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Covid-19 and ageism: ethical assessment of health resources distribution

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Abstract

Ageism is the prejudice or discrimination of older adults, whether through stigmatization or discriminatory practices by society and its institutions. The current covid-19 pandemic context has shown Western society's ageist stance and, consequently, of its protocols on the distribution of health resources, leading to severe negative repercussions to the care of this population. This theoretical essay discusses the manifestations and consequences of ageism in the context of health resource distribution policies during the pandemic, considering the bioethical implications involved in this type of discrimination when considering the principles of justice and human dignity.

Keywords: Coronavirus infections. Ageism. Aged. Bioethics. Public health policy.

Resumo

Covid-19 e ageísmo: avaliação ética da distribuição de recursos em saúde

"Ageísmo" é o preconceito ou discriminação contra a pessoa idosa, seja por meio da estigmatização ou de práticas discriminatórias da sociedade e de suas instituições. No atual contexto da pandemia de covid-19, a postura ageísta da sociedade ocidental e, consequentemente, dos protocolos para distribuição de recursos em saúde tem sido fortemente evidenciada, trazendo consigo prejuízo importante à assistência a essa população. Este ensaio teórico discute manifestações e consequências do ageísmo em políticas de distribuição de recursos na pandemia, pensando as implicações bioéticas desse tipo de discriminação no que se refere aos princípios da justiça e da dignidade humana.

Palavras-chave: Infecções por coronavírus. Ageísmo. Idoso. Bioética. Políticas públicas de saúde.

Resumen

Covid-19 y edadismo: evaluación ética de la distribución de los recursos sanitarios

El "edadismo" se refiere al prejuicio y discriminación a las personas mayores, ya sea por estigmatización o prácticas discriminatorias por parte de la sociedad y sus instituciones. En el contexto actual de la pandemia de covid-19, se ha evidenciado fuertemente la postura edadista de la sociedad occidental y, en consecuencia, de los protocolos que involucran la distribución de los recursos en salud, trayendo consigo un daño importante a la atención en salud de esta población. Este ensayo teórico discute las manifestaciones y consecuencias del edadismo en el contexto de las políticas de distribución de recursos en salud en la pandemia, considerando las implicaciones éticas de esa discriminación respecto a los principios de justicia y dignidad humana.

Palabras clave: Infecciones por coronavirus. Edadismo. Anciano. Bioética. Políticas públicas de salud.

Update

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Derived from the English *age* + *ism*, the term "Ageism" was coined in 1969 by psychiatrist and gerontologist Robert Neil Butler [1]. It refers to the prejudice and discrimination of the individual based on age, including harmful attitudes against older adults and their aging process, whether through stigmatization and stereotyping or discriminatory practices found in society and its institutions [2,3].

In Western society, which values the vigor of youth, looks, and materialism, ageism finds fertile ground to develop [1]. Cultural values perpetuate the prejudice against older adults and old age, which is often ridiculed, devalued, and feared by young people [4]. The stereotype of older adults as fragile, dependent, and unproductive persons prevails, disregarding the heterogeneity of aging.

The current covid-19 crisis has shown an undue emphasis on the concept of chronological age, to the detriment of the notion of biological age, related to the individual's functionality and degree of conservation, with no direct relationship with age (in years) [5]. Such emphasis generalizes the geriatric population and culminates in the devaluation of older lives [6-8]. Thus, the pandemic calls our attention to an ageism that has always been part of social reality, but, like other existing discriminatory practices, is usually manifested in a veiled manner [9,10].

Therefore, it is important to discuss the concept of ageism and its bioethical implications, identifying ageist attitudes – both at the individual and societal levels – and their consequences, as well as combating discriminatory public policies and striving for solidarity between generations. In this article, we discuss ageism specifically within the scope of health resource distribution. The goal is to reflect on the bioethical implications of this type of discrimination regarding the principles of justice and human dignity, considering both the global health scenario and the current covid-19 pandemic. Documentary research was carried out to support the discussion on the topics of covid-19, ageism, and health resources allocation. The critical analysis of the national and international literature found supported this theoretical essay.

Ageism in health care

To assess the repercussion of ageism in the context of the covid-19 pandemic, we must first understand the history of this type of discrimination in health care. Ageist attitudes among professionals in the area, as well as in other sectors of society, are frequent and impact care for older adults [4]. For example, older adults are commonly advised against surgeries, without actual consideration for the real chances of success of the procedure [11]. Chronological age also seems to influence medical professionals' decisions regarding cardiopulmonary resuscitation [12].

Ageism in health care includes an ever-restricted offer of diagnoses and treatments, often motivated by the idea that the complaints of older adults result from the natural senescence process and do not call for further investigation [9,11]. Older adults as an age group are rarely included in research and/or clinical trials, either due to lack of interest or the heterogeneity of this population [11]. Therefore, the care for older individuals suffers a clear and harmful interference from ageism.

Ageism in the covid-19 pandemic

The initial outbreak of the Sars-CoV-2 occurred in China, where research found that 20% of the deceased were 60+ years old and lethality increased with age, reaching 18% in people 80+ years old [13,14]. It was evident, then, that the geriatric population was at risk for covid-19. As the epidemic attained the pandemic status, global health authorities and governments issued alerts to the older adult population about the increased risk of serious and fatal disease associated with the new coronavirus, reinforcing the need for social isolation for this group, which ended up encouraging ageist speeches and attitudes [15].

The talk about ageism in the context of covid-19 came more strongly under scrutiny with the collapse of the health system in Italy, the country with the eldest population in Europe [16]. Given the critical scenario, with high levels of infection and scarcity of resources, health professionals had to prioritize some patients over others [17]. The first protocol for allocating scarce resources during the covid-19 pandemic was issued by the Società Italiana di Anestesia, Analgesia, Rianimazione e Terapia Intensiva (Siaarti). One of the proposed measures to limit admission to intensive

care was chronological age – together with the presence of comorbidities and functional status –, which gave rise to bioethical discussions on screening parameters for resource allocation [18].

The older adult population is mistakenly represented as a homogeneous and vulnerable group of dependent, fragile, and disabled people, unable to contribute to society. Widespread by the press, government institutions, politicians, and social media, this idea disregards the heterogeneity of aging, the social contributions by older adults, and their value as individuals [6,7,9,19]. Ageism, then, creates a gap between young and old people, emphasizing – even more strongly in the pandemic scenario – the susceptibility of older adults. Thus, young people tend to believe they are immune to the virus, potentially leading to risky behaviors and intergenerational tensions, such as hate speech addressed to older adults [6,10].

Older adults are focused on as the group most impacted by the pandemic, both by the media and health policies and recommendations, disregarding comorbidities such as heart disease, asthma, diabetes, smoking, and obesity [8,9,19]. Defining groups based only on chronological age, underestimating other internal differences, is an ageist assumption that encourages prejudice, stereotypes, and discrimination [6,10]. We have reports of older adults over 100 years old who successfully recovered from covid-19, as well as deaths among young adults resulting from the disease, reinforcing the insufficiency of chronological age as the only criterion for establishing health care priorities [7].

With the spread of Sars-CoV-2 across the world, several health resource allocation rationing protocols were created. Siaart's document used the concept of "life-years saved" and considered the expenditures employed on previously healthy people to justify age discrimination [18]. Chronological age continued to be used as a criterion in policies enacted in other European countries, such as Switzerland, and in the United States, especially in resource prioritization and intensive care screening protocols, often arbitrarily, without any standardization of cut-off age points [10,20-22].

In Brazil, the Associação de Medicina Intensiva Brasileira (Amib) and Associação Brasileira de Medicina de Emergência (Abramede) were the first to publish a resource allocation protocol, listing chronological age as one of the three main screening criteria [23]. The proposal conflicted with Article 9 of Resolution 2,156/2016 of the Conselho Federal de Medicina (CFM), which establishes the criteria for admission and discharge from the intensive care unit: *Decisions on admission and discharge from the intensive care unit (ICU) must be made explicitly, without discrimination on grounds of religion, ethnicity, gender, nationality, color, sexual orientation, age, social status, political opinion, disability, or any other forms of discrimination* [24].

After criticism, Amib and Abramede published a second version of the protocol, together with the Sociedade Brasileira de Geriatria e Gerontologia (SBGG) and Academia Nacional de Cuidados Paliativos (ANCP). In the new document, the entities admit that an age criterion could be discriminatory and unconstitutional and suggest including, whenever possible, a bioethicist and a community representative into the screening team [5].

In its official stance on resource allocation, the American Geriatrics Society (AGS) was concerned with strategies adopted in US states where age was considered a screening criterion. According to AGS, this criterion violated the bioethical principle of justice, since it is grounded on implicit biases and, therefore, discriminatory. The institution recommends that cut-off age points should never be used as a categorical criterion for excluding therapeutic interventions [26].

The covid-19 pandemic exposed latent ageism in society, potentiating discriminatory discourses, attitudes, and actions at all levels – from the general population to world leaders and institutions. Ageism also manifests itself in policies for resource allocation and health care in the context of the covid-19 pandemic that establishes chronological age as the sole criterion for determining vulnerabilities, prognosis, and treatment options. Such perspective disregards the heterogeneity of the older adult population, their values, and preferences. Therefore, this article questions the ethics of the age criterion and highlights the need to optimize resources within the critical scenario of the pandemic [6,7,10,17,18].

The unethical aspect of ageism in the allocation of health resources

According to principialist bioethics [27], used as a reference in the construction of the Brazilian Code of Medical Ethics (CEM) [28], the principle of justice proposes that the individual be given their due – meaning, their rights. In this sense, distributive justice seeks fair and equitable resource allocation, including health, according to the rules that structure the dynamics of the social environment. However, there is no single concept of justice capable of assessing all conflicts that originate from resource distribution, leading to different interpretations on how this principle should be applied [27,29].

Several theories aim at applying distributive justice in health. Liberalism prioritizes economic and social freedom in resource distribution. Equalitarianism, on the other hand, promotes equal access to goods, according to the individual's needs. Utilitarianism, in turn, proposes the gathering of various justice criteria to optimize distribution [27]. In their own way, each of these theories seeks to define the concept of justice considering the finitude of health resources. Thus, conflicts regarding proportionality including not only the issue of prevention and health promotion *versus* health care, but also the definition of which social groups should or not benefit from the resource allocation are created [27,29].

Discrimination against older adults (ageism), in most cases, is not covered by theories of distributive justice. However, given the exponential growth of the older adult population worldwide, the segregation of this group in access to care has been accentuated. Such segregation is based on the prejudiced idea that older adults demand more resources as a result of illnesses, but do not contribute as much to the health system, from a socio-economic point of view, when compared to younger people.

According to equity theory, the right to health, with equal access, should minimize the person's disadvantage regarding natural chance or social circumstances, prioritizing a minimum offer, as well as equanimity of opportunities [27,29]. However, some arguments based on this theory use "fair opportunity" to justify the criterion. These arguments advocate for a "normal life span" (everyone should have a similar opportunity to go through different stages in life), emphasize the increased cost of prolonging the life of older adults (to the detriment of the young people, whose treatment would be less expensive and have a greater life span potential), besides pointing out the low therapeutic success of measures instituted for this age group (when compared with younger individuals) [27,30].

The unethical nature of discrimination towards chronological age has yet an institutional face. In this case, ageism is diluted across social rules or procedures [30]. This institutionalization is revealed when we consider that the ethical values of a society act directly as the basis for the formulation of health policies and resource distribution [29].

Even a body as renowned as the World Health Organization (WHO) has perpetuated ageism in its action plans, directly influencing health research and policies around the world. The concept of "disability-adjusted life-years" (DALYs) was first introduced in 1993 to study the impact of disease and support the planning of health-related policies. In its calculation, the concept included the measure of "life-years lost," adjusted according to an arbitrary age/maximum years to be lived – somewhere between 65 and 80 years. Thus, disability was disproportionately valued among both young people and older adults, since the latter were pre-judged due to a greater social dependency supposedly inherent to their age group. The measure was only interrupted in 2010 [30].

Between 2008 and 2013, the WHO worked with the concept of "premature death" in the Global Action Plan for the Prevention and Control of NCDs (such as systemic arterial hypertension and diabetes mellitus). Arbitrarily, the plan established death before the age of 70 as premature, justifying that valuing assistance to the younger population would also benefit older adults in the future [30].

Another example of ageism is the measure of life-years adjusted by quality (Avaq), used in cost-utility analyzes by regulatory institutions for health resources, such as the National Institute for Health and Clinical Excellence (Nice), in England. The calculation is based on life years expectancy associated with an arbitrary numerical value for the quality of life, classifying treatments with less impact on life expectancy as low priority [31].

Such policies discriminate against the older adult population and neglect a series of challenges including multimorbidity, palliative care, or even communicable diseases such as the human immunodeficiency virus. Indirectly, the healthy individuals in an economically productive age group and with a hypothetical longer life expectancy are more valued. In determining how many and what are the "valid life years" to be prolonged, the argument limits the value of life to the production of wealth, labeling older adults as "economically unproductive." But it is ageism itself that actually contributes to the isolation of older adults from the labor market and social life, systematically deepening "unproductivity." Thus, even theories that consider the concept of equity of opportunity end up corroborating ageist policies in health [32].

The institutional ageism present in health policies is also worrying when we observe that about two-thirds of the world's older adult population is allocated in underdeveloped and developing countries [30], where financial resources are generally scarce and, therefore, require a utilitarian logic of distribution. In Brazil, the right to health is enforced by the 1988 Federal Constitution [33] and Law No. 8,080/1990 [34], known as the Organic Health Law, which regulates the Unified Health System (SUS). Health is described as a right of every Brazilian citizen, and that SUS should operate under the universality of access and the integrality and equality of care as principles, with no prejudice of any kind [34]. Thus, in Brazil, the State incorporates egalitarianism, undertaking the responsibility of promoting access to health and defending human dignity based on the premise that distributive justice must be guaranteed according to the needs of each individual to minimize inequalities, whether biological or social [29].

Brazilian health policy differs from that practiced in other countries, such as the United States, where access to health is not egalitarian and shuns socioeconomically vulnerable segments of the population under the justification of liberalism and free-market rules [29]. The Brazilian State embraces human dignity as one of its fundamental principles, as described in Article 1 of the 1988 Constitution, further determining the protection of dignity, well-being, and the right to life of older adults in Article 230 [33]. As such, laws advocating for the dignity of the older person, including access to health care, which is also an established right, are explicit in the legislation.

The unethical aspect of ageism in the covid-19 pandemic

In the current pandemic context, protocols from Brazilian institutions such as Amib, Abramede (in its first version), and Hospital Albert Einstein proposed chronological age, explicitly or not (in the form of "life years to be saved"), as an isolated criterion for allocating scarce resources, especially in situations involving the patient's access to the ICU and advanced life support (ALS) measures [35,36]. Such stance is similar to those protocols proposed in developed countries that strongly felt the impact of the conflict between high demand and scarcity of resources, such as Italy [17], Spain [37], and Switzerland [22]. However, proposing that a young person's right to receive mechanical ventilation prevails given their potential longer life expectancy means minimizing the older adult's right to life and human dignity, disregarding the benefit of interventionist measures for older adults with a good functional reserve and, therefore, positive recovery prospects.

Arguments that use the low probability of recovery of older adults infected with coronavirus as a justification disregard one of the main characteristics of aging: its heterogeneity in terms of functionality and health status [38]. Older adults, even when participating in the same age group, are different from one another, and may or may not present the conditions that imply greater morbidity and mortality from covid-19, as it is the case of frailty syndrome, for example [17,38,39]. In other words, an older person with good functional status and health can benefit from ALS measures as there is no direct relation with chronological age.

Extending their thought beyond biological analysis, Dias and Gonçalves [40] question the extent to which it is correct to consider "life span" under the equitable logic, since this would overlap the right of the young person to that of older adults based on an arbitrary metric that disregards the content – that is, the biography – and the value that the person themselves attributes to their life.

In this sense, in May 2020, the Sociedade Brasileira de Bioética (SBB) drew attention to the ethical aspects of coping with the pandemic regarding resource allocation and the equal use of health technologies. Resolution SBB 1/2020 starts with the consideration that *the respect for human dignity must be the main foundation for decision-making and conduct in health, without any distinction that may imply the devaluation and discrimination of people, communities, or socially vulnerable groups*[41].

From the bioethical point of view, ageism manifested through the chronological age criterion for administering ALS and ICU admission violates both the principle of human dignity and beneficence, as it limits access to potentially beneficial measures for the older person infected with the coronavirus. For this reason, SBB is concerned about protocols for ICU access that accept the age group as a criterion. Unlike such protocols, the institution reinforces respect for human dignity, which is constitutionally guaranteed, as a guide for decision making, as to avoid discrimination in health care.

However, the need remains – even more critical in contexts such as the one we live in – to distribute resources in a manner that benefits the greatest number of individuals. But how to do it ethically, without excluding the older adult community? This is an impossible task if the protocol does not cover the principle of human dignity. The fundamental guideline of any recommendation should be to recognize the individual as unique, with essential and intrinsic value, an end in itself and not as a means[42]. This recognition involves affirming the older adult's right to health, recognizing their value, biography, and relevance to society.

In general, protocols that adopt scientifically supported algorithms to detect clinical conditions indicative of a worse prognosis or less benefit in ALS measures allow for more assertive decisions, regardless of the patient's age range[17,37,41,42]. Conditions such as frailty, multimorbidity, and functional status must be monitored and incorporated into the decision making, prevailing over the isolated chronological age[17,42], since through them it is possible to identify patients for whom ALS would not be beneficial (and could even be harmful, given the risk of dysthanasia). It is also essential to respect advance directives of will in this process, whenever the patient has registered them. Thus, we can allocate scarce resources in a more dignified, just, and beneficent manner, respecting the individual's autonomy.

Final considerations

Usually presented in a veiled manner in the social environment and certain health policies, ageism was fully brought to light in the covid-19 pandemic, either through discriminatory societal posture when labeling older adults as a risk group, or by resource allocation using chronological age as an arbitrary measure for decision making. However, either in regular or pandemic times, ageism cannot be justified. Beyond morally defensible, the right to health and human dignity is constitutionally guaranteed in Brazil, and, from the bioethical point of view, any type of discrimination in the distribution of health resources is reprehensible.

Besides suppressing the opportunity for older adults to benefit from therapeutic measures (including ALS), restrictions based only on chronological age reinforce discrimination against this group and reduce an individual's life to arbitrary numbers, which disregard values and choices. Thus, although there are already several ethical recommendations aimed at more equitable resource allocation protocols, it is still essential to educate health professionals – not just geriatricians/gerontologists – to recognize institutional ageism. Extending and deepening the discussion and knowledge about older adults and their particularities is essential to combat this type of discrimination.

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Update

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Authors' contribution
Tássia Salgado Soares and Uiara Raiana Vargas de Castro Oliveira Ribeiro conducted the bibliographic review, wrote the article and, together with Caroline Perez Lessa de Macedo, designed the study. Carla Corradi-Perini contributed to the critical review of the final version.

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