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EDITORIAL COMMENT

If It Is Not Health Care Access or Insurance Coverage, Then Why Do Racial Disparities Persist?*

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"The glory of medicine is that it is constantly moving forward, that there is always more to learn. The ills of today do not cloud the horizon of tomorrow, but act as a spur to greater effort."
– William James Mayo, National Education Association: Proceedings and Addresses (1928) (1)

There are several indisputable facts. First, heart failure (HF) prevalence continues to increase, and the predictions for 2030 are concerning, with an estimated 8 million individuals in the United States carrying the diagnosis—representing a 23% increase from 2012. Two million of those individuals will be older than 80 years of age (2). Given the rate of increase in prevalence, in 2013 Heidenreich et al. (2) expressed concern that disparities in access to health care could perpetuate the burden of HF for African Americans (AAs). That burden includes a younger age of presentation, a higher number of admissions and readmissions for HF, a greater number of comorbidities, and a higher New York Heart Association functional class on presentation. Second, it is also certain that there are insufficient numbers of HF specialists to care for all the patients with HF and perhaps even not enough cardiologists to do so. However, in a sea of limited resources of cardiology providers, should there be racial disparities of care? Certainly, the answer is a firm "No!"

Publications are replete with studies of the benefits to patients admitted to the hospital with HF when care was given by a cardiology specialist compared with care given by other provider groups (e.g., general internal medicine) (3). These observations have been made regardless of race or ethnicity. The better outcomes reported with cardiology care have been derived from both databases and institutions that deliver care to underserved minorities (4). In 2000, Auerbach et al. (5) reviewed 1,298 patients who were hospitalized with acutely decompensated HF across 5 different areas of the United States. Review of factors associated with having a cardiologist attending noted that those patients who had a lower income and were AA were significantly less likely to receive cardiology care when compared with younger, Caucasian, and more educated patients. Even after adjusting for severity of illness, social factors were strongly associated with receiving care from a cardiologist. These investigators believed that by identifying issues that affected the process of care, barriers could be optimally addressed to improve quality and outcomes, thereby reducing inequalities. Among the barriers assumed were lack of access and lack of insurance coverage, which are common situations for underserved minorities. These reports hypothesized that the major reasons for disparities of care were related to a lack of insurability and a lack of access, all of which begged for a health system change in policy for insurance.

The implementation of the Affordable Care Act (ACA) became a reality in 2014 and has been reported to reduce the probabilities of both noninsurance and lack of access to care. In fact, the uninsured rates have improved more among AAs than among other groups such as Hispanics (6). If these published observations were true for AAs, should not an HF diagnosis be part of the success?

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Fast forward to this issue of *JACC: Heart Failure,* where Breathett et al. (7) offer us the perspective from a large database that both confirms and strengthens previous smaller studies regarding better outcomes with cardiology care, but it also raises new questions about disparities of care. The strengths of this paper are several. First, it includes the sickest of the patients with HF (i.e., those admitted to the intensive care unit [ICU]). Second, the years 2010 to 2014 include the presence of the ACA from January 2014 and allow comparisons with the years before the ACA.

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Third, it involves more than 700 hospitals and includes more than 100,000 patients with more than 20,000 AA, thus allowing sound comparisons. Fourth, insurance was also captured, and given the age of the population (i.e., 71 years), 79% of the Caucasians had Medicare compared with 61% of the AAs. Of interest, 13.8% of AAs had private insurance compared with 10.9% of Caucasians. Medicaid was more common in the AAs at 15.5% compared with 5.4% in the Caucasians. Fifth, admission by a cardiologist to the ICU was associated with better survival for all patients irrespective of race, a finding that argues against the belief that the poor outcomes of AAs with HF are inevitable. In addition, the report by Breathett et al. (7) confirms that the AA patients had more comorbidities, including hypertension, diabetes, and end-stage renal disease.

There are limitations to this report, however, which Breathett et al. (7) have detailed, such as the inability truly to capture the HF phenotype, thereby making controlling for HF type difficult if not impossible, or to infer whether an ICU is a closed or open unit, which may affect the kind of clinician allowed to participate in ICU care. There are likely other confounders that are difficult to measure, such as the culture of care at any specific institution or with patients themselves.

Importantly, however, at the end, Caucasians were 40% more likely to receive cardiology care than AAs, and although that percentage improved over time, the implementation of the ACA only slightly reduced the odds. In this dataset, given a significant percentage of AA patients either with private insurance or Medicare, can we continue to blame the disparity in care to lack of access or insurability? Is it not time to consider preconceived notions of access and inherent, although unrecognized, racial bias and stereotyping that lead to racial health disparities?

The paper by Breathett et al. (7) forces us to look back over 15 years to the Institute of Medicine report: *Unequal Treatment: What Healthcare Providers Need to Know About Racial and Ethnic Disparities in Healthcare,* which examined openly and honestly the potential sources of racial and ethnic disparities in 3 parts assuming equal access to care (8). The first is related to patients' preferences and appropriateness of the clinical system. However, these are believed to play a very small role in explaining disparities of care. The second is related to the health care system itself, with its inherent operational climate and fragmentation of care, with lower-cost care associated with minorities. The third includes the clinical encounter, where the provider may have attitudes toward the minority that include bias (recognized or not), clinical uncertainty, and beliefs about the behavior of minorities. It is uncertain how these provider-residing attitudes ultimately affect the patient's response. Professional societies have also recognized and discussed health equity, the American College of Cardiology with its CREDO (Coalition to Reduce Racial and Ethnic Disparities in Cardiovascular Disease Outcomes) initiative and the American Heart Association with its policies on health equities (9,10). The Institute of Medicine and the professional societies suggest a series of interventions to increase equity, including performance measurement of quality, team care, and education both for providers and patients. Some of these interventions can be summarized as follows: raising public and provider awareness of racial or ethnic disparities in care; expanding health insurance coverage; improving the capacity and number of providers in underserved communities; and increasing the knowledge base on causes and interventions to reduce disparities.

In conclusion, the team approach using guideline-driven quality care is imperative in the ICU setting, where the patients have a high level of illness. Breathett et al. (7) demonstrated that patients with HF benefited from cardiology care applying guideline-directed medical and device therapy, and there was a modest impact on access to care. More data are needed to reduce disparities in care optimally. One can ask, 15 years after the Institute of Medicine report, have we moved the needle much?

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