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VIEWPOINT

Revisiting Restrictions of Rights after COVID-19

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The Siracusa Principles have had a good run over the past 35 years.[1] The public health provisions of the principles, which contain criteria for limiting civil and political rights to advance various public purposes, have offered governments standards for acceptable restrictions on rights to reduce the spread of infectious disease. They require that restrictions be based on a legitimate aim, law, and necessity; evidence-based; the least-restrictive choice; non-discriminatory; and arrived at through a participatory and transparent process. In particular, restrictions must not disproportionately harm marginalized or vulnerable populations or discriminate against them. The standards have proven durable as a human rights approach to controlling outbreaks and sensible from a public health standpoint.

Despite differing traditions and approaches, moreover, there has been convergence between Siracusa and approaches to restrictions on rights emerging from the field of bioethics.[2] Standards of necessity, relevance, proportionality, equitable applications and least restrictive approach, along with procedural fairness, have dominated ethics approaches to restrictions on rights in pandemics.[3] Both approaches require application of the principle of reciprocity, that is, imposing an obligation to ensure that people whose liberty is restricted are not also deprived of rights to food, water, housing, and health, among others.[4]

As with many requirements of human rights and bioethics, these standards are often honored in the breach, from unwarranted detention of people with multi-resistant tuberculosis to fencing in an entire community in Liberia during the 2015 Ebola outbreak.[5] During the COVID-19 pandemic, misuse of emergency public health powers is also evident, such as lockdowns in prisons as a social distancing measure and restrictions on access to abortion in the United States. For the most part, though, the closures and restrictions on travel and work established by public health authorities have respected, and must continue to respect, Siracusa and bioethical concepts. Calls for the UN Committee on Economic, Social and Cultural Rights to issue a General Comment to provide concrete recommendations for operationalizing the Siracusa Principles in law and policy should be uncontroversial.[6]

The principles were never designed, however, to address what has become a central feature of the public health response to the COVID-19 pandemic: the harm inflicted on the health of people who are exempted from restrictions on quarantines and lockdowns. In today's era of vast social and economic inequalities, people in low-paying service jobs are permitted to move around, but at the price of being deemed essential and therefore having to work in circumstances that result in far greater likelihood of exposure to the coronavirus. Their health and lives are subordinated to other community objectives, such as public transport, trash collection, food distribution and retailing, and care for the elderly.

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The perverse aspect of these policies is that marginalized people are not singled out for special restrictions on freedom of movement and other liberties but are rather excluded from public health protections. This exception amounts to a blatant denial of the right to health—sometimes spectacularly so, for example, in meatpacking plants in the United States, where the risks of transmission to a mostly immigrant workforce are enormous yet the industry has been singled out for mandatory continuance when hundreds of others are shut down.[7]

Moreover, unlike other essential workers (for example, health care workers), these service workers face significant additional hardships. Many lack sufficient or adequate personal protective equipment. Few have the option to stay at home, even if they have compromised immune systems or other heightened medical risks. If they decline to work, they may lose their jobs or be delayed in receiving (if not altogether denied) unemployment compensation.

Siracusa never anticipated these concerns. It was conceptualized from the standpoint of individuals whose freedom is restricted, and its concerns with discrimination focused on communities that were subjected to quarantines, detention, and lockdown when others were not. It did not consider circumstances where exceptions to restrictions risk health, not freedom of movement. Ethical analyses, too, failed to anticipate fully this concern, considering essential workers' continuing to work as supererogatory or voluntarily "beyond the call of duty," not a matter of human rights.[8]

The essential worker rules amount to limitations of the right to health under Article 4 of the Covenant on Economic, Social and Cultural Rights.[9] The Committee on Economic, Social and Cultural Rights General Comment on the right to the highest attainable standard of health discusses limitations of rights and Article 4 but, like Siracusa, didn't foresee situations like those arising today.[10]

The drafters of the General Comment can be forgiven for not looking at limitations on the right to health in the context of pandemics, but it is time to fill that gap. There is a solution: when Siracusa criteria are met, *public health measures must be implemented to ensure that they protect the right to health, of all, not just those whose movement is restricted, including determinants such as safe working conditions.* That requirement has three dimensions: first, no use of compulsion or economic penalty to require someone to take the risk of working when authorities have determined that, for the rest of the population, performing a job is dangerous to health; second, instituting effective measures for both ameliorating risk and promoting health of individuals who are considered essential; and third, ensuring that exceptions to social distancing and lockdown rules do not discriminate against particular groups, such as migrants, homeless people, and individuals with child- or elder-care responsibilities.

By emphasizing proportionality, remedies, and non-discrimination, these dimensions are consistent with Siracusa and fundamental bioethical principles even as they extend them to a new context. One could argue that the right to health and ethics requirements, properly construed, demand these approaches anyway. What is crucial is that these right to health considerations are built into decision-making by public health authorities when measures to prevent the spread of infectious disease are instituted in the first place.

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