

## Comparative Effectiveness Research: A Potential Tool for Reducing Health Care Disparities

As the national debate on health reform heats up, one topic that has generated controversy is comparative effectiveness research. Comparative effectiveness research will be used to help providers and patients make more informed treatment decisions. But critics claim that it will be used to ration care, putting bureaucrats between doctors and patients.<sup>1</sup> This is not true. If done right, comparative effectiveness research can equip health care providers with the latest information available on what treatments work best and are the safest. It can also provide patients with access to the same information in an easily understood format. Together, informed doctors and empowered patients can develop the best course of treatment.

With this new body of research comes the potential to do something else that's very important—close gaps in health care quality. Research has shown that racial and ethnic minorities receive lower-quality health care than their white counterparts, even when they are insured and have similar incomes. This fact sheet looks at comparative effectiveness research and its potential for reducing health care disparities.

### What Are Disparities in Health Care Quality?

- Racial and ethnic minorities are more likely to receive lower-quality care (such as fewer screenings, preventive services, referrals, and less timely care)<sup>2</sup> regardless of where they live, their income, or their insurance status. Millions often receive worse care simply because of their race or ethnicity. To learn more about disparities in health care quality, see the textbox, “A Look at Racial and Ethnic Disparities in Health Care Quality,” on page 3.
- As a result of receiving lower-quality care, racial and ethnic minorities have worse health.<sup>3</sup>
- While the effort to reduce racial disparities in health must be comprehensive, one part of the solution is to give doctors and patients the best treatment information available so they can make the most informed health care decisions possible.

### What Is Comparative Effectiveness Research?

- Comparative effectiveness research determines which medical services, drugs, therapies, devices, and procedures work best. This research helps doctors and patients think together about treatment options and decisions.
- In February, the economic stimulus bill (the American Recovery and Reinvestment Act, or ARRA) provided \$1.1 billion for comparative effectiveness research.
- As part of health care reform, congressional committees have drafted legislation that includes comparative effectiveness research efforts and other measures that are designed to improve quality.

## How Can Comparative Effectiveness Research Reduce Disparities?

Before we can improve quality, we need to improve our research. Comparative effectiveness research has several parts to it, such as gathering population samples; testing treatments; collecting and analyzing data; and reporting findings to providers, patients, and communities. Steps must be taken to make sure the research is done well, and that it is made accessible to providers and patients. To get the most use out of comparative effectiveness research, it will be important to do the following:

- **Improve inclusion criteria in studies:** Studies must have samples (groups of people) that reflect the diversity of the U.S. population, and this can be accomplished by oversampling among communities of color. Historically, data collection has focused primarily on differences between African Americans and whites. Data categories should reflect the diversity of our nation and also include American Indian/Alaska Native, Asian, Hispanic/Latino, and Native Hawaiian and Other Pacific Islander populations. It's also important to note that subpopulation differences exist within these broad racial and ethnic groups. For example, one study found that Vietnamese men in California have the highest incidence and death rate from liver cancer compared to men in other Asian subpopulations, such as Filipino, Korean, and Japanese.<sup>4</sup> Researchers should analyze subpopulation differences whenever possible.
- **Recruit and do outreach to communities of color:** Studies often neglect or fail to recruit minority communities. This is due to several factors, including lack of trust among potential participants and lack of access to certain populations. Coordinating with community organizations, health advocacy groups, and other trusted sources is one way to effectively reach communities of color.
- **Take into account multiple chronic illnesses:** Racial and ethnic minorities are more likely than whites to have multiple chronic illnesses such as diabetes, high blood pressure, and high cholesterol. Studies must examine how one intervention for a certain chronic illness affects patients with additional chronic illnesses.
- **Evaluate the effect of interventions in the context of communities:** If possible, clinical trials should examine the effectiveness of interventions within a social context—where people live, work, and play. Communities of color are more likely to encounter structural barriers to good health, such as substandard housing; transportation difficulty; low job availability; less access to education; and limited geographic access to fresh, healthy foods and medical providers. The community environment may have adverse effects on health, and clinical studies must take this into account.
- **Make research useful to communities of color:** Once educational materials are developed for consumers, there must be a high priority on translating research findings into culturally, socially, linguistically, and generation-appropriate tools.

## A Look at Racial and Ethnic Disparities in Health Care Quality

Each year, the Agency for Health Care Research and Quality releases reports that document our nation's progress toward improving quality of care and reducing disparities. The 2008 National Healthcare Disparities report evaluated care across a range of measures (such as referrals and preventive screenings) that are known to keep people in good health. In addition, other studies have identified disparities in the use of specific medical procedures and in patient-provider interactions.

While the overall population might not always receive the best care,<sup>5</sup> low-quality care is an especially serious problem among minority populations. The evidence of the health care disparities facing racial and ethnic groups is overwhelming. For example, when compared with the quality of care that whites receive:

- **African Americans** are more likely to be hospitalized for diabetes-related complications. They are also less likely to receive timely care for an illness or injury.<sup>6</sup>
- **American Indians and Alaska Natives** are less likely to receive recommended care for heart failure and pneumonia. In addition, pregnant American Indian and Alaskan Native women are less likely to receive prenatal care in the first trimester.<sup>7</sup>
- **Asians** are less likely to receive timely care for an illness or injury, and they are less likely to receive appropriate timing of post-surgical antibiotics.<sup>8</sup>
- **Hispanics or Latinos** are less likely to receive recommended hospital care for a heart attack. In addition, pregnant Hispanic women are less likely to receive prenatal care in their first trimester.<sup>9</sup>

Other research shows that disparities exist in physicians' perceptions of patients and in patients' satisfaction with their health care visits. Research suggests that the quality of interaction in the patient-provider relationship may be compromised simply because of the patients' race or ethnicity. For example, the studies have shown that disparities exist:

- **In specific medical procedures:** One study found that physicians had an implicit bias, seeing African Americans as less cooperative with medical procedures for breaking blood clots and less cooperative generally when compared with whites.<sup>10</sup>
- **In communication with doctors:** Another study found whites reported better quality of care for factors such as “the doctor listened to everything I had to say” and “I was involved in decisions as much as I wanted” during their latest physician interaction when compared with African Americans, Hispanics, and Asians.<sup>11</sup>

## Endnotes

<sup>1</sup> See the statement of Senator Jon Kyl on health care reform proposals online at <http://kyl.senate.gov/record.cfm?id=314533>. See also Robert Pear, "U.S. to Compare Medical Treatments," *The New York Times*, February 15, 2009, available online at <http://www.nytimes.com/2009/02/16/health/policy/16health.html>.

<sup>2</sup> Ernest Moy, Elizabeth Dayton, and Carolyn M. Clancy, "Compiling the Evidence: The National Healthcare Disparities Reports," *Health Affairs* 24, no. 2 (March/April 2005): 376-387.

<sup>3</sup> For example, more African American and American Indian/Alaskan Native adults reported being in fair or poor health than white adults. See Centers for Disease Control and Prevention, National Center for Health Statistics, *Summary Health Statistics for U.S. Adults: National Health Interview Survey, 2007* (Hyattsville, MD: National Center for Health Statistics, May 2009). In addition, the infant mortality rate is 2.4 times higher among African American infants than white infants, and the maternal mortality rate is 3.4 times greater for African American women than for white women. See Centers for Disease Control and Prevention, National Center for Health Statistics, *National Vital Statistics Reports, Deaths: Final Data for 2006* (Hyattsville, MD: National Center for Health Statistics, April 2009). Note: The National Center for Health Statistics uses the term "black" in their reports instead of "African American." To be consistent with our terminology, we used African American to describe their findings.

<sup>4</sup> Melissa McCracken, Miho Olsen, Moon S. Chen, Jr., Ahmedin Jemal, Michael Thun, Vilma Cokkinides, Dennis Deapen, and Elizabeth Ward, "Cancer Incidence, Mortality, and Associated Risk Factors among Asian Americans of Chinese, Filipino, Vietnamese, Korean, and Japanese Ethnicities," *CA: A Cancer Journal for Clinicians* 57, no. 4 (July/August 2002): 190-205.

<sup>5</sup> Elizabeth A. Mcglynn, Steven M. Asch, John Adams, Joan Keeseey, Jennifer Hicks, Alison DeCristofaro, and Eve A. Kerr, "The Quality of Health Care Delivered to Adults in the United States," *New England Journal of Medicine* 348, no. 26 (June 2003) 2635-2645.

<sup>6</sup> Agency for Healthcare Research and Quality, *2008 National Healthcare Disparities Report* (Rockville, MD: Agency for Healthcare Research and Quality, March 2009).

<sup>7</sup> *Ibid.* Note that because of the difficulty of collecting data on American Indians/Alaska Natives, only about half of the core report measures of quality could be used to make estimates for this population.

<sup>8</sup> Agency for Healthcare Research and Quality, *op. cit.*

<sup>9</sup> *Ibid.*

<sup>10</sup> Alexander R. Green, Dana Carney, Daniel J. Pallin, Long H. Ngo, Kristal L. Raymond, Lisa I. Iezzoni, and Mahzarin R. Banaji. "Implicit Bias among Physicians and Its Prediction of Thrombolysis Decisions for Black and White Patients," *Journal of General Internal Medicine* 22, no. 9 (September 2007): 1,231-1,238.

<sup>11</sup> Somnath Saha, Jose J. Arbeleaz, and Lisa A. Cooper, "Patient-Physician Relationships and Racial Disparities in the Quality of Health Care," *American Journal of Public Health* 93, no. 19 (October 2003): 1,713-1,719.



1201 New York Avenue NW, Suite 1100 ■ Washington, DC 20005

Phone: 202-628-3030 ■ E-mail: [info@familiesusa.org](mailto:info@familiesusa.org)

[www.familiesusa.org](http://www.familiesusa.org)