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Editorial

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Care Inequality among Older Adults during the COVID-19 Pandemic

Soong-nang Jang[1], Chang-O Kim[2,3]

[1]Red Cross College of Nursing, Chung-Ang University, Seoul, Korea
[2]Institute of Social Welfare, SungKongHoe University, Seoul, Korea
[3]Visiting Doctors Program of Medical Home, Seoul, Korea

While all members of the society have experienced difficulties since the spread of coronavirus disease 2019 (COVID-19), the severity of these difficulties and health threats differ depending on the individual circumstances. Thus, it is important to not only stop the COVID-19 outbreak but also to protect people equally. The direct and indirect pain and difficulties caused by COVID-19 are not limited to the infectious disease setting; thus, the government has a duty to respond to the needs of the older population and alleviate their pain. From a people-centered point of view, we should examine the status of underprivileged groups with a focus on the services and infrastructure of our society. Due to the pandemic, the pre-existing social, political and economic systems are becoming more vulnerable, which has led to the marginalization of socioeconomically vulnerable groups.

Among the COVID-19 prevention and treatment systems, accessibility issues for socially vulnerable groups and discrimination have been reported.[1)] Given the massive role of healthcare infrastructure in the response to the COVID-19 pandemic, questions must be raised regarding how other essential care options are provided and why a proper alternative system has not been established. Delayed medical care utilization and the failure of a continuum of care are expected to adversely affect the health status of older adults. Although we had recognized these problems in healthcare delivery systems even before the outbreak, they are more pronounced in the current situation.

In particular, there are only few plans for health service provision for older people who have a low income, are living alone, and have disabilities and who rely heavily on the public healthcare system and institutions. The recently published "A UN framework for the immediate socioeconomic response to COVID-19" (April 2020) defined a population at risk as that requiring an immediate socio-economic response to COVID-19.[2)] This group is experiencing the highest level of social and economic alienation and needs special attention, namely, (1) people facing substantial exclusion and discrimination (e.g., residents in care facilities, as well as those who are homeless or illiterate), (2) those facing public exclusion and discrimination (e.g., political minorities, those with disabilities, and certain genders), (3) hidden groups (e.g., lesbian, gay, bisexual, trans and intersex [LGBTI], HIV/AIDS patients, immigrants, and vulnerable workers), and (4) people facing social exclusion and discrimination (e.g., women, girls, and specific ethnic groups). Defining vulnerable groups and evaluating whether the government has implemented an immediate socio-economic response are essential for establishing a response to an infectious disease such that no individual is excluded or alienated.[2)] Eating, caring, rehabilitation, and social relationships through social welfare facilities for vulnerable people are essential to maintain their survival.[1)] However, during the shutdown of social welfare facilities, including daycare centers for older adults with dementia, for more than 6 months, only some non-face-to-face services and emergency care were maintained, which, in turn, increased the burden of care for individuals and family members.[3)]

Special needs among the residents of care facilities should also be considered. For example, preventive cohort quarantine measures in care facilities were neither scientifically based nor democratic procedures and were not effectively managed.[1)] The measures to exclude, rather than protect, the people reinforced discrimination and stigma against older people and their caregivers. Poor support and management of care workers responsible for older adults in need are also a problem.[3,4)] The collective social distancing and self-isolation measures have resulted in greater isolation, anxiety, frailty, and even survival for older people with disabilities who are living alone; furthermore, their health and mental well-being considerations.[5)] Preventive cohort quarantine deprives the freedom and safety of facility users, families, and workers. Beyond blocking and distancing, the principle of "meeting" must be

developed.[1] The principle of social distancing contains standards and measures for each step. Most of the measures simply forbid performing certain activities; however, some of the bans are not fair without a proper complementary system. For example, the long-term care system requires a sophisticated re-design to distinguish between contact-free activities and maintaining essential contact services.

In *A Theory of Justice*,[6] John Rawls (1921–2002) proposed social justice based on two principles: (1) as a basic right of citizens, liberties should be allocated fairly to all people (the greatest equal liberty principle) and (2) social and economic inequalities should be arranged for the greatest benefit to the least advantaged of society (the difference principle). Let us apply these principles, the so-called maximin, to the COVID-19 situation. Collective social distancing could be justified only under conditions that provide maximum benefits to older adults receiving end-of-life care. However, the reality is far from this ideal. Thousands of end-of-life older adults are dying alone in the hospice ward because they have to obey the "new laws" of collective social distancing. Thus, the discourse of "collective social distancing" should be converted into "maintaining a safe social network".

Our interviews of community-dwelling older adults with vulnerability revealed that they are exposed to loneliness, suicidal ideation, and nutritional deficiency.[7] A 75-year-old man with a low income who was living alone said, "I am afraid of getting a coronavirus, but sometimes I'd rather get sick of COVID-19 and die suddenly".[7] He had very few fresh vegetables and fruits in his refrigerator and had placed a big pot instead. All his food was delivered by the welfare center, and he placed all this food into the pot and boiled it simply to satiate his hunger every day. His mealtimes were silent, painful, and lonely.[7] Public jobs at which he could earn even a small amount of salary before COVID-19 have all stopped; thus, his livelihood has become more difficult. An independent living with his own empowerment has also disappeared. Food now includes all "relief-supplies" delivered by welfare centers. With social distancing, the opportunity to achieve independent living in terms of economic, functional, and psychological status has disappeared, which means he faces a transition from independent to dependent living. Some local governments have assigned artificial intelligence robot dolls to older adults living alone to allow these adults to communicate with someone and to alleviate their depression.[8] The social networks of older people have decreased during the COVID-19 pandemic; thus, visits to health and welfare services such as home-based primary healthcare and nursing centers should not be reduced; rather, we need to find a way to offer these services.

The non-face-to-face culture using digital devices has expanded rapidly as we have adapted to this pandemic situation. However, older people who are alienated from this information and non-face-to-face life culture experience threats and fear of survival beyond discomfort.[8] Older adults and people with disabilities were provided limited pandemic-related information with new, complex, and frequently changing terms. Everyone who disconnected from the society also had limited information. Because of the biased information, it was difficult for them to access proper support systems, including emergency subsidies for marginalized older populations.

To mitigate the inequality of risk, a fundamental commitment by the government may be an approach for the multi-dimensional risk of infectious diseases and pandemics. No individual should be excluded from the response and a considerate action is required based on needs and circumstances. Cooperative governance that can reflect the voices of vulnerable populations might be the first step in supporting these populations. It is also important to take measures to ensure a safe environment in a crisis and to promote healthy aging equally. The multi-dimensional inequality of COVID-19 risks did not arise suddenly. Inequalities had emerged in various systems in our society even before the current pandemic situation. All citizens of every generation should participate in caring in solidarity with healthcare workers for promoting healthy aging equally in the pandemic era. First, the central and local governments must understand the size of the vulnerable populations and their infection indicators in this pandemic situation. Cooperation with civil organizations is required to investigate their care inequality in detail. Public healthcare budgets should be temporarily increased and services through public healthcare centers for vulnerable populations should be strengthened. In addition, the number of public healthcare professionals in the community needs to be increased to provide care services for vulnerable older people.

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CONFLICT OF INTEREST

The authors claim no conflicts of interest.

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Corresponding Author: Soong-nang Jang, PhD
Red Cross College of Nursing, Chung-Ang University, 84, Heukseok-ro, Dongjak-gu, Seoul 06974, Korea
E-mail: sjang@cau.ac.kr
ORCID: https://orcid.org/0000-0003-2621-945X

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