

FACTS

Bridging the Gap

CVD and Health Equity

OVERVIEW

A person's race or ethnicity shouldn't put them at higher risk for developing cardiovascular disease (CVD), but unfortunately, it is one factor that affects a person's likeliness of suffering a heart attack or stroke and chances of survival if they do. CVD remains the No. 1 killer of Americans¹ and exacts a disproportionate toll on many racial and ethnic groups.² For example CVD accounts for about one-third of the disparity in potential life-years lost between blacks and whites.³

Racial and ethnic minority populations also confront more barriers to CVD diagnosis and care, receive lower quality treatment, and experience worse health outcomes than their white counterparts.⁴ Such disparities are linked to a number of complex factors, such as income and education, genetic and physiological factors, access to care, and communication barriers.^{4, 5} The American Heart Association (AHA) believes that we must bridge the disparity gap and ensure access to quality health care for all who live in the United States.

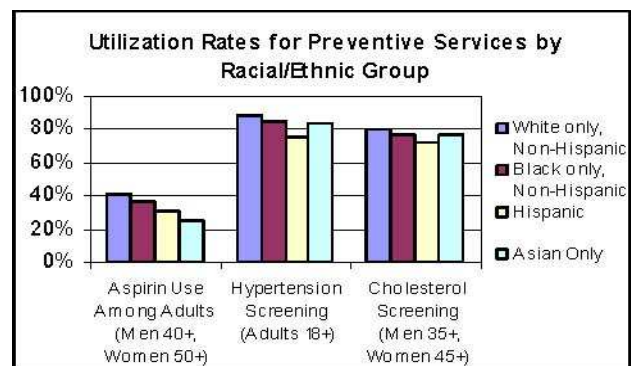
GREATER RISKS, GREATER DEATHS

Many racial/ethnic minority populations have higher rates of CVD and related risk factors:

- CVD age-adjusted death rates are nearly 34% higher for blacks than for the overall U.S. population. Blacks are nearly twice as likely to have a first stroke and much more likely to die from one than whites.¹
- Heart failure before age 40 is 20 times more common among blacks than among whites.⁶
- American Indians/Alaska Natives die from heart disease much earlier than expected – 36% are under 65 compared with only 17% for the U.S. population overall.⁷
- High blood pressure is more prevalent in certain racial/ethnic minority groups in the U.S., especially in blacks¹, for whom the prevalence is among the highest in the world and is increasing.
- Non-Hispanic blacks and Mexican Americans

have a higher prevalence of diabetes than non-Hispanic whites for adults over age 20.¹

- Non-Hispanic blacks and Mexican American women have a higher rate of obesity—a risk factor for CVD and diabetes¹—than the overall population.



Source: Partnership for Prevention. *Preventive Care: A National Profile on Use, Disparities, and Health Benefits*, 2007.

LOWER ACCESS, LOWER QUALITY

Racial/ethnic minority groups are less likely to be insured and have more limited access to quality health care.⁸

- A 2007 U.S. Census report showed that more than half of the uninsured are people of color.⁹
- A recent survey found that Hispanics and blacks are less likely than whites to have access to a regular source of medical care, but having health insurance and a medical home can reduce or eliminate disparities in access and quality.¹⁰
- A recent report on cardiac care quality of racial/ethnic minority groups found evidence of disparities in 84% of the studies examined.¹¹
- Evidence suggests black adults are far more likely than white adults to be admitted to the hospital for angina and congestive heart failure.¹²
- A study on cardiovascular procedures found blacks were more likely than whites to be admitted to an emergency room and had higher post-operative mortality rates.¹³
- Blacks hospitalized with a heart attack are less

likely to receive revascularization compared to white and Hispanic patients, even after adjusting for insurance status and comorbidities.¹⁴

- The *National Healthcare Disparities Report, 2007* found that the proportion of Medicare patients with heart failure who received the recommended hospital care was lower for American Indians/Alaska Natives and Hispanics, compared to whites.¹⁵
- Disparities are also linked to minority patients receiving care in lower-performing hospitals.¹⁶

HEALTH CARE WORKFORCE

There are fewer minority physicians and limited awareness among cardiovascular practitioners about health care disparities.

- Minorities are greatly underrepresented in the U.S. physician workforce. In 2001, only 2% of cardiologists were black, 3.8% were Hispanic, and 12.7% were Asian.¹⁷
- In 2004, almost two-thirds of U.S. medical school graduates were white. Only 6.3% were black, 6.2% were Hispanic/Latino, and less than 1% were Native American.¹⁸
- Many minority patients have difficulty communicating with their health care providers.⁵
- Just 35% of cardiologists recently surveyed agreed that disparities in overall care exist in the U.S., and only 5% believed disparities exist in the care of their own patients.¹⁹
- A recent review of racial/ethnic differences in cardiac care showed that 91% of high quality studies included data on blacks, but only 26% on Hispanics, 14% on Asians, and a mere 5% on Native Americans.¹¹

Health Equity and the Affordable Care Act

The Affordable Care Act helps to address health disparities in a number of ways, including:

- Making affordable health insurance available to those who are currently uninsured;
- Making preventive screening and services available for free in Medicare and new private health plans;
- Expanding programs to increase racial and ethnic diversity among health care professionals;
- Significantly increasing funding for community health clinics, which currently serve an estimated one in four low-income minority residents;
- Requiring the reporting of federal health care data by sex, race, ethnicity, and primary language; and
- Permanently reauthorizing the Indian Health Care Improvement Act.

MORE AND BETTER DATA NEEDED

The Affordable Care Act includes provisions that would require the development of more data on health disparities. Understanding where and why health disparities exist is the first step to addressing them. Although the new HHS Data Collection Standards are a step in the right direction, no standardized requirement exists in the health care industry for collecting, categorizing, or using race/ethnicity data.⁹ The proportion of people in the US who are members of at least two ethnic groups will increase 10% by the year 2050, complicating assessments of health disparities.²⁰

THE AHA ADVOCATES

The AHA and its American Stroke Association division support:

- Meaningful, affordable high-quality health coverage for all U.S. residents that is culturally and language-appropriate;
- The Health Equity and Accountability Act (H.R. 2954), comprehensive legislation designed to help eradicate health disparities.
- Funding at the national and state levels for WISEWOMAN or similar programs, which provide free screening and lifestyle intervention services to low-income, uninsured or underinsured women;
- Improved reporting of health care data, including new drug and medical device safety and efficacy data, by sex, race, and ethnicity;

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