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). Unfortunately, it is a factor that affects the likelihood of an individual suffering a heart attack or stroke, as well as the chances of survival if he or she does. CVD remains the No. 1 killer of Americans and exacts a disproportionate toll on many racial and ethnic groups accounting for about one-third of the disparity in potential life-years lost between blacks and whites.

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. 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. 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.
- Heart failure before age 40 is 20 times more common among blacks than among whites.
- American Indians/Alaska Natives have nearly 20% higher CVD mortality rates than whites.
- High blood pressure is more prevalent in certain racial/ethnic minority groups in the U.S., especially in blacks, 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 whites for adults over age 20.
- Blacks and Mexican American women have a higher rate of obesity—a risk factor for CVD and diabetes—than the overall population.

LOWER ACCESS, LOWER QUALITY
Racial/ethnic minority groups are less likely to be insured and have more limited access to quality health care.
- A 2007 U.S. Census report showed that more than half of the uninsured are people of color.
- A 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.
- Another report on cardiac care quality of racial/ethnic minority groups found evidence of disparities in 84% of the studies examined.
- 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.
- Among heart attack patients, while the percentage of heart attack patients receiving timely percutaneous coronary intervention (PCI) improved for all racial/ethnic groups from 2005 to 2010, Blacks and Hispanics were still less likely than Whites to receive timely PCI.
- Disparities are also linked to minority patients receiving care in lower-performing hospitals.
HEALTH CARE Workforce

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

- Only 13% of physicians identify as an ethnic minority.1
- In 2011, almost two-thirds (62%) of U.S. medical school graduates were white. Only 6.5% were black, 7.7% were Hispanic/Latino, and less than 1% were Native American.2
- Many minority patients have difficulty communicating with their health care providers.3
- Just 35% of cardiologists 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.
- Recent research has shown that ethnic minorities constitute less than 15% of participants in clinical trials on atrial fibrillations and acute coronary syndrome, and less than 30% on trials studying heart failure.4

More and Better Data Needed

The Affordable Care Act includes provisions that require the development of further 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.5 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.6

THE ASSOCIATION ADVOCATES

- Meaningful, affordable high-quality health coverage for all U.S. residents that is culturally and language-appropriate, including through the expansion of Medicaid to cover low-income individuals;
- 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;
- Working with the FDA to develop an Action Plan to address the findings of a recent FDA report documenting continuing gaps in the participation of racial/ethnic minorities in clinical trials, the analysis of data for racial/ethnic differences, and the availability of subgroup-specific data to clinicians, researchers, and patients.
- Improved reporting of health care data, by sex, race, ethnicity, and primary language.

References:

8 The Kaiser Family Foundation and the American College of Cardiology Foundation. Racial/Ethnic Differences in Cardiac Care: The Weight of the Evidence. (Report #6040) Available at: www.kff.org