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Cost of and Access to Surgical Care

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Gadzinski et al[1] found that that while mortality rates are similar between CAHs and non-CAHs, costs are higher in critical access settings, even when patients leave the hospital sooner.

Several aspects of this study deserve comment. First, this study found no differences in perioperative mortality between CAHs and non-CAHs. While perioperative mortality is a convenient end point, many have suggested that it is of limited use in detecting quality differences, especially at the sample sizes that occur in most CAHs.[2,3] While this study represents a good starting point, future work will certainly use more granular markers of surgical quality.

Second, the authors simply and elegantly demonstrate that the higher payments allotted to CAHs result in higher costs. Is this really a problem? Proponents of policies enacted to ensure that CAHs remain fiscally viable will argue that the system is achieving exactly the results for which it was designed. However, those interested in limiting Medicare spending will argue that the higher payments to CAHs are “low-hanging fruit” in terms of opportunities for more efficient spending.

Overall, this study nicely demonstrates that it is difficult to determine what rate is right in terms of how much excess payment is necessary to ensure that emergent surgical care is available at CAHs. Pay too little, and surgeons will migrate away from low-volume, low-revenue rural practices. But pay too much, and Medicare will be unnecessarily subsidizing surgery in these locales.

Where this threshold lies is an empirical question, and policy makers will have to decide. One wonders if their answer might depend on whether they or one of their loved ones has ever needed emergent surgical care late some evening, on a dark and stormy night, in a hospital far, far away.

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