

The comment below was posted on journalreview.org on February 10, 2008. Following the closing of that site, the comment was reproduced here in September 2012.

Implications of the focus on racial/ethnic disparities in control rather than processes in the context of pay-for-performance

A further consideration regarding pay-for-performance and the measurement of healthcare disparities involves the fact that pay-for-performance programs that consider healthcare disparities issues are likely to be focused more on disparities in control among subpopulations deemed to need special attention, such as persons diagnosed as hypertensive, than disparities in processes among the population at large. As discussed in references 6,8-10, 14 of my earlier comment,[1] the former focus involves truncated populations, where the distributions of factors associated with an outcome will tend not to be normal even when the overall distributions of which they are a part are perfectly normal. These references maintain that such fact would seem not to materially alter the typical patterns of changes of measures of differences between rates as the prevalence of an outcome changes (except for odds ratio), as illustrated, say, in Figures 6 and 7 of reference 8 to the earlier comment (though such issue certainly deserves further attention).[2]

But that disparities are examined within truncated populations would have material implications with regard to the approach described in the earlier comment that estimated differences between means of hypothesized distributions. As I have stressed, even as to an overall population, such approach is rather speculative given that we do not know the extent to which the underlying distributions of the groups being compared are in fact normal. But, for reasons explained with respect to Tables 6-8 of reference 14 of the earlier comment, such approach seems fundamentally problematic with regard to distributions in special needs populations that, being truncated portions of larger distributions, are almost certain not to be normal.

While the above comments are intended mainly to concern situations where control disparities are examined, I note that data discussed in the earlier comment involved treatment decisions concerning a population that had experienced acute myocardial infarction. While this a special needs population, I am nevertheless inclined to think that the white and black distributions of factors associate with receiving CABG tend to be more like those in an overall population (that is, tending toward normal) than those in a truncated population, such as, say, the white and black distributions of factors associated with control of hypertension within a population diagnosed as hypertensive. But to the extent that the distributions of factors are more like the latter than the former, it would call further into question the reliability of results of the approach described in the earlier comment.

In any case, that the examination of healthcare disparities in the context of pay-for-performance programs is likely to more often involve disparities in control than

disparities in processes may well further complicate the task of devising rational methods for appraising performance.

1. Scanlan JP. Pay-for-performance implications of the failure to recognize the way changes in prevalence of an outcome affect measures of racial disparities in experiencing the outcome. *Journal Review* Feb. 8, 2008 (responding to Werner, RM, Asch DA, Polsky D. Racial profiling: The unintended consequences of coronary artery bypass graft report cards. *Circulation* 2005;111:1257–63):
http://jpscanlan.com/images/Werner_Circulation_2006.pdf

2. References 6 and 8-10 explain why a study found improvements in care to reduce absolute differences in process outcomes but not reduce (or to increase) absolute differences in clinical control outcomes. Such explanation involves the fact that improvements in the process outcome rates examined tended to involve relatively high favorable outcome rates (that is, in what is termed Zone B in the figures in references 6 of the earlier comment and where further increases tend to reduce absolute differences) while improvements in the control rates examined tended to involve relatively low favorable outcome rates (that is, in what is termed Zone B in the figures in references 6 of the earlier comment and where further increases tend to increase absolute differences). But such explanation involves a different issue from that of whether, within a population needing control, correlations between various measures and the prevalence of an outcome are similar to those observed in the overall population.