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OPINION PIECE OF INTERNATIONAL INTEREST

Lethal ageism in the shadow of pandemic response tactics

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Abstract

Aim: This paper examines aspects of pandemic policy responses to the COVID-19 and SARS-CoV-2 variants and presents an integrated view of the consequences of response tactics at national and health service levels for older adults.

Background: Nurses are positioned at the intersection of health service and policy implementation; therefore, their influence on clinical protocols and health policy directions post pandemic is crucial to preventing further premature deaths in the 65+ years age group and others.

Sources of evidence: Perspectives presented here are based on a critical evaluation of the many published reports, comments, research and insights concerning the pandemic. That evidence, combined with my experience in various fields of study and professional service, enables me to envisage what some decisions and policies may mean for older people, nurses and societies worldwide.

Discussion: Established information on world population patterns and the location and health of national groups has been made less reliable by population shifts caused by years of geo-political conflicts and now the impact of the pandemic. Added to this already chaotic context, the pandemic has further disrupted societies, health services and economies. Ageist responses by these systems have further disadvantaged older people and generated trust deficits that need to be resolved.

Conclusion: When the pandemic recedes, policy and management decisions taken by governments and hospital administrators will be a telling indicator of whether the established systematic ageism exposed during the pandemic will continue to compromise the health and longevity of older adults.

Implications for nursing, health and social policy: The ascendency of nursing influence within the health and social policy environment must be further strengthened to enable nurses to champion equity and fairness in the pandemic recovery effort.

KEYWORDS
ageism, COVID-19, caremongering, nursing, nursing policy and health policy, pandemic, SARS-CoV-2 variants, senicide, service rationing

BACKGROUND

In 2019, one in 11 of the world's people were aged 65+ years, and this ratio was predicted to increase to one in six by 2050 (United Nations, 2019). At that time, most countries had been experiencing longevity increases because of well-integrated social and health policy frameworks. However, population shifts caused by years of geo-political conflicts forcing refugees to flee their homelands have undermined the reliability of population numbers and projections and even the accuracy of census profiles in many parts of the world (Foreign Policy Insider, 2021). Wars, famine and persecution of groups and races have challenged the capacity of most nations to accurately track population movements; and now, a lethal pandemic is sweeping across our world bringing more havoc.

The catastrophic and widespread disruption to existing systems caused by the coronavirus disease 2019 (COVID-19) outbreak in 2019 and the subsequent spread of the more contagious variants of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) now renders redundant, all previous population calculations, predictions and related policies except as a baseline for future comparison. The way forward in returning global health to a known and manageable status continues to be compromised by unreliable information on

pandemic response strategies and untrustworthy reporting of cases and patient outcomes (Ioannidis, 2020; Reis et al., 2020)

SOURCES OF EVIDENCE

The pandemic has affected all aspects of life and activity worldwide, and researchers, writers and commentators from every discipline and interest group have produced a growing collection of insights and evidence on what has happened, and what may still occur. It is important for us, as consumers of this information, to critically evaluate these eclectic commentary to gauge the value of what is being presented and come to an informed view about what is happening. The perspectives that follow are the result of this critique informed by many years of experience in various fields of study and professional service.

DISCUSSION

Multi-national political tactics around the accuracy of reporting continue to conceal the actual number of older adults, and others, who died due to COVID-19 and SARS-CoV-2 variants (Ioannidis, 2020). As of 20 June 2021, the total number of reported cases was 178,117,465 and the reported death toll was 3,875,660 worldwide (COVID Worldwide, 2021), but the real number is likely to be much higher (WHO, 2021). Many governments lack the systematic capacity to observe and report accurately in a crisis (Capano et al., 2020). But in too many societies, the low value placed on this cohort means that the consequences of tactical under-reporting are unlikely to be investigated or debunked. We know that people aged 70+ years and those with health and other problems are in high-risk groups with 80% of reported pandemic-related deaths occurring in that age group (Onder et al., 2020). The destructive role of misinformation campaigns in trivialising risk perceptions and undermining public commitment to protective health behaviours warrants forensic attention (de Bruin & Bennett, 2020), but without internet transparency and with 'freedom of speech' able to be used as a justification, it is doubtful that such people will be investigated despite the deaths linked to misinformation.

Other factors contributing to the concealment of actual numbers of older adult deaths during this pandemic include the parlous state of public health systems and societies that have been overwhelmed with the tragic loss of lives and social upheaval (United National Development Program, 2021). Economies have also been decimated and even more stable nations have been weakened and are behaving like fragile states. In some countries, health systems have completely collapsed (WHO, 2020).

A general lack of national preparedness before 2020 protected long-term weaknesses in social policies and emergency response strategies in most countries. In these, and even in more established societies, the political desire to conceal the extent of their failure to act effectively, encourages a continuing lack of formal and transparent reporting of what is happening (Lau et al., 2021). Anecdotal evidence among nurses suggests that pandemic reporting in many countries is politicised with 'cause of death' being attributed, wherever possible, to co-morbidities rather than COVID-19 infection.

The internet is glutted with dire accounts from people in every country telling of failures of legal and social systems, coroner's cases not investigated, people dying alone at home or in the streets and alleyways, bodies left on the steps of hospitals, people in aged care facilities abandoned, funeral services being inundated with unidentified corpses and having to be buried in mass graves and so forth.

Political tactics to improve the public appearance of what is occurring, especially among older people, has included not counting COVID-19 cases as the cause of death if they occurred 30 days after diagnosis or not counting cases of COVID-19 related deaths occurring in aged care facilities; or not including cases of anyone dying unexpectedly at home; and other covert manoeuvres to reduce their reportable number of pandemic-related deaths. Other countries have simply stopped reporting deaths since those occurring during the initial outbreak of COVID-19. Ongoing concealment of the magnitude of deaths since January 2020 will be difficult to sustain when the surviving national and world populations are eventually tallied, population pyramids are recharted, and national longevity profiles recalculated.

Widespread mismanagement of the pandemic by many national leaders and governments is well documented and instructive in terms of the apparent social acceptance of a high, premature mortality rate for older citizens (Fraser et al., 2020) and the productive years lost around the world (Bendix, 2021).

Calls by politicians and industrialists for borders to reopen and lockdown and quarantine to end before effective vaccination is achieved seem to confirm their wholesale desertion of older and disadvantaged people at most risk. The ancient concept of 'senicide' has been revived to explain some of these responses. This practice concerns the neglect of older people in a crisis, thereby exposing them to mortal risk, and can be applied it to COVID-19 responses (Haines, 2021). Others have analysed published opinions to gauge public sentiment about lethal risks to older people (Xiang et al., 2021) concluding that modern senicide is being facilitated using the pandemic. Ferguson also characterised coronavirus mismanagement that targets older people as senicide (Ferguson, 2021). A moderate view drawn from this polemic is that ageist policies that treat premature deaths of older people as acceptable losses need to be exposed and challenged.

Social responses to the pandemic

The United Nations has been monitoring world demographic patterns but decries the use of age alone to describe population ageing. Mediating factors of health care, culture and tradition, education, political stability and national capacity to provide essential services, enable nations to respond effectively to crises and threats (United Nations, 2019). Unfortunately, some researchers regard population ageing as a problem. Rudnicka

et al. describe ageing as 'the most important medical and social demographic problem worldwide' (Rudnicka et al., 2020, p1). The framing of longevity as a problem negatively positions the remarkable work of the scientists, governments, professionals and societies who develop and preserve opportunities for their people to live long, healthy lives. Ageist problematising promotes discriminatory attitudes within societies, governments, service organizations and public institutions such as health care. Many of these biases remain covert until they are exposed in times of national crisis.

Normalised ageism has long been an influential undercurrent in most societies (Bratt et al., 2018) and has resisted the global movement to end age discrimination and create a society for all ages. Interest in monitoring and measuring the prevalence of ageism and its effects on societies has been growing, and Wilson et al. (2019) recommend that validated scales and formal reporting be used to generate reliable evidence of ageism. Entrenched discrimination based on age is so commonplace that it is rarely challenged although it is perceived differently by different age groups (Garstka et al., 2004) and can impact how older adults fare in their societies (Monahan et al., 2020). For instance, if we are to achieve equitable intergenerational solidarity, intergenerational competition for resources and influence on policy direction (Ayalon et al., 2020) warrants scrutiny for unintended ageism.

Caremongering, a counter-movement to the abandonment of older people, has emerged during the current pandemic, involving compassionate ageism among younger groups using social media networks. Vervaecke and Meisner investigated the spread of caremongering in response to aggressive ageism and also identified critical ageist nuances in policies and services (Vervaecke & Meisner, 2021). Whether this groundswell of positive and benevolent ageism can reduce the long-term damage being caused by global pessimism towards older people or not remains to be seen. Close monitoring for any unintended consequences of caremongering is also advised to discourage further stereotyping of older people through paternalism, sentimentalism and assumptions of dependency and frailty.

The perennial tensions between older and younger population cohorts have been exacerbated by the pandemic resulting in the alienation and/or marginalization of people aged 65+ years (Meisner, 2020) and dismissal of their many sacrifices in response to the COVID-19 pandemic (Barrett et al., 2021; Kornadt et al., 2021). Throughout 2020, the overt trivialisation of risks to older people by young and middle-aged adult population groups catapulted global ageism into sharp relief and in ways that will not easily be forgotten by the many who witnessed it (Cohn-Schwartz & Ayalon, 2020). Social values and community cohesion were redefined by that behaviour and substantial effort will be required to reverse the current damning perception of those groups (Fraser et al., 2020). Nurses, as frontline defenders of public health and equity, need to get involved in endorsing social norms that will be acceptable going forward (Lewis et al., 2020).

Health system responses to the pandemic

All public hospitals have had to respond to drastic changes in patient caseloads and risk management by trying to control demand and shape public expectations around quarantine, vaccination, personal hygiene and treatment availability. The health of nurses and other clinicians, often denied adequate equipment or protection, was jeopardised through poor management judgement. Many clinicians were infected and unable to continue practice. As the consequences of rapidly spreading infection increased pressure on administrators of hospitals and health care systems, decisions around limiting older patients' access to hospitals emerged. Administrative rationing of access to care and treatment (Farrell et al., 2020) and the shunting of older patients between services often depended on how those facilities or practitioners were funded (Cesari & Proietti, 2020). The priority, it seemed, was to make beds available to younger patients or to prevent older people from blocking access by younger people who may need these resources if pandemic infections surged (Chang et al., 2020).

Local hospital administrative policies for rationing of services, bestowing access to some people and not others, may have started as local crisis responses rather than any compliance with government policy or regulation. Some hospitals in Italy and Spain have contingency planning for rationing access to intensive care units, using age, frailty or co-morbidities as criteria for exclusion (Falcó-Pegueroles et al., 2021). The ethical quandaries and moral distress accompanying such decisions and their deadly outcomes add to the stress of health professionals providing services in an environment of scarcity. The use of age alone to determine access to services is not recommended. Montero-Odasso et al. investigated the dangers of using age as a sole determinant and found it to be an insufficient basis for decisions on resource allocation (such as access to intensive care units or ventilators) during the pandemic or in any clinical circumstance (Montero-Odasso et al., 2020). They recommend the use of a clinical frailty assessment of status before being infected as a better determinant than chronological age because healthy older patients are more likely to recover with treatment than others of the same age with multiple chronic conditions. Where an ageist lens is used to decide on service provision for older patients, abuses such as lethal neglect are enabled to occur with impunity (Band-Winterstein, 2015).

Emerging evidence of ageism influencing health service and care priorities during the pandemic is concerning, although unsurprising given the history of normalised ageism in most societies. Ageism directly affects the cost of care through the prolongation of health conditions (Ouchida & Lachs, 2015) and magnifies treatment costs and the prevalence of morbidity (Levy et al., 2020). Research by Lichtenstein reveals that some countries regard older patients as 'coffin dodgers' and have developed 'boomer remover' policies around coronavirus management (Lichtenstein, 2021). The strategy of negative positioning based on some personal characteristic is well-known by those already socially disadvantaged. During

the pandemic, the effects of cumulative disadvantage have multiplied for all who are more vulnerable to infection, social isolation or hardship (Xafis, 2020).

The emergence of trust deficits

The coronavirus pandemic continues to devastate communities and economies, and the sequelae of the COVID-19 and variants will shape future policies and regulations. Through media coverage and personal experience during 2020–2021, people in every country are well aware of governments, health services and employers, who have endorsed tactics, policies and narratives that shift survival risks back onto individuals and families. Consequently, public confidence in those in leadership positions has declined, invalidating the social contract that supports national taxation and wealth redistribution systems essential to providing social institutions. Predictably, widespread caution about trusting global efforts to vaccinate against the SARS-CoV-2 variants is causing what authorities call 'vaccine hesitancy'. The uncertainty about vaccination felt among older, marginalised people who no longer trust governments or health systems to act in their best interests (Zhou et al., 2019) may well be fatal and increase virus mutation.

Trust deficits are difficult to reverse once they are established. Any remedial process will involve revision of mutual expectations between citizens and governments, between patients and health services, and employers and employees as well as between disadvantaged groups including older people, and those who ignored the safety of others and continued to spread the coronavirus (Chang et al., 2020).

At the time of writing this article, the world has had 18 months to learn about this coronavirus and take steps to contain and defeat it. We now know that each transmission of the coronavirus, even by those who experienced only mild symptoms, provides opportunities for the coronavirus to mutate and, out of the millions of mutations, some of the SARS-CoV-2 variants are more deadly, more contagious and possibly more resistant to vaccines.

Nurses and their professional colleagues know that this pandemic is far from over and that it will require more than a frontline effort if further lethal mutations are to be avoided. The national trivialisation of the dangers of contagion, or dismissal of risks to any population or racial groups, will only extend the pandemic and promote further social dissension. We have reached the moment where we have to trust that everyone will do what is necessary to curb the spread, and therefore the constant mutation, of the coronavirus. If mutual trust cannot be relied upon then contagion will continue to devastate our world and compromise future options.

Nurses are widely regarded as trustworthy agents of the health system and are, with other clinicians, the de facto implementers of health and social policies. As such, we are well placed to lead people out of this terrible situation as well as helping to contain the coronavirus and relieve the misery it causes. The trust of our colleagues, communities and societies, requires us to accept responsibility for patient advocacy, veracity in reporting and fidelity to our professional code of ethics (International Council of Nurses, 2015) and the nursing principles of autonomy, beneficence, justice and non-maleficence. Nurses are central to the pandemic response and have the capacity to lead strategy and innovation across all care contexts. The time has come for nurses to step forward and hold the lamp high so that others may see a path to safety.

CONCLUSION

When the pandemic recedes, policy and management decisions taken by governments and hospital administrators will be a telling indicator of whether the established systematic ageism exposed during the pandemic will continue to compromise the health and longevity of older adults. The behaviours of people responding to the effects of the pandemic have redefined societies, cultures and countries, their relationships with each other and the world. Nurses, as a group of professionals who, along with their colleagues, continue to make a courageous stand against the coronavirus, have been acknowledged worldwide as frontline defenders of public health and equity in an environment where older adults' human rights are being dismissed. The ascendency of nurses in health policy arenas needs to be strengthened to enable nursing voices to contribute to the recovery of suffering communities and individuals in ways that respect the rights of people of all ages.

IMPLICATIONS FOR NURSING, HEALTH AND SOCIAL POLICY

Nurses are positioned at the intersection of service and policy implementation and their influence on policy directions post-pandemic are crucial to preventing further spread of the coronavirus and premature deaths in late age. The research and narratives of nurses during the pandemic can inform policy development and influence service administration if given the opportunity. Nurses who are in positions to contribute to policy debates and service re-design depend on the support of all colleagues to ensure that policy revision outcomes reflect our nursing ethos and benefit those under our care.

CONFLICT OF INTEREST

The author declares there is no conflict of interest.

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