Covid 19 Vaccine Certification
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Introduction and summary

1. We are academics specialising in health law and ethics from the universities of Oxford and York.

2. This evidence submission considers important legal and ethical aspects of SARS-CoV-2 vaccine certification schemes, ie schemes (whose origin is either the state or private actors) that require proof of vaccination (or proof of exemption) as a condition of access to services.

3. Our evidence submission covers the following matters:

    a) state-originating vaccine requirements [pages 2-5 paragraphs 12-34]

    b) private-originating vaccine requirements [pages 5-8 paragraphs 35-52]

4. Our **summary conclusions** are:

    a) A state-originating SARS-CoV-2 vaccination status scheme may be compatible with human rights law.

    b) A state-originating vaccination status scheme may be justified ethically, but choices in respect of the relative weight of public protection and fairness may arise.

    c) Equality-related concerns about vaccination status schemes are most pressing, but are not necessarily decisive objections to such schemes.

    d) State-originating vaccination status schemes are preferable to private-originating schemes, not least because of the legal complexity entailed in the latter.

5. Our evidence considers the law in England only.

6. We assume that, as well as offering significant protection for the individual vaccinated, vaccination significantly reduces an individual's risk of transmitting SARS-CoV-2 to others.

7. We assume that the social restrictions currently and previously in place for the control of SARS-CoV-2 are justified.

8. We assume that SARS-CoV-2 vaccination certification would be employed as a condition of access to certain services or sectors of the economy.

9. We assume that under a vaccination certification scheme, unvaccinated individuals would be subject to social restrictions of the kind currently in place or that have been in place in the past. The severity of these social restrictions might vary over time according to prevalence and rate of transmission in society.

10. Vaccine requirements for access to services could be imposed either by the state or public bodies (we will call these state-originating vaccination requirements) or by private actors (we will call these private-originating vaccination requirements). We discuss both types of regimes below.

11. Our discussion is about SARS-CoV-2 vaccination status schemes in principle. We assume that vaccination certification could be implemented in a way that carries a low risk of fraud and is protective of privacy. These challenges are not to be underestimated.

Human rights and equality law aspects of state-originating vaccination requirements

12. State-originating vaccine requirements involve the action of public bodies. Any such measures must therefore be evaluated for their compliance with the Human Rights Act 1998 (and the rights protected by the European Convention on Human Rights (ECHR)) and the Equality Act 2010.

13. For example, the government might legislate to require certain service providers, e.g. pubs, theatres or care homes, to check vaccination status as a condition of entry. We might envisage enforcement for non-compliance consisting in monetary penalties against service providers and possibly private citizens. We assume any such scheme would provide modalities for proving positive SARS-CoV-2 vaccination status, as well as for exemption from vaccination in the case of medical contra-indications.

14. Section 6 of the Human Rights Act 1998 makes it 'unlawful for a public authority to act in a way which is incompatible with [an ECHR] right'. It is very likely that a vaccination certification scheme would interfere with individuals' rights under article 8 ECHR, which protects private and family life, including personal autonomy, bodily integrity, and privacy.

15. Article 8 ECHR is a qualified right. A vaccination certification scheme that interferes with individuals' rights under article 8(1) ECHR may be justified if it: (i) pursues a legitimate aim, (ii) is in accordance with the law and (iii) is necessary in a democratic society, which involves considerations of proportionality.

16. A vaccination certification scheme would pursue a legitimate aim: the protection of life and health, and the protection of the rights and freedoms of others. In addition to the risk of mortality that SARS-CoV-2 infection poses to individuals, there are still many uncertainties regarding morbidities and long-term health effects.

17. We assume that a voluntary vaccination certification scheme would be implemented in a way that was in accordance with law.

18. A vaccination certification scheme could be necessary and proportionate. Prevention of the spread of SARS-CoV-2 seems highly likely to be a pressing social need of the kind discussed

in the case law of the European Court of Human Rights. (See eg *Observer and Guardian v UK* (1992) 14 EHRR 153). In terms of proportionality, the United Kingdom Supreme Court applies the following test:

> (a) is the legislative objective sufficiently important to justify limiting a fundamental right? (b) are the measures which have been designed to meet it rationally connected to it? (c) are they no more than are necessary to accomplish it? (d) do they strike a fair balance between the rights of the individual and the interests of the community? *R (Aguilar Quila) v Secretary of State for the Home Department* [2011] UKSC 45 [45] (Lord Wilson)

19. Introduction of a vaccination certification scheme would enable the relaxation of social restrictions in place, and may reduce the need for future restrictions, or enable future restrictions to apply in a more limited way than to the population as a whole. A vaccination certification scheme that permitted free(r) circulation of vaccinated (and exempt) individuals, while restricting the activities of unvaccinated individuals would arguably provide the safest way to relax restrictions on travel and work that are economically and socially damaging, and that have significant and differential impacts on people's wellbeing and mental health.

20. A vaccination certification scheme would arguably be less restrictive on the ECHR rights than national or local 'lockdowns' or other social restrictions. It may be that, now there is a relatively short delay to vaccine availability across the population, vaccination certification offers a fairer balance between protection of public health and interference with individual freedoms.

21. A further human rights argument against SARS-CoV-2 vaccine certification might be that it constitutes indirect mandatory vaccination. If vaccine certification (or exemption) is required for access to services, individuals might argue that the state is in effect *requiring* them to be vaccinated. This is not obviously true: individuals would have the option to forego vaccination and endure social restrictions. A stringent form of social restrictions has been held compatible with human rights obligations during a time of high SARS-CoV-2 prevalence in the community (*R (Dolan) v Secretary of State for Health and Social Care* [2020] EWCA Civ 1605).

22. In terms of equality law, we note that under the Equality Act 2010, section 1, public authorities are under an obligation, 'when making decisions of a strategic nature about how to exercise [their] functions, [to] have due regard to the desirability of exercising them in a way that is designed to reduce the inequalities of outcome which result from socio-economic disadvantage'. In addition, public authorities who provide services operate under legal duties of non-discrimination, which we discuss further in the section on private-originating vaccine requirements below.

Ethical aspects of state-originating vaccine requirements

23. It is widely accepted that the state can justifiably exert *some* pressure or indeed employ coercive policies to prevent individuals from exposing others to harm, or risk of harm. As

a society, we accept, for example, seatbelt and vision requirements and alcohol limits for driving. Infectious disease control is another case in which the state can justifiably exert pressure or indeed employ coercive policies, and the state has already done so in the context of the SARS-CoV-2 pandemic: the social restrictions currently and previously in place have been coercive (and are, for the most part, we think, justified).

24. Second, a vaccination certification scheme seems to produce a more favourable balance of risks and benefits compared to other available alternatives such as generalised social restrictions, since it would enable vaccinated individuals to avoid the psychological, economic and other harms associated with social restrictions, while (given an assumption that vaccines significantly reduce transmission) posing a small health risk to the public.

25. Third, and assuming a vaccination certification encourages uptake of vaccination, being vaccinated against SARS-Cov-2 will typically be beneficial for individuals themselves, as well as for the wider society, much like seatbelt and vision requirements for motorists provide prudential benefits, as well as benefit other road users. It therefore seems permissible for the state to exert at least indirect pressure on individuals to be vaccinated; there is no obligation on the state to remain neutral in respect of vaccination.

26. Fourth, introducing a vaccination certification scheme that enables vaccinated individuals to access to services to which unvaccinated individuals would not have access would make a further option available to individuals. We would each (assuming access to vaccines) be given the opportunity to choose to reduce our own risk of infection and our risk to others by being vaccinated, or to reduce our own risk and our risk to others by other means, such as submitting to social restrictions. If we accept that social restrictions that apply to all can be justified despite their coerciveness, it seems plausible that the lesser coercion involved in a vaccination certification scheme can also be justified.

27. Since a vaccination certification scheme may allow us to end or to reduce certain social restrictions for vaccinated individuals sooner than it would be safe to end them for all individuals, a vaccination certification scheme may be a less restrictive option compared to maintaining social restrictions for all. States are often thought to be under an obligation to adopt the policy that is, of the possible alternative policies, least restrictive of individual liberties. Alternative policies that prolonged generalised social restrictions would seem to be more restrictive than a vaccine certification scheme that allows the relaxation of restrictions for a proportion of the population.

28. It might be argued that even if a vaccination certification scheme would not be problematic on a population level, it may have disproportionate effects for certain individuals. For example, it may discriminate against unvaccinated individuals by treating them less favourably than vaccinated individuals in ways that are unfair. The unfavourable treatment of unvaccinated individuals would not be arbitrary since they would pose a greater infection risk than vaccinated individuals. But it might be unfair if some individuals have not had the opportunity to take the vaccine (and thus avoid the unfavourable treatment), if certain individuals or groups could not reasonably be expected to take this opportunity, or if it were likely to exacerbate already existing disadvantages of some group.

29. Individuals for whom vaccination is medically contraindicated might easily be exempted from a vaccination requirement and issued with a certificate equivalent to a vaccination certificate. But some individuals may not have had the opportunity to take the vaccine, since vaccination is carried out by the NHS prioritisation list based on age and clinical vulnerability. Some younger adults have not yet had access to vaccination, and children are not yet eligible. Individuals in these groups would therefore not, under the current framework, have access to the vaccination certification scheme or have an opportunity to avoid more stringent social restrictions. Individuals with parental responsibilities may also be disadvantaged if children are not eligible.

30. For groups who have not had fair opportunity to get vaccination, there is a choice to make: either a) we maintain social restrictions for everyone, which would prolong the harms of population-level restrictions (and arguably be unfair on the vaccinated); or b) we institute vaccine certification with restrictions on the unvaccinated (which would be unfair in lack of fair opportunity cases); or c) we exempt those who have not had fair opportunity (which may increase transmission risk and potentially also undermine general compliance with social restrictions).

31. In addition, some disadvantaged groups have lower rates of vaccine uptake than the UK average. If this is true also for the vaccines against SARS-CoV-2, a vaccination certification scheme and vaccine requirements for participation in certain activities and access to certain services would risk exacerbating existing disadvantage for these groups.

32. This is an important ethical concern, but not a decisive reason not to introduce a vaccine certification scheme. Such effects could plausibly be mitigated by, for example, outreach and education programmes. These effects could also be kept in mind when designing social restrictions, e.g. by permitting some of the most important (smaller) forms of social participation for such groups (while imposing vaccine requirements on large gatherings and other high-risk activities), and providing options for mitigating risks in other ways where possible, for example by ensuring access to personal protective equipment.

33. It should be noted that alternatives to the introduction of vaccination certification schemes, such as generalised social restrictions, also affect individuals and groups unequally and exacerbate existing disadvantage, and that the introduction of a vaccination certification scheme and associated relaxation of certain social restrictions may mitigate some of these effects of social restrictions for individuals in disadvantaged groups.

34. We discuss discrimination further at 41-52 below.

Human rights and equality law issues in private-originating vaccine certification

35. In what follows, we consider the legal human rights and equality dimensions of *private*-originating vaccine requirements—for example, pubs and restaurants requiring individuals show that they are vaccinated or exempt as a condition of access, or care homes requiring proof of vaccination as a condition of visiting rights.

36. We do not think that private-originating vaccine requirements are preferable to state-originating vaccine requirements,[1] but the former merit discussion since they may manifest prior to any state scheme.[2]

37. Typically, human rights law applies *vertically*, that is, in the relationship between individuals and the state. Section 6(1) of the Human Rights Act 1998 states that '[i]t is unlawful for a public authority to act in a way which is incompatible with a Convention right'. So at first blush, where no state action is in play, no Convention rights are in play. If a private business refuses an individual services because of a failure to prove vaccination status, the former does not obviously violate any of the latter's rights.

38. However, there is a further and more complicated dimension to the reach of the Convention rights, that is, their *horizontal* effect. The Human Rights Act 1998 enables some enforcement of the Convention rights between private parties. Section 3(1) of the Act requires that '[s]o far as it is possible to do so, primary legislation and subordinate legislation must be read and given effect in a way which is compatible with the Convention rights'. Public authorities must interpret legislation in a way that makes good individuals' human rights claims, if such an interpretation is available. Section 6(3) of the Human Rights Act 1998 clarifies that '"public authority" includes—(a) a court or tribunal…'. Courts must therefore act in accordance with section 3(1) of the Act.

39. Courts must also interpret and possibly develop the common law so that it is in accordance with the Convention rights, even in matters between private parties. Importantly, however, the courts have consistently held that they are not required to create *new* common law rights, only to interpret existing rights in a way that is compatible with the ECHR (see *Venables and Thompson v News Group News Papers and others* [2001] EWHC 32 (QB)).

40. A person wishing to challenge a private actor's imposition of a SARS-CoV-2 vaccination status scheme would have to show that the policy engages some right they enjoy either under legislation or at common law in order for there to be a beachhead for human rights law argument. And of course, even if a beachhead is established, the claimant will need to show that the policy impermissibly infringes their Convention rights.

41. One set of rights that may support a claim against private-originating vaccine requirements in some circumstances are those recognised by the Equality Act 2010.

42. The Equality Act 2010, section 29 makes it unlawful to discriminate (without reasonable adjustments) against individuals in the provision of goods, services, or facilities on grounds of the seven protected characteristics: age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation

[1] Ada Lovelace Institute (2021). 'What place should COVID-19 vaccine passports have in society? Findings from a rapid expert deliberation chaired by Professor Sir Jonathan Montgomery.' [online] Ada Lovelace Institute. Available at: https://www.adalovelaceinstitute.org/summary/covid-19-vaccine-passports/

[2] For a discussion of some of these, see the Royal Society (2021) 'Twelve criteria for the development and use of COVID-19 vaccine passports', available at: https://royalsociety.org/-/media/policy/projects/set-c/set-c-vaccine-passports.pdf

(section 4). Discrimination for the purposes of the Equality Act 2010 can take, among others, a direct (section 13) or indirect form (section 19).

43. The Equality Act 2010 gives private individuals a cause of action against public authorities and, among others, private service providers. The Equality Act 2010 cause of action may provide a site for horizontal effect of the Convention rights. We have seen the Act assist private individuals in claims against providers who have refused services. For example, in *Black & Morgan v Wilkinson* [2013] EWCA Civ 820, a Christian B&B owner was held to have discriminated against a gay couple who she refused a double bedroom. At least four of the Equality Act 2010 protected characteristics might be thought relevant to a potential challenge of a private-originating SARS-CoV-2 vaccination status scheme.

44. First, private-originating vaccination requirements may constitute indirect discrimination on grounds of age. Indirect discrimination involves measures that at face value apply to all, but have a disproportionate impact on some people with a protected characteristic. Until all adults have had fair opportunity to have a SARS-CoV-2 vaccination, because of UK government policy on vaccine prioritisation,[3] a private-originating vaccine requirement will systematically disadvantage younger members of the population, especially those aged 18-39 who will have to wait the longest for immunisation.

45. Second, disability. Proof of vaccination as a condition for access to services may discriminate against those individuals who are unable to be vaccinated because of disability-related contraindications. But these individuals can be exempted as we have stipulated above. Third, pregnancy and maternity—until evidence to support routine vaccination of pregnant women[4] and of children[5] is available, it may be discriminatory under the Equality Act 2010 to require vaccination for access to services. Reasonable adjustments would need to be made for these two categories, which would make any vaccine status scheme more intrusive in terms of privacy and more difficult to operationalise.

46. Fourth and perhaps most contentiously, religion or belief. On religion, a person might claim discrimination under equality law if their religion (genuinely) requires vaccine refusal. However, there do not seem to be mainstream concerns in relation to SARS-CoV-2 vaccines. For example, the Pope has clarified that SARS-CoV-2 vaccines 'can be used in good conscience' notwithstanding that vaccines may be derived from cell lines originating in aborted foetal tissue. More troublesome for private actors may be religious communities with more diffuse structures of authority and for interpretation of scripture.

47. On belief, a belief for the purposes of the Equality Act 2010 (and human rights law in general) is defined in *Grainger v Nicholson* [2010] 2 All ER 253 (EAT) [24]:

> (i) The belief must be genuinely held.
> (ii) It must be a belief and not… an opinion or viewpoint based on the present state of

[3] https://www.gov.uk/government/publications/covid-19-vaccination-care-home-and-healthcare-settings-posters/covid-19-vaccination-first-phase-priority-groups
[4] https://www.nhs.uk/conditions/coronavirus-covid-19/coronavirus-vaccination/coronavirus-vaccine/
[5] Mahase E. Covid vaccine could be rolled out to children by autumn BMJ 2021; 372:n723 doi:10.1136/bmj.n723

information available.
(iii) It must be a belief as to a weighty and substantial aspect of human life and behaviour.
(iv) It must attain a certain level of cogency, seriousness, cohesion and importance.
(v) It must be worthy of respect in a democratic society, be not incompatible with human dignity and not conflict with the fundamental rights of others

48. Here we might want to distinguish the prospects of a successful action for discrimination under equality law according the kind of belief that underpins vaccine refusal. Some people may object to SARS-CoV-2 vaccination on grounds of its association with various conspiracy theories (e.g. 5G, Bill Gates, the 'Great Reset' etc). Even assuming the satisfaction of criterion (ii), such beliefs may face difficulties on criteria (iv) and (v) of the *Grainger* test.

49. We should consider two other sets of objections to SARS-CoV-2 vaccination that may be beliefs for the purposes of the Equality Act 2010. First, some people may believe that mass infection is desirable or that natural infection is preferable to population immunisation. Even if *herd-immunity through infection* beliefs may satisfy criteria (i)-(iv) of the *Grainger* test, they potentially fall foul of criterion (v): they may be incompatible with the fundamental rights of others.

50. Second, and perhaps this is the most persuasive foundation for an equality claim, negative beliefs about vaccination may intersect with race to the extent that reluctance and refusal of SARS-CoV-2 vaccination may be grounded in well-founded distrust of the state arising from its practices of institutionalised racism and injustice. To refuse unvaccinated minority ethnic people access to services may compound existing discrimination.

51. It is important to note, however, that even if discrimination can be established on any of the above grounds, it may be justifiable if it can be shown to be 'a proportionate means of achieving a legitimate aim' (Equality Act 2010, ss 13(2); 19(2)(d)). (See above discussion.)

52. Given the legal complexity of the issues around private-originating vaccine requirements, we reiterate that state action on vaccine requirements is preferable. Moreover, the state is in a better position than private actors to provide a robust justification of any trade-offs in fairness and public protection.