In the Literature

EXPLAINING DISPARITIES IN ACCESS TO HIGH-QUALITY CARDIAC SURGEONS

Evidence of racial disparities in access to health care is well documented, with studies noting inequities for a wide array of conditions, medical treatments, and care settings. Coronary artery bypass graft (CABG) surgery, in particular, has received much attention recently, with researchers focusing on inequalities between minorities and non-minorities in terms of access, outcomes, and care practices.

In the article “Explaining Disparities in Access to High Quality Cardiac Surgeons,” (Annals of Thoracic Surgery, July 2004) researchers from the University of California, Irvine and the University of Rochester School of Medicine and Dentistry, with support from The Commonwealth Fund, find that African Americans and Asian/Pacific Islanders were more likely to be treated by surgeons and hospitals with higher risk-adjusted mortality rates than whites. This finding suggests that policy makers must improve access to high-quality providers when addressing health care disparities.

The researchers sought to explain the inequities by investigating several factors surrounding CABG surgeries. Specifically, the study considers whether the observed racial differences in access to high-quality surgeons were due to socioeconomic differences, racial differences in referrals to high-quality hospitals, or racial differences in referrals to low-volume surgeons.

Past studies have shown widespread disparities in access, outcomes, and quality of care. Among patients at Duke University, for instance, African Americans were 32 percent less likely to undergo CABG surgery than whites, even after controlling for severity of disease and other factors. Minorities are also more likely to experience worse health outcomes. In New York, minorities are more likely to be re-admitted for complications following CABG.

In addition, care practices, like the administering of beta blockers following an acute myocardial infarction, or quality of providers (physicians and hospitals) can vary with the race of patient. This means that minorities may be disadvantaged even when they gain access to care.

About the Study

The researchers in this study examined a sample group of 27,969 patients who underwent CABG surgery in New York State in 1996 and 1997. These data were then augmented with risk-adjusted mortality rates calculated by New York State. This rate, which is interpreted as a measure of the quality of the surgeon, reflects the average performance of a surgeon relative to his or her peers after taking into account differences in disease severity and comorbidities (e.g., ejection fraction). Patients treated by surgeons with lower risk-adjusted mortality rates are assumed to receive better care than those treated by surgeons with higher risk-adjusted mortality rates.

Data Findings

The data show that African Americans and Asian/Pacific Islanders were significantly more likely to be treated by surgeons and hospitals with higher risk-adjusted mortality rates than were whites. Specifically, African Americans were treated by surgeons with risk-adjusted mortality rates 13.8 percent higher and Asian/Pacific Islanders were treated by surgeons with risk-adjusted mortality rates 17 percent higher than whites. The differential in risk-adjusted mortality rates between whites and minorities translates to an additional 170 minority deaths per year on a national basis. The impact is likely not limited to these 170 deaths. Because the risk-adjusted mortality rate is indicative of quality in general, it could extend to adverse outcomes other than in-hospital mortality, like complications or 30-day mortality.
African Americans and Asian/Pacific Islanders are more likely to be treated by physicians with higher average risk-adjusted mortality rates.

Average risk-adjusted mortality rate of physicians treating . . .

<table>
<thead>
<tr>
<th></th>
<th>White Patients</th>
<th>African American Patients</th>
<th>Asian/Pacific Islander Patients</th>
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<tbody>
<tr>
<td>Mortality Rate</td>
<td>2.25</td>
<td>2.90</td>
<td>2.66</td>
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Note: The mortality rate statewide for all patients was 2.44% in 1996 and 2.22% in 1997.