COVID-19 is a disease of older people

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COVID-19 is primarily a disease of older people. In the United States, 31% of cases of COVID-19 have occurred in people over the age of 65 years and 6% over the age of 85 years. People 65 years and older account for 45% of hospitalizations, 53% of ICU admissions, and 80% of deaths. Case-fatality rate increases with age, from 3-5% between 65-74 years, 4-11% 75-84 years and 10-27% above 85 years (1). These USA statistics are generally similar to those reported in other countries such as China and Italy (2, 3). Older people are also more likely to have comorbidities that increase the risk of mortality and morbidity: hypertension, diabetes and coronary heart disease (4). Younger adults are dying from COVID-19 too – it is a threat to everyone – however, older people are bearing the brunt of the pandemic.

The first infections with this coronavirus were recognized in December 2019 in Wuhan, China and since then, over 80,000 people in China contracted COVID-19, with more than 3000 deaths (4). Italy is now second to China in terms of cases and but with more than double the number deaths. Italy has one of the oldest populations in the world, with 23% aged 65 years or older which in part explains why its case fatality rate (7.2%) is so much higher than in China (2.3%) and other countries (5). The USA has also seen a dramatic increase in the number of cases and now is ranked third, with the vast majority of deaths occurring in people aged 65 years or more (1). Older people in residential aged care facilities and nursing homes have even greater risk of death given their age and comorbidities, confounded by the lack of capacity for social distancing from staff and other residents.

It must be a difficult and frightening time for many older people. Some of the media and political rhetoric has implied we do not need to be too alarmed because mortality is mostly confined to older people with underlying illnesses. This is not necessarily correct – many younger adults have had severe infection with significant mortality – but this type of message infers that the lives of older people with underlying illness are less valuable. It has been argued that potential years of life lost should be considered if care is rationed, yet perhaps more critical now is the experience and wisdom

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of older adults. A case in point is Dr. Anthony Fauci, Director of the National Institute of Allergy and Infectious Disease in the United States. His experience with previous epidemics is priceless to us now. Therefore, it is particularly important that now, more than ever, we advocate for our older people, stand up for their rights and listen to their advice.

Italy has been grappling with decisions about which patients should be prioritized for ventilation when intensive care unit (ICU) beds and ventilators are limited and this has mostly come down to decisions based on age, (with a cut-off as young as 65 years in some regions (6)). The United Kingdom appears to be using frailty assessed using a 9 point pictorial scale to allocate critical care interventions (7). Similar decisions will soon face doctors in the USA (8). ICU admission and ventilation may be futile in some frail older people with multimorbidity, however, there is a very big ethical difference between decisions made on the basis of futility versus those based on rationing (9). Withholding and rationing potentially life-saving ventilation just on the basis of age is not acceptable. The field of gerontology has long advocated for alternatives to chronological age to personalize prognosis and treatment choice. A survey of lay people about who to prioritize for ICU admission in the setting of a viral pandemic, found that the most favored response was that the decision should be made be a senior doctor (10), adding a huge burden to doctors working in an overstretched acute hospital system. Geriatricians should have an important role in such decision-making, as well as the management of factors that influence outcomes of many older patients with acute severe illnesses (delirium, complications of immobility, multimorbidity, frailty, functional impairment).

Apart from the threat of a severe and often fatal viral infection, the COVID-19 pandemic is influencing the lives of older people through a wide range of downstream societal consequences. Many countries have introduced social distancing and self-isolation in an attempt to reduce the numbers of people infected and to slow the rate of infection. While this will expectedly reduce the impact of the disease on older people, these interventions will exacerbate the social isolation of

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some older people. Hoarding of food, medications and household products has led to empty shelves in many shops, reducing older people's access to essential items. The prioritization of health care for COVID 19 means fewer resources will be available for the care of older people with other medical problems (11). And the financial collapse linked with COVID-19 will reduce retirement funds that provide income for older people now and for many years to come.

We note that in the rush to publish COVID-19 papers, concerns have been raised that the same patients have been reported in different publications, with the risk of misleading the medical community (12). While making every effort to prevent this issue, the Journals of Gerontology Series A Biological Sciences / Medical Sciences will fast track any appropriate manuscripts about COVID-19 and we will publish them free to view. In this way our Journal can contribute to the international effort to overcome the pandemic and support our older people who are the main victims of this disease and its effects on broader society.

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