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THE PRESENT AND FUTURE

STATE-OF-THE-ART REVIEW

# Quality and Equitable Health Care Gaps for Women

## Attributions to Sex Differences in Cardiovascular Medicine

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**ABSTRACT**

The present review synthesizes evidence and discusses issues related to health care quality and equity for women, including minority population subgroups. The principle of "sameness" or women and men receiving equitable, high-quality care is a near-term target, but optimal population health cannot be achieved without consideration of the unique, gendered structural determinants of health and the development of unique care pathways optimized for women. The aim of this review is to promote enhanced awareness, develop critical thinking in sex and gender science, and identify strategic pathways to improve the cardiovascular health of women. Delineation of the components of high-quality health care, including a women-specific research agenda, remains a vital part of strategic planning to improve the lives of women at risk for or living with cardiovascular disease. (J Am Coll Cardiol 2017;70:373–88)


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**ABBREVIATIONS AND ACRONYMS**

**ACA** = Affordable Care Act

**CV** = cardiovascular

**CVD** = cardiovascular disease

**MI** = myocardial infarction

**NIH** = National Institutes of Health

**OR** = odds ratio

**PCI** = percutaneous coronary intervention

**WHO** = World Health Organization

Over the last century, women have struggled to end inequality and fulfill progressive opportunities in all aspects of their lives. Following decades of hard-fought struggles, women have secured civil rights under landmark voting and job discrimination legislation. Yet, struggles to achieve high-quality and equitable cardiovascular (CV) health care persist today for many women, and evidence abounds that the quality of care received by women of diverse race and ethnicity is pervasively suboptimal, affecting as many as 60 million adult U.S. women. In this review, we synthesize evidence and discuss issues related to CV health care quality and equity of care gaps between women and men, including racial and ethnic minority populations. Although many women receive equitable care, data support a consistent pattern of suboptimal CV care for women at a population level, which is the focus of this review. Overall, case fatality rates for cardiovascular disease (CVD) among Americans have been reduced, but worsening trends are emerging for midlife women, especially among socially disadvantaged subgroups (1). Much of these quality and equitable health care gaps have been observed for decades, and currently, these findings of inequality in health care for women portend a juncture of dangerous indifference, or even upheaval. The overall aim of our review is to promote enhanced awareness regarding differences in the quality of care received by women, focus discussions on the development of critical thinking and identification of gaps in sex and gender science, and help to identify strategic pathways to improve CV health for women.

On behalf of members of the CVD in Women Committee of the American College of Cardiology, we highlight the critical needs for sex- and gender-specific strategies to reduce the continuing accumulation of preventable CV morbidity and mortality that affect the lives of so many women. In this review, we propose transformative policies and visionary changes to improve the lives of women. The financial instability in our health care system can easily result in underuse or deferral of appropriate care for many vulnerable patient subgroups, including women with and without limited financial means. It is precisely when our health care system is in a state of restructuring and championing personalized and precision medicine that opportunities exist for a call to action toward patient-centered effective care of women at risk for or living with CVD (2). It is now that we must ensure that policies allocate sufficient resources, and create universal affordability and access to needed CV health care services (3). As we will discuss, the high rates of morbid and fatal CVD outcomes for women may be preventable when equitable care is finally achieved. The present review will highlight socioeconomic factors that affect care of women, synthesize available evidence on inequities of care disadvantaging women, and propose future strategies to create an equitable health care system. Moreover, our focus centers on the U.S. health care system and the current disadvantages faced by women with regard to receipt of high-quality CV care.

## SOCIOECONOMIC DISADVANTAGE INFLUENCING CARE OF WOMEN

**SOCIAL AND CULTURAL DETERMINANTS OF HEALTH AND DISEASE.** Clinical risk prediction models based on an ever-expanding list of risk factors and comorbid conditions have varying abilities to stratify low- to high-risk female and male populations (4). However, these risk prediction models uniformly underestimate risk among women. Residual risk unaccounted for by clinical variables (e.g., discrimination statistic of ~0.7) (5) include unique nonclinical factors, such as cultural, economic, and environmental factors that influence health care outcomes (**Table 1**) (6,7). A recent World Health Organization (WHO) Report from the Women and Gender Equity Knowledge Network of the Commission on Social Determinants of Health applies the term "gendered structural determinants of health," in which social stratification of women and their allocation to receiving less education, lower paying jobs, having higher rates of poverty, and more familial responsibilities, coupled with societal discriminatory norms and practices consequentially influences health outcomes of women (3). Similarly, "Healthy People 2020" describes social determinants of health as including: 1) safe housing and local food markets; 2) access to educational, economic, and job opportunities; 3) access to community resources and health care services; 4) social support; 5) language and literacy; and 6) varied cultural perspectives toward health care (8). Differential social stratification of women places them uniquely at risk and creates vulnerabilities to worsening outcomes, including varied access and health care–seeking behaviors, as well as the health consequences of diminished financial means (3). Worsening outcomes for women are linked to social issues like workplace equity, whereby reduced incomes and minimal insurance coverage affect care-seeking behaviors and compliance with prescribed treatments.

Although many of these determinants reside outside the health care system, they have direct