COVID-19 and the Long-Standing Vulnerabilities of Older Adults

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The coronavirus pandemic has devastated the health, economic well-being, and emotional security of millions of people in the United States and worldwide. As of mid-August 2020, more than five million Americans had contracted COVID-19, and more than 170,000 had died from the illness. The death toll has been especially steep for older adults, who are vulnerable not only to the virus, but also to the social isolation, stigmatization, and suffering the pandemic has wrought.

Although COVID-19–related deaths can strike anyone, the risk rises dramatically with age. According to the US Centers for Disease Control, adults ages 65 and older make up 16 percent of the US population, yet they account for one-third of the country's COVID-19 cases, half of related hospitalizations and intensive care unit admissions, and a staggering 80 percent of deaths associated with the virus.

Media coverage of the pandemic has underscored its tragic impacts on older adults. Televised images of frail octogenarians slumped over in their wheelchairs in overcrowded hospital hallways, and dying nursing home residents waving to their grandchildren outside their windows, convey the depths of their anguish.

The impact of the pandemic has been indelible and undeniable, yet it also has shed light on important social problems that existed long before the word "coronavirus" entered our collective vocabulary. Three persistent challenges have been exposed and intensified by the pandemic: socioeconomic and racial disparities in mortality; a dire shortage of long-term care workers; and lack of preparation for end-of-life decision making.

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SOCIAL STRATIFICATION OF DEATH

On the surface, epidemiologic data and media portrayals would lead us to believe that COVID-19 is "caused" by old age. That conclusion would not be accurate.

It's true that older adults have weakening immune systems, which render them vulnerable to the virus. Frail older people also tend to live in group settings like nursing homes or assisted living facilities in which disease can easily spread. But old age alone does not put one at risk; millions of healthy older adults have been completely spared by the virus. The risk of contracting and dying of COVID-19 is higher for people with other comorbid conditions, like cardiovascular disease, hypertension, type 2 diabetes, and chronic obstructive pulmonary disorder, conditions that tend to be more common among older adults.

The risk of these and other major health conditions also is stratified on the basis of race and social class. Adults of all ages with fewer socioeconomic resources as well as Black and Latinx people are particularly vulnerable. Chronic illness strikes at higher rates and at younger ages among people who lack health insurance and a regular source of health care, who work in physically dangerous jobs, and who live in neighborhoods with limited access to healthy foods, parks, safe housing, and clean air. Daily and persistent stress related to economic precarity and systemic racism have been linked with chronic inflammation and related health risks.

In the pandemic era, other aspects of daily life, such as living in crowded housing, working in a frontline job as, say, a certified nursing assistant, bus driver, or grocery store clerk (or living with a loved one who holds such a job), or relying on public transit, have added new layers of risk. As a result, Black people are dying from COVID-19 at roughly the same rate as whites more than a decade older. The virus has brought into sharp focus

persistent disparities in the length and quality of life attained by Americans of all ages.

Long-Term Care Struggles

Nursing homes have emerged as the public face of the pandemic. Although less than 1 percent of all Americans currently live in nursing homes and assisted living facilities, these residents account for one in four COVID-19 deaths. Due to the rapid spread of the virus, nursing home residents in many parts of the country cannot visit with their loved ones or enjoy social activities, like movies, in their facility's common room. This isolation intensifies their suffering.

The pandemic has created daunting challenges for staff as well. Many workers at long-term care facilities are putting their own health at risk because their employers have not provided sufficient personal protective equipment and access to quick and accurate testing. These threats are heightened for low-wage workers, especially certified nursing assistants (CNAs), who risk close contact with COVID-19 as they feed, bathe, and medicate residents. They may juggle jobs at several facilities and private homes to make ends meet, increasing their exposure. Some may live in small or crowded quarters, since their meager pay is not sufficient for more spacious housing. Some are reluctant to take time off from work even when sick, for fear of being fired or losing wages.

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When workers become ill or take time off to care for ailing family members, it's hard for their employers to find backup staff, due to a long-standing shortage of care workers. Positions like personal care aide and nursing assistant consistently rank among the fastest-growing jobs in the United States, yet there are not sufficient numbers of workers to fill openings. Part of the reason is that CNAs' median annual earnings, just under $30,000, barely bring a family of four above the federal poverty line. These jobs are disproportionately held by immigrant women and women of color. The pool of paid caregivers will shrink even further should national immigration policies grow more restrictive, or if workers succumb either to the virus or to the pressures of caregiving for loved ones with the virus.

Nursing homes have been beset by other problems, such as insufficient funding and a history of poor infection control. Medically complex care for long-stay older patients is typically reimbursed by Medicaid (the public health insurance program for people with low income), for which the reimbursement rate is substantially lower than the rate paid by private insurance or Medicare (the federal health insurance program for those ages 65 and over, which covers short stays in nursing homes). Nursing homes with many frail long-term (or low-income) patients are largely dependent on Medicaid reimbursement for their revenue. As a result, they are often underresourced, understaffed, and ultimately struggle to provide quality care, even if the hard-working staff members are every bit as concerned, dedicated, and compassionate as their peers working in better-resourced settings. The tendency of low-income older adults with complex medical situations to seek care at struggling nursing homes dependent on Medicaid contributes to a vicious cycle: those who are already the most vulnerable may receive poorer-quality care that intensifies their vulnerability.

Plan Ahead

Death is a fact of life, but Americans remain reluctant to talk about or prepare for their final days. Less than half of all US adults and their families have done advance care planning—the process of documenting and communicating their preferences for end-of-life medical treatments. Legal procedures like creating a living will and appointing a trusted confidant to serve as one's health care proxy are critical steps to ensure receiving care in accord with one's wishes and being treated with respect and dignity at the end of life.

Advance care planning is most effective when accompanied by conversations with health care providers and loved ones, so that patients can make informed choices about whether they desire potentially life-extending interventions like feeding tubes and mechanical ventilation or prefer comfort care and palliation. The capacity to exercise "choice" has arguably been undermined in the COVID-19 era, as health care facilities battle shortages of ventilators and hospital beds, and ethicists debate rationing on the basis of age and preexisting conditions. Yet these challenges make the need for advance care planning all the more urgent.

For most of the late twentieth and twenty-first centuries, the vast majority of older adults have died of diseases that progress slowly, like cancer,

congestive heart failure, and Alzheimer's or related dementias. The fairly long interval between diagnosis and death gives patients and their families time and space to think about and discuss end-of-life issues. With an infectious disease like COVID-19, however, the time period between getting sick and dying may be short and stressful, especially for older adults with comorbid conditions. The speed of physical decline may reduce a patient's capacity to think through or discuss their treatment preferences with loved ones. News outlets have reported stories of patients put on ventilators mere hours after they were visiting with friends.

Intensifying the challenge, COVID-19 is an emerging disease: health care providers do not yet have definitive data on the progression of symptoms, making advance decisions difficult. Moreover, the opportunity for a meaningful end-of-life conversation is limited among patients dying in isolation. Their communication with loved ones may take place through a rushed video call on a nurse's smartphone. The pandemic is sounding a wake-up call for Americans of all ages, but especially those who have comorbid conditions, to do advance care planning early and often—and to think about how their initial preferences may change as their health changes, and as COVID-19 infection rates wax and wane.

Policy and Dignity

International efforts are underway to develop an effective and affordable vaccine for COVID-19, while institutions ranging from schools to businesses to governments are adapting infrastructures to minimize the threat of the virus. Yet broader social programs are needed to mitigate the far-reaching consequences of COVID-19. The pandemic has cast light on and amplified some of the most persistent challenges facing the US health care system.

Policy solutions require thinking broadly and focusing on the underlying problems that have intensified the pandemic's impact on older adults, ethnic and racial minorities, people with limited economic resources, and long-term care facilities and the workers they employ. In the United States, proposals like Medicare for All (or the more moderate Medicare at 60) would expand access to public health care for Americans at younger ages. This is a critically important step because people from historically vulnerable or disadvantaged groups typically experience the onset of chronic diseases years before their 65th birthdays.

Reducing the age at which Americans are eligible for Medicare also would help younger adults engage in advance care planning. One reimbursable end-of-life consultation session with a doctor is now offered to Medicare beneficiaries, under the Affordable Care Act.

Increasing levels of Medicaid reimbursement may ultimately improve the quality of care and staffing at beleaguered nursing homes caring for vulnerable older adults. More innovative strategies to provide personal care workers with adequate compensation and career advancement opportunities would attract employees and reward them appropriately for their important work.

The United States also could follow the lead of other nations, like Australia, Austria, and the Netherlands, that have implemented mandatory prevention measures in long-term care facilities to protect both workers and patients. Specialized care sites, away from uninfected residents, would isolate those receiving treatment for or recuperating from COVID-19. Additional support such as surge staffing, specialized teams, and PPE also would increase safety for these important frontline care workers.

Death from any cause—from COVID-19 to cancer—is, of course, inevitable. Yet the pandemic has created a context in which death may come earlier for older adults, especially racial minorities, those with fewer economic resources, and those being cared for at underresourced facilities. It is time for thoughtfully devised policies that can help reduce persistent disparities in when, how, and the level of dignity with which one dies. ■