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Socioeconomic barriers for women start early and impact health often

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Socioeconomic barriers unique to women, including inadequate access to contraception, postpartum follow-up and maternity leave set women's cardiovascular health back early in life and can result in heart attack, stroke and cardiovascular death in at-risk populations later in life, according to a review paper from the American College of Cardiology Cardiovascular Disease in Women Committee and Health Equity Taskforce published in the *Journal of the American College of Cardiology*. These barriers disproportionately impact women of minority racial or ethnic backgrounds and can be mitigated through changes in policy, support at the community level and diversification within the cardiology workforce.

Members of the committee and task force sought to highlight which socioeconomic factors contribute to the disparities in cardiovascular outcomes in women, including racism and discrimination; income; Medicaid coverage limitations before, during and after pregnancy; rurality; education; ZIP code; social support; language/cultural barriers; and sexual orientation. Cardiovascular disease is estimated to be 80% preventable through lifestyle modifications; however, socioeconomic barriers often prevent such lifestyle changes and continue to contribute to gaps in care.

"These contributing factors are often overlapping, and importantly, are modifiable with actionable solutions," said Kathryn Lindley, MD, FACC, lead author of the paper and chair of the ACC Cardiovascular Disease in Women Committee. "Resolving health care outcomes disparities in women will require both investment in sex-specific science as well as health policy advocacy and incorporating awareness of the impact of these barriers into our health care delivery."

According to the paper, women are disproportionately impacted by stroke, heart failure with preserved ejection fraction and myocardial infarction, while minority women disproportionately bear the burden of cardiovascular disease risk factors. Black and Native American women experience higher rates of total cardiovascular disease, coronary disease and stroke deaths when compared to white women. Black women also are 3.4 times more likely to die from pregnancy complications than white women, Native American/Alaskan Native women have a 69% rate of obesity and only 29.3% of Hispanic/Latina women meet ideal cardiovascular health targets.

"These differences are likely related to a myriad of socioeconomic disparities that create sex- and gender-specific barriers to optimal care," Lindley said.

According to the authors, solutions can start at the individual clinician and researcher level by addressing social determinants of health within their sphere of influence. Women are less likely than men to receive advanced diagnostics and treatments or to be involved in clinical trials, which is multiplied for marginalized groups. However, the authors said, many broader solutions will require change from health policymakers, medical societies and health care institutions.

The authors recommend physician bias training and diversification of the workforce to include more women and minority cardiovascular team members. According to the paper, interventions to reduce bias that disproportionally impact women should be implemented. The ACC led the way in diversifying the cardiovascular workforce when it established the ACC Diversity and Inclusion Initiative in 2018.

The authors also recommend other solutions needed to mitigate disparities, including coordinating efforts to address racism and discrimination to achieve health equity, expanding health care coverage,

implementing digital and mobile health tools to expand patient engagement in health care, providing interpreters for foreign-language patients, subsidizing medical transportation, and reducing costs and increasing access to contraception.

Provided by American College of Cardiology

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