Commentary: Leveling the Playfield: Imbalances in Lung Cancer Care

Brian Mitzman, MD
Division of Cardiothoracic Surgery
University of Utah Health
Salt Lake City, UT

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Corresponding Author:
Brian Mitzman, MD
University of Utah
Division of Cardiothoracic Surgery
30 North 1900 East, #3C127 SOM
Salt Lake City, UT 84132
801-585-5204
brian.mitzman@hsc.utah.edu
Central Message: Safety-net hospitals treat some of the most at-risk patients with the least options for cancer care. Ensuring equivalent outcomes when compared with non-safety-net hospitals should be a priority.

Central Picture: Brian Mitzman, MD

Safety-net hospitals (SNHs) are defined as institutions that “provide care to a substantial share of vulnerable patients regardless of their ability to pay.”[1] Many consider such hospitals as providers of last resort, and assume these institutions have worse outcomes and increased overall costs. In our current era of thoracic surgery, elective resection for lung cancer is associated with low morbidity and mortality,[2-3] and such outcomes should be available for all patients, regardless of financial or social status. In this month’s Journal of Thoracic and Cardiovascular Surgery, Sakowitz and colleagues take a deeper dive, comparing elective lobectomy outcomes and costs at safety-net and non-safety-net hospitals.[4]

Utilizing the Nationwide Readmissions Database, Sakowitz retrospectively reviewed over 282,000 elective hospitalizations for lobectomy for malignancy during a 10 year period, and of those, 14.5% were treated at a SNH. Utilizing ICD-9/10 codes, the authors were able to evaluate specific demographic characteristics of patients, along with perioperative complications. Expenditures were also analyzed by way of cost-to-charge ratios.
So, did Sakowitz and colleagues’ analysis reinforce our expectations of outcomes at SNHs? Somewhat. Rates of minimally invasive surgery between the hospital cohorts were similar, at just over 50%. This is very promising, although we have a long way to go to raise those rates universally. In-hospital mortality rates were equal at 1.4%. There were perioperative morbidity differences however. Treatment at a SNH was associated with higher rates of infectious complications, pneumonia, and blood transfusions. These differences were consistent even after multivariable regression. Regarding cost, there was approximately a $3,000 difference in favor of non-safety net hospitals, which cannot be accounted for by the small 0.3 day difference in length of stay.

As a retrospective review of an administrative database, we have to take these results with a grain of salt since they lack the granularity to truly assess the minutia of clinical care. That said, we do see higher costs and worse morbidity at the safety-net hospitals. The differences however are less than I personally expected to see, and should not be hard to overcome if the actual causes of the variation in outcomes can be determined. Unfortunately, this paper cannot address a major differentiator of safety-net hospitals; association with an academic facility and expertise of the surgeons operating at the SNH. While there are many standalone SNHs, there are quite a few with a direct affiliation with major university thoracic surgical departments. Often these departments will staff the SNH, and one would expect similar patient pathways and protocols when a patient is being treated for lung cancer. I would be interested to know whether association and staffing by a high-volume university center decreases some of these cost and outcome differences. Overall, Sakowitz and colleagues have done an excellent job evaluating
disparities in lung cancer care, and we all must continue to work on leveling the playing field for our patients, regardless of socioeconomic status.

References:


