

Palliative Care in the COVID-19 Pandemic

Briefing Note

The COVID-19 Pandemic, Palliative Care and Human Rights

Issue

Although palliative care is recognized as a component of the right to the highest attainable standard of physical and mental health, healthcare providers, governments, and patients face significant challenges to access that have been amplified by the COVID-19 pandemic.

Background

Even in an emergency, the right to health continues to impose legal obligations on governments that are parties to treaties such as the International Covenant on Economic, Social and Cultural Rights. Measures that limit enjoyment of the right are not ruled out but should be enacted after “the most careful consideration of all alternatives” and must be “duly justified.”¹ The COVID-19 pandemic and related infection control measures create major challenges for enjoyment of the right to palliative care as a component of the right to the highest standard of physical and mental health, including:

- Significant new palliative care need: many patients with severe COVID-19 disease and their families will need palliative care. Patients will face distressing physical symptoms including acute respiratory distress and they and families encounter major psychosocial impacts because of the risk of death and the separation of patients from families upon hospitalisation. Children who have lost parents and grandparents will need psychosocial and spiritual support.
- Major challenges to continuity of palliative care for existing patients: both infection risks and pandemic control measures pose significant challenges to the continuity of care for palliative care patients and their families. Palliative care providers may no longer be able to conduct home visits, and patients may face difficulties accessing outpatient palliative care services or obtaining and filling prescriptions.
- Infection risk for providers and patients: access to personal protection equipment for healthcare providers is a problem in many countries, and community palliative care providers face particular difficulties obtaining appropriate protection. Mobile teams, community health workers and volunteers play a critical role in palliative care provision.
- Increased need for psychosocial and spiritual care: negative mental health impacts of family separations when critical and end of life care are required highlight the importance of psychosocial and spiritual care. Infection control measures further complicate care provision, as providers must limit time with patients, wear full-body protective gear, and must often prevent families from visiting loved-ones.
- Scarcity of resources: inadequately resourced hospitals managing heavy patient loads are triggering the development of rationing and triage plans. Healthcare workers fear having to decide who receives care while patients with chronic or advanced illnesses fear not “qualifying.”



Key Facts

- International human rights law stipulates that governments cannot deny or limit equal access to preventive, curative, or palliative health services.²
 - The right to health is not an absolute right: states must ensure people can enjoy it to the “maximum of available resources.”³
- Access to essential medicines, however, even those that are internationally controlled such as morphine, is a “core obligation” that all states must ensure regardless of income level;⁴
- Human rights norms require states to take appropriate steps to protect healthcare workers from harm;⁵
- The International Convention on the Rights of Persons with Disabilities stipulates that states parties must ‘provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons,’⁶
- The Inter-American Convention on the Human Rights of Older Persons (2018) stipulates a right to palliative care and symptom relief for older persons;
- Recommendation Rec (2003) 24 of the Committee of Ministers of the Council of Europe, identifies ‘palliative care as... an inalienable element of a citizen’s right to health care.’
- Human rights experts have stated that de facto denial of access to internationally controlled essential medicines for the relief of severe pain and symptoms can amount to cruel and inhumane treatment.⁷

Recommendations to UN member states and civil society organisations

- Frame all national responses to the COVID-19 pandemic within a human rights perspective;
 - Ensure the availability, accessibility, affordability and quality of basic palliative care services and essential palliative care medicines on the WHO Model List;
 - Provide testing, treatment and palliation of COVID-19 free of charge to protect families from further financial impacts;
 - Avoid interfering with existing palliative care services or accommodate them if possible;
 - Mitigate negative impacts of infection control restrictions on palliative care services
 - exempt palliative care providers from movement restrictions, modify hospital and hospice visitation policies to facilitate safe visits, and extend morphine and other essential medicine prescriptions for 30 days or more.
 - Develop and distribute provider guidances on palliative care for COVID-19 in collaboration with UN agencies and palliative care associations;
 - Train healthcare workers in basic palliative care techniques including psychosocial and spiritual care;
 - Protect provider safety by ensuring, whenever possible, the availability of protective equipment for all health workers, including mobile teams, community health workers and volunteers involved in palliative care, and ensure access to telehealth technologies;
 - Ensure transparency and clarity around any rationing of treatment or supplies.
 - Although the right to health does not prohibit rationing of treatment in emergencies, it does impose procedural requirements such as transparency and appropriate justification for any such decisions.
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References

1. Ibid., para. 32.
2. UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment 14, The right to the highest attainable standard of health, E/C.12/2000/4, 11 August 2000, http://tbinternet.ohchr.org/_layouts/treatybodyexternal/TBSearch.aspx?Lang=en&TreatyID=9&DocTypeID=11, para. 34.
3. Ibid., para. 47.
4. Ibid., para. 12.
5. Article 7, ICESCR.
6. Article 25a, CRPD <https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/article-25-health.html>
7. Nowak M and Hunt P. Special Rapporteurs on the question of Torture and the Right of everyone to the highest attainable standard of physical and mental health. Letter to Mr D. Best, ViceChairperson of the Commission on Narcotic Drugs, December 10 2008.
8. <https://www.icj.org/wp-content/uploads/1984/07/Siracusa-principles-ICCPR-legal-submission-1985-eng.pdf>
9. See, OHCHR, Covid-19 Guidance, Older Persons <https://www.ohchr.org/EN/NewsEvents/Pages/COVID19Guidance.aspx>

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