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Disparities by Sex Tracked in the 2015 National Healthcare Quality and Disparities Report: Trends across National Quality Strategy Priorities, Health Conditions, and Access Measures

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A B S T R A C T

Introduction: Established by the Affordable Care Act, the National Quality Strategy (NQS) is the national policy goals aimed at improving the quality of health care for all Americans. The NQS established six priorities to provide better, more affordable care for individuals and communities. This is the first analysis of data on the NQS and access measures that focus on sex differences, health conditions, trends, and disparities.

Methods: Measures from the 2015 National Healthcare Quality and Disparities Report (QDR) for the four National Quality Strategy priorities (Patient Safety, Person Centered Care, Effective Treatment and Healthy Living), access to care, and health conditions for women were compared to measures for men. Trends were analyzed for women by health condition and the four NQS priorities and access to care. Baseline year (2000-2002) and most current year (2012-2013) were compared to assess disparity trends. All non-institutionalized women and men in the U.S. over the age of 18 were included in the sample.

Results: Disparities between males and females for the four NQS priority and access measures did not change for 83 percent of measures (n=81); disparities remained constant. The greatest improvement over time for females from the baseline year was in the patient safety measures (3.66 percent increase per year). Access of care measures showed the least amount of improvement with a median change of -1.20 percent per year. The greatest improvement in quality of care by health condition was amongst chronic kidney disease (11.95 median percent change) and HIV/AIDS (6.63 median percent change) measures. Behavioral health measures showed the least amount of improvement with a median change of -0.33 percent per year.

Conclusions: This analysis highlights cardiovascular disease, behavioral health and access to care as problem areas for women that require immediate attention. It is of concern that 83% of the measures showed a persistent disparity over time between men and women. These results indicate that there is room for improving the quality of healthcare received by women and reducing sex-based disparities experienced by women in the healthcare delivery system.

Each year, the Agency for Healthcare Research & Quality (AHRQ) produces the National Healthcare Quality and Disparities Report (QDR) on the progress of achieving improved outcomes in the National Quality Strategy (NQS) priority areas and to identify opportunities for improvement. Although the 2015 report and supporting chartbooks included measures specific to women's reproductive health, such as pregnancy and birth outcomes, its focus was on disparities related to race, ethnicity, and socioeconomic status rather than disparities related to sex. This is the first analysis that uses data compiled for the 2015 report to

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present a summary of sex differences and disparities. The analysis assesses disparities by sex across dimensions of health care quality and access and health conditions.

The quality measures of the QDR are organized around the domains of the NQS. Established by the Affordable Care Act, the NQS is the first national policy to set goals aimed at improving the quality of health care for all Americans. Building on the Institute for Healthcare Improvement's Triple Aim, the NQS established six priorities to provide better, more affordable care for individuals and communities. The priorities are intended to address the range of quality concerns that affect most Americans: patient safety, person-centered care, care coordination, effective treatment, healthy living, and care affordability. It is believed that, by addressing these priorities through multiple stakeholders (e.g., individuals, payers, clinicians, employers, communities), the nation can rapidly improve health outcomes and increase the effectiveness of care for all populations (AHRQ, 2016a).

Methods

This analysis builds on data assembled for the 2015 QDR. It uses the same measures and methods that have been developed by the federal government for tracking trends, disparities, and changes in disparities in the national, annual reports (AHRQ, 2016b). However, rather than focusing on disparities related to race, ethnicity, and socioeconomic status, this analysis focuses on disparities related to sex.

Data

The data used in this analysis represent a compilation of federal and professional organization datasets housed at AHRQ for the annual national report that the U.S. Department of Health and Human Services Interagency Work Group developed. All data are national in geographic scope, offering different types of information to provide complementary perspectives of health care in the United States. Data are available on the National Healthcare QDR website (https://nhqrnet.ahrq.gov).

Only data sources with data collected and reported on a regular basis are included. The data include patient surveys, clinician surveys, administrative data from facilities, medical records, registries, surveillance systems, and vital statistics. As an example, AHRQ's Healthcare Cost and Utilization Project data, the Centers for Disease Control and Prevention's National Vital Statistics System, and the Centers for Medicare & Medicaid Services' Quality Improvement Organization are included in the data used in this analysis.

Data years vary across measures; most trend analyses include data points from the earliest years that data was available (2000–2002) to the most current year that data are available (2012–2013). The current data (2012–2013) were made available in the summer of 2016. It is important to note that, owing to the availability of the data, the analysis provides a snapshot of health care before the implementation of most of the health insurance expansions included in the Affordable Care Act and serves as a baseline to track progress in upcoming years.

Measures

Measures used in this analysis are the same measures used in the 2015 QDR (AHRQ, 2016b) with a few exceptions. Because this analysis focuses on sex-based disparities, measures applicable to one sex only were excluded, including measures of pregnancy, childbirth, and screening for breast, cervical, and prostate cancers. In addition, measures specific to children under age 17 years were excluded; adolescents were included in several measures of behavioral health and human immunodeficiency virus (HIV) care that included people ages 12 and older. The AHRQ measure set undergoes annual review and refinement guided by the U.S. Department of Health and Human Services Interagency Work Group. Appendix A identifies the specific measures selected for this analysis is provided.

Measures in the 2015 QDR are organized around the six priorities of the NQS. Because of insufficient numbers of measures for two priorities—care coordination and care affordability—this analysis focuses on the four following NQS priorities with adequate numbers of measures to examine sex-based disparities.

- Patient safety measures track safety within a variety of health care settings, including hospitals, nursing homes, and ambulatory care settings.
- Person-centered care measures examine individual experiences with care in an office or clinic setting, during a hospital stay, and while receiving home health care. The measures assess perceptions of communication with clinicians and satisfaction with the clinician–patient relationship.
- Effective treatment measures are organized around care for the leading causes of mortality and morbidity in the United States. They are further subdivided by clinical conditions: cancer, cardiovascular disease, chronic kidney disease, diabetes, HIV/AIDS, behavioral health (mental health and substance use), and respiratory disease.
- Healthy living examines health care services that typically cut across clinical conditions, such as lifestyle modifications and preventive services.

Although not identified as an NQS priority area, this analysis also includes access to health care measures. These measures include measures of health insurance, usual source of care, timeliness of care, and infrastructure that supports health care to minority and low-income populations.

Analysis

The 2015 QDR examines the size of disparities using the most recent data available, trends in quality and access for specific groups over time, and changes in the size of disparities between two groups over time. For each measure and each data year, estimates are generated for the U.S. population as a whole, as well as for different "priority populations" defined by age, sex, race, ethnicity, income, education, insurance, locality, and disability status. Estimates are generated using methods appropriate for each data source; for example, estimates from surveys with complex survey designs account for design effects and estimates from vital statistics account for random error.

Summaries of disparities and trends related to race, ethnicity, and income are the focus of the QDR. This paper applies this same approach to examine sex-related disparities. Estimates used in this paper are available on the QDR website and use of these estimates for further analysis is not considered human subjects research by the U.S. Department of Health and Human Services and AHRQ.

To assess the size of the disparity between men and women in the most recent year of data, the difference between the two groups was examined. Differences were considered significant when $p < .05$ on a two-tailed test and the relative difference