Several epidemiologic studies, survey data, and a growing body of literature confirm the persistence of disparities in health care associated with women’s race, ethnicity, income, education, and other factors (Institute of Medicine, 2002; Kaiser Family Foundation, 2004, 2005; National Women’s Law Center 2004; Agency for Healthcare Research and Quality [AHRQ], 2003a,b, 2004a,b, 2005a,b). Differences also remain between men and women in the receipt of evidence-based health care. However, despite the amount of data available, in-depth analysis of gender differences in the quality of health services provided in the United States is still limited. In this special issue, gender disparities across race and ethnicity are discussed in the management of 2 key chronic conditions and in preventive care.

This special issue begins with Correa-de-Araujo et al., (2006) showing that women with acute myocardial infarction or congestive heart failure continue to fare worse than men in the receipt of drug therapy. Also, rates of counseling to quit smoking are low among women and men of any race and ethnicity, but worse for Hispanic and black men. Further, the existence of comorbidities (e.g., diabetes, hypertension/end-stage renal disease) associated with acute myocardial infarction or congestive heart failure does not imply better quality of care for either women or men. Correa-de Araujo et al. also report that only 28.9% of women and 33.9% of men with diabetes receive the 5 process measures recommended for diabetes care (e.g., hemoglobin A1c measurement, eye exam, foot exam, and influenza vaccination within the previous year, and lipid profile within the previous 2 years). Although women and men have similar rates for hospital admission for uncontrolled diabetes, complications with lower extremity amputations remain higher for black and Hispanic men.

In a comprehensive overview of women’s health care utilization and expenditure, Taylor et al. (2006) show that white women continue to use any type of health services more frequently and use more prescription drugs than minority women and men, but both white and Hispanic women pay a higher proportion of income to out-of-pocket medical care expenses. The situation is similar to nearly 30% of older women in fair or poor health; they spend 10% or more of their income on out-of-pocket medical care. These findings are relevant to increase policymakers’ awareness of trends and gaps and provide them with opportunities for improving care by making policy changes.

Whereas Larson and Correa-de-Araujo (2006) make it clear that women from rural areas receive less preventive care than those residing in urban areas, knowledge is very limited about the unique health care needs of and the appropriate processes of care for older adults. In the study by Kosiak, Sangl, and Correa-de-Araujo (2006), a rough baseline for the quality of preventive care received by older women compared to older men is established. As with rural women, older women are significantly less likely to receive a number of preventive tests, to have their blood pressure under control, or to receive care for cardiovascular disease consistent with current science. These findings have serious implications for chronic
well-designed interventions that reallocate resources to improve self-management could mitigate gender differences across racial and ethnic groups. These findings also confirm prior reports indicating that minority women continue to experience disproportionate use of health services; minority women generally use fewer services compared to white women (Satcher, 2001; Kaiser Family Foundation, 2004, 2005). In particular, our findings show Hispanic women faring worse in health and health care than other populations of women. In fact, according to a Kaiser Foundation report, 24% of Hispanic women did not have a physician visit compared to 14% of African American and 11% of white women (Kaiser Family Foundation, 2004). Also, as many as 31% of Hispanic women lacked a regular health care provider compared to 17% of African American and 14% of white women.

Quality of care is a priority for women. They are the decision makers for their own health care as well as that of their family members. The National Healthcare Quality Report and the National Healthcare Disparities Report show that as much as 32% of Asian Pacific Islander, 20% of African-American, 19% of Hispanic, and 16% of white women are dissatisfied with the quality of the health services they receive (AHRQ 2003a,b). Rates of dissatisfaction with care also are considerably significant for women of high income (15%) and those who are poor (25%). Similarly, 15% of women with college education and 21% of those with less than high school education report dissatisfaction with health care.

Striking differences by income and educational levels were consistently observed among the populations examined in the studies presented in this issue. One critical example relates to avoidable hospitalizations for diabetes, which were found to decrease as income increased among women across racial and ethnic groups.

In a recent study assessing variations by gender, race and ethnicity, education, and income on items associated with 5 key domains of patient-centered care (e.g., health beliefs, health literacy, health advice received, doctor-patient relationship, and perceived discrimination), women were found to use various sources of health information and use them more frequently than men (Zambrana et al., forthcoming). Women are less likely, however, to follow doctors’ advice because of the perceived difficulty in understanding instructions, and more likely to perceive discrimination based on gender or race/ethnicity and ability to pay. The differences observed by income and race/ethnicity are relevant and the authors call attention to the need to develop scales to properly measure the patient-centered domains by gender, race/ethnicity, and socioeconomic status.

Health care professionals and policymakers must be aware of women’s health care trends. The depth of data analysis in this series demonstrates gaps in our understanding about current health care performance and opportunities for improvement due to data limitation. The studies in this series compared quality of care among female whites, blacks, and Hispanics. Data on other racial, ethnic, and socioeconomic groups were often not collected or collected in formats that differed from federal standards, making it difficult or impossible to generate estimates of statistical significance or reliability (Moy et al., 2005).

Factors influencing health disparities are numerous, and many are still unexplored and poorly understood. Moreover, how these factors are related is also poorly understood. Social, economic, educational, and system factors may continue to mask some of the real reasons behind disparities. Continued data collection is critical to help identify gaps and eliminate disparities, but collection needs to be broadened to capture additional information about socioeconomic and cultural factors as well as the determinants of health and disease both at community and individual levels. This will facilitate the development of effective interventions that target the specific needs of the populations, individuals, and the health system.

One effort led by AHRQ is the National Health Plan Collaborative to Reduce Disparities and Improve Quality in Diabetes Care. This collaborative brings together 9 of the nation’s largest health insurance plans. All share the common goals of improving the capacity to collect and analyze data on race and ethnicities, linking data to quality measures, developing quality improvement interventions to close gaps in care, and producing results that can be replicated by plans serving commercial, Medicare, and Medicaid populations nationally. In addition, AHRQ in partnership with the National Committee on Quality Assurance is examining the quality of care for cardiovascular disease through the use of national managed care performance data to investigate gender differences in Health Plan Employer Data and Information Set (HEDIS) measures related to heart disease and diabetes. Findings will be used to inform the development of recommendations for quality improvement and elimination of gender gaps in cardiovascular care.

Worldwide, women’s health is a major research and policy priority. Caring for women requires knowledge and experience in a complex mix of general health and wellness, reproductive issues, and specific disease and therapeutic needs. Access to evidence-based information is critical to support clinical decision making, but its value relies on the ability of health care professionals to translate research findings into clinical practice. The findings of the studies presented in this special issue combined with the evidence-based information that supports decision making may serve to catalyze the development of models of care delivery that are
patient-centered and customized to individuals’ needs and preferences.

References


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