the current methodology and measure portfolio. Fourth, the focus on Medicare fee-for-service beneficiaries in some measures may obscure disparities in the type of or lack of insurance coverage.

**Conclusions**

Limitations notwithstanding, public reporting of these measures may bring awareness and resources to areas where improvements can be made to achieve health equity. Like other elements of US News & World Report’s public reporting program, the health equity measure portfolio could be expected to expand and evolve. Input from subject matter experts including, but not limited to, researchers, clinicians, community representatives, and health care leaders will be key to help improve communication of findings to the public, implement strategies to refine the methodology, and identify new data sources to measure additional components of equity relevant to hospitals. Future measures may further expand on existing measure constructs or may explore other facets of health inequities not yet addressed. As the measure portfolio continues to develop, it may be considered for inclusion in the methodology behind future Best Hospitals rankings.

**ARTICLE INFORMATION**

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**REFERENCES**


