Covid-19 Health Crises and Human Rights in Italy and the UK: is an Ethical Rationing of Healthcare resource possible?

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1. Introduction

Using a comparative approach, this chapter explores the ethical and legal implications of States' behaviours in rationing healthcare resources during the Covid-19 crisis. It focuses on Italy and the UK respectively, looking at the first country in Europe to deal with the uncontrolled spread of the virus (in February 2020) and at the one with the highest death rate in Europe, to date[1]. As the emergency unfolded, Italy and the UK both enforced strict country-wide lockdowns to ease pressure on their national healthcare systems and to attempt containment of the pandemic. However, it soon became plain that available healthcare resources were insufficient within both states, following years of not dissimilar economic rationalisation policies. In Italy, the Sistema Sanitario Nazionale (SSN) remains deeply underfunded: a recent Foundation GIMBE report identified that its public funding grew at an average of only 0.9% per year, at a lower rate than the annual inflation average (1.07%). The UK's under-resourcing of its National Health System (NHS) has also long been apparent to advocates for the right to health and equitable resource allocation[2]. The chronic fragilities of both nations' healthcare systems had clearly impeded the right to (good or adequate) health, health equity, and the principle of equality of treatment; this was so, long before Covid-19 forced law and policy makers to frame increasingly fragile medical capacities as acute national emergencies[3].

Against this backdrop, this chapter discusses the controversial criteria that might be used by doctors (in Italy and the UK, respectively) where they are forced to decide upon the rationing of medical treatment, e.g. which patients to admit to a scarce ICU bed, or intubate, or not. Put bluntly, where the wider needs of the populace outstrip available national resources, questions must be asked as to whether such a behavioural, hard choices blueprint for rationing is ethically correct, even where it has ostensibly been justified in domestic law or tolerated within international human rights law terms (i.e. justified discrimination). Even if warranted from a utilitarian ethical perspective, negative impacts may still affect those who are, or rapidly become, the most vulnerable, particularly

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[1] At the time of writing. See further https://coronavirus.data.gov.uk/ (accessed 22.11.20)

[2] HUNT Paul, *Reclaiming social rights*; Aldershot, Ashgate; 1996; OPPENHEIMER Gerard, BAYER Ronald and COLGROVE James, « Health and human rights: Old wine in new bottles? » *in Journal of Law Medicine and Ethics,* 2002, 30, 522; FARMER Paul, *Pathologies of power: Health, human rights and the new war on the* poor; Berkeley, University of California Press; 2003; NEWDICK Christopher, *Who should we treat? Rights, rationing, and resources in the NHS*; Oxford, Oxford University Press; 2005; CALLAHAN Daniel, «Must we ration health care for the elderly? » *in Journal of Law, Medicine and Ethics,* 2012; 40, 10–16.

[3] For Italy, see FOGLIETTA Fosco, *Crisi e dopo-crisi del servizio sanitario nazionale: Quali soluzioni possibili a livello nazionale e regionale?* ; Rimini, Maggioli Editore; 2016; GIOVANNI Fattore, « Crisi economica, salute e sistema sanitario » in *Politiche sanitarie;* Vol. 10, N. 2, 2009. See also https://www.ilsole24ore.com/art/altro-che-rilancio-ssn-la-sanita-fondi-piu-non-bastano-AC2kjVo?refresh_ce=1; https://ilmanifesto.it/la-lezione-di-covid-19-al-nostro-sistema-sanitario/; https://espresso.repubblica.it/inchieste/2018/01/22/news/cosi-stanno-uccidendo-la-sanita-pubblica-1.317368; https://www.corriere.it/dataroom-milena-gabanelli/covid-19-tagli-servizio-sanitario-nazionale-chi-li-ha-fatti-perche/b18749f6-736d-11ea-bc49-338bb9c7b205-va.shtml; https://www.politichesanitarie.it/allegati/00441_2009_02/fulltext/01.Editoriale%20(49-53).pdf (accessed 24.11.20)

older and/or disabled or frail persons. Potential violations of Articles 2 (right to life), 3 (avoidance of inhuman or degrading treatment) and 14 ECHR (non-discrimination) are entirely, perhaps inevitably, possible.

2. Italy versus the UK

The spread of Covid-19 in Italy brought increased demand for ICU admissions when many patients began to suffer acute respiratory failure[4]. This changed the general approach to ICU admissions, which had been previously based on the traditional principle of therapeutic appropriateness[5]. The Società Italiana di Anestesia Analgesia Rianimazione e Terapia Intensiva (Italian Society of Anesthesia, Analgesia, Resuscitation and Intensive Care – SIAAARTI) shared their guidance on the admissions criteria which would identify only certain types of patient as eligible for ICU treatment[6]. The aims of these recommendations were: « *(A) to relieve clinicians from a part of the responsibility in the decisions making process, which can be emotionally burdensome, carried out in individual cases, and (B) to make the allocation criteria for healthcare resources explicit in a condition of their own extraordinary scarcity*[7] ». The guidelines suggest a little flexibility, so as to assess patients' needs daily, and on a case-by-case basis. Key elements included patient age limits, any comorbidities and their functional status[8], thereby creating new vulnerabilities, and, significantly, treatment obstacles, not least for any particularly frail, elderly or disabled patients whose life expectancies would pale in comparison with younger, healthier, or more able-bodied persons. The worst-case scenario, where *all* ICU resources have become completely over-saturated, would see a solution grounded in first come, first served criteria: at that point hospitals presumably could legally deny access to ICUs for any patients subsequently presenting for treatment (and, presumably, admission or assessment).

The situation in the UK was not quite as clear-cut, but still no less worrying. The use of convoluted frailty algorithms (aimed at reserving finite or scarce resources for those who might most benefit from them) seems quite akin to Italy's pragmatic approach to crisis-shaped rationing. It does however alter the notion of the (legally) protected characteristic,[9] turning it from a legislatively safeguarded status into one that speaks of an enhanced, newly dangerous vulnerability[10]. Impacts upon the rates of hospital admission, untested patient discharges (often into high-risk, residential care homes with high rates of infection), and the apparent rise in the use of DNARs[11],

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[4] http://www.salute.gov.it/portale/nuovocoronavirus/dettaglioContenutiNuovoCoronavirus.jsp?lingua=italiano&id=5351&area=nuovoCoronavirus&menu=vuoto (accessed 25.11.20)

[5] DE GAUDIO Raffaele and LANINI Iacopo, *Vivere e Morire in Terapia Intensiva: Quotidianità in Bietica e Medicina Palliativa* ; Firenze, Firenze University Press; 2013; 29.

[6] Siiarti, Clinical Ethics Recommendations For The Allocation Of Intensive Care Treatments, In Exceptional, Resource-Limited Circumstances, March 2016, (available at http://www.siaarti.it/SiteAssets/News/COVID19%20-%20documenti%20SIAARTI/SIAARTI%20-%20Covid-19%20-%20Clinical%20Ethics%20Reccomendations.pdf) (accessed 26.11.20)

[7] Ibid, 3.

[8] Ibid.

[9] Enshrined in the non-discrimination provisions of The Equality Act 2010. https://www.legislation.gov.uk/ukpga/2010/15/contents (accessed 29.11.20)

[10] See further CUSATO Eliana et al, « Some Conceptual Framings: A Discussion » in FERSTMAN Carla and FAGAN Andres, *Covid-19, Law and Human Rights: Essex Dialogues*; Essex, University of Essex School of Law and Human Rights Centre; 2020 on the weaponising of such formerly neutral terms. Arguably, the term 'austerity measures' has become similarly polarising in political discourses.

[11] Do Not Attempt Resuscitation Orders – see further CARTER Charlotte, « People with learning disabilities face 'discrimination' as data shows Covid death rate six times the average » in *Community Care*, 2020 available at https://www.communitycare.co.uk/2020/11/19/people-learning-disabilities-face-discrimination-data-shows-

have yet to be fully analysed but seem likely to spark significant waves of litigation, potentially at the level of Strasbourg complaints[12]. The continued use of wartime rhetoric and heroic imagery by many British politicians, is also somewhat worrying, in terms of further othering those already-vulnerable persons who are often most at risk of succumbing to infection[13].

3. **Ethical analysis**

In an ideal world, each state would engage in meaningful, distributive justice and provide or ensure sufficiently ring-fenced healthcare funding for all who need it: fair and equitable resource allocations would not be tied to issues of health-justiciability, nor would they rest upon inherent or acquired patient characteristics such as age, mental or physical resilience, poverty, life expectancy, or life-quality[14]. For now, however, certain vulnerable individuals are increasingly considered to be more resource consuming than others. This sets the inescapable need to ration against the – surely, over-arching - duty upon states to avoid abject human rights violations where at all possible. A utilitarian approach seems to have been adopted by Italy and the UK alike however, with both nations crafting rules that aim to maximise benefit for the greatest number of people, irrespective of potential rights violations to those who are, or who become, at risk of succumbing to illness[15]. The current guidelines in both countries prioritise and safeguard those with a higher chance of survival, sparking what can be described as an increasingly « *disablist and worrying rhetoric*[16] ».

The Rawlsian publicity condition is similarly flouted, where invisible allocation mechanisms are quickly designed and quietly implemented[17]. As one recent UN Committee (on ESRC rights) stressed, « *if States do not act within a human rights framework, a clear risk exists that the measures taken might violate ESCRs and increase the suffering of the most marginalised groups*[18] ». Arguably, a parallel pandemic was allowed to arise unseen and unchecked within many of the care homes in Italy and the UK, affecting highly vulnerable residents and patients, who saw a wide range of their fundamental human rights and interests firmly side-lined in the service of « *the*

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covid-death-rate-six-times-average/. See also *R v Cambridge Health Authority* (1995) 2 All ER 129 on how the courts are not meant to decide the correctness or otherwise of allocation decisions made by Health Authorities. See also DONNELLY Laura, « Protect the NHS' message led to 90 per cent drop in hospital admissions » *in The Telegraph*; 2020, available at https://www.telegraph.co.uk/news/2020/10/18/protect-nhs-message-led-90-per-cent-drop-admissions/.

[12] IACOBUCCI, Gareth, « Covid-19: Government to issue new guidance on DNAR orders after legal challenge » *in British Medical Association*, 2020.

[13] Allegories include the 'unseen enemy,' 'furlough' (from work), NHS heroes, and most recently the lack of 'truce' by the virus at Christmas.

[14] HARRIS John, « The rationing debate: Maximising the health of the whole community. The case against: what the principal objective of the NHS should really be » in *British Medical Journal* 1997, 1314 (7081), 669-72.

[15] EMANUEL Ezekiel J., *The Ends of Human Life: Medical Ethics in a Liberal Policy*, Cambridge, Harvard University Press; 2014.

[16] HOSKIN Janet and FINCH Jo, « Covid 19, Disability and the new Eugenics: Implications for social work policy and practice » *in Social Work*; 2020 availble at https://sw2020covid19.group.shef.ac.uk/2020/06/02/covid-19-disability-and-the-new-eugenics-implications-for-social-work-policy-and-practice/ (Accessed 31.10.20)
under Covid-19 who suggest that a 'new eugenics' may be unfolding.

[17] FREEMAN Michael D A and LLOYD Dennis, *Introduction to Jurisprudence*; London, Sweet & Maxwell; 2001, 356. Though Rawls did not specifically apply his theories on fair equality of opportunity to healthcare systems, his work merits mention here.

[18] https://www.conectas.org/wp/wp-content/uploads/2020/04/ESCRCommitte-COVID.pdf (para 2)

greater good[19] ». In terms of rationing scarce or finite resources, the UK's Joint Parliamentary Committee on Human Rights (analysing the government's ongoing, ever-changing policy responses to the pandemic) has recently called for a formal enquiry into possible Article 2 ECHR violations, suggesting that certain strategies clearly amounted to unjustifiable, unnecessary forms of discrimination, under both the European Convention and The Equality Act (2020)[20]. Similar requests have been made in terms of Italy [21].

4. **Legal analysis**

Both Italy and the UK are part of the ECHR and the EU. In addition to Articles 2, 3, 8 and 14 of the ECHR[22], as clarified above, Article 35 of the EU Charter of Fundamental Rights establishes that « *[e]veryone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities* ». This does not create an absolute right to good or adequate health or healthcare however: fairly wide discretion is afforded to domestic states, within which they must organise their own systems as best suits them – and manage their health or social care budgets. This is also a key assumption by SIIARI, which confirms that « *[i]t is implicit that the application of rationing criteria is justifiable only after all the subjects involved […] and all possible efforts have been made to increase the availability of resources existing (especially the Intensive Care beds)*[23] ». On the issues of transparency and consent, any reforms to health access policies must involve, as far as possible, all concerned parties. Patients - and their families - must be informed of the extraordinary nature of certain measures, if only to comply with the duty of transparency, and to preserve some level of confidence and trust in the public health service and in those who decision-make or legislate for its future, in both the long and short term.

In relation to issues of non-resuscitation or the refusal of life-saving treatments, it is worth remembering too that Italy is a Catholic state: any withholding or withdrawing of essential treatment therefore holds added significance[24]. Appropriate palliative care must always be provided to hypoxic patients when decisions to cease - or deny - life-sustaining treatments are made, in accordance with national or international recommendations, and as a matter of good clinical practice. Where a prolonged demise is anticipated, patients should be transferred to non-ICU beds; optimal palliative care should similarly be provided to those outside of the ICUs. All guidelines, policies, and emergent customs on end of life treatment should reflect and adhere to the core principles of human dignity and the fundamental medical duty to alleviate human suffering (Article 3, ECHR). And yet, socio-

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[19] For Italy see https://www.dors.it/documentazione/testo/202005/COVID-19-Italy-response.pdf, p. 29, (Accessed 31.10.20). For the UK see DALY Mary, « COVID-19 and care homes in England: What happened and why? »; in *Social Policy and Administration*; 2020; 1-14, 2.

[20] Joint Parliamentary Committee on Human Rights (2020) '*The Government's response to COVID-19: Human rights implications'* paras 72-75, available at https://publications.parliament.uk/pa/jt5801/jtselect/jtrights/265/26502.htm (accessed 21.11.20). The Department for Health and Social Care (DHSC) (15 April 2020) similarly noted that it was 'unacceptable for advance care plans, including Do Not Attempt Resuscitation orders, to be applied in a blanket fashion to any group of people.'

[21] https://www.ansa.it/sito/notizie/politica/2020/06/11/nasce-commissione-inchiesta-covid-19_5a09ff08-019f-4489-a251-33e5c08fa590.html (accessed 29.11.20).

[22] https://www.echr.coe.int/Documents/Research_report_health.pdf (accessed 28.11.20).

[23] Ibid.

[24] DE GAUDIO Raffaele and LANINI Iacopo, *Vivere e Morire in Terapia Intensiva: Quotidianità in Bietica e Medicina Palliativa* ; Firenze, Firenze University Press; 2013; 26.

economic justice - not least where health is concerned – can seldom be absolutely guaranteed even where ostensibly robust, domestic human rights frameworks are evidently in place[25]. As Heri has recently argued, international human rights law may easily overlook certain deeply ingrained « *assumptions and biases that prevent it from adequately capturing real-life harms and inequalities*[26] ».

5. Conclusion

The long term ethical, and human rights-related, impacts of the global pandemic cannot yet be accurately or fully predicted. The European Court of Human Rights has begun to see litigation triggered by pandemic-led rationing[27]; this follows an earlier warning to signatory states that an overwhelming spate of claims might best be avoided by addressing such actions at domestic level. The President of the Consultative Council of European Judges (CCJE) has acknowledged that the pandemic's effects appear to have been 'particularly severe for the most vulnerable groups' meaning that *« human rights concerns in member States are likely to increase the caseload of the ECtHR. That is why it will be in the interest of this Court that as many cases as possible are resolved at national level*[28] ». This does not bode well for pending cases such as *Le Mailloux v. France,* where the Aix and Region Medical Association (SMAER) - together with two individual claimants – sought injunctive relief against the State, to require it to provide citizens, patients, doctors and health professionals with appropriate personal protective equipment (PPE) and to offer mass screening facilities[29]. The urgent application was dismissed by the Conseil d'État, potentially giving rise to infringements of European Convention Articles 2, 3, 8 and 10, given the French State's failure to protect the lives and physical integrity of those within its jurisdiction. Significantly, in addition to the issues of restricting access to specific forms of treatment and diagnostic tests - and a failure to adopt preventive measures - the issue of interference with the private lives of those who have died of Covid-19 'on their own' [30] is also relevant. Arguably, this represents an opportunity for meaningful judicial analysis of the extent to which domestic states might be obliged by the Convention to *actively* address health crises, via engagement in equitable – or at least practicable - resource allocations, so as to prevent abject violations of fundamental human rights. Countries such as Italy and the UK should be especially interested in the outcome. Given the speed with

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[25] MOYN Samuel, *Not enough: Human rights in an unequal world;* Harvard: Harvard University Press; 2018.
[26] HERI Corina, « Justifying New Rights: Affectedness, Vulnerability, and the Rights of *Peasants* » *in German Law Journal*, 2020, 21, 702–720, 702.
[27] *Le Mailloux v. France* (no. 18108/20); judgment is expected on Dec 3rd 2020.
[28] https://rm.coe.int/ccje-2020-2-statement-of-the-ccje-president-3-lessons-and-challenges-c/16809ed060 (19.10.20)
[29] Ibid. They were also seeking the prescription and administration of certain drug combinations (hydroxychloroquin and azithromycin)
[30] https://hudoc.echr.coe.int/eng-press#{%22fulltext%22:[%22Le%20Mailloux%20v.%20France%22],%22kpdate%22:[%222020-11-23T00:00:00.0Z%22,%222020-11-30T00:00:00.0Z%22]} (accessed 30.11.20)

which the matter has been dealt with however (at the time of writing) it seems likely that a finding of inadmissibility is the most probable outcome, entirely in keeping with the CCJE's earlier directive urging member states to settle such matters at national level.

If decision-making by domestic states continues on its current trajectory however, it seems likely that increasingly acute and chronic forms of vulnerability will repeatedly arise. Likewise, if sharp cuts to medical budgets continue to be made, profound consequences will no doubt follow in terms of abject health rights violations, of those who are most vulnerable. The need for states to adopt a « *responsive approach*[31] » that will address rather than exacerbate -or indeed add to - human vulnerability, is clear. And yet, as Newdick has argued, domestic governments do tend to engage in economy-led structural adjustments when they are faced with dwindling resource issues and a need to ration services and supplies. Egregiously thrifty management of the public purse strings tends to follow on from such an exercise (as do taxation increases). An « at all costs » approach to the task of protecting – or more accurately saving – increasing fragile health systems[32], should clearly provoke significant concern amongst human rights advocates and health law practitioners. Any ethics-compliant blueprint for surviving a deadly pandemic must at least acknowledge that « *new norm* » vulnerabilities now exist (i.e. in ICU units, care homes, or in the minds of those who may need medical attention but deny themselves on the basis that it is somehow unpatriotic, or cowardly, to burden an already overstretched health service[33].) As Harwood has stressed, it should have long been apparent to the government that shared weaknesses in care homes (not least physical and socio-economic) would be key, inevitable factors in the spread or containment of infection. A media-led demonisation of acute hospital care occurred quite early on in the first wave of the pandemic and should not be ignored. Not everyone who seeks out medical attention will inevitably go on to need intervention, urgent treatment or indeed hospital admission. Not all patients admitted to hospital will then require nursing in an over-stretched intensive care unit (ICU) or the prolonged use of a scarce ventilator. In terms of using algorithms to determine whether or not to permit or withhold patient treatment, it should also be remembered that the absence or presence of certain vulnerabilities (or indeed frailties) will not necessarily indicate that a patient's death is about to occur[34]. It seems fair to conclude that an ethical, human rights-compliant template for decision-making is now

[31] FINEMAN Martha; « Vulnerability and Inevitable Inequality » *in Oslo Law Review*; 2017, 4, 133; FINEMAN Martha; « Beyond Equality and Discrimination »; *Law Review Forum*; 2020, 73, 51.
[32] See further DONNELLY Laura, « Protect the NHS' message led to 90 per cent drop in hospital admissions » *in The Telegraph*; 2020, available at https://www.telegraph.co.uk/news/2020/10/18/protect-nhs-message-led-90-per-cent-drop-admissions/ (Accessed 31.10.20).
[33] HARWOOD Rowan, « Did the UK response to the COVID-19 pandemic fail frail older people? »; available at https://www.bgs.org.uk/blog/did-the-uk-response-to-the-covid-19-pandemic-fail-frail-older-people (Accessed 31.10.20).
[34] Ibid.

urgently needed; it seems unlikely that one will be emerging any time soon though, where states are continuing to vastly underfund health systems and services.