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Inconsistent and Arbitrary Age-Based Policies During the First Wave of the COVID-19 Pandemic

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ABSTRACT

The COVID-19 pandemic has forced countries to issue public measures to address threats to the safety of citizens and the healthcare system. The role of chronological age in the ways in which different countries coped with the pandemic is particularly intriguing. Based on pool of purposely selected twenty-one countries, this article compares a variety of urgent public health policies that have been enforced during the first wave of the pandemic. It analyzes the ways in which countries introduced instructions related to older people and/or chronological age in relation to: Lockdown, exit and triage policies. It also examined whether the issue of long-term care settings (LTCS) received special attention in the primary guidelines developed in response to the lockdown and exit strategies. The analysis demonstrates inconsistencies within and across countries in the enactment and implementation of age-based measures. Moreover, it suggests that both acts of omission and commission based on age can be interpreted as ageist, arbitrary, not based on evidence, too inclusive, and offensive toward older people and neglectful of specific risk groups.

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Ageism; COVID-19; discrimination; healthcare policy; long-term care; public policy; social distancing; triage; World Health Organization

Introduction

This study is focused on the role that older chronological age captures in policy measures enacted in response to the pandemic during its first wave. The study compares and analyses a variety of official policies that were enacted in different countries during the first wave of the pandemic. On January the 30th, 2020, the World Health Organization (WHO) announced that the new Coronavirus is an acute respiratory illness caused by a novel human virus (SARS-CoV-2, called COVID-19). The virus causes higher mortality in people aged ≥60 years, as well as in people with underlying medical conditions (World Health Organization, 2022). Although different risk factors have been identified over time, especially during the first wave of the pandemic, older chronological age was identified as a major risk factor both in the media and by policy stakeholders. Urgent public health policies that have been enforced in different countries introduced unique instructions related to

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older people and the measures that are needed for their safety, care, and health, but also for the sustainability of the health care systems (Halpern et al., 2020). The present study examined patterns in the use of chronological age in different realms of public health measures presented during the first wave of the pandemic. Specifically, the study analyzed the role of chronological age in policy measures related to lockdown, exist, triage, and long-term policies. This analysis is important to help policy stakeholders to better guide future measures during uncertain extreme situations.

Ageism and COVID-19

The COVID-19 holds greater risks for older adults. Specifically, there is plenty of research to show that age is an independent risk for mortality and severe illness due to COVID-19 (Jordan et al., 2020). This information has been conveyed to the public even during the early stages of the pandemic. Although this information is important to convey, multiple researchers have warned that the spread of the virus coincides with the spread of ageism (Ayalon, 2020; Ayalon et al., 2020), which is defined as stereotypes, prejudice, and discrimination toward people because of their age (Ayalon & Tesch-Römer, 2017, 2018). In the media and in public discourse, older adults have been portrayed as a vulnerable group, while younger people believed that they were immune to the virus (Meisner, 2020; Cohn-Schwartz, & Ayalon, 2020).

In contrast to research that has looked at ageism during the COVID-19 pandemic as manifested in stereotypes and prejudice toward older adults (e.g., the cognitive and emotional components of ageism), the present study examines ageism as manifested in the discrimination of people because of their age (e.g., the behavioral component of ageism, manifested in policy measures during the pandemic). As the pandemic started to threaten the entire world, chronological age was discussed and presented as the most significant risk factor within the context of the pandemic. Therefore, we focused on the role that was given to chronological age when these urgent policies were introduced.

This picture is intriguing, because the literature prior to the outbreak of COVID-19 went into a great length to distinguish between chronological and biological age (Mitnitski et al., 2002). This distinction recognizes the heterogeneity in old age. It also allows for more nuanced distinctions between older people, as in the case of noting the frailty level of individuals as a possible risk, rather than simply relying on one's chronological age. It seems that awareness of the dangerous discriminatory nature (at least in some cases) of chronological age as a sole criterion for policy measures was higher among policymakers, scholars, and the general public prior to the pandemic. The first wave of the pandemic might be identified as a retreat back again to a situation in

which chronological age pushes back biological age in determining public health policies and the public-medical regard toward older adults.

The theoretical framework of the study

Theoretically, the present inquiry is guided by critical age theory. The theory suggests that although clearly chronological age has a biological component, it also is socially constructed. The theory points to the dominance of age discriminatory practices and regulations in current policy measures and laws. Moreover, similar to critical race theory, the theory of critical age suggests that chronological age alone should not be examined as a single criterion. Instead, age should be examined in intersection with other characteristics, such as sex, socioeconomic status, or health. It is the intersection of these various attributes which results in structural inequalities.

Another relevant theoretical framework relies on the concept of institutional or structural ageism (B. R. Levy, 2022a). In a nutshell, this theoretical framework studies and criticizes the ways in which official institutions use chronological age in discriminatory ways toward older adults. Institutional or structural ageism operates in a wide range of domains, including local government and public health systems (B. R. Levy, 2022a). A recent World Health Organization report on ageism concluded that, "Often people fail to recognize the existence of such institutional ageism because the rules, norms and practices of the institution are long-standing, have become ritualized and are seen as normal" (World Health Organization, 2022).

The present study

This article compares 21 countries worldwide in terms of their policies used to curtail the transmission of the virus and manage its effects on healthcare systems during the first wave of the pandemic. It presents reflections of formal decisions of state authorities by examining the reliance on age-based criteria for three of the most essential policy reactions to the virus during the first wave of the pandemic, namely, lockdown, exit and triage strategies. The sample of the reports used for the analysis focused on the restricted timeframe of the first wave of the pandemic, when knowledge and understanding of the pandemic were beginning to accumulate. Thus, the immediate response to the pandemic. All reports reviewed here were published on or before May 2020.

Lockdown represents the initial reaction to the virus, which required citizens, worldwide, to physically isolate to prevent the spread of the virus. Exit represents the return of countries back to a new routine, after the initial chain of contamination was disrupted during lockdown. The

decision to focus on both strategies, rather than merely lockdown strategies stems from the fact that exit strategies provide a longitudinal dimension (occurring after lockdown), possibly allowing countries to change their measures based on accumulated knowledge. Finally, triage represents the decision of health authority regarding the allocation and continuation of treatment during times of scarce resources.

The three strategies selected for review are the most basic ones that represent most clearly the country's overall reaction to the virus to protect its population and its healthcare system. We also examine the governmental response to long-term care settings (LTCS), as these settings specifically target older adults and pose a particular risk not only because of the characteristics of the settings but also due to the characteristics of the residents. These settings represent the weakest link in most countries (Pillemer et al., 2020), with the average death rate during the first COVID-19 wave ranging between 40% and 80%, depending on the country. Although other groups (e.g., people with chronic illness, people with physical disability) also were affected during this intense and chaotic period, the aim of this article is to examine the place of chronological age in policy measures facing COVID-19. We also aim to point to future steps that should be taken to live in a world for all age – when age is no longer a barrier nor a reason for human rights violations, even under extreme conditions and pandemic threats.

Methods

The sample

Countries were purposely selected to cover a range of geographic locations, varied proportions of older adults in the country and different developmental levels. This broad sample allows us to examine the consistency of age-based policies across geographic locations and different country characteristics. See Table A1 in the Appendix for country characteristics.

We specifically focused on policies that were introduced or published by state authorities (e.g., Ministry of Health, Public Health Department). Hence, our focus was top-down measures. Official information was available in English in the case of the following countries: The United States, Argentina, Britain, Germany, Austria, Czech Republic, the Netherlands, Iceland, and Israel. For the other countries, we relied on information available on the internet as well as on data and reports made by the WHO and the United Nations (UN). Data collection occurred during the first wave of COVID-19 and the documents reviewed were produced between January and May 2020. Critical age theory and structural ageism are integrated into the study and support its findings. In that manner, the

critical focus on chronological age is based upon these two main theories as framework.

Procedure and analysis

This study is based on a qualitative methodology. The first author searched for relevant sources using the inclusion and exclusion criteria listed in Table A2 of the Appendix. To enhance credibility, the starting point was official bodies responsible for the measures as explained above. We attempted to obtain more than one official document per country for that purpose. To broaden the search, the first author also relied on non-official documents in the case of Uganda, in order to include a non-Western African country in the sample. Next, the selected reports were extracted by the first author according to the four main areas of focus (e.g., lockdown, exit and triage policies, and LTCS), and then reviewed by the second author. While extracting the data, a particular focus was placed on the role of chronological age regarding each of these four areas. Next, commonalities and differences across countries based on their characteristics were examined using constant comparisons and contrasts. This was done to possibly reach generalizations about common measures enacted within the same geographic region/s and/or other relevant country characteristics examined in this study. Commonalities and differences within countries also were examined regarding the four domains which formed the basis of this analysis. To increase trustworthiness, the second author reviewed and commented on the analysis against available data. Both authors read, compared, and analyzed relevant literature and studies, and extracted arguments and data using a relevant extraction sheet. Disagreements regarding the possible analysis of the collected data in terms of the relevant category or categories, as well as for concerning the understanding of policy instructions, were discussed by the authors to reach a consensus.

Findings

Table A3 (in the Appendix) presents a summary of the findings by country and policy measure. Because we relied on official data available in English, not all policy measures have available data for all countries.

Lockdown and social distancing

Several countries embraced measures that reflect age-based criteria. For instance, Argentina instructed on March 16th the entire population older than 60 to work from home together with pregnant women and other "at-risk populations." In Federal Germany, which published social distance instructions as early as February 7th, the general public was instructed to

avoid contact with the older population. In Iceland, older adults (and other at-risk populations) were instructed on March 31 not to leave their home and to observe social distancing.

In Britain, social distancing instructions were introduced already in January, whereas in mid-March "people at risk" - defined by authorities as "older adults, people with health conditions and pregnant women," were guided to minimize their contact with other people, and on March 31st that recommendation became stricter: they were asked not to leave their home. Similarly, in Israel, on March 4, people older than 60 and people with underlying medical conditions were instructed to avoid crowded settings and to avoid contact with travelers who have arrived from abroad. Later, a national campaign has instructed people at risk to stay home (Dagan & Barda, 2020).

In contrast, in China, no strict age-based policies were noted. On January 23, social distancing guidelines were introduced, in which entire populations in different regions were strictly ordered to stay home. However, and as will be discussed in the following sections, the government did introduce detailed guidelines for LTCS. Similarly, in Austria and the Netherlands, where age-based criteria were not recorded in lockdown and social distance policies, special instructions were presented for LTCS. Japan also did not use specific orders that focus either on at-risk groups or on older adults.

Uganda ordered on March the 31st a general curfew in the entire country and placed a population of more than 45 million citizens under a strict – but identical in terms of age definitions – regime. In Singapore, the entire population was instructed on March 26th to show national responsibility so the state can avoid the need to worsen its policy and order a general lockdown. It should also be mentioned that during earlier stages of fighting the pandemic, Singapore treated in an almost equal fashion places occupied by children and older adults. On January 28th, people who returned from China had to undergo a two-week period of isolation in case they worked with at-risk populations – defined as patients in the healthcare system, and people working with either children or older adults in LTCS. Similar instructions were introduced in Hong Kong.

During the first wave of the pandemic, the United States had the largest number of confirmed cases of COVID-19 of any country. Individual states and the federal government have overlapping responsibilities for funding and regulating care. This is one of the reasons for which the American reaction to the crisis, both in general and in the case of lockdown (next to LTCS for instance), was not coordinated or homogenous. The federal model of governance resulted in 50 different governors making their own decisions.

Exit strategies

Although one would expect similarities between lockdown and exit strategies, our analysis shows differences over time, possibly demonstrating the impact of evidence and/or public attitudes on policy measures. Inconsistencies in terms of age-based decisions continued also when public and commercial systems were going back to a new routine as part of their exit strategies. In Israel, for instance, the first exit strategy of April 18 guided those older than 67 to stay home and maintain social distance and not to return to the workforce. It should be noted that this order was immediately withdrawn and never implemented.

In Austria, the exit strategy (published on April 6) declared that during the program of returning to a cautious routine, "at-risk populations" (defined as various medical conditions) should be protected. However, no other specific guidelines were given at that time. In Denmark, exit strategy plans were first published on March 30 for implementation on April 15. Populations at-risk (e.g., people over 70 years and in particular those over 80 years; people over 65 years old who also have one or more chronic diseases; residents in nursing homes; overweight people; people who have certain illnesses or conditions as well as children with chronic diseases; people of no fixed abode; pregnant women) were instructed to stay in isolation (Police of Denmark, 2020). In contrast, in the Czech Republic, Switzerland, Poland, the United States and France no specific guidelines focusing on older adults were published as part of the exit plan.

Triage

The complex matter of triage deserves special attention. It stands as a unique dilemma with which age has a prominent presence even during more peaceful times. The prioritization of patients' treatment initiation or discontinuation based on various criteria puts older people in a delicate position in times of extreme conditions (Dyer et al., 2008). In reviewing different ad-hoc COVID-19 country-specific triage guidelines, one can find that age was explicitly raised by certain countries as a criterion to refrain from treatment or admittance to an intensive care unit in the case of an overwhelmed healthcare system (Joebges & Biller-Andorno, 2020).

In Italy, for instance, the Society of Anesthesia, Analgesia, Resuscitation and Intensive Care (SIAARTI) had explicitly declared that age limit "may ultimately need to be set" when medical crews would face the exploitation of medical resources. In Switzerland – on the one hand, chronological age did not stand as a criterion. However, age was an explicit factor in resource management through discontinuation of treatment. Moreover, patients older than 85 years were de-prioritized to Intensive Care Units (ICU) beds (if no ICU beds

were available). In contrast, in Belgium, as state authorities discussed triage under extreme conditions, the Society of Intensive Care Medicine has decided to rule out the use of chronological age in times of medical crisis. According to that policy, chronological age was not a good criterion to decide on disproportionate care.

In Germany, health authorities also declared that medical staff would not decide on de-prioritization "solely because of biological age" (Bellelli, G., et al., 2020). However, they did introduce a frailty measure as part of the evaluation process of triage. Therefore, one might claim that they did not completely ignore chronological age as a criterion as frailty is a state associated with older age.

The Japanese COVID-19 patient-led triage application has a low threshold for referrals. Anyone of any age or medical history who self-reports difficulty breathing is advised to go straight to the emergency department. The triage policy is based on a default position of clinical assessment of patients and clinician led triaging.

Long-term care settings (LTCS)

The pandemic posed a significant threat to institutions occupied by older adults (McMichael et al., 2020). We argue that in contrast to the arbitrary use of chronological age as a criterion for social isolation and exit strategy, LTCS deserve a particular attention especially with regard to the allocation of personal protective equipment (PPE) and the maintenance of an adequate staff to resident's ratio. To the most part, we focus on institutional care and not on care provided at home given the greater risk associated with institutional care.

The Chinese case stands as a relevant example. While no explicit age-based decisions were introduced on lockdown and social distance, the government decided to inspect the entire LTC population in Wuhan and Hubei province by February 28, especially in LTCS in which infected people were identified earlier. When an older adult was diagnosed as positive to COVID-19, that person was transferred into a special COVID-19 facility. Furthermore, and to protect medical crews and care personnel in LTCS in regions that were affected, authorities provided LTCS with special PPE. Special guidelines for LTCS did not focus solely on residential settings. All community-based service facilities such as day care centers were suspended during the lockdown period to ensure social distancing. Older people who lived alone, with intensive care needs, or whose family carers or healthcare providers were in quarantine or, were provided with home-based or temporary residential care.

In the United States, at the federal level, the CARES Act allocated a $3-trillion COVID-19 stimulus package passed in late March 2020. The act appears to provide *fewer* financial benefits to the LTC sector than to hospitals

and other health providers. Of the $100 billion CARES Act funds earmarked for health care providers, $30 billion are now being disbursed to hospitals and LTC providers including home health (Harold Van Houtven et al., 2020).

On the issue of prevention of infections in LTCS, the Center for Disease Control (CDC) has published guidelines and continues to update them. The interim guidance (CDC, 2020) focused on the following priorities: keep unrecognized COVID-19 from entering the LTCS, identify infections early and take actions to prevent spread, assess current supply of personal protective equipment and initiate measures to optimize supply, and quickly recognize and manage sever illness.

As mentioned earlier, another relevant country in terms of federal vs. state authority is Germany. Most of the individual states (Länder) issued limitations on visiting LTCS. On March 18, visits in LTCS and hospitals were restricted. In reviewing the key points in Germany's measures regarding LTCS, one can notice that the government has issued financial support and loosened monitoring for care providers during the pandemic so that the residential and ambulatory care that older adults receive can be maintained. Moreover, the German government has announced an increase in care workers' wages. In Denmark, as mentioned, exit strategy plans focused on special instructions relating to older adults as a population at-risk. The state, nevertheless, announced that authorities have been working on a program aimed to ease feelings of loneliness and to allow visits at older adults' homes.

Several countries that used a general policy that lacked age-based criteria on other matters acted differently in relation to LTCS. These countries restricted visitors (including family members) in LTCS. Denmark, for instance, limited visits on site on March 18th. Likewise, in the Netherlands, where the general policy did not seem to use age as a criterion on matters such as lockdown and social distance, visits were banned on March 20th.

In Israel, as another example, a strong criticism was voiced as authorities were in delay to present a coherent response to the situation in LTCS, and COVID-19 related deaths among LTC residents were evident. Only on April 7, and following a series of fatal infections, did the Ministry of Health announce a new policy focusing on LTCS. An expert team recommended that once a resident or member of staff tested positive for the virus, the entire body of residents and staff would be tested as well, even if they were asymptomatic. Prior to that policy change, 24 different LTCS, and the Union of Retirement Homes (A.B.A.) filed a petition to the High Court of Justice, which probably triggered the state to adjust its policy. The petitioners asked the court to order the state to run tests in all LTCS and to equip the staff with protective equipment (HCJ 2466/20 n.d.). Finally, Japan seems to avoid age-based decisions in terms of social distance or triage. However, a certain criticism can be voiced due to the lack of an LTC coherent policy facing the acute risks for older LTC residents.

We can point at several comparative inputs and general findings based upon the sample and data collected in Table A3. For instance, there was no one country that applied all four restrictions altogether in its COVID-19 policy measures. There were, however, two countries (Federal Germany and Israel) that used age-based criteria in three different measures; eleven countries (Argentina, Belgium, Britain, China, Denmark, Hong Kong, Iceland, Italy, Singapore, Switzerland, and the United States) that used such criteria in one measure; whereas we found six countries (Australia, Japan, Poland, the Austria, Netherlands, and Uganda) that did not use age-based criteria at all.

Moreover, our sample and comparative table show that the measure which was in use by most of sampled countries was lockdown (seven different countries have used age-based criteria in their lockdown measure/s: Argentina, Britain, Federal Germany, Hong Kong, Iceland, Israel, and Singapore). The one to follow in that comparative observation was LTC (in five counties: China, Federal Germany, Israel, Italy, and the United States). Three different countries have turned to certain age-based criteria in their triage measure/s (observed in Belgium, Federal Germany, and Switzerland). Only two countries (Denmark and Israel) included age-based criteria in their exit policy measures, which make this measure the one which used this kind of criteria in the most minimalistic way observed.

Discussion

The present review shows that many countries employed age-based criteria in their approach to COVID-19 policy measures. The employment of such criteria represents institutional or structural ageism and has the potential to negatively impact the lives of older people during the pandemic and in years to come through the internalization of ageist messages and stereotypes (Ayalon et al., 2020). Using a critical age perspective, we argue that the pandemic represents a turning point in which different countries worldwide have disregarded the social aspects of chronological age and instead addressed chronological age as if it were equivalent to biological age.

Although some have argued for discriminatory age-based policies toward older people during the COVID-19 pandemic to protect the health care system and maintain resources for younger people (Savulescu & Cameron, 2020), this approach is considered ageist and unhealthy for older people (Avidor & Ayalon, 2020). Selective isolation of older people represents a violation of human rights. Indeed, the rights of people, worldwide, have been violated during the pandemic, regardless of their age. Nonetheless, the selective targeting of people based on their chronological age alone represents an approach that can be interpreted or understood as ageist and may impact the lives of older adults and the relationships between the generations in years to come.

Indeed, some might argue that what governments, institutions, and authorities did during the first wave of COVID-19 should not be interpreted as institutional or structural ageism, but rather, for instance, as practical means with which acute challenges were handled during times of extreme conditions and uncertainty. However, and even though chronological age is a significant risk factor in the context of COVID-19, the use of chronological age as a sole criterion to restrict access to goods and services is discriminatory. One can construct different ways of coping with the challenges of the pandemic that do not use chronological age as a sole criterion that severely impairs fundamental and substantial rights. More sensitive and cautious policies might have taken into account chronological age in addition to frailty status, or medical comorbidities as well as other sociodemographic variables. Nevertheless, regardless of its basis, the entrenchment of human rights based even on a number of criteria, rather than solely on age, is considered harmful and unwarranted.

The case of direct orders to certain populations based on their chronological age alone should be differentiated from recommendations that maintain the autonomy at the hands of older people. Past research has documented the negative impact of selective social isolation on older adults' mental health. Those older adults who were locked in LTCS when the rest of society returned to a new routine described their experiences as traumatic and reported high levels of distress and dissatisfaction (Ayalon & Avidor, 2021). Moreover, research has consistently documented the negative impacts brought by deconditioning, which can easily occur among older adults who are selectively confined to their homes (O'Hanlon et al., 2020). Moreover, it is highly likely that these institutional messages concerning older people as a possible burden to the health care system are internalized by older adults and younger people alike and affect not only older people's aging process, including their possible ability to deal with the negative effects of the virus, but also the relationships between the generations and the aging process of future generations in years to come. Hence, the use of chronological age for policy measures that allow or restrict access to goods and services socially constructs old age in a negative light. Moreover, once certain infringements of human rights become the norm, it is a slippery slope, which may result in future violations of human rights and selective treatment of groups based on their perceived contribution to the social and economic fabric of society.

As this comparative analysis demonstrates, the picture from different countries is eclectic, unorganized, and mostly inconsistent in terms of using different criteria while introducing COVID-19 policies. A possible reason for this inconsistency might be due to the limited influence of an international supervising body, such as the WHO (Lloyd-Sherlock, 2020). This might account for the changing picture which introduces different policies in general, including the use of chronological age as an arbitrary criterion for policy measures and the relative neglect of LTCS. In the past, scholars have identified

international organizations' leadership, involvement, transparency, and decisiveness as central in fighting pandemics (Borowy, 2009). The fact that central global powers, first and foremost, the United States, but also states such as Australia have raised doubts about the efficiency of the WHO in handling the current crisis seems to damage its appearance in the public eye and its worldwide influence. At least some of the current criticism toward the role of the WHO during the crisis can be related to its relative absence from the public arena and the fact that it lacked a designated older persons' unit (Lloyd-Sherlock, 2020).

One of the main claims this analysis carries focuses on the inconsistency and therefore, arbitrariness of age-based policies. At times, this inconsistency is reflected in the same country – as their domestic COVID-19 policy embraces and rejects age-based perspectives at the same time; as in the Italian example, for instance, in which no age-based criterion was in use during lockdown and social distancing, but chronological age was used as a triage criterion or the Swiss policy that simultaneously embraced and rejected chronological age as a criterion for the provision of treatment. This inconsistency points to the limited empirical basis for such age-based policies.

A similar argument can focus on LTCS and state policies that aim to minimize the risks to LTC residents (or the helplessness of authorities in creating adequate guidelines for this population). LTCS probably needed the most attention by authorities (Thompson et al., 2020). Yet, the same countries, such as Britain, that stressed chronological age as a criterion for lockdown or exit strategies – did not have specific guidelines for LTCS, despite their relative susceptibility in case of exposure. Therefore, and based on the eclectic picture of age-based policies, one of the arguments of this paper is that a top-down instructed and detailed policy was obviously missing during the first wave of the pandemic.

Indeed, the diversity between and within countries is large. One might claim that the expectation for consistency regarding age-based policies of so many different countries is exaggerated. Yet, we can point to other public health threats with which diverse countries coped prior to the COVID-19 pandemic. The response to prior threats was led and largely organized by the WHO coordinated efforts. Since the early 1960s, for instance, a long list of countries has developed a public health scheme to handle adverse mass events attributed to compulsory vaccination and medication (such as in the cases of smallpox, thalidomide, or diphtheria – tetanus–pertussis vaccination). Following the introduction of compulsory vaccination to the public in the 1950s, adverse effects have been documented. After West Germany initiated a model program in 1961, dozens of other countries which faced similar challenges implemented similar schemes in their jurisdiction throughout the 1960s and 1970s. France, for instance, followed the German example, and in the 1970s, concerns over adverse events related to diphtheria-tetanus-pertussis

vaccination had led to an international reaction with similar, consistent, programs being established in Austria, Denmark, Japan, New Zealand, Sweden, Switzerland, Britain, Taiwan, Finland, the United States, Italy, Norway, Korea, and several other countries (Looker & Kelly, 2011).

Moreover, with the introduction of (quite similar and consistent) vaccine policy schemes in the abovementioned countries, an international initiative evolved, aiming to harmonizing health policy – initially, at least within the European Union. This has been illustrated by a proposal for a pan-European scheme on that matter (Calderini et al., 2004). Given the capacity of the WHO, the magnitude of the current COVID-19 pandemic, and the inconsistency in different corners of the world as well as within countries, a normative and critical doubt concerning the efficiency of the Organization should be raised and discussed. One might assume that in the 21st century, as scientists, governments, and international organizations have many channels and technical opportunities to discuss, compare, and improve their policy to reach a common ground. This also stands in contrast to earlier examples that have shown a relative synchronized policy of a variety of countries. This possibly attests to the arbitrary nature of age-based policies and the limited rationale available to support such policies. Moreover, one might also ponder the ways in which certain East Asian countries reviewed here acted rather differently in terms of their attention to LTC. Perhaps these public health policies relate to the fact that some of these countries (Japan, China, and more) had more experience with similar threats of pandemics such as SARS in the early 21st century.

Another relevant factor in comparing different countries' policies and reactions to the general challenge of the pandemic is the role of federalism. Some of the countries in the sample (e.g., Germany and the US) have federal system of national (democratic) governance. It is likely that federal countries, with different modes of local-regional and national-federal governance would face greater legal, procedural, and institutional obstacles during acute challenges. For instance, different states within the US varied in the ways their public systems handled the crisis, introduced, and implemented public-health policies; moreover, it seems that in the America case, one might argue that some of the variation within the US were driven by the question of which party (Democratic or Republican) was in control of state governance, and the political affiliation of the state governor. Future research should look into this kind of political-institutional question more closely.

The (relative or certain) lack of consistency in policy and the use of ageist policies are not merely theoretical or a basis for intellectual discussion (Savulescu & Cameron, 2020). The cost of a lack of policy or its inconsistencies are measured in human lives, as in certain countries the share of LTC residents in the total death toll exceeds 80% (MacCharles, 2020). In addition, older adults' personal freedom and independence, access to treatments, perceptions

of old age and aging as well as personal independence have been shuttered and this may affect their life expectancy and quality of life in years to come. It would be rather hurtful if our societal reaction to the pandemic turns to revive biased perspectives and set policies that wrongfully differentiate people based on their chronological age, and that alone.

Policy stakeholders and researchers who wish to reduce or prevent ageism should carefully study the decision mechanisms leading to the response or lack of response to the outbreak. It seems that the governmental and public discourse allowed for a full-blown expression of age-based discrimination in all four imminent responses to the outbreak, namely lockdown and social isolation, exit, triage and LTCS. Moreover, the speedy and urgent entrance to a state of emergency in terms of public health did not sufficiently allow considering the social meaning of ageist approaches. As future threats and medical challenges might reoccur – perhaps also in the case of COVID-19 as some scientists have warned – firm alternative mechanisms and strict guidelines should prevent the reoccurrence of discrimination based on chronological age from taking such a crucial role in public policies and matters of life and death.

The WHO report on ageism which was launched a little over a year after the pandemic started might be a sign for a new future, which guides nations and people worldwide concerning the appropriate approach to older people and the wrongdoing associated with discrimination based on age. Capitalizing on a global campaign, a UN convention for the rights of older people might be particularly valuable as a tool that provides normative standards concerning older people worldwide. Such a convention will ensure that even under extreme conditions, as certainly was the case during the first wave of the pandemic, states will refrain from discriminating older people due to their chronological age and will be forced to acknowledge and respect the diversity that comes with age.

Limitations

The present study has several limitations that should be acknowledged. First, the study covered only a restricted period of time, which represents the first response to the pandemic. Additional research is desired to identify possible changes in policy measures over time. Second, our purposive sample was partially based on availability of official data in English. Hence, the analysis was somewhat restricted because we lacked data concerning some relevant policy measures. Nonetheless, we attempted to identify a large number of countries to reach maximum variability. Finally, we restricted our analysis to the role of chronological age, with a particular focus on older people. Nonetheless, ageism toward younger people also is evident (Ayalon et al., 2019).

Conclusion

When reviewing the findings, it is important to acknowledge the fact that under extreme and pressing circumstances, there was limited information to guide policy measures, especially during the early stages of the pandemic. Moreover, it also is important to note a distinction between orders vs. recommendations aimed to protect certain population groups, as the latter are necessary especially given the issue at hand and do not carry the same negative impact as they do not deprive older people of their autonomy. On the other hand, the reliance on chronological age or any other sociodemographic criterion for this matter, to limit people's rights and autonomy is paternalistic and discriminatory (Ayalon & Avidor, 2021). We also aim to make a distinction between acts of commission vs. omission (e.g., targeting certain populations because of their age vs. disregarding populations at risk because of their age). We argue that during the present pandemic both strategies represent ageist practices. The differential allocation of human rights by a restrictive approach that treats people differently because of their chronological age is ageist and unhealthy (Avidor & Ayalon, 2020). Moreover, the use of chronological age as a criterion for triage decisions is unethical and ageist given the only moderate association between chronological age and biological age or short-term prognosis (Sprung et al., 2013). Specifically, biological age, defined via various physiological parameters has shown to be a better predictor of people's functioning and mortality compared with their chronological age, which is the number of years lived. Hence, biological age is responsible for people's heterogeneity especially in old age (Levine, 2013). Nonetheless, an ethical principle advocated by the WHO stresses the allocation of resources to those in greatest medical need or most at risk (WHO, 2020), suggesting that older adults could potentially be the first to receive treatment as the virus has shown to have a major impact on older people. Finally, because LTCS represent a risk for COVID-19 fast spread and death (Pillemer et al., 2020), LTCS should have received particular attention in COVID-19 policy response and the omission of a targeted response also represents ageism.

Key points

- The use of chronological age as a basis for COVID-19 criterion for policy measures is ageist.
- Many countries employed age-based criteria in their approach to COVID-19 policy measures.
- Selective isolation of older people represents a violation of human rights.
- There were inconsistencies in policy measures employed during the first wave of the pandemic both within and across countries
- The heterogenous response to the pandemic can be partially attributed to the limited role of the World Health Organization in leading the response to the first wave of the pandemic.

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Appendix

Table A1. Country characteristics.

COUNTRY	Geographical Location	Population aged 65 and above (% of total population) (data for 2018, if not mentioned otherwise)	HDI (2018)	Source/s relating to aged-base measures
AUSTRIA	Europe	19	20	Schmidt, A.E., Leichsenring, K., Staflinger, H., Litwin, C., & Bauer, A. (2020). The Impact of COVID-19 on Users and Providers of Long-Term Care Services inAustria. *International Long Term Care Policy Network*. https://ltccovid.org/wp-content/uploads/2020/04/The-COVID-19-Long-Term-Care-situation-in-Austria-28-April-2020–1.pdf Arbeitsgruppe Ethik der Österreichischen Gesellschaft für Anästhesiologie Reanimation und Intensivmedizin (ARGE Ethik ÖGARI). (2020). Allokation intensivmedizinischer Ressourcen aus Anlass der Covid-19-Pandemie. Retrieved from https://www.oegari.at/aktue lles.php
Australia	Pacific	16	6	Communicable Diseases Network Australia (CDNA), (2020, March 13). *Coronavirus Disease 2019 (COVID-19) Outbreaks in Residential Care Facilities*. https://www.health.gov.au/sites/default/files/documents/2020/03/coronavir**us-covid-19-guidelines-for-outbreaks-in-residential-care-facilities.pdf** Australian Government Department of Health, (2020, June 1). *News*. https://www.health.gov.au/news/australian-health-protection-principal-committee-ahppc-advice-on-residential-aged-care-facilities
Argentina	Latin America	11	48	Government of Argentina (2020, June 1). *What measures is the government taking?* https://www.argentina.gob.ar/coronavirus/medidas-gobierno

(*Continued*)

Table A1. (Continued).

COUNTRY	Geographical Location	Population aged 65 and above (% of total population) (data for 2018, if not mentioned otherwise)	HDI (2018)	Source/s relating to aged-base measures
Belgium	Europe	19	17	Meyfroidt, G., Vlieghe, E., Biston, P., De Decker, K., Wittebole, X., Collin, V., Depuydt, P., Duc Nam, N., Hermans, G., Jorens, P., Ledoux, d., Taccone, F.,& Devisch, I. (2020, March 18). *Ethical Principles Concerning Proportionality of Critical Care during the 2020 COVID-19 Pandemic inBelgium: Advice by the Belgian Society of Intensive care medicine*. Hartcentrum Hasselt Hospital. https://www.hartcentrumhasselt.be/professioneel/nieuws-professioneel/ethical-principles-concerning-proportionality-of-critical-care-during-the-covid-19-pandemic-advice-by-the-belgian-society-of-ic-**medicine** Meyfroidt, G., Vlieghe, E., Biston, P., De Decker, K., Wittebole, X., Collin, V., … Devisch, I. (2020). Ethical principles concerning proportionality of critical care during the 2020 COVID-19 pandemic in Belgium: Advice by the Belgian Society of Intensive care medicine – update 26-03-2020. Retrieved from http://www.siz.be/wp-content/uploads/COVID_19_ethical_E_rev3.pdf
Britain	Europe	19	15	United Kingdom National Health Service, (2020, June 1). *Who's at higher risk from coronavirus*. https://www.nhs.uk/conditions/coronavirus-covid-19/people-at-higher-risk/whos-at-higher-risk-from-coronavirus/
China	Asia	11	85	The State Council, The People Republic of China (2020, May 19) http://english.www.gov.cn/news/topnews/202002/15/content_WS5e476a36c6d0595e03c20c83.html
Czech Republic	Europe	20	26	Ministry of Health of the Czech Republic, (2020, May 25). https://koronavirus.mzcr.cz/wp-content/uploads/2020/06/Specification_2505-eng-checked.pdf

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Table A1. (Continued).

COUNTRY	Geographical Location	Population aged 65 and above (% of total population) (data for 2018, if not mentioned otherwise)	HDI (2018)	Source/s relating to aged-base measures
Denmark	Europe	20	11	Police of Denmark (2020, June 1). *About coronavirus/COVID-19*. https://politi.dk/en/coronavirus-in-denmark/frequently-asked-questions; Police of Denmark (2020, June 1). *Controlled reopening of Danish society*. https://politi.dk/coronavirus-i-danmark/seneste-nyt-fra-myndighederne/foerste-trin-i-kontrolleret-genaabning-af-det-danske-samfund Bolding, A. (2020, May 14). TVS. *Another nursing home infected with coronavirus: 160 staff and residents tested*. https://www.tvsyd.dk/covid-19/endnu-et-plejehjem-ramt-af-coronavirus-160-medarbejdere-og-beboere-testet
France	Europe	20	26	Government of France, (2020, June 1). *Coronavirus COVID-19*. https://www.gouvernement.fr/en/coronavirus-covid-19
Germany	Europe	22	4	Lorenz-Dant, K. (2020). Germany and the COVID-19 Long-Term Care Situation. *LTCcovid.org, International Long Term Care Policy Network*, CPEC-LSE
Hong Kong	Asia	17	4	Government of Hong Kong (2020, June 1). *Coronavirus Disease (COVID-19) in HK*. https://www.coronavirus.gov.hk/eng/index.html
Iceland	Europe	15	6	https://www.covid.is/sub-categories/iceland-s-response
Israel	Asia	12	22	Israeli Ministry of Finance, (2020, April 19). *New Coronavirus Routine*. https://www.gov.il/he//departments/news/press_19042020 The Public Committee for Triage of Critical Patients during the Coronavirus Pandemic, April 2020 (in Hebrew).
Italy	Europe	23	29	Vergano, M., Bertolini, G., Giannini, A., Gristina, G., Livigni, S., Mistraletti, G., & Petrini, F. (2020). Clinical ethics recommendations for the allocation of intensive care treatments in exceptional, resource-limited circumstances
Japan	Asia	28	19	Ministry of Health, Labour, and Welfare of Japan, (2020). *Information on theCOVID-19*. https://www.mhlw.go.jp/english/ *Support needed for care homes as COVID-19 group infections hit Japan*. (2020, April 4). The Mainichi. https://mainichi.jp/english/articles/20200404/p2a/00m/0na/015000c
Poland	Europe	18	32	Government of Poland, (2020, April 16). *Prime Minister: We are proposing new rules today as part of the new economic reality*. https://www.gov.pl/web/premier/premier-w-ramach-nowej-rzeczywistosci-gospodarczej-proponujemy-dzisiaj-nowe-zasady

(*Continued*)

Table A1. (Continued).

COUNTRY	Geographical Location	Population aged 65 and above (% of total population) (data for 2018, if not mentioned otherwise)	HDI (2018)	Source/s relating to aged-base measures
The Netherlands	Europe	20	10	Jordan et al. (2020, June 1). Aanscherping bezoek verpleeghuizen ivm COVID-19 [Letter to Dutch House of Representatives regarding COVID-19: Imposing Strict Regulations for Visitors to Dutch Nursing Homes]; Kruse, F., Remers, T. & Jeurissen, P. (2020). The Impact of COVID-19 on Long-Term Care in the Netherlands. *International Long Term Care Policy Network*. https://ltccovid.org/wp-content/uploads/2020/04/COVID19-Long-Term-Care-situation-in-the-Netherlands-26-April-2020.pdf *Nursing home residents may again receive more than one visitor from 15 June*. (2020, June, 3). NOS. https://nos.nl/artikel/2336093-verpleeghuisbewoners-mogen-vanaf-15-juni-weer-meer-dan-een-bezoeker-ontvangen.html
Singapore	Asia	12	9	Singapore Ministry of Health, (2020, June 1). *Past Uptades On COVID-19 LocalSituation*. https://www.moh.gov.sg/COVID-19/past-updates
Switzerland	Europe	19	2	Federal Council of Switzerland, (2020, April 16). *Federal Council to gradually ease measures against the new coronavirus*. https://www.admin.ch/gov/en/start/documentation/media-releases.msg-id-78818.html
Uganda	Africa	2	159	Kizza, J. (2020, March 30). *Coronavirus – Countrywide curfew starts Tuesday*. Newvision. https://www.newvision.co.ug/news/1517271/-coronavirus-museveni-address-nation-pandemic
USA	America	16	15	*The United States leads in coronavirus cases, but not pandemic response*. (2020, April 1). Science Magazine. https://www.sciencemag.org/news/2020/04/united-states-leads-coronavirus-cases-not-pandemic-response White house, CDC, (2020). *Guidelines: Opening America Again*. https://assets.documentcloud.org/documents/6840714/Guidelines.pdf

Note: *The Human Development Index (HDI) is a statistic composite index of life expectancy, education (mean years of schooling completed and expected years of schooling upon entering the education system), and per capita income indicators, which are used to rank countries into four tiers of human development. A country scores a higher level of HDI when the lifespan is higher, the education level is higher, and the gross national income GNI (PPP) per capita is higher. The HDI is used to measure a country's development by the United Nations Development Programme (UNDP)'s Human Development Report Office, and is commonly in use by a variety of institutions and the media.

In the table:

*Source for data on population aged 65 and above: World Bank data (2019), https://data.worldbank.org/indicator/SP.POP.65UP.TO.ZS.

**HDI (2018) source:

United Nations Development Programme: Human Development Reports – Human Development Index and its components (2018), http://hdr.undp.org/en/content/table-1-human-development-index-and-its-components-1.

Table A2. Inclusion and exclusion criteria of the countries that participated in the study.

Inclusion Criteria	Exclusion Criteria
Geographical location (continents)	Non-official information
Global north/global south	Information provided/introduced by the media
Percentage of older adults in the country	Documents and info written in other languages but English
Human Development Index (HDI) rank	
Official information	
Top-down governmental policy	
Documents written in English	

Note: The Human Development Index (HDI) is a statistic composite index of life expectancy, education (mean years of schooling completed and expected years of schooling upon entering the education system), and per capita income indicators, which are used to rank countries into four tiers of human development. A country scores a higher level of HDI when the lifespan is higher, the education level is higher, and the gross national income GNI (PPP) per capita is higher. The HDI is used to measure a country's development by the United Nations Development Programme (UNDP)'s Human Development Report Office, and is commonly in use by a variety of institutions and the media.

Table A3. Policy measures by country.

Country (and relevant criteria in sum)	Lockdown and Social Distancing	Exit policy	Triage	Long term care	Source/s relating to aged-base measures
Argentina (1/4)	Instructed the entire population older than 60 to work from home together with pregnant women and other		-	-	Government of Argentina (2020, June 1). *What measures is the government taking?* https://www.argentina.gob.ar/coronavirus/medidas-gobierno
Australia (0/4)	Age-based criteria were not recorded in lockdown and social distance policies	-	-	-	Communicable Diseases Network Australia (CDNA), (2020, March 13). *Coronavirus Disease 2019 (COVID-19) Outbreaks in Residential Care Facilities*. https://www.health.gov.au/sites/default/files/documents/2020/03/coronavir**us-covid-19-guidelines-for-outbreaks-in-residential-care-facilities.pdf** Australian Government Department of Health, (2020, June 1). *News*. https://www.health.gov.au/news/australian-health-protection-principal-committee-ahppc-advice-on-residential-aged-care-facilities

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Table A3. (Continued).

Country (and relevant criteria in sum)	Lockdown and Social Distancing	Exit policy	Triage	Long term care	Source/s relating to aged-base measures
Austria (0/4)		The exit strategy declared that during the program of returning to a cautious routine, "at-risk populations" (defined as various medical conditions) should be protected. However, no other specific guidelines were given at that time	-	-	Schmidt, A.E., Leichsenring, K., Staflinger, H., Litwin, C., & Bauer, A. (2020). The Impact of COVID-19 on Users and Providers of Long-Term Care Services inAustria. *International Long Term Care Policy Network*. https://ltccovid.org/wp-content/uploads/2020/04/The-COVID-19-Long-Term-Care-situation-in-Austria-28-April-2020–1.pdf Arbeitsgruppe Ethik der Österreichischen Gesellschaft für Anästhesiologie Reanimation und Intensivmedizin (ARGE Ethik ÖGARI). (2020). Allokation intensivmedizinischer Ressourcen aus Anlass der Covid-19-Pandemie. Retrieved from https://www.oegari.at/aktuelles.php

(*Continued*)

Table A3. (Continued).

Country (and relevant criteria in sum)	Lockdown and Social Distancing	Exit policy	Triage	Long term care	Source/s relating to aged-base measures
Belgium (1/4)	-	-	As state authorities discussed triage under extreme conditions, the Society of Intensive Care Medicine has decided to rule out the use of chronological age in times of medical crisis. According to that policy, chronological age was not a good criterion to decide on disproportionate care.	-	Meyfroidt, G., Vlieghe, E., Biston, P., De Decker, K., Wittebole, X., Collin, V., Depuydt, P., Duc Nam, N., Hermans, G., Jorens, P., Ledoux, d., Taccone, F.,& Devisch, I. (2020, March 18). *Ethical Principles Concerning Proportionality of Critical Care during the 2020 COVID-19 Pandemic inBelgium: Advice by the Belgian Society of Intensive care medicine*. Hartcentrum Hasselt Hospital. https://www.hartcentrumhasselt.be/professioneel/nieuws-professioneel/ethical-principles-concerning-proportionality-of-critical-care-during-the-covid-19-pandemic-advice-by-the-belgian-society-of-ic-**medicine** Meyfroidt, G., Vlieghe, E., Biston, P., De Decker, K., Wittebole, X., Collin, V., … Devisch, I. (2020). Ethical principles concerning proportionality of critical care during the 2020 COVID-19 pandemic in Belgium: Advice by the Belgian Society of Intensive care medicine – update 26-03-2020. Retrieved from http://www.siz.be/wp-content/uploads/COVID_19_ethical_E_rev3.pdf

(*Continued*)

Table A3. (Continued).

Country (and relevant criteria in sum)	Lockdown and Social Distancing	Exit policy	Triage	Long term care	Source/s relating to aged-base measures
Britain (1/4)	"People at risk" - defined by authorities as "older adults, people with health conditions and pregnant women," were guided to minimize their contact with other people, and on March 31st that recommendation became stricter: they were asked not to leave their home	-	-	-	United Kingdom National Health Service, (2020, June 1). *Who's at higher risk from coronavirus*. https://www.nhs.uk/conditions/coronavirus-covid-19/people-at-higher-risk/whos-at-higher-risk-from-coronavirus/

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Table A3. (Continued).

Country (and relevant criteria in sum)	Lockdown and Social Distancing	Exit policy	Triage	Long term care	Source/s relating to aged-base measures
China (1/4)	No strict age-based policies were noted. On January 23, social distancing guidelines were introduced, in which entire populations in different regions were strictly ordered to stay home.	No strict age-based policies were noted.	-	The government decided to inspect the entire LTC population in Wuhan and Hubei province by February 28, especially in LTCS in which infected people were identified earlier. When an older adult was diagnosed as positive to COVID-19, that person was transferred into a special COVID-19 facility. Furthermore, and to protect medical crews and care personnel in LTCS in regions that were affected, authorities provided LTCS with special PPE. Special guidelines for LTCS did not focus solely on residential settings. All community-based service facilities such as day care centers were suspended during the lockdown period to ensure social distancing. Older people who lived alone, with intensive care needs, or whose family carers or healthcare providers were in quarantine or, were provided with home-based or temporary residential care.	The State Council, The People Republic of China (2020, May 19) http://english.www.gov.cn/news/topnews/202002/15/content_WS5e476a36c6d0595e03c20c83.html

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Table A3. (Continued).

Country (and relevant criteria in sum)	Lockdown and Social Distancing	Exit policy	Triage	Long term care	Source/s relating to aged-base measures
Czech Republic (0/4)	-	No specific guidelines focusing on older adults were published as part of the exit plan	-	-	Ministry of Health of the Czech Republic, (2020, May 25). https://koronavirus.mzcr.cz/wp-content/uploads/2020/06/Specification_2505-eng-checked.pdf
Denmark (1/4)	-	Populations at-risk (e.g., people over 70 years and in particular those over 80 years; people over 65 years old who also have one or more chronic diseases; residents in nursing homes; overweight people; people who have certain illnesses or conditions as well as children with chronic diseases; people of no fixed abode; pregnant women) were instructed to stay in isolation	-	As mentioned, exit strategy plans focused on special instructions relating to older adults as a population at-risk. The state, nevertheless, announced that authorities have been working on a program aimed to ease feelings of loneliness and to allow visits at older adults' homes. Moreover, used a general policy that lacked age-based criteria on other matters acted differently in relation to LTCS. Restricted visitors (including family members) in LTCS. For instance, limited visits on site on March 18th.	Police of Denmark (2020, June 1). *About coronavirus/COVID-19*. https://politi.dk/en/coronavirus-in-denmark/frequently-asked-questions; Police of Denmark (2020, June 1). *Controlled reopening of Danish society*. https://politi.dk/coronavirus-i-danmark/seneste-nyt-fra-myndighederne/foerste-trin-i-kontrolleret-genaabning-af-det-danske-samfund Bolding, A. (2020, May 14). TVS. *Another nursing home infected with coronavirus: 160 staff and residents tested*. https://www.tvsyd.dk/covid-19/endnu-et-plejehjem-ramt-af-coronavirus-160-medarbejdere-og-beboere-testet
France (0/4)	-	No specific guidelines focusing on older adults were published as part of the exit plan	-	-	Government of France, (2020, June 1). *Coronavirus COVID-19*. https://www.gouvernement.fr/en/coronavirus-covid-19

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Table A3. (Continued).

Country (and relevant criteria in sum)	Lockdown and Social Distancing	Exit policy	Triage	Long term care	Source/s relating to aged-base measures
Federal Germany (3/4)	Published social distance instructions, in which the general public was instructed to avoid contact with the older population	-	Health authorities also declared that medical staff would not decide on de-prioritization "solely because of biological age." However, they did introduce a frailty measure as part of the evaluation process of triage	Most of the individual states (Länder) issued limitations on visiting LTCS. On March 18, visits in LTCS and hospitals were restricted. In reviewing the key points in Germany's measures regarding LTCS, one can notice that the government has issued financial support and loosened monitoring for care providers during the pandemic so that the residential and ambulatory care that older adults receive can be maintained. Moreover, the German government has announced an increase in care workers' wages.	Lorenz-Dant, K. (2020). Germany and the COVID-19 Long-Term Care Situation. *LTCcovid.org, International Long Term Care Policy Network*, CPEC-LSE

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Table A3. (Continued).

Country (and relevant criteria in sum)	Lockdown and Social Distancing	Exit policy	Triage	Long term care	Source/s relating to aged-base measures
Hong Kong (1/4)	During earlier stages of fighting the pandemic, Hong Kong treated in an almost equal fashion places occupied by children and older adults. People who returned from China had to undergo a two-week period of isolation in case they worked with at-risk populations – defined as patients in the healthcare system, and people working with either children or older adults in LTCS	-	-	-	Government of Hong Kong (2020, June 1). *Coronavirus Disease (COVID-19) in HK*. https://www.coronavirus.gov.hk/eng/index.html
Iceland (1/4)	Older adults (and other at-risk populations) were instructed not to leave their home and to observe social distancing	-	-	-	https://www.covid.is/sub-categories/iceland-s-response

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Table A3. (Continued).

Country (and relevant criteria in sum)	Lockdown and Social Distancing	Exit policy	Triage	Long term care	Source/s relating to aged-base measures
Israel (3/4)	People older than 60 and people with underlying medical conditions were instructed to avoid crowded settings and to avoid contact with travelers who have arrived from abroad. Later, a national campaign has instructed people at risk to stay home	The first exit strategy of April 18 guided those older than 67 to stay home and maintain social distance and not to return to the workforce (It should be noted that this order was immediately withdrawn and never implemented)	-	A strong criticism was voiced as authorities were in delay to present a coherent response to the situation in LTCS, and COVID-19 related deaths among LTC residents were evident. Only on April 7, and following a series of fatal infections, did the Ministry of Health announce a new policy focusing on LTCS. An expert team recommended that once a resident or member of staff tested positive for the virus, the entire body of residents and staff would be tested as well, even if they were a-symptomatic. Prior to that policy change, 24 different LTCS, and the Union of Retirement Homes (A.B.A.) filed a petition to the High Court of Justice, which probably triggered the state to adjust its policy. The petitioners asked the court to order the state to run tests in all LTCS and to equip the staff with protective equipment (HCJ 2466/20).	Israeli Ministry of Finance, (2020, April 19). *New Coronavirus Routine*. https://www.gov.il/he//departments/news/press_19042020 The Public Committee for Triage of Critical Patients during the Coronavirus Pandemic, April 2020 (in Hebrew).

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Table A3. (Continued).

Country (and relevant criteria in sum)	Lockdown and Social Distancing	Exit policy	Triage	Long term care	Source/s relating to aged-base measures
Italy (1/4)	-	-	-	The Society of Anesthesia, Analgesia, Resuscitation and Intensive Care (SIAARTI) had explicitly declared that age limit "may ultimately need to be set" when medical crews would face the exploitation of medical resources	Vergano, M., Bertolini, G., Giannini, A., Gristina, G., Livigni, S., Mistraletti, G., & Petrini, F. (2020). Clinical ethics recommendations for the allocation of intensive care treatments in exceptional, resource-limited circumstances
Japan (0/4)	Did not use specific orders that focus either on at-risk groups or on older adults	-	The COVID-19 patient-led triage application has a low threshold for referrals. Anyone of any age or medical history who self-reports difficulty breathing is advised to go straight to the emergency department. The triage policy is based on a default position of clinical assessment of patients and clinician led triaging	Seems to avoid age-based decisions in terms of social distance or triage. However, a certain criticism can be voiced due to the lack of an LTC coherent policy facing the acute risks for older LTC residents.	Ministry of Health, Labour, and Welfare of Japan, (2020). *Information on theCOVID-19*. https://www.mhlw.go.jp/english/ *Support needed for care homes as COVID-19 group infections hit Japan*. (2020, April 4). The Mainichi. https://mainichi.jp/english/articles/20200404/p2a/00m/0na/015000c
Poland (0/4)	-	no specific guidelines focusing on older adults were published as part of the exit plan	-	-	Government of Poland, (2020, April 16). *Prime Minister: We are proposing new rules today as part of the new economic reality*. https://www.gov.pl/web/premier/premier-w-ramach-nowej-rzeczywistosci-gospodarczej-proponujemy-dzisiaj-nowe-zasady

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Table A3. (Continued).

Country (and relevant criteria in sum)	Lockdown and Social Distancing	Exit policy	Triage	Long term care	Source/s relating to aged-base measures
The Netherlands (0/4)	Age-based criteria were not recorded in lockdown and social distance policies	-	-	Used a general policy that lacked age-based criteria on other matters acted differently in relation to LTCS. Restricted visitors (including family members) in LTCS. As the general policy did not seem to use age as a criterion on matters such as lockdown and social distance, visits were banned on March 20th.	de Jonge, H. (2020, June 1). Aanscherping bezoek verpleeghuizen ivm COVID-19 [Letter to Dutch House of Representatives regarding COVID-19: Imposing Strict Regulations for Visitors to Dutch Nursing Homes]; Kruse, F., Remers, T. & Jeurissen, P. (2020). The Impact of COVID-19 on Long-Term Care in the Netherlands. *International Long Term Care Policy Network*. https://ltccovid.org/wp-content/uploads/2020/04/COVID19-Long-Term-Care-situation-in-the-Netherlands-26-April-2020.pdf *Nursing home residents may again receive more than one visitor from 15 June*. (2020, June, 3). NOS. https://nos.nl/artikel/2336093-verpleeghuisbewoners-mogen-vanaf-15-juni-weer-meer-dan-een-bezoeker-ontvangen.html

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Table A3. (Continued).

Country (and relevant criteria in sum)	Lockdown and Social Distancing	Exit policy	Triage	Long term care	Source/s relating to aged-base measures
Singapore (1/4)	The entire population was instructed on March 26th to show national responsibility so the state can avoid the need to worsen its policy and order a general lockdown. It should also be mentioned that during earlier stages of fighting the pandemic, Singapore treated in an almost equal fashion places occupied by children and older adults. On January 28th, people who returned from China had to undergo a two-week period of isolation in case they worked with at-risk populations – defined as patients in the healthcare system, and people working with either children or older adults in LTCS.	-	-	-	Singapore Ministry of Health, (2020, June 1). *Past Uptades On COVID-19 LocalSituation*. https://www.moh.gov.sg/COVID-19/past-updates

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Table A3. (Continued).

Country (and relevant criteria in sum)	Lockdown and Social Distancing	Exit policy	Triage	Long term care	Source/s relating to aged-base measures
Switzerland (1/4)	-	No specific guidelines focusing on older adults were published as part of the exit plan	On the one hand, chronological age did not stand as a criterion. However, age was an explicit factor in resource management through discontinuation of treatment. Moreover, patients older than 85 years were de-prioritized to Intensive Care Units (ICU) beds (if no ICU beds were available).	-	Federal Council of Switzerland, (2020, April 16). *Federal Council to gradually ease measures against the new coronavirus*. https://www.admin.ch/gov/en/start/documentation/media-releases.msg-id-78818.html
Uganda (0/4)	Ordered on March the 31st a general curfew in the entire country and placed the population under a strict – but identical in terms of age definitions – regime	-	-	-	Kizza, J. (2020, March 30). *Coronavirus – Countrywide curfew starts Tuesday*. Newvision. https://www.newvision.co.ug/news/1517271/-coronavirus-museveni-address-nation-pandemic

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Table A3. (Continued).

Country (and relevant criteria in sum)	Lockdown and Social Distancing	Exit policy	Triage	Long term care	Source/s relating to aged-base measures
USA (1/4)	The federal model of governance resulted in 50 different governors making their own decisions	No specific guidelines focusing on older adults were published as part of the exit plan	-	At the federal level, the CARES Act allocated a $3-trillion COVID-19 stimulus package passed in late March 2020. The act appears to provide *fewer* financial benefits to the LTC sector than to hospitals and other health providers. Of the $100 billion CARES Act funds earmarked for health care providers, $30 billion are now being disbursed to hospitals and LTC providers including home health. On the issue of prevention of infections in LTCS, the Center for Disease Control (CDC) has published guidelines and continues to update them. The interim guidance (CDC, 2020) focused on the following priorities: keep unrecognized COVID-19 from entering the LTCS, identify infections early and take actions to prevent spread, assess current supply of personal protective equipment and initiate measures to optimize supply, and quickly recognize and manage sever illness.	*The United States leads in coronavirus cases, but not pandemic response*. (2020, April 1). Science Magazine. https://www.sciencemag.org/news/2020/04/united-states-leads-coronavirus-cases-not-pandemic-response White house, CDC, (2020). *Guidelines: Opening America Again*. https://assets.documentcloud.org/documents/6840714/Guidelines.pdf

Note: In the table.
• The first column on the left concludes the number of types of public health policies that were treated by that country in the sample (from one to four in total).
• Represents missing data due to limited formal information in English on the topic.