ELDERS & CARE WORKERS DURING COVID-19

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Ida Gundersby Rognlien & Katharina Ó Cathaoir, December 2020
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Summary

This working paper is a deliverable of the research project, Legislating Corona: Proportionality, Non-Discrimination and Transparency (PRONTO), funded by Independent Research Fund Denmark (Grant number: 0213-00025B). The paper focuses on two groups who have been particularly affected by the COVID-19 pandemic: elders and care workers. The paper is made up of three parts which can be read separately or together. In Part 1, restrictions on movement imposed on elders in response to COVID-19 in Ireland and Denmark are analysed in light of the principles of proportionality and transparency. This includes stay at home orders and recommendations specific to elders advising them to "cocoon" or avoid social contact. We discuss how embedded and embodied vulnerability can be created through recommendations on social contact and reductions in home help.

In Part II, the restrictions on visits in Danish and Irish nursing homes are evaluated using similar criteria. We explore how nursing homes were given discretion, which appears to have resulted in violations in residents' rights, such as, being without a legal basis stopped from leaving a care home. Furthermore, we discuss how the underlying conditions, such as personal protective equipment and poor living conditions, should be taken into account when analysing proportionality.

Finally, Part III explores the underlying structures facing care workers from a feminist legal perspective. We argue that the overarching frameworks must be included in assessments of the proportionality of restrictions. A particular focus is placed on the difficulty of being compensated for mental health related COVID workplace injuries and the potential implications.

We are grateful to experts who provided comments and feedback on different portions of this paper: Amalie Giødesen Thystrup Ph.D., Associate Professor Lena Wahlberg, Professor Emeritus Lotta Vahlne Westerhäll and Professor Mette Hartlev. Thanks also to Daniela Alaattinoglu PhD, Søren Kjær Jensen, Professor Kirsten Ketscher, project student Sara Margon Prip for inspiration, constructive critique and comments. Furthermore, we wish to thank Katrine Hohwy Stokholm for extremely thorough research assistance. Any mistakes or omissions remain attributable to the authors.
Part I: Restrictions on Elders’ Movements in Response to COVID-19

1. Introduction
In response to COVID-19, in early 2020, all European states adopted legislation to compel or encourage their populations to reduce social contact to slow the spread of the disease and avoid hospital surges. Elders appear to often have been the target of the restrictions. In many cases, general legislation has been adopted with the purpose of protecting elders, while special restrictions have also been imposed on elders “for their own good”.

This paper reflects on restrictions of movement imposed on elders in two European welfare states, Denmark and Ireland. Despite being European welfare states with similar sized populations, the two countries have taken markedly different approaches when it comes to restrictions on movement. This, we suggest, should be viewed in light of the structural challenges present in both states.

We focus on elders because they are particularly vulnerable to serious COVID-side effects or death from COVID-19. Mortality for COVID-19 is highest for persons over 70; 90% of COVID deaths in Ireland were persons over 65 years; while 89% of COVID deaths in Denmark have been persons over 70.1 Furthermore, although everyone has been impacted by the epidemic, COVID regulations and policies, such as prohibitions on gatherings, requirements on distancing, mandatory wearing of masks can have a disparate impact on elders’ emotional, mental and physical health. Where an elder lives alone, is not proficient with technology or is hard of hearing, they may be particularly vulnerable to loneliness and communication difficulties. Elders are also more likely to experience muscle weakness, which is exacerbated by periods of inactivity. There is some evidence for this: ALONE, an Irish non-governmental organisation, reported an increase in calls from elders expressing loneliness to its helpline, as well as physical ailments.2 The Danish organisation, Ældre

Sagen, has also documented the physical and mental effects of COVID on elders through reports from their family/ carers. However, elders are not an homogeneous group, their embodied and embedded vulnerability in connection to old age, intersects with other roles such as for instance being a woman (wife, widow, mother, female relative) having a “foreign ethnicity” (immigrant, asylum seeker, war victim) disability (mental illness) social position (poor, institutionalised, social benefit receiver) and so forth. These individual embedded and embodied differences are relevant when analysing and addressing the elder’s vulnerability as a group.

The embedded and embodied differences in vulnerability between elders entails asking the question what the state (and relevant institutions) needs to do to facilitate building individual resilience towards the different kinds of vulnerabilities. For instance, being poor and without a private social network demands providing different kinds of assets when compared to being a socioeconomically independent elderly person. Being an elderly woman will, for instance, on the general level means you have a lower level of socioeconomic security when compared to elderly men on the group level.

Furthermore, elders have different living situations: they make live alone, with a spouse, with family or in an institution. Sadly, living in a nursing home renders elders medically vulnerable: In Ireland, more than half of all COVID deaths (September 2020) occurred in care homes. In Denmark, deaths in nursing homes were on the lower end internationally (a third of deaths were in care homes) but still significant. While the exact causes of deaths in care homes have not been established at this point, important variables have been identified: access to personal protective equipment (PPE) and testing, regular screening of staff and residents, rapid isolation, adequate sick leave, training and decent pay for staff and sufficient cleaning and hygiene.

Last, but not least, elders are not only vulnerable. They are autonomous human beings with individual rights to develop capabilities in line with other citizens, for instance, to develop, choose and quit relationships, be creative, thrive in healthy environments and so forth. The state’s obligation to respect and facilitate individual’s capabilities underpins human rights, such as, the right to family and private life, the right to health and the right to social security. It is connected to foundational values such as freedom and dignity.

In this paper, we reflect on the restrictions imposed on elders as a topic relevant for the elder’s human right to private and family life, with focus on the principles of proportionality and transparency. We submit that human rights must be dealt with both on a structural level, by legislators, administrative bodies and by the courts. So far, as far as we know, no cases have been brought to the courts on elders’ rights in the time of the pandemic. Therefore, we seek to highlight relevant aspects and questions related to the elder’s right to private and family life in the COVID-19 context and highlight factors to take into consideration when assessing proportionality and transparency. We also suggest that human rights should be integrated at every level, including in emergency preparedness plans.

Ultimately, we argue that it is a mistake to view the COVID-19 pandemic solely as an external threat. COVID-19 originated outside the two countries under study, and they sought to keep the disease out; however, once the disease took hold it re-exposed problems that pre-dated the “crisis”. The effects of COVID should be understood in light of systemic breaches of elders’ dignity, institutional vulnerability, and other social conflicts in the society (inequality, redistribution, downsizing of health care sector). Consequently, the solutions suggested through the law - restrictions on elders’ liberty - are too narrow and fail to address the underlying causes, such as, the limited home support for elderly and poor conditions in nursing homes. Further relevant in this picture is the lack of preparedness in both states when it came to tackling a pandemic like COVID-19.

At the time writing, November 2020, we are approximately eight months in to the pandemic, and we urge that further interdisciplinary research be conducted to understand and prevent the risks at stake for elder’s right to private and family life during a pandemic. In this manner, this paper does not claim to be a comprehensive comparison or assessment of the two countries but a first step to highlighting the human rights under pressure.
2. Restrictions on movement in Ireland and Denmark

Denmark and Ireland, in line with other European states, amended their infectious disease legislation in response to the COVID-19 pandemic. On 20th March 2020, the Irish 1947 Health Act was amended to introduce new powers that authorise the Minister for Health to adopt wide ranging regulations, including (but not limited to) travel restrictions within and to/from state; restrictions requiring people to remain at home, the prohibition of events, and “any other measures that the Minister considers necessary in order to prevent, limit, minimise or slow the spread of COVID-19”.6 The Danish parliament also substantially revised the 1979 Act on Measures against Infectious Diseases on 17 March 2020.7 The Minister of Health was given new powers to create regulations, inter alia, restricting gatherings (§ 6(1)) and giving the police power to close off access to certain areas, e.g. parks (§7(1)). The law was further amended on 4 April 2020 to allow the Minister to restrict gatherings of ten or less.8

In turn, both Ministers used these new powers to restrict movement. In Ireland, a restrictive approach was legislated for, whereby everyone was advised to remain home. The Health Service Executive (HSE) also promoted a policy of “cocooning”, i.e. recommending elders stay indoors at all times. In Denmark, the initial advice that elders should avoid social contact was reversed early in the pandemic due to concerns about their emotional and mental wellbeing. Legally, a more liberal strategy was pursued, whereby gatherings were restricted to a maximum of ten people. However, in both countries, elders appear to have been disproportionately impacted, experiencing loneliness and isolation.


7 Lov om ændring af lov om foranstaltninger mod smitsomme og andre overførbare sygdomme, No. 208 of 17 March 2020, Denmark.

8 Lov om ændring af lov om foranstaltninger mod smitsomme og andre overførbare sygdomme og forskellige andre love, No. 359 of 4 April 2020, Denmark.
3. Ireland

4.1. Stay at home!

From the 8th April 2020, all individuals were required by law not to leave their residence “without reasonable excuse”. A non-exhaustive list of reasonable excuses was provided and updated as new regulations were introduced (see box 1). The order imposes a far-reaching interference on citizens’ rights, including the right to private and family life. Following Article 8 ECHR, restrictions must be in accordance with law, necessary and proportionate to the aim of protecting public health. In the case of elders, while the potential gains are higher due to their medical vulnerability to COVID, the burden imposed can also have severe impacts. While there are many human rights issues at play, here we focus on the foreseeability of the law.

Providing care or assistance to a “vulnerable person” is expressly recognised as a reasonable excuse. However, it is not clear who is or is not a vulnerable person, and as discussed above, vulnerability should be seen in relation to both the embedded and embodied differences between persons, and the different roles one has over a life span. Section 3 of S.I. No. 121/2020 suggests a medical model of vulnerability as the term is explained to include persons “particularly susceptible to the risk posed to health by COVID-19.” The regulation does not define who is “particularly susceptible”, however. Separately, the Health Service Authority (HSE) issued guidance on who is at “very high risk” and “high risk”. Persons aged over 70 years are defined as very high risk or extremely vulnerable, along with others with compromised immune systems. Over 60s are viewed as high risk. The flexibility offered here may lead to confusion as to whom is a vulnerable person.

For example, is a health worker or a person at risk of violence a vulnerable person? Another far reaching inference is that exercise was restricted to specific group sizes/ and kilometre radii (see box 2). The benefit of including strict kilometre radiuses could be commended for transparency. An app was developed to help calculate the distances, but as smart phone use is substantially lower among the elderly, it may have been of limited value to that group. At the same time, the benefit of keeping people within a strict radius must be weighed against the limitation on liberty and movement. The precise public health aim of keeping citizens close to their residence has

not been explained by the government and must be viewed in light of the potential harm of not exercising. Furthermore, confusion emerged as to whether the kilometre radius applied to exercise or all activities (such as assisting vulnerable persons), leading the Prime Minister to tweet a clarification.  

In October, the government decided that visiting a grave - a practice of cultural and emotional significance in Ireland for many elders - could be a reasonable excuse for traveling beyond 5km, but did not include this in the text of the legislation. Individuals reported having been stopped by the police while trying to visit graves earlier in the pandemic. In Northern Ireland, cemeteries were re-opened in May, but not before an elderly man impaled himself trying to enter a locked cemetery to visit his wife’s grave.

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Box 1: Necessary purposes according to s. 31A Temporary Restrictions

Necessary purposes include: (8 April)

- provide an essential service
- procure essential items/services
- procure essential items/services for animals/vulnerable persons
- attend a medical appointment or accompany to a medical appointment or essential medical, health or emergency dental assistance
- seek veterinary assistance
- exercise, either alone or with household, within a 2-kilometre radius
- attend to vital family matters (including to provide care to vulnerable persons)
- attend the funeral of housemate or close family
- fulfil a legal obligation
- access to a child
- exemptions for religious personnel
- move residence where necessary
- provide emergency assistance, avoid injury or illness, or escape a risk of harm, whether to the applicable person or another person.

Necessary purposes added 22 October

- Attend education or accompany a vulnerable person/housemate
- Access childcare
- Return to place of residence
- Leave the State where the person is not ordinarily resident in the State,
- Make an application for planning permission
- Exercise within a 5-kilometre radius

4.2. Criminal sanctions

The lack of clarity in law could have implications for legal certainty, including individuals’ ability to orientate their behaviour to comply with the law. This is particularly concerning as the regulations were accompanied by criminal sanction (a fine to a maximum of €2,500 or imprisonment of up to six months).\textsuperscript{14} It can be questioned whether criminal sanctions are an

efficient public health tool. Furthermore, stigma, fear and stress may thrive in unpredictable criminal regulation, since the police have a broad discretionary competence. On the individual level it can raise legal questions of discrimination, which has been raised by some communities in Ireland, who alleged they were being over policed. The Council for Civil Liberties has opposed the use of criminal sanctions, recommending that resources instead be directed at supporting the vulnerable, such as elderly.

Box 2: Restrictions on exercise (radius and grouping)

<table>
<thead>
<tr>
<th>Date</th>
<th>Restrictions</th>
</tr>
</thead>
<tbody>
<tr>
<td>8 April 2020</td>
<td>Exercise alone within a 2km radius</td>
</tr>
<tr>
<td>5 May</td>
<td>Exercise alone within a 5km radius</td>
</tr>
<tr>
<td>18 May</td>
<td>Exercise outdoors with a maximum of 3 other persons who do not reside in the relevant residence, or with a maximum of 3 other persons, where one or more of such persons resides in the relevant residence and one or more of such persons does not so reside</td>
</tr>
<tr>
<td>8 June</td>
<td>Movement within the county of residence or within a 20 kilometre radius with a maximum of 14 other persons who do not reside together. Indoor gatherings were permitted with up to five others.</td>
</tr>
<tr>
<td>29 June 2020</td>
<td>Indoor gatherings of up to fifty were allowed and outdoor gatherings of up to 200.</td>
</tr>
</tbody>
</table>

4.3. Cocooning Recommendations

While the regulations restricting movement generally did not target elders, the Health Service authority (HSE) advised the elderly, and others at risk, to “cocoon”. Cocooning means that persons who are high risk are advised to stay home as much as possible and limit social interactions to a


very small network for short periods.\textsuperscript{18} However, the phrasing of this ‘advice’ can be critiqued as misleading. For example, The HSE website stated: “if you are in a very high-risk group, you need to cocoon”, while elsewhere on the website “you are advised to cocoon”.\textsuperscript{19} The guidance has changed often, depending on the status of COVID-19 in Ireland (see box 3). This also has implications for transparency, as the high-risk populations must keep up to date with the ever changing guidelines. Although these recommendations were neither legally mandated nor subject to sanction, the phrasing of the recommendations was liable to create confusion. It was not clear to all citizens whether rules were legal mandates (and thereby subject to criminal sanctions) or recommendations, given the directive phrasing and the many legal regulations that did govern social interactions at that point. This could lead to, for example, social stigma, e.g. ‘are you allowed out?’, fears of harassment by police, or, without adequate instruction, the police breaching human rights by imposing a restriction without a legal basis. It can also undermine the population’s trust in COVID regulations.

Furthermore, the June 8\textsuperscript{th} regulations govern vulnerable persons separately: individuals were ‘permitted’ to visit the home of a vulnerable person for social or recreational purposes and gather with a vulnerable person and a maximum of 4 other persons.\textsuperscript{20} Although part of the regulation, these provisions are advisory and unenforceable but it again risks suggesting that cocooning was mandated by the regulations. Finally, the Act did not create the necessary legal basis for allowing/disallowing individuals to visit homes of specific groups.

Cocooning was not mandatory nor subject to sanction. At the same time, the rules were not transparent. They risked elders being socially stigmatised due to their age (or appearance of old age). Cocooning sought to protect those most vulnerable in line with the state’s obligation to protect life and health. Yet, the rules had a heavy toll on many elders’ mental and physical health. It risked placing the responsibility on elders to protect themselves from COVID through long term isolation


\textsuperscript{20} S.I. No. 206 of 2020 - Health Act 1947 (Section 31A - Temporary Restrictions) (COVID-19) (No. 2) Regulations 2020, Ireland.
and made elders dependent on family and community. Research suggests that elders often fear
being a burden on their families and the COVID pandemic may have intensified these concerns.  

<table>
<thead>
<tr>
<th>Box 3. HSE Guidelines on movement directed at elders</th>
</tr>
</thead>
<tbody>
<tr>
<td>27 March – 5 May 2020 “you should stay at home at all times for two weeks and avoid face to face contact. Do not go outside your home and garden. Do not have visitors, except for essential services or attend gatherings.”</td>
</tr>
<tr>
<td>10 April – 5 May 2020: “You need to cocoon if…”</td>
</tr>
</tbody>
</table>
| 5 May those at very high risk are “strongly advised to stay at home and avoid face to face contact”.
7 May - “you may go for a short drive if you stay within 5km from your home, only share a journey with someone who is also cocooning in your home”.
18 May - vulnerable people can meet outdoors with small groups of up to four people for short periods
15 June - “there has been some easing of the cocooning restrictions, Up to 6 people can now visit you or you can visit another household”, Wear a face covering when meeting indoors and ask others to wear a face covering.
20 July - small groups (no mention of 6) permitted.
31 August - persons at high risk were advised to try to limit contacts to six people. |

We submit that cocooning must be viewed in light of the (neo)liberal welfare state model that the Irish state has adopted, where availability of hospital beds and doctors are below the OECD average, and there is a lack of home help available. For example, the state has previously been warned that more healthcare personnel need to be employed to meet demand. Universal healthcare is not guaranteed and it has been consistently stated that the healthcare system is in need of drastic

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These governance failures can heighten dependencies and the need to “cocoon” – citizens are forced to retreat indoors as the public health system cannot meet its purpose. With better investment in health systems and home care, would elders have needed to cocoon? Although since the 1960s the political intention purports to be keeping individuals at home for as long as possible, there is a documented lack of homecare supports. Timonen et al. align the lack of home care supports with the influence of Catholicism on Irish society, in particular the principle of subsidiarity, whereby care is the responsibility of the family, not the state. State aid is targeted at basic needs, such as mobility, ability to feed and bathe oneself unaided etc. It has been suggested that the average hours of public home help provided is a mere 4 hours a week. In 2019, the HSE home help budget was set at €450 million. There is no right to home help; once the home help budget is exceeded, elders often wait many months before the care begins. This eerily coincides with the British approach to poor relief in the 1700s, while in England the destitute had a right to care, the Irish did not. The lack of home supports in Ireland has long been blamed for “delayed discharge”, i.e. persons staying in hospital longer than needed, which places strain on the health system.

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4.4. Conclusions on Irish restrictions on elders

Although the Irish approach was advice not an order, this was at risk of being misunderstood by the public and should have been clarified immediately. Simply put, the risks of cocooning to physical and emotional health are such that it should not be mandated. The structures in place to support elders from loneliness and physical harms are important factors in mitigating impacts of the pandemic. Simply imposing restrictions is unlikely to protect the health of elders from a long-term perspective.

4. Denmark

In contrast to Ireland’s cocooning policy, the restrictions of movement in Denmark were not directed at the elders as such, but the broader community. However, informal advice could restrict the elder’s movement de facto. Further, the restrictions on the person’s movement, and recommendations on contact could affect the elder’s dependency. This interacts with the levelling down of the care and home help during the pandemic and brings up questions related to relatives being carers for elders and the level of care the elder’s received during the pandemic.

5.1 Balancing risks

In Denmark, a cocooning policy like in Ireland, was never pursued but vulnerable persons, such as elders, were advised against close contact in March and April 2020. It was also suggested that that those under 65 should not mind grandchildren while day-care/school was closed. By May 2020, however, the Health Authority suggested that hugging close relatives, such as grandchildren, could be justified due to the importance of social relations for psychological health and quality of life.30

The Health Authority, for example, noted that:

It is important to balance measures to reduce the risk of infection with regard to quality of life. People at increased risk, who are in the last part of their lives, often have a great need to make the most of the last time with their loved ones. Here, the consideration of quality of life may outweigh the consideration of reducing the risk of infection, and it may be considered to follow the above precautions only to the extent that it is deemed not to go beyond personal contact.31

31 Ibid, p. 9
Still, elders in Denmark experience loneliness and isolation due restrictions on gatherings and staying at home because of fear of the virus. Even where individuals are not mandated to stay at home, fear of the virus will “drive” some inside, also leading to physical and mental health consequences. In response, the government adopted a support package for elders in May where the Government and parties from the opposition agreed to establishing a partnership between government authorities, civil society, cultural institutions, private actors and the public sector to develop initiatives that prevent “loneliness, vulnerability and elders lacking in support”. They claimed new methods were available to support visits from family and relatives in a COVID 19 safe way.

In November 2020, for ten days, persons in the Danish region of North Jutland were asked to stay at home as much as possible and avoid travelling between municipalities. The aim was to contain a potential outbreak of new virus mutations found in minks that had spread to people in the region. While these were recommendations, not legal mandates, there was again potential for misunderstandings. Furthermore, we find it problematic that the political discussion focused heavily on the order to cull minks, not on the restrictions imposed on all individuals and the potential harm caused to elders.


### Guidelines on movement directed at elders (Denmark)

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
</tr>
</thead>
</table>
| 13 March 2020 – 4 May 2020 | The Danish Health Authority recommends that people at-risk, including elderly people, “only go out when necessary”.
| 17 March 2020 | The Danish Prime Minister states that “… if you are (…) an elderly person (…), you have to stay at home.”
| 8 April 2020 | Residents in social housing, including nursing homes, are allowed to leave their homes, but other opportunities must be considered.
| 4 May 2020 | People at-risk are no longer advised against attending social activities as long as protective measures are taken.
| 25 May 2020 | People at-risk are advised to curtail physical contact and to avoid places with many people such as public transport.

5.2. The protection of the elders as a legitimate aim
The protection of the elderly was used as a justification for restricting the rights of society at large; the government stated: “It is not least for their sake that we all have to do our part to bring the

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situation under control”.

Individuals were thereby encouraged to tolerate limitations on their rights for the benefit of the elderly.

Elders are, as mentioned in the introduction, not a homogeneous group, and what may be seen as necessary on the general level (protecting health and lives) will have to be analysed in intersection with the elders’ other human rights. The government’s task is to both analyse policies on the structural level, pursuing general goals for the society, and at the same time securing individual rights and the weighing of these rights if in conflict. However, what is seen as conflicts, also has to be assessed, since the distribution of resources may in itself be interlocked within different kinds of models of legitimation, that may in itself be questionable.

The protection of the elders is a legitimate aim in accordance with ECHR art. 8. Taking the elderly perspective seriously entails however a more in-depth analysis of the elder’s broader rights (not only the right to health and life), but also their right to private and family life, their right to care, their right to non-discrimination and so forth.

5.2. Who should be careful – responsibility for embedded and embodied vulnerability

As outlined in the introduction, elders are vulnerable, and the focus on this is essential to prevent elders being infected by COVID-19, and ensure the right to life and health. However, to ensure the full spectrum of human rights, it is crucial to understand (and question) the use of vulnerability in legal argumentation, especially when used in a paternalistic way to defend de facto infringements on the elders’ liberties. In this regard, one difficult question when dealing with the pandemic and the human rights is the question of responsibility for barriers in the society.

One could claim it is the society, not the elders, that has to enable structures to create resilience and diminish barriers for elders to participate on an equal basis as others during the pandemic. This echoes disability rights discourses, where the right to equality entails the state’s responsibility to diminish barriers in the society in order for people with disabilities to participate on the same level

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as others. It is not for the so called disabled person to change him or herself but society should be reshaped to remove barriers.\textsuperscript{44} This is on the surface the ideology in the Scandinavian welfare system during the pandemic; everyone is supposed to participate in the collective work of preventing transmission and the state is supposed to function as the primary facilitator of this collective work. It is not only the vulnerable groups who have to isolate and be careful. Further, the welfare infrastructure pre-existing the pandemic is thought to be the best system to tackle what is seen as a crisis, like a pandemic or an economic crisis. However, as highlighted below in part II section 6.2, there are several structural failures and issues in the elder care sector in the municipality, also in a welfare state like Denmark. Everyone in the Danish welfare system is seen as (morally) responsible to do their best to prevent transmission, including public actors, as well as private institutions/businesses and individuals, for the sake of the elders and also for the sake of not burdening a system that was not ready to handle the pandemic. Some of the moral responsibilities are also recoded into formal legally binding responsibilities and restrictions.\textsuperscript{45} One can trace arguments both related to the best interests of the individual, where the individual’s wellbeing and human rights is seen as a goal in itself, and also based on more utilitarian inspired arguments; what creates the best society for the most people on the structural level. The government views elders’ vulnerability as \textit{embodied}: while at the beginning of the pandemic, the science on how elders were affected by the virus was regarded as unclear,\textsuperscript{46} it is now established that their age renders one medically vulnerable.\textsuperscript{47} However, the institutions may create

\textsuperscript{44}This raises questions on the social position connected to age compared to disability. Further, questions related to what legal obligations the state have to diminish barriers, and will not be dealt with further here. See the different conceptualisations and understandings of disability Schiek, D. (2016) ‘Intersectionality and the Notion of Disability in EU discrimination law’, \textit{Common Market LawReview}, 53(1), 35-63.


\textsuperscript{46}04032020 FAQ fra Sundhedsstyrelsen (2020), mail of 10 November 2020.

embedded vulnerability. For instance, the Danish Health Authority’s recommendation directing elders (and others defined as vulnerable) not to take the public transport in rush hour, downgrades them to a vulnerable position in rush hour while those active in the labour market are prioritised. The same can be said regarding the advice that elders grocery shop outside of busy hours.\textsuperscript{48} At first glance, this might look like an efficient way of handling the different interests at stake, striking a fair balance, and may not be disproportionate. Second, not only the elders, but also the average Dane was advised to take steps to prevent transmission. Further, being only an advice and not a prohibition towards the elders, it might not rise to the level of a rights infringement. However, the potential equality risks at stake are also worthy of reflection, especially when seen in relation to other measures that could have been adopted/should have transparently been evaluated before the pandemic. When the right to private and family life is assessed on the individual level, the cumulative effects of the different informal and formal regulations may together constitute human rights violations if the elder carries a disproportionate burden. The advice on public transport, grocery shopping, cleaning, seen together with lack of home care support (see below), can create a scenario where the elder \emph{de facto} is deprived of fundamental freedoms, and subjected to disproportionate structures. However, whether there is a violation will depend on the case and the positive measures conducted in order to weigh up for the negative burdens. The Government issued a special recommendation for vulnerable persons during the pandemics, and the precautionary principle is here directed at those perceived as vulnerable, instead of the average citizen:

\begin{quote}
\textit{The recommendations should be regarded as principles of hygiene and behaviour, which the individual at increased risk and his or her relatives can take as a starting point when assessing their own individual situation. The recommendations are aimed at all persons with diseases and conditions with increased risk, including persons where there is only a precautionary risk. The higher the age and/or the more and more serious chronic diseases one has, the more attention one should pay to following the recommendations.….} \textsuperscript{49}
\end{quote}

\begin{flushright}
\end{flushright}

\begin{flushright}
\textsuperscript{49} Ibid., pp. 5-6.
\end{flushright}
We argue that which perspective (the elder, the average Dane, the structures or the individual) one adopts when posing and assessing advice and restrictions during the pandemic matter and is worthwhile revisiting when assessing the elder’s right to private and family life both on the general and the individual level. The lack of evidence strengthens the argument to be cautious when imposing restrictions and restrictive advice.\(^\text{50}\)

5.3. Home help and health care
Before the outbreak of the pandemic, research suggested that elders’ quality of life in Denmark had decreased between 2012 to 2017 in connection with a reduction of home help. Receivers of home care feel less safe, and every fifth receiver claims unmet needs related to social contact and activities.\(^\text{51}\) During COVID-19, there was a reduction of both the qualitative and quantitative care help and home help in Denmark, leading to various pressures.\(^\text{52}\) Further, elders may lose practical home help as they wish to limit interactions, for example, citizens who received home care reported feeling unsafe because of lack of transparency and guidelines on the use of protective equipment.\(^\text{53}\) In some cases, those who provide home help are forced to cancel, for example, to look after other dependents (like children while schools were closed). Furthermore, relatives who are carers, often wives and daughters, reported feeling overwhelmed and needing to be “on 24/7”\(^\text{54}\).

In response to the pandemic, Copenhagen Municipality reduced home help, claiming this was necessary to ensure sufficient staffing and minimise the risk of transmission between employees.


and care recipients. The Municipality reported that they acted based on the precautionary principle, inter alia, relying on political statements from the mayor and expert committee.\(^55\) As argued below, we suggest human rights principles must be integrated in the emergency plans, and individual assessments, which we do not see in the current approach.

One question is whether the Municipality could level down the home help, like renovation, on a general basis to relocation of resources in the time of the pandemic. One the one hand, one can argue that, for instance, lack of cleaning and renovation does not infringe the private sphere in a sufficient degree to be an infringement. However, if lack of cleaning and renovation is combined with risk of infection, the elder’s situation becomes more precarious. In that case questions arise on how often one should clean, as the government advised the citizens in general to clean their houses as part of the prevention of transmission. It was also a specific advice given directly to people who were considered particularly vulnerable.\(^56\)

We should note that Copenhagen Municipality’s Health and Care Administration claim that the preliminary results of user survey suggests that receivers of home care in general were satisfied and felt safe with SUFs handling of the pandemic June-August 2020; 79 % told they felt safe about the home care took the necessary precautions to prevent transmission.\(^57\) However, 11 % felt unsafe and reported on fear of being in the risk group and to be isolated from close relationships, and further that the feeling of being unsafe was connected to the uncertainty on the use of protective equipment.\(^58\)

The levelling down of health care raises questions of the elder’s right to health and private life. What may be considered justifiable on a general level, may infringe the individual’s right on a case


by case basis. More research should be conducted on this, in order to secure elders’ right in times of future outbreaks.

5.4. Inevitably and derivative dependency – relational issues

Vulnerability is connected to dependency. The construct of the family and relations in law is crucial to understand how elders are supported, as well as the rights of elders who take care of a partner, relative or spouse. Fineman defines inevitable dependency as the dependency that arises because we are all embodied beings who can receive, for instance, physical and emotional care from others. Because of embodied vulnerability, elders may need help with different kinds of tasks. Fineman explains derivative dependency as that those who care are “[…] dependent on access to sufficient material, institutional and physical resources in order to accomplish that care successfully.”

Derivative dependence is also an issue in the care worker section dealt with below in part III.

In previous work on home help in Denmark, Rognlien argued that there is a risk that care needs are not sufficiently met because the main rule is that the public help is subsidiary to the help provided by persons with, what is seen as, a formal care obligation. Firstly, it is questionable whether the Administrative appeal board (Ankestyrelsen) refusal of public help if the person has a spouse is in accordance with the law. Neglecting help will de facto give the spouse the obligation to provide help. Spouses have a formal obligation to provide for each other economically, but there are no legal consequences if the spouses do not provide care for each other. Is the public authority entitled to rely on private sources of care when they are not provided for by law? Secondly, there is a question of whether this practice leads to discrimination based on gender because more women than men are carers. Finally, there is a question as to whether this practice can be contrary to the elder’s right to proper care (quantitatively and qualitatively). Informal care work may be at risk of being of inferior medical quality than that provided by the professional.

During the pandemic, the levelling down of home help may have placed the vulnerable at an increased risk. This also imposes pressures on informal carers, whom the state regards as primarily responsible for the care of their spouse.

5. Conclusions
While not being as restrictive as the cocooning policy in Ireland, there has been informal and formal limitations of elders’ freedoms, herby freedom of movement and private and family life. Seen together with levelling down of home care, questions arise whether there have been human rights violations.

While individuals – also the elders – do have shared responsibility to diminish the risk of transmission during a pandemic, the government has to create resilience and diminish risks of human right violations both individually and on a general basis. While none of the COVID-19 related measures mentioned here on the general level can be said to constitute a breach on the elder’s right to private and family life, the aspects highlighted above should be dealt with in future interdisciplinary research. We suggest that human rights assessments be integrated in preparedness plans for future outbreaks to minimize the risks addressed here. Third, on the individual level, the right to private and family life has to be assessed in light of the different roles that elders are embedded in as outlined in the introduction of the paper.
Part II: COVID in Nursing Homes

Having highlighted relevant aspects of the right to private and family life and analysed general restrictions on elder’s movements, we proceed to examine restrictions on visiting in nursing homes before introducing some of the structural problems that must also be addressed.

In response to the COVID-19 restrictions, visiting was limited in all nursing homes in Ireland and Denmark. In both countries, nursing home residents normally decide who visits them in line with their rights to family and private life. Visiting restrictions can be an important public health measure as by limiting the number of persons coming in and out of a residence, the risk of transmission is reduced. However, the limitations on visits appear to have had a deep impact on the elderly, their families and carers. Furthermore, prohibiting visitors does not eradicate all risk. Again, we suggest that the limitations on private and family life must be viewed in light of the structural weaknesses that rendered such measures necessary, yet inadequate.

1. Restrictions on visits in Denmark

In Denmark in response to COVID-19, the Patient Safety Authority was given the power to order prohibitions and restrictions on visits to nursing homes to prevent or curb of COVID-19 (s. 5(1)). It is striking that no politicians addressed the restrictions on visiting care homes in the debate on the March amendment to the Communicable Diseases Act. Instead, the bill framed the previous legislation as a barrier to the government’s ability to respond and an obstacle that must be diminished in order to tackle the crisis.

Box 4: Restrictions in Danish Nursing Homes

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60 Section 137 a, Bekendtgørelse af lov om social service, No. 1287 of 28 August 2020, Denmark.
62 However, it was discussed in the second round.
<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 March 2020</td>
<td>Patient Safety Authority may order the municipal council to ban or restrict visitors' access to common and living areas in nursing homes. Measures were institution dependent.</td>
</tr>
<tr>
<td>5 April 2020</td>
<td>Order expanded to include outdoor areas in nursing homes. Visits in critical situations are excluded: critically ill/ dying/ visits to relatives with a cognitive impairment &amp; special need for visit. Formal ban from 6 April.</td>
</tr>
<tr>
<td>25 April 2020</td>
<td>Requirement to end restrictions as soon as possible is removed. Visits should take place outdoors. If outdoor visits not possible, 1-2 people can be named as regular visitors.</td>
</tr>
<tr>
<td>11 June 2020</td>
<td>Visits from the nearest relatives of the resident can be exempted from the restrictions.</td>
</tr>
<tr>
<td>27 June 2020</td>
<td>Visits from the nearest relatives of the resident can be exempted from the restrictions. Each resident may name two additional constant visitors allowed to visit in a specific room, but only two relatives are allowed at a time.</td>
</tr>
<tr>
<td>15 November 2020</td>
<td>Each resident may name two additional constant visitors allowed to visit in a specific room, but only two relatives are allowed at a time.</td>
</tr>
</tbody>
</table>

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64 Bekendtgørelse om afspærring og besøgsrestriktioner på plejehjem og sygehuse i forbindelse med håndtering af Coronavirusyggdom 2019 (COVID-19), No. 317 of 4 April 2020, Denmark.
65 Bekendtgørelse om afspærring og besøgsrestriktioner på plejehjem og sygehuse i forbindelse med håndtering af Coronavirusyggdom 2019 (COVID-19), No. 502 of 23 April 2020, Denmark.
2. Restrictions on visits in Ireland
In Ireland, nursing homes already had the power to prohibit visits that would “pose a risk to the resident” or any other resident, or the resident could request that visits are restricted (s. 11(1)-(2)). From 6 March 2020, private nursing homes took the policy decision to prohibit “non-essential visiting, children or groups”. The Health Authority initially opposed these restrictions, given the likely toll on residents’ mental health. From 13th March however, government policy changed, ordering restrictions on visits to nursing homes until 15 June (see box 5).

<table>
<thead>
<tr>
<th>Box 5 – Restrictions on Irish Nursing Homes</th>
</tr>
</thead>
<tbody>
<tr>
<td>-6 March 2020 Private nursing homes ban all visits</td>
</tr>
<tr>
<td>Exceptions for compassionate purposes</td>
</tr>
<tr>
<td>13 March all nursing homes prohibit visitors except for compassionate purposes</td>
</tr>
<tr>
<td>15 June 2020 Each resident can have two named visitors, but only one can visit at any one time (should be scheduled)</td>
</tr>
<tr>
<td>29 June 2020 Grandchildren can visit but not hug grandparents</td>
</tr>
<tr>
<td>21 July 2020 Visits should usually be limited to one hour usually 2 visitors at a time</td>
</tr>
<tr>
<td>24 August 2020 Visits of up to 4, visitors should wear masks</td>
</tr>
<tr>
<td>11 September – 5 level framework released</td>
</tr>
<tr>
<td>5 October – all counties enter level 3- visits suspended besides critical/compassionate reasons</td>
</tr>
<tr>
<td>Window and remote contact</td>
</tr>
<tr>
<td>Critical &amp; compassion open to interpretation, including distress/ exceptional need</td>
</tr>
<tr>
<td>22 October – all counties enter level 5- visits suspended besides critical-compassionate reasons</td>
</tr>
<tr>
<td>Window and remote contact</td>
</tr>
</tbody>
</table>

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68 Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People), S.I. No. 415 of 2013, Ireland.

3. Impacts on Residents
Both residents and staff reported experiencing stress. Some residents feared not seeing loved ones again and missed human contact. Meanwhile, staff were no longer able to have physical contact with residents as before. The changes and new barriers between the carers and residents created struggles:

Some residents commented that while it was initially very frightening because they did not know what to expect, now, they have got used to the way things are. For example, they and their carers wearing masks. For others, they considered that as time passed and the pandemic continued it became more frightening because they did not know what the future would be like.70

Absolute prohibitions have a heavy toll on residents who are used to regular visits from friends and family:

One resident informed the inspector that she had her first visit from one of her daughter's, and while it was wonderful to see her …the last time she saw her family was in March and as this visit was so short, she said she cried all night following the visit.71

Alongside restrictions on visits, social events and visits from the community were also cancelled, rendering residents under stimulated and alone. It has been claimed that the lack of visits resulted in loss of functions, depressive symptoms, loneliness, deteriorating dementia, lack of stimulation, muscle weakness, cognitive complications, and insecurity among the residents, which may increase the longer the residents are more or less isolated according to experts.72

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Residents with cognitive impairments may struggle to understand the need for restrictions and the absence of family. The Danish Alzheimer’s Society claims that the restrictions caused deteriorating health and reduced quality of life among the residents resulting in suicidal ideation, anger, and fear to an extent where antipsychotic medicine was necessary for some residents. It is therefore welcomed that the restrictions increasingly recognised comforting a distressed resident as a possible exemption from the restrictions (see boxes 4 & 5).

To mitigate the impact, nursing homes organised contactless visits (through windows and remotely). However, these measures were not entitlements and were nursing home and resource dependent. Therefore, it was not always possible to facilitate contact due to staffing issues.

In November 2020, the Alzheimer’s Association published a report based on questionnaires filled out by 1419 respondents, including people suffering from dementia and their relatives, from 15 June 2020 to 30 June 2020. The report concludes a total of seven common tendencies taking place during the COVID-19-pandemic. Firstly, the physical health of one third is deteriorating, and furthermore the


Alzheimerforeningen (2020) Situationen på plejehjem er uholdbar, 27 June 2020, https://www.alzheimer.dk/nyheder/2020/situationen-paa-plejehjem-er-uholdbar/. Before the lockdown, a 94-year-old resident was claimed to be happy and lively and used to receive visits from his relatives 4-5 times weekly. After the introduction of restrictions on visits, the health of the resident were said to be aggravated, and his loneliness increased. After more than two months without visits, the resident was hospitalized and died. The concrete example is complemented by general observations by the DaneAge Association emphasizing that the cognitive functions of the residents aggravated and that their zest for life decreased during the isolation. According to one of the experts from the DJØF Task Force, the restrictions were alarming in terms of the enjoyment of fundamental rights, and the restrictions ought to have been differentiated regionally. However, the government defends the restrictions alleging that they resulted in a lower death toll and therefore were necessary: Svendsen, A. B. and Christensen, R.B. ’94-årige Torben døde ensom under corona-nedlukning: Eksperter kritiserer behandling af ældre’, DR, 11 September 2020, https://www.dr.dk/nyheder/politik/94-aarige-torben-døde-ensom-under-corona-nedlukning-ekspertekritiserer-behandling.

ability to remember, communicate and walk is reduced in one out of four cases. Secondly, one third of the persons suffering from dementia and one out of four of their relatives have felt lonely. Thirdly, every other relative have stated that their quality of life is below the average. Fourthly, every third family experienced less help with practical doings and personal care from the municipal home care. Fifthly, the municipal treatment of people suffering from dementia extensively ceased. Sixthly, four out of ten relatives have experienced less energy and more conflicts. Lastly and seventhly, one out of four relatives have isolated themselves in contemplation of hindering dissemination.76

4. Interpretation of Restrictions
In Denmark, the municipalities are responsible for nursing homes, yet the pandemic required coordination across the national, regional and municipal levels. For example, the Municipality of Copenhagen reported that it experienced difficulties getting clear guidance from the centralised Health Authorities, for instance, about the infection danger in different kinds of situations, such as nursing homes77 and unclear communication between hospitalities regarding elders COVID status.78 Simply put, the system was ill prepared for the coordination needed to combat a pandemic.79 The Municipality of Copenhagen admits that challenges and acknowledges the need to focus on identification of practices that may cause doubt and insecurity among citizens and relatives, such as visiting restrictions.80
SUF claim that they in general acted based on the precautionary principle,81 which in turn may have affected how strictly the nursing homes interpreted the visiting restrictions. SUF reported that citizens struggled to understand the precautionary approach and the use of protective measures and the reasons for when and how to use it, for example, that face mask was not required in all types of

78 Ibid.
79 Ibid.
80 Ibid, pp. 8-10.
81 Ibid., p. 3
home care visits, but was required at public transport. Furthermore, the rules were interpreted differently by nursing homes, meaning that some allowed more contact than others, leading to frustration among relatives.

Non-governmental organisations claim that the restrictions have in some cases been applied unlawfully to impose restrictions that lack a legal basis. For example, the Danish Alzheimer’s Association reported that several municipalities prohibited nursing home residents from hugging their relatives. Furthermore, in some cases, residents have been prohibited from leaving the nursing home. Relatives report that their resident family members were threatened with two weeks isolation if they left for exercise. The Danish Alzheimer’s Association reports that several nursing homes have precluded the relatives of residents in nursing homes from going for a walk with their family member.

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82 Ibid., p. 46.
bring them outside to meet relatives, rendering visits dependent on staff and some residents de facto isolated.  

For example, in spite of a low reproduction rate in May 2020, the residents of nursing homes in Faaborg-Midtfyn were only allowed to receive visits twice a week for 30 minutes. Furthermore, they were only allowed to leave the nursing home provided that they stayed in their own apartment for 14 days afterwards. Therefore, none of the residents left the nursing home. Similar cases are seen in other municipalities. However, according to the Ministry of Health and Senior Citizens, the rules and regulations regarding nursing homes do not concern or interfere with the residents’ access to leave the nursing home.

Under law, staff can only prevent residents from leaving in limited circumstances, such as if they are a danger to themselves (§ 124 d Serviceloven). Furthermore, while the Patient Safety Authority has the authority to isolate individuals suspected to have COVID-19 against their will, nursing homes do not.

In May, the Fredensborg municipality changed its practice whereby a curfew in nursing homes only applied to older people in wheelchair. Previously, only residents who were able to receive visits without the staff taking part could receive a visit or go for a walk, in weekends and in holidays. This is criticized by the Danish Alzheimer’s Association as a practice of differential treatment without a legal basis for enforcing restrictions on egress. This point of view is supported by the Danish Patient Safety Authority: Mailand, P. (2020) ‘Sagen om udgangsforbud på plejehjem tager en ny drejning: Nu er det forskelsbehandling’, sn.dk, 23 May 2020, https://sn.dk/Lokalavisen-Uge-Nyt-Fredensborg/Sagen-om-udgangsforbud-paa-plejehjem-tager-en-ny-drejning-Nu-er-det-forskelsbehandling/artikel/945203.


Bekendtgørelse om undersøgelse, indlæggelse eller isolation og tvangsmæssig behandling i medfør af lov om foranstaltninger mod smitsomme og andre overforbare sygdomme i forbindelse med håndtering af Coronavirussygdom 2019 (COVID-19), No. 368 of 4 April 2020, Denmark.
The potential for misinterpretation pre-existed the pandemic and is illustrated in a case from the Danish Ombudsman from 2010. A woman complained she was only allowed to visit her father’s elderly home one hour a day. There was conflicts between the woman and the employees at the elderly home, which the Ombudsman considered understandable as an basis for restricting the right to private and family life. The Ombudsman’s concerns regarded the procedure.

On a substantive level, the Ombudsman’s interpretation of the right to private and family life is problematic seen from the elder’s perspective. The care facility is the elder’s home; one cannot restrict a neighbour’s right to family life unless noise or other unacceptable disturbance is made. However, visiting restrictions are assessed with reference to administrative competence (a systemic perspective) as opposed to the private sphere perspective. From a human rights perspective, strong reasons have to be provided to limit the individual’s right to private and family life.

Conflicts between family and care homes is not rare when a relative is institutionalized, and we submit that other means should be sought to address conflicts to respect the elder’s right to health and private and family life. What was the underlying conflict? Was it related to the level of care? And most importantly in an elder perspective; what was the father’s view on the conflict and the underlying problems at stake? This brings up questions related to Kongsøgarden case, discussed below, where the elder and relatives were not facilitated in sufficiently participating in the care plans, which would be an even more problematic situation in a COVID-19 situation.

Instead, the Ombudsman focused on procedural issues: the Municipality had not considered the restriction of visits as a “decision” which gives rise to different kinds of legal effects in the Danish Administrative Act, like for instance the right to complain, being heard (the Administrative act § 19), the requirements to give sufficient reasons for a decision etc (the Administrative act § 24). The daughter had not been heard and the decision was not sufficiently reasoned.

5. Summary on visiting restrictions
Visiting restrictions are an interference with the elder’s right to private and family life. It must be asked whether the restrictions were proportionate: could the aim of avoiding transmission justify the emotional and physical harms on the elders? The approach from June appears more proportionate, allowing individuals to receive visits from at least one family member/friend. This approach, we

submit, should be prioritized to avoid violations of family and private life and given that complete isolation from the outside world is neither feasible nor recommendable.  

Furthermore, we suggest that resident’s rights should be strengthened. For example, while nursing homes sought to accommodate outdoor visits, these were not always possible due the staffing shortages. Yet, residents have a right to family and private life and nursing homes have a positive obligation to ensure same.

Individual cases should be dealt with in a pro persona perspective. What is considered human rights friendly on a general level may in the specific individual situation be disproportionate and lack transparency. As outlined in the introduction, the elders must be seen individually and subjected into different roles and positions in both society and the relevant care institutions.

Further, in the assessment of proportionality, one has to take into account the structural issues at stake in the elder care sector in general. When considering the necessity of an interference in the right to private and family life, a question is what transparent justification is proposed for the chosen measure, when other, less intrusive measures could have replaced visiting restrictions. Further, whether positive measures were (and can be) conducted to reduce the individual’s burden of the visiting restrictions.

During a pandemic, when the institutions are experiencing pressure as outlined in the next section, there is a risk that the requirements in law are not followed. More research on this has to be conducted, for instance a mapping of the complaints made on visiting restrictions. On a general level, one can argue that more efficient complaint mechanisms must be established in order to

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92 The Danish DJØF Task Force considers the Danish restrictions on visits in nursing homes as being one of the most restrictive compared to other countries. According to the Task Force, the restrictions shows the dilemma between - on one hand - the freedom of movement and the right to family life and - on the other hand - the right to health, safety, and life. The result of the weighing of these considerations was de facto a national isolation of elderly residents regardless of a low reproduction rate of the virus in some regions. The management of the institution was left a discretionary power, but it solely allowed for intensifications not any relaxations of the restrictions. The Task Force concludes that the restrictions on visits in the nursing homes may be considered as an undue interference with the freedom of movement and the right to family and private life even though the intention was to protect the elderly residents. Therefore, the Task Force advocates for regional and local measures entailing that the restrictions are proportional in the future: DJØF Corona Task Force (2020) Da friheden blev sat på pause, September 2020, https://www.djoef.dk/-/media/documents/djoef/c/corona_task_force_brief_a4_0920_web_ny.ashx.
secure the elder’s rights, see below in section 6.2. There is a question whether there is a lack of proper procedures for complaint and how this factor plays a role in the proportionality assessment. While not being exhaustive, next we will highlight some aspects of structural issues in the elder care sector in Ireland and Denmark. While being two different kinds of welfare systems, both countries lacked proper preparedness for a pandemic, and it resulted in different kinds of structural issues that affected the elders on the individual level negatively during the crises.

6. Structural weaknesses
This section highlights some of the structural problems that may have led to deaths and isolation. It does not claim to comprehensively account for the complex violations that led to an egregious number of deaths in nursing homes. Instead, we emphasise the known weakness that should and could have been tackled long before the pandemic and thereby have avoided the perceived “need” to isolate residents. At the start of the pandemic, despite these conditions being known, nursing homes were neglected and instead visitation rights were restricted, instead of immediate investments in adequate infrastructure.

6.1. Ireland
The reasons underlying the high numbers of deaths in Irish nursing homes are currently not adequately established. Shortages in personal protective equipment and staff, as well as long waits for testing are believed to have played a role. There is disagreement between private nursing homes and Health Service Executive as to the reasons behind these failures. Private nursing homes have suggested they were abandoned by the state, while government ministers inferred that private nursing homes did not use their resources to adequately invest in the necessary provisions.93 The immense loss of lives in Irish nursing homes must be intensely scrutinised and redressed in years to come. For example, the situation in one nursing home was so out of control that the HSE considered calling in the army to meet the needs of the residents. 71 residents were suffering from dehydration due to lack of staff.94 Due to the outbreak, the home’s staff was reduced from 104 to

34. A later report found that staff were unable to work due to long delays in testing.\(^{95}\) An inspection by HIQA identified several issues in staffing. Firstly, agency housekeeping was used, meaning that the nursing home was serviced by a constantly changing staff who lacked adequate training. Secondly, because of inadequate housekeeping the facility was visibly unclean in May 2020 during an inspection. Thirdly, there was insufficient staff to ensure that residents were self-isolating and residents could not have contact with their families or meaningful activities.\(^{96}\) Furthermore, HIQA found that there was a delay in reporting the unexpected deaths of residents during the outbreak, contrary to the rules. The (traumatised)\(^{97}\) families of the 23 residents who died in early 2020 have requested a public inquiry into the circumstances.\(^{98}\)

While loved ones were prohibited, employees, such as care workers but also catering staff, continued to come in and out of residential settings. In its report, HIQA noted that “inward transmission by staff” was likely a key source of introduction.\(^{99}\) Notably, some staff in nursing homes are asylum seekers who live in “direct provision” (institutional accommodation where residents share rooms and bathrooms). Thereby, persons living in cramped institutions (the conditions of which have been subject to sustained criticism), with high risks of transmission spent their days caring for elders in similar conditions. Recognising the potential for transmission, the HSE offered a scheme whereby health workers, including asylum seekers, could apply for temporary accommodation.\(^{100}\) However, this short-term solution fails to address the structures that perpetuate transmission.


\(^{96}\) Ibid.

\(^{97}\) Ibid., p 16


The limited possibilities for self-isolation may also have been a factor in disease transmission. HIQA has repeatedly raised concerns regarding the standard of care given to elders. For example, in 2017 it underscored that “privacy and dignity, safeguarding, good governance and fire safety still need to be addressed among many services”\textsuperscript{101} Notably, the physical environments sometimes lack privacy for intimate care and personal space to meet visitors. In 2015, HIQA commented that residents continue to live in “large and outdated open-plan style wards, which give residents little privacy and dignity”\textsuperscript{102}. While regulations prescribe that all residents must each have a space of 7.4m\(^2\) floor space in their rooms, older nursing homes have until 1 January 2022 to comply. From then on, no nursing home bedroom may have more than 4 residents, except high dependency rooms which may not have more than 6 residents.\textsuperscript{103} Many residents do not have their own room. Furthermore, even patients with their own rooms, may be required to sit in communal areas to be monitored by staff due to low staffing levels. Cramped facilities can make isolating suspected cases difficult.

The extent to which nursing home residents have access to genuine remedies regarding poor conditions or treatment can be questioned. The conditions in one public nursing home are jarring - residents live in two 11-bedded wards with eight residents accommodated in one room, a seven-bedded ward and an eight-bedded room. The centre is permitted to accommodate 38 residents; two showers are available, many residents in shared rooms use bedpans. HIQA has in its last ten inspections found the home “unfit for purpose”. A strange formulation notes, “Overall, the arrangements to enable and ensure the provision of residents’ rights, privacy and dignity could not be facilitated”. Yet, instead of drastic action, the nursing home (in this case the HSE) has been given deadline upon deadline to improve facilities and failed to do so.


\textsuperscript{102} Health Information and Quality Authority (2020) \textit{Annual overview report on the regulation of designated centres for older people – 2015}, p. 23, April 2016, retrieved 19 November 2020, \url{www.hiqa.ie/sites/default/files/2017-02/2016-Overview-Centres-Older-People.pdf}.

\textsuperscript{103} Section 4, \textit{Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) (Amendment)}, S.I. No. 293 of 2016, Ireland.
The state’s failure to meet these obligations is a violation of the residents’ private life, and potentially articles 2 and 3 ECHR. The standard of review and sanctions imposed by HIQA are also worryingly light, given that HIQA has the power the close centres. Notably, the size of nursing homes has been associated with higher COVID mortality, not HIQA compliance, which it could be suggested infers that HIQA reviews are not effective in identifying structural problems.\(^\text{104}\)

While the Minister has the power to set standards, no regulation has been introduced to specify minimum staffing levels. Instead, facilities determine the number and skill of staff “is appropriate to the needs of the residents (s. 15(1) 2013). One resident nurse must be on staff at all times (s. 15(2)) where a resident is assessed as needing full time nursing care. Thus, most staff are not trained nurses and may have been lacking knowledge of infectious disease control. The HIQA report found 50% of nursing homes inspected were non-compliant with infection prevention and control.\(^\text{105}\) It can be questioned whether nursing homes are adequately placed to provide care for those too ill to remain at home. Research suggests that the general standard of medical care in European nursing homes is sub par.\(^\text{106}\)

Furthermore, the lack of connection between the public and private systems seems to have hampered communication. As of July 2020, there were 576 registered nursing homes in Ireland, with approximately 32,000 places.\(^\text{107}\) The majority of these homes are privately owned (80%), fuelled by tax incentives provided to developers between 1997 and 2010.\(^\text{108}\) This increasing privatisation can be of concern as, in Ireland, as in other countries, privatisation of nursing homes is


\(^{107}\) Nursing Homes Ireland (NHI) is the national representative body for the private and voluntary nursing home sector.

associated with lower quality of care.\textsuperscript{109} Public nursing homes are run by the Health Service Executive (HSE), which does not have regulatory powers over private nursing homes. The HSE does not monitor the clinical care provided to residents. Public nursing homes are more expensive for the state due to higher nursing ratios and better working conditions for staff.\textsuperscript{110} In 2017, HIQA noted that small, more “homely” care environments are being forced to close as they are not financially feasible.\textsuperscript{111}

Side by side the inadequate care supports for elders, archaic legislation governs the rights of elders without capacity. Five years after adoption by parliament, the majority of the Assisted Decision-Making (Capacity) Act 2015 has still not been commenced. When commenced, the Act will provide for co-decision making and enduring power of attorney. Until then, in practice, persons with dementia or other cognitive impairments have to be made wards of court, in other words, stripped of the majority of their legal rights, for their affairs to be administrated. HIQA acknowledges that the elderly often end up in institutional care against their will due to lack of support.\textsuperscript{112}

6.2. Denmark
A comprehensive analysis of the impact of the pandemic has not yet been undertaken in Denmark. While not being exhaustive, in the following we highlight selected structural issues at stake in Denmark of relevance to the elder’s right to private and family life during the pandemic. These include issues highlighted by the Municipality of Copenhagen, the media and non-governmental organisations.

In October 2020, the Health and Care Administration (SUF) of the Municipality of Copenhagen released a report evaluating SUF’s COVID-19 preparedness in the beginning of the pandemic and
during summer 2020. The municipality highlighted several problems that should be resolved: the lack of preparedness plans for pandemics, the implementation of guidelines, individualization of responsibility, doubt and insecurity among citizens, and the exhaustion of care workers. Among the factors which SUF stated affected its abilities to act during the pandemic was lack of protective equipment, test capacity and insufficient hygiene focus. In March and April 2020, protective equipment was a challenge, both quantitatively and qualitatively. The demand was greater than the supply, and the hospitals were prioritized above the municipalities. SUF consider the situation improved, but that it still demands attention. Arbejdstilsynet found in October 2020 that a care home breached the Health Authority’s (Sundhedsstyrelsens) guidelines and The Work Environment Act (Arbejdsmiljøloven) by not planning and having efficient measures, such as Personal protective equipment (PPE) and individual oriented guidance to protect the personnel and the person being cared for (the care home Salem case, see part III). The care worker died of COVID-19.

Test capacity on the national level was limited, which undermined the possibility to test residents and care workers. Further, necessary inter sectorial collaboration regarding the testing procedures was not in place. SUF claims that better test capacity has improved the possibility to identify infections, and control outbreaks before largescale transmission occurs. One question is whether use of protective equipment could have been a relevant less restrictive measure in order to achieve

113 SUF is responsible for health services and elderly care in Copenhagen More information on SUF here: https://www.kk.dk/artikel/sundheds-og-omsorgsforvaltningen.


the legitimate aim of the visiting restrictions. The same questions relate to the lack of the testing capacity, and the lack of focus on hygiene.

In addition, the exhaustion of the work force is seen as a problem. Employees worked hard during the pandemic, especially in the lock down March until May, and the report by SUF claims that this level of work effort is not sustainable in a long term perspective, and may contribute to exhaustion and risks for mistakes.\textsuperscript{118} Staffing levels vary\textsuperscript{119} and it has \textit{inter alia} been suggested by various associations and some of the political parties that minimum staffing levels should be established.\textsuperscript{120} It is also claimed that the financial resources in the elder care sector have not followed the demographic development and there are problems with recruiting and maintaining workers in the elder care sector. Further, there is a risk of establishing a minimum level of staff without taking into consideration the qualifications of the staff and the combination of residents at the nursing homes (for instance how many residents with dementia or other special needs).\textsuperscript{121} The interaction between the pre-existing problems addressed in the debates on the elder care sector and the synergies with the pandemic need to be further researched in a human rights perspective.

\textsuperscript{118} Ibid., pp. 24-25


\textsuperscript{121} Rostgaard, T. (2020) ’Professor før ældretopmøde: Kan vi løse problemerne i ældreplejen?’, \textit{Altinget}, 24 August 2020, \url{https://www.altinget.dk/aeldre/artikel/professor-foer-aeldretopmoede-kan-vi-loese-problemerne-i-aeldreplejen}.  

42
This relates to the risks of mental health problems as work-related injuries dealt with in the context of Labour Market Insurance in part III on care workers in the paper. The underlying care worker structures were at risk of affecting the qualitative and quantitative levels of care and protection against COVID-19 during the pandemic.

SUF claims private home care actors have not been systematically integrated in the approaches during the pandemic, and still remains to be resolved. For instance, they have not made daily reports on infected citizens and workers, and the communication of the guidelines have not been done systematically. Further, no formalized meeting between SUF and private actors was established. The municipality is obliged to secure that private actors provide the same standards of care as the public providers. While being different, this relates to the Irish distinction between the private and public responsibility for the elders, see the previous section. The elders have a right to (health care) and private and family life regardless of the provider’s formal status as private or public.

The Patient Safety Authority’s enforcement notice of 19 December 2019 in the Betaniahjemmet case illustrates pre-existing risks in the elder care sector which can be considered intensified during the pandemic. The Patient Safety Authority identified problems regarding the handling of medicine. Furthermore, the nursing home had not prepared an overview over the diseases and decreased functionalities of the patients, and no systematic nursing evaluations or continuous observations had been practiced. Additionally, the record keeping was defective and there were no instructions regarding the competence, responsibility and tasks of the staff. The lack of sufficient healthcare instructions involves a significant risk of patient safety. Furthermore, the care and treatment of the patients depend on nursing evaluations and continuous observations of the patients. Precise and adequate record keeping and instructions regarding the competences, responsibilities and the tasks of the staff are also necessary instruments in this regard.

123 Ibid., p. 27.
124 Ibid., p. 47
During the pandemic, where institutions and staff experience extra pressure, the findings in a case like Betaniahjemmet have to be addressed from the viewpoint of the elder’s right to life, health and in some circumstances questions on the prohibition of torture, degrading inhuman treatment arises. Relatives’ access to the nursing homes also have a function as protectors of the elder’s right, which was restricted during the pandemic.

Other structural/institutional issues have been documented in a Patient Safety Authority administrative decision (21 July 2020) on a nursing home (the Kongsgården case). The Patient Safety Authority concluded that the personal help, care, and treatment offered by Kongsgården risks not being of the necessary quality in compliance with Article 83, Article 86 and Article 87 of the Social Services Act (no. 1287 of 2020), cf. Article 150(1) of the Act. The nursing home did not ensure the right of the residents to self-determination, influence, and involvement in their own lives. Relatives or close friends were not integrated sufficiently in the elder’s care.

In the time of a pandemic, the issues at stake in the decision may be exacerbated. For example, when visiting is restricted, not only the right to maintain and care for important relations were limited, but also the relative’s possibility to ensure and participate in the elder’s care. The case also raises questions related to both the right to health care and the right to private and family life, which the Board did not address.

On a general level, there are practical, financial and social barriers to an elder’s access to justice. Actors have made proposals in order to improve the elder’s procedural rights, such as Faglige Seniorer, which suggests that an independent ombudsman be established in all municipalities.

allowing citizens to submit complaints about issues and failures in nursing homes and home care.\(^{131}\) On the local level, writing a complaint\(^{132}\) regarding the nursing home requires specific skills, with which some elders who suffer from dementia would need support. This means elders with a weaker social network will be at risk of falling behind. Going to Court, for instance with a claim for compensation due to human rights violations, will both be time consuming, financially risky and might not solve – or take too much time to solve - the problems at stake, like for instance those described in the Kongsgården case and Ombudsman visiting restriction case in section 4.\(^{133}\)

7. Conclusions

We write this article as the pandemic continues and the death toll rises. In Ireland and Denmark, the elderly, in particular those in nursing homes, have been disproportionately affected. While it is too early to draw firm conclusions, we have sought to highlight how COVID exposes known governance failures.

Firstly, in Ireland, elders living at home and in care settings were subjected to a restrictive approach. The policy of cocooning, as well as a general order to stay at home, is likely to have


resulted in loneliness and isolation. In the case of those living in adequate conditions, it may however have saved lives. But for many nursing home residents in conditions lacking dignity, they were dangerously exposed.

Secondly, the transparency of regulations must be improved. Recommendations must be unambiguously worded as such to avoid misunderstandings. Guidance regarding flexible rules must be clear to avoid the same rules being applied differently in comparable situations. Consultation with the public is thereby needed. For example, the prohibition on visiting cemeteries is difficult to justify. This anguish of not being able to perform the ritual of tending to a family member’s grave does not seem proportionate in light of the public health aim.

Thirdly, although nursing homes sought to find solutions to the visiting restrictions, such as outdoor visits and remote contact, these approaches are dependent on staffing resources and other underlying structures. The undignified conditions in many nursing homes are not new but were compounded by the pandemic. A long list of recommendations predated the pandemic, such as adequate staffing and improved living conditions. Will they now be addressed?

More research has to be conducted in order to secure the right to health care and the right to private life during the pandemic. This taps into the discussions on the distribution of resources in the society as a whole, and cannot be concluded definitely.\textsuperscript{134} The Danish SUF report’s suggestions on the future emergency plans does not include a human right perspective. We recommend that human rights be integrated in future emergency plans and this paper outlines some of the potential human rights risks at stake which can serve as a relevant background.

\textsuperscript{134} See discussion on the protection of elders in section 4 and the introduction of the Danish bill which mentions that the pandemic will put pressure on public institutions, for instance the health and social sector, and the existing law was insufficient to ensure authorities’ response and the effective use of resources.
Part III The underlying care work structures

As detailed above, governments have imposed strict, sometimes draconian restrictions on elders’ rights. However, these restrictions must be analysed in light of structures that are outside individual control. Evidence suggests that despite strict restrictions, COVID can enter care settings unintentionally through care workers, who are themselves vulnerable to transmission. Care workers are particularly vulnerable to spreading COVID due to the close physical contact that is inherent in their work. Part III discusses the challenges facing care workers from a feminist jurisprudential perspective, including the difficulty of receiving compensation for COVID-related mental illness. These underlying problems pre-existed COVID and the failure of states to address them has rendered workers and persons under their care vulnerable. It calls into question the proportionality of the measures described above.

COVID-19 has gendered aspects. Sex/gender differences are claimed to impact the incidence, mortality and side effects of COVID-19. Furthermore, the European Commission has called for a gender specific analysis of the consequences of COVID-19. Both paid and unpaid care work is dominated by women and as referred to above in part II, the exhaustion of the care workers was seen as a problem by Copenhagen Municipality’s Health and Care Administration (SUF) during the pandemic. The altering of tasks and the reorganization of crisis management was claimed to be a factor that contributed in tackling the pandemic and limit transmission.

In 2018, one of the main problems in the labour market was said to be the mental health issues related to for instance stress. These pre-existing problems risk being exacerbated during the

135 Part III is the work of Ida Gundersby Rognlien with structural and editorial inputs from KOC.
pandemic, in addition to more pandemic specific challenges. Mental health issues at the labour market should be analysed in a gender perspective.

Part III argues that pre-existing discriminatory structural and institutional problems, namely the subordination of care work as a gendered societal problem, are exacerbated by the COVID-19 pandemic. Using the Danish Labour Market Insurance (arbeidsskadesikring AES, the Workers Compensation Act (arbejdsskadesikringsloven ASL), as an example, the paper will discuss structural and institutional risks in the care work sector, intersecting with COVID-19 related challenges.

The paper explores the underlying risks of reproducing inequality in the legal structures of care work, including reports of increased stress, risk of front line workers being infected with COVID-19 and lack of personnel and protective equipment. Focus on prevention in the vulnerable care work sector one of the most important approaches, however the potential individual financial consequences when injured in the time of the pandemic, both illustrates the pre-existing socio-economic inequalities at stake and may have practical importance for the care workers if infected. Further, COVID-19 “derivatives” such as mental illness/injuries and other intersecting problems are at risk of not being recognised in the law, and inequality risks not being redirected by the authorities (relevant institutions). Problems relate to, for instance, gender stereotyping, interpretation of individual vulnerability, causation and socio-economic inequality.

The paper is a work in progress, but due to the urge for research in the field of law during the pandemic we would like to present initial thoughts and relevant questions to be further researched.

1. Underlying gendered problems and discriminatory mechanisms in the care work sector

There is a question if and how societal conflicts\textsuperscript{140} and discriminatory mechanisms risk being recoded into law\textsuperscript{141} Palmer Olsen/Toddington claim:

\textsuperscript{140} Even though gender equality is a recognised goal both nationally and internationally (EU, ECHR, UN Human Rights) there might be conflicts and disagreements within and between the different legal discourses, see more Rognlien, I. G. (2020) \textit{Fattigdom – Diskriminering – Relasjoner. Grunnleggende forsørgelsesrettslige problemer} - PhD-avhandling, Det Juridiske Fakultet, Københavns Universitet with further references.

valid legal rules are not only members of a formally structured legal system, but are also mediated and mediating products of the relationship between law and society. Doctrinal analysis must, therefore, address the transformative dynamics of law, that is, law’s active and always creative ability to re-code normative social conflict into legal conflict.”\(^{142}\)

COVID-19 illustrates, what Martha Fineman sees as, the fundamental, universal existential condition that we are all vulnerable. Drawing upon vulnerability theories, one normative question is how institutions should facilitate and produce assets for persons, with embodied and embedded differences, in order to create resilience against vulnerabilities.\(^{143}\) This paper will discuss structural and institutional risks in the care work sector intersecting with COVID-19 related challenges in a gender perspective.

The care work sector was selected because of the explicit gender and COVID-19 relevance. More women than men do care work, and the care work sector is especially vulnerable to COVID-19 related problems because of the close human contact and the pressure in the front line of the societal combat of the pandemic. However, the questions raised may relate to other fields as well. The qualifications of care work into law is relevant in the fields of social law (for instance the legal effects of qualifying for public home care)\(^{144}\) and family law (for instance division of property when divorced).\(^{145}\)

This paper focuses on “care workers”, who for our purposes include frontline care workers dealing directly or indirectly with COVID-19 infected patients, for instance health care assistants, nurses and renovation personnel, and cleaners at hospitals, in home care, care institutions for elderly, assistants and teachers in kindergartens etc.\(^{146}\)


\(^{146}\) While nurses and doctors were (quite rightly) praised during the 2020 pandemic, long term care workers were neglected in the early stages, where the public focus was squarely on intensive care.
Drawing upon critical constructive feminist theory, this paper asks “the woman questions” as Bartlett frames it. The techniques employed are:

“[...] grounded in women's experiences of exclusion, include "asking the woman question," feminist practical reasoning, and consciousness-raising. Each of these methods is both critical and constructive, and helps to reveal features of a legal issue that more traditional methods tend to overlook or suppress.”

Further, the paper is inspired by positionality as relevant for theory of knowledge, which – for Bartlett:

“[...] retains a concept of nonarbitrary truth based upon experience, yet because it deems truth situated and provisional rather than external or final, it obligates feminists to use their methods to continue to extend and transform this truth.”

The theory provides a framework for asking fundamental questions relevant on all levels of law, and will therefore be fruitful to fulfil the goals of the Danish Labour Market Insurance (AES) and the legal values of equality underpinning it. Choosing this theory also means that questions and arguments posed in this paper must continue to be developed and transformed as law is seen as dynamic, and especially when dealt with in individual cases, which should be conducted from a pro persona approach, drawing on inspiration from the Human Rights discourses.

When for instance describing the pro persona approach, the minority in the ECtHR Garib-case argued:

“[...] the Convention must necessarily be read in a pro persona perspective, placing the individual at the heart of the reasoning. Monica Pinto defines this principle as “a hermeneutic criterion impregnating all human rights law, on the basis of which the most far-reaching norm, or its most extensive interpretation, must be taken into account when it comes to acknowledging protected rights”. Human rights treaties must be interpreted in the manner which best protects the rights and freedoms secured therein. Ultimately it is therefore a matter of selecting the interpretation of rights that is most favourable for the individual. The Court’s mission consists precisely in guaranteeing individual rights and not in whitewashing the decisions of national authorities, especially when those decisions entail a restriction of human rights. While the national authorities are in principle the best placed to assess the needs of society, and while the Court must respect its subsidiary role, it is nevertheless precluded from adopting a pro auctoritate reading of the Convention and the

148 Ibid.
149 Ibid.
Protocols thereto, but must, on the contrary, uphold the effectiveness and maximising of the rights secured to the individual.”

The paper suggests that when, for instance, assessing individual vulnerability as relevant for qualifications/legal effects of the Labour Market Insurance (AES), one must ask what is the most equality friendly interpretation of both the law and the facts in the case. Further, the paper “place[s] the individual at the heart of the reasoning” by analysing roles, structures, relations and underlying discriminatory mechanisms, which subject the individual to different kinds of positions. Stereotypical gendered care structures can be both factual/empirical and legal/normative structures (as they are seen in this paper as interacting). For instance, the stereotype that care work comes from the heart/good will instead of interacting. The paper takes the position that although care workers became subject to new challenges and risks during the 2020 COVID-19 pandemic, their gendered social and economic position precedes this “emergency”. The legal protection of care workers during the pandemic must therefore be viewed in relation to the underlying constructs, namely gender discrimination and the subordinated position of both paid and unpaid care work in society, both in the private and public sector.

More women than men work in the care sector, while the division of care and labour work between men and women in the “private sphere” remains gendered with women taking more responsibility for unpaid care work. Furthermore, the subjection to these roles usually intersect with subjection to the role as unpaid care worker in the private sphere, as a daughter, wife or other...

150 See for instance the minority’s reasoning in ECtHR Garib v. the Netherlands of 6 November 2017, p. 54-57 (para. 10-14) with further references.


female relative, which can lead to different kinds of socio-economic consequences. More women than men have the sole responsibility for their children, and are at risk of poverty traps. Further, the gendered wage gap remains a problem in the Nordics; men earn more than women do, meaning that in a family structure it often appears more financially prudent for women to exit the labour market to fulfil care obligations. These factors risk negative social, emotional (stress and pressure) and economic consequences, like isolation and absence from the labour market, resulting in low pension contributions and wage stagnation. Care work is generally low or unpaid. This can be compared to male dominated workplaces and seen in relation to “the male breadwinner” model that still exists, even though European states – supported and driven by the ECtHR and ECJ - have tried to change this traditional gender stereotypical arrangement of


160 Albæk, K. Casier, F. and Larsen, M. (2019) Er kvindefag stadig lavtlønsfag? Viden til Velfærd Det Nationale Forsknings- og Analysecenter for Velfærd (VIVE), https://www.vive.dk/media/pure/14441/3558078. Larsen, M., Verner, M. and Mikkelsen, C. H. (2020) 'Kønsskævt arbejdsmarked skaber lønforskelle mellem kvinder og mænd', Viden til Velfærd Det Nationale Forsknings- og Analysecenter for Velfærd (VIVE), https://www.vive.dk/da/nyheder/2020/kønsskævt-arbejdsmarked-skaber-lønforskelle-mellem-kvinder-og-mænd?utm_campaign=K%20v%C3%B8n%20m%C3%A6nd%20%7C%20Velfærd%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7C%20%7
relations. Furthermore, similar to some male dominated fields, like construction workers, care work is physically demanding, yet at the same time emotionally and relationally exigent, which may lead to other kinds of burdens, such as stress and mental illness. Since care work often is invisible and fluid/floating, compared to physical work, practical tasks or financial care, the qualifications of social phenomena into law risks not be captured properly, as addressed in section 4, 5 and 6. Third, the gendered structures surrounding care work also calls for other questions when compared with male dominated work places, such as for instance the mentioned unpaid care work in the private sphere.

These structures can have consequences for how financial compensation for work-related injury is measured, since previous connection to the labour market is relevant. For instance, if a woman works part-time because of home care obligations or has been absent from the labour market to care for others or due to stress, she may be entitled to lower compensation. Hence, the woman’s previous subordinated socio-economic position risks being reproduced by legal structures. In the context of the central issue examined in this paper, it means that when assessing the measurements of the compensation, the woman’s paid and unpaid care work are relevant, and may be underqualified compared to what it should be considered the value of the work, see however the discussion on this in section 7 where it is argued this will have to be dealt with in future works.

It is, furthermore, important to note that the scarcity of resources and safety measures in a typical female dominated workplace were already an issue prior to COVID-19. This relates to both lack of equipment, personnel and how the institutions are designed and organised (cost/savings, crowdedness) and is discussed in the section 3. The structural issues allowed to take root in a female dominant environment have potentially life-threatening implications for both the carer and the person being cared for. As outlined in part I, during the pandemic, this previously hidden sphere created spill over effects for the public (spikes in cases in care homes resulted in general movement restrictions, for example).

It is submitted that the feminist perspective used in this paper will be in alignment with the considerations and values behind Danish law, namely the AES and tort systems, and the

vulnerability/frailty principle in the tort law (take the injured party as they are)\textsuperscript{162} see section 6. This is because the right to equality underpins these systems. The concept of equality is often understood as “the wider” principle of equal treatment and redress under the law regardless of different levels of tolerance to exterior sources of harm.\textsuperscript{163} The question is however what more specific equality principle is being used (on all levels of law) and how it should be used and guide the interpretation of the qualifications and remedies of compensation.

2. \textbf{More women than men report on COVID-19 related injuries to the Labour Market Insurance.}\nCOVID-19 related injuries could include infection with COVID-19 and/or other “derivatives” like mental illness because of stress and pressure at the workplace during the pandemic. More women than men report on COVID-19 related injuries at work to the AES, making it a gendered inquiry. Statistics from the Danish Body that administrates the Labour Market Insurance (Arbejdsmarkedets Erhvervssikring AES) demonstrates that as of 30 November 2020, more women (1,482) than men (444) have claimed AES because of COVID-19 related injuries. All cases related to mental health (62) have been denied relief (this is further analysed in section 5). All of the cases where the worker was diagnosed with COVID-19 infection as a final diagnosis (515), were approved. Most claims came from work places in the social- and health care sector (1,213), where work places such as hospitals dominate (633), followed by care homes (259), other/unspecified (115) and home assistance (70).\textsuperscript{164} In order to qualify for AES, the relevant injury has to be work-related in accordance with The Worker’s Compensation Act (Arbejdsskadesikringsloven). Understandings of personhood, ideological, epistemological/ontological positions, will influence both the assessment of the law and the facts as well as, compensation and remedies. For instance, it was claimed in 2016 that the administrative practice was based on the assumption that a work-related injury only was recognised if the relevant incident harmed “a healthy body.”\textsuperscript{165} The questions of what is perceived as a

\textsuperscript{162} Ehlers, A. B. (2017) \textit{Kausalitet i personskaderetten}, Karnov Group, chapter 5 with further references.


\textsuperscript{165} Danish attorneys in tort law/liability law, Søren Kjær Jensen, Kira Kolby Christensen og Laura Tholstrup argued in an article from 2016 that the administrative practice was based on the assumption that a work-related injury only were
healthy, normal body have gendered implications. Evidence from the US shows that women are often misdiagnosed, or their symptoms downplayed and measured against a male paradigm of “normality”.\footnote{Hamberg K. (2008) \textit{Gender Bias in Medicine}, Women’s Health, May 2008, p. 237-243. doi:10.2217/17455057.4.3.237.} This bias is often elevated for women of colour and their diagnostic odysseys are well documented.\footnote{Ehlers, A. B. (2017) \textit{Kausalitet i personskaderetten}, Karnov Group, p. 186.}

The \textit{conditio sine qua non} (but-for causation) principle requires that the alleged cause triggered and thereby was a necessary condition for the effect, i.e. that the effect would not have occurred without it. In tort/liability law one distinguishes between the questions of whether an injury is an effect of $x$ and whether the injury should be compensated by the agent responsible for $x$. In legal discourses, one has discussed whether but-for-causation can be accepted when assessing the latter question, but when assessing the first question one should use the so called NESS-test (\textit{Necessary Element of a Sufficient Set}), which allows for causation to be established even if the but-for-condition is not met.\footnote{Andreas Bloch Ehlers argues for instance that common sense and normative evaluations affect the assessment of requirements of causality, see Ehlers, A. B. (2017) \textit{Kausalitet i personskaderetten}, Karnov Group, p. 106-109.}

Intersecting and competing causes of injuries have to be tackled in law, and entails self-reflective, critical assessment of what is seen as fulfilling the requirements of causation.\footnote{Die trichsom, S. (2018) ‘Vi vet for lite om kvinners helse’, \textit{Kilden Kjønsforskning}, 24 May 2018, \url{http://kjonnsforskning.no/nb/2018/05/vi-vet-for-lite-om-kinners-helse}.} The dominant understanding in Danish law is that vulnerability, which leads to an injury, would not qualify for compensation. For instance, if the care worker had a PTSD diagnosis before the COVID-19 outbreak at work, the PTSD diagnosis is not to be compensated by the Labour Work Insurance. Vulnerabilities that \textit{could} have resulted in the injury, will lead to a reduction in the compensation. For instance, if the PTSD diagnosis intersects with an accident at work, the loss related to the PTSD diagnosis is to be reduced in the measuring of the loss because of the work-related accident.

\footnote{recogised if the relevant incident was able to harm a healthy body: Jensen, S. K., Christensen, K. K. and Tholstrup, L. (2016) Juristen, No. 5 of 2016, p. 187.}

Potential vulnerability intersecting with damage, will however, lead to compensation due to the vulnerability principle.\textsuperscript{170} Causality and adequacy is built upon epistemological and ontological understandings that are not necessarily being discussed transparently in law, and tend to be built upon positivism and logic-oriented approaches in law that interacts/is being influenced by scientific discourses.\textsuperscript{171} Hence, while not being the main inquiry in the paper, underlying questions are to what extent and how one can construe meaningful understandings of the facts/norms in a case (hereby causality). Drawing upon positionality and critical constructive feminist theory, this paper argues that whatever theoretical approach (for example, the but for approach or the NESS-test) one is arguing for in these cases, there is a risk that the gender perspective is not being transparently and sufficiently integrated/interpreted on all levels and understandings of law and the facts.

This paper argues that intersecting causes of an injury must include a sex/gender sensitive interpretation to fulfil the requirements of the vulnerability principle. The crux of the matter is how more precisely vulnerability should be interpreted in a sex/gender sensitive approach.\textsuperscript{172} This raises questions on the different understandings of vulnerability that exist in the legal field.\textsuperscript{173} These overlapping, and sometimes conflicting, understandings of vulnerability in law, risk affecting both the requirements for compensation for work-related injuries, and questions related to the measuring of the financial remedies.\textsuperscript{174} The specifics are dealt with in sections 5, 6 and 7.


\textsuperscript{172} Also other parameters could be relevant like ethnicity, disability, age and socio-economic background. However, gender is the main focus in this paper. See more about intersectionality in law: Rognlien, I. G. (2020) \textit{Fattigdom – Diskriminering – Relasjoner. Grunnleggende forsørgelsesrettsslike problemer} - PhD-avhandling, Det Juridiske Fakultet, Københavns Universitet with further references.


Case law is relevant to understand how the law should be interpreted in similar cases. While not being a review of all the relevant case law in the field, examples from the recent Danish case law are used below to illustrate risks in the legal interpretation and structures in the context of AES and general principles in compensation/tort law. The cases selected represent however, also what is considered as the law at this point in the legal doctrinal discourses. Since cases will differ due to the discretionary character of the qualifications for AES, this paper argues that it is important to highlight and discuss the legal principles guiding the interpretation in individual cases in order to understand the law and to discuss how future COVID-19 related cases should be dealt with in practice. Drawing on the background outlined in sections 1-3, in addition to the examples from case law, the paper seek to address relevant (but not exhaustively) gender questions in this field.

3. COVID-19 related mental and physical injuries
While not being exhaustive, this section describes risks of COVID-19 related mental and physical injuries in a care worker perspective. The Patient Safety Authority report that busyness and changing work conditions contribute to, for instance, medication mistakes. It has been recognised that the COVID-19 pandemic in general has


176 The analysis relies on a COVID-19 report from the Patient Safety Authority (Styrelsen for Patientsikkerhed) based on interviews with health care workers on their experiences during the pandemic. It is not evidence-based research, and only based on the descriptions made by the care workers (given in that specific context) and reports of so-called “adverse events” to the Patient Safety Board. Further the paper draw on the Health and Care Administration (SUF) of the Municipality of Copenhagen’s report in October 2020, evaluating SUF’s COVID-19 preparedness in the beginning of the pandemic and during summer 2020. These reports will in this paper– together with other gender-based research, the theoretical framework and Danish case law – serve as a starting point in order to address relevant legal questions and highlight risks in legal interpretation and structures. More in depth, quantitative and qualitative interdisciplinary research must be conducted in the future, in order to understand the gendered and other societal problems at stake in the care work sector in the light of COVID-19. Secondly, more in-depth analysis has to be made in a non-discrimination perspective to make legal conclusions in the field of AES/tort law. The lack of this research may in itself be highlighted as a gendered societal problem. Thanks to WELMA’s project student Sara Prip who made me aware of: EU-Kommissionens svar på behovet for en kønsspecifik konsekvensanalyse efter corona: Europa-Kommissionen og Ligestillingsudvalget (2020) – Alm. del, bilag nr. 118, 11 September 2020, Folketinget, https://www.ft.dk/samling/20191/almdel/liu/bilag/118/index.htm.
several kinds of effects on mental health.\textsuperscript{177} For the care workers specifically, the report states that they were instructed to do new, different kinds of tasks, outside of their primary field, in line with what were considered the relevant needs during the pandemic. The lack of – and absence of precautions made to avoid situations without enough – personal protective equipment (PPE), have been reported to consume a lot of thoughts and generate worries among care workers. The rotations, changes of the roles and the uncertainty was reported to be difficult. Societal stigma has also been reported because of care workers’ being viewed as likely transmitters of the disease.\textsuperscript{178} Further, workers highlighted that the psychosocial environment must be improved in a long-term perspective, not only in times of a pandemic. It was also reported that even at departments where they are used to high pressure and intensity, there was experiences of fear and pressure. Additionally, it was reported that PPE, like visors to protect against transmission, could give physical pressure damage and other annoyances.\textsuperscript{179} Rapid communication, team spirit, friendly colleagues and the feeling of community, visible leaders and the care workers’ influence on their own situation (for instance, focus on prevention, certainty around when being on stand by for emergency preparedness), were however, reported as some of the important factors contributing to success.


Key findings from a report for LTCCOVID Resources by Tine Rostgaard to support community and institutional Long-Term Care responses to COVID-19, from May 2020, claim that:

- “COVID-19 has been contained in Denmark, with low mortality rates and relatively few persons hospitalised. 563 persons, or the equivalent of 97 persons per 1 million inhabitants have died from the disease (May 25th)
- The pandemic has caused concern for frail older people and in particular nursing home residents, yet there has been little debate about how home care users or staff are affected.

Factors that may have contributed to the relative success of Denmark in preventing and containing the spread of COVID-19 in nursing homes include:

- A quick lock-down of the country.
- A de-centralised and integrative approach to LTC.
- Relatively few and large municipalities (98 in total) which ensures a more effective and coordinated approach.
- Political attentiveness to and broad public support for LTC.
- Due to de-institutionalisation, care for frail older people is more often provided in the home.
- Care is provided by formally employed and well-trained staff.
- The majority of nursing homes are public and modern in providing an individual abode.

Factors that may have exacerbated the situation:

- The testing strategy has changed a number of times and did not initially consider the need to test nursing home residents and staff.
- Initially, Personal Protective Equipment (PPE) was prioritised for the health care sector, so municipal care providers had to find alternative ways to secure protection.
- The guidelines regarding the use of PPE in the nursing home sector have been inconsistent.”

Similar and other structural problems in the care work sector during the pandemic are reported in many European countries.

As referred to in part II, the report of the Health and Care Administration (SUF), Municipality of Copenhagen (October 2020) highlighted several problems that should be resolved: lack of

preparedness plans for pandemics, implementation of guidelines, individualisation of responsibility, doubt and insecurity among citizens, and exhaustion of care workers.\footnote{Københavns Kommune, Sundheds- og Omsorgsforvaltningen, Afdelingen for Evaluering (2020) \textit{Evaluering af SUF's COVID-19 beredskab}, p. 8-10, 46-47, October 2020, \url{https://www.kk.dk/sites/default/files/edoc/Attachments/26686242-38379394-2.pdf}.} Other problems to highlight based on reflections while working with this topic is that COVID-19 intersects with the pre-existing physical risks in the care work sector. The workers are subjected to challenging physical work, for instance lifting of patients.\footnote{Arbejdsmiljønævnet - The Council of Appeal on Health and Safety at Work had by July/August 2020 two cases on risks of violence (not related to COVID-19): \url{https://ast.dk/naevn/arbejdsmiljoklagenaevnet/om-arbejdsmiljoklagenaevnet-engelsk-tekt}. Cases: KEN No. 9028 of 23 January 2020, Social- og Indenrigsministeriet and KEN No. 9029 of 23 January 2020, Social- og Indenrigsministeriet. The majority and the minority vota shows different opinions on the intervention towards the employer which is interesting.} During the pandemic, the workplace was obliged to secure both the normal physical tasks and security, and at the same time ensure protection against COVID-19.\footnote{Arbejdstilsynet, \textit{Manuel håndtering af personer}, \url{https://at.dk/arbejdsmiljoeproblemer/ergonomi/manuel-haandtering-af-personer/}.} The risk of violence when doing care work is a gendered societal problem, since more women than men are care workers.\footnote{The Work Environment Act 2019, Denmark (Bekendtgørelse af lov om arbejdsmiljø, No. 674 of 25 May 2020).} The level of stress and pressure may be exacerbated in connection with the risk of violence, and at the same time the increased risk of COVID-19 infection when experiencing violence.\footnote{Rockwool Fonden – Forskning (2020) \textit{Hver tredje kvinde i sundhedssektoren er udsat for vold eller trusler}, January 2020, \url{https://www.rockwoolfonden.dk/app/uploads/2019/12/Study-paper-147-Prevalence-and-Consequences-of-Violence.pdf}. In English: The Rockwool Foundation – Research (2020) \textit{Prevalence and Consequences of Violence on the Job hits Females in Healthcare Provision Hard}, January 2020, \url{https://www.rockwoolfonden.dk/app/uploads/2019/12/Study-paper-147-Prevalence-and-Consequences-of-Violence.pdf}.} Lack of personnel in the care work sector may be challenging both physically and...
mentally; manually lifting, cleaning, risk of violence and COVID-19 infections and stress related to bearing the responsibilities alone.

The Danish Working Environment Authority (Arbejdstilsynet) found in October 2020 that a care home breached the Health Authority’s guidelines and The Work Environment Act (Arbejdsmiljøloven) by not planning and having efficient measures, such as Personal protective equipment (PPE) and individual oriented guidance during the pandemic to protect the personnel and the persons being cared for (the care home case). A care worker died of COVID-19 and the Danish Working Environment Authority decided that the care home breached The Work Environment Act.188

The structural background outlined in this section, must be brought to light when the individual’s vulnerability are to be assessed. Since we all are vulnerable – and this existential condition is made explicit during COVID-19 – the pandemic can be seen as an invitation to ask how institutions should be responsive to our universal vulnerability and which assets the individual will need to create resilience towards vulnerability.189

4. Financial protection of the individual’s vulnerability
When in need of protection and provision because of vulnerability (an incident like an accident at the workplace, or old age), the worker may be protected by sources from the private sector (family, insurance, labour market) and/or the public sector (social welfare). The sectors are embedded in different, but also overlapping, legal models and structures. When compared, women in general still tend to depend on the public or the husband for financial support, and men tend to be financially self-sufficient (labour market or insurance). Therefore, it is of interest to analyse how these different systems of sources for support are structured.190 In this paper, the focus is on labour market insurance in light of the paper’s methodological framework: raising “the woman question”.


Historically, as focus on risks gradually were attached to different kinds of injuries and damages that workers systematically experienced in the labour market, various forms of insurance-based systems were established to protect the workers. Gradually, alongside the development of the welfare state as we know it today (with different kinds of social security benefits, health care, education), the state’s responsibility was made an important fulcrum, and the state intervened and monitored the parties at the labour market to protect workers, as with the Labour Market Insurance (AES).\(^{191}\)

The Worker’s Compensation Act (Arbejdsskadesikringsloven) regulates the Labour Market Insurance (AES - Arbejdsmarkedets Ervervssikring).\(^{192}\) AES is a “self-governing” institution, managed by parties from the labour market, and administrated by ATP.\(^{193}\) Every Danish employer has to pay a fee to the AES (which it does automatically when paying ATP as part of the salary), and every employee is automatically covered when employed by a Danish based employer.\(^{194}\) AES is made up of representatives of Danish Unions and capacities with interdisciplinary backgrounds, and it is considered a public authority according to the Danish Administrative Act. Its decisions are regulated by the Administration Act (Forvaltningsloven), which means the ordinary principles in the Administrative Law are applicable (e.g. the rule imposing an obligation to gather and include all relevant information in a particular case). When a report on work-related injury is rejected, the worker can complain to the National Social Appeals Board (Ankestyrelsen), a public administrative authority.


The question of which more precise aims the AES system is supposed to achieve must be explored. The Worker’s Compensation Act (ASL) is designed as social insurance, and therefore not intended to compensate the entire loss. While considered a tort system regulated by specialised legislation, the Labour Market Insurance is not designed as an instrument to correct the behaviour of the employer. It is based on objective liability for work-related injuries and not on negligence (culpa), which means it has more in common with the insurance systems. When it comes to the measurement of the compensation, only specified categories of loss are compensated, and with an upper limit on the loss. Hence, the questions of adequacy are predetermined, instead of a system based on an assessment of the entire loss (the insurance/compensation principle).

In contrast, the main underlying aim of Nordic tort law may be claimed to create safety, hereby to compensate loss. Questions to be answered include how the loss more precisely is construed and what more specific (ideological) elements the compensation is being based on in the individual care worker case. Other stated aims which the Nordic tort law pursue include prevention, justice and reasonable division of risks. The models of legitimation one uses to examine the elements of risks, requirements for causation, behaviour (what measures are necessary to prevent certain behaviour entails understandings of e.g. society, personhood and psychology) will have impacts on the final decision. Questions of justice entail reflections on what more precisely the principle of equality entails, herby questions of whom and what is being compared. The aim of insurance will be regulated by the insurance contract, and may be claimed in general to create even more security for employees.

196 However, the financial aspects of the system may have various effects on the employer's behaviour, but will not be dealt with here, see for instance Ibid. See also Andersen, M. L. B. (2018) Psykiske arbejdsskader: juridiske virkemidler i et forebyggelsesperspektiv med fokus på virksomhedens adfærd, p.189 on objective liability and thoughts on the employer’s behavior.
199 Ibid.
the parties involved than the general tort system, since it is mutually onerous. Employer insurance is mandatory with the aim of, inter alia, protecting the workers and regulating the risks of accidents at the workplace. Both the aims and principles of tort law and insurance law underpin the AES.

The worker’s injury is dealt with at the intersection between the general tort law, insurance and the AES. The worker can qualify for insurance (the employer’s mandatory insurance), from the Labour Market Insurance (AES – the Workers Compensation Act – arbejdsskadesikringsloven ASL) and/or as a general tort remedy (the Compensation Act erstatningsloven EAL), depending for instance on the employer’s fault. In addition, the worker may qualify for public social insurance and support, which complements the total picture of financial protection of the individual’s vulnerability.

The legal discourses in the social/welfare system may risk generating and reproducing inequality (and poverty traps), for instance, due to the national model, the relational legal regulation and the social investment paradigm - as dealt with in Rognlien’s PhD thesis on poverty, discrimination and relations in the Nordics.

The (also gendered) systemic structures surrounding the AES, will not be dealt with further in this paper, but serve as a relevant background for raising the paper’s questions.

Both work-related injuries (ervervssygdomme ASL § 7) and work-related accidents (arbejdsulykke ASL § 6) can be compensated by the Labour Market Insurance (AES).

Further, both mental

203 Section 5, 6, 7 and 8, Bekendtgørelse af lov om arbejdsskadesikring, No. 376 of 31 March 2020, Denmark.
illness and somatic illness are covered. The loss must be a consequence (meet the requirements of causality) of the relevant work-related incident/the specific risk. Whether an injury is considered an accident or work-related injuries depends on for how long the worker was under the risk of being injured. A distinction is made between how to assess reports on industrial injuries based on whether the relevant incident(s) or the specific higher risk happened for five days or more, where less than five days is categorized as an accident, and more than five days is seen as work-related injuries. COVID-19 is a recognised work-related injury.\textsuperscript{204}

To be qualified as a work-related injury, there has to be “a disease” and the requirements of causality between the work-related incident/the specific higher risk/ and the injury has to be met. Relevant factors in the assessment may in practice be e.g. the character of the work, explanations from the injured party and others about the working conditions, human contact, measures adopted at the workplace, the possibility for PPE and the employer’s statements about the impact.\textsuperscript{205} The legal effects and relevant remedies are economic compensation, but they are subject to a fixed limit and only specific categories of losses are regulated in the ASL chapter 4 and 5.

5. Mental illness and care work pressure
It is notable that, as referred in section 2, AES rejected all of the claims based on COVID-19 related mental illness. Legal interpretation of mental illness in connection with COVID-19 risks being non-transparent. It can be difficult to fit mental illness within the stringent frames of worker compensation. Which elements and relevant factors risk being left out from a gender perspective? How are the facts in the case construed more precisely (by those reporting the injuries, case handlers, lawyers, courts)? What is accepted as an incident and what is not? When in doubt, where is the importance placed for each element in “the chain of causality”? What more specific focus does the interpreter have when “connecting the dots” in “the chain of causality”? There is a risk of not identifying the gendered systemic underlying problems at a workplace.


COVID-19 does not know borders or legal distinctions; the same can be said about mental illness and care work. Which elements of a floating phenomenon, such as mental illness, can be related to the specific work situation and which relate to the individual’s private life/ general health? For instance, COVID-19 related pressure may lead to different kinds of mental illness, but some people may be diagnosed long after the ‘injury’. Further, the diagnosis risks being perceived as individual vulnerability, and not related to the workplace and therefore not meeting the requirements for causality. The more invisible a sickness is to others, the more difficult proving causation becomes. One should ask, what is considered normal and visible, and from which (or whose) perspective?

To illustrate these risks in legal interpretation, we refer to the PTSD-case (26 June 2020) where the Western High Court (Vestre Landsret), ordered AES to change its recent incorrectly decided practice over several years. Tort Law lawyers had long criticised how AES and the National Social Appeals Board were interpreting the Worker’s Compensation Act when it came to recognition of mental illness related to the workplace. First, the case illustrates how care workers suffering from COVID-19 related mental illness may risk bearing the burden for what is seen as uncertainty and/or disagreements between experts in the medical field. Second, the case illustrates how systemic mistakes risk not being properly compensated. The paper subsequently argues that this must be made visible and critically assessed on all levels of law in order to secure care workers’ right to financial protection if injured during COVID-19.

On 26 June 2020, the Western High Court ruled in favour of a veteran with PTSD from serving in the war in Bosnia in the 1990s. His claim had been rejected by AES and the National Social Appeals Board and was not considered a work-related injury. The reasoning was that the symptoms of the trauma were diagnosed too long after he had served in the military and therefore there was not sufficient connection in time between the incident and when the PTSD was diagnosed.206 The High Court in the PTSD-case held that AES and the National Social Appeals Board/Administrative Board’s interpretation was not in accordance with the Workers Compensation Act.207

The main question before the Court was whether the requirements of causality between the incident (work situation in Bosnia) and the PTSD diagnosis was met. The Court attached weight to the fact that the veteran had been subjected to incidents as a soldier, and that he hadn’t been subjected to burdens of the same character after his home coming. Further, the Court attached weight to The Legal Medical Council’s opinion that the PTSD symptoms probably had been present at an earlier stage, but that previous medical assessors hadn’t been aware of the connection between the incidents during the mission and the symptoms. Since the difference between the National Social Appeals Board’s and The Legal Medical Council assessment of the requirements of causality predominantly relates to questions of medical character, the latter was followed. The PTSD-case is an example of how discussions in one field of experts, here the medical field, can include disagreements on how to define (diagnose) phenomena (diseases and health situations). The WHO has changed their view on PTSD as of 1 January 2022 (PTSD ICD-11), to not focus on the six month visibility of PTSD symptoms. The Legal Medical Council and the affiliated doctor at the National Social Appeals Board seems to have a different understanding of how to diagnose PTSD. The workers who have reported on work-related PTSD injury have wrongly carried the burden of this dispute/perceived uncertainty. In the context of the topic of this paper the question is

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208 The Court concluded that it was not sufficiently documented that he had symptoms of PTSD the first six months after his return, and therefore he did not qualify for compensation according to section 7, 1,1 Bekendtgørelse af lov om arbejdsskadesikring, No. 376 of 31 March 2020, Denmark (PTSD as one of the listed work injuries), and also not because of new medical documentation in 2015, which could have qualified after section 7 nr 2, 1, Bekendtgørelse af lov om arbejdsskadesikring, No. 376 of 31 March 2020, Denmark.

209 In accordance with section 7,1.2. 2, Bekendtgørelse af lov om arbejdsskadesikring, No. 376 of 31 March 2020, Denmark.


211 Justitsministeriet – Civilstyrelsen, Om Retslægerådet (The Legal Medical Council submits medical and pharmaceutical expert evaluation on individuals to public authorities), https://civilstyrelsen.dk/sagsomraader/retslaegeraadet/om-retslaegeraadet.


213 See mentioning of the discussions on the diagnosis on PTSD and the reference to the ICD-10 and the ICD-11 criterions for diagnosis Ibid, p. 18, 15 and 21.

214 Ibid, p. 18, (the National Social Appeals Board’s doctor) and page 11 following (Retslægerådet 4 May 2018. See the veteran’s arguments on this page 21-22. See the National Social Appeals Board’s arguments on the disagreements between medical experts page 24.
how to avoid this or similar situations when the care workers report on COVID-19 related mental injuries.

On the question of whether the incidents in Bosnia in general could lead to PTSD, the Legal Medical Council answered in the affirmative. Further, it was found probable that the stated mental health problems described prior to the diagnosis could have been PTSD, but that it did not seem like the treating doctors at that time were sufficiently aware of the connection between the incidents in Bosnia and the symptoms. The Legal Medical Council also stated that the previous medical documents were not of high quality to assess the questions at stake in the case, but sufficient.

Further, the Legal Medical Council pinpoints that the incident in the chain of causality was necessary but not the only factor, as the veteran both had incidents in childhood and after serving in Bosnia. Therefore, the Legal Medical Council, despite hesitation due to the complexity and uncertainty in the case, concluded that there was more than 50 % chance that the PTSD was caused by the incidents in Bosnia.

The affiliated doctor at the National Social Appeals Board seems to be influenced by a legal interpretation of the special legislation on veterans, where he argues that the six-month visible symptoms approach to PTSD is required. In order to substantiate these arguments he refers to circulars and a statement by prime minister, Mette Frederiksen. In the legal doctrinal discourse, these sources are not seen as weighty. However, it is notable how medical assessments by the affiliated doctor at the National Social Appeals Board were influenced by an interpretation of what was perceived as the law, as one would prefer medical experts to deal with medical assessments and not legal interpretations.

When it comes to the recognition of PTSD as a more complex phenomena than what WHO ICD-10 standard and the six month requirements seemed to frame it, The Legal Medical Council’s assessment seems more in line with the WHO ICD-11 standards. What remains as a question is how

215 Ibid, p. 11.
lack of gendered research on diagnosis and mental health will be perceived in the future in similar cases. The WHO is not necessarily up-to-date when it comes to gender sensitive research. Further, the national context may require other gender sensitive research within the health field. The question is how these expert disagreements and lack of knowledge will be interpreted in law by the administrative bodies, the Courts and other relevant actors, and who is carrying the burden in the end. Gendered implications and interactions with COVID-19 must be brought to the attention both within the legal discourses and within other discourses, such as the medical field.

When the experts disagree, the question is where to place the burden of doubt about the character of the diagnosis when recoded into law. The medical requirements of causality are different and might be argued more restrictive than the legal assessment of the requirements for causality.\textsuperscript{221} One question is how to formulate the questions being asked to the experts in order to clarify uncertainty of the facts and further, to improve communication between expert (scientific) discourses and legal discourses, taking for instance different legal and scientific notions and concepts in to account.\textsuperscript{222} The PTSD-case subsequently illustrates risks in legal interpretation when expert disagreements/perceived uncertainty in the medical field are recoded into law by administrative bodies and the Courts. Further, how the law and the medical assessments risk interacting when the actors are assessing diagnosis and the legal qualifications for compensation. The High Court in the PTSD-case selected between the medical expert’s opinions, but the legal reasoning of the value of these opinions (whether being founded on formalistic, consensualistic and/or essentialist arguments) is not transparently discussed in the High Court’s judgment. The lack of transparency is a problem, and represents a risk in itself. Coming back to the underlying epistemological and ontological questions relevant in this field as addressed in section 1 and 2, both the legal and scientific discourses must be critically assessed in a gender sensitive approach when care wokers COVID-19 related injuries are to be assessed.

In September 2020, the work illness committee \textsuperscript{223} decided that the High Court’s judgment sat aside AES practice as unlawful, and that more research on PTSD’s development was required. Until this

\textsuperscript{221} In this direction: Andersen, M. L. B. (2018) Psykiske arbejdsskader: juridiske virkemidler i et forebyggelsesperspektiv med fokus på virksomhedens adfærd, p. 169-170, Jurist- og Økonomforbundet.


\textsuperscript{223} Erhvervssygdomsudvalget is the committee that makes recommendations to AES on how a specific case should be determined, and makes general recommendations on how to practice the understanding of “erhvervssygdomme”: 

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is in place, the committee recommended a concrete assessment of the new cases and the cases put on hold in this field (reports related to PTSD). Further, previous cases where compensation was refused may be reassessed provided that (a) the cause of rejection is related to the duration/lack of sufficient connection in time between the diagnosis and the incident (b) and, that a psychiatrist diagnoses the person with PTSD. In addition, it is the applicant’s responsibility to make such a claim, since the Committee stated they did not have an automated system for identifying the relevant old cases and did not judge manual identifying of 20,000 cases to be a suitable prioritisation of resources.

In non-discrimination law discourse, for instance in the field of CEDAW, it has been argued that the state and public bodies have a responsibility both for unintentional and intentional mistakes and discriminatory mechanisms, and must break discriminatory cycles. When AES incorrectly decides the law, one can ask, who should carry the burden for such mistakes? Erik Boe claims that this must be considered a general administrative principle of “due diligence”, not only in the individual cases, but also at the structural level, in the administrative system as such. At first sight, AES handling of the systemic breach raises concern from this perspective. When public authorities are held to have incorrectly determined cases requiring the victim to realise this and reapply can be seen as part of the discriminatory mechanisms. The PTSD case may have implications for care workers seeking compensation for COVID-related cases many years after the origin of the trauma. However, at present uncertainty remains regarding


the concrete implications of the case on AES practice. It illustrates that the AES has long misunderstood mental trauma and should rethink this approach.

6. The concept of vulnerability - intersectionality and risks of structural discrimination

As illustrated in section 3, lack of personnel, personal protective equipment and exhaustion of staff have been reported problems in the care work sector in different ways during the pandemic, resulting in reports on mistakes and stress/pressure and even death. Further, the need for a long-term focus on the work environment was reported, i.e. beyond the pandemic. The concept of vulnerability, as outlined above, is connected to mental illness in a specific way, since mental illness for a long time may be seen at “the other” in legal discourses.229 The stigmatisation and sometimes mistrust of mental illness has meant that work-related mental health problems have had a lower status in terms of protection in law.230 The need for regulations of the work environment in the labour market in a mental health perspective have been pointed by, for instance, Marlene Buch Andersen in her thesis on mental health in the Danish labour market and also concluded by the Expert group on the work environment that was established in March 2017.231 Improving the psychological work environment is now a priority for the government, in order to ensure a well-functioning labour market.

When it comes to mental illness caused by COVID-19 related stress, interlinked with pre-existing structural problems at the work place and/or interacts with individual and/or structural vulnerability, there are risks of reproducing gender inequality (see section 1 above).


As of 1 November 2020 a new executive order on the psychological environment came into force. It contains, for instance, regulation on workload and work time (§§13-15), inconsistent and conflicting requirements (§§ 16-18) So-called “high emotional requirements” in the human labour market (§§ 19-21) harassment, and violence (§§ 22-34). The regulation is framed as the employer’s responsibility and The Danish Working Environment Authority (Arbejdstilsynet) can sanction breaches of the law. However, the legislation is relevant in the interpretation of the qualifications for AES, for instance, the interpretation of the individual’s vulnerability. The individual and structural levels are interconnected and must be reflected in law and in the individual cases on AES. It has been argued by Buch Andersen in 2018 that when it comes to the principle of vulnerability/frailty in case law, it has been interpreted restrictively when it comes to mental health cases. This represents a risk of not recognising care worker’s mental health illness related to COVID-19, and should be examined in a gender perspective and this care worker context.

The government describes the aim of the legislation on the Labour Market Insurance 2020 as to achieve an up-to-date worker compensation system, which recognises work-related injuries. The overall purpose of the Government’s policies in this field is to pursue the goal of keeping as many as possible in the labour market. The 2020 regulation was adopted as the government considered that too many “injuries” had been left out of the scope of the concept of “accident” in case law and administrative practice due to restrictive interpretation and, according to the government and others,

232 Bekendtgørelse om psykisk arbejdsmiljø, No. 1406 of 26 September 2020, Denmark.
235 Ibid., p. 188
in conflict with the intentions of the AES. The proposal argues, inter alia, that the new legislation should emphasise a less restrictive interpretation of the qualification of “accident” compared to the interpretations of the Supreme Court in 2013 and 2016 and followed by the National Social Appeals Board.

In a gender perspective, it is interesting that it is being explicitly mentioned that a needle prick (typically in care work situations) automatically will qualify for AES even without consequences for the injured party’s health. In contrast, nothing is mentioned regarding the specific emotional and stress related issues in the care work field, for instance the risk of violence or pressure working with people facing death or serious sickness, mental health problems, which can be argued to represent a similar present risk, but risks being perceived as more vague, as pinpointed above. The revisions/precisions in the law were not supposed to change the burden of proof, which means the worker still has to prove the causality between the incident and the damage. This means that “vague injuries”, like mental illness, and complex intersecting problems/incidents (like individual and structural/institutional vulnerabilities) still may be difficult to prove for the care worker. The


241 When it comes to the gendered differences, see: Section 2 and 3.4, L 216 – Forslag til lov om arbejdsskadesikring, S.I. No. 216 of 2002/1.

kindergarten case below in section 6.1., illustrates some relevant risk factors in this aspect, especially in the lower courts and administrative bodies decisions. Without access to legal aid, the case would not have been resolved in the woman’s favour and a long time had passed before the correct conclusion was reached. Equal access to justice may be part of the discriminatory mechanisms.\textsuperscript{243}

In what seems to be a coincidence, when exemplifying the types of injuries that may be recognised in the law, the Ministry uses two male dominated work places: craftsman and warehouse worker.\textsuperscript{244} Even though, the Ministry emphasises the AES duty to provide information and enlighten the case, what should have been mentioned in this regard is the obligation to recognise (enlighten and acknowledge) the gender inequality risk factors in accordance with principles of mainstreaming. The Ministry uses the notions “natural biologically” and “logical explanation” when describing the connection between the incident and the damage.\textsuperscript{245} In gender research, it has been argued that what is perceived as natural biologically both may be a problem that relates to the biological/social divide and what is perceived as normal biologically (male or female “normal” as the comparator).\textsuperscript{246} Further, what is considered logical will build upon certain legal rationales and foundations, ideologies, understandings of personhood that usually lack transparent considerations in administrative decisions, case law and jurisprudence. This risks stereotyping, stigma and discrimination, and should be reflected transparently; also, where the interpreter assumes there is not a problem, in order to redirect discrimination.

In conclusion, it may be argued that the clarifications in the law 2020 (ASL) were necessary, but not sufficient to redirect the risk of discriminatory mechanisms and securing/redirect socio-economic consequences of care work. Further, there may be a question as to whether the new law


rather obscures some of the real/underlying problems; it seems something has been done about the problems of recognition gaps in the field, but the effects may be arguably superficial. While the new legislation may mean that care workers with COVID-related mental health injuries will gain more just access to compensation, a lack of awareness of the gendered elements remain.

6.1. Lack of awareness of the gendered injury
As discussed above, the Ministry was not satisfied with the restrictive development in the jurisprudence and administrative practice. Yet, the specific gendered issues at stake related to the Workers Compensation Act (ASL) were not addressed by the Ministry. The Ministry referred to the fact that the restrictive interpretation led to a lower number of qualifications and a greater workload for AES when assessing the qualifications, additionally, that less people than the Parliament intended received AES.

For instance, a case from the National Social Appeals Board from 2017 (the shoulder case) illustrates both the restrictive interpretation and gender issues in care work: a woman did not qualify for AES because the pains were transient and treatment was not required. The woman was a social assistant who helped a boy using a wheelchair with his shoes and got kicked in her shoulder. This resulted in shoulder- and back pains and headache, and a blockage in the shoulder for five months.

Both men and women/ male and female dominated work-related injuries could be affected by this restrictive interpretation of the law. However, the specific individually oriented gendered questions in this case were not transparently acknowledged as the case is presented in the National Social Appeals Board decision. What consequences did the blockade in the shoulder for five months have for the woman both in private and in the work situation? Did she have other care responsibilities? What were the routines at the workplace before and after the accident, i.e. was the risk of violence


known? Many of these questions are not seen as relevant in the context of the Workers’ Compensation Act (ASL). That is partly because they are seen as relevant for family law (the division of care work and the financial income between the man and the woman), work environment law, ordinary liability law (if the employer was to blame), social law (if she had irregular connection to the labour market) etc. In one way this sectoral division can be seen as part of the discriminatory problem, where the woman’s situation risks being interlocked in different legal rationales, and the cross-sectorial and intersectional problems are at risk of not being addressed properly.

COVID-19 illustrates the concept of injuries being interpreted to include also transient injuries, since COVID-19 does not always need treatment, but may have long term unknown consequences. The Ministry has suggested clarifying in the text of the Act that also passing injuries will qualify, regardless of whether they require treatment. Yet, none of the mentioned gendered issues were addressed, neither by the Parliament. Therefore, this paper may function as a reminder of gender mainstreaming – that is also to ask the individually oriented gendered questions - on all levels of law and policies.

6.2. Lack of personnel and resources
Lack of personnel and resources were claimed to be an issue in the care work sector during the pandemic, see section 3. A case from the Danish Supreme Court (the kindergarten case) illustrates the intersectional problems at stake when a care worker develops illness/injury due to work-related problems. While the lack of personnel and labour environmental law were not the directly

252 Judgement by the Danish Suprême Court (2012) U.2012.524 ’Erstatningspligt for psykisk skade’, Karnov. https://pro.karnovgroup.dk/document/7000506494/1. Andersen, M. L. B. (2018) Psykiske arbejdsskader: juridiske virkemidler i et forebyggelsesperspektiv med fokus på virksomhedens adfærd, p. 163, Jurist- og Økonomforbundet where she argues that the judgment represents an expansion of the scope of mental illness as a relevant ground for compensation and a rejection of the preexisting physical injury or danger previous the mental injury) argued in the jurisprudence (Ehlers calls this ”the deductive either-or argumentation”), however that the burden of proof still might be heavy see page 168 etc. When it is a medical assessment of causality between the incident and the injury it is easier to
relevant legal questions before the Court, they can be regarded as underlying problems (perhaps together with factors such as leader abilities, which in itself may also be both embodied and embedded vulnerabilities). It has been claimed in legal works that unless there is an “especially violent experience”, like the harassment in the kindergarten case, it can be difficult for the worker to lift the burden of proof for work-related mental illness because of the requirements of causality and adequacy. This paper would also like to highlight this risk as relevant for the gendered questions raised in this paper. However, the potential in the Supreme Court case, together with the legislation on the mental health environment at the labour market, give reason to optimism. The administrative bodies have to be aware of these risks in the interpretation, and choose the most equality friendly interpretation when in doubt.

The woman in the case was more sick than “normal” due to a back injury. In her absence, the supervisor did not find substitutes, and she felt guilty. There had been different kinds of problems in the institution for a while, and during a staff weekend organised to improve the working conditions in the kindergarten, she addressed the lack of substitutes in her absence. The superior had engaged a (private) supervisor to help with the issues. An escalation of conflicts arose during the weekend, later described as harassment towards the woman, and she ended up with the impression she had been fired. She developed mental illness/injury; PTSD, anxiety and depression.

The question before the Supreme Court was whether the woman’s mental illness could be considered as an injury to the person in the Compensation Act EAL § 1, and whether the Employer (the Municipality) was responsible for the injury. The Court concluded the mental illness was a personal injury in accordance with EAL § 1. Further, the Municipality as an employer had handled the staff weekend in an irresponsible manner, and was responsible for the injury according to the Compensation Act. In order to qualify for general compensation, the employer has to be at fault (culpa). The relevant elements in the assessment of fault (culpa) in this case was that the supervisors, in the Court’s opinion, must have understood that the woman was in a psychologically

establish the requirements of causality as a legal conclusion. The legal requirements of causality is however different (and might be argued less restrictive) than medical requirements of causality, see page 169.

tense situation and that the mental injury was a foreseeable cause of her irresponsible treatment at the staff weekend.\textsuperscript{254}

When it comes to the treatment at the staff weekend, the Court referred to the descriptions made by a psychologist and a specialist psychiatrist. In short, they describe the situation as harassment.\textsuperscript{255} The applicant explained that she had long-term emotional strain before the staff weekend. It caused her PTSD, anxiety and depression, and that she was not able to return to the labour market on normal terms.\textsuperscript{256}

\textbf{6.3. Structural approach to vulnerability}

While harassment is treatment between two (or more) specific people – with a (primary) inter-relational focus, structural issues, like lack of personnel, can be relevant.\textsuperscript{257} Structures and institutional organization influence how individuals treat each other inter-relationally. The concept of stigma as developed by e.g Solanke (influenced by among others Foucault-inspired work addressing the “holes” in Goffman’s individually oriented stigma theories)\textsuperscript{258} addresses the inter-relational and institutional elements in the stigma phenomena.

The Supreme Court in the Kindergarten case referred to in section 6.2. neither explicitly addresses, nor explicitly acknowledges the structural problems as a cause, factor or element, in the regime the woman was affected by - like lack of work force and how it influenced her and the workplace in general. Yet, even though it is not a decisive/necessary factor for the Supreme Court’s conclusions, one can argue that the Supreme Court indirectly recognised the structural issues at stake, such as lack of enough personnel, and that it served as a background to understanding the problems at stake.

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Drawing upon legal discourses within intersectionality theory and structural discrimination, further the concept developed by Erik Boe on “due diligence” as a general principle, we argue these factors are to be assessed and attributed weight when analysing mental health problems in the care work sector related to the COVID-19 pandemic. This could for instance be that depending on what future gender studies reveal; the systemic failures (not by fault/culpa) that produces embedded vulnerabilities in the care work sector serve as a starting point when a care worker reports on the development of a mental health disease because of the stress at the work place. In this direction, a shift of burden of proof, have been argued by for instance Filtenborg et al. related to COVID-19 infections. More gender aware research on these topics remains to be done and is not limited to a specific COVID-19 context.

As Fineman frames it:

«Social identities are manifested within institutions and do not manifestly reflect individual characteristics, such as race or sex. However, they do represent the allocation of power and privilege between occupants based on the social function of the institution and their social roles within it.»

When constructing the problems on the individual case level, the choice of perspective is influential/relevant. Some of the problems in the kindergarten case, seem to relate to a superior who the employees, not only the woman, found dominating and lacking appropriate leadership qualities. However, the problems at stake may also be construed in the light of research on stress in the care work sector as such, lack of capacity/resources etc: the institution (the kindergarten) did not hire a temporary displacement to carry the workload connected to the woman’s absence on

different forms of sick leave due to her back injuries. This contributed to stress at the workplace in general, which was blamed on/placed/directed against the woman individually. This is the structural (the care work sector as such) and the institutional (the specific kindergarten) problems in the case. The case illustrates how mental illness, seen as a question of compensation for work-related injuries, cannot be analysed properly without being addressed in its broader context. The stress in the society and in specific institutions related to COVID-19, will intersect with the structural issues discussed in the sections above.

7. Paid and unpaid care work
As elaborated on in section 1 and 2, women work part-time partly because of unpaid care work at home. It has different socio-economic consequences, which is a classical topic in the feminist jurisprudential discourses. This will be relevant when women are to be compensated because of COVID-19 related injuries, because previous income structures will be reproduced in the measurement of the compensation. The Supreme Court judgment in the part-time-case U.2020.356, illustrates the discriminatory issues at stake related to the qualification of part-time work and unpaid care work at home.

The woman was working as a nurse and was involved in a car accident. She was working as a part-time night shift nurse at the time, and the question before the Court was related to the measuring of the economic damage. Was she supposed to be considered as working part-time or fulltime when measuring her loss? She had been taking care of her oldest child, who was in need for extra support. The former annual income formed a base for measuring of the loss. The Supreme Court concluded that the main rule is that the claimant is considered as having a fulltime income, because she could have worked full time, even though she did not use this potential. The counterarguments

266 Section 5, 1, and section 2, Bekendtgørelse af lov om erstatningsansvar, No. 1070 of 24 August 2018, Denmark. Section 17, Bekendtgørelse af lov om arbejdsskadesikring, No. 376 of 31 March 2020, Denmark.
by the lower courts and the insurance company illustrates the risk in the practice in the National Social Appeals Board and the AES.267

However, this full-time principle does not apply when assessing the “incapacity loss percentage”.268 In a neo liberal economic perspective, this makes sense and may seem coherent because people who in fact have worked full time will receive more financial compensation than people on part-time. This is in alignment of the workfare principles underpinning the Danish welfare system and the focus on investing in people at the labour market in the social investment paradigm.269 Hence, it is a prerequisite for this paradigm that the policies make people participate at the labour market. It illustrates how the full-time principle at first glance may look like an equality measure, but in reality is a “good will” approach. The underlying structural issues at stake are arguably being reproduced in this system. Women have always had the main responsibility for unpaid care work, one relevant question in this regard is therefore, what kind of systems are in place to redirect this? This must be dealt with in future gender interdisciplinary research – also in the field of law.

8. Requirements of causation the injury and the damage
The questions of how so-called “particular/individual vulnerability” should come into play when assessing causation is a well-discussed field in the legal jurisprudence, see above.270 The classical question of requirements of causality between the injury and the damage is a legal question, and not for instance, a medical question of causality, nor a question only particularly fit for the administrative level (meaning therefore less intense judicial review).

267 Insurance company refers to U.2014.3729.
270 See for instance: Ehlers, A. B. (2017) Kausalitet i personskaderetten, Karnov Group, with further references. See his discussion on the distinction between adequacy and causality. Vulnerability may play a role on both qualifications for compensation and the legal effects.
Kjær Jensen et al. argued in 2016 that individual vulnerability only could be relevant for the assessments of the financial remedies.\(^{271}\) The burden of proof is closely connected to the question of attaching weight to the individual vulnerability (See, on the interpretation of vulnerability, section 6). When it comes to the burden of proof, Kjær Jensen et al. argued in 2016 that according to the Supreme Court case law, potential vulnerability, only gives reason to reduction in the compensation if the injury with overwhelming certainty and independent of the work-related injury would reduce the ability to work/the health situation – in accordance with the vulnerability/frailty principle.\(^{272}\)

In August 2020, the Supreme Court ruled in favour of a man (the moped case) who had been in a moped accident on his way to work.\(^{273}\) He had both back injuries and undiagnosed ADHD before the accident. The question before the Court was whether and how these vulnerabilities should/were to come into play in the assessment of causality. AES concluded the accident led to a 50 % loss of earning capacity. The Legal Medical Council concluded that his pre-existing lower back injuries were not exacerbated by the motor accident. The man also had ADHD before the accident, and had been working full time. According to the Supreme Court, this meant that neither ADHD nor lower back problems could give reason to the reduction of the estimation of his loss of work capacity. Further, the mental illness he had developed was because of the accident and the work-related training he had to undergo with pains. The Court concluded he had experienced 75 % loss of earning capacity. The High Court argued and ruled opposite to the Supreme Court, finding in favour of the insurance company. The Court mostly relied implicitly on the argument that AES had special competence/practical knowledge to evaluate the questions at stake, and this required a less intensive judicial review.\(^{274}\) The High Court argued that the decision before AES was sufficiently justified, 

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and that the applicant had not proved otherwise.\textsuperscript{275} The Supreme Court has clarified this classical legal question about judicial review of causality. However, the arguments by the insurance company and the High Court illustrate risks at stake in the field.\textsuperscript{276} It is a question how the Supreme Court judgement will be followed on the administrative level when it comes to applying the principle of vulnerability/frailty. COVID-19 infections or “derivatives” may intersect with so-called “individual vulnerability.” The risks in legal interpretation pointed out here will be of importance when inequality questions on behalf of care workers in a COVID-19 context are to be addressed.

9. Conclusions and perspectives
None of the cases at AES on COVID-19 related mental illness have been accepted as of November 2020, and it raises the question why. More women than men report work-related injury to AES. Most of the cases come from the care work sector, dominated by women. The topic is therefore gendered. This paper has outlined some of the (gendered) structural issues already at stake before COVID-19.

More in depth, interdisiplinary research must be conducted in the future, in order to understand the gendered and other societal problems at stake in the care work sector in light of COVID-19.

Secondly, more in-depth analysis has to be conducted in a non-discrimination perspective to make legal conclusions in the field of AES/tort law. The lack of this research may in itself be highlighted as a gendered societal problem.

What is perceived as an “individual vulnerability” is interpreted, as well as how causation between relevant elements is interpreted, will affect the care worker’s financial compensation if injured at work. As illustrated in the sections above, women’s so called “vulnerability” might be embodied and embedded in different ways, depending on the social structures at the workplace. The intersection between structural/institutional problems and individual vulnerability are at risk of being mixed, misinterpreted and assessed in a gender stereotypical way. Mental illness and stress related problems risk being seen as an individual weakness and not as a problem at the workplace as


such. The new legislation on the mental health at work is one step in the direction of signaling the workplace’s responsibility for institutional embedded vulnerability. However, when interpreting the individual’s situation, a gender sensitive approach must be conducted on all levels of law. There is a question as to whether the stress related issues have been properly documented by the employers of care workers. Other questions relate to whether the employers and managers were concerned about documenting all the mistakes that was made (which may shed light on the stressful situation). How will the individual in these vulnerable structures be considered? Even though the pandemic will be recognised as a specific stressful situation, there is a risk that care workers are being compared with each other; why did some cope with the stress and others did not? This illustrates that AES as an individualised institution (instead of for instance universal, no discretionary assessments of individual vulnerabilities) may be at risk of not (fully financially) recognising women who had to face the COVID-19 front line despite their pre-existing problems (be it structural or “individually” related).

The PTSD case illustrates the lack of proper systems to redress AES mistakes. As a minimum, systems should be established, which make it possible to contact the claimants who were wrongfully assessed, and rejected from AES. Further, there must be a question of efficient compensation for the mistakes done by AES, as suggested in section 5. However, further analysis on this remains to be done.

Gender sensitive research should be conducted on how care workers might develop long term socio-psychological effects from the COVID-19 pandemic. However, lessons from vulnerability research reminds us that the development of mental illness can differ greatly from person to person, and what is considered as a “normal” development of, for instance PTSD, or other diagnoses, is not only a medical question, but also a question to be critically evaluated in law.

All in all, it calls for more gendered research on these aspects of law in a COVID-19 perspective. Stressing self reflectice critical assessments of the interdisciplinary (gendered) aspects of law. As suggested in the introduction, the techniques employed can with Bartlett be:

“[...] grounded in women's experiences of exclusion, include "asking the woman question," feminist practical reasoning, and consciousness-raising. Each of these methods is both
critical and constructive, and helps to reveal features of a legal issue that more traditional methods tend to overlook or suppress.”

Care workers are at risk of stereotypes related to their “good heart” or perceived wish to make personal sacrifices for the greater good and due to their affection towards other people. These gendered stereotypes must be analysed and discussed as they are at risk of being recoded into law and creating socio-economic inequality between men and women. They must be seen in light of the financial safety net in place to mitigate vulnerability in general, such as in the private sphere (the division between the man and the woman) the tax and social security system, the private insurance and tort law system, and the labour system.

These underlying problems pre-existed COVID-19 and the COVID-19 pandemic has a way of accelerating/exacerbating already existing negative discriminatory mechanisms. The failure of states to address them has rendered workers and persons under their care vulnerable. It calls into question the proportionality of the measures described in part I & II.

The paper’s preliminary conclusions can be summarised as: the vulnerability of care workers at the workplace will affect the care of the elders. The Labour Market Insurance becomes a symbol of what care workers risk, and must be dealt with more in depth in future interdisciplinary gendered research. The state has positive obligations to protect the life and health for both elders and care workers.