EXECUTIVE SUMMARY

Introduction

The *National Healthcare Quality and Disparities* Report (NHQDR) is sometimes described as a "document of record" that has summarized the status of health and healthcare delivery in the United States since 2003. To compile this report, the NHQDR team prioritizes reporting data and measures that are broadly representative of the performance of the nation's healthcare system over time.

Multiple data partners, including all states and agencies throughout the Department of Health and Human Services (HHS), contribute data to the report. Before the report is finalized and submitted by the Secretary of HHS to the U.S. Congress, the report undergoes multiple cycles of review by reviewers who include representatives from contributing agencies.

Summary of the Report

The 2021 NHQDR is organized in sections that provide an overview of the healthcare system and summarize access, quality, and disparity measures. The Quality and Disparity sections are further divided into domain-specific chapters that highlight key healthcare trends or gaps in care. The appendixes include a list of data sources, definitions and abbreviations, and measures used in summary maps.

Overview of Disease Burden and the Healthcare System

The NHQDR provides an overview of the context in which people receive healthcare services, including a summary of disease burden in the United States; number, distribution, and characteristics of hospitals and healthcare workers who deliver services; and distribution of healthcare expenditures. Findings include:

- The leading causes of death in the United States are heart disease, cancer, and unintentional injuries. However, unintentional injury is the leading cause of years of potential life lost (YPLL).
- Death rates from unintentional injury have been rising, while deaths from heart disease and cancer have declined.
- Rates of suicide, another important contributor to YPLL, have also been rising.
- While the number of full-time, year-round healthcare workers has almost doubled since 2000, healthcare worker shortages still exist in many states. In addition, lack of racial and ethnic diversity persists within the healthcare workforce, notably among psychologists, therapists, dentists, advanced practice nurses, physician assistants, emergency medical technicians, and registered nurses.

Access to Healthcare

Of nine core access measures, five were improving over time: two measures related to access to health insurance, two measures assessing timely access to care, and one measure assessing patients' access to services when they perceive a need. Only one measure worsened over time: it assessed access to specialty care services for children. Notably, despite an overall increase in access to health insurance, a measure of access to dental insurance has not changed.

Although the overall trend in access to care has improved, significant disparities by race, ethnicity, household income, and location of residence persist for access to health insurance and access to dental insurance. Disparities by race, ethnicity, household income, location of residence, and insurance type also exist for having an ongoing source of care, receiving timely care, and receiving care when needed.

Quality of Care

- **Person-Centered Care:** More than half (14 of 26) of Person-Centered Care measures were improving. No measures were worsening. The three measures that improved most reflect more discussion about pain by home health care providers, more emotional and spiritual support from hospice providers, and better communication about medications prescribed during hospital stays.
- **Patient Safety:** More than 40% (11 of 26) of Patient Safety measures were improving. Only one measure worsened. The three measures that improved most reflect fewer adverse events in nursing homes (two measures) and fewer adverse drug events involving the blood thinner heparin in hospital settings. The only worsening measure reflects declining review of over-the-counter medication by home health care providers.
- **Care Coordination:** More than half (5 of 9) of Care Coordination measures were improving, but one-third (3 of 9) were worsening. The three measures that improved the most reflected improved communication with patients at hospital discharge, timely initiation of home health care services, and fewer home health care patients needing hospital admission. The three measures that worsened relate to increased reliance on emergency departments for conditions that could normally be managed at home or in ambulatory settings (two measures) and less consideration of patients' preferences when planning hospital discharge.
- **Affordable Care:** When accounting for the overall population, all (2 of 2) Affordable Care measures remained stable. However, closer examination of these measures by insurance status showed that over time, people with public insurance experienced lower out-of-pocket spending and were better able to have a usual source of care. By contrast, trends for people with private insurance showed higher out-of-pocket spending, while their likelihood of having a usual source of care did not change.
- **Effective Treatment:** More than 40% (15 of 35) of Effective Treatment measures were improving, while approximately 11% (4 of 35) of measures worsened. The three measures that improved most reflected better care for people with colon cancer and HIV and less inappropriate prescribing of antibiotics for people with viral respiratory infections. The three measures that worsened most reflected worsening trends in the opioid and suicide epidemics.
- **Healthy Living:** Almost two-thirds (40 of 63) of Healthy Living measures were improving, while three measures worsened. Among the many improving trends, the three measures that improved most reflected increased vaccinations for adolescents and for people receiving home health care services and less use of physical restraints in long-stay nursing homes. The two measures that worsened most reflect decreased pneumococcal vaccinations for nursing home residents and a troubling rise in childhood obesity.

Disparities in Healthcare

- **Race and Ethnicity:** Table ES-1 shows the number of measures for which racial or ethnic minority groups have better, same, or worse care compared with White groups. Compared with White groups, the number of measures that were worse exceeded the number of measures that were better for all racial and ethnic minority groups except Asian groups. Some healthcare disparities, such as those related to HIV outcomes, were common to most racial and ethnic minority groups. Other healthcare disparities were more prominent for certain groups, reflecting specific contexts and issues experienced by that group.

  Each racial or ethnic minority group has experienced improving care for many measures, but significant disparities persist because White populations experienced similarly improving care. Since 2000, disparities have narrowed for only about 8% of measures for American Indian and Alaska Native populations, 2% of measures for Asian populations, 3% of measures for Black populations, 4% of measures for Hispanic populations, and 10% of measures of Native Hawaiian/Pacific Islander populations.

Table ES-1. Number and percentage of quality measures for which selected racial or ethnic groups experienced better, same, or worse quality of care compared with White groups

Race or Ethnic Group	Better	Same	Worse
American Indian and Alaska Native	12 (11%)	53 (49%)	43 (40%)
Asian	50 (29%)	75 (43%)	48 (28%)
Black	21 (11%)	90 (46%)	84 (43%)
Hispanic	34 (20%)	76 (44%)	62 (36%)
Native Hawaiian/Pacific Islander	15 (19%)	43 (53%)	23 (28%)

- **Income:** People in poor and low-income households experienced worse care than people in high-income households on more than half of quality measures (67 of 117 and 65 of 116 measures, respectively). The disparate measures reflected lack of access to health insurance, lack of access to healthcare services, and lack of timely access to care. People in poor and low-income households experienced better care than high-income households on approximately 5% and 3% of measures, respectively. Since 2000, disparities have increased on approximately 5% of quality measures, including measures related to opioid-related conditions, and have decreased for only one measure.
- **Insurance Status:** Compared with people under age 65 with private insurance, people under age 65 with public insurance experienced worse care on nearly 40% (27 of 69) of quality measures and better care on 10% (7 of 69) of measures. People under age 65 with no health insurance experienced worse care on more than 60% (37 of 61) of measures and better care on about 7% (4 of 61) of measures.

  The largest disparities experienced by people under age 65 with public insurance reflect difficulty arranging a usual source of care, lower quality communication from providers, and lower quality care for breast cancer. The largest disparities experienced by people under age 65 with no insurance reflect difficulty arranging a usual source of care and lack of access to routine preventive services.

Notably, people under age 65 with public insurance or no insurance had better outcomes for a measure of out-of-pocket spending than people under age 65 with private insurance.

Over time, disparities among insurance groups have remained unchanged, except for one measure related to influenza vaccinations for people with diabetes. For that measure, the disparity narrowed between uninsured people and people with private insurance.

- **Residence Location:** Compared with people in large fringe metropolitan counties (i.e., the suburbs of large cities), people in urban cores, medium and small cities, and nonmetropolitan areas all experience worse care on more measures than better care. The types of healthcare disparities experienced by people in different locations suggests people in different locations have different underlying healthcare needs. For example, HIV and asthma stood out as conditions that disproportionately affected people in densely populated counties, whereas limited access to routine care services and increased risk of dying in a hospital stood out as prominent concerns for people in less densely populated counties.

  Overall, healthcare disparities among residence locations have not changed over time. An exception is a narrowing disparity between large fringe metro and large central metro areas in terms of hospital admissions for opioid-related conditions. However, this finding reflects a disappointing trend in which opioid-related hospitalization rates increased faster in suburban communities than in urban cores.

Key Findings and Trends

All measures reported in the 2021 NHQDR were collected in 2019 or earlier, before the rapid health system changes prompted by the COVID-19 pandemic. However, when viewed as a whole, the NHQDR still offers valuable information that can contribute to understanding how our nation's healthcare system has performed over time.

Readers should view the 2021 NHQDR as a definitive "snapshot" of where the nation stood as it entered the COVID-19 pandemic. The report can help answer questions about which aspects of our healthcare system exhibited the highest and lowest levels of quality and which were or were not improving before the COVID-19 pandemic.

Key lessons from the 2021 NHQDR include:

- **Several areas in which the nation has invested in quality improvement and patient safety have shown substantial improvements. For example:**
  - From 2000 to 2018, the HIV death rate decreased from 5.2 to 1.5 deaths per 100,000 population.
  - From 2000 to 2018, the rate of colon cancer deaths decreased 36%, from 20.8 to 13.4 deaths per 100,000 population.
  - From 2002 to 2018, the percentage of adults age 65 and over who received at least 1 of 33 potentially inappropriate prescription medications for older adults decreased from 19.3% to 10.2%.

- **The United States has seen significant gains in the number of people covered by health insurance and who have a usual source of healthcare. For example:**

  - From 2002 to 2018, the percentage of people under age 65 years who had any period of uninsurance decreased by 33%, and the percentage of people under age 65 who were uninsured all year decreased by 42%, with the largest change occurring after 2013. Concurrent with these trends, the percentage of Americans who have access to a usual source of care has improved.

- **Personal spending on health insurance and healthcare services decreased for people under age 65 with public insurance and increased for people with private insurance. For example:**

  - For people with public insurance, the percentage under age 65 whose family's health insurance premium and out-of-pocket medical expenditures were more than 10% of family income decreased from 17.7% to 12.7% (2002-2018).
  - For people with private insurance, the percentage under age 65 whose family's health insurance premium and out-of-pocket medical expenditures were more than 10% of family income rose from 12.3% to 19.3% (2002-2018).

- **Access to dental care and oral healthcare services remains low and has not substantially improved, particularly for people with low income or who live in rural areas. For example:**

  - The percentage of people under age 65 with any period of private dental insurance in the year showed no statistically significant change from 2006 to 2018, going from 54.0% to 58.9%.
  - The percentage of adults who received preventive dental care services in the calendar year showed no statistically significant change from 2002 to 2018, going from 33.6% to 35.4%.
  - Rates of emergency department (ED) visits for dental conditions remained persistently high from 2016 to 2018: 312.3 visits per 100,000 population in 2016 and 290.2 visits per 100,000 population in 2018.
  - Compared with people in the highest family income quartile, people in the lowest family income quartile were less likely to report having any private dental insurance during the year: 13.4% in the lowest income quartile vs. 81.1% in the highest income quartile.
  - Compared with people in who live in non-low-income ZIP Codes, people who live in low-income ZIP Codes had significantly higher rates of ED visits for dental conditions: 511 visits per 100,000 population in low-income areas vs. 213.4 visits per 100,000 population in non-low-income areas in 2018.
  - Compared with people in large fringe metropolitan counties (i.e., the suburbs), people who reside in micropolitan and noncore counties (i.e., small towns and rural areas) had significantly lower rates of dental insurance: 49.2% and 48.2% in micropolitan and noncore areas, respectively, vs. 66.6% in large fringe metropolitan counties in 2018.

  - Compared with large fringe metropolitan counties, nonmetropolitan counties had significantly higher rates of ED visits for dental conditions: 459.7 visits per 100,000 population in nonmetropolitan areas vs. 210.3 visits per 100,000 population in large fringe metropolitan counties in 2018.

- **The opioid and mental health crisis worsened in the years leading up to COVID-19. Limited access to substance abuse and mental health treatment may have contributed to this crisis. For example:**

  - Opioid-related ED visits and hospitalizations more than doubled between 2005 and 2018.[i]
  - From 2015 to 2019, there were no statistically significant changes in the percentage of people ages 12 and over who needed treatment for illicit drug use and received such treatment at a specialty facility, going from 18.3% to 17.8%.
  - Suicide death rates rose 23%, going from 14.0 deaths to 17.2 deaths per 100,000 population between 2008 and 2018.[ii]
  - The percentage of adults with a major depressive episode who received depression treatment in 2008 to 2019 showed no statistically significant changes, going from 68.3% to 66.3%.
  - From 2008 to 2019, the percentage of children ages 12-17 with a major depressive episode who received depression treatment showed no statistically significant changes, going from 37.7% to 43.3%.

- **While Black, Hispanic, and American Indian and Alaska Native communities all experienced substantial improvements in healthcare quality, significant disparities in all domains of healthcare quality persist. Even when rates of improvement in quality exceeded those experienced by White Americans, they have not been enough to eliminate disparities. For example:**

  - Despite an overall decrease in HIV death rates, including in Black populations, a significant disparity persists. From 2000 to 2018, HIV deaths in Black populations decreased from 23.3 deaths to 6.2 deaths per 100,000 population. Still, deaths in Black populations remain more than 6 times as high as HIV deaths in White populations (0.9 deaths per 100,000 population).
  - From 2001 to 2018, the incident rates of end stage renal disease due to diabetes decreased 48% from 526 to 273.1 events per million population in American Indian/Alaska Native communities and decreased 29% from 525.7 to 372.2 per million population in Black communities. Despite these gains, significant disparities persist among non-Hispanic American Indian and Alaska Native, Black, and White populations, with respective incident rates of 273.1, 372.2, and 152.2 events per million population in 2018.

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[i] More recent, provisional data from the National Center for Health Statistics (NCHS), which are described in this report, indicate that the opioid crisis has *accelerated* during the pandemic.

[ii] More recent data, described in this report, describe a 1-year reversal in this trend in 2019. The decrease in suicide deaths occurred in White populations only, while death rates in Black populations continue to rise.

- Similarly, the incident rates of end stage renal disease due to diabetes decreased 29% from 410 to 292.7 events per million population from 2001 to 2018 in Hispanic communities. Despite these gains, incident rates in 2018 in Hispanic communities were still more than double the rates in non-Hispanic White communities (142.8 events per million population).

The relationships between race/ethnicity, socioeconomic status, gender, age, and geography and health are complex and not easily summarized in a single document. The full set of findings in the 2021 NHQDR provide additional nuance and insights concerning the complexity of quality and disparities in American healthcare. Thus, readers are encouraged to explore the NHQDR Data Query website, where they may access the full collection of data that were used to produce this report.