Statement from the President and Members of the National Executive Committee of the British Society of Gerontology on COVID-19

The British Society of Gerontology is the learned society representing gerontologists in the United Kingdom. This is a statement from the President and Members of the National Executive Committee made on 20 March 2020 in relation to the unfolding political, policy and media rhetoric and government policy concerning age divisions in response to the COVID-19 pandemic.

We urge the Government to reject the formulation and implementation of policy based on the simple application of chronological age. We also call on government and media organisations to be cautious in their use of language. It is essential that we continue to foster generational and societal cohesion during the course of the pandemic. Only by bringing the generations together in this time of crisis can we ensure that the least damage is done to people living in the UK and other countries.

We affirm the prime goal to control and limit as far as possible the spread of COVID-19. To achieve this goal requires a clear focus on evidence-based practice, using high quality research. We fully support action taken to limit physical interactions, maintain hygiene standards and restrict non-essential travel, and we understand that actions to contain and delay infection will require disruption to our everyday lives.

We urge the Government to ensure rapid COVID-19 testing for our front-line health and social care workforce and the wide range of individuals and organisations who are leading the response to the pandemic. We are also in favour of providing tests for the wider population. This allows people to respond appropriately to the pandemic, ensuring that the right people isolate themselves at the right time. Wider testing is also essential to provide access to robust data that can be used for research and modelling to assist us now in responding to and containing the virus, and in preparing better for future pandemics.

However, for the reasons set out below, we object to any policy which differentiates the population by application of an arbitrary chronological age in restricting people's rights and freedoms. While people at all ages can be vulnerable to COVID-19, and all can spread the disease, not all people over the age of 70 are vulnerable, nor all those under 70 resilient. Older adults are actively involved in multiple roles, including in paid and unpaid work, civic and voluntary activity in local communities, and providing vital care for parents, partners, adult children and grandchildren. Quarantining the more than 8.5 million people over 70 years of age will deprive society of many people who are productive and active and who can be a key part of the solution by supporting the economy, families and communities. If blanket measures are taken to quarantine older people when others in the population are not quarantined, this places additional burdens on families, communities and businesses, and causes harm to those individuals.

1. As a population group, it is wrong and overly simplistic to regard people who are aged 70 and above as being vulnerable, a burden, or presenting risks to other people. Many people in this age group are fit, well, and playing an active role in society. Older people participate in paid work, run businesses, volunteer, are active

in civil society and the cultural life of communities, and take care of family members including parents, spouses/partners, adult children (especially those living with disabilities), and grandchildren. There are currently more than 360,000 people over 70 in paid work, including one in seven men between 70 and 75 and one in sixteen women (see Table 1). Almost one million people over the age of 70 provide unpaid care, including one in seven women in their 70s. One in five people aged between 70 and 85, over 1.5 million people, volunteer in their communities. People in good health are especially likely to volunteer at older ages with almost a third of those in their early 70s doing so. Older adults should not be excluded but should be seen as a vital and necessary part of economic and community life.

Table 1. Selected activities by age group and sex, percentages

Labour market participation	age 55 - 59	age 60 - 64	age 65 - 69	age 70 - 74		
Men	79	60	27	13		
Women	73	44	16	6		
Caring	age 55 - 59	age 60 - 64	age 65 - 69	age 70 - 74	age 75-79	80+
Men	13	10	12	9	7	7
Women	24	20	17	15	13	7
Volunteering	age 16 - 24	age 25 - 39	age 40 - 54	age 55-69	age 70-85	
All	21	15	18	20	21	

Sources: Labour market participation and Care: English Longitudinal Study of Ageing, Wave 8; Volunteering: Understanding Society, Wave 8; Office for National Statistics 2018-based principal population projections

We are grateful to Professor Jenny Head and Dr Martin Hyde for analysis

2. Serious health risks particularly identified for coronavirus are prevalent across the population. Not only do high risks exist across age groups, but also many people in older age groups have no underlying health conditions. As indicated in Table 2, almost half of people in their early 60s have one of a range of health conditions (hypertension, heart disease, diabetes, lung disease, asthma or cancer). Almost one in five people in their 60s have two or more of these conditions. More than 30% of people in their 70s have none.

Table 2. People with health conditions (any of heart disease, diabetes, lung disease, asthma, cancer), percentages

People with health conditions (any of hypertension, heart disease, diabetes, lung disease, asthma, cancer), percentages

	Age					
	55-59	**60-64**	**65-69**	**70-74**	**75-79**	**80+**
Any	42	48	55	63	72	74
2 or more	13	17	20	26	29	34

Source: English Longitudinal Study of Ageing, Wave 8; respondent reported conditions

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3. It may be correct that age itself on average is presenting a risk for coronavirus even without other health conditions. However, this will not be the case for all individuals, amongst whom biological age and immune responses vary greatly. More importantly, this will on average be a gradually increasing risk with any specific age being an arbitrary point on this line. Choosing an arbitrary age, such as 70, presents the age risk as binary. This poses dangers for people below as well as above the age threshold. People below the age threshold will not be charged with the same level of responsibility for preventing the spread of COVID-19 and may falsely believe that they are not at high risk of serious illness or death. Government messaging that people aged 70 and over are vulnerable due to their age runs the risk that other groups may not take seriously messages about the need to maintain physical distance from others and to self-isolate. Messaging about how to avoid catching and spreading coronavirus should apply to everyone irrespective of age.

4. If people are to be motivated to change their behaviour, they need to accept that they are personally at risk (perhaps due to an underlying health condition or family circumstances). Sweeping age-related discrimination is unlikely to achieve the desired behaviour change. People who feel fit, strong and healthy will feel that the message does not apply to them and will characterise themselves as belonging to a group apart. The age-based messaging also risks pitting young against old. It may make older people feel resistant to what they are being told, which they do not see as applying to their situation. Media, government and public health professionals should strive to use language that resonates, rather than obfuscates, how people identify in their everyday lives.

5. People of all ages, when staying at home or trying to distance themselves physically from others, remain members of families, friendship networks and communities. All measures should be implemented with an awareness of people's need for social support and solidarity. It is clear that physical distancing needs to happen across the whole population at once, and sensible rules for maintaining mental and physical health during this period need to be employed. We cannot implement a policy that will severely weaken the physical and mental health of some age groups through isolation while others are more protected. Given the centrality of both mental and

physical well-being, there is a need for clear guidance on what people can do to maintain and improve their physical and mental health while keeping physically apart from others. This will only be effective if the message from Government is not divisive around age.

6. Research points to the fundamental importance of social connections for personal well-being and physical and mental health. The COVID-19 crisis has prompted considerable discussion of loneliness and social isolation amongst older people suggesting, quite wrongly, that these are vulnerable states that apply to older people alone. Increasingly, media discourse is also promoting the view that all older people are lonely and socially isolated. Contrary to this discourse, the evidence shows that loneliness and social isolation affect people of all ages. Recent studies suggest that young adults may be at greater risk of loneliness than older adults, with one in ten people aged 16-24 years being often lonely, compared to three per cent of people aged 65 and over (see Table 3). We also know that people can be lonely or socially isolated even when living with others. Loneliness and social isolation are already intractable social issues that warrant thought and action about connectedness and support across all age groups and communities. Evidence shows that being seen to be part of community life can act as a buffer against feelings of isolation, give people a sense of meaning in life, and protect against depression. Voluntary and community organisations, charities and statutory organisations should receive financial and structural support during this time to continue their longstanding work on tackling isolation and loneliness regardless of age. They should also be supported and encouraged to develop new strategies to improve the number and quality of people's social connections during the current time. This should include using both old and new communication technologies, ranging from radio and TV to the internet and digital devices, to facilitate social connections between people of all ages. We should be thinking of this period as an opportunity to bring people and generations together, especially by helping to bridge digital divides across society where these exist.

Table 3. Reported frequency of loneliness by age group, percentages

	16-24	25-34	35-44	45-54	55-64	65-74	75+
Often/always	10	6	5	4	5	3	3
Some of the time	23	18	12	15	16	11	17
Occasionally	27	27	24	23	23	22	23
Hardly ever	29	30	35	35	31	32	30
Never	12	18	24	23	24	32	28

Source: Office for National Statistics (2018) Analysis of characteristics and circumstances associated with loneliness in England using the Community Life Survey, 2016 to 2017 (available at: https://bit.ly/3b8wSzr)

7. Living alone is a separate issue that has not been adequately considered or addressed. While this is an issue that disproportionately affects people aged 75 and

over, especially older women, it affects all age groups and generations. About a third of men aged 80 and over are single, divorced or widowed, but this is the case for 70 per cent of women in this age group (see Table 4). There is an implicit assumption in much discussion about COVID-19 that people will have co-resident family members to look after them, to recognise that they are ill, to keep them hydrated, to help them if they are unable to get back to bed after going to the toilet, to try to encourage some nutrition or to call an ambulance. Co-resident family members can also advocate for hospitalisation or hospital care if needed. If people live alone and no-one is permitted to see them, who will do this? With a simple message to older people who live alone that they must cut themselves off from others, we are also conveying the message that we expect them to become ill without care and even die. Some countries have constructed and converted isolation centres to enable people with coronavirus to move to a place where they can be cared for appropriately, thus isolating them from families and friends but also offering access to care. There is an urgent need for clear policies aimed at supporting people who live alone of all ages. Equally, we need policies that can provide testing, intermediate care facilities (potentially requisitioning hotels, student accommodation, or office buildings), and tangible support for people who live alone.

Table 4. Marital status by age group and sex, percentages

			Men			
	55-59	**60-64**	**65-69**	**70-74**	**75-79**	**80+**
Married or civil partner	71	71	77	78	73	64
Single, divorced or widowed	29	29	24	25	27	36
			Women			
	55-59	**60-64**	**65-69**	**70-74**	**75-79**	**80+**
Married or civil partner	65	65	69	65	55	30
Single, divorced or widowed	35	35	31	36	45	70

Source: English Longitudinal Study of Ageing, Wave 8
We are grateful to Professor Jenny Head for analysis

8. As well as health and social care workers, family and friends who will need to provide care to people who become unwell form the front line of society's response to the pandemic and will need to be acknowledged and treated as such. For many people with families who they love and with whom they live or who live within close proximity, it is anathema to leave them to be severely ill, self-care in that state, and potentially die alone. Overwhelmingly, family members will provide hands-on care for one another. They will ignore entreaties to physically distance as they tend to their children, their spouses/partners and their parents and grandparents, knowingly taking risks as they do so. Families will do this for the loved ones they live with, and those they do not live with. To expect otherwise is to ignore the interconnectedness of families and the behaviour of people. Here, rather than tell families to ignore each other, we need to offer rapid testing, advice and supplies (masks where useful for intimate care, eye protection, gowns, gloves, sanitisers, soap). We should also be

providing financial support for people faced with additional costs associated with managing daily life when family members have coronavirus, such as keeping the washing machine running and purchasing cleaning and hygiene products. We need to ask people to isolate as connected clusters rather than keeping loved ones apart. We need to work with human behaviour and not against it.

9. Special thought should be given to how people might connect with loved ones who live in care settings. Denying people the chance to see their friends and relatives where the physical and mental wellbeing of both depends on that contact, and where other forms of contact may well not be facilitated, is a most drastic curtailment of human rights and needs. Testing becomes crucial, to know who has had the virus, who may be immune, and who may be able to visit in a safe way without danger. Policy and practice should seek innovative ways for people to visit their loved ones virtually, or across physical or spatial barriers. We need to have a much more nuanced and evolving discussion of this particular challenge.

10. Some common sense is also needed about so-called "self-isolation". Socially isolating in a large house with a garden, good internet connection and a steady income is a completely different experience to socially isolating in a tiny flat, with no internet and under financial stress. Online food and other deliveries, which feature as a key policy response to coronavirus, are not an option for a large number of people, do not apply at all in many rural areas, and are already difficult to obtain as companies struggle to meet surging demand. We need to find a way to allow people to walk or cycle to local shops, to take exercise (for themselves and their pets), and to wave at one another and make social connections while maintaining a safe distance and observing hygiene requirements, without being singled out or intimidated. We need to think about sustainable policies, perhaps staggering who can go out for what purpose and when, how many people can be at particular places at a particular point in time, and national and reliable delivery of hand sanitisers to food shops and pharmacies on entry and exit. Maintaining physical and, especially, mental health whilst keeping people safe and well is a priority. Exercise, personal mobility and human contact are key to healthy ageing and need to be promoted long beyond the current pandemic.

11. A key message from research on social aspects of ageing is that policy and practice should be attuned to the diversity of older people in countries like the UK. The older population is far from homogenous and differs substantially according to such characteristics as age, gender, ethnicity/race, sexual orientation, disability, socioeconomic status, marital status, household composition, place of residence and care roles. Given the diversity of older people, and the considerable social and spatial inequalities that characterise later life, broad-brush policy approaches based solely on chronological age are likely to disproportionately disadvantage some groups. They may also ignore the specific needs of marginalised groups of older people, including those who have particular health conditions, live in long-term care settings, are homeless, or are imprisoned. Research on ageing has made considerable progress in recent years in drawing attention to the heterogeneity of older people. It would be a highly retrograde step if this progress was undone by

policy measures that reinforce the view that all people over a certain age share a particular set of characteristics.

12. As well as preparing policies for living through this pandemic, we need to think about death, and the potential for death rates not witnessed for generations in the UK. We need sensible, realistic and emotionally supportive frameworks for attending funerals, and for coping with individual and collective grief. Such frameworks are needed regardless of the age of people coming to terms with loss.

In this unprecedented period, we call for urgent and ongoing data collection and rigorous analysis of social and economic inequalities, and of the impact of inequalities through this crisis on the living conditions of people, their mental and physical health, and mortality. We call for urgent policy action to redress these inequalities. COVID-19 is bringing into stark vision the impact of many years of politically motivated austerity policies that have substantially eroded health and social care services and community and voluntary sector support. The crisis demands an urgent reversal of these policies and calls for future investment in social as well as health care. In particular, we call for the social and domiciliary care workforce to be fairly treated. We call for them to be protected as front-line workers against this epidemic. We call for their high levels of skill to be recognised not only in the form of words, but also in terms of their pay, job security and working conditions.

If physical distancing policies are to succeed, they need to take account of who people are, how they perceive themselves, how they behave, and their emotional needs. Such policies will be difficult to police, and enforceable sanctions are hard to imagine. We need to carry the hearts and minds of the nation with us in the months ahead if we are to ensure the least physical interaction and least spread of the disease. The COVID-19 response emphasises more strongly than ever before the need for co-ordinated ageing policy that cuts across government departments.

We note that policies identifying an arbitrary chronological age for restrictions of human liberties are out of line with approaches in other jurisdictions, including Scotland and Ireland. People of all ages are privileged with the same rights and policies need to be applied at population level. Ageism – the stereotyping, prejudice, and discrimination against people on the basis of their age – has detrimental consequences for societies and individuals. We reject firmly the ageist and stereotypical assumptions that underly public and policy pronouncements that rely solely on the application of chronological age.

We close by declaring our strong support and admiration for clinicians making hard decisions, including, in due course, potentially about rationing life-saving resources. In anticipation of these, we stress that it is not possible for clinicians to make moral judgements about the value of human life based on age. Faced by the pressures of a pandemic, clinicians will in all likelihood know next to nothing about the lives of the people they are being asked to treat and cannot weigh one life against another. All clinical decisions for access to testing and treatment as they unfold should be made on clinical need; using age alone as a criterion for decision making is fundamentally wrong.

Signed, 20 March 2020

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