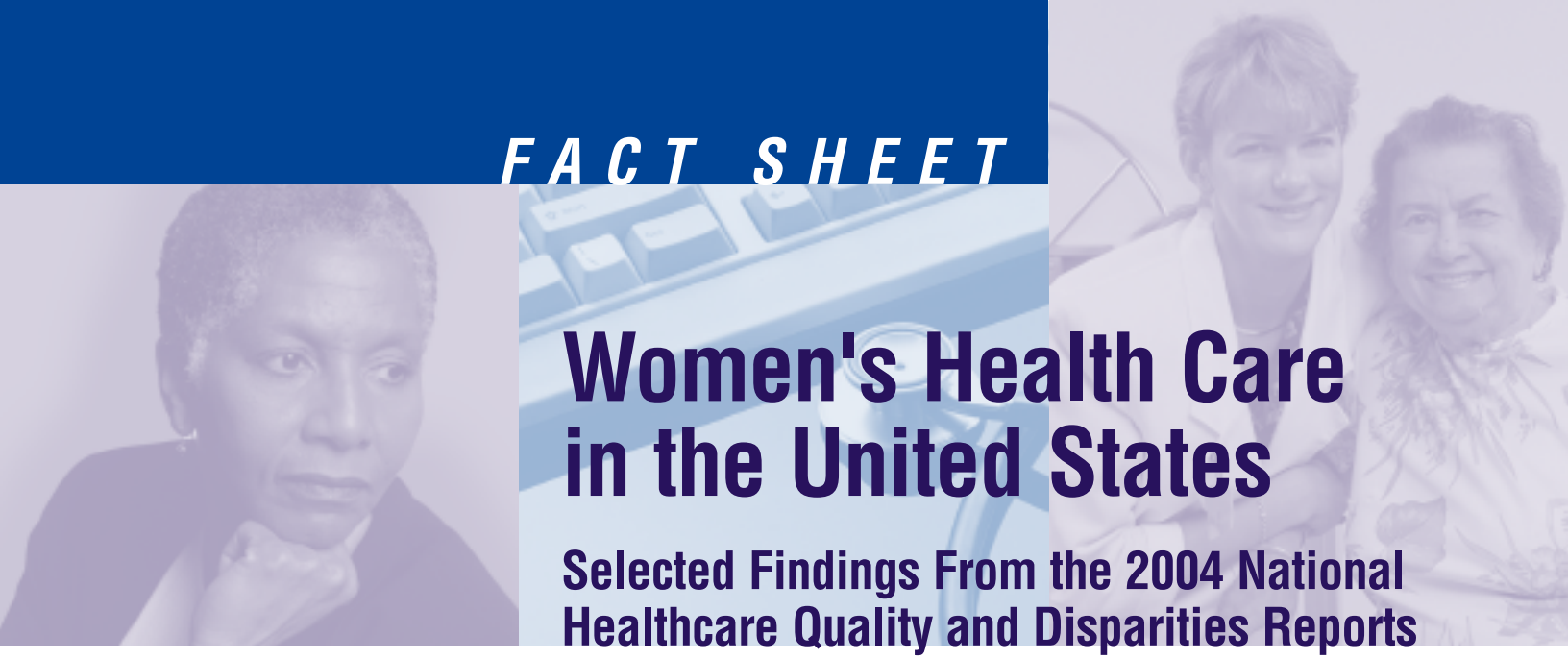
FACT SHEET



Women's Health Care in the United States

Selected Findings From the 2004 National Healthcare Quality and Disparities Reports

The mission of AHRQ is to improve the quality, safety, efficiency, and effectiveness of health care by:

- Using evidence to improve health care.
- Improving health care outcomes through research.
- Transforming research into practice.

Key Findings in This Fact Sheet:

- Gaps in quality of care are pervasive especially for:
  - Racial and ethnic minorities.
  - People of lower socio economic status.
  - Some geographic regions of the country.
- Differences in quality of care are evident for women compared with men.
- The overall quality of health care for women in the United States is improving slowly.

Introduction

Despite the high quality of the U.S. health care delivery system, many Americans do not get all the health care that they need. Improving the quality of care that Americans receive could save thousands of lives, millions of lost work days, and billions of dollars each year.

To address this problem, Congress mandated that the Agency for Healthcare Research and Quality (AHRQ) prepare annual reports on health care quality and disparities. First released in 2003, the National Healthcare Quality Report (NHQR) and the National Healthcare Disparities Report (NHDR) track the Nation's annual progress in improving quality and reducing disparities in health care. The reports[i] document continuing deficiencies in care, particularly for minorities and the poor.

Women and Health

Females in the United States number 140 million people, comprising over half of the total population. In addition:

- Nearly 30 percent of females are racial/ethnic minorities.[1]
- Black women have higher death rates than whites due to heart disease, cancer, and stroke. Hispanic, Asian and Pacific Islander (API), and American Indian and Alaska Native (AI/AN) women have lower death rates due to these conditions.[2]
- Black and Hispanic women are more likely to report that they are in fair or poor overall health or that they have diabetes.[2]
- Poverty disproportionately affects women. Nearly 13 million women live in households with incomes below the Federal poverty level.[2]
- Women are more likely than men to report having arthritis, asthma, autoimmune diseases, and depression.[2]
- Poor or near poor women are more likely than high income women to report fair or poor overall health and limitations of activity; they are also more likely to report having anxiety or depression, arthritis, asthma, diabetes, hypertension, obesity, and osteoporosis.[3]

[i]The NHQR and NHDR, including analyses and data cited in this Fact Sheet, are available at: www.qualitytools.ahrq.gov.

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Purpose of This Fact Sheet

This Fact Sheet builds upon the NHQR and NHDR's analyses for women by examining, for selected measures:

- Disparities in care among women by race, ethnicity, and socioeconomic status (SES, as measured by income and education).
- Disparities in health care for women compared with men.
- Trends and State variation in women's health care over time.

Disparities in Women's Health Care

Types of Disparities

Disparities discussed below are presented in two major areas: (1) gender; and (2) race/ethnicity and SES (as measured by income and educational level).

Gender disparities. Significant gaps exist between the care received by men and women in the United States. Across measures in the 2004 NHQR with data by gender:

- Women receive better care than men for 18 percent of measures, worse care for 22 percent, and comparable care for 59 percent.
- Women tend to receive better preventive care for cancer and cardiovascular disease than men, while men tend to receive better treatment for end stage renal disease and heart disease.

Racial/ethnic and socioeconomic disparities. In addition to gender disparities observed among women, racial/ethnic and socioeconomic disparities are also evident. Of measures with data for women in the 2004 NHDR:

- Black women receive poorer quality care than whites for 53 percent of measures and have worse access to care for 29 percent.
- Hispanic women receive poorer quality care than non-Hispanic whites for 60 percent of measures and have poorer access for 87 percent.
- For services unique to women, blacks and Hispanics both receive poorer quality care for 75 percent of measures.

Disparities in Quality and Safety

This section presents information on disparities in three areas in which disparities in quality or patient safety have been demonstrated—screening for breast and cervical cancer, treatment of heart attack (acute myocardial infarction), and complications after surgery.

Cancer screening. An estimated 662,870 women will be diagnosed with cancer in 2005, and cancer is projected to lead to death for 275,000 women. An estimated 211,240 women will be diagnosed with breast cancer and 10,370 with cervical cancer; 40,410 and 3,710 women are projected to die of breast and cervical cancer, respectively.[4]

Mammograms and Pap tests are an effective means of reducing the incidence of late stage breast and cervical cancers, respectively, and mortality caused by these cancers.

U.S. population

- In 2000, the overall rate of Pap tests was below the Healthy People 2010 (HP2010) goal of 90 percent. The overall mammography rate reached the HP2010 goal of 70 percent.

Race/ethnicity

- Compared with whites, blacks had higher rates of Pap tests and lower rates of mammography, Asians had lower rates of both services, and AI/ANs had lower rates of mammography (Figure 1).
- Hispanics had lower rates of both services than non-Hispanic whites.
- For Pap tests, no racial or ethnic group achieved the HP2010 goal.
- Only white women achieved the HP2010 goal for mammography.

Socioeconomic status

- Poor, near poor, and middle income women had lower rates of both Pap tests and mammography than high income women.
- Women with less than high school education and high school graduates had lower rates of both services than women with at least some college education.
- No socioeconomic group achieved the HP2010 goal for Pap tests.
- Only high income women and women with at least some college education achieved the HP2010 goal for mammography.

Treatment of heart attack. Each year, about half a million women die of heart disease[5]; it is the leading cause of death for both women and men.

Although major risk factors for heart disease can often be prevented or controlled through lifestyle changes, physicians are less likely to counsel women than men about diet, exercise, and weight reduction.[6]

After a first heart attack, women are less likely than men to receive diagnostic and therapeutic procedures[7] and cardiac rehabilitation[8] and more likely to die or have a second heart attack.[9] Receipt of beta-blockers and aspirin upon arrival at the hospital for a heart attack is an effective means of minimizing the negative impact of the heart attack.

Medicare population

- In 2002, Medicare beneficiaries hospitalized for a heart attack received a beta-blocker upon hospital arrival only 76 percent of the time and aspirin on arrival only 85 percent of the time (Figure 2).
- People ages 75-84 and 85+ were less likely than those 65-74 to receive both medications.

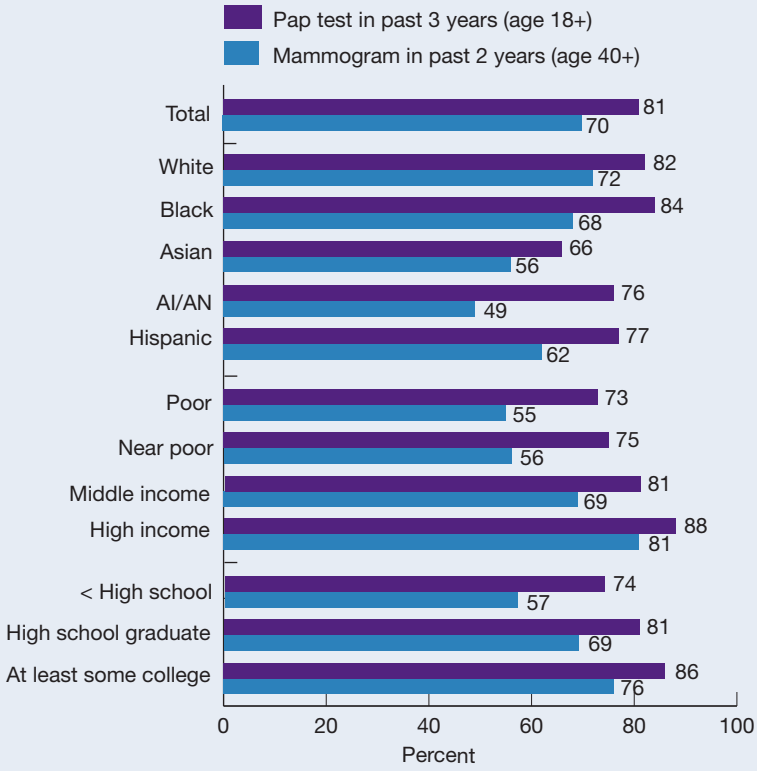
Gender

- Women were less likely than men to receive both medications.

Race/ethnicity

- Compared with non-Hispanic whites, blacks were less likely and APIs were more likely to receive aspirin, and Hispanics were less likely to receive both medications.

Figure 1. Women age 18+ with Pap test in past 3 years and women age 40+ with mammogram in past 2 years, by race/ethnicity, income, and education



Source: Centers for Disease Control and Prevention, National Health Interview Survey, 2000.

Postoperative complications. An estimated 44,000 to 98,000 Americans die each year as a result of medical errors, making it the eighth leading cause of death.[10] Postoperative pulmonary embolus/deep vein thrombosis (blood clots) and septicemia (bloodstream infections) are examples of patient safety events in which some disparities are evident.

U.S. population

- In 2001, about 9 of every 1,000 surgical discharges were complicated by a postoperative blood clot and about 10 of every 1,000 elective surgery discharges were complicated by a postoperative blood stream infection (Figures 3 and 4).

Gender

- Women had higher rates of postoperative blood clots and lower rates of postoperative septicemia than men.

Race/ethnicity

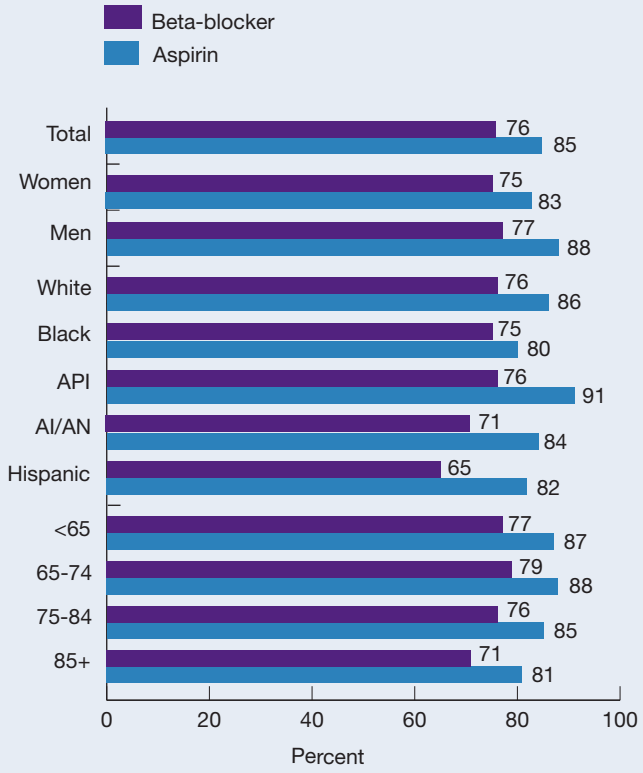
- Compared with non-Hispanic white women, black women were more likely to have either complication, Hispanic women were more likely to have postoperative septicemia, and API women were less likely to have postoperative blood clots.

Trends in Care Over Time

Overall Quality of Care for Women

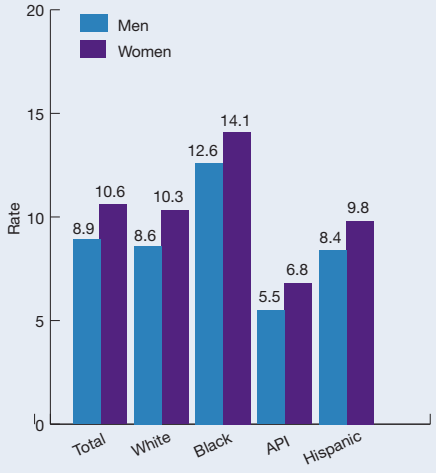
The overall quality of health care for women in the United States is improving slowly . From the 2003 NHQR to the 2004 NHQR:

Figure 2. Medicare beneficiaries with acute myocardial infarction who receive beta-blocker and aspirin on hospital arrival, by gender, race/ethnicity, and age



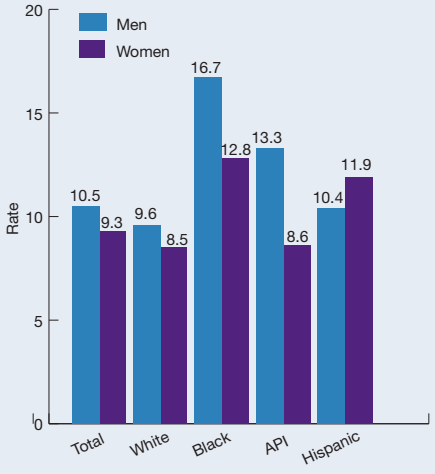
Source: Centers for Medicare & Medicaid Services, Quality Improvement Organization program, 2002.

Figure 3. Postoperative pulmonary embolus/deep vein thrombosis per 1,000 surgical discharges, by race/ethnicity



Source: Agency for Healthcare Research and Quality, Healthcare Cost and Utilization Project, 2002.

Figure 4. Postoperative septicemia per 1,000 elective surgery discharges, by race/ethnicity



Source: Agency for Healthcare Research and Quality, Healthcare Cost and Utilization Project, 2002.

- Of measures with trend data for women, 59 percent showed improvement, with a median change of 1.4 percent, comparable to change observed in the general population.
- For services unique to women, 60 percent of measures improved.

Although these improvements are modest, they also show that improvement is possible.

Trends and Variation in Quality and Access

This section presents trend data for women on one quality measure—early prenatal care, including State variation in care—and one access measure—insurance coverage.

Early prenatal care. Childbirth and reproductive care are the most common reasons for women of childbearing age to use health care. With more than 11,000 births each day in the United States, childbirth is the most common reason for hospital admission.[11] Comprehensive prenatal care may prevent complications of pregnancy which can have lifetime effects, and reduce preterm labor and neonatal mortality.[12,13]

Initiating prenatal care in the first trimester is an effective way to promote good health for both mother and child.

U.S. population

- Between 1998 and 2002, prenatal care in the first trimester improved. Current rates are still below the HP2010 goal of 90 percent.

Race/ethnicity

- In all years, blacks, Native Hawaiians and Other Pacific Islanders (NHOPIs), and AI/ANs had lower rates compared with whites; Asians had higher rates compared with whites (Figure 5).
- Hispanics had lower rates compared with non-Hispanic whites.
- All racial and ethnic groups had better rates in 2002 compared with

1998 except NHOPIs, for which the change was not statistically significant.

- No racial/ethnic group achieved the HP2010 goal.

Socioeconomic status

- In all years, mothers with less than a high school education and high school graduates had lower rates compared with mothers with at least some college education (Figure 6).
- All educational groups had better rates in 2002 compared with 1998. The largest gains were experienced by mothers with less than a high school education.
- Only mothers with at least some college education surpassed the HP2010 goal.

State variation

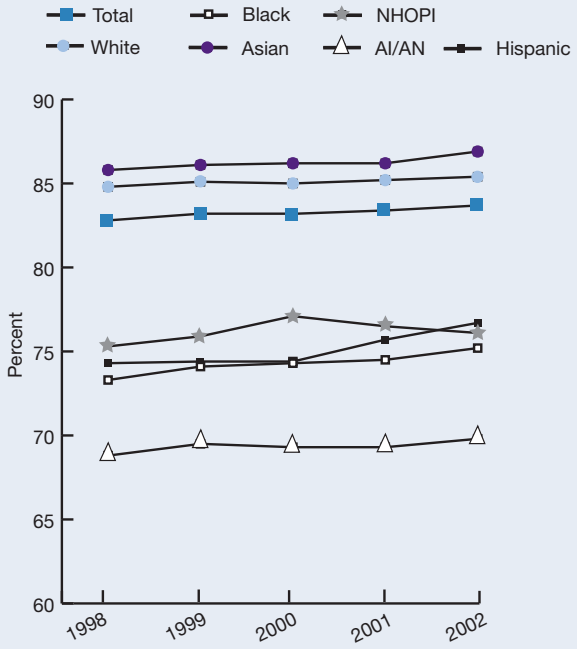
- *All* States in the New England census division were at least 10 percent above the national average for receipt of early prenatal care in all years from 1999 to 2002 (Figure 7).
- Most States in the West North Central census division were at least 10 percent above the national average in all 4 years.
- Most States in the Middle Atlantic and West South Central census divisions were at least 10 percent below the national average in all 4 years.

Insurance coverage. Many women face barriers, including lack of health insurance, that make the acquisition of basic health care services difficult. In 2003, 15.6 percent of Americans were uninsured.[14] The uninsured report more problems getting care[15,16] and get less therapeutic care.[15,17] They are diagnosed at later disease stages, sicker when hospitalized, and more likely to die early.[3,14,18]

U.S. population

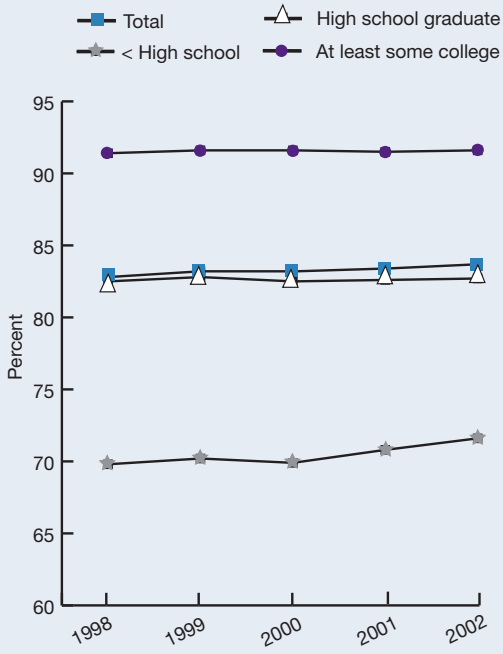
- Since 1999, the percent of women under age 65 with health insurance has been stable. However, current

Figure 5. Prenatal care in the first trimester, by race/ethnicity



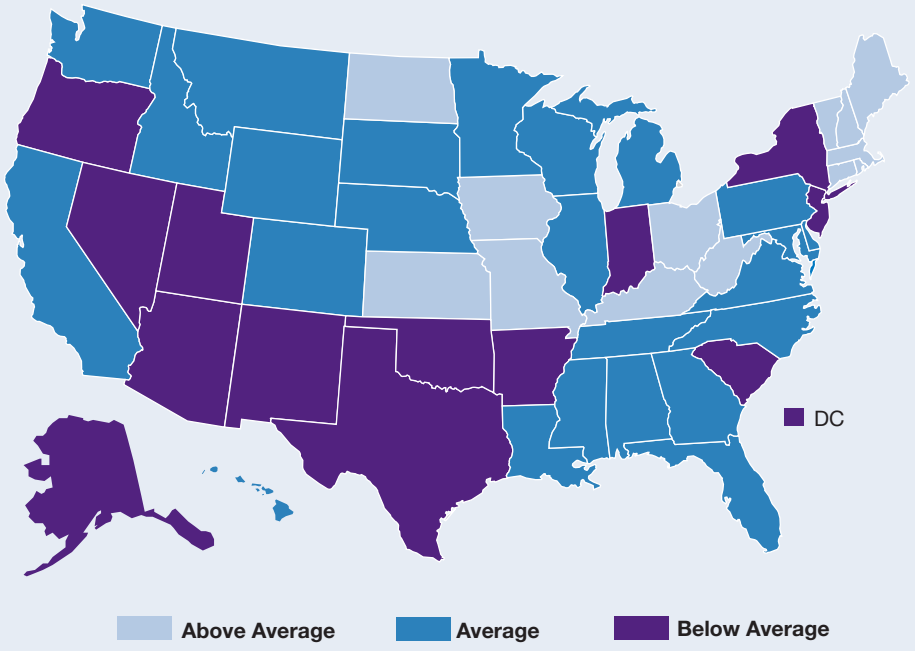
Source: Centers for Disease Control and Prevention, National Vital Statistics System, 1998-2002.

Figure 6. Prenatal care in the first trimester, by education



Source: Centers for Disease Control and Prevention, National Vital Statistics System, 1998-2002.

Figure 7. State variation in prenatal care in the first trimester



Source: Centers for Disease Control and Prevention, National Vital Statistics System, 1998-2002.

rates are below the HP2010 goal of 100 percent.

Race/ethnicity

- In all years, black women had lower rates than white women, and Hispanic women had lower rates than non-Hispanic white women (Figure 8).
- Between 1999 and 2001, rates of health insurance have been stable among all racial and ethnic groups.
- No racial group achieved the HP2010 goal.

Socioeconomic status

- In all years, women with less than a high school education and high school graduates had lower rates than women with at least some college education (Figure 9).
- Between 1999 and 2001, the rate of health insurance improved among near poor women and was stable for women in other income groups.
- No income group achieved the HP2010 goal.

Looking Toward the Future

Two of the major activities currently underway at AHRQ to address women's health care needs are briefly described below.

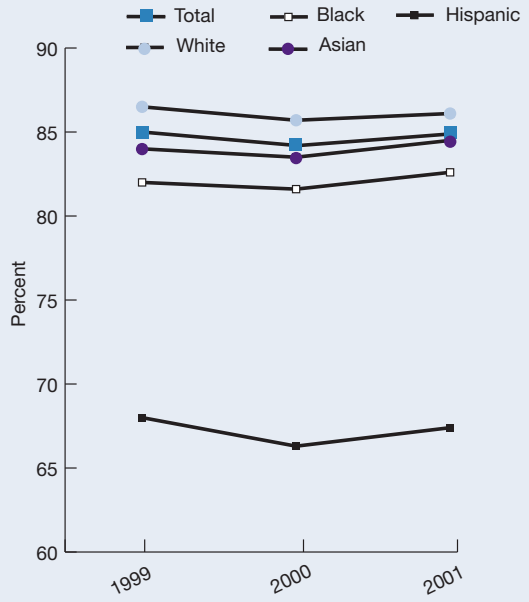
Database Development

To expand understanding of the safety and quality of women's health care, AHRQ is currently launching a collaborative effort to develop a comprehensive database of safety and quality measures for obstetric and neonatal health care. This database will aim to clarify what is known about obstetric/neonatal health care safety and quality and pave the way to filling gaps in knowledge.

NHQR/NHDR Women's Supplement

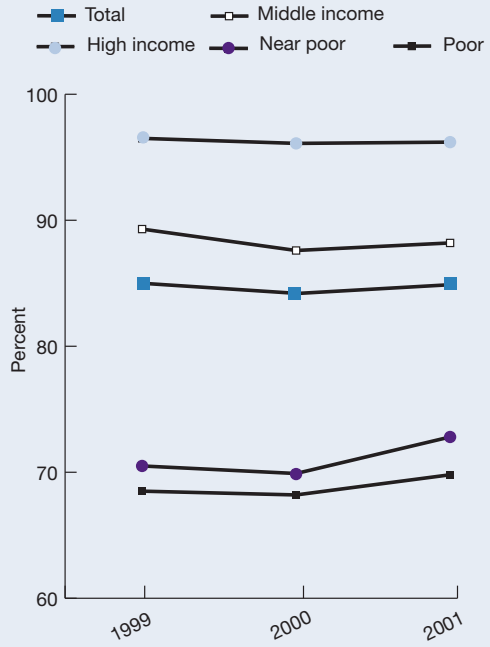
AHRQ's National Healthcare Disparities Report includes a section dedicated to analyzing the state of women's health care. In addition, AHRQ is in the planning stage of

Figure 8. Women under age 65 with health insurance, by race/ethnicity



Source: Centers for Disease Control and Prevention, National Health Interview Survey, 1999-2001.

Figure 9. Women under age 65 with health insurance, by family income



Source: Centers for Disease Control and Prevention, National Health Interview Survey, 1999-2001.

developing a supplemental report that will include comprehensive analyses of women's health care. The purpose of this exhaustive examination, now in progress, is to facilitate in the implementation of quality improvement efforts that target interventions for those populations and areas in women's health where there are opportunities for improvement.

For More Information

For more information on AHRQ initiatives related to women's health, please contact:

Rosaly Correa-de-Araujo, M.D., M.Sc., Ph.D.
Senior Advisor on Women's Health
540 Gaither Road
Rockville, MD 20850
Phone: 301-427-1550
E-mail: rcorrea@ahrq.gov

Further information on AHRQ's programs and other activities in women's health are available on the AHRQ Web site: www.ahrq.gov. For specific references to all detailed tables on women's health in the 2004 National Healthcare Quality and Disparities Reports see: www.qualitytools.ahrq.gov.

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