Lê Cook et al., “Measuring racial/ethnic disparities in health care: methods and practical issues”

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- reviews methods of measuring racial/ethnic healthcare disparities
- based on the IOM Unequal Treatment report, propose a definition for racial/ethnic disparities and discuss strengths and critiques
- discuss implementation and situate discussion in international context
- compare different implementations of the IOM definition
- there are multiple ways to measure disparities
- disparity means more than difference, it means inequality and unfairness
- application to healthcare differences between racial and ethnic groups is controversial and requires choice about what differences are justifiable
- article focuses on healthcare utilization differences, which will subsume access and quality differences
- three common definitions of racial/ethnic healthcare disparities:
  - residual direct effect (RDE): race/ethnicity coefficient in a multivariate regression model after adjustment for all other factors available to the researcher, including socioeconomic status (SES) variables
  - compare unadjusted means, all differences count as disparities
  - IOM definition: disparities are differences in health care services received by the two groups that are not due to differences in the underlying health care needs or preferences of members of the groups
- critical choices: IOM definition includes SES differences in racial/ethnic differences and adjusts for health status
• identifying datasets with appropriate health status, preferences, and SES variables
  
  - can use nationally representative datasets with large minority samples: MEPS, National Latino and Asian American Survey, National Epidemiologic Survey on Alcohol and Related Conditions, Healthcare Cost and Utilization Project, Medicare claims data
  
  - try to match IOM definitions with variables in data, unmeasured variables might be a problem
  
  - predict optimal levels of care using health status variables
  
  - SES, education, etc. can be measured
  
  - preferences are hard to measure

• what differences should count as a disparity?
  
  - which variables are acceptable sources of differences is ambiguous and context dependent
  
  - problematic groups of variables: preferences, geography, insurance status, comorbidities
  
  - preferences: patients are not fully informed, have different attitudes towards the health system
  
  - geography: is geographical distribution of racial/ethnic groups unfair in itself?
  
  - insurance status: minorities can have different insurance status, insurance status correlated with unmeasured health status and also healthcare access
  
  - comorbidities: correlated with race, recognition depends on healthcare use; are comorbidities a need or a system-level variable?

• choosing a statistical method to implement the IOM definition
  
  - reduced covariate model
  
  - propensity score method
  
  - rank and replace method
  
  - propensity score with rank and replace adjustment