



2014 National Healthcare Quality and Disparities Report

CHARTBOOK ON CARE AFFORDABILITY



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2014 NATIONAL HEALTHCARE QUALITY AND DISPARITIES REPORT CHARTBOOK ON CARE AFFORDABILITY

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CARE AFFORDABILITY

Organization of the Chartbook on Care Affordability

- Part of a series related to the National Healthcare Quality and Disparities Report (QDR).
- Contents:
 - Overview of the QDR
 - Overview of Care Affordability, one of the priorities of the National Quality Strategy
 - Summary of trends and disparities in Care Affordability from the QDR
 - Tracking of individual measures of Care Affordability
 - ◆ Access problems due to health care costs
 - ◆ Inefficient care due to use of services associated with more harm than benefit

National Healthcare Quality and Disparities Report

This Care Affordability chartbook is part of a family of documents and tools that support the National Healthcare Quality and Disparities Reports (QDR). The QDR includes annual reports to Congress mandated in the Healthcare Research and Quality Act of 1999 (P.L. 106-129). These reports provide a comprehensive overview of the quality of health care received by the general U.S. population and disparities in care experienced by different racial, ethnic, and socioeconomic groups. The purpose of the reports is to assess the performance of our health system and to identify areas of strengths and weaknesses in the health care system along three main axes: access to health care, quality of health care, and priorities of the National Quality Strategy.

The reports are based on more than 250 measures of quality and disparities covering a broad array of health care services and settings. Data are generally available through 2012, although rates of uninsurance have been tracked through the first half of 2014. The reports are produced with the help of an Interagency Work Group led by the Agency for Healthcare Research and Quality (AHRQ) and submitted on behalf of the Secretary of Health and Human Services (HHS).

Changes for 2014

Beginning with this 2014 report, findings on health care quality and health care disparities are integrated into a single document. This new National Healthcare Quality and Disparities Report highlights the importance of examining quality and disparities together to gain a complete picture of health care. This document is also shorter and focuses on summarizing information over the many measures that are tracked.

Key Findings of the 2014 QDR

The report demonstrates that the Nation has made clear progress in improving the health care delivery system to achieve the three aims of better care, smarter spending, and healthier people, but there is still more work to do, specifically to address disparities in care.

- Access improved.
 - After years without improvement, the rate of uninsurance among adults ages 18-64 decreased substantially during the first half of 2014.
 - Through 2012, improvement was observed across a broad spectrum of access measures among children.
- Quality improved for most NQS priorities.
 - *Patient Safety* improved, led by a 17% reduction in rates of hospital-acquired conditions between 2010 and 2013, with 1.3 million fewer harms to patients, an estimated 50,000 lives saved, and \$12 billion in cost savings.
 - *Person-Centered Care* improved, with large gains in provider-patient communication.
 - Many *Effective Treatment* measures, including several measures of pneumonia care in hospitals publicly reported by the Centers for Medicare & Medicaid Services (CMS), achieved such high levels of performance that continued reporting is unnecessary.
 - *Healthy Living* improved, led by doubling of selected adolescent immunization rates from 2008 to 2012.
- Few disparities were eliminated.
 - People in poor households generally experienced less access and poorer quality.
 - Parallel gains in access and quality across groups led to persistence of most disparities.
 - At the same time, several racial and ethnic disparities in rates of childhood immunization and rates of adverse events associated with procedures were eliminated, showing that elimination is possible.
- Many challenges in improving quality and reducing disparities remain.
 - Performance on many measures of quality remains far from optimal. For example, only half of people with high blood pressure have it controlled. On average, across a broad range of measures, recommended care is delivered only 70% of the time.
 - As noted above, disparities in quality and outcomes by income and race and ethnicity are large and persistent, and were not, through 2012, improving substantially.
 - Some disparities related to hospice care and chronic disease management grew larger.
 - Data and measures need to be improved to provide more complete assessments of two NQS priorities, *Care Coordination* and *Care Affordability*, and of disparities among smaller groups, such as Native Hawaiians, people of multiple races, and people who are lesbian, gay, bisexual, or transgender.

2014 Chartbooks

The 2014 QDR is supported by a series of related chartbooks that:

- Present information on individual measures
- Are updated annually
- Are posted on the Web (<http://www.ahrq.gov/research/findings/nhqrdr/2014chartbooks/>)

The order and topics of the chartbooks are:

- Access to care
- Priorities of the National Quality Strategy
- Access and quality of care for different priority populations

The new QDR and supporting chartbooks are further integrated with the National Quality Strategy (NQS). The NQS has three overarching aims that build on the Institute for Healthcare Improvement's Triple Aim[®] and that support HHS's delivery system reform initiatives to achieve better care, smarter spending, and healthier people through incentives, information, and the way care is delivered. These aims are used to guide and assess local, State, and national efforts to improve health and the quality of health care.

To advance these aims, the NQS focuses on six priorities that address the most common health concerns that Americans face. Quality measures tracked in the QDR have been reorganized around these priorities, and a chartbook will be released marking progress for each NQS priority. Care affordability is one of these NQS priorities and the topic of this chartbook.

Priority populations are noted in the legislation that requires AHRQ to report on health care disparities (42 U.S.C. 299a-1(a)(6)). These populations consist of groups with unique health care needs or issues that require special focus, such as racial and ethnic minorities, low-income populations, and people with special health care needs.

Chartbooks Organized Around Priorities of the National Quality Strategy

1. Making care safer by reducing harm caused in the delivery of care.
2. Ensuring that each person and family is engaged as partners in their care.
3. Promoting effective communication and coordination of care.
4. Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.
5. Working with communities to promote wide use of best practices to enable healthy living.
6. **Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.**

Care Affordability is one of the six national priorities identified by the National Quality Strategy (<http://www.ahrq.gov/workingforquality/index.html>).

National Quality Strategy Priority 6



 Priority 6: Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models

LONG-TERM GOALS

1. Ensure affordable and accessible high-quality health care for people, families, employers, and governments.
2. Support and enable communities to ensure accessible, high-quality care while reducing waste and fraud.

The National Quality Strategy recognizes that while this will be a challenge, the goal of reducing health care costs is important to everyone because of the impact of rising costs on families, employers, and State and Federal governments. Reducing costs must be considered hand in hand with the aims of better care, healthier people and communities, and affordable care.

The National Quality Strategy will foster strategies that reduce waste from undue administrative burdens and make health care costs and quality more transparent to consumers and providers so they can make better choices and decisions.

Chartbook on Care Affordability

- This chartbook includes:
 - Summary of trends across measures of Care Affordability from the QDR.
 - Figures illustrating select measures of Care Affordability.
- [Introduction and Methods](#) contains information about methods used in the chartbook.
- Appendixes include information about measures and data.
- A Data Query tool (<http://nhqrnet.ahrq.gov/inhqrdr/data/query>) provides access to all data tables.

Care Affordability Trends

- Few measures of Care Affordability can be tracked over time.
- Two measures of Care Affordability showed worsening over time from 2002 to 2010:
 - People who indicate a financial or insurance reason for not having a usual source of care
 - People unable to get or delayed in getting needed medical care, dental care, or prescription medicines due to financial or insurance reasons
- No measures of Care Affordability:
 - Achieved 95% performance and were removed from the reports this year
 - Improved quickly, defined as an average annual rate of change greater than 10% per year
 - Showed elimination or widening of disparities

Measures of Care Affordability

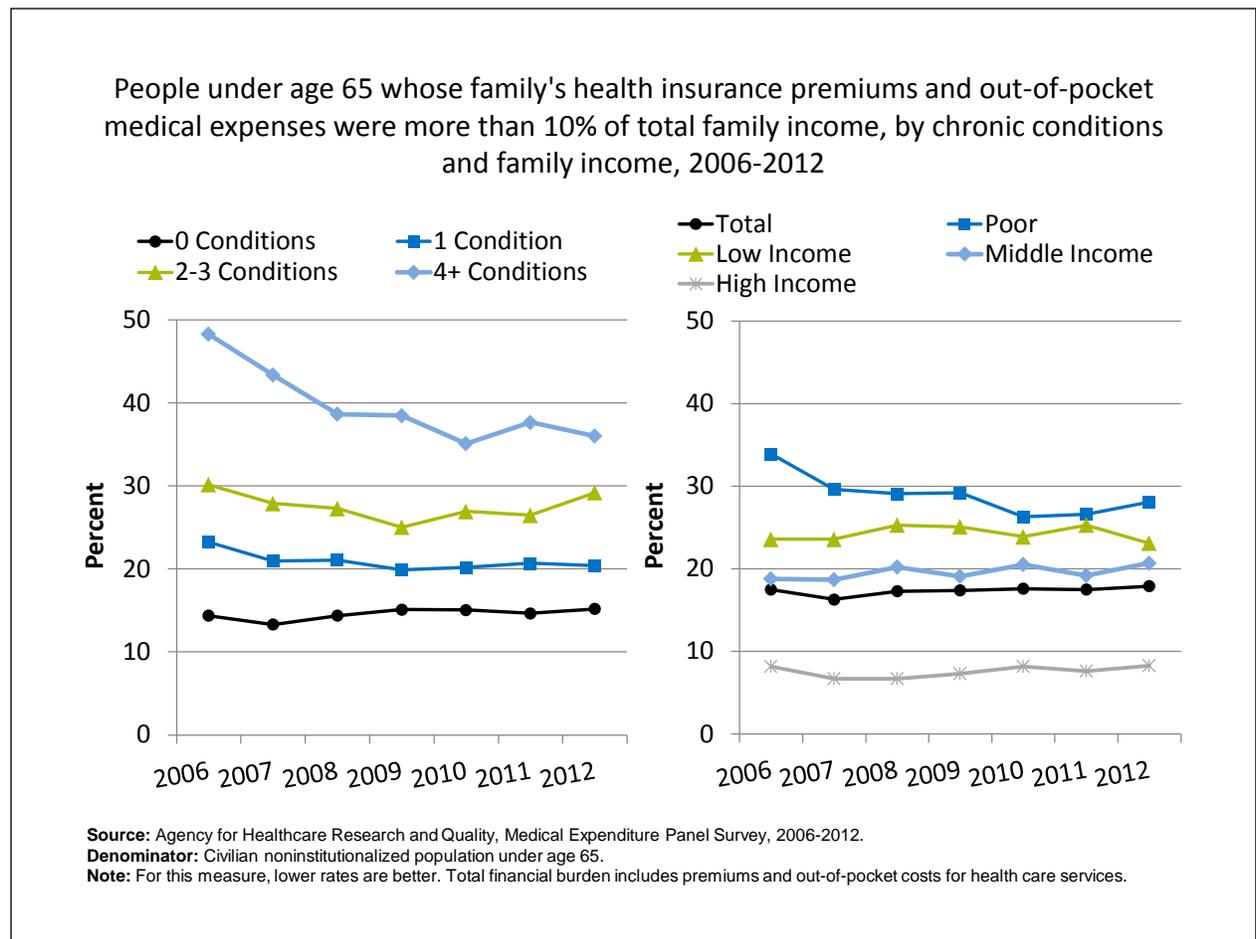
- This chartbook tracks measures of Care Affordability through 2012 and 2013, overall and for populations defined by:
 - Age,
 - Race, ethnicity,
 - Income, education, insurance, and
 - Number of chronic conditions.
- Measures of Care Affordability include:
 - Access problems due to health care costs
 - Inefficient care due to use of services associated with more harm than benefit

Measures of Access Problems Due to Health Care Costs

High health care costs can prevent some patients from receiving the care that they need.

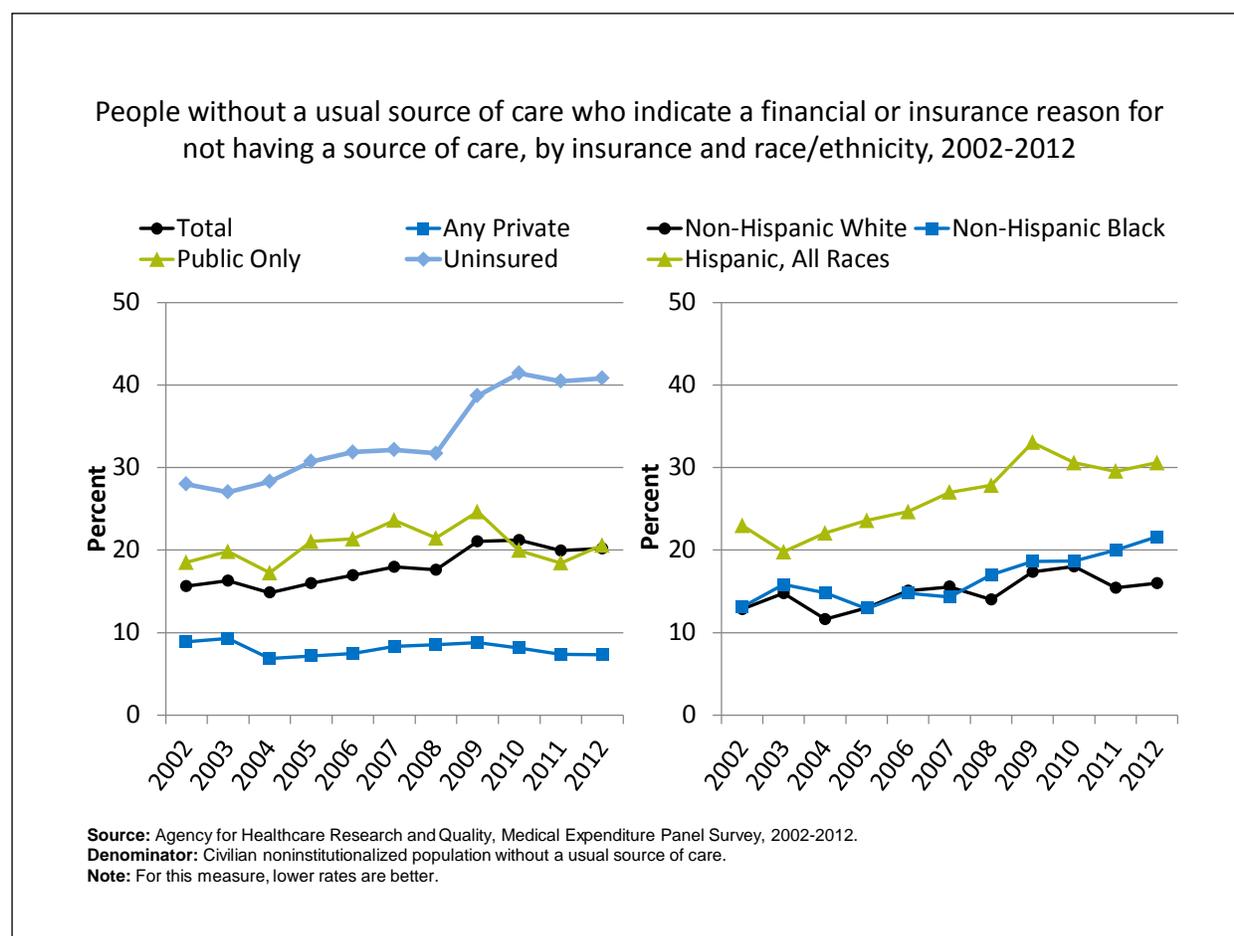
- People under age 65 whose family's health insurance premiums and out-of-pocket medical expenses were more than 10% of total family income
- People without a usual source of care who indicate a financial or insurance reason for not having a source of care
- People unable to get or delayed in getting needed medical care, dental care, or prescription medicines who indicate a financial or insurance reason for the problem

High Burden of Insurance Premiums and Out-of-Pocket Expenses



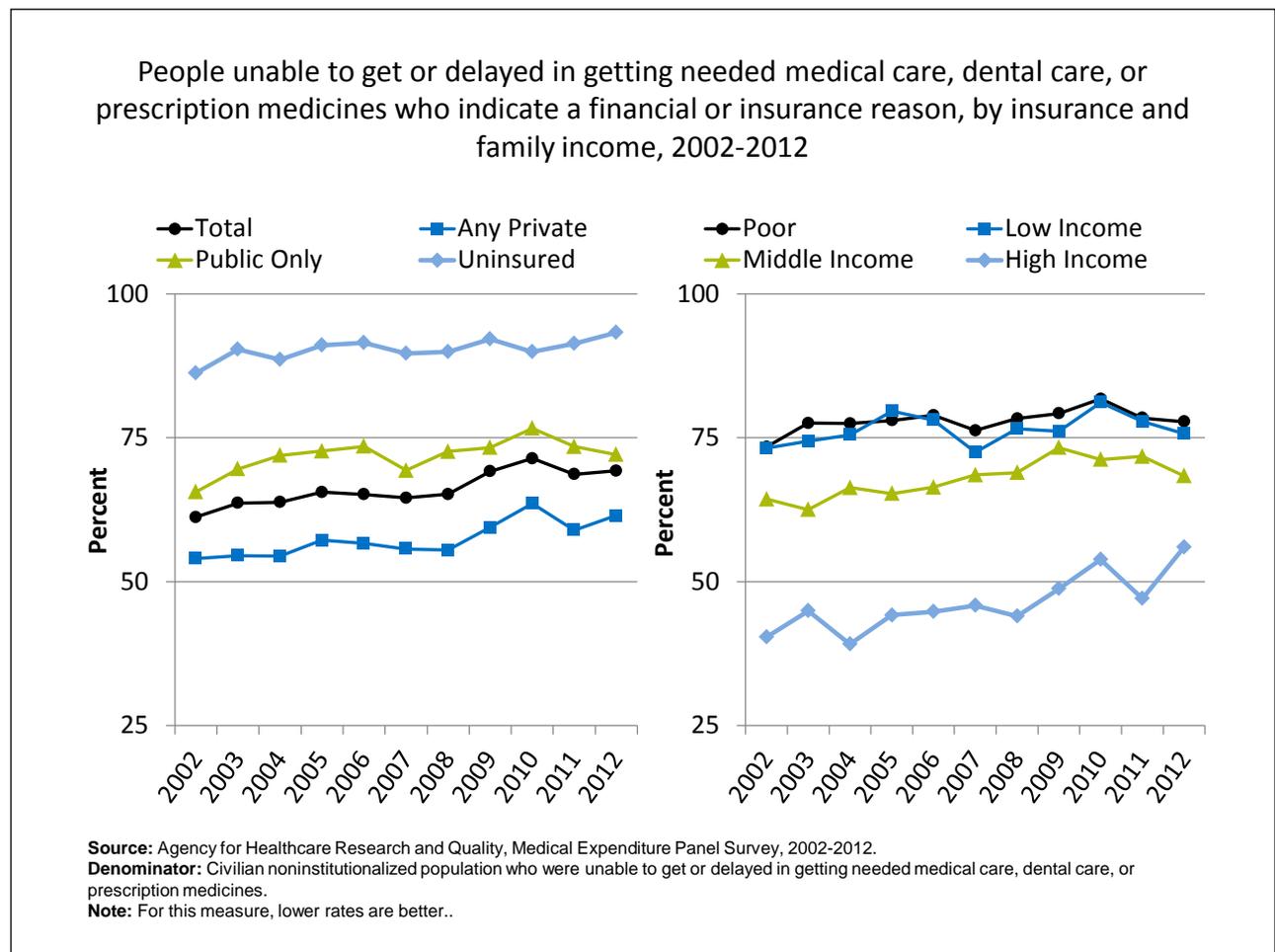
- **Importance:** Health care expenses that exceed 10% of family income are a marker of financial burden for families.
- **Overall Percentage:** In 2012, 17.9% of people under age 65 had health insurance premium and out-of-pocket medical expenses that were more than 10% of total family income.
- Trends:
 - From 2006 to 2012, there were no statistically significant changes in the overall percentage.
 - Among people with 4 or more chronic conditions and poor people, the percentage improved.
- **Groups With Disparities:** In 2012, the percentage of people under age 65 whose family's health insurance premium and out-of-pocket medical expenses were more than 10% of total family income was about 3 times as high for poor individuals and low-income individuals and more than twice as high for middle-income individuals compared with high-income individuals.

People Without a Usual Source of Care for Financial or Insurance Reasons



- **Importance:** High-quality health care is facilitated by having a regular provider, but some Americans may not be able to afford one.
- **Overall Percentage:** In 2012, 20.2% of people without a usual source of care indicated a financial or insurance reason for not having a source of care.
- **Trends:**
 - The overall percentage worsened from 2002 to 2010 and then leveled off.
 - The percentage worsened among uninsured people and among Blacks and Hispanics.
- **Groups With Disparities:** In 2012, the percentage of people without a usual source of care who indicated a financial or insurance reason for not having a source of care was higher:
 - Among uninsured people and people with public insurance compared with people with any private insurance.
 - Among Hispanics and Blacks compared with Whites.

People Unable To Get or Delayed in Getting Needed Care



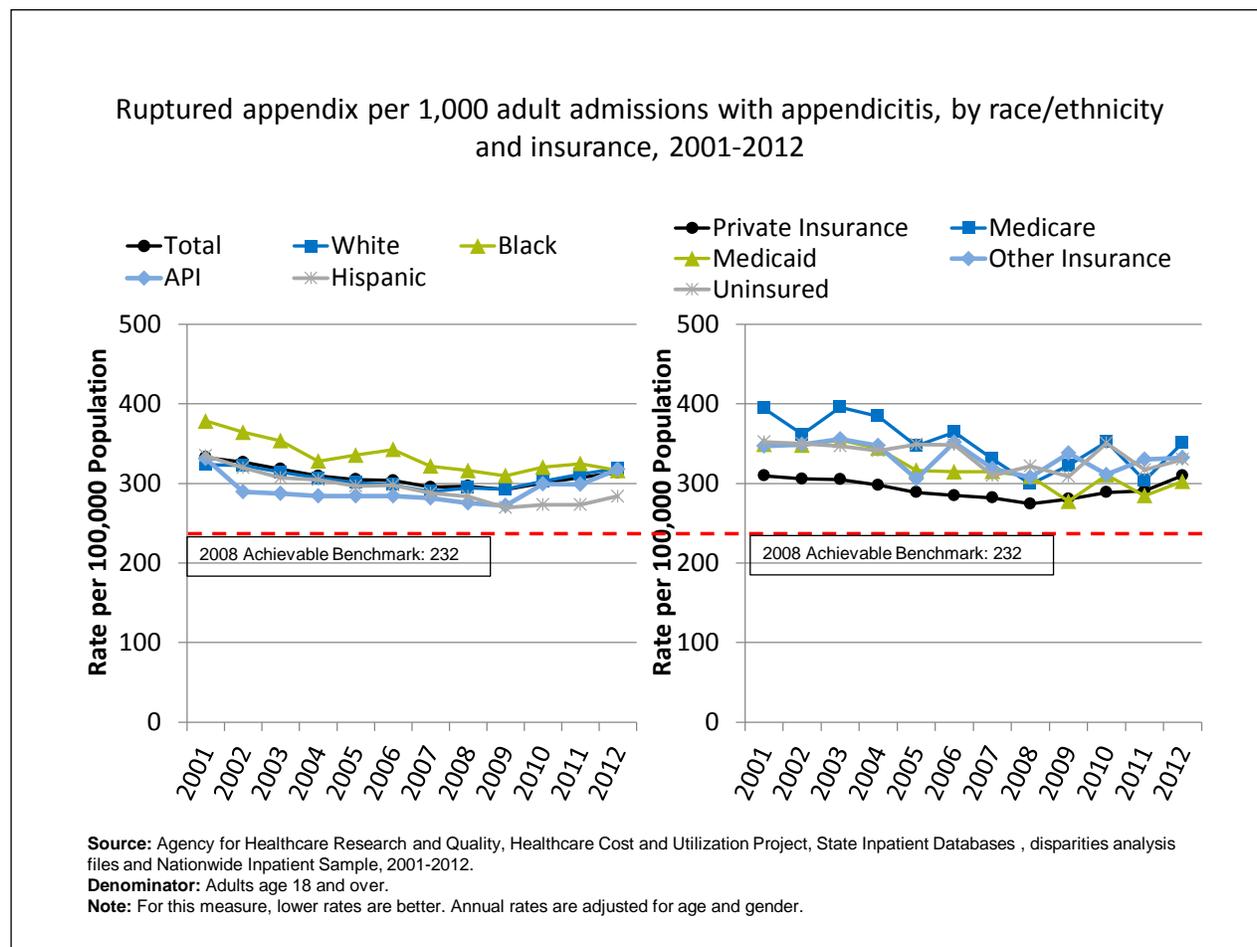
- **Importance:** Some Americans cannot afford all the care they need.
- **Overall Percentage:** In 2012, of people unable to get or delayed in getting needed medical care, dental care, or prescription medicines, 69.3% indicated a financial or insurance reason for the problem.
- **Trends:**
 - The overall percentage worsened from 2002 to 2010 and then leveled off.
 - The percentage worsened among people with any private insurance and among people from middle- and high-income families.
- **Groups With Disparities:** In 2012, the percentage of people unable to get or delayed in getting needed medical care, dental care, or prescription medicines who indicated a financial or insurance reason for the problem was higher:
 - Among uninsured people and people with public insurance compared with people with any private insurance.
 - Among poor, low-income, and middle-income people compared with high-income people.

Measures of Inefficiency

Inefficient care includes delayed care that is more costly and care with costs that exceed benefits.

- Ruptured appendix per 1,000 adult admissions with appendicitis
- Men age 40+ who had a screening prostate-specific antigen test in the past year

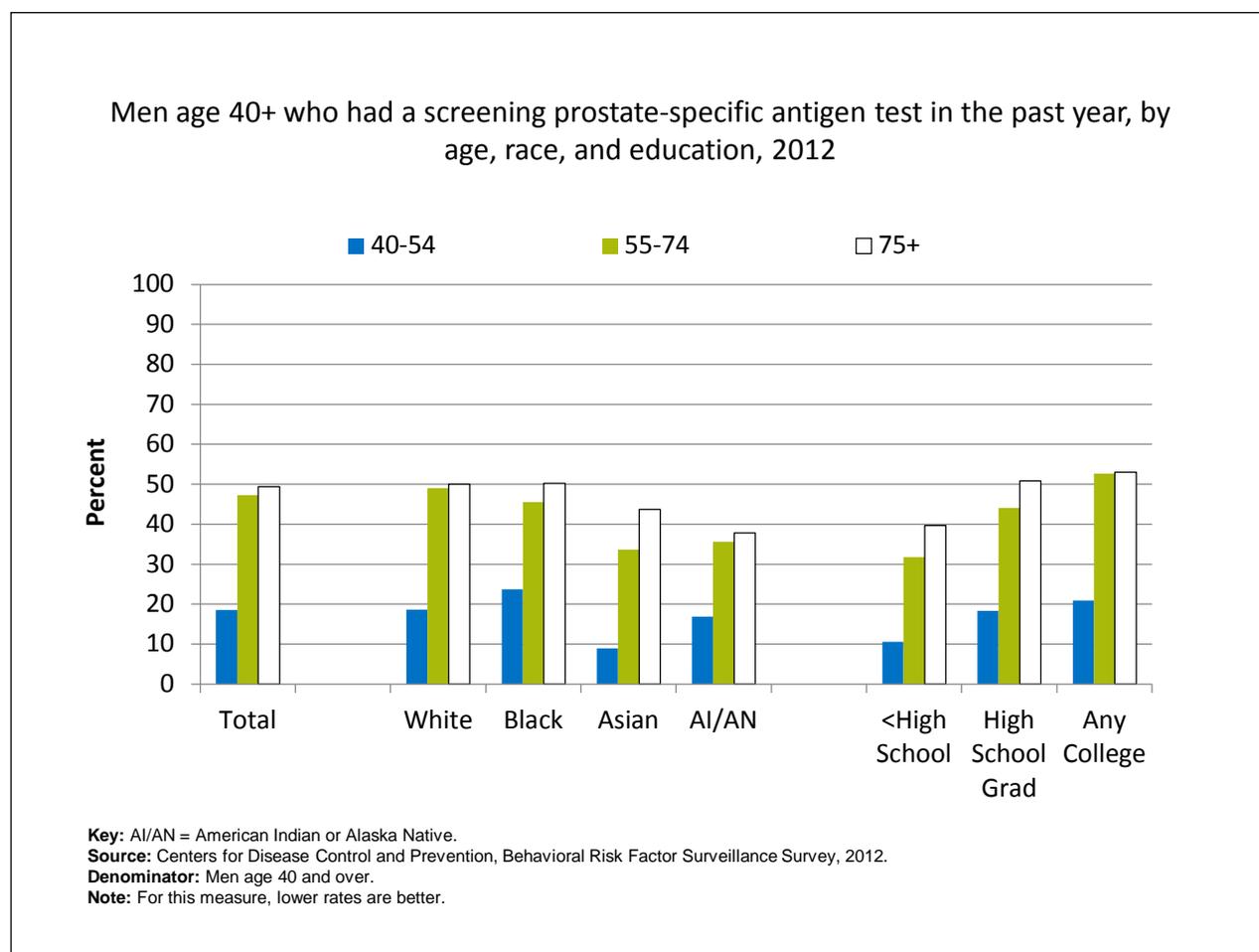
Ruptured Appendix



- **Importance:** Timely assessment of abdominal pain and diagnosis of appendicitis reduces rates of ruptured appendix.
- **Overall Rate:** In 2012, there were 314 ruptured appendixes for every 1,000 adult admissions with appendicitis.
- **Trends:**
 - From 2001 to 2012, there were no statistically significant changes in the overall rate.
 - The rate improved among Blacks and Hispanics and among people with Medicare, Medicaid, and other insurance.

- **Groups With Disparities:** In 2012, the rate of ruptured appendix was:
 - Lower among Hispanics compared with Whites.
 - Higher among people whose primary payer was Medicare compared with people whose primary payer was private insurance.
- **Achievable Benchmark:**
 - In 2008, the top 4 State (Connecticut, Hawaii, Massachusetts, New Jersey) achievable benchmark for ruptured appendix per 1,000 admissions with appendicitis was 232.
 - No group reached the benchmark by 2012.

Men Age 40+ Who Had a Screening Prostate-Specific Antigen Test



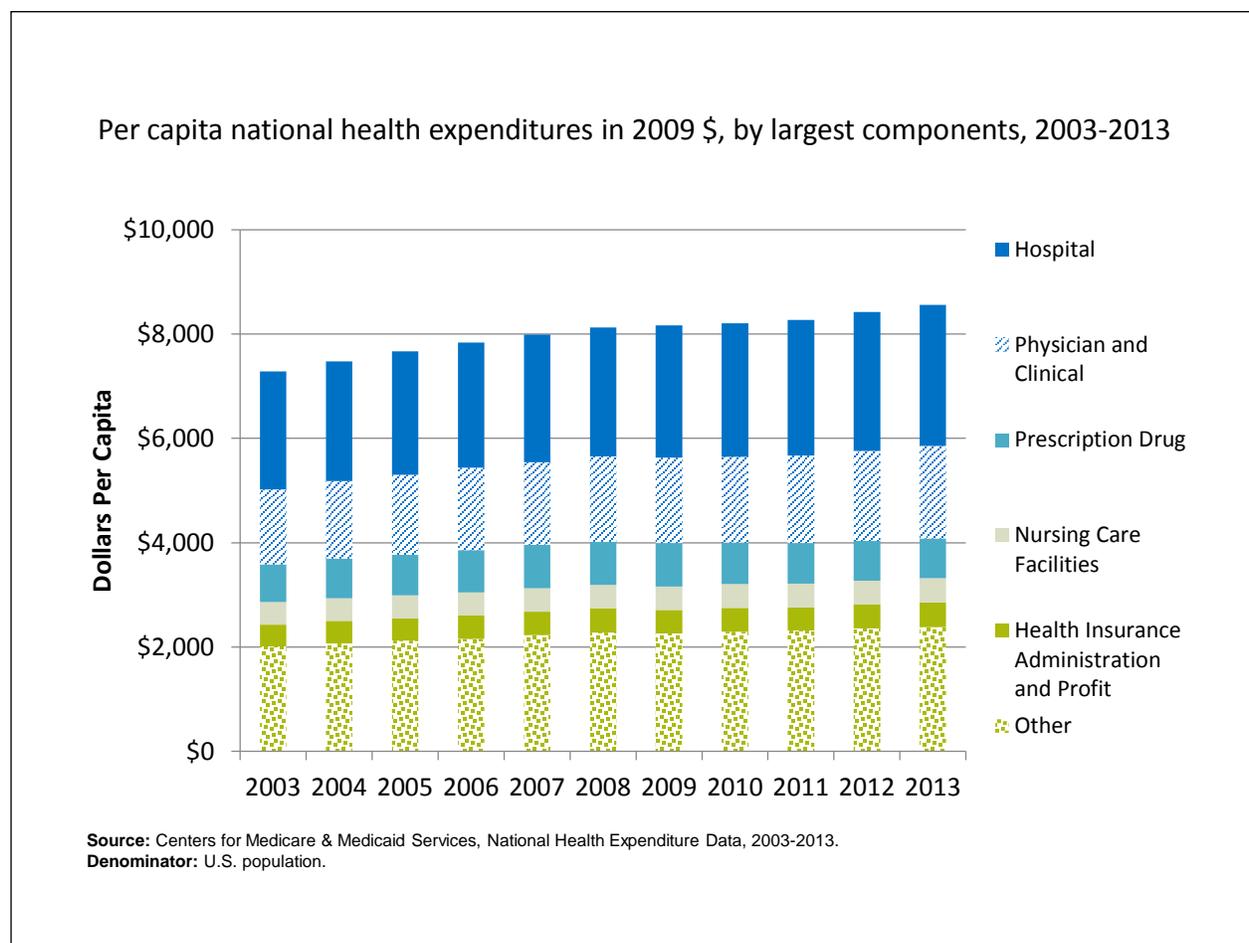
- **Importance:** Finding more harm than benefit, in 2008, the U.S. Preventive Services Task Force recommended against screening men age 75 and over with prostate-specific antigen (PSA) tests. In 2012, this recommendation was extended to all men.
- **Overall Rate:** In 2012, half of men age 40 and over reported a PSA test in the past year (data not shown).
- **Groups With Disparities:**

- Among men ages 55-74, Blacks, Asians, and American Indians and Alaska Natives were less likely than Whites to receive PSA testing.
- In 2012, men with less than a high school education were less likely than men with any college to receive PSA testing across all age groups. High school graduates ages 40-54 and 55-74 were also less likely to receive PSA testing than men with any college.

Supplemental Measures of Care Affordability

- Supplemental measures
 - May provide contextual information related to health care quality
 - Are not part of the measure set tracked in the QRDR because they are difficult to interpret
- Supplemental measures of Care Affordability:
 - Per capita national health expenditures

Per Capital Health Expenditures



- **Importance:** Higher per capita national health expenditures may make health care unaffordable for some Americans.
- **Trends:**
 - Total per capita national health expenditures in 2009 dollars rose from \$7,283 in 2003 to \$8,555 in 2013.
 - Expenditures on hospitals and physicians rose at 2% per year while expenditures on prescription drugs changed little.
- The five largest components of national health expenditures were hospital, physician and clinical, prescription drug, and nursing care expenditures, along with health insurance administration and profit.