Societal views of older adults as vulnerable and a burden to society during the COVID-19 outbreak: Results from an Israeli nationally representative sample

Ella Cohn-Schwartz, PhD[1] and Liat Ayalon, PhD[2]

[1] Department of Public Health, Faculty of Health Sciences, Ben-Gurion University of the Negev, Be'er Sheva, Israel.

[2] Louis and Gabi Weisfeld School of Social Work, Bar Ilan University, Ramat Gan, Israel.

*Corresponding author: Ella Cohn-Schwartz

Department of Public Health, Faculty of Health Sciences, Ben-Gurion University of the Negev, Be'er Sheva, 84105, Israel. Email: ellasch@bgu.ac.il

Funding

Conflict of Interest

None reported.

Abstract

Objectives: To examine the factors associated with older adults' perceptions of ageism in society during the COVID-19 outbreak, in particular the portrayal of older people as a burden and as vulnerable.

Methods: Data are based on a nationally-representative survey of adults aged 50+ in Israel, conducted during the COVID-19 outbreak (*N*=888). Regression models predicted perceptions of societal ageism. The independent variables were dying anxiety, experiences of age-based discriminations and social resources.

Results: Participants who believed older adults were perceived as a burden during the COVID-19 outbreak had higher dying anxiety and reported more age-based discrimination. Living with children and contact with family were protective against perceptions of adults as a burden. Participants who believed older adults were perceived as vulnerable had higher dying anxiety and were less likely to live with children.

Discussion: The daily lives of older adults can impact their perceptions of societal ageism during the COVID-19 outbreak.

In 2016, the World Health Organization has embarked on a global campaign to combat ageism with the goal of changing the way we think, feel and act towards people because of their age (Officer & de la Fuente-Núñez, 2018). Four years later, due to the COVID-19 outbreak, ageism became ever more prominent in the global discourse (Ayalon et al., 2020; Ayalon, 2020). Specifically, two main narratives have become prominent. The first is the "vulnerability narrative." As older adults are at a higher risk for COVID-19 severe illness and mortality, current discourse has portrayed them as a highly homogenous and vulnerable group. The "burden narrative" has flourished as a result of an overwhelmed healthcare system that cannot provide adequate care to all (Ayalon et al., 2020; Ayalon, 2020). As a result, in some countries, an age limit for intensive care treatment or a ventilator machine was established (Truog et al., 2020) . This practice highlights the notion of older adults as a burden to society.

This study aims to examine how the narratives of "vulnerability" and the "burden" of older adults are perceived in the context of the COVID-19 outbreak by adults in mid to later life. In doing so, we evaluate dying anxiety, experiences of ageism, intergenerational and social contact as potential predictors. Specifically, according to the terror management theory, one explanation for ageism stems from people's fear of death and dying (Martens et al., 2005). As older adults remind us of our own mortality, we attempt to distance ourselves from them and might hold more ageist attitudes towards older people to protect ourselves from the discomfort involving frailty and sickness associated with older age (Lev et al., 2018). Hence, we expect that individuals with higher dying anxiety might also believe others are distancing themselves from older adults.

The perceived experience of age discrimination might also contribute to people's perceptions of societal ageism. Past research has shown that those individuals who reported exposure to age discrimination also reported worse self-perceptions of aging (Han & Richardson, 2015). Possibly, the experience of discrimination serves as a priming effect to ageist attitudes and might make adults more sensitive to ageist attitudes in other contexts. Hence, we expect age discrimination to be associated with higher perceived ageism.

In contrast, social contact is expected to be associated with lower perceived ageism. A recent review found intergenerational contact to be highly effective in reducing people's ageist attitudes (Burnes et al., 2019). Specifically, individuals with more intergenerational contact are more likely to report non-ageist views that portray older and younger people as belonging to the same community. On the other hand, the division between young and old people in society is thought to promote ageist attitudes and animosity between the generations (Hagestad & Uhlenberg, 2005). Social contact with friends and family might also have an ageism-reducing effect (Santini et al., 2017; Schwartz et al., 2020) and lead older adults to perceive society in general as less ageist.

This study is important as it highlights societal perceptions of older adults during the COVID-19 outbreak. Moreover, it attempts to identify potential predictors of these perceptions in order to potentially intervene and change the experiences of older adults.

Methods

Participants and procedure

Data are based on a nationally representative survey of adults aged 50 and above in Israel. Surveys were conducted in Hebrew via the telephone. Data were collected between March 29 – May 3 2020, a period in which Israel employed partial lockdown due to the COVID-19 outbreak (Ministry of Health, 2020a, 2020b). The sample was composed of 1,092 people.

The sample for the current study consisted of adults who had full information on all the study variables. Thus, it consisted of 888 participants. Selectivity analysis showed that participants who did not have full information were older, had less years of education, were less likely to live with children and less likely to experience discrimination. They did not differ in terms of perceptions of bias against older people, gender, health, dying anxiety and social contacts.

Measures

Perceptions of societal ageism. Perceptions of ageism during the Corona times were measured using two questions. Participants were asked to rate to what extent they thought that people aged 60+ were perceived as a burden or as vulnerable by society following the coronavirus pandemic. Responses were rated on a scale from 0 ("not at all") to 10 ("to a great extent"). The 60+ age was chosen because it represents a high-risk group for serious illness and death of COVID-19 (Li et al., 2020; Zhang et al., 2020).

Social-demographics. Background information was gathered using age, gender and years of education. Years of education were a continuous variable. We recoded scores higher than 30 to missing. Participants were also asked to define the state of their health, with responses ranging from 1 ("bad") to 5 ("excellent "). Chronic illnesses were a count of six illnesses: diabetes, high blood pressure, heart problems, high cholesterol levels, arthritis and cancer.

Dying anxiety. The dying anxiety subscale of the death anxiety scale includes six items (e.g., "I'm afraid of the suffering that is related to dying") (Carmel & Mutran, 1997). Responses ranged from 1 ("strongly disagree") to 5 ("strongly agree"), Cronbach's alpha = 0.89.

Age-based discrimination in healthcare. We measured experiences of discrimination in the healthcare system (i.e. during visits to doctors, HMOs or hospitals). Respondents were asked how often they had four discriminatory experiences in the healthcare system because of their age in a year (e.g. "being treated with less respect because of your age"). These options were based on the leave-behind questionnaire of the Health and Retirement Survey (Willis et al., 2006). We calculated a dummy variable that was 1 if participants reported having any such experience.

Social resources. We asked participants with whom they lived. Responses were divided into: living alone; living with a partner; with children; with a partner and children; with someone else. We also inquired about the frequency of non-face-to-face contact with non-cohabiting family members and with friends since the outbreak of COVID-19. Responses ranged from 1 ("never") to 8 ("several times a day ").

Data analysis

We began out analyses with descriptive data of the study sample. We then conducted bivariate analyses of the study variables with the two dependent variables. The main stage of analysis was regression models that predicted the dependent variables using the independent study variables.

Results

Table 1 shows the sample characteristics of the study. Participants reported relatively high dying anxiety and almost a quarter experienced discrimination due to their age in the healthcare system. More than half lived with a partner and they maintained frequent contact with family and friends during the outbreak. Participants were less likely to agree that people aged 60+ are perceived as a burden by society during the outbreak, while they were significantly more likely to agree that those aged 60+ are perceived as vulnerable (t = -29.47, $p < .001$).

Table 1 also shows bivariate associations with the outcome variables. Individuals who thought that older adults are perceived as a burden were also older, had worse health, reported higher dying anxiety, experienced age-based discrimination in healthcare, were less likely to live with children and had less contact with their family and friends. Those who

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thought older adults were perceived as vulnerable were more likely to be women, tended to rate their health as worse, reported higher dying anxiety and experienced age-based discrimination in healthcare.

The main stage of analysis was regressing perceived societal ageism on the independent study variables (Table 2). The first regression model predicted perceptions of adults as a burden. Older participants were more likely to think that adults are perceived as a burden. Additional associations were seen with dying anxiety and with experiences of age-based discrimination in healthcare, while lower perceptions of adults as a burden were associated with living with children and contact with non-cohabiting family members. The next model in Table 2 predicted societal perceptions of adults as vulnerable. Associations emerged with being a woman and with dying anxiety, while those who lived with children were less likely to think older adults are perceived as vulnerable.

While the ageism measures ask about perspective on adults age 60+, the sample included adults age 50+. This study design allows for comparison of study results among those both under and over the age of 60. To examine these differences, we performed additional analyses (not shown) in which age was dichotomized into two groups (50-59 and 60+). The main effect of age remained similar when using age as dichotomous (i.e. a significant association with perceptions of older adults as a burden). We also examined an interaction of the main study variables with the dichotomous age variable. The only significant interaction was of discrimination in relation to perceptions of adults as vulnerable – only respondents aged 60+ who experienced discrimination thought adults were perceived as vulnerable, while no such association was seen among those aged 50-59.

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Discussion

The current study set out to examine older adults' perceptions of societal ageism during the COVID-19 outbreak. It examined two aspects of societal perceptions - older adults as a burden and as vulnerable. Ageist stereotypes can become internalized and become a "self-fulfilling prophecy" (Wurm et al., 2013), thus it is necessary to understand how adults think society views older people. The findings indicate that adults are less likely to believe society sees older adults as a burden and more likely to believe they are seen as vulnerable. These perceptions are influenced by their daily lives and personal characteristics.

Risk factors for perceived societal ageism were higher dying anxiety and age-based discrimination in healthcare. In accordance with the terror management theory (Martens et al., 2005), fear of dying can further make adults feel alienated from society. Additionally, encountering ageism in healthcare settings might provide adults with evidence that such ageist perceptions are prevalent in society in the times of the COVID-19 pandemic, particularly if these adults are aged 60+. Social resources emerged as protective, in particular, living with children and maintaining contact with family members during the COVID-19 outbreak. Intergenerational contact with children and social contact with family members could serve as evidence that adults are not negatively perceived by others. Contact with children could be especially important in this regard, due to the relevance of intergenerational contact to reducing ageist attitudes in society (Burnes et al., 2019).

This study has several strengths, especially its large representative sample collected at the height of the COVID-19 pandemic in Israel. We note a possible limitation concerning the items about societal ageist biases. While we interpret them as representing the perceptions that older adults have of society, they might also assess these adults' own ageist attitudes.

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That is, the way people perceive societal views might partially reflect their own views. Additionally, we note that in Israel triage was not based on chronological age. Thus, findings might be different in countries such as Italy that had chronological age as a criterion for triage (Truog et al., 2020).

To sum, the current investigation showed that during the COVID-19 pandemic, older adults perceived society as more ageist if they encountered ageism and feared dying, while maintaining intergenerational and familial contacts protected them from such perceptions. These findings indicate that the way older adults perceive societal ageism is related to their own interpersonal experiences. They provide impetus to improve the daily experiences of older adults and reduce their fear of dying, especially in the current times of the COVID-19 pandemic. Policy stakeholders should be aware of the prominent role that perceptions of vulnerability and burden have in the lives of middle aged and older adults during the current pandemic. As such, the entire discourse concerning COVID-19 should be modified to ensure that it does not spread ageist perceptions (Brooke & Jackson, 2020; Levy, 2003). Further efforts should aim to enhance intergenerational contact (while protecting older adults from COVID-19 infections) due to the beneficial psychological effects of such contacts to intergenerational solidarity and cohesion.

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Table 1. Sample characteristics of the study and bivariate analyses

Variable	Mean (SD)	%	Range	Bivariate analyses	
				Older people burden	Older people vulnerable
Older people burden	4.01 (3.45)		0 - 10		
Older people vulnerable	7.44 (2.46)		0 - 10	r = 0.35***	
Age	63.24 (9.07)		50 - 91	r = 0.28***	r = 0.06
Gender: women		48.2%		t = -1.57	t = -3.69***
Education (years)	14.94 (2.93)		0 - 30	r = -0.05	r = -0.05
Self-rated health	3.15 (1.04)		1 - 5	r = -0.16***	r = -0.09**
Chronic illnesses	1.08 (1.18)		0 - 6	r = 0.16***	r = 0.03
Dying anxiety	4.11 (1.00)		1 - 5	r = 0.18***	r = 0.24***
Discrimination in healthcare		23.65%		t = -7.72***	t = -2.52*
Live alone		16.44%		F = 7.55***	F = 2.24
Live with: partner		57.66%			
Live with: children		7.77%			
Live with: partner and children		16.22%			
Live with: Other		1.91%			
Contact with family in corona	6.99 (1.35)		1 - 8	r = -0.11**	r = -0.03
Contact with friends in corona	6.21 (1.70)		1 - 8	r = -0.10**	r = -0.02

Note: * $p < .05$, ** $p < .01$, *** $p < .001$; In the bivariate associations, Pearson correlations measured the associations with continuous variables, t-tests measured them for dichotomous variables and ANOVAs for categorical variables.

Table 2. Hierarchical linear regression models predicting perceptions of burden and
vulnerability of older adults in society during corona times

Variable	Older people burden			Older people vulnerable		
	Coefficient	SE	B	Coefficient	SE	B
Age	1.71	0.24	0.24 ***	-0.04	0.18	-0.01
Gender: women	0.39	0.22	0.06	0.41	0.17	0.08 *
Education (years)	-0.04	0.04	-0.04	-0.02	0.03	-0.02
Self-rated health	-0.01	0.12	0.00	-0.08	0.09	-0.03
Chronic illnesses	0.12	0.10	0.04	-0.02	0.08	-0.01
Dying anxiety	0.53	0.11	0.15 ***	0.53	0.08	0.22 ***
Discrimination in healthcare	1.76	0.26	0.22 ***	0.34	0.20	0.06
Live with: partner[1]	0.28	0.30	0.04	-0.24	0.23	-0.05
Live with: children[1]	-1.09	0.47	-0.08 *	-0.96	0.36	-0.10 **
Live with: partner and children[1]	-0.46	0.39	-0.05	-0.57	0.30	-0.09
Live with: Other[1]	0.22	0.81	0.01	-0.11	0.62	-0.01
Contact with family in corona	-0.23	0.08	-0.09 **	-0.04	0.06	-0.02
Contact with friends in corona	-0.12	0.07	-0.06	-0.03	0.05	-0.02
R^2			0.20			0.08

Note: * $p < .05$, ** $p < .01$, *** $p < .001$; [1] Reference: living alone.