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The Barrier that Deters the Geriatric Population from Receiving Quality Healthcare

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Abstract:

Purpose: This literature analysis aims to understand the tangible and intangible barriers that impact the growing geriatric population in preventing from receiving quality healthcare

Methods: This literature review allowed for the investigation of the various types of barriers when the American geriatric population tries to access high-quality healthcare. Different types of settings were considered; however, there was a focus on Philadelphia. The analysis allowed for the creation of possible associations and solutions for this issue. Additional articles about the most significant barriers were searched based on an original article by Horton and Johnson (2010).

Results: Cost seems to be one of the important, tangible aspects in regards to the lack of access and quality of care (Fitzpatrick et al. 2004). The highest percentage of all health spending consisted of the elderly population. As of 2016, there were 7,000 practicing geriatricians in the United States (Hafner 2016). There is a positive relationship between health literacy, of the geriatric population, and perception of social standing (Fernandez et al. 2016). Approximately 20% of elderly patients belonged to the dislike subgroup--making going to the doctor the most cited reason for delaying care (Sun and Smith 2017).

Conclusion: Medical professionals, public health officials, and policymakers must address the negative aging stereotypes and delay of health care delay amongst the geriatric population. Once the negative stigma of aging is gone, then additional programs and resources can be developed to assist the elderly population. Recently there has been a shift towards patient/person-centered care--focusing on "personal choice and autonomy for people receiving health services" (Kogan, A. C., Wilber, K., & Mosqueda, L. 2016).

Background:

The geriatric population, or commonly known as the elderly, in the United States, is considered to include individuals that are age 65 and older. In 2016, the geriatric population increased to 49.2 million Americans (Roberts, Ogunwole, Blakeslee, & Rabe 2018). Since the advances of modern medicine, this number is expected to increase drastically. Looking further into the future, the American geriatric population is expected to be 83.7 million in 2050 (Ortman, Velkoff, & Hogan 2014). Although the geriatric population's health and well-being are expected to improve as well, over 80% of older Americans have at least one chronic medical condition (Horton and Johnson 2010). With such a large percent of the aging population suffering from a variety of chronic conditions, a considerable amount of attention has been geared toward "designing treatment protocols to prevent or inhibit the progression of specific chronic diseases…" (Wolff et al. 2002).With this increase in chronic medical conditions for this population, there is an increased need for consistent, reliable and continuous medical care.

In a 2016 Center for Disease Control and Prevention (CDC) report, the American geriatric population self-reported having the lowest percentage of "good", "very good" or "excellent" overall health; therefore, having this population has the highest percentage of "fair" or "poor" overall health (Center for Disease Control and Prevention 2018b). Synder et al. (2009) reported that cancer survivors of the geriatric population were less likely to receive preventative care services when compared to "matched controls." In another study, Weaver et al. (2010) observed the delay of medical care due to disparities in cancer, a type of chronic medical condition, survivors. In the 65 and older sample, individuals with a cancer history were not more likely than their same-age peers who did not have cancer. There were observed differences that

suggest “the occurrence of medical comorbidities also may contribute to differences in forgoing care” (Weaver et al. 2010). Forgoing medical care is more common among the 65 and older population, regardless of whether the individual had cancer or not (Weaver et al. 2010).

In Pennsylvania, when compared to the United States, there is a similar trend in the quality of and access to healthcare for the geriatric population. According to the CDC, in 2016, Pennsylvanians aged 65 or older reported the second highest self-reported rating of having a “fair” or “poor” health (Center of Disease Control and Prevention 2018a). The Patient Safety Authority is an independent state agency created under the Medical Care Availability and Reduction Error (MCARE) Act in 2002 (Patient Safety Authority 2017). “Under the MCARE Act, healthcare facilities must report Serious Events (events that harm the patient) and Incidents or ‘near misses’ (events that do not harm the patient) to the Authority” (Patient Safety Authority 2017). The data that is reported annually in the authority’s reports are only in regards to Serious Events and Incidents. Although the year of 2016 continued the downward trend of high-harm events, this is not the number of monthly reports that the Patient Safety Authority received in 2016. Out of these monthly reports, a majority of these reports are from older Pennsylvanians. According to the demographic information, the Patient Safety Reporting System (PA-PSRS) collects, the number and percentage of reports that the 65-74-year-old age group is the second highest reported group right after the 55-64-year-old group. A close third is the 75-84-year-old age group (Patient Safety Authority 2017). The reporting system demonstrates the idea of the low quality of healthcare in the geriatric population in the state of Pennsylvania. Patients, who are 65 years or older make up 41.0% of all of the PA-PSRS reports. This statistic represents “greater representation in the healthcare system regarding the number of [hospital] admissions

and patient days" (Patient Safety Authority 2017). From this, it can be concluded that the elderly Pennsylvanians spend more time in the hospital and are less likely to receive any preventative care. In 2015, 39.8% of patients admitted to hospitals were at least 65 years of age. In addition to the 2016 data reported by the PA-PSRS, the 2016 data from the Pennsylvania Health Care Cost Containment Council (PHC4) showed the highest proportion of hospital reports in the 65-74-year-old population (Patient Safety Authority 2017). An individual's address does not just tell where he or she lives--it could predict the individual's life expectancy (Giordano 2018).

Two neighborhoods in Philadelphia, separated only by a few miles, can create a vast difference in regards to life expectancy. According to a census tract, individuals living in Philadelphia's Strawberry Mansion neighborhood is expected to live until 64. Seventeen minutes away, in Philadelphia's Lower Merion section, the average life expectancy at birth is 92 years (Giordano 2018). Consistent with population numbers, the Patient Safety Authority concludes one of the highest numbers of hospitalization reports in the Southeastern part of Pennsylvania. After adjusting the reported volume, the Southeast has the lowest number of Serious Events and Incidents reports per 1000 patient days (Patient Safety Authority 2017). Although this report seems promising for the Southeastern region, it does not factor in age difference. Approximately 1.6 million individuals live in Philadelphia and of these individuals, 24% are ages 55 and older (Philadelphia Corporation for Aging 2016). Of this percentage, 53% are aged 65 years or older. There is a surprising percentage of the geriatric population, in the county of Philadelphia, that face detrimental experiences of safety, neighborhood, and community factors. These factors pose a threat to their health and well-being. Across the Southeastern Pennsylvania region, 5.4% did not leave their homes during the daytime in the past month because they did not feel safe; out of

the 5.4%, 10.6% of the older Pennsylvanians lived in Philadelphia County (Public Health Management Corporation 2014). Although the elderly population in Philadelphia County reported had the most favorable rating of "feeling of neighborhood togetherness" out of the other counties in Southeastern Pennsylvania, this was not the case for "feeling of neighborhood belonging" and "participation in neighborhood organizations" (Public Health Management Corporation 2014). The geriatric population, living in Philadelphia County, were the least likely to report they felt a sense of belonging in the neighborhood (11.5%) and participating in community organizations (53.5%). "These household, neighborhood, and community factors are important social determinants of health and can have a significant impact on the overall well-being of older adults, many of whom have additional health-related needs" (Public Health Management Corporation 2014).

Methods:

Design:

This literature review revealed why the geriatric population faces tangible and intangible barriers when trying to access high-quality healthcare. A literature review allowed for the investigation of the various types of barriers that the geriatric population face in different settings; however, there was a focus more on urban areas, more specifically Philadelphia, where the medical field is prospering. An analysis of a literature review will, also, allowed for the creation of possible associations between the barriers of healthcare for the geriatric population.

Materials:

This literature review was broad when choosing keywords to search due to interchanging of the terminology. The articles that were included had a minimum requirement, specifically

applying to the geriatric population in the United States of America. While the background information and some statistics included articles dating back to 2004, recent articles were cited to ensure information was still relevant. Additional articles were searched based on an original article by Horton and Johnson (2010) that mentioned the barriers of access to the quality of healthcare for the geriatric population. Then, it was determined which barriers were the most significant by which barriers had the highest statistics.

Results and Discussion:

The geriatric population faces many challenges regarding their health and well-being. This includes their medical conditions, which mainly consists of them to see at least one physician regularly, but also how this population can access the care they need and the quality of care they receive. There are many gaps in the access and quality of care, which the geriatric population receive, especially in the later stages of life. The access and the quality of care, which the geriatric population obtains is affected by many physical barriers (Buttigieg, Ilinca, de Sao Jose, & Larsson 2018).

Tangible barriers:

Cost of medical care seems to be one of the important, tangible aspects in regards to the lack of access and quality of care (Fitzpatrick et al. 2014). Poverty can limit the elderly population from seeking healthcare (Horton and Johnson 2010). Nineteen percent of elderly Philadelphians live below 100% of the Federal Poverty level (Philadelphia Corporation for Aging 2016). In a study conducted by Fitzpatrick et al. (2004), older adults who earned $50,000 US dollars or more were 2.6 times less likely to report barriers accessing health care when compared to older adults earning less than $12,000 US dollars (Horton and Johnson 2010). A

$10,000 US dollar increase in median income gave an individual an additional 0.5 years of life (Giordano 2018). Under the Affordable Care Act, Medicare has given the perception of making access to health care, for older Americans, look similar (Fitzpatrick et al. 2004).

"Not all elderly adults qualify for health insurance coverage sponsored by the government, like Medicare and Medicaid." (Horton and Johnson 2010). Out-of-pocket spending is the most significant financial burden for Medicare patients (Fitzpatrick et al. 2004). When compared to 12% of the population aged 18-44, 40% of the older population, in 2003, spent more than $1000 per year on out-of-pocket medical expenses (Horton and Johnson 2010). American senior citizens have more barriers, related to cost when compared to seniors in other industrialized countries. When compared to seniors in other industrialized countries, in 2014, elderly Americans "are more likely… to report skipping needed medical care due to costs (19% vs. 6% on average), having difficulty paying medical bills (11% vs. 3% on average), and spending $2000 or more in out-of-pocket expenses (21% vs. 7% on average)" (Cox 2014). It was reported, in 2016, 36% of all health spending consisted of the elderly population. When comparing this population to other age groups, this is the highest percentage in regards to health spending. It is, also, shown spending on medical services increases when an individual is in the older age group (Sawyer and Claxton 2019). With an increased need for medical service, the nationwide shortage of physicians and more specifically geriatricians impacts this population more drastically.

In the United States, geriatrics is a medical specialty that is not a favorite choice among internal medicine residents. As of 2016, there were 7,000 practicing geriatricians in the United States (Hafner 2016). There is a significant difficulty in "recruiting doctors into relevant medical

specialties, such as geriatric medicine…" (Fisher, Garside, Hunt, & Lo 2015). One of the challenges is the number of medical schools teaching geriatric medicine. The number has decreased (Fisher et al. 2015). To meet the increasing demand, the American Geriatrics Society estimates medical schools need to "train at least 6,250 additional geriatricians between now and 2030, or about 450 more a year than the current rate" (Hafner 2016). There are many reasons as to why there is a comparably low number of geriatricians. The field of geriatrics is one of the lowest paying specialties in medicine. A geriatrician, in private practice, earns approximately $20,000 less, "although geriatrics requires an extra year or two of training beyond that of a general internist…" (Hafner 2015). Also, medical students have a negative view or attitude towards elderly patients (Fisher et al. 2015). There are, occasionally, medical students and residents who are inspired by an old family member and choose to pursue geriatrics; however, the majority of medical students and young physicians admit to the difficulty to be interested in the slow-paced field of geriatrics and having to deal with all of the complications of caring for the older population (Hafner 2015). Although the healthcare system is set up in frameworks, it can get complex.

Tangible/Intangible barrier:

Navigating healthcare system presents difficulties among a majority of the population, especially for the elderly population. In a previous study, researchers concluded government health care patients lacked the knowledge to thoroughly understand the programs' rules and regulations (Horton and Johnson 2010). Horton and Johnson (2010) observed that 48% Medicare and Medicaid recipients felt the "application was unduly long and complicated, and simply obtaining the application and other documentation was a major challenge." Health literacy is

defined as the "degree to which individuals have to obtain, process, and understand basic health decision" (Howard, Gazmararian, & Parker 2005). Research has shown there is an established relationship between health literacy and health outcomes. Many models indicate that health outcomes are influenced by health literacy; health literacy affects the self-efficacy, knowledge, health behaviors, health-related perceptions and experiences, and familiarity with health concepts (Fernandez, Larson and Zikmund-Fisher 2016). Fernandez et al. (2016) confirmed a "significant positive relationship between self-reported health literacy and health behaviors… and perceptions of social standing and control over health" among the elderly population. This study found that the female participants, who were inadequately health literate were less likely to receive a mammogram in the past two years. Findings from other studies of older adults, with a minimal amount of health literacy, have negative perceptions about themselves and worry about being seen as incompetent. It was determined, from these studies, there is a positive relationship between health literacy of the geriatric population and perception of social standing (Fernandez et al. 2016). The impression of the physician's attitudes and behaviors, towards the elderly's health and well-being is also a cause for the lack of quality health care of the geriatric population (Fitzpatrick et al. 2004).

Intangible barriers:

Studies exemplify great ageism and negative stereotypes of the condition and abilities of the older research participants. Studies, in which age discrimination is evident, display themes of "using inappropriate and diminishing language with older individuals" (Buttigieg et al. 2018). Since health care professionals heavily base their medical professionalism on research, it is not

surprising these medical professionals mimic similar attitudes and behaviors towards geriatric patients.

The age of the individual greatly influences the access to critical care, in which geriatric patients receive from medical professionals. There is a "significant difference in the access to treatment, depending on the patients' chronological age" (Buttigieg et al.2018). The difference in treatment is evident, in previous findings, through ageism and age discrimination against the geriatric population. This discrimination is among many health care and social services professionals. Health care professionals display ageism through neglect in routine care. The theme of neglect is demonstrated by the health care professionals not being accurate in the diagnosis due to the use of ageist language, and using cheaper medical supplies on older patients (Buttigieg et al. 2018). Over time physicians and other healthcare professionals may develop a particular pattern of speech "sometimes referred to as patronizing communication or elderspeak based on stereotyped expectations about the aging process" (Sun and Smith 2017). Another study concluded insensitive treatment, in regards to communication and attitude, towards the elderly population was the reason why ageism exists in the health care system (Buttigiegg et al. 2018). Physicians spend less time with patients due to completing managerial tasks; therefore, patients interpret this as a lack of care. This disregard could prevent patients from seeking medical attention in the future (Fitzpatrick et al. 2004). "Nonetheless, such attitudes can lead to improper care or delayed diagnosis, assessment, and treatment with clear risks for negative health outcomes" (Buttigieg et al. 2018).

These attitudes displayed by the health care professionals reinforced the geriatric patients feeling invisible/forgotten and feeling like objects rather than humans (Buttigieg et al. 2018).

Several previous studies conclude “psychosocial concerns” are far more significant than other tangible or logistical reasons when the elderly avoid or delay seeking medical care (Sun and Smith 2017). These concerns include the “perceived lack of responsiveness” and attention from the physician (Sun and Smith 2017). The feeling of being forgotten sets the stage for geriatric patients of establishing their perception of aging. This perception is created when the population subjectively evaluates one’s own experience, in regards to aging. “Self-perceptions of aging (SPA)” cause negative ramifications for “the health of the aging population” (Sun and Smith 2017). This population’s views of aging affect their health and use of medical resources. Prior research has shown individuals, aged 65 and older, with negative perceptions of aging are less likely to seek preventive medical care; therefore, these individuals are more likely to use immediate medical care or being hospitalized. One cause for this may be that older adults with a negative viewpoint are delaying necessary medical care and then cause further health complications. “Finally, older adults with more negative SPA were more likely to belong to the subgroup who disliked going to the doctor. Although only approximately 20% of respondents belonged to the dislike subgroup, disliking going to the doctor was the most cited reason for delaying care among all respondents ” (Sun and Smith 2017).

Differences in rural settings:

Recent data from the Health and Human Resources Administration of the US Department of Health and Human Services, accessing health care is a major challenge that faces patients in rural populations. The barriers display a “visible and disproportionate lack of services” (Douthit, Kiv, Dwolatzky, & Biswas 2015). These challenges, then, cause serious consequences, which affect the health outcomes of these patients. Douthit et al. (2015) concluded that there were

similarities of the types of barriers, which exist for all geriatric patients regardless of their location; however, it seems like these barriers more greatly affect elderly patients, who live in rural settings. One issue that appears to be defining for older adults is transportation on getting to the doctor. Getting to and from the doctors is an obstacle when elderly patients attempt to accessing health care. In previous studies, elderly patients in rural counties were interviewed how they travel to doctor's appointments for regular checkups and follow-up appointments. The study drew conclusions that possession of a vehicle did not dramatically affect attendance for appointments; however, the study concluded that older patients are not likely to travel to go to doctor's appointments if the physician's' office is far away. Another study showed that travel time increases difficulty in traveling to attend appointments (Douthit et al. 2015). Although patients try to overcome this challenge, an additional study suggests that distance is an excuse for elderly patients, living in rural areas, for not receiving care. To ensure patients have access to care and with digital medical technology advancing, online medical services were made available across the United States and in other parts of the world (Douthit et al. 2015).

"The implications for the provision of health services, from essential health education and information to making an appointment and checking the results of investigations online, have made telemedicine an attractive proposition in rural health and across long distances" (Douthit et al. 2015).

Conclusions:

It is especially important that we, as a society, can provide as many solutions as possible. First, medical professionals, public health officials, and policymakers must address the negative aging stereotypes and delay of health care delay amongst the geriatric population. "Promoting

more positive aging self-perceptions may help older adults counter automatic old age attributions and take time to more critically evaluate their symptoms. Consequently, older adults with more positive views on aging may interpret new bodily discomforts as cues for seeking medical attention rather than inevitable products of the aging process" (Sun and Smith 2017).

Once there is no negative stigma of aging, then additional programs and resources can be developed to assist the elderly population. Defined by the World Health Organization (WHO), intrinsic capacity is the overall health and well-being of an individual. Intrinsic capacity encompasses mobility, cognition, vitality, psycho-social, and neurosensorial. The association of intrinsic capacity is a result of additive results of many social and economic variables. These variables are detrimental to the health of individuals across their lifetime. "One crucial consequence is that an older age the people with the greatest health needs tend to also be those with the fewest resources to call on to address them. This association has major implications for policy, which will need to be crafted in ways that overcome, rather than reinforce these inequities" (Beard, Officer, de Carvalho, Sadana, Pot, Michel, Llyod-Sherlock, Epping-Jordan, Peeter, Mahanani, Thiyagarajan & Chatterji 2016).

In response, the World Health Organization published a world report on healthy aging. It includes a framework designed to take into account the later part of life. This report focuses on themes of capacity and ability, highlighting healthy aging should be defined "as the process of developing and maintaining the functional ability that enables wellbeing in older age" (Beard et al. 2016). There are four areas of priority, the WHO suggests focusing on, which will achieve the aim of functional ability and intrinsic capacity in the older population. Most importantly, the healthcare system needs to direct attention on a more integrative approach to the

"multidimensional demands of older age" rather than treating specific diseases independent from one another (Beard et al. 2016). Therefore, healthcare should be reformed to provide affordable and comprehensive long-term care. Long-term care should provide the ability to function for the elderly population who are at great risk to lose substantial amounts of capacity. Also, this care and support should coincide with "basic rights, fundamental freedoms, and human dignity (Beard et al. 2016). Improvement amongst measurement, monitoring, and understanding is needed to close the gap of analyzing major concepts, specifically the exclusion of the elderly population in clinical trials for which they are the primary recipients. Advancement of the contribution of five realms of functional ability that are essential for healthy aging: meeting the basic needs of the geriatric population; "learn, grow, and make decisions; move around; build and maintain relationships; and contribute. Together these abilities enable an older person to age safely in a place that is right for them, to continue to develop personally and to contribute to their communities while retaining autonomy and health" (Beard et al. 2016). Successful programs of rural telemedicine include sharing information and improving communication between providers, policymakers, and the community. One improvement that needs to be made is the communication aspect. In rural communities, in the United States, one-quarter of households do not have access to the Internet. Less than one-third of the elderly rural population use the Internet to retrieve information regarding their health and well-being; among the geriatric population with low levels of health literacy, 10% or less is capable of searching and retrieving information regarding health online. The health outcomes, which result, might be because rural patients have "different health-seeking behaviors compared to their urban counterparts; and this, coupled with

different approaches to patient care among physicians, exacerbates the disparity in expectations and delivery of care" (Douthit et al. 2015).

Since the practice of medicine is consistently improving, society must be able to adapt to these advancements to improve the quality of life of the geriatric population. The World Health Organization's report stresses redeveloping the healthcare system "to ensure coverages of integrated services without financial burden, that are centered on the needs and rights of older people, and to deliver care built around a common goal of functional ability" (Beard et al. 2016). Recently, there has been a shift towards patient/person-centered care (PCC). Rather than focusing on the "traditional biomedical model," PCC favors "personal choice and autonomy for people receiving health services" (Kogan, A. C., Wilber, K., & Mosqueda, L. 2016). A defining characteristic of patient-centered care is how it is implemented and accomplished. Literature reviews on PCC focus on how it includes the implementation of the patient's "preferences, values, beliefs, and family or fictive kin into the decision making process related to daily life and care in clinical practice and in social serving settings" (Kogan et al. 2016). Patient-centered care has become an important route of patient care, especially for the elderly population. PCC is more likely to affect on these patients because this population requires more complex care than younger patients. Although PCC for the geriatric population has been successfully implemented and practiced in long-term care, dementia care, hospital-to-home transitional care, and palliative and hospice care, there is a significant gap of PCC implementation in outpatient care, such as home-based and community-based services.

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