

Growing Consumerism in Healthcare: The Cost of Distrust

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Many are describing the healthcare consumer as the future king, fueled by the shift in control of the healthcare dollar away from the employer to the individual consumer, and the growing prevalence of health and medical information on the Internet.

The growing consumerism in healthcare means that all consumer issues will become bigger as well: this means satisfaction, choice, compliance, involvement in decision-making, and trust.

In this article I would like to explore the issue of trust in medical professionals--low trust specifically--and the costs of low trust to both healthcare providers and patients.

For the purposes of this article, trust is assessed via the measurement of two related beliefs as captured in the PATH (Profiles of Attitudes Toward Healthcare) model¹: one, the belief that healthcare professionals are not as competent as the medical profession and media would portray them, and two, that healthcare professionals routinely prescribe medications without really knowing all the potential side-effects to patients. Adults who hold these beliefs are predisposed to look with skepticism at treatment regimens prescribed by physicians whether by experience or from a pre-existing bias.

Trends Related to Distrust

Trends reported in this article come from the 1998 Sachs/Scarborough HealthPlus survey for Los Angeles². Based on HealthPlus, a sizeable proportion of adults have little faith in physicians. In the Los Angeles market, over a fifth of adults communicate low trust in medical professionals. Based on the LA adult population alone this represents over 3.6 million adults. About thirty percent have moderate trust.

On the down side, distrust of physicians is associated with a greater propensity to avoid *discretionary* healthcare. By discretionary healthcare, I mean things like check-ups, physicals, flu shots, treatments for various kinds of infections, or other minor ailments an adult or child might "ride out". In the LA market, adults with low trust seek the care of a primary care physician at rates ten percent below the norm. This is not true of those adults with moderate trust. The same low rate is reported for use of pediatricians among low trust adults; for optometrists it is nearly 20 percent below the norm. The reported use of physician assistants or nurse practitioners is nearly 30 percent below the norm. This is not the case for those adults with moderate trust. In many ways, these disciplines represent that first line of medical intervention for minor ailments or health problems, and the presence of distrust weakens them.

These low rates do not necessarily translate over to what might be considered *non-discretionary* healthcare. By this I mean treatment for severe chronic problems that are very difficult to avoid. For example, adults with low trust report the need for a

cardiologist at a rate about 25 percent higher than the norm. This high rate does not occur among adults with moderate trust. So the question arises, what is the relationship between not seeking care for minor problems and the need for care for major health problems? Could the avoidance of the more general medical care cited above due to distrust play some role in the greater need for more specialized critical care later?

As expected, the seeking of alternatives to medical care is much more prevalent among those adults with low trust, but occurs among moderate trust adults as well, although to a lesser extent. The reported use of chiropractors among low trust adults is 12 percent above the norm. The use rate of acupuncturists is 20 percent above the norm; for naturopaths it is 63 percent above the norm. It appears that low trust adults avoid some medical care in favor of non-medical alternatives. Adults with moderate trust tend to use them both medical and non-medical alternatives.

Depending on what side of the isle you sit on, this is either good or bad for the patient. Regardless, low trust in medical professionals contributes to decreased revenues for some medical care providers, increased revenues for many alternative, non-medical practitioners, and increased confusion for the patient who must choose between favoring one over the other.

Distrust is also associated with higher rates of non-compliance. Let's use the taking of prescriptions medications to illustrate the point. Low trust adults report the taking of medications as directed "some of the time" at rates 35 percent above the norm. In the LA population about one third of one percent of adults report "seldom" taking medications as directed according to HealthPlus. Among low trust adults, this rate is nearly four times greater! Even if we assume that non-compliance is under-reported, it does not effect the implications deriving from the effects of low trust. Clearly, distrust has more than a negligible impact on compliance. Both the patient and the provider are the loser.

Is there any evidence to suggest that the incidence of certain diseases have a greater association with distrust in medical professionals?

Yes. Without going through a comprehensive listing, data for LA shows that adults with low trust report kidney disease at a rate 97 percent above the norm. For breast cancer, the rate is 49 percent above the norm. For colon cancer, the rate is 45 percent above the norm. The incidence of diabetes (without insulin) is 10 percent above the norm. The reporting of enlarged prostates occurs at a rate that is 22 percent above the norm. These finding clearly show some adverse associations between the health of the patient and their inherent distrust of medical professionals. Here, clearly the low trust adult is the loser.

First Steps in Treating Distrust

What can be done to deal with those with a propensity to distrust? Some strategies can be suggested here.

Know who they are. Knowing a particular person has high distrust is not enough. Feelings or attitudes of high distrust do not exist in a vacuum. Distrust is associated with more than one pattern of healthcare behavior and thinking as demonstrated by the

PATH model. The practitioner needs to know which pattern they are dealing with to be the most effective.

For example, one group of adults with high distrust engages in only moderate healthcare information seeking, have low health involvement, and have a lower propensity to seek alternative care. Their distrust is less likely to be based on any information or facts they have. Compliance will be a problem, but there will be few occasions where the adult is being pulled to do something different by an outside influence.

A different group of adults with high distrust are very health involved, display high information seeking, and a high propensity to seek alternatives to medical care. These adults spend a fair amount of time gathering information supporting their distrust and their use of alternatives to regular medicine. Compliance will be a greater problem among these adults than among the first group because they will have information they perceive as justifying any modifications they choose to make. In addition, because this latter group of adults readily seeks and uses alternatives, where there is a conflict between regimens prescribed by alternative practitioners and medical practitioners, their propensity to prefer the former is greater.

Each type of adult needs a different approach to treat and or minimize the potential complications that could arise from their distrust.

Don't be in denial about distrust. Medical practitioners need to recognize that potentially one in five patients they see suffer from severe distrust. Medical professionals need to acknowledge this like they would acknowledge any other complicating factor to treatment.

When you identify a low trust adult, treat the low trust. Strategies and tactics, perhaps not medical ones but psychological ones, need to be developed to reduce the complications from high distrust. Again, as discussed above, a "one size fits all" treatment strategy will likely be insufficient for both types of high distrust adults. With one group, the practitioner only has to deal with an inherent personal bias. With the other group, the practitioner must deal with the personal bias, the information that supports it, as well as behavior patterns associated with the avoidance of conventional medicine or the use of alternatives.

Distrust of medical professionals is like any other factor contributing to disease. For hundreds of years healers denied the existence of germs. As they were recognized, procedures were adopted to reduce their potential harm.

As consumerism grows, so will the need to recognize and treat distrust.

¹ The PATH model describes healthcare consumers based on the interaction of an array of eleven dimensions of healthcare behavior, behavioral intention, and attitudes. The PATH model is based on nine profiles identified through research that display different levels and interactions among the eleven PATH dimensions. The patterns of healthcare behavior and thinking of ninety percent of adults can be explained by the nine-profile PATH model. For more information about the PATH model go to: www.pathinstitute.com.

² Data for this article comes from the 1998 Sachs/Scarborough HealthPlus Survey for Los Angeles, California. The data for Los Angeles is based on 8,489 adult interviews; the PATH subset consists of upwards of 5,000 adult interviews.