



HEALTHCARE QUALITY AND DISPARITIES IN WOMEN



Highlights From the 2011
National Healthcare Quality
and Disparities Reports

Introduction to the NHQR and NHDR

Since 2003, the Agency for Healthcare Research and Quality (AHRQ) has annually reported on progress and opportunities for improving health care quality and reducing health care disparities. As mandated by the U.S. Congress, the National Healthcare Quality Report (NHQR) focuses on “national trends in the quality of health care provided to the American people” while the National Healthcare Disparities Report (NHDR) focuses on “prevailing disparities in health care delivery as it relates to racial factors and socioeconomic factors in priority populations.”

Priority populations include racial and ethnic minorities, low-income groups, women, children, older adults, residents of rural areas and inner cities, and individuals with disabilities and special health care needs.

Women’s Health

Quality and disparities measures in health care for women are integrated throughout both reports. This

document extracts and highlights the measures in a single document. It is organized around the same framework as the larger NHQR and NHDR but collapses some components to provide a broader view. The reports describe health along eight components, shown in the box. The components of effectiveness are organized around eight clinical areas. Naturally, some measures will cross components. For example, receipt of discharge instructions for heart failure is related to effectiveness of heart disease care as well as care coordination. For the purposes of this document, measures with clinical context are presented with the effectiveness measures. Other

measure sets describe health care delivery and systems issues and are discussed together.

This document is intended to serve as an “index” so readers can focus on women’s health measures of interest and then refer to the primary reports for detailed information. New analyses of other measures are not included but are planned for future publication.

NHQR/NHDR Components of Quality Care

1. Effectiveness
2. Patient Safety
3. Timeliness
4. Patient Centeredness
5. Care Coordination
6. Efficiency
7. Health System Infrastructure
8. Access to Care



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Effectiveness of Health Care

Readers are referred to the two reports for a description of methods, definitions, and criteria. However, when groups were compared (for example, women versus men), two criteria were applied to determine whether the difference between two groups was meaningful. The difference between the two groups must have been statistically significant ($p < 0.05$) and the relative difference between the two groups must have been at least 10%.

Cancer

Colorectal Cancer

Colorectal cancer is the third most common cancer in adults. Cancers can be diagnosed at different stages of development. Cancers diagnosed early before spread has occurred are generally more amenable to treatment and cure; cancers diagnosed late with extensive spread often have poor prognoses.

- From 2000 to 2007, the rate of advanced stage colorectal cancer in males age 50 and over decreased significantly, from 111.4 to 88.0. During the same period, rates for females age 50 and over also showed a significant decrease, from 83.2 to 67.0. In all years, males had significantly higher rates of advanced stage colorectal cancer compared with females.

Breast and Cervical Cancer

The reports include measures related to screening and treatment. They reflect the recent recommendation of the U.S. Preventive Services Task Force for mammograms every 2 years for women ages 50-74.

- From 2000 to 2008, the percentage of women ages 50-74 who reported they had a mammogram in the past 2 years did not change significantly.
- From 2000 to 2007, the rate of advanced stage breast cancer in women ages 50-64 decreased

from 106 to 96 per 100,000 women. Rates among women ages 40-49 and age 65 and over did not change significantly

- A third general measure is the rate of breast cancer deaths per 100,000 women. This rate decreased significantly from 27% in 2000 to 23% in 2007.

Cervical cancer measures include a preventive care process measure of Pap smear use:

- From 2000-2008, the percentage of women age 21 and over who received a Pap smear in the last 3 years decreased from 87.5% to 84.5%.

Chronic Kidney Disease

Early referral to a nephrologist is important for patients with progressive chronic kidney disease approaching kidney failure. Patients who begin nephrology care more than a year before kidney failure are less likely to begin dialysis with a catheter, experience infections related to vascular access, or die during the months after dialysis initiation.

- In 2008, only 28% of new end stage renal disease patients began nephrology care more than 12 months before start of dialysis. There were no statistically significant differences between male and female patients.
- From 2000 to 2007, the percentage of dialysis patients who were registered on a waiting list for transplantation increased from 15% to 17%. In all years, females were less likely than males to be registered on a waiting list.

Diabetes

Diabetes is the most common cause of kidney failure. Keeping blood sugar levels under control can prevent or slow the progression of kidney disease due to diabetes. While some cases of kidney failure due to diabetes cannot be avoided, other cases reflect inadequate control of blood sugar or delayed detection and treatment of early

kidney disease due to diabetes. Diabetes can also lead to lower extremity amputation.

- ❑ Between 2000 and 2008, the overall incidence of end stage renal disease (ESRD) due to diabetes did not change. Males had higher rates than females.
- ❑ From 2000 to 2007, males had significantly higher rates of admission for lower extremity amputation. In 2005-2007, the amputation rate for males was 4.8 per 1,000 admissions compared with 2.2 per 1,000 admissions for women.

Heart Disease

According to the National Center for Health Statistics, women's death rate from heart disease in 2008 was nearly eight times the death rate from breast cancer. That year, females had higher rates of inpatient heart attack mortality than males. Several benchmarks related to heart disease that represent the top 10% of reporting States have implications for women's health:

- ❑ The 2008 top 3 State achievable benchmark for inpatient heart attack mortality was 47 per 1,000 admissions. At the current rate, males could attain the benchmark in less than 1 year; however, females could not attain the benchmark for at least 2 years.
- ❑ In 2009, the top 5 State achievable benchmark for patients with heart failure and left ventricular systolic dysfunction prescribed an angiotensin-converting enzyme inhibitor or angiotensin receptor blocker at discharge was 96%. At current rates, both gender groups could attain the benchmark within 2 years.
- ❑ From 2004 to 2008, the overall hospitalization rate for congestive heart failure decreased significantly overall and for each gender group. The 2008 top 4 State achievable benchmark for heart failure admissions was 195 per 100,000 population. At current rates of improvement,

women could achieve the benchmark in 7 years while men would take 14 years.

HIV and AIDS

Recommended services for HIV include two or more CD4 cell counts, highly active antiretroviral therapy, two or more medical visits in an HIV care setting, and Pneumocystis pneumonia prophylaxis for patients with CD4 cell count below 200. Although care delivery for males and females may be similar, outcomes can vary by gender.

- ❑ In 2008, there were no statistically significant gender differences in the percentage of people with HIV receiving recommended services.
- ❑ In 2009, the percentage of newly diagnosed cases of AIDS in female patients was lower than in males, 6.7% compared with 20.6%.
- ❑ In 2007, the HIV infection death rate for males was more than twice that for females (5.4 per 100,000 population versus 2.1).
- ❑ Between 2006 and 2010, 67% of women ages 15-44 with a recently completed pregnancy had an HIV test as part of prenatal care.

Maternal and Child Health

- ❑ From 2004 to 2008, rates of obstetric trauma with 3rd or 4th degree laceration decreased from 30 to 24 per 1,000 vaginal deliveries without instrument assistance. Declines were observed in all age, racial/ethnic, area income, and payment source groups except Medicare beneficiaries. Mothers whose payment source was Medicare, Medicaid, or self-pay/uninsured/no charge had lower rates of obstetric trauma than mothers whose payment source was private health insurance. In all years, Blacks and Hispanics had lower rates than Whites and residents of the lower three area income quartiles had lower rates than residents of the highest area income quartile. In all years, Asian/Pacific Islanders had higher rates than Whites.

- ❑ The 2008 top 3 State achievable benchmark was 17 per 1,000 deliveries. At the current annual rate of decrease, this benchmark could be attained overall and in most age, payment source, racial/ethnic, and income groups in about 4 years. Mothers age 25-34 or whose payment source is private insurance would need 5 to 7 years. Black mothers have already attained the benchmark, as have mothers with Medicaid. Residents of the highest area income quartile would need 5 years, while Asian/Pacific Islanders would need more than 13 years.

Transgender Health Issues

The 2011 NHDR included lesbian, gay, bisexual, and transgender (LGBT) populations. LGBT individuals experience differences in receipt of health care services and are sometimes denied services. Due to lack of data availability in Federal surveys, the 2011 NHDR includes an excerpt from the National Transgender Discrimination Survey Report. Key findings reported were:

- ❑ Transgender people are more likely to be uninsured and less likely to have employer-based health insurance than the general population.
- ❑ About half of transgender people postponed care when sick or injured and postponed preventive health care due to cost. Among uninsured transgender people, 88% postponed preventive care due to cost.
- ❑ About 30% of transgender people postponed care when sick or injured or postponed preventive health care due to discrimination and disrespect by providers. Female-to-male transgender people were most likely to postpone care due to discrimination.
- ❑ Nearly 20% of transgender people have been denied services by a doctor or other provider because of their transgender or

gender-nonconforming status. Racial and ethnic minority transgender people are more likely to be denied services.

Mental Health and Substance Abuse

Mental disorders are common in the United States and internationally. An estimated 26.2 percent of Americans ages 18 and older — about one in four adults — suffer from a diagnosable mental disorder in a given year.¹ According to the World Health Organization, unipolar depression, predicted to be the second leading cause of global disability burden by 2020, is twice as common in women.

- ❑ In 2009, adult females with a major depressive episode were more likely than their male counterparts to receive any treatment for depression in the last 12 months (67.4% compared with 59%). However, the rate for females has decreased since 2008 while the rate for males has increased.
- ❑ From 2000 to 2007, males had suicide rates about four times as high as females.
- ❑ In 2008, females who were treated for substance abuse were significantly less likely than males to complete treatment (42.6% compared with 48.5%).

Musculoskeletal Diseases

- ❑ From 2001 to 2008, the percentage of female Medicare beneficiaries age 65 and over who reported ever being screened for osteoporosis with a bone mass or bone density measurement increased among all racial, ethnic, income, and insurance groups.

¹ Kessler RC, Chiu WT, Demler O, Walters EE. Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). *Arch Gen Psychiatr*, 2005 Jun;62(6):617-27.

- ❑ In all years, Hispanic and non-Hispanic Black women were less likely to be screened for osteoporosis than non-Hispanic White women; poor, low-income, and middle-income women were less likely to be screened than high-income women.

Respiratory Diseases

In general, significant gender differences are not seen in respiratory disease measures, but women fare better on some measures and worse on others.

- ❑ In 2008, the rate of deaths per 1,000 admissions with pneumonia was lower for women than for men (33.1 vs. 39.3).
- ❑ Asthma admissions per 100,000 population were much higher for women age 18 and over than for men.

Lifestyle Modification

Lifestyle can have a major impact on health. For example, obese women are more likely to develop gestational diabetes and have difficulties in labor than women at a healthy weight. In addition, smoking and obesity both contribute to or worsen heart disease, which is a leading cause of death in women. Health care providers can encourage behavior changes that can improve health and reduce the risk of disease.

- ❑ From 2002 to 2008, there were no statistically significant changes by gender in the percentage of current adult smokers who were advised to quit smoking.
- ❑ From 2002 to 2008, there were no statistically significant changes in either gender group in the percentage of adults with obesity who received advice about healthy eating. In 2008, the percentage was just under 50% for males and females.
- ❑ In 2008, female adults with obesity were more likely than males to ever receive advice to exercise more (60.8% compared with 53.8%).

- ❑ From 2002 to 2008, female adults with obesity were less likely than males to exercise at least three times a week (for 2008, 41.8% compared with 52.3%).

Functional Status Preservation and Rehabilitation

A person's ability to function can decline with disease or age, but it is not always an inevitable consequence. Services to maximize function are delivered in a variety of settings, such as providers' offices, patients' homes, and long-term care facilities. Screening for possible risks can help women maintain optimal function.

- ❑ From 2000 to 2008, the rate of short-stay residents with pressure sores fell from 22.6% to 18.9%. For high-risk long-stay residents, the rate fell from 13.9% to 11.7%. Improvements included rates for both males and females. In all years, females were less likely than males to have pressure sores.
- ❑ The 2008 top 5 State achievable benchmark for high-risk long-stay residents and pressure sores was 7.1%. At the current 2% annual rate of decrease, this benchmark could be attained overall in about 16 years. Females could attain this rate in 11 years; males would need 27 years.

Supportive and Palliative Care

Disease cannot always be cured, and disability cannot always be reversed. For patients with long-term health conditions, managing symptoms and preventing complications are important goals.

- ❑ From 2000 to 2009, the rate of short-stay residents with pressure sores fell from 22.6% to 17.8%. For high-risk long-stay residents, the rate fell from 13.9% to 10.9%. Rates improved for both males and females, but in all years, were less likely than males to have pressure sores.
- ❑ The 2008 top 5 State achievable benchmark for high-risk long-stay residents with pressure

sores was 7%. At the current annual 2% rate of decrease, females could attain this benchmark in 8 years.

Health Care Delivery and Systems

Information about health care delivery and systems are presented in the chapters about Patient Safety, Timeliness, Patient Centeredness, Care Coordination, Efficiency, Health System Infrastructure, and Access to Care. A variety of measures described women's health within these components.

- ❑ In 2009, females had higher rates of postoperative catheter associated urinary tract infections (3.3% compared to 2.6%).
- ❑ In 2008, females had a significantly lower rate of death following postoperative complications than males (109.4 per 1,000 discharges compared with 135.7). However, since 2005, the rates represent an increase for both females and males.
- ❑ From 2002 to 2008, females were less likely to be uninsured all year than males (in 2008, 13.3% compared with 17.5%).
- ❑ Females were more likely to have a usual primary care provider than males (79.2% compared with 71.8%).
- ❑ In all years, females were more likely than males to be unable to get or delayed in getting needed medical care, dental care, or prescription medicines.

Summary

Improving quality and reducing disparities require measurement and reporting, but these are not the ultimate goals. The fundamental purpose of improvement in health care is to make all patients' and families' lives better. The NHQR and NHDR concentrate on tracking health care quality and disparities at the national level, but the statistics reported in the reports reflect

the aggregated everyday experiences of patients and their providers across the Nation. It makes a difference in people's lives when breast cancer is diagnosed early with timely mammography; when a patient suffering from a heart attack is given the correct lifesaving treatment in a timely fashion; when medications are correctly administered; and when doctors listen to their patients and their families, show them respect, and answer their questions in a culturally and linguistically skilled manner.

AHRQ includes women in their priority populations, because women have unique health care needs or issues that require special focus. In addition to analyses in the NHQR and NHDR, AHRQ supports research on all aspects of health care provided to women, including enhancing the response of the health system to women's needs, understanding differences between the health care needs of women and men, understanding and eliminating disparities in health care, and providing evidence to inform women in their health care decisions.

For More Information

The 2011 NHQR and NHDR are available online at www.ahrq.gov/qual/qrdr11.htm.

To learn more about the mission and activities of AHRQ's Division of Priority Populations, please visit the AHRQ Web site at www.ahrq.gov/populations. For information and/or questions about specific activities related to priority populations, you may contact us at: Prioritypops@ahrq.hhs.gov

Agency for Healthcare Research and Quality
Office of Extramural Research, Education and
Priority Populations (OEREP)
Division of Priority Populations
540 Gaither Road
Rockville, MD 20850



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