Box 5-1.

Global Aging and Minority Populations: Healthcare Access, Quality of Care, and Use of Services

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In addition to the common concerns about aging, older adults from minority and migrant groups face additional worries about support and access to services as they age. Barriers and discrimination at many levels may impact access to needed services for themselves or loved ones, formal financial arrangements and security, and physical accommodation in older age. The impact of discrimination and ongoing disadvantage over a lifetime are borne out by recent numbers: lower life expectancies and higher disease burdens.

Despite recent attention, the gaps in life expectancy and other indicators are not closing, for instance, in indigenous populations in Australia, Canada, and New Zealand, and for those with lower levels of education (Olshansky et al., 2012; Mitrou et al., 2014). The variations in health often reflect differences by group status such as race, ethnicity, immigration, socioeconomic status, sexual and gender identities, and physical and mental abilities (National Institutes of Health, 2013). This is likely compounded by additional language, linguistic, and cultural barriers (Warnes et al, 2004; Bramley et al., 2005; Sayegh and Knight, 2013). Among lesbian, gay, bisexual, and transgender (LGBT) older adults, experiences of discrimination and victimization are linked to poor health outcomes, yet they often experience barriers to accessing care and remain largely invisible in services given their stigmatized identities (Fredriksen-Goldsen et al., 2011; Fredriksen-Goldsen et al., 2013). Among those with intellectual, emotional, and physical disabilities, adjustments in healthcare information are often needed to better match capacity (Emerson et al., 2011).

Health inequities, resulting from economic, environmental, and social disadvantage, are costly. In the United States, where the 65-and-older population has nearly complete health care coverage by Medicare, it is estimated that among Blacks, Hispanics, and Asian Americans, nearly one-third of direct healthcare expenditures are excess costs as a result of health inequities (LaVeist, Gaskin, and Richard, 2009). Furthermore, when examining differences in health care quality in the United States, those living in poverty, compared to those with high incomes, received worse care for 47 percent of the quality measures; people aged 65 and older received worse care for 39 percent of the quality measures compared to adults aged 18 to 44 (Figure 5-1; Agency for Healthcare Research and Quality, 2012). There were also significant differences by race and ethnicity. Ensuring appropriate access to and use of care and quality care are critical factors in the promotion of health, especially for racial and ethnic minorities, indigenous and aboriginal people, immigrants, LGBT people, as well as those with intellectual, emotional, and physical disabilities.

Across population groups, several factors have been linked to inequities in health, including the heightened risk of exposure to social determinants of poor health (such as poverty, unemployment, isolation, and discrimination) and other structural and organizational barriers, including lack of available services and institutional and societal biases in services as well as policies (Braveman, Egerter, and Williams, 2011). In addition, older adults from these population groups may be at elevated risk of adverse health behaviors as well as at risk of reduced health literacy. They may also be reluctant to utilize healthcare services, preventative screenings, and other health promotion activities. Promoting health equity, embedded within a life course perspective, is critical for older adults across diverse population groups to have the capacity to reach their full health potential (Fredriksen-Goldsen et al., 2014).

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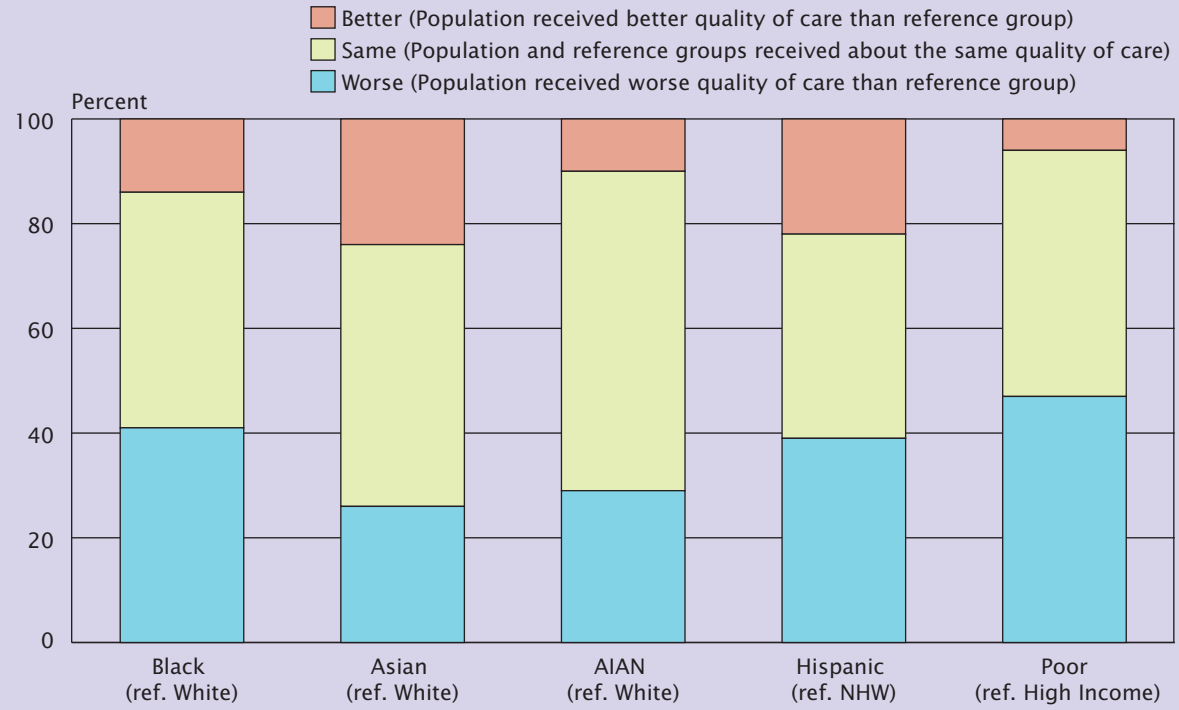
Figure 5-1.

Proportion of Quality Measures for Which Members of Selected Groups Experienced Better, Same, or Worse Quality of Care Compared With Reference Group in the United States: 2011



AIAN American Indian or Alaska Native. NHW Non-Hispanic White.
Note: "ref." is reference groups.
Source: Agency for Healthcare Research and Quality, 2012.

HEALTH SYSTEM'S RESPONSE TO AGING IN HIGH-INCOME COUNTRIES

Older population in higher-income countries are typically further along the epidemiologic transition; however, many of the existing health care systems were created at the early stages of the antibiotic era and still need to evolve to provide well-coordinated and integrated care for chronic diseases. Health systems in high-income countries are at different stages of this evolution, but most have cost and continuity of care issues related to long-term treatment of chronic conditions. In some cases, the systems themselves, to some extent, shape population preferences (Mair, Quinones, and Pasha, 2015). Regardless of preferences though, removal of financial and other barriers to access, through universal coverage efforts, would benefit all people including vulnerable populations in wealthier countries (Nolte and McKee, 2012).

Just as national health and social systems are at different stages in their service capacity, some countries have older adult populations with declining disability, while other countries have increasing