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Institutional ageism and the pandemic

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A previous article in this series, by Alisoun Milne, demonstrated forcefully how the government's responses to the COVID-19 pandemic have scandalously exposed to grave risks care home residents and staff (Milne, 2020). That this was a conscious act of government policy, leading to thousands of unnecessary deaths, reveals, among other things, how deeply rooted ageism is in British society. Ageism also underpinned the long term neglect of residential and nursing homes, the vast majority of residents of whom are frail older people, and the cuts that were forced on them by austerity policies. This is not to argue that ageism is the only factor behind the government's mishandling of the pandemic. A fuller account would include underfunding and the long term privatisation of the NHS, the neoliberal prioritisation of private contractors over public bodies, the finance-led reorganisation of the national virus testing service, as well as sheer incompetence and a wilful, insouciant failure to learn lessons from other countries. None the less ageism has played a major role.

The starkest indicator of ageism is to be found in the huge loss of life among older people. The overall death rate is monstrous and dwarfs the German total by a factor of 6-7 times (and Germany has a larger population) but, among people diagnosed with COVID-19, those aged 80 or over are seventy times more likely to die than those aged under 40. It is predicted that more than 50 per cent of deaths from the virus will be care home residents (Laing, 2020). The total of such deaths was 34,000 by mid-June, ten times the level in Germany. In other words, the highest death toll from the pandemic has taken place among a very vulnerable population, but one which was in settings that could, and should, have been protected. The Health Secretary's 'protective ring' was pure PR fantasy and never existed. Just the opposite in fact, rather than being protected, care home residents were needlessly exposed to fatal risks by the forced discharge of older people from hospitals without the stipulation of a negative test for coronavirus, or indeed without any test at all (Iacobucci, 2020).

Thus protection for the NHS was bought with the lives of those most vulnerable to infection. Not surprisingly, therefore, the majority of deaths from COVID-19 have not taken place in hospitals but in care homes. In the last 2 weeks of April three-fifths and two-thirds respectively of coronavirus deaths took place in care homes, and less than a quarter in both weeks in hospitals. For the week ending 12 June the figures were 66.5% (care homes) and 19.5% (hospitals) (ONS, 2020). As well as these deaths directly attributable to COVID-19 the ONS reports 9,429 unexpected extra deaths among people with dementia in April, in England, and 462 in Wales – 83% and 54% higher than usual. Anecdotal evidence from charities, such as the Alzheimer's Society, plausibly points the finger at the loss of contact with family and friends. The President of the ADASS used more measured terms than this scandal warranted:

A key lesson is that a pandemic response that focused on emptying acute hospital beds without considering the impact on social care had huge consequences; prioritising PPE and testing for hospitals, with social care as an afterthought, was not right. (Bullion, 2020, p.2)

The woeful neglect of care homes, resulting in huge unnecessary loss of life, is the result of institutional ageism – a situation in which people are systematically discriminated against by policies, practices or attitudes on the basis of their age (Bytheway, 1995). So too is the fact that staff working in these homes are underpaid, under-trained and under-valued. The policy of 'herd immunity' exposed those in care homes to danger and was only discontinued when the predicted loss of life was regarded as too risky in political terms. That such a policy could be instigated in a democratic society emphasises the deeply ingrained nature of ageism.

The government's response to the pandemic has made frequent use of negative stereotyping of older people. For example the idea that everyone over the age of 70 should be isolated, when the reason for the close statistical association between COVID-19 and late old age is the prevalence of multimorbidity (two or more chronic conditions), not age per se. The prevailing belief that multimorbidities are an inevitable part of being old is itself rooted in ageism – a belief often internalised by older people themselves. As argued below, if resources were devoted to preventing chronic conditions, instead of simply accepting them as inevitable, the lives of millions of people, now and in the future, could be transformed (Walker, 2018). The frequent references to 'underlying conditions' among virus victims reinforces this ageist belief in the inevitability of chronic ill health, and also minimises the loss of life as these older people were expected to die soon anyway.

The search for a vaccine against COVID-19 is itself imbued with ageism, because there is no reference to the lowered immunity, or immunosenescence, experienced by many people in advanced old age. This causes much lower than average vaccine receptiveness. For example annual influenza vaccines have only 30-40% effectiveness among very old people with multimorbidities. Thus, if vaccine research is not accompanied by work on how to raise immunity levels, such as the use of geroprotector drugs, the most vulnerable will not be protected.

As well as unambiguous institutional ageism the pandemic has thrown up plenty of examples of its more compassionate, benevolent or well-meaning form. For example the widespread stereotyping of older people as vulnerable and dependent homogenises millions of people and thereby glosses over the many intersectionalities and huge inequalities among them – divisions, such as ethnicity, which have a direct bearing on susceptibility to COVID-19 (Public Health England, 2020). As Eleni Skoura-Kirk (2020) has pointed out, there is also an element of 'othering' in some of this apparently benign ageism.

If we want to emerge from the pandemic as a more socially just society there has to be a concerted national attack on all forms of ageism, wherever they reside. Rooting out ageism should form one part of a complete transformation in our approach to ageing and older people – a new national ageing strategy. Its starting point would be a recognition that ageing is lifelong. Despite the great preponderance of virus deaths among older people it is not chronological age but health, ethnicity and socio-economic status that are the main causal factors. Older people in general are not vulnerable, it is the preventable chronic conditions associated with later life that cause vulnerability. A huge national effort is needed to prevent those multimorbidities, along with a rejection of the ageist assumption that they are part and parcel of growing old. Given lifelong ageing, prevention means embracing all ages, young and old. The key measures include the promotion of physical and mental health; major reductions in income and health inequalities; ending prejudice; rapid improvements in air quality; fair access to nutritionally beneficial food; and the transformation of the NHS from an acute care service to a public health one focused on prevention. A new national ageing strategy must rescue the social care sector from decades of neglect and 10 years of deep spending cuts. It should be combined with health care, provided on the same free at the point of use basis, operated as a public service, be well funded, and in terms of quality and staffing accorded parity with the NHS.

If such a strategy had been in place, with a competent government in power, the UK's response to the pandemic would have been very different, with far fewer deaths among older people and their carers, paid and unpaid. As many as 30,000 lives might have been saved.

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To the top ↑