Care Homes and Older Members of the Community

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Introduction

What does the Catholic tradition say about caring for older members of the community? **[1]** Do we have a special responsibility to provide for the needs of older people during a pandemic?

It is now increasingly clear that many of the deaths in the current COVID-19 crisis have occurred in aged care facilities. **[2]** Aged care homes around the world have found themselves under-resourced and under-prepared for the challenges of the coronavirus pandemic. The consequences have been catastrophic. Residents have been neglected, staff are overworked, and the casualty rate from COVID-19 has been higher in aged care homes than in any other area of society.

The Catholic Church has consistently affirmed the dignity and moral worth of older members of the community. They are a living treasure for society, and are deserving of our care and support. Society must ensure that older people receive adequate medical attention during a public health crisis, and that aged care facilities are adequately resourced to cope with the stresses associated with a pandemic. This briefing provides a summary of some of the concerns raised recently about the aged care sector, and offers recommendations for aged care policy during the COVID-19 pandemic.

Aged Care Today

A variety of social and economic factors – including an ageing population and inadequate funding – have placed increased pressure on aged care services in recent years. There are 400,000 people in residential care homes in the UK, which amounts to roughly 3.5% of people over the age of 65. **[3]** As a proportion of population, this is higher than the United States, where approximately 1.3 million older people (or 2.5% of people over 65) live in long term care facilities, though lower than Australia, where approximately 179,000 people (or roughly 5% of people over 65) live in aged care facilities. **[4]**

People in aged care facilities tend to be less healthy than other people of the same age. 70% of people in care homes in the UK, for example, have dementia or severe memory problems. **[5]** Many suffer from chronic illnesses. People in aged care facilities also tend to be socially isolated, and this can compound existing health problems. **[6]**

The aged care sector in the UK has in recent years faced several serious challenges, including a funding crisis, rising costs of care and staffing shortfalls. **[7]** The sector is a mix of private, charity, and publicly funded services, yet all providers appear to be experiencing financial difficulties. **[8]** Councils have cut roughly £7 billion in funding from adult social care over the past ten years. **[9]** The cost of caring for the elderly has also risen rapidly in recent years, in part due to an increase in dementia-related disabilities. **[10]** Many staff are underpaid – as well as undertrained – and it has been difficult for care homes to recruit staff to care for residents with more extensive needs. **[11]** These stresses have been both exposed and compounded by the COVID-19 pandemic.

The Aged Care Sector and COVID-19

Aged care homes around the world have struggled to control the spread of coronavirus. Many care homes have failed to implement adequate protocols to prevent the virus from infecting residents. **[12]** In the UK, a shortage of personal protective equipment (PPE) in care homes appears to have been one of the main factors behind the rapid spread of the virus in care homes across the country. **[13]** A lack of community testing in the UK has also made it difficult to respond quickly to COVID outbreaks in aged care facilities. **[14]** In some cases, the virus has spread from nursing home to nursing home through workers who are employed at multiple sites. **[15]**

There is growing evidence that many COVID-positive aged care residents have been denied adequate medical care. **[16]** In some cases, health authorities have instructed nursing homes to care for their own residents who develop COVID-19, rather than take them to hospital. Care homes have also received sick patients from hospitals before their COVID-19 test results have been returned, creating increased risk of contagion. **[17]** Within aged care homes, however, the ability to provide adequate care for residents is limited. Aged care facilities do not have critical care units, nor do they have medical professionals trained to deal with the myriad of complications that older people can experience when they contract COVID-19. Some residents and their families have been asked to revisit their care plans and to consider a 'do not resuscitate' decision. **[18]**

Care homes have struggled to find replacement workers when nursing home employees fall ill or refuse to attend work; this has further compounded the stresses of the coronavirus pandemic. Harrowing stories have emerged in some countries of aged care residents who were left to die in their beds unattended by care home staff. **[19]**

Residents in some facilities have also been cut off from their families. Aged care providers have rightly been concerned to limit the number of visitors admitted to care homes so as to avoid the spread of disease. Yet in some cases alternative arrangements have not been made so that residents are able to contact their families during the pandemic.

Ethical Principles and Aged Care

The response of governments and health authorities to the situation in aged care facilities has often been inadequate. This raises the question, however, of what an ethically informed COVID-19 plan for the aged care sector might look like. To this end, we can identify several Catholic ethical principles that should govern the public health response to the threat of a virus like COVID-19 in the aged care sector.

First, all human beings have an intrinsic and inalienable dignity. It has been the consistent teaching of the Catholic Church that human persons are willed by God in a special way: 'God has imprinted his own image and likeness on man (cf. Gen 1:26), conferring upon him an incomparable dignity'. **[20]** It is an all too common belief that the lives of those who are frail and infirm are not as worthwhile as the lives of those who are fit and healthy i.e. that they have no particular value. The philosophical assumptions behind this view are deeply problematic – it makes the worthwhileness of human life conditional on 'quality' of life, rather than value being an intrinsic property of human life. Like other benefits for the person, life is

important because the person him or herself is morally important, and extending access to this benefit – even if other goods and lives need consideration too – is never worthless in itself. **[21]** Much of contemporary medical ethics is based on a view that sees the maximisation of wellbeing as the end of moral action. In practice, this view results in the value of life being reduced to metrics such as Quality Adjusted Life Years (QALYs) and even seen as reducible to zero or below. In the face of such an outlook – which effectively posits different categories of human life – we must affirm the equal and transcendent moral importance of all human beings, including older members of the community, and the continued value of their lives.

It is a mistake, in any case, to think that people in older life cannot live lives of value. As Pope Francis recently stated, 'every season of life is a gift from God and has its own beauty and its importance, though marked by fragility'. **[22]** If anything, our society's attitude towards ageing betrays a preoccupation with physical wellbeing and an undervaluing of meaning and spirituality. To overcome this prejudice, society must work to foster 'a climate of mutual interaction and enriching communication between the different age-groups'. **[23]**

Second, all human beings are entitled to basic medical care. As the United States Conference of Catholic Bishops states, 'the first right of the human person, the right to life, entails a right to the means for the proper development of life, such as adequate health care'. **[24]** That is, respect for life implies a commitment to provide adequate medical care to people when they are ill, injured or otherwise in need. This right to basic medical care applies to all of humanity, no matter at what stage of life they find themselves. In practice, this means that people in aged care settings should be afforded the same care and support as other members of the community.

Some commentators have rightly warned of a double standard in how society thinks about health and social care, and healthcare workers and social care workers. **[25]** The initial approach of authorities to COVID-19 seemed to reflect this mentality. The slogan behind the UK Government's pandemic response, for example, has been 'Stay at Home, Protect the NHS, Save Lives'. Yet the idea of protecting social care was conspicuously absent from government messaging until recently. NHS workers were rightly recognised as heroes, yet only later were care workers included. Provision of PPE has consistently been worse for care homes than for hospitals and rates of death from COVID-19 are significantly higher among social care workers than healthcare workers. **[26]** Most strikingly deaths in care homes in the UK were not included in official statistics until late April, several weeks after the crisis escalated. This was in part because deaths in hospitals were easy to count on a daily basis, as the system is centralised, but it also reflected an attitude where the deaths of older people were noticed less. Yet the lives and needs of older people are of equal importance to the lives and needs of younger generations. **[27]** This philosophical conviction must be reflected in health and social care systems. Health authorities must beware of an implicit bias against meeting the needs of care homes and prioritising care for younger people.

Third, society should give priority to the needs of those who are most vulnerable. A foundational principle of Catholic Social Teaching is that of a preferential option for the poor, which is that 'the poor, the marginalised and in all cases those whose living conditions interfere with their proper growth should be the focus of particular concern'. **[28]** In the situation we currently find ourselves in, the elderly are one group who could be categorised as 'marginalised' and deserving of 'particular concern'. In practice, this means that

the needs of older members of the community should be of primary concern in public discourse, rather than being ignored in the national agenda. Taken together, these principles present a distinctively person-centred vision of aged care, based on belief in the essential dignity of each human person. Care for older people is one of the great moral challenges of our times, and is an integral part of fostering a culture of life. These considerations point to several practical recommendations concerning the aged care sector.

Practical Recommendations

First, aged care providers must be supported in preventing the spread of COVID-19 in their facilities. This means ensuring that aged care workers are provided with adequate PPE, and that COVID-19 testing be made available where necessary.

Second, care home residents must be given freedom to decide how they wish to be cared for should they fall ill during the pandemic. They must not be pressured to choose less costly or more convenient medical options **[29]** nor should they have Do Not Attempt Resuscitation decision put in place without their knowledge or consent. **[30]** Rather, they must be afforded the same rights that other patients are afforded in public healthcare services. Any other approach would be unethical and potentially illegal. **[31]**

In some cases aggressive treatment may be inadvisable, such as when a patient is very ill and facing imminent death. Yet there is a clear ethical difference between evaluating the benefits and risks of treatment and adopting biased quality of life judgements which lead to healthy elderly patients being deprived of basic care.

Third, residents of care homes must not be denied admission to hospital if they fall ill and would benefit from admission. Staff from care homes have an obligation to make arrangements for residents to be transferred to hospital, and hospital emergency response staff must not refuse service to aged care homes.

Fourth, there must be full transparency about the impact of COVID-19 on nursing homes, including accurate and up-to-date reporting of nursing home deaths and infection rates. One of the obstacles to forcing government action on the dire situation in the sector has been the lack of accurate data on how badly affected nursing homes have been by the crisis.

Fifth, residents of care homes should be provided with an adequate means of contacting their family and friends, especially if residential visits have been temporarily suspended. Care homes should be supported in utilising new technologies to allow residents to contact their friends and family. In other cases, care homes may be in a position to allow residents to be withdrawn from care if they or their family request this. Deprivation of Liberty safeguards should only be used when strictly necessary.

Finally, there is an urgent need for authorities to acknowledge their failure adequately to protect older people in care facilities in the first phase of the pandemic. If the reasons for these failures are not reviewed and addressed then older people will continue to be at heightened risk even as countries gradually relax their restrictions on the general population. What is needed is not just the aspiration to do good but practical steps to prevent the repetition of past failures.

Conclusion

The coronavirus has caused unprecedented upheaval in our individual and collective lives. Yet few sectors of society have been as badly affected as the residents and staff of aged care

facilities. The extremely high death rate in aged care homes will likely be viewed as one of the great failures of health authorities' responses to the COVID-19 crisis.

While the threat of overwhelmed ICU wards may have passed, the threat to care homes is far from over, and it is imperative that governments and health authorities continue to respond to the needs of the aged care sector. This includes the provision of better healthcare services for care homes, the provision of PPE for aged care staff, and respect for the rights and liberties of care home residents. At a deeper level, our leaders should reflect on the influence of ageist bias in their attitudes towards the needs of care home residents and staff. The COVID-19 pandemic has stretched governments to their limit. But this does not license a suspension of ethics. On the contrary, history shows that it is in a time of crisis that our concern for society's most vulnerable becomes of greatest importance.

Endnotes

[1] The term 'older people' and 'older population' refers to people over the age of 65.

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[5] *Ibid.*, 11.

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[19] Graham Keeley. 'Corpses of the elderly found abandoned in Spanish care homes', *Al Jazeera*, 25 March 2020.

[20] Saint John Paul II. *Centesimus Annus: Encyclical on the 100th Anniversary of Rerum*

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[21] Helen Watt, 'The Dignity of Human Life: Sketching out an "Equal Worth" Approach', *Ethics & Medicine* 36.1 (2020): 7-3.

[22] Pope Francis. *Speech to the members of the Italian National Association of Senior Workers*, 15 October 2016.

[23] Saint John Paul II. *Evangelium Vitæ: Encyclical on the Value and Inviolability of Human Life*, Vatican City: Libreria Editrice Vaticana, 1995: n.94.

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[25] Mason, 2020.

[26] Office of National Statistics 'Coronavirus (COVID-19) related deaths by occupation, England and Wales: deaths registered up to and including 20 April 2020', ONS, Statistical bulletin 11 May 2020.

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