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Review

COVID-19 and NHS Rationing: Consequences for the Wellbeing and Care of Older Adults

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ABSTRACT

Introduction: This paper critically examines the care of older adults during the early phase of the COVID-19 pandemic (March–June 2020), drawing on social and occupational justice theories. It highlights systemic neglect and advocates for equitable access to meaningful engagement, autonomy, and participation in health-related decision-making for older adults.
Methods: A broad review was conducted using peer-reviewed literature, policy documents, UK print media, and international news sources such as CNN, Sky News, Al Jazeera through databases including the Cochrane Library, CINAHL, Medline, and Google Scholar were used.
Findings: The analysis offers a contextual critique of NHS and social care resource management in the UK, serving as a benchmark to compare healthcare responses in the United States during the same period. It reveals a moral polarization between rationing and rationalizing elder care and argues that promoting Advance Care Directives risks undermining professional ethical commitments to the sanctity of life.
Conclusion & Implications: For occupational therapists, this study provides a framework to examine and address structural determinants affecting older adults' experiences, especially in crises. It calls for urgent, justice-oriented systemic reform that moves beyond reactive measures toward proactive preparedness. This paper advocates for the adoption of an Occupational Justice Audit Tool to guide equitable system responses, the establishment of mandatory community-based Advance Care Planning hubs and proactive policies to ensure equitable, dignified engagement for aging populations.

Key Words: Covid -19, cost rationing, herd Immunity, occupational therapy, social justice, medical ethics

INTRODUCTION

Coronavirus and COVID-19: COVID-19, caused by the SARS-CoV-2 virus, was first identified in Wuhan, China, in late 2019 and spreads primarily through respiratory droplets and contaminated surfaces. While symptoms vary widely, from mild fever to severe respiratory distress, older adults and individuals with underlying health conditions are at greater risk for severe outcomes (National Health Service [NHS], 2020). The COVID-19 pandemic has starkly revealed the vulnerabilities embedded within neoliberal health systems, particularly those shaped by decades of efficiency-driven, privatized governance. This systemic fragility disproportionately affected older adults, especially individuals from marginalized racial and ethnic groups, by undermining collective healthcare responsibilities and exposing longstanding institutional neglect (Khunti et al., 2020). Consequently, the pandemic highlighted critical gaps in health equity that directly impact occupational wellbeing.

Data from the United Kingdom and United States illustrate how pandemic responses exacerbated existing disparities, with older adults from ethnic minority backgrounds facing heightened risks. For example, intersectional discrimination based on age and race contributed to their exclusion from equitable care (Hewitt & Kapadia, 2021). Furthermore, structural determinants, including but not limited to overcrowded housing, frontline employment, and limited healthcare access, amplified exposure and adverse outcomes in these communities (Centers for Disease Control and Prevention [CDC], 2022). These systemic barriers also impeded timely testing, treatment, and vaccination, culminating in significantly higher hospitalization rates among Black and Hispanic populations (CDC, 2022).

These health inequities must be understood as manifestations of deeper social justice failures, characterized by misrecognition, maldistribution, and political exclusion (Fraser, 1995). To unpack these complex dynamics, Kimberlé Crenshaw's intersectionality framework provides a valuable lens, demonstrating how overlapping identities including race, age, gender, and class compound marginalization and shape health outcomes (Crenshaw, 1989). Building on these insights, this paper explores the structural and intersectional drivers of health injustice during the pandemic and advocates for justice-oriented public health systems that prioritize inclusive, sustained equity, not only during crises but as an ongoing imperative to support occupational wellbeing.

Our analysis draws on a review of scholarly literature, official policy documents, and media coverage from April 2020 to 2025. Sources included peer-reviewed journals, UK and international news outlets such as CNN, Sky News, Al Jazeera, and materials accessed through academic databases such as the Cochrane Library, CINAHL, Medline, and Google Scholar. Particular attention was given to publications addressing NHS resource allocation and the pandemic's impact on older adults, given their centrality to both ethical debates and real-world triage decisions. We prioritized studies that examined elderly experiences, included healthcare perspectives, and maintained transparency in data reporting, allowing for an ethically grounded and contextually relevant examination of rationing under systemic strain.

LITERATURE REVIEW

Marginalization, Ableism, and Ageism in Pandemic Preparedness and Response

Gouzoulis and Galanis (2021) argue that the financialization of public services significantly weakened elder care through chronic underfunding, understaffing, and poor infection control strategies. In the United Kingdom, long-term underinvestment led to care delays, staff burnout, and a backlog of unmet needs (British Medical Association, 2024). The discharge of untested patients into care homes without adequate safeguards further illustrated institutional neglect and increased mortality risk (Hopkins et al., 2020).

Although public health measures were designed to protect, they often marginalized older adults by restricting autonomy and reinforcing ageist assumptions about frailty. This contributed to occupational injustice, limiting opportunities for meaningful occupational engagement and independence (Oostlander et al., 2024). The absence of professional guidance during early responses allowed political strategies like “herd immunity” to shape public discourse. Traditionally, herd immunity refers to population-level protection achieved predominantly through vaccination, indirectly safeguarding those who remain unvaccinated (Royal College of Physicians, 2016). Nevertheless, the pandemic witnessed a problematic distortion of this principle, as some public discourse promoted natural infection strategies with ethically concerning implications due to their high mortality risk among vulnerable groups (Moser, 2020). This tension underscores the enduring challenges of balancing public health imperatives with ethical stewardship, especially within systems committed to protecting vulnerable populations (Peterson et al., 2020). These narratives presented elder deaths as inevitable, which devalued their lives both symbolically and materially (Peterson et al., 2020).

In the United States, similar ethical dilemmas emerged. Age-based rationing of life-saving care disproportionately affected older adults, with younger patients often prioritized under utilitarian frameworks (Farrell et al., 2020). Goodley (2020) highlights how ageism intersected with ableism, rendering elders with disabilities particularly vulnerable. Structural racism further compounded inequities, as older adults from marginalized communities faced greater barriers to access, quality care, and timely treatment (Mullard et al., 2023). Meanwhile, healthcare workers, often lacking institutional ethical support, were left to navigate moral distress under conditions of scarcity (Faux-Nightingale, 2021).

Ethical principles regarding end-of-life care also influenced pandemic responses. While the British Medical Association (2007) had previously supported the withholding of life-prolonging treatment in cases where death is inevitable, this principle may have been misapplied during the pandemic. Older adults were at times discouraged from seeking hospital care and prompted to sign advance directives, limiting their access to treatment (Hopkins et al., 2020).

Though blanket age-based exclusions were widely condemned, alternative methods such as assessing biological age or treatment potential still reduced individuals to clinical criteria (Hulkower, 2020). Later shifts toward vulnerability-based vaccine distribution reflected more equitable approaches aligned with Rawlsian justice (Buchanan & Miller, 2021; Rawls, 1999).

Importantly, the pandemic revealed critical gaps in holistic care. Occupational therapy supports individuals in engaging with meaningful daily activities, fostering independence, participation, and quality of life throughout the lifespan (American Occupational Therapy Association [AOTA], 2020; WFOT, 2012). Occupational therapy, grounded in person-centered and context-aware practice, was well positioned to address the psychosocial impacts of isolation and disrupted routines (AOTA, 2020). However, widespread service suspensions limited its reach and undermined core values of autonomy, participation, and dignity.

In sum, the pandemic revealed the consequences of narrowly biomedical and efficiency-focused systems. It underscored the urgent need for care models that uphold equity and recognize the full humanity of older and adults with disabilities through inclusive, ethical, and occupation-based approaches.

Theoretical Discussion

Research on public health ethics, particularly those upholding the sanctity of life (Clarke, 2023), finds its most comprehensive grounding in social justice theory. Social justice promotes the equitable distribution of power, resources, and responsibilities through inclusion, collaboration, and equal access. However, systemic inequalities based on ability, age, race, gender, religion, and sexual orientation continue to hinder its universal application. As a result, social injustice persists, contributing to poorer physical and emotional health, and increasing vulnerability and suffering (Ayala et al., 2011).

To elaborate, this paper draws on the 1996 Social Model of Disability, one of Britain's earliest and most influential rights-based frameworks, which has been integral to shaping occupational therapists' professional training and development. The model shifts the focus beyond rehabilitation, urging practitioners to confront issues of social exclusion and to adopt choice-driven approaches. At its core, the Social Model of Disability reframes disability not as an inherent medical condition but as a socially constructed phenomenon, where participation is limited by structural barriers, inaccessible environments, and systemic exclusion (Oliver, 1996).

It therefore stands in contrast to the medical model, which pathologizes disability and locates the "problem" within the individual. By centering the role of societal barriers, the Social Model calls for structural transformation to enable full inclusion in work, education, and community life. In the UK, however, rationing decisions within the NHS have disproportionately disadvantaged people with disabilities, eroding access to essential supports and threatening the core capabilities needed for autonomy and meaningful daily engagement (Nussbaum, 2011).

For occupational therapists committed to justice, inclusion, and holistic wellbeing, these patterns present both an ethical challenge and a professional imperative. Real inclusion, as the Social Model reminds us, requires more than physical access; it demands a reconfiguration of societal norms, institutions, and systems. Justice for individuals with disabilities lies in recognizing their inherent dignity and ensuring they have both the resources and the opportunities to thrive (Oliver, 1996; Nussbaum, 2011; Fraser, 1995).

Building on this perspective, the study draws on Nancy Fraser's (1995) dual framework of redistribution and recognition, providing a critical lens for examining age-based inequities in healthcare. Redistribution addresses structural and material inequalities, while recognition focuses on the cultural devaluation and misrecognition of marginalized groups. This dual approach is especially pertinent to elderly care, where the COVID-19 pandemic exposed not only disparities in resource allocation but also the societal marginalization of older adults. Fraser's framework illuminates how neglect operates on both economic and symbolic levels, manifesting in limited access to care and the erosion of dignity and social worth.

This perspective aligns closely with the ethical foundations of occupational therapy, which frames participation, autonomy, and well-being as essential components of social justice. Occupational therapy advocates for equitable engagement in meaningful activities, particularly for structurally disadvantaged populations such as older adults (WFOT, 2012). As such, Fraser's framework is instrumental in understanding and addressing the multifaceted nature of exclusion in care and the creation of occupational injustice within healthcare.

Notwithstanding its value, Fraser's theory has been critiqued for its limited engagement with ageism, as it tends to emphasize race, gender, and class (Calasanti, 2005). To address this theoretical limitation, this article also drew on Martha Nussbaum's Capabilities Approach, particularly the capability of affiliation, which underscores the importance of social bonds, mutual recognition, and dignity as fundamental to human well-being and justice (Nussbaum, 2011). Affiliation is especially relevant in aging populations, where relational disconnection and diminished societal value are prevalent and often intensified during crises.

Social isolation among older adults has been associated with increased risks of depression, cognitive decline, and mortality (Courtin & Knapp, 2017). During the COVID-19 pandemic, such isolation was amplified by restrictive public health measures, contributing to worsened physical and mental health outcomes and, in some cases, hastened death (Sepúlveda-Loyola et al., 2020; Wu, 2020). Together, Fraser's and Nussbaum's frameworks provide a robust foundation for this review, emphasizing that justice for the elderly care must encompass both material support and the affirmation of identity. This dual emphasis supports a holistic understanding of inclusion, one that recognizes older adults not only as recipients of care but as individuals deserving of visibility, dignity, and continued engagement in social life (Nussbaum, 2011).

Kimberlé Crenshaw's Critical Race Theory deepens this analysis through the lens of intersectionality, revealing how overlapping forms of oppression, such as those based on race, class, gender, and age, intensify marginalization (Crenshaw, 1989). In this vein, it is arguable that older adults from minoritized racial backgrounds would have encountered compounded barriers often due to the intersection of systemic ageism and racism, further exacerbating health inequities during crises like COVID-19.

From another perspective, Pierre Bourdieu's theory deepens understanding of how inequality in elderly care was replicated during COVID-19 through symbolic violence, cultural capital, and field dynamics (Bourdieu, 1986). Bourdieu describes symbolic violence as the normalization of age-based neglect, where exclusion appears legitimate. Cultural capital comprising language proficiency, educational attainment, and social comportment shapes individuals' ability to access healthcare resources and is inequitably distributed. Field dynamics refer to structured social arenas like healthcare, where actors compete for advantage within existing hierarchies (Bourdieu, 1993).

Together, these concepts reveal how marginalization was embedded in broader structures of social power. Although not explicitly focused on justice, Bourdieu's framework reveals how institutions, including healthcare, media, and government, normalize and conceal systemic ageism and marginalization of older adults, framing these disparities as natural or inevitable rather than socially constructed. This invisibilization perpetuates the neglect and unequal treatment experienced by elderly populations during the pandemic, underscoring the urgent need to identify and dismantle such hidden power structures to achieve authentic social justice in healthcare.

Integrating Fraser's redistributive-recognition framework, Nussbaum's capabilities emphasis, Crenshaw's intersectionality, and Bourdieu's analysis of power dynamics provides a comprehensive theoretical foundation. Together, they illuminate the multilayered injustices faced by elderly populations and underscore that achieving social justice requires dismantling structural inequalities, recognizing diverse identities, and exposing institutional power mechanisms that sustain exclusion.

The Canadian Model of Occupational Participation (CanMOP)

The Canadian Model of Occupational Participation (CanMOP) is a model of choice for understanding meaningful occupational participation within diverse social contexts. The model closely aligns with Nussbaum's (2011) Capabilities Approach and Fraser's (1995) theory of justice, each emphasizing meaningful participation as fundamental to human dignity and well-being. Nussbaum (2011) argues that human development transcends mere resource access, encompassing the ability to engage in fulfilling activities that promote autonomy and social connection. Similarly, Fraser (1995) contends that justice requires both redistribution, i.e., addressing material inequalities, and recognition, i.e., valuing diverse identities and contributions. CanMOP operationalizes these principles by focusing not only on access but on individuals' capacity to actively engage in meaningful roles within enabling environments (Egan & Restall, 2022).

The COVID-19 pandemic underscored CanMOP's relevance, especially regarding older adults' struggles to maintain participation amid social distancing, mobility restrictions, and health risks, which exacerbated social isolation and threatened key capabilities such as affiliation and bodily integrity (Nussbaum, 2011). Fraser's framework further reveals that these adverse effects were unevenly distributed, disproportionately impacting low-income and older adults with disabilities due to entrenched inequalities. This highlights the necessity of policies that both redistribute resources, such as healthcare and technology, and recognize older adults' societal contributions to foster inclusive participation.

CanMOP's strength lies in its holistic approach, acknowledging that occupational participation is shaped by social, political, and economic contexts. This complements Fraser's assertion that justice involves more than economic equity, requiring cultural recognition as well. However, CanMOP tends to prioritize occupation as the primary driver of wellbeing, whereas Nussbaum and Fraser advocate for a broader perspective that includes political agency, emotional health, and social inclusion. Moreover, while CanMOP identifies barriers to participation, it insufficiently addresses systemic power imbalances that Fraser critiques, such as the marginalization that reinforces social hierarchies. Integrating Nussbaum's capabilities framework with Fraser's dual emphasis on recognition and redistribution can enrich CanMOP, creating a more comprehensive model. Such a fusion ensures that interventions facilitate meaningful engagement while actively confronting structural inequalities that impede participation beyond the Canadian context.

DISCUSSION

The COVID-19 pandemic exposed significant ethical and logistical dilemmas in healthcare rationing, particularly around ICU beds, ventilators, and vaccine allocation. Globally, policymakers often prioritized younger patients using a utilitarian framework aimed at maximizing life years and societal benefit. While potentially justifiable in emergencies, this approach raises concerns about ageism and the equal value of all lives (Swift & Chasteen, 2021). Moving forward, rationing protocols should account not only for chronological age (i.e., years since birth) but also for biological age reflecting physical health, cellular condition, and functional capacity alongside overall health status and projected outcomes. We further argue that an ethical framework must balance survival maximization with fairness and dignity, necessitating collaboration among bioethicists, gerontologists, older adults, and the broader public (Berlinger et al., 2022).

Moreover, healthcare workers experienced moral distress during triage, particularly when withdrawing care from older patients in favour of younger ones (Santos & Verdi, 2025). This emotional toll led some to resist established protocols, highlighting the need for comprehensive psychological support, including counseling, ethical training, and peer-support systems (Fitzgerald & Curtis, 2020). Intensive care unit shortages led to suboptimal care, such as ventilation in non-ideal settings, raising mortality risks and highlighting the urgent need for mobile ICUs, adaptable infrastructure, and real-time resource tracking (Fraser et al., 2021). Without clear national guidelines, inconsistent and ethically questionable rationing occurred, reinforcing the need for pre-established, ethically grounded policies (Emanuel et al., 2020).

Building on this, age-based exclusion from ICU and vaccine access sparked ethical concerns, as rationing by age alone is unjust without considering factors like frailty and comorbidities, ultimately reinforcing that medical need, not age, should guide allocation decisions (Savulescu et al., 2020). Vaccine distribution first focused on older adults because of their vulnerability, then expanded to include immunocompromised people and frontline workers, highlighting the need for a flexible, data-driven approach and clear, culturally sensitive communication to reduce vaccine hesitancy in marginalized communities (World Health Organisation [WHO], 2021).

Ultimately, rationing must protect vulnerable populations in line with Rawls' (1999) theory of justice, which supports fairness through positive discrimination. Effective policies must address socio-economic inequalities and strengthen community-based healthcare to promote equitable outcomes (WHO, 2021). Additionally, encouraging the use of advance care directives (ACDs) and establishing national registries can mitigate ethical dilemmas during future crises, supporting clearer decision-making processes (Snyder et al., 2020). Advanced care directives play a critical role in fostering patient autonomy and ensuring that care preferences are respected during times when individuals cannot communicate their wishes, particularly amid critical or chronic illness (Sudore et al., 2017). However, limited public awareness and inconsistent communication during the pandemic diminished their effective use, undermining trust in patient-centered care models. Integrating ACDs within a robust ethical framework, alongside continuous healthcare worker training and inclusive policy formulation, is critical to upholding fairness, dignity, and accountability in emergency responses.

CONCLUSION

The COVID-19 pandemic illuminated the systemic marginalization embedded in neoliberal health systems, where market efficiency and personal responsibility eclipsed collective care. These dynamics exacerbated existing health disparities and deepened occupational injustices, particularly for older adults. As Wilcock and Hocking (2015) assert, occupational injustice arises when systemic barriers obstruct individuals' engagement in meaningful life roles. The pandemic made clear that dominant social and institutional structures remain ill-equipped to protect aging populations, especially those from racially and socioeconomically marginalized backgrounds. These groups encountered disproportionate barriers to healthcare, social inclusion, and prioritized services underscoring entrenched structural ageism and fragmented, exclusionary policies.

Addressing these injustices requires more than technical fixes. Fraser's (1995) justice framework, Crenshaw's (1989) intersectionality, and Bourdieu's (1986) theory of capital point to the need for redistributive justice, recognitive justice, and participatory parity. These must be integrated into aging policy and emergency planning. Similarly, Nussbaum's (2011) The Capabilities Approach and the Canadian Model of Occupational Participation assert that meaningful engagement is a fundamental right for all, including older adults, not a luxury.

To avoid repeating the ethical failures exposed by COVID-19, we must reconceptualize older adults as valuable contributors and prioritize occupational justice in public health planning. This paper proposes three actionable recommendations:

1. **Occupational Justice and Emergency Planning Framework**

   For future practice, public health and occupational therapy stakeholders should develop an Occupational Justice Audit Tool to systematically assess how emergency policies affect older adults' engagement in meaningful occupations. To date, no standardized auditing framework exists. By grounding this tool in interdisciplinary collaboration, it could foster inclusive, ethical preparedness and accountability during crises, ensuring that older adults' participation, autonomy, and occupational rights are prioritized in policy planning and implementation.

2. **Mandated Community-Based Advance Care Planning (ACP) Hubs**
   We recommend that the NHS establish dedicated Advance Care Planning (ACP) hubs within long-term care systems to ensure that culturally responsive, legally binding care directives are readily accessible and actionable, thereby preparing residents, families, and care teams for effective decision-making during crises. By centralizing ACP and embedding it as a core component of emergency preparedness, this approach transforms ACP from a fragmented, optional service into an integrated, accountable, and innovative mechanism for equitable crisis response. Coordinated stakeholder engagement combining top-down leadership with active participation from care providers, residents, and families ensures clarity, alignment, and readiness across the system.

3. **Justice-Oriented Health Policy**
   Integrating redistribution, recognition, and participation can ensure dignity, inclusion, and access to meaningful occupation throughout the life course. Ultimately, the pandemic presented a critical opportunity to reimagine aging within health systems. Achieving just and resilient societies requires dismantling structural inequities and centering older adults in the design of ethical, inclusive, and occupation-focused policy.

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