

Impact of Perceived Racism on Healthcare Access Among Older Minority Adults



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Introduction: Older minority individuals are less likely to receive adequate health care than their white counterparts. This study investigates whether perceived racism is associated with delayed/forgone care among minority older adults, and whether poor doctor communication mediates this relationship.

Methods: Study cohort consisted of minority participants, aged ≥ 65 years, in the 2015 California Health Interview Survey (N=1,756). Authors obtained data in November 2017, and statistical analyses were performed from February to April 2018. Multivariable logistic regression analyses were conducted with relevant covariates, including insurance coverage, years living in the U.S., and language. A mediation analysis was also performed.

Results: Among minority older individuals, perceived racism was significantly associated with delayed/forgone care (AOR=3.92, 95% CI=1.38, 11.15, $p=0.010$). Poor doctor communication significantly and partially mediated the relationship (AOR=3.64, 95% CI=1.30, 10.21, $p=0.014$), accounting for 9.9% of the total effect.

Conclusions: Perceived racism may contribute to health disparities for older minority individuals in part through doctors communicating messages that discourage adequate utilization of health care. Future research should explore culturally sensitive communication skills that reduce this barrier to receiving adequate health care.

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INTRODUCTION

Although more than 98% of adults aged 65 years or older are covered through Medicare and other combinations of insurance types,¹ racial/ethnic minority older adults continue to access health care inadequately, contributing to disparities in their health outcomes.² Moreover, the proportion of Americans aged 65 years or older is projected to increase from 14.5% in 2014 to 23.5% in 2060, and the older population is becoming more racially and ethnically diverse.³ Improving the healthcare access of ethnic minority older adults is a national goal in the *Healthy People 2020* initiative.⁴

Previous research documents that older black and Hispanic people are at higher risk of having unmet or undermet healthcare needs compared with older white people.^{5,6} Also, prior research has found a tendency for

some healthcare providers to hold negative implicit attitudes toward patients of color and to express these biases through communications with their patients (e.g., subtle forms of disrespect or not recommending procedures).⁷ However, to the authors' knowledge, the current study is the first to investigate whether perceived racism

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Table 1. Selected Characteristics of Adults Aged ≥65 Years in California by Perceived Racism, 2015 CHIS

Characteristics	Perceived racism		Total, %	p-value ^a
	No, %	Yes, %		
Sample size				
Unweighted sample, N	1,668	88	1,756	
Weighted population in California, N	1,834,103	82,456	1,916,559	
Predisposing factors				
Age, years				0.002
65–74	63.1	83.8	64.0	
≥75	36.9	16.2	36.0	
Sex				0.442
Female	55.1	62.1	55.4	
Male	44.9	37.9	44.6	
Race/ethnicity				0.389
Non-Hispanic black	12.8	22.5	13.3	
Hispanic	32.3	33.7	32.3	
Non-Hispanic Asian	23.4	21.2	23.3	
Other ^b	31.5	22.7	31.1	
Marital status				0.208
Married	56.2	47.0	55.8	
Never married	6.7	3.6	6.6	
Other ^c	37.1	49.4	37.6	
Geographic region				0.121
Urban	56.8	72.1	57.5	
Second city	17.7	14.1	17.5	
Suburban	17.4	12.1	17.2	
Town and rural	8.2	1.7	7.9	
Years in U.S.				0.700
U.S. born	43.4	47.3	43.5	
<5	1.4	0.0	1.3	
5–9	2.4	5.6	2.5	
10–14	1.0	1.5	1.0	
≥15	52.0	45.7	51.7	
English proficiency				0.493
English only	34.0	38.2	34.2	
ESL ^d - very well/well	32.2	21.8	31.8	
ESL - not well/not at all	33.8	40.0	34.1	
Educational attainment				0.258
≤High school diploma	57.5	67.6	57.9	
Some college	17.9	16.4	17.8	
≥College degree	24.7	16.1	24.3	
Enabling factors				
Poverty status				0.531
≤200% of FPL ^e	49.7	57.2	50.0	
201%–400% of FPL	28.2	27.9	28.2	
>400% of FPL	22.2	14.9	21.9	
Employment status				0.664
Employed	19.7	14.1	19.4	
Unemployed	77.4	82.3	77.6	
Other ^f	2.9	3.5	3.0	
Health insurance coverage				0.589
Employment-based	4.4	0.3	4.3	

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Table 1. Selected Characteristics of Adults Aged ≥ 65 Years in California by Perceived Racism, 2015 CHIS (continued)

Characteristics	Perceived racism		Total, %	p-value ^a
	No, %	Yes, %		
Medicare only	32.1	37.5	32.4	
Medicaid only	3.6	0.0	3.4	
Medicare and Medicaid (dual eligible)	38.0	38.2	38.0	
Other ^b	20.2	22.4	20.3	
Uninsured	1.7	1.7	1.7	
Need factors				
Self-reported health status				0.180
Very good/excellent	30.5	18.4	29.9	
Poor/fair/good	69.5	81.6	70.1	
Serious psychological distress				0.101
Yes	3.3	9.8	3.6	
No	96.7	90.2	96.4	
Health behavior - Disability status				0.062
Yes	50.3	66.8	51.0	
No	49.7	33.3	49.0	
Health behavior - Current smoking status				0.493
Yes	6.6	8.9	6.7	
No	93.4	91.1	93.3	
Health behavior - Binge drinking status				0.210
Yes	10.6	17.5	10.9	
No	89.5	82.5	89.2	
Health behavior - Obesity status				0.274
Yes (BMI ≥ 30.0)	27.0	35.9	27.4	
No	73.0	64.1	72.6	

^aCompares proportion differences by perceived racial/ethnic discrimination using a Bonferroni-corrected, weight-adjusted χ^2 statistic. Only age (in bold) significantly differed by perceived racism ($p < 0.01$).

^bIncludes two or more racial or ethnic groups.

^cIncludes partnered, divorced/separated, or widowed

^dIndicates English as a second language

^eIndicates federal poverty level.

^fIncludes with a job/business, but not at work, and looking for work.

^gIncludes privately purchased and other public benefit programs.

CHIS, California Health Interview Survey; ESL, English as a second language; FPL, federal poverty level.

contributes to health disparities in delayed/forgone care among ethnic minority older adults. Furthermore, previous studies have not explored whether poor doctor communication, the mediator of the current study, may contribute to this disparity in delayed/foregone care.

Thus, two hypotheses are examined in minority older adults: (1) perceived racism contributes to delayed/forgone care, and (2) poor doctor communication mediates the association of perceived racism with delayed/forgone care.

METHODS

Study Population

The 2015 California Health Interview Survey (CHIS), the most recent year available when this study was conducted, was

analyzed. A strength of the CHIS, the largest U.S. state health survey,⁸ is that it is conducted in five languages to over-sample Asians, Hispanics, and other racial/ethnic minority groups.⁸ Inclusion criteria consisted of participants aged ≥ 65 years ($n=6,972$), who were racial/ethnic minority-group members with complete data ($n=1,756$).

The mean age of the sample was 71.7 years (SD=6.4 years), consisting of non-Hispanic blacks (13.3%), Hispanics (32.3%), Asians (23.3%), and two or more racial/ethnic groups (31.1%; Table 1 provides further description of the cohort).

Measures

Participants were asked: *Was there ever a time when you would have gotten better medical care if you had belonged to a different race or ethnic group?* Response options were *yes* or *no*.

Participants were asked: *How often does your doctor or medical provider listen carefully to you?* and *How often does your doctor or*

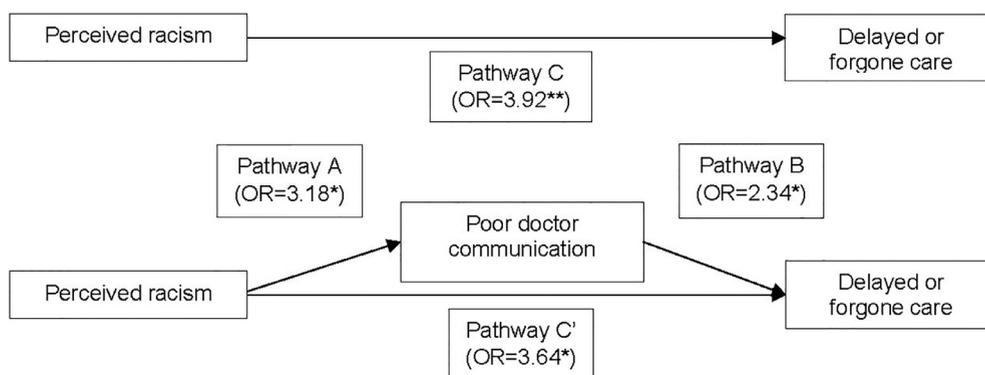


Figure 1. Conceptual model of the mediating effect of poor doctor communication on the relationship between perceived racism and delayed/forgone care in minority older adults.

Note: * <0.05 , ** <0.01 , and *** <0.001 . All covariates from the full model were adjusted for.

medical provider explain clearly what you need to do to take care of your health? Responses of *never* or *sometimes* were coded as 1; responses of *always* or *usually* were coded as 0.

Participants who responded *yes* to any of the following questions were categorized as having experienced delayed or foregone care: *During the past 12 months, did you delay or not get a medicine that a doctor prescribed for you?* and *During the past 12 months, did you delay or not get any other medical care you felt you needed—such as seeing a doctor, a specialist, or other health professional?* Forgoing necessary care was a subset of those reporting delaying/not getting medical care.

Covariates that could predict the outcome consisted of predisposing, enabling, and need factors.⁹ Predisposing factors were age, sex, marital status, geographic region, years in the U.S., English proficiency, and education. Enabling factors were income, employment status, and health insurance coverage. Need factors were self-reported health status, serious psychological distress, disability status, and health behaviors (i.e., smoking status, binge drinking, and obesity status).

Statistical Analysis

To examine whether perceived racism acted as a determinant of delayed/forgone care, regression analysis of delayed/forgone care on perceived racism was performed. To examine whether poor doctor communication mediated the perceived racism–delayed/forgone care association, two complementary mediation analyses^{10,11} were conducted. These multivariable logistic regression analyses adjusted for all covariates. Analyses were conducted using Stata, version 15.1 MP/Core-6, adjusting for weights that took into account CHIS’s complex survey sample design.⁸

RESULTS

In support of the first hypothesis, perceived racism was associated with 3.92 times greater odds of delayed/forgone care (95% CI=1.38, 11.15, $p=0.010$). Perceived racism was also associated with 3.18 times greater odds of poor doctor communication (95% CI=1.27, 7.95, $p=0.014$).

Mediation analyses, using the three Baron and Kenny mediation criteria¹⁰ and controlling for covariates, supported the second hypothesis that poor doctor communication mediates the association between perceived racism and delayed/forgone care. The first criterion was met by the independent variable predicting the outcome. The second criterion was met by poor doctor communication being associated with 2.34 times greater odds of having delayed/forgone care (95% CI=1.13, 5.03, $p=0.024$). The third criterion was met by the magnitude of perceived racism decreasing to 3.64 times greater odds of having delayed/forgone care (95% CI=1.30, 10.21, $p=0.014$; Figure 1). As perceived racism still predicted delayed/forgone care with poor doctor communication entered, the poor doctor communication was a partial mediator.

Further, VanderWeele’s mediation approach¹¹ also confirmed the second hypothesis: controlled direct effect (coefficient=2.18, 95% CI=1.37, 3.45, $p=0.001$), natural indirect effect (coefficient=1.22, 95% CI=1.15, 1.31, $p<0.001$), and marginal total effect (coefficient=2.66, 95% CI=1.68, 4.21, $p<0.001$) were significant. This partial mediator accounted for 9.9% of the total effect.

DISCUSSION

As predicted, the perception of racism increased the likelihood of delaying or forgoing necessary medical care, and poor doctor communication played a significant mediating role in the relationship.

Although the Medical Board of California enacted the Cultural and Linguistic Competency of Physicians Act in 2003,¹² the current findings suggest that poor communication skills of doctors and their biases still play roles in older minority patients delaying or forgoing necessary medical care. These findings suggest that

healthcare providers treating older minority patients would benefit from training to reduce bias and increase culturally competent communication skills.

As poor doctor communication was a partial mediator of the association between perceived racism and delayed/forgone care, other mediators should be explored. One possible factor is distrust of healthcare providers by minority elderly patients caused by observing or hearing about acts of racism. Regardless of whether this is found to be another factor, healthcare settings might want to find ways to increase trust, and ethnic minority older patients should be encouraged to advocate for treatments and second opinions.

A strength of this study is that a number of factors were adjusted, which could explain unmet/foregone care including English as a non-native language, years living in the U.S., poor health behaviors, and not having health insurance coverage. That is, perceived racism appears to contribute to the disparity above and beyond these factors.

Future research should explore whether the dynamics reported in this study differ between diverse ethno-geriatric population groups. In the current study, subgroup analyses by minority group were not performed because of limited sample sizes. In addition, future qualitative research can examine which components of doctor communication contribute to unmet health needs of minority older adults.

CONCLUSIONS

Overall, this study highlights that perceived racism contributes to disparities in care access among minority older adults. Inadequate doctor communication may discourage minority older adults from receiving needed medical care in a timely manner. As a key mediator, doctor communication skills should be amenable to intervention, potentially decreasing perceived racism and increasing healthcare access for minority older adults.

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Author contributions: Rhee and Levy contributed to the study concept and design; Rhee acquired the data and performed statistical analyses and drafted the manuscript; all authors helped with interpretation of data and critical revision of manuscript for important intellectual content; and Levy supervised the study. Rhee had full access to all the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.

Publicly available data were obtained from the University of California, Los Angeles (UCLA) Center for Health Policy Research (<http://healthpolicy.ucla.edu/chis/Pages/default.aspx>). Analyses, interpretation, and conclusions are solely

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