# Poorer and minority older adults are suspicious of the US health care system

April 1 2021, by Marc Cohen and Jane Tavares

Credit: Unsplash/CC0 Public Domain

Just over two weeks before she died of complications from COVID-19 in December 2020, Dr. Susan G. Moore recorded a smartphone video from her bed in an Indiana hospital. In the recording, which went viral, the Black physician accused a white doctor of letting racial bias affect

his medical decisions, from evading her requests for a CT scan, to playing down her pain complaints and refusing to prescribe additional narcotic painkillers.

"He made me feel like I was a drug addict," Moore, a 52-year-old family physician, said into the camera. "I maintain that if I was white, I wouldn't have to go through that."

Moore's experience and death sparked a national conversation on biases in the U.S. health care system. In a new study that we worked on with a team of fellow researchers, we found that health care providers are often not hearing their patients, especially those who are poorer or minorities. It's not uncommon for people to feel that their care preferences aren't being taken into account, according to our research. Further, the effect is magnified if the patient is poor or a person of color.

## A failing grade

We analyzed information collected in a biannual national survey called the Health and Retirement Study. Along with colleagues at the LeadingAge LTSS Center at the University of Massachusetts Boston and the Center for Consumer Engagement in Health Innovation, we found that fully one-third of U.S. respondents age 50 and older reported the health care system "never," or only "sometimes," considered their care preferences. The other two-thirds reported their preferences were "usually" or "always" taken into account.

One may or may not consider two-thirds a passing grade—in schools, this would be a "D" or "F"—but certainly everyone would agree there's room for improvement. What troubled us most is that our study reveals significant differences in how health care workers relate to minorities and the nonwealthy, and the fact that many of those respondents believe no one is paying attention to their care preferences.

We found that one in five individuals with incomes below the federal poverty line—US$12,880 a year for an individual, or $26,500 for a family of four—reported that health care providers accounted for their preferences "rarely" or "only sometimes." Only one in 10 individuals living above the poverty line said the same. The wealthy, by comparison, were much more likely to report that health care providers listened to them.

Regarding race, 16% of non-Hispanic Blacks, nearly one in six, reported that their preferences were "never" taken into account. Among Hispanics, 23% or nearly one in four reported the same. Compare this to non-Hispanic whites, where only 8% – fewer than one in 10—said their health care providers never listen to them.

## Why it matters

These disparities have life-and-death implications. We found that when patients feel their health care providers have ignored their preferences, they either engage less or stop seeking medical care altogether. Overall they are less likely to use health care services in the future, even when they report poor health.

Our findings suggest a partial explanation for why coronavirus vaccination is proceeding more slowly in minority communities. Although Black individuals and other people of color tend to have more serious complications with COVID-19, they are still less inclined to get a vaccine. According to a mid-2020 study in the United Kingdom, part of the reason people opt out of getting vaccines is distrust of medical professionals. Our new study suggests that this distrust may stem from the belief they that don't feel heard by providers.

This problem isn't just about the COVID-19 pandemic, however: Minority older populations also tend to have higher rates of hypertension

and heart disease. So the consequences of any reluctance to use health services can be serious.

Clearly stark wealth and income gaps in the U.S. are big parts of this problem. But Dr. Moore's testimony suggested that racial bias, even if unconscious, can also play a large role. To assure that all individuals seek and receive good medical care—including treatment and vaccination for COVID-19—health care providers need to refocus on a core tenet of "person-centered care": paying attention to the expressed needs and preferences of all patients.

**Measuring what matters**

The good news is that opportunities for change are out there:

- Programs that focus on goals that patients set themselves provide a useful model that could be emulated. This approach has mostly been tried in settings like nursing homes and assisted living centers, but it may also provide lessons for the broader health care system.
- We can strengthen reporting tools like the Star rating system, a quality rating system which in part measures patients' experiences, and is used by Medicare to help consumers make better-informed choices. It is also used as a basis for providing financial incentives to health plans that perform well on these measures.
- The Age Friendly Health Systems Initiative, which is rapidly spreading with more than 1,900 health care systems joining the movement, emphasizes putting a focus on what matters most to older adults in all medical interactions and settings.
- Our findings associate a reliable source of care with the higher likelihood that providers are taking patients' preferences into account, suggesting that it's also essential to improve primary

care.

## Hearing the consumer's voice

Care providers can improve immediately by letting patients and their families share, speak out and genuinely participate in care decisions. Such dialogs can take place beyond the confines of the exam room or the hospital bedside. One popular approach involves hospitals and clinics creating patient and family advisory councils, which then participate in the design of clinical programs.

On-the-ground medical workers can't do this without institutional support. Medical schools and employers need to invest in communications training to help care providers learn how to build bonds with patients based on trust and mutual respect. Implicitly, this also means that both care providers and their managers must consistently give patients enough time to express their issues and concerns.

The deadly nature of this pandemic has combined with the existing weaknesses in our health care system to make these initiatives even more urgent. Our study shows that the U.S. desperately needs public policies that end racial disparities and ensure the economic security of older adults. Fortunately we already know some solutions that only need to be reinforced and scaled.

President Biden campaigned on a promise to "build back better" from the pandemic. Our findings make clear that this needs to include the health care system too. Addressing these issues head on is critical to achieving a more equitable health care system that not only listens to patients, but also hears them.

Provided by The Conversation