

COVID-19: The Ethics of Vaccine Certification ('Vaccine Passports')

A Briefing Note

Introduction

A report published by the SET-C (Science in Emergencies Tasking: COVID-19) group at **The Royal Society** has published a helpful discussion document on COVID-19 vaccine certification.¹ The report identifies twelve criteria that must be satisfied *if* 'vaccine passports' are to be usefully employed:

- meet benchmarks for COVID-19 immunity;
- accommodate differences between vaccines in their efficacy, and changes in vaccine efficacy against emerging SARS CoV-2 variants. It should be:
- internationally standardised with
- verifiable credentials for
- defined uses, and based on
- a platform of interoperable technologies
- secure for personal data
- portable and
- affordable for individuals and governments. It should meet:
- legal and
- ethical (equity and non-discrimination) standards, and,
- the conditions of use should be understood and accepted by passport holders.

These are all factors that we should expect a government review to address; the remainder of this briefing note will focus primarily on the penultimate criterion (ethical standards) although the criteria overlap to an extent.

Arguments for and against 'Vaccine Passports'

The Ada Lovelace Institute convened an expert working group chaired by Professor Jonathan Montgomery to examine practical and ethical implications of 'vaccine passports'. Their published review² highlighted a number of ethical issues, summarised below to which we would subscribe:

Public health: making the community safer. The effectiveness of this approach is based on the premise that only those who will not transmit the virus are able to take part in activities that would normally present a risk of transmission. *But this aim is not scientifically advisable at present*, as it has not been established that vaccination status reduces the risk of transmission to others (as opposed to the risk of the vaccinated person contracting COVID-19).

Furthermore, **there is the potential of undermining public health** by treating a collective problem as an individual one. Digital 'vaccine passports' could potentially undermine other public health interventions and suggest a binary certainty (passport holders are safe; those without are risky) that does not adequately reflect a more nuanced and collective understanding of risk posed and faced during the pandemic. It may be counterproductive or harmful to encourage risk scoring at an individual level when risk is more contextual and collective – it

will be national and international ‘herd immunity’ that will offer ultimate protection. Passporting might foster a false sense of security in either the passported person or others, and increase rather than decrease risky behaviours.

Personal liberty: enhancing the freedoms of those who have a passport to do things that would otherwise be restricted due to COVID-19 (always noting that granting permissions for some will, in relative terms, increase the loss of liberty experienced by others). This could have a particularly profound benefit for those facing harm and isolation due to the virus, for example those in care homes unable to see relatives.

Conversely, ‘vaccine passports’ risk **exacerbating distrust by marginalised groups** and increasing vaccine hesitancy. It has been argued that one of the benefits of ‘vaccine passports’ is to encourage uptake of COVID-19 vaccines. In the UK, which has already seen over 90% uptake of first doses in the over 75s and elderly care home residents and where nearly 90% of unvaccinated adults say they would be vaccinated if available, it is not clear there is much additional benefit to be gained by further incentivising vaccination. However, there is a downside risk that it could reduce trust and increase vaccine hesitancy if the scheme is seen as introducing mandatory vaccination by the back door. This may be particularly acute amongst marginalised groups who may already have greater levels of mistrust, such as Black and Asian communities, who are already seeing lower rates of vaccine uptake.

They also risk **exacerbating inequalities within societies**. Existing distrust of the state, identity infrastructure and vaccines are also expected to put some groups at a particular disadvantage. Access to digital technology, forms of identification, tests and vaccines is already unequal, and vaccine passports may unintentionally mirror and reinforce existing inequalities without wider programmes for addressing health inequalities.

There is also a danger of **increasing inequalities between nations**. International cooperation will be necessary, particularly for schemes enabling international travel. But scientific concerns could quickly become geopolitical ones, with countries using recognition of (and access to) vaccines as a form of political power and influence. There is pressure on governments to acquire vaccine supplies, which in turn triggers a form of ‘vaccine nationalism’ – where richer countries are able to buy up supplies of vaccines where poorer ones can’t. Tying movement to vaccine certification could supercharge protectionism and entrench existing global inequalities. International friction is unhelpful when vaccination is, ultimately, a global public good. Any individual country’s fate is tied to reaching international ‘herd immunity’ as we are seeing with emergent new strains.

Economic benefits: supporting industries (and the wider economy) struggling in lockdown by enabling phased opening, for example in entertainment, leisure and hospitality.

However, there are **risks associated with focusing on vaccine passports rather than on other interventions**. There may be a comparatively narrow window where there is scientific confidence about the impact of vaccines on transmission and enough of a vaccinated population that it is worth segregating rights and freedoms. Once/if there is population level ‘herd immunity’ it will not make sense to differentiate and passports would be unnecessary. Passports may be a tempting distraction. They bring political, financial and human capital costs that must be weighed against their benefits. They might crowd out more important policies to reopen society more quickly for everyone, such as by vaccine rollout and test, trace and isolate schemes, and other public health measures.

(To these concerns identified in the Review, we could add increased risk of criminal activity through fraud with attendant implications for people-trafficking and blackmail).

Future risks: Normalising health status surveillance by creating long-term infrastructure in response to a time-bounded crisis. It is likely that SARS-CoV2 will become endemic, like seasonal flu and other infectious disease-causing pathogens (or perhaps even contained, like measles), at which point it will no longer require the emergency and intrusive measures justified by its present transmissibility and fatality. Accepting this as a reasonable scientific expectation for the near future, raises concerns about the longevity of emergency apparatus, and that such **infrastructure – once built – will not be stripped back**. Reference was made by the expert group to post-9/11 security infrastructure at airports, and the once-limited but now essentially mandatory Aadhaar identity system in India. There was pessimism about the likelihood of vaccine-passport technologies being ‘switched off’ once the crisis has passed. Building these roads could lead to path dependency: once an infrastructure exists, it will make certain future choices more favourable and block others. This might be a particular issue **if the status of other health conditions were to be added**. The current uncertainty, ongoing social anxiety and economic cost of the pandemic makes the technical fix of a novel tool and emergency infrastructure seem attractive, but the starting point should be identifying specific problems and looking at whether and how these could be addressed through existing practices and laws

There were also particular concerns in the expert group that digital identity systems could be introduced as part of an emergency infrastructure, but **used for different or expanded purposes**. The wider merits of digital identity systems (for example) must be disaggregated from the immediate health context and considered in their own right. Concerns were raised about how information might be used more broadly than was intended. Information might flow to third parties, and personal data may be repurposed. Even with the most privacy-preserving technology, the expectation is that health data will be viewed by different actors, from healthcare settings, employers, clients, police and pubs to insurance companies, who may have different levels of experience and trustworthiness in handling personal data.

Additional Concerns

There are three additional main concerns not specifically taken up in the Ada Lovelace Institute Review document: ‘inadvertent’ non-vaccination, informed consent and freedom of belief and religion, all of which have the potential to lead to discrimination or inequalities.

Inadvertent non-vaccination: If access to jobs, services, travel and other opportunities were to be limited to people who carried a valid vaccine passport, those who lack such validation will, undoubtedly, be adversely affected. This includes not only those who might choose not to be vaccinated, but also those who, because of physical or mental health conditions, are unable to be vaccinated. Families with children for whom no vaccine exists would also be adversely affected with regard to travel and some other leisure activities.

Even if a form of medical waiver were to be introduced, it is difficult to see how this might work in practice, particularly with regard to identifying mental health reasons for non-vaccination. Such reasons could include distress or anxiety caused by anti-vaccination propaganda.

Given that anti-vaccination propaganda and mis-information have been disproportionately targeted at UK minority ethnic communities and those living in areas of deprivation, existing divisions and inequalities could be exacerbated.

Informed Consent: It is not necessary to agree with individuals' choices to uphold their right to make them. Consent for any procedure must be both *free* and informed; adding 'incentives' or penalties runs the risk of introducing coercion, thereby undermining genuinely free choice.

Freedom of Religion/belief: if an individual or a group were to object to vaccination because of their beliefs (which could cover a spectrum from objections to using aborted foetal cells to testing on animals) their freedom of belief or religion should not be compromised by the introduction of any form of coercion.

Some Salient Christian Values

A number of Christian principles, some of which may also be shared by people of other religions or none, are particularly relevant for the Church of England in deciding whether or not to support or utilise 'vaccine passports'..

Identification with the poor and marginalised.

Respect for individuals' dignity.

Belief in Grace and mercy, not judgement.

Commitment to equality.

Principles in Decision-making

For some years, the Mission and Public Affairs division of the Archbishops' Council has adopted four cascading guiding principles in decision-making in areas of medical ethics and health policy:

Affirmation of life

Care of the Vulnerable

Building a caring and cohesive society

Respecting Individuals

These principles can be applied to the issue of vaccine passports with fine balances having to be struck when formulating policy and determining practice.

Government Policy and Private Practice

While it is the case that the Church has determined to encourage individuals from all communities and background to be vaccinated both for their own sake and, *potentially*, the

sake of others, it does not necessarily follow that vaccine passports should receive the same endorsement.

In particular, it should be noted that *the acceptability of vaccine passports may depend, in some circumstances on whether vaccines are shown only to protect those vaccinated or whether they are also found to limit the transmission of the virus.*

Vaccine passports could be utilised in a number of ways. **The examples below are indicative, not exhaustive.**

The government could mandate that all those who have been vaccinated will receive a vaccine passport that should be made available on request for access to a select number of goods or service (such as international travel). If vaccines are protective only, it is difficult to see how this does not compromise individuals' freedom of choice as well as acting in a discriminatory fashion with regard to some members of society without adding anything to saving lives or protecting the vulnerable. At the same time, however, governments of other countries might demand a vaccine passport before permitting entry in order to minimise the risk of visitors becoming ill and putting added strain on their health services. If vaccines prove to limit transmission of the virus, then a better argument can be made for their utilisation though this is likely to fall short of justifying making them mandatory.

Government could require vaccine passports for access to some services ranging from receiving an organ transplant to participation in communal activities in public buildings. Vaccine passports would not be mandatory for all, but required for some. If vaccination primarily protects recipients rather than others this would not be justifiable in most cases. If, however, it were to be shown at a future date that vaccination substantially reduced transmission of the virus, an argument could be made that certain activities that are likely to have a notable percentage of vulnerable people attending who cannot be vaccinated, should therefore have a requirement of a vaccine passport for other participants.

The government could make available vaccine passports to those vaccinated individuals who request them in order for them to gain access to certain goods and services if such a vaccine passport is required *by the provider* of goods or services and such a requirement is shown to be legal. Examples might include international travel to countries which require such certification or access to private premises such as hotels. While such requirements might not be desirable or even always wholly appropriate, if they are lawful, then the provision of vaccine passports ought to be permitted.

Government could permit private businesses and venues to require vaccine passports from employees or from clients or customers to access goods or services. In general, this would not be justifiable unless it could be shown either that others are likely to be put at notable risk by the presence of individuals who have not been vaccinated (such as other employees) or the business is put at notable increased risk of financial loss from individuals who have not been vaccinated. Insurance companies, for example, fall in the latter category although there are issues to be resolved with regard to those who cannot be vaccinated (and might, in any case, already represent an increased insurance risk) and those who choose not to be vaccinated with their choice representing an added insurance risk.

Individual businesses, venues and organisations could encourage patrons to produce vaccine passports in order to access services or admission to events. The reasons for this could vary

from limiting liability to safeguarding others and could cover a wide range of contexts such as membership of gyms or access to theatres or football stadiums. If this were to become widespread it is important that their use does not include essential goods and services and that exemptions are given to those who cannot be vaccinated although, as already noted, how this would be accomplished is not straightforward.

The Church has adopted a clear policy of encouraging people to be vaccinated, but, other than in very exceptional circumstances, it would be difficult for it to justify limiting access to services or organisations on the basis of vaccine passports. Such an approach would run contrary to the principle of the Church being a home and a refuge for all. Similarly, only in exceptional circumstances is the Church likely to utilise ‘vaccine passports’ should they become available in order to facilitate additional services to its members or to the wider community, preferring to continue to emphasise existing mitigations.

Conclusion

While the Church is, in principle, opposed to making use of ‘vaccine passports’, it should adopt a flexible approach to their *limited* wider use with the important caveats that **such use ought to be demonstrably beneficial to society as a whole, protective of the vulnerable in particular, non-discriminatory in nature and proportionate in use.**

¹ <https://royalsociety.org/-/media/policy/projects/set-c/set-c-vaccine-passports.pdf?la=en-GB&hash=A3319C914245F73795AB163AD15E9021>

² <https://www.adalovelaceinstitute.org/summary/covid-19-vaccine-passports/> (and link to pdf report)