

Article

COVID-19 Pandemic and the Plight of the Elderly: Nordic Experiences

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Abstract: Part of the rationale behind public health measures is protecting the vulnerable. One of the groups most vulnerable to COVID-19 are the elderly and, consequently, many countries adopted public health measures that aimed to keep the elderly safe. The effectiveness and the consequences of those measures, however, leaves a lot to be desired. In my article, I will look at the steps that the Nordic countries took to protect their elderly and assess their success. I will further analyze those in the light of standard ethical theories. Public health crises often call for choices between two evils. Selecting patients for intensive care is one such choice, and again, it seems that for the elderly, the outcome was less than favorable. Overall, from the point of view of ethics, many countries failed miserably when it came to the treatment of the elderly. I will end my paper by discussing the lessons we can learn from the COVID-19 pandemic and suggests measures we need to take to offer genuine respect for the rights of the elderly.

Keywords: COVID-19; ethics; pandemic; elderly; scarcity; vulnerable; prioritisation; triage; human rights



Citation: Takala, T. COVID-19 Pandemic and the Plight of the Elderly: Nordic Experiences. *Philosophies* **2022**, *7*, 103. <https://doi.org/10.3390/philosophies7050103>

Academic Editor: Fabrizio Turoldo

Received: 17 August 2022

Accepted: 13 September 2022

Published: 16 September 2022

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1. Introduction

The healthcare sector in the Nordic countries is under increasing pressure, due to aging populations combined with advances in the medical sciences and the resulting increased ability to diagnose, treat and cure various conditions. While, arguably, some advances have brought the price of certain interventions down, there are also a growing number of very expensive diagnostic tools, medications, and procedures available. Scarcity of funds and the need to prioritize have become the norm. As Ó Cathaoir et al. (2021) acutely observe, for countries that have ratified, for instance, the International Covenant on Economic, Social and Cultural Rights and are, thereby, committed to recognizing the Right to Health without discrimination, this is not only a moral problem, but also a legal one [1].

One area in which the Nordic Health care systems are clearly underperforming is care for the elderly, both in care homes and in home care. The situation seems to be the worst in Sweden and Finland. In order to cut costs and meet budget pressures, care homes have been privatized and much of the elderly care, in general, outsourced. When care institutions are run according to the rules of market capitalism, problems will arise. Attempts to increase profits and growth year after year have led to substandard care, needless suffering, and premature deaths. Over-worked and sometimes underqualified members of staff are rotated between different locations in the name of efficiency. There is very little continuity in care. Overall, there is a personnel shortage contributing to over- and under-medicating, and to a lack of professional care and activities. Reports of residents' personal hygiene not being attended to, malnutrition, dehydration, and other mistreatment, are far too common [2]. These problems were made worse by the pandemic, and some of the efforts to protect the elderly from COVID-19 made them catastrophic.

As of January 2022, 94% of all the COVID-19 deaths in Sweden took place in long-term care facilities (LTCF). There were a staggering number of deaths, at 19.2% deaths per 100 LTCF beds in Sweden. In Finland, with significantly lower overall COVID-19 mortality,

there were 0.5% deaths per 100 LTCF beds, but even so, 65% of people who died of the virus were LTCF residents [3]. Obviously, not all LTCF residents are elderly, but a significant majority are. Statistically, the older you are, the more likely you are to die of the virus. However, this alone does not explain the high rates of death among residents [4].

2. Save Lives or *Primum Non Nocere*

Early on, “the elderly” became one of the groups viewed as the most vulnerable and as such, one of the groups targeted with protective measures, many of which were restrictive. The criteria for who belonged to the group (in terms of age) varied from country to country. Finland used 70 years as the cut-off point. When the pandemic hit, people aged 70 and older were asked to stay at home and told that it would be better if they had no visitors. This was actually a recommendation and not a mandate, but the wording was such that people interpreted it to mean that this was required [1]. The rationale was that the most efficient way to protect vulnerable groups from the virus—and the risk of death—was to minimize their social contacts.

When asked to justify the restrictive policies, politicians and public health officials alike still tend to say that their “first priority was to save lives”. Obviously, this is not true without qualification, which is apparent if we look at the different policies adopted by different countries. Sweden’s qualified answer could have been “our first priority was to save lives as long as it didn’t hurt the economy or inconvenience the not-so-vulnerable” and Finland’s, “our first priority was to save lives and some inconveniences to the not-so-vulnerable are acceptable, and less important sectors of the society such as culture can be limited, but the overall economy should not suffer too badly.” Other countries, for instance in Southern Europe, as well as China, adopted much more restrictive measures than the Nordic countries.

However, if we look at the pandemic as a medical ethics issue, which it at least partly is, what is striking is the lack of attention given to the first principle of medical ethics: *Primum non nocere*—first, do no harm. Perhaps, in the very beginning, when we knew so little about the virus, some of the more drastic restrictions were understandable and perhaps even justifiable. However, as the weeks and months went by and our understanding of the virus increased, more attention should have been given to the various harms caused by the measures taken. Loss of life is surely a harm, but it is not the only one. A lot more attention should have been directed towards balancing and assessing the risks and harms. Maybe we could have extended the requirement of minimally inconveniencing masks and eased the restrictions on people in care homes? With the elderly, it often seemed that the loss of life was the only harm properly considered, and even with that, most countries failed.

3. Incalculable Harms Caused

Many elderly people suffered a multitude of harms during the pandemic. Their access to health services and other care and support was compromised, and at times, nonexistent. Even essential support, such as nutrition, hydration and help with daily hygiene, was neglected. Their activities were severely limited, movement restricted and normal social interactions made, at times, impossible. The pandemic also made the elderly less safe from violence, neglect, and abuse [5].

All these caused unacceptable suffering and led to numerous not-directly-COVID-related deaths, as the physical and mental wellbeing of many older people deteriorated during the pandemic. Everyone, young or old, in need of non-urgent medical care or social care had their needs unmet during the pandemic, but as a group, those living in care homes had the worst fate. And it was not only the residents who suffered, it was also their relatives and friends who were put through agony. With the less-than-satisfactory conditions in many care homes, many people had visited their loved ones not only to spend time with them, but also to make sure they were properly taken care of and that they had what they needed. With visits to care homes banned, relatives became helpless. While some were able to use phones and video calls to keep in touch, a significant number of

those living in care homes were unable to work the devices unassisted and for some, in the rare occasions that assistance was available, the voices and video were just confusing and caused anxiety. Thousands died in care homes alone and often family members were only allowed in afterwards to collect the belongings of the deceased. They could not do anything to ensure that the last months of their loved ones were, at the very least, tolerable.

Lockdowns, home schooling, limited social contacts, and disruptions to normal life caused a multitude of harms to everyone, some more severe than others. However, for everyone who lived through the pandemic, there became a day when restrictions were lifted, and they were able to start undoing the damages done. They had a future. Pivotal moments in people's lives might not have gone to plan, but there were new plans to be made, new memories to be created. For those who died alone, isolated from their loved ones, that was it. Nothing could be done to make it better.

4. Failure to Protect

Banning visits to care homes was justified as a necessary measure to protect the vulnerable. Next of kin were seen as a threat. Unfortunately, it was then that the care staff became the threat. Especially in the beginning of the pandemic, the care staff were totally inadequately equipped with personal protective equipment (PPE) such as masks, gloves and gowns. The governments were quick to provide hospital staff with the required PPE, but for a long time, they were not provided to those working in care homes and in home care. This exposed both themselves and their patients, and customers, to the virus. In addition, because many of the care staff members worked on hourly contracts and could not afford to stay off work if they were feeling a little under the weather, and because staff members were rotated among different locations, often, it was the staff who brought COVID-19 to care homes [6]. And once the virus got in, the majority of staff and residents were at risk of getting infected. And because care home residents tend to be feeble and have underlying medical conditions, for them, getting infected with COVID-19 has a high likelihood of resulting in death.

Once vaccinations became available, one would have thought that they would have provided an extra layer of protection, which they did, but only to a degree. None of the Nordic countries required care staff to get vaccinated. In Sweden, the unvaccinated were moved away from personal care, but in Finland, they were allowed to continue in their previous jobs. People living in care homes had been deprived from seeing their loved ones in the name of protecting them, but the inadequately equipped and underpaid staff brought the virus in, regardless. Now, with vaccines, there was an additional means with which to protect the residents, but this was not required. The injustices brought on to the elderly in care homes kept piling up through the pandemic.

If people are deprived of a multitude of basic goods in life, they must, at the very least, get better protection in return. And even if better protection could have been provided, it is unclear whether, ultimately, the paternalism over the care home residents and their next of kin was defensible. Most liberal theories allow the curtailing of people's freedom to protect others, but with the elderly, their freedoms were taken away, essentially, to protect themselves [7]. Once it became clear that the pandemic was not going to go away anytime soon, much more should have been done to find ways to respect the rights of care home residents.

5. Isolation as Incarceration

Even when the general bans forbidding visits to care homes were lifted, many institutions upheld the policies, citing "inability to arrange them safely" as the reason. In most cases, it was more about the unwillingness to spend resources than actual inability. Some care homes with residents with persistent and active relatives were able to find solutions. For instance, temporary structures with two entrances and see-through dividers were set up in the yards of care homes [8]. Most people living in care homes, however, had no such opportunities.

Once the virus was circulating in a care home, even more drastic measures of isolation were put in place. Many residents, including people with dementia, for whom it was particularly stressful, were confined to their rooms and even contact with staff was kept to an absolute minimum [4]. This brought the harm caused to a whole new level.

In short, care home residents were put under similar circumstances to prisoners, or maybe even worse. Their freedom was taken away, they were not allowed visits from their loved ones, they had no idea when the isolation might end, and they felt, in many cases quite reasonably, unsafe. There is nothing that justifies treating people, especially those approaching the end of their life, like this.

6. Ageism and Postcode Paternalism

In many instances, age was used as a shortcut to determine whose movements were restricted and even who had access to care. There is some evidence of underhand discrimination: cases where older patients were ‘triaged’ to allow resources to be used on younger patients instead [4,9]. People died in care homes in large numbers, because they were never moved to hospitals to receive treatment. In Sweden, biological age was explicitly included in the priority-setting criteria in situations where the intensive care unit was at full capacity [10]. Given that pandemics are public health issues and that public health deals with numbers and statistics, it is understandable that categories like “the elderly” and “people above certain age” dominated the discussions. However, from an ethics point of view or from the viewpoint of human rights, relying on such morally irrelevant categories leads to unjust practices. What was not considered is that “[t]he older population is an incredibly diverse group, with chronological age only loosely correlated to biological age” [5]. Age is just a number and age-based discrimination is no more acceptable than, for example, discrimination based on sex, gender, religion, or ethnic origins.

Another largely morally irrelevant category resulting in discrimination was the place of residency. At times, everyone in a given country living in long-term care facilities, including nursing homes (regardless of their age), had their basic rights and liberties curtailed, while those in home care had it, in most cases, slightly better. At least, relatives and friends were able to visit—although this was discouraged. At other times, the geographical location of the care home within a country determined the level of restrictions. This happened when the prevalence of the virus was significantly different in different parts of the country.

Restrictions were laid on people simply based on their age and place of residency, and after the initial panic response to the pandemic, much more should have been done to stop such discrimination.

7. Ethical Analyses

Initial analyses have shown that the treatment of the elderly during the pandemic has been unacceptable. For a more theoretical scrutiny, I will utilize Häyry’s (2021) classification of standard ethical theories; act utilitarianism, rule utilitarianism, moral legalism, Kantian ethics, natural law ethics, and virtue ethics [11].

Act utilitarianism is a theory that requires us to aim to maximize “a good” or minimize “a bad” with each individual decision we make. It is arguable whether it can be seen to be applicable to policy decisions, as policies are intended to guide several decisions at different times and in different circumstances. However, since deciding on a policy is an individual act of deciding, let us assume that act utilitarianism can be applied here. The overall aim of the restrictions placed on the elderly was to save the maximum number of lives, which is clearly a good utilitarian goal. Act utilitarianism could have been used to justify the initial restrictive policies, but as soon as it became obvious, especially as was the case in Sweden, that the goal of saving lives was not met, the policies should have been revised. Further, act utilitarianism also requires us to make decisions that minimize “a bad”, which in this case were the numerous harms caused to the elderly by the restrictions. Strategies to minimize harms, other than financial harms, were never fully discussed and

had hardly any place in policy decisions. From a utilitarian point of view, this was a clear oversight, if not negligence.

Rule utilitarianism is about formulating ethical rules that maximize “a good” or minimize “a bad”, which can then be applied to relevantly similar circumstances. As such, it lends itself more readily to assessing policy decisions. As was shown earlier, however, the restrictive policies put in place were not very accurate in capturing “relevantly similar circumstances”. Mere age or place of residency proved to be discriminatory categories that failed to identify morally relevant similarities.

Moral legalism is not an actual ethical theory, but it often guides people’s ethical thinking. The basic tenet of moral legalism is that in order to be moral, we simply need to obey the prevailing laws. For those who uphold moral legalism, there is no need to question the existing laws. Something is morally wrong if it is legally forbidden. For example, in the Nordic countries, discussions about recreational drugs often take a moral legalistic turn. “Of course, drugs are wrong. They are illegal.” In the context of the COVID-19 pandemic, human rights lawyers frequently argued that many of the restrictive policies violated international human rights and were, therefore, wrong. Keeping elderly people in extended isolation, in circumstances similar to incarceration, is a clear example of such violations.

At the core of *Kantian ethics* is the requirement to “[a]ct in such a way that you treat humanity, whether in your own person or in the person of any other, never merely as a means, but always at the same time as an end” [12]. This is known as the humanity principle. Assessing the actions taken during the pandemic, taking into account the humanity principle, takes us to the heart of the principle itself. What exactly do “as a mere means” and “as an end” mean? The isolation of people in care homes was done to protect them (“as an end”) and to protect other residents (“as a means”), but when this led to people dying alone without adequate care, it is difficult to see how the practice could have been in accordance with the humanity principle. Further, it could even be argued that the involuntary isolation of the elderly was, from the start, a case of treating them as mere means. It deprived the elderly of their autonomy, which in the Kantian model, is key to our humanity.

Thomas Aquinas is the paramount theorist of *natural law ethics*. According to him, the basic principle of natural law ethics is that good is to be done and evil avoided. There are certain basic human goods, such as life, procreation, knowledge, society, and reasonable conduct, that should be pursued [13]. Many policy decisions to counteract the effects of COVID-19 were made to protect a number of goods on his list and, as such, natural law ethics would support them. However, since the success of these policies has been questioned, in hindsight, support from natural law ethicists might not be unequivocal, but there is more to natural law ethics.

Aquinas is also often mentioned as the originator of the *doctrine of double effect*. To put it simply, the principle states that sometimes it is acceptable for our actions to have bad outcomes as long as they were not intended, but merely foreseen, and the good effect produced by the act (which itself needs to be good, or at least morally neutral) needs to follow immediately and to be good enough to outweigh the bad side-effect [14]. The principle can be used, for instance, in end-of-life situations, to justify administering adequate amounts of pain killers even when it is foreseen that doing so will hasten the person’s death, which would otherwise be wrong, according to natural law ethics. Similar logic can be used to allow abortions in rare cases. Arguably, it might be possible to justify the isolation of the elderly, and the resulting harms, based on the doctrine of double effect. The overall aim was to protect life and society and while the harms to the elderly were to a degree foreseen, they were an unintended consequence. Some ethical and verbal acrobatics would be needed to show that isolation in itself was a neutral act, but with clever wording, such as not talking about isolation, but “keeping safe”, it could be done. So, arguably, it might be possible to use the doctrine of double effect to justify the policy decisions with bad consequences. However, outside natural law ethics, the doctrine of double effect is

often criticized, and its legitimacy is not widely recognized, so the value of such support would be limited.

Virtue ethics was long forgotten, but it has, during the past few decades, seen a resurgence, with the rise of care ethics and various other situational ethics. A virtue ethics-and, especially, care ethics-based analysis of the treatment of the elderly during the pandemic would make us more aware of the needs of the vulnerable groups and the special relationships in care situations. Virtue ethics would not have many good things to say about the policy decisions taken that affected the elderly, but it could pave the way forward.

8. Ethics in a Pandemic—Some Concluding Remarks

Nordic welfare states need to re-think the way the long-term care facilities are organized so that they stop being places of frequent unethical conduct and human rights violations. The governments need to improve and take equal responsibility for the welfare and rights of all citizens. By now, it should be clear that to uphold the values of a welfare state, health and social care cannot be turned into, and allowed to continue as, mere businesses. More resources need to be directed towards taking care of the aging population. This also includes better work conditions and salaries for care staff.

Further, we need to start preparing for future pandemics and other public health crises, in order to have processes in place that do not systematically discriminate against certain groups of people. We have to be open to more nuanced ways of assessing harms and benefits. It is very likely that saving the greatest number of lives should not even be the main goal, but rather minimizing harms across the board. The necessary burdens need to be distributed more evenly. Sacrificing the rights of the most vulnerable cannot be the solution.

Funding: This research was funded by the Ministry of Agriculture and Forestry of Finland, grant number VN/2470/2022; and Jenny and Antti Wihuri foundation, project “Crises of justice” [Oikeudenmukaisuus kriisissä].

Conflicts of Interest: The author declares no conflict of interest.

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