

Announcing *The Lancet Regional Health-Europe* commission on inequalities and disparities in cardiovascular health



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The continued and widening disparities in cardiovascular health, despite overall declines in cardiovascular mortality, highlight the inequities in the distribution of advancements in cardiovascular care. These inequities disproportionately affect certain groups within the population, underscoring the need for targeted efforts to ensure equitable healthcare access and outcomes for all individuals.¹ Subgroups within the population experiencing relative increases in age-adjusted mortality rates due to heart disease from 2019 to 2022 include the elderly aged 65–74 years (7.6%), those aged ≥85 years (9.2%), women (9.8%), Black adults (10.6%), American Indian or Alaska native (9.6%) and Asian or Pacific islander (12.2%).¹ Moreover, individuals with severe mental illnesses such as depression and psychosis have an approximately 35%² higher risk of experiencing a major cardiovascular event, and face up to five times higher risks of cardiovascular mortality and sudden cardiac death.³ Addressing cardiovascular disease disparities in these subgroups of populations—women, ethnic minorities, elderly and those with mental health conditions—is one of the most important challenges in global public health.

To address inequalities and disparities in cardiovascular health among disadvantaged populations, *The Lancet Regional Health–Europe* has launched a pivotal Commission dedicated to addressing these issues. This Commission is tasked with carrying out an exhaustive assessment of available data on the incidence and outcomes of cardiovascular disease, both at a global and regional level. It will offer a detailed overview of existing

gaps in data and pinpoint the most achievable objectives for enhancing health outcomes. Addressing the persistent disparities in cardiovascular health, this endeavour aims to serve as a catalyst for change. It seeks to usher in a new era of equity in cardiovascular health care and research, ensuring that progress benefits all sectors of society, especially those who have been historically underserved. By focusing on comprehensive assessments and targeted interventions, the initiative is dedicated to bridging gaps in treatment and outcomes, making strides toward equal health opportunities for every individual.

The decision to focus on women stems from recognizing that cardiovascular diseases often present differently in women compared to men, impacting diagnosis, treatment, and outcomes.⁴ While women are generally perceived to have a lower risk of coronary heart disease mortality due to a lower disease prevalence, data from the past two decades reveal higher mortality rates among women, particularly following myocardial infarction.⁵ Emphasizing women's cardiovascular health is crucial for addressing historical gaps in research and healthcare practices that have overlooked these differences. Identifying the precise causes of outcome disparities between women and men is challenging due to women's underrepresentation in cardiovascular research and clinical trials.⁶ This underrepresentation has resulted in significant sex-based disparities in the treatment of atherosclerotic cardiovascular disease, with research revealing distinct pathophysiological and risk factor profiles for men and women.⁶ The commission will analyse how sex and gender differences influence cardiovascular disease risk factors, comorbidities, symptom presentation, diagnostic methods, treatment approaches, and outcomes.

The inclusion of neglected ethnic and racial groups emphasizes the heightened burden of cardiovascular

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disease they endure.^{7,8} In the United States, Black individuals face a disproportionately higher burden of cardiovascular disease risk factors such as hypertension and obesity and are more than twice as likely to die of cardiovascular disease, relative to White adults; American Indians are also at an elevated risk of coronary heart disease.⁹ In Europe, persistent disparities are evident. For instance, Surinamese and Antillean populations in the Netherlands and South Asian individuals in the UK experience higher coronary heart disease mortality rates compared to their White counterparts.^{7,8,10} These disparities underscore the critical need for culturally sensitive interventions and the dismantling of systemic barriers to healthcare that perpetuate these inequalities.⁵ Addressing cardiovascular health disparities necessitates a deep understanding of several foundational concepts, including the definitions of ethnicity, race, and indigeneity, and their intersection with social disadvantages, education, and gender. The Commission will provide an overview of inequalities in cardiovascular health screening, diagnosis, and treatment, with a focus on diverse populations distinguished by ethnicity and race. By exploring the intersections of racial or ethnic identity, gender, and social disadvantages, the Commission aims to identify and propose innovative solutions to narrow the health equity gap.

Focusing on the elderly addresses the increasing prevalence of cardiovascular disease in aging populations and their specific needs for specialized care.¹¹ Aging significantly increases cardiovascular disease risk, with a notable portion of acute coronary syndrome hospitalizations and deaths occurring in those over 65.¹¹ Age-related changes in cardiovascular physiology and increased comorbidity rates affect disease presentation and treatment responses. As the population ages, the

demand on healthcare services and the need for enhanced support and tailored treatment approaches increases. Prioritizing the cardiovascular health of the elderly is crucial to enhance their quality of life as called for by the UN's Decade of Healthy Ageing.¹² The commission will explore the escalating cardiovascular disease burden among older adults, with a focus on prevention, treatment, and strategies to uphold their physical and mental well-being.

In light of the intricate link between mental well-being and cardiovascular health, this Commission will also focus on individuals with mental health conditions or those exposed to psychological stress.¹³ Mental health conditions such as depression and anxiety can increase cardiovascular disease risk by influencing behavior, stress responses, and health practices.¹³ Conversely, experiencing cardiovascular disease is a stress-inducing event, exacerbating pre-existing mental health conditions and/or leading to new conditions such as anxiety disorders, depression. Recognizing stress as a shared risk factor for mental health and cardiovascular issues advocates for integrating stress management into preventive healthcare. The aim of the Commission encompasses summarizing current research to pinpoint gaps in understanding cardiovascular health among those with mental health conditions developing strategies to enhance their cardiovascular outcomes, raising awareness about the unique obstacles they face, and delineating future research priorities.

The establishment of a Commission on Inequalities and Disparities in Cardiovascular Health by The Lancet Regional Health–Europe is crucial for several compelling reasons. Firstly, the Commission would provide a vital platform for understanding the root causes of cardiovascular health disparities and identifying the

Challenges and Disparities in Cardiovascular Health

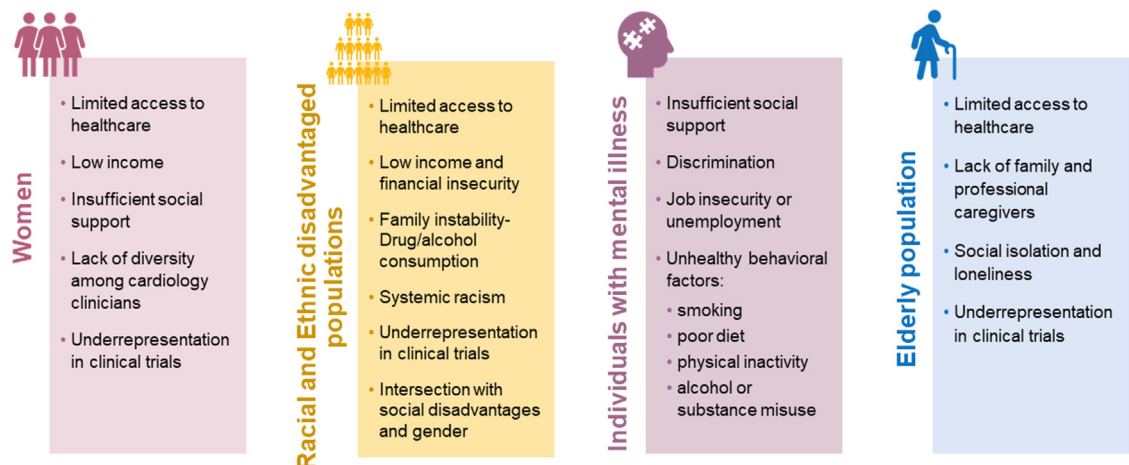


Fig. 1: Key challenges to guide the work of The Lancet Regional Health–Europe commission on inequalities and disparities in cardiovascular health.

specific needs and barriers faced by various groups, including women, the elderly, specific ethnic/racial groups, and individuals with stress or mental illness. Secondly, it would play a pivotal role in informing policy development aimed at reducing health inequalities. By pinpointing high-impact areas for intervention, policies can be tailored to ensure that funding and resources are directed towards those most in need and where they can have the greatest impact. Thirdly, the commission can serve as a catalyst for collaborative efforts to address cardiovascular health disparities through advocacy and awareness raising. This collaborative approach ensures that policy recommendations are rooted in scientific evidence while also incorporating practical aspects and the lived experiences of those most impacted by health disparities.

By tackling the key challenges (Fig. 1) associated with cardiovascular health disparities stemming from sex and gender differences, mental health status, aging, ethnicity, and race, this commission will advance the overarching objective of attaining the three UN Sustainable Development Goals on good health and well-being (SDG 3), gender equality (SDG 5), and reduced inequalities (SDG 10).

The Lancet Regional Health Europe Commission on Inequities and Disparities in Cardiovascular Health is chaired by Professor Raffaele Bugiardini, University of Bologna (Italy), Co-Chairs are Professor Chris P Gale, Leeds Institute of Cardiovascular and Metabolic Medicine at the University of Leeds (UK), and Dr Martha Gulati, Barbara Streisand Women's Heart Center Smidt Heart Institute, Cedars-Sinai Medical Center Los Angeles CA (US). The Commissioners are grouped in four Working Groups: women, ethnic minorities, elderly, and mental health conditions. Each of the Working Groups has a coordinator. See the list of contributors and Commission organization in the Appendix.

Contributors

RB, SA, AM, NT, VV and PJ contributed to study design and editing of the manuscript. CG, MG, LB, EC and OM contributed to editing of the manuscript.

Declaration of interests

RB reports participation on the data safety monitoring board of Aptabio Therapeutics. CG reports funding from Horizon 2020, grants or contracts from Alan Turing Institute, British Heart Foundation, National Institute for Health Research, Abbott Diabetes, Bristol Myers Squibb and European Society of Cardiology, consulting fees from AI Nexus, AstraZeneca, Amgen, Bayer, Bristol Myers Squibb, Boehringer-Ingelheim, CardioMatics, Chiesi, Daiichi Sankyo, GPRi Research B.V., Menarini, Novartis, iRhythm,

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Appendix A. Supplementary data

Supplementary data related to this article can be found at <https://doi.org/10.1016/j.lanepe.2024.100926>.

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