

Persuasion, not coercion or incentivisation, is the best means of promoting COVID-19 vaccination

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ABSTRACT

Savulescu (forthcoming) argues that it may be ethically acceptable for governments to require citizens be vaccinated against COVID-19. He also recommends that governments consider providing monetary or in-kind incentives to citizens to increase vaccination rates. In this response, we argue against mandatory vaccination and vaccine incentivisation, and instead suggest that targeted public health messaging and a greater responsiveness to the concerns of vaccine-hesitant individuals would be the best strategy to address low vaccination rates.

Julian Savulescu's article 'Good reasons to Vaccinate: Mandatory or Payment for Risk?' discusses which actions governments should take if a COVID-19 vaccine is approved and available for widespread use. Savulescu notes the grave medical, social and economic harms caused by the COVID-19 pandemic and argues that it may be ethically acceptable for governments to require citizens to be vaccinated against COVID-19. Savulescu also recommends that governments consider providing monetary or in-kind incentives to encourage citizens to choose to be vaccinated.

We agree with Savulescu that governments have a strong ethical obligation to stop the spread of the pandemic, and that a safe and effective COVID-19 vaccine has the potential to enormously reduce the severity of the pandemic if the vast majority of the population is vaccinated quickly. We also agree that given current polling data, it is unlikely that a high enough proportion of the population would volunteer to receive the vaccine so that herd immunity is quickly achieved.¹⁻³ However, we argue that, given the characteristics of any potential COVID-19 vaccine, governments should not make

vaccination mandatory. We are also sceptical about Savulescu's proposal for in-kind or monetary incentives for vaccination, as this will not effectively address the reasons why citizens may avoid vaccination. Finally, we suggest evidence-based public health measures to build public trust in vaccination without resorting to coercion or incentives.

A MANDATORY VACCINE?

As Savulescu notes, there are important ethical differences between a potential COVID-19 vaccine and existing vaccines, such as the MMR vaccine. Given the current speed of the clinical trials process for COVID-19 vaccine research, as well as the likelihood that any approved vaccine would be rushed into mass production, a COVID-19 vaccine will have much more limited safety and efficacy data available than is the case for existing vaccines. This, in addition to the widespread politicisation of vaccine research, means that citizens can reasonably be much less certain that a COVID-19 vaccine will be safe and effective than they would be about other vaccines.

We are not convinced, based on current information, that it would be ethical for a government to make a COVID-19 vaccine compulsory by criminalising vaccine refusal or implementing significant financial penalties to overcome vaccine hesitancy. In order to argue that government coercion can be justified in certain situations, Savulescu suggests three situations which he considers to be analogous to the case of a COVID-19 vaccine: conscription, taxation, and compulsory seat belts.

The conscription and taxation examples are similar in the sense that they are both instances of government coercion to solve a collective action problem. Conscription requires citizens to join the military to contribute the public good of national defence, while taxation requires that citizens contribute money to pay for social and public goods. While in some circumstances governments may legitimately use coercion to prevent free-riding and solve collective action problems, appealing to the legitimacy of coercion in Savulescu's

examples does not strengthen the case for mandatory COVID-19 vaccination. We do not have the space here to discuss the case of conscription in detail, however, this is an extremely complex ethical problem and it is difficult to determine whether conscription (or warfare) could ever be ethically justifiable. In order to justify the controversial idea that a COVID-19 vaccine should be mandatory, Savulescu appeals to the similarities with an even more controversial and dubious situation, that of the ethics of conscription. We find this argument unconvincing.

In the less contentious example of taxation, there is an important difference with the case of mandatory COVID-19 vaccination. Our intuition that it is reasonable to require people to pay taxes is at least partly based on the assumption that tax rates will not be so high as to cause a real risk of harm to the taxpayer. Mostly, tax rates are progressive and people on very low incomes typically pay little or no tax. There would likely be different moral intuitions about taxation in a case where people were required to pay 80% of their income in taxes and that this put them at significant risk of harm. In contrast, even if a COVID-19 vaccine passes all clinical trials, citizens may not unreasonably still have concerns about the quality of safety and efficacy data.

Savulescu's example of mandatory seat belts is different in that it is based on cost-benefit analysis—a small cost or inconvenience of wearing a seat belt is outweighed by the vastly larger known benefit of reducing injuries and deaths from car accidents. However, given citizens' uncertainties about safety and efficacy data, it is much less clear that the known benefits of COVID-19 vaccination will so vastly outweigh the risks or costs of vaccination as to justify compelling citizens to receive a COVID-19 vaccine.

MONETARY OR IN-KIND INCENTIVES?

We are also sceptical about the effectiveness of Savulescu's proposals for in-kind or monetary payments to encourage citizens to receive a COVID-19 vaccine.

To first address the case of a monetary payment, Savulescu notes that it is widely considered acceptable to pay people in compensation for inconvenience or risk. For example, blood donors in some countries are paid a small amount to compensate them for their time and travel costs. People in dangerous occupations, such as logging, are often paid more than those of similar skill levels to compensate them for the higher risk.

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However, a monetary payment does not seem likely to raise vaccination rates by compensating people for either inconvenience or risk.

A monetary payment for vaccination is likely to be small. As the goal is to reach herd immunity, everyone in the population would need to receive an equal payment. Even a payment of \$A50 per person will cost over a billion dollars when paid to all 25 million Australians. Such a small payment would be sufficient to compensate for inconvenience but not for risk. People are typically paid much larger sums than \$A50 to incentivise them to take up a dangerous occupation.

However, as Savulescu notes, opinion polls suggest that only 30% of the population would want to receive a COVID-19 vaccine soon after it is made available. As this is a much larger proportion of the population than is hesitant about or refuses to receive existing vaccines such as the Measles, Mumps and Rubella (MMR) vaccine, it does not seem that general aversion to inconvenience is at the root of the problem. It is likely to be equally convenient or inconvenient to receive an MMR vaccine as a COVID-19 vaccine, yet the proportion of people reluctant to receive the COVID-19 vaccine is much higher. This implies that the majority of COVID-19 vaccine hesitancy is due to risk aversion rather than inconvenience, and a \$A50 payment is unlikely to be enough to overcome this.

Savulescu also mentions the possibility of 'in-kind' incentives for vaccination, such as being exempted from requirements to wear masks or practice social distancing. However, this seems likely to undermine the social norm of mask-wearing without providing an extra incentive to receive a COVID-19 vaccine. Many people dislike wearing a mask, however, they do so due to social pressure to conform to the prevailing norms. If it is clear at a glance that everyone else on a train is wearing a mask, this creates a strong norm that mask-wearing is expected in this situation. If, however, only half the people in a given location are wearing a mask, then this significantly weakens the social pressure to conform. Enforcement of mask wearing would also become much more difficult if there was a legitimate excuse for not wearing a mask which would need to be individually checked (such as checking a certificate of vaccination). In-kind payments such as this seem likely to undermine the social norms for mask wearing and social distancing without providing a significant incentive for vaccination.

ALTERNATIVES?

Savulescu's proposals attempt to use coercive or incentive structures to overcome a problem of communication and trust. To receive a new vaccine, citizens must be able to trust that the public health information from the government is correct, that the vaccine being injected into their body is safe and effective, and that the government has made a substantial effort to ensure the safety and well-being of all the citizens receiving the vaccine. There is evidence that trust in government,⁴ social institutions and other people⁵ more generally has been declining internationally for decades. Confused messaging and poor preparation from governments at the start of the pandemic may also have undermined social trust. In the absence of social trust, a coercive or incentive-based approach may backfire.

Savulescu may object here that the problem of declining social trust is a complex long-term trend with multiple causes. It is not clear whether policies can be successfully targeted to turn this trend around. Furthermore, the pandemic is an emergency, where time is essential. If a vaccine is safe and effective, achieving herd immunity in 2022 rather than 2023 will save many lives and livelihoods.

However, we would argue that this objection significantly underestimates the risks of an incentive or coercion-based approach and overlooks alternative ways of improving public health communication and overcoming vaccine hesitancy. Detailed data are already available on members of the population who will likely be hesitant about a COVID-19 vaccine, and this will assist public health officials to produce targeted messaging to address vaccine myths and misinformation in the community. For example, some studies suggest that COVID-19 vaccine hesitancy will probably be more common in people from disadvantaged backgrounds and in culturally and linguistically diverse populations.^{6,7} Having vaccine spokespersons who are trusted by vaccine-hesitant social groups—as well as targeted messaging directly addressing the COVID-19 vaccine myths and misinformation common in these communities—will be very important in increasing vaccination rates. Indeed, one significant issue appears to be that many people still underestimate the virulence of COVID-19.² Instead of allocating funds to incentivise vaccination, it may be better to spend these resources to ensure that primary care providers have time to listen to vaccine-hesitant members of the community and to address

their expressed concerns.⁸ Public health messaging emphasising the social benefits of vaccination, furthermore, has been shown to have a positive effect on intention to vaccine in adults.^{9–11}

Savulescu could object that this strategy of open, evidence-based public health education may undermine the goal of rapid vaccination. After all, if public health professionals and clinicians admit that the safety and efficacy data for a COVID-19 vaccine is weaker than the safety and efficacy data for other commonly used vaccines, then people will choose to avoid vaccination. We would respond to this by first noting that openness about the clinical trials for COVID-19 vaccines is likely to raise trust, not lower it. For example, some people may not realise that vaccines are tested on tens of thousands of people in phase 3 clinical trials who are carefully monitored for any adverse reaction which may in any way be related to the vaccine. Furthermore, people may be more willing to undergo the small risk of vaccination against COVID-19 if they perceive that public health professionals and the government treating them with respect, as equal citizens to be persuaded, rather than inferiors to be coerced. Finally, using coercion or incentivisation to promote COVID-19 vaccination risks a public backlash and may well be unsuccessful in promoting COVID-19 vaccination. It is already apparent that scepticism about the virulence of COVID-19 and strong suspicion of pharmaceutical companies, scientists, and policy-makers has become part of some people's social and political identities. An attempt to coerce rather than persuade may be seen as a threat from distant and patronising elites and feed into existing social and political divisions without resulting in higher rates of vaccination.

In the case of vaccination for COVID-19, therefore, we suspect that methods of persuasion, rather coercion or incentives, will be the most effective means to achieve adequate vaccination rates.

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