Fault Lines: COVID-19, the Charter, and Long-term Care*

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Abstract

COVID-19 has underscored the crucial role of the single-payer health care system in ensuring access to care based on need, consistent with the Canadian Charter of Rights and Freedoms (the Charter) and international human rights guarantees. But significant fault lines were exposed when health authorities across the country concentrated their pandemic readiness efforts on maximizing hospitals’ capacity to deal with the anticipated surge of COVID-19 patients, without considering the potentially disastrous consequences for an already struggling long-term care system. COVID-19 laid bare the reality that barriers to care continue to exist as a function of who patients are and where they are being treated. Focussing on COVID-19 hospital transfer decisions and their impact on the life, liberty, and security of the person and the equality rights of long-term care residents, this chapter argues that governments and health care decision makers in Canada must recognize that access to a comprehensive range of care is a fundamental right, and that human rights-based accountability is urgently needed in the battle against COVID-19, and beyond.

* This paper is dedicated to Robert Bycraft, Anna Babey, and the many other grandparents, parents, and friends whose lives have been cut short by the COVID-19 pandemic./Ce chapitre est dédié à Robert Bycraft et Anna Babey, ainsi qu’aux nombreux autres grands-parents, parents, amis et amies qui ont perdu la vie en raison de la pandémie de COVID-19.

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Résumé
Les failles : la COVID-19, la Charte et les soins de longue durée

La COVID-19 a souligné le rôle crucial du système de soins de santé à payeur unique pour assurer l'accès aux soins en fonction des besoins, conformément à la Charte canadienne des droits et libertés et aux garanties internationales relatives aux droits de la personne. Mais d'importantes failles ont été mises au jour lorsque les autorités sanitaires de tout le pays ont concentré leurs efforts sur l'optimisation de la capacité des hôpitaux en prévision de l'augmentation du nombre de patients et de patientes atteints de la COVID-19, sans tenir compte des conséquences potentiellement désastreuses sur un système de soins de longue durée déjà en difficulté. La pandémie a révélé qu'il existe toujours des obstacles aux soins en fonction de l'identité des patients et des patientes et de l'endroit où ils et elles sont traités. Ce chapitre porte sur les décisions en matière de transfert hospitalier dans le contexte de la COVID-19, ainsi que sur leurs répercussions sur la vie, la liberté et la sécurité des personnes et sur les droits à l'égalité des réésidents et résidentes des centres de soins de longue durée. Il soutient que les gouvernements et les décideurs en matière de soins de santé au Canada doivent reconnaître que l'accès à une gamme complète de soins est un droit fondamental et qu'il est urgent de miser sur une responsabilisation fondée sur les droits de la personne dans la lutte contre la COVID-19, et au cours des années qui viennent.

COVID-19 has underscored the crucial role of Canada’s single-payer system in ensuring that everyone has access to care based on need, in keeping with the Canada Health Act, the Canadian Charter of Rights and Freedoms (the Charter), and international human rights guarantees. But significant fault lines in our system were also exposed when health authorities across the country concentrated their pandemic

2. Canada Health Act, RSC 1985, c C-6.
readiness efforts on maximizing the capacity of hospitals to treat those who fell critically ill. In pursuit of that objective, non-emergency surgeries (including for cancer, cardiac, and other serious illnesses) were cancelled, and diagnostic testing, clinical trials, palliative care, medically assisted death, and other hospital services were suspended. The resulting costs to life and health are only now being calculated.

Beyond hospitals, the pandemic also deepened pre-existing access problems within the broader health care system. As other chapters in this book document, long-standing inequalities in health services for Indigenous people on reserves and in rural and remote areas were amplified, as were barriers to prison health.


abortion,\textsuperscript{10} pharmaceuticals,\textsuperscript{11} mental health care,\textsuperscript{12} and substance dependence programs.\textsuperscript{13} Perhaps most egregiously, the failed promise of equal access to care is reflected in the massive death toll in long-term care.\textsuperscript{14} While we expect, and domestic and international human rights demand, that care be available based on need, COVID-19 has laid bare the reality that barriers continue to exist as a function of who patients are and where they are being treated. Focussing on the unfolding tragedy in long-term care, I will argue that governments and health care decision makers must recognize that access to a comprehensive range of care is a fundamental right, and that human rights-based accountability is urgently needed in the battle against COVID-19, and beyond.

COVID-19 and Long-term Care

In 2018–2019 there were 191,835 long-term care residents in 1,319 facilities in Canada, outside Quebec.\textsuperscript{15} Their average age was 83, and over two thirds were women.\textsuperscript{16} Over 70\% had heart/circulation diseases; over half, musculoskeletal diseases; and over two thirds, neurological diseases, including dementia.\textsuperscript{17} Like hospitals, long-term care facilities


\textsuperscript{11} Jan Malek, “COVID-19 Shows that Pharmacare is Needed Now” (24 April 2020), online: CouncilofCanadians<canadians.org/analysis/covid-19-shows-pharmacare-needed-now>.

\textsuperscript{12} Kathleen Finlay, “So Far, Canada’s Answer to COVID-19 Mental Health Crisis Doesn’t Measure up”, \textit{Ottawa Citizen} (30 April 2020), online: <ottawacitizen.com/opinion/finlay-so-far-canadas-answer-to-covid-19-mental-health-crisis-doesnt-measure-up/>.


\textsuperscript{14} Tonda MacCharles, “82\% of Canada’s COVID-19 Deaths Have Been in Long-term Care, New Data Reveals”, \textit{Toronto Star} (7 May 2020), online: <www.thestar.com/politics/federal/2020/05/07/82-of-canadas-covid-19-deaths-have-been-in-long-term-care.html>.

\textsuperscript{15} “Quick Stats: Profile of Residents in Residential and Hospital-Based Continuing Care, 2018–2019” at Table 1, online: Canadian Institute for Health Information <www.cihi.ca/en/quick-stats>.

\textsuperscript{16} Ibid at Table 3.

\textsuperscript{17} Ibid at Table 6. See eg “British Columbia Residential Care Facilities Quick Facts Directory 2018 Summary” (2018) at 1, online (pdf): Office of the Seniors Advocate
are regulated at the provincial/territorial level. But although governments provide over 70% of funding, long-term care falls outside the framework of the Canada Health Act and the single-payer system.18 As a result, levels of public investment and ownership vary greatly across the country, and no national standards or uniform conditions exist.19

There is wide agreement that “funding and services have not kept pace with increasing needs of residents.”20 Over the past 20 years, health care and seniors’ advocacy groups, labour unions, public interest and human rights organizations, researchers, ombudspersons, and governments themselves, have criticized the substandard condition of many facilities, the insufficient level of public funding, the undue financial burden placed on low-income seniors, wait times, and the lack of oversight and failure to enforce existing health, safety and other regulations.21 Poor wages and working conditions, as Pat Armstrong,


Hugh Armstrong, and Ivy Bourgeault outline in Chapter E-1 of this book, have been a long-standing issue for staff—also predominantly women. In this context, the impact on long-term care residents of COVID-19 and government decisions around how to manage it were catastrophic. While “horror stories from Italy convinced authorities they had to free up room on [hospital] wards and in intensive care units for potential COVID-19 sufferers,” the obvious threat the virus posed in long-term care facilities did not seem to register. In Quebec, like elsewhere:

The focus was on ensuring hospitals could manage their COVID-19 caseloads... Officials opened as many hospital beds as possible by postponing elective surgeries and relocating patients to hotels or elder-care facilities. Instead, the virus struck hardest in those very facilities for seniors. The ensuing devastation came in a part of the system that had long been underfunded, understaffed, and packed with vulnerable people.

Reports from across Canada suggest that, even as patients were being moved from hospitals to long-term care facilities without prior testing, long-term care residents infected with COVID-19 were being denied transfer to hospitals for treatment. Personal protective equipment and

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22. Pat Armstrong, Hugh Armstrong and Ivy Bourgeault, this volume, Chapter E-1; Canadian Health Coalition, *supra* note 19 at 11.


COVID-19 testing were heavily rationed and, in some cases unavailable, allowing the virus to spread rapidly among patients and staff, and leading to deadly outbreaks in almost every province. As workers fell ill or were quarantined, conditions for remaining staff and residents deteriorated further. Reports emerged of nurses caring for 20 to 30 residents without assistance, staff working back-to-back 12- and 16-hour shifts; and infected and non-infected residents sharing rooms. By the time health authorities intervened in one Montréal home, “residents were found ... unclothed, severely malnourished, dehydrated, without their medication and left in their feces and urine...”

Patient transfers from hospitals to long-term care facilities did not end in Ontario until a month after the province declared a state of emergency, with “hospital occupancy rates at a historic low ... 69%, down from 96% before the pandemic.” Only then did the province

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Nursing Homes”, Globe and Mail (14 April 2020), online: <www.theglobeandmail.com/opinion/editorials/article-how-canada-gave-a-pandemic-the-key-to-the-countries-nursing-homes/>. For instance, as of April 17, 2020, only 22 of 899 nursing and retirement home residents with COVID-19 in Toronto were being treated in hospital and, as of May 12, only 24 of 364 cases of COVID-19 in long-term care in Alberta had been hospitalized; Grant & Ha, supra note 5.


announce a plan to increase testing of staff and residents, restrict staff from working in more than one facility, and redeploy health care staff into long-term care homes. A week later, Ontario and Quebec called on the federal government for aid from the Canadian military.

COVID-19, the Charter, and Access to Care

By mid-April, governments across Canada recognized that long-term care homes were “facing unprecedented tragedy.” Ontario Premier Doug Ford admitted: “I know the system ... is absolutely broken.” In Quebec, Premier François Legault asked: “How could we have gotten into the situation we’re in, where we didn’t take care of our elders, the most vulnerable?” Prime Minister Justin Trudeau confessed: “We are failing our parents, our grandparents, our elders.” What governments and health officials have not yet acknowledged is that this public health failure is an equally inexcusable violation of Charter and international human rights.

Article 12 of the International Covenant on Economic, Social and Cultural Rights recognizes the right of everyone in Canada “to the enjoyment of the highest attainable standard of physical and mental health,” including to “medical service and medical attention in the event of sickness,” “without discrimination of any kind.” Although the Canadian Charter does not contain an explicit right to health care,

34. Berthiaume, supra note 31.
36. Ibid art 12(2)(d).
s. 7 protects “the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.” 38 Section 15 guarantees “equal protection and equal benefit of the law without discrimination and, in particular, without discrimination on the basis of race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.” 39

The Supreme Court of Canada has affirmed that the Charter applies not only to governments, but to hospitals and other private entities when they are delivering publicly funded health care. 40 The Court has been more ambivalent about the Charter as a source of positive obligations to ensure access to such care. 41 In Eldridge v British Columbia (Attorney General), the Court held that failure to provide interpretation services for the Deaf within the public system violated the Charter’s equality guarantees. 42 In contrast, in Auton (Guardian ad litem of) v British Columbia (Attorney General), the Court ruled that lack of funding for autism treatment did not violate s. 15, because a finding of discrimination “would effectively amend the medicare scheme and extend benefits beyond what it envisions—core physician-provided benefits plus non-core benefits at the discretion of the province.” 43 In Chouaili v Québec (Attorney General), striking down Quebec’s ban on private health insurance, Chief Justice McLachlin opined that, “The Charter does not confer a freestanding constitutional right to health care. However, where the government puts in place a scheme to provide health care, that scheme must comply with the Charter.” 44 Six years later, in Canada (Attorney General) v PHS Community Services Society, the Court found that, by depriving the Insite supervised injection facility’s clients of “potentially lifesaving medical care ... and health-protecting services,” the federal government had violated their rights to life and security of the person. 45

38. Charter, supra note 3 at s 7.
39. Ibid, s 15.
42. Eldridge, supra note 40 at para 80.
43. 2004 SCC 78 at para 44.
44. 2005 SCC 35 at para 104.
45. 2011 SCC 44 [Insite] at paras 91-92. In the Chief Justice’s words, at para 93: “Where a law creates a risk to health by preventing access to health care, a deprivation of the right to security of the person is made out... Where the law creates a risk not just to the health but also to the lives of the claimants, the deprivation is even clearer.”
Given these inconsistencies in the case law, it is unclear to what extent pandemic-related inaction by health care decision makers within and outside the long-term care system, including the failure to provide sufficient COVID-19 testing or personal protective equipment, to adopt adequate containment measures, or to effectively regulate care and working conditions, might be subject to Charter review.\textsuperscript{46} While Chaoulli and Auton have been heavily criticized, both decisions present significant hurdles for Charter claimants seeking positive rights to care under s. 7, or arguing s. 15 demands more than equal access to existing services.\textsuperscript{47} But even a narrow reading of the current jurisprudence leaves little doubt that decisions to move patients from hospitals to long-term care, and not to transport long-term care residents to hospitals if they fell ill with COVID-19, raise serious Charter concerns.

In terms of s. 7, these transfer decisions severely compromised long-term care residents’ physical and mental health, security, and autonomy. They increased not just the risk of death, but of dying in “horrific conditions.”\textsuperscript{48} These decisions did not, by any measure, comply with principles of fundamental justice. They were made without “effective participation” by those affected;\textsuperscript{49} they undermined their own public health objectives,\textsuperscript{50} and they caused grossly disproportionate harm.\textsuperscript{51} As one adult son described his mother’s experience—after being hospitalized for a fall that left her incapable of returning home—of being moved to a long-term care facility where she died of COVID-19 three weeks later: “When I talked to her at the hospital, she

\textsuperscript{46} In Ontario Nurses Association v Eatonville/Henley Place, 2020 ONSC 2467, nurses working in four Ontario long-term care facilities obtained an injunction, based in part on s. 7 of the Charter, forcing their employers to provide them with adequate personal protective equipment; Katherine Lippel, this volume, Chapter E-3; Vanessa Gruben & Louise Bélanger-Hardy, this volume, Chapter E-4.


\textsuperscript{48} Brewster & Kapelos, supra note 27; Insite, supra note 45 at paras 91-93.

\textsuperscript{49} New Brunswick (Minister of Health and Community Services) v G(/), [1999] 3 SCR 46 at paras 73, 119.

\textsuperscript{50} Insite, supra note 45 at paras 129-32.

\textsuperscript{51} Ibid at para 133.
told me she didn’t want to go there... But they were telling her that was the only option she had.”

The violations of long-term care residents’ s. 7 rights can be ascribed to where they receive care. As the Globe and Mail averred: “If COVID-19 has shown us anything, it’s that whatever is done to protect hospitals during pandemics also needs to be done for seniors’ facilities.” The infringement of long-term care residents’ s. 15 rights are, on the other hand, a consequence of who they are. More than anywhere else, long-term care residents in Canada bore a disparate and unfair share of the cost of pandemic preparedness. Unlike other Canadians, they did not receive the “equal protection and equal benefit” of that pandemic planning, or of the publicly funded health and hospital system it was trying to defend. Instead, “most of the nursing—and retirement home residents who have succumbed to COVID-19 in Canada died inside the virus-stricken understaffed facilities, while many of the hospital beds opened up for coronavirus patients sat empty.”

Whether intentional or not, governments’ pandemic-related actions and inaction amounted to differential, adverse, treatment that perpetuated disadvantage on a number of prohibited grounds of discrimination—most obviously on the basis of age. As Martine Lagacé, Linda Garcia, and Louise Bélanger-Hardy contend in Chapter D-2 of this book, the role of ageism cannot be overstated: “The COVID-19 pandemic may be unprecedented in recent times, but its impacts are being felt in [long-term care facilities] because of the way seniors’ care has been undervalued, underfunded, and privatized.” Carole Estabrooks summarizes a more insidious dynamic: “About 95 per cent

52. Grant & Ha, supra note 5. The facility in question was one singled out in the Canadian Military’s damming report on conditions in five Ontario nursing homes the military was called in to support; Brewster & Kapelos, supra note 27.


56. Brewster & Kapelos, supra note 27.

57. Martine Lagacé, Linda Garcia & Louise Bélanger-Hardy, this volume, Chapter D-2.

of the paid workers are women, 75 per cent of unpaid caregivers are women, two thirds of people with dementia are women and two thirds of people in nursing home are women. This is a highly gendered environment and we cannot ignore that.” Coupled with age and sex, social condition is, as Steven Lewis underscores, also a salient factor: “Less prosperous seniors who far outnumber those able to afford upscale alternatives are left to take their chances in the nursing home lottery.” Finally, a large majority of long-term care residents have physical and cognitive illnesses and impairments. The multiple failures that contributed to COVID-19 deaths and other harms in long-term care are, as Tess Sheldon and Ravi Malhotra’s chapter (Chapter D-9 in this volume) explains, manifestations of systemic discrimination based on physical and mental disability that s. 15 prohibits.

Charter rights are not absolute. Section 1 permits, “such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.” Intensive hospital care or ventilation is not the appropriate treatment in every COVID-19 case. Most long-term care residents have pre-existing medical conditions, and many are in their final years of life. In one Nova Scotia facility experiencing one of Canada’s worst COVID-19 outbreaks, only 20 of almost 500 residents had not signed do-not-resuscitate orders. It is likely that only a small minority of residents would opt for aggressive COVID-19 hospital treatment, were it offered. But it is virtually certain that no one would have chosen to be needlessly exposed to the virus, to receive little or no palliative or comfort care, and to die in forced isolation, leaving family and loved ones to cope with anger as well as grief.

60. Lewis, supra note 18; Canadian Health Coalition, supra note 19; National Union of Public and General Employees, supra note 19.
62. Colleen M Flood, Bryan Thomas and Kumanan Wilson, this volume, Chapter C-1.
64. Canadian Institute for Health Information, supra note 15.
65. Rankin, supra note 28.
66. Grant & Ha, supra note 5; Reith, supra note 25; Payne & Duffy, supra note 25.
In the face of COVID-19, governments and health authorities were forced to make difficult decisions and trade-offs, in a very short time, often with incomplete and inadequate information. As Colleen M. Flood, Bryan Flood and Kumanan Wilson discuss, the courts will undoubtedly exercise considerable deference towards those choices. Containing the pandemic and ensuring hospitals and the health care system could manage the projected surge of COVID-19 patients were critical objectives. There were, however, long-standing warnings about the danger of viral outbreaks in long-term care facilities. Recommendations made by the Federal SARS Commission to mitigate this risk were disregarded, even as measures were implemented in hospitals. With few exceptions, the threat to long-term care residents was not seriously considered in most parts of the country. Inattention to the vulnerability of the long-term care system and to the particular risks created by COVID-19 transfers was not a rational means of achieving public health objectives and, in fact, undermined them. In sum, the failure to take into account, much less adopt proactive measures to protect, the life, security, and equality of long-term care residents, cannot be justified under s. 1.

The Way Forward: Comprehensiveness and Accountability

With long-term care residents representing only 1% of the Canadian population, but over 80% of COVID-19 deaths, political leaders have expressed sadness and shame; governments have committed to conducting post-pandemic reviews; health profession regulatory bodies have signalled their intention to investigate; criminal inquiries have been called for, and lawsuits have been launched.

67. Flood, Thomas & Wilson, this volume, Chapter C-1.
68. Ibid; Paola Loriggio, “Proposed Lawsuits Raise Questions on ‘Reasonable Care’” Ottawa Citizen (4 May 2020) NP3.
69. Tomlinson & Robertson, supra note 26; Globe and Mail, supra note 25.
Whatever answers are ultimately found, the devastation caused by the pandemic has exposed two significant fault lines that must be addressed.

The lack of comprehensiveness of the single-payer system is the first and most obvious barrier to equal access to care for long-term care residents, like for those seeking home care, mental health, substance abuse, pharmaceutical, dental, and other crucial services that are excluded from the Canada Health Act. The prioritization of hospitals in governments’ pandemic preparedness is a reflection of the privileged status of acute care delivered by physicians and hospitals within the public system. William Lahey observes that:

[The] compartmentalization of our health care system obscures the nature of the premises and assumptions on which we implicitly rely when we make choices about ... funding... These include a premise that ... curing is more important than caring (as well as prevention), that dealing with the episodic illness of the healthy is more important than dealing with chronic illness and disability, and that physical health takes priority over other dimensions of health, including mental health.

Expansion of the Canada Health Act to include long-term care has been identified as a major step towards resolving underfunding, lack of uniform standards, and other systemic problems within the current “mashup of systems” as the National Institute on Aging has described it. Whether through the Canada Health Act or new federal/provincial/territorial framework legislation, the full integration of long-term care


76. MacCharles, supra note 14; Armstrong, supra note 59; National Union of Public and General Employees, supra note 19; “Mark Hancock Calls on Trudeau to Fix Long-term Care Now” (21 May 2020), online: Canadian Union of Public Employees <cupe.ca/mark-hancock-calls-trudeau-fix-long-term-care-now>.
into a comprehensive, properly funded, public health care system is long overdue.\textsuperscript{77}

The tragic experience of COVID-19 in long-term care highlights a second barrier to equal access to care for disadvantaged groups: the absence of human rights-based accountability for health care decision-making.\textsuperscript{78} The interdependence between human rights and accountability is well understood internationally, and UN treaty monitoring bodies have criticized Canada for failing to meet its obligations in both areas.\textsuperscript{79} Paul Hunt explains:

Because of the complexity, sensitivity and importance of many health policy issues, it is vitally important that effective, accessible and independent mechanisms of accountability are in place to ensure that reasonable balances are struck by way of fair processes that take into account all relevant considerations, including the interests of disadvantaged individuals, communities, and populations.\textsuperscript{80}

The life, security of the person, and equality rights of long-term care residents were directly implicated in choices made by governments and health and hospital authorities in relation to the pandemic—most especially by COVID-19 transfer decisions. Yet no accountability mechanisms were in place to ensure that the rights and interests of this vulnerable group were taken into account in early pandemic planning, or that long-term care residents or those advocating on their behalf were included or even consulted, until the rising death count became a national disgrace. Over and above public expressions “of anger ... sadness ... frustration [and] grief,”\textsuperscript{81} federal and provincial/territorial governments must accept and affirm that access to care is a

\textsuperscript{77} Lewis, supra note 18; Canadian Health Coalition, supra note 19.


\textsuperscript{80} Hunt, supra note 79 at para 64.

\textsuperscript{81} Browster & Kapelos, supra note 27.
human right. And they must establish effective mechanisms, capable of preventing and providing meaningful accountability and remedies for violations of that right.

There is a growing understanding in Canada that “the pandemic did not cause the crisis; it came along and caused a massive shock to the long-term care system, shining a harsh light on fractures in a system that was ripe for catastrophe.” 82 The lack of comprehensiveness and the absence of effective human rights accountability mechanisms within our publicly funded system, have created and reinforced discriminatory barriers to care for many disadvantaged groups. For residents in long-term care, caught in the battle against COVID-19, these fault lines have proven fatal. Moving forward, “The hope is that the deaths of so many people will not be in vain, and governments will finally take serious action.” 83

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82. Brown, supra note 59.