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Compulsory vaccination for Covid-19 and human rights law

5 Introduction and summary

We are academics working in the areas of philosophy and law, with specialisations in, *inter alia*, moral and political philosophy, biomedical ethics, health law, and human rights law.

Our submission pertains to compulsory Covid-19 vaccination:¹ a requirement on
10 individuals to undergo vaccination as a condition of release from pandemic-related
restrictions on liberty, including on movement and association.²

Our evidence is forward-looking. We expect that a Covid-19 vaccine will become
available in sufficient quantity to enable population-wide immunisation.³ At that stage,
the Government will need to consider the means of delivery, including whether it is
15 necessary to legislate for compulsory vaccination. We consider the human rights law
dimensions of compulsory vaccination by reference to the Human Rights Act 1998 and
the European Convention on Human Rights. As such, our submission primarily
addresses a live issue the second question in the Committee's call for evidence:

20 *What will the impact of specific measures taken by Government to address the
Covid-19 pandemic be on human rights in the UK?*

Our evidence takes the following form:

1. A discussion of the reasons why compulsory vaccination may need to be considered;
2. An overview of relevant legal provisions;
3. An examination of the human rights law compliance of compulsory vaccination.

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Our analysis under 3 establishes two parity arguments:

- a. If Covid-19 'lockdown' measures are compatible with human rights law, then it is
arguable that compulsory vaccination is too (*lockdown parity argument*);
- b. If compulsory medical treatment under mental health law for personal and public
30 protection purposes is compatible with human rights law, then it is arguable that
compulsory vaccination is too (*mental health parity argument*).

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¹ We note that there is disagreement about what compulsion means and as to whether different kinds of non-voluntary vaccination schemes are in fact compulsory schemes. This is in part a theoretical disagreement, and in part a practical one to do with the nature of state sanctions that back any scheme. See Emma Cave, 'Voluntary vaccination: the pandemic effect' (2017) 37(2) LS 279-304. In this submission, we take a coarse-grained or bird's eye view of the issue, that is, we will not engage here with the detail of specific policy schema for compulsory vaccination.

² Much of our argument is applicable, *mutatis mutandis*, to Covid-19 prophylactic treatment. For clarity and brevity, we focus on vaccination.

³ The UK Government has purchased 190m doses of three vaccine candidates, either on risk or in principle: Sarah Bosely, 'UK secures deals for 90m doses of coronavirus vaccine' *The Guardian* (20 July 2020) <https://www.theguardian.com/world/2020/jul/20/uk-deals-doses-coronavirus-vaccine> accessed 20/07/20.

35 **Our chief conclusion is that, as and when a vaccine becomes available at scale, the Government should give serious consideration to compulsory immunisation as a means of reducing the impacts of Covid-19. There is an arguable case for the compatibility of compulsory vaccination with human rights law.**

1. Vaccine hesitancy

40 A Covid-19 vaccine promises to be the best means to mitigate the impacts of the pandemic on individuals and society. Yet sufficient voluntary uptake of a vaccine cannot be guaranteed.⁴ Voluntary vaccine uptake may be limited by ‘vaccine hesitancy’, which the World Health Organization (WHO) describes as ‘the reluctance or refusal to vaccinate despite the availability of vaccines’.⁵ Vaccine hesitancy in respect of Covid-19 may arise because of the influence of anti-vaccination movements, the uneven demographic distribution of Covid-19 morbidity and mortality risks,⁶ or the mistaken
45 belief that Covid-19 immunity has already been acquired.

Should a Covid-19 vaccine become available at scale, we cannot expect sufficient voluntary uptake. It is necessary for the Government to consider a policy of compulsory vaccination, with appropriate exceptions.⁷ Such a policy requires an assessment of its impact on human rights.

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2. Relevant law

This section sets out the law relevant to both our parity arguments: the public health law that governs the control of disease; and mental health law that governs the detention and treatment of individuals with a mental disorder.

55 2.1. Public Health Law

Here we outline current law on disease control. We explain the absence of legal power to mandate vaccination and the legal basis for restrictions relevant to the *lockdown parity argument*.

60 Part 2A of the Public Health (Control of Disease) Act 1984 (PHA 1984) and the Coronavirus Act 2020 provide the legal basis for Covid-19 pandemic control measures.

⁴ By sufficient we mean a level of vaccination in the population that achieves herd immunity.

⁵ World Health Organization, ‘Ten threats to global health in 2019’ (2019) <https://www.who.int/news-room/feature-stories/ten-threats-to-global-health-in-2019> accessed 20/07/17. See also Nuffield Council on Bioethics, ‘The rise of vaccine hesitancy’ (2019) <https://www.nuffieldbioethics.org/blog/the-rise-of-vaccine-hesitancy> accessed 20/07/17.

⁶ eg Among BAME communities, older people, people with pre-existing medical conditions, socio-economically disadvantaged people etc.

⁷ The requirement to vaccinate need not be exceptionless. For example, it should include exclusions for individuals in whom vaccination is likely to be unsafe or ineffective. In order to minimise restrictions on liberty, it might also include an exclusion for individuals who are willing to lower their infection and transmission risk through other means, for example, through submitting to ‘lockdown’ and other mitigation measures. The thought here is that for any one individual, either compulsory vaccination or other restrictions on liberty may be consistent with human rights law, but not both, that is, should an individual opt for restrictions on liberty, it may be hard to justify compulsory vaccination: see Isra Black, ‘Refusing Life-Prolonging Medical Treatment and the ECHR’ (2018) 38(2) Oxford Journal of Legal Studies 299-327.

Sections 45B and 45C of the PHA 1984 grant Ministers the power to make regulations for the purposes of ‘preventing, protecting against, controlling or providing a public health response to the incidence or spread of infection or contamination in England and Wales’. The Coronavirus Act 2020, schedules 18 and 19 give similar powers to the
65 Northern Ireland Department of Health and to the Scottish Ministers respectively.⁸

The regulations laid down under these legal regimes have included extensive restrictions on ‘persons, things or premises’⁹—commonly described as ‘lockdown’.¹⁰ For example, restrictions on leaving the home without ‘reasonable excuse’,¹¹ restrictions on gatherings,¹² and restrictions or closures of businesses.¹³

70 In addition, Schedule 21 of the Coronavirus Act 2020, grants extensive powers across the four UK jurisdictions to screen and assess individuals who have potentially been infected with coronavirus outside the UK.

**Neither the Coronavirus Act 2020, nor the PHA 1984 grant the executive the power to mandate vaccination. Indeed, section 45E of the PHA 1984 and schedules
75 18 and 19 of the Coronavirus Act 2020 rule out provisions requiring medical treatment, including ‘vaccination or other prophylactic treatment’.¹⁴**

A policy of compulsory vaccination would thus require primary legislation.

2.2. Mental Health Law

We set out some provisions of the Mental Health Act 1983 relevant to the grounds on
80 which a person may be detained—‘sectioned’—under the Act, and the legal basis for treatment of detained persons without consent. These are presented for the purposes of establishing the *mental health parity argument* below. This is an illustrative, rather than exhaustive, exposition of the law.

Section 3 of the Mental Health Act permits the detention of an individual in hospital for
85 treatment provided:

⁸ Schedule 18 of the Coronavirus Act 2020 amends the Public Health Act (Northern Ireland) 1967, and Schedule 19 of the Coronavirus Act 2020 creates public health protection regulations *de novo*.

⁹ PHA 1984, section 45C(3)(c).

¹⁰ See The Health Protection (Coronavirus, Restrictions) (England) Regulations 2020, The Health Protection (Coronavirus) (Restrictions) (Scotland) Regulations 2020, The Health Protection (Coronavirus Restrictions) (Wales) Regulations 2020, The Health Protection (Coronavirus, Restrictions) Regulations (Northern Ireland) 2020. There have been successive iterations of these statutory instruments, as the relevant governments have eased lockdown restrictions.

¹¹ The Health Protection (Coronavirus, Restrictions) (England) Regulations 2020 (revoked), section 6.

¹² The Health Protection (Coronavirus, Restrictions) (No. 2) (England) Regulations 2020, section 5; The Health Protection (Coronavirus, Restrictions) (England) Regulations 2020 (revoked), section 7.

¹³ The Health Protection (Coronavirus, Restrictions) (No. 2) (England) Regulations 2020, Schedule 2; The Health Protection (Coronavirus, Restrictions) (England) Regulations 2020 (revoked), Schedule 2.

¹⁴ Coronavirus Act 2020, Schedule 18, section 25E (Northern Ireland); Coronavirus Act 2020, Schedule 19, section 3 (Scotland). Note that the PHA 1984, section 45G(2)(a), the Coronavirus Act 2020, Schedule 18, section 25G(2)(a), the Coronavirus Act 2020, Schedule 19, section 4(2)(a) all include the requirement that a person submit to ‘medical examination’, which the PHA 1984, section 45T(3) and Coronavirus Act, Schedule 18, section 25Y(3) define as including ‘microbiological and toxicological tests’. The Coronavirus Act 2020, Schedule 19, does not define medical examination for the purposes of Scotland.

(a) he is suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital; and

(c) it is necessary for the health or safety of the patient **or for the protection of other persons** that he should receive such treatment and it cannot be provided unless he is detained under this section¹⁵

(d) appropriate medical treatment is available for him.

Part IV of the Mental Health Act 1983 governs consent to treatment for patients detained under section 3 of the Act. Section 63 of the Mental Health Act 1983 provides that the consent of any patient, including those who possess decision-making capacity under the Mental Capacity Act 2005, ‘shall not be required for any medical treatment given to him for the mental disorder from which he is suffering...’. Section 63 of the Act is subject to specific and limited exceptions in respect of certain kinds of treatment.¹⁶

The legal regime for treatment without consent under the Mental Health Act 1983 derogates from the common law requirement that individuals (who are so able) must give consent in order for medical treatment to be lawful.¹⁷

Mental health law permits the detention of a person for treatment for the protection of others, and permits compulsory medical treatment of a person so detained.

3. Compulsory vaccination and human rights law compliance

We focus on the human rights enshrined in the European Convention on Human Rights (ECHR), since these rights are domestically enforceable in virtue of the Human Rights Act 1998 (HRA 1998). The UK is also a party to other international human rights law instruments, which we do not treat here.¹⁸

We explain the basis on which a compulsory vaccination measure interferes with ECHR rights, and advance two parity arguments for why such interference may be justified.

¹⁵ Emphasis added.

¹⁶ Mental Health Act 1983, sections 57, 58, 58A.

¹⁷ *Ms B v An NHS Hospital Trust* [2002] EWHC 429 (Fam); *King's College NHS Foundation Trust v C* [2015] EWCOP 80.

¹⁸ See Emily Postan, ‘Written evidence from the Mason Institute for Medicine Life Sciences and the Law, the university of Edinburgh, School of Law (COV0115)’ (*UK Parliament Joint Committee on Human Rights*, 2020) footnote 1 <https://committees.parliament.uk/writtenevidence/5569/html/> accessed 20/07/22.

3.1. Compulsory vaccination and interference with private and family life

Our focus is on article 8 ECHR, which protects, *inter alia*, the right to private and family life,¹⁹ since this is most relevant to compulsory medical treatment.

115 Article 8 ECHR provides:

1. Everyone has the right to respect for his private and family life [...]

120 2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

125 The case law of the European Court of Human Rights establishes that the provision of medical treatment without consent constitutes an interference with article 8 ECHR: ‘the imposition of medical treatment, without the consent of a mentally competent adult patient, would interfere with a person's physical integrity in a manner capable of engaging the rights protected under Article 8(1) of the Convention’.²⁰

130 **Vaccination is defined as medical treatment for the purposes of the PHA 1984. A compulsory vaccination policy is likely to constitute an interference with the right to private life protected by article 8(1) ECHR for people who would refuse vaccination given the choice.**

135 Note, however, that article 8 ECHR is a qualified right. This means that interference with, for example, the right to private life, may be justified—interference will not violate article 8 ECHR—so far as it is in accordance with the law and necessary in a democratic society in pursuit of the legitimate aims listed in article 8(2) ECHR. **The most important element of the evaluation whether a measure constitutes a violation of article 8 ECHR is the analysis of its proportionality.**

140 Our strategy is to address the justification (including proportionality) of the interference with article 8 ECHR that compulsory vaccination entails through two parity arguments. First, if ‘the lockdown is lawful’ in terms of its human rights law compliance,²¹ then it is arguable that compulsory vaccination is too (*lockdown parity argument*). Second, if non-consensual treatment under mental health law for public protection purposes is complaint with human rights law, then it is arguable that compulsory vaccination is too (*mental health parity argument*). The idea underlying this strategy is that interferences with some of the interests protected by the ECHR are commensurable, that is, we can

¹⁹ We doubt whether a compulsory vaccination scheme would attain the *minimum level of severity* so as to engage the protection of article 3 ECHR, which prohibits torture or inhuman or degrading treatment or punishment: *Ireland v United Kingdom* (1979-80) 2 EHRR 25 (ECtHR); *The Greek Case* (1969) 12 YB 1 (ECmHR).

²⁰ *Pretty v United Kingdom* (2002) 35 EHRR 1 (ECtHR) [63].

²¹ Jeff King, ‘The Lockdown is Lawful’ (*UK Constitutional Law Association*, 2020) <https://ukconstitutionallaw.org/2020/04/01/jeff-king-the-lockdown-is-lawful/> accessed 2020/07/17; Jeff King, ‘The Lockdown is Lawful: Part II’ (*UK Constitutional Law Association*, 2020) <https://ukconstitutionallaw.org/2020/04/01/jeff-king-the-lockdown-is-lawful/> accessed 2020/07/17.

145 evaluate the degree of different kinds of interference with human rights on a comparable
basis. This is the case in respect of the qualified rights, including article 8 ECHR.

3.2. **The lockdown parity argument**

150 The domestic and human rights law compliance of ‘lockdown’ measures, that is,
restrictions on persons, things, and premises through the various Health Protection
(Coronavirus, Restrictions) Regulations is a subject of controversy.²²

155 Some uncertainty regarding the compatibility of ‘lockdown’ with Human Rights Law,
has been resolved by the recent Administrative Court decision of *Dolan v Secretary of
State for Health*.²³ The applicant, Mr Dolan, sought permission to bring a judicial
review challenge to the legality of ‘lockdown’ on very extensive public law and human
rights law grounds. The applicant failed on all grounds but one, which was reserved. We
might characterise the current state of the law as follows: current ‘lockdown’ measures
are compatible with article 5 ECHR (the right to liberty), article 8 ECHR (the right to
private and family life), article 11 ECHR (the right to freedom and assembly) among
others, with consideration of article 9 ECHR (the right to freedom of religion) reserved.

160 The *Dolan* decision does not deny that the lockdown engages the ECHR rights
contained in articles 5, 8 and 11.²⁴ Rather, interference with these rights is justified
because of the potential human rights impacts of Covid-19 for individuals and others,
and in virtue of the State’s positive duty to safeguard the life within its jurisdiction.²⁵
The following is representative of the Court’s reasoning:

165 [T]here is no realistic prospect that the courts would find regulation 7 [restriction on
gatherings] in its current form to be a disproportionate interference with the rights
guaranteed by Article 11 of the Convention. The context in which the regulation was
made was one of a pandemic where a highly infectious disease capable of causing

²² For a flavour of the academic debate, cf Jeff King (n 21) and Alan Greene, ‘States should declare a State of Emergency using Article 15 ECHR to confront the Coronavirus Pandemic’ (*Strasbourg Observers*, 2020) <https://strasbourgobservers.com/2020/04/01/states-should-declare-a-state-of-emergency-using-article-15-echr-to-confront-the-coronavirus-pandemic/> accessed 20/07/17. See also the following written evidence to the Committee: Merris Amos, ‘Written evidence from Merris Amos, Professor of Human Rights Law, Queen Mary University of London (COV0026)’ (*UK Parliament Joint Committee on Human Rights*, 2020) <https://committees.parliament.uk/writtenevidence/1624/html/> accessed 20/07/22; Merris Amos, ‘Human Rights Law and the COVID-19 Pandemic in the United Kingdom Part 2 (COV0029)’ (*UK Parliament Joint Committee on Human Rights*, 2020) <https://committees.parliament.uk/writtenevidence/1739/html/> accessed 20/07/22; David Mead, ‘Written evidence from Professor David Mead, School of Law, University of East Anglia (COV0077)’ (*UK Parliament Joint Committee on Human Rights*, 2020) <https://committees.parliament.uk/writtenevidence/2881/html/> accessed 20/07/22; David Mead and Joe Purshouse, ‘Written evidence from Professor David Mead and Dr Joe Purshouse, School of Law, University of East Anglia (COV0068)’ (*UK Parliament Joint Committee on Human Rights*, 2020) <https://committees.parliament.uk/writtenevidence/2783/html/> accessed 20/07/22; David Mead and Joe Purshouse, ‘Written evidence from Professor David Mead and Dr Joe Purshouse, School of Law, University of East Anglia (COV0069)’ (*UK Parliament Joint Committee on Human Rights*, 2020) <https://committees.parliament.uk/writtenevidence/2783/html/> accessed 20/07/22

²³ *Dolan & Ors v Secretary of State for Health And Social Care & Anor* [2020] EWHC 1786 (Admin).

²⁴ Save in the case of article 5 ECHR, where the restriction on staying overnight at a place other than one’s residence was held not to constitute a deprivation of liberty within the meaning of the ECHR: *Dolan* (n 23) [71]-[73].

²⁵ *Osman v United Kingdom* (2000) 29 EHRR 245 (ECtHR).

170 death was spreading. The disease was transmissible between humans. The scientific understanding of this novel coronavirus was limited. There was no effective treatment or vaccine.

175 The regulation was intended to restrict the opportunities for transmission between humans. The regulation therefore limits the opportunity for groups of individuals to gather together, whether indoors or outdoors. The regulation was time-limited and would expire after 6 months in any event. During that period, the government was under a duty to carry out regular reviews and to terminate the restriction if it was no longer necessary to achieve the public health aim of reducing the spread and incidence of coronavirus within the population.²⁶

180 What is important for the purposes of the *lockdown parity argument* is that the Regulations deriving their power from the PHA 1984 may provide for very substantial interferences with the ECHR rights that nevertheless are proportionate and justified. This is the case even though the impact of these measures falls unevenly across society and is very grave for many people.²⁷ Yet, the PHA 1984 rules out compulsory medical treatment, including vaccination. This seems difficult to justify.

185 Let us assume that a Covid-19 vaccine available at scale is safe, efficacious and administered in a conventional way, for example, by injection. Even accounting for any harms associated with non-consensual administration, the interference with an individual's private life that compulsory vaccination entails seems proportionate in light of the seriousness of Covid-19 risks and impacts. Moreover, a policy of compulsory
190 vaccination seems less burdensome on the interests the ECHR protects as a whole than 'lockdown', that is, the degree of interference with bodily integrity entailed in compulsory vaccination seems less than the degree of interference with other liberties arising from lockdown

195 In the event that a policy choice between 'lockdown' and compulsory vaccination were coterminous, it would, in our view, be strange to opt for lockdown over compulsory vaccination. The absence of the legal power to require individuals to undergo vaccination is hard to explain.

200 **It is arguable that if 'lockdown' restrictions are compatible with human rights law, so too is compulsory vaccination. Current public health law rules out medical treatment, including vaccination, but permits extensive restrictions on personal activity, such as free movement and association. The law privileges the interest in bodily integrity over other liberties. The *lockdown parity argument* asks for a justification for treating bodily integrity as distinctively important relative to these other interests.**

205 3.3. *The mental health parity argument*

²⁶ *Dolan* (n 23) [95]-[96]. We note that the more extensive 'lockdown' restrictions introduced in March 2020 were not litigated in *Dolan*, due to their revocation. As such, their compatibility with human rights law has not been established. However, it is plausible that a court faced with a challenge to those regulations would reach similar outcome to *Dolan*.

²⁷ eg women subjected to domestic abuse or violence and black and minority ethnic people: see Emily Postan (n 18).

In response to the *lockdown parity argument* above, it might be objected that there is indeed something distinctive about bodily or physical integrity. The idea here is that we cannot in fact compare interference with bodily integrity with interference with other liberties, or that interference with bodily integrity is always worse than interference with
210 other liberties. Our *mental health parity argument* addresses this objection by reference to mental health law, which permits compulsory interference with bodily integrity.

The criteria for detention under section 3 of the Mental Health Act 1983 require that appropriate treatment for the person's mental disorder is available and that it is not possible to provide treatment without detention. It is clear that the objective of section 3
215 of the Mental Health Act 1983 is not merely to detain individuals with mental disorder for their own protection or the protection of others, but also to administer treatment for these purposes. Section 63 of the Mental Health Act 1983 permits treatment without consent to persons detained under the Act, even if they possess decision-making capacity.

220 Mental health law provides an example where the law permits—exceptionally—compulsory interference with a person's bodily integrity for their own protection and that of others when the nature and degree of their circumstances gives warrant. The case law establishes that compulsory treatment in this context may be compatible with articles 3 and 8 ECHR.²⁸

225 We can argue by analogy from the compatibility with the ECHR of compulsory treatment in mental health law to the human rights law compliance of compulsory vaccination. In the context of highly infectious disease, every person is at risk of infection and a potential threat to the life and health of others—a person's default state is of a nature and degree to warrant immunisation. Vaccination protects the individual
230 from possible serious harms. Vaccination also contributes to the protection of the community generally and the protection of its vulnerable members specifically.²⁹ Given vaccine hesitancy, it may be necessary to compel vaccination in order to achieve herd immunity. The justifications for compulsory vaccination map onto the criteria for detention and treatment contained in the Mental Health Act 1983.

235 **The law permits compulsory interference with bodily integrity under mental health law. This derogation from the common law principle of *no treatment without consent* is compatible with the ECHR. It is arguable that if compulsory treatment under mental health law is compatible with human rights law, so too is compulsory vaccination. Importantly, the same protected interest—that in bodily integrity—is**
240 **at stake in the two contexts the *mental health parity argument* compares.**

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²⁸ *Herczegfalvy v Austria* (1993) 15 EHRR 437; *R (on the application of B) v S (Responsible Medical Officer, Broadmoor Hospital)* [2006] EWCA Civ 28.

²⁹ Including those who cannot safely undergo immunisation.