



# Health Care Quality and Disparities in Women:

## Selected Findings From the 2010 National Healthcare Quality and Disparities Reports

Women's health is a priority population for AHRQ, meaning women have unique health care needs or issues that require special focus. The Agency for Healthcare Research and Quality (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. This fact sheet focuses on findings in the National Healthcare Quality and Disparities Reports, two of many AHRQ publications that address women's health.

Since 2003, 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 summarizes 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 higher view. The reports describe health along the following components:

- Effectiveness
- Patient Safety
- Timeliness
- Patient Centeredness
- Care Coordination
- Efficiency
- Health System Infrastructure
- Access to Care



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Priority Populations

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 that 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 additional measures and data can be identified in the NHQR and NHDR appendix tables.

## Effectiveness of Health Care

The NHQR and NHDR describe methods, definitions, and criteria for measures. 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 and the relative difference between the two groups must have been at least 10%. In addition, some measures include an achievable benchmark, which represents the performance of the top 10% of States with available data.

Four core effectiveness measures apply only to women. These are:

- Women age 40 and over who reported they had a mammogram within the past 2 years.
- Rate of advanced stage breast cancer per 100,000 women age 40 and over.
- Rates of obstetric trauma with 3rd or 4th degree laceration.
- Older women who reported ever being screened for osteoporosis.

## 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. The rate of cancer cases diagnosed at advanced stages is a measure of the effectiveness of cancer screening efforts and of adherence to followup care after a positive screening test.

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

Breast cancer measures are tracked annually, but results are presented in odd calendar years. Two core measures relate to breast cancer and are presented here with a third measure of interest.

- Women age 40 and over who reported they had a mammogram within the past 2 years was 67.1% in 2008, slightly up from 66.6% in 2005.
- Rate of advanced stage breast cancer per 100,000 women age 40 and over was 95.3 in 2007, up slightly from 93.9 in 2006, and very similar to the rate of 95.6 in 2005.
- A third general measure is the rate of breast cancer deaths per 100,000 women. This rate was 22.9 in 2007, continuing a very slight decrease from 23.5 in 2006 and 24.1 in 2005.

Cervical cancer measures include a preventive care process measure of Pap smear use that has worsened over time.

- From 1999 to 2008, the percentage of women age 18 and over who received a Pap smear in the last 3 years decreased from 80.8% to 75.6 %.

## Diabetes

In general, women do well on the diabetes measures compared with men.

- From 1999-2001 to 2005-2007, males and females had significant decreases in the hospitalization rate for lower extremity amputation.
- In all years, males had significantly higher rates of admission, about twice the rate of females.

## End Stage Renal Disease (ESRD)

- In 2008, the percentage of female adult hemodialysis patients receiving adequate dialysis was higher than that of males.
- In 2006, females were less likely than males to be registered on a waiting list for kidney transplant (15.6% compared with 18.2%).

## Heart Disease

Heart disease is the leading cause of death. In 2007, females had higher rates of inpatient heart attack mortality than males. Several benchmarks are presented with implications for women's health.

- The 2007 top 4 State achievable benchmark for inpatient heart attack mortality was 54.6 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 almost 3 years.
- In 2008, the top 5 State fibrinolytic medication achievable benchmark was 60.7%. At the current rate of improvement, males should reach the achievable benchmark in a little over 2 years, but females would not reach the benchmark for more than 4 years.
- From 2005 to 2008, the percentage of hospitalized adult patients with heart failure

who were given complete written discharge instructions improved from 57.5% to 82.0%. Improvements were observed among both males and females. The 2008 top 5 State achievable benchmark was 88%. At the current 12% annual rate of increase, this benchmark could be attained overall and for both males and females in less than a year.

## HIV and AIDS

HIV infection deaths reflect a number of factors, including underlying rates of HIV risk behaviors, prevention of HIV transmission, early detection and treatment of HIV disease, and management of AIDS and its complications.

- In 2007, the HIV infection death rate for males was more than twice that of females (5.4 per 100,000 population versus 2.1).

## Maternal and Child Health

- From 2004 to 2007, rates of obstetric trauma with 3rd or 4th degree laceration decreased from 40 to 32 per 1,000 vaginal deliveries without instrument assistance. Declines were observed in all urban-rural locations, but in most years, residents of small metropolitan, micropolitan, and noncore (rural) areas had lower rates of obstetric trauma than residents of large fringe metropolitan areas (suburbs).
- The 2007 top 3 State achievable benchmark was 25 per 1,000 deliveries. At the current 8% annual rate of decrease, this benchmark could be attained overall and in most urban-rural locations in about 3 years. Residents of large fringe metropolitan areas would need about 4 years to attain the benchmark.
- Declines were observed among all racial/ethnic and area income groups. In all years, Blacks and Hispanics had lower rates than Whites and residents of the lower two 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 achievable benchmark could be attained overall and by most racial/ethnic and income groups in about 3 years. Whites and residents of the highest area income quartile would need 4 years, while Asian/Pacific Islanders would need more than 23 years.

### **Mental Health and Substance Abuse**

According to data from the Healthcare Cost and Utilization Project, in 2007, 12.5% of emergency department visits were related to mental health and substance abuse. One in five hospital stays included some mention of a mental health condition as either a principal or secondary diagnosis.

- In 2008, 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 (68% compared with 57.8%).
- From 1999 to 2007, males consistently had suicide rates almost four times as high as females.
- Females who were treated for substance abuse were significantly less likely than males to complete treatment (41.0% compared with 47.1%).

### **Respiratory Diseases**

Overall, women fared well on the respiratory disease measures.

- There were no statistically significant differences between males and females in the percentage of patients with pneumonia who received recommended hospital care.
- The percentage of adults who completed tuberculosis therapy within 1 year improved for both males and females from 1999 to 2006. However, in 2006, females were more likely to complete treatment than males (85.5% compared with 82.2%).

### **Lifestyle Modification**

Unhealthy behaviors place many Americans at risk for a variety of diseases. Problems such as smoking and obesity contribute to or worsen heart disease, a leading cause of death. Helping patients choose and maintain healthy lifestyles is a critical role of health care.

- From 2002 to 2007, female current adult smokers were more likely than males to receive advice to quit smoking.
- Female obese adults age 20 and over were more likely than males to have been told by a doctor or health professional that they were overweight (70.6% compared with 60.7%).
- From 2002 to 2007, the percentage of adults with obesity who received advice about healthy eating improved for females. In 2007, there was no statistically significant difference between males and females.
- In 2007, female adults with obesity were more likely than males to ever receive advice to exercise more (63.3% compared with 54.9%). Yet from 2002 to 2007, female adults with obesity were less likely than males to exercise at least 3 times a week (for 2007, 41.5% compared with 51.4%).

### **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 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 disability groups.

## 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 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%. Rates improved for both males and females, but 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 with pressure sores was 7.1%. At the current annual rate of decrease, females could attain this rate in 11 years; males would need 27 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 describe women's health within these components.

- In 2007, females had a lower rate of postoperative respiratory failure than males (9.0% compared with 14.8%).
- From 2004 to 2007, a significant decrease was seen among males and females in the inpatient pneumonia mortality rate. In 2007, females had a significantly better inpatient pneumonia mortality rate than males.
- In 2007, females had a significantly lower rate of postoperative sepsis than males (14.1 per 1,000 hospital discharges compared with 17.7).
- In 2007, females had a significantly lower rate of deaths following complications of care than males (99.8 per 1,000 discharges compared with 112.1).
- In 2007, the percentage of female patients who received potentially inappropriate medications was significantly higher than for male patients (18.1% compared with 11.8%).

- From 2002 to 2007, females were less likely to be uninsured all year than males (in 2007, 13.0% compared with 17.4%).
- Females were more likely to have a usual primary care provider than males (79.9% compared with 72.6%).
- In all years between 2002 and 2007, females were more likely than males to be unable to get or delayed in getting needed medical care, dental care, or prescription medicines.

## Summary

Four themes from the 2010 NHQR and 2010 NHDR emphasize the need to accelerate progress if the Nation is to achieve higher quality and more equitable health care in the near future.

- Health care quality and access are suboptimal, especially for minority and low-income groups.
- Quality is improving; access and disparities are not improving.
- Urgent attention is warranted to ensure improvements in quality and progress on reducing disparities with respect to certain services, geographic areas, and populations, including:
  - Cancer screening and management of diabetes.
  - States in the central part of the country.
  - Residents of inner-city and rural areas.
  - Disparities in preventive services and access to care.
- Progress is uneven with respect to eight national priority areas:
  - Two are improving in quality: (1) Palliative and End-of-Life Care and (2) Patient and Family Engagement.
  - Three are lagging: (3) Population Health, (4) Safety, and (5) Access.
  - Three require more data to assess: (6) Care Coordination, (7) Overuse, and (8) Health System Infrastructure.
  - All eight priority areas showed disparities related to race, ethnicity, and socioeconomic status.

## Additional Information

The 2010 National Healthcare Quality Report and National Healthcare Disparities Report are available online at <http://www.ahrq.gov/qual/qdr10.htm>.

Additional information on programs and activities related to women's health at AHRQ is available at <http://www.ahrq.gov/research/womenix.htm> or by contacting:

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