



## Older Persons and the Right to Health in the Nordics during COVID-19

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Abstract (150 words): We reflect on the extent to which Nordic countries have safeguarded the right to health of older persons during the pandemic in 2020. All Nordic states have ratified the International Covenant on Economic, Social and Cultural Rights and thereby committed to recognising the right to health. We use the AAAQ framework developed by the Committee on Economic, Social and Cultural Rights to draw attention to aspects of the respective states' responses.

The COVID-19 pandemic has had significant impacts on the health of older persons, from the direct effects of the virus, such as illness and death, to indirect impacts, like isolation and loneliness. We find that Nordic states have at times failed to prioritise the full realisation of the core obligations of the right to health for older persons, namely, non-discrimination and provision of essential healthcare. Resource constraints cannot justify discrimination or failure to respect autonomy, integrity and human dignity.

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## 1. Introduction

The COVID-19 pandemic has had significant impacts on the health of older persons, from the direct effects of the virus, such as illness and death, to indirect impacts, like isolation and loneliness. The vast majority of COVID deaths worldwide occurred among older persons, with persons living in care homes often particularly affected. Meanwhile, restrictions on gatherings and visits to institutions, as well as fear of the virus, isolated older persons from friends and relatives. Routine treatments have been postponed and home care reduced. In care homes, there have been reports of failures to meet informed consent standards, difficulty in accessing treatments and unlawful enforcing of restrictions.

To combat the pandemic, states adopted and modified response strategies in a context of uncertain evidence and data concerning the transmissibility, diagnosis and treatment of the novel virus. This posed the combined challenge of designing appropriate legislation and policies for preventing and slowing the spread of COVID-19, as well as resources and capacity for timely diagnosis and treatment, while maintaining a functioning healthcare system. As each state has had to adjust the allocation of resources in accordance with the developing epidemiological situation within its territory, health care systems have engaged in priority setting to identify the most effective measures in light of available resources.

While deaths in Nordic countries remained on the lower end of the scale in 2020 as compared to other European countries, lives have been lost. At the end of 2020, Iceland has had the lowest loss of life, with 29 COVID-19 deaths in total (8.1 per 100,000), all but one in persons over 60 years of age.<sup>1</sup> In Norway, 436 deaths were attributed to COVID (8.1 per 100,000),<sup>2</sup> and 561 in Finland (10.1 per 100,000).<sup>3</sup> In Denmark, deaths have been higher: 1,298 persons died from COVID-19 in 2020 (22.3 per 100,000), 89 % of whom were over 70.<sup>4</sup> Sweden remains the sad, and much publicised outlier. At the end of 2020, 437,379 persons were infected and 8,727 persons had died (85.3 per 100,000). Between one third and 60% of COVID deaths in Nordic countries in 2020 occurred in care homes.<sup>5</sup>

Nordic states have ratified the International Covenant on Economic, Social and Cultural Rights (ICESCR) and thereby committed to recognising the right to health. The states have obligations to respect, protect and fulfil the right to health in line with available resources. Such resource constraints cannot justify indirect discrimination or failures to respect autonomy, integrity and human dignity. In this article, we reflect on the extent to which Nordic countries – as welfare states with advanced healthcare systems - have safeguarded the right to health of older persons during the pandemic, focusing on 2020. While we use the term “older persons”, we are focused on persons who depend on others for support or care. Given space constraints, we do not conduct an in-depth comparison or review of each of the five Nordic countries but instead, using the AAAQ framework developed by the Committee on Economic, Social and Cultural Rights (CESCR), we draw attention to selected aspects. This framework is introduced in the next section.

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<sup>1</sup> COVID-19 á Íslandi – tölfræði, 2021, ‘Uppsafnaður fjöldi andláta innanlands eftir aldurshópum’, 20 January. Retrieved 1 June 2021, [www.covid.is](http://www.covid.is).

<sup>2</sup> Worldometer, ‘Coronavirus cases (Norway)’. Retrieved 12 May 2021, [www.worldometers.info/coronavirus/country/norway](http://www.worldometers.info/coronavirus/country/norway).

<sup>3</sup> Worldometer, ‘Coronavirus cases (Finland)’. Retrieved 12 May 2021, [www.worldometers.info/coronavirus/country/finland](http://www.worldometers.info/coronavirus/country/finland).

<sup>4</sup> ‘For første gang under corona har Danmark reel overdødelighed’, *Berlingske*, 5 January 2021.

<sup>5</sup> A. Comas-Herrera, et al, *Mortality associated with COVID-19 in care homes: international evidence* (LTC COVID, 1 February 2021).

## 2. Framework: The Right to Health of Older Persons

Under Article 12 ICESCR, states are obligated to 'recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health', including older persons.<sup>6</sup> The right to health is also recognised in other UN Conventions, such as the Convention on the Elimination of Discrimination against Women,<sup>7</sup> the Convention on the Elimination of all forms of Racial Discrimination (CERD)<sup>8</sup> and the Convention on the Rights of Persons with Disabilities (CRPD).<sup>9</sup> Yet, there is general agreement that older persons are often subject to ageism, which can have implications for their access to healthcare services. For example, the World Health Organisation (WHO) has stated that 'ageism generates exclusion and disadvantage, leading to the denial of a range of rights, which affect health, such as access to nutritious food, water and health-care'.<sup>10</sup> This situation preceded the COVID-19 pandemic but, as discussed in section 3, the authorities' responses have exposed and heightened the vulnerabilities of older persons. In this section, we introduce states' obligations in the context of the COVID pandemic.<sup>11</sup>

Two state obligations under Article 12 ICESCR are particularly important in the context of COVID-19, namely, the duty to take steps necessary for 'the prevention, treatment and control of epidemic, endemic, occupational and other diseases' and 'the creation of conditions which would assure to all medical service and medical attention in the event of sickness'. Furthermore, the CRPD prohibits discrimination based on disability and obligates states to, *inter alia*:

(a) Provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons...

...

(d) Require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, *inter alia*, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care;

...

(f) Prevent discriminatory denial of health care or health services or food and fluids on the basis of disability. (Article 25)

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<sup>6</sup> See also, United Nations Principles for Older Persons, adopted by General Assembly resolution 46/91 of 16 December 1991, article 1.

<sup>7</sup> UN General Assembly, Convention on the Elimination of All Forms of Discrimination Against Women, 18 December 1979, United Nations, Treaty Series, vol. 1249, p. 13, Article 12.1.

<sup>8</sup> UN General Assembly, International Convention on the Elimination of All Forms of Racial Discrimination, 21 December 1965, United Nations, Treaty Series, vol. 660, p. 195, Article 5(iv).

<sup>9</sup> UN General Assembly, Convention on the Rights of Persons with Disabilities, 13 December 2006, A/RES/61/106, Annex I, Article 25.

<sup>10</sup> Eighteenth session of the UN Human Rights Council, Panel discussion on the Realization of the Right to Health of Older Persons, Statement by the World Health Organization (Geneva, 16 September 2011).

<sup>11</sup> See further, K. Ó Cathaoir, 'Human Rights and Health in Times of Pandemics: Necessity and Proportionality' in: M. Kjaerum, M.F. Davis and A. Lyons (eds.), *COVID-19 and Human Rights* (Routledge, 2021); K.M Kimmel, 'Right to Life and Right to Health in Priority Setting in the COVID-19 Prevention Strategies in Finland, Norway and Sweden', in: S. Kirchner, *Governing the Crisis. Law, Human Rights and COVID-19* (LIT Verlag, 2021).

CESCR's General Comment on the Right to Health introduces a non-binding but authoritative interpretation of states' obligations.<sup>12</sup> Similar to the CRPD, the General Comment makes it clear that the right to health includes not only access to healthcare but also a wide range of socioeconomic factors.<sup>13</sup> Several aspects can inform our understanding of states' obligations to protect the health of older persons during the COVID-19 pandemic.

Firstly, the AAAQ framework calls on states to ensure availability, accessibility, acceptability and quality (AAAQ) of healthcare and health determinants. This includes access to acceptable health facilities and services, and affordable healthcare that is respectful and of good quality.<sup>14</sup> Secondly, following Article 2.2 ICESCR, any discrimination on grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil, political, social or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health, is prohibited.<sup>15</sup>

However, the right is not absolute, and states have a 'margin of discretion' in choosing which measures are suitable.<sup>16</sup> The right to health can be limited, following Article 4 ICESCR, where 'in accordance with the law, including international human rights standards, compatible with the nature of the rights protected by the Covenant, in the interest of legitimate aims pursued, and strictly necessary for the promotion of the general welfare in a democratic society.'<sup>17</sup> Limitations should furthermore be proportional, i.e. the least restrictive alternative must be adopted, of limited duration and subject to review.<sup>18</sup> The ICESCR does not include derogation provisions.<sup>19</sup>

Even in times of resource constraint, the Committee highlights that the vulnerable must be protected 'by the adoption of relatively low cost targeted programmes'. States have an obligation to provide affordable alternatives 'to the maximum of available resources', and to eliminate discriminatory practices relating to the realisation of the right to health without delay.<sup>20</sup> This extends to evidence-based interventions to promote and protect public health, as well as the underlying determinants of health, during a crisis.<sup>21</sup> Therefore, in the context of a global pandemic, resources should be allocated based on available resources and the best available medical evidence on effective means to protect health.

Furthermore, in exercising their margin of appreciation, states should give priority to subsistence rights and essential services targeting those most in need in an equitable manner.<sup>22</sup> This, combined with the requirement of non-discrimination, forms the core obligations under

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<sup>12</sup> UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant), 11 August 2000, E/C.12/2000/4.

<sup>13</sup> See also, CESCR, General Comment No. 6: The Economic, Social and Cultural Rights of Older Persons, 8 December 1995, E/1996/22.

<sup>14</sup> General Comment No. 14, *supra* note 12, para. 12.

<sup>15</sup> *Ibid*, para 18.

<sup>16</sup> *Ibid*, para 53.

<sup>17</sup> *Ibid*, para 28.

<sup>18</sup> *Ibid*, para 29.

<sup>19</sup> Ssenyonjo argues that there should be no need for states to derogate from the ICESCR even during an emergency, M. Ssenyonjo, 'Reflections on state obligations with respect to economic, social and cultural rights in international human rights law', *The International Journal of Human Rights* 15(6) (2011), 990-991. However, Warwick claims that CESCR has made shift towards accepting emergency accommodations during economic crisis, B.T.C. Warwick, 'Socio-Economic Rights during Economic Crises: A Changes Approach to Non-Retrogression', *International and Comparative Law Quarterly*, 65(1) (2016), 253-259.

<sup>20</sup> General Comment No. 14, *supra* note 12, para 18.

<sup>21</sup> *Ibid*, paras 16 and 18.

<sup>22</sup> CESCR, General Comment No. 3: The Nature of States Parties' Obligations (Art. 2, Para. 1, of the Covenant), 14 December 1990, E/1991/23, para 12.

ICESCR. In General Comment No. 14, the Committee identifies these core obligations as non-derogable, and in General Comment No. 3 lists primary health care among them.<sup>23</sup> In requiring states to provide effective, low-cost measures to ensure subsistence for the most vulnerable groups, even under severe resource constraints, CESCR emphasises that during a state of emergency, there is an even greater need to ensure the realisation of the right to health of vulnerable groups and marginalised people.<sup>24</sup>

States have obligations to respect, protect and fulfil the right to health. Respect requires states to refrain from denying access to preventive, curative and palliative healthcare.<sup>25</sup> Protect mandates that states adopt legislation or other measures to ensure equal access to healthcare and other health-related services provided by third parties.<sup>26</sup> While General Comment No. 14 is not specific to older persons, the UN independent expert on older persons recommends specialised healthcare for this group:

gerontology and geriatrics... should become part of all medical professional training and pursue a biopsychosocial instead of a merely biomedical approach... Moreover, geriatric wards should be established in all hospitals to ensure the delivery of comprehensive, compassionate care that recognizes the special needs of older persons with a view to optimizing their quality of life and functional ability.<sup>27</sup>

Finally, the obligation to fulfil means that states should give sufficient recognition to the right to health in their political and legal systems, and ensure provision of healthcare and underlying determinants of health fairly and effectively within available resources. Failure to meet these obligations can result in violations of the right to health. Persons or groups whose rights are violated should have access to judicial or other types of remedies at national and international levels, as well as reparations.<sup>28</sup>

The right to health under international law lays out a broad framework of obligations that can be used to evaluate state compliance. However, the implementation thereof varies at national level, as introduced in the next section.

### 3. Nordic Responses: Older Persons and the Right to Health

All Nordic countries have made a legal commitment to older persons' right to health by ratifying the ICESCR, CEDAW, CERD and CRPD.<sup>29</sup> However, Nordic countries have dualist legal systems, and only Norway has incorporated ICESCR into domestic law, where it is given priority in a situation of conflict with domestic law (together with other central conventions).<sup>30</sup> While only Finland has ratified the Optional Protocol to the ICESCR, all Nordic countries have ratified the Optional Protocol to CEDAW, and Denmark, Sweden and Finland have also ratified the Optional Protocol to the CRPD. Before discussing the impact of the COVID-19 prevention measures, we provide a short outline of the legal framework for the right to health(care) in each Nordic country.

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<sup>23</sup> General Comment No. 14, *supra* note 12, para 47; General Comment No. 3, *ibid*, para 10.

<sup>24</sup> General Comment No. 3, *ibid*, para 12.

<sup>25</sup> General Comment No. 14, *supra* note 12, para 34.

<sup>26</sup> *Ibid*, para 36.

<sup>27</sup> Visit to Mozambique - Report of the Independent Expert on the enjoyment of all human rights by older persons, A/HRC/42/43/ADD. 2, para 104.

<sup>28</sup> General Comment No. 14, *supra* note 12, para 79.

<sup>29</sup> States also have relevant obligations following the European Social Charter, Biomedicine Convention and European Convention on Human Rights but these are not the focus of this article.

<sup>30</sup> Human Rights Act of May 21, 1999.

In their domestic laws, Nordic countries recognise patients' rights and human rights.<sup>31</sup> All countries commit to equal access to good quality healthcare and respect for human dignity and bodily integrity.<sup>32</sup> A right to healthcare in the Nordic countries is provided in accordance with the principle of need, which guarantees health services based on the patient's health status as assessed by a physician. For example, the individual generally does not enjoy entitlements to specific treatments if the physician concludes that a different treatment will be adequate in light of the patient's need. Patients do not always have a formal right to appeal refusal of care, although they are entitled to file complaints regarding healthcare or request a second opinion.

In Nordic countries, regional or municipal authorities are mostly responsible for arranging health and social care for residents.<sup>33</sup> Access to healthcare for older persons is predominately governed by healthcare legislation,<sup>34</sup> while older persons care services, such as nursing home care, is provided for in social care legislation.<sup>35</sup> Furthermore, each state has enacted special legislation concerning the prevention of contagious diseases,<sup>36</sup> which were employed as the main regulatory measure for COVID-19 responses. Due to the unprecedented severity of the pandemic, some Nordic countries have also amended healthcare or social legislation.<sup>37</sup>

In summary, although there are differences that go beyond the scope of this article, Nordic healthcare systems are underpinned by similar principles, namely, equal access to necessary treatment, the right to bodily integrity and non-discrimination.<sup>38</sup> Furthermore, Nordic healthcare is decentralised with municipalities and regions having responsibility for providing health and care services to older persons. In the coming sections, we assess the extent to which

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<sup>31</sup> Patient rights are provided for in special legislation in each country: Norwegian Patients' Rights Act (*Lov om pasient- og brukerrettigheter* 2 July 1999 no. 63); Swedish Health Care Act (*hälso- och sjukvårdslag* (HSL) 2017: 30), Patient Act (*Patientlag* (PL) 2014: 821) and Patient Safety Act (*Patientsäkerhetslag* (PSL) 2010: 659); Icelandic Patients' Rights Act No. 74/1997; Danish *Sundhedsloven* (Consolidated Act no. 903, 26/08/2019); Finnish Act on the Status and Rights of Patient (*laki potilaan asemasta ja oikeuksista* (Patient Act) 785/1992).

<sup>32</sup> Swedish HSL Chapter 3 paragraph 1, section 2; Icelandic Patient Rights Act, article 1 (1); Finnish Patient Act section 2; The Norwegian Patients' Rights Act § 1-1; Danish Health Act, § 2 (full citations *ibid*).

<sup>33</sup> In Norway, the state is responsible for specialised healthcare according to the Act on Specialized Healthcare of 21 May 1999.

<sup>34</sup> Norway, Denmark and Sweden, *supra* note 32. Finland: Health Care Act (1326/2010), Iceland: Act no. 40/2007 on Health Services, Act no. 112/2008 on Health Care Insurances, Patients' Rights Act No. 74/1997. In Iceland, core health services of each healthcare district are mostly provided by the state, but nursing home services and home care are provided by other actors such as municipalities, often with the state's support, see e.g. Article 32 of Act no. 40/2007 on Health Services, Art. 9 of Act no. 125/1999.

<sup>35</sup> Swedish Act on Social Services (*Socialtjänstlag* 2001:453); Finnish Social Welfare Act (*sosiaalihuoltolaki* 1301/2014); Norwegian Act on Health- and Care Services 24 June 2011; Icelandic Act no. 125/1999 on issues related to older persons; Finnish Act on Supporting the Functional Capacity of the Older Population and on Social and Health Care Services for Older Persons (980/2012); Prop. 1990/91:14 *om ansvaret för service och vård för äldre och handikappade m.m.* (The Responsibility of Service and Care of Older People and Disabled); Danish Social Service Act § 192a (Consolidated Act no. 1287, 28/08/2020 *lov om social service*) See also, *Almenboligloven* § 5 (Consolidated Act no. 1203, 03/08/2020 *Almenboligloven*).

<sup>36</sup> Norwegian Act on Protection against Contagious Diseases (*Lov om vern mot smittsomme sykdommer* 5. august 1994 no. 55); Swedish Communicable Diseases Act (*Smittskyddslag* 2004:168); Icelandic Infectious Disease Act no. 19/1997; Danish act on infectious diseases (*Lov om foranstaltninger mod smittsomme og andre overførbare sygdomme* (no. 208, 17/03/2020) (plus later amendments) (replaced in 2021 by *Epidemiloven* no. 285, 27/02/2021) ) and the Finnish Communicable Diseases Act (*tartuntatautilaki* 1227/2016).

<sup>37</sup> For example, Norway adopted the Temporary Corona Act of March 27, 2020, which gave the government permission to adopt a range of regulations to handle the crisis, mostly in the specialised healthcare service. Sweden enacted special legislation for COVID-19 prevention in 2021 (*Lag (2021:4) om särskilda begränsningar för att förhindra spridning av sjukdomen covid-19*) and Iceland adopted amendments to the Infectious Disease Act, with Act no. 2/2021, amending Act no. 19/1997.

<sup>38</sup> See further, E. Rynning and M. Hartlev (eds), *Nordic Health Law in a European Context Welfare State Perspectives on Patients' Rights and Biomedicine* (Brill, 2011).

the Nordic countries have protected older persons' health during the pandemic, using the AAAQ framework established by CESCR.

### **3.1. Availability of healthcare**

In 2020, governments reduced the availability of healthcare to meet the demands of COVID-19, such as by postponing examinations, treatments and surgeries.<sup>39</sup> In Nordic countries, this required suspending or amending various pieces of legislation that provide for entitlements to different healthcare services, sometimes within specific timescales. While restrictions on the right to healthcare can be legitimate, there is a need to examine whether, when restricting availability, sufficient attention was afforded to the needs of older persons, including the right to non-discrimination and maintenance of minimum level of services required for living with dignity.

In Denmark, in response to COVID-19, the law on infectious diseases was amended, inter alia, giving the Minister for Health the power to suspend certain medical entitlements when necessary to ensure hospital capacity for treatment and care of persons infected with, inter alia, COVID.<sup>40</sup> Following these powers, the Minister issued a regulation allowing the healthcare regions to delay planned and future examinations and treatments and deviate from deadlines set under the Health Act, such as the requirement to ensure treatment within one month.<sup>41</sup> Non-acute or life threatening conditions, or conditions where delayed treatment does not entail a risk of loss of mobility and where it is professionally justifiable to postpone treatment, could be postponed.<sup>42</sup> When conducting an individual clinical assessment, the impact on the patient's quality of life and functionality must, inter alia, be considered.<sup>43</sup> This may be an important safeguard for older persons as it focuses on functionality not only life expectancy. The Danish Health Authority has monitored activity in the health care sector throughout the pandemic, although it has not commented on whether specific groups, such as older persons, are thought to be particularly affected.<sup>44</sup> The Danish Regions have launched an expert review of the impact of the lockdowns on public health, which may clarify impacts on particular groups, like older persons.<sup>45</sup>

In Finland, during the spring of 2020 certain deadlines for accessing care were temporarily waived based on the Emergency Powers Act (1552/2011). This allowed municipalities to exceed maximum waiting times for arranging non-urgent care and assessing service needs in accordance with the Social Welfare Act, which led to delays in receiving necessary care. Guidance issued by the Ministry of Social Affairs and Health stressed the importance of providing care in cases where a delay could cause the patient's condition to deteriorate, and

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<sup>39</sup> For example, in Norway the regulation of March 25, 2020, specified the need to cancel other treatments and examinations. Breast screening was cancelled for all women. The same regulation specified that patients in nursing homes ill with Covid-19 should be treated in the nursing home and not moved to hospital except in situations where special reasons indicate that treatment in hospital clearly will prolong the patient's life significantly and increase quality of life. See also the Norwegian Corona Commission, NOU 2021: 6, pp. 333-334.

<sup>40</sup> 12d(1)-(3) Epidemiloven.

<sup>41</sup> Bekendtgørelse om begrænsning af rettigheder på sundheds-og ældreområdet i forbindelse med håndtering af Coronavirussygdom 2019 (COVID-19) (no. 1066).

<sup>42</sup> Sundhedsstyrelsen, 2021, 'Rammer for udskydelse af sygehusaktivitet grundet COVID-19', 6 January. Retrieved 1 June 2021, [www.sst.dk/-/media/Udgivelser/2020/Corona/Sygehusaktivitet/Rammer-for-udskydelse-af-sygehusaktivitet.aspx?la=da&hash=EA9112E1386C844379BA9F70BA97A35C2E155A61](http://www.sst.dk/-/media/Udgivelser/2020/Corona/Sygehusaktivitet/Rammer-for-udskydelse-af-sygehusaktivitet.aspx?la=da&hash=EA9112E1386C844379BA9F70BA97A35C2E155A61).

<sup>43</sup> Ibid.

<sup>44</sup> Sundhedsstyrelsen, *COVID-19: Monitorering af aktivitet i sundhedsvæsenet* (2020), 2021) (7 editions so far).

<sup>45</sup> [www.regioner.dk/services/nyheder/2021/marts/regionerne-vil-afdaekke-folkesundheden-efter-corona-nedlukningen](http://www.regioner.dk/services/nyheder/2021/marts/regionerne-vil-afdaekke-folkesundheden-efter-corona-nedlukningen)

addressing the needs of vulnerable groups.<sup>46</sup> However, municipalities were left with wide discretion concerning the practical operation of such measures.

In Norway, a temporary regulation<sup>47</sup> on changes to health legislation in light of the COVID-19 outbreak based in the temporary Corona Act<sup>48</sup> was adopted. Certain rights under the Patient Rights Act were suspended for all patients, such as the right to an individual plan. Most of the legal changes affected specialised healthcare, where patient rights to healthcare according to the ordinary regulation were restricted, i.e. right to a second opinion and a certain time limit for necessary treatment from the specialist healthcare service. Most of the measures adopted to handle the pandemic in the health and care services for older persons in local nursing- and care homes and home-based care services were based on the Act on Protection against Contagious Diseases,<sup>49</sup> which divides the protective responsibilities between municipalities and national authorities (the Directorate of Health and the Government), allowing municipalities to adopt stricter regulations according to need. Services requiring close contact with patients were put on hold based on national and communal regulations, including physiotherapy, activity, rehabilitation and training programs.<sup>50</sup> These restrictions affected older persons negatively and contributed to inactivity leading to reduced health status, especially since nursing home staff were under extreme pressure due to the pandemic and due to the Government giving most attention to the specialised health care sector.<sup>51</sup>

In Sweden, medical care was mostly maintained in 2020. The regions succeeded in maintaining almost 80 percent of planned operations and treatments compared to 2019 during the corresponding period. In the beginning of October, 90 percent of the operation volume from the beginning of the year was performed.<sup>52</sup> There was no regulation for allowing cancelling of routine treatments.

In Iceland, the postponement of all optional surgeries was set by executive orders (*Icel. Auglýsing*)<sup>53</sup> based on Art. 5(1) of Act no. 41/2007, which allows the Director of Health to give instructions to healthcare institutions and personnel.<sup>54</sup> The Directorate of Health emphasised that urgent surgeries and diagnostic research that could not wait for more than 8 weeks should still be undertaken. In cases of doubt, the Directorate relied on the relevant specialist to make a ‘balanced assessment’ in each case.<sup>55</sup> While Iceland never announced a nationwide emergency, the National University Hospital of Iceland moved to emergency level, the highest level of risk according to its response and contingency plan, on 25 October 2020.<sup>56</sup> The decision to do so (for the first time in its history) was made following a group outbreak of COVID-19

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<sup>46</sup> Finnish Ministry of Social Affairs and Health, COVID-19 aiheuttaman poikkeustilan huomioiminen perustason sosiaali- ja terveydenhuollon palvelujen toiminnassa, revised guidance 16 April 2020.

<sup>47</sup> Temporary regulation of 27 March 2020 no. 462.

<sup>48</sup> Act of 27 March 2020 No. 17.

<sup>49</sup> Act 5 August 1994 No. 55.

<sup>50</sup> The Corona Commission NOU 2021: 6 p. 333.

<sup>51</sup> Ibid, p. 346.

<sup>52</sup> The Sweden’s Municipalities and Regions Report 2021-01-22, The Pandemic and the Medical Health Care 2020.

<sup>53</sup> See for example Stjórnartíðindi, B deild, ‘Auglýsing um fyrirmæli landlæknis um frestun valkvæðra skurðaðgerða og annarra ífarandi aðgerða’, October 26 2020 and March 23 2020). Retrieved 1 June 2021. [www.stjornarradid.is/](http://www.stjornarradid.is/).

<sup>54</sup> Embætti landlæknis, 2020, Frestun valkvæðra skurðaðgerða vegna COVID-19, March 22. Retrieved 1 June. [www.landlaeknir.is/um-embattid/frettir/frett/item40390/frestun-valkvaedra-skurdadgerda-vegna-covid-19](http://www.landlaeknir.is/um-embattid/frettir/frett/item40390/frestun-valkvaedra-skurdadgerda-vegna-covid-19).

<sup>55</sup> Stjórnartíðindi, supra note 53.

<sup>56</sup> Embætti landlæknis (2020), Talnabrunnur – Fréttabréf landlæknis um heilbrigðisupplýsingar, December. Retrieved 1 June 2021. [www.landlaeknir.is/servlet/file/store93/item44014/Talnabrunnur\\_Desember\\_2020.pdf](http://www.landlaeknir.is/servlet/file/store93/item44014/Talnabrunnur_Desember_2020.pdf). See also Landspítali (2019) Viðbragðsáætlun Landspítala, October 9 [www.landspitali.is/library/Sameiginlegar-skrar/Gagnasafn/BRUNNURINN/Vidbragdsaaetlun-LSH/vidbragdsaaetlun\\_lsh\\_okt\\_2019.pdf](http://www.landspitali.is/library/Sameiginlegar-skrar/Gagnasafn/BRUNNURINN/Vidbragdsaaetlun-LSH/vidbragdsaaetlun_lsh_okt_2019.pdf)

at the hospital's geriatrics ward (see further section 3.3). Despite this, data provided by the Directorate of Health shows that there was much greater contraction in hospital services during the spring than during the period during which Landspítali operated on emergency level.<sup>57</sup>

In summary, in response to COVID-19, Nordic countries introduced possibilities for reducing routine healthcare. The regulations highlight the need for an individual assessment and the need to preserve patients' right to life. Danish and Finnish regulations also underscore not only threats to life but also the right to health, i.e. risks of irreversible loss of mobility. At the time of writing, we lack precise information on whether certain groups, such as older persons, were adversely affected. It is however likely that vulnerable persons delayed seeking treatment to avoid the associated risks.<sup>58</sup>

### **3.2. Accessibility of healthcare**

In this section, we discuss challenges relating to ensuring health service accessibility for older persons during the pandemic. With healthcare services under extreme pressure due to an influx of patients in need of intensive care, there is a risk that older persons (often presenting without a support person) are denied care based on their age, a cognitive impairment or an unjustified assumption that they are not healthy enough to withstand treatment. Finally, accessibility of healthcare can be de facto reduced when older persons are required to remain at home or when their movements are restricted.

#### *Restrictions on movements and social contact*

While curfews as seen in many European states have not been imposed in the Nordics, regulations have limited sizes of social gatherings. As a result, activities and other types of clubs have been cancelled or moved online. Besides legal restrictions, older persons have been advised to limit social contact. As a result, older persons appear to have experienced loneliness and isolation due to restrictions and because of 'choosing' to stay at home due to fear of the virus.<sup>59</sup>

In March and April 2020, the Danish Health Authorities suggested that those over 65 should not look after their grandchildren while day care and/or schools were closed. By May 2020, however, the Health Authority noted that hugging close relatives, such as grandchildren, could be justified due to the importance of social relations for mental health and quality of life.<sup>60</sup> Recommendations in Finland, in place until June 2020, instructed persons older than 70 years to avoid unnecessary face-to-face interactions, to stay indoors, and to seek assistance, for example, to run errands. Problematically, the recommendation was phrased as an obligation,<sup>61</sup> which is likely to have contributed to the negative effects of isolation during the spring of 2020. In Sweden, such recommendations lasted until October 2020, advising older persons not to have close contact with individuals outside their household. Analyses indicate that this recommendation reduced the number of cases of serious illness and death due to COVID-19

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<sup>57</sup> Embætti landlæknis, *ibid.*

<sup>58</sup> For example, in the autumn of 2020 the Finnish Institute for Health and Welfare (THL) reported that waiting times had become longer, while demand for specialised care was down from previous years, suggesting that much of the normal need for services had become hidden, as patients chose to not seek care in fear of contracting the virus, THL 2020, 7 Oct. Retrieved 4 May 2021, <https://thl.fi/fi/-/yli-puoli-vuotta-hoitao-odottaneiden-maara-kasvanut-sairaanhoitopiireissa-kesan-aikana-pitkaan-hoitao-odottavia-ennatyksellisen-paljon>.

<sup>59</sup> T. Prakash, 2020 'Ældre er corona-ensomme: 27-årige Cangül hjælper via telefonen', *DR.dk*, 24 October 2020, [www.dr.dk/nyheder/indland/aeldre-er-corona-ensomme-27-aarige-cangul-hjaelper-telefonen](http://www.dr.dk/nyheder/indland/aeldre-er-corona-ensomme-27-aarige-cangul-hjaelper-telefonen)

<sup>60</sup> Sundhedsstyrelsen, *Håndtering af COVID-19: Anbefalinger til personer i øget risiko* (04-05-2020 NACL Sagsnr. 04-0100-380), p. 6.

<sup>61</sup> See for example Finnish Government press release 140/2020, 16 March 2020.

among this age group. Yet, the recommendations have also resulted in a decline in mental health among older persons and may have an adverse effect on physical health. These negative consequences were likely to worsen the longer the recommendations remained in place. There might also be a considerable backlog of healthcare needs among this group.<sup>62</sup>

We furthermore note that even without restrictions, older persons may have felt compelled to limit their movements and self-isolated to safeguard their health. Emerging evidence suggests that social isolation has increased physical inactivity, loneliness, and risk of violence<sup>63</sup> with impacts on functional capacity and well-being more broadly.<sup>64</sup>

### *Prioritisation of Intensive Care*

States must prioritise access to healthcare goods and services in line with human rights. In response to the pandemic, it is evident that all Nordic states have engaged in prioritisation, with Denmark, Norway and Sweden releasing publicly available guidelines.<sup>65</sup>

The Danish regions developed a guideline on visitation, prioritisation and ethical considerations in treatment of critically ill patients in intensive care.<sup>66</sup> The principles of justice and equality are highlighted, stating that patients must be prioritised in relation to need and expected effect in a transparent manner and not ‘first come, first serve’ or in a discriminatory manner, for example, based on age.<sup>67</sup> It does not seem that these aspects of the guidelines contribute anything new to Danish healthcare but instead are a restatement and reminder of the unacceptability of prioritisation based on age or disability.<sup>68</sup> The Norwegian Directorate of Health also published guidelines for prioritisation during the pandemic, stressing the importance of following the existing criteria for health prioritisations: expected benefit of treatment vs. resources (cost-benefit considerations), and the seriousness of the patient’s condition. Intensive care should be given based on individual assessment, while age should not be a criterion. The following should be considered: prognosis of life expectancy, how ill the patient is from lung disease (COPD) or chronic kidney disease, and the likelihood of heart failure.<sup>69</sup> In general, most nursing home patients remained in the nursing home according to the same guideline. The Corona Commission found that the prioritisation guidelines issued by

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<sup>62</sup> Folkhälsomyndigheten, *Utvärdering av åldersgräns för särskilda råd till personer 70 år eller äldre* (2020-05-27); K. Romero Starke, et al., ‘The Age-Related Risk of Severe Outcomes Due to COVID-19 Infection: A Rapid Review, Meta-Analysis, and Meta-Regression’ *International journal of environmental research and public health* 17(16) (2020) 5974; S. Hägg, et al., ‘Age, frailty and comorbidity as prognostic factors for short-term outcomes in patients with COVID-19 in geriatric care’ *Journal of the American Medical Directors Association* 21(11) (2020) 1555.

<sup>63</sup> Ríkislögreglustjóri, greiningardeild, 2021, ‘Ofbeldi gegn öldruðum á Íslandi – Stefnumiðuð greiningarskýrsla’, March 2021. Retrieved 1 June 2021, [www.logreglan.is/wp-content/uploads/2021/03/Ofbeldi-gegn-oldrudum.pdf](http://www.logreglan.is/wp-content/uploads/2021/03/Ofbeldi-gegn-oldrudum.pdf).

<sup>64</sup> Valtioneuvoston ‘COVID19-tiedepaneelin raportti’ 1 June 2020.

[https://valtioneuvosto.fi/documents/10616/21411573/VNK\\_Tiedepaneelin\\_raportti\\_200601.pdf/b3c837ba-02a1-693b-ccf5-fbdada481c01/VNK\\_Tiedepaneelin\\_raportti\\_200601.pdf](https://valtioneuvosto.fi/documents/10616/21411573/VNK_Tiedepaneelin_raportti_200601.pdf/b3c837ba-02a1-693b-ccf5-fbdada481c01/VNK_Tiedepaneelin_raportti_200601.pdf)

<https://forskning.no/aldring-oslomet-partner/inaktivitet-er-var-tids-tause-morder/1769629> ; Corona Commission, *supra* note 50, p. 346.

<sup>65</sup> Iceland postponed optional treatments, but further details on prioritisation were left to be assessed by the appropriate health personnel, Stjórnartíðindi, *supra* note 53.

<sup>66</sup> Regionernes Oplæg til Vejledning, Visitation, prioritering og etiske overvejelser ifm. behandling af kritisk syge patienter på intensivafsnit, 2020. [www.altinget.dk/misc/Opl%C3%A6g.pdf](http://www.altinget.dk/misc/Opl%C3%A6g.pdf)

<sup>67</sup> *Ibid.*

<sup>68</sup> Intensive care in Finland was continued according to the same clinical and ethical criteria as before, outlined in the ethical code of the Finnish Society of Intensive Care, see Suomen tehohoitoyhdistys, 2019, ‘Eettiset ohjeet’. Retrieved 22 Apr 2021, <https://sthy.fi/yhdistys/eettiset-ohjeet/> (accessed). Access to intensive care is to a great extent based on capacity of benefit based on individual assessment, in which among other criteria the focus is on frailty rather than age.

<sup>69</sup> Prioriteringsnotat 25. mars 2020: Prioritering av helsehjelp i Norge under covid-19-pandemien.

the Directorate of Health did not give sufficient attention to the broad range of health- and care responsibilities of the municipalities, and had a too limited focus on the specialised health care sector, especially intensive care needs.<sup>70</sup>

In Sweden, the Health Care Act and the Patient Act state that care must be provided on equal terms, and those with the greatest need must first receive care in accordance with the priority order established by parliament in 1997.<sup>71</sup> In response to the COVID epidemic, on 27 March 2020, the National Board of Health and Welfare published a document, aiming to supplement the statutory prioritisation scheme. The concept of biological age was introduced for priority setting taking place when the intensive care ward<sup>72</sup> is at full capacity.<sup>73</sup> Normally, the patient's benefit from a measure is assessed based on capacity to benefit, namely life expectancy and quality of life attainable after intensive care. However, the new guidelines based priority solely on the number of months that the patient was expected to live after treatment.<sup>74</sup> In our view, this was a problematic change of prioritisation criteria, as priority categories based on available life-years draws focus from an individual assessment of the patient's ability to recover and rehabilitate from physically demanding treatment, and the quality of life attainable. Instead, the *Socialstyrelsen* guidelines risk steering physicians to determine access to intensive care based on biological age, rather than the clinical factors that are normally considered in intensive care.<sup>75</sup>

This would mean that resource use (the cost-effectiveness principle) for intensive care would be determined by a value-judgement based on age, contrary to the principle of need and non-discrimination. We note that the contingency guidelines for demand spikes were devised in light of the severe shortages in intensive care capacity experienced, for example, in Italy during the first wave of the pandemic. However, these concerns should be addressed through a robust national response to prevent the spread of the virus and excessive hospitalisations, and to ramp up intensive care capacity during increases in the caseload. It is our view that, in the event of a worst-case scenario where hospital beds are full, applying additional criteria for rationing would not change the fact that individual patients, of any age, would be denied the right to necessary intensive care. Chronological age has generally been rejected as a criterion for priority setting, as it is not in line with the principle of equal worth of human life or the requirements of acceptability or non-discrimination. Furthermore, any failures within the national pandemic prevention should not result in an obligation on physicians to incorporate an age criterion into their decision-making, contrary to their clinical discretion. Therefore, we

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<sup>70</sup> Corona Commission, *supra* note 50, p. 346.

<sup>71</sup> 1996/97:SOU14 Prioriteringar inom hälso- och sjukvården.

<sup>72</sup> In the context of COVID-19 care, intensive care refers to medical care which aims to monitor and sustain the patient's bodily functions, for example with use of a ventilator. Hospital care for COVID-19 outside of intensive care may include, for example, oxygenation or medication to prevent blood clots.

<sup>73</sup> L. Vahlne Westerhäll, 'Några myndigheter i coronatider – ett rättsligt perspektiv' (Some Authorities in Times of Corona – a Legal Perspective), 2020-21 NR 1, s. 73 ff.; L. Vahlne Westerhäll, 'Tillsyn och prioritering' (Supervision and Prioritisation), *Socialmedicinsk Tidskrift* (forthcoming). According to the guidelines, when there is a need to decide between patients with the same likelihood of benefitting from intensive care, priorities should be set based on biological age, where treatment should be provided first to the patient with the greater remaining lifespan. *Socialstyrelsen* (2020), *Nationella principer för prioriteringar inom intensivvård under extraordinära förhållanden* (National Principles of Prioritizations within Intensive Care during Extraordinary Circumstances), p. 7.

<sup>74</sup> Priority groups included patients with a lifespan of 0-6 months, 6-12 months, and 12 months or more after intensive care, *Socialstyrelsen*, *ibid*. See also L. Vahlne Westerhäll, *ibid*.

<sup>75</sup> For older persons persons in a frail state due to old age and other diseases, in the event of a severe case of COVID-19, intensive care could cause more suffering than benefit. Therefore, it is important that physicians discuss with the patient or their family / representative, whether respect for patient's dignity and autonomy would call for arranging palliative care rather than intensive care. See also, Bettina Husebø, 'Ethiske dilemmaer på sykehjemmet' (Ethical dilemmas in the nursing home] *Bergens Tidende* 2 April 2020.

find that the appropriate course of action in line with equal treatment based on the principle of individual need would be to retain the priority setting criteria as confirmed by the Swedish Parliament during normalcy, and to take every possible measure to avoid overburdening intensive care units.

### *Access to Healthcare in Institutions*

Older persons living in nursing homes were particularly vulnerable during the pandemic. Having to rely on assistance from staff for daily routines and unavoidable encounters with other residents reduce their opportunity to define daily contacts and to seek recourse for violations of their rights. Findings from an ongoing review concerning older persons living in residential care facilities by the Swedish Inspectorate of Care and Support (IVO)<sup>76</sup> provide an illustrative example of this vulnerability and the measures needed to ensure access to healthcare and non-discrimination.

IVO examined access to care and treatment based on an individual needs assessment for suspected or confirmed COVID-19 patients in residential care homes in 21 regions.<sup>77</sup> Overall, IVO concluded that there were serious shortcomings in medical care and treatment, and that none of the regions had taken full responsibility for ensuring individually tailored care and treatment. The shortcomings relate to four main concerns: individual needs assessment; disclosure, participation and informed consent; compliance with regulations concerning end-of-life care; and insufficient documentation in health records.<sup>78</sup>

At the beginning of the pandemic, Swedish regions issued guidelines, which stated that if one to three patients in residential care tested positive for COVID-19, the ward should be considered as infected and no further testing should be performed on patients with symptoms. This resulted in these patients not receiving patient status. Before older persons started to fall ill during the first wave, several regions also made general decisions on eligibility of patients for intensive care in hospitals. In some cases, IVO found that decisions about care and treatment had only been preceded by a note about the estimation of fragility, without appropriate individual medical needs assessment.

Primary healthcare centres sometimes issued treatment restrictions, excluding care other than palliative care from consideration without an individual assessment, resulting in severe limitations on the range of care available. Furthermore, doctors rarely performed physical examinations of patients in residential care, even when the responsible nurse considered that there was a need. Any treatment provided was given at the nursing home rather than in a hospital, often without an individual decision regarding care, and in some cases, there was no follow-up on COVID-19 test results. IVO emphasised that, in light of the novelty of COVID-19, its varying clinical manifestations, high mortality rates in older age groups and classification as dangerous to public health and society under the Communicable Diseases Act, the patient must receive an individual medical assessment, and positive test results must be followed up.

IVO also assessed whether decision-making regarding palliative care was made in accordance with laws and regulations, and whether the care provider had fulfilled its obligation to document such decision-making. Formally, a physician and another registered healthcare professional should be present during end-of-life communication. However, this was not

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<sup>76</sup> Prop. 2016/17:43 s. 75.

<sup>77</sup> IVO, being ultimately responsible for medical healthcare according to section III of the Medical Healthcare Act (2017: 30), HSL, has examined the regions' work during the Covid-19 pandemic at an overall level.

<sup>78</sup> IVO, 2020, 'Ingen region har tagit sitt fulla ansvar för individuell vård och behandling', 24 Nov 2020. [www.ivo.se/publicerat-material/nyheter/2020/ingen-region-har-tagit-fullt-ansvar-for-individuell-vard/](http://www.ivo.se/publicerat-material/nyheter/2020/ingen-region-har-tagit-fullt-ansvar-for-individuell-vard/)

always the case. Medical records showed that, in many cases, there was a lack of documentation regarding consent and participation. At nursing homes, doctors were commonly absent during end-of-life conversations and palliative care appeared in many cases to be given without the patient (or a representative's) consent. IVO emphasised the importance of appropriate medical records for ensuring individual assessment and informed consent. Some patients in residential care suffered from an impaired general condition or died without medical charts indicating that an individual assessment had been made by a doctor, or if any treatments were prescribed. In IVO's opinion, medical records should have indicated which factors at an individual level motivated that care was given at the nursing home rather than at the hospital.

The predominant number of regions have fallen short in terms of formal compliance with how palliative care should be provided and how end of life communication should be conducted. The review of the 21 regions shows that older persons in residential care who fell ill with COVID-19 were often not subject to an individual assessment, and thus did not gain patient status. This is contrary to the principle of legal certainty about predictability and controllability and the principle of justice on the right to equal care. These two principles, in turn, originate in the principle of the equal value of all humans.

### **3.3. Acceptability and Quality**

According to General Comment No. 14, healthcare must respect medical ethics, be culturally appropriate and age sensitive. In light of the underlying determinants of health, COVID-19 responses should strive to mitigate the negative effects of pandemic prevention measures. Restrictions on individual autonomy which are not necessary or proportionate for protecting the health of others must be avoided. In this section, we highlight that, as noted by CESCR, older persons continue to live in degrading conditions.<sup>79</sup> We also note the implications of restrictions on visitation to care homes, and challenges in homebased care. Finally, we draw attention to difficulties in access to complaints and remedies.

#### *COVID Reductions on Homebased Care*

During COVID-19, municipalities in Denmark reduced home help qualitatively and quantitatively.<sup>80</sup> Furthermore, carers were sometimes forced to cancel, for example, to look after other dependents (like children while schools were closed)".<sup>81</sup> In Norway, regulation 25.3.20 allowed for reduced service provision by the municipalities based on prioritisation of needs. The Corona Commission found that such reductions resulted in reduced health status for people dependent on services from the municipalities, including older persons.<sup>82</sup> Furthermore, in Copenhagen, for example, citizens who received home care reported feeling unsafe because of lack of transparency and guidelines on the use of protective equipment.<sup>83</sup> In Norway, older persons receiving homebased care services complained that staff did not wear masks when visiting them, resulting sometimes in recipients being exposed to the virus or

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<sup>79</sup> See the latest communication from the Committee on Economic Social and Cultural Rights, Norway, Concluding Observations 2 April 2020: 'The Committee is concerned about reports indicating the high incidence of violence against and abuse of older persons living both in domestic and institutional settings. It is also concerned that a third of older persons in hospitals and in health and care services in municipalities are malnourished or at risk of malnutrition (E/C.12/NOR/CO/6 paras. 36 and 37).

<sup>80</sup> Københavns Kommune, Sundheds- og Omsorgsforvaltningen, Afdelingen for Evaluering (2020) *Evaluering af SUF's COVID-19 beredskab*, October 2020, p. 23,

<sup>81</sup> ÆldreSagen (2020), 'Nyt fra de klemte er de glemte', 16 December 2020, [www.aeldresagen.dk/presse/viden-om-aeldre/oevrigt/2020-nyt-fra-de-klemte-og-de-glemte](http://www.aeldresagen.dk/presse/viden-om-aeldre/oevrigt/2020-nyt-fra-de-klemte-og-de-glemte).

<sup>82</sup> Corona Commission, *supra* note 50, p. 333.

<sup>83</sup> Københavns Kommune, *supra* note 80, p. 36.

isolated in their homes due to the quarantine regulations.<sup>84</sup> The Norwegian Corona Commission found that compared to the neighbouring countries, especially Denmark, the Swedish authorities (*Folkhälsomyndigheten* and *Socialstyrelsen*) were late in providing clear guidelines for the use of visors and masks in the care for older persons, and late in recommending testing of all patients and staff when an outbreak of the virus occurred in an institution.<sup>85</sup>

In November 2020, the Danish Alzheimer's Association published a report based on questionnaires filled out by 1419 respondents, including people with dementia and their relatives, from 15 June 2020 to 30 June 2020. The report highlights seven common tendencies during the COVID-19-pandemic. Firstly, one third of respondents report a deterioration in physical health, while one in four cases report a reduction in the ability to remember, communicate and walk. Secondly, one third of the persons suffering from dementia, and one out of four of their relatives, have felt lonely. Thirdly, every other relative stated that their quality of life is below average. Fourthly, every third family experienced less help with practical things and personal care from municipal homecare. Fifthly, the municipal treatment of people suffering from dementia effectively ceased. Sixthly, four out of ten relatives have experienced less energy and more conflicts. Lastly, one out of four relatives have isolated themselves to hinder COVID transmission.<sup>86</sup>

#### *COVID in Care Homes and hospital geriatrics wards*

During the pandemic, many older persons died in nursing homes due to COVID-19. Questions have been asked as to whether residents received acceptable and adequate healthcare and whether they were treated with dignity. While there are concerning reports from all Nordic countries, in depth evaluations are so far lacking (besides in Sweden).

In Norway, residents died due to several serious outbreaks. For example, in a private nursing home in Bergen, 18 out of 46 patients had died by the end of May 2020.<sup>87</sup> Another serious outbreak was reported in November 2020 where 9 out of 23 patients died due to the coronavirus during a period of two weeks, and all residents were infected.<sup>88</sup> The Corona Commission found that half of the deaths took place in nursing homes, and that one third of the infected individuals in nursing homes died. However, the Commission emphasised that the corona-related deaths happened in a few institutions only, and that most nursing homes avoided large outbreaks.<sup>89</sup> Furthermore, the Corona Commission found that most virus transmission in nursing homes was related to health staff working in several institutions and thereby spreading the virus.<sup>90</sup> It made interesting observations in relation to staffing. Norway relies on part-time staff more than the other Nordic countries,<sup>91</sup> while Sweden has less formal and less regulated personnel compared to neighbouring countries, who experience greater job security. Finland is mentioned as the country with highest level of education among the employees in older persons' care, while Norway has the highest number of staff. It is estimated that residents in nursing homes in Norway have ten times more access to a doctor compared to older persons in Sweden

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<sup>84</sup> Several articles in newspapers, e.g. in *Bergens Tidende* 24.4 and 17.9.2020. See also Norde Aker, 'Hvorfor bruker ikke hjemmetjenesten munnbind?', 19 April 2020. Retrieved 1 June 2021, <https://nab.no/nyheter/hvorfor-bruker-ikke-hjemmetjenesten-munnbind/19.20894>

<sup>85</sup> Corona Commission, supra note 50, p. 345, with reference to the Swedish Corona Commission (SKK).

<sup>86</sup> Alzheimerforeningen, 2020, Corona og livet med demens derhjemme, November 2020. Retrieved 1 June 2021, [www.alzheimer.dk/media/197974/corona-og-livet-med-demens-endelig.pdf](http://www.alzheimer.dk/media/197974/corona-og-livet-med-demens-endelig.pdf).

<sup>87</sup> Diane Berbain, 'Er Kriseberedskapen på Sykehjemmene våre god nok?', SV. Retrieved 1 June 2021, [www.sv.no/bergen/2020/05/25/er-kriseberedskapen-pa-sykehjemmene-vare-god-nok](http://www.sv.no/bergen/2020/05/25/er-kriseberedskapen-pa-sykehjemmene-vare-god-nok).

<sup>88</sup> Norwegian National Broadcasting (NRK) November 24.

<sup>89</sup> Corona Commission, supra note 50, p. 402.

<sup>90</sup> Ibid, p. 344.

<sup>91</sup> Ibid, p. 341.

(measured in time). The Swedish Corona Commission (SKK) shows that other surveys indicate that employees in Swedish care for older persons have a more stressful work situation than their colleagues in other Nordic countries. The contrast between Norwegian and Swedish personnel is significant.<sup>92</sup>

In the early stages of the pandemic, it appears that COVID infections in older persons were often missed because of the differences in presentation. For example, evidence now shows that delirium is a symptom in older adults. The Norwegian newspaper, *Bergens Tidende*, documented that more than 130 older patients died before the Public Health Institute recommended testing based on other symptoms than fever, coughing, breathing problems etc.<sup>93</sup> The belated testing for atypical symptoms in older persons indicate that older persons did not receive adequate treatment in time.

In October 2020, an outbreak at the geriatrics ward of the Landspítali National University Hospital, Iceland was confirmed. The geriatrics ward hosts older patients, many of whom had complex health issues and were in need of extensive rehabilitation after acute illnesses. Between 22-29 October 2020, a total of 98 cases were identified: 52 personnel and 46 patients. Up to 100% of patients and 52% of personnel were infected in some of the departments within the ward.<sup>94</sup> According to preliminary findings of an investigation into the group outbreak, the main reasons for the outbreak are traced to unsatisfactory housing, poor air quality and facilities in general at the geriatrics ward. Many of the patients do not have their own bathroom and sanitary facilities, they shared meals in the common canteen, and continued to receive group sessions with physiotherapists. Additionally, the facilities, such as locker rooms and canteens for personnel, were found unsatisfactory, and departments within the geriatrics ward shared equipment leaving any division between patients and personnel at each department blurred.<sup>95</sup> At least 13 COVID-19 deaths are related to this outbreak and approximately 200 people were infected.<sup>96</sup>

### *COVID Restrictions in Care Homes*

Besides the conditions in institutions, the acceptability of the restrictions imposed on residents should be discussed. Relatives have complained of their old and ill parents dying during the pandemic, not due to the virus itself, but due to strict measures denying visits by even close relatives at the end of their lives.<sup>97</sup> Reports also tell of old people without relatives having not had any visits over months.<sup>98</sup>

It seems that municipalities have interpreted national regulations and guidelines stricter than necessary, due to national guidelines being unclear on essential points. For example, in Norway, regulations indicated the need for very strict visiting restrictions as part of the duty to

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<sup>92</sup> Ibid., p. 345.

<sup>93</sup> Article 13 November 2020. The Corona Commission observed the problem of atypical symptoms among older persons in nursing homes, *supra* note 50, p. 344

<sup>94</sup> Landspítali (n.d.), *COVID-19 hópsýking á Landspítala - Bráðabirgðaskýrsla*, Landspítali gæða- og sýkingavarnadeild, pps. 23-24.

<sup>95</sup> Ibid.

<sup>96</sup> Stundin, 2020, Svandís segir stjórnendur Landspítala bera ábyrgðina á Landakoti, November 25. <https://stundin.is/grein/12361/svandis-segir-stjornendur-landspitala-bera-abyrgdina-landakoti/>.

<sup>97</sup> See for example interview with Adele Matheson Mestad, the director of the Norwegian Institution for human rights (NIM) in the journal *Juristen* nr. 4/2020, p. 56, where she states: ‘We have received many inquiries of the kind ‘«my mother died of the corona measures. She stopped eating and died two weeks later’’. See also the illustrating article “Grandma needs a hand to hold” by Áshild Torsnes Espeland in *Bergens Tidende* 13 May 2020. *Bergens Tidende* documented visit prohibitions in nursing homes in Bergen and found that the nursing homes were closed for visits in 100.000 patient days all together from March 2020 to January 2021 (*Bergens Tidende* 11 January 2021).

<sup>98</sup> Norwegian Broadcasting (NRK) 23. September 2020.

provide adequate care, while not specifying the duty to make individual proportionality assessments, and flexibility when patients are severely ill and likely to die shortly.<sup>99</sup> There are also reports of persons being denied visits in their private homes, which was later declared illegal based on existing regulations.<sup>100</sup>

In Finland, the Office of the Parliamentary Ombudsman received several complaints concerning restrictions on meeting family members, visits to nursing homes and information on restrictions. Based on that, the Deputy-Ombudsman investigated the restriction on visits and movement.<sup>101</sup> Problems identified include the lack of opportunities to go outside, the impact of restrictions on functional capacity and well-being, lack of information, isolation of older persons in their bedrooms and problems related to the use of video calls and other technical solutions. In addition, the complaints highlight situations in which residents of nursing homes have not been allowed to leave. In one case, a woman was not permitted to attend her husband's funeral.<sup>102</sup> In some cases, restrictions were not based on legislation, guidance was not always based on legislation and it was unclear whether the latter was binding. On the other hand, according to the National Supervisory Authority for Welfare and Health's survey of care homes conducted in autumn 2020, most care homes managed to arrange contact with relatives and loved ones safely during the pandemic.<sup>103</sup>

In Denmark, persons living in nursing homes also seem to have had their movements curtailed without a legal basis. One municipality instituted a curfew in nursing homes whereby only residents who were able to receive visits without help from staff could be visited or go for a walk on weekends and during holidays.<sup>104</sup> Furthermore, the Danish Alzheimer's Association reported that several municipalities prohibited nursing home residents from hugging their relatives without a legal basis.<sup>105</sup> Relatives report that their family members were threatened with two weeks isolation if they left for exercise.<sup>106</sup>

In contrast, the Norwegian Corona Commission pointed out that Sweden waited two weeks longer to restrict visits compared to Norway, Denmark and Finland. When national restrictions on visits were introduced on 1 April 2020, 100 persons had already died due to COVID-19 in Sweden.<sup>107</sup> Therefore, we underscore that visiting restrictions can be necessary in emergency situations, but that their implementation in line with human rights is crucial. The misapplication of the rules illustrates the vulnerability of older persons in institutions.

### *Access to complaints and remedies*

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<sup>99</sup> Communication from the Directorate of Health, 14.3.2020.

<sup>100</sup> These issues are pointed out by the Corona Commission, *supra* note 50, p. 342-344.

<sup>101</sup> EOAK 5463/2020, [www.oikeusiamies.fi/r/fi/ratkaisut/-/eoar/5463/2020](http://www.oikeusiamies.fi/r/fi/ratkaisut/-/eoar/5463/2020), also earlier case EOAK 3232/2020, [www.oikeusiamies.fi/r/fi/ratkaisut/-/eoar/3232/2020](http://www.oikeusiamies.fi/r/fi/ratkaisut/-/eoar/3232/2020).

<sup>102</sup> EOAK 3513/2020.

<sup>103</sup> Valvira, 2020, 'Suurin osa hoivakotien vanhuksista on saanut tavata läheisiään turvallisesti pandemian aikana'. Retrieved 1 June 2021, [www.valvira.fi/-/suurin-osa-hoivakotien-vanhuksista-on-saanut-tavata-laheisiaan-turvallisesti-pandemian-aikana](http://www.valvira.fi/-/suurin-osa-hoivakotien-vanhuksista-on-saanut-tavata-laheisiaan-turvallisesti-pandemian-aikana).

<sup>104</sup> Peter Mailand, 'Sagen om udgangsforbud på plejehjem tager en ny drejning: Nu er det forskelsbehandling', Sjællands Nyheder, 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>.

<sup>105</sup> Alzheimerforeningen, 2020, 'Kommuner forbyder ulovligt plejehjemsbeboere at kramme deres nærmeste', 5 November 2020, [www.alzheimer.dk/nyheder/2020/kommuner-forbyder-ulovligt-plejehjemsbeboerne-at-kramme-deres-naermeste/](http://www.alzheimer.dk/nyheder/2020/kommuner-forbyder-ulovligt-plejehjemsbeboerne-at-kramme-deres-naermeste/).

<sup>106</sup> ÆldreSagen, 2020, 'Nyt fra de klemte er de glemte', No. 8, 29 June 2020, [www.aeldresagen.dk/presse/viden-om-aeldre/oevrigt/2020-nyt-fra-de-klemte-og-de-glemte](http://www.aeldresagen.dk/presse/viden-om-aeldre/oevrigt/2020-nyt-fra-de-klemte-og-de-glemte).

<sup>107</sup> Corona Commission, *supra* note 50, p. 345.

Finally, we note that in the event of a violation of the rights as described above, there are practical, financial and social barriers to an older person's access to justice.<sup>108</sup> Regardless of the national legal basis (e.g. general regulations or individual decisions), the state has to ensure efficient legal remedies to protect fundamental rights, such as the right to private and family life. In 2010, The Danish Ombudsman criticised a municipality because it had not considered the restriction of visits in a care home as a 'decision' which gives rise to legal effects under the Danish Administrative Act, such as, the right to complain, be heard and the requirements to give sufficient reasons for a decision.<sup>109</sup>

In Finland, decisions on visitation restrictions have been considered to be administratively appealable in the latest case-law. The Administrative Supreme Court (2021:1) ruled that even though the visitation ban in Finnish care homes was a non-binding recommendation, a decision by the head of municipal disability services to forbid visitation at a municipal facility was an administrative decision given under the Finnish Communicable Diseases Act, and therefore subject to appeal in an administrative court. The decision had a direct and severe impact on the right to protection of private and family life under ECHR Article 8 and Section 10 of the Finnish Constitution.<sup>110</sup>

In Denmark, recommendations on how to improve the older persons' procedural rights propose establishing an independent ombudsperson in all municipalities, allowing citizens to submit complaints about issues and failures in nursing homes and homecare.<sup>111</sup> We note furthermore that writing a complaint regarding a nursing home requires specific skills, with which some older persons who suffer from dementia would need support. This means older persons with a weaker social network will be at risk of falling behind. While citizens have a constitutional right to appeal restrictions on liberty, going to court will be time consuming, financially risky and might not solve – or take too much time to solve - the problems at stake.

#### 4. Conclusions and Recommendations

At the time of writing, the COVID-19 pandemic remains ongoing. The first months of 2021 marked an increase in excess mortality in the Nordics due to COVID-19, with continuing outbreaks among older persons and care home residents. New mutations also led to stricter restrictions than ever in Nordic countries. At the same time, there are reasons for optimism as the vaccine roll out has reached the most vulnerable and older persons in the Nordics, with promising reductions in cases and deaths. Although we hope that the pandemic will soon be fully under control, the restrictions imposed on older persons remain in need of analysis. Reports and data on the implementation of restrictions, as well as the implications thereof, remain lacking. As a result, it is generally not possible to draw specific conclusions as to whether states have fulfilled or violated their obligations. Instead, we reflect on what the Nordic countries' approaches reveal about proportionality and prioritisation in a pandemic.

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<sup>108</sup> See for instance on principal issues in hospitals in Norway: M. L. Sæther, 2015, 'Menneskerettslige utfordringer i norske sykehjem', *Idunn.no*, 4 August 2015.

<sup>109</sup> Folketingets Ombudsmand, 2010, Kommunes besøgsrestriktioner for pårørende til plejehjemsbeboere var en afgørelse - 2010 20-7. Also, T. Schultz and J. Klausen, 2013, 'Retten til hjemmehjælp', *Ugeskrift for Retsvæsen*, U.2013B.360, p. 360-368.

<sup>110</sup> See also case from Administrative Court. Itä-Suomen HAO 16.10.2020 20/1059/1, [https://finlex.fi/fi/oikeus/hao/2020/ita-suomen\\_hao20201059](https://finlex.fi/fi/oikeus/hao/2020/ita-suomen_hao20201059) and case LSSAVI/7369/2020 from the Regional State Administrative Agency of Western and Inland Finland, in which the elderly care unit erroneously applied the visitation restriction as binding. Rather than allowing family members to visit their older relative, the unit instated a palliative care decision for the patient to justify an exemption from the restriction, and then forced the patient to quarantine without appropriate grounds as required under § 60 Communicable Diseases Act.

<sup>111</sup> B. Pabst, *Faglige Seniorer*, 2020, 'Ombudsmand skal sættes ind mod svigt på plejehjem', 10 November 2020, <https://fagligsenior.dk/2020/09/23/ombudsmand-skal-saettes-ind-mod-svigt-paa-plejehjem/>.

Firstly, we examined *availability* of healthcare and highlighted how Nordic countries have introduced regulations to allow for a reduction in healthcare to cope with the increased pressure caused by the pandemic. While these restrictions appear to pursue a legitimate aim, we are concerned about the impacts on the right to health of older persons. Although data remains limited at this point, we expect that these reductions may have implications for the health of older persons in the coming years. We are concerned that specialised healthcare has been prioritised, while services provided by municipalities, performing crucial functions for older persons, have not been given sufficient attention.

Secondly, in terms of *accessibility*, healthcare has been indirectly restricted through limitations on freedom of movement and prioritisation. We recognise that such restrictions are based on a legitimate aim and can be necessary. Emerging evidence suggests however, that such restrictions have had detrimental impacts on the health of older persons. In terms of prioritisation of access to treatment, we have criticised the Swedish guidelines for introducing biological age given that it is speculative and thereby non-transparent.

Furthermore, IVO's findings on Swedish nursing homes indicate violations of the right to health and possibly other rights. It appears that discriminatory criteria, such as age and disability, have been used without medical assessments. The right to health requires that older persons consent to any care they receive in the same way as everybody else, and it is the duty of the care staff to ensure that such consent is obtained. Furthermore, good palliative care must correspond to the level of care that the individual needs and must be prescribed after individual assessment. Presently, there is inadequate data to conclude whether similar violations have taken place in other Nordic countries. In line with the rights of older people, we underscore the need for a comprehensive review of deaths in nursing homes, which should include an assessment of access to healthcare. We also recommend an assessment of how healthcare prioritisation has been carried out in practice.

Thirdly, we explored *acceptability and quality* of healthcare. We note that reductions in home help have been documented in Denmark and Norway, with potential implications for the health of older persons. We propose that homecare should be seen as part of the essential bundle of right to health entitlements and not reduced without an individual assessment of the impacts. We also draw attention to the impact of COVID in some nursing homes and geriatrics wards and the conditions that may have contributed, concluding that these are contrary to the requirement of acceptability and quality of health care.

Finally, the right to life and health of older persons in nursing homes have in some cases not been sufficiently protected during the pandemic, especially in the first phase. This is also due to structural factors, which we believe indicate that care for older persons needs to change to avoid similar violations in the future. Reports illustrate the vulnerability of older people in institutions, suggesting that restrictions have been misapplied in a manner that violates residents' rights. Visiting bans are primarily interferences with the right to private and family life but we propose they can also violate the right to life and health if long-term and far reaching, such as excluding all visitors or refusing dying patients contact with their spouse or close relatives.<sup>112</sup>

We find that in implementing restrictions, Nordic states have at times failed to prioritise the full realisation of the core obligations of the right to health for older persons, namely, non-discrimination and provision of essential healthcare and social contact. Even necessary priority setting should entail an assessment of the implications for those who are most vulnerable, and unreasonable individual effects should be mitigated appropriately. Furthermore, resource

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<sup>112</sup> See articles in *Bergens Tidende* 11 January and February 2021.

constraints cannot justify indirect discrimination or failure to respect autonomy, integrity and human dignity, as has happened in older persons care homes as described in this article. In our view, these core obligations under the ICESCR should be integrated into public preparedness planning and processes to ensure that the rights of the most vulnerable are appropriately protected and fulfilled, especially under a crisis such as a global pandemic.

It is difficult to draw firm conclusions on the extent to which differences among the Nordic countries' legislation on patients' rights and healthcare have impacted older persons' right to health during the pandemic. We are concerned that Swedish patients' limited right to become a patient allowed authorities to stop testing once one patient on a ward was diagnosed with COVID-19 and that limited means of legal redress were available in such cases. Generally, Nordic legislation was not pandemic-ready and needed to be revised in haste meaning there was not always an adequate assessment of older persons' rights. For example, legislatures hurriedly introduced regulations suspending health entitlements enshrined in law to free up capacity for treating COVID patients. In other cases, legal entitlements were not complied with or restricted unlawfully by new guidelines. Furthermore, because of limited redress, unwell older persons are sometimes dependent on others to defend their rights. For example, while all Nordic countries have Ombudspersons, it is regrettable that only the Finnish authority has examined the restrictions on older persons to date despite similar violations seeming to have taken place in other Nordic countries.

Experts predict that further pandemics are likely and therefore it is necessary to avoid repeating mistakes.<sup>113</sup> We therefore recommend that comprehensive, independent reviews of the restrictions imposed to address the pandemic are conducted in all Nordic countries. The reviews should examine whether states have met their human rights obligations, not only in relation to civil and political rights, but also social rights, like the right to health, given that Nordic states have ratified the ICESCR. Key issues in need of analysis include whether restrictions on access to healthcare were proportionate, namely whether an adequate balance was reached between fighting the pandemic and protecting healthcare generally. Furthermore, the manner in which restrictions were applied should be examined, for example, whether visiting restrictions were applied in conformity with the law, e.g. Article 8 of the European Convention on Human Rights. Finally, we highlight the need to improve opportunities for complaints and redress for older persons in line with states' obligations under the right to health. These reviews will be instrumental in identifying institutional as well as systematic failures in guaranteeing the realisation of social rights and other fundamental rights, drawing lessons learned from the COVID-19 response, and improving preparedness in the face of new crises.

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<sup>113</sup> See, for example, The Independent Panel for Pandemic Preparedness & Response, COVID-19: Make it the Last Pandemic, May 2021.