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Viewpoints

COVID-19 and human rights—why should the public health community be concerned?

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Why should public health practitioners be concerned with human rights during the COVID-19 pandemic? Surely this is not the time for legalistic hair-splitting about rights. We are dealing with a deadly, infectious disease.

Quite the contrary, we suggest. COVID-19 is undoubtedly a global health emergency, which warrants broad and urgent responses. However, human rights and public health should not be seen simply as competing public policy objectives, with a compromise on one side needed to attain the other. Indeed, this framing of the issues readily leads to human rights abuses in the name of public health. Instead, we propose an approach which focuses on State obligations to protect and promote the right to health, including in the COVID-19 crisis, firmly grounded in international law.

Nobody has the right to shout 'fire' in a crowded theatre without good reason. Public health measures, including contact tracing and restrictions on movement, quarantine and isolation, are needed to protect and promote the right to health for everyone. But where and when do we draw the line? Is it better to challenge government excesses in the middle of a crisis, or should we step back and try to fix later any mistakes that were made? Neither, of course, is ideal—it is far better to build public health law capacity to respond appropriately to public health emergencies *before* crises arise. This is the first lesson from COVID-19. It is of course difficult to plan measures when we are dealing with a new and unknown health threat. Any measure must be based on as much evidence as possible, thus the basic message voiced by the WHO: Stick to the agreed policy, but evaluate regularly and correct if it does not prove appropriate.

Let's be clear that we often balance our health with other competing economic or social demands or pleasures (think of tobacco, alcohol, salty snacks and sweet pastries). Some of us may risk our health to help others in our line of work. Healthcare professionals responding to COVID-19 come to mind. We also see this with police, other first responders and emergency personnel in many contexts. People go shopping, take public transport and come to work with respiratory infections and we largely tolerate it—yet we know that influenza can be especially deadly for older people. In democratic societies, governments balance health and other social and economic concerns constantly.

At the same time, all States are subject to international legal frameworks which impose both obligations to protect health and limits on actions to restrict rights. Some rights—such as the rights to life; freedom from torture and other cruel, inhuman or degrading treatment or punishment; and freedom from medical or scientific experimentation without free consent—are absolute and cannot be suspended even in public health crises. Other rights—such as freedom of movement—can be limited to restore public order or protect public health. However, governments must ensure their actions are prescribed by law, and necessary and proportional to the threats involved. The burden is on the State and its regulatory bodies to justify any limitation on rights. Nor can there be any discrimination, for example, on ethnic or religious or even age grounds.

Further, emergency powers to limit rights should be narrowly drafted, limited in duration, subject to judicial review and should be clearly communicated to the public. Legislative approval should be required for any further, temporary extension of the limitations. Experience from epidemics, such as HIV and Ebola, demonstrates that community trust and engagement is central to achieving sustained changes in social, sexual and drug-use behavior. Heavy-handed police action and threats of incarceration for failure observe measures, such as social distancing is counterproductive.[1] When communities fail to follow public health guidance, we have to ask 'What was wrong with the message or the way it was delivered?' 'Were communities and their leaders fully involved in designing and communicating the guidance?' 'Are there other factors (such as corruption) which lead to distrust in government action on public health?'

The European Centre for Non-Profit Law (ECNL) and its global counterpart monitor government responses to COVID-19 that affect civic freedoms and human rights. The online 'COVID-19 Civic Freedom Tracker' includes State limitations on expression, assembly and privacy around the globe.[2] Usefully, positive government practices in responding to COVID-19 are also documented.

Across Europe, as in other regions, States have responded to COVID-19 with lockdowns and other restrictions on movement.[3] After the immediate threat from COVID-19 passes, will these measures be promptly rescinded? Public health practitioners familiar with the social and economic determinants of health may well be concerned. The health impacts of climate change and economic recession loom in the near future. As always, governments will need to make hard choices about the allocation of scarce resources. Now is the time to be vigilant—it might be too easy for governments with an authoritarian inclination and little tolerance for dissent to maintain without public health justification bans on street protest marches and other mass gatherings in the name of public health.

The international and European regional human rights frameworks provide robust mechanisms for setting norms and standards for State action, monitoring of laws and their implementation, and accountability for abuses or inaction on rights. Further, the European Convention on Human Rights extends to all 47 Council of Europe Member States and includes sanctions mechanisms for non-compliance with orders of the European Court of Human Rights.[4] As noted in the European Competencies Framework for Public Health Workforce, public health practitioners should be familiar with the

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international, regional and national legal frameworks in which they are working.[5] The responses of States to COVID-19 and other pandemics are regulated both by WHO's *International Health Regulations (2005)* and by international and regional human rights frameworks. This is the second lesson from COVID-19: civil and political rights must be safeguarded more than ever in times of public health emergencies.

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Covid-19: a test for our humanity

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The Covid-19 pandemic is not a war zone of combat and competing interests, but a 'test of our humanity', as the German president Frank-Walter Steinmeier said in his television speech on 11 April 2020. This is as time of carefully addressing ethical principles that both guide and challenge acts and policies, to investigate how these principles contribute to upholding humanity, and how they inform us about unsolvable dilemmas. These are times we have to act even though we might make the wrong decisions. Part of testing our humanity is preparing ourselves to face the wrong decisions that were made in times of uncertainty.

There seems to be confusion about what contributes to humanity. All over the world, groups claim that their humanity is under pressure because their right to freedom is restricted. But, is it the loss of some liberties that threatens humanity, or is it a sign of humanity that some take burdens to protect others? For some, herd immunity was the magic word to reach a most humane strategy: the idea that if only enough people fell ill to Covid-19 and recovered, based on their antibodies the disease cannot spread anymore. Yet, to reach herd immunity through a population-wide experienced disease, rather than vaccination, also means, to at least accept that some people will not fully recover from Covid-19 or even die.

Others argued that to prepare our health care facilities is a sign of humanity. In the heat of the crisis, images of quickly erected hospitals captured an undercurrent of implicit bias towards an idea that 'right to healthcare' can be narrowed to 'a right to ICU care'. Questions about access to scarce goods like protective clothing got a different understanding when heart-breaking appeals to our humanity from staff of care- and nursing homes drew attention to questions about who's protecting whom (e.g. supply of protective clothing) and to what end (health vs. family values)?

We contend that we need a moral language that offers conceptual clarity and does not shy away from normative guidance in this 'test of humanity'. It is necessary to identify ethical principles and rules that inform what claims are justified and consequently need to be acted upon. We propose the use of seven ethical principles that, in no particular hierarchical order, shed light on the problems at hand. These principles structure the questions we face and offer a framework of what at least should be addressed when trying to reach decisions defensible and transparent decisions. The principles that play a role in analysing the ethics of Covid-19 are population health maximization, justice, autonomy, harm avoidance ('harm principle'), public trust, solidarity and reciprocity and protection of the vulnerable. These principles, based on the six principles in Schröder-Bäck et al. 2020.[1] with the addition of the vulnerability principle are briefly explained in table 1.

Covid-19 has affected everybody's life but not in equal ways. In many European countries residents in long-term care facilities (LTCF) were affected in various ways: failed reporting, limited testing, shortage of protective measures, infectious staff, lack of training and lock down for visitors.[2] The principle of population health maximization demands monitoring systems that include the entire population, i.e., including residents in LTCF. Justice requires non-discrimination: where you reside should not matter, and age is not a valid argument as such. The vulnerability principle asks for specific identification of who is vulnerable to what[3]: not all elderly people are equally vulnerable (high socioeconomic-status still offers good protection) and vulnerability can be enhanced by the decisions other people make. Consequently, responsibilities need to be specified, e.g., 'outbreak management teams' have to give dedicated specialists the power to act upon the specific identified vulnerabilities. Having these dedicated specialists—with a

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