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Congenital Heart Disease and Social Determinants of Health

According to a new American Heart Association scientific statement published in the Journal of the American Heart Association, medical and surgical treatments have improved and survival but disparities driven by social determinants of health (SDOH) limit access to the lifelong specialty care needed by people with congenital heart disease.

The new statement focuses on the impact of SDOH – the conditions in which people are born and live, such as education, employment, housing, income, and access to food and safety – among people born with congenital heart defects. Societal factors impact the ability of people born with congenital heart disease to get appropriate specialty treatment throughout their lives and particularly when they are transitioning from paediatric to adult care.

According to Keila N. Lopez, the Chair of the statement writing group and an associate professor of pediatrics and medical director of the transition medicine division of pediatric cardiology at Texas Children's Hospital/Baylor College of Medicine in Houston, social determinants of health affect every single facet of congenital heart disease. Differences in the social determinants of health are directly linked to worse health outcomes and disparities in health outcomes, such as life expectancy, are often due to systemic and structural racism factors that negatively affect lifelong health.

The statement also points out that while there has been overall improvement in outcomes due to advances in surgical and medical care for congenital heart defects, there has been minimal improvement in equitable access to care. Specialty care services are concentrated in urban areas, making access difficult for those who live in rural or smaller communities. A higher proportion of people with private insurance are referred to hospitals with lower mortality compared to those who have public insurance.

Strategies to address these access issues include increasing specialist availability via satellite clinics in nonurban areas and increasing telehealth capabilities. Investigating policies for public insurance accessibility both within states and across state lines will be important to ensure access to care.

Nonsurgical factors also affect the type of care available at different institutions such as variations in home monitoring and visitation programmes; the availability of programmes to support nutrition, growth and cognitive development (such as school-based outreach); and varying levels of cultural competence. Also, the availability of non-English language providers and resources can make a difference in the quality of care at different institutions. The statement suggests the need for data to understand institutional referral patterns, hospital volume, and the resources, income and insurance needed to receive care at the hospitals with appropriate specialty care.

There is a need for more CHD health professionals, and a need to increase diversity among paediatric cardiologists. Fewer than 8% of CHD physicians are people from diverse racial and ethnic groups, although the percentage in paediatric cardiology fellowship programmes edged up slightly between 2006 and 2016 (from 7.7% to 9.9%, respectively).

Suggestions to improve diversity include: 1) establishing high school and undergraduate pipeline programmes that expose young students to health care professionals that look like them and encourage them along the educational pathway to health care professions; 2) recalibrating medical school admission to include holistic assessment of applicants; 3) substantial cost reduction for graduate or medical school; 4) establishing and funding minority-serving medical schools; and 5) greater focus on retention and promotion of physicians from diverse racial and ethnic groups.

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