COVID-19, inequality and older people: developing community-centred interventions

Introduction

In March 2020, our research began with tentative first steps in thinking about the likely impact that a new disease – SARS-CoV-2 (COVID-19) – might have on older populations, and in particular the communities in GM with whom we were already working. At the time of writing (December 2022), COVID-19 continues to have a serious impact on communities and health systems, coming in successive waves (rather than a seasonal cycle), and with the constant threat of new variants. Vaccinations have reduced the shockingly high death toll, but hundreds of people in the UK (mostly over 60) still die every week with COVID-19 mentioned as one of the causes, or are living with the consequences of the pandemic. In the week ending 9 December 2022 in England alone, 295 deaths were recorded involving COVID-19, 272 of whom were people aged 65 and over (ONS, 2022c) – the continued toll of deaths amongst older people still attracting relatively little official or media comment.

The aim of this book has been to document the way different groups of older people responded to the pandemic, with a particular focus on those living in urban neighbourhoods. Chapters 4 to 7 gave particular emphasis to understanding how people experienced COVID-19, in the context of their family and friends, homes, neighbourhoods, and wider social networks. These dimensions of everyday life are, invariably, the building blocks of people’s lives. But at the same time, they are also the starting point for how we need to develop effective policies for supporting people during periods of crisis associated with pandemics such as COVID-19. In this chapter, we argue that preparation for pandemics in vital areas such as vaccine development and manufacture must also be complemented by direct engagement with the lived experiences of communities themselves – and especially those who are likely to be especially vulnerable to the effects of pandemics.

This chapter develops an argument for developing what we call ‘community-centred’ policies in the area of public health. The discussion is, first, situated in the context of debates around supporting ‘ageing in place’ and developing ‘age-friendly cities and communities’. Second, we outline the basis for a ‘community-centred’ approach for tackling COVID-19. Third, we identify
a series of recommendations for those engaged in developing urban health policies to tackle future waves of COVID-19 and similar pandemics.

**Developing age-friendly communities**

Policies in Europe have emphasised the role of the local environment in promoting ‘ageing in place’, a term used to describe the aim of helping people to remain in their own homes and neighbourhoods (rather than residential care) in later life (Wiles et al, 2012). The World Health Organization has been especially influential in raising awareness about how to adapt urban environments to the needs and preferences of people ageing in place, through the development of its ‘Age-Friendly Cities and Communities’ project. Alley et al define an age-friendly city as a ‘place where older people are actively involved, valued, and supported with infrastructure and services that effectively accommodate their needs’ (2007: 4). In 2010, the World Health Organization launched the Global Network of Age-Friendly Cities and Communities, which by 2023 had reached a membership of around 1,400 cities and communities in 44 countries across the Global North and South.

The period from the mid-2000s saw a substantial growth of interest in age-friendly issues, with a variety of projects and achievements linking ageing populations to the need for changes to the built and social environment, transportation, housing and neighbourhood design (World Health Organization, 2018; Stafford, 2019; van Hoof et al, 2021). However, a combination of widening inequalities within and between urban environments, and the impact of austerity on local government and city budgets, has raised questions about future progress in developing age-friendly programmes and related activities (Buffel et al, 2018).

To these pressures, the impact of COVID-19 should now be added, with the pandemic having its greatest impact (as highlighted in Chapter 2) on areas characterised by high levels of deprivation, often with ageing populations, poor quality housing and communities experiencing long-term decline through deindustrialisation (Beatty and Fothergill, 2021). Buffel et al (2021) suggest that under social distancing guidelines, older people living in socio-economically deprived urban neighbourhoods experienced a ‘double lockdown’ as a result of interrelated social and spatial inequalities associated with COVID-19. Yet, despite the known pressures on low-income communities, little was done to inject extra resources into these communities at the start of the pandemic, or to engage directly with organisations working with some of the most vulnerable and excluded groups in such areas (Marmot et al, 2020; Munford et al, 2022).

Both elements need urgent consideration if there is to be greater protection from the impact either of the continuation of COVID-19 or from future pandemics. In what follows, emphasis is given to the importance of close
engagement with communities, viewed in the context of a redistribution of financial resources in favour of lower-income areas. This should be seen as a pre-condition for developing effective policies for tackling the social and geographical inequalities associated with the impact of COVID-19.

Community participation and COVID-19

The argument of this chapter is that communities have, to date, been marginalised in strategies to combat COVID-19. Christakis (2020) highlights two broad ways to respond to pandemics: first, pharmaceutical interventions (PIs), such as medications and vaccinations; second, non-pharmaceutical interventions (NPIs) which are either individual (for example, mask-wearing, self-isolating) or collective (for example, shutting schools, banning large gatherings). To date, collective NPIs have largely comprised of actions led by government, delivering messages, for example, through press conferences, the internet, social media platforms and the national press. These interventions have been complemented by the work of regional and local authorities, in many cases using networks developed prior to the pandemic. However, the evidence suggests that neighbourhoods and the different groups within them have been at the receiving end of actions to combat COVID-19, rather than being treated as equal partners. As Marston et al note: ‘[these actions] have largely involved government telling communities what to do, seemingly with minimal community input’ (2020: 1676).

Absent in current NPIs is the type of community-centred model put forward by Public Health England, which suggests that:

Community (or citizen) participation, that is the active involvement of people in formal or informal activities, programmes and/or discussions to bring about planned change or improvements in community life, services and/or resources, has long been a central tenet of public health and health promotion. … There is a compelling case for a shift to more people and community-centred approaches to health and well-being. The core concepts that underpin this shift are voice and control, leading to people having a greater say in their lives and health; equity, leading to a reduction in avoidable inequalities, and social connectedness, leading to healthier more cohesive communities. (Public Health England, 2015: 8–9)

Yet, these principles were not implemented in the development of COVID-related NPIs, notably in the type of approach from central government, with PIs, and vaccines in particular, presented as the ‘magic bullet’ for managing the pandemic, as opposed to being integrated with neighbourhood-focused
activities. A number of reasons can be identified for bringing communities to the forefront of future strategies. Marston et al make the general point that:

[C]ommunities, including vulnerable and marginalised groups can identify solutions: they know what knowledge and rumours are circulating; they can provide insights into stigma and structural barriers; and they are well-placed to work with others from their communities to devise collective solutions. Such community participation matters because unpopular measures risk low compliance. With communities on side, we are more likely—together—to come up with innovative, tailored solutions that meet the full range of needs of our diverse populations. (Marston et al, 2020: 1676)

Targeting low-income areas with tailored public health messages is essential because of the ‘clustering’ of ‘at risk’ groups. The evidence suggests that areas with a concentration of overcrowded housing had the worst outcomes from COVID-19. The Centre for Ageing Better (2020) in association with The King’s Fund, reporting on the first wave of the pandemic, found that of the 20 local authorities with the highest COVID-19 mortality rate, 14 had the highest percentage of households living in homes with fewer bedrooms than needed.

One of the weaknesses in current approaches of working with older people is an over-reliance on access to the internet as a means of communication. This ignores the extent of digital exclusion among particular groups – notably, but not exclusively, the older population. In 2020, according to ONS (2020) figures, 11.4 per cent of people aged 65–74 had never used the internet, with this figure rising to 38.8 per cent for those aged 75 and over. These age groups are likely to be further disadvantaged by the decline of local newspapers – 265 closed in the UK in the period 2005–2020 (Tobitt, 2020). Given this context, more traditional means of communication about COVID-19 and future pandemics will most probably be necessary (for example, leaflets in different languages through doors; advertising in shops) to complement digital communication and related approaches.

In addition, developing a community-centred approach is important in convincing people that their own actions really can make a difference. Christakis makes the point that:

If we see pandemics purely as a function of biological details … we may be lulled into thinking there is nothing we can do to prevent or arrest such events. But if we see pandemics as sociological phenomena as well, we can more clearly recognize the role of human agency. And the more we see our own role in shaping the emergence and unfolding
of pandemic diseases, the more proactive and effective our responses can be. (Christakis, 2020: 316)

The next section of this chapter considers how a community-centred strategy might be developed, one which acknowledges the long-term impact that the pandemic is likely to have, especially for those vulnerable due to their age, ethnicity or living in an area of high deprivation.

Community-centred strategies and tackling COVID-19

This section addresses the question of how to develop specific strategies which can strengthen the impact of NPIs but also facilitate (where necessary) the uptake of PIs. These proposals should be viewed as a contribution to developing a new public health strategy focused on protecting lower-income communities. The focus of the discussion will be on older adults, but the examples given are relevant to other age groups as well. The areas covered include: promoting community participation; recruiting advocates for those who are isolated and/or socially excluded; developing social infrastructure; creating a national initiative for supporting community-centred activity; and developing long-term community-centred policies.

Promoting community participation

What might community empowerment mean given the importance of protecting people against either future variants of COVID-19 or its equivalent? Our approach to participation is that it is more than just about ‘consulting’, ‘involving’ or ‘engaging’ people. Instead, the emphasis should be on renegotiating power and building capacities to help people gain more control over the neighbourhoods in which they live. Some potential areas of work here include: first, drawing on collaborative methods of co-research, as developed, for example, by Blair and Minkler (2009), Buffel (2019) and others. Older people, trained in research skills, are best placed to play a vital role in: deepening our understanding of attitudes towards COVID-19 – especially among groups experiencing various forms of social exclusion; assisting dissemination of advice and messaging about protection from the virus; and challenging negative stereotypes of older people by emphasising the skills and knowledge which they can bring to support work to control the virus.

Second, working with ‘informal’ and ‘formal’ leaders within communities could assist the uptake of PIs and encourage people to stay as safe as possible. The importance of this has increased given evidence about misleading/false information spread through social media, notably about the benefits of vaccines. One example of the central role of community leaders was evident
in January 2021 when a group of imams delivered sermons in mosques across the UK which sought to reassure worshippers about the safety and legitimacy of COVID-19 vaccinations and remind them of the Islamic injunction to save lives (Sherwood, 2021). The move came amid evidence of anxiety within Muslim communities about the roll-out of vaccines, and concern about slow take-up in some parts of the UK. The Scientific Advisory Group for Emergencies concluded that:

Community engagement can identify strategies to make the vaccine more accessible, including in settings outside of formal health service provision, and increases trust between formal organisations and community members. This requires involving community leaders as partners … to promote local buy-in and develop community plans. … Community forums that address the cultural and historical context of vaccine research mistreatment and including diverse representation of stakeholders can increase trust. (Scientific Advisory Group for Emergencies, 2020: 7)

Third, building on existing networks and neighbourhood organisations will be vital in developing community-based interventions. Again, this can be through both ‘informal’ and ‘formal’ networks. Gardner (2011) highlights the importance of what she terms ‘natural neighbourhood networks’. These refer to the ‘web of informal relationships and interactions that enhance well-being
and shape the everyday social world of older people ageing in place’ (Gardner, 2011: 263). Gardner’s research demonstrates the importance of ‘third spaces’ for older people (for example, informal sites such as cafés, local businesses, libraries and local streets), all of which must be considered essential facilities for conveying information and supporting people during the pandemic.

In terms of formal networks, the UK Network of Age-Friendly Communities, supported by the Centre for Ageing Better, has 55 members across the four UK countries. Many of these networks implemented important initiatives to support people during the pandemic, including campaigns to challenge ageist narratives, developing innovative forms of social participation, and distributing information booklets targeted at older people who are not online (Centre for Ageing Better, 2020). This work was supported in a number of areas in England by the local partnerships formed through the National Lottery-funded ‘Ageing Better’ programme, which ran from 2015 to 2022. ‘Ageing Better’ was designed to tackle problems relating to loneliness and social isolation among older people, with a particular focus on people living in low-income neighbourhoods (McKenna et al, 2022). The variety of projects and initiatives developed by the programme, with their emphasis on co-production and improving social connections, provides an important resource for developing community-based approaches to public health (Yarker and Buffel, 2022).

**Recruiting community advocates**

The second area for intervention concerns recruiting ‘community advocates’ for those who may not have anyone who can speak on their behalf. In reality, many older adults are able to safeguard their interests or have a ‘convoy of support’ (family, friends, neighbours) who are able to intercede on their behalf. However, there are increasing numbers in the population who may be having their interests ignored at times of crisis such as COVID-19. Klinenberg, in research on the impact of the 1995 Chicago heat wave, pointed to the rise of an ageing population of urban residents living alone: ‘often without proximate or reliable sources of routine contact and social support’ (Klinenberg, 2002: 230). He pointed, in particular, to problems faced by older men who had outlived ‘their social networks or become housebound and ill, often suffer[ing] from social deprivation and role displacement in their later years’ (Klinenberg, 2002: 230; see Chapter 6, this volume).

The issue identified by Klinenberg has undoubtedly become more serious in the intervening years – with a growth in the population of men and women living alone, in circumstances where accessing help has become increasingly difficult. Beach and Bamford (2014), using data from the English Longitudinal Study of Ageing, found that 14 per cent of older men experienced moderate to high social isolation compared to 11 per cent of women. Almost one in four older men (23 per cent) had less than monthly contact with their children,
and close to one in three (31 per cent) had less than monthly contact with other family members. For women, these figures were 15 per cent and 21 per cent, respectively. The authors concluded that as the population of older men continues to grow and more people in this group find themselves living alone, social isolation and the potential issues it brings are set to get worse.

Social isolation need not necessarily be such an acute problem if services are plentiful and easily available. However, the combination of austerity and COVID-19 has drastically rationed support of all kinds – the impact of which may be especially severe for isolated men who may, in any event, according to Beach and Bamford (2014), be less likely to seek medical or other forms of help when needed. In this situation, and given the long-term pressures which health and social care are likely to experience, developing a network of advocates within communities will be important to prevent isolated individuals being denied appropriate treatment and support. Advocates could be drawn from existing organisations, for example local Age UK branches, Good Neighbours and befriending groups. However, this would require resourcing for training and financial support to those carrying out such work, an issue considered in further detail in the following section.

**Developing social infrastructure**

A key recommendation from this study is that investing in community-based services and organisations will be vital in ensuring social, psychological
and practical support for marginalised and vulnerable groups. Government allocations of funding to the voluntary and community sector will need to increase, and the resilience of neighbourhoods, already weakened before the pandemic, will require strengthening (Marmot et al, 2020). Alongside community-based capacity building and supporting local initiatives, investing in the physical and institutional infrastructure of cities is crucial. The development and maintenance of social connections should also form a key part of recovery strategies to build back fairer communities (Marmot et al, 2020; Manchester City Council, 2022). The social support generated in spaces such as libraries and community centres has been found to be protective of health and well-being across the life course (Cotterell et al, 2018; Hertz, 2020).

Building on Klinenberg’s (2018) research on the importance of social infrastructure, Finlay and her colleagues make the point that such community spaces ‘represent essential sites to address society’s pressing challenges, including isolation, crime, education, addiction, physical inactivity, malnutrition, and socio-political polarization’ (Finlay et al, 2019: 2). Social infrastructure is essential in the recovery from the COVID-19 pandemic for promoting social connections, community cohesion, and for continuing to support age-friendly communities. Installing designated age-friendly benches in parks, ensuring seating to allow people to queue comfortably in shops and promoting accessible, green, safe and inviting public spaces, are just a few examples of how ‘age-friendly’ interventions may address the needs of different age groups (Yarker, 2022a).

**National funding**

The fourth argument is for a national, government-funded initiative to support community-centred work. Marston et al make the case for funding community engagement taskforces to ensure that a community voice is incorporated into responses to pandemics such as COVID-19. They argue that this will require:

> Dedicated staff who can help governments engage in dialogue with citizens, work to integrate the response across health and social care, and coordinate links with other sectors such as policing and education. This engagement will require additional resources to complement existing health services and public health policy. Dedicated virtual and physical spaces must be established to co-create the COVID-19 response, with different spaces tailored to the needs of different participants—e.g., different formats for discussion, timings, locations, and levels of formality. (Marston et al, 2020: 1677)
Some areas may already have taskforces working along these lines, but the need both for additional funding from central government, and the importance of raising the profile of community-centred work, will be vital. This work will be especially important in developing effective policies over the longer term, given the possibility of a return of high levels of COVID-19 and the re-adoption of social distancing in some form. The implications of this last point are addressed in more detail in the final section of this chapter.

**Developing long-term community-centred policies**

Finally, the impact of COVID-19 can be measured in a variety of ways – in terms of reduced quality of life, lost income, mortality and long-term illness. Reflecting on all these, we know that the pandemic has already accelerated the decline in life expectancy which had started to affect poorer areas in England and Wales over the period 2010–2020 (Aburto et al, 2021). We also know, as outlined at the beginning of this chapter, that COVID-19 remains an ever-present danger in the community, especially for people aged 65 and over, who remain the majority of those dying from COVID-19 or subject to long-term serious illness. Accepting COVID-19 as an ever-present part of the community is consistent with views about the interaction between diseases and long-term patterns of global social and community change.

Christakis (2020) makes the point that COVID-19 needs to be placed within the wider context of globalisation, mass migrations and increased urbanisation with these factors contributing to the persistence of infectious diseases. He argues that:

> Outbreaks of novel pathogens reflect, among other things, changes in the way in which humans come into contact with animals. In fact, two of the biggest challenges humans face—extreme weather events … and periodic outbreaks of serious diseases—may be linked by climate change. People driven from their homes by changes in the weather or people clearing new land for cultivation may come into contact with animals (who may also be driven from their homes) in ways that increase the likelihood of the emergence of new pathogens in our species. (Christakis, 2020: 298–299)

However, it should also be noted that increased instability in the world coincides with the rise in populations (such as those comprising people over 60) who are especially vulnerable to infectious diseases. COVID-19 (or some variant) is likely to persist for some time for a variety of reasons (Horton, 2021). PIs – for those countries that can afford them – will certainly be vital in controlling the spread of the virus. At the same time, as commentators such as Christakis (2020) have pointed out, many ‘unknowns’
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remain: their affordability (for many countries); their efficacy against new mutations; and their supply. Given this context, developing neighbourhood-level public health systems will be essential to run alongside successive programmes of vaccinations. Developing this argument, three priorities might be highlighted.

First, community-centred work needs to be understood within a wider context of ‘community development’. COVID-19 has preyed on neighbourhoods damaged by cuts to basic services and social infrastructure, lack of investment in housing, and the rise of precarious forms of employment. Any long-term strategy to combat the pandemic must address the multiple forms of deprivation affecting many communities in the UK. These, as the evidence shows, are drivers for transmission of the virus, notably through overcrowded households, with members employed in high-risk occupations passing the virus across generations (Scientific Advisory Group for Emergencies, 2020).

However, community development must also come from ‘below’, with the pandemic giving impetus to what Sennett refers to as ‘localised sociability’, assisted by the strengthening of neighbourhood-based organisations (Sennett, 2020: 143). This may be especially important given the impact of successive lockdowns in potentially reinforcing social isolation among some groups. The effects of successive lockdowns remain unclear: for example, in creating a loss of confidence in moving around neighbourhoods; re-establishing relationships; and developing new contacts. One possible consequence will be the need to establish new forms of solidarity within communities, drawing on the collective organisation of older people. Relevant examples which emerged before the pandemic include the ‘Village’ movement, and Naturally Occurring Retirement Communities (both developed in the United States), and consolidation of the World Health Organization’s global network of age-friendly cities and communities (Buffel et al, 2018). These, and other approaches, provide useful models for the direct involvement of older people in rebuilding communities in which they are likely to have spent a significant part of their adult life.

Second, COVID-19, as numerous reports have made clear, has exposed and exacerbated long-standing inequalities affecting BAME groups in the UK. Racism and discrimination also played an important role in this regard, as highlighted in research cited in Chapter 2. However, the impact of institutional racism and inequality in exposing ethnic minority people to higher rates of COVID-19 was predictable, given available knowledge about poverty, co-morbidities, poor-quality housing and low incomes affecting many of those in South Asian and other BAME communities. The question is why there was a failure to develop preventative forms of community-centred working with BAME groups from the start of the pandemic. Such targeted work, involving community leaders wherever possible, will certainly be
essential over the medium and longer term. However, as suggested earlier, this type of initiative will require additional sources of funding to support what are financially constrained organisations even in ‘normal times’.

Third, as observed in Chapter 2, COVID-19 has proved catastrophic for people in residential care – in the UK as well as for many other countries. By mid-January 2021 in the UK, one-third of fatalities were among care home residents – 32,000 people after taking into account those who had died after being admitted to hospital (Booth and McIntyre, 2021). This is an extraordinary figure, which indicates a systemic failure to safeguard a highly vulnerable group. Bold thinking is certainly needed by the research and policy community about the future of residential and nursing home care: challenging rather than colluding with current models of care. Privatisation has proved a flawed model; but the public or not-for-profit sector does not provide a straightforward solution either. The way forward must certainly be to ‘downsize’ from ‘industrial-scale’ care, potentially looking at placing the management of homes within a local authority framework. Crucially, such homes should be embedded in their surrounding neighbourhood. Developing viable models which provide some degree of protection for people will be challenging, but the impact of COVID-19 has confirmed the urgent need for major reforms of the residential and nursing home sector.

Conclusion

COVID-19 has presented a defining public health challenge for the 21st century. The issues identified in this chapter underline the need to implement a community-based strategy which foregrounds values of empowerment, anti-ageism and anti-racism. The devastating impacts of COVID-19 must prompt us to rethink the kind of infrastructure needed to support vulnerable populations in times of crisis. For older people – as with other groups – the consequences of the pandemic have weakened the ‘informal’ networks which sustain everyday life. But the effects have been amplified for those living in socio-economically deprived neighbourhoods where austerity and now COVID-19 have had the greatest impact.

The task now is to find solutions to the issues posed by the pandemic, and to ensure that older people are active participants in developing the new public health policies necessary for the years ahead. Communities demonstrated considerable resilience through the various periods of lockdown associated with COVID-19. But the combination of austerity and cuts to welfare programmes, along with the damage inflicted by the pandemic, has meant considerable work will be required to restore the physical and social infrastructure of communities. This chapter has set out some of the key steps for involving communities themselves in this process, an essential next step in the process of ‘building back fairer’ from COVID-19 and its aftermath.