

# Health Service Access Barriers for Older People in the Region of the Americas



**PAHO**



Decade of Healthy Aging in the Americas

**situation and challenges**



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The purpose of the series is to provide regular updates on the different action areas of the Decade of Healthy Aging (2021-2030) in the Region, as well as other related issues.

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## Introduction

By 2025, older people will make up 18.6% of the total population of the Region of the Americas (1). The demographic transition generated by the decrease in the fertility rate and the increase in life expectancy has increased the number of older people in the population. In the next 25 years, assuming this upward trend continues, this population is expected to double in the Region (1). Hence, in line with the priorities and objectives of the Healthy Aging Program of the Pan American Health Organization (PAHO), it is vital to understand the health care needs of this population.

This forward-looking perspective obliges us to assess the specific needs of older people. Child health has been a priority for health systems owing to high childhood disease and death rates. However, in some regions, these indicators have improved substantially, especially in developed countries. At the same time, people in these regions are living increasingly longer lives, and when they reach advanced age they tend to suffer from multiple diseases that can lead to disability and dependence. These conditions are currently the main contributors to the disease burden in health systems. Making countries aware of this present and future population scenario will alert them to the need to adapt ecosystems to the needs of older people.

Older people may have characteristics that affect their access to and use of health services in comparison with young people. These characteristics include economic vulnerability and dependence on younger relatives, a higher prevalence of chronic diseases and, as a result, polypharmacy (2-4). Therefore, it is of vital importance to rethink the current design of health systems and the social conditions in which older people live, as these are among the determinants that promote or hinder their access to health services.

In light of this situation, this report explores some of the specific barriers faced by older people in accessing health services in the Region of the Americas. The information presented was obtained by means of a literature review. The search terms used were “access”, “health service”, “older persons”, “older people”, “Americas”, “Latin America”, and “North America.” The search results include studies and research using data from population surveys, gray literature, and position papers.



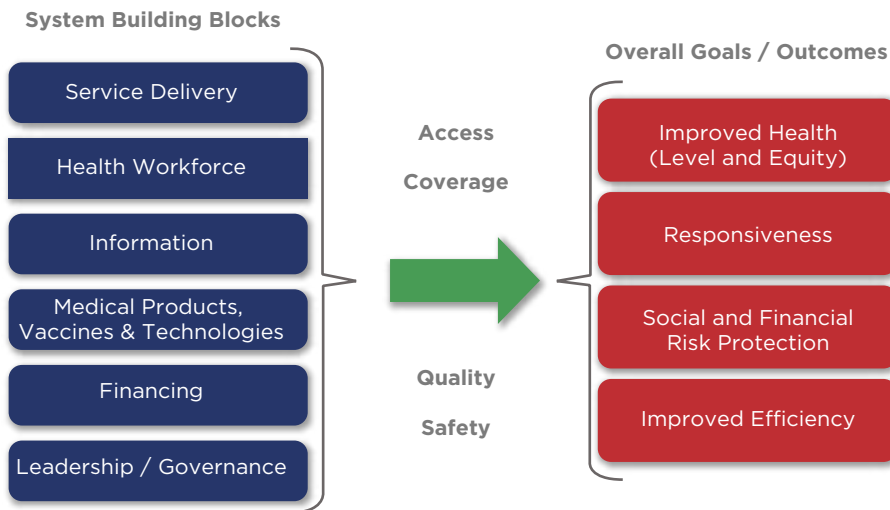
The objective of this project is to identify the barriers faced by older people in accessing health services and propose specific recommendations for the Region with a view to improving the health and the lives of this population group. According to the World Health Organization (WHO) (5), the more accessible a health system is, the more people will use it, since access impacts the final outcomes of the system, both good and bad (in terms of population health, financial protection, and people's satisfaction). The chapters of this report have been organized on the basis of a model of access to health services that seemed relevant to understanding the barriers perceived by older people.

## Access to health services

Access to health services is one of the outcomes, or outcome metrics, of some health system performance models (6, 7). In addition to access, the WHO health system building blocks model establishes three other outcomes: quality, safety, and coverage of health services (see Figure 1) (6, 7). These outcomes are among the six building blocks of health systems: 1) service delivery; 2) health workforce; 3) information; 4) medical products, vaccines, and technologies; 5) financing; and 6) leadership and governance. The four goals, or end results, of a health system are: 1) improved health status of the population; 2) responsiveness; 3) social and financial risk protection; and 4) improved efficiency (6, 7). Hence, ascertaining the performance of outcome indicators is of vital importance to improve the end results of a health system by adapting and improving the building blocks.

Access, as defined by Murray and Frenk (8), is a means rather than an end. According to the WHO *World Health Report 2000* (5), access is a determinant of responsiveness to people's legitimate expectations. Consequently, improving determinants of access to health services will help improve people's health status and satisfaction and reduce financial risk.

**Figure 1.** The WHO Health System Framework



Source: World Health Organization. Everybody’s Business: Strengthening Health Systems to Improve Health Outcomes: WHO’s Framework For Action. Geneva: WHO; 2007. Available from: <https://apps.who.int/iris/rest/bitstreams/52187/retrieve>

There are numerous definitions of access to health services, and there is no standard concept that is applicable worldwide (9–11). The heterogeneity of the concept persists because access includes several dimensions of the health system and even extends to factors outside the system (i.e., social determinants of health) (6, 11). This report uses the definition of access from the PAHO Strategy for Universal Access to Health and Universal Health Coverage: “Access is the capacity to use comprehensive, appropriate, timely, quality health services when they are needed (12).

Just as there are numerous definitions of access, behind them there are numerous dimensions that determine access (10, 13). The dimensions most frequently included in access models and definitions are availability, geographical accessibility, and acceptability (13). Other dimensions include affordability or financial accessibility, effective coverage, and organization of the system. Some authors classify these dimensions from an economic perspective, based on factors related to the supply of services (the health system) and the characteristics of demand (people). The objective of identifying these dimensions is to structure the various factors involved in access to services and to be able to measure them, which means incorporating them in a model that organizes them on a continuum of seeking and receiving or “reaching” care.

## Conceptualization of barriers

Barriers are factors that impede access to health services. As mentioned, one of the conceptual frameworks used to organize barriers to access to health services is a framework that distinguishes between demand-related and supply-side factors in the health market. On the demand side of health services, there are barriers that impede older people and their families from accessing services. These are usually personal and contextual factors related to the community in which they live. Supply-side determinants, meanwhile, are factors related to the health system that influence the use of the services offered to older people and their families (9).

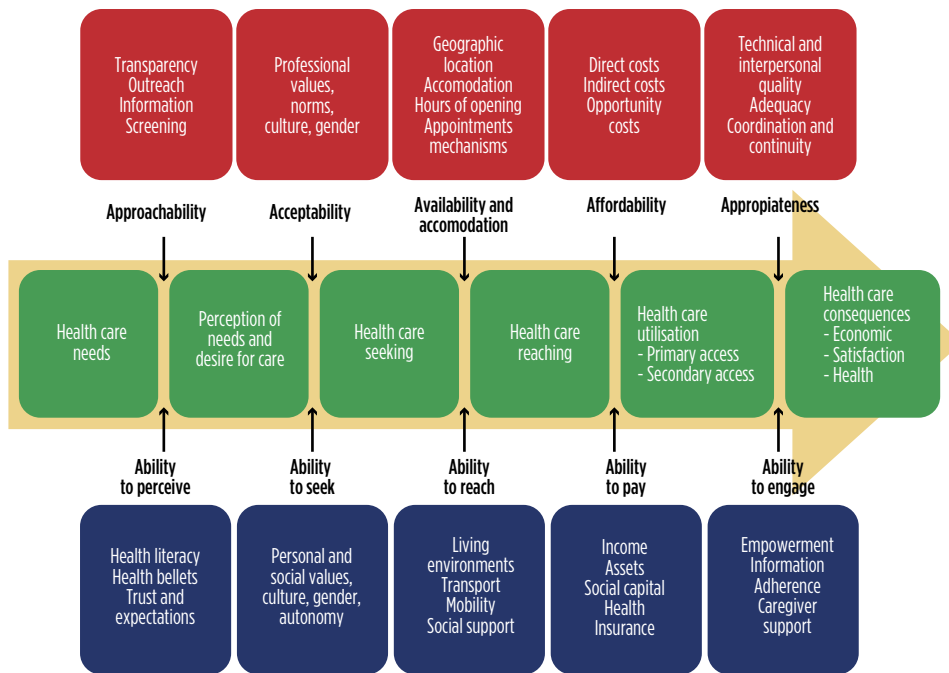
Most access models define the characteristics of the system (supply) as the main factors that determine people's interaction with it. The reality, as several authors have noted, is that factors, characteristics, and abilities that exist in the community, in individuals, and in their caregivers also have an impact on access to health services (9, 10). Levesque et al. (10) describe a model that considers supply and demand along a continuum of access to health services. This model is especially interesting for analyzing access barriers for older people, since, in addition to considering five dimensions of the health system (supply) that encourage or impede access, it also identifies five abilities of individuals, their caregivers, and their communities (demand) that enable them to achieve effective access. This concept of ability makes it possible to distinguish the capabilities of different populations, making it a useful model for characterizing the specific barriers faced by older people. For this reason, this report will use this model to describe findings relating to barriers to access to health services for older people in the Region of the Americas.

The description of each of the stages and dimensions of access will be described at the beginning of the relevant section.

Levesque's model (10) makes it possible to identify barriers along the continuum of care, which also contributes to determining the specific needs of older people at different stages of their interaction with the health system in order to truly improve their health and their satisfaction with the service received. In that regard, a population survey conducted in 2000 in four cities in the Region of the Americas (Mexico City, Montevideo, Santiago, and São Paulo) revealed that 70% of older people suffered from a chronic disease (2), which suggests that most of this population group will have frequent and continuous contact with the system.

In order to identify the barriers that older people face in accessing health services, it is necessary to know the factors involved in the access continuum, from the standpoint of both supply (health system) and demand (individuals and community) (see Figure 2).

**Figure 2.** A conceptual framework of access to health care.



Source: Levesque J-F, Harris MF, Russell G. Patient-centred access to health care: conceptualising access at the interface of health systems and populations. *Int J Equity Health*. 2013;12(1):18. Available from: <https://doi.org/10.1002/14651858.CD013812>

As can be seen, access is the result of the interaction of multiple factors (supply and demand), so intervening on one of them will increase the likelihood that older people interact with the system and improve their health status. However, even if a conceptual framework is established to visualize in an organized way the dimensions to which access barriers are linked, it must be borne in mind that there are intersections between them. As mentioned by Jacobs et al. (9), barriers to access are not always mutually exclusive, but can interact with and influence each other. Likewise, the use of health services does not equate to access; it is simply evidence that access to services was achieved, but it does not reflect the barriers that had to be overcome or the determinants that prevented access by other people, even when they needed care (4, 14). To improve access to health services for this population group, it will be necessary to reduce or eliminate the multiple barriers they face and design systems focused on older people that enable them to interact with the system in a user-friendly way.

PAHO's Strategy for Universal Access to Health and Universal Health Coverage defines the concept of "universal access" as "the absence of geographical, economic, sociocultural, organizational, or gender barriers. Universal access is achieved through the progressive elimination of barriers that prevent all people from having equitable use of comprehensive health services determined at the national level (12)." Thus, identification of the barriers that prevent access and the reduction or elimination of these barriers will be the means to offering health services in an equitable manner to the entire population. As noted by Wallace et al. (2), access will be equitable when the only determinant for accessing health services is the need for health care.

Finally, the last block of Levesque's model (10), health care consequences, is determined by the adequacy of the system and the ability of people to engage with it, dimensions which, in turn, are related to the effective coverage of health services and their quality. Effective coverage is a recent concept and one to which some models attribute subdimensions, such as the quality of services and the ability to use services in a timely manner when needed (13). However, since in WHO's health system building blocks, quality and coverage are understood to be two independent outcomes of access, they will not be analyzed in this report. It is worth noting that other authors have also argued that these concepts related to adequacy should not be included in access (15). The same goes for most barriers related to lack of quality of health services, as they occur once the person is already using the services. However, while this aspect is not included in detail in this report because it falls outside its scope, the quality of services represents an area of great interest as a subject of research, as it is associated with the difficulties faced by older people when interacting with the system (such as long waiting times, complexity of care owing to multiple diagnoses and specialists, and interaction with different levels of care).

As we have explained, the use of the Levesque model (10) makes it possible to establish the needs and abilities that determine a person's access to health services. This report applies a people-centered approach to care and will therefore use the concept of "person," rather than "patient."

## Barriers to health service access

### Health care needs

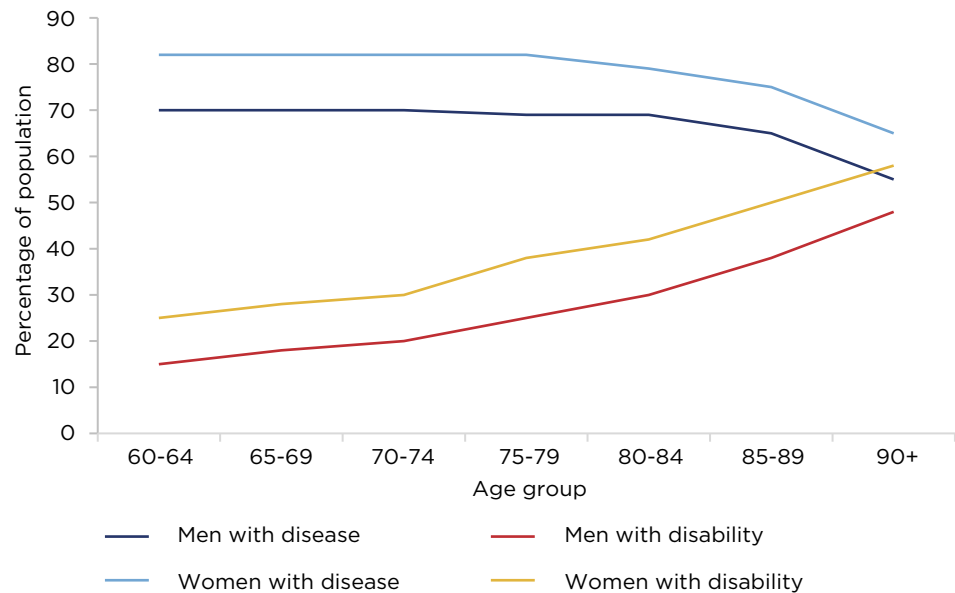
The first step in determining barriers to health service access is to know the health care needs of the population. Epidemiological research makes it possible to identify the main diseases and disabilities affecting older people. With this in mind, a starting point for systems to explore health care needs is through the concept of healthy aging, a term coined by WHO that highlights the functional ability and intrinsic capacity of older people.

Functional ability is defined as the “health-related attributes that enable people to be and to do what they have reason to value” (16). Identifying these attributes would allow systems to be redesigned to provide integrated, senior-centered care. Intrinsic capacity, on the other hand, is “the composite of all the physical and mental capacities of an individual” (16), making it, along with the environments in which older people live, a fundamental part of functional ability.

The health care needs of older people have been documented in multiple studies. In the Region of the Americas, between 70% and 80% of older people suffer from one or more chronic diseases; 50% suffer from multiple chronic diseases; and 60% take three or more prescription medications (2,4). In contrast, analysis of a population survey showed that only 20.7% of people over 60 years of age reported being in good health (17).

It is known that disabilities begin to increase considerably from the age of 60. According to a World Bank analysis of aging in Latin America and the Caribbean (17), the prevalence of disability increases progressively after the age of 60, among both men and women (see Figure 3). Thus, the longer the life expectancy, the higher the percentage of people with disabilities. Therefore, health promotion from the age of 60 should include measures aimed at reducing disabilities. This is related to the life-course approach, a concept that has been promoted by WHO and PAHO for some years. PAHO defines it as “the dynamic relationship of previous exposures throughout life with the subsequent health results and the mechanisms by which positive or negative influences shape human trajectories and social development, impacting the health outcomes of the individual and the population” (18). In line with this definition, what is done or not done at any stage in life will impact health and capacity trajectories, and therefore health outcomes, for older people.

**Figure 3.** Prevalence of disease and disability among the population aged 60 years and over in seven cities in Latin America and the Caribbean, by age group, 1999-2000



Source: Cotlear D. Population aging: is Latin America ready? Washington, D.C.: World Bank; 2011. Available from: <https://openknowledge.worldbank.org/entities/publication/2466119f-2b0f-5c73-b479-1d1649498d1e>

This information makes it clear that there is a need for access to health services by older people, and meeting it will require that these needs be perceived from both the supply and the demand sides. The existence of information systems that generate data on older people is therefore of vital importance. However, most health systems do not adequately measure the needs and the differences that exist among older people using disaggregated data (17).

Population surveys are a very important method for identifying and measuring health service access barriers. However, in the Region of the Americas, many of these surveys are conducted exclusively among children, mothers, and young adults aged 49 or younger (e.g., demographic and health surveys and multiple indicator cluster surveys). Such surveys leave out the voices of older people, whose characteristics and difficulties are distinct from those of younger populations. However, in some countries, such as Mexico, Brazil, Canada, and the United States, there are surveys that focus specifically on older people:

- Mexico: Mexican Health and Aging Survey (ENASEM) (2018)
- Brazil: Longitudinal Study of the Health of Older people (ELSI) (2015)

- United States of America: Health and Retirement Study (2016)
- Canada and United States of America: Commonwealth Fund International Health Policy Survey of Older Adults in 11 Countries (2014)

Some of the results mentioned in this report were derived from analysis of the data from these surveys.

There are also national population surveys, some of which generate age-disaggregated information. The research conducted for this report identified only one subregional survey focused on older people in the Americas, the *Salud, Bienestar y Envejecimiento* (Health, Well-being, and Aging), or SABE, survey in Latin America and the Caribbean, which was carried out by PAHO between 1999 and 2000. Several of the studies and some of the information detailed in the report were derived from this survey. However, since the SABE survey was conducted more than 20 years ago, the information would need to be updated in order to understand the current context and redesign health systems in accordance with the new needs of older people. A survey similar to the multiple indicator cluster survey—launched by the United Nation’s Children Fund (UNICEF) in 1990, with a focus on children and women—is needed for older people.

It is also important to note that the capacities and health care needs of older people are heterogeneous. This cohort exhibits varying levels of functional ability, so generalizing based on the characteristics of some older people would exclude many others—such as, for example, those who are enjoying healthy aging. It is important to note that chronological age does not necessarily imply a loss of functional ability or poor health status. For example, there are people between the ages of 60 and 69 who have more health care needs than people over 70. This is why the recommendations made below call for research on the heterogeneity of the needs, characteristics, and capacities of older people.

Most of the studies considered for this report make comparisons between the various characteristics (mainly social) of older people; we did not find any studies that compared the abilities of older people with those of younger population groups. Studies aimed at differentiating barriers by age group could make it clear that older people have more health care needs and yet encounter more barriers in accessing health services.



## Perception of needs and desire for health care

Once health care needs are known, it is important that, on the supply side, the health system ensures that the necessary services are approachable. On the demand side, individuals, caregivers, and communities respond to this approachability with the ability to perceive the need for health care (10).

### Approachability of health services

Approachability is the factor that enables systems to promote the health resources and services available to various populations. Within this category, Levesque et al. (10) identify transparency, outreach, dissemination of information, and screening as fundamental measures for making the system approachable by its users.

Once the specific needs of older people are known, it is essential for the health system to reach them through communication aimed specifically at this population group, since their care needs are greater and having access to health services can largely preserve their functional ability. For example, awareness of the availability of preventive and immunization activities, among others, is lower among older people who reported barriers to care. According to a study conducted in the United States of America, the probability of receiving counseling related to preventive medicine and public health is lower among older people who perceive barriers to access to health services. Moreover, older people who perceived such barriers were more likely not to receive recommended preventive care, such as immunizations and periodic screenings, and were more likely to have unmet health care needs, which increased when multiple barriers were perceived (4). Preventive services are vital to avoiding disabilities and complications arising from chronic diseases, so ensuring adequate awareness of such services will reduce the feeling that there are access barriers.

One way of improving the approachability of health services in some of the countries of the Region of the Americas has been home medical visits. These home health care programs have shown health benefits for older people (19). Because they are a variable of location of health services, they will be discussed in the subsection on timely availability of care (14).

### Ability to perceive the need for health care

Just as the health system has a responsibility to make itself approachable to people in order to improve access, users must also have the ability

to perceive their health care needs and seek services. This ability may be influenced by a person's level of health literacy, beliefs about health and illness, and expectations of and trust in the health system (10).

People over the age of 60 tend not to use health services even when they perceive the need for care. According to a World Bank report analyzing data from the Program for the Improvement of Surveys and the Measurement of Living Conditions in Latin America and the Caribbean (MECOVI), carried out between 1997 and 1999 by the World Bank, the Inter-American Development Bank (IDB), and the Economic Commission for Latin America and the Caribbean (ECLAC), gaps between health needs and health service utilization are more frequent among older people than younger persons, although they are similar to those among children (17). Among older people, the use of health services did not increase as rapidly as perceptions of the need to seek services (17). However, such gaps were found to be associated more with income than with age. It is not surprising, therefore, that most published studies on the barriers faced by older people mainly correlate socioeconomic variables with access.

The health status of older people in the Region has also been found to correlate with the probability of seeking medical care in the last year. Older people who perceived their health to be poor and who suffered from a chronic illness or a disability that rendered them unable to perform activities of daily living had a lower likelihood of not having sought medical care in the year prior to the study and a higher likelihood of perceiving barriers to access to health services (2). Such findings may serve to guide efforts to reduce barriers to access for these specific groups.

## Health-care seeking

The third step in the process of accessing health services involves seeking available services. From the supply side, acceptability is related to the cultural and social characteristics according to which health systems are organized (10). These foundations on which systems are organized will determine, on the demand side, the ability of older people to seek health services to meet perceived care needs.

## Acceptability of health services

According to Levesque's model (10), the social and cultural factors within the health system that determine the acceptability of services include the professional values, norms, culture, and gender of health professionals.

In the literature search carried out for this report, little information was found on the relationship between these factors and the decision of older people to seek health services and the access barriers they encounter.

Some of the findings indicate that ageism, defined as “stereotypes (how we think), prejudice (how we feel), and discrimination (how we act) directed towards people on the basis of their age,” has been identified as a barrier to access to health services for older people (20). In particular, institutional ageism—which includes institutional norms and rules—has reduced this population’s access to procedures and treatments and their participation in clinical trials (3).

Another aspect of ageism is lack of knowledge among health professionals about the features and characteristics of the diseases that tend to affect older people. Ignorance of the specific needs of older people leads to a decrease in the number of diagnoses made and to delayed diagnosis (3). This prevents timely access to health care for older people, which, in turn, may lead to further complications and disabilities. The lack of knowledge among health professionals could be a reflection of ageism in the institutions that educate health professionals or of a bias towards prioritizing the health of mothers and children dating back to the Millennium Development Goals. During their training, medical students spend three times as long learning about pediatrics as they spend training in geriatrics. Academic curricula have been found in which no training at all in geriatrics is provided (3). Knowledge by health personnel of the specific needs of older people will help improve the acceptability of health services and thus reduce access barriers for this population group. The 194 nations gathered at the Sixty-ninth World Health Assembly launched the Global Campaign to Combat Ageism with the aim of reducing or eliminating discrimination against older people on the basis of their age (21). The *Global Report on Ageism*, published in 2021 as part of the Campaign, provides evidence and proposes specific measures that States and the main public and private actors can take to improve the current situation of ageism in the world (20). In addition, a [toolkit](#) (22) was created to inform the public about what ageism is, address the issue in communities, raises awareness, and disseminate the message on social networks under the hashtag #AWorld4AllAges.

### **Ability to seek health services**

People’s ability to seek health services is related to knowledge of available options and the right to health, as well as autonomy and

capacity to seek care. According to Levesque et al. (10), this ability is influenced by personal values, culture, and even gender.

Although age is already an important determinant of access for all people, breaking down this cohort of persons over 60 years of age into smaller groups reveals important differences between them. In some cities in the Americas, the relative age of older people has been correlated with the likelihood of seeking medical services. People aged 60–69, for example, are less likely to have sought health services than those aged 69 years and older (2). The reasons for these differences should be explored further.

Among older people, disability constitutes a major access barrier, as it limits autonomy and independence in seeking health services. The presence of disabilities among people over 60 years of age is greater than among younger persons and, as indicated above disabilities increase gradually over the years. Many of these disabilities limit the ability older people to perform activities of daily living. One study correlated the performance of such activities with the wealth of older people and found that those with greater purchasing power had fewer limitations than those from lower socioeconomic strata (2). Accordingly, programs to improve ability to perform activities of daily living could be more specifically targeted towards populations with fewer resources. Another example would be disabilities related to communication or mental health. A study conducted in the United States among persons with speech limitations and symptoms of depression showed that individuals with these characteristics were more likely to perceive barriers to access to health services (4). People with cognitive limitations were more likely to perceive barriers related to availability and accommodation, and older people with a speech difficulty perceived four times as many barriers to access as persons who did not have any difficulty (4). These findings make it possible to conclude that it is important to conduct research on the barriers faced by cohorts with different disabilities.

Regarding gender differences, several articles note greater use of health services by women over 60 years of age than by men in the same age group. One study, after controlling for differences between needs and enabling factors, concluded that women over 60 were more likely than men of the same age to seek health services (2). At the same time, it has been observed that, where there is universal coverage, older men are more likely than older women to report availability barriers. Women have been found to use more primary health care services and receive more preventive care than men (4), which may be related

to women's greater use of health services for reproductive health care from the age of 15 onwards. However, some studies have shown that, if the use of services of gynecological and obstetric services is excluded, women's and men's use of health services is the same (17).

What cannot be ignored is that when women do have contact with a health service, irrespective of the reason, they are more likely to receive information on health promotion and to participate in preventive and screening activities. According to an analysis by the Program for the Improvement of Surveys and the Measurement of Living Conditions in Latin America and the Caribbean (MECOVI), older women perceive more health problems than men, regardless of socioeconomic status, a factor which was also associated with the use of health services (17). On the other hand, a study conducted among men over 60 years of age found that the factors that limited the use of medium- and high-complexity health services or the acceptance of hospitalization in Brazil were illiteracy, lack of private insurance, recent diagnosis of some disease, functionality problems, and self-perception of very poor health (23). These specific findings among men show that communicative efficacy will be essential to foster a good relationship and good communication between health workers and older men, as studies show that they appear to be less proactive with regard to their health.

## **Health care reaching**

Ability to reach health services will depend, from the supply standpoint, on the timely availability of services and, from the demand standpoint, on the ability of older people to reach services when they need them (10). Health care reaching constitutes the fourth block of access in the model used in this report.

## **Timely availability**

The timely availability of health services will depend on health facilities and personnel being within the reach of the population when needed. This, in turn, will depend on the number of health facilities that exist (at the first, second, and third levels) and on the availability of the necessary resources (personnel, supplies, etc.) to enable them to function effectively (10). Poor distribution of such resources will generate inequity and, therefore, barriers to access for disadvantaged populations.

It has been observed that older people's main point of contact with the health system is primary care and that poor access to primary care services, or better geographical access to hospitals, increases the rate of hospitalization and emergency room visits among older people. According to an analysis of the SABE survey, outpatient visits were the main gateway into the health system for older people in Latin America and the Caribbean (2), a finding that is important for guiding coverage programs aimed at the population over 60 years of age. Similarly, it has been found that access to primary care may differ from access to hospital care in this population group. Studies published in Brazil and the United States found that older people with fewer economic resources made greater use of hospital care services than wealthier people (14). Another study conducted in Texas (United States of America) showed that older people living in areas with poor access to primary care services but acceptable access to hospital services were more likely to be hospitalized and cared for in emergency rooms for conditions which could be treated on an outpatient basis (and which, if adequately cared for in primary care, would not have required hospitalization) (24). Similarly, in Virginia (United States of America), access to a primary care facility was shown to be associated with lower rates of avoidable hospitalization among older people (25). It has also been observed that the more chronic diseases that an older person suffers, the higher the probability that the person will be hospitalized (26). Although the reasons for these differences are unknown, some authors assert that low use of preventive services and higher rates of comorbidity in the poorest population strata are factors (14).

As indicated in the section on the approachability of health services, new models of home care have shown satisfactory results in reducing access barriers for some groups of older people. Home visits help reduce inequity in access among populations with fewer resources and improve effective access for older people (19). Most of these programs are conducted in rural and resource-poor communities. Home health care programs in Brazil and Canada, where the majority of health services are public, have been shown to be particularly favorable for poorer people (14), so there are fewer home health programs for older people in high-wealth quintiles (2). On the other hand, in the United States of America, where most home health programs are offered by private providers, older people with greater purchasing power have greater access to them (14). What is clear is that these programs have lowered the access barrier posed by transportation to a health facility, so it will be important to extend them to more older people, including those in higher income quintiles.

## Ability to reach health services

People who need health care should have the ability to reach health services thanks to good mobility and ability to travel to medical facilities. These factors will depend on the ecosystems, environments, and areas in which older people live (10).

Older people living in rural areas face a significant barrier to access. In Brazil, Chile, Mexico, and Uruguay, most were living in urban communities when the SABE survey was conducted in 1999 (2). One study found that people over the age of 60 living in rural communities in the United States of America identify more barriers to access to services than those living in urban communities (4). In Mexico, it was observed that older people living in rural communities with fewer than 2,500 inhabitants were less likely to have been hospitalized in the previous year and had visited a medical facility less frequently than older people in urban areas (27). Another study found that those living in rural areas are 77% less likely to have health insurance than those living in urban areas (28).

Access problems associated with transportation have been found to be related to socioeconomic status and age. Older people with low socioeconomic status encounter more transportation-related barriers to access than those in the highest wealth quintiles (14). The oldest persons in the older population are less likely to have long travel times to health services, and those living in homes with a family member who has completed secondary education have fewer barriers to access for geographical reasons, take less time to get a medical appointment, and have shorter waiting times at medical facilities than older people living with relatives with a lower level of education (2).

In 2007, with a view to achieving age-friendly communities and cities, WHO published *Global Age-friendly Cities: A Guide* (29). The report makes a number of recommendations for governments and government decision-makers for improving the environments in which people over 60 live. Creating age-friendly environments will provide this population group with more opportunities to maintain and improve their capabilities and thus their quality of life. Moreover, an age-friendly city or community provides a better environment for everyone.



## Use of primary health care and hospital services

Use of health services has been one of the most studied of the building blocks in the continuum of access to health services. According to Levesque (10), use of services will depend, on the supply side, on the affordability of the system and, on the demand side, on people's ability to pay. Based on this precept, socioeconomic status has generally been seen as one of the main barriers to access to health services for older people (10). Since it is not easy to measure effective access to health services, utilization of these services is often used as an indirect indicator to determine whether there are differences between different population groups (11). However, this indicator only shows a small part of the continuous and complex path towards access to services, so it is important also to analyze other dimensions and not focus exclusively on the economic aspect, which is what most current publications tend to do.

### Affordability

The health system is responsible for making services affordable for the population. Affordability is determined by factors such as the cost of services and opportunity costs (10). In countries belonging to the Organization for Economic Cooperation and Development (OECD), and in most European countries, where coverage is offered for older people, unmet health care needs are studied. While the same approach should be applied in the Region of the Americas, some countries do not provide health coverage to older people, which is indisputably the primary barrier to health service access.

The level of national economic development has been found to be associated with the proper performance and functioning of a health system. The level of access to health services in the capitals of Brazil, Chile, Mexico, and Uruguay is influenced by national wealth, health spending, and the organization and delivery of services (2). According to Wallace and Gutiérrez (2), inequity in access to health services for older people in some large cities in Latin America is the result of the interaction between the pattern of economic inequality and the design of the health system. For example, when the SABE survey was conducted in Mexico City in 1999, the most important barrier to access was found to be the large proportion of older people who did not have health insurance. Other studies have found that there is less inequity in access in countries with universal health systems and, conversely, greater inequity in the use of health services and more favorable treatment for the wealthiest strata in countries where universal coverage is not offered, such as Mexico (14).



Achieving universal coverage is an important factor in lowering barriers. However, focusing exclusively on affordability policies is not enough. In a study conducted in the United States of America, where people over 65 years of age have health coverage, about 25% of respondents indicated that they perceived multiple barriers in other dimensions of access (4). The Medicare program in the United States of America provides health coverage for people 65 and older, which means that those between the ages of 60 and 65 are not eligible. In relation to this, a study showed that, of the people who did not have health coverage, 90% were under 65 years old. In this same age group, the probability of perceiving barriers across all dimensions of access was three times higher (4).

Even when a health system provides universal coverage, there are ways of measuring whether access to these services is effective. In Mexico, for example, young people, despite having public health care coverage, incurred out-of-pocket expenses when they opted to visit private medical services because of the ineffectiveness and inefficiency of the public health care services (30). In Mexico City and Santiago (Chile), older people who sought care in public health care services had longer travel times to medical facilities, took longer to get an appointment, and spent longer times waiting in health facilities compared with those who went to private providers (2).

### **Ability to pay**

Once service costs have been established, individuals will determine whether their ability to pay will cover their health care needs without incurring catastrophic expenditure (10). This ability will be determined mainly by the capacity to generate economic resources, which, in the case of older people, has been a difficult variable to measure (14). The reason for this is that some older people do not receive a direct income from a work activity; rather, they are dependent on social programs, pensions, savings, or the income of direct relatives. Owing to the complexity of measuring this economic variable, the SABE survey measured the socioeconomic level of older people on the basis of the assets they had at home. According to the analysis by Wallace and Gutiérrez (2), the poverty rate among older people varied among the four countries studied, with poverty affecting over one third of older people in Mexico, 10% in Brazil and Chile, and 2.4% in Uruguay.

Socioeconomic status has been found to be closely associated with older people' use of health services. Achieved access (i.e., whether or not a person visited a health facility when the need for care arose) varied by wealth among older people in Santiago, Mexico City, and Montevideo,

but not in São Paulo, which might be attributable to the fact that Brazil has a universal health system (2). The results of a systematic review showed lower use of health services and greater access problems among older people with lower levels of wealth and education, with variations depending on the country and the type of services used and covered by public health insurance (14). Likewise, socioeconomic status was related to whether or not older people went to a health service, regardless of other variables; the correlation showed that those in lower socioeconomic strata were less likely to visit a medical provider than persons in the upper socioeconomic strata (2). The same association was observed for Brazilians over 65 years of age with health insurance, who visited a medical provider more times in the course of a year (14).

Socioeconomic status is linked not only to use of health services, but also to access to specialist or higher-level services. A systematic review showed that, in most countries, older people from higher socioeconomic strata are more likely to consult specialists than poorer people (14). Something similar occurs with specialist services such as dentistry. In Brazil, older people with higher levels of income and education were more likely to have visited a dental health service than people with low levels of income and education (14). Dental care is one of the medical services for which greater inequities in access by economic stratum are observed. Another population-based study of people with diabetes aged 50 years and older, conducted as part of the Mexican National Health and Aging Study (ENASEM) in 2018, found that people with diabetes who had health insurance were 57% more likely to visit a dental professional than people without health coverage. Self-medication was also lower among people with diabetes who had health insurance than among those without insurance (28).

Whether or not people have health insurance is correlated with a greater or lesser number of barriers to access to health services. The aforementioned population-based study of people with diabetes who had health insurance found that they were 75% more likely to seek medical services than those without coverage (28). The main difference in the level of health service usage was disparity in coverage. In Brazil, despite having a system that provides universal health coverage, the population with private health insurance had a perception of better health than the population covered by public insurance, and not having private health insurance was associated with fewer visits to medical services (17, 27).

Similarly, the type of health insurance (public or private) that people have has been correlated with the use of medical services. An analysis conducted in four cities in Latin America found that the type of health

insurance that older people had was linked to their socioeconomic status. People from the upper economic strata were more likely to have private insurance, whereas those in the lower socioeconomic strata tended to have public insurance (2). Compared with older people with private health insurance, those with public insurance were less likely to visit a doctor's office, and those without health insurance were more likely not to have sought medical care even once during the year prior to the survey (2).

Finally, even when people over 60 have access to a universal coverage system, they consider out-of-pocket expenses to be a major barrier. In the United States of America, one factor limiting the use of health services is out-of-pocket payments, since the program that covers people over 65, Medicare, does not cover all health care expenses (14). A study by Fitzpatrick et al. (14) found that 22.3% of older people in the United States identify out-of-pocket spending as a major barrier to access to medical care, followed by transportation problems (21%).

## **Health care consequences**

The last stage of access to health services reflects the final outcomes or objectives of a health system—i.e., the consequences of health care. These include improved health, economic protection and people's satisfaction with the care received. The properties related to the appropriateness of the health system, on the supply side, and the ability of people to engage with that system, on the demand side, will improve these final outcomes (10).

As mentioned above, this relationship with the system partly reflects effective coverage, quality of health services, and interaction with the system. For this reason, and because it includes factors that go beyond access barriers, it was not a main focus in the literature review on access barriers for older people. Nevertheless, because it is a relevant issue for this population group, owing to the constant interaction they have with the system, this section recognizes some initiatives in the Region of the Americas that seek to improve these dimensions.

## **Appropriateness, continuity, and quality of health services**

The appropriateness of the health system and whether its use leads to better health outcomes will depend on the technical and interpersonal quality of services and the adequacy and adequate coordination and continuity of care (10).

Most older people suffer from chronic diseases, which means that their interaction with the system is continuous and complex. In addition, their care requires contact with different levels of care and different specialists, so it is vital to create integrated systems centered on the needs of older people.

The concept of comprehensive health care reflects the response to the needs of older people. WHO defines comprehensive care as “services that are managed and delivered so that people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease-management, rehabilitation and palliative care services, coordinated across the different levels and sites of care within and beyond the health sector, and according to their needs throughout the life course” (31).

The Institute for Healthcare Improvement (IHI) in the United States is currently promoting a campaign called “Age-Friendly Health Systems,” with an approach focusing more on the meso level of services (hospitals). It is a conceptual framework that integrates four main points: aligning care with what matters most to the person, ensuring that medications do not interfere with what matters to the person, preventing dementia and delirium, and promoting activity for the benefit of mobility.

Another tool for improving the appropriateness and quality of health services for older people is the Integrated Care for Older People (ICOPE) handbook, published by WHO (32). The handbook makes a series of recommendations for primary and community health care professionals for identifying and promoting care with the aim of slowing losses of intrinsic capacity among older people. Disseminating this preventive and older-person-centered information could help to improve quality of life for this population.

### **Ability to engage with the system**

Finally, people must be able to engage with the system and participate in their own treatment and care. Their ability to engage may be determined by factors such as empowerment, the information available to them, treatment adherence, and caregiver support (10). The caregiver determinant will also be a key factor for older people who have some dependency or limitation in performing activities of daily living.

## Access barriers in the context of the COVID-19 pandemic

The COVID-19 pandemic has impacted the health of many people, but especially older people (33). Although high mortality from SARS-Cov-2 infection in people over 70 years of age has been one of the most visible consequences of the global emergency, it has not been the only one (1, 34). Social distancing and isolation measures have interfered with the way in which services of various types are delivered and have therefore increased access barriers for vulnerable populations such as older people (35, 36).

This population's need for health care is evident, and there have already been studies that have documented the deterioration in the condition of older people with cognitive diseases as a result of lack of access to health services during the pandemic (34). According to a report by the Inter-American Development Bank (34), there were six challenges with regard to the care of older people during the pandemic: 1) scarcity of material and management resources for a scenario of the magnitude of the pandemic, 2) small number of caregivers who rotate among the various long-term care services, 3) misconceptions about the capacity and resources of long-term care services, 4) lack of coordination between care and health services, 5) insufficient attention to the mental health consequences of isolation, and 6) ageism.

As mentioned in the subsection on timely availability, home care programs have shown improvements in health outcomes for older people. Some governments in Latin America and the Caribbean have implemented more such programs to improve older people's access to health and social services during the COVID-19 pandemic. In Chile, for example, efforts have been made to deliver medicines and food, collect pensions, and provide home health care services to older people with mobility difficulties (37).

In addition, information technologies and telemedicine have been one of the solutions offered by health systems to bring health services closer to older people and promote physical activity and mobility in the face of social distancing measures. In Chile, monitoring and medical assistance programs for older people were implemented. In Havana, Cuba, some civil society associations have offered medical assistance by telephone. In Guadalajara, Mexico, a hotline was set up to provide social and psychological support to older people (37). Although these initiatives are welcome, the problem is that not all older people have the technological resources and skills to achieve effective access to such services. It has been observed that women and older people are less

likely to be connected to the Internet than men and young people (38). Therefore, to reduce barriers to access to these digital services, it will be necessary to reduce the digital divide for older people.

The pandemic has generated a paradigm shift in the way health services are delivered. A transition from in-person care to virtual services and telemedicine is taking place. This trend is likely to continue, so it will be important to create government programs and measures that improve connectivity and access to and ability to use technologies among older people.

## Recommendations

The recommendations are categorized according to the same building blocks and barriers presented above.

### Health care needs

Improve metrics and research on access among older people:

#### **By collecting specific data on older people:**

- o Identify older people as a vulnerable group with inequitable access. The differences between older people and young people and younger adult populations will need to be investigated further. Most current studies make comparisons between older people, but not with a view to differentiating them from younger people. Studies focusing on differentiating barriers by age group could make it clear that older people have more health care needs and yet encounter more barriers in accessing health services. Targeted programs and measures could thus be designed for them. A starting point might be found in the WHO Decade of Healthy Aging baseline report (38), which provides information on healthy aging globally based on an approach focused on intrinsic and functional capabilities, not just ill-health.
- o Recognize the heterogeneity of older people' abilities and characteristics in order to promote specific measures for groups with similarities (see below for information on latent class analysis). These data could be disaggregated, for example, by age, gender, economic capacity, health status, etc.
- o Include new methods of collecting data on older people, such as

conducting surveys at all levels of care, on satisfaction and quality, or use of medical information and qualitative information systems (13).

- o Make an effort at the regional level, such as that carried out between 1999 and 2000 through the SABE survey, to collect specific data on older people throughout the Region of the Americas, following the example of the multiple indicator cluster survey, which focuses specifically on child and maternal health in some countries of the Region.

**Through new research methods:**

- o Mixed methods: Conduct studies using mixed methods to gather qualitative information on the barriers faced by older people and to identify the underlying reasons (10).
- o Multivariate analysis: Given the complexity and the interaction of the dimensions of access to health services, and the involvement of factors related to both the health system and to older people, multivariate analysis studies are needed.
- o Spatial analysis: Spatial analysis studies have been used in other regions to measure access to health services and correlate it with variables such as the age of older people.
- o Latent class analysis: Intrinsic abilities differ among older people, so latent class analysis studies should be conducted in which older people with similar abilities or limitations are grouped together in order to measure access to health services for each cohort.

**Through an approach based on interaction with and quality of services:**

- o Appropriate and easy interaction with health services for older people is an imperative for a quality, person-centered health system. This approach should be emphasized with a view to adapting processes of interaction with the system to the needs of persons over 60 years of age. To this end, the following measures should be envisaged:
  - Conduct surveys of patient-reported outcome measures (PROMs).
  - Conduct satisfaction surveys among older people.

- Carry out qualitative studies on the interpersonal and technical quality of services.
- o Create a model like the one proposed by Levesque (10), but that, instead of proposing a continuum of care for older people, proposes a diagram that reflects cyclical care and continuity (for example, a rotating arrow).
- o Identify examples of service delivery models with a people-centered approach, such as:
  - The current Age-Friendly Health Systems campaign of the Institute for Healthcare Improvement in the United States.
  - WHO's Integrated Care for Older people (ICOPE) strategy.

## Perception of need and desire for care

### **Health system (supply): Approachability of health services**

- o Provide information on the services available for older people, from preventive activities, such as vaccination and regular check-ups, to primary care for chronic diseases.
- o Promote community health programs for prevention, follow-up, and early intervention that specifically target older people in order to reduce the loss of capacities.
- o Reduce barriers to access to telemedicine and virtual health services through the provision of technologies and training in their use.

### **People/community (demand): Ability to perceive the need for health care**

- o Conduct qualitative analysis studies exploring topics based on answers to the question "What matters to you?" in order to identify the real needs of older people in terms of their perceptions with regard to health.
- o Promote health literacy campaigns tailored to the needs of older people.



## Health care seeking

### **Health system (supply): Acceptability of health services**

- o Combating ageism:
  - Increase and improve education and training time for health professionals on the needs and capabilities of older people, which is vital to reduce adverse effects and improve the quality of care for this population.
  - Use tools developed in the framework of the Global Campaign to Combat Ageism, such as the toolkit (22) designed to help start conversations on the subject.

### **People/community (demand): Ability to seek health services**

- o Recognize that there are differences by age groups within the population of older people. Given the heterogeneous characteristics of older people, it is important to know why some age groups have reported fewer medical visits.
- o Create programs to improve the ability to perform activities of daily living among populations with fewer resources, since these are the groups that show greater limitations.
- o Implement programs to combat the major disabilities (i.e., disease burden) among older people.
- o Encourage older men to identify their health care needs and seek appropriate services and, especially, to participate in preventive and health promotion activities.

## Health care reaching

### **Health system (supply): Timely availability**

- o Implement home care programs for seniors who need such care. These models have shown great benefits in terms of health outcomes. However, they must be implemented with an equity-based approach in order to reach people from all walks of life.
- o Locate primary care centers in rural communities with scarce resources. This has been shown to reduce travel times to health services for older people living in these areas (2).

- o Apply spatial analysis studies to study barriers impeding older people in the Region of the Americas from reaching health services.
- o Determine the availability of human resources with specific training who can meet the needs of older people.
- o Improve indicators related to geriatrics professionals and multidisciplinary care teams focusing specifically on older people.

#### **People/community (demand): Ability to reach health services**

- o Promote specific programs for older people living in rural communities, who face greater barriers to access. Also, prioritize older populations that do not live in age-friendly cities.
- o Implement the recommendations of the WHO publication *Global Age-Friendly Cities: A Guide* (29).

## **Use of primary health care and hospital services**

#### **Health system (supply): Affordability**

- o In the absence of universal coverage, give priority to access for vulnerable populations (9). In this case, countries can focus on offering health service coverage plans specific to older people. Covered services could be selected on the basis of the priorities and main health care needs of older people in each local or regional context.
- o Strengthen primary care services, as they are the main gateway to access for older people and have been shown to help improve their health (2).

#### **People/community (demand): Ability to pay**

- o Collaborate with the social services sector, which in some countries offers economic protection programs for older people. This is important because this money can be used to pay for services that are not covered by public health insurance, such as dental and specialist services, which are the areas in which persons in lower socioeconomic strata most frequently encounter access barriers.
- o Promote jobs that enable older people to remain economically active.

## Health care consequences

### **Health system (supply): Appropriateness, continuity, and quality of health services**

- o Redesign health systems to create communication and referral systems focused on older people, providing high-quality health services that facilitate access to vulnerable populations (39).
- o Provide tools that facilitate health system interaction and treatment adherence for older people and their caregivers.

### **People/community (demand): Ability to engage with the system**

- o Involve caregivers in all stages of health care.
- o Include empowerment programs and dissemination of information on how to contact health services in case of need.

## Recommendations aimed at other sectors

As the report shows, while health service coverage is a key pillar of access, it is not the only one. It is therefore necessary to create more programs aimed specifically at combating non-economic barriers. In order to reduce the multiple barriers faced by older people, action is needed by various sectors that affect their daily lives. This is even more true in the current COVID-19 scenario, in which social and health services could generate synergies to reach older people (face-to-face or digitally).

## Contextualizing the recommendations

All these recommendations should be understood, adapted, and accepted in accordance with the context of each country. The report highlights the heterogeneity of barriers among the countries of the Region. Some countries, for example, have a higher poverty rate, while others offer specific or universal health coverage. A local analysis of political, cultural, and geographical conditions and of available resources will be essential to design programs that will be effective in reducing barriers to access (9).

## Complex problem, complex solution

It should also be recalled that, if possible, the solutions to be implemented should include programs that have an impact on both supply and demand and that address all kinds of barriers and not only financial barriers.

## References

1. Pan American Health Organization. People over 60 have been hardest hit by COVID-19 in the Americas. Washington, D.C.: PAHO; 2020 [accessed 22 November 2021]. Available from: <https://www.paho.org/en/news/30-9-2020-people-over-60-have-been-hardest-hit-covid-19-americas>.
2. Wallace SP, Gutierrez VF. Equity of access to health care for older adults in four major Latin American cities. *Rev Panam Salud Publica*. 2005;17(5-6):394-409. Available from: <https://doi.org/10.1590/s1020-49892005000500012>.
3. Inouye SK. Creating an anti-ageist healthcare system to improve care for our current and future selves *Nature Aging*. 2021;1(2):150-2. Available from: <https://www.nature.com/articles/s43587-020-00004-4>.
4. Thorpe JM, Thorpe CT, Kennelty KA, Pandhi N. Patterns of perceived barriers to medical care in older adults: a latent class analysis. *BMC Health Serv Res*. 2011;11(1):181. Available from: <https://doi.org/10.1186/1472-6963-11-181>.
5. World Health Organization. World Health Report 2000. Health Systems: Improving Performance. Geneva: WHO; 2000. Available from: <https://apps.who.int/iris/handle/10665/42281>.
6. Roberts M, Hsiao W, Berman P, Reich M. *Getting Health Reform Right: A Guide to Improving Performance and Equity*. Oxford: Oxford University Press; 2008.
7. World Health Organization. Everybody's Business: Strengthening Health Systems to Improve Health Outcomes: WHO's Framework for Action. Geneva: WHO; 2007. Available from: [https://apps.who.int/iris/bitstream/handle/10665/43918/9789241596077\\_eng.pdf?sequence=1&isAllowed=y](https://apps.who.int/iris/bitstream/handle/10665/43918/9789241596077_eng.pdf?sequence=1&isAllowed=y).
8. Murray CJL, Frenk J. A framework for assessing the performance of health systems. *Bull World Health Organ*. 2000;78:717-731. Available from: <https://apps.who.int/iris/bitstream/handle/10665/268164/PMC2560787.pdf?sequence=1&isAllowed=y>.
9. Jacobs B, Ir P, Bigdeli M, Annear PL, Van Damme W. Addressing access barriers to health services: an analytical framework for selecting appropriate interventions in low-income Asian countries. *Health Policy Plan*. 2012;27(4):288-300. Available from: <https://doi.org/10.1093/heapol/czr038>.

10. Levesque J-F, Harris MF, Russell G. Patient-centred access to health care: conceptualising access at the interface of health systems and populations. *Int J Equity Health*. 2013;12(1):18. Available from: <https://doi.org/10.1186/1475-9276-12-18>.
11. Peters DH, Garg A, Bloom G, Walker DG, Brieger WR, Rahman MH. Poverty and access to health care in developing countries. *Proc Nat Acad Sci*. 2008;1136:161-171. Available from: <https://doi.org/10.1196/annals.1425.011>.
12. Pan American Health Organization. Strategy for Universal Access to Health and Universal Health Coverage (Document CD53/5, Rev. 2) 53rd Directing Council of PAHO, 66th Session of the Regional Committee of WHO for the Americas; 2014 Sep 29-Oct 3; Washington, D.C.: PAHO; 2014. Available from: <https://www.paho.org/en/documents/strategy-universal-access-health-and-universal-health-coverage>.
13. Houghton N, Bascolo E, Del Riego A. Monitoring access barriers to health services in the Americas: a mapping of household surveys. *Rev Panam Salud Publica*. 2020;44:e96. Available from: <https://doi.org/10.26633/RPSP.2020.96>.
14. Almeida APSC, Nunes BP, Duro SMS, Facchini LA. Socioeconomic determinants of access to health services among older adults: a systematic review. *Rev Panam Salud Publica*. 2017;51:50. Available from: <https://doi.org/10.1590/S1518-8787.2017051006661>.
15. Frenk J. El concepto y la medición de accesibilidad. *Salud Publica Mex*. 1985;27(5):438:453. Available from: <https://saludpublica.mx/index.php/spm/article/view/422/411>.
16. World Health Organization. World Report on Ageing and Health. Geneva: WHO; 2015. Available from: [https://apps.who.int/iris/bitstream/handle/10665/186463/9789240694811\\_eng.pdf?sequence=1&isAllowed=y](https://apps.who.int/iris/bitstream/handle/10665/186463/9789240694811_eng.pdf?sequence=1&isAllowed=y).
17. Cotlear D. Population Aging: Is Latin America Ready? Washington, D.C.: World Bank; 2011. Available from: <https://openknowledge.worldbank.org/entities/publication/2466119f-2b0f-5c73-b479-1d1649498d1e>.
18. Pan American Health Organization. Building Health Throughout the Life Course. Concepts, Implications, and Application in Public Health. Washington, D.C.: PAHO; 2021. Available from: 9789275123027\_eng.pdf.

19. Thumé E, Facchini LA, Tomasi E, Vieira LAS. Home health care for the elderly: associated factors and characteristics of access and health care. *Rev Panam Salud Publica*. 2010;44(6):1102-1111. Available from: <https://doi.org/10.1590/s0034-89102010005000038>.
20. World Health Organization. Global Report on Ageism – Executive Summary Geneva: WHO; 2021. Available from: <https://apps.who.int/iris/rest/bitstreams/1336307/retrieve>.
21. World Health Organization. Global Strategy and Action Plan on Ageing and Health 2016-2020: Towards a World in Which Everyone Can Live a Long and Healthy Life [Document A69/17] Sixty-ninth World Health Assembly. Geneva: WHO; 2016. Available from: [http://apps.who.int/gb/ebwha/pdf\\_files/WHA69/A69\\_17-en.pdf?ua=1](http://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_17-en.pdf?ua=1).
22. World Health Organization. Global Campaign Against Ageism - Toolkit. Geneva: WHO; 2020. Available from: <https://www.who.int/publications/m/item/global-campaign-to-combat-ageism-toolkit>.
23. Bibiano AMB, de Lima Silva V, da Silveira Moreira R. Factors associated with the use of health services by elderly men in Brazil: a cross-sectional study. *BMC Public Health*. 2019;19(1):859. Available from: <https://doi.org/10.1186/s12889-019-7232-0>.
24. Huang Y, Meyer P, Jin L. Spatial access to health care and elderly ambulatory care sensitive hospitalizations. *Public Health*. 2019;169:76-83. Available from: <https://doi.org/10.1016/j.puhe.2019.01.005>.
25. Daly MR, Mellor JM, Millones M. Do avoidable hospitalization rates among older adults differ by geographic access to primary care physicians? *Health Serv Res*. 2018;53(Suppl. 1):3245-3264. Available from: <https://doi.org/10.1111/1475-6773.12736>.
26. Wang HHX, Wang JJ, Lawson KD, Wong SYS, Wong MCS, Li FJ, et al. Relationships of multimorbidity and income with hospital admissions in 3 health care systems. *Ann Fam Med*. 2015;13(2):164-167. Available from: <https://doi.org/10.1370/afm.1757>.
27. Salinas JJ, Al Snih S, Markides K, Ray LA, Angel RJ. The rural-urban divide: health services utilization among older Mexicans in Mexico. *J Rural Health*. 2010;26(4):333-341. Available from: <https://doi.org/10.1111/j.1748-0361.2010.00297.x>.

28. García Pérez A, González-Aragón Pineda AE, Villanueva Gutiérrez T. Access to healthcare services between insured and uninsured adults aged  $\geq 50$  years with diabetes in Mexico: The Mexican Health and Aging Study (MHAS-2018). *Public Health*. 2021;194:176–181. Available from: <https://doi.org/10.1016/j.puhe.2021.03.006>.
29. World Health Organization. *Age-Friendly Global Cities: A Guide* Geneva: WHO; 2007. Available from: [https://apps.who.int/iris/bitstream/handle/10665/43755/9789241547307\\_eng.pdf?sequence=1&isAllowed=y](https://apps.who.int/iris/bitstream/handle/10665/43755/9789241547307_eng.pdf?sequence=1&isAllowed=y).
30. Gutiérrez JP, García-Saisó S, Dolci GF, Ávila MH. Effective access to health care in Mexico. *BMC Health Services Research*. 2014;14(1):186. Available from: [https://doi.org/10.1186/1472-6963\(14\)-186](https://doi.org/10.1186/1472-6963(14)-186).
31. Briggs AM, Valentijn PP, Thiyagarajan JA, Araujo de Carvalho I. Elements of integrated care approaches for older people: a review of reviews. *BMJ Open*. 2018;8( 4):E021194. Available from: <https://doi.org/10.1136/bmjopen-2017-021194>.
32. World Health Organization. *Integrated Care for Older People (ICOPE): Guidance for Person-centred Assessment and Pathways in Primary Care*. Geneva: WHO; 2020. Available from: <https://apps.who.int/iris/rest/bitstreams/1257934/retrieve>.
33. Sands LP, Albert SM, Suitor JJ. Understanding and addressing older adults' needs during COVID-19. *Innov Aging*. 2020;4(3):igaa019. Available from: <https://doi.org/10.1093/geroni/igaa019>.
34. Ortega I, Sancho M, Stampini M. *Fragilidad de las instituciones de cuidado a la vejez ante el Covid-19: lecciones aprendidas y recomendaciones para la reforma de los servicios*. Washington, DC: Inter-American Development Bank; 2021. Available from: <http://dx.doi.org/10.18235/0003111>.
35. United Nations. *Policy brief: the impact of COVID-19 on older persons*. New York: United Nations; 2020. Available from: <https://unsdg.un.org/resources/policy-brief-impact-covid-19-older-persons>.
36. Rivera-Hernandez M, Ferdows NB, Kumar A. The impact of the COVID-19 epidemic on older adults in rural and urban areas in Mexico. *J Gerontol B Psychol Sci Soc Sci*. 2021;76(7):E268-E274. Available from: <https://doi.org/10.1093/geronb/gbaa227>.

37. Pan American Health Organization. Snapshot of Age-friendly Cities and Communities in the Americas during the COVID-19 Pandemic: Lessons Learned. Washington, D.C.: PAHO; 2021. Available from: [https://iris.paho.org/bitstream/handle/10665.2/54702/PAHOFPLHLCOVID-19210029\\_eng.pdf?sequence=1&isAllowed=y](https://iris.paho.org/bitstream/handle/10665.2/54702/PAHOFPLHLCOVID-19210029_eng.pdf?sequence=1&isAllowed=y).
38. World Health Organization. Decade of Healthy Ageing: Baseline Report. Geneva: WHO; 2020. Available from: <https://www.who.int/publications/i/item/9789240017900>.
39. Kruk ME, Gage AD, Arsenault C, Jordan K, Leslie HH, Roder-DeWan S et al. High-quality health systems in the Sustainable Development Goals era: time for a revolution. *Lancet Glob Health*. 2018;6(11):e1196-e 1252. Available from: [https://doi.org/10.1016/S2214-109X\(18\)30386-3](https://doi.org/10.1016/S2214-109X(18)30386-3).



With the aim of providing an overview of the current knowledge available on the health and well-being of older people in the Region of the Americas during the United Nations Decade of Healthy Aging (2021-2030) and guiding actions aimed at promoting healthy aging, this report identifies the main barriers faced by older people in accessing health services.

These include six barriers related to access: health care needs, perception of needs, health care seeking, health care “reaching” (i.e., obtaining health care), health care utilization, and health care “consequences” (health, satisfaction, economic protection), the description and analysis of which are addressed from the standpoint of supply of and demand for services. This approach to the issue makes it possible to delve into the specific barriers that hinder older people’s access to health services, which differ from the barriers faced by people in younger population groups. The impact of factors such as the COVID-19 pandemic, which has significantly increased access barriers, is also highlighted.

This report, which is part of *The Decade of Healthy Aging in the Americas: Situation and Challenges*, provides elements to help the countries of the Region of the Americas to formulate strategies aimed at eliminating barriers to access to health services, based on the premise that lowering these barriers will foster better health and promote healthy aging.