



## Considering the cost of CABG

It is evident to me that one of the consequences of the article by Gary Naglie and colleagues<sup>1</sup> on the age difference in the cost of coronary artery bypass grafting (CABG) will be an attempt by the cost managers to reduce the numbers of seniors who have this procedure. This is ageism at its worst.

Considering that half of the cost of health care for an individual occurs in the last year of life (when he or she is sickest, unto death), it should have been self-evident that it costs more to treat older people. The need to put a figure on this escapes me. However, it will not, you can be sure, escape the cost-cutters. There will be a push to limit this procedure to those under 65 years of age, even though the "research" does not demonstrate that the outcome is different among those who are younger, or that the postoperative life span is longer or more productive.

This appears to me to be a nasty article, which serves no good purpose, but will, I fear, produce bad consequences.

**Michael J. Walsh, MD**  
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### Reference

1. Naglie G, Tansey C, Krahn MD, O'Rourke K, Detsky AS, Bolley H. Direct costs of coronary artery bypass grafting in patients aged 65 years or more and those under age 65. *CMAJ* 1999;160(6):805-11.

### [Three of the authors respond:]

We are chagrined by Michael Walsh's perception that we have been authors of a "nasty" article, but we are not unaware of the irony of this accusation. As practitioners who primarily care for seniors, we routinely advocate that CABG be performed in patients over 65 years of age, both for our own patients and at a policy level. What particularly concerns us about Walsh's comments is the potential for misunderstanding and misuse of descriptive costing information. We wish to emphasize

most strongly that clinical policy is only indirectly related to descriptive costing information. Whether CABG should be performed in seniors depends primarily on 3 things: efficacy, effectiveness and cost-effectiveness.<sup>1,2</sup> Cost-effectiveness expresses the relation between the cost and the clinical value of an intervention. Transplants, for example, are very costly, but they are usually cost-effective because they are extremely effective. A cost-effectiveness model that we are working on suggests that the same is likely to be true for CABG in seniors.<sup>3</sup> It is quite expensive but probably worth doing because it is very effective in prolonging life (for selected indications) and relieving angina.

So what is descriptive costing information good for? Costing studies allow us to identify categories of heavy resource utilization (e.g., drugs, investigations, inpatient care) and to direct future research efforts to areas in which the potential gain would be greatest. Our results indicate that the majority of the cost difference between older and younger patients was accounted for by the difference in the length of stay in the intensive care unit and on the ward. Identification of modifiable factors that contribute to longer stays for older patients may lead to interventions that decrease costs and also potentially improve clinical outcomes.

We strongly discourage the misuse of costing data alone to guide clinical policy. We hope that this descriptive costing study will not be fodder for the "cost-cutters," rather that it will promote further research that will lead to improvements in CABG for patients over 65.

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### References

1. Detsky AS, Naglie IG. A clinician's guide to cost-effectiveness analysis. *Ann Intern Med* 1990;113:147-54.

2. Laupacis A, Feeny D, Detsky AS, Tugwell PX. How attractive does a new technology have to be to warrant adoption and utilization? Tentative guidelines for using clinical and economic evaluations. *CMAJ* 1992;146:473-81.
3. Naglie G, Krahn M, Tansey C, Detsky A, Bolley H. Is coronary artery bypass surgery cost-effective in the elderly? [abstract]. *Clin Invest Med* 1997;20(Suppl):S23.

## Home is where the health care is

None of the 4 selected class 1 studies in the review paper by Lee Soderstrom and colleagues<sup>1</sup> reported genuine acute home care programs. In the selected studies, the definitions of acute home-based care were problematic. Richards and colleagues<sup>2</sup> described hospital in the home (HIH) as "a generic term, referring to a package of home based nursing and rehabilitation services," whereas Shepperd and colleagues<sup>3</sup> restricted the eligibility to patients older than 60 years with 5 broadly defined conditions. These studies included patients selected on the basis of their clinical condition and its burden on the hospital, rather than on the basis that they had definite acute care needs and that this care could be appropriately delivered at home. The presence of validated research instruments seemed to influence the conditions chosen for inclusion in some trials. Data on the length of stay presented in these trials suggest strongly that the programs were additive to hospital stays and not substitutive.

The appropriate definition of HIH is one in which the patient requires treatment that, without the presence of the HIH, would otherwise require care in hospital. Substitution is the critical component of HIH care; it can be demonstrated through the use of hospital technologies or drugs not usually associated with community care (e.g., intravenous therapy and pumps, low molecular weight heparin), by the delivery of 24-hour care to patients or by the fact that hospitals retain the legal and financial responsibility for care provision. None of these preconditions