CARDIOVASCULAR DISEASE OUTCOMES: PRIORITIES TODAY, PRIORITIES TOMORROW FOR RESEARCH AND COMMUNITY HEALTH

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Key Words: Cardiovascular Disease, Stroke, Health Disparities, Cultural Competency, Prevention

The disparities and differences in heart disease and stroke among Black, White and Hispanic populations tell a compelling and continuing story that should drive research agendas to improve health outcomes. With Black men and women having the highest prevalence of hypertension, Black females having higher rates of coronary heart disease, stroke and breast cancer than White females, and Blacks, at all ages, having a greater risk for stroke mortality than Whites, researchers and health care providers must understand the clinical appropriateness of treatment for different states of disease among distinct populations. Further, to eliminate health disparities, the health care systems and legal regulatory climate must facilitate access to care while biases, prejudices and stereotyping by health care providers and all those in the health care system must be eliminated. Importantly, research continues to illustrate that many are dying prematurely or have advanced stages of disease because of disparate care.

This article explores four strategies to address inequitable care and to work toward eliminating poorer health outcomes among minorities. First, those who deliver health care must adopt a quality-focused approach that improves the care of all patients while facilitating the reduction and elimination of health disparities. Second, cultural awareness and cultural competency must be improved. Third, we must remove barriers to access and promote public policies that lead to greater health awareness and healthier environments. Lastly, but most importantly, we need a prevention focus as the reduction in the onset of disease is the first step towards improving health outcomes. (Ethn Dis. 2012; 22[Suppl 1]:S1-7–S1-12)

“Of all forms of inequality, injustice in health care is the most shocking and inhumane.”
—Dr. Martin Luther King, Jr., 1966

INTRODUCTION

As pertinent today as they were in 1966, the words of Dr. Martin Luther King, Jr. set a framework from which our research agenda should be built to include equality in health access, delivery and patient outcomes as central elements of any forward moving strategy. From this framework, priorities can be established to focus on approaches and programming that will work toward improved cardiovascular disease outcomes.

As a primary step, researchers and health professionals should recognize the changing demographic of the United States. Today, one in three of all Americans are minorities; by 2020, four in 10 Americans will be minorities; and, by 2050, projections indicate that there will no longer be a majority ethnicity or race in this country, with Whites comprising only 46% of the population. Since we expect a number of pluralities to be the norm in 2050, it becomes even more important to be sensitive to the needs for all Americans, if we expect to succeed in our roles as health care providers.

HEART DISEASE AND STROKE STATISTICS – 2010 UPDATE

The most recent evidence tells a compelling story about the disparities and differences in heart disease and stroke among Black, White and Hispanic populations. According to the latest data from the CDC and the National Center for Health Statistics, Black females outpaced White females for rates of coronary heart disease, stroke and breast cancer.2 (Figure 1). Likewise, Blacks, at all ages, have a greater risk for stroke mortality when compared with Whites and other ethnic groups3 (Figure 2). And, just as dramatically, non-Hispanic African American men and women have the highest prevalence for hypertension and have had such for several decades (Figure 3).4

In its 2003 report, the Institute of Medicine defined health disparities as racial or ethnic differences in health care that are not due to access-related factors, clinical needs, patient preferences or the appropriateness of the intervention.5 The authors further allowed for equal access to care and based on metrics that identified quality of care noted residual differences in health that remained as a function of race and ethnicity. Some of these differences are readily explained by disease severity and patient preference but what persists reflects a non-physiological contribution to different health outcomes. That residual difference is evidence of disparate care and is attributable to a number of provider-, system- and patient-level factors. To better understand disparities in health care we should begin investigating causative issues within the ecology of care.