COVID-19 and Ageism: Has the Pandemic Allowed Prevailing Ageist Attitudes in Healthcare to Go Viral?

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ABSTRACT

Current perceptions of older adults are often met with prejudice and misconceptions that constitute what has been characterized as 'ageism'. Rarely are older persons considered indispensable members of the medical community who deserve our respect and support. While it is unclear if and when this pandemic will end, it is clear is how COVID-19 has unveiled the prevalent ageist attitudes against older people, underscoring an unsettling discourse about age and human worth that has allowed us easily to question the value of older adults. In this commentary, we highlight specific recommendations that can be made to combat ageism during and after the COVID-19 pandemic, with exploration of vaccine administration and inequities across long-term care homes.

RÉSUMÉ

Les perceptions actuelles des personnes âgées se heurtent souvent à des préjugés et à des idées fausses qui constituent ce que l'on appelle l'"âgisme". Les personnes âgées sont rarement considérées comme des membres indispensables de la communauté médicale qui méritent notre respect et notre soutien. Bien que l'on ne sache pas si et quand cette pandémie prendra fin, ce qui est clair, c'est la façon dont la COVID-19 a dévoilé les attitudes âgistes répandues à l'encontre des personnes âgées, soulignant un discours troublant sur l'âge et la valeur humaine qui nous a permis de remettre facilement en question la valeur de ces derniers. Dans ce commentaire, nous soulignons les recommandations spécifiques qui peuvent être faites afin de combattre l'âgisme pendant et après la pandémie de la COVID-19, tout en explorant l'administration du vaccin et des inégalités dans les foyers de soins de longue durée.

Keywords: *Ageism, long-term care, COVID-19 vaccination*

"The true measure of any society can be found in how it treats its most vulnerable members."
-Mahatma Gandhi

INTRODUCTION

Older adults are often met with prejudice and misconceptions that constitute ageism. They are seldom given a platform to advocate for themselves and are

infrequently considered when programmatic decisions are made. As the pandemic unfolds, ageism is leading to the revictimization of older populations and catalyzing recurrent waves of disease spread. In this paper, we discuss how the COVID-19 pandemic has accentuated pre-existing ageist attitudes in healthcare, underscoring an unsettling discourse about age and human worth, and we make specific recommendations to overcome such practices in modern medicine.

RESPONSE TO COVID-19 IN LONG-TERM CARE HOMES (LTCHS)

Since the onset of this pandemic, it has become increasingly clear that a tailored and concerted approach to protect older adults in LTCHs is needed. Health care providers worldwide have expressed concerns over the safety of LTC residents, calling for more personal protective equipment (PPE), infection control strategies, and adequate staffing.1 Canada has stood out, internationally, for having a lopsided pandemic response that prioritized the needs of acute care settings (such as hospitals) over LTCHs, despite 73% of COVID-19-related deaths have occurred in LTCHs.[1,2] During the first wave, LTCHs were reticent to transfer residents to hospitals, in an effort to avoid overcrowding, although COVID-19 was spreading more rapidly in these LTCHs. Inconsistencies in masking practices and symptom screening policies among LTCHs were also widespread during the first wave.[3] This further contributed to the high mortality rate among residents in Ontario nursing homes. The majority of these deaths were preventable, unnecessary and negligent, given that jurisdictions in Canada that better supported these settings recorded fewer fatalities.[4]

Chronic understaffing has resulted in lackluster care among LTC residents. It was estimated that more than 6000 personal support workers (PSWs) were needed in the summer to adequately staff LTCHs across Ontario.[5] In the worst-hit COVID-19 LTCHs, emergency staff shortages were addressed by redeploying rapid response (hospital and community-based) health care teams, in addition to the Canadian Armed Forces and the Red Cross.[6] Staffing continues to be a critical issue, in part due to the low pay and few benefits for LTC workers compared to those working in other health care settings. Ontario's new staffing plan includes a $1.9 billion investment to recruit and retain PSWs to achieve an average of four hours of daily direct care.[7] The province's directive to allow staff to work with a single employer,[7] while well-intentioned, further exacerbates the staffing shortage. To address chronic understaffing, accelerated PSW training programs should be made available, similar to the training model implemented by George Brown College in partnership with Rekai Centres.[8] While work on this front is already occurring in Ontario[9], it is imperative for other provinces and territories to follow, as chronic understaffing is an issue that affects LTCHs across Canada. Improving incentives to work in LTCHs should include increased and standardized training and wages for workers, as well as full-time employment contracts that come with hazard and paid sick leave. Toronto's city-run municipal LTCHs proactively implemented the four-hour care standard in 2019 by fundraising $24 million to cover the added staffing costs. Indeed, it was this staffing model that was lauded as the "secret sauce" for containing the virus[10] by preventing at-risk or asymptomatic staff from coming to work and spreading the virus.

IS AGEISM DRIVING THE SECOND WAVE?

As COVID-19 continues to spread, it is invariably making its way into LTCHs, putting older patients at increased risk of infection. A MMWR Report by the Centres for Disease Control and Prevention showed that infection waves among younger populations seeded infections in older adults, suggesting that younger persons act as vectors of transmission.[11] Given the potency of asymptomatic COVID-19 spread, stringent adherence to preventive behaviors and community mitigation strategies are needed to reduce the risk of infection and transmission of COVID-19 to older adults.

Older adults have been drastically affected by a careless response to the pandemic. Particularly, the response in LTCHs across Ontario and Quebec during the initial wave6 was the Achilles' heel that drove the surge in Canada's case fatality rate. Until now, more than half of Ontario's 625 LTC facilities have experienced outbreaks and upwards of 3700 residents have died.[12] The blanket approach to infection control in LTCHs lacks nuance and contributes to further mental and physical challenges for residents. For instance, extremely restrictive visitor policies in LTCHs may not be the best way forward. In guarding the physical health of residents, their mental and emotional well-being is

compromised. Family caregiver access can help alleviate the burden on staff by providing essential care. There is mounting evidence that staff are more likely than visitors to serve as vectors of SARS-CoV-2 transmission in LTC facilities.4 Instead of restricting visitors to the point that resident well-being is compromised, strategies to minimize the potential for infection spread should be implemented. Providing adequate PPE and infection control strategies for staff, residents, and visitors should be made a top priority to mitigate the spread of COVID-19. Further, Ontario now has active symptomatic and asymptomatic screening requirements for staff and visitors. Rapid COVID-19 tests that produce results within minutes will begin to be implemented across LTCHs in Ontario starting in March 2021; however, there is no clear policy as to how this will occur.[13] We also need to think about creating additional spaces to allow for social distancing between residents in LTCHs. Brown et al. found that shared rooms in nursing homes are associated with larger and deadlier outbreaks.[14] Long-term residents in LTCHs were three times more likely to live in a shared space in Ontario than in British Columbia (B.C.).[4] As of Sept. 10, 2020, there were already 1,817 resident deaths in Ontario, compared to 156 in B.C..[4]

VACCINE ACCESS AND VISITOR POLICIES ACROSS LTCHS

Ever since the COVID-19 vaccine rollout began in December 2020, Ontario has been grappling with a series of challenges.[15] Despite the campaign's acceleration throughout January 2021, the province continues to run into problems with vaccine shortages.[15] This has forced the provincial government to create prioritization plans such as giving primary access for vaccination to LTC residents and extending the time between first and second doses for other low-risk individuals.[15] Additionally, the Pfizer-BioNTech vaccine has strict storage requirements (i.e., below -70oC), which has further complicated vaccine delivery.[16] This has sparked ongoing discussions around where the vaccine should be distributed – at LTCHs or at vaccine delivery sites, most of which are hospital-based. Delivery sites are the preferred option as they are better equipped than LTCHs to store the Pfizer vaccine, however, LTC residents would need to be moved to these sites in order to receive their vaccination.[16] There are roughly 78,000 LTCH residents across Ontario.[17] As of May 21, 2021, around 5 percent of LTC residents are not fully vaccinated against COVID-19.[18] In order to continue to protect our most vulnerable population, vaccination delivery to LTCHs must continue to be prioritized and expedited. For this, political parties and vaccine manufacturing companies must work together to reach a consensus.

In addition to continuing to prioritize the vaccine campaign in the LTC sector, policies surrounding social outings for highly vaccinated LTCHs should be reconsidered promptly. Currently, the Ministry of Long-Term Care allows for some social interactions such as communal dining. However, resident outings for social reasons and temporary absences remain banned, as are visits from family members who aren't official caregivers.18 Visitor policies in LTCHs have changed very little since last fall, despite high vaccination rates that would allow for safe outdoor visits.[19] The delay in updating the policy extends the burden on the family members who have qualified as caregivers, while also prolonging the suffering of both residents and loved ones who have been separated for a year. Policies should reflect the high vaccination rates present in LTCHs and the directive on visitor policies in LTC needs to be reconsidered now.

LIMITATIONS OF ONTARIO'S COVID-19 RESPONSE

The province of Ontario has failed to properly protect residents in LTC. As of May 21, 2021, 95 percent of LTC residents are fully immunized in Ontario.[18] Ontario has shown tremendous progress in the COVID-19 vaccine roll-out to LTC, however, there are still individuals in LTC and retirement homes waiting to be vaccinated.[18] There has been adequate time and vaccinations to provide doses to every single individual across both sectors. What is more concerning is the question of what happens once vaccinations have been completed. While vaccines will contribute to a decrease in COVID-19 mortality, they do nothing to address the structural issues in LTCHs that have caused ongoing abuse and neglect in an increasingly privatized industry. A recent report from the Canadian Armed Forces (CAF) revealed long-known truths of the crisis in LTC that caregivers and family members have been saying for years.[20] The CAF report details disturbing conditions in LTCHs. It also highlighted serious concerns about PPE shortages, staffing shortages, and failure to follow basic procedures to keep both staff and residents safe.[19] There must be coordinated action between the federal and provincial governments to find a lasting

solution to this crisis: a solution that ensures the health, care, and dignity of seniors in all LTCHs.

RECOMMENDATIONS FOR FUTURE SUCCESS

The COVID-19 pandemic has given us a wide lens into the state of Canada's healthcare system. So far, our response has failed older adults. How, then, must we define the way forward? We acknowledge that sustained efforts will be required to respond to COVID-19 over an indefinite period of time. In order to have a meaningful impact on addressing ageism during this pandemic, we urge that attention be paid to five aims: (1) ensure that there is monetary commitment and adequate planning between the government and all those involved to generate a stable workforce that can meet growing LTCH needs, (2) establish strict infection-control strategies in the general population (e.g. follow the COVID-zero policy with test-trace-isolate-support)[21], (3) continue to allow for essential family caregiver access to LTCHs, (4) reconsider visitor policies in highly vaccinated LTCHs, and (5) mandate national standards to correct the longstanding structural issues in long-term care.

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Conflict of Interest

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