

Ten questions on the next phase of the UK's COVID-19 response

October 2020

Overview

- There are a number of questions which remain as to the next phase of the response to the COVID-19 pandemic.
- **What values have informed the most recent decisions on COVID-19 restrictions?** Public health measures involve a number of challenging trade-offs between different rights and interests. Alongside the scientific evidence, it must be made clear which values are guiding decisions about which, and whose, interests take priority, and why.
- **Is the government considering the use of “immunity certificates” in the next phase of the response?** Any approach which relies on a [system of ‘immunity certification’ raises a number of ethical questions](#) concerning individual rights versus the public interest, and social justice. If the Government is considering such a system, there must be a robust and open debate now.
- **How will development of an effective COVID-19 vaccine affect uptake - and what should be done?** Issues around the speed of development, changes in regulation, and communication with the public may all affect public trust and uptake of any vaccine. Consideration about how to address these issues should take place now.
- **What discussions are taking place on setting priorities for vaccine allocation within the UK?** There is a range of different values which can be taken into consideration when setting priorities for access to limited doses of a vaccine. What values and interests will guide decision-making in this area must be clearly set out.
- **How will the UK ensure a sustained commitment to global solidarity?** The global nature of the pandemic shows the importance of working as part of a global effort. Although welcome steps have been taken with regard to the [distribution of vaccines](#), it is important that it is part of a sustained effort and not just temporary.
- **How is information about underlying inequalities which have been exposed by COVID-19 featuring in decision-making - and what action will be taken longer term?** The knowledge of how COVID-19 has affected different groups should continue to feature in discussions, as well as forming part of longer-term action to address inequalities.
- **How will public trust and solidarity in the COVID-19 response be ensured?** Recent incidents of blame and the characterisation of the public as selfish or reckless will surely have an impact on public trust and solidarity, at a time when it is essential.
- **What support is to be given to those bearing the greatest burdens?** If some parts of society are to be asked to bear greater burdens in the COVID-19 response, the [state has a duty to ensure they are supported to do so](#).
- **How will new measures take account of principles of respect and fair and equal treatment?** Any public health measures must be carried out in a way that shows respect for people as individuals of equal moral worth.
- **What next?** It is clear that we will have to learn to live with COVID-19 for some time. In light of that, there is an urgent need for a clear and published strategy on what decisions may need to be made in the coming months; what considerations will inform them; and who will be involved and consulted.
- Underlying all of this is the need to engage with, and account in a transparent way, to all sections of society for the decisions that are taken. [This is essential for trust and trustworthiness](#).

Since the beginning of the year, the UK Government has introduced a number of public health measures in response to the COVID-19 pandemic. Many of those measures have been eased in recent months but, in response to an increase in the number of new cases and a rising R number, some new restrictions have been introduced, with the prospect of more to come over winter.¹

The pandemic has created a number of profound ethical challenges. This briefing note summarises the questions that remain about the next phase of the COVID-19 response, and elucidates some of the values that should inform discussion.

It does not offer conclusions or recommendations as to a way forward: that can only come through careful and informed debate - one which the Nuffield Council on Bioethics (NCOB) is ready to support. Instead, it draws on a number of enquiries and briefings previously published by the NCOB to highlight the ethical considerations which must continue to inform the country's response to the next phase, and to emphasise the importance of ethics in the decision-making process.

1. WHAT VALUES HAVE INFORMED THE MOST RECENT DECISIONS ON COVID-19 RESTRICTIONS?

The response to the COVID-19 pandemic has involved a number of challenging decisions. There is no rigid set of rules which produces the “right” answer in these circumstances. The Government's early insistence on “following the science” obscured other consideration and analysis necessary in reaching decisions. As we have argued throughout the response to the pandemic, “science” is only one part of the equation: it is a question of values which determines what policy decision is made.²

An approach which aimed solely to prevent COVID morbidity and mortality would justify almost any intervention, no matter how restrictive. Such an approach, however, would fail to take account of a vast number of other competing interests. This is where a number of challenging trade-offs need to be made: between the health of individuals (with different risk profiles); the capacity and long-term stability of the NHS; wider concepts of health (the effects of measures imposed on physical and mental health); individual financial health and wider economic health; and the various short and long-term social impacts of isolation.

These are complex decisions, further complicated by the fact that not all of them are straightforward trade-offs in the traditional sense. Most of these considerations are interrelated (for example, the state of the economy has long-term impacts on health and wellbeing), while many have different timescales - the impact of COVID-19 has been made immediately apparent in terms of directly attributable mortality and morbidity, but the impacts of school closures, the sum of the financial consequences, the impact on diagnosis and treatment of non-COVID illnesses, and the effects of denying people visits to family members in care homes or hospitals may not be felt for some time.

In April, we wrote jointly with Involve to the Prime Minister and Chief Medical and Scientific Officers, [to call for greater transparency and public involvement](#) in the next phase of the COVID-19 pandemic. Shortly afterwards, the Prime Minister pledged to ensure “maximum transparency” about how decisions to tackle COVID-19 are being made.³

Yet there is still a deficit of information about the evidence underlying decisions⁴ and how different interests and risks are being weighed - as well as concerns about the level of parliamentary scrutiny that has been brought to bear on those decisions.^{5 6 7} Despite the Prime Minister's assurance that the most recent restrictions have been “carefully judged to achieve the maximum reduction in the R number with the minimum damage to lives and livelihood”⁸ there has been little in the way of open deliberation of how different interests and risks are being balanced; of what interests take priority and why; and of who will be asked to bear the greater burdens and for how long. These questions need to be consciously and transparently addressed, in an inclusive and public fashion, to inform any future decisions.

2. IS THE GOVERNMENT CONSIDERING THE USE OF “IMMUNITY PASSPORTS” IN THE NEXT PHASE OF ITS RESPONSE?

Leaked documents from the government’s newly proposed mass testing scheme ‘Operation Moonshot’ suggest that testing for access to certain spaces “feature heavily” in the plans, with references to immunity/virus free passports.⁹ “Immunity certification” relies on the premise that if effective markers of immunity from COVID-19 could be identified, this could then be used to determine whether an individual should be permitted to move in certain spaces or perform certain tasks. Such a process could exist either in the public sphere - for example, to waive isolation for particular individuals - or in the private sphere - as a condition of access to commercial spaces, or as a condition of employment.

In addition to a number of uncertainties which still exist about protective immunity to COVID-19 (whether the presence of antibodies equates to immunity; the duration of any protection they confer; and the possibility of reinfection),¹⁰ the idea of immunity certification also raises many ethical questions.

Our rapid policy briefing [COVID-19 antibody testing and ‘immunity certification’](#) highlights the tension that such an approach could create between individual rights and public interests and the potential social disruption which might follow: a preference for those who can demonstrate immunity and a stigmatisation and loss of opportunity for those who cannot; the commodifying of biological markers and the creation of systems or approaches which put a premium on immunity status; and the subsequent incentive to fake, manipulate, or misreport test results.¹¹ It also highlights that the negative effects of any certification system are likely to fall disproportionately on the already socially marginalised and disadvantaged: those in low-paid, insecure sectors of the economy for whom testing may be used to require large parts of the workforce to return to work.

There is a similarly urgent need for discussions to take place on the development of test and trace practices which also have the potential to lead to differential treatment of people in terms of permitting or restricting access to particular spaces and services.

The implications of any such approach need to be carefully and deliberately considered. If the Government is considering these measures, they must be subject to a robust and open debate.¹²

3. HOW WILL DEVELOPMENT OF AN EFFECTIVE COVID-19 VACCINE AFFECT UPTAKE - AND WHAT SHOULD BE DONE?

Our rapid policy briefing [Fair and equitable access to COVID-19 treatments and vaccines](#) highlights the speed at which many vaccines are being developed. Timelines and processes for development and approval have been accelerated with the support of regulatory authorities, but with huge variation in global approaches: China and the United Arab Emirates have both approved emergency usage of a vaccine still in Phase 3 trials;¹³ Russia has approved use of a vaccine without Phase 3 trials or publication of any earlier results;¹⁴ and there has been political pressure in the USA for the Food and Drug Administration (FDA) to approve a vaccine in time for the upcoming Presidential Election.¹⁵

The speed and urgency of trials should not compromise the safety of participants, quality of the trials, or ethical standards. There are already concerns that the accelerated process, and how that is being communicated to the general public, may (among other factors) impact on public trust and willingness to take up a vaccine.¹⁶ Human challenge trials for a vaccine - where healthy volunteers are deliberately infected with COVID - one of which is due to begin in early 2021,¹⁷ also present new challenges which warrant careful ethical review and public engagement.^{18 19}

Over-optimism about what a vaccine might achieve - whether there will be an effective one, whether it will only be partially effective, how effectiveness might differ in certain groups (e.g. the

elderly or children) - has been a particular feature of discourse in the past few months. In many contexts it is being touted as a panacea rather than one possible part of the solution.²⁰

4. WHAT DISCUSSIONS ARE TAKING PLACE ON SETTING PRIORITIES FOR VACCINE ALLOCATION WITHIN THE UK?

The UK has already secured early access to around 340m doses of six different vaccine candidates currently being trialled.²¹ If and when a successful COVID-19 vaccine becomes available, there will not be enough doses or adequate delivery systems for the entire population to receive it immediately.²² That being the case, priority groups for the first doses need to be identified.

Internationally, the WHO Strategic Advisory Group of Experts on Immunisation (SAGE) has published a values framework which identifies healthcare workers, adults over 65, and adults with certain illnesses (cardiovascular and respiratory diseases, cancer, diabetes and obesity) as priority groups.²³ In the UK, the Joint Committee on Vaccination and Immunisation (JCVI) has published updated interim advice which recommends prioritising older adults resident in care homes and care home workers, followed by those aged 80 and over, and health and social care workers. Remaining groups follow in age order - although the advice notes that this may change depending on the nature of the precise vaccine approved for use.²⁴

There is a range of different values which can be taken into consideration when setting priorities for access. The one most commonly taken prioritises maximising benefit - prioritising frontline workers who are vital to the provision of health and other services, and able to continue to save the “most lives” (although this is also founded in duties of reciprocity that the state gives back to those who made sacrifices at the beginning of the pandemic), followed by those most vulnerable to risk of infection and morbidity and mortality.²⁵ Other approaches, however, could include prioritising younger people who are the greater transmitters of the virus,²⁶ or a social justice approach which takes account of the disparities experienced by particular groups (e.g. racial and ethnic groups) and asks for those to be weighed as part of the decision.²⁷

As with all decisions made throughout the pandemic, there is no single scientific answer. It is all a matter of which values and interests are prioritised and why. That discussion should be had now, and the outcome communicated clearly with the public, well in advance of a vaccine becoming available.

5. HOW WILL THE UK ENSURE A SUSTAINED COMMITMENT TO GLOBAL SOLIDARITY?

The COVID-19 pandemic has been truly global, in a way that few other crises have been. This global nature indicates a need for action to prioritise and feed into global efforts, in recognition of a moral responsibility towards others which extends beyond geographical boundaries. Financial and logistical support for less well-resourced countries will be essential in order to ensure that the pandemic can be brought under control - an issue particularly important in the context of the development and allocation of vaccines.

A number of commentators have already warned of the rise in “vaccine nationalism”, where money and national interest wins out and wealthier countries pre-purchase huge stocks of vaccines in development to the detriment of others.^{28 29} Our rapid policy briefing [Fair and equitable access to COVID-19 treatments and vaccines](#) highlights the importance for policies for fair and equitable access to be in place prior, or concurrent, to development and distribution, as well as highlighting the challenges around regulation, commercial practices, and intellectual property rights that need to be addressed.

Considerable steps have already been taken, including the UK’s £250 million pledge to the Coalition for Epidemic Preparedness Innovations (CEPI), the international coalition to find a

vaccine,³⁰ and, most recently, agreement to the WHO's COVID-19 vaccine allocation plan, Covax.³¹ The UK's commitment to these initiatives is to be welcomed, but it is not without question. The UK joined online on deadline day amid struggles to meet funding targets, with the WHO arguing that more countries need to contribute in order to meet the \$2 billion target.³² Furthermore, under the Covax scheme, vaccines will initially be made available to 3% of the population of participating countries, building over time to 20%. There is a question of what will happen after those targets are met and whether there will be a sustained commitment from the UK to support low- and middle-income countries, or a retreat into focusing on increasing UK stocks.

There is also a tension with an increasingly isolationist political approach,³³ British exceptionalism,³⁴ and developments which hint at a politicisation of aid.³⁵ Rather than solidarity in the truest sense of the word - a willingness to carry costs to assist others in recognition of a shared feature, system, or interest³⁶ - there is a risk of seeking a much more narrow concept of solidarity, through exclusion or exceptionalism; a resowing of many of the social and political divisions seen in the UK in recent years.³⁷ We must ensure that global solidarity and a commitment to equitable allocation of vaccines is not a temporary fix or mere rhetoric, but is borne out in action.

6. HOW IS INFORMATION ABOUT UNDERLYING INEQUALITIES WHICH HAVE BEEN EXPOSED BY COVID-19 FEATURING IN DECISION-MAKING - AND WHAT ACTION WILL BE TAKEN LONGER TERM?

As the pandemic has progressed, there has been clear evidence that it has not affected all groups equally: older age, the presence of pre-existing conditions, geographical area, gender are all associated with risk of infection, more severe symptoms, and higher rates of death. It has now also been established that ethnicity is an indicator of risk, with those from Black, Asian and Minority Ethnic communities more affected compared with the White British population.³⁸

The reasons for this are multi-faceted and associated with increased exposure to COVID-19 (through factors associated with occupation, use of public transport, and housing); increased risk of complications and death (due, in part, to a higher incidence of chronic and multiple long term conditions occurring in BAME communities); and structural racism and discrimination (affecting, in particular, many BAME key workers, but also affecting how BAME groups accessed testing and treatment).³⁹ Crucially, however, COVID-19 has also exposed and exacerbated longstanding pre-existing inequalities - both in terms of how people experience the virus, and how they have experienced measures to combat the virus.⁴⁰ Some of these effects will be long term, and many will continue unabated with further restrictions.

Questions around unequal impacts should also feature in discussions that should be taking place around prioritisation and allocation of treatments and vaccines. Longer-term they must be part of a wider question about what action will be taken beyond suppressing the virus and towards addressing those inequalities long term.

7. HOW WILL PUBLIC TRUST AND SOLIDARITY IN THE COVID-19 RESPONSE BE ENSURED?

Throughout lockdown, citizens have been expected to regulate their own behaviours - whether to self-isolate, whether to travel to work which cannot be carried out at home, whether to visit a pub or restaurant once they reopened. This places a high level of responsibility on individuals to determine whether their own actions are compliant, under the threat of enforcement, but without unambiguous guidance from the government - which creates a culture of 'responsibilisation'.

The corollary of that culture of responsibilisation is one of blame: that it is the fault of the public for not complying with restrictions when infection rates rise again. Certain sections of the

community have been singled out for blame: Black, Asian and minority ethnic backgrounds⁴¹ (particularly those from Muslim backgrounds, with a decision to impose a local lockdown in parts of Northern England the night before Eid al-Adha⁴²); young people socialising;⁴³ and students returning to universities.⁴⁴ This has led to pitting communities against each other - whether in sowing the seeds of intergenerational conflict between the younger and older, or encouraging neighbours to “shop” each other for not observing social gathering rules.⁴⁵ Blame and the characterisation of the public as selfish or reckless will surely impact on trust and trustworthiness, and a sense of public solidarity, at a time when that is of crucial import.

8. WHAT SUPPORT WILL BE GIVEN TO THOSE BEARING THE GREATEST BURDENS?

The measures taken in response to the pandemic do not fall equally on everyone: instructions to isolate or to work from home are incumbent on people having the financial and practical means to do so. Other measures taken have resulted in business closures (whether temporary or permanent) and loss of employment.

The state has a strong duty, founded in the principles of solidarity and reciprocity,⁴⁶ to ensure that those who take on increased burdens are supported to do so.⁴⁷ There have been various measures introduced throughout the pandemic, from statutory sick pay (SSP) being paid on the first day of illness, and to those self-isolating without symptoms;⁴⁸ the furlough scheme;⁴⁹ and a range of financial support measures for businesses.⁵⁰ As various measures continue, campaigners from various sectors are warning that this is not enough: the end of the furlough scheme in October threatens mass unemployment⁵¹ and new restrictions on hospitality venues will have a serious, and perhaps irreversible, impact on many businesses.⁵²

The state also has a particular duty of solidarity towards healthcare workers given the additional burdens they bear in providing care within the NHS. At the beginning of the pandemic there were serious concerns around adequate provision of personal protective equipment (PPE)⁵³ and there are now similar concerns around provision of testing.⁵⁴ These concerns will come to the fore again as the number of cases, and cases requiring hospitalisation, increase.

9. HOW WILL NEW MEASURES TAKE ACCOUNT OF PRINCIPLES OF RESPECT AND FAIR AND EQUAL TREATMENT?

The manner in which public health interventions are introduced and managed is as ethically significant as what those interventions are. Even where it is justified to restrict people’s liberties, it must be done in a way that shows respect for them as individuals of equal moral worth.⁵⁵

As frustration around new measures has grown, so has a call for older and more vulnerable individuals to continue to self-isolate so that younger, healthier people can continue to live their lives - an approach described as “segmenting and shielding”.⁵⁶ In his 22 September speech, the Prime Minister responded to this suggestion, noting the suffering that it would bring with it - “is just not realistic”.⁵⁷ Aside from the practical problems of stopping the spread of the virus, such a proposal fails to treat people as individuals of equal moral worth: suggesting that some parts of society are less important than others, and should therefore be prepared to accept far greater burdens than others. Elements of this can be seen already in the approaches and policy taken with regard to visitors in care homes (with some dementia patients not having received visitors since March)⁵⁸ or to family members being able to be with patients at the end of life.⁵⁹ Campaigners are calling for changes to be made to these policies.

Another part of ensuring people are treated fairly and respectfully is providing them with clear and timely information about the development of the pandemic, and the measures being considered and implemented - underscoring again the central importance of transparency and trustworthiness in the pandemic response.

10. WHAT NEXT?

It is clear that we will have to learn to live with COVID-19 for some time. In light of that, there is an urgent need for a clear and published strategy on what decisions may need to be made in the coming months; what considerations will inform them; and who will be involved and consulted. Without a roadmap through this next stage of the response, there is a risk of ad hoc decisions being made without a considered and consistent framework to guide them. There are no straightforward answers to the challenges we face: that can only come from open and informed policy and public debate. It is critical that there are clear mechanisms for ethical deliberation as part of that.

NUFFIELD COUNCIL ON BIOETHICS WORK ON COVID-19

We have been working throughout the pandemic to provide support, information, and advice to ensure that ethics is a key consideration in rapidly developing government and societal response to the COVID-19 pandemic, particularly in the UK. This includes:

- Rapid policy briefing: *COVID-19 antibody testing and 'immunity certification'*, and a background discussion paper which helped inform it
- Rapid policy briefing: *Fair and equitable access to COVID-19 treatments and vaccines*
- Joint letter with Involve to the Prime Minister calling for greater transparency and public involvement in the UK response to the COVID-19 pandemic
- Rapid policy briefing: *Responding to the COVID-19 pandemic - ethical considerations*
- *Guide to the ethics of surveillance and quarantine for novel coronavirus*
- Webinar series on COVID-19
- COVID-19 ethics resources repository
- A series of opinions pieces responding to research and policy developments in the COVID-19 pandemic

You can access all of these [online](#).

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