
I. Introduction

There are large racial and gender disparities in healthcare that are not explained by differences in patient access, preferences, or severity.¹ These disparities are believed to contribute to differences in health outcomes, and are often ascribed to prejudicial providers [Green et. al (2007), Fincher et.al (2004), van Ryn and Fu (2003), Ayanian et.al (1999), Bogard et. al (1994), van Ryan (2002), Schulman et. al (1999) and]. This view is shared by the Institute of Medicine's (IOM) influential *Unequal Treatment* report that reviewed the literature on racial and ethnic disparities in healthcare in order to understand its principal determinants. The report concludes that provider prejudice in the context of the clinical

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white (or male and female) patient. Under statistical discrimination the marginal returns will be the same

patient characteristics (X) such as age, medical history, and lab results, and other factors that

However, the effect of prejudice can be identified if information on the treatment effect among the treated population is available. The treatment-on-the-treated parameter is

differs by race or gender. But in the Knowles *et al.* model, the return to searching motorists in the absence of prejudice are equalized across all subgroups in equilibrium – otherwise, $\rho_{aTm} -$

evidence points to large therapeutic gains from many of these treatments. In this context, racial and gender disparities in treatments may directly translate into lost lives. This view is shared by others, and there is a rich tradition of studying disparities in treatments and

data on the patients—detailed information is provided on laboratory tests, the location of the myocardial infraction, and the condition of the patient at the time of admission.

The CCP used administrative data to identify patients admitted with an AMI

heart attack). This selection of healthy patients into treatment biases OLS estimates toward finding a large effect of intensive treatment. We follow the work of McClellan et.al (1994) and estimate equation (7) using instrumental variables. In particular, we use the differential distance (measured as the distance between the patient's zip-code of residence and the nearest catheterization hospital minus the distance to the nearest non-cath hospital) as an instrument

specific models. If the two models yield similar predictions (not only on average, but throughout the distribution of covariates), then a plot of predictions obtained from the sex and race specific models on those obtained from the common effects model, should align along a 45-degree line. In the two panels of Figure 4 we illustrate this test, and note that the common-effects model provides an excellent summary of how patients are being triaged. There are also

confirm that the benefit from treatment is the same for men and women (or blacks and whites) wa e9.

reject this hypothesis in favor of prejudice against men and whites. Thus, even after accounting for lower costs of treatment for women and blacks, we find no evidence of prejudice.

benefit of treatment was the same for all groups. An interesting alternative would be if medical care providers used lower values of β (and hence a higher value of life) for whites or

References

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Appendix . Construction of CCP Estimation Sample:

The CCP used bills submitted by acute care hospitals (UB-92 claims form data) and contained in the Medicare National Claims History File to identify all Medicare discharges with an International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) principal diagnosis of 410 (myocardial infarction), excluding those with a fifth digit of 2, which designates a subsequent episode of care. The study randomly sampled all Medicare beneficiaries with acute 0 200 0 0Tm /F2.0 1 in 50 states between February 1994 and July 1995, and in the remaining 5 states between August and November, 1995 (Alabama, Connecticut, Iowa, and Wisconsin) or April and November 1995 (Minnesota); for details see O'

but the sample was representative of the Medicare fee-for-service (FFS) patient population in the United States in the mid-1990s. After sampling, the CCP collected hospital charts for each patient and sent these to a study center where trained chart abstracters abstracted clinical data. Abstracted information included elements of the medical history, physical examination, and data from laboratory and diagnostic testing, in addition to documentation of administered

Details of data coll

Figure 1a: Graphical Illustration of Unprejudiced Provider Behavior

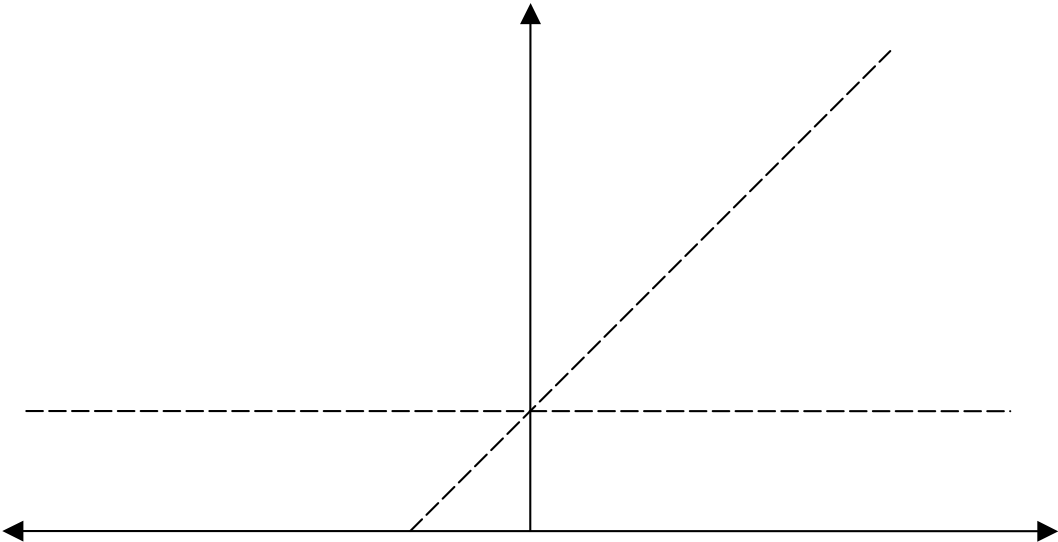


Figure 2: Reweighting the Distributions of Propensities by Sex (Panel A), and Race (Panel B)

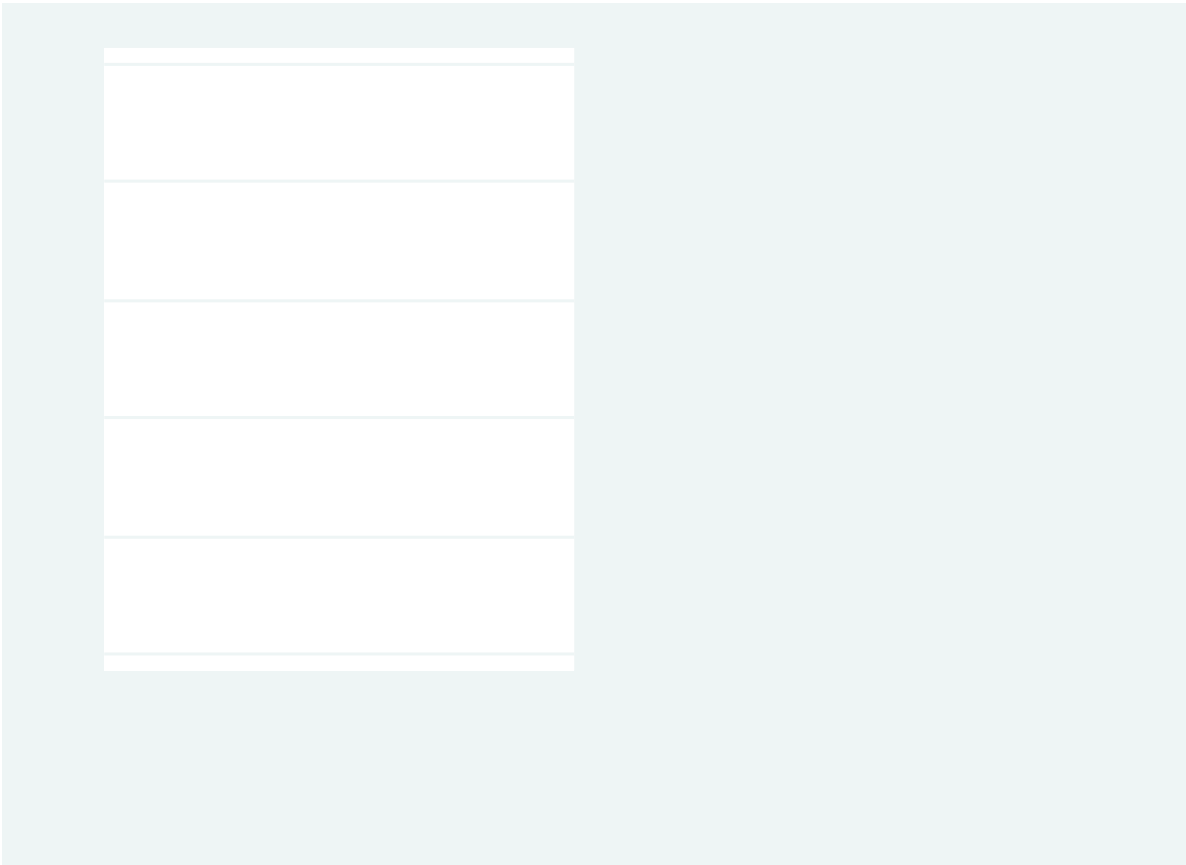


Figure 3: Distribution of Propensity to receive Catheterization for Patients who received Cathete

Table 1: Means by Sex and Race of Selected Variables



Table 4: Black-White Differences in the

Table 6: Instrumental Variable Estimates of the Effect of Intensive Management on One-Year Survival, by Propensity to Receive Catheterization (from Chandra and Staiger, 2007)

