Response to NZMJ editorial by Dr Elana Curtis entitled

Deserving of more: framing of Māori inequities in cardiovascular care remain a challenge

We appreciate the comments by Dr Elana Curtis in relation to our recent article about worse morbidity and higher mortality in Māori compared to Europeans undergoing coronary artery bypass surgery (CABG) at Auckland City Hospital. However we are concerned that this could be interpreted to indicate that Māori may get lower quality care and may be contributed to by institutional racism.

We have no information that Māori received reduced quality of care and some findings from our study are reassuring; for example scores to estimate overall need for CABG (access score, Māori; 54.5 (8.5) vs European 53.5 (8.8) p=0.39) and urgency for surgery (Māori; 38.4 (SD 14.2), European 37.6 (SD 14.1), p=0.62), were similar for Māori and European patients. Also Māori did not wait longer for in-hospital surgery or elective surgery between evaluation by the cardiology services across the four Auckland hospitals and performing the procedure (in-hospital 8.0 days vs 7.8 days, p=0.95, elective 45.2 days vs 71.4 days, p=0.16). In addition Māori were prescribed the same high rate of evidence-based medications as Europeans such as aspirin (100% vs 98%) and statins (91% vs 88%) at discharge.

We believe the greater cumulative burden of disease and comorbidity in Māori are the major reason for increased mortality following cardiac surgery, and these factors may not be adequately captured using standard risk scores such as the EuroScore. In our study Māori presented later in their disease process as evidenced by lower ejection fractions and more heart failure, and more Māori were on dialysis. Also surgical cross clamp and bypass times were prolonged in Māori suggesting that their operations were more complex.

Previous studies have identified a much higher prevalence of cardiovascular risk factors, and of undiagnosed and untreated cardiovascular disease in Māori, particularly those in rural populations. Risk factors including diabetes, hypertension and smoking, and the quality of medical care over the life course, as well as delays in presentation, investigation and treatment are likely to impact mortality related to CABG, in addition to other adverse health outcomes.

We are very aware of the health inequalities that Māori suffer and are committed to improving outcomes in Māori and made a call in our manuscript to lower the Surgical Priority Score for Māori to improve their access to CABG. Indeed one of us (HW) initiated the screening of Māori in primary prevention to be undertaken 10 years earlier than Europeans (age 35 vs 45 in men and 45 vs 55 years in women) in order to enable Māori to be receive earlier non pharmacologic and pharmacologic therapies as appropriate.

We agree that further research is required to define the basic causes of the inequities in Māori we identified, and importantly open discussion to identify strategies to improve outcomes.
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References: