Journal Scan

Recent Literature Worth Noting

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Equity in Canadian Health Care: Does Socioeconomic Status Affect Waiting Times for Elective Surgery?
Samuel E.D. Shortt and Ralph A. Shaw
<www.cmaj.ca/cgi/content/full/168/4/413>

Background: Waiting times for surgical and other procedures are an important measure of how well the healthcare system responds to patient needs. In a universal healthcare system such as Canada's, it is important to determine if waiting times vary by socioeconomic status (SES). We compared waiting times for elective surgery of patients living in low and high socioeconomic areas.

Methods: We reviewed the medical charts of all patients who underwent elective surgery at a Canadian academic health centre between 1992 and 1999. Using patient postal codes we assigned SES on the basis of five characteristics in the 1996 census data. We compared waiting times for surgery for people from regions in the lowest third (low SES group) with that for patients from regions in the upper third (high SES group).

Results: On average, patients in the high SES group waited 31.1 days and those in the low SES group waited 29.3 days. When differences in waiting times for 22 common procedures were examined between the groups, only the difference for prostatectomy was statistically significant: patients in the high SES group waited 4.4 fewer days than those in the low SES group.

Interpretation: We found little evidence that residing in a region in which SES was in the lowest third was associated with longer waiting times for elective surgery.

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The Implications of Regional Variations in Medicare Spending. Part 1: The Content, Quality, and Accessibility of Care
Elliott S. Fisher, MD, MPH; David E. Wennberg, MD, MPH; Thérèse A. Stukel, PhD; Daniel J. Gottlieb, MS; F. L. Lucas, PhD; and Étoile L. Pinder, MS
<www.annals.org/issues/v138n4/abs/200302180-00006.html>

Background: The health implications of regional differences in Medicare spending are unknown.

Objective: To determine whether regions with higher Medicare spending provide better care.

Design: Cohort study.

Setting: National study of Medicare beneficiaries.

Patients: Patients hospitalized between 1993 and 1995 for hip fracture (n = 614, 503), colorectal cancer (n = 195, 429), or acute myocardial infarction (n = 159,393) and a representative sample (n = 18,190) drawn from the Medicare Current Beneficiary Survey (1992–1995).

Exposure Measurement: End-of-life spending reflects the component of regional variation in Medicare spending that is unrelated to regional differences in illness. Each cohort member's exposure to different levels of spending was therefore defined by the level of end-of-life spending in his or her hospital referral region of residence (n = 306).

Outcome Measurements: Content of care (for example, frequency and type of services received), quality of care (for example, use of aspirin after acute myocardial infarction, influenza immunization), and access to care (for example, having a usual source of care).

Results: Average baseline health status of cohort members was similar across regions of differing spending levels, but patients in higher-spending regions received approximately 60% more care. The increased utilization was explained by more frequent physician visits, especially in the inpatient setting (rate ratios in the highest vs. the lowest quintile of hospital referral regions were 2.13 [95% CI, 2.12 to 2.14] for inpatient visits and 2.36 [CI, 2.33 to 2.39] for new inpatient consultations), more frequent tests and minor (but not major) procedures, and increased use of specialists and hospitals (rate ratio in the highest vs. the lowest quintile was 1.52 [CI, 1.50 to 1.54] for inpatient days and 1.55 [CI, 1.50 to 1.60] for intensive care unit days). Quality of care in higher-spending regions was no better on most measures and was worse for several preventive care measures. Access to care in higher-spending regions was also no better or worse.

Conclusions: Regional differences in Medicare spending are largely explained by the more inpatient-based and specialist-oriented patterns of practice observed in high-spending regions. Neither quality of care nor access to care appear to be better for Medicare enrollees in higher-spending regions.

The Implications of Regional Variations in Medicare Spending. Part 2: Health Outcomes and Satisfaction with Care
Elliott S. Fisher, MD, MPH; David E. Wennberg, MD, MPH; Thérèse A. Stukel, PhD; Daniel J. Gottlieb, MS; F. L. Lucas, PhD; and Étoile L. Pinder, MS
<www.annals.org/issues/v138n4/abs/200302180-00007.html>

Background: The health implications of regional differences in Medicare spending are unknown.

Objective: To determine whether regions with higher Medicare spending achieve better survival, functional status, or satisfaction with care.

Design: Cohort study.

Setting: National study of Medicare beneficiaries.

Patients: Patients hospitalized between 1993 and 1995 for hip fracture (n = 614,503), colorectal cancer (n = 195,429), or acute myocardial infarction (n = 159,393) and a representative sample (n = 18,190) drawn from the Medicare Current Beneficiary Survey (MCBS) (1992–1995).

Exposure Measurement: End-of-life spending reflects the

component of regional variation in Medicare spending that is unrelated to regional differences in illness. Each cohort member's exposure to different levels of spending was therefore defined by the level of end-of-life spending in his or her hospital referral region of residence (n = 306).

Outcome Measurements: Five-year mortality rate (all four cohorts), change in functional status (MCBS cohort), and satisfaction (MCBS cohort).

Results: Cohort members were similar in baseline health status, but those in regions with higher end-of-life spending received 60% more care. Each 10% increase in regional end-of-life spending was associated with the following relative risks for death: hip fracture cohort, 1.003 (95% CI, 0.999 to 1.006); colorectal cancer cohort, 1.012 (CI, 1.004 to 1.019); acute myocardial infarction cohort, 1.007 (CI, 1.001 to 1.014); and MCBS cohort, 1.01 (CI, 0.99 to 1.03). There were no differences in the rate of decline in functional status across spending levels and no consistent differences in satisfaction.

Conclusions: Medicare enrollees in higher-spending regions receive more care than those in lower-spending regions but do not have better health outcomes or satisfaction with care. Efforts to reduce spending should proceed with caution, but policies to better manage further spending growth are warranted.

Geographical Variations in Medicare Spending (editorial)
Kenneth I. Shine, MD
<www.annals.org/issues/v138n4/full/200302180-00015.html>

What's Enough, What's Too Much? (editorial)
Charles E. Phelps, PhD
<www.annals.org/issues/v138n4/full/200302180-00016.html>

The Implications of Regional Variations in Medicare—What Does It Mean for Medicare? (Editorial)
Gail R. Wilensky, PhD
<www.annals.org/issues/v138n4/full/200302180-00017.html>