

Tale of two countries: attitudes towards older persons in Italy and Israel during the COVID-19 pandemic as seen through the looking-glass of the media

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ABSTRACT

The COVID-19 pandemic has exposed the many challenges and difficulties of healthcare systems caring for older frail people. This public health crisis has indeed jeopardised the concept of the welfare state, in particular the right of older people to uncompromised healthcare. Together with the clinical challenges facing the geriatric patient and the organisational difficulties of the healthcare systems, sociocultural factors may have also played a substantial role in the strategies that countries have applied in coping with the pandemic. In this opinion article, we report attitudes towards the older populations of two countries, Italy and Israel, during the COVID-19 pandemic as viewed through the looking-glass of the media.

INTRODUCTION

The development of geriatrics and gerontology has played a leading role in promoting a more positive approach to older people and the ageing process, both at a national level in many countries, and internationally. The WHO has determined that ‘Every person—in every country in the world—should have the opportunity to live a long and healthy life’.¹ The WHO has also recently developed a database of age-friendly practices² to promote healthy ageing. The need to embrace a multidimensional approach to older persons while considering vulnerabilities and resources has been emphasised, as well as the importance of focusing on functions rather than diseases,³ the promotion of healthy ageing⁴ and the development of Geroethics.^{5,6} Nevertheless, many misconceptions regarding ageing are still present in society and these potentially influence behaviours. The presence of these misconceptions may have significant ramifications, particularly during times of crisis (eg, during the COVID-19 pandemic), and these attitudes and beliefs may result in negative attitudes and feelings towards older people.

In this article, we present how two countries, Italy and Israel, have responded to the COVID-19 pandemic at the early stages. We hope that the situations here exemplified, coming from the experiences of two countries that are similar yet different, might help highlight the many sociocultural barriers that have influenced the response to the COVID-19 pandemic. In particular, these two countries have been among the first to be hit by the pandemic outside China. The very first cases were indeed detected in Italy and Israel on the exactly same date (ie, 21 February 2020).^{7,8} Moreover, we

here focus our attention on ‘a deep and old malady’ (as depicted by the WHO⁹), that has been exposed in both countries by the outbreak of the pandemic, namely ageism. Ageism represents a form of unfair categorisation of people based on age, leading to injustice in different aspects of society.

AGEISM

Ageism, according to the recent definition provided by the WHO,⁹ ‘involves how we think (stereotypes), feel (prejudices) and act (discrimination) in relation to others and ourselves based on age’. This definition highlights how these attitudes can encompass all ages. Considering the older population, it refers to the idea that getting older represents a social problem to be solved, neglected and/or disregarded.¹⁰ It results in the belief that being old implicitly determines social consequences. Ageism is a pervasive form of discrimination with explicit or implicit expressions. It is often more socially accepted than other types of discrimination. ‘Globally, one in two people are ageist against older people’, according to the WHO. Factors that increase the risk of being a target of ageism are being older, being care-dependent and having a lower healthy life expectancy. Importantly, ageism is often applied with a subtle, silent collaboration of the person themselves, who may develop the tendency to self underestimate his/her capacities (the so-called self-directed ageism, an example of the Pygmalion effect). Ageism emerges in several contexts and on different levels:

- ▶ Individual. The older person is automatically considered a non-autonomous, non-independent person without reason.
- ▶ Clinical. Some diseases (eg, dementia, chronic fatigue, malnutrition) are considered natural (even almost necessary) consequences of the ageing process. Ageing itself is regarded as a terminal disease.
- ▶ Healthcare. The older person is excluded from clinical and research protocols because of his/her chronological age. Similar issues apply when guaranteeing fair and equal access to services.
- ▶ Sociocultural. Older persons might be excluded from job opportunities, educational occasions, public transportation and/or civic participation in events and activities.
- ▶ Mass media. The mainstream media generally tends to emphasise and promote youth, implicitly stigmatising old age.



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During the COVID-19 pandemic, older persons have been particularly at risk of experiencing adverse events (including death) from SARS-CoV-2 infection and from environmental restrictions (eg, social isolation). In addition, especially during its earliest phases, the pandemic has acted as a catalyst of an ageism outbreak, exacerbating the precarious situation of the older population and challenging the intergenerational relationships.¹¹

The relationship between COVID-19 pandemic, ageism and media communication has been analysed in previous studies. An empirical Chinese research,¹² for example, has collected data using mixed method (both qualitative and quantitative) based on content analysis from five mainstream Chinese media outlets. The analyses took into account 568 articles of various types published between 3 January 2020 and 3 May 2020. In particular, it was examined how the media constructed the vulnerability of older adults during COVID-19 pandemic. It resulted that older population was depicted as:

- ▶ Passive recipients of the resources and support of the community.
- ▶ A homogeneous and dependent group, vulnerable to the pandemic.
- ▶ A 'threat' to public health, in contrast with the younger generation.

A TALE OF TWO COUNTRIES: ITALY AND ISRAEL

The study of material published by professional organisations and reports exposed by the mass media throughout the first COVID-19 outbreak in two countries, Italy and Israel, can be useful in order to present how these countries have responded to the COVID-19 pandemic.

A population and policy overview

Italy

Italy has a tax-funded National Health Service (NHS), which provides universal coverage to citizens and residents. It works through a network of public and accredited private healthcare facilities, mainly free of charge. Unfortunately, the Italian NHS has been undergoing over the past years to financial restrictions; regional autonomies have consequently accentuated inequalities in the system in terms of quality of and access to care services. Compared with most of the other European countries, Italy has relatively fewer hospital beds (ie, 3.14 per 1000 inhabitants) and relatively lower per capita (€2572) and total (8.7% of the country's gross domestic product) healthcare expenditure.¹³ For this reason, a considerable number of people turns to private healthcare services.

Italy results with the highest life expectancy at birth in Europe (men 81 years, women 85.3 years). The Italian population currently counts 7 million (11.7%) individuals aged 75 years and older. The demographic pyramids highlight that older persons are largely represented, this is also partly because of the low newborn rate.

Different care models for older adults are observed in the different Italian regions, such as residential care, home care, cash-for-care model (attendance allowance). Funds and health plans for managing frail older adults have been created in recent years: the National Fund for Non-self-sufficiency, intended to support in-home care; the National Plan for Chronicity, a document regulating the care and protection of patients suffering from chronic diseases, providing a care plan characterised by personalised diagnostic, therapeutic and assistance pathways. Nevertheless, public services that provide support and assistance to frail older adults and their carers are often insufficient. In over

50% of cases, the assistance to frail older adults is independently supplied by the patient's family or through hired family assistants. Italy counts about 7400 long-term care facilities (around 80% privately financed), with almost 310 000 beds. Still, such numbers are not aligned with the real needs, as highlighted by the comparison with other European countries.¹⁴

Older persons in Italy frequently present many of the significant issues of geriatric patients, such as loneliness (38.2%), multimorbidity (42.3%) and disabilities (22%),¹⁵⁻¹⁷ but the relatively low numbers of years lived with disability suggest that the Italian population was in an overall good state before the pandemic.¹⁸ The subsequent number of casualties due to COVID-19 were therefore somewhat of a surprise. As a consequence of the steadily ageing population, the demand for geriatric care and medical support has been continuously growing over the past years. Interestingly, however, is that although the demographic trend is often indicated as the main threat to the sustainability of the public health system, ageing does not represent a major burden, especially if compared with other factors (such as new medical technologies, the Baumol effect or socioeconomic development).¹⁹ Indeed, discussions on cost containment in public health frequently present the oldest part of the population as an economic burden for families and the healthcare system. During the last decades, several scientific societies have been trying to improve training and education in geriatrics and the correct interpretation of the process of ageing.

Israel

Compared with Italy, Israel is a small country with a total population of 9.2 million, of which 11% are aged 65 years and older.²⁰ The demographic structure of Israel is considered to be young, with a high fertility rate of 3.1 births per woman, which is significantly higher than the Organisation for Economic Co-operation and Development average.²¹ At the same time, the life expectancy in Israel is high, being 84.3 years for women and 80.6 years for men at birth. Life expectancy also remains high at age 65, being 21.3 years for women and 19 years for men.²² The high life expectancy, together with a large wave of immigration of predominantly younger people in the 1990s, has resulted in a rapid increase in the number of older people in Israel. Israel has a universal subsidised healthcare policy with all citizens being eligible from one of the four Health Funds as a basket of services. The vast majority of older people reside in the community, with only 3.5% living in long-term facilities. An extensive array of subsidised services are available, both in the community and as in-patient care. These include rehabilitation, hospital-at-home, home care, palliative care, chronic nursing care and skilled nursing care facilities, as well as supportive special units for the cognitively impaired. Israel has an active geriatric and gerontological scientific community influencing health policies targeting the older population. In addition, several national plans and strategies have been developed in dementia care, falls, polypharmacy and palliative care. Of interest is that the existence of this well-developed structure of community and hospital-based services allowed for a fairly rapid reorganisation of the healthcare system as it struggled to respond to the COVID-19 pandemic.^{23 24}

The COVID-19 pandemic and the older population

Italy

COVID-19 revealed essential weaknesses and malfunctions in the Italian healthcare system, especially in those settings (eg, nursing homes, primary care) mainly devoted to caring for older persons. Such inadequacy might have been responsible for poor

resource allocation and lack of integrated communication with the rest of the healthcare system. On the other hand, problematic statements released during the first phases of the pandemic wrongly suggested that ‘the coronavirus only affects the elders’.²⁵ These arguable positions quickly transformed the older population into a sacrificial victim, introducing a sense of impotence and paving the way for clinical decisions based on chronological age.

In a scenario of extremely scarce resources, as the one lived by several regions of Northern Italy in February–April 2020, the leading Italian Society of Anesthesiology (SIAARTI) published quite controversial recommendations for the triage of COVID-19 patients. Although the document mentioned the individual’s multimorbidity and functional status for proper resource allocation (mainly ventilators), the recommendations were still primarily driven by the chronological age parameter.²⁶ In the second version published in January 2021, the role of chronological age in decisional algorithms was diminished, giving higher priority to assessing comorbidities and clinical complexity.²⁷

Across clinical settings, services seen as non-essential for the management of COVID-19 (eg, physical therapy, occupational therapy, palliative care, outpatient clinics) were suspended and resources reallocated to the front line against the overwhelming pandemic. Although the choice may make sense (ie, resources go where they are needed), the decision implies that all patients have similar requirements, priorities and needs. It came to be true that services valued as ‘non-essential’ were indeed critical for the health of many older persons who were precluded from hospital care (because of their age/frailty status) and usual services (redirected elsewhere). One of the major problems in Italy has been indeed stemming from past decisions which preferred the well-established hospital-centric model of care and the subsequent poor investment in community services and long-term care facilities. These congregate-living environments registered the highest mortality rates not only for an intrinsic susceptibility, but also for delayed diagnostic-therapeutic strategies and containment actions in response to the widespread infection.²⁸

Moreover, the fragmentation of care and the poor connection between the hospital and the local territory led to the isolation of frail older persons at home, further burdening the families and informal caregivers. The social isolation of geriatric patients (and their caregivers) was also amplified by the needed physical distancing and the applied countermeasures to reduce the epidemiological curves of the pandemic.

These actions increased social isolation, loneliness, mental distress, morbidity, physical impairments and mortality in older persons. A higher incidence of abuses on older persons has also been reported in the USA,²⁹ a phenomenon that might not surprisingly also apply to the Italian situation. The social isolation and its consequences would have probably been exacerbated if the hypothesis of selective segregation for the older persons had been applied, as suggested by some politicians/economic analysts.³⁰ The emerging alternative forms of social engagement and medical assistance through virtual interaction collided with the high prevalence of digital illiteracy in older persons, contributing to a digital divide.

In September 2020, a dedicated commission was created by the Health Ministry to conduct an important reform of social and healthcare for the older population, with the specific goal of encouraging the transition to community care, reshaping services and introducing innovative practices. A fruitful debate has been developed about the need for substantial remodelling of our healthcare system.³¹

Israel

Soon after the outbreak of COVID-19 in Israel (March 2020), all people aged 60 years and older were determined to be at risk, instructed to go into lockdown and refrain from contacts with others. The motivation behind this was to prevent exposure to the virus and a rapid rise in cases, similar to what was happening at the time in Italy and Spain, that might have made healthcare services collapse. An extensive campaign was conducted on all mass media instructing children and grandchildren to refrain from visiting saba and savta (ie, grandfather and grandmother) to not place them at risk for contracting COVID-19: ‘Do not go near Saba and Savta: You may infect them with Corona and kill them!’.³² A positive, emotional advertisement was broadcasted on the media showing a young family who had arranged to have grandfather’s favourite chair repaired and then lifted with a crane onto the balcony of the grandparents’ apartment to receive the delicious baked goods from the grandmother. Children were actively encouraged by the media to keep in contact with their older parents utilising social media: ‘Saba and Savta by remote control’.³³ At the time of lockdown, soldiers of the Home Front took an active role in visiting older people at home and providing essential supplies: ‘Back to back with the Home Front: the youth that does not allow older people to be alone at home’.³⁴ The positive, caring (but somewhat paternalistic) atmosphere towards older citizens that prevailed in Israel resulted in the rapid establishment of a working group of the Israel Geriatric Society to determine guidelines for caring for older patients.³⁵ In addition, a National Authority was established as ‘The Shield for Fathers and Mothers’³⁶ to coordinate all matters of screening, treatment and immunisations of nursing homes residents. When Israel commenced an extensive national immunisation programme, the population aged 60 years and older was given priority for vaccination: ‘Older persons and health workers priority for immunisations’.³⁷

The COVID-19 pandemic and ageism Italy

An extraordinary amount of ageistic comments in the media stigmatising older persons as frail, passive, or a burden have been seen over the past months. At the same time, younger people have often been uniformly portrayed as incautious and irresponsible. Some political leaders and media portrayed the pandemic as a problem only for people who were of no use to the society. This sentiment is evident in many public statements in which the older persons who died because of the virus were depicted as having ‘low productivity potential’, not responding to the ‘utility and performance criteria’ of the society or representing ‘collateral damage’.³⁸ Some even praised Darwin’s laws of natural selection to save the young and future generations.

In this scenario, the restrictions applied to protect the population have been responsible for significant economic issues. The life of many productive activities has been posed at severe risk. The financial crisis combined with the identification of the COVID-19 as a ‘disease of old age’ has determined a growing resentment among young and adult persons, threatened by job insecurity and income uncertainty. There has been an amplification of the already present generational gap, with older persons seen as wasters of public resources and responsible for the healthcare system fragility. The generational preference is today becoming a spread concept. There is the risk that the younger persons may expect to have priority access to healthcare services despite the universal coverage of the Italian (public) healthcare system.³⁹ These attitudes, together with the

partial reduction of restrictions after the waves of COVID-19 pandemic (motivated primarily to sustain the economic activities challenged by many weeks of lockdown), might have influenced the willingness/capacity to adhere to the preventive recommendations. Gatherings in clubs and touristic locations during the summer movida,⁴⁰ crowds along highstreets, the vibrant discussions about ski resorts for Christmas vacation,⁴¹ and parties for New Year's Eve are emblematic representations of the pervasive egocentric individualism. In the name of personal freedom, safety measures and mutual responsibilities started to be overlooked. To stop the increasing ageism across the country during the first wave, influential personalities have called to strengthen the sense of community. The President of the Italian Republic, Sergio Mattarella, stated that 'it is crucial for a community to preserve and care for older persons as best as possible: it is not so obvious that there are so many deaths affecting older persons and this must not be accepted with sufficiency or resignation'.⁴² Pope Francis criticised the so-called 'throw-away culture' typical of the contemporary society,⁴³ in particular when some political leaders and media portrayed the pandemic as a problem of persons without contribution to the society. Furthermore, during his interventions, the Pope amplified the message that 'nobody saves himself alone', emphasising the importance of fighting indifference and selfish attitudes. The aim of their speeches was to foster, in times of crisis, the founding values and guiding principles of the Italian Constitution and Catholic social tradition: universalism, solidarity, equality, human dignity.

Israel

The extensive measures adopted in Israel aimed at isolating and protecting the older population were very effective in decreasing morbidity and mortality in the older population and preventing healthcare services being overwhelmed. In spite of these very positive outcomes, many viewed these measures as ageist in nature. An 80-year-old woman complained, 'Until Corona, I didn't feel old at all'.⁴⁴ Many complained they were being isolated at home unnecessarily, leading to loneliness, deterioration in their health and functional decline. The Israel Gerontological Society as a professional body objected to a blanket lockdown of older people: 'The price of isolating senior citizens: A disaster to society'.⁴⁵ Many also argued against clinical decisions made based on chronological age as a manifestation of ageism: 'Corona risk: Not only the age counts'.⁴⁶

CONCLUSIONS, LIMITATIONS AND IMPLICATIONS FOR FUTURE STUDIES

Especially at the early stages, the COVID-19 pandemic may have exacerbated or fostered pre-existing, insidious ageism in our societies. Attitudes and beliefs prevalent before the pandemic certainly influenced scientific recommendations and potentially ageist health policy decisions at the COVID-19 outbreak. During the COVID-19 outbreak, the importance of increasing awareness of the particular needs of the older population has become clearly evident. It is necessary to lay the foundation of integrated services to take care of the older persons' health determinants. Society should recognise and negate the pervasive ageism affecting clinical and political actions, starting from disseminating a clear explanation of the meaning of ageing and strengthening intergenerational solidarity. It is necessary to stress the importance of older persons for the sustainability of our society, underlining that the public expense sustained for the older persons in Western Countries is due for ethical and equity reasons but remunerated by tangible and precious contributions

to the society.⁴⁷ The Green Paper on Ageing, published by the European Commission in January 2020, has raised awareness around the importance that older people play across different sectors of the society (ie, active workforce, financial supporters, caregivers, volunteers, community leaders). It also explains the relevance of developing the so-called 'Silver economy', consisting of all the economic aspects related to needs and preferences of older people. Not surprisingly, the paper insisted on fostering the active involvement of older persons in the decision-making processes of the society.⁴⁸

In this context, geriatricians may play a unique role⁴⁹ and use their expertise in promoting new models of care and encouraging mutual respect between all population groups in society.

It is noteworthy that the above-mentioned cases were chosen based on media examples that were produced amid the first wave of COVID-19 pandemic without a specific methodology. The dynamics of events, as the pandemic progressed, resulted in useful developments and positive changes thanks to the produced debate on the topic of ageism. The WHO⁹ has identified three main recommendations to fight ageism, particularly developing specific research in the field:

1. 'Invest in evidence-based strategies to prevent and respond to ageism'.
2. 'Improve data and research to gain a better understanding of ageism and how to reduce it'.
3. 'Build a movement to change the narrative around age and ageing'.

During the COVID-19 pandemic, media have both played a positive (eg, disseminating ad hoc health policies and social solidarity initiatives) and negative role (eg, by amplifying ageist messages). It is necessary that media might take clearer position, better inform and promote the fight against stereotyping persons for their age.

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