# The potential implications and inequalities in the care of older people in a post-COVID world: An autoethnographic account

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## Abstract

Healthcare smart homes have been positioned as a potential innovative solution to the current global ageing crisis and an alternative for the care of older people within a post-COVID-19 world. However, such innovations have emerged within a particular dominant discourse in which older people are framed and pathologized as societal burdens. This autoethnographic paper, based on my reflections and recent ethnographic fieldwork with older residents of healthcare smart homes, explores the potential changing landscapes of care and home that older people may experience in a post-COVID-19 world. Previously, healthcare smart homes were associated with wellbeing, choice and autonomy, however, with the negative impacts of COVID-19 on care homes and the care sector, healthcare smart homes and digital-by-default care may become the prominent option for the future care of older people. I argue this may cause increases in the social, economic and geographical inequalities around access to smart health technologies. Many of these inequalities are experienced more strongly by individuals from different intersectionalities including age, disabilities and class. Furthermore, potential feelings of autonomy experienced by older people using smart health technologies may be reduced when a post-COVID-19 move to digital-by-default health and social care becomes a necessity rather than a choice.

## Introduction

*In March 2020, when the UK government first announced that adults aged over 70, those who were eligible for the flu vaccine and pregnant women should shield for 12 weeks, one of my first concerns was for my key research participants and their support networks. I had just spent the last six or so months getting to know each of them personally, and so knew of the importance they placed on being able to get out and about in their communities, be that to participate in community events, or even just to walk their dogs or go shopping. Yet, through lockdown and the implications of COVID-19, my key participants, all of whom were aged over 70 and lived with multiple chronic conditions and disabilities, were being asked to completely change their routines in a way that was not of their choosing. They had each spoken at length of the importance of having routines and things that they did every day, week or year to maintain a sense of independence and normality. For Angela, this was swimming in the sea every year, for George, this was attending his poetry groups and his lunch clubs and for Iain, it was being able to move to a new house. Meanwhile, for Georgette and Geoff, it was being able to walk their dogs. Each relied on carers (be they formal or informal) to some extent, and so this was an additional worry. One of the first things I did was text George, as he lived by himself and his daughter lived further away, to let him know I was happy to help him by leaving food on his doorstep for instance. This would have been possible because George, unlike my other key participants lived near to me. However, I remember being hesitant to do so given that George had often spoken at length at not wanting to be considered old or as a person requiring, rather than providing, support. So, I was worried my offer of assistance might be construed as patronising.*

In this paper, I reflect on the potential implications of the COVID-19 pandemic on my research participants, and how this may signal the need for a reimagining, or re-constructing, of some of the components of the dominant healthcare smart home narrative and the future care options for older people. Specifically, the suggested benefits of greater wellbeing, choice and autonomy in healthcare and housing decisions from healthcare smart home living (Liu *et al.*, 2016; Bennett, Rokas and Chen, 2017) may need to be reconsidered. In addition to autoethnographic reflections, I draw on my current ethnographic research which explores the experiences of older people and their wider caring networks who live in rural healthcare smart homes in Scotland, to highlight the potential texture of lived experience (Ellis, Adams and Bochner, 2011; Lake, 2015; Hine, 2019) before, during and after COVID-19.

In the paper, I will first offer some context on healthcare smart homes, followed by a discussion on the inequalities and intersectionalities that have been perpetuated through COVID-19, specifically concerning my research around older people and smart care at home. Next, I will discuss how the COVID-19 pandemic is shifting the landscapes of care and home. I follow this with a discussion on the potential impact of the role of choice and autonomy (or lack of) around care in the home of older people when a digital-by-default health and social care system may be sought after COVID-19. Throughout the paper, I will highlight how different intersectionalities, specifically, social standing, economic standing and age may lead to differing impacts in a digital-by-default future home care system.

## Introducing healthcare smart homes

Healthcare smart homes are digitalised homes that allow an older person to remain independent and promote their wellbeing through the use of technology at home (Bennett, Rokas and Chen, 2017; Majumder *et al.*, 2017; Burrows, Coyle and Gooberman-Hill, 2018). Examples of such technology include wearable fall alarms, remote GPS trackers and portable heart rate monitors, as well as more ubiquitous smart technologies such as smart speakers. These homes are suggested by some policy-makers and developers (Layzell, Manning and Benton, 2009; Wilson, Hargreaves and Hauxwell-Baldwin, 2017) as a potential innovative solution to a series of wider societal issues related to a global ageing population, specifically: reducing the burden on health and social care services (Weicht, 2013); increasing opportunities for ageing-in-place (at home) (Aceros, Pols and Domènech, 2015); the changing spaces of care in times of austerity, promoted as greater choice and autonomy (or responsibilisation) in healthcare and housing decisions as we age (Bevir, 2016; Power and Hall, 2018); and sustaining rural communities (Philip and Williams, 2019). The use of the phrase innovative solution adds a moral angle to the discourse. As Neven and Peine (2017) argue, the use of ideographic words such as freedom, democracy and innovation, are easily understood as good and as such are morally hard to critique. The use of innovative smart technologies is presented as a triple win (Neven and Peine, 2017): for society; older people; and, the economy. This innovation-focussed discourse does not immediately recognise the work and costs that are required by older people for such a triple win to occur and can mask many inequalities concerning the care of older people (Aceros, Pols and Domènech, 2015; Golant, 2017; Neven and Peine, 2017). Inequalities, such as social, economic and geographic access to appropriate homes, care and smart technology, have intersected to an unprecedented level during the time of COVID-19. Thus, the potential implications for COVID-19 to normalise a digital-by-default approach to health and social care may serve to further heighten some of these existing inequalities for older people.

## Inequalities and intersectionalities perpetuated through COVID-19

No doubt, we can all summon examples from television, film and the wider news media, of portrayals of older people as frail and needy, as burdens on others (Katz, 2000). Such stereotypical images are prolific and underpinned by a desire to control and exert power over others (Fealy *et al.*, 2012; Aceros, Pols and Domènech, 2015). Thus, I was unfortunately not surprised by the narrative put across by some media outlets and governments across the world, as the COVID-19 deaths of older people, or those with an underlying condition, portrayed as somehow more acceptable than the COVID-19 deaths of those who were younger or without any underlying health conditions (Express, 2020; Sun, 2020). The subdivision of accounted deaths divided between those with and without underlying health conditions, or of a particular ‘acceptable death’ age shone a light on one of the unequal ways in which the existing structures have heightened the impacts of COVID-19 on older people, especially those with underlying health conditions. As such, some of the unequal treatment that some older people have experienced through COVID-19 have been perpetuated through these pre-existing powerful media narratives, as they have been further stigmatised as an increased burden and a risk on society. Although heightened, this use of language and framing for discussing older people and people with disabilities and underlying conditions has existed for years (Weicht, 2013; Bülow and Söderqvist, 2014; Aceros, Pols and Domènech, 2015). This pandemic has merely brought such discussions more into clearly and explicitly into view.

These framings are also connected to specific inequalities that many older people experience in everyday life. Social inequalities include access to safe and appropriate housing (Hooyman and Kiyak, 2011; Colic-Peisker, Ong and Wood, 2015). Meanwhile, economic inequalities include access to appropriate care and smart health technologies (Balta-Ozkan *et al.*, 2013; Currie, Philip and Roberts, 2015). And, finally, geographic inequalities are felt particularly by those in rural areas in which care may be more expensive or necessitate a move away from home for appropriate access to care (Dowds *et al.*, 2018). Furthermore, access in terms of the well-documented digital divide (Williams *et al.*, 2016; Park, 2017; Philip *et al.*, 2017) can be felt by individuals of all ages, but often older people in rural areas are particularly impacted. The digital divide is ‘used to cover a broad range of social differences in access to and use of digital equipment and services, most notably personal computers, and the ability to access the internet in terms of both physical connection and facility of use’ (Sparks, 2013). For Philip et al (2017) the digital divides are therefore two-fold: 1) socio-economic digital divides; 2) divides that result from technological infrastructure inequalities. I would argue that many of these socio-economic digital divides are experienced more frequently, and strongly, by those from lower-class backgrounds (who may not be able to financially afford the smart technology devices or the internet that enables them), or for those with certain disabilities or age profiles which the technologies do not traditionally easily cater for, or at least not without an additional financial cost.

Due to the existing structures within our increased neoliberal societies (Bevir, 2016), a range of intersectionalities have experienced especially difficult times through the COVID-19 pandemic (Eaves and Al-Hindi, 2020; Standring and Davies, 2020). Intersectionalities are social categories which are influenced by power relations, such as race, gender and class (Eaves and Al-Hindi, 2020). There have been reports of individuals of particular racial backgrounds (i.e. black) being both more susceptible to the virus (Guardian, 2020a), and also often in receipt of worse levels of (or no) care (Eaves and Al-Hindi, 2020). Similarly, for gender intersectionalities, women have tended to take on more caring responsibilities during this time, in place of formal carers, nurseries and schools (Manzo and Minello, 2020). Meanwhile, there have been specific impacts on individuals from working-class backgrounds in terms of their prevalence in risky and non-furloughed jobs such as carers, bus drivers and factory workers (Guardian, 2020b), or residing in poorer housing conditions (Rogers and Power, 2020) without security or outdoor space for instance. However, in this paper, I focus on the intersectionalities of age and disability. During the UK’s response to the pandemic all those aged over 70 have been grouped together in their requirement to shield (World Health Organisation, 2020), with all those over 70 treated as a risk to themselves and wider society, no matter of how otherwise healthy or unhealthy they may be. Yet multiple authors have discussed the existence of a third and fourth age in later life (Bytheway, 2005; Leibing, Guberman and Wiles, 2016; Ekerdt *et al.*, 2017; Peine and Neven, 2020). The third age is a new post-retirement stage of life concerned with personal fulfilment, whilst the fourth age is a period of life associated with dependency, decrepitude and death (Ekerdt *et al.*, 2017). The COVID-19 pandemic, at least in the UK, has in some ways re-classified all older people over 70 together and perpetuated further the stereotype of all older people as frail and burdensome members of the fourth age. This no doubt caused further problems for informal familial carers, many of whom are aged over 70 themselves (AGE UK, 2017). Relatedly, those with disabilities (or underlying health conditions) have, at least within the UK’s pandemic response, been dehumanised and pathologized to a certain extent (Mitchell *et al.*, 2017; Ahmad *et al.*, 2020) as ableist and normative health and social care planning still dominates within many of our societies. Furthermore, within the UK specifically, critics of the Coronavirus Act (the emergency legislation which the UK government passed at the start of lockdown) said it allowed local councils to downgrade their duty of care towards disabled and older people (BBC NEWS, 2020). For older people who also live with a disability, including several of my key research participants, this can be a double blow, as they are stereotyped and stigmatised as a risky member of society on account of both their age and disability. As such, these inequalities and intersectionalities have converged during the COVID-19 pandemic creating a potential shift in experiences of health and social care, and the home.

## COVID-19 shifting landscapes of care and home

I also wonder if the implications of the COVID-19 lockdown will ultimately change how we, as a society, consider spaces and places of care, borrowing a phrase that Power and Hall (2018) have referred to previously as ‘shifting landscapes of care’. With the recent moves towards increased healthcare at home, will the impacts of COVID-19 make these shifting landscapes more widespread and permanent? Furthermore, older people themselves and their wider caring networks, in other words, the potential recipients of smart healthcare, may change their perceptions of the devices as a result of COVID-19. Such perceptions could be positive in terms of increased safety, empowerment and social interactions (Hargreaves, Wilson and Hauxwell-Baldwin, 2018), although without autonomy, and proper social and economic access the perceptions of use may become more negative. George, one of my key participants, highlighted this issue when discussing his intercom alarm which he had to answer every morning to let the housing officer know that he was okay.

When I find that I can’t…you know it’s hard for me to get down on my knees no matter mind anybody else. I do rely on the care people manning the intercom you know. If I…I don’t sleep well…but if I don’t put off the wee signal in the box, then a wee voice comes through the intercom, ‘are you alright Mr White’. It’s reassuring and gives a sense of security that there’s somebody there. But on the other hand, it chips away at the person.

[Meeting three with George, Cupar, August 2019]

### Changing role of the home during the pandemic

Within the dominant narrative behind the push for healthcare smart homes, one constantly promoted benefit is the ability to live at home for longer (Burrows, Coyle and Gooberman-Hill, 2018). However, during the pandemic staying in your own home has been presented as more of a sacrifice, and something that we *have to do*, rather than something that we *get to do* as a benefit. Thus, the act of staying at home is portrayed as either a benefit and a sacrifice depending on the age, and healthiness of the resident. Relatedly then are the potential impacts of the meaning of home during, and as a result of, the pandemic. Some people will have spent their last few weeks or months isolated at home, ultimately dying alone. For others, even the fear of such a potentially isolated and lonely death will have long-lasting implications on their associations with their homes.

For authors such as Cristoforetti, Gennai and Rodeschini (2011) and Wiles et al. (2012), the home has been considered as a refuge, a site of safety, however, the impacts of the COVID-19 pandemic may alter this somewhat, with the home becoming considered a prison, even a death sentence. According to Maalsen and Dowling (2020: 2), ‘the COVID-19 crisis is accelerating the rate at which digital technologies cross the threshold of our homes and is rescripting privacy in the process’. Relatedly, will home even continue to ‘feel like home’ when everyday routines such as walking the dog, attending a lunch club, and having in-person visits from your family are removed? For some, including several of my participants, all routines in the home will have moved online, and have become digital-by-default (Philip *et al.*, 2017). This means that in many ways my key participants, and many other older adults, are having to simultaneously adapt to and learn new home routines including skype calling family and order shopping online, as well as cope with the new stresses and pressures of living through a global pandemic, which may include bereavement of a loved one. Thus the home during this time has, in addition to being a potential site of safety and refuge (Chapman and Hockey, 1999), become a site of social interactions (Lee *et al.*, 2017), and ultimately through, COVID-19, a space and place of survival. In many ways, the home is becoming reclassified once more as simply a house (i.e. merely a place of shelter). Relatedly, the pandemic has reemphasised that for some, often from lower class-backgrounds or with disabilities, their homes have proven to be inadequate for their needs in terms of being safe and homely places to shield due to inadequate space or access (Eaves and Al-Hindi, 2020; Maalsen and Dowling, 2020), or lack of security due to poor renting conditions (Rogers and Power, 2020). Furthermore, necessary changes to routines in the home that smart health technologies can require, such as constant surveillance and increased time spent in the home (Burrows, Coyle and Gooberman-Hill, 2018), may mean certain groups of people (e.g. older people) are less receptive to having, and using, smart healthcare in their home.

Although, there is also a concern that the home may start to feel less secure if residents still also rely on in-person care, especially when carers may not have the correct (or enough) PPE to product themselves and their clients from the virus. This links to Gurney’s (2020) recent discussions around the home as a place of harm, especially during the COVID-19 pandemic. Thus, the pandemic may have amplified some of the impacts and experiences that my participants discussed in terms of living with smart (health) technologies. The potential impacts of COVID-19 also draw attention to the need for greater critical discussions and research on the experiences and perceptions around not only ageing-at-home, or sheltering-in-place (Hillcoat-Nallétamby and Ogg, 2014; Aceros, Pols and Domènech, 2015), but also the potential of dying-at-home (Visser, 2019), either directly or indirectly as a result from COVID-19.

### Changing desires for and of healthcare in the home during COVID-19

The actions, or inactions, of the UK government within this crisis may also heighten the desire for living in healthcare smart homes because of how the underfunded and overburdened health and social care services (Power and Hall, 2018) have been impacted as a result of COVID-19. When speaking with my participants, months before the start of the pandemic, many highlighted how they did not want to move into a care home or spend time in hospital because of their own (or their friend’s) previous negative experiences. The pandemic has drawn increased attention to the overburdened health and social care services (Horsfall *et al.*, 2017; Kim, Gollamudi and Steinhubl, 2017; Iacovone *et al.*, 2020) in terms of shortage of staff, protective and infrastructural equipment including ventilators and hospital beds (Buckingham, 2020; Scally, 2020). There have been stories in the news of outbreaks in care homes, even in perceived safer remote areas like the Isle of Skye (BBC, 2020b) ultimately abandoned care homes (filled with residents) (BBC, 2020a) and staff having to reuse their PPE because of shortages (Mason, 2020). All of these stories may increase the already existing fears and concerns of older people and their support networks, over having to move to a care home (Hillcoat-Nallétamby and Ogg, 2014; Aceros, Pols and Domènech, 2015), and so may strengthen the arguments for remaining at home with the aid of smart health technology. Relatedly though, through my recent research I found that some of my key participants adopted and utilised smart health technologies in their homes, not for their benefit, but to give their friends and family (their wider caring networks) peace of mind. One of my key participants, expressed this sentiment clearly when discussing her community fall alarm bracelet.

Angela: Oh, and I’ve got, I must have taken it off. Where did I put it? I must have taken it off before the shower, I think. But I have a thing that you press [a community fall alarm] that…Billy Hughes and Ellie…he’s just retired, he was a P.E. teacher...but they’re on the end of it.

Rachel: Why did you get your alarm? Just precaution or because you fell?

Angela: No, no. Just really to give family peace of mind.

Rachel: Yeah often it’s not really for you is it?

Angela: That’s right.

[Meeting one with Angela, Pitenweem, July 2019]

As such, given the wide-ranging risks from COVID-19, this feeling and pressure to unburden their friends and family may be ever more present.

Also, one aspect that has not yet had many discussions in the smart home and smart technology literature is the use of smart technology for hygiene reasons (Wilson, Hargreaves and Hauxwell-Baldwin, 2015; Marikyan, Papagiannidis and Alamanos, 2019). The COVID-19 crisis has shone a light on a potential new benefit of smart health technology, in that by being able to assist at a distance, passively or through voice-activation, the physical interactions with others such as carers and family members are reduced and thus increasing safety from exposure to the virus. There are many negatives to this including potential social isolation (Sixsmith and Sixsmith, 2008) and anxiety if users come into difficulties in using their smart technology (Hine, 2019), however, one advantage is the potential benefit of lower amounts of human contact for increases in hygiene levels (and thus less likelihood of passing on potentially deadly viruses) (Maalsen and Dowling, 2020).

As such the desires for smart healthcare at home, especially from policymakers and the wider caring networks of older people, may be increasing as a result of the shifts towards digital-by-default healthcare during the pandemic, as care homes become increasingly risky and home care staff have been often ill-equipped with appropriate levels of PPE. However, moves to digital-by-default care may reduce the potential positive benefits such as wellbeing, empowerment and autonomy of and for older people. In turn, this may reduce the feelings of homeliness for older people who now have to, rather than choose to, live at home for longer because of numerous external pressures (Bennett, Rokas and Chen, 2017; Burrows, Coyle and Gooberman-Hill, 2018). I will now discuss this potential issue in more detail in terms of these shifting landscapes of choice of care at home.

## Discussion: The role of choice in care in the home in a post-COVID-19 world

A key implication of the COVID-19 pandemic concerning the care of older people through the assistance of smart technology must be around the changing notion of choice and empowerment.

### Choice within a post-COVID-19 healthcare smart home

When I was undertaking my fieldwork, my participants were using their smart (health) technologies out of choice, to some degree, however, this level of choice was in some cases instigated by their children, and in some cases their wider caring networks. Yet, to some degree, it was a choice and as such had some empowering benefits because of the activities it enabled the users to carry out, such as using Alexas for memory aids or being able to continue living alone or cook for oneself at a time of their choosing. However, these empowering benefits and level of choice may be somewhat lower for those adopting smart (health) technologies out of necessity during COVID-19 lockdown, as this was generally considered the less-risky option. For example, older people who have bee, required to shield for 12 weeks may have been somewhat forced (because of lack of alternative viable options for care and socialisation) to adopt new smart technologies for interacting with their families living elsewhere, for organising shopping and for talking to their GPs. Many of these risks were heightened because of the inequalities that many older people face every day in terms of a poorly funded home care sector resulting in low carer retention rates, meaning older people rarely have a single dedicated carer, and thus both carers and clients are exposed to a greater number of people. Furthermore, looking to the future, older people from lower-class backgrounds (i.e. with likely fewer lifetime savings) may be at a disadvantage if they cannot afford, or do live in the right geographic location to be able to install and maintain certain privately-commissioned smart health technologies in their home (e.g. broadband or smart speakers), thus putting them at a disadvantage if or when their healthcare becomes digital-by-default. Thus, the potential empowering benefits may be reduced as use of these technologies becomes more a matter of life or death rather than an empowering choice. Although understandable at the height of the pandemic, the risk of COVID-19 to wider society and the health services has been prioritised as the singular most important issue during 2020, however it remains to be seen if other risks (i.e. risks to mental health, isolation, surveillance) will be similarly prioritised alongside COVID-19 as we move beyond lockdown. However, this notion requires further research.

### Care and older people in a digital-by-default future

The use of these technologies at home can have multiple benefits such as social connections, safety, and enhanced capabilities (Wilson, Hargreaves and Hauxwell-Baldwin, 2017). However, if they continue to be promoted as the societal norm across the board after the end of the COVID-19 pandemic, then the vision of the use of these technologies for personal empowerment and wellbeing (Lê, Nguyen and Barnett, 2012; Majumder *et al.*, 2017) may disappear completely. My key participants spoke at length about the importance they placed on maintaining routines such as walking their dogs and swimming in the sea, and so if they are denied these opportunities through the lockdown and enforced isolation, there is a potential for them to lose confidence in their abilities to do these activities and hence they are likely to experience further physical and social isolation (Imrie, 2004). As Georgette, one of my key participants highlighted when discussing the closure of services in her communities and further moves to a digital-by-default (Philip *et al.*, 2017) society.

Georgette: Aye…. well our problem just now is losing the post office. There’re no banks here, well the mobile bank comes, but the post office, well the shop that it’s in is closing on the 4th of October so I don’t know what’s going to happen.

Rachel: So, you’d have to go to Alness?

Georgette: well that’s the nearest. You can get the money out of the hole in the wall right enough, but it’s the paying the bills. I pay them in the post office.

Rachel: Would you pay for your alarm in the post office?

Georgette: Aye, the alarm, and the light and the gas. You might be able to pay it at the co-op, because you can get electric pay in there. But I don’t know how it’s going to work.

Rachel: Usually you can get prepaid top-up ones there so surely you could. But it is hard.

Georgette: Aye maybe you could, but I just usually take it off my pension every week. I suppose I could do it direct debit, it’s just the same more or less. I’ll have to get Lynne to look into it for me. They’ve not given anybody much time; I mean it’s only a fortnight away.

Rachel: That’s true, when did they tell you?

Georgette: A month ago. But there was a rumour going around that one of the shops was going to give them space down there. But whether they will or not I don’t know. We just have to wait and see.

Rachel: But it is hard, even if you can do it online if that’s just part of your routine, where each week you go in and you do these things.

Georgette: Aye, you go in and you collect your pension and pay your bills and do the shopping and that.

Rachel: It keeps you doing things in your community.

Georgette: It’ll come to the point I won’t be needing to go out at all.

Rachel: That’s a bit of worry of mine of making these fancy smart homes, where people can stay at home for longer, as people don’t actually want to be housebound.

Georgette: Well, that’s it. It would be awful if I was stuck in a place on my own all day. I have to get out with the boss [Molly her west highland terrier]. Then you meet people, and it makes you want to go out.

[Meeting three with Georgette, Invergordon, September 2019]

As such, the dominant narrative for healthcare smart home development needs to be re-considered and re-imagined to better reflect the lived experiences of older people particularly felt during COVID-19. When once the use of smart (health) technologies at home was one in a long list of care at home options, the potential for digital-by-default systems due to observed cost- and efficiency-savings may emerge from smart (health) technology use during the pandemic. If this occurs, then the experiences of older people may continue to be, and feel, somewhat ignored by those in positions of power.

## Conclusions

*Now, we are in the middle of Summer, months after the lockdown began, we are cautiously dipping our toe in the water of the so-called ‘new normal’. In the UK, officially 46,000 have died from COVID-19 (although many suspect the real figures to be much greater). Globally deaths sit at almost 650,000, which again may be a modest calculation. I, like many others, worry that this is not the end, and more of a temporary pause, the intermission in a play, with the second act much more horrifying than the first. Yet for many, there is still no intermission and the inequalities are ever more apparent. Rises in infections are now being recorded in care homes, and many of these care home residents still cannot have visits from their friends and families. Many more people from lower-class and non-white backgrounds have died through their work on buses, in supermarkets and care homes. Recently calls have been made to look into the UK government’s response to the pandemic in terms of the timing of measures and how they have protected (or more likely failed in their attempts) to protect more vulnerable members of society including individuals with disabilities and from certain ethnic backgrounds.*

In this paper, I have highlighted some of the inequalities that older people, and one example of intersectionality, experience in everyday life concerning social, geographical and economic access to varying forms of care at home. These are inequalities that have, in many cases, been emphasised through the COVID-19 lockdown. This links to other issues of inequalities and intersectionalities of society further highlighted and perpetuated in the pandemic such as the questionable low-skill and low-pay of key workers including social care workers (Rose-Redwood *et al.*, 2020), who are often from working- or lower-class backgrounds. Older people, or those with underlying health conditions or disabilities, often already stereotyped within society, have been further stigmatised as acceptable losses in the pandemic. Their deaths have been framed as more acceptable than the deaths of younger people or those without underlying health conditions or disabilities. Additionally, when healthcare smart homes were previously promoted as an innovative solution to the crisis of ageing that enabled wellbeing, choice and autonomy, within the lockdown this benefit was lost as the risks to life became too great.

However, I worry that the inequalities concerning the varying forms of access to care may be heightened in a post-COVID world if such technologies are almost forced on older people, by society and their wider caring networks, as a less-risky option than care home living or frequent in-person visits to the hospital or their GP. For instance, as another recession looks likely in much of the world, including the UK, the impacts of varying levels of financial access to either in-person or digital health and social care may become increasingly apparent. Simultaneously, the pandemic has re-classified all older people over 70 as members of the fourth age, rather than a wide-ranging group of individuals. As such, remote smart health technologies, including community fall alarms and remote CCTV cameras, will likely be targeted and advertised more towards the wider caring networks under the auspices of ‘ensuring peace of mind’ and safety of their loved ones (Katz and Marshall, 2018; Peine and Neven, 2020) rather than towards the older people themselves, many of whom may be very capable of, and appreciate maintaining control of their own healthcare needs. Although such technological installations may be encouraged by the wider caring networks (e.g. family members) out of the best of intentions, there will always be risks, if not from COVID, from other sources, and the benefits from users having enough choice and autonomy in their care at home may far outweigh the risks of COVID-19.

Furthermore, older people’s identities are more than simply the risks they pose on themselves and society, as well as more than their desires to age-at-home (Aceros, Pols and Domènech, 2015; Katz and Marshall, 2018). Ultimately, the ‘crisis of ageing’ (Neven and Peine, 2017) cannot be innovatively solved by smart health technology because it is a social, and somewhat socially constructed, rather than technological, problem. The impacts of the crises of ageing and coronavirus have been worsened in many ways by the structural inequalities (Adams and Niezen, 2016; Katz and Marshall, 2018) and intersectionalities that exist in our current society. The media and (often) government-level stigmatisation and pathologization of older people, people with disabilities and individuals of varying races and genders have enabled societal responses which aim to ‘solve’ global ageing and the COVID-19 pandemic through further potential stigma and stereotyping, such as through digital-by-default healthcare. These solutions do little to consider these intersections of society such as older people as individuals with their own fears, desires and needs. The very structures that created these inequalities and intersectionalities need to be rebuilt and re-centred with a focus on these intersectional individuals as autonomous beings who are more than simply their label (i.e. of an older person, a person with disabilities) and its associated and pre-determined potential wider risks and burdens to, and on, society.

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