October 9, 2024

The Honorable Robert Otto Valdez, Ph.D., M.H.S.A
Director
Agency for Healthcare Research and Quality
5600 Fishers Lane
Rockville, MD 20857

Dear Dr. Valdez:

We write to express our concern about the complexity and pervasive nature of ageism in health care and request that the Agency for Healthcare Research and Quality (AHRQ) examine the impact of ageism on quality and equity of care, patient safety, and health outcomes.

Ageism refers to stereotypes, prejudice, and discrimination directed towards people on the basis of their age. While ageism is often subtle, it is woven into our workforce, our health care system, and our everyday interactions. Ageism undermines older adults and their contributions to our communities. Research shows that 81 percent of adults aged 50-80 report experiencing internal ageism, 65 percent are exposed to ageist messages, and 45 percent face ageism in interpersonal interactions. These staggering statistics demonstrate how ingrained ageism is in our society.

Ageism within health care leads to poorer health outcomes, avoidable morbidity, and costly preventable adverse events. Ageism costs the health care system $63 billion annually. In health care, ageism is expressed in our policies, the practices of health care providers, and negative assumptions held by older adults themselves. At the macro level, ageism is complex and reflected in health care access issues which result in older adults being less likely to receive care consistent with medical guidelines, payment policies that do not adequately reimburse for complex care needed for older adults, and exclusion or underrepresentation of older adults in clinical trials and other research.

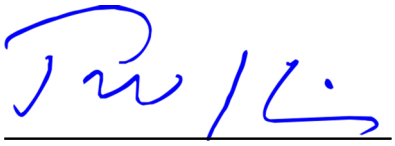
At the micro level, practices such as the use of ageist language and elder speak, exclusion of older patients from plan of care conversations, and variations in treatment practices due to a patient's age all affect patients' quality of care. Self-directed ageism can also lead to adverse outcomes for a patient if their beliefs on aging lead them to believe that the symptoms they are experiencing should be considered a "normal" part of aging. For example, while some cognitive decline is expected as we age, memory loss, confusion, changes in behavior, and inability to complete activities of daily living are all signs of changes in cognitive ability that need to be evaluated by a medical professional. Moreover, people who internalize ageist societal messages tend to have poorer physical, cognitive, and mental health. The reverse is also true—individuals who internalize positive aging messages are likely to exhibit benefits in physical, cognitive, and mental health—highlighting the need to promote age inclusivity.

We respectfully request that AHRQ examine this issue and provide a synthesis of existing evidence on ageism in health care to inform efforts to reduce ageism within the health care system. Specifically, we request your assistance to answer the following questions:

1. What is the full scope of ageism within health care?
2. What is the impact of ageism and intersectionality on both the micro and macro levels of health care related to health equity and outcomes?
3. What is the evidence for interventions to address ageism and promote age inclusivity in health care?

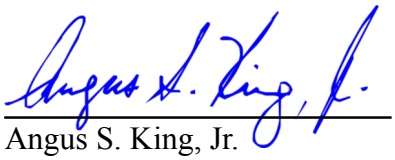
With AHRQ's mission to improve the quality, safety, and equity of health care, we believe your organization is well suited to support Congress' effort to address ageism in health care. Results of the requested review will help inform practice, quality improvement efforts, education of health professionals, and policy.

Sincerely,



Tim Kaine
United States Senator

Bernard Sanders
United States Senator



Angus S. King, Jr.
United States Senator

Robert P. Casey, Jr.
United States Senator