

SUPPORTING OLDER ADULTS TO ACCESS HEALTHCARE SERVICES TO ENABLE THEM TO AGE-IN-PLACE

A LITERATURE REVIEW

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Attestation of Authorship

I hereby declare that this submission is my own work to the best of my knowledge and belief. I have not used any other sources, material written by another person or material previously published except those listed in the reference list and identified as references. I further declare that this dissertation has not been submitted to any other institution.

23 September 2019

Date

Signature

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Abstract

The world is experiencing unprecedented growth among older adults (World Health Organisation (WHO), 2005). New Zealand is also seeing an increase in older adults. New Zealand government policy favours the notion that older adults “age-in-place”, that is, in their own homes or communities opposed to being institutionalised if possible (Ministry of Health (MOH), 2006). However, this population is experiencing a myriad of barriers that impact their health which in turn affects their ability to age-in-place. How healthy older adults are and the accessibility of the healthcare services determines whether ageing-in-place is possible or not. Evidence has suggested that older adults have the greatest health needs due to functional ability as well as chronic conditions becoming prevalent (Black, 2008). This means they will use healthcare services more but due to barriers accessing the services, less utilisation of such happens. Services that support older adults to age-in-place are available in most countries but there are barriers to accessing them. This literature review aims to uncover what is already known about the barriers faced by older adults, as well as expanding the understanding and knowledge of the barriers to accessing healthcare services. Any gaps in the information available will be uncovered and recommendations for practice in New Zealand will be made.

CHAPTER 1

In chapter 1, the background history regarding the subject is provided, New Zealand context is provided, the researcher is introduced, the aim, relevance and significance of the project are also outlined.

INTRODUCTION

1.1 Background.

Human life has three stages which are childhood, youth and elderly. The older adults aged 65 years and over, as this dissertation will focus on, is the last stage of the cycle. This age group's attitude to aging in respect to psychological loss, physical change and psychological growth determines the barriers they face when accessing healthcare services. The ability to identify a health problem and seek help also determines health outcomes among this population.

Aging is defined by the World Health Organisation (WHO), (2015) as a result of damage to molecular and cellular processes accumulating over time. It is said to be affected by environmental influences or diseases. Biologically, it leads to a decrease in physical as well as mental capacity, which increases the risk of diseases and finally leads to death, WHO (2015) says this happens gradually. Aging is also associated with life transitions, such as retirement and relocation as well as the death of partners and friends (WHO, 2015). Aging has different meaning in different cultures Canvin, Maclead, Windle and Sacker (2018) state that in the United Kingdom (UK), aging can be the reason to seek healthcare service or it can be a reason not to, while Japan perceives aging as maturity and a socially valuable part of life according Karasawa, Curhan and Ryff (2011) when a comparison on how Japanese and Americans perceives aging was done. In the United States of America (USA), aging is measured by their worth, active engagement in work as well as individual achievements, therefore, shifting out of active engagement and moving towards dependency on others is seen more negatively (Karasawa et al., 2011). For this reason, there is a tendency to resist aging in the USA.

Due to technology and medical advancement, people are living longer than ever before. This has seen the rate of older adults increasing rapidly all over the world (WHO, 2015). WHO (2015) predicts the number of older adults to double from 12% to 22%; that is, from 900 million to 2 billion by 2050. With the aging population increasing, concerns have arisen as to how

they can stay safe and healthy in their own homes if possible and attain health in its fullness, as defined by WHO. WHO (2015) defines health as not only the absence of disease, but the complete state of physical, mental and social wellbeing. Aging literature has well established the decline in health status and cognitive function among this population (Atkinson et al., 2007). These declines, if severe, can have a profound impact on the older adults' ability to access healthcare services; hence, the poorer quality of life. However, during this period, preventative measures that includes screening, chronic disease monitoring and health checks lead to some older adults needing more healthcare and more services may need to be involved. Atkinson et al. (2007) stated that most older adults do not experience dramatic declines and function relatively well. Coping with everyday life situations and meeting demands can be difficult for some older adults. Though people are living longer, there is no guarantee of good, dignified or meaningful health if they are not able to access healthcare services. The decrease in functional ability in addition to one or two chronic conditions means more medical attention will be needed but accessing this was found to be problematic (WHO, 2015).

1.2 New Zealand context.

According to the Office for Senior Citizens (2015), 650, 000 older adults are over 65 years equating to 14% of the New Zealand population in their 2014 report. The number is projected to increase to 1.2 million by 2034, making 22% of the population. This trend of increasing older adult population has also been noted worldwide (WHO, 2015). This population has been facing difficulties to access healthcare services, predominantly primary care. Achieving access to primary healthcare has been a problem that dates back to 1978 when the Alma-Ata Declaration on Primary Health Care was signed, and governments were encouraged to formulate policies to sustain primary healthcare (Jatrana & Crampton, 2009). The Primary Health Care Strategy, as well as the Positive Ageing Strategy, are among some strategies the New Zealand government established in 2001 in response to increasing aging population in New Zealand. Ensuring access to services is among the seven principles that guide the 2001 New Zealand Health Strategy. Identifying factors that enable older adults to age-in-place is among their goals (Office for Senior Citizens, 2015), however, access barriers remain paramount and become worse as people age.

The New Zealand health system is largely tax funded; healthcare users pay only 40% to access primary healthcare. Having said that, affordability remains a problem for some older adults. According to the Common Wealth Survey carried out in 2018 for eleven countries,

New Zealand included, it concluded that New Zealanders had better health, but cost was identified as a barrier (Carcadden et al., 2018).

New Zealand, among other nations, has adopted the use of International Assessment Instrument (InterRai), which is a tool used to assess the level of care for older adults. Parsons et al. (2013) stated that although this tool was found to be very effective in identifying the needs of older adults and points them to the appropriate services according to their needs, it does not take into account affordability. However, Palapar et al. (2017) state that although problems can be identified by the use of InterRai, it is not guaranteed that the services will be provided. This tool is used by health professionals who have been trained to use it and this include the Needs Assessment Service Co-ordinators (NASC) who mostly use it. Getting an initial assessment from the NASC can be through referral from General Practitioner (GP), other multi-disciplinary teams (MDT), family as well as self referral (Office for Senior Citizens, 2015). Accessing available services from the government in New Zealand will only be possible after a NASC assessment without which, this will have a big impact on the older adult's health as their needs will not be assessed and required services provided early.

In New Zealand, services available for older adults include; Older Persons Health, Needs Assessment and Service Co-ordination, Assessment Treatment and Rehabilitation, A+ Links Home Help Services, Community Services, Primary Health Organisation providing Home Care Services, Super-gold card for seniors and community-based-services among other services. Access to these services will see the provision of some services like; completing activities of daily living, equipment to use at home, home help for cleaning and laundry, help with showering and meals on wheels among other services provided. These can be provided after a person's level of care has been assessed and referrals to get such are done.

New Zealand is multicultural. There are minority groups, indigenous (Maori) and people from the Pacific Islands as well as other migrants from all over the world. Looking at the cultural mix in New Zealand, the older adult population, barriers to healthcare services are mostly financial, paucity of Maori and Pacific Islanders in primary workforce, unavailability of culturally responsive services and geographical barriers (Jatrana & Blakely, 2008). Minority groups mostly immigrants, also face language barriers as well as isolation on top of the mentioned barriers. Concerning the indigenous people of New Zealand (Tangata Whenua) the crown has the responsibility to fulfil its promises that this population have protection and can participate and work in partnership with the Iwi. This was founded when the Treaty of Waitangi

was signed in 1840 (Ang, 2015). Cultural safety is one of the examples to improve Maori access to services; this is included in the New Zealand nursing and midwifery programmes and has been taught since 1992. Another initiative was having Maori service providers run by Maori and there were 240 providers in 2004 (Ellison-Loschmann & Pearce, 2006). However, in Kai Tiaki New Zealand report of 2018, there are 280 Maori providers noted meaning there is very slow increase in Maori providers. This slow increase might be due to funding as it was reported that funding was declining for the Maori providers (Ministry of Health, 2019). In terms of workforce, MOH (2019) reported that Maori registered nurses were 3, 003 in 2005 while non-Maori registered nurses were 37, 127 and in 2018, Maori registered nurses increased to 4, 163 while non-Maori went up to 52, 193. Maori doctors were said to be 234 in 2004 while non-Maori were 8, 757. In 2016, Maori doctors were 465 while non-Maori totalled 13, 695. Maori makes 14.6% of New Zealand population whereas Pacific Island people makes 6% (MOH, 2019). Given the small percentage of health professionals of these populations, they are more likely to be seen by a non-Maori or non-Pacific health professional.

1.3 Personal background of the author.

When I was 13 years old, my grandmother was diagnosed with type 2 diabetes mellitus (T2DM) and hypertension. I remember my grandmother and I catching the bus in the early hours of the morning and travelling for 2 hours to the nearest hospital for monthly check-ups. During one of these visits, I was taught how to administer insulin as my grandmother's blood sugar level was no longer controlled by tablets alone. I had no idea then what T2DM was and no one bothered to inform me. Even if I had been informed, at 13 years of age I could not be expected to fully understand what it was or what was involved in and around the treatment. There was no information about how the insulin was stored or why it was given. When we got home, I put the insulin in my grandmother's bedroom where the temperature under the corrugated roof could reach over 36 degrees or even 40 degrees at times. This meant my grandmother was not getting any therapeutic dose at any given time as the insulin was no longer useful; however, the daily injection was given as directed.

Leaving Zimbabwe, I went to the United Kingdom where I worked with older adults in the private hospitals and rest homes as a healthcare assistant. This role came naturally as caring for older adults was not new for me. I later moved to New Zealand in 2006 and enrolled into nursing in 2007. After graduating, I worked for a private hospital (aged care) for two years

before joining public hospital working in a general medicine ward where I have been practicing for the past seven years.

The phenomenon of the ageing population as well as my practice prompted this study. During my practice, some older adults are admitted in appalling conditions and they do not have the basic services required for them to age well in place. In my experience of working as a registered nurse, many older adults are admitted to hospital with health problems that could have been averted had they accessed services earlier. Upon talking to the older adults, most of them seem to have no information of the available services that they can access, these services are then initiated before they leave the hospital. Understanding the dynamic of what each older adult needs is essential to preparing a personalised care plan, as well as designing services and implementing programmes for older adults. In New Zealand, the government encourages older adults to age-in-place; therefore, it is important to find the barriers that this rising population face to get healthcare services, so their care and support is managed. Consequently, it is necessary to study about barriers that older adults face in accessing healthcare services.

Going back to my first experience with older adults - my grandmother - there were barriers on every level that affected my grandmother's quality of life, which eventually shortened her life. These barriers included accessibility, availability and affordability, as well as acceptability. There was no existence of pension and no formal support system then and it is still the same. Traditionally, the family is responsible for the material support of older adults. I noticed that in first world countries where this should no longer be a problem, there are still the same barriers that older adults face to access healthcare services. I was there for my grandmother, but now family dynamics are changing. Families are moving further and further away from their older parents/relatives, some older adults relocate to follow their children which will in turn lead to more barriers due to language, culture and isolation among other barriers.

1.4 Theoretical position of this review.

Health behaviour theories were formulated to reveal why some people use healthcare services while others do not. Rotter's locus of control theory Biondo & MacDonald Jr (1971) is going to anchor this integrative literature review. Bentley (2003) stated that a theory of research study can be held together by a theoretical framework. Its relevance strongly ties to the belief people have that their health is their responsibility or that it is controlled by others as well as an individual's control over their own environment. Literature regarding older adults' health beliefs and behaviours shows that self-reported health seems to consist of an objective assessment of health as well as a component of subjective belief-laden McDonald-Miszczak et al. (2000). Gesler, Arcury, and Koenig (2000) concluded that an influence of culture is evident in health locus of control.

Jacobs-Lawson, Waddell, and Webb (2011) explained that beliefs of the relationship between one's behaviour and health state is internal locus of control. External influence are the actions of health professionals such as doctors largely determines health outcomes. Looking at external locus of control, the influence that family members have on older adults to access health care services is unknown, however, friends' and family's advice cannot be ruled out in contributing to the use of healthcare services. Health locus of control has been found to have an impact on health behaviours and health status of the older adults (Jacobs-Lawson et al., 2011). This includes the older adults' participation in preventive measures that can delay or reduce complications that arise from common chronic diseases associated with ageing.

For the older adults to access healthcare services, both internal and external locus of control play a significant role. There are some known factors that influence access as well as utilisation of healthcare services, some of which include affordability, location, age, gender, availability and setting up of services (Bentley, 2003). Health professionals can act as a barrier for older adult to access services due to them having limited or no knowledge of the services available for the older adults.

1.5 Aim.

The aim is to find ways to bridge the barriers and build on the enablers so that the older adults can receive support they need according to their changing health needs, so their quality of life is improved at home.

1.6 Objectives.

The goal is to become familiar with the knowledge base of the scientific information about the barriers that the older adults face when accessing healthcare services so that:

1. Knowledge of the barriers and enablers to accessing services nationally and internationally will help identify the gaps in older adults not getting the services they need on time.
2. To identify healthcare services in place to support older adults to remain in their own homes and how healthcare services are sourced.
3. When barriers and enablers are identified as well as services available for older adults, the gaps will eventually show as to why the older adults are not getting the healthcare services they need on time. How to bridge the gap between 1) and 2) will place this research in context after this literature review.
4. Develop an early intervention that will later be tested in a feasibility trial so that this population gets a tailored approach to the healthcare services they need.

1.7 Significance.

The focus of this study is to find out why older adults are not able to access healthcare services to meet their healthcare needs in a timely manner; hence, this integrative literature review will help identify the gaps.

CHAPTER 2

Chapter 2 will cover the methodology used in this project. It will also cover the design, formulating of the question, past literature, literature search, inclusion and exclusion criteria, the PRISMA flowchart for selection of articles, data evaluation, quality evaluation, and finally, data analysis.

2.0 METHODOLOGY

2.1 Design.

An integrative literature review aims to uncover what is known as well as uncover any gaps. Torraco (2005) states that it stimulates new thinking about the topic as well as catalyses further research and can be used when one wants to learn more about a topic. This study, which concentrates on the barriers and enablers for older adults accessing services, will identify gaps in the current research as well as using the available literature to create new knowledge. Whittemore and Knafl (2005) state that this is the only method that allows combination of experimental and nonexperimental methodologies. Stages to be followed in this literature review will be: formulating of the problem, literature search, data evaluation, quality evaluation, data analysis, the presentation stage and its implication for practice according to Whittemore and Knafl (2005).

This approach is informed by the philosophical paradigm of post positivist. Post positivist advocated pluralism hence experimental and nonexperimental research methods will be ideal to answer the question (Giddings & Grant, 2006). Based on the question to be answered, it is important to capture people's experiences, narratives and processes, and this can be captured by qualitative research. Braun and Clarke (2013) said that this allows development of theory, description and understanding. The testing of the hypothesis will be done using a quantitative method. It is important to have statistics of the older adults who are not able to access healthcare services captured in figures, hence quantitative methods provide measurable cause and effect as well as statistics (Braun & Clarke, 2013). PRISMA will be used for the literature selection process. The integrative literature review, based on the framework of Whittemore & Knafl (2005), will guide the thematic data analysis. Hong et al.'s (2018) Mixed Methods Appraisal Tool (MMAT) will guide the critique of the literature.

2.2 Formulating the research question.

When formulating a research question, Aslam and Emmanuel (2010) said that the issue to be examined should be clearly specified. This highlights the issue to be known: the background question of what one wants to know, its relevance, when, how and where. In this instance, what the barriers are for older adults accessing healthcare services when they live in their own homes prompted the investigation. In the ward I work in, we have had older adults admitted without any services in place and often necessary referrals are needed to have the appropriate services put in place before the older adults are discharged home. The issue here is not primarily what the older adults' needs are or what services are available to the older adults, but rather, how the older adults could have accessed these services earlier to avoid or reduce the likelihood of hospital admissions and what influenced this accessing. Knowing why these older adults are not having the available services initiated as soon as they require them is the issue that needs to be investigated and answered. This prompted the question: What are the barriers and enablers for older adults accessing healthcare services to enable them to stay in their own homes. The population of interest are the older adults aged 65 years and over, and the variables of interest are healthcare services and the enablers and barriers to accessing services. Aslam and Emmanuel's (2010) Population, Intervention, Control and Outcomes (PICO) was used in the process of formulating the question.

Table 1

Using the PICO (Population, Intervention, Control and Outcomes) approach

Population	Intervention	Control	Outcome
Older adults	Barriers	-	Decrease barriers
65 years and over	-	--	
Home alone			

2.3 Literature search.

A literature search is an important aspect of a literature review. Timmins and McCabe (2005) stated that the initial search of literature can be used to identify a topic of interest as it shows the recent published research on a topic. A literature search can also narrow down a topic selection (Timmins & McCabe, 2005). Timmins and McCabe (2005) stated that a well-defined topic and appropriately narrow topic will yield a pertinent search. Local and international literature were scoped to gain an overview of the barriers that older adults face across the world.

The research question prompted the literature search. The inclusion and exclusion as well as the terms were decided. Primary source articles were of interest as Bramer et al. (2018) state that secondary source articles may affect the quality of literature reviewed as there is possibility of bias during the interpretation of someone's work. The inclusion and exclusion criteria are listed below. Literature to be reviewed was selected on its basis of relevance regarding barriers the older adults have in accessing healthcare services. This is the second step in an integrative review according to (Whittemore & Knafl, 2005). The university databases were the initial step to finding relevant research. AUT databases such as CINAHL complete (via EBSCO), Medline (via EBSCO) and SCOPUS were used to find the articles needed for review. Keywords like "older adults" or "elderly" or "older people" or "geriatrics", "barriers" or "challenges" or "difficulties" or "limitations" and "access" was used as the basis for the search. The search terms were refined using Boolean operators to combine or refine keywords. Results were refined to include availability of full text and abstracts. Google Scholar was also used for hand searching of reference lists of some retrieved papers so that primary research literature within the inclusion category could be obtained.

2.4 Inclusion and exclusion criteria.

Table 2

Inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria
From year 2000 to 2018	Studies published before year 2000
Full text	Without full text
In English	In other languages
Academic journals	Other types of articles
Older adults 65 years and above	65 years and below
Barriers to accessing healthcare services in the community	Barriers in care settings
Older adults who live at home	Older adults who do not live at home

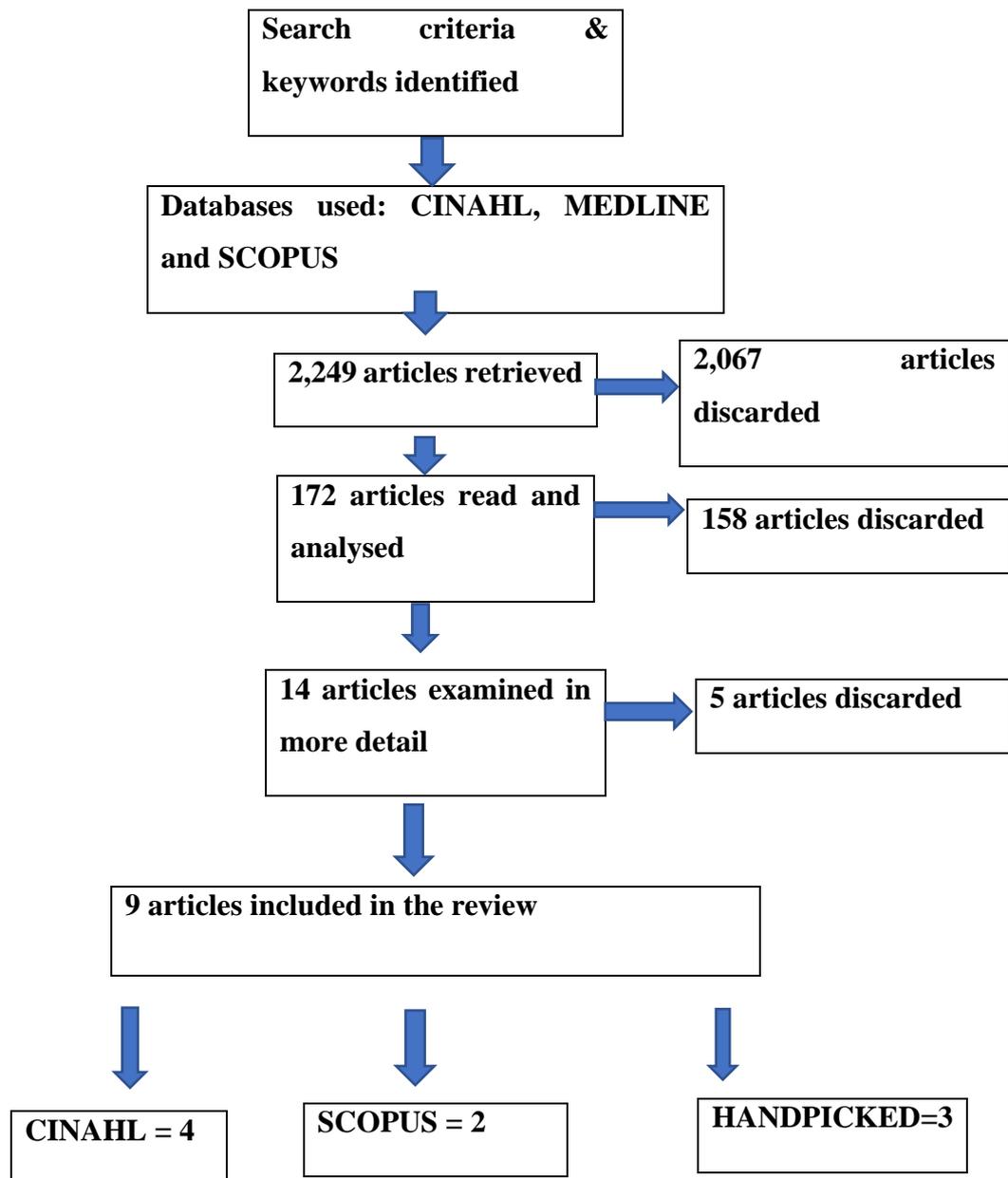
2.5 Data Evaluation.

Search terms used were “older adults” or “elderly” or “older people” or “geriatrics” and “barriers” or “challenges” or “difficulties” or “limitations” and “access” where CINAHL via EBSCO was used. This yielded 866 articles. Upon narrowing in view of inclusion criteria, 57 articles remained. Out of the 57 articles, 9 articles were selected. After reading the abstracts, only 4 articles were found to be relevant for the literature review. MEDLINE via EBSCO produced 1,140 articles and after narrowing according to the inclusion criteria, 117 articles remained. Out of the 117 articles, 2 duplicate articles were eliminated as they were included already from the CINAHL search, none was chosen. SCOPUS was also used and the search terms “barriers for older people accessing healthcare services” was used. Two hundred and forty-three articles were found from between 2000 to 2019, only two articles were relevant, and these were chosen for the review. The search engine Google Scholar was also used to hand

search reference lists of the articles that were chosen for the review. Three articles were handpicked. All articles chosen were primary research articles. Google Scholar was also used to check if the selected articles were cited by other authors.

Figure 1

PRISMA flowchart for selection of article process



2.6 Quality evaluation.

Quality evaluation was done using the Mixed Methods Appraisal Tool (MMAT) by Hong et al. (2018) to appraise the methodological quality of the articles that were selected for the review. MMAT was chosen because it can appraise qualitative, quantitative and mixed methods research publications. All nine studies' quality approval were independently conducted. No article was excluded from the review because of this process. Whitemore and KnafI, (2005) stated the articles with weaker scores must be treated with caution; hence, lesser reference will be given when concluding the review. See Appendix 1.

2.7 Data analysis.

The articles for review included four quantitative studies and five qualitative studies. Four of the articles were from the USA, two from the United Kingdom (UK), one from Australia, one from Japan and one from New Zealand. All the articles were primary research that took place in the community and the focus was on older adults aged 65 years and above.

The third stage was to analyse the data collected. Once the articles to be reviewed were selected, they were printed. Whitemore & KnafI's (2005) qualitative descriptive approach using thematic analysis guided the analysis. Inductive data analysis was used. Briefly, this started with the reading of the articles focusing on abstracts, introduction and conclusion of each article. While skimming through the articles, notes were taken and recorded in a Word document, which included methodology used, the aim of the study, findings, and the discussions. This information was then entered into a table and descriptions, such as name of author, year it was published, methodology, setting, results and recommendations, were noted. A flowchart depicting the decisions of all articles retrieved from the literature search is provided in appendix 2.

CHAPTER 3

The third stage of literature review is producing the report. An overview of the results of this integrative review is provided in this chapter. Data characteristics will be described; following this, there will be a presentation of the emerging themes. A figure illustrating my explanation of the emerging themes is provided.

3.0 RESULTS.

Articles included in this literature review were thoroughly read and analysed and were found to meet the objectives for this study, with the goal of becoming familiar with the knowledge base of scientific information on the barriers that the older adults face accessing healthcare service. There were nine articles that met these criteria. As an integrative review, different methodologies and research designs were included in this literature review. Five studies adopted a qualitative approach and the other five adopted a quantitative approach. No mixed methods were used.

3.0.1 Data characteristics.

Nine articles were eligible for this study. There were four from USA, one from Australia, two from UK, one from Japan and one from New Zealand. In these studies, both qualitative and quantitative methods were used. For the quantitative designs, all four studies used surveys; Bentley, 2003; Fitzpatrick, Powe, Cooper, Ives & Robbins, 2004; Li, 2006; Thorpe et al., 2011). The qualitative design had a mixture of methods; one article used focus groups Ford et al., (2018), while interviews were used in two articles: (Greaves and Rogers-Clark 2009; Sheridan et al., 2015). Bentley (2003) used mini ethnography. Duggleby, Abdullah and Bateman (2004) mixed interviews and focus groups.

3.0.2 Theme formation.

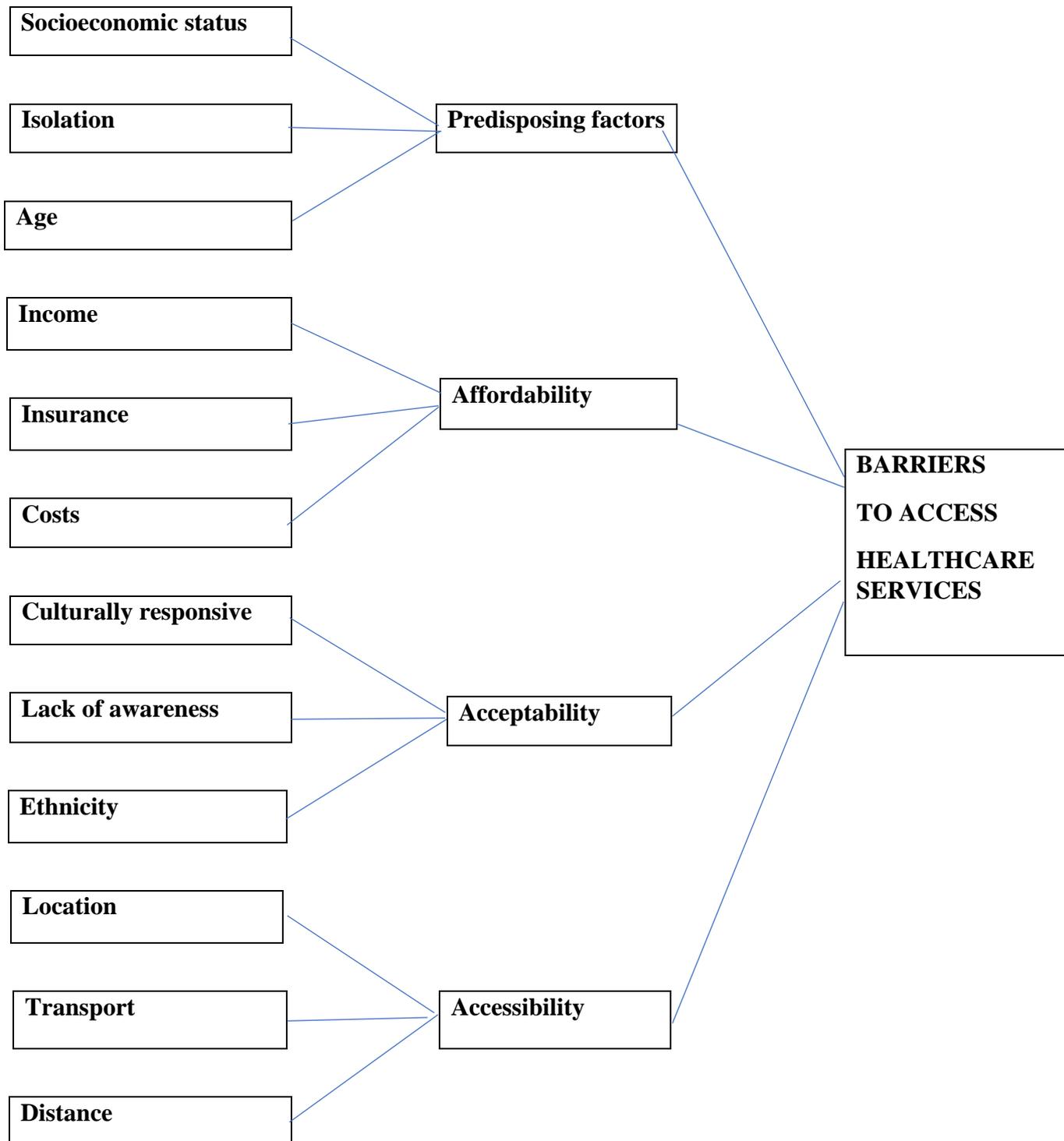
Extraction of data was done in relation to the review question and themes that captured important aspects of the data. There was a question as to what counts as a theme, but this was answered by Clark and Braun (2006), who stated that a theme should capture an important aspect of the topic being researched and should not depend on how much it appears in the data. The themes identified, analysed and coded were accurate reflection of the data. The approach used was inductive as Whitemore and Knafl (2005) state that themes should be linked to data and this is evidenced by the themes identified in this review. Codes were noted then condensed into recurring larger codes, then subthemes. The subthemes were grouped into themes, and the

number of themes were further reduced by combining related themes into broader themes until four main encompassing themes were identified. See Appendix 3.

Four themes emerged in this integrative review, namely: predisposing factors, affordability, acceptability and accessibility. Each theme will be discussed individually, including the presentation of subthemes. Six articles identified the first theme: predisposing factors as one of the barriers older adults face to access healthcare services with subthemes socioeconomic status, social isolation and age. The second theme identified was affordability, seven articles identified affordability with subthemes of income, insurance and costs involved with accessing healthcare services. The third theme identified was acceptability. This was identified in six of the articles and this involved culturally responsive services, communication and ethnicity. Accessibility was identified in seven articles with subthemes of location, transportation and distance. This is presented in appendix 3.

Figure 2

Subthemes and themes that emerged from this review.



3.1 Predisposing factors.

From the articles reviewed, it was noted that predisposing factors later translate into barriers to access healthcare services. For older adults to age-in-place, their physical, mental and social capability affect their capacity to function independently at home.

3.1.1 Socioeconomic status. Predisposing factors, for example, education, culture, location, race and income, have been long-standing barriers to healthcare access as noted by Sheridan et al. (2015). Chiyoe et al. (2010) echoed the same sentiments and highlighted how education provides knowledge and skills of life, which will later be important to gain access to resources and information about health. Not only that, but how education provides opportunities to promote better income, which will determine where you live, what you eat and the health insurance you will have, among other things. Ford et al. (2014) also pointed out how skills developed during early years will be used later in life to navigate through the health system. Socioeconomically disadvantaged older adults were found to be less likely to speak up. The tendency to be less cooperative with health professionals was also found in ethnic minorities. Szczepura (2005) pointed out that in UK, this might be because of poor linguistic competence, it was pointed out that 20% of men and half of Bangladeshi and Pakistani women are illiterate in any language in the UK. This was said to lead to less shared decision making (Sheridan et al., 2015). However, Chiyoe et al. (2010) highlighted that both those with low socioeconomic status and high socioeconomic status were equally the same when it came to seeking healthcare. In the study, those with lower socioeconomic status never had check-ups, while those with high socioeconomic status were too busy to seek healthcare. In the same study, those with lower socioeconomic status were more sensitive to cost of care, distance and transport, however, those with low socioeconomic status were found to have lower health status than those with higher socioeconomic status (Chiyoe et al., 2010). Li's (2006) study stressed that those with a higher level of education were found to be more aware of the services available.

3.1.2 Isolation. Isolation was identified as a barrier to access healthcare services for older adults. Three articles expressed how this acted as a barrier for older adults to age-in-place. Greaves and Rogers-Clark (2009) highlighted that those who have family and community connections can easily overcome other barriers for example, transport as family may provide that as well as sharing of health knowledge, those who do not have connections are less likely to age-in-place. Bentley (2003) supports this as findings from the study said

that pressure from family and friends encourages older adults to use healthcare services though the study was not clear to what extent. However, Greaves and Rogers-Clark (2009) noted that sometimes the social networks/connections are available, but the older adults may be reluctant to ask for help fearing burdening others or fearing that they may end up being placed in a rest home. Informal support from families extends to neighbours who play a big role in the older adults' lives to age-in-place. Support, for example, meal preparation, shopping, housekeeping and finance management were also mentioned by (Bentley, 2003). Family support also extends to emotional and social support as well as help to access healthcare service. Without this support, as another study Black (2008) pointed out, functional decline is imminent for some older adults and some older adults were said to develop feelings of loneliness, anxiety and low self-esteem. According to Greaves and Rogers-Clark (2009), these feelings were a central feature of socially isolated older adults; the inability to access appropriate healthcare services was said to increase these feelings. Another study said that social isolation is severe for older adults, especially during this time of their lives as some of them face stressful life transitions; for example, health problems, disabilities, loss of friends/partners/family and disabilities (Cornwell & Waite, 2009).

3.1.3 Age. Age was mentioned by Fitzpatrick et al. (2004) but not explored as the study design did not allow this. Sheridan et al. (2015) also mentioned age as a barrier for accessing healthcare services. Most of the barriers to healthcare services can be related to aging and are brought about by age. Once physical capacity is limited, Carvalho et al. (2017) in another study said it can be difficult to use healthcare services, even if the services are available. The study highlights that older adults' physical and mental capacity should be the focus on which coordination and integration of services should be started. In Bentley's (2003) study, older adults linked some illnesses to ageing and not seek healthcare for example, constipation that can be prevented by physical activity, hydration and fiber. However, age-related decline affects how older adults access healthcare services (Corcoran, McNab, Girgis & Colagiviri, 2012).

3.2 Affordability

3.2.1 Income. For older adults to be economically stable, is measured by their income. However, their socioeconomic status which includes education and income adequacy influences access to medical services. The relationship of prices of services to patient income and health insurance determines their ability to pay for health services.

Studies by Bentley 2003; Fitzpatrick et al., 2004; Thorpe et al., 2011; Li, 2006 indicated that in countries where health care is not free at point of service low income is a barrier to access healthcare services. Having no pension for older adults in Japan, as reported by Chiyoe et al. (2010), leads to the older adults not desiring to access healthcare services; hence, they end up postponing or not seeking healthcare. Older adults with low income were found to be lower in health status than higher income groups, as well as being more sensitive to the cost of healthcare (Li, 2006). Duggleby et al.'s (2004) study did not identify financial difficulties as a barrier in the study as the participants were well elderly women who might not be using the health system often.

3.2.2 Insurance. Not having medical insurance was said to be a major barrier to mitigate healthcare services in USA (Fitzpatrick et al., 2004; Duggleby et al., 2004). Not only affording the insurance, but the process of getting the insurance was described as a long process. Then there was the problem with the insurance not covering certain problems like pre-existing conditions as well as not covering dental, vision and hearing of which is a necessity for this population (Duggleby et al., 2004). Fitzpatrick et al. (2004) noted that regardless of provision of Medicare for older adults in USA, out-of-pocket costs remain a burden to Medicare beneficiaries. Out-of-pocket costs were also echoed by Chiyoe et al. (2010) who reported that most of the older adults in the study had incurred out-of-pocket costs. These costs lead to older adults not visiting the doctor on time but later presenting to emergency services. Thorpe et al. (2011) noted that the lack of health insurance meant older adults had severe barriers to access healthcare services.

3.2.3 Costs. The cost associated with receiving healthcare services was mentioned by Greaves and Rogers-Clark, 2009; Li, 2006; Chiyoe et al., 2010; Fitzpatrick et al., 2004; Thorpe et al., 2011 as one of the barriers to accessing healthcare services for older adults. Costs included transportation cost, use of taxis and other costs involved when receiving healthcare services such as prescriptions. Some older adults will require services, for example, audio or eye testing which are not free of charge and they also come with hidden costs; for example, the cost of getting to these services. The costs associated with buying hearing aids and glasses was mentioned in another study by Goins et al. (2005). Not only that but some prescriptions not being collected related to cost.

3.3 Acceptability.

For older adults to use the services, they should be acceptable. This includes interaction between older adults and provider attitudes, treatment practices, culturally safe services and access to information.

3.3.1 Culturally responsive services. The third theme that emerged from the review was acceptability of the services provided. (Greaves and Rogers-Clark, 2009; Duggleby et al., 2004; Bentley, 2003; Fitzpatrick et al., 2004; Thorpe et al., 2011; Sheridan et al., 2015) identified language barrier between the older adults and the service providers causing a barrier to access health services. This extended to how the health professionals communicate and their attitudes as well as the available services meeting the needs of the recipients. Lack of engagement from clinicians was explored by Sheridan et al. (2015). Older adults were found to not disclose their decline in health as there was no engagement from the health clinicians as well as fearing what might happen to them for example, placement in rest homes, while Greaves and Roger-Clark (2009) pointed out health professionals not taking time to listen to older adults, created a barrier. Duggleby et al. (2004) highlighted the trust the older adults put in their GP. Even though they may have contact with multidisciplinary teams, their focus is on the information provided by their GP; therefore, this may lead to undertreatment or possibly no treatment if the GP does not provide adequate information. Fitzpatrick et al. (2004) found that if older adults are not satisfied with provider services, it may impact their perception of access to healthcare services and eventually, this affects clinical outcomes. The feeling of powerlessness was raised by Greaves and Rogers-Clark (2009) as well as by Sheridan et al. (2015), while Ford et al.'s (2018) study mentioned feelings of being unwelcome and worthless when not treated with respect. If older adults do not get what they expect as well as not being listened to, they become powerless, which will then translate to developing coping mechanisms and they end up not disclosing their needs. Sheridan et al. (2015) said that not disclosing needs was not only a coping mechanism but also a statement of self-determination if the services provided are not acceptable. Thorpe et al. (2011) stated that with perceived barriers, older adults were less likely to receive preventative care. Long waiting times for specialist services or even at the GP were also seen as a barrier. In Greaves and Rogers-Clark's (2009) study, some older adults had to wait for about two years for specialist services then a referral to different departments after that long wait. Some older adults cited this as the reason they do not even want to start seeking healthcare services.

Culturally responsive services for Maori and Pacific Island people have been an ongoing problem. DeSouza (2008) stated that without including beliefs and practices of Maori and Pacific Island people into interventions, whatever health services offered will lack relevance and efficacy is compromised. Services provided must be appropriate, and acceptable as if this is not recognised, use and access of the healthcare services by this population group will be reduced. If there is no recognition of cultural beliefs, no positive health outcomes will be achieved. Therefore, there is need for flexibility and this may be achieved by including important cultural characteristics such as the incorporation of Tikanga Maori, the provision of cultural assessment practices and the involvement of whanau (family) among others, some of which may not be universally appropriate but if it will enhance access then it will be beneficial for this population group (Boulton, Tamehana & Brannelly, 2013). Poorer health has been reported among Maori and Pacific Island people compared to other ethnicities. A combination of factors which has been linked to this include social and economic status, behavioural risks such as smoking, discrimination and access to healthcare services (MOH, 2006). There has been a very slow increase in the availability of culturally responsive services which has the prime importance for Maori people. A total of 240 Maori health providers were noted in 2004, Ellison-Loschmann and Pearce (2006) and a total of 280 Maori health providers noted in 2018 as reported in Kai Tiaki New Zealand, an increase of 40 Maori health providers in fourteen years which is very slow progress. The needs of Maori and Pacific Island people also include the availability of health professionals of the same ethnicity, provision of training for existing health professionals, improving cultural awareness as well as enhancing existing services (Boulton et al., 2013).

3.3.2 Lack of awareness. Three of the articles (Duggleby et al., 2004; Li, 2006; Sheridan et al., 2015) suggest that older adults are often unaware that they can access healthcare services despite some of them having higher needs for healthcare services. In one study, Li (2006) indicated that knowledge of the existing healthcare services posed as a barrier for older adults to access healthcare services. Both Sheridan et al. (2015) and Duggleby et al. (2004) questioned how much knowledge healthcare professionals have on the available services for the older adults. Duggleby et al. (2004) emphasised the need for health professionals to have knowledge of services available for older adults as well as knowledge to identify the rising need/decline of the older adults and the services available for them. This was a concern as Duggleby et al. (2004) pointed out, since most participants gained knowledge of healthcare services from family and friends and not from health professionals. Lack of awareness was the

fault of both health professionals as well as the older adults (Duggleby et al., 2004). In rural areas, knowledge about health and health services was found to come from a limited number of sources as well as knowledge being shared was found to be limited (Bentley, 2003). Bentley (2003) said that relying on information from family and friends was seen to delay care and prevent visiting the GP at times. The GP was also seen as the gatekeeper to other healthcare services and the participants were not aware that they could access other services in the same study.

Fitzpatrick et al. (2004) said that reduced quality of care was independently associated with race, less perception of GP, issues with ability to explain, listening skills and trust issues arising with interaction of different races. Sheridan et al. (2015) reported that ethnic minorities in New Zealand had a lower rapport with health professionals due to language barrier and culture differences, which is a big concern as chronic conditions are said to be prevalent in this population. Therefore, without building enough rapport, a lot of health issues are left unattended. This same issue of lower rapport with health professionals was also reported to be similar with Africans in USA in another study (Rhee et al, 2019). Sheridan et al. (2015) highlighted that minority races of older adults were more likely to have less shared decision making as well as physician dominance during their encounters with healthcare services. In another study, Lai and Chau's (2007) findings indicated that the gap brought about by culture between service providers and service users played a key role on Chinese older adults' access barriers in Canada. There is a need for healthcare services to move away from structuring its services to assume that everyone is the same and therefore experiences the same healthcare outcomes (Lai & Chai, 2007).

3.4 Accessibility.

3.4.1 Location. How services are provided and accessed has a big impact on older adults. This includes location, which will extend to rural and small cities. Consideration should be directed to the location of services, how older adults will get there, how far they will travel, and the costs involved for transport. Adequate providers and appropriate services to meet that population was another factor that was identified. Ford et al. (2018) said that rurality has been associated with difficulties accessing healthcare services and that older adults travel longer distances for specialty services. There was a sense of belonging mentioned by Bentley (2003) to the extent of some people not regarding the advice from the doctors if they don't belong to that village or do not act like the villagers. Chiyo et al. (2014) pointed out the danger

of villagers fulfilling certain healthcare roles without any formal training, hence, some older adults will be reluctant to call or visit the doctor. Chiyoe et al. (2014) also pointed out that the sparsity of medical facilities in rural areas in Japan was a major concern for the older adults; hence, some resort to using indigenous remedies if they cannot get to a medical facility. For those located in remote areas, Ford et al. (2018) said that they are socioeconomically disadvantaged already. This ranges from being able to identify a health problem to getting an appointment with the GP and lastly, getting to that appointment. Thorpe et al.'s (2011) study showed that access to health services, especially preventative, screening and yearly vaccinations which are important to maintain the health of older adults to prevent new illness but are sometimes not possible depending on one's location. The issue of limited qualified professionals in remote areas was an issue raised by Li (2006), while another study Goins et al. (2005) highlighted the exodus of specialist and doctors to bigger cities, citing the need to make more money and better schooling for their children.

3.4.2 Transportation. Transport is a big issue when it comes to older adults accessing healthcare services if these services are situated far away from or even close to the health services. Many older adults have lost their licences and rely on family or taxis, which come with costs. Those who still have their driver's licence were found to prefer to drive shorter distances and at certain times of the day to appointments (Greaves & Rogers-Clark, 2009). This same issue was cited by Chiyoe et al. (2014), who stated that driving limitations after their licence was taken lead to older adults not seeking treatment. Fear of travelling and costs of public transport was cited in Bentley (2003). Bentley (2003) also stated that getting to the shops, doctors or to relatives was a problem. Transport, therefore, was found to determine if older adults make appointments, make it to the appointment, go for routine screening, pick up prescriptions and go to social clubs (Greaves & Rogers-Clark, 2009). Ford et al. (2014) said that having a car was a key resource of being able to go and see the GP. However, Greaves and Rogers-Clark (2009) noted that even though having a car can be a good resource; however, in this age group, some have restricted driving times and distances. Some older adults prefer to drive at certain times; hence, this decreases their availability to accept appointments if there is no flexibility in appointment times, so a barrier is created.

3.4.3 Distance. Distance to get to healthcare services is linked to where one resides and transport to get to the necessary services. Rural towns and small cities have been cited as major factors that put older adults at a disadvantage. For older adults living in these areas to age-in-place, it is reliant on their physical and mental health then the availability and ability to

access formal and informal support services. Thorpe et al. (2011) noted that those living in rural areas were more likely to have barriers to access or availability of services. Bentley (2003) pointed out that a village/community was a place that holds certain attitudes, values, norms and behaviours; however, the advantage of this population in the village/community is the connectedness it has with their neighbours and support from family.

CHAPTER 4

In chapter 4, the review will be discussed, gaps will be identified as well as recommendations made. The limitations will be identified before finally summarising the whole integrative review of this project.

4.1 DISCUSSION

Findings from other articles will be discussed in this chapter and links will be made to the nine articles that were selected in this integrative review. Four themes that emerged from the nine reviewed articles will be the basis of the discussion. To some extent older adults believe their health is controlled by others or their own responsibility. From the themes, a pattern that emerged is that the barriers to access healthcare services can be self-imposed. The environment can also play a part in it which correlates with Jacobs-Lawson et al.'s (2011) internal locus of control.

The barriers arise with age related depletion of physical and physiological capacity. Barriers to accessing healthcare services have been around for a while, but there is a need to find ways to reduce them. With the rising population of older adults, there are rising new demands pressing challenges on the healthcare services. Are the healthcare services prepared to meet the rising demand? If not, presentation to emergency departments by older adults with advanced conditions that could have been managed if healthcare services were accessed on time is going to rise.

From the articles reviewed, four themes emerged, which are predisposing factors, affordability, acceptability and accessibility. These themes were found to be interrelated and they provide an insight into the barriers the older adults have accessing healthcare services. The nine articles retrieved for this integrative review have shown that barriers for the older adults to access healthcare services exists in different levels across different countries. These findings are consistent with other research.

Predisposing factors such as age, isolation and socioeconomic status were discussed as barriers for older adults seeking health care services (Duggleby et al., 2004; Fitzpatrick et al., 2004; Li, 2006). It was noted that predisposing factors later translate into barriers to access healthcare services. For older adults to age-in-place, their physical, mental and social capability affect the capacity to function independently at home. Greave and Rogers-Clark (2009) stated that some of the older adults see some health problems they have as a normal part of ageing and

therefore they do not seek healthcare. This was also pointed out in another study (Rhee et al., 2019). Age was apparent as a barrier. Sun and Smith (2017) found that older adults found it difficult to distinguish old age symptoms from symptoms that were serious.

In previous studies (Nattham & Seung Chun, 2019; Nelms et al., 2009; Goins et al., 2005; Cornwell & Waite, 2009), isolation was identified as a barrier in older adults' awareness and knowledge of healthcare services; hence, creating a barrier to service uptake. This is magnified by the changing society as more and more older adults' families are relocating. Wright-St Clair et al. (2017) pointed out how late-life immigration has an impact on social networks as some will be leaving behind their families and friends. In another study, Cheng et al. (2002) mentioned that having a spouse or some form of social support will lessen the barriers to healthcare access due to the support they provide. Cornwell and Waite (2009) expressed that one's social connectedness shows one's social networks, their level of social participation, their access to information, transport as well as emotional support.

Rurality has been associated with poor health outcomes due to sparsity of healthcare services. Spacing of the services was pointed out by Fitzpatrick et al. (2004), and in another study, Gesler et al. (2000) highlighted that for older adults with one or two long term conditions, spaced services would make it difficult for them to attend appointments.

Nattham and Seung Chun (2019) also link socioeconomic characteristics with unmet healthcare needs among the older adults in Thailand. Therefore, socioeconomic status and culture determines the barriers to access healthcare services. Nattham and Seung Chun's (2019) research found that 59% of older adults aged 65 and over have basic or below basic health literacy; hence, are at risk of not understanding risks and benefits of treatment or preventative measures, and therefore, they cannot advocate for themselves. In Korea, Young et al. (2016) also echo the same sentiments and relate worsening of health status and developing of chronic diseases to lower health literacy of older adults. Therefore, health professionals must have knowledge of services and step up as well as being advocates for this population. In Australia, Greaves and Rogers-Clark (2009) said that despite the implementation of the project Community Links which was meant to enhance health professionals' knowledge of the available services, the results were not evident in the older adults' journey; therefore, there is need for health professionals to be aware of the services available. Delali Adjoa's (2019) study cited the lack of geriatrics teaching in medical schools stating that only 4% of the schools taught geriatrics and 72% of staff did not have geriatric expertise.

Affordability acts as a considerable barrier for older adults to access healthcare services among the literature reviewed. This included income, insurance and costs related to healthcare needs. These financial barriers reported in this literature review are prime examples of how affordability is a barrier to healthcare access. Gildner et al. (2019) linked income as an important measure to older adults' economic stability. Jatrana and Crampton's (2009) study pointed out that even though New Zealand's health system is heavily subsidised, older adults are not able to afford healthcare services. Carcadden et al., (2018) confirms that cost was a barrier in New Zealand to access healthcare. Perception of financial security among older adults extends to government support programmes and in New Zealand there is a superannuation pension for older adults that ranges from \$17,754 to \$24,721.84 per year depending on one's circumstance (Office for Senior Citizens, 2015). There are also other benefits like disability and accommodation that the older adults can access in New Zealand, but this depends on residence status as well as knowledge of the services.

Xiaoting (2014) relates not affording healthcare services and not having health insurance to older adults not able to utilise healthcare services in China. Although some countries have subsidised medical services and free hospital visits, in some parts of the world the older adults heavily rely on family financial support as there is no social support available (Nelms et al., 2009). In Ghana, older adults are dependant on families. Aboderin (2004) said that formal welfare is mostly adult children or family providing support; however, this has been noted to be declining due to modernisation and ageing theory perspective leaving the older adults with no support at all. Apt (2012) and Delali (2019) also blamed modernisation and urbanisation on contributing to the challenges faced by older adults in developing countries. With changing family dynamics, being home alone was found by Nattham and Seung Chen (2019) to have a big impact on the older adults.

In another study Goins et al., (2005) costs is magnified if one has chronic conditions and needs a lot of regular medications. The use of home remedies can be related to costs as shown in Goins et al. (2005) and Van Rooy, Mufume and Amadhila (2015), but Bentley (2003) relates it to isolation where the older adults are reluctant to ask for help therefore resort to using home remedies. Van Rooy et al.'s (2015) study in Namibia relates it to a group of people sharing beliefs and attitudes and not wanting to move away from tradition. A study by Goins et al. (2005) identified copying strategies the older adult use to cope with costs of medication, which include; decreasing dosage, skipping dosages, doing without,

supplementing with alternatives or limiting other expenses therefore ending up not getting a therapeutic dosage as required.

Acceptability emerged as the third theme. Health services were found not to be conducive to the older adults. This ranged from being responsive to their raising needs, how these services were delivered and these services being culturally acceptable. Firstly, older adults were found to lack knowledge of the available services (Duggleby et al. 2004; Li 2006; Sheridan et al., 2015). In another study, Harrison et al. (2014) also noted that although the services are available, some older adults are not aware of these services as well and some clinicians not taking time to inform the older adults of the available services. Delali Adijoa (2012) pointed out the need for medical schools to have geriatric teaching in the curriculum as lack of staff expertise on geriatrics was noted to be 72%. Black (2008) emphasised that service providers should have knowledge of the available services. These same sentiments were echoed by (Rhee et al., 2019). The Ministry of Social Development (2009) pointed out that not knowing how to access formal support and services maybe the reason why older adults may not be resilient, especially those with community-focused social networks, even those with family-focused social networks, family will also not be aware of what formal support or services the older adults can access.

Ford et al., (2018) highlighted the pressure from the health services that are faced with increased demands, but the resources remains stagnant. A tendency to reorganise services to reduce costs was imminent, some of which, pointed out by Ford et al. (2018) include fewer home visits, modifying appointment system and having more telephone consultations. This will only precipitate the barriers of accessing healthcare services. Using the example of having more telephone consultation, Ford et al.'s (2018) research highlighted difficulties with engaged telephone lines by older adults as well as having difficulty navigating their way through the receptionist. Being aware of the available services will decrease access barriers. Bentley (2003) said, some older adults stated that they get health information from the television and the radio. Information like their rights, the services they can access and how they can access them as well as prevention campaigns can be beneficial to older adults and their families if delivered by television or radio.

Having culturally responsive services for indigenous populations was a way to combat some barriers faced by indigenous populations Deborah van and Elsa (2018), but with societies ever migrating, this can solve this problem to an extent, but it will not eradicate it. Cultural

differences may lead to misunderstandings which might have serious implications. However, diversity of cultures may also play a role in how older adults perceive their health. Cultural diversity among patients and healthcare professionals also play a big role. In another study, Rhee et al. (2019) pointed out the issues of trust and poor communication skills pertaining to ethnic minority groups. Ford et al. (2014) saw limited resources within the healthcare system contributing to barriers the older adults face, but Greaves and Rogers-Clark (2009) suggest that it might be due to health professionals not being aware of the services available for older adults

The issue of waiting long to see a doctor was raised by Duggleby et al. (2004), while Chiyoe et al. (2010) noted long waiting hours and Sheridan et al. (2015) pointed out shorter consultation time as well as long waiting hours. Fitzpatrick et al. (2004) talked about the doctor spending less time with some older adults in this study. Sheridan et al. (2015) said that some participants reported having gone home before being seen while in another study, Nattham and Seung Chun (2019) said that with long waiting times to see the health professional in Thailand, one must be very sick to visit them. Once the older adults are faced with situations like long waiting times to see the GP, less time spent with the GP and lack of continuity of care, this will eventually lead to use of coping skills, which includes not disclosing illness, not having check-ups and finally, not trusting the healthcare system. Feelings of powerlessness and irritation were also noted to develop (Sheridan et al., 2015). Sheridan et al. (2015) relates the feeling of powerlessness to not engaging with treatment, while Duggleby et al. (2004) pointed to feelings of powerlessness when health professionals seem not to care or understand their problems. The feeling of powerlessness when needs are not met was also mentioned in another studies Kristenson et al. (2010) and Conner et al. (2010) who said that the feeling of powerlessness is brought about by racial discrimination and mistrust of the system for minority races. These effects will have an impact on their perception of care and may later translate into barriers for seeking future care.

However, from the articles reviewed, the older adults are not very keen to voice their needs to clinicians due to several reasons, that includes: lack of engagement, fear of losing their independence, not being prepared to be the recipient of assistance as well as lack of knowledge from the clinicians of the rising need/decline of the older adult. Canvin et al. (2018) said that the fear of losing ability of living alone, while Sun and Smith (2017) suggested that yearning for independence might hinder the older adults to present to healthcare services, thereby limiting healthcare professionals' knowledge of their needs and the ability to plan appropriate services.

How health services are accessed was raised by Chiyoe et al. (2014) who said that studies in USA and UK has demonstrated that accessibility to health services is an important factor for the health of the older adults. These results are congruent with a study by Dobner et al. (2016) that demonstrated that location of services affects the utilisation of healthcare services. Not only that, but service providers must be aware that mobility radius diminishes as people grow older (Kim, 2012). Those who live far from healthcare services often travel longer distances to access health care services and formal support. Dobner et al. (2016) said that this affects the likelihood of attempting to access healthcare services. Not only do transport issues arise in rural areas, but a study in low-density urban city in USA also showed this affected the urban areas as well (Adorno et al., 2018). Issues like public transport being available but the older adults needing to get to the bus stop to use it, or if there is provision of scheduled pick up and drop off, the waiting times at the doctors maybe unpredictable, leaving the older adults to wait longer to be picked up once dropped off (Adorno et al., 2018). However, in another study, Galambos (2005) stated that older adults in rural areas were found to have lower health expectations and as a result of this, they were found to delay seeking healthcare services.

Deborah Van and Elsa (2018) highlighted unreliable public transport limiting access to healthcare services, while Black (2008) pointed out that they take a few days to recover after attending appointments when they had to travel far and there was a tendency of not attending dreading the strain it causes. Those who were still driving cited fuel cost and anxiety when they had to drive for long distances, while those who drive in big cities where not very confident driving in a congested environment. In another study, Van Rooy (2015) pointed out the conditions of roads; for example, hills and the weather conditions, which makes it difficult for older adults to attend to their healthcare appointments.

More importantly, although barriers to access healthcare services are widely documented among the older adults, how these are to be addressed is not thoroughly explored. Furthermore, many of these barriers are brought about by ageing and yet this has not been the focus of targeting services to older adults. Focus should be on preventative efforts and determinants of health because untreated conditions and lack of prevention can lead to severity of diseases, which will result in increased emergency visits with longer hospital stays. More often, this results in poor quality of life and more money spent in trying to rectify the situation. This integrative literature review was carried out to understand the barriers that older adults face when accessing healthcare services to age-in-place and to identify the knowledge gap. The nine studies included in the review demonstrate that there are four main

barriers for older adults to access healthcare service and these barriers are found on the supply side (health care services) as well as on the demand side (older adults). This demands that both sides of healthcare need to be addressed so that accessibility barriers to healthcare services by older adults are decreased.

The literature revealed that barriers for older adults to access healthcare differ as older adults come from culturally and economically diverse backgrounds. The intention was not to look at a single barrier but look at older adults holistically. Most studies focused on a single problem that leads to barriers of accessing healthcare services; hence, ended up not included in this review.

4.2 GAP IDENTIFIED

4.2.1 Awareness of available service. Literature shows that older adults experience several barriers to access healthcare services that adversely affect their quality of life and decrease their possibility to age-in-place. However, how much knowledge the older adults and healthcare professionals have on the services available for older adults has not yet been explored. Services can be available but knowing when and how to access them is critical, this will determine if the older adults will age well in place.

4.3 RECOMMENDATIONS.

4.3.1 NASC assessment. Older adults should have an initial Needs Assessment done once they access healthcare services at GP level to ascertain their needs. Issues for example, isolation will be picked up early as well as follow-up arrangements made according to rising needs. The initial contact should not happen because there is a fall or an acute illness that brought the older adults in contact with health professionals, but this should happen long time before things get out of hand.

4.3.2 Improve knowledge of available services. Improve knowledge about available services and encourage health professionals to refer older adults to appropriate services per rising needs can be an effective start in improving older adults' health. This should be included during training as well as orientation of new health professionals (for registered nurses). An effective process would provide opportunities for implementation of preventative strategies; therefore, reduction in older adults seeking care when problems/diseases are well advanced. Discussions of health promotion, for example, diet,

mental health, exercise and falls prevention should be included in consultation when the older adults contact health professionals, Carcadden et al.'s (2018) Common Wealth survey has shown that 33% to 54% older adults did not have a discussion pertaining this with their primary care providers in seven countries, New Zealand included. It was proven that timely medical care reduces serious health adverse events (Sun & Smith, 2017).

4.3.3 Research. More research is needed that involves both health professionals and older adults as service users to allow different perspectives of access to healthcare services. This will also inform how much knowledge the health professionals have of the services available and how the older adults can access the services. Research should also target at getting information of how many older adults are presenting at emergency services without services to help them age-in-place.

4.3.4 More geriatric registered nurses. The rapidly growing population of older adults is presenting challenges to healthcare systems around the world. Health professionals should have confidence in their roles and should collaborate. Constraints in healthcare services decrease access to resources. Health professionals sometimes have large workloads and will not be able to see patients within the recommended time frames. This affects delivery of care. There will be no time for teaching, health awareness, and health promotion when health professionals are working under pressure (Youngworth & Twaddle, 2011). There is a need for more geriatric nurses in the community to facilitate the linking of services to older adults. Increased costs to employ more geriatric nurses will be inevitable if health gains are to be achieved. The geriatric nurses will be responsible for ensuring that the recommended services needed by the older adults are provided and preventative care is delivered at community level. This will also include making sure that the older adults in that area are registered with a local GP.

4.3.5 MDT input. WHO (2015) defines health as not merely the absence of diseases but a complete physical, mental and social wellbeing. Looking at this definition, there is need to have an MDT approach when providing health services to the older adults. The involvement of MDT should not start when there is an acute incident that brings the older adults in contact with healthcare professionals, but it should be a long time before there are is a problem. Lorgin and Horman (2003) stated that once older adults are hospitalised, an increase in dependency occurs. There is need to avoid this. Ideally, the initiating of services should start

at the GP level. There should be a geriatric nurse who will be able to assess the following: how the older adults are managing at home and home safety. They will then be able to provide health education and make referrals to available services.

Managing of motor skills, strength and balance as well as exercise programmes should not start when there has been a fall; this should be initiated when deterioration is noted, and an exercise programme put in place together with transport arrangements to such programmes sorted to maintain mobility. Kim et al. (2012) stated that when older adults are provided with the knowledge and the benefits of physiotherapy, their participation was noted to increase.

Occupational therapists should be engaged early so that the needs assessment is done, and changes will be easily noticed. Maintaining activities of daily living, assessment of home environment, recommendation of equipment, renovations needed to the home to be conducive, assessment of occupational performance and current occupational function should also be assessed earlier.

NASC assessment should be initiated when older adults turn 65. Not everyone will require assistance, but that initial assessment will ascertain who is needing assistance then and who will need their assessment revisited in a given time frame.

The social side will be dealt with by the social workers. This will include social situation, psychosocial support, support during loss, grief, career stress, vulnerable adult and financial crisis. The constraints in the health system will not go unnoticed though, as well as access to resources, but more geriatric nurses should be employed in the community to work with the GP staff.

This does not limit the involvement of other disciplines when required but referrals should be made per rising need.

4.4 LIMITATIONS.

A more diverse sample would have been good to gain understanding of experiences of older adults in other parts of the world especially those countries with resource constraints. However, findings point out barriers faced by older adults and community-based healthcare services may find ways to respond to the barriers identified; for example, prevention, education and outreaching the older adults. Grey literature was not included in this integrative review, inclusion of which would have fostered a balanced picture of the evidence available as well as the comprehensiveness of the review would have been increased.

Indigenous populations for example, Aborigines in Australia and Maori in New Zealand have been noted to have healthcare problems early on in life; hence, access to healthcare services needs to be initiated earlier than the rest of the population. The inclusion of 65 years and over limited this population's involvement.

4.5 CONCLUSION.

Key links to facilitate older adults to age-in-place includes informing, linking them to service providers and providing services to assist them to age-in-place. Although the shift to holistic care is evident in assessments and services available, what is missing is linking the older adults to the services. The older adults should be empowered to do this through awareness of available services they can access, as well as health professionals having knowledge of services so the timely referrals to needed services are done as per rising needs. Older adults have general barriers to access healthcare services ranging from predisposing factors, affording the services, acceptability of the services and how these health services are accessed; therefore, there are still many barriers preventing them from accessing healthcare services. These barriers need to be addressed to ensure this population can successfully access health services as well as healthcare systems being responsive to older adults and understanding their needs.

Having these factors identified leads to an understanding of how healthcare professionals reinforce access barriers. Both healthcare professionals and older adults need to work together to bridge these barriers. Services should be satisfactory as service satisfaction may influence access. It is not good enough to have enough healthcare services but not satisfying the needs of the older adults as service satisfaction may influence use. If the right services at the right time and in the right place are provided as well as awareness of these services, older adults will be able to access them without difficulty and will be able to age-in-place.

Appendix 1

Mixed Methods Appraisal tool (MMAT) Hong, Pluye & Fabregues et al. (2018)

Article	Category of study design	Methodological quality criteria	Yes	No	Can't tell
1. Barriers to Health Care Access Among the Elderly and Who Perceives Them	Quantitative Survey Questionnaires	Variables are clearly defined Measured accurately Measures justified for answering the question Validated and reliability tested Questionnaires pre- tested prior to data collection	Yes Yes Yes	No	Can't tell
2. The experience of socially isolated older people in accessing and navigating the health care system	Longitudinal Qualitative Interpretive approach In-depth interviews	Is the qualitative approach appropriate? Are in-depth interviews adequate to address the question? Are the findings adequately derived from the data? Is the interpretation of the results sufficiently substantiated by the data? Is there coherence between qualitative data sources, collection, analysis and interpretation?	Yes Yes Yes Yes Yes		
3. Rural older adults' access barriers to in-home and community-based services	Quantitative Survey	Variables are clearly defined Measured accurately Measures justified for answering the question Validated and reliability tested Questionnaires pre- tested prior to data collection Is the sampling strategy relevant to address the question? Is the sample representing the targeted population?	Yes Yes Yes Yes Yes		Can't tell Can't tell
4. Persevering: the experience of well elderly women overcoming the barriers to the U.S. health care system	Qualitative Descriptive thematic Focus group interviews	Is the qualitative approach appropriate to answer the research question? Is the data collection adequate to answer the research question? Clear links between - Data sources Data analysis Data interpretation Are the findings clearly derived from the data?	Yes Yes Yes Yes Yes		
5. Patterns of perceived barriers	Quantitative	Variables are clearly defined Measured accurately	Yes Yes		

to medical care in older adults: a latent class analysis.	Wisconsin Longitudinal Study Survey	Measures justified for answering the question Validated and reliability tested Questionnaires pre- tested prior to data collection	Yes		Can't tell Can't tell
6. Barriers to accessing health care: the perspective of elderly people within a village community	Qualitative Mini-ethnography Semi-structures interview	Is the qualitative approach appropriate to answer the research question? Is the data collection adequate to answer the research question? Clear links between - Data sources Data analysis Data interpretation Are the findings clearly derived from the data?	Yes Yes Yes Yes Yes Yes		
7. Patients' engagement in primary care: powerlessness and compounding jeopardy. A qualitative study	Qualitative In-depth interviews	Is the qualitative approach appropriate to answer the research question? Is the data collection adequate to answer the research question? Clear links between - Data sources Data analysis Data interpretation Are the findings clearly derived from the data?	Yes Yes Yes Yes Yes Yes		
8. Access to primary care for socio-economically disadvantages older people in rural areas: A qualitative study	Qualitative	Is the qualitative approach appropriate to answer the research question? Is the data collection adequate to answer the research question? Clear links between - Data sources - Data analysis - Data interpretation Are the findings clearly derived from the data?	Yes Yes Yes Yes Yes Yes		

9. Barriers to health care among the elderly in Japan	Quantitative Cohort study	Variables are clearly defined Measured accurately Measures justified for answering the question Validated and reliability tested Questionnaires pre- tested prior to data collection	Yes Yes Yes Yes		Can't tell
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Appendix 2

Characteristics of findings

Article, Author and year	Methods/Sample size	Title	Country	Setting	Recommendations	Results	Target population
1. Fitzpatrick, A. L., Powe, N. R., Cooper, L. S., Ives, D. G., & Robbins, J. A. (2004)	Questionnaires 5,888 participants men and women	Barriers to Health Care Access Among the Elderly and Who Perceives Them	United States America	Primary	Future studies to consider ascertainment of socioeconomic variables along with perceptions of care and other psychological factors when looking at barriers healthcare access in the older adults.	Most barriers for accessing health care service were due to unresponsiveness of the doctors medical bills and female gender. Race was not a significant factor.	Older adults
2. Greaves, M., & Rogers-Clark, C. (2009).	Longitudinal qualitative, interpretive study In depth interviews 6 participants	The experience of socially isolated older people in accessing and navigating the health care system	Australia	Primary	Recommendations where that of working in partnership with the older adults, building of trusting and respectful relationships and that they needed reassurance.	Barriers ranged from depletion of social networks, decreased mobility, transport, and a common experience of fear was noted.	Older adults
3. Li, H. (2006)	Survey 283 rural older adults	Rural older adults' access barriers to in-home and community-based services	United states of America	Primary	Focus was directed at assessments, specific services, education about available services and awareness. Healthcare professionals need to advocate for older adults so that they can receive the required services.	Barriers identified were transportation, unavailability, unawareness, race and educational attainment.	Older adults

4. Duggleby, W., Abdullah, B., & Bateman, J. (2004)	Focus groups and interviews 46 participants, women aged over 65	Persevering: the experience of well elderly women overcoming the barriers to the U.S. health care system	United States of America	Primary	Recommendations were to remove barriers.	Time and accessibility were the barriers found to be affecting the older adults receiving care.	Older adults
5. Thorpe, J. M., Thorpe, C. T., Kennelty, K. A., & Pandhi, N. (2011)	Wisconsin Longitudinal Study 5,465 community dwelling older adults	Patterns of perceived barriers to medical care in older adults: a latent class analysis.	United States of America	Primary	Healthcare organisations should have policies targeting interventions designed to improve access for the older adults population.	Availability and accessibility were found to be barriers accessing health care service. Accommodation and affordability were also identified.	Older adults
6. Bentley, J. M. (2003)	Qualitative Mini-ethnography	Barriers to accessing health care: the perspective of elderly people within a village community	United Kingdom	Primary	Patient-focused studies on prescribed medication deputing services, credibility of health information and studies on gathering differences in consulting differences.	Main themes that emerged from the data were coping with health and illness and legitimising access.	Older adults
7. Sheridan, N. F., Kenealy, T. W., Kidd, J. D., Schmidt-Busby, J. I. G., Hand, J. E., Raphael, D. L., ... Rea, H. H. (2015).	Qualitative Interviews 42 participants	Patients' engagement in primary care: powerlessness and compounding jeopardy.	New Zealand	Primary	General Practitioners to adopt new approaches within the primary healthcare.	Participants did not feel heard by health professionals, as a result this acted as a barrier to access healthcare.	Older adults

		A qualitative study					
8. Ford, J. A., Turley, R., Porter, T., Shakespeare, T., Wong, G., Jones, A. P., & Steel, N. (2018)	Qualitative Focus groups 15 participants	Access to primary care for socio-economically disadvantaged older people in rural areas: A qualitative study	United Kingdom	Primary	More support is needed in the rural areas in terms of transports as well as appointments being booked when public transport is available.	Barriers identified included engaged telephone lines, availability of appointments, and interactions with receptionist.	Older adults
9. Chiyoe, M., Tetsuji, Y., Chia-Ching, C., Toshiyuki, O., Hiroshi, H., & Katsunori, K. (2010)	Quantitative Survey 15,302 participants	Barriers to health care among the elderly in Japan	Japan	Primary	Studies that investigate the consequences of delayed care are needed.	Low income participants found cost, distance and transportation barriers while the higher income participants were busy or did not see the need or reason to seek care.	Older adults

Appendix 3

Identifying of themes

Author	Accessibility	Affordability	Acceptability	Predisposing factors
Fitzpatrick, A. L., Powe, N. R., Cooper, L. S., Ives, D. G., & Robbins, J. A. (2004)	X	X	X	
Greaves, M., & Rogers-Clark, C. (2009).	X	X	X	X
Li, H. (2006)	X	X	X	X
Duggleby, W., Abdullah, B., & Bateman, J. (2004)	X		X	X
Thorpe, J. M., Thorpe, C. T., Kennelty, K. A., & Pandhi, N. (2011)	X	X		
Bentley, J. M. (2003)	X		X	X

Sheridan, N. F., Kenealy, T. W., Kidd, J. D., Schmidt-Busby, J. I. G., Hand, J. E., Raphael, D. L., ... Rea, H. H. (2015).			X	X
Ford, J. A., Turley, R., Porter, T., Shakespeare, T., Wong, G., Jones, A. P., & Steel, N. (2018)	X			
Chiyoe, M., Tetsuji, Y., Chia-Ching, C., Toshiyuki, O., Hiroshi, H., & Katsunori, K. (2010)	X	X		X

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