Lockdown, public good and equality during COVID-19

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On 22nd September 2020 the UK Government announced new lockdown restrictions to supress the COVID-19 virus, with some areas of England having more restrictive lockdown guidance. Students in a number of cities have been confined to their halls of residences after outbreaks of COVID-19 and in Manchester security guards were preventing students leaving the buildings. The scientific community are, unsurprisingly, divided over the question of how far lockdowns should extend.[1] Monday 21st September 2020 saw the publication of two open letter to the UK government and Chief Medical Officers. One group, Sunetra Gupta *et al*,[2] argued for a selective lockdown targeting the most vulnerable. The other, headed by Trisha Greenhalgh, arguing that attempts to suppress the virus should operate across the whole community.[3] As we enter what appears to be a second wave of COVID-19 infections and accompanying lockdown measures, ethical debates over the appropriateness and extent of such measures are critical.

Julian Savulescu and James Cameron[4] in their article on lockdown of the elderly and why this is not ageist, put forward the case that, 'an appropriate approach may be to lift the general lockdown but implement selective isolation of the elderly.' Their central claim is that selective isolation of the elderly is to be preferred to imposing lockdown on all members of society. The aim of lockdown, restricting movement and key activities, is designed to reduce the number of deaths from COVID-19 and also to prevent the healthcare system from becoming overwhelmed. As the elderly are at significantly more risk of having severe cases of COVID-19 and therefore more likely to place demands on healthcare services, they are clearly prime candidates for lockdown measures, measures that will not only benefit them but the whole of society. This is not ageist as they point out that differential treatment is not always discrimination if there is a morally relevant reason for the differential treatment. The morally relevant reason in this case is that the elderly, and other groups who may be vulnerable to COVID-19, are at greater risk of adverse effects from COVID-19 and consequently more likely to burden the heath service if they get COVID-19. Even if this is discrimination they claim that it would be proportionate,

as it benefits both the elderly and the wider population. Savulescu and Cameron argue that to require everyone to be lockdown is the levelling down of equality – that is: 'In order for there to be equality, people who could be better off are made worse off in order to achieve equality.' And in their view such levelling down is 'morally repugnant' and unethical.

In his response to Savulescu and Cameron, Jonathan Hughes[5] takes issue with their claim that general lockdown measures that affect all members of society equally are a form of levelling down of equality. Hughes argues that the claim that the levelling down of equality is always unethical can be challenged, but his main argument is that 'the choice to maintain a general lockdown, rather than easing it for the young while maintaining it for the elderly, is not an instance of levelling down.' For selective lockdown of the elderly to be an instance of levelling down of equality, it would have to make everyone else worse off with no additional benefit to the elderly. However, Hughes argues that a general lockdown does produce benefits or reduce burdens for the elderly and hence is not the levelling down of equality. General lockdown will result in lower levels infection in the wider population and thus the elderly are less likely to contract COVID-19. Even during lockdown many elderly people have carers or service providers visiting them to perform caring responsibilities and with lower general infection rates these visits are less likely to result in the spread of infection. Hence, the elderly are less likely to become a burden on the health service and lower levels of infection will mean an easing of lockdown for everyone sooner. 'These considerations demonstrate that maintaining a general lockdown in preference to selective lockdown of the elderly and vulnerable need not only equalise the burdens by making the young and healthy worse off, but can benefit the elderly in absolute as well as relative terms.'[5]

As both Savulescu and Cameron, and Hughes note there is an issue of proportionality that needs to be considered. Savulescu and Cameron give three reasons why the selective lockdown of the elderly, the restriction of their liberty, is proportionate: the benefits to others are significant; the restriction will produce benefit for the elderly; and finally, this is the option

that results in the least amount of liberty restriction. Hughes also points out, as do Savulescu and Cameron, that the harms to the elderly due to lockdown might be greater than for other groups, and therefore a general lockdown could be justified on the grounds of Parfit's Priority View, that benefiting the worse off is more important.

This raises the problem of how we determine who is worse off in this scenario, as both sets of authors point out that the elderly may have fewer social networks and hence be more socially isolated and find lockdown particularly hard. Further, if they only have a limited time to live, lockdown may present a relatively greater loss. However, the young, who are facing huge disruption to their social development, their education and a curbing of their freedoms and life choices at critical junctures (ie, going to University and being away from home for the first time), may want to argue that they are much more greatly harmed than the elderly. These potential inter-generational trade-offs need to be debated, and Stephen John argues we need to think about lockdown in terms of intergenerational justice. He argues age is a relevant categorization for discussing lockdown policies in relation to COVID-19, as it is generally 'an epistemically robust category, which can be operationalized.'[3] and has particular significance for the aetiology of COVID-19. As John observes, 'However we approach the ethics of lockdown, we need to do ethical work in deciding how to describe the effects of lockdown in the first place. In turn, I want to suggest that this process is an important, although easily overlooked site of ethical and political contestation.'[6] The effects of the COVID-19 response on those who are likely to suffer less from the disease, the younger generation, and on those whose non-Covid healthcare has been suspended, according to some, are likely to outweigh the harms caused by COVID-19 itself.[7] Hence, describing the effects of COVID-19 and lockdown policies is no simple task.

Elsewhere in this issue the Editor's Choice article, Protecting health privacy even when privacy[8] is lost by T.J. Kasperbauer considers the ethical and regulatory issues raised by the flow and sharing of data in modern healthcare. He points out that the predominant model of safeguarding the privacy of healthcare data is one of information control, that is an attempt to limit

access to personal health data. However, limiting access has important implications for developments in healthcare such as leaning health systems and precision medicine, initiatives that require a large amount of health data. Limiting access could make many data-linkage schemes unfeasible in practice. Such uses of data have the potential to make significant contributions to improving healthcare, both in terms of developing new treatments and at an organisational level, re-designing patient pathways and utilising healthcare resources more effectively.[9] As an alternative to a control view of privacy, he suggests three measures that could be instituted to enable greater sharing of data, 'such that pervasive data sharing would not automatically entail a loss of privacy.' These are: data obfuscation, this is making the data obscure so it is not possible to make inferences about individuals; penalisation of data misuse; and transparency, making any access to our data transparent so that it discourages inappropriate data use and we can see who has accessed our data. There are trade-offs and difficulties with all these suggestions as Kasperbauer notes and although changing laws around privacy is possibly the most important and most effective of these measures it is also the most difficult.

The value of big data sets rests on their size and comprehensiveness, my desire to keep my health data private and opt out of big data initiatives can comprise their success. Therefore, we need to explore ways of balancing individual concerns over privacy, with using data for the greater good, and how to address possible tensions between the two.[10] How policy makers and healthcare systems will manage information privacy will be a growing issue and is another example, along with the COVID-19 pandemic,[11] of how we are increasingly thinking about ethical issues at a community, rather than an individual, level and in wider global contexts. In a more connected bioethics, concepts such as justice and more community-based values such as stewardship, solidarity and reciprocity are likely to become key tools to frame these debates.[12]

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