

Editorial Commentary: Racial and Economic Inequity Leads to Diminished Access to Rotator Cuff Repair: We Treat as One



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Abstract: In a review of a U.S. State's health care data as it pertained to rotator cuff repair, there were key differences relating to the patients' race, ethnicity, and income status and eventuality for surgery. Black race, Hispanic ethnicity, and Medicaid insurance are associated with lower rates of rotator cuff repair, and Asian race, male gender, and workers' compensation insurance are associated with a greater rate. Consideration of these covariates can make us more aware of specific disparities that lead to differences in rotator cuff repair and to greater health care access in general. Patient, physician, and systemic factors are critical to reach a better level of understanding and potential treatment. There is a need for improved inclusivity and equity for all patients seeking rotator cuff repair.

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"Of all the forms of inequality, injustice in health is the most shocking and inhumane."

—Dr. Martin Luther King, Jr.

I am a White, non-Hispanic, non-Medicaid, soon-to-be Medicare-receiving orthopaedic surgeon and editorial reviewer for *Arthroscopy*. That makes me more likely to have a rotator cuff repair (should I need one), living and practicing in New York State based on the article of Alan Hwang, Linda Zhang, Gabriel Ramirez, Michael Maloney, Ilya Voloshin, and Caroline Thirukumaran entitled "Black Race, Hispanic Ethnicity and Medicaid Insurance Are Associated With Lower Rates of Rotator Cuff Repair in New York State."¹ Should I have a work-related injury, I will also likely have a cuff repair based on the authors' thorough review of the Statewide Planning and Research Cooperative System (SPARCS) 10 Database of New York State that adds workers' compensation as an additional covariate for positive rotator cuff repair. Asian race and male gender also correlated with greater cuff repair rates.

The authors' charge was to investigate all patients for rotator cuff repair in New York State, not just the Medicare population, and to see how race, ethnicity, and insurance type (measurement of a patient's economic status) affect rates of rotator cuff repair. Not surprising, they found that if the patient was African American, of Hispanic ethnicity, and with Medicaid insurance, rotator cuff repair was much less likely to happen. These findings are consistent with previous publications surrounding these 3 covariates that have been published relating to cardiovascular, prostate, total knee/hip arthroplasty, and meniscectomy surgeries.²⁻⁴

Speculation abounds as to the causes of the reviewed SPARCS data, and the authors include "patient factors, physician factors, and systemic factors." Patient reasons point to cultural issues, including personal beliefs and trust in outcome results. Physician dynamics include decreased awareness of patient circumstances and sensitivities. Systemic issues consisted of "access to health care resources."

I find the Medicaid component to the SPARCS findings worthy of further dissection. There are many programs and eligibility requirements that vary from state to state. New York State Medicaid may differ from other states. According to one report, 14 states refused to expand Medicaid under the Affordable Care Act, which is thought to be why African Americans were found to be more likely to be uninsured.⁵ The report also noted that 90% who were uninsured due to the

The author reports no conflicts of interest in the authorship and publication of this article. Full ICMJE author disclosure forms are available for this article online, as supplementary material.

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0749-8063/22925/\$36.00

<https://doi.org/10.1016/j.arthro.2022.07.009>

respective State's lack of Medicaid expansion lived in the South.

The concept of "low-volume surgeon and facility" and how it affects the Medicaid patient abounds in the literature. Traditionally, a Medicaid surgeon is thought to have a lower-volume surgical practice that further translates to work in a lower-volume hospital. One wonders, though, if this concept is as true today.

Medicaid cases typically are performed in academic teaching centers and are at times covered by "higher-volume surgeons." While physician-owned surgery centers may not accommodate Medicaid patients, the academic centers generally do. Further work should extend to the breakdown of surgicenters and zip code locale. Academic institutions typically are found in urban centers. I am wondering that, as the payment system in the academic environment morphs from payment/case to a relative value unit (RVU), which is currently happening, will the walls of Medicaid access to "higher-volume" surgeons and hospitals be partially broken down.

The article points to the need for improved inclusivity and equity for all patients seeking rotator cuff repair. How this is achieved is never simple. I do think we can at least take a few baby steps. Improved self-awareness to these issues is a good start. Education with visual aids that are explained in very basic terms to patients as it relates to the pros and cons of rotator cuff repair may start to break down some barriers of patient misperception. The issue of medical insurance, specifically Medicaid, is complicated. Will a private practice group allow a junior associate to participate with a Medicaid program? The RVU system levels the playing field somewhat for the operative surgeon, as the case performed is typically allotted the same RVU units whether the patient is a commercial payer or a Medicaid patient.

Hospitals, too, need to be mindful of the inequity in care as more and more Medicaid plans are being dropped by the individual or networked hospitals. Patients are then forced to find a participating hospital to have the surgery and so may have to travel many miles. The patient who underwent rotator cuff repair must then find a participating physical therapy facility that may or may not participate with the patient's insurance.

The sooner we recognize and acknowledge our systemic shortcomings, the sooner we can move closer to a more equitable health care in the United States. We treat as one should be our common goal.

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