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Age Discrimination in Healthcare: The Argument for a Multi-Level, Intersectional Response

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CSA Society of Certified Senior Advisors

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Ageism in healthcare is prevalent across the globe (Economist Intelligence Unit, 2009). In the United States specifically, age discrimination is associated with over 17 million cases of the eight most expensive health conditions, as well as a one-year economic loss of $63 billion in healthcare-related costs (Levy et al., 2020). Age discrimination in healthcare manifests in a variety of ways, including paternalistic communication, barriers to receiving timely and effective services, and exclusion from research and clinical trials. One in 17 adults age 50 and older reports experiencing frequent age discrimination in healthcare, and this may contribute to new or worsened disability (Rogers et al., 2015). Ageism in healthcare can literally have life or death implications, given that older patients who experience it have a higher probability of death than younger patients (Grant et al., 2000). To combat ageism and make healthcare settings safer for older adults, industry leaders and advocates can consider implementing up-to-date best practices in education, organizational culture, and policy.

Biases and Stereotypes

Why does ageism occur in healthcare? In part, it's due to biases and stereotypes. To an extent, we all internalize negative stereotypes about aging and older people. If healthcare providers make assumptions that older people are challenging to care for, frail, unproductive, dependent, or cognitively impaired, this bias can lead to unfair treatment. Furthermore, difficult decisions are often made in healthcare settings, and it is not uncommon for healthcare services to be rationed. When providers are under pressure to decide who receives services, they may favor younger people due to an assumption that illness and death is more common or even considered more acceptable among older adults.

Examples of age-based rationing came to the fore during the COVID-19 pandemic. As the virus was initially spreading, voices in the media and elsewhere expressed sentiments that the threat was not severe because it would primarily affect older people, that medical interventions should target younger generations, and that a targeted lockdown of older adults offered a promising solution to reopening the economy (Acemoglu et al., 2020; Ault, 2020; Barnes, 2020; Morrow-Howell & Gonzales, 2020). Specifically, an investigation found that the state of Alabama rationed medical care, including ventilators, based on age and disability-related cutoffs (Ault, 2020). Alabama later agreed to revise its COVID-19 ventilator policy.

Elderspeak

An example of ageism through interpersonal communication in healthcare is called *elderspeak.* Elderspeak is an infantilizing way of communicating with older adults, particularly those living with dementia, based on negative age stereotypes. Elderspeak portrays older adults as incompetent and is not only patronizing but often manipulative. Elderspeak may include speaking slowly, using a high-pitched voice, or the use of inappropriate terms such as "honey" or "sweetie" when speaking with older people. One recent study

identified elderspeak in 84% of interactions between nursing home staff and patients (Williams et al., 2017). Elderspeak is a form of implicit bias that contributes to paternalism and reduced person-directed care in healthcare settings. The use of elderspeak by healthcare professionals is disempowering and limits older patients' autonomy in making decisions about their healthcare needs. Counteracting elderspeak requires healthcare practitioners to develop self-awareness of their implicit bias and practice new communication patterns when interacting with older patients. Figure 1 (drawn from Williams et al., 2005) provides examples of elderspeak and alternative strategies for practitioners to implement.

Education & Culture Change

Other strategies proposed to reduce ageism in healthcare include educational programs, intergenerational learning, and strong organizational leadership to implement changes in practice and policy (Nemiroff, 2022). To add to this, it is critical to address internalized ageism when crafting educational materials. Since ageism is so widely accepted and often invisible, we have all internalized prevalent age stereotypes throughout our lives. As a result, we need to continually reflect and consult with older adults to ensure educational materials are an improvement in ethical practice, rather than another insidious reflection of ageist stereotypes.

Efforts to combat ageism in healthcare must go beyond education to changing environments. One example is Age-Friendly Health Systems. Age-Friendly Health Systems focus on aligning with "what matters" to each individual older adult and their family caregivers while implementing evidence-based practices which cause no harm. Additionally, the culture change movement in long-term care (led by Pioneer Network and the Eden Alternative) has helped transform healthcare environments from cold, institutional settings to places where older adults truly feel "at home" in their living environment. This culture change movement emphasizes creating environments where older people can express autonomy and self-determination while cultivating meaningful relationships. Pioneer Network offers a "continuum of person-directedness" (Figure 2) to help practitioners visualize this transformation: from providing services to older adult clients/customers, to creating an environment where elders truly make the decisions about their daily routines and needs. Recently, in collaboration with Christian Living Communities, this continuum was updated to include "citizenship" as the final stage in this model, which reflects the cultivation of a true community where systemic barriers have been removed.

Figure 1.

FEATURES OF ELDERSPEAK AND ALTERNATIVE STRATEGIES

- Diminutives (inappropriately intimate terms of endearment, imply parent-child relationship)
  Examples: honey, sweetie, dearie, grandma
  Alternative strategy: refer to residents by their full name (i.e., Mrs. Robinson) or by their preferred name
- Inappropriate plural pronouns (substituting a collective pronoun, such as "we," when referring to an independent older adult)
  Example: "Are we ready for our medicine?"
  Alternative strategy: "Are you ready for your medicine?"
- Tag questions (prompts the answer to the question and implies the older adult cannot act alone)
  Example: "You would rather wear the blue socks, wouldn't you?"
  Alternative strategy: "Would you like to wear the blue socks?"
- Shortened sentences, slow speech rate, and simple vocabulary (sounds like baby talk). These communication patterns do not improve comprehension of speech for most older adults and are perceived as patronizing or demeaning.

From "Enhancing communication with older adults: Overcoming elderspeak," by K. Williams, S. Kemper, & M. L. Hummert, 2004, Journal of Gerontological Nursing, 30(10) (https://doi.org/10.3928/0098-9134-20041001-08). Copyright 2013 by SLACK Incorporated. Reprinted with permission.

The Importance of an Intersectional Perspective

In addition to the above recommendations, responding to ageism in healthcare requires applying an intersectional perspective. Older adults are a highly heterogenous group who include older adults of color, disabled older adults, older adults of diverse sexualities and gender identities, and many other identities. Therefore, ageism in healthcare is rarely experienced on its own, but rather through intersecting experiences with sexism, racism, ableism, transphobia, and other forms of oppression. The concept of "double jeopardy" has most often been applied to describe intersecting experiences of ageism and sexism. However, research has also applied this concept to describe how both ageism and racism led to COVID-19

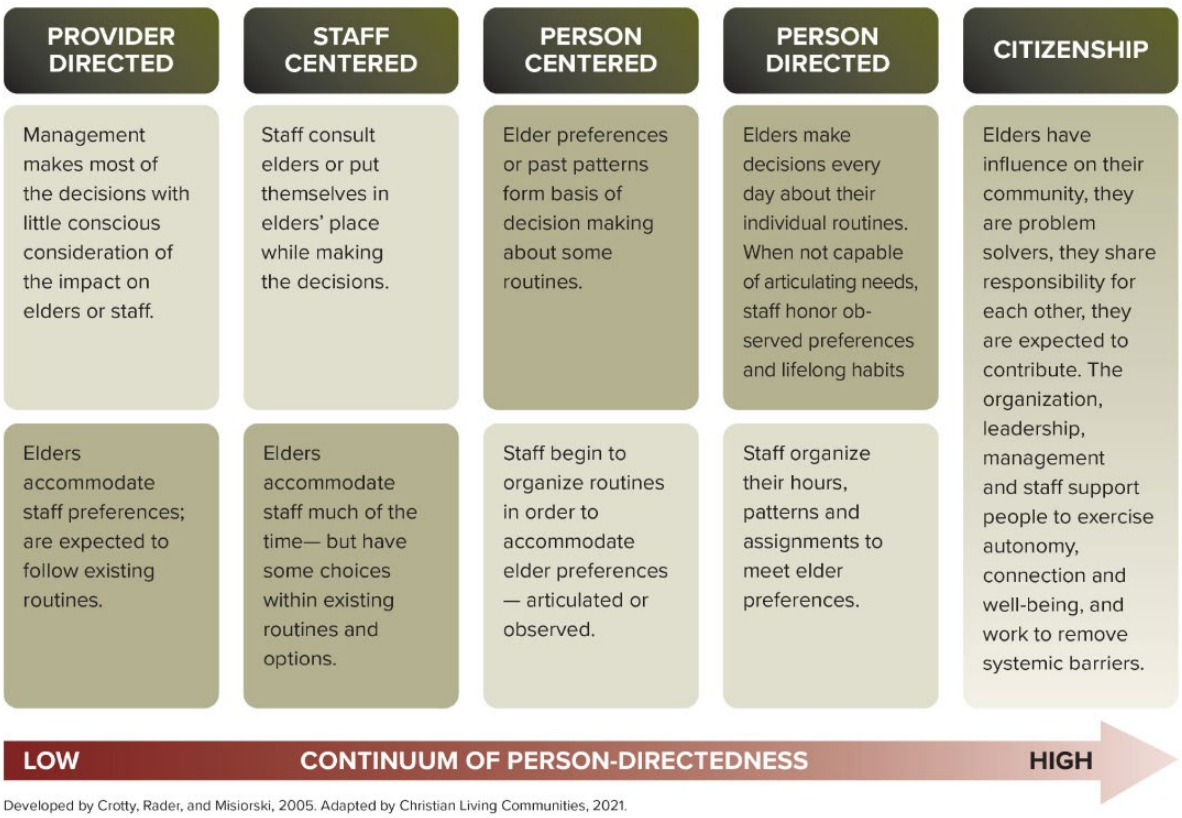
related disparities in morbidity and mortality rates, particularly for Black older adults (Chatters et al., 2020). In one recent qualitative study (Steward et al., 2023), a 63-year-old African American woman shared the following experience: "As I've gotten older, now the question becomes did that happen because of my age and disabilities, and not so much about my race…And sometimes I can't tell the difference." This study found that stereotypes related to mental (in)competence may be one way ageism and racism intersect. Therefore, educational initiatives which intentionally counter such stereotypes could be provided to healthcare practitioners in an effort to combat stereotypes at the intersection of ageism and racism.

Policy Lessons From COVID-19

At a more macro-level, reducing ageism in healthcare will require a change in policy. Particularly, it is important that we learn from mistakes made during the COVID-19 pandemic, such as the habitual, lazy use of age cutoffs when determining resource allocation during crises. Readers can consult the clinical practice guidelines provided by Montero-Odasso et al. (2020) in the Resources section below for alternatives to using age alone as a criterion for making decisions about resource allocation. Given the heterogeneity of experiences in later life and the fact that people are living longer and healthier lives, scholars suggest that the clinical frailty scale may be a more multifaceted tool which better predicts clinical outcomes than age alone (Montero-Odasso et al., 2020, p. 153; Nemiroff, 2022).

Abolishing age cutoffs may also be a useful strategy for ensuring that clinical trials are more inclusive of older people. Additional recommendations for health researchers include reducing the number of exclusion criteria, including older adults throughout the study design process, providing transportation and easy physical access to research institutions, and personalized, face-to-face recruitment methods (Witham & McMurdo, 2007). Going forward, it is imperative that healthcare practitioners and researchers apply triage and research protocols rooted in best practices rather than outright age discrimination. Best practices place patients' wishes and goals for care at the center of any plan.

Figure 2: Pioneer Network Continuum of Person-Directedness



From "Continuum of Person-Centered Care" by Pioneer Network, 2023 (https://www.pioneernetwork.net/culture-change/continuum-person-directed-culture/). Copyright 2023 by Pioneer Network. Reprinted with permission.

From the Personal to the Systemic

Ageism in healthcare is an insidious social justice issue which manifests at the implicit, interpersonal, environmental, and systemic levels. Given this, it is imperative that healthcare practitioners are educated about strategies to combat ageism: cultivating awareness of our own implicit bias, improving interpersonal communication, changing the healthcare environment, and reforming policies. A targeted approach that considers the causes and interventions across each of these levels is essential in order to effectively combat ageism in healthcare settings. •CSA

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