Health at the time of CoViD-19: tyrannical, denied, unequal health

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HEALTH AT THE TIME OF COVID-19: TYRANNICAL, DENIED, UNEQUAL HEALTH

ABSTRACT: CoViD-19 is producing a number of changes in the meaning of health. In order to protect our health, States have restricted the exercise of many rights: movement, education, work, etc. Health has thus become a tyrant that crushes all other rights. On the other hand, shortages impose choices for access to intensive care beds, leading to a tragic selection between those who can be treated and those who cannot. In this way, CoViD-19 has denied the health of the excluded. Finally, the pandemic has revealed a condition of great inequality in access to treatment. The article examines these dynamics within a framework of constitutional principles in order to draw lessons for the possible emergence of new pandemics.

KEYWORDS: CoViD-19 pandemic; right to health; tragic choices; shortages; equality

1. Tyrannical health

Talking about health is not easy. It has never been easy, and nowadays, it is even more difficult. In fact, until yesterday, in our rich societies at least, we were used to take a status of good health for granted. It was the base of all our rights and all our activities: working, meeting colleagues, teaching, spending time with our family and friends, playing our favorite sport, walking, planning holidays, and so on. Health, in short, allowed us to live fully.

Today, on the contrary, health prevents us from living fully. The need to protect health (individual and collective health have never been so linked and opposite, at the same time) imposes measures that are making many people lose their jobs; measures that prevent us from teaching the way we were used to do, and that prevent us from visiting our families and friends, from travelling around, even from having a coffee all together. Nowadays, health has become a tyrant, that crushes all other rights. In this way, health has become the enemy of all our rights; and paradoxically it has become also the enemy of health itself. Healthy lifestyles, in fact, are very important: our health depends, for instance, on not staying too much at home, not spending too much time in front of a computer; our health depends on exercises and workouts, on walking, running, moving in the open air. All these ac-

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tions are limited or even prohibited in a number of countries, today. The measures to protect health, therefore, are at the same time the enemy of all our rights, and the enemy of health itself.

Is it possible to draw a legal framework to this tyrannical feature of health? Can we reconcile all these measures (that limit our fundamental rights and liberties) with a constitution-oriented biolaw[1]?

It is not the first time that the need to protect individuals and the community (the need to protect the *salus rei publicae*) asks for sacrifices and for limitation of liberties. In fighting against terrorism, for example, we have already seen/experienced a number of limitations of rights.

In the USA, for instance, we can go back to *Jacobson v. Massachusetts*, (1905), where we can read as follow: "the liberty secured by the Constitution [...] does not import an absolute right in each person to be at all times, and in all circumstances, wholly freed from restraint. There are manifold restraints to which every person is necessarily subject for the common good"[2]. Obviously, culture and the law have changed a lot since 1905, but the general principle remains valid.

In Europe, a number of Courts expressed a similar view, making clear that exceptional measures limiting fundamental liberties must comply with a number of conditions and guarantees. Italy's Constitutional Court, for instance, confirmed (in 1982, in an anti-terrorism case) that exceptional measures have to be temporary and limited in time, they must be issued in accordance with a democratic procedure (usually involving Parliament); they must be proportionate (based on a rationality test, they must affect other rights as little as possible in order to protect compelling interests and relevant goals)[3]. Considering the CoViD-19 pandemic, a fourth condition maybe perhaps added: exceptional measures have to be evidence-based, meaning that their relevance has to be based on scientific evidence, not just on political discretion[4].

The European Court of Human rights established a similar principle: exceptional measures, limiting fundamental rights, must be limited in time, issued according to the rule of law (with a democratic decision-making process), and they must respect the principle of proportionality, passing a rationality test[5].

It is not easy to apply all these criteria to the exceptional measures issued for fighting CoViD-19. Nobody knows, for instance, how long the pandemic will last, and if there will be a second wave or another infection. Besides, with the need to respect the social distancing rules, it is not even easy to bring together all members of Parliament.

With the peculiarities of the case, however, it seems necessary, to ensure that inevitable limitations to rights remain exceptional in nature and do not become normal. From this point of view, as painful as it is, we may have to tolerate a tyrant – tyrannical health – but only exceptionally, only for a very limited period of time, with the mentioned procedural and substantial guarantees and the respect of the rule of law and proportionality.

[1] Biolaw is here understood as the law that deals with medicine and life sciences.

[2] The case considered Massachusetts compulsory vaccination: *Jacobson v. Massachusetts*, 197 U.S. 11 (1905).

[3] See Corte costituzionale, decision n. 15 of 1982.

[4] A case in point is the *Model State Emergency Health Powers Act*, issued by the *Center for Law and the Public's Health* at Georgetown and Johns Hopkins Universities after 9/11.

[5] See, for example, *National Security and European case-law*: https://bit.ly/3kruTuV.

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2. Denied health

Denied health is a second reason why talking about health today is not easy. So far, we had become used to a broad definition of health. Reading from the Preamble to the Constitution of the World Health Organization, health is not merely the absence of disease or infirmity, health is a state of complete physical, mental and social well-being. This definition entered into force in 1948 and it has not been amended since then.

Today, in the middle of the pandemic, talking about health in such broad terms is, unfortunately, unworkable and unrealistic. In some parts of the world, the number of seriously ill people has exceeded (and is still exceeding) the number of ICU beds, for instance, and it is impossible to guarantee access to the necessary care for everyone. In those situations, selection criteria had to be applied (and are still applied) for access to life saving treatments, such as ventilators. And since "omnis determinatio est negation" (as Spinoza reminds us) this selection means not being able to give treatments to – some – people who need them.

Bioethics and biolaw have dealt a lot with this topic, establishing and questioning criteria for admission to and discharge from ICU beds. In each country, there have been several proposals and, in turn, severe critiques. In *The Lancet*, an article admitted: "Critical care triage to allow the rationing of scarce ICU resources might be needed. Researchers must address unanswered questions"[6]. And many other articles on the need to set criteria for admission to ICU has been published in Journals as such *Jama*, *The British Medical Journal, New England Journal of Medicine* and so on. Besides, all national bioethics committees also considered the issue, the *Nuffield Council* in the UK, the bioethics committee in Germany, France, Spain, the *Hastings Center* in the US and others.

In Italy, the National Bioethics Committee published an opinion, on the "pandemic emergency triage"[7]. We focused, as many others, on a number of clinical criteria in order to ensure the maximum benefit for the largest number of patients. We wrote that "Each patient should be seen in the totality of his/her clinical situation, considering all necessary assessment factors, such as: the severity of the clinical condition, comorbidity, pre-existing diseases, and other clinical data". We have also considered age, not as a unique, cut-off parameter, but in the correlation with the current and prognostic clinical evaluation. The priority – we concluded – should be established by evaluating the patients with the greatest chance of survival. In this way, we also refused to suggest priorities based on fixed categories, established a priori, such as a particular disability or ethnicity or people with dementia or health care workers.

[6] J. Phua, *Intensive care management of coronavirus disease 2019 (COVID-19): challenges and recommendations*. *The Lancet*, vol. 8(5) May 1, 2020 (https://www.thelancet.com/journals/lanres/article/PIIS2213-2600(20)30161-2/fulltext?fbclid=IwAR2ULaUJJJ0B6XYbVyhaN_HT8qKRVdEHaTSCpzvVJ_9hOEe6y3jguN3wjDU).

[7] *Covid 19: clinical decision-making in conditions of resource shortage and the "pandemic emergency triage" criterion*, 8 April 2020 (http://bioetica.governo.it/en/opinions/opinions-responses/covid-19-clinical-decision-making-in-conditions-of-resource-shortage-and-the-pandemic-emergency-triage-criterion/). I recognize a conflict of interest here, being a member of the Committee.

Other councils and committees adopted similar approaches with a number of different nuances. But all in all, the point is that the pandemic forced doctors to select between people: those to be treated and those not to, with consequence, for the latter, of a denial of treatment and health.

As for health as a tyrant, is it possible to design a legal framework for the denial of health? Can we reconcile the selection of patient to be treated with a constitution-oriented biolaw?

Out of the many possible approaches, two are worth mentioning. The first approach consists in considering this selection an extreme choice; but a choice not so unusual for doctors; a choice taken within a horizon not entirely unknown to medical practice, to bioethics and biolaw. One can think about organ allocation, for instance, where it is necessary to select who will receive the organ and who will not. And even ordinary triage in ER is essentially a choice – triage has a French root, actually meaning to select. In the first approach, therefore, the pandemic triage is an extreme and tragic choice, but which is taken within an ordinary logic, following not so unusual coordinates in medicine.

The second approach, on the contrary, considers the pandemic triage a decision that subverts and overthrows the very principles of medical ethics, biolaw and its constitutional basis. Involving a choice of life or death, this decision is something that cannot be part of the doctor's duties and responsibility – and something for which no doctor is trained. Accordingly, the selection of who will live and who will die is considered a radical change and an impermissible shift of the professional paradigm.

Looking at the two approaches, I cannot tell which is right or wrong; maybe there's something right and something wrong in both of them. For sure, being forced to select people to access to ICU beds conflicts with, at least, a couple of basic principles of biolaw.

I refer to the logic of balance of interests usually applied to conflicting positions & the principle of equality.

But can we still speak of a real balance of interests in the mentioned situation? Here, choice cannot find the balance between a reasonable (and limited) compression of one right compared to the proportionate prevalence of another: actually, it annuls any chance of life of one patient for saving another one. The really hard and cruel choice is to make an assessment of the life expectancy of two persons, comparing them with each other.

Usually, the balance of interest technique tries to save at least (meaningful) parts of the right which has to give way to the prevalence of the other. But (according to constitutional law) even the former has to be guaranteed, at least in its essential content (*Wesensgehalt* theory). In the case of pandemic emergency triage, on the contrary, one right entirely erases the other.

Also the principle of equality is in conflict with the pandemic emergency triage. How can we reconcile it with the need to ensure the greatest chance of survival for the greatest number of people? This goal, utilitarian as it may be, forces to treat the people who statistically have the greatest chance of recovery and those who statistically will take less time to heal, so as to free the bed for another sick person as soon as possible. This logic, however, goes to the detriment of the most seriously ill patients, and those who will need longer to recover.

The constitutional problem here is that the principle of equality would require to give more time, more attention, more resources etc. exactly to the most vulnerable patients. In sum, equality means devoting the greatest effort to the most vulnerable, not vice versa. Here lies the difference between

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formal equality, and substantial equality (in comparative constitutional terms): formal equality leads to treating everyone equally, without considering the different conditions and states of need, while substantial equality requires treating different categories in a different and reasonable way, giving more to those who need more. According to the pandemic emergency triage, on the contrary, the most serious patients and the sick persons with fewer chances of survival are excluded from treatment: The greater vulnerability, the greater loss.

If the pandemic emergency triage is very problematic, are there better alternatives? I doubt so. First of all, there is not such a thing as a neutral choice in this subject. Even the usual emergency triage criterion (first come, first served) cannot be considered neutral as it depends on a mere time factor with no rationale at all. Perhaps, a random selection, a lottery could be neutral, but no Country has adopted such a choice, maybe because it is utterly unprincipled. Therefore, facing a shortage in medical resources, criteria for life-saving treatments have to be adopted.

As painful as it is, it seems we have no choice that to tolerate a tyrannical health and also the denial of health; however, only for an exceptional and limited period of time, and giving some priorities based on as principled and as reasonable as possible criteria, without forgetting to adjust and prepare health systems, in order to avoid future shortage situations.

3. Unequal health

A deeply unequal health is a third feature that, unfortunately, characterizes our health today. I mean a situation where the level of wellbeing is conditioned not by the probability of surviving in exceptional circumstances, but by the poverty or the color of the skin. "Brasil" just to give an example «is adding around 25,000 new confirmed cases a day, more than the United States. Russia and India are not far behind, with 8,000 or so apiece. All told, poorer countries account for some three-quarters of the 100,000 or so new cases detected around the world each day»; and CoViD-19 infections are rising fast in Bangladesh, India and Pakistan: «Hospitals over there are already struggling to cope»[8]. In this regard, a United Nations document, titled *When it rains it pours: covid-19 exacerbates poverty risks in the poorest countries* denounces the following. «As the number of COVID-19 cases continues to rise in Africa and Southern Asia, and the global economy enters a synchronized recession unseen since the Second World War, the world's poorest countries brace for yet another shock that threatens to deepen global inequalities and exacerbate an already challenging situation»[9].

Even within individual Countries, health is protected unequally and the pandemic is exacerbating the differences: «At first, the coronavirus pandemic was called the great equalizer […]. But as more data becomes available, one thing is clear: Covid-19 has only magnified the systemic inequalities that persist in the United States. And nonwhite Americans, especially African Americans, have been hit hard

[8] *The Economist*, June 4 and 6, 2020.

[9] See P. Akiwuni, G. Valensisi (Division for Africa and Least Developed Countries) 4 May 2020: https://unctad.org/en/pages/newsdetails.aspx?OriginalVersionID=2356.

on nearly every front»[10]. In other words, the pandemic affects anyone, but does not affect anyone, equally[11].

Therefore, in addition to tyrannical health and denied health, unequal health also occurs. Here again, it is possible to wonder if can we draw a legal framework to this kind inequality in health: Can we settle unequal health within a constitution-oriented biolaw?

While I observed earlier that tyrannical health and denied health can – exceptionally – be reconciled with the principles of biolaw, I simply see no way to reconcile unequal health in a similar way with those principles[12].

No shortage condition or necessary pandemic triage can justify, even temporarily or in exceptional terms, a distinction based on social status or ethnic origin. This discriminatory situation could in no way be reconciled with the most basic principles of contemporary constitutionalism. And these selection factors, as well as those based, for example, on dementia or the gender of the sick, must in no way relate to access to care. Their connection with mortality rates, therefore, constitutes a blatant and intolerable infringement of the very core of contemporary constitutionalism, in usual times as well as in exceptional ones.

From this point of view, in sum, it could be argued that the fight against CoViD-19 also involves a necessary fight against all discrimination of this kind. In this perspective, a few initiatives have already been proposed. *People' Vaccine*, for instance, gathered more than 140 world leaders and experts for guarantees that CoViD-19 vaccines and treatments will be provided free of charge to everyone, everywhere[13]. And *Declare Covid-19 Vaccine A Global Common Good Now*, made an appeal to all international organizations and governments to adopt legal measures and make official statements declaring CoViD-19 vaccines as a Global Common Good, free from any patent right belonging to anyone[14].

[10] H. Kaur, *The coronavirus pandemic is hitting black and brown Americans especially hard on all fronts. CNN, May 9, 2020* (https://edition.cnn.com/2020/05/08/us/coronavirus-pandemic-race-impact-trnd/index.html). See also M. Webb Hooper, *COVID-19 and Racial/Ethnic Disparities*, in *Journal of American Medical Association*, May 11 2020 (https://jamanetwork.com/journals/jama/fullarticle/2766098); M. Chowkwanyun, *Racial Health Disparities and Covid-19 — Caution and Context*, in *The New England Journal of Medicine*, May 6 2020 (https://www.nejm.org/doi/full/10.1056/NEJMp2012910); K. Ravi, *Ethnic Disparities in COVID-19 mortality: are comorbidities to blame? The Lancet*, June 19, 2020.

[11] The estimated age-adjusted CoViD-19 mortality rate for African-American compared to white-Americans, for instance, is 3.8; for American-Indian is 3.2; for Hispanic 2.5. See the data presented by McKinsey & Co.: *Insights on racial and ethnic health inequity in the context of COVID-19*, July 31, 2020: https://mck.co/3ksc1Ms.

[12] A more articulated position, including a debate on the meaning of "emergency", in a 1997 case of the Constitutional Court of South Africa: *Soobramoney v Minister of Health* (Kwazulu-Natal) (CCT32/97) [1997] ZACC 17.

[13] See https://www.unaids.org/en/resources/presscentre/featurestories/2020/may/20200514_covid19-vaccine-open-letter.

[14] http://vaccinecommongood.org/?fbclid=IwAR3DWK4gKcpZudLFwKMaq3fRteBRNRYvD_i_WgoYlKiUdjxelvc6m9Eyjc0.

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4. Lessons to be learned

The comparison of CoViD-19 with war is in many ways not accurate[15]. As in wartime, though, some rights that we previously took for granted have been crushed by tyrannical health; and some doctors in some hospitals have to adopt selection criteria for access to scarce medical resources, leading to a denied health. Worldwide, the pandemic is also having an impact on the poorest and most disadvantaged countries and populations, leading to an intolerable deterioration in their status and health.

This situation is among the hardest that can happen. It is not by chance that bioethics emerged (according to someone) facing a similar dilemma: I refer to so called *God Committee* at the Seattle Artificial Kidney Center in 1960, where patients were selected in order to get the first hemodialysis treatment. In that case, it was not possible to choose between a good and a bad solution: they had just to choose the lesser of two evils, which unfortunately, is at the center of our debate also today.

In any case, we are experiencing an emergency that undermines and sometimes even altogether denies some basic principles of a constitutional-oriented biolaw (equality and the right to be cured, among others). For this reason, it is necessary that this situation does not happen again, and to prevent it from repeating itself, a few lessons must be learned.

In recent months, we have experienced some 'very unusual' situations (exceptional situation) that we all hope will soon pass, and which are characterized by tyrannical health, denied health, and increasing unequal health.

It is essential that we do not get used to these unusual and exceptional situations.

On the contrary, there are other "very unusual" and exceptional situations that I hope will last and will become usual and ordinary. We have been forced to accelerate data sharing and knowledge sharing among researchers, for instance, in order to get a vaccine or a cure as soon as possible; we have been forced to work together (lawyers, philosophers, bioethicists, computer scientists, Members of Parliaments, and so on); we have also been forced to use the powerful instruments of artificial intelligence for clinical research, finding for a vaccine and for a treatment[16].

At a more general level, we have been forced to rethink some features of our national health systems, and started to think about how we could strengthen equality (in general, and equality in the access to care); we have been forced to reconsider global hygiene standards and higher levels of healthcare, and we started to reassess our global strategies for international food standards, for animal respect and welfare, and for environmental sustainability. And maybe, a stronger sense of generosity and solidarity can arise from this difficult period. These expectations can be considered quite utopian, but, for instance, are shared by the *Nuffield Council on bioethics*, which recently, highlighted a need for action to ensure that vaccines and treatments for CoViD-19 are offered fairly, to avoid deepening inequalities for disadvantaged populations[17]. And the president of the *Hastings Center*

[15] See F.G. Miller, *Pandemic Language*. *The Hastings Center*, July 21, 2020: https://bit.ly/2ZO2qaC.

[16] See for example materials collected by the Council of Europe on *Artificial intelligence and the control of COVID-19*: https://www.coe.int/en/web/artificial-intelligence/ai-covid19.

[17] See *Policy briefing: Key challenges for ensuring fair and equitable access to COVID-19 vaccines and treatments*, 29 May 2020: https://www.nuffieldbioethics.org/news/policy-briefing-key-challenges-for-ensuring-fair-and-equitable-access-to-covid-19-vaccines-and-treatments.

Mildred Solomon said: «In this dark hour, we can see important cultural shifts toward a more compassionate, inclusive future»[18].

These are the "very unusual" situations that I hope will last, the emergency lessons that I hope will become ordinary practice; because it is important that this period ends as soon as possible, but it is equally and maybe even more important that it does not end in vain.

[18] *A Perilous Moment for Our Nation,* June 6, 2020: https://www.thehastingscenter.org/news/a-perilous-moment-for-our-nation/.

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