

Policy Brief

Older Adults and COVID-19 – Protection from Direct and Indirect Harm

Ethical Recommendations Regarding Older Adults in the COVID-19 Pandemic

Key Messages

The COVID-19 pandemic is associated with a range of potential harms, especially for older adults. This paper provides an overview of the different types of harms and develops recommendations to address these harms. Direct harms are associated with the health-related risks of a SARS-COV-2 infection. Indirect harms, on the other hand, may result from appropriate protective measures, such as social isolation through social distancing. In addition, there are prejudices and stereotypes that especially older people are experiencing throughout the pandemic.

We want to raise awareness about the different types of harms as well as about necessary trade-offs and weightings between potential direct and indirect harms. In addition, we propose the following measures to minimize and mitigate harms:

- Supervise and monitor care for older patients, especially in nursing homes
- Minimize negative effects of specific protective measures and employ digital technologies to relieve isolation and loneliness
- Organize the distribution of vaccines to allow for equitable access
- Avoid paternalism and promote self-determination, including advance directives and advance-care planning
- Prevent age discrimination in healthcare, especially in the allocation of medical resources
- Counter ageism and negative stereotypes of old age and promote intergenerational

solidarity

This paper is intended for policy makers and health professionals. Furthermore, it is intended for informing the media and the general public.

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Background

The risk of severe cases of and death from COVID-19 increases significantly in the age groups above 50 years, who are therefore considered particularly vulnerable in the current pandemic (Bonanad et al., 2020). Protecting their health has been a focus of measures preventing the spread of SARS-CoV-2. This applies both to general measures for the population as a whole and to specific measures only conceived for this group or groups. For instance, general social distancing, social isolation of members of high-risk groups, as well as lockdown measures at large are all intended to prevent the spread of the disease to particularly vulnerable populations. However, such measures come at high social and economic costs to the general population. Social isolation can lead to an increased mental and physical health burden. Confinement and home schooling may cause or intensify conflicts within families. General lockdowns increase the precariousness of jobs and businesses.

Against this backdrop, some experts and politicians initially proposed to merely isolate high-risk groups, and thus avoid the expenses of comprehensive strategies (Standl et al. 2020). The intention behind such suggestions may have been the protection of these groups. However, there was also the implication that the costs of general measures were too high to “just” protect the group of older adults. In many (social) media statements, they are depicted as a group whose members are no longer economically productive and will probably die soon anyway (Ayalon et al., 2020). Furthermore, while older adults benefit, younger people are said to pay an unfairly high price for comprehensive measures in terms of the current psychological burden as well as adverse developmental effects and future economic costs. Implicit or explicit statements about the value or alleged worthlessness of the lives of older adults have become an important part of the narrative of the COVID-19-pandemic (Ehni & Wahl, 2020). Previously existing negative stereotypes of old age,

age-discrimination, and ageism have already become more visible in debates on the pandemic. This has been the case, for instance, in some discussions pointing explicitly and, more frequently, implicitly to the option or need for age-based rationing of health-care resources. Age-discrimination is explicitly rejected in recent recommendations for dealing with a potential scarcity of resources in intensive care for COVID-19 patients. Nevertheless, some such documents introduce age-limits as criteria for access to care (Ehni, Wiesing, & Ranisch, 2021). Such criteria and reflections on lower priorities for older adults may well reinforce already existing hidden age-based rationing of medical care (Brockmann 2002). This adds to the potential of harm from COVID-19 for older adults and has to be addressed. Thus, put positively, the current pandemic may also serve as an opportunity to identify such existing trends more clearly and discuss them more explicitly. This may result in future improvements regarding the situation of older adults, in particular in relation to age-discrimination and ageism.

Purpose

This policy brief offers a broad-scale set of recommendations in order to protect older adults from direct health-risks through COVID-19 as well as harm resulting from measures of infection control. Moreover, these recommendations are intended to reduce the indirect harm resulting from protective measures, such as the severing of social contacts as well as the reinforcement of ageism and age-discrimination.

Different types of harm to older adults during COVID-19

Following D'Cruz and Banerjee (2020), different types of individual harm result to older adults from the COVID-19 pandemic, each of which has to be addressed in appropriate ways. An important distinction is the one between direct harm from the disease as well as respective medical treatment, and indirect harm from measures against the pandemic and reactions to them. Preventing severe direct harm can justify public-health measures which limit individual freedom. However, such measures may in turn also create indirect harm which has to be balanced carefully against their benefit or the direct harm they prevent. This balancing can be even more difficult if different types of harm and different groups are concerned, for instance, if short term effects on physical health in

older adults in high-risk groups are weighed against long-term effects in educational achievements and career opportunities in younger age groups.

It is beyond the scope of our policy brief to carry out such calculations. Firstly, we want to examine shortcomings in the measures which were intended to protect older adults during the COVID-19 pandemic. Secondly, we want to examine how the harm from measures intended to protect this age group could be reduced by appropriate additional measures. And thirdly, we develop suggestions how a specific type of harm resulting from age-discrimination during the pandemic can be addressed. This type of harm occurs when public-health measures are presented as if mainly older adults were at risk from severe cases of COVID-19, and therefore these measures would be primarily beneficial to these age groups. Not only does this perspective create a false sense of security from the disease among younger age groups, but it has also the potential to foster intergenerational conflicts. Moreover, it can also exacerbate stereotypes of older adults and ageism (Meisner 2020).

Direct harm includes long- and short-term consequences of the disease, such as mortality, chronic illness, and side effects from treatment such as damage from invasive artificial ventilation. As long as no effective curative treatment or prevention of COVID-19 existed or was generally available, protective gear such as masks and behavioral measures such as social distancing and quarantine were the only means to prevent the spread of infection. Therefore, in such situations, it was of crucial importance to provide those who are in contact with high-risk groups and people in these groups with protective equipment and to organize rapid testing for an early isolation of infected patients. In particular, this was of paramount necessity in long-term care institutions, where the infection can spread rapidly. Shortcomings in this respect have led to a large number of preventable deaths in nursing homes across many countries (Gosch, Heppner, Lim, & Singler, 2021; Szczerbińska, 2020; Wolf-Ostermann et al., 2020). The vaccination campaigns of recently approved vaccines have changed the situation. They provide effective ways to prevent at least severe cases of COVID-19. At the same time, they bring about their own challenges, e.g., regarding equitable access of all older adults. This is the case, for instance, if booking vaccination appointments depends on specific social support, technological requirements, or means of transportation which may not be accessible for some older adults (Whiteman et al. 2021).

Indirect harm from the COVID-19 pandemic results firstly from the side-effects of measures such as social distancing and quarantine. Limitations of individual freedom and negative effects on well-being

and physical as well as mental health are of particular significance. Specific measures for high-risk groups should avoid simple paternalistic restrictions and leave as much space as possible for the individual judgement of the person affected. According to previous research, social isolation has been found to result in adverse consequences such as increased mortality, depression, obesity, and risk for viral infection (Courtin and Knapp 2017). In order to mitigate such negative effects, support should be provided in different forms, such as neighborhood networks helping with everyday provisions and assistance with digital technologies in nursing homes, to allow for some form of social contact despite isolation. Secondly, indirect harm results from negative stereotypes of old age, ageism, and the discrimination of older adults. This includes expressions of disregard for the lives of older people in the debates on political measures and degrading comments about older adults in social media. Disrespect and ageism can not only lead to discrimination in medical care and other services, but also have negative effects on physical, psychological, and cognitive health (Ayalon et al., 2020; Gosch et al., 2021; Levy, Slade, Chang, Kanno, & Wang, 2020; Wurm, Diehl, Kornadt, Westerhof, & Wahl, 2017). Such attitudes must be avoided and countered by politicians, the media, and platform providers. In short, discrimination on the basis of chronological age must be prevented.

Recommendations

- Pay specific attention to and monitor care for older patients and, in that context, nursing homes especially require specific attention and should be monitored

In many countries, the residents of nursing homes are among those with the highest mortality (Gosch et al., 2021; Wolf-Ostermann et al., 2020). Staff often is underequipped with protective gear and masks. Thus, caretakers have been overwhelmed by the developments during the pandemic. In some extreme cases, nursing home residents have been abandoned by their caretakers and left to their fate. This points to the necessity of close controls and the monitoring of nursing homes in this situation, and to the necessity of overall improvements regarding staff and equipment beyond the pandemic. At the same time, the home-care setting and the role of outpatient-care services in the pandemic should not be neglected, especially since home-care still represents the prevalent type of nursing in many countries.

- minimize negative effects of specific protections

One suggested strategy has been to isolate those who belong to a risk group. From the beginning of the pandemic, epidemiological projections have pointed to the ineffectiveness of such a strategy (Omer, Yildirim, & Forman, 2020). Those who belong to high-risk groups are too numerous, and once the spread of the disease is unchecked, it will also spread to those seemingly protected since perfect isolation (including caretakers etc.) is impossible (Gesellschaft für Virologie, 2020). In this context, it is also important to emphasize that not all older individuals have a particularly high risk and not all high-risk groups are constituted by older adults (Rahman and Jahan 2020). Social isolation of the vulnerable also has severe effects on the mental and physical health of those in already difficult situations (Benzinger et al. 2021). This not only applies to residents of nursing homes, but also to older adults living independently at home. For these groups, social services should be organized, such as neighborhood help and remote psychological counselling.

- organize the distribution of vaccines to allow for equitable access

The development of effective vaccines rightly came with a lot of hope, in particular for the older population. While many national vaccination programs prioritize people of an older age, such campaigns also come with the risk of additional ageism that demands counteraction. For example, the digital procedure for the vaccination appointment may be inaccessible for a large number of the very old. The locations may also be difficult to access since a low-threshold support for transportation seems to be the exception in many communities, concurrent with avoidance of public transport. There is also a lack of transparency regarding the handling of vaccination for those in a terminal life-stage. This is also the case for severely cognitively impaired persons including the involvement of a legal proxy in the required decision-making process (see also Hunger et al. 2021).

- promote digitalization

During the pandemic, social media and video calls have gained importance to ameliorate the consequences of social isolation and to allow for communication and exchange when personal encounters are no longer possible or advisable. It is therefore important to provide these technologies to those who will benefit most from them and to support nursing homes in building the necessary infrastructure and digital competence. This could also mean supporting staff and health care workers in fulfilling their tasks (Huter et al., 2020).

- avoid paternalism

One ageist stereotype equates old age with a second childhood (Covey 1992). Based on such views and attitudes, some decision-makers may find stricter guidance for older adults appropriate and enforce rigid directives for their own good. However, even well-meaning paternalism vis-a-vis older adults is inappropriate. They have the right to be informed about their respective risks and to decide for themselves what risks to take, for instance, in order to meet relatives and other social contacts according to the same restrictions which apply to everybody.

- promote self-determination including advance directives and advance-care planning

Only a small proportion of all adults, older adults, or the residents in European long-term-care-facilities have formulated advance directives or participated in advance-care planning (Andreasen et al., 2019). In a health crisis such as the current COVID-19 pandemic that involves an increase of critical and terminal illness, these documents are of crucial importance to avoid unwanted intensive care, e.g. artificial ventilation. General practitioners and legal representatives should be ready to discuss patient wishes in order to safeguard autonomy in situations when it might no longer be possible to obtain someone's actual will. At the same time, however, there must be no pressure to draft such documents or to forego care in the case of resource scarcity.

- prevent age-discrimination in medical care, in particular in the allocation of medical resources

Some recommendations for the prioritization of scarce healthcare resources suggest chronological age as a criterion for access to intensive care measures like artificial ventilation. According to several reports, more or less explicit age-rationing indeed took place during the first wave of the pandemic when hospitals were overwhelmed by the number of patients arriving in a short period of time, for instance, in certain regions of France or in Italy (Craxi, Vergano, Savulescu, & Wilkinson, 2020; D'Cruz & Banerjee, 2020). However, older adults are a highly heterogeneous group and chronological age alone is far from being a valid predictor for future health status or for the success of medical measures for a particular patient (Lowsky, Olshansky, Bhattacharya, & Goldman, 2014). Therefore, stereotypical notions of old age appear particularly problematic when it comes to the prioritization of access to potentially lifesaving medical treatment (Farrell et al., 2020).

- counter ageism and negative stereotypes of old age



Negative stereotypes and statements about the value of lives of older adults have proliferated in the comments of politicians and in social media (Soto-Perez-de-Celis 2020). Some politicians have claimed that protecting the lives of older adults is not worth the social and economic costs. Instead, older adults were meant to either just isolate themselves and get out of the way or accept dying. Some politicians even commended such deaths (Meisner, 2020). Such statements are an expression of ageism that degrades older people and has negative effects on the psychological and physical health of those concerned. Fortunately, these statements have provoked strong societal opposition. It is important to note that ageism can take different forms in the context of the pandemic, from degrading stereotypes to a well-meaning but paternalistic “compassionate ageism” (Vervaecke & Meisner, 2020). There is a general duty to expose and counteract any form of age stereotypes, ageism, and the resulting age discrimination.

- promote intergenerational solidarity

Appeals for intergenerational solidarity have surged amidst the COVID-19 pandemic. Indeed, the crisis underlines the relevance of mutual appreciation and support between members of younger and older generations. However, maintaining and intensifying such solidarity is a formidable challenge during the pandemic. This also becomes apparent in the initiated vaccination processes and the accompanying priority-setting due to shortages of the vaccine and fraught logistics. An important means to strengthen intergenerational solidarity may be the stimulation of dialogue and public deliberation between young and old in which conflicts can be addressed and mutual stereotypes be dispelled. In addition, statements by ethics boards and policy recommendations play a major role for the development of solidarity in the pandemic. At the same time, it is important to recognize the normative limits of appeals to intergenerational solidarity. Thus, supporting and protecting older people during a serious public-health crisis is ultimately not just a matter of solidarity but rather of fundamental moral and legal principles such as basic human rights or demands for social justice. (Ellerich-Groppe, Pfaller, & Schweda 2021)

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