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Good afternoon.

My name is Dr. Timothy Farrell. I am a geriatrician and Associate Professor of Medicine at the University of Utah School of Medicine, and a Physician Investigator at the Veterans Affairs Salt Lake City Geriatrics Research, Education, and Clinical Center (GRECC).

I'm honored to provide this testimony on behalf of the American Geriatrics Society (AGS), where I serve as Vice Chair of the Ethics Committee. Our committee developed the recent AGS position statement entitled "Resource Allocation Strategies and Age-Related Considerations in the COVID-19 Era and Beyond."

The AGS appreciates the emphasis that the committee has placed on the healthcare workforce and older adults in its draft framework. AGS members work to improve health, independence, and quality of life and to ensure that older adults have access to high-quality health care that is free of ageism. The AGS believes that vaccination strategies should focus on achieving the greatest possible reductions in disease-related death and morbidity.

We therefore strongly recommend that our national vaccine allocation strategy do the following:

**First**, prioritize the health workforce, broadly defined to cover workers across care settings, including in long-term care, assisted living and other congregate living facilities, and home and community-based settings.

**Second**, prioritize access for high-risk populations, including older adults, those living in congregate settings, people with chronic health conditions, and communities of color.

**Third**, avoid using age as a criterion given the diversity of the older adult population. We believe it is not the role of the AGS, this committee or the government to assign different values to individual life based on age, income potential, or other factors. We respectfully recommend that the committee instead consider the effect of vaccine distribution on public health, mortality, and decreasing demands on the healthcare system in general.

I will address each of these three points in turn.

The AGS strongly recommends that the committee include an expansive definition of the healthcare workforce that is comprehensive as to type of worker and setting of care. Our U.S. healthcare workforce provides care not just in acute care hospitals but also in nursing homes, assisted living and other congregate living facilities, and at home and in the community. We must ensure that direct care workers—such as certified nursing assistants, home care workers, dietary aides, and others who work in facilities where COVID-19 patients are cared

for—are prioritized. This is in addition to the priority that will be given to health professionals such as doctors, nurses, pharmacists, and social workers. Preventing infection in healthcare workers is an important public health intervention to decrease the exposure of all of us—but most critically, our vulnerable populations—to coronavirus infection.

We appreciate that older adults, people with chronic conditions, and others at high risk of dying from COVID-19 are prioritized in the draft framework. However, the AGS would like to speak on behalf of *all* older adults, given our concern that portions of the underlying analysis that informed these recommendations lean on stereotypes that potentially devalue older adults. We refer specifically to the idea that age in and of itself is a potential criterion for making allocation decisions. Our current reality is that, due to advances in our understanding of diseases and how to treat them, people are living healthy lives even when they have heart disease or other chronic conditions. Resting these recommendations on an analysis that does not reflect the complexity of how we age runs the risk that older people will be discriminated against because of their age when this framework is implemented.

I would like to highlight four principles from the recent AGS position statement that are particularly relevant to the issue I just raised:

**First, age should never be used to exclude someone categorically from a standard of care, nor should age “cut-offs” be used in allocations.**

**Second, to avoid similar biases, factors such as “life-years saved” and “long-term life expectancy” should not be used, since they disadvantage older adults and are often unreliable.**

**Third, when assessing comorbidities, decision makers should carefully consider the impact of age, race, ethnicity, and social determinants of health.**

**Fourth, resource allocation strategies must be transparent, applied uniformly, and regularly (and rigorously reviewed).**

We strongly encourage the committee to expand its analysis related to age and fairness by incorporating these principles. In a just health system, resources are allocated equitably using criteria that treat similarly situated people the same.

The AGS appreciates the work of the committee and your focus and commitment to developing a fair and equitable strategy that is transparent and free of age or other discrimination. Thank you very much again for the opportunity to provide this testimony.

When it comes to how we all age, it behooves us all to remember that it is often the ninth inning of life that is the most important.