Assessing Covid Status Certifications

A Proportionality Litmus-Test

An Essex Autonomy Project Working Paper
University of Essex

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Executive Summary

This working paper contributes to ongoing policy debates about whether and how Covid Status Certificates (CSCs) should be used in the UK's COVID strategy. Interlocutors in the public debate about CSCs have already expressed concerns about their impact on civil liberties and human rights. We seek to provide a structured approach to evaluating the human rights compatibility of various possible uses of CSCs.

The paper highlights a number of civil liberties and human rights issues surrounding the use of CSCs. It explores their implications for the right to privacy of one's health-related data, the right to a family life, the right to form relationships with other individuals and the world, freedom of religion, freedom of assembly, and freedom of association. We also highlight the possibility that CSCs could result in direct and indirect discrimination against some of the most vulnerable members of society, including BAME individuals, the elderly, and the digitally disadvantaged.

In our view, current deliberations regarding the use of CSCs should make use of a 'proportionality litmus test' that can be used to scrutinise any interference with civil liberties and human rights. In the annex to the paper, we provide a worked example of the application of this test to the use of CSCs to regulate visits to care homes, the subject of an ongoing research project being conducted by the authors of this paper. Based upon this analysis, we offer the following recommendations, along with a general call for the voices of human rights experts to be included in ongoing discussions regarding CSCs:

1. The Government must consider whether any interference with the privacy of individuals' sensitive health-related information resulting from CSCs is proportionate to the objectives sought, and it must establish safeguards to ensure that sensitive health-related information is not disclosed to parties that have no interest in accessing it.
2. Public authorities must consider whether there is a *rational connection* between CSCs and the objectives they pursue. Put simply, public authorities must be able to

demonstrate how CSCs are likely to achieve their objective, despite persisting doubts about the reliability and effectiveness of tests and vaccinations.

3. Public authorities should consider whether there are less rights-restrictive means available for the protection of public health in any particular setting. CSCs might provide some individuals with a ticket to freedom, opening doors to pubs, theatres, concerts, places of worship, care homes, government buildings, and more. But they might also exclude those who cannot access testing and/or vaccination from economic, social, familial, cultural, and civic life in the 'new normal.' The question that must be asked is whether there are ways of safeguarding public health and promoting economic wellbeing that are less restrictive for this latter group.
4. More work is needed to ensure that CSCs do not entrench existing inequalities. CSCs must not worsen the digital divide, further the alienation of racial and ethnic minorities, or further the marginalisation of vulnerable members of society.
5. Any new legislation or amendments must provide for continual review of the necessity and impacts of CSCs, as it is presently difficult to predict exactly how CSCs might be used and how circumstances might change as the United Kingdom's pandemic response continues.

About the Authors:

Both the working paper itself and this executive summary were prepared by the research team of the Autonomy Project at the University of Essex. The Autonomy Project is a research and public policy initiative focusing on the ideal of self-determination (autonomy), particularly in care contexts. Principal Authors: Dr Vivek Bhatt (v.bhatt@essex.ac.uk), Dr Margot Kuylen (mkuyle@essex.ac.uk) and Prof Wayne Martin (wmartin@essex.ac.uk).

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Introduction

This working paper explores civil liberties and human rights issues relating to the use of COVID Status Certificates (CSCs). It is offered as a contribution to ongoing policy debates about whether and how CSCs should be used in the UK's COVID strategy. At the time of writing, the UK government has charged the Chancellor of the Duchy of Lancaster with undertaking a review of the use of CSCs. The Terms of Reference for the review characterise CSCs as "using testing and vaccination data to confirm in different settings that people have a lower chance of transmitting COVID-19 to others."[1] There is at present no single well-defined proposal about how CSCs would be configured or deployed; a variety of different approaches have been discussed and debated. This paper does not adopt a position on the policy question as to whether CSCs should be used; instead, it seeks to articulate a principled 'litmus test' that can be used to assess particular proposals and practices.

In setting the parameters for our discussion we shall assume that any CSC would assign an individual to one or another COVID risk group based upon the person's vaccination status, recent test results, recent recovery from COVID-19 infection, or some combination of these. CSCs might be used in a variety of settings:

[1] Cabinet Office, 'Terms of Reference – COVID-status Certification Review' (*GOV.UK,* 15 March 2021) < https://www.gov.uk/government/publications/covid-19-response-spring-2021-reviews-terms-of-reference> cited 17 March 2021.

1. To provide evidence to a current or prospective employer that an employee has received a COVID vaccination or a recent negative test.
2. To implement an international vaccination passport scheme.
3. As a condition of entry into particular events or venues, such as live music events, theatres, restaurants, pubs, or care homes. This is known as 'pre-event passporting.'

These proposed uses of CSCs might be introduced in the service of a number of objectives:

- Protection of particularly vulnerable groups, such as care home residents;
- Reducing the risk of exposure involved in activities such as music concerts and festivals, thus allowing their resumption;
- Allowing activities involving a high risk of exposure to resume sooner than they otherwise would have;
- Reducing the health risks associated with any activities or events where presentation of a valid CSC is a condition of entry;
- Incentivising testing and vaccination by making people's enjoyment of certain rights and freedoms contingent upon the ability to present a valid CSC.

Public debate about CSCs has already given voice to concerns about the impact of CSCs on civil liberties and associated human rights. This working paper surveys these issues and proposes a framework for assessing this impact. We draw on both the common law tradition and modern human rights standards in order to propose a 'litmus test' to which particular uses of CSCs should be subjected. The approach that we recommend makes use of an established test for proportionality. While use of CSCs might help protect public health and/or accelerate the reopening of parts of the UK's economy, these benefits cannot simply be assumed; they must be demonstrated and then carefully weighed against the potential interference with civil liberties and human rights, with particular attention to the rights of already marginalised and disadvantaged members of society. The proportionality litmus test that we propose has deep roots in English common law and modern human rights jurisprudence. It demonstrates that any use of CSCs would need to be supported by clear evidence and by policies defining and delimiting their permissible use.

Two Potential Misunderstandings

CSCs have already been the subject of intensive debate in the media, among civil society organisations, and in Parliament. Unfortunately, these discussions and debates have often been derailed by misleading assumptions. It is therefore worth spending a few words inoculating ourselves (so to speak) against two potential misunderstandings.

A first potential misunderstanding pertains to nomenclature. Whether in the press, amongst lobbying organisations or even in Parliament, much of the discussion of CSCs has revolved around the idea of a *vaccine passport*. This terminology has taken hold of the debate, perhaps in part because of the precedent established for the use of Yellow Fever Vaccination Passports, which are required for some international travel. At an earlier stage of the debate, some referred to the proposed instruments as *immunity passports*. Both of these terms are deeply misleading. Consider first the idea of an "immunity passport." There is at present no way of establishing definitively that a person has *immunity* from COVID. Vaccinations are not 100% effective in preventing disease; tests yield both false positives and false negatives; there are as yet many open questions about the potential for COVID re-infection. Because there is no way to definitely establish that any individual person has immunity, the issuance of immunity passports cannot seriously be contemplated.

The term *vaccine passport*, which currently dominates the public debate, is also deeply misleading. Vaccination is one pathway for obtaining a low-risk COVID status, but the terms of reference for the current review clearly envision other pathways as well – for example through a recent negative COVID test. From a civil liberties and human rights perspective, this difference is significant. There are currently many who have no way of accessing a COVID vaccine, or may be medically ineligible to accept one, and so would be locked out of a COVID vaccine passport. But this would not prevent them from obtaining a CSC which offered such individuals other pathways to certification.

A second potential area of misunderstanding pertains to the *current situation* as regards CSCs. The debate is often currently framed as a debate about *whether to introduce* such instruments. But this is to overlook the fact that such certifications *already exist*. Certification of a negative COVID test is already a requirement in certain domestic contexts,

including visiting a resident in a care home, and routine testing is strongly encouraged in settings including secondary schools and universities. So the current policy question is not really about whether to *introduce* CSCs. We already have them! The debate is more productively framed as a question about how CSCs can or should be *used*. What is needed, we believe, is a method for *regulating* their use, including a litmus test for distinguishing permissible from impermissible uses. We turn now to the task of formulating such a test.

Relevant Legal Frameworks

Many interlocutors in the debate about CSCs have raised concerns about their impacts upon civil liberties. For example, during a Westminster Hall Debate held on 15 March 2021, the Hon Fleur Anderson noted that 'we do not want a two-tier system in which those who are not vaccinated, especially the marginalised, are blocked from essential public services, work or housing; we do not want the passport abused and extended beyond what is legally required, or want it extended in time.'[2] We have already noted the difference between CSCs and 'vaccine passports' above, and we are doubtful that the use of CSCs is legally *required* at this stage. But the comments made by the Member for Putney highlight some of the key civil liberties and human rights issues arising from the use of CSCs. Risk-based certification threatens the privacy of sensitive health-related information, and it risk excluding many individuals from economic, social, cultural, and civic life. If the use of CSCs is not clearly delimited by relevant law or regulation, they are likely to place those with protected characteristics under anti-discrimination law at a particular disadvantage, and they could result in discrimination against members of protected groups.

The use of CSCs might also advance the enjoyment of certain human rights. CSCs might allow individuals to resume their social and family lives, participate in cultural life, and return to work. And they may further the right to the highest attainable standard of health by reducing the risk of exposure to the virus in certain settings. Yet these benefits must carefully be weighed against the costs for civil liberties and human rights, and, in this section, we

[2] HC Deb 15 March 2021, vol 691, col 20WH. Available: https://hansard.parliament.uk/Commons/2021-03-15/debates/8D4B8782-7BA5-475B-A48A-370859B78209/VaccinePassports.

demonstrate how the proportionality test by UK courts can facilitate and structure this balancing exercise.

Public Law

Government decisions and practices are subject to public law considerations. Public law requires the Government and other actors exercising public authority to act lawfully, fairly, rationally, and in accordance with human rights law. The principle of lawfulness requires public authorities to make decisions in accordance with legislative procedures and to refrain from exceeding their statutory authority. Fairness, meanwhile, requires that public decision-making processes are free of bias. According to Lord Sumption, rationality in public law is 'a requirement of good faith, a requirement that there should be some logical connection between the evidence and the ostensible reasons for the decision, and (which will usually amount to the same thing) an absence of arbitrariness.'[3] Thus, a lawful decision made by a public authority is one that is consistent with relevant legislative frameworks, is free of bias, and is based upon the evidence available at the time.

Decisions made by public authorities, including those pertaining to CSCs, are subject to challenge on public law grounds. These challenges may take the form of complaints, Ombudsman procedures, formal appeal of decisions, and judicial review. The past year has demonstrated that courts are willing to review the public law dimensions of Government responses to COVID-19. For example, in February 2021, the claimants in judicial review proceedings against the UK Government challenged the rationality of a decision not to implement national guidelines for the allocation of critical care resources if intensive care units are overwhelmed by a wave of COVID-19 infections.[4] Justice Swift rejected this argument, noting that the number of disadvantages of national triage policy meant that it was not arguable to characterise the lack of guidance as irrational. The proceedings nevertheless demonstrate that courts are willing to consider, among other things, the question of whether public authorities have acted rationally in making decisions to

[3] *Hayes v Willoughby* [2013] UKSC 17 at 14. Available: https://www.bailii.org/uk/cases/UKSC/2013/17.html.
[4] Dominic Wilkinson and Jonathan Pugh, 'Is it Irrational Not to Have a Plan? Should there have been national guidance on rationing in the NHS?' (*Journal of Medical Ethics Blog,* 2 March 2021) < https://blogs.bmj.com/medical-ethics/2021/03/02/is-it-irrational-not-to-have-a-plan-should-there-have-been-national-guidance-on-rationing-in-the-nhs/> cited 15 March 2021.

implement – or not implement – certain measures. In the context of CSCs, rationality requires that public authorities have taken account of all relevant evidence, including data pertaining to the accuracy and reliability of tests and the effectiveness of vaccines in preventing asymptomatic transmission of the virus.

Human Rights

The European Convention on Human Rights (ECHR) was incorporated into UK law by the Human Rights Act 1998 (HRA). As a result, the rights enumerated in the Convention are individually justiciable within the United Kingdom. Public authorities bear a statutory obligation to act in accordance with Convention rights,[5] and should also consider the possibility that any use of CSCs in a manner that contravenes Convention rights may be subject to judicial review. We outline the human rights engaged by CSCs below.

Private and family life (ECHR Art 8)

Article 8 entails a number of rights including the right to privacy of data pertaining to one's health; the right to make healthcare decisions, including to refuse medical interventions; the right to personal development and fulfilment; and the right to develop relationships with other individuals and the world.[6] The state bears an obligation not to limit or violate the sphere of personal and social life protected by Article 8, except as in accordance with the law and necessary in a democratic society in the interests of national security, public safety, economic wellbeing, prevention of disorder or crime, protection of health or morals, or the protection of the rights and freedoms of others.[7] In our view, CSCs are likely to have many significant implications for the rights protected by Article 8. Firstly, the widespread use of CSCs may jeopardise the privacy of data relating to individuals' health, which will be held in vaccination and testing databases and may be used by a range of public and private actors. The ECtHR has previously held that it is unlawful to disclose individuals' health-related data to third parties with no interest in accessing that information, as the extent of the violation of the individual's privacy would be disproportionate to any 'pressing social need' being

[5] Human Rights Act 1996, s 6.
[6] Jean-François Akandji-Kombe, *Positive Obligations under the European Convention on Human Rights* (Human Rights Handbook No. 7, Council of Europe, 2007) 37. Available: https://rm.coe.int/168007ff4d.
[7] *European Convention on Human Rights,* Art 8(2).

pursued.[8] The Court has held, furthermore, that states must establish appropriate safeguards to protect sensitive health-related data against unnecessary disclosure.[9] The Government's deliberations regarding CSC must take the right to privacy into account, and clear lines must be drawn to ensure that any use of health-related data is human rights-compliant. For example, an employer of social care workers might have an interest in knowing that a prospective employee poses a 'low risk' of COVID-19 transmission, but they have no ostensible interest in knowing the underlying reasons for that level of risk. The prospective employee might have recently recovered from COVID-19, or they might be testing regularly because the vaccine is medically contraindicated as a result of an underlying health condition. Disclosure of this information would clearly violate the individual's Article 8 rights, as it bears no relevance to the economic and public health objectives being sought.

As noted above, Article 8 protects a broad range of rights. These include the right to a social and family life, and to form relationships with other individuals and the world. The social and familial implications of CSCs should not, therefore, be taken lightly. The use of CSCs for pre-event passporting in settings such as pubs, restaurants, music events, festivals, theatres, and function rooms may prevent certain individuals from attending events such as family gatherings, weddings, funerals, memorials, and graduation ceremonies. Furthermore, as we note in Annex 1, the use of CSCs for care home visits might similarly affect the right to a family life by preventing certain individuals from visiting care home residents, especially where the physical layout of a care home prevents outdoor and screened visits.[10] By making access to a variety of venues conditional upon a negative test result or vaccination, CSCs will directly limit many individuals' ability to form and maintain relationships with others and the world around them. The Government bears the burden of demonstrating that this far-reaching interference with Article 8 rights is in accordance with law, is necessary in the interests of pursuing a pressing social need,[11] and, as we discuss below, is proportionate to the objectives sought.

[8] *PT v Moldova* [2020] ECHR 335 at 31. Available: https://www.bailii.org/eu/cases/ECHR/2020/335.html.
[9] Ibid.
[10] Department of Health and Social Care, 'Guidance on Care Home Visiting' (9 March 2021) <https://www.gov.uk/government/publications/visiting-care-homes-during-coronavirus/update-on-policies-for-visiting-arrangements-in-care-homes> cited 12 March 2021.
[11] *European Convention on Human Rights,* Art 8(2).

Freedom of religion, expression, assembly, and association (ECHR Arts 9-11)

The use of CSCs for pre-event passporting may also have implications for the rights to religion, expression, and free association with others, as they are likely to result in denial of entry to places of worship, religiously significant events such as wedding ceremonies, funerals, memorial services, public lectures, town halls, protests, and events organised by citizens' associations. The rights enumerated in Articles 9 to 11 protect not only freedom of thought and belief, but also the freedom to worship, practice one's religion, receive and impart information and ideas, to participate in cultural life, and to participate in various forms of associations with others. These are all important aspects of civic life within a democratic society and enable individuals to exercise many other political, social and cultural rights. As above, any limitations upon Articles 9 to 11 rights must be in accordance with law and necessary in a democratic society in the interests of a pressing social need, such as the protection of public health. While many of these rights were limited by the various lockdown measures imposed from March 2020 onwards, their limitation resulting from CSCs raises particularly concerning human rights issues as it is, at present, difficult to know how long CSC requirements will be in place, whether they will effectively prevent transmission of the virus, or whether any mechanisms will be established for continuous review of their effects on society. This highlights the possibility that the human rights restrictions resulting from CSCs are disproportionate to the objective being pursued, an issue we explore in the following section.

Interferences with Convention rights

The ECHR and HRA allow for some interferences with the rights enumerated in Articles 8 to 11. Any interference with these rights must be in accordance with law and necessary in a democratic society, pursuing the interests of national security, public safety, economic wellbeing, prevention of disorder or crime, protection of health or morals, or protection of the rights and freedom of others. Any measure that interferes with these rights is, therefore, subject to the tests of necessity and proportionality.[12] In our view, these tests of necessity and proportionality provide a vital framework for differentiating between human rights-

[12] *Handyside v United Kingdom* [1976] ECHR 5. Available: https://www.bailii.org/eu/cases/ECHR/1976/5.html.

compliant and non-compliant uses of CSCs. These tests are well established in jurisprudence and provide a structured approach for balancing the rights and interests of individuals and communities.

In order to satisfy the **necessity test,** the relevant public authority must be able to demonstrate that the restrictive measure 'meets a pressing social need.'[13] Human rights law recognises that national authorities are in the best position to identify and respond to 'pressing social needs' within a domestic context. But the necessity test nevertheless invites consistent scrutiny of the need for CSCs. While CSCs might be necessary as lockdown restrictions are eased in Spring 2021, certification may no longer be necessary if there is widespread vaccination of the UK population and 'herd immunity' is reached. Similarly, CSCs may become necessary once more if vaccine-resistant variants emerge, or once the vaccine is no longer effective in preventing acute illness resulting from COVID-19.

The ECtHR's approach to **proportionality** varies according to the right in question and the circumstances of the alleged violation. UK courts' approach to proportionality is, however, based upon a structured and rigorous test derived from Commonwealth courts' decisions regarding constitutional and legislative bills of rights.[14] This approach is more onerous than the contextually variable approach taken by the ECtHR, and its structure can be particularly helpful to policymakers as they deliberate upon the compatibility of various uses of CSCs with human rights standards. The proportionality test in UK law comprises four stages: (i) legitimate objective, (ii) rational connection, (iii) minimal interference, and (iv) fair balance.

i. At the **legitimate objective stage, the responsible public authority must demonstrate that the objective pursued by the restrictive measure is sufficiently important to justify the limitation of a fundamental right.** A measure adopted in the spirit of upholding one or more human rights will generally satisfy the 'legitimate objective' stage. By contrast, a measure that pursues a discriminatory objective – such as a policy that aims to exclude members of a minority ethnic, racial, or religious group from education, employment, social welfare, or government services – will fail to satisfy this requirement.

[13] Ibid at 48.

[14] *R v Oakes* [1986] 1 SCR 103 at 70. Available https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/117/index.do.

ii. At the **second stage, the relevant public authority must demonstrate that the restrictive measure is rationally connected to its objective.** The public authority must show how the measure, including the proposed interference with human rights, is likely to achieve its objective.[15] In the context of CSCs, the public body responsible for their design and implementation must be able to demonstrate how certification is likely to achieve its objective of protecting public health and promoting the country's economic well-being. The Government bears the onus of demonstrating this rational connection, and it must, therefore, be able to show that CSCs are likely to achieve their objectives despite the fact that new mutations, vaccine failure, and fraudulent activity are likely to reduce the certificates' reliability.[16] For example, CSCs are likely to reduce the risk of exposure to COVID-19 in a crowded music venue only if it is established that vaccines prevent transmission of the virus, that accurate tests are available to all who need them, and that these tests can be taken close enough to the time of the individual's attendance of the music event to ensure that he or she is a low infection risk. The relevant public authority must be able to cite such information in order to demonstrate that the use of CSCs in this context is rationally connected with the objective sought.

In order to demonstrate that the use of CSCs is rationally connected with its objective, the relevant public authority must also be able to show that their implementation is viable within the proposed time frame. If CSCs are implemented through the use of a smartphone app or the use of printed barcodes, it must be shown that the relevant information systems and technologies have been designed and tested so as to ensure their reliability and accessibility.

iii. At the **minimal interference stage, the relevant public authority must be able to demonstrate that the 'least rights-restrictive' means of achieving the legitimate**

[15] The Australian Attorney-General's Department's guide to assessing the human rights compatibility of legislation is a particularly helpful resource relating to this stage: Australian Attorney-General's Department, 'Assessing the Human Rights Compatibility of Bill and Legislative Instruments' (March 2020) < https://www.ag.gov.au/sites/default/files/2020-03/Flowchart.pdf> cited 9 March 2021.

[16] The Royal Society, '12 Criteria for the Development and Use of COVID-19 Vaccine Passports' (14 February 2021) < https://royalsociety.org/-/media/policy/projects/set-c/set-c-vaccine-passports.pdf?la=en-GB&hash=A3319C914245F73795AB163AD15E9021> cited 12 March 2021.

objective has been used.[17] For example, it is likely that there are less rights-restrictive means of ensuring safety in the waiting room of a GP clinic than denial of entry to all individuals who are unable to present a valid CSC. A less restrictive alternative might for example involve a requirement that all visitors wear masks, maintain a distance from others, use hand sanitiser upon entry, and only present at the clinic immediately before their appointment time.

iv. At the **fair balance stage, the relevant public authority must demonstrate that the human rights 'cost' resulting from the restrictive measure is justified by the 'benefit' achieved through the protection of a public interest.** In some circumstances, even the least restrictive means used to pursue an objective will be excessive in their impact on the individual's rights. This is especially likely to be the case in situations in which the use of CSCs renders an individual unable to access essential goods and services including food, medicines, healthcare and government services. This is not an exhaustive list, however. The 'fair balance' arm of the test requires detailed and dynamic analysis of each interference with human rights resulting from the implementation of CSCs. This is likely to require continuous engagement with human rights experts and legal practitioners as deliberation and monitoring regarding CSCs continues.

This four-stage approach provides a principled 'litmus test' that should be used to scrutinise proposed uses of CSCs in the UK's overall COVID strategy.

Anti-discrimination

The framework established by the ECHR and HRA requires that individuals are able to exercise the enumerated rights without discrimination as to sex, race, colour, language, religion, political opinion, national or social origin, association with a national minority, property, birth, or other status.[18] Any rights-restrictive measure that pursues a discriminatory objective is unlawful. Discrimination occurs when two people are treated differently upon the basis of one of these objectively identifiable characteristics and there is no reasonable and

[17] Alan DP Brady, *Proportionality and Deference under the UK Human Rights Act: An Institutionally Sensitive Approach* (Cambridge University Press, 2012) 8; *Witold Litwa v Poland* [2000] ECHR 141. https://www.bailii.org/eu/cases/ECHR/2000/141.html.

[18] *European Convention on Human Rights,* Art 14.

objective justification for the difference in treatment.[19] The ECtHR has held that a distinction made on the basis of an individual's health status, including an infectious disease, is included in the term, "other status."[20] Thus, in the absence of an objective and reasonable justification, differential treatment of individuals who are living with or recovering from COVID-19 will amount to unlawful discrimination.

The ECHR framework for anti-discrimination dovetails with the UK's anti-discrimination and equal opportunity legislation. The Equality Act 2010 prohibits direct and indirect discrimination against persons with protected characteristics, which include age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation. The Act protects against discrimination in the workplace, education, public transport, and access to public services. It establishes positive obligations for those performing public functions to address socioeconomic inequality through their work. And it requires relevant public authorities to strive to eliminate the inequality of opportunity faced by persons with protected characteristics.[21]

The use of CSCs raises the spectre of direct and indirect discrimination. The disclosure of information regarding health status is likely to expose persons to unlawful discrimination in workplaces, in seeking access to government services and social welfare, and in the course of their social lives. Meanwhile, without adequate regulation of CSCs, it is possible that their use will transcend the goal of protecting public health.

It is also likely that the use of CSCs will have unintended negative consequences for disadvantaged and marginalised members of society. Marginalised persons who have consistently had negative encounters with the state are among the least likely to test or receive a vaccine and are, therefore, particularly likely to be disadvantaged by the widespread introduction of CSCs.[22] Similarly, those without access to digital technology are less likely to find information about testing and vaccination and may be unable to obtain CSCs if they are issued online. Furthermore, as noted in other studies, CSCs are likely to place BAME individuals at a particular disadvantage.[23] This is because, firstly, engagement with

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[19] *Zarb Adami v Malta* [2006] ECHR 637 at 73. Available: http://www2.bailii.org/eu/cases/ECHR/2006/637.html.

[20] *Kiyutin v Russia* [2011] ECHR 439 at 57. Available: https://www.bailii.org/eu/cases/ECHR/2011/439.html.

[21] Equality Act 2010, pt 1, pt 10.

[22] Reference here?

[23] Ana Beduschi, 'Digital Health Passports for COVID-19: Data Privacy and Human Rights Law' (University of Exeter, 2020) <

state-provided health services is particularly low in minority ethnic communities.[24] Secondly, if CSCs are issued digitally, facial recognition software may be used to verify the identities of those who have received a negative test result and/or are fully vaccinated. A number of UK technology firms have designed, or offered to design, smartphone apps that use facial recognition technology to issue CSCs[25] – technology known to be inaccurate in verifying the identities of members of racial minorities.[26] The widespread use of such technologies might, therefore, place individuals with protected characteristics at a particular disadvantage.

Recommendations

We submit that decisions regarding CSCs must be driven by relevant civil liberties and human rights considerations, which are protected under common law and a number of legislative frameworks. In order to ensure that the widespread use of CSCs does not lead to the erosion of human rights and civil liberties, we call for regulations that identify acceptable and unacceptable uses of CSCs by both public authorities and private actors. Drawn from the jurisprudence of UK courts, the tests of necessity and proportionality provide a structured approach for evaluating the potential uses of CSCs – one that complies with relevant human rights standards. In particular, we call upon decision-makers to have due regard for the following human rights issues:

i. CSCs will have significant implications for the right to privacy of health-related data. In its deliberations, the Government must consider whether the interference with individuals' privacy is proportionate to the objectives sought, and it must establish safeguards to ensure that sensitive health-related information is not disclosed to parties that have no interest in accessing it.

ii. We are concerned that the restriction of the rights to a private and family life, freedom of expression, freedom of assembly, and freedom of religion resulting from

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https://socialsciences.exeter.ac.uk/media/universityofexeter/collegeofsocialsciencesandinternationalstudies/lawimages/research/Policy_brief_-_Digital_Health_Passports_COVID-19_-_Beduschi.pdf> cited 11 March 2021.

[24] Ibid.

[25] Jane Wakefield, 'Coronavirus: NHS App Paves the Way for 'Immunity Passports' (*BBC News,* 27 May 2020) < https://www.bbc.co.uk/news/technology-52807414> cited 15 March 2021; Rob Kitchin, 'Civil Liberties or Public Health, or Civil Liberties and Public Health? Using Surveillance Technology to Tackle the Spread of COVID-19' (2020) Space and Polity, 3. Available: https://doi.org/10.1080/13562576.2020.1770587.

[26] Patrick Gother, Mei Ngan and Kayee Hanaoka, 'Face Recognition Vendor Test (FRVT) Part 3: Demographic Effects' (*US Department of Commerce,* 2019). Available: https://doi.org/10.6028/NIST.IR.8280.

the use of CSCs might be disproportionate to the economic and public health interests sought. In particular, we urge the relevant public authorities to consider whether there is a *rational connection* between CSCs and the objectives they pursue. Put simply, public authorities must be able to demonstrate how CSCs are likely to achieve their objective, despite persisting doubts about the reliability and effectiveness of tests and vaccinations.

iii. Public authorities should consider whether there are less rights-restrictive means available for the protection of public health in any particular setting. CSCs might provide some individuals with a ticket to freedom, opening doors to pubs, theatres, concerts, places of worship, care homes, government buildings, and more. But they might also exclude those who cannot access testing and/or vaccination from economic, social, familial, cultural, and civic life in the 'new normal.' The question that must be asked is whether there are ways of safeguarding public health and promoting economic wellbeing that are less restrictive for this latter group.

iv. More work is needed to ensure that CSCs do not entrench existing inequalities. CSCs must not worsen the digital divide, further the alienation of racial and ethnic minorities, or further the marginalisation of vulnerable members of society. The state bears an obligation to ensure that the widespread implementation of CSCs does not further the difficulties faced by these individuals.

v. Any new legislation or amendments must provide for continual review of the necessity and impacts of CSCs, as it is presently difficult to predict exactly how CSCs might be used and how circumstances might change as the United Kingdom's pandemic response continues. We call for the voices of human rights experts to be included in these efforts to monitor the implementation and use of CSCs.

Annex 1
Case Study: CSCs in Care Home Visits

Visits to care homes have been sharply curtailed during the pandemic, and in some cases have been banned outright. The Parliamentary Joint Committee on Human Rights recently wrote to the government, expressing concerns about the impact of such bans on the right to family life under ECHR Art 8. Consider the following hypothetical configuration of use of CSCs in the context of facilitating care home visits:

- Residents of care homes are allowed a set number of 'designated visitors' who are permitted to visit residents in care home settings, even during lockdowns.
- Designated visitors are permitted an unlimited number of visits, with limitations on forms of contact, but without limitations on the place of contact.
- Designated visitor status is granted only to persons in possession of a valid CSC demonstrating low COVID risk status.
- Low COVID risk status can be obtained either through a completed cycle of vaccination OR through a negative COVID test within the past 72 hours.
- Family members who do not have a CSC low COVID risk status but who have not tested positive for COVID and are asymptomatic have access to limited alternative visitation arrangements – for example either outdoors (for residents whose mobility permits outdoor visits) and/or with physical-barrier separation (for those who cannot manage outdoor visits).
- The policy governing this use of CSCs for care home visits is subject to regular review, and includes a guideline for terminating the policy when COVID risk in the care home falls below a defined level.

We believe that this Case Study represents a use of CSCs that would be likely to pass our proposed proportionality litmus test, subject to conditions.

Aim: The use of CSCs in this context has a well-defined and legitimate purpose: to facilitate the exercise of a fundamental right while mitigating the risk of COVID infection.

Rational Connection: The means selected for pursuit of this purpose have a rational relationship to the purpose. The use of CSCs in conjunction with other infection control and public health measures adds an additional layer of protection against COVID infection in care homes where residents belong to a particularly vulnerable population, have not yet received both doses of their vaccination, and may not be protected against new variants of the virus.

Minimal Interference: The proposed practice represents an easing of more restrictive practices (e.g., permitting window-visits only), by providing a less intrusive method for mitigating the risk of infection while facilitating visits. Critically, the practice includes a mechanism for regular review and a plan for moving to even less restrictive visitation practices as the risk of infection subsides.

Fair Balance: The proposed practice represents a fair balance between the human rights cost of enforcing these restrictions and the public health gains associated with this use of CSCs. The balance of benefits over costs is ensured by the inclusion of a measure whereby those who may not have a CSC nonetheless enjoy an alternative pathway to the exercise of their Art 8 rights. However, the 'fair balance' arm of the test might not be satisfied if there were no mechanism for considering case-by-case exceptions, for example to facilitate exceptional visits with suitable precautions in end of life situations.