

MEDICINE AND SOCIETY: PEER-REVIEWED ARTICLE

Ageism as a Source of Global Mental Health Inequity

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Abstract

Ageism manifests as stereotyping of or discrimination against people—usually older adults—because of their age. Since ageism contributes to global mental health inequity among older people, responding to their needs should be a clinical, ethical, and policy priority. This article suggests how relatively simple, low-cost, high-yield interventions can be implemented globally and domestically to improve the well-being and quality of life of older individuals.

Origins of Ageism

More than 50 years ago, psychiatrist Robert Butler coined the term *ageism*, which he defined as a process of “systematic stereotyping of and discrimination against people because they are old, just as racism and sexism accomplish this with skin color and gender.”¹ The term arose during his 1969 interview with novice *Washington Post* reporter, Carl Bernstein,¹ which concerned younger adults’ objections to turning an apartment complex in a posh neighborhood in Chevy Chase, Maryland, into a high-rise to house older individuals of various races and ethnicities. Instead of attributing their objection to community racism, Butler attributed it to ageism, a **prejudice against older people** based on age. Furthermore, Butler confessed that, in his own field, many psychotherapists harbored a disdain for older patients. Characterized as “therapeutic nihilism,” these attitudes, he suggested, impeded clinicians’ efforts related to patient care.²

Studies conducted during the 1980s concerning mental health clinicians’ attitudes toward older adult patients revealed that they gave older patients consistently poor therapeutic prognoses.^{3,4} The view was that older adults were essentially beyond treatment, reflecting a reluctance to care for them. Such attitudes have persisted, as evident by their being reported in the 1990s in studies from Israel,⁵ Great Britain,⁶ Australia,⁷ and Portugal.⁸ These attitudes led to a general belief on the part of many clinicians that depression is a normal part of aging. Although few recognized the term *ageism* or its implications at the time, the insidious attitudes and effects of ageism have since been documented worldwide, and we argue that it is a source of global mental health inequity among older adults. Adding to our assertion, the 2016 standards of the Council for Accreditation of Counseling and Related Educational Programs fail to mention ageism or older people.⁹

Ageism as a Source of Inequity

Health inequity involves the unfair allocation of resources or treatment options based on a person's race, sex, sexual identity or orientation, or age, whereas health equity is the fair allocation of health care resources to all members of society.¹⁰ The World Health Organization (WHO) stresses that health inequities are clear “systematic differences in ... health status.”¹¹

McClung et al define health equity as “when every person has the opportunity to attain his or her full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances. Health inequities are reflected in differences in length of life; quality of life; rates of disease, disability, and death; severity of disease; and access to treatment.”¹²

Asada identified health inequity as a moral concern due to the value that most people place on their health and the general consensus that access to health care is viewed as a necessity; limitations of that right represent an ethical, if not a legal, wrong.¹³ To measure health inequity, Asada proposed operationalizing a concept of equity and a measurement strategy that includes measures of health (eg, life expectancy), unit of time (eg, life stage or life course), and unit of analysis (eg, individuals or groups). Moreover, she argued that it is critical to compare health status using methods that take into account population size.

We recognize that measuring health outcomes to determine the consequences of ageism has proven challenging, given that older people generally have more advanced disease than younger members of society. However, it is possible to measure access to care, attitudes of health care professionals toward older individuals, quality of life, and various other measures to determine health care inequities. Furthermore, we must stress that equity is not the moral equivalent of equality, and we reject the use of these terms interchangeably. We emphasize that no 2 people are the same, although there are general treatment options that apply globally to classes of individuals (eg, COVID vaccination). Equality entails the exact same access to treatment for all. Equity, however, acknowledges that individuals' needs may differ but that they should be afforded rights and access to treatment, as exemplified by policies and laws mandating access to public services by persons with disabilities. Not all follow the same path, but they are afforded fair opportunity based on need.

Health Outcomes

Although the effects of ageism on mental health are generally understudied, notable examinations exist. For example, Herrick et al emphasize that mental health problems of older adults can exacerbate physical symptoms and that early detection of mental health problems has the potential to prevent some physical problems related to untreated mental illness.¹⁴ In addition, loneliness and ageism holistically affect mental health, specifically by contributing to anxiety and depressive symptomology.^{15,16,17}

With a particular emphasis on the influence of individual and systemic factors that lead to health inequities, a meta-analysis conducted by Chang et al revealed that, in 10 studies, ageist attitudes predicted a shorter lifespan in adults aged 50 and older in Australia, China, Germany, and the United States.¹⁸ In relation to mental health, 95.5% of 44 studies found that ageism affected psychiatric conditions—in particular, the onset and continuance of depressive symptoms over the lifespan. Finally, “a greater prevalence of significant ageist-health findings was found in less-developed countries

than more-developed countries,” and less educated older people were more likely to experience adverse health effects of ageism.¹⁸ A systematic review by Hu et al¹⁹ included a subset of observational studies from the United States, Britain, and Canada on ageism and its relation to health, which demonstrated that the prevalence of perceived age discrimination was higher than the prevalence of perceived sexual and racial discrimination.^{20,21,22} The authors found a range of health outcomes associated with ageism and stressed that it should be regarded as a public health risk.¹⁹ Using data from 5083 diverse women in the National Longitudinal Survey of Mature Women, Shippee et al explored long-term effects of age discrimination in the US workplace on mental health.²³ They found age discrimination to be a “significant predictor of women’s depressive symptoms and life satisfaction over the life course, even controlling for other forms of discrimination and other factors.”²³

Effects of COVID-19

This article would be incomplete without mentioning the global effects of COVID-19, which most profoundly affected the physical and mental health of the aging population. The virus highlighted and widened existing gaps in physical and mental health care. Not only were older adults particularly susceptible to dying from the disease, but they were also susceptible to the effects of loneliness due to prolonged social isolation, which reinforced the ageist perception of society and of older adults themselves that they were expendable and an incumbrance. Kessler and Bowen emphasized that a “thwarted sense of belonging and perceived burdensomeness are risk factors for suicidality” and that prevailing attitudes of politicians and the public served to reduce older adults’ attention to their own mental health, thus affecting their longevity and physical and mental health.²⁴

Other authors have identified issues related to ageism and health inequities during the height of the pandemic. Banerjee pointed out that older adults were not necessarily comfortable with the mechanisms of communication (eg, smart phones, social media) and so were unaware of evolving situations related to the pandemic, making them easy targets of misinformation and inadequate precautionary measures and increasing incidences of depressive disorders, complex posttraumatic stress, and adjustment reactions.²⁵ Flett and Heisel found that, during the COVID-19 pandemic, fear, loneliness, and isolation combined to undermine the mental health of the population of older adults.²⁶

Mitigating Ageism and Inequity

Action strategies. Results from the 2021 *Global Report on Ageism* confirmed that ageism is a social determinant of age-based health inequities and poor health outcomes.²⁷ Globally, ageism affects billions of people, with at least 1 in 2 adults ages 16 through 99 holding ageist attitudes, with even higher rates reported in countries with lower incomes.²⁸ Combating ageism has been listed in the *Global Report* as 1 of 4 action areas of the Decade of Healthy Ageing (2021-2030).²⁷ In 2021, the WHO released a plan for the Decade of Healthy Ageing (2021-2030), which it described as “10 years of concerted, catalytic, sustained collaboration.”²⁹ Embracing a human rights approach, the plan stresses 4 areas for action, one of which, Area 3.1, endeavors to “change how we think, feel and act towards age and ageing.”²⁹ Proposed action strategies are to develop communities that foster older people’s abilities, to deliver person-centered integrated and **primary health services** that respond to the needs of older people, and to provide long-term care for those older people in need of it.

Medical education. Burnes et al conducted a systematic review and meta-analysis examining the effectiveness of 3 intervention strategies designed to change students' attitudes toward aging: education, intergenerational contact, and a combination of education and intergenerational contact.³⁰ One controlled, prospective, longitudinal trial included in the meta-analysis that combined intergenerational contact (via biannual structured interviews with a senior community-dwelling mentor during the first 2 preclinical years) and education (via small-group discussion of interviews mediated by geriatrics faculty) found that this low-intensity intervention to introduce entering medical students to healthy older people positively affected attitudes toward aging.³¹ Furthermore, Meshel and McGlynn found that middle-school students randomly assigned to a 6-week intervention involving cross-age contact developed more positive attitudes toward older people, whereas those assigned to the didactic condition did not.³² In sum, although Meshel and McGlynn did not find that the interventions translated into any reductions in health inequity for older populations, Burnes et al found that interventions using a combination of education and intergenerational contact produced the most significant improvements in the attitudes of females and of adolescents and young adults towards older adults.³⁰ The authors stressed that low-cost interventions resulted in substantial reductions of ageism and should be part of an international, public health effort to reduce this pernicious problem. Similarly, Mikton et al¹⁶ emphasized the need for global investments in effective strategies for prevention and intervention, research, and the construction of a movement to alter the present global playbook about aging.

We emphasize that the scourge of ageism contributes to global mental health inequities among older adults. We stress that a moral imperative exists to address **mental health inequities** extant in the rising worldwide population of older adults. The global institution of relatively simple interventions would be both low-cost and exceptionally high yield and would have the potential to demonstrably reduce real and opportunity costs of health care as well as to improve the well-being and quality of life of present and future cohorts of older individuals.

The clear and demonstrable health inequity of ageism and its negative effects on older persons' mental health violates one of the key tenets of medical ethics—namely, justice and fairness. Respecting older persons means acknowledging that they are deserving of mental health care. It is past time to reconcile this inequity on both a local and a global scale.

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