Disparities in stroke care prevail among US racial/ethnic groups

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Disparities between racial/ethnic minorities and whites cross all aspects of stroke care, according to an American Heart Association/American Stroke Association scientific statement.

The statement, published online in Stroke*: Journal of the American Heart Association*, is a comprehensive analysis of the role of race and ethnicity in stroke care and its impact on the numbers of people who have a stroke, live with its effects or die among minority groups compared to whites. It also addresses how access to care, response to treatment and participation in clinical research affects these groups.

"We see disparities in every aspect of stroke care, from lack of awareness of stroke risk factors and symptoms to delayed arrival to the emergency room and increased waiting time," said Salvador Cruz-Flores, M.D., M.P.H., lead author of the statement and professor of neurology and director of the Souers Stroke Institute at St. Louis University in Missouri. "These disparities continue throughout the spectrum of the delivery of care from acute treatment to rehabilitation."

Experts in different areas of stroke care analyzed the issue of racial and ethnic disparities in current scientific literature. Hispanic-Americans, African-Americans, Asian-Americans and Native-Americans constitute 28 percent of the U.S. population.

Because that is expected to almost double by the year 2050, "there is an increasing need to reduce racial and ethnic disparities in health care," the

authors said.

The review also included Alaskan Natives, and Native Hawaiians/other Pacific Islanders.

The burden of risk factors is different among racial and ethnic groups according to the statement. For example, African-Americans have a high prevalence of hypertension, diabetes and obesity as well as other risk factors for stroke, while Hispanic-Americans have a high prevalence of metabolic syndrome and diabetes compared to whites and African-Americans. The metabolic syndrome is a cluster of risk factors that include three or more of the following: elevated waist circumference, elevated triglycerides, reduced good cholesterol, elevated blood pressure and elevated fasting glucose.

Other factors that impact these disparities range from economic and social issues to cultural and language barriers. In addition, attitudes, beliefs and compliance among populations differ and the perceived or true presence of racial bias within the healthcare system can negatively impact a patient's compliance with a healthcare provider's advice, medications or treatment, according to the statement.

"It is important for members of ethnic and racial minority groups to understand they are particularly predisposed to have risk factors for heart disease and stroke," Cruz-Flores said. "They need to understand these diseases are preventable and treatable."

Educating the public and healthcare community can improve stroke care for minorities, he said.

Some of the statement recommendations include:

- Development of public health policies to close the gap between minorities and whites in all aspects of stroke prevention, incidence and care;
- More education and research to reduce disparities in stroke care;
- Increased access to insurance coverage in minority populations; and
- More research on American Indians, Asian Americans and Pacific Islanders.

"It is striking that we are in the 2lst century, with many advances in stroke care, yet we are still struggling to fix the differences that are present not only in the distribution of the disease but also in the level of care we provide to the different racial and ethnic groups," Cruz-Flores said.

Provided by American Heart Association