Structural Racism and Income-Related Health Inequities in the Ontario Government and its Public Health Units' Response to the COVID-19 Pandemic

*Kathleen Hammond, Katie Cheung & Noshin Ullah**

Early reports in Canada indicated that the health impacts of COVID-19 would be disproportionately worse for marginalized groups due to existing health inequities. While the federal, provincial, and territorial governments had extensive emergency powers at their disposal, the bulk of the pandemic response came from the provinces and territories. Despite warnings about the anticipated disparate impact of the pandemic, data from Ontario indicates that racialized populations and individuals in lower-income households were the worst hit by the

Les premiers rapports au Canada ont indiqué que les impacts du COVID-19 sur la santé affecteraient les groupes marginalisés de façon disproportionnée en raison des inégalités existantes dans le domaine de la santé. Bien que les gouvernements fédéral, provinciaux et territoriaux disposent de pouvoirs d'urgence étendus, l'essentiel de la réponse à la pandémie est venu des provinces et des territoires. Malgré les avertissements concernant l'impact disparate anticipé de la pandémie, les données de l'Ontario indiquent que les populations racialisées et

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pandemic. This paper explores four aspects of the Ontario government and its 34 public health units' emergency response: (1) data collection on COVID-19 and health inequities, (2) administration of COVID-19 testing, (3) the provision of medical services to those with COVID-19, and (4) distribution of COVID-19 vaccines. For each of these four aspects of the Ontario government and its 34 public health units' response, we highlight central areas where structural racism and income-related health inequities were apparent. We acknowledge the significant practical barriers, such as lack of information and severe resource constraints, involved in pursuing health equity goals during the COVID-19 pandemic. However, for each of these areas, we recommend steps that could have been taken by the Ontario government and the public health units, in part through the province's emergency powers, to redress the disparate impact of the pandemic. We suggest that the Ontario government had a moral duty to combat these inequities, as well as a possible legal duty to do so in light of the *Canadian Charter of Rights and Freedoms* and certain international human rights obligations.

les personnes appartenant à des ménages à faible revenu ont été les plus durement touchées par la pandémie. Cet article explore quatre aspects de la réponse d'urgence du gouvernement de l'Ontario et de ses 34 unités de santé publique : (1) la collecte de données sur le COVID-19 et les inégalités en matière de santé, (2) l'administration des tests de dépistage du COVID-19, (3) la prestation de services médicaux aux personnes atteintes du COVID-19, et (4) la distribution des vaccins contre le COVID-19. Pour chacun de ces quatre aspects de la réponse du gouvernement de l'Ontario et de ses 34 unités de santé publique, nous soulignons les domaines centraux où le racisme structurel et les inégalités de santé liées aux revenus étaient apparents. Nous reconnaissons les obstacles pratiques importants, tels que le manque d'informations et les contraintes sévères en matière de ressources, liés à la poursuite des objectifs d'équité en matière de santé pendant la pandémie du COVID-19. Cependant, pour chacun de ces domaines, nous recommandons des mesures qui auraient pu être prises par le gouvernement de l'Ontario et les unités de santé publique, en partie grâce aux pouvoirs d'urgence de la province, pour remédier à l'impact disparate de la pandémie. Nous soutenons que le gouvernement de l'Ontario avait le devoir moral de combattre ces inégalités, ainsi qu'une éventuelle obligation légale de le faire à la lumière de la *Charter canadienne des droits et libertés* et des certaines obligations en vertu du droit international relatif aux droits humains.

Introduction

Disasters highlight longstanding health inequities for members of marginalized groups such as racialized communities, Indigenous peoples, low-income populations, women, members of the LGBTQI2S community, and people with disabilities.[1] Health inequities are caused by differential access to material resources, privilege, and power. After the first wave of the COVID-19 pandemic,[2] Dr. Theresa Tam, the Chief Public Health Officer of Canada, noted in her "Report on the State of Public Health in Canada 2020" that the health impacts of COVID-19 were disproportionately worse for marginalized groups because of health inequities,[3] and that the intersection of multiple factors such as gender, race, and class further exacerbated the risk and impact of COVID-19.[4]

1 See e.g. Clare Wenham et al, "Women are most affected by pandemics — lessons from past outbreaks" (2020) 583:7815 Nature 194; Jodie G Roure, "The Reemergence of Barriers during Crises & Natural Disasters: Gender-Based Violence Spikes among Women & LGBTQ+ Persons during Confinement" (2020) 21:2 Seton Hall J Diplomacy & Intl Rel 23; Maya Sabatello, Scott D Landes & Katherine E McDonald, "People With Disabilities in COVID-19: Fixing Our Priorities" (2020) 20:7 American J Bioethics 187; Laura M Stough & Ilan Kelman, "People with Disabilities and Disasters" in Havidán Rodríguez, William Donner & Joseph E Trainor, eds, *Handbook of Disaster Research,* 2nd ed (Cham: Springer International Publishing, 2018) 225.

2 See e.g. Allan S Detsky & Isaac I Bogoch, "COVID-19 in Canada: Experience and Response to Waves 2 and 3" (2021) 326:12 JAMA 1145 at 1145 (although different sources rely on different dates to describe the various waves of the COVID-19 pandemic in Canada, the first wave in Canada is generally thought to have occurred between January 2020 and June 2020); Public Health Ontario, "COVID-19 in Ontario: A Summary of Wave 1 Transmission Patterns and Case Identification" (2020) at 2, online (pdf): *Public Health Ontario* <www.publichealthontario.ca/-/media/documents/ncov/epi/2020/08/covid-19-wave-1-transmission-patterns-epi-summary.pdf?la=en> [perma.cc/ZL77-9A5A].

3 See Public Health Agency of Canada, "From Risk to Resilience: An Equity Approach to COVID-19" (October 2020) at 2, 19, online (pdf): *Government of Canada* <www.canada.ca/content/dam/phac-aspc/documents/corporate/publications/chief-public-health-officer-reports-state-public-health-canada/from-risk-resilience-equity-approach-covid-19/cpho-covid-report-eng.pdf> [perma.cc/L2A9-7256] [From Risk to Resilience].

4 See *ibid* at 22.

Although governments in Canada at the federal, provincial, and territorial levels have a range of emergency powers in emergency and public health legislation, the bulk of the pandemic response came from the provinces and territories.[5] The Ontario government had extensive emergency powers to respond to the COVID-19 pandemic by virtue of the *Health Protection and Promotion Act*[6] (*HPPA*) and the *Emergency Management and Civil Protection Act*[7] (*EMCPA*). In Ontario, the pandemic response was a joint effort between the provincial government and its 34 public health units, which often adopt, adapt, and operationalize the provincial government's framework given their regional needs and capacities.

Despite the warnings that the pandemic would disproportionately impact marginalized populations, and despite the extensive emergency powers that the Ontario government had at its disposal, data from Toronto indicates that racialized populations made up 69% of the city's cases,[8] and 39% of the city's reported cases were from individuals in lower-income households.[9] The Ontario government has been criticized for not taking into account people's differences in access to material resources, privilege, and power in its response.[10]

5 See generally Marie-Eve Couture-Ménard et al, "Answering in Emergency: The Law and Accountability in Canada's Pandemic Response" (2021) 72 UNBLJ 1.

6 RSO 1990, c H.7 [*HPPA*].

7 RSO 1990, c E.9 [*EMCPA*].

8 See From Risk to Resilience, *supra* note 3 at 22 (early data suggested that racialized populations made up over 80% of Toronto's COVID-19 cases, more recent data, as of December 31 2021, suggests that racialized populations made up 69% of the reported cases); Toronto Public Health, "COVID 19: Ethno-Racial Identity & Income" (last visited 26 February 2023), online: *City of Toronto* <www.toronto.ca/home/covid-19/covid-19-latest-city-of-toronto-news/covid-19-pandemic-data/covid-19-ethno-racial-group-income-infection-data/> [perma.cc/E5VN-NAZC] [Toronto Public Health].

9 See Toronto Public Health, *supra* note 8 (lower income is calculated based on income bands and household size, for example, when the household contains two to four persons, an income ranging from $30,000 to $49,999 will be characterized as low).

10 See e.g. Bobby Hristova, "'No excuse': Hamilton vaccine group member wants BIPOC community prioritized" (19 April 2021), online: *CBC News* <www.cbc.ca/news/canada/hamilton/hamilton-bipoc-vaccine-priority-1.5989119> [perma.cc/96KS-MAE9]; Bella Pick, "Ontario is prioritizing dining over the disabled with its vaccination policy" (5 April 2021), online: *Toronto Star* <www.thestar.

In this paper we explore four aspects of the Ontario government and its 34 public health units' emergency response: (1) data collection on COVID-19 and health inequities, (2) administration of COVID-19 testing, (3) the provision of medical services to those with COVID-19, and (4) distribution of COVID-19 vaccines. For each of these four aspects of the response, we highlight central ways that the Ontario government and the provincial public health units did not adequately account for structural racism, income-related health inequities, and intersectionality in responding to the COVID-19 pandemic. We acknowledge the significant practical barriers, such as lack of information and severe resource constraints, involved in pursuing health equity goals during the COVID-19 pandemic. However, we argue that the Ontario government could have done more to address the disparate impacts of the pandemic through policy and the use of emergency powers. We argue that it had a moral duty to combat these inequities, as well as a possible legal duty.[11]

This paper is divided into three parts. In Part I, we explain and define health inequity, structural racism, and income-related health inequities. We situate the current discussion in the existing literature that documents the health inequities faced by racialized and low-income communities in day-to-day health care, during prior pandemics, and during the COVID-19

com/opinion/contributors/2021/04/05/ontario-is-prioritizing-dining-over-the-disabled-with-its-vaccination-policy.html?rf> [perma.cc/HNB3-5Z5E]; Mike Crawley, "These 'hot spots' getting vaccine priority are less hard-hit by COVID-19 than Ontario average" (12 April 2021), online: *CBC News* <www.cbc.ca/news/canada/toronto/ontario-covid-19-vaccination-postal-code-hot-spots-1.5983155> [perma.cc/PC9R-3CA5].

[11] Canadian federal, provincial and territorial governments could have also done more to prepare for a pandemic, given that an influenza pandemic had been widely predicted by epidemiologists and Canada's lack of preparedness has been commented on by the media and commentators. Better pandemic preparedness could have been the first important step taken by Canadian governments to help prevent health inequities. See e.g. Grant Robertson, "'We are not prepared': The flaws inside Public Health that hurt Canada's readiness for COVID-19" (26 December 2020), online: *The Globe and Mail* <www.theglobeandmail.com/canada/article-we-are-not-prepared-the-flaws-inside-public-health-that-hurt-canadas/> [perma.cc/8T3N-GJYP]; Amir Attaran & Elvina C Chow, "Why Canada is Very Dangerously Unprepared for Epidemic Diseases: A Legal and Constitutional Diagnosis" (2011) 5:2 JPPL 287; See also Alice Yu et al, "COVID-19 in Canada: A self-assessment and review of preparedness and response" (2020) 10:2 J Global Health 1 at 2 (authors even refer to Canada's preparation for and approach to dealing with the pandemic as "passive [...] relative to other nations" at 2).

pandemic. In Part II, we describe the nature of the emergency powers that Ontario had at its disposal. We then highlight key areas under four aspects of the Ontario government and public health units' response where structural racism and income-related inequities were apparent. For each of these areas, we recommend steps that the Ontario government and its public health units could have taken and discuss ways in which emergency powers could have been used to achieve these steps. In Part III, we explore the Ontario government's moral duty, as well as possible legal duty, to combat these inequities.

This paper serves as a learning opportunity for Ontario and other Canadian provinces and territories on how to use their extensive emergency powers to address structural racism and income-related health inequities in ongoing responses to COVID-19, and in the event of a future pandemic. It is also in conversation with scholarship that has been published during the COVID-19 pandemic that comments on structural racism and income-based inequities and how to address these in COVID-19 responses.[12]

I. Structural Racism and Income-Related Health Inequities

Before discussing the extent to which the Ontario government accounted for structural racism and income-based inequities, it is necessary to understand what we mean by equity, structural racism, and income-based inequities.

There are many dimensions to health care, all of which engage equality and equity to ensure that resources are distributed fairly and that everyone has adequate access to care. Though both concepts are similar in nature and share qualities to an extent, health inequities, which are the focus of this paper, differ from health inequalities. Health inequality is a generic term that is used to refer to differences in the "health achievements of individuals and groups."[13] It is merely a descriptive term and does not have a moral element.[14] An example of a health inequality, for instance, are differences in health based on age because young people often have better health than older

[12] See e.g. Crista E. Johnson-Agbakwu et al, "Racism, COVID-19, and Health Inequity in the USA: a Call to Action" (2022) 9:1 J Racial & Ethnic Health Disparities 52.

[13] Kawachi, SV Subramanian & N Almeida-Filho, "A glossary for health inequalities" (2002) 56 J Epidemiology & Community Health 647 at 647.

[14] See *ibid* at 647. See also Mariana C Arcaya, Alyssa L Arcaya & SV Subramanian, "Inequalities in health: definitions, concepts, and theories" (2015) 8 Global Health Action 1 at 2.

people.[15] As Kawachi and colleagues point out, health inequalities describe differences that do not evoke moral concern and that we would not usually consider unjust.[16] The authors additionally offer the example of the difference in health between a person who dies in their 40s during a sky diving accident and their twin sibling who does not skydive, and dies at age 80.[17] These differences or variations in health achievements do not evoke moral concern.[18]

On the contrary, moral judgement is integral to the definition of health inequities, and many forms of health inequalities are also inequitable. Health inequity refers to "inequalities in health that are deemed to be unfair or stemming from some form of injustice."[19] Health inequities are influenced by the social determinants of health.[20] These include, for example, education, income, employment and job insecurity, housing, access to health services, discrimination, and racism.[21] Social determinants of health can influence health in positive and negative ways. Many are not within the control of individuals and stem from systemic biases, causing unjust differences in health outcomes.

Structural racism and low-income can have huge negative impacts on health outcomes and are the source of health inequities. When referring to structural racism we are referencing the culmination of ways society fosters racial discrimination by reinforcing systemic inequities, segregating groups, and preventing them from equally participating and benefitting from education and political and health systems.[22] This is done by establishing a dominant group and reinforcing their power through institutions, policies, laws, and access to resources.[23] In Canada, "[…] racism has been increasingly recognized as an important driver of inequitable health outcomes for racialized Canadians."[24] Worse health outcomes have been found among racialized groups, including Indigenous peoples.[25]

In Canada, a determination of whether a person, or family, is of low-income status is based on comparing a family's income with the appropriate low-income cut-off (LICO), which depends on the family size.[26] These cut-offs are based on data from the Survey of Household Spending and they convey the "income level at which a family may be in straitened circumstances because it has to spend a greater proportion of its income on necessities than the average family of simi-

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15 See Kawachi, *supra* note 13 at 647.

16 See *ibid*.

17 See *ibid.*

18 See *ibid.*

19 *Ibid.*

20 See *ibid* at 648; See also National Academies of Sciences, Engineering, and Medicine, *Communities in action: Pathways to health equity* (Washington, DC: The National Academies Press, 2017) at 99.

21 See World Health Organization, "Social determinants of health" (last visited 26 February 2023), online: *World Health Organization* <www.who.int/health-topics/social-determinants-of-health#tab=tab_1> [perma.cc/R7UK-4Q7T]; See also Margaret Whitehad, "The Concepts and Principles of Equity and Health" (1992) 22:3 Intl J Health Services 429 at 431–432; Public Health Agency of Canada, "Social determinants and inequities in health for Black Canadians: A snapshot" (8 September 2020), online (pdf): *Government of Canada* <www.canada.ca/en/public-health/services/health-promotion/population-health/what-determines-health/social-determinants-inequities-black-canadians-snapshot.html> [perma.cc/8QKY-2BJ9] [PHAC, "Inequities in health for Black Canadians"]; See also Yin Paradies et al, "Racism as a Determinant of Health: A Systematic Review and Meta-Analysis" (2015) 10:9 PLoS One 1.

22 See e.g. Zinzi D Bailey et al, "Structural racism and health inequities in the USA: evidence and interventions" (2017) 389:10077 Lancet 1453 at 1453, 1455; Zinzi D Bailey, Justin M Feldman & Mary T Bassett, "How Structural Racism Works – Racist Policies as a Root Cause of U.S. Racial Health Inequities" (2021) 384:8 New England J Medicine 768 at 768 [Bailey, "Racism as a Determinant of Health"].

23 See Bailey, "Racism as a Determinant of Health", *supra* note 22 at 769; See also Charlotte Reading, "Understanding Racism" (2013) at 5, online (pdf): *National Collaborating Centre for Aboriginal Health* <www.nccih.ca/docs/determinants/FS-Racism1-Understanding-Racism-EN.pdf> [perma.cc/EV6L-KYNG].

24 PHAC, "Inequities in health for Black Canadians", *supra* note 21 at 2; See generally National Collaborating Centre for Determinants of Health, "Let's Talk: Racism and Health Equity" (2018) at 4, online (pdf): *National Collaborating Centre for Determinants of Health* <nccdh.ca/images/uploads/comments/Lets-Talk-Racism-and-Health-Equity-EN.pdf> [perma.cc/A5XS-HJVN] [NCCDH].

25 See NCCDH, *supra* note 24; See generally Naomi Adelson, "The Embodiment of Inequity: Health Disparities in Aboriginal Canada" (2005) 96:2 Can J Public Health S45.

26 See "Low income definitions" (27 November 2015), online: *Statistics Canada* <www150.statcan.gc.ca/n1/pub/75f0011x/2012001/notes/low-faible-eng.htm> [perma.cc/4NL3-FY35].

lar size."[27] A 2018 report on key health inequalities in Canada found that low-income populations consistently had worse health outcomes.[28]

Structural racism and income are also closely intertwined. Racialized individuals, for instance, are also more likely to be living in poverty and attain lower levels of education.[29] In order to mitigate barriers and disparities, addressing either structural racism or income exclusively would have limited effects. Focusing on eliminating racial bias for example is certainly necessary; however, it does little to address the fact that racialized populations are disproportionately part of low-income/education groups. Similarly, working towards addressing class disparities is essential but would be futile to do without acknowledging disparities due to race.[30] It is therefore crucial that these factors be studied and utilized in conjunction with each other to begin closing the inequity gap in health. For individuals with the same needs, tackling inequity means providing the same resources. For individuals with different needs, tackling inequities means providing these individuals with resources reflective of this need.[31] This paper's focus is on the extent to which the Ontario government and Ontario's public health units considered social determinants of health like structural racism and income in responding to the COVID-19 pandemic, in order to reduce health inequities for racialized and low-income populations.

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27 *Ibid.*

28 See generally Public Health Agency of Canada, "Key Health Inequalities in Canada: A National Portrait" (August 2018), online (pdf): *Government of Canada* <www.canada.ca/content/dam/phac-aspc/documents/services/publications/science-research/key-health-inequalities-canada-national-portrait-executive-summary/hir-executive-summary-eng.pdf > [perma.cc/DW58-53TX].

29 See American Psychological Association, "Ethnic and Racial Minorities & Socioeconomic Status" (July 2017), online: *American Psychological Association* <www.apa.org/pi/ses/resources/publications/minorities> [perma.cc/F7YP-N2P7].

30 See Kawachi, *supra* note 13 at 651.

31 See Barbara Starfield, "The hidden inequity in health care" (2011) 10:15 Intl J Equity in Health 1 (when individuals with the same needs are not provided with the same resources, this is referred to as horizontal inequity; when individuals with greater needs are not provided with resources reflective of this need, this is referred to as vertical inequity).

A. Structural Racism and Income-Related Inequities with Access to Health Care in Canada and During Canada's Prior Pandemics

Structural racism and income-related inequities have long been entrenched in access to health care in Canada. The advent of Medicare in Canada in conjunction with the *Canada Health Act*[32] has sought to serve many Canadians by making certain health care services available but has not necessarily resulted in equitable access to this care.[33] Though inequity in health care due to racial factors has been widely reported in the United States,[34] scholars have observed that Canada lags in providing much of this data.[35] The literature that does exist in Canada paints a very grim picture of the treatment and lack of access to health care resources for low-income and racialized communities including immigrants, refugees, and Indigenous peoples.[36] It highlights three main areas of inequity

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32 RSC 1985, c C-6.

33 See Danielle Martin et al, "Canada's universal health-care system: achieving its potential" (2018) 391:10131 The Lancet 1718 at 1729.

34 See e.g. Keon L Gilbert et al, "Visible and Invisible Trends in Black Men's Health: Pitfalls and Promises for Addressing Racial, Ethnic, and Gender Inequities in Health" (2016) 37:1 Annual Rev Public Health 295 at 301; Vincente Navarro, "Race or class versus race and class: mortality differentials in the United States" (1990) 336:8725 Lancet 1238 at 1238–1239.

35 See e.g. Mushira Mohsin Khan et al, "Are visible minorities 'invisible' in Canadian health data and research? A scoping review" (2017) 13:1 Intl J Migration Health & Soc Care 126 at 127; Stephanie Wiafe & Robert Smith, "The Lack of COVID-19 Race-Based data in Canada Perpetuates Systemic Racism" (14 September 2020), online: *Institute for Science, Society and Policy* <www.issp.uottawa.ca/en/news/lack-covid-19-race-based-data-canada-perpetuates-systemic-racism> [perma.cc/6SRQ-T8DX].

36 See generally David A Alter et al, "Lesson From Canada's Universal Care: Socially Disadvantaged Patients Use More Health Services, Still Have Poorer Health" (2011) 30:2 Health Affairs 274; Forouz Nader et al, "Assessing Health Care Access and Use among Indigenous Peoples in Alberta: A Systematic Review" (2017) 28:4 J Health Care for Poor & Underserved 1286; Dalia L Rotstein et al, "Health service utilization in immigrants with multiple sclerosis" (2020) 15:7 PLoS One 1; Chinenye Nmanma Nwoke & Brenda M Y Leung, "Historical Antecedents and Challenges of Racialized Immigrant Women in Access to Healthcare Services in Canada: an Exploratory Review of the Literature" (2021) 8:6 J Racial & Ethnic Health Disparities 1447. See e.g. Adelson *supra* note 25 at S45; Martin et al, *supra* note 33 at 1729.

in access to health care for racialized and low-income groups. These are: (1) the unique barriers faced by Indigenous peoples in accessing health care;[37] (2) difficulties in accessing specialist services, homecare, and long-term care, especially among immigrants and newcomers to Canada;[38] and (3) difficulties in accessing privatized services, especially dental and mental health services, among racialized and low-income groups.[39]

Previous pandemics and public health emergencies in Canada have also brought pre-existing health inequities to the forefront and have been met with responses that did little to tackle these inequities. This was evident in responses to early Influenza outbreaks (1918-1920), during which death rates were higher among individuals from racialized communities and/or from lower income regions. It was also common practice to segregate racial minorities, including Asian Canadians and Indigenous populations in hospitals, and to put patients who were of lower income in second-rate wards

37 See e.g. Nam Hoang Nguyen et al, "Barriers and Mitigating Strategies to Healthcare Access in Indigenous Communities of Canada: A Narrative Review" (2020) 8:2 Healthcare 1; Tim Michiel Oosterveer & T Kue Young, "Primary health care accessibility challenges in remote indigenous communities in Canada's North" (2015) 74:1 Intl J Circumpolar Health 1; Wanda Phillips-Beck et al, "Confronting Racism within the Canadian Healthcare System: Systemic Exclusion of First Nations from Quality and Consistent Care" (2020) 17:22 Intl J Environmental Research & Public Health 1.

38 See e.g. Daniel W Harrington et al, "Access granted! barriers endure: determinants of difficulties accessing specialist care when required in Ontario, Canada" (2013) 13 BMC Health Services Research 1; Seong-gee Um, Thrmiga Sathiyamoorthy & Brenda Roche, "The Cost of Waiting for Long-Term Care: Findings from a Qualitative Study" (2021), online (pdf): *Wellesley Institute* <www.wellesleyinstitute.com/publications/the-cost-of-waiting-for-ltc-qualitative-study/> [perma.cc/QRW5-LZ7A]; Danial Qureshi et al, "Describing Differences Among Recent Immigrants and Long-Standing Residents Waiting for Long-Term Care: A Population-Based Retrospective Cohort Study" (2021) 22:3 JAMDA 648.

39 See e.g. Bruce Wallace et al, "Self-reported oral health among a community sample of people experiencing social and health inequities: cross-sectional findings from a study to enhance equity in primary healthcare settings" (2015) 5:12 BMJ Open 1; Bruce B Wallace & Michael I Macentee, "Access to Dental care for Low-income Adults: Perceptions of Affordability, Availability and Acceptability" (2012) 37:1 J Community Health 32; Anna Durbin, Susan J Bondy & Janet Durbin, "The Association Between Income Source and Met Need Among Community Mental Health Service Users in Ontario, Canada" (2012) 48:5 Community Mental Health J 662; Mary Bartram, "Income-based inequities in access to mental health services in Canada" (2019) 110:4 Can J Public Health 395 at 398.

in comparison to middle class patients.[40] Racial discrimination was also apparent during the tuberculosis outbreaks in the 1930s, when many hospitals refused to admit Indigenous patients. Though some hospitals had what were called Indian wards, this further contributed to the segregation of Indigenous patients.[41] Furthermore, as author Maureen Lux discusses, when Indian hospitals (such as Camsell hospital in Alberta) were implemented, they often had colonial agendas, such as providing research opportunities for medical students, as opposed to fulfilling the needs of Indigenous populations.[42]

Although the medical community has progressed in preventing the spread of influenza with the advent of vaccines, treatment remains unequal amongst various ethnic groups. Data collected from the Canadian Health Survey between 2003-2009 found that though certain Asian ethnic groups (including those of Filipino or Southeast Asian descent) were more likely to be vaccinated for the flu compared to non-ethnic groups, the lowest vaccination rates were found among self-identifying West Asian, Arab, and Black individuals, meaning that many racialized individuals remain at greater risk.[43] Differences in these vaccination rates have been attributed to differing access to vaccine programs, personal bias, and/or attitudes of clinicians.[44]

40 See Government of Canada, "The Spanish Flu in Canada (1918-1920) National Historic Event" (1 December 2022), online: *Parks Canada* <www.pc.gc.ca/en/culture/clmhc-hsmbc/res/information-backgrounder/espagnole-spanish> [perma.cc/E6DN-XE2C]; D Ann Herring & Ellen Korol, "The North-South Divide: Social Inequality and Mortality from the 1918 Influenza Pandemic in Hamilton, Ontario" in Esyllt W Jones & Magdalena Fahrni, eds, *Epidemic Encounters: Influenza, Society, and Culture in Canada, 1918–20* (UBC Press, 2012) 97; Esyllt Jones, "Surviving influenza: lived experiences of health inequity and pandemic disease in Canada" (2020) 192:25 CMAJ E688–E689.

41 See Maureen K Lux, "Care for the 'Racially Careless': Indian Hospitals in the Canadian West, 1920–1950s" (2010) 91:3 Can Hist Rev 407 at 407–429.

42 See Mary-Ellen Kelm, "Separate Beds: A History of Indian Hospitals in Canada, 1920s–1980s by Maureen Lux (Review)" (2017) 34:1 Can Bull Medical History 240; Government of Canada, "Indian Health Policy" (1979), online: *Government of Canada* <www.publications.gc.ca/site/eng/9.865668/publication.html> [perma.cc/6M5Y-FD7S].

43 See Susan Quach et al, "Influenza vaccination coverage across ethnic groups in Canada" (2012) 184:15 CMAJ 1673.

44 See Bradford D Gessner, "Ethnic disparities in influenza vaccination in Canada" (2012) 184:15 CMAJ 1661–62.

Following the spread of Severe Acute Respiratory Syndrome (SARS) in 2003, it became clear that public health planning must be socio-culturally appropriate and that any interventions must be inclusive of Indigenous peoples and other marginalized groups.[45] The H1N1 pandemic of 2009 further demonstrated the need for this approach. Through consultation with various stakeholders, the Senate Committee report on Canada's response to the 2009 H1N1 influenza pandemic reported on lessons learned and recommendations for future pandemics.[46] It noted that during the H1N1 pandemic, Indigenous people made up a disproportionate amount of hospitalizations, intensive care admissions, and deaths.[47] In particular, the report highlighted the need for more consultation with First Nations, Inuit, and Métis peoples in revising the Canadian Pandemic Influenza Plan for the Health Sector (the Plan).[48] Inuit representatives, for instance, felt that the Plan did not address the unique needs of their communities and was not culturally appropriate.[49] A focus group conducted with a Métis community in Manitoba found that regarding vaccinations, prioritization of Indigenous peoples was not always taken well.[50] Themes of mistrust, fear, and a lack of understanding emerged from the study.[51] Though some individuals were more inclined to be vaccinated when priority was given, others were fearful of being used as test subjects.[52]

Currently, many consider HIV (human immunodeficiency syndrome)/AIDS (acquired immunodeficiency syndrome) an ongoing epidemic that

45 See Theresa Tam, "Fifteen years post-SARS: Key milestones in Canada's public health emergency response" (3 May 2018) 44:5 Can Communicable Disease Report 98 at 100.

46 See generally Standing Senate Committee on Social Affairs, Science and Technology, "Canada's Response to the 2009 H1N1 Influenza Pandemic" (December 2010), online (pdf): *Senate of Canada* <www.sencanada.ca/content/sen/Committee/403/soci/rep/rep15dec10-e.pdf> [perma.cc/2YM3-RE2K].

47 See *ibid* at 41.

48 See *ibid* at 41.

49 See *ibid* at 42.

50 See S Michelle Driedger et al, "Factors influencing H1N1 vaccine behavior among Manitoba Metis in Canada: a qualitative study" (2015) 15:1 BMC Public Health 128 at 138.

51 See *ibid* at 134.

52 See *ibid.*

stems from underlying health inequities. HIV infection is generally associated with and found to be more prevalent within socially disadvantaged groups and individuals who have lower income.[53] Between 1995 and 2001, there were over 1,000 deaths attributed to HIV in the province of British Columbia alone.[54] Approximately 32.8% of these individuals passed away without receiving any treatment for their condition.[55] Researchers found that Indigenous ethnicity, lower income, and female sex were associated with a lower chance of having received treatment before death.[56] Among Indigenous women living with HIV, poor health status can stem from a lack of understanding of the disease and treatment options.[57] A lack of health care services on reserves and in non-urban areas also makes it difficult to obtain treatment.[58] Recent research has also shed light on the smaller minority of Francophones living with HIV/AIDS in Canada.[59] Considering the official languages of Canada, not having services available in French is a barrier for Canadian-born Francophones as well as many African-born individuals.[60] Linguistic challenges are often not given much priority considering HIV/AIDS services are already stretched thin and have limited resources, and it is difficult to recruit bilingual individuals because of the lower salary for professionals working with these groups.[61] United States modelling has suggested that overall incidence rates of HIV/AIDS are projected to

53 See Jennifer A Pellowski et al, "A Pandemic of the Poor: Social disadvantage and the U.S. HIV Epidemic" (2013) 68:4 American Psychologist 197 at 199, 204.

54 See Evan Wood et al, "Prevalence and Correlates of Untreated Human Immunodeficiency Virus Type 1 Infection among Persons Who Have Died in the Era of Modern Antiretroviral Therapy" (2003) 188:8 J Infectious Diseases 1164 at 1166.

55 See *ibid* at 1164.

56 See *ibid* at 1169.

57 See Jane McCall, Annette J Browne & Sheryl Reimer-Kirkham, "Struggling to Survive: The Difficult Reality of Aboriginal Women Living With HIV/AIDS" (2009) 19:12 Qualitative Health Research 1769 at 1776.

58 See *ibid* at 1774.

59 See generally Andre A Samson & Noah M P Spector, "Francophones living with HIV/AIDS in Ontario: The unknown reality of an invisible cultural minority" (2012) 24:5 AIDS Care 658.

60 See *ibid* at 661.

61 See *ibid* at 660–61.

decrease with the implementation of targeted strategies.[62] However, the incidence rate will not reach parity between white and Black groups.[63]

Taken together, this research reveals the ways in which past public health emergencies have exacerbated existing inequities as well as the systemic discrimination, segregation, and experimentation that have been part of past responses to health emergencies. It illustrates the need for more socio-culturally appropriate health responses to public health emergencies that are informed by community input. These responses must consider the history, ongoing fear, mistrust of medical institutions, and continued prevalence of systemic discrimination and stigma faced by racialized and low-income groups.

B. Racial and Income-Related Health Inequities During the COVID-19 Pandemic

The spread of COVID-19 has similarly exacerbated pre-existing inequities and demonstrated the need to implement socio-culturally appropriate strategies to mitigate them. As the infectious disease evolved in Canada, it became clear that it did not affect everyone equally. Minority race and low income were prominent factors associated with a higher likelihood of contracting COVID-19 and developing more severe health outcomes.[64]

Across Canada and within larger cities like Toronto and Montreal, racialized individuals and low-income households were among the groups over-represented in COVID-19 infections.[65] As we mentioned in the Introduction section, Toronto data from May 31, 2021, indicates that racialized populations made up 69% of the city's cases, even though racialized

62 See Bohdan Nosyk et al, "'Ending the Epidemic' Will Not Happen Without Addressing Racial/Ethnic Disparities in the United States Human Immunodeficiency Virus Epidemic" (2020) 71:11 Clinical Infectious Diseases 2968 at 2969.

63 See *ibid*.

64 See "COVID-19 in Ontario – A Focus on Neighbourhood Diversity, February 26, 2020 to December 13, 2021" (April 2022) at 1–2, online (pdf): *Public Health Ontario* <www.publichealthontario.ca/-/media/documents/ncov/epi/2020/06/covid-19-epi-diversity.pdf?la=en> [Neighbourhood Diversity] [perma.cc/V3NP-668E].

65 See From Risk to Resilience, *supra* note 3 at 22 (in Montreal, as of May 2020, disadvantaged neighbourhoods had 2.5 times more cases than affluent neighbourhoods).

groups only make up about half of the city's population.[66] The same data indicated that 39% of the city's reported cases were from individuals in lower-income households.[67] Ontario data from April 27, 2020 had indicated that COVID-19 infection and hospitalization rates were considerably higher among individuals in low-income neighborhoods compared to affluent neighborhoods.[68] These rates were also higher among immigrants to Canada. In Ontario, 25% of the population is represented by permanent immigrants, and data as of June 2020 indicated that 43.5% of this population had contracted COVID-19.[69] Analyses conducted by groups such as the Ontario Native Women's Association suggest that Indigenous peoples have been affected by COVID-19 at a disproportionate rate in areas such as Thunder Bay.[70] Data from Indigenous Services Canada as of September 14, 2021 indicated that the rate of COVID-19 in First Nations people living on reserve is 40% higher than the rate in the general Canadian popu-

66 See Toronto Public Health, *supra* note 8; Loprespub, "Inequities in COVID-19 Health Outcomes: The Need for Race- and Ethnicity-Based Data" (December 2020), online: *Library of Parliament* <www.hillnotes.ca/2020/12/08/inequities-in-covid-19-health-outcomes-the-need-for-race-and-ethnicity-based-data/> [perma.cc/DK7L-MUEA] [Library of Parliament]. See also From Risk to Resilience, *supra* note 3 at 22.

67 See Toronto Public Health, *supra* note 8 (lower income is calculated based on income bands and household size. For example, when the household contains two to four persons, an income ranging from $30,000 to $49,999 will be characterized as low).

68 See "Lower income people, new immigrants at higher COVID-19 risk in Toronto, data suggests" (12 May 2023), online: *CBC News* <www.cbc.ca/news/canada/toronto/low-income-immigrants-covid-19-infection-1.5566384> [perma.cc/8RSY-NAD8]; "COVID-19 - What We Know So Far About… Social Determinants of Health" (April 2020), online: *Public Health Ontario* <www.publichealthontario.ca/-/media/documents/ncov/covid-wwksf/2020/05/what-we-know-social-determinants-health.pdf?la=en> [perma.cc/Y2HA-76AJ] (data from April 27, 2020, indicated that rates of COVID-19 were 113 cases per 100,000 in lower-income neighbourhoods, compared with 73 cases per 100,000 in affluent neighbourhoods).

69 See Guttmann A et al, "COVID-19 in Immigrants, Refugees and Other Newcomers in Ontario: Characteristics of Those Tested and Those Confirmed Positive, as of June 13, 2020" (June 2020) at 8, online: *ICES* <www.ices.on.ca/Publications/Atlases-and-Reports/2020/COVID-19-in-Immigrants-Refugees-and-Other-Newcomers-in-Ontario> [perma.cc/6T9E-TBFP].

70 See Logan Turner, "Indigenous people likely affected by COVID-19 at disproportionate rate in Thunder Bay, but no clear data" (17 May 2021), online: *CBC News* <www.cbc.ca/news/canada/thunder-bay/indigenous-covid-rates-tbay-1.6027643> [perma.cc/X2YK-H6QU].

lation, and the "case fatality rate among First Nations people living on a reserve is 57% of the fatality rate in the general Canadian population."[71]

Mortality rates have also been higher among those living in the most diverse neighborhoods.[72] Higher mortality rates have been associated with factors such as being more likely to live in crowded households, barriers to or discrimination in accessing services, and being employed in essential worker positions.[73] Many outbreaks for instance occurred in factories, including meat processing facilities.[74] At these processing facilities, 41% of workers were from racialized groups.[75] In a study conducted by Brock University and the Canadian Arab Institute, researchers collected survey responses to understand the impacts of COVID-19 on racialized communities in Canada along five categories: physical, financial, emotional, spiritual, and social.[76] Researchers found Arab respondents were less aware and less satisfied with their community responses than non-Arab respondents.[77]

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71 Indigenous Services Canada, "Confirmed cases of COVID-19" (April 2022), online: *Government of Canada* <www.sac-isc.gc.ca/eng/1598625105013/1598625167707> [perma.cc/8796-F3JZ]. See also Christy Somos, "A year later, Indigenous communities are fighting twin crises: COVID-19 and inequality" (25 January 2021), online: *CTV News* <www.ctvnews.ca/health/coronavirus/a-year-later-indigenous-communities-are-fighting-twin-crises-covid-19-and-inequality-1.5280843> [perma.cc/EU8Y-76X9].

72 See Neighbourhood Diversity, *supra* note 64 at 1–11; see Library of Parliament, *supra* note 66.

73 See Library of Parliament, *supra* note 66.

74 See Bryony Lau, "Their lives are at risk': Variants heighten concerns at meat plants" (March 2021), online: *Healthy Debate* <www.healthydebate.ca/2021/03/topic/variants-meat-plants/> [perma.cc/TQ7E-AK38].

75 See From Risk to Resilience, *supra* note 3 at 22.

76 See generally Gervan Fearon & Walid Hejazi, "Experiences of Racialized communities during the COVID-19 Pandemic" (2021), online (pdf): *Canadian Arab Institute at Brock University* <www.static1.squarespace.com/static/5e09162ecf041b5662cf6fc4/t/60ba62750ce2e444cbc23a4f/1622827637523/Brock+Report+-+May+2021.pdf> [perma.cc/5YKV-RXGL].

77 See *ibid* at 7, 19 (75% of non-Arab respondents were aware of their community taking steps to deal with the pandemic versus 61% of Arab respondents, however, satisfaction with community responses was not all that different, 53% of non-Arab respondents were satisfied or somewhat satisfied compared with 47% of Arab respondents).

As preliminary data began to appear, illustrating the racial and income-related health inequities during the pandemic, it became evident that the response to the pandemic needed to be adapted to mitigate these inequities.

II. Ontario's Neglect of Structural Racism and Income-Related Health Inequities in Four Aspects of its COVID-19 Response

As stated in the Introduction section, the federal government has numerous tools at its disposal for responding to the COVID-19 crisis.[78] However, the bulk of the pandemic response has come from provinces and territories that have all "utilized their emergency powers, either by virtue of their public health legislation (which contain special emergency powers) and/or their general emergency legislation."[79] In Ontario, extensive emergency powers were granted through the *HPPA*[80] and the *EMCPA*.[81]

The *HPPA* is public health legislation that has special emergency powers. It allows the Chief Medical Officer of Health (CMOH) to issue directives to health boards or medical officers with regards to infectious diseases and health hazards, among others, if the CMOH believes there is an "an immediate risk of, a provincial, national, or international public health event,

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78 The federal government has at its disposal the *Emergencies Act,* RSC 1985, c 22 (4th Supp) and the Peace Order and Good Government power under the *Constitution Act, 1867* (UK), 30 & 31 Vict, c. 3, reprinted in RSC 1985, Appendix II, No 5. It invoked the *Emergencies Act* in response to the Freedom Convoy Protests, declaring a public order emergency that was in effect from February 14th to February 23rd, 2022. During the pandemic the federal government also adopted many pieces of legislation (e.g. fiscal and financial measures) specific to the pandemic. It has also applied the *Quarantine Act* SC 2005 c. 20 to impose testing and quarantine requirements on travelers.

79 Couture-Ménard et al, *supra* note 5 at 4.

80 See *HPPA*, *supra* note 6.

81 See *EMCPA*, *supra* note 7; Marie-Eve Couture-Ménard & Rebecca Schur, "A Comparative Grid of Provincial Health Emergency Powers in Canada" (June 2020), online (pdf): *McGill Research Group on Health and Law* <www.mcgill.ca/healthlaw/files/healthlaw/2020-june-couture-menard_me_and_schur_r-analysis_grid_emergency_powers.pdf> [perma.cc/7JA2-8ZTT] (authors provide a thorough overview of the emergency powers that all provinces and territories, including Ontario, had at their disposal).

a pandemic or an emergency with health impacts anywhere in Ontario"[82] and that the measures are needed in order to respond.[83] The *HPPA* allows the Minister of Health and Long-Term Care ("Minister") to order the emergency procurement, acquisition and seizure of medications and supplies, and to order people to provide medications and supplies to another person.[84] The *EMCPA* is Ontario's general emergency legislation, it allows the Lieutenant Governor in Council (or Premier if urgency requires) to declare a 'state of emergency' in Ontario.[85] During a declared emergency, the Lieutenant Governor can make a wide range of orders[86] to prevent, reduce or mitigate harm.[87]

Powers granted to the Ontario government through these two pieces of legislation allow the government to: (1) mobilize human and material resources to respond to overwhelming demands for health care and other services,[88] (2) collect data to alleviate the effects of the emergency,[89] (3) restrict the movement or gathering of people to limit the spread,[90] and (4) allow authorities to act outside usual legislative requirements to eliminate processes and formalism in order to respond quickly to the public health

82 *HPPA, supra* note 6, s 77.9(1)(a)(2).

83 See *ibid,* s 77.9(1)(b) (the Minister of Health and Long-Term Care can enact regulations to further specify the meaning of terms such as "pandemic" for the purposes of section 77.9).

84 See *ibid,* s 77.5(1).

85 See *EMCPA*, *supra* note 7, s 7.0.1(1). The order can be made if certain criteria are met under s 7.0.1(3). The head of council of a municipality can also declare that an emergency exists in the municipality or in part of the municipality under s 4(1). 'Emergency' is defined under s 1 as "a situation or an impending situation that constitutes a danger of major proportions that could result in serious harm to persons or substantial damage to property and that is caused by the forces of nature, a disease or other health risk, an accident or an act whether intentional or otherwise." Events must meet specific criteria to trigger the use of emergency powers.

86 See *ibid*, s 7.0.2(4).

87 See *ibid,* s 7.0.2(2).

88 See e.g. *ibid* ss 7.0.2(4)4, 7.0.2(4)6, 7.0.2(4)8, 7.0.2(4)9, 7.0.2(4)10, 7.0.2(4)12; *HPPA*, *supra* note 6, s 77.5(1).

89 See e.g. *EMCPA*, *supra* note 7, s 7.0.2(4)13; *HPPA*, *supra* note 6, s 77.5(6).

90 See e.g. *EMCPA*, *supra* note 7, ss 7.0.2(4)2, 7.0.2(4)5.

threat.[91] In other words, the Ontario government has extensive ability to respond to the COVID-19 pandemic, in a way that mitigates inequities, through usual public policy-making processes and through these powers. Ontario's 34 public health units then adopt, adapt, and operationalize the Ontario government's framework according to their regional needs and capacities.[92]

Given the extensive powers that the Ontario government had at its disposal to mitigate inequities, we now turn to four aspects of the Ontario government and its public health units' response to COVID-19: (1) its data collection on COVID-19 and health inequities, (2) its administration of COVID-19 testing, (3) the provision of medical services to those with COVID-19, and (4) its distribution of COVID-19 vaccines. For each of these four aspects of its response we identify central areas where structural racism and income-related health inequities were apparent, and we discuss any steps the Ontario government and public health units took to address these inequities. Often through comparison with examples of best practice from other jurisdictions, we discuss how the Ontario government might have used usual public-policy making processes or its emergency powers to address the health inequities we identify, as well as general steps that the public health units could have taken to better mitigate inequities.

A. Data Collection on COVID-19 and Health Inequities

The first flaw with the Ontario government's response is that in responding to the COVID-19 pandemic, data collection has been incomplete and has not accounted for equity-related indicators. To respond to an outbreak, complete data that accounts for equity-related indicators is necessary to identify vulnerable populations so that specific proactive and preventative actions can be taken for these populations.[93]

91 See e.g. *HPPA*, *supra* note 6 s 77.6(5) (this provision allows the CMOH to disclose information obtained through an emergency order despite legislative provisions that protect personal information and privacy).

92 See Ontario Ministry of Health and Long-Term Care, "Health Services in Your Community: Public Health Units" (March 2021), online: *Ontario Ministry of Health and Long-Term Care* <www.health.gov.on.ca/en/common/system/services/phu/> [perma.cc/9CUY-AC4D].

93 See Alexandra Blair et al, "Identifying gaps in COVID-19 health equity data reporting in Canada using a scorecard approach" (2021) 112:3 Can J Public Health 352 at 353.

Dr. Theresa Tam's "Report on the State of Public Health in Canada 2020," which was published in October 2020 after the first wave of the pandemic outlined the unequal impact COVID-19 would have across different populations.[94] The report stated that "some populations, already experiencing poorer health and fewer opportunities to achieve good health, faced the pandemic at a greater risk of direct impacts."[95] Preliminary data from the United States had also suggested that racialized people were at higher risk for COVID-19 during the first wave of the pandemic.[96] As we outlined in Part I of this paper, we also know from previous health emergencies that racialized and low-income individuals are most at-risk for negative impacts in a pandemic. Sociodemographic and race-based data is substantially important and Ontario also has extensive data collection powers through the *EMCPA* which allows any person to collect, use, or disclose information that the Lieutenant Governor in Council thinks is necessary to deal with an emergency.[97] However, the Ontario government initially refused to collect this data stating that there was no need.[98] A similar problem was evident in other Canadian provinces.[99] In response, an open letter called for the Ontario government to begin race-based data collection,[100] and an organization

94 See From Risk to Resilience, *supra* note 3 at 19–37.

95 *Ibid* at 19.

96 See Alex Boyd, "Race-based coronavirus data not needed in Canada yet, health officials say" (April 2020), online: *Toronto Star* <www.thestar.com/news/canada/2020/04/10/race-based-coronavirus-data-not-needed-in-canada-yet-health-officials-say.html> [perma.cc/MZ5E-CUGX]; Kathleen Foody, "Rate of deaths, illness among black residents alarms cities" (6 April 2021), online: *AP NEWS* <www.apnews.com/article/health-us-news-ap-top-news-virus-outbreak-public-health-1862bf401d6aad1d182e0bd967488c90> [perma.cc/R35R-XVPL].

97 See *EMCPA*, *supra* note 7, s 7.0.2(4)13. This is subject to s 7.02(7), which requires, among other things, that the information be used to deal with an emergency. The Chief Medical Officer can also, when there is an immediate or serious risk, direct a health information custodian to supply them with personal health information. See *HPPA*, *supra* note 6, s 77.6(1).

98 See Boyd, *supra* note 96.

99 See *ibid.* See also George J Sefa Dei and Kathy Lewis, "COVID-19, Systemic Racism, Racialization and the Lives of Black People" in Carl James & Audrey Kobayashi, eds, *Impacts of COVID-19 in Racialized Communities* (Ottawa: Royal Society of Canada, 2021) at 25.

100 See Alliance for Healthier Communities, "Open letter to premier Doug Ford, deputy Christine Elliott and Dr David Williams regarding the need to collect and socio-demographic and race based data" (April 2020), online: *Alliance for Healthier Communities* <www.allianceon.org/news/Letter-Premier-Ford-Deputy-Premier-Elliott-and-Dr-Williams-regarding-need-collect-and-use-socio> [perma.cc/74U4-3JK5].

called the Black Health Equity Working Group was founded to collect and use socio-demographic data such as on race/ethnicity and income to highlight the need for data collection at testing, tracing, and hospitalization.[101]

Eventually, Ontario and a few other provinces, such as Manitoba, started to collect race-based data while others, such as Quebec, continued to refuse to do so.[102] Ontario's collection of race-based data began through policy mechanisms in June 2020 although a number of impacted communities and experts (like the Black Health Equity Working Group) had already expressed a need for it.[103] Although the Ontario government required the collection of socio-demographic data at tracing by all public health units, it was considered too onerous to collect at testing centers.[104] Alexandra Blair and colleagues assessed the health equity-oriented COVID-19 reporting across Canadian provinces and territories as of December 31, 2020.[105] They looked at reporting on the "cumulative totals of tests, cases, hospitalizations, deaths

101 See Kwame McKenzie, "Socio-demographic data collection and equity in covid-19 in Toronto" (7 April 2021) 34:100812 eClinicalMedicine 1 at 1.

102 See Eric Andrew-Gee, "Manitoba charts new course by collecting race-based data on COVID-19" (12 May 2020), online: *The Globe and Mail* <www.theglobeandmail.com/canada/article-manitoba-charts-new-course-by-collecting-race-based-data-on-covid-19/> [perma.cc/RQ84-HPC7]; Franca G Mignacca, "Quebec is still not publishing race-based data about COVID-19. These community groups aim to fill the void" (19 August 2020), online: *CBC News* <www.cbc.ca/news/canada/montreal/community-groups-launch-national-covid-19-race-database-1.5691937> [perma.cc/4G4B-NQ9V]; "Introducing Race, Income, Household Size, and Language Data Collection: A Resource for Case Managers" (June 2020), online (pdf): *Public Health Ontario* <www.publichealthontario.ca/-/media/documents/ncov/main/2020/06/introducing-race-income-household-size-language-data-collection.pdf?la=en> [perma.cc/N2K7-GJFT].

103 See Wellesley Institute, "Tracking COVID-19 Through Race-Based Data" (18 August 2021) at 3, online (pdf): *Ontario Health* <www.ontariohealth.ca/sites/ontariohealth/files/2021-08/Tracking%20COVID%2019%20Through%20Race%20Based%20Data-EN.pdf> [perma.cc/9RQS-7N75] [Wellesley Institute, "Tracking COVID-19 Through Race-Based Data]; Kwame, *supra* note 101 at 1.

104 See *ibid*.

105 See Blair et al, *supra* note 93.

and population size" and examined whether provinces and territories gave information province and territory-wide, or whether specific information for regions and local areas could be obtained.[106] They also looked at the extent to which this data identified equity-oriented social markers like age, sex, race, ethnicity, income, and vulnerable settings (like detention facilities, homeless shelters) etc.[107] They presented their results for provinces, territories, and Canada as a whole, using a scorecard approach with A being the highest and F being the lowest score.[108] As François Béland points out, the pandemic seems to have illustrated the Canadian health care system's failure to gather data corresponding to equity indicators,[109] because overall, Alexandra Blair and colleagues gave Canada an F in its equity-oriented reporting.[110]

While Ontario ranked slightly better than most other provinces in its reporting on age, sex, and on cases in provincial detention facilities, it did not report on immigration, race/ethnicity, income, or education in conjunction with its information on tests, cases, hospitalizations, deaths and population size.[111] This is especially peculiar given that information on population sizes by immigration status, race/ethnicity, income etc. are available through the Canadian census for each province/territory, as well as for local regions.[112]

The lack of data collection in the first wave, and ongoing data collection since, has been a missed opportunity to lessen impacts of COVID-19 on racialized and low-income communities. For example, an analysis of a subset of American clinical research studies on COVID-19 treatments found that most studies did not report or utilize racial/ethnic data, and Black patients and communities were under-represented in all studies in relation to their disease burden.[113] This lack of representation in

106 See *ibid* at 352–55.

107 See *ibid* at 355–58.

108 See *ibid* at 355–56.

109 See François Béland, "Pandemics, inequities, public health, information, response: Canada's failure?" (2021) 112:3 Can J Public Health 349 at 351.

110 See Blair et al*, supra* note 93 at 355–56.

111 See *ibid* at 356.

112 See *ibid*.

113 See Hala T Borno, Sylvia Zhang & Scarlett Gomez, "COVID-19 disparities:

clinical studies hinders the development of understanding treatment outcomes that are inclusive and relevant to specific racial and ethnic groups.

An illustration of the importance of this data is evident in the Peel region, just west of Toronto. In Peel, data collected and made public by its public health unit and regional government revealed that the region's South Asian community was being disproportionately affected by COVID-19.[114] The data prompted local organizations serving these racialized communities to be more strategic in coming up with responses. Indus Community Services, a local non-profit, applied for government funding which allowed it to hire individuals to knock on doors, rally leaders to dispel myths about vaccination and provide relief funds and accommodation for those who needed to self-isolate.[115] If the Ontario government had put policy in place or used its powers through the *EMCPA*[116] to ensure collection of this information by all its public health units during the first wave, efforts could have been more targeted and used effectively to prevent infection and death in populations that were at risk due to pre-existing health inequities.[117] Ontario public health units could have prevented this failing by collecting thorough data early on, as Peel's health unit did.

B. Administration of COVID-19 Testing

COVID-19 testing was a second important aspect of the Ontario government's response. Testing is essential on an individual basis to identify who has contracted COVID-19 and, consequently, who needs to receive treatment or isolate from others.[118] On a broader communal scale, testing identifies where

An urgent call for race reporting and representation in clinical research" (2020) 19:100630 Contemporary Clinical Trials Communications 1 at 1–3.

114 See Roberto Rocha & Tara Carman, "How Tracking Ethnicity and Occupation Data is Helping Fight COVID-19" (14 June 2021), online: *CBC News* <www.cbc.ca/news/canada/how-tracking-ethnicity-and-occupation-data-is-helping-fight-covid-19-1.6060900> [perma.cc/QSQ2-J2EZ].

115 See *ibid*.

116 See *EMCPA*, *supra* note 7, s 7.02(4)13.

117 See McKenzie, *supra* note 101 at 2.

118 See NIH Leadership, "Why COVID-19 Testing is the Key to Getting Back to Normal "(September 2020), online: *National Institute of Aging* <www.nia.nih.gov/

there is risk of spreading the infection and where public health efforts must be placed to mitigate the spread of COVID-19.[119] We will demonstrate that, in their approach to COVID-19 testing, the Ontario government and its public health units failed to adequately account for differential access to resources, privilege, and power for individuals in low-income and racialized communities.

1. Testing Not Initially Available to People in Congregate Settings

The first aspect of testing that did not adequately deal with structural racism and income-related health inequities was the Ontario government's prioritization plan. At the beginning of the pandemic (in March 2020), COVID-19 testing was only available for specific groups: those who were in contact with confirmed cases and who had symptoms, "those who were admitted to hospital with acute respiratory illness, health-care workers with symptoms or who were part of an investigation into an institutional outbreak, people living in long-term care homes (LTCs) and retirement homes, and First Nation community members living on reserve."[120] Although prioritization of First Nation community members was an important step in accounting for health inequities, there were other groups that should have also been prioritized in March. It was not until April 2020 that individuals living in congregate settings, such as group homes, supportive housing, shelters, correctional facilities, retirement homes, and LTCs were prioritized for testing.[121] Data from outbreaks later revealed the surge of cases in group homes/supportive housing, shelter settings and correctional facilities.[122]

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news/why-covid-19-testing-key-getting-back-normal> [perma.cc/8YRU-M85X]; Eduardo Sanchez, "COVID-19 Science: Why Testing is so Important" (April 2020), online: *American Heart Association* <www.heart.org/en/news/2020/04/02/covid-19-science-why-testing-is-so-important> [perma.cc/Q9Z3-SXRF].

119 See Sanchez, *supra* note 118.

120 Jackie Dunham, "Ontario Limits Who Can Be Tested for COVID-19 Due to Demand for Nasal Swabs" (14 March 2020), online: *CTV News* <www.ctvnews.ca/health/coronavirus/ontario-limits-who-can-be-tested-for-covid-19-due-to-demand-for-nasal-swabs-1.4853260> [perma.cc/GP3M-YC4D].

121 See "Ontario Significantly Expanding COVID-19 Testing" (10 April 2020), online: *Government of Ontario* <www.news.ontario.ca/en/release/56644/ontario-significantly-expanding-covid-19-testing> [perma.cc/2CDR-MBUN] (On April 10, 2020, the office of the Premier of Ontario announced that testing would be available to those in congregate settings).

122 See "COVID-19 Outbreaks in Congregate Living Settings: February 26, 2020 to July 16, 2021" (September 2021), online: *Public Health Ontario* <www.publichealthontario.ca/-/media/Documents/nCoV/epi/covid-19-outbreaks-cls-epi-summary.pdf?rev=c459c192403e426ab932e99e204dd301&sc_lang=en> at 2 (which demonstrates the outbreaks in group homes, supportive housing, shelter settings and correctional facilities) [perma.cc/BZ2N-ERJP]; Linwei Wang et al, "Heterogeneity in testing, diagnosis and outcome in SARS-CoV-2 infection across outbreak settings in the Greater Toronto Area, Canada: an observational study" (2020) 4 CMAJ Open E627 at E634 (which demonstrate the disproportionate number of cases in long-term care homes and shelters).

This revelation is significant because low-income and racialized populations are overrepresented in some congregate settings such as correctional facilities, and shelters.[123] As of July 2020, individuals living in congregate settings had a 2 to 18 times higher rate of being infected and diagnosed with COVID-19 and,[124] as of May 2020, residents of LTCs had a disproportionately high fatality rate amongst those diagnosed.[125] High rates of infection and diagnosis can be attrib-

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123 See Akwasi Owusu-Bempah et al, "Race and Incarceration: The Representation and Characteristics of Black People in Provincial Correctional Facilities in Ontario, Canada" (2021) Race & Justice at 4–6; Jamil Malakieh, "Adult and youth correctional statistics in Canada, 2018/2019" (December 2020) at 5, 7, online (pdf): *The Government of Canada* <www150.statcan.gc.ca/n1/en/pub/85-002-x/2020001/article/00016-eng.pdf?st=fznf8RFV> [perma.cc/U9XM-BLBD]. See also "Poverty" (last visited 15 March 2023), online: *Homeless Hub* <www.homelesshub.ca/about-homelessness/education-training-employment/poverty> [perma.cc/7GAX-67MX] (there is a strong correlation between poverty and being unhoused making it more likely that low-income populations use shelters) [Homeless Hub, "Poverty"]; "Racialized Communities" (last visited 13 March 2023), online: *Homeless Hub* <www.homelesshub.ca/about-homelessness/population-specific/racialized-communities> [perma.cc/X6XD-54LL] (people who are unhoused in Canada are disproportionality racialized individuals making it more likely that they might use shelters) [Homeless Hub, "Racialized Communities"]; "Fact Sheet#9 Racialized Poverty in Housing & Homelessness" (March 2009) at 1, online (pdf): *Colour of Poverty* <www.colourofpoverty.ca/wp-content/uploads/2019/03/cop-coc-fact-sheet-9-racialized-poverty-in-housing-homelessness-2.pdf> [perma.cc/CB5C-RTX4] [Colour of Poverty, Fact Sheet 9] (indicates that 28-34% of the shelter population in Canada is Indigenous).

124 See "Rapid Review: What factors increase the risk of COVID-19 outbreaks in congregate living settings? How do outcomes compare to outbreaks in community settings?" (31 July 2020) at 2, online (pdf): *National Collaborating Centre for Methods and Tools* <www.nccmt.ca/uploads/media/media/0001/02/069da80fe4a3468b618bb8163c27aba52d087efc.pdf> [perma.cc/J86Y-F3L7] [NCCMT].

125 See Wang et al, *supra* note 122 at E628–E634.

uted to factors associated with congregate living facilities. For individuals living in LTCs, difficulties in maintaining physical distance and mitigating exposure to staff arise from cognitive and functional impairment, advanced age, and having pre-existing health comorbidities.[126] For individuals living in shelters, difficulties in maintaining physical distance stem from living and working in densely populated conditions, unknowingly interacting with asymptomatic individuals, limited use of face masks, precarious hygienic conditions, and undiagnosed or uncontrolled mental and physical comorbidities.[127] Thus, these groups are at a greater risk of infection, transmission, and fatality and were in need of immediate testing to identify and mitigate the spread of COVID-19.[128] The Ontario government's decision not to prioritize individuals in congregate settings in March may have been, in part, due to the fact that Canada had a shortage of testing supplies, was logistically unprepared for large amounts of testing, and was operating on little information.[129] Better pandemic preparedness, given that an influenza pandemic was widely predicted by epidemiologists, could have been the first important step taken by Canadian governments to help prevent inequities.

2. Barriers to Accessing Testing Sites and Acquiring Rapid-Antigen Tests

Second, a variety of barriers made it difficult for racialized and low-income populations to access in-person test sites and rapid antigen test kits (RATs). Wait times for COVID-19 tests were as long as six hours,[130] and many assessment centers, labs, and pharmacies had testing backlogs, causing test

126 See Ammar Saad et al, "Health Equity Implications of the COVID-19 Lockdown and Visitation Strategies in Long-Term Care Homes in Ontario: A Mixed Method Study" (2022) 19:7 Int J Environmental Research & Public Health 1 at 10.

127 See e.g. Massimo Ralli et al, "Asymptomatic patients as a source of transmission of COVID-19 in homeless shelters" (2021) 103 Int J Infectious Diseases 243 at 244.

128 See generally Kevin A Brown et al, "Association Between Nursing Home Crowding and COVID-19 Infection and Mortality in Ontario, Canada" (2021) 181:2 JAMA Internal Medicine 229; "Racism, Homelessness, and COVID-19" (May 2020), online: *National Law Center on Homelessness and Poverty* <www.homelesslaw.org/wp-content/uploads/2020/05/Racism-Homelessness-and-COVID-19-Fact-Sheet-_Final_2.pdf> [perma.cc/Q23M-XQJM].

129 See Yu et al, *supra* note 11 at 5.

130 See Adrianna Tetley, "Ontario Needs Testing Strategies That Work For Everyone" (23 September 2020), online: *Alliance for Healthier Communities* <www.allianceon.org/news/Ontario-needs-testing-strategies-work-everyone> [perma.cc/J2VZ-7XF7].

results to take up to 11 days.[131] These obstacles made COVID-19 testing difficult to access for everyone, but was likely particularly harmful for racialized and low-income populations who are more likely to have jobs where they do not get paid sick leave, paid time off, or have a lack of job security, which puts them at risk of losing their job if they do not come to work.[132] They may also be less likely to have access to a car, making it more difficult for them to access some testing centers.[133] The Ontario government could have implemented public policy directed towards putting testing centers in more accessible places, such as on public transit routes, or could have used powers through the *EMCPA* that allow it to establish facilities for the care of individuals.[134] Some testing centers also did not provide testing services in

131 See Graham Slaughter, "Ontario's testing backlog leaves some waiting over a week for results" (1 October 2020) online: *CTV News* <www.ctvnews.ca/health/coronavirus/ontario-s-testing-backlog-leaves-some-waiting-over-a-week-for-results-1.5129521> [perma.cc/E76P-QBBW].

132 See e.g. "Before it's Too Late: How to Close the Paid Sick Day Gap During COVID-19 and Beyond" (14 July 2020) at 4, online (pdf): *Decent Work and Health Network* <www.d3n8a8pro7vhmx.cloudfront.net/dwhn/pages/135/attachments/original/1604082294/DWHN_BeforeItsTooLate.pdf?1604082294> [perma.cc/8MCL-UTVS] [Decent Work and Health Network]; David Macdonald, "COVID-19 and the Canada workforce; Reforming EI to protect more workers" (March 2020) at 5, online (pdf): *Canada Centre for Policy Alternatives* <www.policyalternatives.ca/sites/default/files/uploads/publications/2020/03/CCPA%20Report_COVID19%20and%20the%20Canadian%20Workforce.pdf> [perma.cc/DEP5-UMGL] (which outline how lower-income workers are less likely to have paid sick leave). See also Sheila Block & Grace-Edward Galabuzi, "Canada's Colour Coded Labour Market: The gap for racialized workers" (March 2011) at 3, 15, online: *Canada Centre for Policy Alternatives* <www.policyalternatives.ca/sites/default/files/uploads/publications/National%20Office/2011/03/Colour%20Coded%20Labour%20Market.pdf> [perma.cc/L2HZ-JK8W]; "Fact Sheet #5: Racialized Poverty in Employment" (March 2019), online (pdf): *Colour of Poverty* <www.colourofpoverty.ca/wp-content/uploads/2019/03/cop-coc-fact-sheet-5-racialized-poverty-in-employment-2.pdf> [perma.cc/QBG5-JVMR] [Colour of Poverty, Fact Sheet 5] (explains that racialized groups are over-represented in part-time and precarious employment, which have lower wages, no benefits and job insecurity).

133 See e.g. Nicholas J Klein, "Subsidizing Car Ownership for Low-Income Individuals and Households" (2020) J Planning Education & Research 1 at 9, 10.

134 See e.g. *EMCPA*, *supra* note 7, s 7.02.(4)4.

the primary languages of communities, which might have deterred certain individuals from getting testing.[135] Public health units could have combatted these language barriers through the help of translators or volunteers from community organizations who spoke the primary languages of communities.

As the pandemic progressed, many health organizations pleaded for better testing strategies that would be catered to different communities' needs, rather than a one size fit all approach.[136] The Ontario government and public health units continued to take steps to improve access to testing. For instance, they worked towards trying to provide test results more rapidly[137] and they introduced mobile testing and pop-up testing facilities in hotspot areas in 2021.[138] However, there was often poor communication as to who was eligible for testing, where these sites were located, and how long they would stay.[139]

Ontario also began to distribute free RATs, which are tests that can be taken at home and that "look for proteins from the COVID-19 virus."[140] As of February 9th, 2022, the provincial government began distributing millions of RATs through pharmacy and grocery locations, "as well as through community partners in vulnerable communities."[141] There was a limit of one box of tests per household and it was left to retailers to determine how tests

135 See "Priority strategies to optimize testing and screening for COVID-19 in Canada: Report" (January 2021), online: *Government of Canada* <www.canada.ca/en/health-canada/services/drugs-health-products/covid19-industry/medical-devices/testing-screening-advisory-panel/reports-summaries/priority-strategies.html#a7> [perma.cc/96A8-TLC9] [Priority Strategies].

136 See e.g. Tetley, *supra* note 130.

137 See "COVID-19 Test Collection and Analysis" (last modified 28 November 2022), online: *Ontario Health* <www.ontariohealth.ca/COVID-19/testing-analysis> [perma.cc/D9JU-685N] [Ontario Health].

138 *Ibid.*

139 See Aedan Helmer, "Confusion over Ottawa's mobile pop-up testing sites as demand surges" (18 September 2020), online: *Ottawa Citizen* <ottawacitizen.com/news/confusion-over-ottawas-mobile-pop-up-testing-sites-as-demand-surges> [perma.cc/J5QW-FRNC].

140 Ontario Health, *supra* note 137.

141 "Rapid testing for at-home use" (last modified 2 November 2022), online: *Government of Ontario* <www.ontario.ca/page/rapid-testing-home-use> [perma.cc/XQA4-Z52X].

were distributed, which resulted in a first come, first served approach.[142] Public health officials urged residents to consider fairness and access when obtaining RATs, and to not hoard or resell tests at exorbitant prices when provided free of charge by the provincial government.[143] However, officials acknowledged that there was a lack of requirements for stores to ensure that residents did not hoard RATs, and noted the possibilities and opportunities this created for the public.[144] The provincial government's decision to make participating retailers responsible for distribution planning may not have served the community in the best way possible if participating vendors or other pop-up locations were unaware of the specific needs in the community, when participating retailers are not located in rural areas, or when they are located in areas with limited accessibility to transportation.

COVID-19 Test Finders was an initiative that was created by Ontario physicians to help Canadians access free RATs.[145] The same group started a petition called "Free the RATs" requesting that the government distribute tests directly to Canadians.[146] The Ontario petition has approximately 20,000 signatures, and the total signatures for all the petitions for all the provinces is over

142 See *ibid.*

143 See Bill Hodgins, "Don't hoard the RATs': 4 take-aways from Peterborough health unit's COVID-19 and Omicron update" (December 2021), online: *The Peterborough Examiner* <www.thepeterboroughexaminer.com/local-peterborough/news/2021/12/16/don-t-hoard-the-rats-4-take-aways-from-peterborough-health-unit-s-covid-19-and-omicron-update.html> [perma.cc/FW4W-THK4]; Phil Tsekouras, "Ontario says it will 'track down' and fine those reselling COVID-19 rapid antigen test kits for unfair prices" (December 2021), online: *CTV News* <www.toronto.ctvnews.ca/ontario-says-it-will-track-down-and-fine-those-reselling-covid-19-rapid-antigen-test-kits-for-unfair-prices-1.5715743> [perma.cc/ML2F-FRPG].

144 Antonella Artuso, "Ontario distributing free COVID test kits through grocers, pharmacies" (February 2022), online: *Simcoe Reformer* <www.simcoereformer.ca/news/local-news/ontario-distributing-free-covid-test-kits-through-grocers-pharmacies> [perma.cc/B9NE-6DJB].

145 See Nicole Bogart, "COVID Test Finders Twitter account is like Vaccine Hunters for rapid tests" (December 2012), online: *CTV News* <www.ctvnews.ca/health/coronavirus/covid-test-finders-twitter-account-is-like-vaccine-hunters-for-rapid-tests-1.5701743> [perma.cc/FVL-9MLN].

146 See John Paul Tasker, "As U.S. accelerates distribution of rapid tests, critics call on Ottawa to catch up" (23 January 2022), online: *CBC News* <www.cbc.ca/news/politics/canada-rapid-test-crunch-1.6323448> [perma.cc/BJC6-

75,000.[147] Other countries, such as the United States, Germany, Singapore, and the United Kingdom, sent tests directly to people's home to ensure more equitable access.[148] The Ontario government could have created a similar system by virtue of public policy or through its distribution powers under the *EMCPA*.[149] By virtue of these same powers, the Ontario government could have distributed the free RATs in areas and locations that have a higher concentration of unvaccinated individuals, especially children and other high-risk groups, to provide a more fair and streamlined approach to distribution. This would also have facilitated access to these tests for people in vulnerable groups who do not have residential addresses and could not receive tests shipped to their home. For instance, the Korean government specifically targeted unvaccinated children and high-risk groups by distributing free RATs to public schools, senior care facilities, neighbourhood welfare centers, etc.[150] Distributing RATs to at-risk or "hot spot" neighbourhoods was one of the goals of Ontario's distribution of RATs. However, an investigation by the Toronto Star found that "just one-fifth of RATs went to hot spot neighbourhoods in the first ten months" of the initiative.[151]

3. Lack of Paid Sick Leave

Third, there are many negative repercussions of having a positive test which may deter individuals from getting tested. These repercussions are

G9WW]; "#FreeTheRATsCampaign" (January 2022), online: *Zero Covid* <www.zerocovidcanada.org/rapid-test-petitions> [RATs Campaign].

147 See RATs Campaign, *supra* note 146.

148 See Tasker, *supra* note 146.

149 See *supra* note 7, s 7.0.2(4)9.

150 See Kim Tong-Hyung, "S. Korea to give out rapid tests as omicron shatters record" (16 February 2022), online: *AP News* <www.apnews.com/article/coronavirus-pandemic-health-business-pandemics-seoul-439624ee5ee50c9ef45609a2c93648a4> [perma.cc/7UA5-PJ6Z].

151 See Sara Mojtehedzadeh & Rachel Mendleson, "Ontario's rapid test distribution slammed by opposition critic as 'anything but equitable'" (11 April 2022), online: *The Toronto Star* <www.thestar.com/news/investigations/2022/04/11/ontarios-rapid-test-distribution-slammed-by-opposition-critic-as-anything-but-equitable.html?rf> [perma.cc/9QFG-VLRB]; Raju Mudhar, "The inequitable distribution of rapid tests in Ontario" (12 April 2022) at 00h:00m:52s, online (podcast): *The Toronto Star* <www.thestar.com/podcasts/thismatters/2022/04/12/the-inequitable-distribution-of-rapid-tests-in-ontario.html> [perma.cc/FLV2-B2SV].

heightened for individuals who are unable to get paid time off, receive sick leave, or who do not have job security.[152] This puts racialized and low-income individuals at a disadvantage as these groups are overrepresented in part-time and precarious employment positions, which are likely to have lower wages and lack benefits and job security.[153] It was not until April 29, 2021, over a year after the pandemic was declared by the World Health Organization (WHO), that the Ontario government amended the *Employment Standards Act*[154] (*ESA*) to require employers to "provide employees with up to three days of paid infectious disease emergency leave because of certain reasons related to COVID-19." This leave was available to employees who were sick with COVID-19, as well as those who were getting COVID-19 testing, waiting for test results, getting medical treatment for "mental health reasons related to COVID-19," getting vaccinated or experiencing side effects from vaccination, self-isolating after receiving medical advice, or providing care or support to certain relatives for COVID-19 reasons.[155] The Ontario government should have mandated this much earlier to encourage COVID-19 testing. In addition, Ontario should have provided salary payment for absences of two hours or more, and for up to two work weeks.[156] The latter would have allowed people to take time off when sick, self-isolate, get tested, get vaccinated, and would have protected them from income loss if their workplace were to close because of an outbreak.[157]

152 See Priority strategies*, supra* note 135.

153 See Colour of Poverty, Fact Sheet 5, *supra* note 132.

154 SO 2000, c 41 ss 50.1(1.2)–(1.3) [*Employment Standards Act*]; "Ontario COVID-19 Worker Income Protection Benefit*"* (last modified 26 July 2022), online: *Government of Ontario* <www.ontario.ca/page/covid-19-worker-income-protection-benefit> [perma.cc/EKP5-QZU8] [ON Protection Benefit].

155 See *Employment Standards Act*, *supra* note 154, s 50.1(1.2); ON Protection Benefit*, supra* note 154.

156 See Alison Thompson et al, "Benefits of paid sick leave during the COVID-19 pandemic" (28 April 2021) at 1, online: *Ontario COVID-19 Science Advisory Table* <www.covid19-sciencetable.ca/sciencebrief/benefits-of-paid-sick-leave-during-the-covid-19-pandemic/> [perma.cc/2VRE-7YYV].

157 See *ibid.*

4. Lack of Available Housing to Isolate

Fourth, other impediments, like living in unsafe or overcrowded houses or living in buildings with multiple units, can make testing less relevant. This concern is especially apparent for individuals living in group homes, shelters, or encampments, as there is a lack of sufficient space for sick individuals to socially distance themselves from others.[158] Data suggests that in Toronto the number of COVID-19 cases is nearly four times higher in overcrowded living areas.[159]

In May 2020, the Northwest Territories Housing Corporation, an agency of the Government of the Northwest Territories,[160] the Emergency Management Organization (EMO), and the Department of Health and Social Services reserved 130 housing units in 27 communities for individuals who needed to safely self-isolate.[161] These units were later turned into affordable housing to reduce issues of overcrowding, and to enhance self-isolation and physical distancing measures to mitigate future COVID-19 outbreaks in the territory. In 2017, the Department of Public Safety and Emergency Preparedness, a federal government department also known as Public Safety Canada, developed "An Emergency Management Framework in Canada," which gave rise to the EMO, and established a common approach in collaborative emergency management initiatives in each province and territory. The purpose of this framework was to increase collaboration in emergency

158 See From Risk to Resilience, *supra* note 3 at 25; Stephanie Elliott & Scott Leon, "Crowded housing and COVID-19: Impacts and solutions" (July 2020), online: *Wellesley Institute* <www.wellesleyinstitute.com/housing/crowded-housing-and-covid-19-impacts-and-solutions/> [perma.cc/8VX9-PR69].

159 See Jennifer Pagliaro, "Toronto pushes for quarantine centres for those in overcrowded housing who test positive for COVID-19" (July 2020), online: *The Toronto Star* <www.thestar.com/news/gta/2020/07/02/toronto-pushes-for-quarantine-centres-for-those-in-overcrowded-housing-who-test-positive-for-covid-19.html> [perma.cc/D9VL-2YYA].

160 See Housing Northwest Territories, "About the NWTHC" (last visited 30 March 2023), online: *Government of Northwest Territories* <www.nwthc.gov.nt.ca/en/about-nwthc> [perma.cc/78SS-TNLN].

161 See *ibid*; "Northwest Territories Housing Corporation announces units previously reserved for self-isolation purposes to be allocated" (25 May 2020), online: *Government of Northwest Territories* <www.gov.nt.ca/newsroom/northwest-territories-housing-corporation-announces-units-previously-reserved-self> [perma.cc/3BS3-SE97].

management by leveraging resources and capacities across the country.[162] The decision made in allocating additional housing units in the Northwest Territories was guided by the EMO, which works directly with federal government institutions, first responders and voluntary organizations, and other stakeholders and communities to address emergencies.[163] Although the province of Ontario also has a designated EMO, adequate discussions with the Ontario government were not conducted in addressing or providing any solutions to self-isolation needs in housing or accommodation during COVID-19. Compared to the Northwest Territories' approach, Ontario failed to provide adequate housing for its residents. In Ontario, voluntary isolation facilities and hotels were funded by the provincial government and federal governments with over $42 million dollars spent to create and expand these centers across the province.[164] For instance, one of these sites was in the Peel Region.[165] The sites offer voluntary isolation housing at no cost and with no Ontario Health Insurance Plan (OHIP) health card required if you meet certain criteria.[166] However, despite having these voluntary isolation sites available, these facilities operated just below 40% capacity since they opened.[167] The Ontario government should have pro-actively established facilities for care earlier on in the pandemic, and could have relied, if need be, on powers it has through the *EMCPA* to do so.[168] Some individuals from hotspot communities noted that they were unaware of or not given the option to go

162 See "Emergency Management" (November 2021), online: *Public Safety Canada* <www.publicsafety.gc.ca/cnt/mrgnc-mngmnt/index-en.aspx> [perma.cc/NM2L-SUAS].

163 See *ibid.*

164 See Angelina King, "Ontario has more than 1,000 COVID-19 isolation beds, so why are they less than half full" (2 February 2021), online: *CBC News* <www.cbc.ca/news/canada/toronto/ontario-1000-covid-isolation-beds-less-than-half-full-1.5896905> [perma.cc/Y9FR-VLHR].

165 See "Region of Peel self-isolation program" (December 2020), online (pdf): *Region of Peel* <www.mississaugahaltonhealthline.ca/healthlibrary_docs/COVID-19%20Self-isolation%20program%20flyer_v10-FINAL-email-web.pdf> [perma.cc/8PLF-CT4L].

166 See *ibid.*

167 See King, *supra* note 164.

168 See *EMCPA, supra* note 7, s 7.0.2(4)4. In extreme situations, the Ontario government also has powers to expropriate property through the *HPPA*. See *HPPA*, *supra* note 6, s 77.4(1).

to self-isolation centers even after speaking with a public health unit.[169] For some people, a variety of barriers made it difficult to get a COVID-19 test at the first sign of symptoms. For people who live in crowded multigenerational housing, by the time they found out about a positive COVID-19 diagnosis, it was often too late, and they had already potentially infected family members.[170] This comes back to issues with accessing testing that should have been accounted for. The Ontario government could have also made it protocol, by virtue of *HPPA* powers, to set out precautions and procedures for public health care workers to make access to isolation housing available for people who would need it and would not be able to self-isolate at home while they waited for test results.[171] At the very least, they could have told them about voluntary isolation housing upon testing, so that they were informed and could prepare for the possibility of going to isolation housing.[172]

C. Provision of Medical Services to Individuals with COVID-19

The provision of COVID-19 related medical services was a third important part of the Ontario government and its public health units' response to COVID-19. The wake of the pandemic resulted in resource shortages ranging from intensive care unit beds, ventilators, and personal protective equipment (PPE), reaching a point where organizations and hospitals were requesting PPE donations from citizens.[173] Non-urgent surgeries were also cancelled with prioritization of care implemented as restrictions began to lift. However, hospitals were strained to capacity with COVID-19 patients throughout the pandemic. The Ontario government pledged a total of $351 million dollars for 2,250 additional beds in 57 hospital facilities in October 2020.[174] However, the increase in the number of beds did not equate

169 See King, *supra* note 164.

170 See *ibid*.

171 See *HPPA*, *supra* note 6, s 77.7(1).

172 See King, *supra* note 164.

173 See Leah Johansen, "How to help Toronto & GTA hospitals during the coronavirus pandemic" (27 March 2020), online: *City News* <www.toronto.citynews.ca/2020/03/27/how-to-help-local-hospitals-during-the-coronavirus-pandemic/> [perma.cc/2J3V-FWBX].

174 See Mike Crawley, "Why Ontario hospitals are full to bursting, despite few COVID-19 patients" (2 November 2020), online: *CBC News* <www.cbc.ca/news/canada/toronto/ontario-hospital-occupancy-covid-19-hallway-healthcare-1.5784075> [perma.cc/U63K-5EY9].

to an increase in hiring front-line health care workers like physicians or nurses to assist with the overwhelming number of COVID-19 patients in the hospitals,[175] which evidently led to front-line health care workers facing burnout.[176] Even a year later in January 2021, hospitals were still over capacity and required patients to be transferred to rural hospitals or placed in beds in hallways or conference rooms.[177] Given this lack of resources, the systemic inequities (e.g. discrimination, failures to deliver culturally sensitive care, fewer health clinics on Indigenous reserves,[178] less access to OHIP coverage and to private insurance) that make it more difficult for racialized and low-income communities to access general health care were accentuated during the pandemic in accessing COVID-19 related medical services.[179]

175 See Mitchell Thompson, "Ontario Hospitals Will Face Staffing Shortages Until 2026, Provincial Fiscal Watchdog Says" (16 December 2022), online: *PressProgress* <www.pressprogress.ca/ontario-hospitals-staffing-shortages-2026-20221216/> [perma.cc/GH2Y-R8EX].

176 See Krista Hessey, "'I couldn't take it anymore': Why some medical staff are calling it quits amid COVID-19" (24 April 2021), online: *Global News* <www.globalnews.ca/news/7782649/covid-19-medical-staff-mental-health/> [perma.cc/25ZM-EPZP].

177 See Scott Miller, "Rural Ontario hospitals prepare to take patients from overcrowded city ICUs" (15 January 2021), online: *CTV News* <www.london.ctvnews.ca/rural-ontario-hospitals-prepare-to-take-patients-from-overcrowded-city-icus-1.5268923> [perma.cc/3SK9-WL29]; Mike Crawley, "Some of Ontario's biggest hospitals are filled beyond capacity nearly every day, new data reveals" (22 January 2020), online: *CBC News* <www.cbc.ca/news/canada/toronto/ontario-hospital-hallway-medicine-healthcare-beyond-capacity-1.5420434> [perma.cc/6C6F-SM62].

178 See Nguyen et al*, supra* note 37 at 4; Gloria Galloway, "Ottawa still failing to provide adequate health care on reserves: report" (25 January 2017), online: *The Globe and Mail* <www.theglobeandmail.com/news/politics/ottawa-still-failing-to-provide-adequate-health-care-on-reserves-report/article33746065/> [perma.cc/GG9K-9S3G].

179 See Lise Dassieu et al, "Chronic pain experience and health inequities during the COVID-19 pandemic in Canada: qualitative findings from the chronic pain & COVID-19 pan-Canadian study" (2021) 20:147 Intl J Equity Health 1 at 9.

1. Lack of OHIP Coverage

One aspect of access to COVID-19 medical services that did not adequately deal with structural racism and was income-related was a lack of access to OHIP coverage. Access to OHIP coverage is conditional on a person's immigration status. Temporary workers who have lost their jobs and individuals who have overstayed their visas lose their status and thus their health care access, new immigrants often face a three-month waiting period before having access to publicly funded health care, and immigrant detainees and refugee claimants do not have access.[180] As Graham Hudson and colleagues point out, during COVID-19, many temporary workers, such as seasonal agricultural workers, lost their jobs, which can result in loss of their status in Canada, and thus health care.[181] Restrictions on international travel also left international students and visitors stranded without health care coverage.[182] Ontario has taken steps to help mitigate these inequities, such as covering the costs of all services deemed medically necessary for uninsured patients and waiving the wait for new immigrants to allow them to access provincial health care immediately.[183] However, some hospitals are continuing to demand unnecessary documentation and are still charging

[180] They may be eligible for the Interim Federal Health program. However, this program has been criticized for providing insufficient coverage. See e.g. Graham Hudson et al, "COVID-19 exposing cracks in our universal healthcare" (22 October 2020), online: *Healthy Debate* <www.healthydebate.ca/2020/10/topic/covid-19-cracks-in-healthcare/> [perma.cc/LV7Y-YDTY].

[181] See *ibid.*

[182] See *ibid*. See also Joan Atlin et al, "Impact of COVID-19 on the Economic Well-Being of Recent Migrants to Canada. A Report on Survey Results from Permanent Residents, Temporary Workers, and International Students in Canada" (December 2020) at 3, online (pdf): *World Education Services* <www.eric.ed.gov/?id=ED610500> [perma.cc/U3AY-32ZR].

[183] See Health Services Branch, Ministry of Health, "COVID-19 Expanding access to OHIP Coverage and Funding Physician and Hospital Services for Uninsured Patients" (20 March 2020), online (pdf): *Ontario Ministry of Health* <www.health.gov.on.ca/en/pro/programs/ohip/bulletins/4000/bul4749.pdf> [perma.cc/8DMA-RN9S]; Health Network for Uninsured Clients, "Access to health care for uninsured patients during COVID-19 in Toronto: A brief guide for health care and social service providers" (29 March 2020) at 1, online (pdf): *Wellesley Institute* <www.wellesleyinstitute.com/wp-content/uploads/dlm_uploads/2020/03/Access-to-health-care-for-uninsured-patients-during-COVID-19-in-Toronto_-guide-for-providers.pdf> [perma.cc/2WL3-KY67].

patients.[184] This is a problem that needs to be addressed in the public health units that are not keeping up with changes made by the Ontario government.

2. Barriers to Accessing Telehealth Services

A second aspect of access to COVID-19 medical services that may create barriers is caused by changes to the delivery of health care services that came into place because of the COVID-19 pandemic. Access to day-to-day health care as well as some health care specifically related to COVID-19 shifted from in-person office services to virtual services within the first four months of the pandemic when physical distancing measures were set in place.[185] Telehealth applications such as Ontario Telemedicine Network (OTN), Tia Health, and Maple provided primary care and a virtual walk-in service that replaced in-person office visits with phone calls, video visits, and secured text messages during the pandemic.[186] These telehealth platforms increased accessibility to primary care physicians with certain applications being covered by OHIP, and helped many Canadians seek health care especially when there was fear of infection or risk of viral transmission in visiting medical offices or hospitals.[187] However, Telehealth applications are still inaccessible to many individuals who do not have privatized health coverage or the financial means to pay for Telehealth services that are not covered by the provincial health plan, and those who have language barriers, or do not have access to stable internet, or electronic devices like a cellphone, telephone, laptop, or computer where Telehealth platforms are used.[188] Public libraries, which are relied on by

[184] See Graham Hudson et al*, supra* note 180.

[185] See Richard H Glazier et al, "Shifts in office and virtual primary care during the early COVID-19 pandemic in Ontario, Canada" (2021) 193:6 Can Medical Association J E200 at E205.

[186] See "Solutions for Patients" (August 2021), online: *Ontario Telemedicine Network* <otn.ca/patients/> [perma.cc/3QCN-HY8C]; "How it Works" (August 2021), online: *Maple* <www.getmaple.ca/for-you-family/how-it-works/> [perma.cc/6HWF-7NWT]; "Services" (August 2021), online: *TIA Health* <tiahealth.com/online-medical-services/> [perma.cc/77CR-BYTF].

[187] See Meghan McMahon et al, "Informing Canada's Health System Response to COVID-19: Priorities for Health Services and Policy Research" (2020) 16:1 Healthcare Policy 112 at 116.

[188] See Tracy A Lustig, *The Role of Telehealth in an Evolving Health Care Environment:*

many for access to computers, were also closed in Ontario during much of the pandemic.[189] The Ontario government could have used its powers under the *EMCPA*, which allow it to "[establish] facilities for the care [...] of individuals"[190] and "[authorize] facilities […] to operate as is necessary,"[191] to allow people without Internet and/or computers to access these platforms at libraries (such as in private study/meeting rooms) or other facilities.

3. Lack of Mask Distribution

Thirdly, throughout the pandemic, the use of face masks has been an important preventive health care measure.[192] However, the cost of face masks makes them inaccessible to some groups. Scholars such as Jianhong Wu and colleagues, have suggested that Ontarians should continue to acquire protective supplies like masks, and that if supplies are low, Ontario should develop an optimal distribution strategy.[193] Ontario has strengthened their domestic supply chains for PPE, like masks, through Ontario-based manufacturers and have distributed these to congregate settings and other essential settings, like hospitals, schools, and retirement homes.[194] However, whereas countries like the United States, Japan, Taiwan, and the province of Manitoba have distributed free masks to the public, this has not been done by the

Workshop Summary (Washington DC: The National Academies Press, 2012) at 17.

189 See Tebasum Durrani, "COVID-19 disproportionately affects those living in poverty. And this impacts us all" (March 2020), online: *Healthy Debate* <www.healthydebate.ca/2020/03/topic/covid-19-low-income-poverty/> [perma.cc/NNC8-UFPX].

190 *EMCPA*, *supra* note 7, s 7.0.2(4)4.

191 *Ibid,* s 7.0.2(4)8.

192 See Nancy HL Leung et al, "Respiratory virus shedding in exhaled breath and efficacy of face masks" (2020) 26:5 Nature Medicine 676 at 679.

193 See Jianhong Wu et al, "Quantifying the role of social distancing, personal protection and case detection in mitigating COVID-19 outbreak in Ontario, Canada" (2020) 10:15 J Mathematics Industry at 11.

194 See Government and Consumer Services, News Release, "Ontario Bolstering Stockpile and Distributing Record Levels of Critical Supplies" (17 February 2022) online: *Government of Ontario Newsroom* <www.news.ontario.ca/en/release/1001610/ontario-bolstering-stockpile-and-distributing-record-levels-of-critical-supplies> [perma.cc/N4AR-ZWLW].

Canadian or Ontario government.[195] Masks can be costly, and especially at moments of particularly high demand, their prices have spiked, making them inaccessible, particularly to low-income groups.[196] In particular, inequities in access to more expensive masks like N95 masks have prompted initiatives such as those undertaken by a registered nurse in Kingston Ontario to raise money to purchase N95 masks and distribute them to vulnerable populations.[197] Ontario could have, like Taiwan, instituted price controls on masks through its *EMCPA* powers.[198] It could have also developed public policy on mask distribution or distributed masks by virtue of its distribution powers under the *EMCPA*.[199] Masks could have been distributed to households or been made available at major retail chains, like what was done in the United States, but with a focus on providing these to at-risk communities.[200]

195 See Siân Jones, "The Great Mask Divide: Lessons from Asia" (19 June 2020), online: *Asia Pacific Foundation of Canada* <www.asiapacific.ca/publication/great-mask-divide-lessons-asia> [perma.cc/964W-J9ZA]; Kyodo, "Japan to give two masks each to 50 million households to fight virus" (2 April 2020) online: *The Japan Times* <www.japantimes.co.jp/news/2020/04/02/national/japanese-government-distribute-two-masks-per-household-abe/> [perma.cc/WN8N-VTA2]; Jeff Mason & Lisa Baertlein, "U.S. to distribute 400 million free N95 masks at CVS, Walgreens in COVID fight" (19 January 2022), online: *Reuters* <www.reuters.com/world/us/us-make-400-million-n95-masks-available-free-fight-covid-19-pandemic-official-2022-01-19/> [perma.cc/FAJ9-45DJ]; Government of Manitoba, Media Bulletin, "Province Providing Free KN95 Masks to Manitobans" (23 December 2021) online: *Government of Manitoba* <news.gov.mb.ca/news/index.html?item=53024> [perma.cc/VX83-MCVU].

196 See Jack Lakey, "Face mask prices have soared during the COVID-19 pandemic. But is it gouging?" (2 April 2020), online: *Toronto Star* <www.thestar.com/news/gta/the-fixer/2020/04/02/face-mask-prices-have-soared-during-the-covid-19-pandemic-but-is-it-gouging.html?rf> [perma.cc/ZWJ7-7SMP].

197 See Darryn Davis, "Kingston RN working to get N95 masks to vulnerable populations" (22 January 2022), online: *Global News* <www.globalnews.ca/news/8531552/kingston-rn-n95-masks-effort/> [perma.cc/DTF5-WU92].

198 See *EMCPA, supra* note 7, s 7.0.2(4)11.

199 See *ibid,* s 7.0.2(4)9.

200 The United States government distributed 400 million free N95 masks at major retail chains. See Mason & Baertlein, *supra* note 195.

4. Insufficient Measures that Address Social Determinants of Health

Finally, measures that address underlying social determinants of health are particularly important to help combat structural racism and income-related health inequities. One such measure would have been the re-introduction of a basic income guarantee in Ontario. Although the federal government introduced the Canada Emergency Response Benefit (CERB) to provide financial support to workers in Canada who stopped working because of reasons related to COVID-19,[201] CERB had a number of downfalls. For instance, it excluded undocumented and non-status workers, many seasonal workers, and those who earned under $5,000 in 2019 or in the twelve months prior to their application.[202] The federal government needs to reform the program in the future to address these gaps. Additionally, basic income guarantees can be an important way to reduce health inequities and have been found to improve physical and mental health.[203] Ontario piloted a basic income guarantee in 2016, which was later canceled. Through the program, eligible couples or individuals were guaranteed a minimum income level, regardless of employment status, and were provided monthly basic income payments.[204] Assessments of the Ontario pilot program found that it improved both physical and mental health.[205]

[201] See "Canada Emergency Response Benefit (CERB)" (last visited April 2021), online: *Government of Canada* <www.canada.ca/en/services/benefits/ei/cerb-application.html> [perma.cc/CMC2-BGEM].

[202] See Andrew Langille, "How the Canada Emergency Response Benefit is Failing Low-Income Precarious Workers, and How it Can be Fixed" (17 April 2020), online (blog): *The Law of Work* <www.lawofwork.ca/how-the-canada-emergency-response-benefit-is-failing-low-income-precarious-workers-and-how-it-can-be-fixed/> [perma.cc/4KNG-HUP5].

[203] See e.g. Wayne Simpson, Greg Mason & Ryan Godwin, "The Manitoba Basic Annual Income Experiment: Lessons Learned 40 Years Later" (2017) 43:1 Can Public Policy 85 at 93 (which discusses the improved health outcomes from the Manitoba Basic Annual Income Experiment, Mincome).

[204] See Ministry of Children, Community and Social Services, "Archived – Ontario Basic Income Pilot" (24 April 2017), online: *Ontario* <www.ontario.ca/page/ontario-basic-income-pilot> [perma.cc/QK68-WT48].

[205] See Mohammad Ferdosi et al, "Southern Ontario's Basic Income Experience" (March 2020) at 4, online (pdf): *McMaster University Labour Studies* <www.labourstudies.mcmaster.ca/documents/southern-ontarios-basic-income-experience.pdf> [perma.cc/48CK-V2Q5].

Resuming this program could have been an effective preventative health measure to minimize health inequities during the COVID-19 pandemic.

D. Distribution of COVID-19 Vaccines

A fourth and crucial aspect of the Ontario government's response to COVID-19 was the rollout of the vaccine. Despite Canada's financial efforts in procuring current and future COVID-19 vaccines, the vaccine rollout in Canada has had a decentralized and difficult beginning compared to higher-income OECD[206] countries like the United States and United Kingdom because of complex geography, procurement issues, and delay of distribution.[207] Criticisms of Canada's vaccine rollout have reflected its challenge in accessing vaccines and reliance on foreign suppliers.[208] When there were vaccine shortages or restrictions on vaccine eligibility, some individuals took necessary measures to secure vaccination, such as travelling to other provinces and territories or the United States.[209] However, this is not always an option for many groups who cannot afford to travel, or cannot leave the country because of immigration-related issues.

[206] Organisation for Economic Co-operation and Development (OECD) is an international organization that works alongside governments, policy makers and citizens to establish evidence-based international standards and solutions for social, economic and environmental challenges. See Organisation for Economic Co-operation and Development, "About" (2021), online: *OECD* <www.oecd.org/about/> [perma.cc/87HU-AKPB].

[207] See Gregory P Marchildon, "The rollout of the COVID-19 vaccination: what can Canada learn from Israel?" (2021) 10:12 Israel J Health Policy Research 1 at 1.

[208] See *ibid*. See also Jonathan Forani, "'We took our eye off the ball': How Canada lost its vaccine production capacity" (25 November 2020), online: *CTV News* <www.ctvnews.ca/health/coronavirus/we-took-our-eye-off-the-ball-how-canada-lost-its-vaccine-production-capacity-1.5204040> [perma.cc/7B49-XZS7].

[209] See e.g. Jackie Hong, "B.C. couple accused of flying to Yukon to get vaccinated must wait for 2nd dose, ministry says" (26 January 2021), online: *CBC News* <www.cbc.ca/news/canada/british-columbia/bc-couple-vaccination-1.5889269> [perma.cc/NA8U-EXGE]; Allison Lampert & Steve Scherer, "Vaccine tourism: Canadians fly south for shot as U.S. demand falls" (5 May 2021), online: *Reuters* <www.reuters.com/business/healthcare-pharmaceuticals/vaccine-tourism-canadians-fly-south-shot-us-demand-falls-2021-05-05/> [perma.cc/NXS5-UB24].

The federal government procures the vaccines, whereas provincial and territorial governments administer the vaccine based on independent criteria for priority. Since provincial and territorial governments rely on the delivery of vaccines from the federal government, there is a gap between vaccine delivery and administration.[210] The delivery of vaccines also requires advanced logistics to make sure that the storage and transportation conditions of vaccines are met. For example, the Pfizer vaccine requires a very low storage temperature of -70 C to remain stable.[211] As such, the federal government mostly sent the Moderna vaccine, which can be shipped and stored at regular freezing temperatures, to the three territories in northern Canada as these territories do not have the infrastructure to store and deliver the Pfizer vaccines.[212]

Ontario's vaccination plan was a three-phase rollout based on priority. In Phase 1, vaccines were delivered to approximately 1.8 million people from December 2020 to March 2021. Those who were eligible in Phase 1 included high-risk populations such as congregate living seniors, health care workers, adults in First Nations, Métis and Inuit populations, adult chronic home care recipients, and adults aged 80 and older.[213] In Phase 2, vaccines were delivered to approximately 9 million people from April 2021 to June 2021. Phase 2 focused on mass vaccine deliveries. Those who were eligible included adults aged 55 and older, individuals living in high-risk congregate settings like shelters and group homes, individuals with certain health conditions, certain essential caregivers, those who cannot work from home, and people who live in hot spot communities.[214] Lastly,

[210] See "COVID-19 immunization: Federal, provincial and territorial statement of common principles" (last modified 11 August 2021), online: *Government of Canada* <www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/canadas-reponse/covid-19-immunization-federal-provincial-territorial-statement-common-principles.html> [perma.cc/9LP6-48YT].

[211] See *ibid;* Beth Brown, "First doses of Moderna COVID-19 vaccine arrive in Nunavut" (December 2020), online: *CBC News* <www.cbc.ca/news/canada/north/vaccine-arrives-nunavut-1.5856653> [perma.cc/66PX-7ZW9].

[212] See *ibid*.

[213] See Government of Ontario, "Ontario's COVID-19 vaccination plan" (last visited June 2021), online: *Ontario Health* <www.web.archive.org/web/20210630102517/covid-19.ontario.ca/ontarios-covid-19-vaccination-plan> [perma.cc/N95F-XC4H] [Government of Ontario, "Ontario's COVID-19 vaccination plan"].

[214] Ontario Ministry of Health, "COVID-19: Guidance for Prioritization of Phase 2 Populations for COVID-19 Vaccination" (last visited April 2021) at 10, online (pdf): *Ontario Health* <www.web.archive.org/web/20210430201738/www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/vaccine/COVID-19_Phase_2_vaccination_prioritization.pdf> [perma.cc/6HJQ-SY66] [Prioritization of Phase 2].

Phase 3, has gone from July 2021 onwards. In Phase 3, all remaining Ontarians were eligible to receive the vaccine.[215] For each of Ontario's 34 public health unit, the local medical officer of health submitted a plan for how vaccines would be administered - whether they would be through mass vaccination clinics, pharmacies, physician's offices, etc.[216] This means that the Ontario COVID-19 vaccination plan was split into 34 different sets of delivery models.[217] Despite the fact that administration of the vaccine is an integral way to minimize health inequities, structural racism and low inequities were apparent in several areas of the vaccine rollout by the Ontario government and its public health units.[218]

1. Racialized and Low-Income Communities Overlooked in the Priority Groups

The first aspect of the vaccine rollout that did not adequately account for these inequities was the priority groups and hot spot approach taken by the Ontario government.

Prioritization of the most at-risk communities is an important way to minimize health inequities for certain populations such as racialized communities and low-income populations.[219] Importantly, the Ontario government employed this approach to prioritize at-risk groups (as outlined above).[220] However, some groups may have been overlooked. For instance, even though

[215] See Government of Ontario, "Ontario's COVID-19 vaccination plan", *supra* note 213.

[216] See Colin D'Mello, "Ontario government to have 34 different COVID-19 vaccination plans" (22 February 2021), online: *CTV News* <www.toronto.ctvnews.ca/ontario-government-to-have-34-different-covid-19-vaccination-plans-1.5319286> [perma.cc/.CN35-XRNJ].

[217] See *ibid.*

[218] See Shainoor J Ismail et al, "Navigating inequities: a roadmap out of the pandemic" (2021) 6:1 BMJ Global Health 1 at 5–7.

[219] See *ibid* at 6–7.

[220] See Prioritization of Phase 2, *supra* note 214 at 12.

we know that Black and South Asian individuals were among the groups that were hardest hit by the pandemic, they were not a priority group.[221]

In order to encapsulate groups that were hard-hit by the pandemic, the Ontario government used the hot spot tactic - a place-based approach that focuses on identifying areas that demonstrate high rates of COVID-19 transmission, illness, and death. Hot spots were identified by the Ontario Science Advisory Table using data accumulated over previous waves of the pandemic.[222] The Ontario Science Advisory Table came up with neighborhoods that were in the top 30% of COVID-19 incidence and provided this recommendation to the Ontario government.[223] The Ontario government ultimately made the final selection of hot spots. This was a promising start for prioritizing racialized and low-income communities, since the hardest hit areas were largely comprised of these groups.[224] However, some of the identified hot spots were critiqued for having lower case rates than the Ontario average.[225] Additionally, as a place-based approach, this tactic does

not specifically confront social inequities. If the government had collected data on equity-related indicators, they perhaps might have discovered that a better approach would be to specifically confront social inequities and focus on racialized groups or low-income groups, rather than place.[226] Allocation within priority groups (like the hot spots, or congregate settings) could have also been established. This would have been helpful given the low vaccine supply, and could have addressed heightened inequities for certain people within these groups (e.g. a racialized person living in a hot spot or congregate setting). For instance, allocations for Ontario Black and South Asian individuals are important to consider given these individuals are more likely to be essential workers in health care, labour, and housing, and notably more likely to contract COVID-19.[227] Communities like the City of Hamilton pushed the Ontario government to prioritize vaccination of Black, racialized, disabled, and working-class communities and requested changes to the vaccination booking system to prioritize these groups.[228]

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[221] See Samantha Artiga & Jennifer Kates, "Addressing Racial Equity in Vaccine Distribution" (3 December 2020), online (blog): *Kaiser Family Foundation* <www.kff.org/racial-equity-and-health-policy/issue-brief/addressing-racial-equity-vaccine-distribution/> [perma.cc/9QPB-8GJX]; Dakshana Bascaramurty, "Racialized Canadians have some of the highest rates of COVID-19 infections in the country. Who can allay their doubts about taking the vaccine?" (26 January 2021), online: *The Globe and Mail* <www.theglobeandmail.com/canada/article-racialized-canadians-need-the-covid-19-vaccine-more-urgently-than-most/> [perma.cc/U3F5-GWFS].

[222] See Sharmistha Mishra et al, "A Vaccination Strategy for Ontario COVID-19 Hotspots and Essential Workers" (23 April 2021) at 3–4, online (pdf): *Science Briefs of the Ontario COVID-19 Science Advisory Table* <covid19-sciencetable.ca/wp-content/uploads/2021/04/Science-Brief_Vaccines-in-Essential-Workers_20210423_published3.pdf> [perma.cc/B2XZ-4PV2].

[223] See Kevin A Brown et al, "A Strategy for the Mass Distribution of COVID-19 Vaccines in Ontario Based on Age and Neighbourhood" (26 February 2021) at 3–4, online (pdf): *Science Briefs of the Ontario COVID-19 Science Advisory Table* <www.covid19-sciencetable.ca/wp-content/uploads/2021/02/Science-Brief_Vaccine-by-FSA_20210301_version-1.1_published-2.pdf> [perma.cc/6ZJU-54YJ].

[224] See James Iveniuk & Scott Leon, "An uneven recovery: Measuring COVID-19 vaccine equity in Ontario" (April 2021) at 8, online (pdf): *Wellesley Institute* <www.wellesleyinstitute.com/wp-content/uploads/2021/04/An-uneven-recovery-Measuring-COVID-19-vaccine-equity-in-Ontario.pdf> [perma.cc/QN59-JUQZ].

[225] See Elizabeth Payne, "COVID-19 science advisory table says it did not select hot spot postal codes" (15 April 2021), online: *Ottawa Citizen* <www.ottawacitizen.com/news/local-news/covid-19-science-advisory-table-says-it-did-not-select-hot-spot-postal-codes> [perma.cc/ZN86-4QK4]; Mike Crawley, "Some areas not hard-hit by COVID-19 getting vaccination priority in Ontario, data reveals" (12 April 2021), online: *CBC News* <www.cbc.ca/news/canada/toronto/ontario-covid-19-vaccination-postal-code-hot-spots-1.5983155> [perma.cc/TH63-CQLC].

[226] See Iveniuk & Leon, *supra* note 224 at 8. See also Faiza Amin & Meredith Bond, "U of T research students study inequities of the vaccine rollout in COVID-19 hotspots" (21 April 2022), online: *City News* <www.toronto.citynews.ca/2022/04/21/toronto-vaccine-inequities-covid19-student-research/> [perma.cc/R62P-JMF8] (and the quote by Jamal, which suggests that the government was not able to use race-based data to target communities most in need of the vaccine); California Healthy Places Index, "About the HPI" (2022), online: *The Public Health Alliance of Southern California* <www.healthyplacesindex.org/about-hpi> [perma.cc/A4R9-EPPC] (California's Healthy Places Index (HPI) used social determinants of health to obtain a score for each neighborhood in California to target neighborhoods that fell within the lowest HPI quartile).

[227] See Artiga & Kates, *supra* note 221; Bascaramurty, *supra* note 221.

[228] See Ameil J Joseph, "OPEN LETTER: Hamilton Public Health needs to work with community members to prioritize vaccinations for Black, racialized, disabled and working class communities" (5 April 2021), online: *Google Forms* <www.docs.google.com/forms/d/e/1FAIpQLSfPl62rbfYz3alFOznsIsqdvdm-Ql_UDCeC76wO2EtmUlHwH9A/viewform> [perma.cc/ZV4K-SQSD].

2. Barriers to Delivering Vaccines

Second, structural racism and income-related health inequities are evident in the delivery of the vaccine by public health units. A recent report by the Institute for Clinical and Evaluative Sciences found that areas with the highest incidence of COVID-19 had the lowest levels of vaccination.[229] Specifically, James Iveniuk and Scott Leon discovered that "poverty, racialization, and COVID-19 rates [were] negatively associated with vaccination rates" and that the vaccines were not being distributed in equitable ways to areas with low-income and racialized populations.[230] Many of the practical barriers (e.g. not having stable Internet, limited access to transportation, long wait times, inability to leave work, no access to childcare) that made it difficult for racialized and low-income groups to access COVID-19 testing also made it difficult for these groups to access the vaccine.[231] However, there were some barriers specific to receiving the vaccine. One of these barriers is that densely-populated areas that were some of the most hard-hit and occupied by many minorities living in multi-generational housing, such as Toronto's Northwest, had vaccine deserts – meaning that people in these neighbourhoods could not get the vaccine in their own neighbourhood and had to travel to receive the vaccine.[232] Public health units create and administer vaccination plans in their respective areas, so these practical barriers are attributable to these units. In April 2021, the Ontario Ministry of Health released a set of strategies to support access to vaccination in hotspot communities such as providing mobile or pop-up clinics in neighborhoods, residential areas, and workplaces. However, the Ontario government could have implemented policies about clinic locations, accessibility, promotion of the clinic, community partnerships etc., earlier, for public health units to follow in delivering the vaccine to marginalized communities.[233]

Structural racism was also demonstrated in the case of racial migrants who are overrepresented in many essential jobs and are at higher risk of COVID-19 transmission, but who have less access to the vaccine because of not always having a health card or government identification.[234] Across Canada, each provincial and territorial government mandates their own immunization process and decides priority groups and locations of vaccination sites.[235] In Ontario, for example, residents must present a piece of government-issued photo identification to receive their vaccine.[236] Select

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229 See Public Health Alliance of Southern California, "Institute for Clinical Evaluative Sciences, COVID-19 Dashboard" (April 2021), online: *Institute for Clinical Evaluative Sciences* <web.archive.org/web/20210430201631/www.ices.on.ca/DAS/AHRQ/COVID-19-Dashboard> [perma.cc/3AX3-K46Z] [Institute for Clinical Evaluative Sciences].

230 See Iveniuk & Leon, *supra* note 224 at 8.

231 See Centre for Research & Education on Violence Against Women & Children, *"More Exposed & Less Protected" in Canada: Racial Inequality as Systemic Violence During COVID-19* (2020) at 3, online (pdf): Centre for Research & Education on Violence Against Women & Children <www.vawlearningnetwork.ca/docs/Systemic-Racism-Covid-19-Backgrounder.pdf> [perma.cc/NCR9-DXCX]; Iestyn Williams, "Priority setting during the COVID-19 pandemic: going beyond vaccines" (2021) 6:1 BMJ Global Health 1 at 3. Note that priority setting is only part of vaccine dissemination planning. Other steps, such as engagement with patient groups, will be necessary for health equity. See also Justin Presseau et al, "Strategies to Support Ontarians' Capability, Opportunity, and Motivation for COVID-19 Vaccination" (23 June 2021) at 3, online (pdf): *Science Briefs of the Ontario COVID-19 Science Advisory Table* <www.covid19-sciencetable.ca/wp-content/uploads/2021/06/Science-Brief_Strategies-to-Support-Ontarians-Capability-Opportunity-and-Motivation-for-COVID-19-Vaccination_v.1.1_20210623_published.pdf> [perma.cc/D7NS-BGJ9] (identifies different barriers and steps that could be taken to deal with these barriers to vaccination); Amin & Bond, *supra* note 226.

232 See Saron Fanel, "Advocates say COVID-19 'vaccine desert' leaves racialized communities behind in rollout", (22 March 2021), online: *CTV News* <www.toronto.ctvnews.ca/advocates-say-covid-19-vaccine-desert-leaves-racialized-communities-behind-in-rollout-1.5357999?cache=sazhusyrecmk> [perma.cc/SJ6V-TUKT].

233 See Amin & Bond, *supra* note 226; Caitlin Arizala et al, "Evaluating & Improving COVID-19 Vaccine Clinics For Racialized Youth In Toronto's COVID-19 Hotspots" (Poster delivered at the 2021-2022 UTSC Undergraduate Research Symposium, Toronto, April 5 2022) [unpublished].

234 See *ibid*; Verity Stevenson, "Lack of vaccine access, cramped living lead to rise in COVID-19 outbreaks among migrant workers in Quebec" (2 June 2021), online: *CBC News* <www.cbc.ca/news/canada/montreal/outbreaks-temporary-foreign-workers-quebec-1.6048628> [perma.cc/5LME-2ZLU].

235 See Ryan Patrick Jones, "Advocacy groups call for COVID-19 vaccine plan for migrants, undocumented workers" (25 February 2021), online: *CBC News* <web.archive.org/web/20210331003100/www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/vaccine/COVID-19_know_about_your_vaccine_appt.pdf> [perma.cc/YD28-CHJP].

236 See Ontario Ministry of Health, "What you need to know about your COVID-19 vaccine appointment" (March 2021) at 2, online (pdf): *Ontario Health* <web.archive.org/web/20210312201732/www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/vaccine/COVID-19_know_about_your_vaccine_appt.pdf> [perma.cc/8T5X-RKTM].

vaccination clinics do provide low-barrier walk-in access for individuals who do not have the required documentation or identification to receive a vaccine, but it is only limited clinics that provide this option and they do not allow individuals to book appointments online.[237] For migrant workers, depending on which province or territory they are residing in, these barriers prevent accessibility to vaccinations if they do not possess the required documentation needed to receive the shot. Again, the Ontario Ministry of Health (in April 2021) suggested implementing more flexible low-barrier approaches to verify an individual's identification when verification of age or address could not be demonstrated or validated.[238] However, the Ontario government could have been less stringent in their ID requirements for receiving COVID-19 vaccines from the beginning.

Physicians whose practices include delivering health services to Indigenous people have also fought to receive strategic planning and support from the government in getting COVID-19 vaccines to vulnerable urban Indigenous populations that reside in Toronto, off reserves.[239] Indigenous peoples who live in Toronto, a "red zone" for COVID-19 infection, have a disproportionate burden of systemic barriers in assessing health services, and face health inequities such as higher rates of poverty, unemployment, and food security, resulting in lower life expectancies and poorer health.[240] With the lack of any kind of formal governance from the Ontario government that advocates for urban Indigenous people who are geographically dispersed throughout the city, it is understandable how this population was overlooked.[241] Further, vaccination plans that do include a

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237 See Michael Garron Hospital, "Mobile and pop-up vaccine clinics in east Toronto" (August 2021), online: *Toronto East Health Network* <web.archive.org/web/20210806162515/www.tehn.ca/covid19/covid-19-vaccine/mobile-and-pop-vaccine-clinics-east-toronto> [perma.cc/5GVB-MB5E].

238 See Prioritization of Phase 2, *supra* note 214 at 12.

239 See Brendan Kennedy & Stephanie Nolen, "Toronto's Indigenous population largely overlooked in COVID-19 vaccine plans, doctor who work with them say" (23 January 2021), online: *Toronto Star* <www.thestar.com/news/gta/2021/01/23/torontos-indigenous-population-largely-overlooked-in-covid-19-vaccine-plans-doctors-who-work-with-them-say.html?rf> [perma.cc/E79Y-9PBR].

240 See *ibid*.

241 Indigenous Services Canada (ISC) supplements health programs and services to First Nations communities. ISC is supporting vaccination in urban communities, but they are not administering vaccines. Some public health units are also focusing on vaccinating Indigenous residents, but there is no clear province-wide strategy for those who live in big cities. See "Indigenous Services Canada COVID-19 Vaccine Plan" (January 2021) at 3, online (pdf): *Indigenous Services Canada* <www.indigenousnurses.ca/sites/default/files/inline-files/INDIGENOUS%20SERVICES%20CANADA%20COVID-19%20VACCINE%20PLAN%20Jan%202021.pdf> [perma.cc/92ZV-G5ZL]. See also Government of Canada, "COVID-19 vaccines and Indigenous peoples: Indigenous peoples in urban communities" (last visited April 2022), online: *Indigenous Services Canada* <www.sac-isc.gc.ca/eng/1606941379837/1606941507767#s3> [perma.cc/H8BY-4KK2]; Travis Dhanraj, "Questions mount over lack of COVID-19 vaccination plan for Ontario's urban Indigenous communities" (17 March 2021), online: *Global News* <www.globalnews.ca/news/7702589/covid-ontario-government-vaccination-plan-urban-indigenous-communities/> [perma.cc/DQ7X-B2P2] (as Dr. Richardson, the strategic lead in Indigenous Health at Women's College Hospital, pointed out, Indigenous communities in urban centres have been left to figure things out on their own).

model for urban Indigenous people ignore the structural racism that many Indigenous peoples face as these plans typically involve or are provided through hospitals.[242] Many urban Indigenous peoples have remarked how including mobile health units are preferred in receiving vaccinations, although this method poses its own logistical issues like vaccine tracking.[243] The differences in experience between on reserve and off reserve Indigenous peoples illustrate the flaws that can arise with race-based classifications when they are not employed in a way that accounts for the intersection of race with other characteristics. The Ontario government should have put into place a province-wide strategy for those who live in cities.

3. Insufficient Engagement with Medical Distrust

Third, the Ontario government and public health units needed to do more to address distrust in medical institutions. As discussed in Part I of this paper, colonialism, structural racism, and a history of segregation and experimentation during prior health emergencies has fostered distrust by low-income and racialized individuals in the health care system. This distrust in medical institutions may lead to vaccine hesitancy in some communities.[244] For instance, Statistics Canada revealed in March 2021 that 77% of Black Canadians said they were unlikely to get the vaccine com-

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242 See Dhanraj, *supra* note 241.

243 See *ibid*.

244 See generally Janessa Griffith et al, "COVID-19 Vaccine Hesitancy in Cana-

pared to 49% of Canadians overall.[245] Vaccine hesitancy is defined by the WHO as "delay in acceptance or refusal of vaccines despite availability of vaccination services."[246] Before labeling a group such as Black Canadians as vaccine hesitant, it is important to note that reduced likelihood to get the vaccine may be caused by a combination of structural barriers and/or mistrust caused by historical and present anti-Black racism.[247]

Many Indigenous peoples have also expressed hesitancy to get the vaccination.[248] For instance, former Assembly of First Nations National Chief Matthew Coon Come wrote about concerns with COVID-19 vaccines.[249] For Indigenous peoples, these concerns stem from Canada's history of Indigenous peoples being subjected to medical experimentation and other abuses within Canadian medical institutions. In Part I of this paper on prior pandemics, we noted how during the tuberculosis outbreaks of the 1930s,

da: Content Analysis of Tweets Using the Theoretical Domains Framework" (2021) 23:4 J Medical Internet Research 1.

245 See "COVID-19 in Canada: A One-year Update on Social and Economic Impacts" (11 March 2021), online: *Statistics Canada* <www150.statcan.gc.ca/n1/pub/11-631-x/11-631-x2021001-eng.htm> [perma.cc/LV7R-K9PU], cited in Mzwandile Poncana, "Marginalized communities in Toronto are taking vaccinations into their own hands" (4 June 2021), online: *The Pigeon* <www.the-pigeon.ca/2021/06/04/marginalized-communities-toronto-vaccines/> [perma.cc/5XVP-PGCB] [Poncana].

246 Robb Butler, "Vaccine Hesitancy: What it means and what we need to know in order to tackle it" (March 2016) at 2, online (pdf): *World Health Organization* <web.archive.org/web/20210706085145/who.int/immunization/research/forums_and_initiatives/1_RButler_VH_Threat_Child_Health_gvirf16.pdf> [perma.cc/DR4J-3NWC]. See also Azza Eissa et al, "Increasing SARS-CoV-2 vaccination rates among Black people in Canada" (2021) 193:31 CMAJ E1220 at E1220.

247 See *ibid*. See also Sandra C Quinn & Michele P Andrasik, "Addressing vaccine hesitancy in BIPOC communities – toward trustworthiness, partnership and reciprocity" (2021) 385:2 New England J Medicine 97; Simar Singh Bajaj & Fatima Cody Stanford, "Beyond Tuskegee – Vaccine Distrust and Everyday Racism" (2021) 384:5 New England J Medicine e12.

248 See Ian Mosby & Jaris Swidrovich, "Medical experimentation and the roots of COVID-19 vaccine hesitancy among Indigenous Peoples in Canada" (2021) 193:11 CMAJ E381 at E381.

249 See Jamie Pashagumskum, "Former AFN national chief and Cree grand chief speaks out against vaccine" (7 January 2021), online: *APTN News* <www.aptnnews.ca/national-news/former-afn-national-chief-and-cree-grand-chief-speaks-out-against-vaccine/> [perma.cc/8TST-2TDH].

Indian hospitals were used for research opportunities.[250] Ian Mosby, for instance, documents a series of nutritional studies that were conducted in the James Bay Survey of the Attawapiskat and Rupert's House Cree First Nations, one in Northern Manitoba and six others in residential schools.[251] Without understanding and working to deal with these issues in rolling out the vaccine, the inequities for these groups will continue to be exacerbated.

Health professionals need to educate themselves about Canada's history of medical experimentation and structural racism before administering vaccines. Public health units must reach out to their community organizations and engage with faith-based organizations, community centers, ethnic, and linguistic community groups, and community leaders (for instance Indigenous elders) to ensure community-driven educational efforts in order to build vaccine confidence, reduce misinformation, and address any location access barriers.[252] Preferably, these education initiatives should have also been done early on before the vaccines arrived in order to give people time to process and learn.[253]

Immunization plans on-reserve involve collaboration between provincial governments, First Nations communities, and federal government. One such collaborative program, Operation Remote Initiative (ORI), was directed at providing the first, second, and third doses of the vaccine to 29 remote Indigenous communities in Northern Ontario. The program was co-developed through a partnership with Nishnawbe Aski Nation, the Northern Public Health Units, and Ornge.[254] Cultural sensitivity

250 See Kelm, *supra* note 42.

251 See Ian Mosby, "Administering Colonial Science: Nutrition Research and Human Biomedical Experimentation in Aboriginal Communities and Residential Schools" (2013) 46:91 University of Toronto Press 145.

252 See Prioritization of Phase 2, *supra* note 214 at 14.; Mosby & Swidrovich, *supra* note 248 at E382.

253 See Avery Zingel, "Work with communities to address vaccine hesitancy, say Indigenous leaders" (8 January 2021), online: *CBC News North* <www.cbc.ca/news/canada/north/work-with-communities-vaccine-hesitancy-indigenous-leaders-1.5865677> [perma.cc/YY5L-J2SU].

254 See Government of Canada, "Operation Remote Immunity 3.0 wraps up after coordinating nearly 200 vaccine clinics in 29 remote and isolated communities" (last modified 22 February 2022), online: *Indigenous Services Canada* <www.canada.ca/en/indigenous-services-canada/news/2022/02/operation-

was one of the underlying principles of the vaccination process and vaccinators completed cultural sensitivity training before administering vaccines.[255] ORI, however, was only for Indigenous peoples living on reserve in remote locations. While systems of culturally appropriate care are being developed to improve Indigenous health care more broadly in the province,[256] more training could have been provided by the Ontario government and public health units in conjunction with First Nations communities for those working with urban Indigenous peoples in Ontario.

In many instances, community organizations took their own initiatives to remove barriers for vulnerable groups to get the vaccine. The Black Health Vaccine Initiative hosted pop-up vaccine clinics in Toronto geared towards Black, African, and Caribbean residents. Friends of Chinatown Toronto promoted the availability of pop-up vaccine clinics in Toronto's Asian community like in the Kensington-Chinatown region. Additionally, the Latin American COVID-19 Task Force initiated vaccine partnerships with local clinics and hospitals. This resulted in pop-up vaccine clinics for the Spanish speaking community, served as a public health resource and educational tool, and assisted community members that needed help with booking and attending their vaccination appointments.[257] These organizations took initiative in outreaching to their respective communities that had lower vaccination rates by spreading the word, advertising clinics, assisting with logistical barriers in their respective languages, and addressing any questions. They also reassured those who are not Canadian citizens that they could still get vaccinated, since ID hesitancy is as vigorous as vaccine hesitancy in these communities, and many individuals in these communities are worried about revealing their immigration status.[258] These community groups provide a

remote-immunity-30-wraps-up-after-coordinating-nearly-200-vaccine-clinics-in-29-remote-and-isolated-communities.html> [perma.cc/3SNL-S4EY].

255 See Logan Turner, "'Operation Remote Immunity' ramps up as Ornge prepares to vaccinate 31 fly-in First Nations" (19 January 2021), online: *CBC News* <www.cbc.ca/news/canada/thunder-bay/operation-remote-immunity-1.5878114> [perma.cc/J632-XNRQ].

256 See e.g. "September 2016 Mandate letter: Health and Long-Term Care" (last modified 29 June 2022), online: *Government of Ontario* <www.ontario.ca/page/september-2016-mandate-letter-health-and-long-term-care> [perma.cc/2T3R-25TH].

257 See Poncana, *supra* note 245.

258 See *ibid*. See also Samantha Beattie, "The behind-the-scenes, back-alley push to get Toronto's Chinatown vaccinated against COVID-19" (7 June 2021), online: *CBC News* <www.cbc.ca/news/canada/toronto/chinatown-toronto-vaccine-1.6051808> [perma.cc/BAV4-5REE].

much-needed way to fill voids left by the Ontario government and its public health units to reach hard-to-reach groups. The Ontario government and public health units could have provided more support for and collaborated more closely with community groups to dismantle vaccine inequities.[259]

III. The Ontario Government's Moral and Possible Legal Duty to Combat Health Inequities During the COVID-19 Pandemic

Having identified gaps in Ontario's COVID-19 response and having suggested steps that could have been taken to address structural racism and income-based inequities, we turn now to the question of whether the Ontario government and its public health units have a duty to redress these inequities. In this section, we suggest that the Ontario government and public health units have a moral duty, and a possible legal duty, to redress these inequities.

A. Moral Duty to Combat Health Inequities

Scholars across a multitude of disciplines have explored ethical, moral, and justice-based arguments for addressing health inequalities, disparities, and inequities.[260] As we explained in Part I of this paper, health inequities

259 See e.g. Germaine Tuyisenge & Shira M. Goldenberg, "COVID-19, structural racism, and migrant health in Canada" (2021) 397:10275 Lancet 650 (who suggests that one of the most powerful ways to advance the rights of migrant communities for instance is for decision makers to listen to and work with community organizations such as the Migrant Rights Network in Canada).

260 While we focus on the moral arguments for addressing inequities, scholars have also used justice-based arguments for instance to support addressing health inequities. See e.g. JP Ruger, "Ethics and Governance of Global Health Inequalities" (2006) 60 J Epidemiol Community Health 998 at 999. JP Ruger argues that John Rawls' and Thomas Nagel's work reveals that there is no moral obligation to remedy health disparities, but there is a justice obligation that is owed to citizens. That justice obligation may support addressing health disparities. Research that has explored Ontarians' support for addressing health inequities has also found that Ontarians are willing to support a wide range of interventions to address health inequities. See Maritt Kirst et al, "Addressing health inequities in Ontario, Canada: what solutions to the public support?" (2017) 17:7 BMC Public Health 1.

have a moral element and are inequalities in health that stem from a form of injustice. While a number of authors use "health disparity" instead of "health inequity," both terms denote health differences that stem from an injustice.[261]

JP Ruger relies on the theory of health ethics, which integrates Aristotle's political theory,[262] and Amartya Sen's capability approach,[263] to illustrate why health disparities are morally problematic and why efforts to reduce them are justified.[264] Ruger suggests that deprivations in people's health are unjust because they affect people's well-being and agency.[265] Since health is a prerequisite to other capabilities, other human capabilities become inaccessible when a person is suffering from deprivations in their health. These reductions in functioning conflict with the view that justice requires policies to bring "people as close to good functioning as their natural circumstances permit," and this is morally troubling.[266] Ruger's other work outlines the duties of international actors and nation states to address these inequities, and steps that may be taken towards this goal.[267] In applying Ruger's analysis to the Ontario government and its public health units' response to COVID-19, action or inaction by the Ontario government and its public health units that resulted in subminimal care for racialized and low-income

[261] Health disparities refer to health differences that are linked to "economic, social or environmental disadvantage." Like health inequities, there is an underlying moral element, because they stem from an injustice. Health equity underlies the commitment to reduce these disparities. See Paula Braveman, "What are Health Disparities and Health Equity? We Need to be Clear" (2014) 129: Suppl 2 Public Health Reports 5 at 6, citing Healthy People, "Disparities" (last modified 6 February 2022), online: *Office of Disease Prevention and Health Promotion* <wayback.archive-it.org/5774/20220414003754/https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities> [perma.cc/EW2X-V8PD].

[262] See e.g. Martha Nussbaum, "Nature, function, and capability: Aristotle on political distribution" in von H Gunther, ed, *Aristoteles Politik* (Lanham, MA: Rowman and Littlefield, 1998).

[263] See e.g. Amartya Sen, *Inequality Re-examined* (Cambridge, MA: Harvard University Press, 1992).

[264] See *ibid* (Ruger's health ethics theory is based in Amartya Sen's capability approach and Aristotle's political theory).

[265] See Ruger, *supra* note 260 at 999 (specifically, Ruger suggests that they reduce people's capability to be healthy intrinsically and instrumentally).

[266] See *ibid*.

[267] See *ibid* at 998, 1001.

groups is morally troubling because of the "reduced capability of physical and mental functioning or even for being alive" that these groups faced as a result.[268] This justifies a duty of the government to address these inequities.

Whereas Ruger suggests that disparities in health are morally wrong because they lead to deprivation in people's health, Cynthia M Jones draws our attention to structural racism and low-income as the source of health disparities. Jones' two-part argument is that health disparities are a moral wrong that perpetuate substantive inequities, and that need to be addressed.[269] Jones relies on number of ethical theories and principles such as contractarian ethics, Kantian ethics, and utilitarian ethics to illustrate that health disparities are morally problematic.[270] Most importantly, however, Jones argues that health inequities are morally wrong because they exemplify historical and contemporary injustices stemming from racism, classism, colonialism, and other forms of discrimination and oppression.[271] Jones argues that moral principles are usually construed to entail duties to act or not act based on whether an action is found to be wrong. So, Jones argues that by judging health inequities to be a moral wrong, then it follows that there is a moral duty to address health disparities. These duties are stronger for organizations, like government, that have greater power to address them.[272] Thus, applying Jones' argument in the Canadian context, the racial and income-based health inequities that have been exposed by COVID-19 are morally wrong because they stem from injustices of systemic discrimination and colonialism in Canada (as set out in Part I). This wrong is linked with a moral duty owed by the provincial government to address inequalities arising from pandemic response. This is the case given that most of the pandemic response fell within their ambit. This is in line with the Truth and Reconciliation Commission of Canada's call upon the federal, provincial, territorial, and Aboriginal government to acknowledge that the "current state of Aboriginal health in Canada is a direct result of

[268] See *ibid* at 999.

[269] See Cynthia M Jones, "The Moral Problem of Health Disparities" (2010) 100:Suppl 1 American J Public Health S47.

[270] See *ibid* at S48.

[271] See *ibid*.

[272] See *ibid* at S49.

previous Canadian government policies" [273] and to "close the gaps in health outcomes"[274] between Indigenous and non-Indigenous communities in Canada.

Stephen B Thomas similarly looks at racial and ethnic health disparities, in the context of examining whether there is a moral foundation to the public policy goal of health equity in the United States.[275] Thomas relied on the work of Madison Powers and Ruth Faden who suggest that social justice is the moral foundation of public health.[276] Powers and Faden suggest that social justice is the moral foundation of public health, so there is a moral imperative to consider who is exposed to hazards that harm health, and to address these.[277] Thomas then goes on to suggest that there is a moral duty in public health to achieve health equity and suggests interventions that can be taken to fulfill this moral duty.[278] Applying Thomas, Powers, and Faden's scholarship to the present case suggests that in making decisions related to public health, there is a moral duty owed by the government and these public health units to prevent harm to those who were most at-risk of COVID-19, notably racialized and low-income groups. This moral duty is accentuated by the fact that the Ontario government and its public health units could have helped combat these inequities – there is an obligation born of capacity.

B. Legal Duty to Combat Health Inequities

In addition to having a moral duty to redress health inequities, the Ontario government and public health units might also have a legal duty

[273] Canada, Truth and Reconciliation Commission of Canada, *Calls to Action*, (Ottawa, 2015) at 2 [Canada, "Calls to Action"]. See also Canada, Truth and Reconciliation Commission of Canada, *Honouring the truth, reconciling for the future: summary of the final report of the Truth and Reconciliation Commission of Canada*, (Ottawa, 2015) at 160–64.

[274] Canada, "Calls to Action", *supra* note 273 at 2–3.

[275] See generally Stephen B Thomas, "Racial and Ethnic Disparities as a Public Health Ethics Issue" in Anna C Mastroianni, Jeffrey P Kahn & Nancy E Kass, eds, *The Oxford Handbook of Public Health Ethics* (2019) [Thomas].

[276] See *ibid.* See also Madison Powers & Ruth Faden, *Social Justice: The Moral Foundations of Public Health and Health Policy* (Oxford: Oxford University Press, 2006).

[277] See Powers & Faden, *supra* note 276 at 81.

[278] See Thomas, *supra* note 275 at 9–10.

to do so. Access to health care is embodied within the objectives of the *Canada Health Act*.[279] In Part I, we outlined how Canada's single-payer system aims to ensure needs-based access to care[280] but how this has not necessarily resulted in equitable access to care. This paper demonstrates how there was a lack of equitable access to care during the COVID-19 pandemic. Governments may have a legal duty to provide access to care in keeping with international human rights obligations and the *Canadian Charter of Rights and Freedoms*[281] (*Charter*). Not providing equitable access to care for racialized and low-income groups may be a violation of international human rights obligations and the *Charter*.

1. International Human Rights Obligations

The *International Covenant on Economic, Social and Cultural Rights*[282] (*ICESCR*), to which Canada is a state party, for instance, recognizes the right of everyone in Canada to "the highest attainable standard of physical and mental health." State parties to the Covenant have to take steps to prevent, treat and control an epidemic, and "create conditions that would assure to all medical service and medical attention in the event of sickness,"[283] "without

[279] See *Canada Health Act*, *supra* note 32, s3.

[280] See *ibid*.

[281] Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11 [*Charter*].

[282] *International Covenant on Economic, Social and Cultural Rights,* 16 December 1966, 993 UNTS 3 art 12(1) (entered into force 3 January 1976, accession by Canada 19 May 1976) [*ICESCR*]. Canada ratified the *ICESCR* without any reservation, but it has not adopted the optional protocol which would have allowed complaints of violations to be presented at an international level. See generally United Nations, "*International Covenant on Economic, Social and Cultural Rights*" (16 December 1966), online: *United Nations Treaty Collection* <www.treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-3&chapter=4&clang=_en#top> [perma.cc/N84W-63UB]; United Nations, "Optional Protocol to the *International Covenant on Economic, Social and Cultural Rights*" (10 December 2008), online: *OHCHR* <www.ohchr.org/en/instruments-mechanisms/instruments/optional-protocol-international-covenant-economic-social-and> [perma.cc/SU2P-NV6N].

[283] *Ibid,* arts 12(2)(c), 12(2)(d).

discrimination of any kind as to race, colour, […] or other status."[284] The *ICESCR* is a legally binding instrument and state parties are responsible for fulfilling their obligations through legislation and domestic measures to the extent of their available resources.[285] Article 28 provides that the *ICESCR*'s provisions "extend to all parts of federal States without any limitations or exceptions."[286] This has been interpreted to mean that the *ICESCR* is binding on the federal government, as well as the provinces and territories.[287] "Rights that are within provincial competence are the obligation of the provincial and territorial governments."[288] Thus, responsibility for implementing the treaty and ensuring the highest attainable standard of health and access to medical services, including during a pandemic, without discrimination, lies jointly on federal and provincial governments, such as the Ontario government.[289]

International human rights treaty monitoring bodies have the willingness and ability to enforce international rights when necessary.[290] As a State Party to the *ICESCR*, Canada must report approximately every five years to the UN Committee on Economic, Social and Cultural Rights.[291] This report is a collaborative effort between the federal, provincial, and

[284] *Ibid*, art 2(2).

[285] See also "Canada's appearance at the United Nations committee on Economic, Social and Cultural Rights" (27 October 2017), online: *Government of Canada* <www.canada.ca/en/canadian-heritage/services/canada-united-nations-system/reports-united-nations-treaties/commitments-economic-social-cultural-rights/canada-appearance.html> [perma.cc/TW4M-AB4N] [Government of Canada, "Canada's Appearance"].

[286] *ICESCR*, *supra* note 282, art 28.

[287] See "Social, cultural and economic rights under international law" (2023), online: *Ontario Human Rights Commission* <www.ohrc.on.ca/en/human-rights-commissions-and-economic-and-social-rights/social-cultural-and-economic-rights-under-international-law#fn28> [perma.cc/BN6D-UGWV] [Ontario Human Rights Commission]. See also Government of Canada, "Canada's Appearance" supra note 285.

[288] Ontario Human Rights Commission, *supra* note 287.

[289] See Government of Canada, "Canada's appearance", *supra* note 285.

[290] See YY Brandon Chen, "International migrants' right to sexual and reproductive health care" (2022) 157:1 Intl J Gynecology & Obstetrics 210 at 213.

[291] See Government of Canada, "Canada's appearance", *supra* note 285.

territorial governments.[292] The Committee examines these periodical reports and adopts general comments on "the scope of the protected rights and indicating the areas on which information should be provided."[293]

Additionally, the *Universal Declaration of Human Rights*[294] (*UDHR*) paved the way for the *International Covenant on Civil and Political Rights*[295] (*ICCPR*) which has bound states like Canada since it was ratified in 1976. It specifically establishes everyday rights such as "the right to life, equality before the law," and prohibits discrimination, which comprise the International Bill of Human Rights.[296] Thus, Canada is also legally bound to fulfill human rights guaranteed by *ICCPR*, and all levels of government must demonstrate that limitations are rooted in evidence and are justifiable.[297]

2. Charter of Human Rights and Freedoms

The *Charter* is also an important source of a legal duty as government action must not infringe on the fundamental rights and freedoms set out within unless that infringement is reasonably justified.[298] As such, a number of scholars have explored the important role of the *Charter* as a source of accountability for health care decision makers.[299] Although section 32(1)

[292] See *ibid.*

[293] Monica Pinto, "*International Covenant on Economic, Social and Cultural Rights*" (16 December 1966), online: *UN Audiovisual Library of International Law* <www.legal.un.org/avl/ha/*icescr*/*icescr*.html> [perma.cc/VHG3-SHVL].

[294] GA Res 217A (III), UNGAOR, 3rd Sess, Supp No 13, UN Doc A/810 (1948) 71.

[295] See *International Covenant on Civil and Political Rights*, 19 December 1966, 999 UNTS 171, Can TS 1976 No 47 (entered into force 23 March 1976).

[296] See "The Foundation of International Human Rights Law" (2023), online: *United Nations* <www.un.org/en/about-us/*udhr*/foundation-of-international-human-rights-law> [perma.cc/SM54-5ML6].

[297] See Eric Mykhalovskiy et al, "Human rights, public health and COVID-19 in Canada" (2020) 111 Can J Public Health 975 at 976.

[298] See *Charter, supra* note 281, s 1.

[299] See Couture-Ménard, *supra* note 5 at 34–37; Martha Jackman, "*Charter* Review as a Health Care Accountability Mechanism in Canada" (2010) 18 Health LJ 1 at 1; Catherine Régis, "La valeur de l'imputabilité dans l'allocation des

of the *Charter* states that it applies to Parliament and the government of Canada, in the delivery of publicly funded health care the Supreme Court of Canada in *Eldridge v British Columbia*[300] has affirmed that the *Charter* also applies to other quasi-or non-governmental bodies. As Martha Jackman sets out, this might include regional and local health authorities, community health clinics, etc.[301] Additionally, *Charter* sections 7 and 15 are of particular interest in examining whether the Ontario government and its public health units had a legal duty to redress inequities for racialized and low-income groups during the COVID-19 pandemic. Section 7 protects rights to "life, liberty and security of the person," unless the deprivation of the right is in accordance with principles of fundamental justice.[302] Section 15 guarantees that "every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination, and in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability."[303]

a. Section 7 and 15 Charter Claims

A number of *Charter* challenges have already been launched claiming that the federal and provincial governments have violated section 7 and 15 *Charter* rights during the pandemic.[304] As reports on the horrific conditions in LTCs during COVID-19 have emerged, so have dozens of

resources au Canada: Une perspective de politiques publiques" (2008) 2 McGill JL & Health 27 at 55.

300 1997 3 SCR 624 at para 44 [*Eldridge*].

301 See Martha Jackman, "The Application of the Canadian *Charter* in the Health Context" (2001) 9:2 Health L Rev 22 at 23–24.

302 See *Charter, supra* note 281, s 7.

303 *Ibid*, s 15.

304 See e.g. Rosa Saba, "CERB and CRB discriminated against Canadians with disabilities, new *Charter* challenge claims" (26 November 2021), online: *Toronto Star* <www.thestar.com/business/2021/11/26/cerb-and-crb-discriminated-against-canadians-with-disabilities-new-*charter*-challenge-claims.html> [perma.cc/DCH5-28BJ] (a *Charter* challenge is being launched, for instance, by workers with disabilities who are arguing that the federal government's COVID-19 relief programs – the Canada Emergency Response Benefit (CERB) and the Canada Recovery Benefit (CRB) – discriminated against workers with disabilities).

legal actions in Ontario focusing on the government's mismanagement of LTCs.[305] One such class action lawsuit (*Nisbet*) alleges that LTC residents' section 7 and 15 rights were violated.[306] The plaintiff and class members argued that section 7 was violated through Ontario's failure to take steps to protect the elderly residents of LTCs which "resulted in widespread illness, suffering and loss of life."[307] They also argued that section 15 equality rights were violated because the plaintiff and class members were discriminated against on the basis of age. The Ontario government's actions, such as allowing the plaintiff and class members to receive substandard care, failing to administer sufficient COVID-19 testing, and failing to adequately staff LTCs, were different than the active steps Ontario took in hospitals.[308] They argue that this differential treatment violated section 15 rights by devaluing class members' integrity, dignity, and lives.[309]

Analogous to the LTC litigation, racialized and low-income groups may also be able to claim section 7 and section 15 violations. Racialized and low-income groups could make section 7 claims arguing that decisions or actions taken by the Ontario government and its public health units compromised their health and security and increased the risk of death, and that their rights were deprived in a way that does not accord with the principles of fundamental justice.[310] For instance, despite the prediction that racialized and low-income groups would be the worst hit by the pandemic, preliminary research suggests that the Ontario government's failure to implement early Ontario wide collection of data with equity-related indicators severely hindered the development of treatment and prevention plans for racialized communities.[311] While some public health units col-

305 See "BRIEFING NOTE: Covid-19 in Long-Term Care Litigation & Legal Action (16 September 2020), online: *Ontario Health Coalition* <www.ontariohealthcoalition.ca/index.php/briefing-note-covid-19-in-long-term-care-litigation-legal-actions/> [perma.cc/2HFY-AZCT] (which provides an overview of all COVID-19 in Long Term Care Litigation and Legal Action).

306 See *Nisbet v Ontario,* 2021 ONSC 3072 (Statement of Claim at para 192).

307 *Ibid* at para 195.

308 See *ibid* at para 198–99.

309 See *ibid* at para 201.

310 See *Charter, supra* note 281, s 7.

311 See Amin & Bond, *supra* note 226.

lected COVID-19 data, data on race was often missing.[312] Lack of direction from the Ontario government and lack of equity data collection by the public health units have may increased risks for already marginalized individuals. The decision not to collect this data, especially when public health units were collecting other data, could be argued to be arbitrary.

The Ontario government's COVID-19 testing priority and vaccine rollout plan, the public health units' distribution of RATs and placement of COVID-19 testing and vaccine sites (that led to vaccine deserts, and testing and vaccines in places only reach-able by car) have all contributed to the high incidence of COVID-19 and high mortality rates among racialized and low-income groups.[313] The same could be said of the failure by the Ontario government to provide adequate and timely housing for people who tested positive for COVID-19 in group homes, shelters, and encampments to isolate.[314] This might have led to the higher number of cases among people living in these settings, which similarly infringes life and security of the person by compromising physical safety and leading to or increasing the risk of death.[315] The delay in providing paid sick leave (and the decision to only provide three days thereof) through amendments to the *Employment Standards Act*[316] prevented people from being able to get tested or vaccinated which could have resulted in people going to work when sick. As we have set out, this might be especially true for racialized and low-income groups who are more likely to be in employment situations where it is more difficult to take time off.[317] Lack of testing, vaccination, or going into work when sick increases the chance of

312 See Wellesley Institute, "Tracking COVID-19 Through Race-Based Data", *supra* note 103 at 2.

313 See Amin & Bond, *supra* note 226.

314 See Canadian Alliance to End Homelessness, "Call to Action: Governments must urgently act to protect people experiencing homelessness from Omicron" (January 2022), online: *Canadian Alliance to End Homelessness* <www.caeh.ca/call-to-action-omicron/> [perma.cc/3D5F-R348].

315 See Alexandra Mae Jones, "Shelter outbreaks leave people experiencing homelessness even more vulnerable during COVID-19" (March 2021), online: *CTV News* <www.ctvnews.ca/canada/shelter-outbreaks-leave-people-experiencing-homelessness-even-more-vulnerable-during-covid-19-1.5356600?cache=> [perma.cc/R6RP-SRJ8].

316 See *Employment Standards Act, supra* note 154, ss 50.1(1.2)–(1.3).

317 See e.g. Decent Work and Health Network, *supra* note 132. See also Block & Galabuzi, *supra* note 132 at 3, 15.

spreading COVID-19, and lack of vaccination makes it more likely that someone will catch COVID-19 and/or experience more severe symptoms.[318]

Racialized groups may also be able to argue that section 15 equality rights were violated. They could argue that certain conduct by the Ontario government and its public health units amounted to differential, adverse treatment that perpetuated disadvantage on a number of prohibited grounds of discrimination such as race, national or ethnic origin, and citizenship. The guarantee of equality is analyzed through the lens of "substantive equality," which requires paying attention to the context of the claimant group's situation and recognizes that identical treatment can often produce serious inequality.[319]Although, as we outlined in Part I, income and structural racism are closely intertwined, income is not a ground of discrimination under section 15, so we have framed possible section 15 arguments on the basis of race and citizenship.[320]

First, COVID-19 testing was initially not available to people in congregate settings – settings which have a high proportion of racialized individuals.[321] Congregate settings ultimately had significantly higher rates of infection and fatality.[322] Second, the vaccine rollout plan allocated vaccines to certain groups at different phases of the rollout plan. Although certain vulnerable groups were prioritized, others, like Black and South Asian individuals, were not included in Phase 1 of the rollout despite being among the most at-risk of contracting COVID-19. They were only indirectly included in Phase 2, if they were in a hot spot community, despite the fact that they were ultimately among one of the groups that was hardest hit by the pandemic.[323] Third, public health units did not distribute the vaccines in equita-

318 Laith J Abu-Raddad, Hiam Chemaitelly & Adeel A Butt, "Effectiveness of the BNT162b2 Covid-19 Vaccine against the B.1.1.7 and B.1.351 Variants" (2021) 385:2 New England J Medicine 187 at 187.

319 See *Fraser v Canada (Attorney General),* 2020 SCC 28 at para 47 [*Fraser*].

320 See e.g. Martha Jackman, "Constitutional Contact With the Disparities in the World: Poverty as a Prohibited Ground of Discrimination Under the Canadian *Charter* and Human Rights Law" (1994) 2:1 Rev Constitutional Studies 78.

321 See Owusu-Bempah et al, *supra* note 123 at 6; Malakieh, *supra* note 123 at 7. See also Homeless Hub, "Poverty" *supra* note 123; Homeless Hub, "Racialized Communities" *supra* note 123; Colour of Poverty, Fact Sheet 9, *supra* note 123 at 1.

322 See NCCMT, *supra* note 124; Wang et al, *supra* note 122 at E634.

323 See Bascaramurty, *supra* note 222 at para 7; Katherine DeClerq, "On-

ble ways to low-income and racialized populations, despite the high rates of COVID-19 incidence in these communities.[324] For instance, there were vaccine deserts in densely-populated areas, like Toronto's Northwest, that are occupied by many racialized groups living in multi-generational housing. Fourth, the placement of COVID-19 testing and vaccine sites in places not easily accessible by public transport might have made it more difficult for racialized populations to access, given that these groups may be less likely to have access to a car, in comparison to non-racialized groups.[325] Fifth, insufficient steps were taken to provide vaccines to urban Indigenous people and to engage with medical distrust and vaccine hesitancy that are linked to structural racism. Vaccine deserts, placement of vaccination sites, and insufficient steps to deal with medical distrust may have contributed to the negative association between poverty, racialization, and vaccination rates.[326]

All five of these actions made it more difficult for racialized populations, who were hardest hit by the pandemic, to access testing and vaccines. Testing prevents the spread of COVID-19. The vaccine also limits the spread of COVID-19 and helps protect individuals from contracting COVID-19 and from becoming seriously ill. As a result, this differential treatment of racialized groups makes it more difficult for them to access testing and the vaccine and devalues their safety and lives. Further, although the Ontario government eventually covered the costs of "medically necessary" health care related to COVID-19, this was originally not freely available to non-citizens, and vaccines remained less accessible to non-citizens such as temporary workers and migrants.[327] This differential treatment for non-citizens similarly devalues their safety and lives.

tario releases new detailed list of those eligible for COVID-19 vaccine in Phase 2" (5 March 2021), online: *CTV News* <www.toronto.ctvnews.ca/ontario-releases-new-detailed-list-of-those-eligible-for-covid-19-vaccine-in-phase-2-1.5334968> [perma.cc/AA4B-3ZAB].

[324] See Iveniuk & Leon, *supra* note 224 at 3, 8.

[325] See From Risk to Resilience, *supra* note 3 at 23; Klein, *supra* note 133 at 9, 10.

[326] See Iveniuk & Leon, *supra* note 224 at 8.

[327] See Stevenson, *supra* note 234.

b. Barriers to section 7 and 15 Charter Claims

There are a number of barriers that litigants will face in their section 7 and section 15 claims. The first is that precedent from the Supreme Court of Canada says that sections 7 and 15 of the *Charter* do not include positive rights, such as rights to health care, housing, and other goods.[328] Although the door to positive entitlements could occur in future, the current position on positive rights under section 7 is summarized in Chief Justice McLachlin's statement in *Chaoulli v Quebec (AG)*[329] where she wrote: "the *Charter* does not confer a freestanding constitutional right to health care." However, McLachlin went on to write that "where the government puts in place a scheme to provide health care, that scheme must comply with the *Charter*."[330]

The Supreme Court of Canada has provided mixed decisions on whether there are positive obligations under section 15.[331] As Martha Jackman points out, in *Eldridge*, the court found that failing to provide interpretation services for the Deaf violated the *Charter*'s section 15 equality guarantee.[332] However, in *Auton v British Columbia*[333] the court did not find that a lack of funding for autism treatment violated section 15, which limited the court's earlier progressive reading of section 15 in *Eldridge*.[334] This lack of recognition of positive rights by Canadian courts means that courts are likely to refuse to recognize any claims deemed to be positive rights claims. This poses an obstacle to claimants arguing for positive rights, such as a right to housing to self-isolate.[335]

[328] See Michal Da Silva, "Positive *Charter* Rights: When Can We Open the "Door"? (2021) 58:3 Osgoode Hall LJ 669 at 669.

[329] 2005 SCC 35 at para 104.

[330] *Ibid.*

[331] See Martha Jackman, "Chapter D-3: Fault Lines: COVID-19, the *Charter*, and Long-term Care" in Colleen M Flood, et al, eds, *Vulnerable: The Law, Policy and Ethics of COVID-19* (Ottawa: University of Ottawa Press, 2020) 341 at 347 [Jackman, "Chapter D-3: Fault lines"].

[332] *Ibid*. See generally *Eldridge*, *supra* note 300.

[333] 2004 SCC 78 paras 38, 69.

[334] See Da Silva, *supra* note 328 at 677.

[335] See Jackman, "Chapter D-3: Fault lines", *supra* note 331 at 348.

Second, a barrier under section 7 is that each of these claims will be subject to showing sufficient causal connection between the government action and the limit on life or security. Chief Justice McLachlin explains in *Canada (Attorney General) v Bedford*,[336] for instance, that the government action does not need to be the only cause of the prejudice suffered, but there needs to be a real link between the action and prejudice. The evidentiary burden of showing this link can be problematic for section 7 claimants, especially when there may be multiple factors leading to the prejudice suffered, as the impact they are showing may be complex (such as an impact on health) and when they may not have an adequate amount of resources.[337] For instance, it might be difficult to show that the Ontario public health units' placement of COVID-19 testing centers in places that are only accessible by car caused less testing and more outbreaks. It might be alternatively argued that the harm is caused by societal context, such as not having a car. If the latter is the case, then the government is unlikely to be liable.

Third, a barrier that may arise for claimants arguing a violation of section 15 equality rights is that many of the examples of discrimination that we have identified would constitute adverse effects discrimination. Adverse effects discrimination was recognized in *Andrews v Law Society of British Columbia*[338] - the Supreme Court of Canada's first decision under section 15(1). In *Andrews*, Justice McIntyre accepted that a seemingly neutral law or action could be discriminatory. McIntyre wrote "[it] must be recognized…that every difference in treatment between individuals under the law will not necessarily result in inequality and, as well, that identical treatment may frequently produce serious inequality."[339] Recognizing and remedying adverse effect discrimination is crucial to substantive equality – which has been identified as "the philosophical premise of [section] 15."[340] However, despite this promising start, scholars have identified a large number of barriers to successfully claim adverse effects discrimination.[341] Jonnette Watson Hamilton and Jennifer Koshan note that these barriers include: "heightened evidentiary and causation requirements, arguments denying distinctions based on 'choice,' the 'neutrality' of policy decisions, the difficulty of connecting adverse treatment to protected grounds via comparative analysis, and a focus on stereotyping and prejudice that make it more difficult to prove adverse effects discrimination."[342] The section 15 equality arguments that we suggest, about the way vaccines were distributed, are claims of adverse effects discrimination. The caselaw suggests that there may be significant barriers to successfully mounting these claims.[343]

Fourth, another barrier for claimants arguing a violation of section 15 equality rights will be section 15(2) of the *Charter*. In *R v Kapp,*[344] the Supreme Court of Canada said that the purpose of section 15(2) is to allow governments to implement programs aimed at helping disadvantaged groups without fear of the program being challenged under section 15(1). Section 15(2) can insulate government programs from scrutiny if the government can show that the program has an ameliorative purpose and that the program targets a disadvantaged group.[345] *Kapp* involved a "reverse discrimination" claim. The Supreme Court of Canada subsequently elaborated on section 15(2) in *Alberta (Aboriginal Affairs and Northern Development) v Cunningham*,[346] which involved a claim that an ameliorative program was underinclusive. The claim was launched by members of the Peavine Métis community and dealt with the differentiation under the *Métis Settlements Act*[347] between Métis who were registered under the *Indian Act*[348] and those who were not. Building on *Kapp*, Chief Justice McLachlin added that there also must be a "corre-

336 2013 SCC 72 at para 76.

337 See Madiha Vallani, "Sections 7 and 15 of the Canadian *Charter* of Rights and Freedoms in the Context of the Clean Water Crisis on Reserves: Opportunities and Challenges for First Nations Women" September 2018 Masters of L Research Papers Repository Western U 1 at 45.

338 1989 SCR 143 at 165.

339 *Ibid* at 164.

340 *Fraser*, *supra* note 319 at 40.

341 See Jonnette Watson Hamilton & Jennifer Koshan, "Adverse Impact: The Supreme Court's Approach to Adverse Effects Discrimination under Section 15 of the *Charter*" (2014) 19:2 Rev Constitutional Studies 191 at 192–94.

342 *Ibid* at 231.

343 See *ibid* at 192.

344 2008 SCC 41 at para 16.

345 See *ibid* at paras 41, 44, 49 (the court found that this was an intent-based analysis, meaning that the legislative goal, rather than effect, is the paramount consideration).

346 2011 SCC 37 at para 2 [*Cunningham*].

347 RSA 2000, c M-14, s 75.

348 RSC 1985, c I-5, s 2(1).

lation between the program and the disadvantage suffered by the target group."[349] *Cunningham* also confirmed that the *Kapp* framework applies to all equality claims, including claims of under-inclusion and adverse effects, not just reverse discrimination claims (like in *Kapp*).[350] This means that a program could be ameliorative and discriminatory at the same time.

Jena McGill helpfully reviews the post-*Kapp*-*Cunningham* jurisprudence, specifically cases of under-inclusion. As McGill illustrates, this jurisprudence has mixed results.[351] In some situations courts have declined to apply section 15(2). In other situations, courts have found that the section 15(2) requirements have not been met, and in others they have found that the section 15(2) requirements and the distinction will not face further scrutiny.[352] McGill notes that there is a further distinction that emerges in the case law, which has to do with the positioning of the claimant with regard to the group targeted by the ameliorative program.[353] McGill argues that when a claimant is facing "insider-underinclusion," in other words, when the claimant is a member of the group that is targeted for ameliorative purposes, section 15(2) seems to be less likely to be operative.[354] In cases of "outsider-underinclusion," where a claimant is outside the group that is targeted for ameliorative benefits, section 15(2) is more likely to be operative.[355]

Section 15(2) may create a barrier when the government can show that a program has an ameliorative purpose, even if the effect of the program is underinclusive or has discriminatory effects. For instance, this may occur if claimants argue that the COVID-19 testing plan or vaccine rollout plan

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349 *Cunningham*, *supra* note 346 at para 44.

350 See Jena McGill, "Ameliorative Programs and the *Charter*: Reflections on the section 15(2) Landscape since R v *Kapp*" (2017) The Can Bar Rev 213 at 224.

351 See *ibid* at 225–26.

352 See *ibid*.

353 See *ibid* at 228–29.

354 See *ibid* at 229. See e.g. *Cunningham v Alberta (Minister of Aboriginal Affairs & Northern Development,* 2009 ABCA 239 at paras 28–29; *Canadian Doctors for Refugee Care v Canada (Minister of Citizenship and Immigration),* 2014 FC 651 at para 346.

355 See McGill, *supra* note 350 at 229. See e.g. *Pratten v British Columbia (AG),* 2012 BCCA 480 at para 42; *International Association of Fire Fighters, Local 268 v Adekayode*, 2016 NSCA 6 at paras 142–43.

in Ontario was discriminatory because even though it was intended to be ameliorative, it was underinclusive. As McGill points out, it might depend on how the group that the ameliorative benefits are aimed at is defined.

Finally, it is also important to note that *Charter* rights are not absolute. For both section 15 and section 7 claims, the government will have the opportunity to argue that limits on these rights were reasonable and proportionate to a valid government objective.[356] As Emmett Macfarlane points out, when government objectives are in favour of health and safety, they are more likely to be considered pressing and substantial. As such, analysis of the reasonableness of limitations may begin with this in mind.[357] This may be more likely for challenges of initiatives like the vaccine rollout or distribution of RATs, which were intended to improve health and safety. Additionally, governments and health authorities had to make difficult decisions often with inadequate information, and scarce resources.[358] Although a future influenza pandemic had been widely predicted by epidemiologists, and the federal and provincial governments should have been better prepared, the courts are likely to exercise considerable deference towards government choices.[359]

There are thus several barriers that *Charter* claimants will face in arguing violations of section 7 and section 15. Despite these barriers, certain conduct by the government and public health units, such as not collecting data with equity-indicators, the lack of early testing in congregate settings, the vaccine deserts, and the lack of a vaccination model for urban Indigenous people, raise serious *Charter* concerns.

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356 See *Charter, supra* note 281, s 1. See also Peter W Hogg, *2020 Student Edition Constitutional Law of Canada* (Toronto: Thomson Reuters, 2020) at 47–54 (explains that the Supreme Court of Canada has expressed the view that a violation of fundamental justice could not be justified under section 1 of the *Charter*. Hogg notes that the Supreme Court still routinely moves on to the section 1 analysis, however, no majority has yet to find that a section 7 breach is justified under section 1).

357 See Emmett Macfarlane, "Public policy and Constitutional Rights in Times of Crisis" (2020) 53 Can J Political Science 299 at 299.

358 See Colleen M Flood, et al, "Civil Liberties vs. Public Health" in Colleen M Flood, et al, eds, *Vulnerable: The Law, Policy and Ethics of COVID-19* (Ottawa: University of Ottawa Press, 2020) 249 at 252.

359 See e.g. Jeffree Taubenberger et al, "The Next Influenza Pandemic: Can It Be Predicted?" (2007) 297:18 JAMA 2025 at 2025.

Conclusion

The Ontario government had the ability to account for and mitigate structural racism and income-related inequities in its response to the COVID-19 pandemic through usual public policy-making processes as well as through the extensive emergency powers it had at its disposal. Although usual public policy-making processes might be a preferable approach, important powers that could have been used include data collection powers,[360] powers to fix prices,[361] powers to require the occupier of any premises to deliver possession of the premises to the Minister for public health purposes,[362] powers to establish facilities for the care and shelter of individuals,[363] powers to distribute and make available necessary goods,[364] powers to authorize facilities to operate as necessary,[365] and powers to issue directives regarding precautions and procedures to be followed.[366] While we recognize that governments were operating under severe resource constraints and lack of information, the Ontario government and public health units did not sufficiently account for the impact of historical and ongoing discrimination, stigma, and stereotyping, and vulnerable groups' existing fear and mistrust in medical institutions. It also did not account for the ways in which inequity is compounded by the intersectionality of race, income, precarious legal status, housing, access to OHIP, etc. This paper reveals that in four aspects of its response, the Ontario government could have done more to address health inequities for low-income and racialized populations. The Ontario government and public health units had a moral duty and possible legal duty, through international human rights obligations and the *Charter*, to do so.

The first failure was the Ontario government's inadequate pandemic preparedness and unwillingness to seek and spread best practices early on. Despite its data collection powers[367] the Ontario government did not collect data with equity-related indicators early in the pandemic. This made it more difficult for the province to target health inequities in its administration of COVID-19 testing, its provision of medical care for individuals with COVID-19, and its vaccine distribution strategy. Although testing and vaccine administration helpfully prioritized some vulnerable groups, such as Indigenous peoples living on reserve, important at-risk populations might have been overlooked. The hot spot approach was a lesson in how marginalization occurs when geography trumps social demographic data in public health. The administration of COVID-19 testing, and vaccination was also not adequately catered to different community needs. For instance, practical barriers (like inaccessible locations, long wait times and inability to isolate after receiving a positive COVID-19 test result), and systemic racism in the administration of testing and vaccine provisions create access barriers for low-income and racialized groups. There has also been insufficient outreach to local communities to develop community-driven educational efforts to reduce vaccine hesitancy.[368] The gaps left by the Ontario government were in some instances filled by trusted community organizations (such as the Black Health Vaccine Initiative, Friends of Chinatown Toronto, the Latin American COVID-19 Task Force, and Indus Community Services), and the responses of these organizations should be looked to for best practices on how to tailor pandemic responses in ways that actually fulfill the needs of low-income and racialized communities. In terms of medical services, the pandemic has revealed larger issues with the provision of publicly funded health care services in Ontario. Although changes such as covering the cost of health care for uninsured patients is a step in the right direction of mitigating inequities, there may still be ongoing issues with how this is operating in practice. More preventive measures also need to be considered, like free distribution of masks, and long-term solutions to health inequities like the revival of Ontario's basic income guarantee pilot.

As we cyclically enter more waves of the pandemic and we continue to offer booster COVID-19 shots, this kind of analysis is important for assessing initiatives that have been taken to tackle inequities and to highlight areas for improvement. It serves as a lesson for Ontario, its public health units, and other jurisdictions on the ongoing steps that are needed to address privilege, access, and power, and to try to prevent the disproportionate health impact of a pandemic on racialized and low-income communities created by inequities.

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360 See e.g. *EMCPA*, *supra* note 7, s 7.0.2(4)13.

361 See e.g. *ibid,* s 7.0.2(4)11.

362 See e.g. *HPPA*, *supra* note 6, s 77.4(1).

363 See e.g. *ibid*; *EMCPA*, *supra* note 7, s 7.0.2(4)4.

364 See e.g. *EMCPA*, *supra* note 7, s 7.0.2(4)9.

365 See e.g. *ibid,* s 7.0.2(4)8.

366 See e.g. *HPPA*, *supra* note 6, s 77.7(1).

367 See e.g. *ibid,* s 77.5(6); *EMCPA*, *supra* note 7, s 7.02(4)13.

368 See Kennedy & Nolen, *supra* note 239.