



Promoting solidarity in contested political spaces and public health emergencies: examining Covid-19 vaccination on the island of Ireland*

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ABSTRACT

This article examines to what extent solidarity can be promoted in contested political spaces as part of mounting an effective response to public health emergencies. It examines the Covid-19 vaccination programmes in Ireland and Northern Ireland and identifies challenges in promoting solidarity in the island of Ireland. In these circumstances, it is suggested that a promising way forward in promoting solidaristic practices would encompass working from a baseline of shared health values, drawing upon (cross-border) institutional and jurisdictional support structures. Accordingly, building on a model set out by Prainsack and Buyx, we propose a tripartite solidarity framework which is not tiered or hierarchical in approach. Instead, it comprises three dimensions – jurisdictional, institutional and interpersonal – with shared health values operating as a centrifugal force.

Keywords: solidarity; public health emergencies; Covid-19 pandemic; vaccination; Ireland; Northern Ireland; island of Ireland.

INTRODUCTION

Solidarity has been recognised as a foundational approach in dealing with public health emergencies. It has relevance both in a global context and in relation to a particular healthcare situation. Access to Covid-19 vaccination programmes has raised ethical questions about

* Research for this article was undertaken as part of the funded project, 'A Public Health, Ethics and Law Research Network' (PHELN) (ES/V009222/1 & IRC/V009222/1). The support of the Economic and Social Research Council (ESRC) and the Irish Research Council (IRC) are gratefully acknowledged.

how we should understand the principle of solidarity during public health emergencies. In general terms, solidarity is a principle that encompasses notions of justice, equity and protection for population health and health systems, but which also recognises our communal interconnectedness and our mutual interdependence in managing threats to our collective public health.¹ At a global level, questions of solidarity in responding to Covid-19 have largely centred on differences in access to vaccines between the Global South and the Global North.² However, the principle is also relevant in other contexts. In this article, we examine the principle of solidarity in a contested political space arising from (contemporary or historical) communal conflict or disputes over territorial borders. In spaces such as this, communal interconnectedness is either absent or substantially reduced. In order to explore this, we draw on the experience of vaccination for Covid-19 on the island of Ireland. This provides the basis for reconsidering how we might promote solidarity in contested political spaces as part of mounting an effective response to public health emergencies.

We propose a non-hierarchical, tripartite framework which is composed of three dimensions – jurisdictional, institutional and interpersonal – in which shared health values operate as a centrifugal force. Such values can be characterised as drawing on self-interest in promoting health and wellbeing where it enhances individual, family and community health, as well as facilitating daily social and economic life. While incorporating all three dimensions may be the optimal approach in creating an effective response to public health emergencies, we appreciate that this may not be possible given the dynamics of politically contested spaces. It is for this reason that our preference is for a non-hierarchical approach. Nevertheless, aspects of one or more of such dimensions can usefully combine to strengthen this response, drawing on shared health values.

In order to examine these arguments in more detail, we examine how the principle of solidarity has been understood in the context of public health emergencies within the relevant literature. We set out the historical developments of both jurisdictions in the island to provide the context for challenges pertaining to solidaristic approaches. In this regard, we draw upon the work of Prainsack and Buyx who developed

1 N Winchester, 'Covid-19 vaccinations: is the Global South falling behind?' (House of Lords Library 24 August 2021) ; T C de Campos, 'Guiding principles of global health governance in times of pandemics: solidarity, subsidiarity, and stewardship in Covid-19' (2020) 20 *American Journal of Bioethics* 212-214.

2 For example, see F Hassan, L London and G Gonsalves, 'Unequal global vaccine coverage is at the heart of the current Covid-19 crisis' (2020) 375 *British Medical Journal* n3074.

a tiered, hierarchical approach to generating solidarity.³ We adapt it for the purposes of considering how solidarity can be promoted more effectively in a politically contested space during a time of public health emergency.

Consequently, the aim of this article is to identify modifications to an existing model of solidarity (presented by Prainsack and Buyx) which can apply wherever there is a contested political space or whenever there is one landmass with different jurisdictions. The modifications suggested apply because the strongest jurisdictional forms of solidarity are arguably less effective on the island of Ireland due to political conflict. The focus of this article is on solidarity within a specific epidemiological zone that is found within two jurisdictions.

There are three sections to this article: the first section describes solidarity in the context of the Covid-19 vaccination campaign on the island of Ireland. The second examines the Prainsack and Buyx model of solidarity as a useful vehicle for analysis of the principle of solidarity. This part, however, also identifies the limitations of the model as it applies to a contested political space. The third part sets out a modification of Prainsack and Buyx's model in Ireland and Northern Ireland and shows how the model might be used and applied in places that share an epidemiological zone but have contrasting jurisdictions.

SOLIDARITY IN THE CONTEXT OF THE COVID-19 VACCINATION CAMPAIGN ON THE ISLAND OF IRELAND

The concept of solidarity is one that is rooted in history, politics, theology, philosophy and thinking. It is seen in classical social theory, in Christian theory and in socialist theories. Newer developments in solidarity have included its presence in communitarianism, where the need of societies to take collective responsibilities for others draws from Rawls' theories of public reason and justice.⁴ In this regard, solidarity is aligned with reciprocity, citizenry and universality. People share their understanding of society and its goals based upon the application of ideas relating to the common good. Hechter developed solidarity to consider the concept of groupness that can be viewed in different contexts, including public health, where solidarity can be used to justify a strong commitment of state authorities to public health.⁵ Solidarity in emerging theories and conceptualisations can be linked to notions

3 B Prainsack B and A Buyx, 'Solidarity: reflecting on an emerging concept in bioethics' (Nuffield Council on Bioethics 2011). Also see B Prainsack and A Buyx, *Solidarity in Biomedicine and Beyond* (Cambridge University Press 2017).

4 J Rawls, *Political Liberalism* (Colombia University Press 1996); J Rawls, *A Theory of Justice* revd edn (Oxford University Press 1999).

5 M Hechter, *Principles of Group Solidarity* (University of California Press 1987).

of charity, dignity, altruism and social capital. According to Alexander, ‘solidarity is a central dimension of social order and social conflict, yet it has largely been absent from influential theories of modern society’.⁶ Solidarity is taken to mean different things according to different views of the world. Morgan and Pulignano, have defined solidarity as ‘a set of bridging and bonding processes which are embedded in moral discourses, political coalitions and social performances’.⁷ Equally, solidarity has been linked to various theories about identification, symmetry and sameness.⁸ Definitions of solidarity have been vague, and this vagueness has led to a lack of consistency and cohesion in its application.⁹ Accordingly, Prainsack and Buyx have proposed a clearer model, which will be described in a later section of this article.¹⁰ In determining the degree to which solidaristic practice has been effective in the vaccination response on this island, let us firstly describe the (still) contested nature of Ireland and Northern Ireland.

The island of Ireland: a contested political space

Following the Act of Union 1801, the island of Ireland operated as one jurisdiction, largely governed by the United Kingdom (UK) Parliament. After the Irish War of Independence (1919–1921), the island was partitioned in 1921 into two jurisdictions, with Northern Ireland being formed from the six counties with a Protestant majority in the north-east of the island.¹¹ Following the signing of the Anglo-Irish Treaty, the Irish Free State was formally created in 1922, which subsequently became the Republic of Ireland in 1949 (Ireland).¹² Since partition over a hundred years ago, there have been successive periods of sectarian conflict in Northern Ireland, of which the most high profile, colloquially known as ‘The Troubles’, lasted for 25 years in the mid to late twentieth century. In 1998, the Belfast/Good Friday Agreement (GFA) was signed, which paved the way towards peace on the island. The GFA is predicated on Ireland giving up its territorial claim

6 J C Alexander, ‘Morality as a cultural system: on solidarity civil and uncivil’ in V Jeffries (ed), *The Palgrave Handbook of Altruism* (Palgrave Macmillan 2014) 303.

7 G Morgan and V Pulignano, ‘Solidarity at work: concepts, levels and challenges’ (2019) 34(1) *Work, Employment and Society* 18–34, 20.

8 Ibid.

9 Prainsack and Buyx, ‘Solidarity: reflecting on an emerging concept in bioethics’ (n 3 above) 3, 33. Also see K P Rippe, ‘Diminishing solidarity’ (1998) 1(3) *Ethical Theory and Moral Practice* 335–374, 357.

10 Prainsack and Buyx, ‘Solidarity: reflecting on an emerging concept in bioethics’ (n 3 above).

11 Government of Ireland Act 1920, 10 & 11 Geo 5, ch 67.

12 M Ó Fathartaigh and L Weeks, *Birth of a State: The Anglo-Irish Treaty* (Irish Academic Press 2021).

to Northern Ireland, with its future sovereignty left open-ended. Complex power-sharing arrangements were also put in place to ensure representation for both communities in Northern Ireland. While entrenched political positions regarding the territorial border have lessened, North–South tensions continue to erupt over the ‘border question’ in line with the vagaries of local politics and communal divisions, as well as changes in the international political landscape.

Since the signing of the GFA, sectarian divisions have continued to undermine power-sharing arrangements politics in Northern Ireland. This has led to the collapse of such arrangements and the imposition of direct rule by the UK Government on successive occasions. In January 2020, devolved power-sharing institutions were restored, following agreement with local political parties, although its longevity remains uncertain.¹³ In Ireland, the results of the most recent general election saw a significant rise in the popular vote of Sinn Féin, the political party which advocates for a united Ireland.¹⁴ In response, the current Irish Government has sought to regain its middle-ground legitimacy in the area through its ‘shared island’ initiative, underpinned by significant funding for a research and policy programme.¹⁵ Separately, tensions over the border question were heightened in the wake of the UK’s decision to leave the European Union (EU), colloquially known as Brexit.¹⁶

Ireland remains an EU member state and therefore subject to the rules and obligations of such membership. This has added new tensions to Ireland’s relationship with the UK and with Northern Ireland, a flashpoint for which has been the Northern Ireland Protocol.¹⁷ Negotiated as part of Brexit, the Protocol involves Northern Ireland remaining subject to EU regulation of customs and the movement of goods as part of managing the only land border which now exists between the EU (Ireland) and the UK (Northern Ireland).¹⁸ Having provided this background context to the island of Ireland as a contested political space, we now turn to consider the extent to which solidarity was promoted in the context of the two Covid-19 vaccination programmes on the island of Ireland.

Cross-jurisdictional arrangements and institutional structures exist under the GFA to facilitate increased exchange and cooperation

13 UK Government, *New Decade, New Approach* (UK Government 2020).

14 K Meagher, ‘Rise of Sinn Féin: Irish unity is now mainstream’ (*Politics.co.uk* 5 March 2020).

15 Department of the Taoiseach, *Shared Island*.

16 A Whysall, ‘Northern Ireland on the brink, again: the responsibility of London’ (*Queen’s Policy Engagement QPOL* 16 April 2021).

17 D Frost and B Lewis, ‘David Frost and Brandon Lewis: we must find a new balance in how NI protocol is operated’ *The Irish Times* (Dublin 2 July 2021).

18 UK Government, *Northern Ireland Protocol*, CP346 (2020).

between the Northern Ireland Executive and the Irish Government, including political leaders, civil servants, and expert advisors. However, such structures have been largely left to languish in the absence of a commitment on the part of both governments to develop sustainable cross-border policy and expert and institutional co-operation across a range of policy areas.¹⁹ This lack of high-level political commitment to facilitating jurisdictional solidarity is particularly evident in (public) health.

One of the knock-on effects of the lack of commitment at the jurisdictional level in matters of (public) health has been to impede the development of a shared public understanding of both the similarities and differences between the respective health systems on the island of Ireland.²⁰ This is so, notwithstanding the fact that the two health systems on the island have a good deal in common. Although there is a greater role played by private health insurance in Ireland, both jurisdictions operate predominantly publicly funded health services, which are overseen by the Health Service Executive (HSE) in Ireland and Health and Social Care (HSC) in Northern Ireland. Both have similar longstanding problems with the funding and sustainability of their health systems, exacerbated by under-investment, poor workforce retention, long waiting lists and a reluctance to engage in much needed institutional reform of both health and social care.²¹ While there is a greater degree of subsidisation (or free of charge) of primary care, prescriptions and dental care in Northern Ireland,²² subsidisation also takes place in the Irish health service, albeit targeted at designated vulnerable populations.²³

In public health, high-level cross-jurisdictional co-operation was very limited prior to the Covid-19 pandemic. A notable exception has been ongoing cross-border political support for the Institute for Public Health, which was established to facilitate co-operation in the area, with offices in both Ireland and Northern Ireland.²⁴ When Covid-19 emerged as a pandemic in early 2020, a promising development

19 Good Friday Agreement, Strand 2, [North–South Ministerial Council](#), which was established to foster consultation, co-operation and action within the island of Ireland, within specific areas including (aspects of) healthcare.

20 D Heenan, ‘Collaborating on healthcare on an all-island basis: a scoping study’ (2021) 32(2) *Irish Studies in International Affairs* 413–444.

21 M Dayan and D Heenan, ‘[Change or collapse: lessons from the drive to reform health and social care in Northern Ireland](#)’ (*The Nuffield Trust* 10 July 2019); A Bergin and S McGuinness, ‘Who is better off? Measuring cross-border differences in living standards, opportunities and quality of life on the island of Ireland’ (2021) 32(2) *Irish Studies in International Affairs* 143–160.

22 Borderpeople, ‘[Healthcare](#)’.

23 Health Service Executive (HSE) ‘[Medical card application process](#)’.

24 Institute of Public Health, ‘[About](#)’.

involved the activation of intergovernmental mechanisms under the GFA, which subsequently facilitated the signing of a Memorandum of Understanding (MoU) to facilitate greater North–South cooperation to deal with the pandemic.²⁵ Although the MoU recognised that the island operated as ‘one epidemiological zone’ in relation to both the spread and the need to contain Covid-19,²⁶ political cooperation was not forthcoming in practice. This was exemplified through repeated political posturing on the part of both governments to the effect that each jurisdiction had performed better than the other in dealing with the public health emergency.²⁷

The required government co-operation needed in order to generate jurisdictional solidarity was made more complicated by political considerations that were beyond their territorial control on the island, as highlighted by the rollouts of their Covid-19 vaccination programmes. The Northern Ireland programme was inextricably linked into political and regulatory approval processes, as well as supply arrangements, overseen by the UK Government. As an EU member state, Ireland also faced external constraints, being subject to similar processes and arrangements determined at the EU level, which impacted the timing and pace of its own vaccination programme. This all occurred against the background of Brexit and increasingly fractious relations between the UK and the EU. This included their fraught exchanges over side-effects arising from the AstraZeneca vaccine (now known as the Vaxzevria) which had been initially developed with UK Government support, as well as UK–EU supply arrangements for the vaccine.²⁸

A range of structures exist under the GFA to facilitate shared institutional arrangements between the two jurisdictions; however, in the absence of high-level political support they have not operated effectively to date.²⁹ This has meant that cross-border exchange and co-operation has largely taken place through (medical) expert and civil servant networks. In the area of health, this has involved liaison as and when needed between the Chief Medical Officers (CMOs) in the two

25 Memorandum of Understanding: Covid-19 Response – Public Health Cooperation on an All-Ireland Basis between the Department of Health, Ireland (and its Agencies); and the Department of Health, Northern Ireland (and its Agencies) (7 April 2020).

26 M Tomlinson, ‘Coronavirus: Ireland is one island with two very different death rates’ *The Irish Times* (Dublin 22 April 2020).

27 A Nolan et al, ‘Obstacles to public health that even pandemics cannot overcome: the politics of Covid-19 on the island of Ireland’ (2021) 32(2) *Irish Studies in International Affairs* 225–246.

28 N Beake, ‘EU and AstraZeneca reach deal to end vaccine row’ (BBC News 3 September 2021).

29 See Heenan (n 20 above) 414.

jurisdictions, as well as between those working in their respective public health agencies. This is in addition to notable examples of medical experts championing the development of all-island approaches, in order to bring expertise to bear in the treatment of particular patient groups.³⁰ The EU has also played a key role in funding cross-border healthcare initiatives, particularly in the border regions. This has included an EU-wide regulatory regime, which operates to facilitate access to cross-border healthcare on the island, although it remains uncertain as to whether this will continue in the light of Brexit.³¹

Within each jurisdiction, institutional leadership shown by (public) health and regulatory professionals in managing Covid-19 vaccination programmes helped to promote solidarity. This served to enhance public trust leading to high levels of vaccine uptake, with 85 per cent of the eligible population in Ireland, and 88 per cent of the eligible population in Northern Ireland, having received two vaccine doses at the time of writing.³² This was underpinned by the speed at which the UK (including Northern Ireland) moved to obtain regulatory approval for Covid-19 vaccines under emergency provisions in December 2020.³³ With supplies of AstraZeneca (now Vaxzevria) vaccines readily available, the UK rollout of the Covid-19 vaccination programme began shortly after regulatory approval was granted in line with group prioritisation criteria published by the UK's Joint Committee on Vaccination and Immunisation (JCVI). The UK's devolved administrations, including Northern Ireland, followed the JCVI's advice, with the approach taken being primarily age-based, in line with the available morbidity and mortality data.³⁴

The Covid-19 vaccination programme in Northern Ireland proved to be remarkably successful, moving quickly to vaccinate priority groups. The head of the programme also made clear how this was to work in practice, taking account of political and communal sensitivities in a

30 T Hervey, I Antova, M L Flear, J V McHale, E Speakman and M Wood, 'Health "brexternalities": the Brexit effect on health and health care outside the United Kingdom' (2021) 46 *Journal of Health Politics, Policy and Law* 177, 192–194.

31 For an overview, see Heenan (n 20 above); see also Cooperation and Working Together Partnership, '[What we do](#)'; Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the application of patients' rights in cross-border healthcare OJ L 88/45. 4.4.2011.

32 Government of Ireland, '[Vaccinations](#)'; NI Department of Health, Information Analysis Directorate, '[Covid-19 in Northern Ireland: Vaccination Status of Deaths and Hospitalisations Updated to Include Weeks 3 to 6](#)' (17 January to 13 February 2022).

33 The Human Medicines (Coronavirus and Influenza) (Amendment) Regulations 2020, No 1124.

34 UK Government, Department of Health and Social Care, Joint Committee on Vaccination and Immunisation, '[Advice on priority groups for Covid-19 vaccination](#)' (30 December 2020; updated 6 January 2021).

society that continues to be largely divided along sectarian lines. The way in which any spare vaccines were to be allocated was also made clear; choices regarding the preferred brand of vaccine were respected where possible; and easy access to vaccination was organised for carers of those in the highest priority groups. Sustained efforts were also made to encourage vaccination on the part of traditionally marginalised groups, such as those in socio-economic deprived areas and members of the Roma community, many of whom worked in congregated settings in Northern Ireland, such as meat-processing plants.³⁵

Ireland found itself in a different position in relation to the initial rollout of its Covid-19 vaccination programme. As an EU member state, it required EU regulatory approval before it could proceed with implementing the programme, and this was given several weeks after UK regulatory approval. This was combined with significant difficulties in securing a ready supply of vaccines, which followed on from problems with EU procurement arrangements. Against a background of initial scarcity of supply, the Irish Covid-19 Immunisation Strategy Group was established to manage priority groups for vaccination. In November 2020, the Group proposed a complex four-phase approach to the rollout of the vaccine, which incorporated among other relevant factors, occupations and care-giver roles. In February 2021, this approach was replaced by a simpler one based on age and medical vulnerability. As a result, there was considerably more public debate on the issue than was seen in Northern Ireland, or the UK more generally.³⁶ Overall, institutional leadership in Ireland facilitated an efficient and effective rollout of the Covid-19 vaccine over time.³⁷ This was in spite of some early challenges, which are further discussed under the interpersonal dimension below.

There were a number of solidarity-challenging events in Ireland. In two high-profile cases of surplus, vaccines were given in one case to the children of a medical consultant and in another, to teaching staff at a private school attended by the children of the hospital chief executive. There was a significant public and political backlash in such cases, with concerns being voiced about fairness and equity in circumstances where there had been a clear privileging of those with high socio-economic status, rather than focusing on clinical need or

35 P Donnelly, Head of the Northern Ireland COVID-19 Vaccination Programme, 'Speaker presentation' at PHELN Webinar on COVID-19 Vaccination in the UK and Ireland (16 June 2021).

36 C O'Brien and M Wall, 'No change to vaccine priority despite opposition from teachers' union' *The Irish Times* (Dublin 6 April 2021).

37 M E Tumelty, M Donnelly, A M Farrell and C Ó Néill, 'Covid-19 vaccination and legal preparedness: lessons from Ireland' (2022) 29(2) *European Journal of Health Law* 240–259.

vulnerability.³⁸ Both these incidents took place in the absence of any policy being in place which addressed what should be done with surplus doses, although this was swiftly remedied. Unlike in Northern Ireland, initial policy in Ireland had proceeded on the basis of an implied collective understanding of fairness and equity, which subsequently had to be made explicit.³⁹

Turning to cross-border institutional solidarity, the verdict is more mixed. There was a degree of institutional co-operation, including liaison between the CMOs in both jurisdictions on a regular basis, as well as the strengthening of existing connections between those working in the Northern Ireland and Irish public health agencies.⁴⁰ However, the respective Covid-19 vaccination programmes in both jurisdictions operated for the most separately, without cross-border institutional (or jurisdictional) engagement. This may have been attributable in part to highlighted differences in regulatory approaches with regard to time between vaccinations, as well as vaccine procurement and supply.

Notwithstanding the formal adoption of the MoU between the two jurisdictions during the first wave of the Covid-19 pandemic, there has been little evidence of solidarity being generated on a (cross-) jurisdictional basis on the island of Ireland to date. One of the few exceptions involved Irish citizens, who were resident in Northern Ireland, being able to apply in Ireland to join the EU digital vaccination certificate scheme.⁴¹ The potential to use the pandemic as a route to greater cross-jurisdiction solidarity in public health was not realised, notwithstanding existing jurisdictional mechanisms to do so under the GFA. Instead, the political (and sectarian) divisions over the 'border question' that have long impeded the development of jurisdictional support structures have persisted.

Both jurisdictions were (and have remained) committed to voluntary, rather than mandatory, vaccination in line with respect for individual autonomy. Alongside such commitment, however, a range of opportunities and supports were provided to address vaccine hesitancy. The role of family – in particular, what is colloquially known as the 'Mammy effect' – also proved to be an important motivator in both jurisdictions on the island, with Irish mothers ensuring that their

38 V Clarke, 'HSE boss "extremely annoyed" at vaccines given to private school teachers' (*Breakingnews.ie* 26 March 2021).

39 S Ní Bhriain, Member, National Public Health Emergency Team, Ireland (NPHE), 'Speaker presentation' at PHELN Webinar on Covid-19 vaccination in the UK and Ireland (16 June 2021).

40 The Executive Office, Meeting of Irish Government and Northern Ireland Executive Ministers concerning North South Cooperation to Deal with Covid-19 (14 March 2020).

41 Government of Ireland, 'Request an EU digital Covid certificate for vaccinations received in a non-EU country'.

offspring made and attended their vaccination appointments. While the interpersonal dimension was significant in both jurisdictions, there were some interesting divergences. Against a background of sectarian division in Northern Ireland, particular consideration was given to designing public messages associated with vaccination; how best to prioritise vulnerable groups for vaccination; how to ensure access to vaccination for socially marginalised groups; and how surplus vaccines would be allocated. In an openly divided society, an ethically principled approach grounded in fairness, equality and human rights had to be made explicit and had to be seen to be upholding the highest standards in this regard.⁴²

Interestingly, the vaccination strategies adopted in both jurisdictions were similar in terms of intent but differed in terms of protocols adopted, with implications for how we should understand the interpersonal dimension of our framework. In the context of a divided society such as Northern Ireland, an explicit rationale was offered for prioritisation and the use of surplus vaccines, which took place at the outset of the rollout. In contrast, early high-profile instances of individuals failing to adhere to priority criteria in Ireland revealed the need to make its own rationale explicit, rather than just assuming shared health values in relation to vaccine prioritisation and surplus. Making clear the values which underpinned the vaccine rollout served to promote interpersonal solidaristic practices and enhanced public trust more generally. In turn, this laid the groundwork for what have been very high rates of Covid-19 vaccination in both Northern Ireland and Ireland.

Accordingly, it is evident that, notwithstanding effective vaccination measures adopted in each jurisdiction, the potential of enhancing cross-jurisdictional vaccination practices, policies and co-operation through the adoption of solidaristic approaches was not fully realised. In many ways, an opportunity was lost to bring people, institutions and jurisdictional thought and action together in a way that might have enhanced the 'joined-up' response of two jurisdictions navigating one epidemiological space. We suggest that the concept of solidarity, itself, needs to be reframed and the next two parts develop this reasoning.

42 Ibid.

PRAINSACK AND BUYX'S MODEL OF SOLIDARITY AND ITS LIMITATIONS

Prainsack and Buyx believe that the many understandings of solidarity that exist in the public domain have led to a lack of consistency and coherence.⁴³ This has led them to a new working definition of solidarity as signifying 'shared practices reflecting a collective commitment to carry "costs" (financial, social, emotional or otherwise) to assist others'⁴⁴ and offer a tiered, hierarchical model for solidarity, as follows.

Tier 1 (interpersonal) operates at the lowest level, where 'solidarity comprises manifestations of the willingness to carry costs to assist others with whom a person recognises sameness or similarity in at least one relevant respect'.⁴⁵ The first tier relates to the individual. In this tier, the individual is associated with others, sameness is reflected in facing a shared threat. It must be accompanied by action that is enacted with the most vulnerable. It is, essentially, related to action that is based upon potential sameness or symmetry.

Tier 2 is the next level, which involves *group practices* in circumstances where solidarity is described as a 'manifestation of a collective commitment to carry costs to assist others who are all linked by means of a shared situation or cause'. The second tier of Prainsack and Buyx's model contains group practices. This involves the collective commitment to carry costs where the group share the risks and goals. In sharing practice, they support each other in the attainment of goals.

Tier 3 is described as the 'hardest' form of solidarity, where it is said to involve not just social norms but where principles and values manifest themselves in *contractual or other legal norms*.⁴⁶ The third and final tier of this model is, thus, the contractual and legal tier. This tier cannot operate unless tier 1 and tier 2 exist. This tier is manifest in actions taken by welfare states, by individual actors working contractually and can be seen in the operation of international treaties or procedures.

This model is descriptive in the sense that it lays out the conditions that are required for solidarity to apply in practice. The model is not prescriptive in so far as it does not say what ought to be done by society. But it does suggest that societal and political actions that consider solidarity are preferable to those that do not. It is not normative in the sense that their model does not set out what ought to apply in social norms. It has, however, normative dimensions in the sense that

43 Prainsack and Buyx, 'Solidarity: reflecting on an emerging concept in bioethics' (n 3 above) 36.

44 Ibid xiv, para 30.

45 Ibid xiv, para 34.

46 Ibid xv, 49.

governmental or institutional policies that reflect a willingness to accept costs to help others are considered to be preferable to policies that fail to consider or accommodate solidarity. Solidarity is expanded as the conceptual basis for legal and regulatory frameworks. In this regard, it is primarily a public concept that is distinguished from such personal concepts as love and friendship and private relationships. Prainsack and Buyx's concept of solidarity is not based upon idealism and neither is it a theoretical odyssey. It is grounded in practical application. It is not something that is concerned about what society ought to do. Rather, it describes what society and its jurisdictions and institutions actually do. It considers how the political, economic and background social considerations enable and foster solidarity. The state-enforced measures of public health, such as vaccination, cannot, however, according to Prainsack and Buyx, only be argued based on solidarity but must primarily arise from the duties of the state to protect vulnerable people.

Prainsack and Buyx's model offers a plausible and useful solution to applying the principle of solidarity in most contexts. It brings together individual, the group and the legal/contractual frameworks that instil and propel social actions, including health-related actions. However, we suggest that the promotion of solidarity on the island of Ireland does not necessarily fit exactly within this well-established model. We argue that it does not fully encompass the political and social difficulties that apply to politically contested spaces in which a lack of trust exists cross-jurisdictionally. Prainsack and Buyx have stated that the success of the model is dependent upon three criteria: trustworthy institutions, political stability and the availability of safety nets to support people when things go awry. In the context of Northern Ireland and Ireland there are, as previously discussed, difficulties with trust, and political instability applies. This is coupled with intransigence on both sides that has historically often been difficult to overcome. What is missing from the model is a variable that can potentially unite rather than divide. It is our contention that the current terms used by Prainsack and Buyx need to be changed in order to encompass more fully the Northern Irish/Irish context. We consider that the term 'groups' for the second tier suggests benign groups that have a shared value system. This is far from the reality in Northern Ireland and Ireland. But both jurisdictions have institutions that govern or fail to govern at group level. By changing the name from 'group' to 'institutions' we try to be more solidaristic. There is greater potential to promote solidarity at the level of institutions than, perhaps, at the level of social groups. We suggest that the term 'legal and contractual frameworks' does not sufficiently encompass the way in which two jurisdictions can operate in a single epidemiological space. A new term is suggested ('jurisdictional') which includes legal

and contractual frameworks but allows for jurisdictional application and promotes the cross-jurisdictional consideration of solidarity and its application in practice.

The Prainsack and Buyx model is based upon a tiered approach, and interestingly the individual is at the bottom of the tier. That suggests a hierarchy and that the legal frameworks are hierarchically superior to the individual. In jurisdictions where the search for primacy is often at the root of conflict ('My God is better than your God', 'My view of history is truer than yours'), then it becomes vital to reduce conflict and promote solidarity. The concept of a tier in our view is at variance with the very specific type of solidaristic approach that is required in a contested political space. In Ireland and Northern Ireland, solidarity is a fraught concept and is not easily achieved. The model suggested by Prainsack and Buyx is focused on action at the three levels suggested, and, as previously discussed, it is not a model based upon any form of philosophical reasoning. That is at once its strength and its weakness. It very validly pinpoints the need for action rather than theorising but, in our view, in a contested space action will come most meaningfully from shared understandings and shared values, and we consider that a new dimension is needed that forms a bridge between the action-specific model and the need for societal buy-in at individual, institutional and jurisdictional level. Accordingly, we propose that the model be modified to consider values, and particularly health values, as being the force from which action at individual, institutional and jurisdictional level can evolve. As it stands, Prainsack and Buyx's model is very sound, but it implies that action will happen, without embedding action on values that can be shared by dissenting voices.

To reiterate, the model advocated by Prainsack and Buyx very usefully provides a coherent and consistent approach to solidarity which could be generalisable in many contexts. In relation to Ireland and Northern Ireland, where mutual mistrust and, particularly in Northern Ireland, political instability characterise these contexts, some modifications to the model are required. The next section describes those modifications more fully.

MODIFICATION OF THE MODEL

Promoting solidarity in politically contested spaces may prove to be difficult, where dysfunctional governance may exist against a background of communal conflict and/or disputes over territory. With this in mind, and modifying the Prainsack and Buyx approach, we wish to propose a non-hierarchical, tripartite framework for how we should understand solidarity in public health emergencies in such spaces. It is comprised of three dimensions: *jurisdictional*, *institutional*,

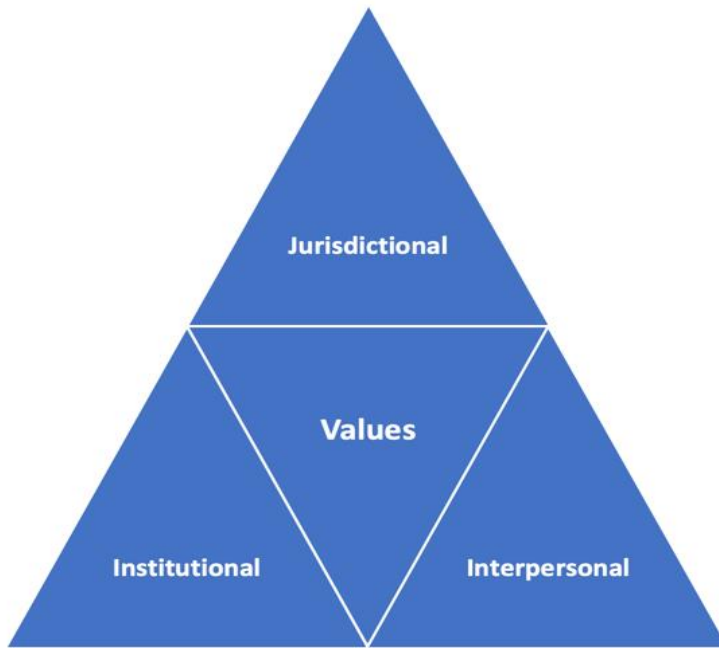


Figure 1

and *interpersonal*, with one or more of the dimensions offering the potential to promote solidarity in public health emergencies, all of which are connected to a recognition of *shared health values* which is the centrifugal force in and around which the three dimensions operate (see Figure 1).

The model presented by Prainsack and Buyx is unapologetically action-focused. It is linked to theoretical idealism, and it is based purely upon meaningful actions that can contribute to society. It is our contention that a model solely based upon behaviours would be inefficient and potentially unusable in a context such as the island of Ireland where there is sometimes a lack of mutual respect, a mistrust between institutions and some degree of political instability – all variables that Prainsack and Buyx consider essential. Consider the troubled and torturous political to-ing and fro-ing that has gone on to resolve the Northern Ireland Protocol in the aftermath of Brexit (which, as we write, is still the subject of political intransigence, although flickers of hope are emerging.) We contend that actions at interpersonal, institutional and jurisdictional level need to be embedded in a belief system that is shared by individuals, institutions and by the two jurisdictions on the island. We believe that *health values* constitute a potential shared belief system to which all people within this model could align themselves and, so, provide additional buy-in

to the vaccination practices advocated. Let us tease out the concept of shared health values further.

Values, viewed from a biological lens, are a product of instincts: psychology considers values as motives for action.⁴⁷ Sociological and anthropological theories situate values as basic determinants of social action.⁴⁸ Rokeach explains that people's values guide their behaviour.⁴⁹ However, there is little agreement about the impact of values on action: '[p]erhaps the greatest black box in all of behavioural science'.⁵⁰ Hechter is concerned that values have disappeared in social science discourse because 'values in all their forms are unobservable'.⁵¹ He states that '[s]imply postulating values is unconvincing when the processes for generating them are unknown, and measurement problems abound'.⁵² Health values are clinically defined by Porter as 'outcomes relative to costs'.⁵³ But, health as a value is more significant than that; it matters to and for patients beyond the boundaries of resource spend.

Values have a troublesome status: they differ in the scope of their application and in the degree to which they are shared socially. Some are pervasive, some are rare, some are instrumental, and some are immanent.⁵⁴ In summary, there is a general concern in much of the literature that health, as a value, is not measured and is one that has been surprisingly underutilised in health research.⁵⁵ Health value is generally assumed to be universally high, but this is a perception not fully founded in empirical data.⁵⁶ Lau and Hartman's study demonstrates how the concept of health as a value can be 'both theoretically and empirically useful', and they develop a scale to measure health as a value.⁵⁷ Their research found that 'health was the most highly ranked of ... nine values' evaluated by questionnaire respondents. Valuing

47 M Hechter, L Nadel and R E Michod, 'Acknowledgements' in M Hechter, L Nadel and R E Michod (eds), *The Origin of Values* (Aldine de Gruyter 1993). Also see George Mandler, 'Approaches to psychology of value' in M Hechter, L Nadel and R E Michod (eds), *The Origin of Values* (Aldine de Gruyter 1993).

48 Hechter et al, 'Acknowledgements' (n 47 above).

49 M Rokeach, *The Nature of Human Value* (Free Press 1973).

50 Hechter et al, 'Acknowledgements' (n 47 above).

51 M Hechter, 'Values research in the social and bahavioral sciences' in M Hechter, L Nadel and R E Michod (eds), *The Origin of Values* (Aldine de Gruyter 1993).

52 Ibid 2–3.

53 M E Porter, 'What is value in health care?' (2010) 363 *New England Journal of Medicine* 2477–2481, 2477.

54 Hechter (n 51 above)

55 R R Lau and K A Hartman, 'Health as a value: methodological and theoretical considerations' (1986) 5(1) *Health Psychology* 25–43, 26.

56 Ibid 26.

57 Ibid 40.

health is related to the goal of ensuring that a population remains healthy and that it has positive health outcomes.

Lau and Hartman demonstrate that when individuals are faced with a choice between two conflicting goals they will usually try to obtain the desired goal.⁵⁸ They indicate that there is a causal link between values and behaviour '[t]o the extent that human behaviour is under conscious direction, people act in a way that will promote the realization or achievement of things in life that they value'.⁵⁹ In the context of Covid-19, the probable desired goal of communities in both jurisdictions was to avoid the disease and to prevent its spread. Kristiansen shows that health value by itself predicts performance of preventative health behaviour and practice, particularly behaviour that involves a direct threat to health.⁶⁰ Lau and Hartman have demonstrated that there is some link between beliefs and behaviours in so far as beliefs can predict performance, as measured by readiness to engage in preventative measures that promote good health.⁶¹

Health matters to people in Ireland and Northern Ireland. It may, in fact, matter more than (or just as much as) the particular political or religious affiliations that they have. It is potentially something that joins people and, in modifying Prainsack and Buyx's model, we place values at the centre of the model in so far as the actions that take place at interpersonal, institutional and jurisdictional level have the potential to be more productive when they are derived from, or at the very least, aligned with shared values pertaining to health. It is likely that focusing on the cross-jurisdictional shared value that is given to health could result in an uptake in vaccination as a preventative measure in both jurisdictions. If we follow the reasoning of Kristiansen, health value by itself predicts performance of preventative health behaviour and practice, particularly behaviour that involves a direct threat to health.⁶² In this case, the Covid-19 pandemic is recognised as the threat to health and the vaccination procedures constitute the preventative health measures that could improve the health of society at large. This has particular validity, given the fact that the pandemic's reach was within one epidemiological zone on the island of Ireland. Accordingly, values are now positioned at the epicentre of the triad, and they have an impact on each level of the construct. This impact, as has been noted by multiple theorists, is not easily measured or quantified empirically, but is, nonetheless, a tangible part of improving health

58 Ibid 26.

59 Ibid 25-26.

60 C M Kristiansen, 'Values correlates to preventative health behaviors' (1985) 49 *Journal of Personality and Social Psychology* 748-758.

61 Lau and Hartman (n 55 above).

62 Kristiansen (n 60 above)

behaviours through a shared belief system.

Thus, in the context of vaccination practice, the most pertinent application of shared or value belief system to which individuals, institutions and both jurisdictions can buy in is the combined value that is placed upon health itself. Vaccination in many ways involves altruism – a type of solidarity with others that is made by the person who is vaccinated in the hope that, by being vaccinated, the likelihood of others contracting the disease or becoming gravely ill is reduced. If people, institutions and governmental bodies in both jurisdictions have a joint belief in the value of vaccination as a preventative health measure, then, in purely clinical terms, there will be an improved outcome in terms of vaccination uptake.

Such values are grounded in an understanding that all individuals strive for good health, irrespective of politics, geography, religion or socio-economic status. While grounded to some extent in self-interest, this may lead to the promotion of health and wellbeing on an individual, family and community basis, in order to facilitate daily social and economic life. The *jurisdictional* dimension refers to how the exercise of constitutional and legal powers by political leaders can promote solidarity in public health emergencies. This reflects a top-down awareness of the ways in which institutions may function and citizens interact, to promote solidaristic practices. The *institutional* dimension encompasses arrangements, whether within jurisdictions or on a cross-jurisdictional basis, which promote knowledge exchange, as well as policy and regulatory leadership, at the institutional level. The powers available to facilitate such arrangements are derived from the jurisdictional level, which involve higher-level political decision-making and/or the exercise of constitutional powers. The *interpersonal* dimension refers to the conduct of solidaristic practices on an interpersonal basis as between individuals, which may be underpinned by a common understanding of shared health values (as noted above). Such understanding may be enhanced by existing socio-cultural mores in local settings, which place a premium on such relations as part of daily social and economic life.

Jurisdictional dimension

The jurisdictional dimension, which forms part of our proposed solidarity framework, refers to how the exercise of constitutional and legal powers by political leaders can generate solidarity in response to public health emergencies.

Institutional dimension

This dimension of our proposed solidarity framework refers to the use of institutional arrangements, whether within a jurisdiction or on a

cross-jurisdictional basis, to promote knowledge exchange, as well as policy and regulatory leadership at the institutional level. This may be facilitated by civil servants, those with professional expertise and other non-government actors. Again, a sharing of value ascribed to health and, in this case, aligned with the promotion of vaccination as a desired societal outcome, lies at the heart of institutional decision-making.

Interpersonal dimension

This dimension refers to solidarity which is generated through interpersonal relations between individuals, notwithstanding differing political or religious allegiances or indeed living on different sides of a border. Although it draws inspiration from tier 1 of the Prainsack and Buyx model, we view the interpersonal dimension for present purposes as encompassing an understanding of shared health values in the context of contested political spaces. While to some degree motivated by self-interest, such values coalesce around the importance of facilitating individual, family and communal health and wellbeing. Such understanding may be enhanced by existing local socio-cultural mores which place a strong emphasis on interpersonal relations in the conduct of social and economic life. This is the case on the island of Ireland. What is described as ‘personalism’ has long been a feature of Irish social and cultural life.⁶³ In part, this needs to be set against an historical background of British rule in Ireland, which bred mistrust in official institutions and a lack of allegiance to the state, with alternative (moral) leadership offered by a strongly authoritarian Catholic Church. While Northern Ireland and Ireland have diverged significantly with respect to the role played by religious affiliation in communal and political life since partition, personalism nevertheless remains a strong feature of interpersonal relations on the island. In the circumstances, it provided a pre-existing basis for promoting solidarity on an interpersonal basis in response to the Covid-19 pandemic, which likely contributed to the success of the respective vaccination programmes on the island. In line with our proposed framework, we understand the interpersonal dimension as having foregrounded the importance of ethical values such as autonomy, fairness and equity in the rollout of Covid-19 vaccination programmes in both jurisdictions, albeit with differing emphases reflecting particular local concerns.

The idea of Ireland and Northern Ireland as being a contested space is, of course, not a stagnant concept. There have been troughs and valleys in the co-development of both jurisdictions, and there have been many examples of harmony between individuals, communities, organisations, institutions and leaders and representatives at

63 J Coakley and M Gallagher, *Politics in the Republic of Ireland* 6th edn (Routledge 2018) ch 2.

jurisdictional level. Equally, the background of mediation, negotiation and formulation of peace treaties following fractured decades provides another backdrop. But those decades of negotiation have led to a discursive environment – a recognition that otherness in terms of political value does not negate the sameness of the human condition. The last number of decades have taught us that the bonds that unite intransigent groups on all sides of the political divide can sometimes be bridged harmoniously and usefully by the building of discursive coalitions and networks. We contend that focusing on the values that unite dissenting individuals, groups and jurisdictional bodies has the potential to dilute otherness and promote solidarity. We accept the definition of Prainsack and Buyx that solidarity involves taking the costs, accepting responsibility, that it involves action to achieve a common purpose. The success of our framework and its application is dependent upon changes in thought and ideology, and this will not be easily achieved.

The scenario that might be presented if this proposed framework were in operation includes the following (idealised) dimensions:

The principles of the GFA, including the cross-border communicative element, would be fully in operation rather than lying dormant. Politicians, regulators, policy-makers and healthcare professionals would work together to ensure that vaccination policy and practice in the two jurisdictions worked hand in glove. There could be increased cross-border communication at every level that recognised the distinct jurisdictional practices unique to each jurisdiction, but aligned their thinking to the shared health values that united both jurisdictions. The MoU would be fleshed out and put into operation in its entirety and would be driven by shared health values. There would be greater understanding of the health systems that pertain in both jurisdictions. Work between the CMOs of Ireland and Northern Ireland would be extended and deepened and practices would be shared transparently and in a mutually respectful manner. Leadership in both jurisdictions would have a strong sense of health values and would work collaboratively, cooperatively and cross-jurisdictionally to promote practices aligned with those values. Joined-up thinking at institutional level would ensure that the regulation and timing of vaccines in both Northern Ireland and Ireland were aligned appropriately. At interpersonal level, people in both jurisdictions would recognise that they shared the same health values and they would be responsive to actions at institutional and jurisdictional level that promoted positive health outcomes and vaccine practices that improved public health.

CONCLUSION

This article examined how we might promote solidarity in responding to public health emergencies in contested political spaces, through an examination of the rollout of Covid-19 vaccination programmes in Northern Ireland and Ireland. We found that the jurisdictional dimension played a minimal role in the rollout of the respective programmes. This was so notwithstanding the fact that the island of Ireland operates as a single epidemiological space, where the existence of cross-border jurisdictional arrangements could have facilitated an all-island approach. With regards to the institutional dimension, there was evidence of some cross-border co-operation, albeit limited to expert and civil servant dialogue and shared agreed actions. The interpersonal dimension of solidarity was quite effective in both jurisdictions, particularly when it was grounded in shared values and explicit understanding of the rationale governing vaccination.

Institutional leadership and support structures successfully met many challenges in relation to the rollout of Covid-19 vaccination programmes in both jurisdictions. However, they worked for the most part in parallel, rather than together on an all-island basis. Our findings show that there are likely to be particular challenges in promoting solidaristic practices in contested political spaces, suggesting that any hierarchical, tiered approach is likely to be of limited value. Working from a baseline of shared health values to support interpersonal relations, in circumstances where there is strong institutional leadership on specific issues, is likely to offer a more promising way forward in this context. The proposed modification of Prainsack and Buyx's model of solidarity could provide a vehicle for enhancing solidaristic practices in a contested political space because of its non-hierarchical nature and its explicit focus on action emanating from shared values.