The Barriers that Deter the Geriatric Population From Receiving Quality Healthcare

Graduate Program in Biomedical Sciences—School of Health Sciences
Jacquelyn Smith, Anne Egan D.O. and Denah Appelt, PhD

ABSTRACT

In the United States, the geriatric population is considered to include individuals that are 65 years or older. In 2018, there was an estimated 45.2 million elderly Americans (Roberts et al. 2018). Since the advances of modern medicine are progressing, this number is expected to increase drastically. Furthermore, the geriatric population is projected to double between the years 2010 and 2030, reaching 71 million Americans (Shronton and Johnson 2015). Looking further into the future, the American geriatric population is expected to be 83.7 million by 2050 (Gorman et al. 2014). In a 2018 Center for Disease Control and Prevention (CDC) report, the American geriatric population self-reported the highest percentage of “fair” or “poor” overall health (Center for Disease Control and Prevention 2018). In response, the United States Department of Health and Human Services set up additional programs and resources to improve this rating; however, with the many health complications that occur among Americans, there has been a surprising inconsiderate quality of care for this population. The disparity becomes significant since many geriatric patients deal with chronic health complications. Previous studies show that there are both tangible and intangible barriers to why the geriatric population faces issues with access to healthcare or the quality of care. This retrospective analysis looked at the different types of barriers for the geriatric population in the United States. This study investigated the barriers in rural settings, urban settings, and more specifically Philadelphia, where the medical field is expanding to better care for this population. Physician’s behavior and attitude towards patients, “difficulty in getting to the doctor, the absence of services, lack of care progression opportunities for physicians, and the increased financial burden” are the main barriers, which geriatric patients face when trying to access quality healthcare (Douthit et al. 2015). One might think tangible barriers, such as the cost of medical care, would be the major barrier facing this population. However, studies concluded that the perceived behavior and attitude of the physician is the most significant barrier that deters the geriatric population from wanting to receive medical care. Possible solutions to this issue include reform of healthcare policy and focusing on patient-centered care.

METHODS

This literature review helped understand why the geriatric population face tangible and intangible barriers when trying to access high-quality healthcare in different settings: rural, urban, and more specifically the city of Philadelphia. Possible associations between the barriers of healthcare for the geriatric population were made based on the analysis.

REFERENCES

Aging in the United States

• 2018 CDC report: elderly Pennsylvanians reported the second highest self-reported rating of having a “fair” or “poor” Health Status (Center for Disease Control and Prevention 2018).
• Highest proportion of hospital reports in the 65-74 year-old population
• Conclusion: elderly Pennsylvanians spent more time in the hospital and are less likely to receive any preventative care (Patient Safety Authority 2017).

Aging in Philadelphia

• Approximately 24% Philadelphia are ages 65 and older. Of this percentage, 53% are ages 65 years or older (Philadelphia Corporation for Aging 2016)
• The average life expectancy at birth gender varies within Philadelphia
• Lower Merion—92 years
• 10 point percentage increase in unemployment = 1.5 year loss of life
• Decreased life expectancy linked to fewer elderly adults being insured (Giordano 2018)

Intangible barriers

• Perceptions of physicians’ behaviors and attitude
• Health care professionals display negative through neglect in routine care
• Due to use of agental language and cheaper medical supplies on older patients (duTouquet et al. 2018)
• Over that the healthcare professionals develop pattern of speech “referred to as… stereotypic” (Sun and Smith 2017)
• Results: professional attitudes reinforced feelings of invisibility/forgotten and feeling like objects (duTouquet et al. 2018)
• “Psychosocial coercion”—age bias in delay medical care
• Stages for establishing elderly’s perception of aging (Sun and Smith 2017)
• Negative perceptions of aging mean less likely to seek preventive medical care
• Approximately 25% had difficulty going to the doctor
• Most cited reason for delaying care (Sun and Smith 2017)

Tangible barriers

• CDC: “Earning < $12,000 US dollars = 2.6x more likely to report barriers accessing health care (Kho and et al. 2018)
• 2016: American seniors have more cost-related barriers when compared to seniors in other industrialized countries
• Skill needed medical care (15% vs. 5%) Difficulty paying medical bills (15% vs. 25)
• Spent $200 in out-of-pocket expenses (21% vs. 7%) (Cow 2014)
• Average health spending increases with age
• Elderly patients: 36% (the highest percentage) of “health spending” (Seppen and Cleaton 2019)
• 10% of elderly Philadelphians live below 100% of the Federal Poverty level (Philadelphia Corporation for Aging 2016)
• Health literacy
• Government health care patients tend to lack knowledge to understand the programs’ rules and regulations
• 48% Medicare and Medicaid recipients felt the application was a major challenge

Comparison of Rural and Urban Setting

Barrier of Healthcare

Cultural Perceptions

Rural Setting = Negative

Urban Setting = Less Negative

Getting to Doctor’s Office/Lack of Transportation or Distance

Rural Setting = Difficult

Urban Setting = Less Difficult

Access of Services

Rural Setting = Yes

Urban Setting = No

Financial Burdens

Rural Setting = Yes—Less Disability

Urban Setting = Less Disability—New Roof of Medicine

Possible solutions

• Wider capacity: the overall health and well-being of an individual including social and economical variables
• Crosstalking Mediation, cognition, identity, psycho-social, and neurocognitive
• World Health Organization (WHO) suggests an aim of functional ability and intrinsic capacity in the older population
• Integrative approach rather than treating specific diseases independently
• Affordable
• Comprehensive (Breed et al. 2016)
• Advancement should contribute to functional ability for healthy aging
• Meeting the basic needs
• “Learn, grow, and make decisions; move around, build and maintain relationships; and contribute” (Seppen et al. 2016)
• Patient/person-centered care (PCOC)
• Favors personal choice and autonomy
• 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” (Roop et al. 2015)
• Greater effect on geriatric population