

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 nearly 40% of the disparity in life expectancy between blacks and whites.^{1,2,3,4}

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.⁵ 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.⁶ The American Heart Association/American Stroke Association (AHA/ASA) 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

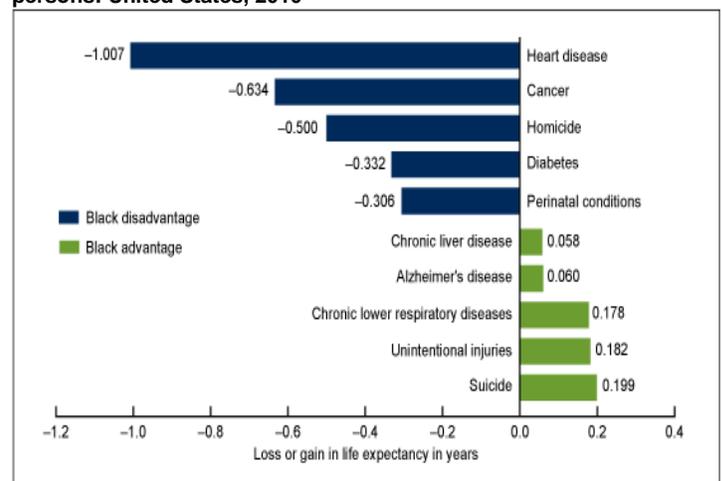
Many racial/ethnic minority populations have higher rates of CVD and related risk factors:

- Certain ethnic and racial minorities continue to have the highest burden of coronary heart disease and stroke mortality in the US, despite a decline in the overall population.^{1,3}
- Even though rates of stroke incidence have declined for whites, blacks are still nearly twice as likely to have a first stroke and have higher prevalence for risk factors.^{1,3,7}
- Hospitalization rates for heart failure are significantly higher in black communities than among whites.⁸
- Survival to 30 days after discharge is more than

twice as poor for blacks as for whites, and survival among Hispanics is also lower than among whites.⁹

- American Indians/Alaska Natives have nearly 20% higher CVD mortality rates than whites.¹⁰
- High blood pressure and other risk factors are more prevalent in certain racial/ethnic minority groups in the U.S., especially among blacks.^{1,11}
- Blacks and Hispanics have a higher prevalence of diabetes than whites for adults over age 20.¹²
- Blacks and Hispanics have drastically higher obesity rates than whites.¹³

Contribution of the leading causes of death to the difference in life expectancy between black and white persons: United States, 2010



SOURCE: CDC/NCHS, National Vital Statistics System, Mortality.

LOWER ACCESS, LOWER QUALITY

Racial/ethnic minority groups are less likely to be insured and have more limited access to quality health care.¹⁴

- A 2013 U.S. Census report showed that more than half of the uninsured are people of color.¹⁵
- Non-English speakers are less likely to seek

medical care, even if insured, and are more likely to report negative health care experiences.¹⁵

- A report on cardiac care quality of racial/ethnic minority groups found evidence of disparities in 84% of the studies examined.¹⁶
- Blacks and Hispanics are more likely than whites to have no access to some preventive screening services.¹⁷
- Blacks and Native Americans are over 40% less likely to receive IV thrombolysis for stroke.¹⁸
- Racial/ethnic minorities are more than 50% less likely to take statin medications used to treat high cholesterol, compared to whites.¹⁹
- Blacks are far more likely than whites to have a heart attack, and have higher mortality and readmission rates at 1-year follow-up.²⁰
- 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.²¹
- Minorities with coronary heart disease are less likely to receive referrals for cardiac rehabilitation.²²
- Minorities are more likely to receive care in lower-performing hospitals.²³

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.²⁴
- In the past three decades, there has been little growth among black medical school graduates. Minority-serving institutions continue to be the largest producers of black and Latino physicians.²⁴
- Just 33% of primary care providers believe that disparities in overall care exist.²⁵

MORE AND BETTER DATA NEEDED

Understanding where and why health disparities exist is the first step to addressing them. Increasing diversity in clinical trials and analyzing research results by subgroup is needed to further our understanding of how minorities are impacted by CVD. Greater consistency and reporting of health care data by race/ethnic subgroup is also needed. 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.²⁶ 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.²⁷

- According to a recent FDA report, minorities were underrepresented in major cardiovascular clinical trials published between 1997 and 2010 – only half of the trials reported racial data.²⁸

- The vast majority of ethnic minorities believe that racial diversity in clinical trials is imperative to improving the quality of healthcare research.²⁹

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.
- Addressing barriers to minority participation in cardiac rehabilitation.
- 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.
- Implementation of the FDA's Action Plan to improve 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.

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³ Centers for Disease Control and Prevention. Deaths: Final data for 2013. *National Vital Statistics Reports* Vol. 64, Number 2.

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⁶ Agency for Healthcare Research and Quality. National Healthcare Disparities Report 2013. AHRQ Publication No. 13-0003. Rockville, MD 2014.

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⁸ Chang, PP, et al. Incidence and survival of hospitalized acute decompensated heart failure in four US communities (from the Atherosclerosis Risk in Communities Study). *The American journal of cardiology*. 2014; 113: 504-510.

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¹¹ Hicken MT, et al. Racial/ethnic disparities in hypertension prevalence: reconsidering the role of chronic stress. *Am J Public Health*. 2014;104(1):117-123.

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²¹ Cram, P, et al. Racial Disparities in Revascularization Rates Among Patients with Similar Insurance Coverage. *J Nat'l Med Assoc*. 2009; 101: 1132-1139.

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