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ACC NEWS

President's Page: Access to Cardiovascular Care: Defining the Role of the ACC

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A major issue confronting our society in general, and the medical profession specifically, is access to health care for all citizens. Estimates that 10% to 18% of the nation's population are without medical insurance (1) have provoked questioning of the benefit to Americans of committing the world's largest proportion of a gross national product to health care. In response, the American Medical Association, the American College of Physicians and other groups of concerned physicians (2–4) have proposed altering our current system of health care. Access to a basic level of care is a component of all plans offered to date and efforts are being made to define this level. For example, the state of Oregon is actively bringing ordinary citizens into the process of establishing how the health care dollars will be spent.

The question that confronts me as the new ACC president and that confronts the College itself is what is the role of the ACC in the evolving changes in the health care system? With this in mind, a Bethesda conference on access to cardiovascular care will be held in October 1991 under the leadership of Francis Klocke, MD, chair of the Bethesda Conference Committee, and Melvin Cheitlin, MD, who will be chairing the specific conference on access. This conference should provide an important opportunity to define the extent of the problem of access to cardiovascular care and to consider not only economic, but also other potential barriers to access and good cardiovascular health for our citizens. I am optimistic that a framework will be developed for definition of ACC policy and recommendations for ensuring achievement of one stated objective of the ACC: to develop strategies to maintain access for all persons, particularly the elderly and disadvantaged, to cardiovascular care (5).

The ACC/AHA Task Force model. One of the greatest challenges is defining what constitutes those cardiovascular services that should be available to all of our citizens. What methodology should be used to define a basic level of cardiovascular care? Services judged to be essential should achieve this status based on an analysis of effectiveness, cost and impact on quality of life including the opportunity to maintain or restore a productive life-style. A "clinical reality index" needs consideration as one blends data on effectiveness with data on patient age and clinical condition. Past experience with the American College of Cardiology/American Heart Association (ACC/AHA) Task Forces to define guidelines of care may also provide direction in this new task. Quantitative data to define outcomes of specific diagnostic and therapeutic strategies are fundamental to defining essential services. In my judgment, a model of these task force reports, is the recent report on coronary artery bypass surgery led by John W. Kirklin, MD. This document brings together detailed and critical analyses of extensive data on outcomes after coronary artery bypass surgery that form the basis for establishing the appropriate use of this procedure. However, in contrast to coronary artery bypass surgery, which has a wealth of randomized studies and excellent observational data bases, the quality of evidence to judge outcomes in many other areas is not as strong. Nonetheless, decisions need to be made and all recommendations regarding a basic level of cardiovascular care must be continually reviewed and modified, pending additional experience and research. The reality of clinical medicine is that not all decisions on what are appropriate versus inappropriate, essential versus nonessential services fit into a rigid definable protocol. This has been reflected in the ACC/AHA Task Force statements, which have established a hierarchy of indications for a given procedure. This hierarchy has usually included the following categories: class I, general agreement for use; class II, divergence of opinion on use and class III, consensus procedure not indicated. Perhaps all class I indications in current guidelines should be included in the universal access with further debate regarding class II and exclusion of class III indications. Combining

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Table 1. Utilization of PTCA and CABG—1986

	Chronic IHD (414)	Chronic Angina (413)	Unstable Angina (411.1)	Acute MI (410)
First listed diagnosis	577,000	319,000	410,000	758,000
PTCA	51,000	12,000	20,000	37,000
CABG	126,000	13,000	23,000	42,000

Data kindly provided by Dr. Manning Feninleib and Robert Pokras, National Center for Health Statistics. Figures in parentheses indicate ICD-9-CM codes.

some estimate of the degree of medical uncertainty with cost-sharing concepts might provide an intrinsic marketplace force that could be restored to the system. All who are practicing medicine recognize that the "blank check" era of medicine is gone forever and we must continue to critically analyze the utilization of resources. How many routine baseline laboratory tests, noninvasive diagnostic tests and invasive procedures are truly essential and should be included finally in a basic package of cardiovascular care? How many interventions might be eliminated if the patient critically questioned the need for them and would have to pay for a portion of the services that are not essential for decision making? What are the legal ramifications of such a process? It is not possible to build unlimited testing and interventional license into the assured cardiovascular care concept with any expectation of credibility with others influential in the process of revising the health care system. We should, however, defend vigorously that which is certain and proved to be effective care in the best interest of our patients. Our efforts must be consistent with the mission statement of the American College of Cardiology that includes "to foster optimal cardiovascular care" (5).

Quantifying data on underutilization versus overutilization of services. In addition to using the approach that has been utilized for establishing practice guidelines, a method of analysis to provide a perspective on current volumes of cardiovascular services and their costs seems essential in preparation for the discussion and debate of the basic cardiovascular care package. Such analyses may help to identify priorities for further investigation. Studies of appropriateness of care have focused primarily on overutilization of procedures, but little attention has been paid to underutilization of such services. The problem is exemplified in Table 1 where I list data kindly provided by Dr. Manning Feinlieb and Robert Pokras of the National Center for Health Statistics, from their studies on procedures and coronary heart disease (6). I have selected four ICD-9 codes, including chronic ischemic heart disease, chronic angina pectoris, unstable angina and acute myocardial infarction. The numbers of coronary angioplasty procedures and coronary artery bypass graft operations for each of these first listed diagnoses are provided. For example, of 577,000 first listed diagnoses for chronic ischemic heart disease, 51,000 were associated with coronary angioplasty and 126,000 with coronary bypass surgery. Of the 410,000 first listed diagnoses of unstable angina, 20,000 were associated with coronary angioplasty and 23,000 with coronary bypass surgery. Does this represent under- or overutilization? Because of limited data on individual patients, current national data bases do not allow precise answers to these questions. Furthermore, these data bases include only those patients who come to a hospital. Recent studies (8) documenting that the leading cause of excess mortality in Harlem is related to cardiovascular disease provides a single but notable example of a large underserved population that needs access to medical care in general and cardiovascular care in particular. We all know of many other examples, particularly in the central cities, where access is seriously impaired. We therefore need quantitative data that describe current services and the population served and also estimates of those who currently do not receive care and the type of services they need. These estimates would provide some perspective on the financial impact of the improved access to cardiovascular care. This rationale obviously raises the question of financial constraints of improving access at least within our current levels of charges. Others have already asked why high charges should be allowed to continue to prevent proper access to such care and the cardiovascular community will need to be prepared to deal with this important question.

Role of ACC members. It is clear that I do not see an easy solution but I am enthusiastic about the College's efforts to carefully consider these questions. We need to hear from our membership and, to that end, the Strategic Planning Committee will include questions regarding access to care in its next environmental survey of the membership of the American College of Cardiology. As we proceed, it also seems important to be clear about the impact of factors other than access that contribute to cardiovascular mortality and morbidity and to be sure that our methodology is sensitive to this distinction. A recent Swedish study (9) documented continued higher mortality rates in lower socioeconomic groups, as compared with those in a higher socioeconomic status. Thus, in a system where access is presumed equal for all, major differences in mortality based on socioeconomic differences persist.

In the recent Northwestern National Life Insurance Company Survey on Health Care Rationing (10), the following question was asked: "If rationing of health care services becomes necessary in the future, which of the following groups would you trust to make decisions about how to ration services?" At the top of the list among those responding was a national panel of medical professionals. We, as individual physicians, and the ACC, as the leading professional society for cardiologists, should therefore work hard to meet the expectations of the society in which we practice.

In summary, the role of the ACC must be to continue to emphasize the importance of high quality, accessible care and to continue to act in the best interest of our patients. Within this role we should provide leadership in defining those services that should be available to all of our citizens.

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