



Ageism in the American Healthcare System

Liza Turcotte

ABSTRACT

The growing population of elderly Americans constitutes an escalating social problem for society as a whole. The health care system is becoming increasingly strained as this faction increases in number and demands more time and services. Gerontologists continue to debate the merits of providing care to all elderly versus allocating resources based on chronological age and illness level. At the heart of this debate is ageism, a phenomenon particularly strong in America, which devalues the aged and the aging process. This paper seeks to determine the causes of ageism, explain how the current medical establishment perpetuates this problem, and discuss potential solutions to the existence of ageism in the health care system. Despite alarming statistics and a health care system ill-equipped and inappropriately designed to manage their unique needs, arguments within this paper contend that the elderly should receive high quality healthcare. Put simply, a poorly constructed healthcare system is the problem, not the elderly population in need of service. Ageism, and gerontology in general, are relatively new areas of study and, as a consequence, often lack breadth and depth. In the absence of sufficient research, the inclusion and combination of outside variables is intended to serve as evidentiary support for the prevalence of ageism in America's health care system.

Chrestomathy: Annual Review of Undergraduate Research at the College of Charleston

Volume 2, 2003: pp. 284-298

© 2003 by the College of Charleston, Charleston SC 29424, USA.

All rights to be retained by the author.



Introduction

While the population of elderly in the United States continues to climb, the health care system is unable to maintain quality of care well into old age. Several factors are to blame for the discrepancy in care between society's young and old populations. Of primary concern is ageism, the American devaluation of the aged and the aging process, and the impact this social thought process has on the health care system as a whole. The ability to find and pay for quality medical attention, the onset of multiple illnesses and disabilities, and long-term care needs are additional obstacles elderly face when confronted with the need to seek attention in the current medical establishment (Hooyman and Kiyak, 578).

When viewed as a social problem, as opposed to a strictly personal problem, age inequality is only a minute segment of broader social issues within the American social system. Age inequality is a derivative of status, power, and many times, wealth inequalities. A combination as socially potent as this often is highly detrimental to those experiencing the aging process in such conditions. As a future gerontologist and geriatric care manager, leveling the playing field for the imminent onset of large numbers of elderly will be part of my future career.

To effectively examine and address the problem of age inequality, attention needs to be focused in several directions. On a most basic level, who is looking for and receiving care? What is characteristic of this group, and why are they posing a threat to the current medical establishment? As already mentioned, concentration on ageism is essential to understanding the aging process. A clear definition of ageism, therefore, is essential, including a discussion of the origin, the prevalence, and the factors perpetuating this prejudice. A look at the environment surrounding medical ageism is also of value when debating this phenomenon, so considering the current medical establishment is necessary, particularly when proposing solutions to the issue. As is true with most social problems, socioeconomic status (SES) is at play and is certainly worthy of consideration for its part in the promotion of ageism in medicine. Before undertaking the monumental task of scrutinizing, analyzing, and rectifying biased dispositions toward the elderly, a thorough examination of current

theoretical debates must also be considered.

While the concerns of the elderly are currently also the concerns of a small portion of the medical and health fields, this will soon change as the graying of America picks up pace (Still). The question essential to this paper and ultimately to American health care is the same. What social obstacles currently exist in obtaining quality care in old age?

Topic Discussion and Relevance

The study of aging is not a new field. Nearly every intellectual pursuit has sparked new ideas, approaches, and debates about one of life's great mysteries: the aging body. While philosophers, scientists, psychologists, and theorists focused on what aging meant, how individuals reacted to the aging process, and how to stop or delay the process itself, only recently has the application changed directions. Sociologists, and most specifically gerontologists, have now joined the pursuit for answers, concerned with how the process of aging reflects itself socially. Examining the elderly population from a sociological perspective has undoubtedly brought new insights to a problem everyone will face, on an individual and social level, within their lifetime.

A very narrow focus of gerontology, a subfield of sociology concerned with aspects of aging, is ageism. A phenomenon particularly strong in America, ageism may be defined as, "Attitudes, beliefs, and conceptions of the nature and characteristics of older persons that are prejudicial, distorting their actual characteristics, abilities, etc." (Hooyman and Kiyak, 38). While ageist attitudes are extremely prevalent in all aspects of American culture, a particularly dangerous and intriguing pattern of age discrimination emerges within the health care system.

Before delving into the prevalence of medical ageism and all its components, an introduction into the population under consideration is necessary. The proportion of elderly in relation to the population as a whole is growing quite rapidly. Since the study of gerontology emerged as a strong presence within sociology in the 1960s, the population of elderly has been multiplying at twice the rate of those under 65 (Wolinsky, Mosely and Coe, 210), and within that population,

eight in ten suffer from a persistent, habitual illness or disability (Maddox, 117). While for many Americans, and many within the health care profession, these statistics serve merely to reinforce a looming problem, consider that 75% of the population can expect to reach 65 (Maddox, 117). The use of health care by the elderly is also accompanied by alarming statistics. The industry can expect that nearly a third of total expenditures be allocated to elderly patients (Wolinsky, Mosely, and Coe, 290), the majority of which is specifically devoted to alleviating symptoms of chronic or terminal illness (Palmore, 135). The establishment is also faced with the challenge of treating a group with stabilized disability rates but increased longevity (Duncan and Smith, 282). The combination of misdiagnosis (usually resulting from improper training in elderly health problems) and the high complexity of illness and disability in older patients is undoubtedly a partnership which will further increase both institutional and personal disbursements for the management of health conditions.

Put simply, these statistics, when viewed as a whole, cement a daunting irony within the current medical establishment: advances in technology and treatment allow people to live longer and healthier lives, but the system fails to provide quality support in the end. While the elderly are most affected by this inconsistency, all people seeking medical attention are forced to rely on ambulatory care and have few options when long-term care is required to sustain quality of life. It appears the system is poorly designed to handle emerging health problems, illnesses that are long-term in nature rather than acute, and that the system itself is in need of reconstruction if current cohorts of Americans desire life-long healthcare.

At this point the available research becomes hazy. While the majority of people concerned with the elderly agree that ageism is present and serious, there are few studies to indicate the prevalence, the effects, and propose solutions. There are, however, myriad studies proclaiming that the elderly are draining resources, that the current medical establishment potentially poses a threat to their well-being, and that the situation should be rectified. How to go about changing the situation is the missing information.

The remainder of this paper attempts to sort through the disorganized, rudimentary, and often controversial information which

is available on the experience of the elderly within the American health care system. While only basic research currently exists, a symptom of a growing area of study and snowballing need for data, big conclusions exist underneath the surface which may lead to big solutions. Before examining the literature, it is necessary to review the popular theories within gerontology regarding the status of the older population within the health care system, perhaps in the process uncovering preexisting attitudes affecting research.

Theory

This paper has, and will continue to argue that the elderly should not be considered second class citizens when it comes to health care. There is, however, some opposition facing gerontologists, citing the vast amount of health care expenditures on elderly patients, the large number of elderly who are heavy health care consumers, and a health care system experiencing rapid inflation as society progressively reaches even older ages. At the heart of this debate is Daniel Callahan, a staunch proponent of limiting health care for the elderly, not at the risk of their lives, he argues, but at the risk of the system as a whole.

Callahan argues against extending lives beyond a reasonable length of time, asking, "Is it sensible, in the face of the rapidly increasing burden of the health care costs of the elderly, to press forward with new and expensive ways of extending their lives?" (Callahan, 219) His argument hinges on three primary points: (1) high health care consumption by the elderly detracts from available resources for children; (2) that the eventual death of the elderly leads to unbalanced spending on their health care needs; and (3) the majority of recent medical advances were not designed under the premise that the elderly would be the primary users (Callahan, 220-221). At the heart of Callahan's assertions that limiting health care to the elderly is reasonable lies one fact, that because so many elderly are terminally ill the amount spent on sustaining their failing health is really a waste of resources (Callahan, 222).

Callahan's contention may reflect the kind of health services the elderly receive. Assuming the medical establishment holds similar views, healthcare providers may choose to focus their attention in other directions, bypassing elderly patients as time consuming,

expensive, and untreatable. Statistics previously discussed support Callahan's irrefutable claims that older populations are costly to manage. The following literature review, however, challenges this position, ultimately proposing a shift toward long-term and away from ambulatory care, a shift in line with the health problems currently plaguing the entire population, and may help alleviate strain on the health care system. Available literature on ageism also continually points out the importance of medical school training in the field, very little of which actually occurs. It is possible that our current system, functioning to treat acute illnesses, fails to address the real health care needs of the elderly, thereby making Callahan's worries seem more convincing than they need to be.

Literature Review

The body of literature, small as it may be, does provide insight into the experience of aging within the American medical system. There are six primary themes emerging from the research, all of which will be discussed further in this section, and all of which provide a strong, while sometimes indirect basis for the existence of medical ageism. Briefly, these themes include: (1) a strong tendency to present statistics that the population is aging and that this maturation has, and will continue to negatively impact the health care system; (2) identifying the particular health concerns of the elderly, thereby suggesting that the system innately works against older populations when quality care is concerned; (3) a discussion of ageism as a concept and identification of its possible origins, (4) problems in the current system which limit the kinds and quality of care the elderly have access to, (5) the relation of socioeconomic status (SES) to the caliber of care, and (6) proposed solutions to bettering health care for elderly patients.

Statistical Significance

The growing population of elderly is a well-known fact; however, the impact on the health care system is not as well documented in popular sources. While most people are aware that growing numbers in the 65 plus age group constitute a potential problem, the extent of this concern is less publicized. As mentioned earlier in the paper, the elderly age group is doubling in number

(Wolinsky, Mosely, and Coe, 210), and nearly 80% suffer a chronic health problem (Maddox, 117). In a time when 75% of the population can expect to reach old age, these statistics certainly indicate a point of consideration. Health care costs are simultaneously skyrocketing, a large portion of which is the end result of treatment for the terminally ill. Palmore maintains that there was a 9% increase in federal health care disbursements in the period from 1962 to 1980 (135), 31% of the total costs likely attributable to elderly patients (Wolinsky, Mosely, and Coe, 209). Faced with statistics like this, it would be difficult for anyone to deny the onset of a potentially disastrous issue within the health care industry.

Statistics as alarming and threatening as these point toward problems with long-term care, toward a system operating in such a way that it ignores modern health problems. The medical establishment has become efficient and advanced in treating the acute illnesses which historically plagued the population, and has failed to keep the same pace in chronic medicine. Because older populations suffer from chronic illnesses, as is discussed in the upcoming section, it is easy to draw the most basic conclusion: that the elderly are draining the healthcare system rather than the system inadvertently drains itself.

Health Concerns of the Elderly

Considering this impending problem, it is also important to consider the health problems and risk factors which generate such high use of health services in the elderly population. On a basic level, the elderly experience complicated medical problems, many of which overlap or are consequences of other health related issues (Pasupathi and Lockenhoff, 202). Nearly 80% have chronic conditions (Maddox, 117), and because the aging body metabolizes medications differently and diseases may appear with varying side-effects in older patients, risk of side effects and inappropriate diagnosis increases exponentially with each prescribed treatment (Pasupathi and Lockenhoff, 202). Overall decline in sensory systems may also affect the adherence rate to these treatments (Coe,186), particularly since many elderly are no longer able to see their life-long doctors, as they are deceased or are no longer practicing (Wolinsky et al., 216). Duncan and Smith (265, 282) also consider that economic factors affect health care attainment.

Soaring costs, complex Medicare policy, and already uncertain economic conditions combine to make obtaining quality care all the more troublesome.

Addressing problems within the structure is also significant in that it could possibly be the single most important factor in determining the conditions which breed ageism. The health care system itself is poorly adapted to treat elderly patients, a circumstance Ward accurately describes:

The system emphasizes institutional treatment sites for acute conditions, and is poorly adapted to the chronic, long-term care often characterizing the service needs of older people (Ward, 65).

In addition to an ill-developed system, the workers comprising this system are also ill-equipped for the job. The few medical schools with programs geared specifically toward working with elderly patients are often unable to recruit students into the program (Palmore, 133). As a consequence of a broad lack of interest in the area, and mainstream medical programs devoting little time to the health needs of the elderly, geriatric medicine suffers. In an examination of medical school programs, geriatric departments were found in only three medical schools, and of the remaining 142 schools, only around 10% mandated some course work in geriatrics (Kovner, Mezey, and Harrington, 1). Seeking a geriatrician may prove to be even more of a struggle. In addition to finding a lack of trained doctors, Kovner, Mezey, and Harrington also found a lack of geriatricians, medical professionals specializing in elderly health, 2.5 professionals per 10,000 elderly by their estimation (1). In another area of health care, hospitalization, further complications emerge when confronted with cost. The privatization of hospitals often places profit-making ahead of patient care, and the desired length of stay for an elderly patient may be far longer than Medicare is willing to cover (Wilkinson and Ferraro, 351). In a system where the only repercussions for ageist health professionals include a decline in health for their patients, whose health naturally declines because of biological aging processes and may be undetectable to the untrained eye, professionals have little motivation to change

their attitudes (Still). These patterns give evidence that the health care system falls short of providing quality and personalized care to its elderly patients.

Ageism as a Concept

The statistics, health concerns of this burgeoning population, and the inadequate medical establishment all combine to produce of ageism. While the current health care system perpetuates the problem, researchers speculate that medical school is at the origin. The few schools which require course work in geriatrics are exceptions to the rule. The large majority of schools do not educate, sensitize, or prepare their students to work with the elderly (Wilkinson and Ferraro, 350-351). Additionally, many elderly reflect socially pervasive attitudes about the use of health care by their age group, often stating that they drain valuable resources and waste time (Ward, 63), and many from the current cohort do not challenge doctor's opinions and diagnoses (Still). Because ageism is not contested within the system, patients often do not insist on better care, and currently no repercussions exist, doctors are free to assess elderly health poorly. In fact, widespread sentiments about elderly patients include a variety of poor character traits and beliefs about treatment options. Physicians without much knowledge in the field of geriatrics tend to misdiagnose or ignore psychological problems, focus strictly on physical questions, provide fewer treatment options, and have more negative sentiments about the encounter after it is over (Palmore, 134). Pasupathi and Lockenhoff maintain, in fact, that failing to make the distinction between disease and normal, progressive, biological aging perpetuates the prejudice cycle, pigeonholing the entire population as a group experiencing widespread, rapid, and inevitable decline (208). Palmore goes even further in his description of characteristics of health professionals which play a role in poor health care for the elderly:

Health professionals have had little education about normal aging processes...Second, they tend to share a strong sense of death, which they associate with elders. Third, they have a biased experience with elders because they tend to see and treat only the most frail,

sick, and senile aged...Fourth, professionals' feelings about their own parents or older relatives can conflict with their dealings with an elderly patient (134).

The consequences of generalizing the elderly in this fashion are glaring. Ward contends that physicians habitually view their aging patients as "...entering a 'terminal sick role'...", an outlook which may have serious effects on the quality of treatment physicians provide (66).

The Impact of Ageism on the Current Medical Establishment

Monisha Pasupathi and Corinna E. Lockenhoff provide one of the few articles which directly addresses ageism in the medical profession. The authors of "Ageist Behavior" describe many of the shortcomings on a personal level, focusing more on individual interaction with doctors than broad social implications. Pasupathi and Lockenhoff assert that doctors lump the elderly together, failing to recognize individual symptoms and complaints, and view them as a group entering a stage in which treatable conditions are few and far between. This attitude is of extreme importance when considering the treatment the elderly receive. Pasupathi and Lockenhoff detail the characteristics which are pervasive in relationships between the elderly and their physicians, a range encompassing shortcomings, misdiagnosis, the resulting health effects, and a comparison to encounters with younger patients. For the purposes of clarity, I divide Pasupathi and Lockenhoff's critique into two subdivisions: the weaknesses and misdiagnoses together, effects and comparison together.

Pasupathi and Lockenhoff contend that the elderly receive deficient care on the basis of age and provides two categories of poor care: insufficient education of their patients and misdiagnosis of their ailments. The authors state that elderly patients are presented with fewer treatment options than other patients, including therapy, alternative medicine, and pain control, and preventative measures occur with less frequency. On a similar note, Pasupathi and Lockenhoff mention that referrals to other health professionals, particularly for mental distress, are low when considering that the majority of patients may breach the conversation themselves. The issues of death and

advance directives also appear to be taboo subjects when treating the elderly, two topics which are especially relevant to this population. These two examples, however, may not be surprising in light of the fact that doctors are more hurried and abrupt with their 65 plus patients (Pasupathi and Lockenhoff, 205-209).

The effects of the poor treatment outlined above are potentially serious. Considering that the elderly body metabolizes medications differently, older people have disproportionately high incidents of negative side effects and complications from other prescriptions (Pasupathi and Lockenhoff, 206). Additionally, declines in short term memory, vision, and hearing (Coe 1987, 186) often result in incorrect usage of prescribed medication (Pasupathi and Lockenhoff, 206). Coe claims that a good relationship with a doctor, one which is supportive and constant, is often an indicator of health care regimen maintenance (184). While this makes logical sense, doctors continue to be less likely to exhibit the exact characteristics which have shown to be effective in ensuring patient compliance: receptivity, thoroughness, patience, and exhibitions of emotional support (Pasupathi and Lockenhoff, 208).

Socioeconomic Status and Ageism

While age itself appears to be the dominating factor in determining the overall quality of care in old age, socioeconomic status (SES) appears to have an impact as well. Duncan and Smith, in an article primarily concerned with the income and overall wealth of the aging population, describe the current economic situation of elders:

Recent cohorts of elderly are much better off economically than are older cohorts. The improvement is largely due to rising Social Security benefits, combined with greater amounts of income from financial assets and private pensions. Increases in these sources have more than offset falling earnings, to produce a sharp improvement in the average economic position of the elderly (270).

Beyond income itself, social factors moderate health care attainment.

House provides a clearer picture how age and SES interact to produce stratified health care attainment.

SES significantly moderates the relation of age to health, with the upper socioeconomic strata approaching the ideal of relatively low levels of morbidity and functional limitations until quite late in life, whereas at lower socioeconomic levels morbidity and functional limitations rise steadily throughout middle and early age (House et al., 214).

Put basically, lower SES means more hurdles for ailing elders, often referred to as “double jeopardy,” ranging from the inability to find doctors who take them seriously, not only because they are old but also because they fall into lower SES categories, to the ability to pay for often expensive treatments. The culture of different SES groups is also a mitigating factor in maintaining one’s health. Higher SES patients are less likely to take no for an answer and have a more persistent attitude in pursuing high caliber care, a lifelong habit which likely translates into better health in old age (Still).

Proposed Solutions

Having discussed prominent obstacles, how can this problem be remedied? Researchers and gerontologists have proposed a variety of solutions. Gerontologist Brenda Still proposes that simple awareness raising campaigns, both in medical schools and on a societal level, are the key. Medical schools should require a social gerontology course to educate students about obstacles the elderly face, including a modified role-taking exercise designed to elicit empathetic notions about elderly physical ailments (Still). As evidenced in this paper, research on this population is seriously lacking, and the existing body of literature relies on questionable sampling techniques. More longitudinal research geared toward understanding characteristics specific to cohorts is necessary (Ward, 67) in combination with studies focusing on how elderly experience this phenomenon, an area absent from current research (Still). An increase in government regulation and wide-spread interest would certainly cement the importance of

improving the quality of care for the elderly. Maddox provides a description of governmental responsibilities:

Legislation has created a Federal Council on Aging to coordinate governmental programs for older persons, an Administration on Aging to develop and complement service programs in the various states, and a National Institute on Aging within the National Institutes of Health. Although welfare in later life is not yet secure, the issue appears to be a matter of implementation rather than intent (122).

Gerontologists tend to agree, however, that considerable changes to the health care system and the demands for quality will change as the Baby Boomers come of age. As a large and well-financed group, they will lead the way in revolutionizing the health care system for generations to come (Still).

Discussion and Conclusion

While the literature provides a strong basis to begin delving into more focused studies regarding aging in the health care system, some basic shortcomings of the groundwork need attention. The most glaring deficiency involves the amount of available data. With thirty years under its belt, gerontology has failed to produce a large body of definitive evidence regarding any aspect of ageism in the health care system. Gerontological research is a weighty area, involving exceedingly intricate design complications and is confronted by many hurdles more standardized research fields do not face. Conducting ethical studies while still maintaining the health of subjects, who vary greatly in their capacities, is always an issue. Confounding variables are frequent, high drop out rates result from illness, disability, or death, and preserving the validity of findings from cross-sectional studies (which tend to be most popular) in light of cohort inconsistencies is troublesome. While the complexities of conducting this research are a problem alone, it is also a factor in the ability to quickly build bodies of research (Hooyman and Kiyak, 31-37). To make sufficient progress toward a solution, which will become an increasingly troublesome

problem if left unaddressed, geriatrics must devote more time to myriad quality studies.

Arguably, however, this is unlikely to occur unless pervasive attitudes in related fields undergo some changes. As discussed in the previous section, most gerontologists agree medical school is the breeding ground for ageist attitudes in the health field and therefore should be the target for combating ageism. It goes without saying that the elderly will continue to receive second class care without an overhaul in the system educating health care providers. The healthcare system as a whole, an additional problematic area, is also in need of updating. In an era when people suffer from chronic illnesses the current system will not suffice. Medical school and the healthcare system must work hand-in-hand, as one directly affects the other, if the elderly are going to receive better care. Gerontology is a multidisciplinary field, and support from other related research fields is a must.

Research into ageism provides limitless directions. The most pressing issue is collecting data in support of the existence of ageism, establishing prevalence and need for change at the forefront. Data from medical school students may be of particular interest, focusing on the lack of commitment to the field, attitudes affecting this shortcoming, and proposed solutions to advancing geriatrics as a field of study. There are certainly other variables affecting the elderly within the health care system, many of which have received very little attention, and the addition of this information may advance the field considerably. Very basically, gerontology needs evidentiary support to make headway before the Baby Boomers enter the health care system.

Works Cited

Callahan, Daniel. "Limiting Health Care for the Old," in Nancy S. Jecker (ed.), *Aging and Ethics* (Humana Press, 1991), pp. 219-226.

Coe, Rodney M. "Communication and Medical Care Outcomes: Analysis of Conversations Between Doctors and Elderly Patients," in Russell A. Ward and Sheldon S. Tobin (eds.), *Health and Aging: Sociological Issues and Policy Directions* (Springer Publishing, 1987), pp.

180-191.

Duncan, Greg J. and Ken R. Smith. "The Rising Affluence of the Elderly: How Far, How Fair, and How Frail?" *Annual Review of Sociology* 15 (1989), pp. 261-289.

Hooyman, Nancy R. and H. Asuman Kiyak. *Social Gerontology: A Multidisciplinary Perspective* (Allyn and Bacon, 2002).

House, James S., James M. Lepkowski, Ann M. Kinney, Richard P. Mero, Ronald C. Kessler, and A. Regula Herzog. "The Social Stratification of Aging and Health," *Journal of Health and Social Behavior* 35 (1994), pp. 213-234.

Kovner, Christine Tassone, Mathy Mezey, and Charlene Harrington. "Who Cares for Older Adults: Workforce Implications of an Aging Society; Geriatrics Need to Join Pediatrics as a Required Element of Training the Next Generation of Health Care Professionals," *Health Affairs* (September 2002-October 2002).

Maddox, George L. "Sociology of Later Life," *Annual Review of Sociology* 5 (1979), pp. 113-135.

Palmore, Erdman B. *Ageism: Positive and Negative* (Springer Publishing, 1990).

Pasupathi, Monisha and Corinne E. Lockenhoff. "Ageist Behavior," in Todd D. Nelson (ed.), *Ageism: Stereotyping and Prejudice Against Older Persons* (MIT Press, 2002).

Still, Brenda. Interview with Liza Turcotte. Written notes. Charleston SC, September 26, 2002.

Ward, Russell A. "Services for Older People: An Integrated Framework for Research," *Journal of Health and Social Behavior* 18 (1977), pp. 61-77.

Wilkinson, Jody A. and Kenneth A. Ferraro. "Thirty Years of Ageism Research," in Todd D. Nelson (ed.), *Ageism: Stereotyping and Prejudice Against Older Persons* (MIT Press, 2002).

Wolinsky, Frederick D., Ray R. Mosely II, and Rodney Coe. "A Cohort Analysis of the Use of Health Services by Elderly Americans," *Journal of Health and Social Behavior* 27 (1986), pp. 209-219.