2018 Trends in the Health Sciences

The Mother of Invention: Technologically Savvy Older Adults Drive Change

Since the start of the personal computer revolution in the 1980s, the assumption has been that older folks were not very adept at using these devices and the smartphones and iPads they spawned. With the generation that invented much of this technology now entering older adulthood, that conventional wisdom is being flipped.

“As the Baby Boomers age, they will see technology as providing an opportunity to live independently longer,” said Theresa (Terri) Harvath, 2017–18 Chair of GSA’s Health Sciences Section. “Their attitudinal differences, their values, and their educational attainments will influence how this generation ages.”

Let’s look at Harvath’s vision of trends that will affect the health of older people in coming years and decades—and the need for continued education and research as need drives change.

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Turning 65 in the 21st Century: Technology as Caregiver

The huge Baby Boomer generation—now moving into the third stage of life—has a predilection for having it their way. They also have the numbers, the money, and the voices to reframe aging and remake the systems through which we help people as they age, Harvath said.

Medicine, education, technology, culture, religion: change in each of these areas was a daily expectation as those born in 1946 to 1964 moved through the decades. Given the pace of innovation, the new drugs and interventions available for treating and preventing disease, and the sheer numbers of those turning 65 each day (10,000 people), chances are the Boomers can press the world into whatever mold they wish.

Still, those in this generation—and in Generation X (1965–1980), which begins reaching 65 in 2030—face a number of challenges, starting with caregiving. “As we have become a more mobile society, families continue to provide care, but they do so from a distance,” Harvath said. “They try to support the older family member in the community and supplement that to some degree with congregate care or supported care environments. We have seen the advent of assisted living and other models, particularly in states such as Oregon that have done a lot with adult foster care and group home kinds of situations.”

The next wave of community-based long-term care will likely be very technology-dependent, Harvath predicted. “When I lived in Portland, a new continuing care retirement community was built with smart technology,” she recalled. “It was very popular. The apartments filled quickly—but nobody wanted the smart technology activated because they didn’t need it yet. The technology was there for when they needed more support to be able to continue living independently.”

Among the technological innovations in the apartments were movement sensors that measure gait or detect if residents became more sedentary, sensors in the bed that check weight and sleep patterns, and devices for logging refrigerator opening and closing. Technologies are also available for estimating adherence using WiFi-communicated data on the removal of caps from bottles of medication. The future could see application of GPS technology in tracking people with conditions such as dementia, Harvath said.

Obesity and Opioids: Influencing Health at Older Ages

While the number of years of life expectancy at 65 has never been greater than it is today, troubling trends are apparent. For many Americans, obesity, diabetes, and opioids have combined to make getting to 65 the hardest part.

“Certainly, more people today have the capacity to get to old age, but now we’re seeing people not get to old age with as much health as they might have otherwise,” Harvath said.

“I remember early in my career saying it seems like there have always been people who lived to old age; some of the longevity we are seeing now is a result of more people surviving childbirth and childhood. When we look at the increasing numbers of individuals with obesity, diabetes, and other chronic conditions, we have to ask, ‘Have we really made strides that have advanced the capacity to live a healthy life after you’ve reached a certain age?’ The years of life expectancy at 60 or 65 may continue climbing, Harvath notes, but chronic illness and opioid misuse have already combined to produce early morbidity and mortality. “Certainly, more people today have the capacity to get to old age, but now we’re seeing people not get to old age with as much health as they might have otherwise,” Harvath said.

“There are already some reversals in longevity within certain subgroups of the U.S. population because of the chronic illness and obesity epidemic,” Harvath said. “When you add the opioid epidemic, we could see an end to our advances in longevity. If, however, we can get people to move more through health promotion efforts, wellness programs, and wearable technologies, we might be able to reverse some of these concerning declines in the health of middle-aged and older adults.”

Diversity in America—but Not in Health Professions?

With the United States on track to be a majority nonwhite country by midcentury, the “browning of America” will present a number of challenges to the health care system beyond the more obvious language and cultural barriers.

Harvath lives in Sacramento, California, which is already majority nonwhite. “It’s one of the most ethnically, racially diverse larger
cities in the country,” she said. “Yet it remains quite segregated. The health inequalities are quite evident. Some are economic and a result of inadequate access to quality health care and health insurance; some of the inequities are a result of implicit bias and systemic discrimination that results in treatments for underrepresented minority patients that don’t reflect the best available evidence.”

Despite this diversity among the population and those presenting to the health care system, getting more diversity among health providers has remained a “chicken-or-egg dilemma,” Harvath said. “While there continues to be intention in schools of health to try and create pipeline opportunities to attract a more diverse student body, a rate-limiting factor is the lack of diversity of the faculty and staff. Students look at the faculty and wonder, ‘Will I fit in there?’ It’s a real challenge: how do we attract more diverse students in the absence of diverse faculty? How can we foster the development of diverse faculty if we don’t have diverse students who can grow into faculty positions?”

Even when a diverse faculty and student body are in place, the challenges don’t stop. “The faculty retention of underrepresented minority faculty is not as good as it is with majority white faculty,” Harvath said. “On the student side, even after being admitted to health professions programs, minority students, who are often first-generation college students, face many challenges and barriers navigating complex educational and health care systems.”

The Changing Faces of Long-Term Care

The shifting demographics of America’s minorities becoming the majority is not the only challenge to a country still struggling to find a way to, as one Disney tune put it, “paint with all the colors of the wind.” Racial and ethnic categories are just the beginning when it comes to stereotyping others, and perhaps none of these labels could disrupt assignments to semiprivate rooms and congregate dining facilities as much as sexual orientation and gender identity.

The trend toward openness in LGBTQ communities has been liberating for many, and not doing so could be detrimental for health. “Traditionally, older LGBTQ adults have been very closeted,” Harvath said. “With the legalization of gay marriage and all of the work that’s been done around gay rights, we’re going to see more open and ‘out’ older adults. We haven’t necessarily trained our health professional and paraprofessional staff to be sensitive to the unique needs of this population. In semiprivate rooms of nursing homes, there may be some older adults who really take offense at being housed with somebody who’s gay, even if they’re the same gender, or with somebody whose gender is less discernable or who is transgendered.”

These LGBTQ individuals also can have unique health care needs—ones that can be missed for many reasons. “I think to the extent that a trusted relationship with your health care provider is an important component of getting the care you want and need, older LGBTQ persons may defer care or not disclose concerns or questions fully when they encounter less-than-sensitive health care providers because of a fear of being judged.”

Part of the issue is that some LGBTQ individuals—in rural or conservative areas in particular—have often deferred health care throughout their lives, Harvath explained. “They may have chronic issues that have not received the best care throughout life because of feeling like their needs were not well addressed or sensitively attended to locally,” she said.

In addition, Harvath explained, “Populations in nursing homes and other congregate care environments tend to be predominantly white and underrepresented minority groups and other sociocultural groups tend to be relatively low users of this care. Furthermore, the costs associated with these programs are becoming prohibitively expensive. To meet the needs of an increasingly diverse population of older adults, we need to make community-based long-term care supports and services more accepting and inclusive in order to help these older adults stay in their communities for longer periods of time.”
Learning More About What People Want

“I think we need to be humble about what it is we believe we know about what older adults want, about what’s important to them, about what care should look like for them because we know that the Baby Boomers are likely to have stronger opinions and not be necessarily as compliant as the Greatest and Silent Generations were,” Harvath concluded. With this in mind, it will be important to continue to study what is working, what people are doing, and what they would like to see.

For Further Reading


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