Irish Medical Journal
Established 1867

Issue: Ir Med J; Vol 113; No. 4; P50

Protecting Our Longevity Dividend During Covid-19

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If the highest mortality rate of the Covid-19 pandemic - 15% of those infected - was among children rather than those over the age of 80, we would expect to see prominent emphasis on children and paediatrics in guidance and planning. This would be even more so if mortality in residential care for children approached that of older people in residential care, 33% in the first major series[1].

Unfortunately international and much national planning for COVID-19 is notable for a failure to adequately frame and prioritize the crisis in terms of the special issues relating to older people, the group with the highest levels of mortality, as exemplified by the response of the World Health Organization[2]. Worse still, there are alarming reports of ageism in resource allocation for critical care in Italy, defended overtly by their national society of intensivists[3].

While we are fortunate in Ireland to have a number of geriatricians in senior leadership posts within the health service, they work in a system and society that still lags behind in appreciating the longevity dividend. The Citizen's Assembly on older people was an unhappy insight into the general population's perceptions of older people[4], largely reflecting a failure model of ageing rather than valuing the positivities and many contributions of older Irish citizens. In addition, we have lost valuable resources for promoting good policy and practice with older people, such as the National Council on Ageing and Older People, the Centre for Ageing Research and Development in Ireland: as recently as February 2020 the Royal College of Physicians in Ireland dissolved its Policy Group on Ageing.

On the positive side, the National Public Health Emergency Team (NPHET) have undertaken a formidable exercise in mobilizing the Irish health system in an incredibly short period of time. Many radical changes have been implemented in hospital care, teleworking and team arrangements which may remain as positive new features of the post-pandemic health system. The contracting of private hospitals at great expense shows what can be done if political will exists, equally displayed by billions of euros of revenue and income support provided to employers and the general population.

No such clear diversion of comparable major resources was apparent for older people at the time of writing and there will be salutary lessons in terms of what were challenges for older people and the adequacy of the societal and healthcare response. These range from diversion of care from non-COVID-19 illness such as stroke and fragility fractures, fear of attending hospital, psychological impacts of cocooning, reduction of home care services, and fear of occult or overt ageism in resource allocation for critical care. It is notable that two of the five systematic reviews on Covid-19 commissioned from the Health Information and Quality Authority by the NPHET were centred on children, and none on older people.

Two areas in particular not addressed in a timely and focussed manner were the experiences of those living with dementia and residents of nursing homes. Many measures, from cocooning and social distancing to attaining services during a pandemic, are particularly challenging for those with cognitive impairment[5], as is restriction of visitors at home and in nursing homes. Intensive work with dementia experts and advocacy groups is needed to urgently develop guidelines and direct resources to assist in care and support of those living with dementia.

Although less than 5% of older Irish people are resident in nursing homes, one in three of us will spend time in a nursing home before we die. While many residents have complex care needs, there is considerable heterogeneity among residents, as the memoirs of the 98 year-old nursing home resident Diana Anthill attest[6].

Despite the many good working practices and efforts of those working in the nursing home system, the large-scale privatization of the nursing home system without debate has been a problematic aspect of our care system for older people[7] There is little clarity on medical leadership and governance, pay and conditions, integration with secondary care and therapy services, as well as the extent to which profits in the sector were invested, if at all, into reserve capacity to manage epidemics and pandemics. The funding provided by the National Treatment Purchase Fund for the Nursing Home Support Scheme (the so-called 'Fair Deal') raises concerns as to its adequacy for providing complex care. In addition, many of the recommendations of the Leas Cross review[8] were not implemented in part or at all.

Initial Department of Health responses to the impact of Covid-19 on nursing homes seem to propose increased funding and stripping community services, but it is likely that the real needs would be better served by secondment of expertise staff from other arenas without undermining community care, given difficulties in the nursing home sector in recruitment and retention, and staff absence due to infection, quarantine or withdrawal from service. In addition, consideration of more formal leadership and governance arrangements, such as the medical director model mandated by US law, need to be implemented for planning for epidemics as well as the many complexities of nursing home care between such crises. Investing in integration and partnership with secondary care services will also be important.[9]

An important and sophisticated element of nursing home practice at any time is the development of advance care planning: the presence of a rapidly developing pandemic adds urgency to implementation of such plans, ideally clarifying preferences for intensification of care and whether or not transfer to the general hospital is envisaged[10]. A parallel imperative is the development of clear palliative care pathways and support, including a mechanism to allow for presence of a family member when the resident is dying. Already there are reports of older people dying alone of COVID-19 in hospitals and nursing homes in Ireland: a combination of information, consent, provision of personal protective equipment and due quarantining of the relative should ensure that this inhumane situation does not recur.

The task of responding to Covid-19 in Ireland has been immense, and has in general displayed strength, resourcefulness, solidarity and political will. These qualities have been less notable in terms of Ireland's response to the needs of older people. We need to ensure that the lessons of COVID-19 will ensure that equity and appropriately high clinical response will apply equally to us as we age, and all older people, for this and future catastrophic health crises.

Keywords: Nursing Homes; Covid-19; Coronavirus; Aged (MeSH)

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