Coronary surgery, ethnic origin, and value in health care

See page 1094 for the article to which this Editorial refers

Selecting patients for costly therapy and providing adequate access can be a major sociological problem within medicine today. Such challenges, highlighted in the report by Goldsmith et al.[1] in this issue, concern the in-hospital outcome of coronary surgery in patients of Indo-Asian and white Caucasian background in the United Kingdom. The authors compared results of 194 pairs of patients undergoing surgery between November 1994 and January 1997. The patients were matched for age, sex, and date of procedure in the two groups. They noted more non-elective surgery in the Indo-Asian group, as well as a trend toward higher hospital mortality — 6.7% in Indo-Asians vs 2.6% in white Caucasians. The results of this study were confined to the in-hospital period, raising questions, as the authors note, about long-term outcome, including relief of angina pectoris, other measures of quality of life, survival, and freedom from non-fatal events.

A somewhat parallel concern regards the outcome of coronary surgery in African-Americans vs Caucasians in the United States. This comparison was studied by Gray et al., who noted a similar in-hospital mortality in African-Americans and Caucasians but a higher long-term mortality in the former due to more co-morbidity[2].

The results of this study probably cannot be adequately used to judge whether there is a different response to coronary surgery in Indo-Asians, which would necessitate using different criteria for patient selection. When several high-risk subgroups were examined, the differences between the Caucasians and the Asians could in part, be accounted for. Thus, in non-elective cases, the mortality was 9% in Asians and 7% in Caucasians. When the patients were stratified by the Parsonnet score[3], there was considerable overlap in mortality between the ethnic groups in both the low-and high-risk patients. Thus, pending further information to the contrary, patient selection in Indo-Asians can quite reasonably continue to be guided by clinical and angiographic suitability, informed by clinical trial results that have compared coronary surgery to medicine, coronary surgery to angioplasty, and outcome data from major single institutions and cooperative registries.

A major and somewhat troubling question raised by this study concerns patient access to care. While a high rate of emergency care was noted in both groups, 42.8% of the Asian group was considered to have had coronary surgery on a non-elective basis. That surgical outcome is generally worse if performed urgently as an emergency[3,4] raises troubling questions about the ability to provide adequate access if the non-elective rate reaches close to 50% and is higher in one population than another.

Patient access to care is a complicated issue that goes beyond simply having facilities available. It includes proximity of facilities, transportation, cultural barriers, and patient and professional education, just to name a few. The general notion in most industrialized countries is that access to care should be similar for different racial, ethnic and economic groups for critical procedures such as coronary surgery. This study suggests that this may not be so. While there is clearly a societal demand for egalitarian provision of critical services, that does not mean it is a reality. In the United States, Carlisle et al.[5] have shown that there were higher rates of revascularization in areas of higher socio-economic status, at least suggesting problems in patient access.

Another problem raised by the high frequency of non-elective care, is a lack of standards. The reader may wonder if the high level of non-elective care would be similarly judged in his/her own institution. There is a very clear need to provide standard definitions to permit more meaningful communication. In this regard, professional societies, especially the European Society of Cardiology, the Society of Thoracic Surgeons, and the American College of...
Cardiology share a critical role\textsuperscript{[6]}. The professional societies are also interested in database development to foster more outcome assessment studies, such as the present paper\textsuperscript{[1]}. The issues before society are extensive and wide ranging. Considerable resources are being expended on coronary surgery, as well as other expensive therapies. These services compete for scarce resources, generally without sufficient information to make informed choices. An unfortunate response is to seek to decrease funding, without regard to how cost-effective a service is. Making a service cost-effective might begin by showing how it compares to competing demands for resources and then seeking to optimize the provision of that service. Efforts to optimize coronary surgery have been ongoing for a number of years\textsuperscript{[3-7]}. Databases are critical to this activity, as results from databases may be used to inform clinicians and then change practice and improve outcome\textsuperscript{[7]}. The narrow view of good outcomes may be broadened to consider quality of care. Care of good quality should include adequate patient access and facilities that promote favourable outcomes, as measured by quality of life, survival, freedom from events, and patient satisfaction. What society wants is value, that is good quality of care at a fair price. In an egalitarian society, value is demanded for all groups, not just the wealthy. If providers seek to get paid for a service, then value must be demonstrated; society deserves no less. For services of demonstrated value to be available, however, resources must be available both to provide the service and to demonstrate the value.

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\textbf{References}


