International Journal of Law
www.lawjournals.org
ISSN: 2455-2194
Received: 22-02-2026, Accepted: 25-03-2026, Published: 09-04-2026
Volume 12, Issue 2, 2026, Page No. 42-46

Elder rights in the post-pandemic era: Lessons learned from COVID-19's impact on nursing home populations and healthcare prioritization

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Abstract
The COVID-19 pandemic revealed significant systemic shortcomings in safeguarding the rights of older individuals, especially within nursing homes and long-term care settings. Older adults, who constituted a disproportionate percentage of pandemic-related deaths across nearly all affected countries, experienced institutional neglect, age-based healthcare rationing, enforced social isolation, and insufficient legal safeguards during this unprecedented global health crisis. This study offers a thorough examination of the pandemic's effects on nursing home residents, critically assesses the structural and legal deficiencies that rendered older adults particularly susceptible, and derives policy recommendations for the post-pandemic period. Drawing upon international case studies, human rights law, research on aging, and public health policy, this paper posits that the rights of older adults should be recognized as legally enforceable entitlements, rather than merely aspirational objectives. It advocates for substantial legal reforms, increased financial investment in long-term care, and the establishment of a legally binding international accord concerning the rights of older individuals.

Keywords: Elder rights, COVID-19, nursing homes, long-term care, healthcare rationing, post-pandemic policy, gerontology, human rights law

Introduction

The COVID-19 pandemic, which started in late 2019 and spread over the world through 2020 and beyond, was one of the worst public health calamities in history. The infection affected people of various ages, but the effects were very different for everyone. Older persons, especially those living in nursing homes, residential aged care institutions, and other group long-term care settings, have much higher death rates and levels of suffering than the general population. In many high-income nations, people living in long-term care institutions made up 40 to 75 percent of all COVID-19-related deaths. But biological causes alone did not cause the size of this calamity. It was, in large part, the result of systemic and structural problems: long-term care was chronically underfunded, infection control infrastructure was inadequate, the care workforce was severely understaffed and underpaid, and legal frameworks did not treat elder rights as real, enforceable rights. When the epidemic started, people living in nursing homes were some of the most legally unprotected and mistreated people in society, and the results were terrible. This research paper provides a thorough analysis of the pandemic's effects on nursing home residents, investigates the structural and legal deficiencies that facilitated such harm, and extracts pragmatic policy recommendations for the post-pandemic period. Section 2 gives information about how long-term care and elder rights systems were before the pandemic. In Section 3, we look at the most important aspects of violations of senior rights that happened during the pandemic. Section 4 looks at how different countries responded and what happened as a result. Section 5 examines current legal frameworks and delineates their constraints. Section 6 gives policy suggestions that are based on facts. Section 7 provides final thoughts on the moral obligations that this crisis has placed on governments and the global community.

The main point of this article is that the disproportionate suffering of older individuals during COVID-19 was not unavoidable; it was the expected result of years of systematic neglect, and it calls for a policy change that is based on real respect for the rights of older people as human rights.

Background: Long-Term Care and Elder Rights before the Pandemic

1. The Global Long-Term Care Landscape

Before COVID-19, the global long-term care sector was already under a lot of structural stress. Demographic aging—caused by lower birth rates and longer life expectancy—had progressively increased the number of older persons who needed residential care. The World Health Organization (WHO) said that by 2019, about 15% of people 60 and older had some kind of disability that needed ongoing care. Projections showed that the number of older adults around the world would double to 1.5 billion by 2050 (WHO, 2021) [12]. In many parts of the industrialised world, nursing homes and residential care facilities had become the main way for institutions to meet the care demands of this growing population. But these places always had trouble getting enough resources. Over 70% of nursing facilities in the US were run for business, which put pressure on them to keep costs down instead of improving care quality (Grabowski & Mor, 2020) [3]. The care home sector in the UK, which is mostly private, was also underfunded since the money from local authorities didn't keep up with the real cost of care. In Europe and North America, frontline care workers made very little money, and staff turnover rates in the field were often over 50% per year. This meant that there were always not enough staff and residents didn't always get the care they needed. In many places, the rules that govern long-term care institutions weren't strict enough to find or fix these problems. There weren't many inspections, the enforcement

mechanisms weren't strong, and residents didn't have strong legal ways to claim their rights or get help when the institution failed.

Before COVID-19, the global long-term care industry was already working under a lot of structural stress. Demographic aging—caused by lower birth rates and longer life expectancy—had progressively increased the number of older persons who needed residential care. The World Health Organization (WHO) said that by 2019, about 15% of people 60 and older had some kind of disability that needed ongoing care. Projections showed that the number of older adults around the world would double to 1.5 billion by 2050 (WHO, 2021). In many parts of the industrialised world, nursing homes and residential care facilities had become the main way for institutions to meet the care demands of this growing population. But these places always had trouble getting enough resources. Over 70% of nursing facilities in the US were run for business, which put pressure on them to keep costs down instead of improving care quality (Grabowski & Mor, 2020) [3]. The care home sector in the UK, which is mostly private, was also underfunded because local authorities didn't provide enough money to cover the real cost of care. In Europe and North America, frontline care workers were paid at or near the poverty line, and staff turnover rates in the sector were often over 50% per year. This meant that there were always too few staff members and residents didn't get the care they needed. In many places, the rules that govern long-term care institutions weren't strict enough to find or fix these problems. There weren't many inspections, the enforcement systems weren't very strong, and residents didn't have strong legal ways to express their rights or get compensation for problems at the facility.

2. The International Elder Rights Framework

The current international human rights framework, as it stands, offers a fragmented and inadequate foundation for safeguarding the rights of older individuals. While the Universal Declaration of Human Rights, enacted in 1948, recognized rights pertaining to life, dignity, and healthcare, it failed to specifically consider the requirements of older adults. Subsequently, in 1991, the United Nations Principles for Older Persons were introduced, delineating five core principles: independence, participation, care, self-fulfillment, and dignity. Although these principles were important, they lacked legal force and provided no means of implementation.

The 2002 Madrid International Plan of Action on Ageing offered a more comprehensive structure. However, like its predecessors, it depended on states' voluntary compliance and lacked any way to hold them accountable. Prior to the establishment of a dedicated international legal structure, the rights of elderly individuals residing in institutions were safeguarded solely by broad human rights tenets and the inconsistent standards of national legislation. Despite the persistent advocacy of civil society organizations and legal scholars for a specific UN Convention addressing the Rights of Older Persons, the creation of such a convention remained unrealized as of 2020 (Trebilcock, 2021) [9]. This lack of a specific legal instrument would later prove to be a significant issue when the pandemic began.

COVID-19 and Elder Rights: Key Dimensions of Violation

1. Healthcare Rationing and Age-Based Discrimination

One of the more morally troubling parts of the pandemic's effect on older people was the creation of crisis standards of care that used age as a factor in deciding who got limited medical resources. throughout the spring of 2020, intensive care units throughout Europe and North America were full. This forced hospitals and health systems to make tough choices regarding who to provide ventilators to, who to let into the ICU, and who to move to another hospital. In certain places, like portions of Italy, Spain, the UK, and several U.S. states, triage policies made older patients less important, sometimes even keeping them out of the hospital and telling them to only obtain palliative treatment. These actions were a serious breach of the right to medical care that is not based on race, as stated in Article 25 of the Universal Declaration of Human Rights and many national constitutions and anti-discrimination laws. Researchers and advocates for disability rights have documented instances where elderly nursing home residents were denied ambulance transport to hospitals during acute illness, essentially condemning them to die without receiving the medical evaluation to which they were legally entitled (Amnesty International, 2020) [1]. The Office of the United Nations High Commissioner for Human Rights explicitly opposed such practices, stating that rationing choices must be predicated on individual clinical assessment rather than age or handicap status (OHCHR, 2020) [6]. It is true that the ethical basis for crisis triage is complicated. Healthcare systems with limited resources must decide how to best use them to get the most benefit. But the evidence shows that in many places, these decisions were based on ageist ideas, such the idea that older lives are less valuable to save, instead of careful, individualised clinical evaluation. This is the most serious kind of age discrimination: it takes away people's right to live.

2. Enforced Isolation and the Right to Social Participation

One of the most ethically grave dimensions of the pandemic's impact on older adults was the emergence of crisis standards of care that incorporated age as a determining criterion in the allocation of scarce medical resources. As intensive care units reached capacity across Europe and North America in the spring of 2020, hospitals and health systems were compelled to make difficult decisions about ventilator allocation, ICU admission, and hospital transfer. In several jurisdictions—including parts of Italy, Spain, the United Kingdom, and various U.S. Triage protocols, whether explicitly stated or implied, often assigned lower priority to older patients. In some cases, this meant they were denied hospital admission and only offered palliative care.

These actions constituted a significant breach of the right to equitable medical treatment, as articulated in Article 25 of the Universal Declaration of Human Rights and further specified in various national constitutions and anti-discrimination laws. Instances were documented by researchers and disability rights organizations wherein elderly nursing home residents were denied ambulance transport to hospitals during medical emergencies, thereby effectively dooming them to death without the medical evaluation to which they were legally entitled (Amnesty

International, 2020) [1]. The Office of the United Nations High Commissioner for Human Rights explicitly condemned these practices, emphasizing that rationing decisions should be predicated on individual clinical evaluations, rather than age or disability (OHCHR, 2020) [6]. The ethical framework governing crisis triage is admittedly complex. Healthcare systems facing resource scarcity must make decisions about how to allocate limited interventions for maximum benefit. However, the evidence suggests that in many jurisdictions, these decisions incorporated ageist assumptions—the view that older lives are inherently less worth saving—rather than rigorous individualized clinical assessment. This represents age discrimination in its most consequential form: a form that denies people the right to life itself.

3. Institutional Neglect and Workforce Crisis

The pandemic also showed what happens when the long-term care sector has too few workers and pays them too little. As COVID-19 spread among nursing home workers, facilities had to deal with huge staff shortages. Those who tested positive had to stay away from others, and several people left the pitch completely because they were short on PPE and were worried about their own safety. In some places, these shortfalls led to institutional neglect, as residents went without enough food, water, medication, or basic hygiene care for long periods of time. In Canada, the UK, Spain, and the US, investigative journalism and public enquiries after the pandemic found terrible conditions in facilities that had turned into isolated crisis zones, cut off from the resources and oversight that could have lessened the damage (Human Rights Watch, 2020) [4].

The underlying causes of this crisis—a care staff that is mostly women, racially marginalised, and financially unstable, working in a field that has long been seen as less important than acute healthcare—were well-known before the pandemic. COVID-19 didn't cause these problems, but it made it very clear how much they cost people. The professionals who cared for people throughout the pandemic, frequently putting their own lives in danger and not getting any protection, should be recognised as heroes and victims of significant institutional injustice.

Comparative National Responses: Variation and Its Determinants

A cross-national analysis shows that the COVID-19 death rates in nursing homes vary greatly from country to country. This can't be explained by epidemiological reasons alone, which suggests that policy choices and structural conditions were key in deciding results. Countries with stricter rules, more staff at the start, and quicker government action usually had better outcomes for nursing home residents. Australia is a warning sign. By the middle of 2020, residential aged care facilities were responsible for around 75% of the country's COVID-19 deaths, which was the greatest percentage among similar countries. A later Royal Commission into Aged Care Quality and Safety determined that infection control was not working well, staffing levels were too low, and regulatory supervision was not working well. The Commission's last report, which came out in 2021, said that the epidemic showed that the sector was in crisis even before COVID-19 came along and recommended for major changes to the law (Royal Commission into Aged Care Quality and Safety, 2021) [8].

On the other hand, South Korea had invested heavily in community-based care options, digital health infrastructure, and pandemic preparedness after the 2015 MERS outbreak. As a result, the country's nursing home death rates were much lower than those of similar countries. Long-term care facilities were responsible for about 12 percent of all COVID-19 deaths. A strong testing system, the ability to trace contacts, and a quick government response were all important aspects. Another important factor was a healthcare culture that cared more about the well-being of older adults. Germany, too, had better results than nations with more broken systems because it had stricter rules, more nurses for each resident, and faster delivery of PPE to care homes (Comas-Herrera *et al*., 2021) [2].

Canada's experience was especially bad. Investigations in Quebec and Ontario found that military officers sent to help in nursing homes found residents living in filthy beds, without water, and with wounds that weren't being treated. Federal and provincial investigations that came after showed the effects of years of underfunding and poor regulation. This led to proposals for a national long-term care strategy and required national standards for residential care. As of 2025, these policy changes are only partially in place. This shows the difference between what people say they learned and what they actually do.

The differences in outcomes between countries show that the biological traits of the virus or its hosts did not entirely determine how many older people died during the epidemic. It was strongly influenced by prior policy decisions regarding the level of investment in care, the stringency of regulations, and the seriousness with which the rights of beneficiaries are regarded.

Legal Frameworks and Their Limitations

The epidemic revealed a serious deficiency in the legal safeguarding of older rights at both international and national levels. Existing frameworks, albeit delineating significant concepts, were deficient in binding authority, enforcement capability, and specificity necessary to safeguard older persons in institutional environments during emergencies. The lack of a specific binding treaty on the rights of older people at the international level produced a major hole in the human rights system. The International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights, and the Universal Declaration of Human Rights are all important basic protections for human rights, but they need to be explained in more detail when it comes to older adults living in residential care. The UN Open-Ended Working Group on Ageing was set up in 2010 to look at international standards for the rights of older people. By the time the pandemic started, it had made only minimal progress toward a binding document. The pandemic has given us new and important proof of why we need such an instrument.

The legal loopholes were just as important at the national level. In many places, nursing home residents didn't have a legal right to visitors, which meant that when governments put blanket prohibitions on visitors, individuals had no legal way to fight those bans or ask for a proportionality review. Most of the time, the rules for care homes only looked at physical care requirements and financial accountability, not the civil and political rights of the people who lived there. In many places, whistleblower protections for care workers who wanted to disclose neglectful conditions were not

strong enough, which made people less likely to speak up. Some countries had ombudsman systems, but they usually didn't have enough resources and couldn't punish establishments that didn't follow the rules.

In 2020, numerous places quickly passed emergency health laws that made these disparities even worse. Health ministers or facility administrators typically had broad powers, but these powers often didn't include any clear protections for the rights of older people, any statutory proportionality standards, or any built-in sunset provisions that could be reviewed by Parliament. This led to a legal system where administrative decisions could take away the rights of nursing home patients without any checks or balances from the courts. The cumulative result of these failings in both international and domestic law was to leave older persons in institutional care, which is one of the most vulnerable groups in any community, with very little legal protection when they needed it the most. To fix these problems, we need more than just small changes; we need big changes to the law.

Policy Recommendations for the Post-Pandemic Era

1. A Binding International Convention on Elder Rights

The most significant and enduring reform that could arise from the pandemic experience is the establishment of a specific UN Convention on the Rights of Older Persons. Such a convention would set minimum standards for how older people are treated in community and institutional care settings. It would also make it illegal for healthcare providers to discriminate against older people based on their age and set up ways to monitor and hold people accountable, similar to the Convention on the Rights of the Child and the Convention on the Rights of Persons with Disabilities. The pandemic has made it clear that this transformation needs to happen right away. States and civil society organisations should work more harder to have it passed (Trebilcock, 2021) [9].

2. Comprehensive Domestic Elder Rights Legislation

Governments at the national level need to pass or enhance laws that protect the rights of older people in all contexts, including institutions. Such laws should make visitation a basic right for nursing home residents, set minimum staffing levels, require regular independent inspections with real enforcement powers, require elder care facilities to be included in national emergency preparedness planning, and not allow age to be the only factor in crisis triage protocols. Emergency laws that affect older people living in care homes should have to go through a mandatory proportionality assessment and include a sunset clause.

3. Structural Investment in Long-Term Care

Legal changes need to be followed by a lot of money spent on long-term care infrastructure. This includes spending money on physical infrastructure, such as infection control facilities, single-room accommodations to limit transmission, and digital communication tools to keep residents connected. It also includes spending money on the staff. Care workers should be paid fairly for the skills and responsibilities of their jobs, have strong protections for their health and safety at work, have access to continued training, and have clear paths for moving ahead in their careers. Governments can also look into different types of care models that don't rely as much on group settings. For example, they may give more support to home-based and community-based care, which may help older people stay independent and connected to others.

4. Digital Inclusion as a Rights Imperative

The epidemic drove nursing home residents to be alone, which showed a huge digital divide among older persons in institutional care. During visiting bans, residents who didn't have smartphones, iPads, or dependable internet connections were completely cut off from their family. The policy agenda for the post-pandemic world must see digital access for older persons as a matter of rights. Nursing homes should have to give its inhabitants access to video calling technologies and help with learning how to use computers. National digital inclusion policies should make older persons in institutional care a priority group. This means that emergency plans should include guaranteed ways for them to interact with others online.

5. Elder Participation in Policy and Preparedness Planning

Any meaningful post-pandemic reform agenda must include the meaningful participation of older adults themselves in its development and implementation. The principle of 'nothing about us without us,' long established in disability rights advocacy, applies with equal force to elder rights. Governments and care facilities should create structured mechanisms for resident advisory councils, elder rights ombudsman services, and representation of older adults in emergency planning committees. Research on elder rights and long-term care should include older adults as research partners, not merely as subjects.

Conclusion

The COVID-19 epidemic was a crisis for the rights of older people in many ways, and it needs to be seen as such. The terrible death rates in nursing homes, the forced isolation that took away residents' dignity and connections to loved ones, the age-based triage decisions that made it seem like older lives didn't matter, and the institutional neglect that followed the collapse of the workforce: these were not just sad but unavoidable results of a new virus. They were the expected results of decades of neglect of the system, weak legal protections, and a general cultural devaluation of elderly people that is common in both legislative and institutional settings around the world.

It is apparent what we learned from the pandemic. Elder rights should be seen as real, enforceable legal rights, not just nice ideas that can be put into practice when it's easy. The right to life, non-discriminatory medical care, social involvement, and dignity in residential settings remain intact with advancing age. Democratic societies must protect them with all the legal, institutional, and financial resources they have.

The time after the epidemic is a crucial time for big changes to happen. Public enquiries, royal commissions, parliamentary probes, and civil society advocacy activities have collectively produced an unparalleled corpus of material regarding the failures and necessary reforms. The translation of this evidence into authentic policy reform hinges on the enduring political commitment of governments, the advocacy of elder rights organisations and legal scholars, and the testimonies of older adults who endured the conditions discussed in this paper—individuals

who merit significantly better treatment from the societies and institutions responsible for their care.We learned at a great cost during the epidemic that protecting the rights of older people is not a minor issue in social policy. It is a test of how seriously a society takes its most important promises. It's time to take that test.

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