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LEGAL QUARTERLY

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JOURNAL INFORMATION

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Supplementary Issue on COVID-19

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Editorial to the Supplementary Special Issue on COVID-19 Law: breadth, depth and future implications

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INTRODUCTION

The COVID-19 pandemic, now approaching its third year, is a question for epidemiology, behavioural psychology and politics. It is also a question for law. Action to deal with COVID-19 has important legal dimensions. Many of these are national – or even sub-national – for example, the different laws and guidelines on COVID-19 across the four nations of the United Kingdom (UK). But those laws have to be adopted in the context of a multilevel web of international legal relations. The World Health Organization's International Health Regulations (2005) (IHR) are central to this response. It is under the IHR that COVID-19 became a 'Public Health Emergency of International Concern'.

The pandemic is far from over. While many of the wealthier countries in the world, usually in the global North, have benefited from hugely successful mass vaccination on a scale and speed never seen before, there are clear signs that the coming months will prove difficult, with several countries seeing the reintroduction of precautionary measures. Meanwhile, the pandemic is producing an even more terrible toll of suffering and death in many of the poorest countries in the world, mostly found in the global South. The ninth meeting of the IHR Emergency Committee only underscored the need for continued caution and vigilance against COVID-19.[1]

It is against the backdrop of the continuing COVID-19 pandemic that the *Northern Ireland Legal Quarterly* is proud to bring together and publish a range of its past[2] and upcoming[3] contributions on the topic as a supplementary special issue, in addition to our four standard issues a year. The past contributions in particular were attempting

1 World Health Organization, Statement on the ninth meeting of the International Health Regulations (2005) Emergency Committee regarding the coronavirus disease (COVID-19) pandemic.

2 Details of past publication are supplied where necessary via an asterisked note on the first page of republished contributions in the special issue.

3 Here 'upcoming' means not yet published in a standard issue of the journal.

to contribute to a still unfolding set of events. What unifies all these contributions is how they each have something original and important to say about the legal response to the pandemic that could be termed 'COVID-19 law'.

The contributions to this supplementary special issue underline the breadth and depth of COVID-19 law. It covers legal arrangements at various levels of governance, across a range of substantive areas, and with multiple implications that will continue to attract much attention in the years ahead. The latter include, but are not limited to, the following:

- law and constitutionalism;
- devolution, difference and fragmentation in the laws of the four parts of the UK;
- how public health emergencies reshape or recast rights and responsibilities;
- whose voices count in constructing legal responses;
- power, position and vulnerability; and
- justice, equity and fairness.

In the following sections, I provide an overview of the contributions, trace some thematic connections and outline their implications. It is anticipated that the contributions to this supplementary special issue will help stimulate further discussion about the legal response to current and future crises during the years ahead.

ARTICLES

Article contributions are organised into those considering COVID-19 law at various levels of governance in the UK and those focusing on particular legal issues.

Developments at different levels of governance in the UK

The articles in this first group discuss matters relevant to law and constitutionalism. The first offering in this selection, an upcoming article by Moosavian, Walker and Blick, considers UK-level coronavirus legislation. The authors argue that the approach to legislation has moved from regression to panic and, moreover, evidences a disdain for constitutionalism. Specifically, instead of utilising core legislation, including the all-encompassing Civil Contingencies Act 2004 (CCA 2004) and the sectoral Public Health (Control of Disease) Act 1984 (PHA 1984), the UK government instead panicked in the face of the COVID-19 pandemic to introduce the Coronavirus Act 2020 (CA 2020) through the Westminster Parliament at breakneck speed (seven days), followed by a four-week recess. The UK government also introduced

regulations under the PHA 1984. In reflecting on these key components of COVID-19 law in the UK against the backdrop of pre-existing laws, the authors argue that the selection of legal instruments and the design of their contents are not only poorly judged, but that, in side-lining the CCA 2004, the UK government has wrought significant damage to the UK's constitutional fabric. This analysis contributes much toward the discussion on the legal response to the pandemic and the evolution of constitutionalism in the UK.

Next, Holder looks at some of the implications of the CA 2020 for the law in Northern Ireland. As he explains, the CCA 2020 contains specific provisions for Northern Ireland and also adds a new temporary section in the Public Health Act (Northern Ireland) 1967 (PHANI 1967). The modified PHANI 1967 provides the legislative basis for the Health Protection (Coronavirus, Restrictions) Regulations (Northern Ireland) 2020, which were laid before the Northern Ireland Assembly and came into force on 28 March 2020.

While the law in the area of COVID-19 has been fast moving in Northern Ireland, as it has elsewhere, and continued to develop after the original publication of this article, the point made in it remains important and timely. That is, from the perspective of law in Northern Ireland, which is now in its centenary year, COVID-19 legislation can be understood as in some ways a continuation of a pattern of law stemming from the very creation of the jurisdiction, from so-called special powers in 1922, to Troubles-era legislation, and more specific legislation introduced post-9/11.

Further, just as that legislation raised concerns, COVID-19-related legislation in Northern Ireland raises concerns around issues including: legal certainty through its vague, expansive and arbitrary wording, including the 'stay at home' rule; maintenance of the rule of law, including through limited democratic discussion in the Assembly, public dissemination and transparency, given the months-long delay in official publication online; gaps between announcements of changes to the law and the changes actually being made; and the excessive use of fines and other enforcement measures by the Police Service of Northern Ireland against Black Lives Matter anti-racism protests on Saturday 6 June 2020. Although apparent across the articles in this section, this article in particular highlights the importance of public health emergencies in the reshaping or recasting of rights and responsibilities. This and the following article add to this discussion by further highlighting both the importance of devolution settlements to determining rights and responsibilities and their development in response to wider forces that intersect with the specifics of each jurisdiction.

Indeed, the specifics of devolved law-making are brought into even clearer relief in the new article by Harrington, Hughes Moore and Thomas. They argue that the contemporaneous challenges of the COVID-19 pandemic and Brexit have invigorated steps – conscious or otherwise – towards a Welsh health law. Beginning with the original devolution settlement for Wales in 1998, there has been growing divergence from the approach taken in other parts of the UK. This has been seen in Welsh measures on organ donation, tobacco control and the structure of the health service, and made even more apparent throughout the pandemic. The authors consider the specific values for a coherent and singular body of Welsh health law, which would not only underpin and underline its difference from other health laws elsewhere in the UK, but could provide the foundations for further developments and possible divergence.

The discussion of legal developments in Northern Ireland and Wales also underscores the relevance and evolving nature of devolution, which is creating differences in law across the UK. Much of the legal scholarship on COVID-19 relating to the UK, cited in these contributions, may take an Anglo-British frame for granted and largely overlook devolution.[4] Scholarship that focuses on law at the devolved level of governance may help to widen and diversify this frame.

Specific issues relating to the COVID-19 pandemic and legal responses

The second group of articles, focusing on specific legal issues rather than COVID-19 law itself at particular levels of governance, begins with Antova's discussion of disability and COVID-19. In this new article, Antova argues that grassroots disability ethics can be used to improve legal and policy responses to the pandemic. The author points to the importance of different approaches to ethics, in particular those emerging from individuals and groups who tend to be deemed 'lay' as opposed to those 'experts' whose expertise and knowledge are credentialised. More deeply, Antova's argument for the development of ethics from the grassroots points to the significance of diversifying ontologies and epistemologies, and in turn methodologies, to better understand and shape legal and wider responses to acute public health problems and, wider still, to other kinds of problems, whether in the public health domain or beyond. This article raises the key question of whose voices count in the crafting and implementation of legal responses to COVID-19 and, indeed, closely related questions of power, position and vulnerability. Grassroots disability ethics appears to hold

4 M Brazier and J Montgomery, 'Whence and whither "modern medical law"?' (2019) 70(1) Northern Ireland Legal Quarterly 5.

real potential to empower, reposition and reduce the vulnerability of those disabled within dominant modes of law and policy making. This may in turn improve the justice, equity and fairness of legal and policy responses.

These kinds of questions and concerns also find resonance in McMahon's article. This focuses on the jurisdiction of Ireland to consider the legal avenues available to national governments for compulsory licensing of patented health-technologies for COVID-19, in instances where patent holders either refuse to license such technologies or refuse to do so under reasonable conditions. The article was published in the second half of 2020, just as attention was turning to securing effective vaccines and treatments for COVID-19. The author argues that it is incumbent upon the Irish government, and other national governments, to re-evaluate the current operation of such licensing mechanisms to ensure that they are effective within the context of the pandemic in maintaining access to vaccines and treatments.

The discussion is thus of relevance outwith Ireland. Indeed, it resonates with calls for compulsory licensing and the waiver of intellectual property rights by member states of the World Trade Organization under its Agreement on the Trade-Related Aspects of Intellectual Property (TRIPS), which sets minimum standards for protecting intellectual property. These calls aim to ensure fair and equitable access to vaccines and treatments for COVID-19 around the world, especially in poorer countries that are overwhelmingly in the global South. TRIPS meant it became harder for poorer countries in particular to import generic versions of patented life-saving antiretrovirals to treat people with HIV in place of more expensive patented versions. McMahon highlights the importance of power, position and vulnerability and charts some ways forward towards the resolution of these and related important issues of justice, equity and fairness.

In their article, Hudson and Wragg also advance discussion on justice, equity and fairness, by reference to related intellectual property issues in the context of copyright law and education during the COVID-19 pandemic. While the focus is on higher education in the UK, many of the authors' ideas are relevant to primary and secondary education in the UK and, wider still, to education in other countries. Hudson and Wragg consider whether the impact of the COVID-19 pandemic could justify new limitations or interventions in UK copyright law so that higher education institutions can serve the needs of their students. Various suggestions for using exceptions in the Copyright, Designs and Patents Act 1988 are discussed, in particular, fair dealing and the exemption for lending by educational establishments.

Overall, the article argues that a public interest defence to copyright infringement, to the extent it still exists in UK law, may not be available, but that it may still be relevant to remedies. In addition, the authors argue that compulsory licensing, although permissible under international copyright law, is not a desirable intervention, and as such, instead, expanding the range of legislative exceptions to encourage voluntary collective licensing would be attractive. The article's resonance will outlast the pandemic in that, as the authors explain, the current emergency only underscores issues with the prevailing model for academic publishing and may speed up the turn by universities towards in-house and open access publishing and for a wider range of material than hitherto.

Ward's upcoming contribution rounds out the articles and looks to the past to reflect on COVID-19 law and the lessons for constitutionalism. In doing so, Ward points to the importance of human nature in shaping legal responses to rare and allegedly unpredictable public health emergencies. Resonating in particular with Moosavian et al's contribution, Ward explains how the panicked response of government came after repeated warnings that the UK was ill prepared for what many experts have said was an inevitable pandemic. In the absence of any planned mitigation, and as seen in the past, government resorts to measures designed to reduce public life to its barest state. In placing legal responses to the COVID-19 pandemic within a longer historical setting, this article provides powerful support for renewed efforts to build resilience into government responses for inevitable future public health emergencies.

COMMENTARIES AND NOTES

Finally, we have two contributions to Commentaries and Notes, both of them previously published in the journal, and which remain highly relevant to the present pandemic. Indeed, both contributions provide lessons for future law and practice, perhaps especially in relation to the wider justice, equity and fairness of decisions made under existing laws and legal frameworks.

Burrell and Kelly reflect on COVID-19 and the challenge it provides for innovation policy and law in the UK as a part of its long-term implications. They caution that the pandemic forces us to take a long overdue look at doing things differently. In particular, although the steps taken to develop COVID-19 vaccines have been hugely successful, those steps could have been fewer in number, and development far faster, if funding for research on SARS had not dried up as the risks of SARS receded. The authors explain how the UK's innovation model is overly patent-centric and market-focused, resulting in underinvestment in promising treatment opportunities and the

skewing of priorities towards maximising shareholder value and other measures of immediate success. To take one example, the pandemic is likely to have prompted research bureaucrats within universities to recategorise research that was previously seen as wasteful, such as into novel corona viruses and the history of pandemics, as now being highly impactful. Tackling the problems with the UK's innovation model is only going to become more necessary due to climate change and the urgent need to develop mitigation technologies.

The importance of the pandemic for prompting reflection on remodelling law to future crises, and climate change in particular, is central to our final contribution by Sanchez-Graells, which discusses public procurement law. This law stems from the relevant European Union (EU) legislation. As such, although the discussion focuses on the situation in the English National Health Service, the discussion is relevant to the healthcare systems in EU member states, and areas of the public sector that have used the extremely urgent procurement exception to enable a response to the COVID-19 pandemic. Reflecting on the dysfunction and abuse of 'unregulated procurement' amidst COVID-19, Sanchez-Graells elucidates the need for reflection on public procurement rules to deal with impending challenges such as climate change.

CONCLUSION

The need for further reflection on the suitability and potential revision of the law to deal with emergencies of all kinds, not least climate change, resonates across the contributions towards this supplementary special issue. Such revision will need to meet the immensity of the task at hand. As outlined at the beginning of this introduction, the contributions to this special issue make clear that any successful attempt will need to give due regard to *inter alia*: law and constitutionalism; devolution; rights and responsibilities; whose voices count in discussion; power, position and vulnerability; and justice, equity and fairness. This special issue provides salient prompts and reference points for that immensely important discussion that will resonate long into the future.

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Coronavirus legislative responses in the UK: regression to panic and disdain of constitutionalism

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ABSTRACT

The United Kingdom has considerable prowess in handling emergencies, not just in counterterrorism but also in a wide range of other real or imagined disasters, including public health risks. Core legislation has been installed, including the all-encompassing Civil Contingencies Act (CCA) 2004 and the more specialist Public Health (Control of Disease) Act (PHA) 1984. Despite these finely honed models, the UK state regressed to panic mode when faced with the COVID-19 pandemic. Rather than turning to the laws already in place, Parliament fast-tracked the Coronavirus Act 2020, with scant debate of its shabbily drafted contents. In addition, the UK Government has relied heavily, with minimal scrutiny, on regulations under the PHA 1984. The article analyses the competing legal codes and how they have been deployed to deal with COVID-19. It then draws out the strengths and weaknesses of the choices in terms of the key themes of: the choice of sectoral versus general emergency legislation; levels of oversight and accountability; effectiveness; and the protection of individual rights. Following this survey, it will be suggested that the selection of legal instruments and the design of their contents has been ill-judged. In short, the emergency code that is the most suitably engineered for the purpose, the CCA 2004, has been the least used for reasons which should not be tolerated.

Key words: COVID-19; emergency legislation; pandemic; constitutionalism; Civil Contingencies Act 2004; Public Health (Control of Disease) Act 1984; Coronavirus Act 2020.

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INTRODUCTION

The United Kingdom (UK) has garnered considerable prowess in handling emergencies, as prominently illustrated by its encyclopaedic counterterrorism laws. Less widely appreciated are the extensive codes available to the UK Government covering other real or imagined disasters, ranging from floods to meteor strikes, including public health risks. Here, too, core legislation has been installed, such as the all-encompassing Civil Contingencies Act 2004 (CCA 2004) and the sectoral Public Health (Control of Disease) Act 1984 (PHA 1984).[1] Despite these finely honed models, the UK state regressed to panic mode when faced with the COVID-19 pandemic. Rather than utilising the laws already in place to handle crises like the pandemic, Parliament fast-tracked the Coronavirus Act 2020 (CA 2020). This crucial statute was passed within seven days (19–25 March 2020),[2] having been subjected to brief and poorly attended debates, after which Parliament vanished into recess for four weeks. In addition, the UK Government has installed, with minimal scrutiny in any form, extensive regulations under the PHA 1984 which have become the chief instruments of policy.

This article reviews the contents and defects of the CA 2020, followed by an examination of the competing features of pre-existing laws: the PHA 1984 and CCA 2004. Thereafter, it argues that the selection of legal instruments and the design of their contents have been ill-judged. In short, the emergency code which is the most suitably engineered for the purpose, the CCA 2004, has been the least used for reasons which should not be tolerated, resulting in substantial damage to the constitutional fabric of the UK.[3]

CORONAVIRUS ACT 2020

The CA 2020 runs to over 342 pages, so this summary is necessarily selective.[4] The Act's stated purpose is to implement the UK Government's *Coronavirus: Action Plan* of 3 March 2020,[5] which seeks to 'Contain, Delay, Research, and Mitigate'. All aspects of that *Plan* are potentially covered, though little has since been heard of this *Plan*. Rather than refining it or assessing its success, plans moved onto

1 For surveys, see Clive Walker and James Broderick, *The Civil Contingencies Act 2004: Risk, Resilience and the Law in the United Kingdom* (Oxford University Press 2006); Clive Walker (ed), *Contingencies, Resilience and Legal Constitutionalism* (Routledge 2015).

2 See Parliamentary Bills: Coronavirus Act 2020: stages.

3 For other jurisdictions, see Comparative Covid Law; COVID-19 Civic Freedom Tracker; COVID-19 Government Measures Guide 2.0.

4 See also *CA 2020: Explanatory Notes*.

5 Policy Paper: Coronavirus (COVID-19) Action Plan.

the subsequent phases, and included documents such as *Our Plan to Rebuild*,[6] the *Winter Plan*,[7] and now a stepped roadmap.[8] While the most eye-catching and contentious measures concerned containing and delaying the spread of coronavirus via varying degrees of lockdown of the general populations, the bulk of the legislation is technical and specialised in nature.

The initial titles in the CA 2020 contend with health and social care. Provisions seek to boost available personnel through relaxing health registration requirements to temporarily allow for the registration of an extra intake of suitably experienced persons (such as recent graduates or retired personnel) as regulated healthcare professionals even if they lack some formalities of the normal registration requirements. The recruitment of emergency volunteers is also encouraged by establishing a new form of unpaid statutory leave and powers to compensate for some loss of earnings and expenses. The National Health Service (NHS) Volunteer Responders scheme[9] recruited 750,000 people within days of its announcement, three times more than planned. Further encouragement to grow health system capacity is given by the conferment of individual indemnity for clinical negligence in some circumstances.[10] Next, death certification and coronial interventions are short-circuited by enabling a doctor to certify the cause of death without referral to a coroner.[11] Inquests with juries are also curtailed.[12]

Second, physical and social security are reinforced by a power to require information about food supply chains[13] with a view to potential state intervention. Statutory sick pay is also extended and subsidised.[14]

Third, personal liberties are gravely affected. The scale of these changes to fundamental legal processes is extraordinary and expansive. Various surveillance powers are widened in terms of authorising authorities for the taking and retention of personal data.[15] Notably, no extra powers have yet been devised for compulsory population contact-tracing purposes, though the NHS COVID-19 app, which collected data centrally, was devised by the technological wing of the health

6 CP 239, 2020.
7 CP 324, 2020.
8 COVID-19 Response (Cabinet Office, 22 February 2021); Health Protection (Coronavirus, Restrictions) (Steps) (England) Regulations 2021, SI 2021/364.
9 'NHS volunteer responders: 250,000 target smashed with three quarters of a million committing to volunteer' (NHS, 29 March 2020); NHS Volunteer Responders, 'Volunteer now to support the COVID-19 vaccination programme'
10 CA 2020, s 11.
11 Ibid s 18.
12 Ibid s 30.
13 Ibid s 25.
14 Ibid s 39.
15 Ibid ss 22–24.

service, NHSX, and, after abandonment of the initial version,[16] was rolled out.[17] Many questions raised by the Joint Committee on Human Rights about privacy safeguards and independent oversight remained unanswered.[18] In March 2021, a scathing report by the Public Accounts Committee found that this NHS Test & Trace system, which cost an 'unimaginable' £37 billion, had failed to deliver discernible benefits to the UK's pandemic response.[19] More direct intrusions into civil liberties have included regulatory powers to direct the suspension of port operations,[20] which are intended to ensure border monitoring but could also be applied internally (such as to cruise ships).[21] Next, public health officers and other officials can enforce quarantining under section 51.[22] Section 52 allows for regulations to ban events, gatherings and the use of communal premises aimed at the apparently healthy general population. Rights of due process are affected under sections 53 to 57, by which various pre-trial hearings may take place by live video links. Democratic rights may have also been affected by powers under sections 59 to 70 and 84 to postpone (as in wartime) pending elections for local authorities, the London mayor, and even the General Synod of the Church of England. Local authority meetings can also be trimmed (section 78). Finally, there are winners and losers in terms of property rights: tenants in the private, social and business rented sectors have been protected from eviction for a specified time (sections 79 to 83).

16 See Ian Levy, 'The security behind the NHS contact tracing app' (*National Cyber Security Centre*, 4 May 2020).

17 NHS COVID-19 App. For standards, see European Commission, Recommendation (EU) 2020/518 of 8 April 2020, *Common Union toolbox for the use of technology and data to combat and exit from the COVID-19 crisis, in particular concerning mobile applications and the use of anonymised mobility data*; eHealth Network, *Mobile applications to support contact tracing in the EU's fight against COVID-19: Common EU Toolbox for Member States; European Data Protection Board, Guidelines 04/2020 on the use of location data and contact tracing tools in the context of the COVID-19 outbreak* (21 April 2020).

18 Joint Committee on Human Rights, *Human Rights and the Government's Response to Covid-19: Digital Contact Tracing* (2019–21 HC 343/HL 59). See also Andy Phippen and Emma Bond, 'COVID-19 and tech solutions – another politician's fallacy?' (2020) 31 Entertainment Law Review 191; Marion Oswald and Jamie Grace, 'The COVID-19 tracing app in England and "experimental proportionality"' [2021] Public Law 27.

19 House of Commons Public Accounts Committee, *Covid-19: Test, Track and Trace (Part 1)* (2019–2021 HC 932).

20 CA 2020, s 50.

21 See 'Covid Scotland: UK-only cruise ship MSC Virtuosa "barred from docking in Greenock"' (*The Scotsman*, 8 June 2021).

22 The UK Government cites *Kudla v Poland* App no 30210/96, 2000-XI and *Pretty v UK* App no 2346/02, 2002-III in its Memorandum to the Joint Committee on Human Rights: The Coronavirus Bill 2020, para 24.

Scant oversight mechanisms have been applied to this sprawling legislative edifice. First, by section 97, the Secretary of State must prepare and publish a report every two months on the status of the provisions in the Act. In addition, the report must include a statement that the Secretary of State is satisfied that the status of those provisions is 'appropriate'. No further explanation of this term is provided in the Act or wider guidance, indicating that this requirement is undemanding or even cosmetic. Second, by section 98, the House of Commons is enabled to debate and vote on the continuation of the Coronavirus Act 2020 every six months based on a motion 'That the temporary provisions of the Coronavirus Act 2020 should not yet expire.'[23] This review power is extraordinarily confined and has hindered subsequent much-needed meaningful parliamentary scrutiny of the Act.[24] The House of Lords is allowed no part to play, yet no reasons were given for its exclusion. The only obvious precedents for this treatment are the Provisional Collection of Taxes Act 1968, section 1 (relating to the annual Budget proposals), and the European Union (Withdrawal) Act 2018, section 13, by which the negotiated withdrawal agreement and the framework for the future relationship had to be approved by a resolution of the House of Commons (a 'meaningful vote') while the House of Lords was required by motion merely to take note by debate (a rather meaningless vote). These two precedents could arguably provide justification on the basis that the enhanced democratic credentials of the House of Commons might be peculiarly relevant in those specific contexts. But they cannot support the complete exclusion of the Lords from scrutiny and review of CA 2020 measures of such immense magnitude. The third precaution is that, by section 89, the Act is to expire after two years, but, even then, the 'relevant national authority' (basically, a minister of the Crown under section 90) can extend the life by regulation for six months at a stretch. Proposals to shorten this period, such as to one year, or even shorter, were rejected.[25] For the Scottish Parliament's equivalent, the Coronavirus (Scotland) Act 2020,[26] a final sunset of 30 September 2021 is specified by section 12. However, successor legislation can be installed, and so the Coronavirus (Extension and Expiry) (Scotland) Bill 2021 plans to extend the legislation (with some omissions) until 31 March 2022.[27]

23 The initial draft set two years which was a point of criticism: House of Lords Select Committee on the Constitution, *Coronavirus Bill* (2019–21 HL 44) para 8.

24 For renewal on 25 March 2021, see HC Deb 25 March 2021, vol 691, col 1195; Fiona de Londras, 'Six monthly votes on the Coronavirus Act 2020: a meaningful mode of review?' (*UK Constitutional Law Blog*, 25 March 2021).

25 House of Lords Delegated Powers and Regulatory Reform Committee, *9th Report* (2019–21 HL 42) para 4; HL Deb 25 March 2020, vol 802, col 1771, Earl Howe.

26 Asp 7.

27 SP Bill 1. See Coronavirus (Extension and Expiry) (Scotland) Bill, 24 June 2021.

CHOICE OF LEGISLATIVE PLATFORMS

Appearances at the start of the pandemic emergency[28] seemed to suggest that the CA 2020 would offer the main legislative platform for a response to COVID-19, and so this instrument grabbed the attention of Parliament. But appearances turned out to be deceptive. As this part explains, the CA 2020 has been relatively silent compared to some alternative platforms.

CA 2020: firing duds

The CA 2020 was passed in great haste on grounds of national emergency, but its usage has been relatively modest, as demonstrated by two sample areas: the justice system and economic interventions.

For the struggling justice system,[29] a mixed picture has involved some restrictions to its usual functioning alongside some instances of governmental forbearance. Sentencing by the judges has taken account of the more severe lockdown conditions in prison,[30] while the Ministry of Justice introduced the End of Custody Temporary Release scheme for suitable prisoners, within two months of their release date, to be temporarily released from custody, though this action was taken under rule 9A of the Prison Rules 1999 and rule 5A of the Young Offender Institution Rules 2000.[31] It was reckoned that up to 4000 prisoners would be released under this scheme, but, as of 3 July 2020, only 209 prisoners had been released,[32] and the scheme seems to have been in abeyance since then with no plans to restart.[33] Thus, the CA 2020 was not used to ameliorate the conditions of offenders.

Another planned intervention also fizzled out. Criminal trials by jury in England and Wales were suspended for some months after 23 March 2020,[34] leading to huge backlogs of cases, though some

28 The situation was identified as a 'moment of national emergency': Prime Minister's statement on coronavirus (COVID-19), 23 March 2020.

29 See *Impact of the Pandemic on the Criminal Justice System* (Criminal Justice Joint Inspectorate, 19 January 2021).

30 *R v Manning* [2020] EWCA Crim 592; *HM Advocate v Lindsay* 2020 HCJAC 26.

31 'End of Custody Temporary Release' (Ministry of Justice and HM Prison and Probation Service 24 April 2021). See *R (Davis) v Secretary of State for Justice* [2020] EWHC 978.

32 House of Commons Justice Committee, *Coronavirus (Covid-19): The Impact on Prisons* (2019–21 HC 299) paras 52, 57; and see *Government Response* (2019–21 HC 1065). See further House of Commons Justice Committee, *Coronavirus (Covid-19): The Impact on the Probation System* (2019–21 HC 461).

33 *Government Response* (2019–21 HC 1065).

34 'Review of court arrangements due to COVID-19, message from the Lord Chief Justice'. The pause did not breach the right to trial by jury or cause a delay contrary to s 22(3) of the Prosecution of Offences Act 1985: *R (McKenzie) v Crown Court at Leeds* [2020] EWHC 1867 (Admin).

recovery took place after May 2020 through the greater use of live links under section 51 and also the opening of 60 adapted 'Nightingale' courts.[35] The shift from physical to online hearings raised profound concerns about how to assist and assess the participants,[36] and also to ensure open justice.[37] In its review of the impact of the pandemic upon the court system, the House of Commons Constitution Committee has made various criticisms of the 'crisis level' backlogs in the criminal justice system, deeming them 'neither acceptable, nor inevitable'.[38] More severe modifications to the right to jury trial entered into consideration as a potential reform under the CA 2020 in England and Wales[39] but have as yet come to nought. Elsewhere, drastic changes were opportunistically envisaged in Scotland by early drafts of the Scottish Parliament's Coronavirus (Scotland) Act 2020 which contained proposals to suspend trial by jury and to add exceptions to hearsay rules of evidence. This attempt to railroad through fundamental change was rebuffed by the vocal opposition of Scottish legal professions. Fresh proposals, *Covid-19 and Solemn Criminal Trials*,[40] were tabled, but the threat to jury trial again receded with greater attention to virtual hearings and elongated time limits as in England.[41] The threat has not, however, vanished since the Police, Crime, Sentencing and Courts Bill will replace temporary provisions in the Coronavirus Act 2020 relating to live video and audio court hearings in criminal courts, including live link directions relating to a jury.[42] A variety of other criminal justice issues, such as impacts on custody time limits,[43] the extended retention

35 See Sally Lipscombe and Graeme Cowie, *Coronavirus Bill: Implications for the Courts and Tribunals* (House of Commons Library 08865, 2020); Ministry of Justice, 'Speech: Lord Chancellor outlines his plans to recover the justice system from COVID-19', 4 June 2021.

36 *Inclusive Justice: A System Designed for All: Interim Evidence Report: Video Hearings and their Impact on Effective Participation* (Equalities and Human Rights Commission 2020); *Explaining the Case for Virtual Jury Trials during the COVID-19 Crisis* (JUSTICE 2020); Hannah Quirk, 'Covid 19 and juryless trials?' [2020] Criminal Law Review 569.

37 *Sutter v Switzerland* App no 8209/78, (1984) 6 EHRR 272 [26]–[27]; *Pretto v Italy* App no 7984/77, (1984) 6 EHRR 182 [21].

38 House of Lords Select Committee on the Constitution, *Covid-19 and the Courts* (2019–21 HL 257).

39 House of Commons Justice Committee, *Coronavirus (COVID-19): The Impact on Courts* (2019–21 HC 519) para 77.

40 'Criminal trials during COVID-19 outbreak' (Scottish Government, 14 April 2020).

41 See Coronavirus (Scotland) (No 2) Act 2020 (asp 10), sch 2.

42 (2021–22) HL no 40, cl 169 and sch 19.

43 Prosecution of Offences (Custody Time Limits) (Coronavirus) (Amendment) Regulations 2020, SI 2020/953, permitted pre-trial detention to increase from 182 to 238 days. See Luke Marsh, 'The wrong vaccine' (2021) Legal Studies 1–17.

of profile data[44] and domestic abuse remain to be fully assessed.[45] As for civil process, including coronial hearings, the facility of online and closed circuit links has again been promoted.[46] Wider impacts on the legal profession are still to be tackled.[47] On these issues, the CA 2020 has been silent.

The CA 2020 has had more impact on economic and social life than civil and political life. Various ambitious and ruinously expensive schemes of aid to businesses[48] and the furloughing of employees[49] have been implemented. In addition, restrictions on the treatment of tenants have also been applied to prevent evictions.[50] Further legislation (the Stamp Duty Land Tax (Temporary Relief) Act 2020) also reduced stamp duty from June 2020 until October 2021.

PHA 1984: the weapon of choice

The CA 2020 received Royal Assent on March 25. Yet, the very next day, additional measures were introduced via the PHA 1984. In short, part 2A of the PHA 1984 was inserted by the Health and Social Care Act 2008 following the UK's experience of SARS in 2003 and to give effect to the International Health Regulations 2005. It provides powers under sections 45C(1), (3)(c), (4)(d), 45F(2) and 45P which authorise the executive authorities to issue regulations to protect against infectious disease. Under these powers, the Health Protection (Coronavirus, Restrictions) (England) Regulations 2020[51] were issued.

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44 Coronavirus (Retention of Fingerprints and DNA Profiles in the Interests of National Security) Regulations 2020, SI 2020/391 and 973.

45 See House of Commons Home Affairs Committee, *Home Office Preparedness for Covid-19 (Coronavirus): Domestic Abuse and Risks of Harm within the Home* (2019–21 HC 321) and *Government Reply* (2019–21 HC 661). Note also the Domestic Abuse Act 2021, the background to which pre-dates COVID-19.

46 See *Chief Coroner's Guidance on COVID-19* (No 34, 29 March 2021); Rudi Fortson, 'Adjusting to Covid 19 under the English legal system' (2021) 2 eucrim 116–122.

47 House of Commons Justice Committee, *Coronavirus (COVID-19): The Impact on the Legal Professions in England and Wales* (2019–21 HC 520) (covering practical difficulties arising from remote working and financial difficulties). For the limited uplift in legal aid funding, see 'Lord Chancellor outlines his plans to recover the justice system from COVID-19' (Ministry of Justice, 4 June 2021).

48 Business Support.

49 See 'Coronavirus Job Retention Scheme and Job Retention Bonus' (HM Treasury, 2 October 2020). The schemes rely on the CA 2020, ss 71, 76.

50 See Coronavirus Act 2020 (Residential Tenancies: Protection from Eviction) (Amendment) (England) Regulations 2020, SI 2020/914; Business Tenancies (Protection from Forfeiture: Relevant Period) (Coronavirus) (England) (No 2) Regulations 2020, SI 2020/994. See further 'Guidance for landlords and tenants' (Ministry of Housing, Communities and Local Government, 21 June 2021).

51 SI 2020/350.

Corresponding instruments were issued for Wales,[52] Scotland[53] and Northern Ireland,[54] albeit with many inexplicable variations. These regulations expanded upon an earlier regulatory order issued in February 2020[55] which had been, as might be expected for public health legislation, confined to the detention for screening or treatment of potentially infected individuals. Many later amendments, variants, and editions have followed ever since.[56]

The PHA 1984 regulations go far beyond dealing with the sick. They impinge upon many activities of the general population and impose extraordinary restrictions on general liberty, often very similar to those allowed by the CA 2020. A major aim throughout has been to minimise social interactions, including by 'lockdowns', which prevailed in various forms and levels at least until 19 July 2021 when, in England, a lifting of most restrictions occurred.[57] The lockdown regulations have appeared mainly in the PHA 1984 and were not granted by the CA 2020, which could have been designed to afford greater clarity and accountability,[58] The PHA 1984 regulations have entailed the enforced closure of some businesses and restrictions on others (regulations 4 and 5), including entertainment and hospitality venues.[59] Most draconian of all, the initial lockdown under regulation 6 stated that 'no

52 Health Protection (Coronavirus Restrictions) (Wales) Regulations 2020, SI 2020/353 (W80).

53 Health Protection (Coronavirus) (Restrictions) (Scotland) Regulations 2020, SSI 2020/103. See Robert Shiels, 'The instant law of coronavirus' [2020] Scottish Law Times 153, 245; Paul Scott, 'Responding to COVID 19 in Scots law' (2020) 24 Edinburgh Law Review 421.

54 Health Protection (Coronavirus, Restrictions) Regulations (Northern Ireland) 2020, NISR 2020/55. See *COVID 19 and the Law* (Committee on the Administration of Justice 2020); Daniel Holder, 'From special powers to legislating the lockdown: the Health Protection (Coronavirus, Restrictions) Regulations (Northern Ireland) 2020' (2020) 71 Northern Ireland Legal Quarterly OA1.

55 Health Protection (Coronavirus) Regulations 2020, SI 2020/129.

56 See especially (No 2) SI 2020/684; (No 3) SI 2020/750; (No 4) SI 2020/1200.

57 'Speech: PM statement at coronavirus press conference' (Prime Minister's Office, 14 June 2021); Health Protection (Coronavirus, Restrictions) (Steps etc) (England) (Revocation and Amendment) Regulations 2021, SI 2021/848; Health Protection (Coronavirus, Restrictions) (Self-isolation) (England) (Amendment) Regulations 2021, SI 2021/851. Scotland and Wales planned a more stepped reduction through to August 2021: 'More normality if progress continues' (Scottish Government, 22 June 2021) ; '"Next steps towards a future with fewer covid rules" – First Minister' (Welsh Government, 14 July 2021).

58 House of Lords Select Committee on the Constitution, *Covid-19 and the Use and Scrutiny of Emergency Powers* (2021–22 HL 15) paras 55, 56, 63.

59 Further enforcement powers were added by the Health Protection (Coronavirus, Restrictions) (Local Authority Enforcement Powers and Amendment) (England) Regulations 2020, SI 2020/1375.

person may leave the place where they are living without reasonable excuse' (which might include the need to obtain basic necessities and to travel to work where it was not reasonably possible to work at home). Under regulation 7, public gatherings of more than a specified (and variable over time and jurisdiction) number of people were forbidden. A person who contravened these requirements committed an offence, punishable by a fine, and the police were given powers to disperse individuals or gatherings and to issue fixed-penalty notices (regulations 8 to 10). Large gatherings (of more than 30 people) in breach of the regulations became subject to a fixed-penalty notice of £10,000 just before the August Bank Holiday 2020.[60]

These key regulations, which grew through hundreds of amendments, have been critiqued by several eminent practitioners.[61] They highlight multiple problems: divergences between the CA 2020 and the regulations; obscurities in the meaning of the regulations; confusing government and other guidance, especially police guidance, as compared to the primary regulatory texts;[62] excessive or inconsistent police enforcement; and arguments that some elements are *ultra vires*. Some technical corrections have been made through amending regulations,[63] but many problems remained.

The resort to PHA 1984, immediately following the more compendious scheme of the CA 2020 (which covers many of the same issues and more besides), seems extraordinary. Part of the explanation may be familiarity. The PHA 1984 had already been invoked against COVID-19 in early 2020 and (as explained above) had been considered in previous threatened pandemics, and so the need for decisive action could most comfortably be met by resort to this established pathway. Yet, the same eminent lawyers mentioned above who cast doubt on the *vires* of the regulations were also sceptical as to whether legal validity or clarity could more securely be delivered under the CA 2020. However, familiarity may also breed constitutional contempt; the regulations could be, and were, made without any forewarning or

60 Health Protection (Coronavirus) (Restrictions on Holding of Gatherings and Amendment) (England) Regulations 2020, SI 2020/907, r 2.

61 See Lord Sandhurst and Anthony Speaight, *Pardonable in the Heat of Crisis – But We Need Urgently to Return to the Rule of Law* and Benet Brandreth and Lord Sandhurst, *Pardonable in the Heat of Crisis – Building a Solid Foundation for Action* (Society of Conservative Lawyers 2020); Tom Hickman, *Eight Ways to Reinforce and Revise the Lockdown* (UK Constitutional Law Association 2020).

62 House of Lords Select Committee on the Constitution (n 58 above) paras 153–177; John Sorabji and Steven Vaughan, '"This is not a rule": COVID-19 in England and Wales and Criminal Justice Governance via Guidance' (2021) 12 European Journal of Risk Regulation 143.

63 See especially Health Protection (Coronavirus, Restrictions) (England) (Amendment) Regulations 2020, SI 2020/447.

public consultation under the emergency procedure set out in section 45R of the PHA 1984 – and without any draft having been laid and approved by parliamentary resolution. As a backstop, the regulations expire after six months (subject to reissuance).

CCA 2004: right weapon, wrong time

The CCA 2004 represents a legal landmark. It consolidated and expanded legal duties and powers to ensure that public authorities prepare for, and respond to, a wide variety of risks as set out in the *National Risk Register* (in which pandemic influenza tops the list).[64] While the CCA 2004 was impelled by domestic and global crises, it was not enacted in haste but benefited from a prolonged consultation period led by a special parliamentary Joint Select Committee.[65] The CCA 2004 systematically furnishes executive bodies with duties to plan and cooperate (part 1)[66] and with measured powers to respond to an 'emergency' (part 2), subject to vital legal and parliamentary oversight to avert improper responses. The widest range of risks is addressed: terrorist attacks, protests, environmental events – and human and animal disease pandemics. Consequently, the CCA 2004 was expressly designed to tackle circumstances such as COVID-19. Indeed, the Speaker's Counsel, Daniel Greenberg, is reported to have confirmed 'unequivocally that the powers under the Civil Contingencies Act … are absolutely appropriate for the current emergency'.[67] Yet, the UK Government resorted to alternative legislation. Why?

As shall be noted later, part 1 of the CCA 2004, dealing with 'civil protection' through planning and resilience reinforcement, has been in play to some extent, but part 2, 'Emergency Powers', has remained unused even though it could cover much of the work of the PHA 1984. Section 19(1)(a) defines an 'emergency' as including 'an event or situation which threatens serious damage to human welfare in the United Kingdom or in a Part or region'. Calamities such as pandemic influenza were expressly considered during debates. That occurrence qualifies as threatening 'human welfare only if it involves, causes, or may cause' one or more of a series of outcomes under section 19(2). At least three of the items set out in that list arise from COVID-19: 'loss of human life'; 'human illness or injury'; and 'disruption of services relating to health'. Several other threats to 'human welfare' are also

64 The latest edition was published in 2017: National Risk Register of Civil Emergencies (Cabinet Office 2017).

65 See Joint Committee on the Draft Civil Contingencies Bill, *Draft Civil Contingencies Bill* (2002–03 HL 184/HC 1074).

66 Part 1 already requires what the National Audit Office has called for in terms of coordination and the development of 'playbooks': *Initial Learning from the Government's Response to COVID 19* (2021–22 HC 66).

67 HC Deb 23 March 2020, vol 674, cols 118–119, David Davis.

relevant. In short, COVID-19 is a qualifying 'emergency'. This finding underscores the point that appropriate legislation was already in place to address the COVID-19 crisis without resort to an entirely new and hastily enacted emergency framework such as the CA 2020.

Under section 20, 'emergency regulations' can be issued when the further conditions of section 21 are 'satisfied' in the mind of the executive officers, subject to a declaration of necessity, appropriateness, proportionality, and compliance with human rights. Section 21 reiterates that the issuance of regulations requires an emergency to be taking place, or to be about to occur, and that it is necessary 'to make provision for the purposes of preventing, controlling or mitigating an aspect or effect of the emergency'. Existing legislation must be unsuitable or considered potentially ineffective. Section 23 repeats the criteria of appropriateness and proportionality, adds the need for geographical limitation, and specifies other specific curtailments: no forced military service, no banning of industrial strikes, no new indictable offences or changes to criminal procedures, and no amendments to the CCA 2004 or to the Human Rights Act 1998. Overall, the UK Government back in 2004 emphasised the notion of a 'triple lock' – that restraints will be imposed on emergency regulations by reference to seriousness, necessity and geographical proportionality.[68] These 'locks' are not adequately explained and have to be drawn together from sections 19 (seriousness) and sections 21 and 23 (necessity and geographic proportionality).[69] Thus, proportionality is explained just in geographical terms. The test is baldly stated when an emergency is declared (section 20(5(b)) and when the regulations are issued (section 23(1)(b)), but not when the regulations are applied.[70] Likewise, the condition of necessity is left unelaborated, save in section 21(5) and (6) where emergency regulations are not needed if the 'same' as existing legislation which can deal with crisis, such as terrorism legislation, unless the choice of existing legislation would result in serious delay or ineffectiveness. The House of Lords Select Committee on the Constitution depicted section 21(5) as a 'significant barrier' to the use of the CCA 2004.[71] However, this view underestimates the value of the 'triple lock' as a barrier to excessive reactions and fails to note that no minister has claimed that section 21(5) blocked the use of the CCA 2004. Arguably, amongst more pressing general problems,[72] is that there is no express requirement of

68 See Draft Civil Contingencies Bill Consultation Document (Cabinet Office 2003) para 19.

69 For discussion, see Walker and Broderick (n 1 above) 5.02.

70 Compare: Anti-terrorism, Crime and Security Act 2001, ss 17 and 19; Regulation of Investigatory Powers Act 2000, ss 5, 22, 23, 28, 29, 32, 49, 51, 55 and 73–75.

71 House of Lords Select Committee on the Constitution (n 58 above) para 214.

72 Joint Committee on the Draft Civil Contingencies Bill (n 65 above) para 38.

objectivity in any of the tests – the minister is allowed to use powers on the basis of satisfaction without the qualification of reasonableness, a standard which is notorious for encouraging unfounded intrusions into liberties as illustrated by wartime detention powers.[73]

Subject to these criteria and limits, section 22 provides that emergency regulations can 'make provision of any kind that could be made by Act of Parliament or by the exercise of the Royal Prerogative'. The list of potential uses – which itself is not exhaustive – is sweeping. As a result, the potential coverage of the CCA 2004 is far broader than competing legislation and less susceptible to challenge than the CA 2020 or the PHA 1984. It could even grant powers to the military such as to override normal traffic management schemes in order to facilitate operations such as disease testing stations or deliveries of vaccinations.[74] The only possible obstacle to its operation in the circumstances of the COVID-19 emergency is that CCA 2004 regulations are not permitted to 'alter procedure in relation to criminal proceedings' (section 23(4)(d)), whereas the CA 2020 (section 53 and schedule 23) allows live video links in court proceedings, including in criminal cases. But this obstacle to the use of the CCA 2004 was never mentioned in the parliamentary debates and surely could have been overcome by simple primary legislation. Aside from this drawback, neither the declaration of emergency under the CCA 2004 nor the potential list of regulations necessarily demands the further, and politically distasteful, issuance of a derogation notice under article 4 of the International Covenant on Civil and Political Rights or article 15 of the European Convention on Human Rights (ECHR). Derogation is not inevitable[75] but depends on the impacts on human rights of invoked regulations. Unlike some other countries,[76] the UK Government has asserted that its COVID-19 legislation to date is compatible with human rights.[77] Bearing in mind the qualified nature of most human rights in this context, an assessment will be considered later in this article. But the CCA 2004 includes superior oversight safeguards (to be described

73 See *Liversidge v Anderson* [1942] AC 206.

74 A COVID Support Force was placed in readiness in March 2020, and by 13 November 2020, there were 2342 military personnel assisting with 42 open Military Aid to Civilian Authority requests: 'COVID Support Force: the MOD's continued contribution to the coronavirus response' (Ministry of Defence, 21 May 2021). See House of Commons Defence Committee, *Manpower or Mindset: Defence's Contribution to the UK's Pandemic Response* (2019–21 HC 357).

75 See Council of Europe, *Respecting Democracy, Rule of Law and Human Rights in the Framework of the COVID-19 Sanitary Crisis: A Toolkit for Member States* (SG/Inf(2020)11, Strasbourg, 2020).

76 See Council of Europe, 'Notifications under Article 15 of the Convention in the context of the COVID-19 pandemic'.

77 See Memorandum to the Joint Committee on Human Rights (n 22 above).

next) and is thus better positioned than other legislative platforms to ensure it is invoked only 'to the extent strictly required by the exigencies of the situation' as required by international law. Some authors have advocated derogation as a way of marking out the legislation as special and temporary so that it does not become 'normalised'.[78] However, the history of derogation in Northern Ireland shows that derogation itself can too easily become normalised and entrenched as a parallel system without evident expiry date; furthermore, even if successfully challenged, the emergency contents will be quickly distilled into the 'normal' legal system.[79] So, better safeguards can be maintained by legislation which avoids the use of permissive derogations, works within boundaries which do not trigger derogation, and so sets careful limits to permissible boundaries of law even in an emergency. The CCA 2004 and, to a lesser extent, the Terrorism Act 2000 are fine exemplars of such an approach.

The CCA 2004 excels compared to its COVID-19 legislative rivals because it better avoids the disdain which they show for constitutionalism. By comparison, precautions in the CCA 2004 against excessive usage or a lingering life are far more extensive and effective. They include (section 26) that each emergency regulation remains in force for a maximum of 30 days (though a new regulation can then be issued). In debates on the CA 2020, the government minister dismissed that timeframe as too short,[80] but it is relatively short precisely to ensure unremitting public accountability which is proportionate to the extent and duration of the emergency powers being invoked.

Regulations under the CCA 2004 must be laid before Parliament 'as soon as is reasonably practicable' (section 27); if each House has not expressly approved a regulation within seven days, it falls, and Parliament can also later by resolution annul or amend a regulation. If Parliament is prorogued or the Commons or Lords adjourned when a regulation is issued and would be unable to consider it, the Monarch or the relevant Speakers, respectively, must reconvene the sitting (section 28). A less powerful, but still notable, prerequisite is that the UK Government must 'consult' with the devolved executives in Scotland, Wales and Northern Ireland, unless obviated by pressing

78 Alan Greene, 'Derogating from the European Convention on Human Rights in response to the coronavirus pandemic: if not now, when?' [2020] European Human Rights Law Review 262; Kanstantsin Dzehtsiarou, 'Article 15 derogations: are they really necessary during the COVID-19 pandemic?' [2020] European Human Rights Law Review 359; Alan Greene, 'On the value of derogations from the European Convention on Human Rights in response to the COVID-19 pandemic: a rejoinder' [2020] European Human Rights Law Review 526; Alan Greene, *Emergency Powers in Time of Pandemic* (Bristol University Press 2021).

79 See Clive Walker, *Terrorism and the Law* (Oxford University Press 2011) ch 1.

80 HC Debs 23 March 2020, vol 674, col 132, Penny Mordaunt.

circumstances (section 29). This consultation is important since social, economic and even legal circumstances can differ from England. Emergency regulations are to be treated as 'subordinate legislation' under the Human Rights Act 1998, even if 'they amend primary legislation' (section 30). Thus, a court can annul a regulation if found incompatible with the ECHR, thereby going beyond a mere declaration of incompatibility.[81] The present UK Government's election manifesto 2019[82] expressed distaste for the Human Rights Act and, beyond that, the powers of judges by way of judicial review.[83] This suggests that another reason for avoiding the CCA 2004 was to preclude more vigorous oversight via these mechanisms.

As well as parliamentary oversight mechanisms, the CCA 2004, section 24,[84] requires the appointment of 'emergency coordinators' for Northern Ireland, Scotland and Wales, and 'regional nominated coordinators' for each region of England. The objective is to facilitate coordination of activities under the emergency regulations. The officials are subject to directions and guidance by ministers but in turn can override local authorities. Their absence increases the risk of a national emergency response that prioritises some regions (such as London and the south-east) over others, political opposition (or opportunism) by devolved or local politicians and a lack of audit over whether emergency responses are being evenly or adequately undertaken across the land. One might argue that the disagreements between Westminster and local mayors over the terms of lockdown (especially in Manchester in October 2020)[85] might have been less contentious and more constructive if the more consistent approach provided for by the CCA 2004 had applied.

Are there any arguments or features in the CCA 2004 which have ruled out its use aside from the fears of political (in)convenience? Several arguments have been voiced by the UK Government.

First, the Leader of the House (Jacob Rees-Mogg) expressed the view that a known risk could not become an 'emergency':

> Unfortunately, the Civil Contingencies Act would not have worked in these circumstances, because the problem was known about early

81 See Human Rights Act 1998, ss 3 and 4.

82 Conservative and Unionist Party Manifesto 2019, 48.

83 See 'Independent review of administrative law' (pending) (Ministry of Justice, 31 July 2020).

84 Note also the CCA 2004, s 25, provided for expert consultation regarding the setting-up of tribunals, but this mechanism was abolished as part of a more general 'bonfire of the quangos' by the Public Bodies (Abolition of Administrative Justice and Tribunals Council) Order 2013, SI 2013/2042.

85 Mike Kane MP argued that 'Not since the Peterloo massacre of 1819 has the state displayed such coercive power over the people of Greater Manchester.' HC Deb 21 October 2020, vol 682, col 1093.

> enough for it not to qualify as an emergency under the terms of that Act. The legal experts say that if we can introduce emergency legislation, we should do so rather than using the Civil Contingencies Act, because if we have time to introduce emergency legislation, we obviously knew about it long enough in advance for the Act not to apply. That is why that Act could not be used.[86]

This assertion appears to be mistaken because it automatically rules out the CCA 2004's application to any pandemic or other emergency where the danger emerges and grows. There is no rule in the CCA 2004 against the foreseeability of a crisis. If the causes of emergency can only be wholly unpredictable, then why would the CCA 2004 encourage so much time and money to be spent on planning and resilience in part 1?

A second reason for the UK Government's marginalisation of the CCA 2004 is its 'triple lock' feature, as acknowledged by Prime Minister Boris Johnson on 2 November 2020:

> As for the legal basis, the Civil Contingencies Act has a strict test known as the triple lock that must be met before emergency regulations under the Act can be made. One of these tests is that there must not be existing powers elsewhere, and the Public Health Act 1984 offers clear powers to impose restrictions on public health grounds. That is why … the Public Health Act is the more appropriate route.[87]

In response, it might be again noted that the CCA 2004 does not have a binary set of tests under the triple lock, and section 21(5) and (6) in particular ask whether other powers would be 'sufficiently effective' within the test of necessity (as discussed previously). So, without wishing to deny the role of the triple lock as a mechanism which encourages restraint and preference for sectoral legislation,[88] it should not be seen as automatically demanding or justifying a shift to any alternative legislation (such as the PHA 1984). That legislation can cover some of the same ground but patently contains shortcomings which could have been avoided or minimised through use of the CCA 2004. The key advantages of the CCA 2004 remain: clear and comprehensive powers; uniformity of application; and enhanced restraints and accountability. No other legal source can match these attributes – certainly not the PHA 1984.

A third argument against the CCA 2004 was offered in response to the Joint Committee on Human Rights' report, *The Government's Response to Covid-19: Human Rights Responses* (discussed further later in this article).[89] Once again, the CCA 2004 is depicted as 'a last resort, where it is not possible to take conventional or accelerated primary legislation through Parliament, and thereby to allow

86 HC Deb 19 March 2020, vol 673, col 1188.
87 HC Deb 2 November 2020, vol 683, col 45.
88 Joint Committee on the Draft Civil Contingencies Bill (n 65 above) app 9, q 1.
89 (2019–21 HC 265/HL 125); *Government Response* (CP 335, 2020).

Parliamentary scrutiny before measures pass into law'. As argued above, the CCA 2004 should not be understood as a binary choice or as a complete 'panacea',[90] but that Act does allow more involvement by Parliament, especially at the start of the emergency when panic often lowers the parliamentary guard. Conversely, the implication that the PHA 1984 regulations are 'conventional' and allow superior scrutiny should be rejected.

The CCA 2004 is designed to cope with disruptions to constitutional order and everyday life beyond the capabilities of its rivals, thereby avoiding further primary legislation and legal challenges. Overall, the CCA 2004 represents a carefully debated and designed legislative code which has stood the test of time. A Civil Contingencies Act Enhancement Programme review was commenced in 2011,[91] but the conclusion of the *Report of the Post Implementation Review of the Civil Contingencies Act (2004) (Contingency Planning) Regulations 2005* in 2017 was that no major change was required.[92] Part 1 of the legislation has prompted considerable and much improved planning and resilience efforts, and the fact that part 2 had never been invoked was a reflection of the success of part 1 as well as of the effective safeguards written into part 2. Perhaps the only doubts about part 2 relate to the absence of express powers to detain without trial[93] or to force relocation.[94] In practice, these uncertainties (and one cannot be sure that section 22 forbids the grant of such powers) can be overcome by the grant of powers of direction backed by arrest and a summary offence.

Now that a truly severe and widespread emergency has undoubtedly arisen, the UK Government has shirked from the appropriate invocation of part 2. This failure may relate to a lack of capacity or prioritisation in the Cabinet Office, the Civil Contingencies Secretariat of which should provide the central hub of emergency management but has

90 House of Lords Select Committee on the Constitution (n 58 above) para 40.

91 See *Policy Paper: Civil Contingencies Act Enhancement Programme – Programme Initiation Document* (Cabinet Office 2011).

92 See *Report of the Post Implementation Review of the Civil Contingencies Act (2004) (Contingency Planning) Regulations 2005*. Note that the defunct Health Protection Agency was replaced as a First Responder by the Secretary of State for Health: Health and Social Care Act 2012, s 306(4), sch 7, para 16.

93 The Bill's sponsors refused to rule out detention without trial: Walker and Broderick (n 1 above) para 5.26.

94 The lack of a clear power was noted in connection with the Toddbrook Reservoir (Whaley Bridge) incident in 2019: David Balmforth, *Toddbrook Reservoir Independent Review Report* (DEFRA 2020). The Floods and Water Management Act 2010, s 33 and sch 4, provides for reservoir owners to prepare flood plans.

been missing in action in terms of clear coordination and messaging.[95] Perhaps there has been some hollowing out of its authority both downwards through devolution and sideways by the growth of the powerful Environment Agency which has 10,000 staff compared to just under 100 within the Cabinet Office's Civil Contingencies Secretariat.[96] These administrative and legislative failures in central government were arguably compounded by the political desire to avoid more stringent oversight and accountability by the resort to more malleable powers under the PHA 1984 and the CA 2020.

CONSEQUENCES OF CHOICE OF THE LEGISLATIVE PLATFORM

The choice between the CA 2020, the PHA 1984 and the CCA 2004 is not merely a decision about the formal, legislative basis of COVID-response measures. This part of the article analyses the legislative options according to substantive criteria in order to draw out their respective strengths and weaknesses.

Sectoral versus general emergency legislation

The contention that constitutional safeguards have been neglected might be mitigated if the PHA 1984 or CA 2020 could be depicted as specialist 'sectoral' legislation rather than 'emergency' legislation. This line of argument was made by the New Zealand Law Commission in its *First Report on Emergencies* of 1990 and *Final Report on Emergencies* in 1991.[97] The Commission recommended that emergency powers should, whenever possible, be conferred by 'sectoral legislation' – legislation deliberated upon and designed in advance of the emergency and tailored to the specific needs of each kind of emergency.

If a 'sectoral' approach can be properly adopted, then the full majesty of the CCA 2004 would not be required, and well-tailored public health legislation could instead apply. Indeed, more targeted legislation could meet more precisely the public health needs of society and avoid disproportionality and the tainting of other spheres. However, the

95 See Guidance: Preparation and Planning for Emergencies (Cabinet Office, 20 February 2013). Note also the disbandment of the Threats, Hazards, Resilience and Contingency Committee: 'Boris Johnson scrapped Cabinet Pandemic Committee six months before coronavirus hit UK' (*Telegraph Online*, 13 June 2020). For institutional reforms, see Aidan Shilson-Thomas et al, *A State of Preparedness* (Reform UK, 2021).

96 Hansard (House of Commons) UIN 207215, 17 January 2019.

97 *Report No 12: First Report on Emergencies* (New Zealand Law Commission 1990) 11. See also *Report No 22: Final Report on Emergencies* (New Zealand Law Commission 1991).

PHA 1984 and the CA 2020 cannot truly be categorised as 'sectoral legislation', and certainly not well-tailored sectoral legislation, because they lack at least four essential features.

First, sectoral legislation should be limited to a 'sector'. The advantage is that the relevant sector stakeholders and even the public can be engaged in the shaping and running of the legislation. There is no legal definition of a 'sector', but some idea of the meaning can be derived from the definition of 'critical national infrastructure(s)' which picks out 13 'sectors'.[98] The CA 2020 covers multiple sectors and embodies no mechanisms to engage with affected sectors.

The second beneficial feature of sectoral legislation is time to consider, debate and consult. Following on from the last point, sectoral legislation can be properly considered in advance in debates and subsequently in implementation. It follows the usual public and parliamentary timetable for debate (not a fast-track) and can utilise the usual structures for implementation (consultative and advisory bodies, draft proposals). For their part, the CA 2020 and the PHA 1984 regulations afforded almost no time to consider, debate and consult.

The third feature of sectoral legislation might be termed 'WYSIWYG': 'What you see is what you get.' The details of what is to be achieved in law are set out largely on the face of the sectoral legislation and do not await implementation by regulations which are even less amenable to scrutiny. In this aspect, the CA 2020 sets out ample details in its hundreds of pages but still embodies some very broad regulation-making powers, especially section 50 (power to suspend port operations), section 51 (powers relating to potentially infectious persons), section 52 (powers to issue directions relating to events, gatherings and premises), section 61 (power to postpone certain other elections and referendums) and section 62 (recalls), section 88 (power to suspend and revive provisions of this Act) and section 90 (power to alter expiry date). Much modern legislation contains broad regulation-making powers, but the collection here is not confined to one sector, and many expansive powers affect the general public rather than one sector.

The fourth feature which sectoral legislation should reflect is oversight. Post-legislative oversight in the context of a given sector is likely to be superior to omnibus legislation as it can be specialist and targeted. Yet, the PHA 1984 and CA 2020 both fail since they embody weak mechanisms, even compared to the comprehensive CCA 2004.

98 Chemicals, civil nuclear communications, defence, emergency services, energy, finance, food, government, health, space, transport, and water: 'Critical National Infrastructure' (Centre for the Protection of National Infrastructure, 20 April 2021).

Levels of oversight and accountability

Sectoral legislation should take advantage of its narrower focus by enhancing scrutiny in making, usage and duration. However, the precautions in the CA 2020 and PHA 1984 are much weaker than those specified for the CCA 2004.[99] The results are reflected in poor quality legislation, confusion between guidance and law, lack of consultation and debate, and an absence of criteria for making assessments. The inability of ministers to answer 'basic questions' has been condemned as 'lamentable and unacceptable' by the House of Commons Public Administration and Constitutional Affairs Committee.[100]

These defects were exacerbated by the failure of Parliament to adapt, especially in the early months, to the circumstances of crisis.[101] Though the House of Commons Committee on Procedure has now considered various issues around adapting to the pandemic, especially remote participation by members,[102] it took several months after March 2020 for numbers to return to the Commons Chamber and for the Select Committee to get to grips with the emergency. Certainly, the level of parliamentary attendance during passage of the CA 2020 and the main PHA 1984 regulations and in the early months of the pandemic was abysmal.[103] In May 2020, the House of Lords established the COVID-19 Committee to consider the long-term implications of the COVID-19 pandemic on the economic and social wellbeing of the UK in a way which can cut across the departmental-based structure of the

99 See Ronan Cormacain, *Rule of Law Monitoring of Legislation – Coronavirus Bill* (Bingham Centre 2020); Sandhurst and Speaight (n 61 above); and Brandreth and Sandhurst (n 61 above).

100 See *Government Transparency and Accountability during COVID-19* (2019–21 HC 803) para 143.

101 See *Parliaments and the Pandemic* (Study of Parliament Group 2021).

102 See *Procedure under Coronavirus Restrictions: Proposals for Remote Participation* (2019–21 HC 300); *Procedure under Coronavirus Restrictions: Remote Voting in Divisions* (2019–21 HC 335); *Procedure under Coronavirus Restrictions: The Government's Proposal to Discontinue Remote Participation* (2019–21 HC 392); *Government Responses* (2019–21 HC 565).

103 The House of Commons Commission (Decision of 16 April 2020) paved the way for remote attendance but did not change the rules as to quorum. The rules were implemented at HC Deb 21 April 2020, vol 675, col 2, and remained in place until 30 March 2021: House of Commons Chamber proceedings during the COVID-19 pandemic. For the rules in wartime, see Jennifer Tanfield, *In Parliament 1939-50* (House of Commons Library 20, 1991). For foreign legislatures, see Elizabeth Bloomer (ed), *Continuity of Legislative Activities during Emergency Situations* (Library of Congress 2020).

House of Commons.[104] However, Parliament has still not seen fit to insist upon other augmented oversight, unlike, say, the Independent Reviewer of Terrorism Legislation.[105]

The performance of Parliament on scrutinising the detail of the COVID-19 secondary legislation also leaves much to be desired.[106] It has been estimated that, as at 16 November 2020, 294 pandemic-related regulations had been made: 205 were subject to the 'negative' procedure; 75 were subject to the 'affirmative' procedure (but 67 were made using the urgent power under the PHA 1984, so making them more akin to a negative type); 13 were subject to the 'draft affirmative' procedure; and one was simply 'laid'; 41 came into effect before they were laid before Parliament.[107] Most regulations are made under the PHA 1984, part 2A, under the negative procedure; just 17 fall under the Coronavirus Act 2020. It almost goes without saying that consultation exercises with the general public and expert authorities about regulatory designs have been virtually non-existent. A challenge on these grounds to the Adoption and Children (Coronavirus) Amendment Regulations 2020, which amended protection systems around timescales, contacts and visits in social care, prevailed on appeal in *R (Article 39) v Secretary of State for Education*.[108] The Secretary of State had acted unlawfully by failing to consult the Children's Commissioner and other bodies representing the rights of children in care before introducing the regulations having regard to the vulnerability of children in care and the expertise of the Children's Commissioner (which surpassed the local authorities which were consulted).

Parliament has been slow to address its abnegation of responsibility. Eventually, at the six-month renewal debate, the Speaker, Lindsey Hoyle, made clear his dissatisfaction:

> The way in which the Government have exercised their powers to make secondary legislation during this crisis has been totally unsatisfactory. All too often, important statutory instruments have been published a matter of hours before they come into force, and some explanations why important measures have come into effect before they can be laid before this House have been unconvincing; this shows a total disregard for the House.

104 House of Lords Select Committee on COVID-19: the Committee published its first report in April 2021, *Beyond Digital: Planning for a Hybrid World* (2019–21 HL 263). See also Scottish Parliament COVID-19 Committee, *Legacy Report* (SP 1010, 2021).

105 See Nina Malik, *Leaving Lockdown: The Impact of COVID-19 on Civil Liberties and National Security in the UK and US* (Henry Jackson Society 2020) 13.

106 See also Keith Ewing, 'Covid-19: government by Decree' (2020) 31 Kings Law Journal 1.

107 See Hansard Society, Coronavirus Statutory Instruments Dashboard.

108 [2020] EWCA Civ 1577.

> The Government must make greater efforts to prepare measures more quickly, so that this House can debate and decide upon the most significant measures at the earliest possible point.[109]

In response, the Secretary of State for Health and Social Care promised in September 2020, with manifest loopholes, that

> ... for significant national measures with effect in the whole of England or UK-wide, we will consult Parliament; wherever possible, we will hold votes before such regulations come into force. But of course, responding to the virus means that the Government must act with speed when required, and we cannot hold up urgent regulations that are needed to control the virus and save lives. I am sure that no Member of this House would want to limit the Government's ability to take emergency action in the national interest, as we did in March.[110]

Next, some institutional formations have emerged during the pandemic, with the potential for imposing independent scrutiny, but their roles and designs have not been the subject of debate or legislation in Parliament. One prominent example comprises experts appointed to advise the UK Government who form the Scientific Advisory Group for Emergencies (SAGE) (plus various sub-groups) which feeds into the Cabinet Office emergency planning structures.[111] SAGE was activated to provide scientific advice on the H1N1 (swine flu) pandemic in 2009 and has been revived on seven occasions before COVID-19. Criticisms have related to the selection of members and also other attendees, transparency (which has improved over time through the disclosure of members and minutes) and the nature of subsequent relationships between collective scientific advice and ministerial decisions.[112] Another important structure has been the Joint Biosecurity Centre which was announced in May 2020 to provide a threat assessment: 'A new UK-wide joint biosecurity centre will measure our progress with a five stage COVID alert system.'[113] The idea derived from the

109 HC Deb 30 September 2020, vol 681, col 331.

110 Ibid cols 388–389, Matthew Hancock.

111 Scientific Advisory Group for Emergencies. See *Enhanced SAGE Guidance: A Strategic Framework for the Scientific Advisory Group for Emergencies (SAGE)* (Cabinet Office 2012); Lawrence Freedman, 'Scientific advice at a time of emergency: SAGE and Covid-19' (2020) 91 Political Quarterly 514.

112 See House of Commons Science and Technology Committee, *Scientific Advice and Evidence in Emergencies* (2010–11 HC 498); Cabinet Office (n 111 above); Nyasha Weinberg and Claudia Pagliari, 'Covid-19 reveals the need to review the transparency and independence of scientific advice' (*UK Constitutional Law Blog*, 15 June 2020).

113 HC Deb 11 May 2020, vol 676, col 24, Boris Johnson. For geographical alert levels applied through regulations, see Health Protection (Coronavirus, Local COVID-19 Alert Level) (England) Regulations 2020, SI 2021/1103 (Medium), 1104 (High), 1105 (Very High).

Joint Terrorism Assessment Centre which sets alert levels in regard to terrorism and draws strength from being multidisciplinary and independent. Whether the new centre can attain similar advantages and can produce unassailable advice free from political influences cannot yet be gauged.[114]

By contrast, some institutions under part 1 of the CCA 2004 have been put into operation and function under clear rules. Thus, Local Resilience Forums have remained in force to handle implementation and coordination, and there are Strategic Coordinating Groups and Tactical Coordination Groups at this level.[115] However, without prime reliance on the CCA 2004, there arise overlapping responsibilities and powers, with other structures (such as local mayors and enterprising Members of Parliament) becoming much more prominent. Furthermore, some of the expected planning and state of readiness within the Cabinet Office, on which the CCA 2004 vitally depends, has been far from evident or satisfactory.[116] Devolved administrations have also complained about the lack of coordination including through Cabinet Office Briefing Rooms (COBR) meetings.[117]

The periodic reviews of the legislation have also been perfunctory. The two-monthly reports have been largely confined to plotting the issuance and usage of powers without evaluation.[118] Renewal of the CA 2020 in September 2020 involved the publication of a slightly fuller 'analysis' document (which was in reality factual rather than evaluative)[119] and a 90-minute debate.[120] Another substantial, mainly factual review was issued in February 2021.[121] The Scottish reviews likewise involve the laying of a report every two months and full renewal after six months under sections 12 and 15 of the Scottish

114 Any system must also overcome the considerable amount of disinformation published about COVID: House of Commons Digital, Culture, Media and Sport Committee, *Misinformation in the COVID-19 Infodemic* (2019–21 HC 234).

115 See *Emergency Response Structures during the COVID-19 Pandemic* (Local Government Association 2020).

116 See House of Commons Public Accounts Committee, *Whole of Government Response to COVID-19* (2019–21 HC 404).

117 See House of Commons Scottish Affairs Committee, *Coronavirus and Scotland: Interim Report on Intergovernmental Working* (2019–21 HC 314).

118 See *Two Monthly Report on the Status on the Non-devolved Provisions of the Coronavirus Act 2020* (CP 243, May 2020; CP 282, July 2020; CP 298, September 2020; CP 334 December 2020).

119 *The Coronavirus Act Analysis* (CP 295 2020).

120 HC Deb 30 September 2020, vol 681, col 388.

121 HM Government, *Covid-19 Response* (CP 398, 2021).

Act, but the relevant reports have conveyed markedly more detail and evaluation.[122]

A comprehensive independent review was announced by the Prime Minister in May 2021.[123] It will take place under the Inquiries Act 2005, but its work will not even commence until spring 2022, by which time one might predict that over 130,000 deaths will have occurred and around £450 billion in public funds will have been expended.

Effectiveness

As suggested by the Hansard Society,[124] problems ensuing from an inadequate legislative superstructure include: rapid amendment, repeat amendment and revocation arising from poor quality of drafting and misconceptions, technical errors and omissions. Unclear powers also increase the risk of arbitrary or inconsistent application and are more susceptible to legal challenge.

One illustration is the powers relating to lockdowns with restraints on physical movement outside one's place of abode. Controversially, the restraints have been applied to the whole population under the PHA 1984 regulations rather than just applying to those who are infected or suspected to be infected or even more at risk ('Clinically Extremely Vulnerable').[125] The extent of these legal powers, and their variance from accompanying guidance,[126] has caused confusion, the vacating of convictions, and the need to revise and reissue regulations.[127] Thus, according to the Crown Prosecution Service in May 2020: 'All 44 cases under the Act were found to have been incorrectly charged because there was no evidence they covered potentially infectious people, which

122 Scottish Government, *The Coronavirus Acts: Two-Monthly Report to Scottish Parliament* (SG/2020/92; SG/2020/130; SG/2020/186; SG/2020/248; SG/2021/13; SG/2021/52; SG/2021/114). For evaluation, see Pablo G Hidalgo, Fiona de Londras and Daniella Lock, 'Parliamentary scrutiny of extending emergency measures in the two Scottish Coronavirus Acts' (*UK Constitutional Law Blog*, 21 June 2021).

123 HC Deb 12 May 2021, vol, 695, col 137.

124 See Hansard Society (n 107 above). See also Ronan Cormacain and Ittai Bar-Siman-Tov, 'Legislatures in the time of Covid-19' (2020) 8(1–2) Theory and Practice of Legislation 3–9.

125 Compare 'Can we be forced to stay at home?' (David Anderson QC, 2020); Jeff King, 'The lockdown is lawful' (*UK Constitutional Law Association*, 1 April 2020); National Audit Office, *Protecting and Supporting the Clinically Extremely Vulnerable during Lockdown* (2019–21 HC 1131).

126 See House of Commons Home Affairs Committee, *Home Office Preparedness for Covid-19 (Coronavirus): Policing* (2019–21 HC 232) para 7.

127 See the case of Marie Dinou: Jennifer Brown, *Coronavirus: The Lockdown Laws* (House of Commons Library Briefing Paper 8875, 2020) 8: 28 editions have been issued between March and June 2021, reflecting frequent changes in regulations.

is what this law is intended for.'[128] Resulting problems for the police have been mitigated by the sensible compliance of the public and the calming down of police approaches.[129] The latter, as represented by the College of Policing, have sensibly engaged in a policy of the relegation of coercion to the last step in line with the mantra, 'Engage, Explain, Encourage, Enforce'.[130] Thus, just 24,933 notices were issued between 27 March and 16 November 2020 compared to 'hundreds of thousands of COVID-19 related incidents',[131] though the £10,000 fixed penalty notice for large gathering has proven controversial because of frequent successful challenges.[132]

Unity and consistency of purpose in dealing with a universal pandemic is better tackled by national legislation which avoids or at least minimises jurisdictional confusion and special local pleading. For instance, the rules as to multiple tiers of restraint and the catalogue of measures within them have varied between different jurisdictions of the UK for reasons which have nothing to do with Scottish, Welsh or Irish mutations in the virus, other factual differences, or even distinct legal systems but are attributable to variant policy choices.[133] These localised versions tended to get worse rather than better after around May 2020.[134] For example, Scottish legislation was passed in autumn 2020 to add restrictions on leaving or entering Scotland, and these were then imposed to restrict travel to areas of north-west England, even though they were largely unenforceable and even though parts of

128 'CPS announces review findings for first 200 cases under coronavirus laws' (Crown Prosecution Service, 15 May 2020). The failure rate has continued to be very high: 'February's coronavirus review findings' (Crown Prosecution Service, 22 March 2021).

129 The Chief Constable of Northamptonshire had threatened to set up roadblocks and search shopping trolleys for 'non-essentials': John Simpson et al, 'Coronavirus: police chief forced to back down after threat to search shopping' *The Times* (London, 10 April 2020).

130 COVID-19 Policing Brief in Response to Health Protection Regulations (College of Policing 2020). The document has been replaced by 'Understanding the law'.

131 *Policing the Pandemic* (National Police Chiefs' Council 2020) and 'Fixed penalty notices issued under COVID-19 emergency health regulations by police forces in England and Wales' (National Police Chiefs' Council, 30 November 2020).

132 See Jennifer Brown, *Coronavirus: Enforcing Restrictions* (House of Commons Library Briefing Paper 9024, 2020) 13.

133 Compare: Health Protection (Coronavirus, Restrictions) (All Tiers) (England) Regulations 2020, SI 2020/1374; Health Protection (Coronavirus) (Restrictions and Requirements) (Local Levels) (Scotland) Regulations 2020, SSI 2020/344. Wales and Northern Ireland currently operate unitary restrictions: Health Protection (Coronavirus Restrictions and Functions of Local Authorities) (Amendment) (Wales) Regulations 2020, SI 2020/1409; Health Protection (Coronavirus, Restrictions) (No 2) Regulations (Northern Ireland) 2020 and Amendment Nos 15 and 17, NISR 2020/150, 256 and 287.

134 House of Lords Select Committee on the Constitution (n 58 above) paras 98, 117.

Scotland had worse infection rates.[135] In addition, localised inputs and controls can tempt local politicians into decisions or behaviour which appears to show partiality, such as the attendance by Northern Ireland ministers at the funeral of Bobby Storey on 30 June 2020 in potential breach of regulations about large gatherings,[136] though allegations of favouritism have also arisen at a national level in connection with the award of contracts for the supply of goods and services[137] or the non-prosecution of government adviser Dominic Cummings.[138] The assertion of the primacy of devolved administrations in public health affairs only makes sense if one views the COVID-19 pandemic as a localised emergency and as a public health emergency. In reality, neither boundary is accurate or makes sense. The pandemic is international and, while arising from health causes, has impacts well beyond that sector, with major impacts on individual liberties and social and economic life.

Arising out of the jurisdictional confusion created by a sectoral public health approach, which then draws in devolved administrations, many of the first 200 convictions under the PHA 1984 had to be set aside: 'Errors usually involved Welsh regulations being applied in England or vice versa.'[139] Even the House of Commons Scottish Affairs Committee has expressed concern about jurisdictional divergence when dealing with exactly the same problems and wonders how Scottish interests might fit alongside institutions such as Cabinet Office structures like the COBR and the Joint Biosecurity Centre.[140]

The problems of approaching a global pandemic through devolved administrations can be further illustrated through the performance of federal constitutions. An instructive case-study might be the United

135 See Health Protection (Coronavirus) (Restrictions and Requirements) (Local Levels) (Scotland) Regulations 2020, SSI 2020/344, sch 7A, as amended by SSI 2020/389, SSI 2021/193, 211, 242 and 262; Alex Massie and Claire Elliot, 'Scots' maladies laid bare in Dundee, the Covid capital of Europe' *Sunday Times* (London, 11 July 2021) 19.

136 *An Inspection into the Police Service of Northern Ireland's handling of the Bobby Storey funeral on 30 June 2020* (HM Inspectorate of Constabulary and Fire and Rescue Services, 17 May 2021); 'PPS upholds decisions not to prosecute any individual in connection with Storey funeral' (Public Prosecution Service Northern Ireland, 10 June 2021).

137 See *R (Good Law Project) v Secretary of State for Health and Social Care* [2021] EWHC 346 (Admin); *Good Law Project v Minister for the Cabinet Office* [2021] EWHC 1569 (TCC).

138 *Redston v DPP* [2020] EWHC 2962 (Admin).

139 Crown Prosecution Service (n 128 above).

140 Scottish Affairs Committee (n 117 above). See Gareth Evans, 'Devolution and COVID-19' [2021] Public Law 19.

States (US),[141] where the policy under President Trump during 2020 was to treat the COVID-19 crisis as a matter mainly for state responsibility, whereas President Biden in 2021 has adopted much stronger centralised federal direction through his National Strategy of January 2021 and a raft of Executive Orders.[142] As in many aspects of this transition, controversy abounds as to which President has been more successful, and the invention of vaccines has been a transformative intervening event. In addition, many US states are powerful polities and able to fend for themselves. However, a national approach seems to have brought advantages, including scaling counter-measures to fit the emergency, which is national and requires comprehensive mobilisation, reducing the possibility of conflicting and competing disparate approaches, better ensuring equality of treatment, and gaining efficiency of operations through scale.

Protecting individual rights

Emergencies have the tendency to interfere with protected rights, but at least the CCA 2004 foresaw that danger and put in place explicit and effective limits. By contrast, the CA 2020 pays little special heed to the protection of rights. Its impacts, such as on the rights to run businesses and to travel abroad,[143] have stirred much opposition. As already described, based mainly on powers in the PHA 1984, part 2A, a variety of intrusions into individual rights have been imposed. Those relating to the justice system have already been considered. Some rights in other contexts will be examined here.

First and foremost, the initial lockdown measures made it an offence to leave one's residence without 'reasonable excuse'.[144] According to the ECHR, article 5(1)(e), no one can be deprived of liberty, though preventing the spread of infectious disease is a specified exception.[145]

141 See John F Witt, *American Contagions* (Yale University Press 2020); Elizabeth Goiten, 'Emergency powers, real and imagined: how President Trump used and failed to use presidential authority in the COVID-19 crisis' (2020) 11 Journal of National Security Law and Policy 27; Emily Berman, 'The roles of the state and federal governments in a pandemic' (2020) 11 Journal of National Security Law and Policy 61; James G Hodge Jr, 'Nationalizing public health emergency legal responses' (2021) 49 Journal of Law, Medicine and Ethics 315.

142 President of the United States, *National Strategy for the COVID 19 Response and Pandemic Preparedness* (2021) followed by Executive Order 13987 and many others.

143 The restrictions on travel abroad emerged in June 2020 when track and trace systems were considered more effective to monitor the restrictions. See Health Protection (Coronavirus, International Travel) (England) Regulations 2020, SI 2020/568, and 2021, SI 2021/582; House of Lords Secondary Legislation Scrutiny Committee, *37th Report* (2019–21 HL 189).

144 Health Protection (Coronavirus, Restrictions) (England) Regulations 2020, SI 2020/350, r 2(4)(a), 6.

145 See *Enhorn v Sweden* App no 56529/00, [2005] 19 BHRC 222 [43].

Much initial academic debate concerned whether lockdown measures actually amounted to a potential restriction on liberty or a lesser restriction on freedom of movement (which is not ratified by the UK).[146] Though the courts confirmed the latter stance,[147] it is clear that liberty in a general or colloquial sense is at stake. The article 8 privacy right has also been affected in numerous ways, such as by prohibiting individuals from different households from physically meeting,[148] and infringed 'family life' and wider relationships, both of which are protected by article 8.[149] The lockdown also entailed closing buildings for religious worship,[150] impacting upon the right to freedom of religion covered by article 9. The article 11 right to peaceful assembly and association was also restricted by initial lockdown measures that prohibited gatherings of more than two people[151] and provided police with enforcement powers to break up prohibited gatherings and issue fines.[152] Yet, such restrictions did not prevent the emergence of all protests across the political spectrum from those directly opposing lockdown measures to those advocating 'Black Lives Matter'.[153] Indeed, article 5, 8, 9 and 11 violations have been argued (albeit unsuccessfully) in the English legal challenges to date, along with the protocol 1 rights to property and education, which have been impacted by business restrictions[154] and school closures[155] respectively.

Second, the need to protect human life has been frequently relied upon by the UK Government when justifying its lockdown measures. Yet, the state has a positive obligation to uphold article 2.[156] In the health context,

146 See Dominic Keene, 'Leviathan challenged – the lockdown is compliant with human rights law (part two)' (*UK Human Rights Blog*, 11 May 2020).

147 *R (Dolan) v Secretary of State for Health & Social Care* [2020] EWCA Civ 1605 [92]–[94]. See also *Terkeş v Romania* App no 49933/20, 20 May 2021.

148 Health Protection (Coronavirus, Restrictions) (England) Regulations 2020, SI 2020/350, r 7.

149 *Mostaquim v Belgium* App no 12313/86, (1991) 13 EHRR 802 [36], [45]–[46]; *Marckx v Belgium* App no 6833/74, (1979) 2 EHRR 330 [45]; *Bensaid v UK* App no 44599/98, (2001)33 EHRR 205 [47]; *Niemietz v Germany* App no 13710/88, (1992) 16 EHRR 97 [29].

150 Health Protection (Coronavirus, Restrictions) (England) Regulations 2020, SI 2020/350, rr 5(5), 6(1), 7.

151 Ibid r 7.

152 Ibid rr 7, 8, 10.

153 'Coronavirus: inside the UK's biggest anti-lockdown protest' (*Independent Online*, 16 May 2020); 'Black Lives Matter protests held across England' (*BBC Online*, 20 June 2020).

154 Health Protection (Coronavirus, Restrictions) (England) Regulations 2020, SI 2020/350, rr 4, 5, 9.

155 See House of Commons Public Accounts Committee, *COVID-19: Support for Children's Education* (2021–22 HC 240).

156 *Osman v United Kingdom* App no 23452/94, (1998) 29 EHRR 245 [115]–[116].

the systemic failure to secure the proper organisation and functioning of the public hospital service, or its health protection system, amounted to a violation of article 2 when patients had died in cases involving Turkey[157] and Portugal,[158] and this doctrine has been recognised, albeit narrowly, by the English courts.[159] With COVID-19, attention turned to, for example, the shortages in personal protective equipment (PPE) for key NHS and care home workers[160] and the absence of safeguarding procedures governing the transfer of patients from hospitals to care homes.[161] Academic commentators have suggested that such controversial failures might invite article 2-based challenges.[162] Finally, the article 14 right to protection from discrimination could arise from the same areas of inadequate health practices and systems because of the widely reported differential impact of COVID-19 responses upon certain groups, particularly women, black and minority ethnic and disabled people.[163] In January 2021, the parliamentary Women and Equalities Select Committee concluded that governmental economic support schemes had 'overlooked labour market and caring inequalities faced by women' and that the Government's priorities for recovery are 'heavily gendered in nature'.[164]

As this brief account demonstrates, such is the range of fundamental rights affected by the UK's lockdown that it is perhaps simpler to catalogue *un*affected rights. This breadth of engaged rights is merely a legal reflection of the obvious fact that COVID-19 responses have radically changed our lives and world, for the time-being at least. With such extraordinary and pervasive impacts, the imperative to ensure

157 *Asiye Genç v Turkey* App no 24109/07, 27 January 2015; *Aydoğdu v Turkey* App no 40448/06, 30 August 2016. See also *Mehmet Şentürk and Bekir Şentürk v Turkey* App no 13423/09, 9 April 2013; *Center of Legal Resources on behalf of Valentin Câmpeanu v Romania* App no 47848/08, 17 July 2014.

158 *Fernandes v Portugal*, App no 56080/13, 19 December 2017.

159 *R (Parkinson) v HM Coroner for Kent* [2018] EWHC 1501 (Admin); *R (Maguire) v HM Senior Coroner for Blackpool* [2020] EWCA Civ 738.

160 House of Commons Public Accounts Committee, *NHS Capital Expenditure and Financial Management* (2019–21 HC 344).

161 The National Audit Office confirmed that 25,000 patients were discharged into care homes without testing: *Readying the NHS and Adult Social Care in England for COVID-19* (2019–2021 HC 367) paras 3.19–3.20. See *As If Expendable* (Amnesty International 2020).

162 Ed Bates, 'Article 2 ECHR's positive obligations – how can human rights law inform the protection of health care personnel and vulnerable patients in the Covid-19 pandemic?' (*OpinioJuris*, 1 April 2020); Conall Mallory, 'The right to life and personal protective equipment' (*UK Constitutional Law Association*, 21 April 2020); Shaheen Rahman, 'Article 2 and the provision of healthcare' (*UK Human Rights Blog*, 19 November 2020).

163 'COVID-19: understanding the impact on BAME communities' (Public Health England, 16 June 2020).

164 *Unequal Impact? Coronavirus and the Gendered Economic Impact* (2019–21 HC 385).

high-quality policy and decision-making, even in such challenging circumstances, is vital. Therefore, close attention should be paid to the overall performance of Parliament and the courts.

As for Parliament, a critical assessment has already been offered in this article, and, for most of the time since March 2020, the performance of Parliament has been sorely wanting. There is, however, an important postscript in the field of human rights since the Joint Committee on Human Rights released in November 2020 an important report, *The Government's Response to Covid-19: Human Rights Responses*.[165] Many of the issues covered in this article were rehearsed.[166] Overall, the Committee bemoaned the decision not to invest greater reliance on the CCA 2004 which has better safeguards for rights.[167]

As for the courts, most challenges have failed. Even when an objection is sustained, such as the arguments in the *Good Law Project* cases against the processes adopted for the award of PPE and communications research contracts, no mandatory order was granted and criticism was expressed about the joining of claimants for political purposes.[168] Likewise, a narrow interpretative approach avoided a breach of the absolute right to liberty under article 5 in *R (Francis) v Secretary of State for Health & Social Care*.[169] On the one hand, the High Court found that the legal powers under the PHA 1984, section 45G, could impose self-isolation for a specified period after a positive test (including of close contacts). On the other hand, it was an equally crucial finding that this imposition of confinement did not amount to detention (which would require an order from a justice of the peace under section 45D followed by clinical management), but was restraint on movement not amounting to quarantine. In this way, an Englishman's home is not necessarily his prison hospital, but only because the court defined the boundaries of detention as not including a home curfew if unaccompanied by other restraints.[170]

Most other rights affected by COVID-19 legislation are qualified not absolute, and so account must be taken of the variable intensity of the standard of proportionality[171] and the margin of appreciation which

165 2019–21 HC 265/HL 125; see also Government Response (CP 335, 2020).

166 2019–21 HC 265/HL 125 paras 203–216.

167 Ibid para 222.

168 *R (Good Law Project) v Secretary of State for Health and Social Care* [2021] EWHC 346 (Admin); *Good Law Project v Minister for the Cabinet Office* [2021] EWHC 1569 (TCC).

169 [2020] EWHC 3287 (Admin). See Health Protection (Coronavirus, Restrictions) (Self Isolation) (England) Regulations 2020, SI 2020/1045.

170 Ibid [64]. Compare: *Secretary of State for the Home Department v JJ* [2007] UKSC 45.

171 See *R (Daly) v Secretary of State for the Home Department* [2001] UKHL 26; *Bank Mellat v HM Treasury (No 2)* [2013] UKSC 39.

the ECHR affords to national authorities.[172] Domestically, two factors determine the intensity of proportionality review. First, democratic legitimacy is commonly cited by reviewing judges as a reason to afford greater latitude to executives, especially where measures entail complex or sensitive political judgments.[173] The polycentricity of the problem can be a further warning signal against judicial intervention,[174] perhaps more so nowadays than the political interest in the topic.[175] A second crucial factor determining the intensity of judicial scrutiny is expertise,[176] whereby judicial deference is justified because the decision-maker enjoys specific expertise and responsibility.[177] Such 'epistemic deference' is adopted by the courts where an issue is beset with empirical uncertainty, and it covers both the underlying scientific or similar evidence used by government and, crucially, how government chooses to use such data to inform policy.[178]

The implications of COVID-19 restrictions have been considered in the context of qualified rights in two key English cases:[179] *R (Dolan) v Secretary of State for Health & Social Care*[180] and *R (Hussein) v Secretary of State for Health & Social Care*.[181] The deferential approach in both of these English cases can be contrasted with that of the later Scottish decision in *Reverend William Philip & Others*.[182]

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172 *Handyside v United Kingdom* App no 5493/72 (1979) 1 EHRR 737, [48]–[49].

173 *Secretary of State for the Home Department v Rehman* [2001] UKHL 47; *R (Gentle) v Prime Minister* [2008] UKHL 20. See Rebecca Moosavian, 'Judges and high prerogative: the enduring influence of expertise and legal purity' [2012] Public Law 724.

174 *R (Mott) v Environment Agency* [2016] EWCA Civ 564.

175 *Miller v Prime Minister* [2019] UKSC 41 [39].

176 *R (Huang) v Home Secretary* [2007] UKHL 11 [16].

177 Alan Brady, *Proportionality and Deference under the Human Rights Act* (Cambridge University Press 2012) 113, 117, 67–69.

178 Ibid.

179 For leading jurisprudence elsewhere, see: (Australia) *Palmer v Western Australia* [2021] HCA 5; (France) *Association Civitas, Conseil d'Etat* 446930, 29 November 2020, *Syndicat Jeunes Médecins*, Conseil d'Etat 439674, 22 March 2020; (Germany) *T* (1 BvR 828/20) (15 April 2020); *M* (1 BvQ 37/20) (17 April 2020), *F* (1BBQ 44/20) (29 April 2020); (Ireland) *O'Doherty & Waters v Minster for Health, Ireland* [2020] IECA 59; (Israel) *Ben Meir v Prime Minister* (2020) HCJ 2109/20, *Loewenthal v Prime Minister* (2020) HCJ 2435/20; (Netherlands) *Stichting Viruswaarheid.nl* ECLI:NL:GHDHA:2021:285; (New Zealand) *Borrowdale v Director-General of Health* [2020] NZHC 2090; (South Africa) *De Beer v Minister of Co-operative Government & Traditional Affairs* (2020) High Court of South Africa 21542/2020; (USA) *South Bay Pentecostal Church v Newsom* 592 US ____ (2021), *Tandon v Newson* 593 US ____ (2021).

180 [2020] EWHC 1786 and [2020] EWCA Civ 1605.

181 [2020] EWHC 1392.

182 *Reverend Dr William Philip for Judicial Review of the Closure of Places of Worship in Scotland* [2021] CSOH 32.

Democratic legitimacy was referred to in *Dolan*, an application for judicial review of the lockdown measures on grounds including their alleged violation of a wide range of human rights. At first instance, Lewis J claimed that the appropriateness of the lockdown measures was a political issue more suitable for public debate than judges:

> The role of the court in judicial review is concerned with resolving questions of law. The court is not responsible for making political, social, or economic choices. The court is not responsible for determining how best to respond to the risks to public health posed by the emergence of a novel coronavirus. Those decisions, and those choices, are ones that Parliament has entrusted to ministers and other public bodies.[183]

Lewis J also alluded to polycentricity by mentioning the mix of political, social and economic factors that inform public health policy choices. The exceptional circumstances of COVID-19 were viewed as a factor complicating the public health aims of the lockdown regulations, arguably making them more unsuitable for judicial determination:

> Against that background, it is simply unarguable that the decision [to impose restrictions via the Regulations] … was in any way disproportionate to the aim of combatting the threat to public health posed.[184]

Yet, this categorical claim should be treated with circumspection, not least because it problematically suggests that proportionality review is potentially rendered weakest when the human rights stakes are highest, as in the coronavirus situation. Such deference to government amounts to *de facto* immunity for all but the most extreme policies, resulting in identical outcomes to the blanket immunity for high policy areas associated with prerogative powers that courts have long abandoned.[185]

The *Dolan* challenge expressly questioned the scientific evidence used by the UK Government to justify lockdown measures, especially the data from Professor Neil Ferguson, including lack of peer review, modelling assumptions and the author's incorrect predictions in previous pandemics.[186] Yet, Lewis J did not refer to these arguments in his judgment and paid limited attention to the Government's evidential base for lockdown measures because:

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183 *R (Dolan) v Secretary of State for Health & Social Care* [2020] EWHC 1786 [7], [5].

184 Ibid [61].

185 Moosavian (n 173 above) 745–746.

186 'Statement of Facts and Grounds and Written Submissions of the Claimant' [89], [123]. A flavour of these allegations was considered in the later appeal: *R (Dolan) v Secretary of State for Health & Social Care* [2020] EWCA Civ 1605 [82].

> The courts recognise the legitimacy of according a degree of discretion to a minister 'under the urgent pressure of events, to take decisions which call for the evaluation of scientific evidence and advice as to the public health risks'.[187]

This attitude prevailed in the circumstances of gaps or shortcomings in the current science:

> ... the context ... was one of a pandemic where a highly infectious disease capable of causing death was spreading. ... The scientific understanding of this novel coronavirus was limited.[188]

The Court of Appeal in *Dolan* was markedly even less indulgent towards the expansive agenda of the claimants and indeed criticised the practice of 'rolling' and 'evolving' judicial review by which new issues or arguments were added as the case went along.[189] The court engaged in detail only with the first ground of appeal (*ultra vires*) and viewed the remaining two (breach of public law principles and breach of human rights) as being out of time.[190] The Court of Appeal found that the PHA 1984 powers allowed for responses to pandemics to impose restrictions on the whole population.[191] Many of the deferential signals voiced in the High Court were echoed here, encapsulated as follows: 'This was quintessentially a matter of political judgement for the Government, which is accountable to Parliament, and is not suited to determination by the courts.'[192]

The severe risk and time pressures of the COVID-19 situation were also noted in the earlier case of *Hussein*. Here, the claimant sought an interim order prohibiting enforcement of the regulations on the basis they represented a disproportionate interference with the article 9 right to religion by preventing Friday prayer at mosques during Ramadan. Swift J claimed the virus represented 'a genuine and present danger' and noted the 'truly exceptional circumstances, the like of which has not been experienced in the UK for more than half a century'.[193]

Proportionality was raised in *Hussein*, wherein the claimant argued that the Health Secretary could have taken less intrusive lockdown

187 *R (Dolan) v Secretary of State for Health & Social Care* [2020] EWHC 1786 [59].

188 Ibid [95].

189 *R (Dolan) v Secretary of State for Health & Social Care* [2020] EWCA Civ 1605 [118].

190 Ibid [42].

191 Ibid [65], [68], [71], [78].

192 Ibid [90]. *Dolan* was also cited in the more specific circumstances of a plan to hold a vigil for murder victim Sarah Everard: *Leigh v Commissioner of the Metropolis* [2021] EWHC 661 (Admin).

193 *R (Hussein) v Secretary of State for Health & Social Care* [2020] EWHC 1392 [19].

measures so as to enable mosque attendance with appropriate social-distancing measures still in place.[194] Dismissing this argument in brief terms, Swift J claimed that the minister must be allowed a 'suitable margin of appreciation to decide the order in which steps are to be taken to reduce the reach and impact of the restrictions in the 2020 Regulations'. This leeway regarding the means by which public health could be maintained was necessary due to the complex (polycentric) political, social and economic assessments involved. It was thus deemed a matter for political debate rather than judicial 'second-guessing'.[195]

Swift J also noted that 'consideration of scientific advice' was part of the complex mix of political and other elements that informed what steps the minister would take.[196] He found that the regulations were rationally connected to the legitimate aim of protecting public health by reducing opportunities for people to gather and mix; they '[rest] on scientific advice ... that the COVID-19 virus is highly contagious and particularly easily spread in gatherings of people indoors'.[197] However, Swift J did not undertake sustained scrutiny of the Health Secretary's justifications. He noted that the minister's submissions regarding this application were 'generic', but nevertheless deemed them 'likely to be sufficient' and confirmed they amounted to a 'valid response'.[198]

By way of comment, though a degree of deference to central government is defensible in the context of a health crisis,[199] there are two problems with the approach adopted in these cases. First, it creates an uneven playing field, making it almost impossible for claimants to challenge government in certain areas (such as public health emergencies) even where they can point to credible evidence to support their arguments. *De facto* non-justiciability is no more desirable than the *de jure* non-justiciability which has been curtailed in recent times. Second, refusal to undertake a full, intensive human rights proportionality review represented a missed opportunity to require the Government to provide more detailed reasons and evidence to justify its regulations and its scientific claims.

The approach of Lord Braid in the Scottish case of *Reverend William Philip and Others* – a similar article 9-based challenge to that in *Hussein* – represents an illuminating alternative approach.

194 Ibid [20]
195 Ibid [21]
196 Ibid [21]
197 Ibid [19]
198 Ibid [26].
199 There may be less deference to local government, shown in *Hertfordshire County Council v Secretary of State for Housing* [2021] EWHC 1093 (Admin), whereby online council meetings were not permitted after the expiration of regulations. Company meetings may be remote under the Corporate Insolvency and Governance Act 2020, s 37 and sch 14.

Philip demonstrates that courts do have the capacity to take a more robust level of review, even during a pandemic when considerations of expertise and democratic legitimacy are pertinent. Rather than relying on such factors to restrain inquiries, Lord Braid undertook a detailed and carefully reasoned application of the four-stage proportionality test. He closely examined the surface logic of the Scottish Government's justifications and statistics (without questioning the scientific evidence *per se*). Issues such as the severity of the public health threat and the political nature of the Government's decision were incorporated into the proportionality test as weighted factors rather than brick walls. Braid also afforded countervailing weight to the petitioners' arguments, including the particular importance of the article 9 right, the inadequacy of alternative online worship and the availability of low-risk alternatives to a blanket closure of Scottish places of worship.[200] As a result, the court concluded that this closure in the January 2021 lockdown was a disproportionate and unlawful violation of the petitioners' article 9 rights.[201]

Especially in the light of this outlier decision, the leeway afforded by proportionality enables a range of rights-compliant COVID-19 restrictive measures to be devised and applied. Future and ongoing constraints may also be anticipated, especially around the compulsory application of vaccines[202] or proof of COVID immunity as a condition of services or employment.[203] Though the response to the pandemic will inevitably severely limit human rights, it should by no means make them redundant. The English COVID-19 cases demonstrate that the judges are clearly not keen to usurp the functions of Parliament and so place the onus of scrutiny on others. The woeful performance of Parliament to date is therefore a particular disappointment. If reliance is to be placed on the political limbs of the state for fair and effective policy, Parliament must become more active in interrogating policy and upholding individual rights.

200 *Reverend Dr William Philip for Judicial Review of the Closure of Places of Worship in Scotland* [2021] CSOH 32 [101]–[126].

201 For more detailed discussion, see Rebecca Moosavian, Clive Walker and Andrew Blick, 'Proportionality in a pandemic: the limitations of human rights' (forthcoming).

202 Compulsory vaccination of children was upheld in *Vavricka v Czech Republic* App no 47621/13, 4 April 2021.

203 See Department of Health and Social Care, *COVID Status Certification Review* (Cabinet Office, 29 March 2021).

CONCLUSION

A severe and prolonged public health emergency has arisen because of COVID-19, such as to shake the foundations of international[204] and national lives. Legislative responses should be comprehensive and even unpalatable. But whether the PHA 1984 and the CA 2020 offer the best medicine can be disputed. These models of emergency legislation contradict the wishes of Parliament's better self, as represented by the CCA 2004, and contradict the considered warnings of the House of Lords Select Committee on the Constitution in its report, *Fast-Track Legislation: Constitutional Implications and Safeguards*.[205] Like special legislation against terrorism,[206] it has proven an uphill struggle to control the coronavirus state. The advent of effective vaccines from the beginning of 2021 onwards[207] has given governments the opportunity to curtail the COVID restrictions, but the mechanisms to ensure proportionality in the path to recovery remain weak.

The CCA 2004 should have been selected to play a central role in the national crisis, especially at its commencement, in preference to the more rushed, less certain and less accountable alternatives.[208] Thereafter, more permanent sectoral laws should be designed for the lengthier recovery stages.[209] Otherwise, the current legislative models stand testament to official panic and form part of the problem rather than the solution. As the UK Government's COVID-response to date has demonstrated, disregard of constitutionalism increases the risks of pursuing untested and flawed policies, diminishing democracy and weakening fundamental human rights. Such consequences should not be added to COVID-19's already catastrophic legacy.

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204 UNSCR 2532 (1 July 2020) called for the cessation of all hostilities (with exceptions). See Maurizio Acari, 'Some thoughts in the aftermath of Security Council Resolution 2532 (2020) on Covid-19' (2020) 70 Questions of International Law 59. For other international law obligations, see Antonio Coco, '"Prevent, respond, cooperate states" due diligence duties vis-à-vis the Covid-19 pandemic' (2020) 11 Journal of International Humanitarian Legal Studies 218; Independent Panel for Pandemic Preparedness and Response, *COVID-19: Make it the Last Pandemic* (World Health Organization 2021).

205 See House of Lords Select Committee on the Constitution, *Fast-Track Legislation: Constitutional Implications and Safeguards* (2008–09 HL 116).

206 Clive Walker, *The Anti-Terrorism Legislation* (3rd edn, Oxford University Press 2014) ch 1.

207 This programme is national: 'Coronavirus vaccinations' (NHS Digital); 'COVID-19 vaccination programme' (Public Health England, 14 July 2021).

208 House of Lords Select Committee on the Constitution (n 58 above) paras 41, 48.

209 A model has been devised by Liberty, The Coronavirus (Rights and Support) Bill 2021.

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From special powers to legislating the lockdown: the Health Protection (Coronavirus, Restrictions) Regulations (Northern Ireland) 2020*

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ABSTRACT

The Health Protection (Coronavirus, Restrictions) Regulations (Northern Ireland) 2020 were made through temporarily inserted provisions by Westminster's vast and rushed Coronavirus Act 2020. This itself limits duties to notify deaths to the coroner, despite Article 2 European Convention on Human Rights duties being particularly relevant to deaths in care homes and of frontline workers. The regularly amended March 2020 Northern Ireland regulations have themselves raised 'legal certainty' issues. Until June, official websites carried no accessible information as to their scope. Initial concerns on lack of clarity over matters such as driving for exercise gave way to greater controversy regarding the application of the regulations to the Black Lives Matter protests on 6 June 2020 through Police Service of Northern Ireland powers that had only been extended through an eleventh hour amendment the night before. The enforcement powers themselves are so widely drafted that they are reminiscent of the Special Powers Acts of the past. These issues are explored in this article.

Keywords: COVID-19; emergency legislation; Northern Ireland; Health Protection (Coronavirus, Restrictions) Regulations (Northern Ireland) 2020; Special Powers Acts; Black Lives Matter; Common Travel Area; inquests.

INTRODUCTION

Northern Ireland (NI) is no stranger to emergency legislation. From the Special Powers Acts,[1] Troubles-era legislation,[2] the 'normalised'

* First published in NILQ 71.4 (2020) Winter: 537–555.

1 The Civil Authorities (Special Powers) Act (Northern Ireland) 1922 remained on the statute books for the lifetime of the Stormont Parliament. The legislation was repealed under direct rule (by the Northern Ireland (Emergency Provisions) Act 1973). For analysis on its operation see: Laura K Donohue, 'Regulating Northern Ireland: the Special Powers Acts 1922–1972' (1999) 41(4) Historical Journal 1089–1120.

2 Northern Ireland (Emergency Provisions) Act 1973. See also the Prevention of Terrorism (Temporary Provisions) Act 1974 and subsequent Acts.

and post-9-11 provisions,[3] and residual NI-specific measures,[4] such powers have been in place throughout its existence. The COVID-19 pandemic presents a different type of proposition in that urgent and quite different provisions are required to save lives in the context of a public health emergency that is unprecedented in living memory.

Like all emergency law, such provisions must be compatible with human rights obligations that require restrictions to be *inter alia* proportionate, time-bound and non-discriminatory. There is also the requirement of legal certainty (in essence, the rules must be clear). There are also positive obligations, including duties to safeguard vital socioeconomic well-being, but also the 'right to life' duties under European Convention on Human Rights (ECHR) Article 2. These require public authorities to take all reasonable steps to save lives and also encompass duties to investigate certain deaths to which acts or omissions of public authorities may have contributed. This duty is of particular importance in the context of the UK having reportedly surged to have the highest COVID-19 death toll in Europe,[5] raising the prospects of thousands of additional avoidable deaths having been resultant from high-level policy decisions, and the urgent need to 'learn lessons' before any future surge.

The UK government chose not to utilise the existing Civil Contingencies Act 2004 and instead rushed through Westminster the vast Coronavirus Act 2020. This Act contains NI-specific provision and also temporarily inserts a new section in the existing Stormont-era Public Health Act (Northern Ireland) 1967 (PHANI 1967), augmenting wide regulation-making powers. It is the modified PHANI 1967 that enables the Health Protection (Coronavirus, Restrictions) Regulations (Northern Ireland) 2020 (NI COVID-19 Regulations), which constitute the principle emergency provisions in this jurisdiction introduced in response to COVID-19. The original NI COVID-19 Regulations were made, laid before the Assembly and came into force on 28 March 2020.

Whilst measures restricting movement, assembly and liberty are necessary in the context of a deadly pandemic, the NI COVID-19 Regulations are not without their issues. The enforcement powers for

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3 The Terrorism Act 2000 provided permanent UK-wide provisions and replaced the Northern Ireland (Emergency Provisions) Act 1996 and the Prevention of Terrorism (Temporary Provisions) Act 1989. Post 2001, there were a further series of legislative provisions including: Anti-Terrorism, Crime and Security Act 2001; Terrorism Act 2006; Counter Terrorism Act 2008; Terrorist Asset Freezing etc Act 2010; Terrorism Prevention and Investigations Measures Act 2011; Protection of Freedoms Act 2012; and Counter Terrorism and Security Act 2015.

4 Justice and Security (Northern Ireland) Act 2007.

5 See Robert Booth and Pamela Duncan 'UK coronavirus death toll passes 50,000, official figures show' *The Guardian* (2 June 2020) citing research by Johns Hopkins University.

some regulations are so vague and arbitrary (providing that a 'relevant person may take such action as is necessary to enforce any requirement') they are reminiscent of the Special Powers Acts. Questions over legal certainty have also arisen. Initially, this concerned the extent the 'stay at home' rule permitted travel for exercise where initial Police Service of Northern Ireland (PSNI) statements were contradictory. In addition, there are issues with public dissemination and transparency, key conditions for the rule of law, since for several months there was no official public website where the restrictions under the NI COVID-19 Regulations were clearly set out. For the minority of the public who may be used to reading legislation, a consolidated version of the NI COVID-19 Regulations (which by 12 June 2020 had been amended six times) was also not available for some time. A brief period of legal limbo has also occurred between the announcement of certain changes and the law being duly altered. The problems this poses had been mitigated by a general policing response that had not been widely considered as heavy-handed. However, this changed in the context of the issuing of fines and other enforcement measures by the PSNI against Black Lives Matter anti-racism protests on Saturday 6 June 2020, making use of an extension of enforcement powers to outdoor gatherings, through an amendment to the NI COVID-19 Regulations that had only been made and commenced the night before.[6] Whilst at the time of writing the direction of travel is to ease the regulations as part of the Executive roadmap out of lockdown, restrictions may be reintroduced in response to any second wave, providing an opportunity for necessary modifications in the interim.

In June 2020 a new separate set of regulations was also made by the NI Department of Health to enforce a 14-day 'self-isolation' rule for persons returning to Northern Ireland from outside the (UK/Ireland) Common Travel Area (CTA).[7] The regulations, made on a Friday and commenced the following Monday with limited prior Assembly scrutiny, contain significant ambiguities, particularly in relation to re-entry over the land border.

This commentary explores these issues in detail. It does so by first considering the applicable human rights law framework, before moving to look at the initial moves to legislate on these islands in response to the pandemic, and finally turning specifically to examine the outworking of the Coronavirus Act 2020 and the NI COVID-19 Regulations, paying specific attention to some of the key vagaries.

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6 See 'Coronavirus: "Between 60 and 70" fines at anti-racism protests' *BBC News* (8 June 2020); and 'Laws restricting protest in Northern Ireland "unacceptable"' Press Statement (Amnesty International and CAJ, 8 June 2020).

7 The Health Protection (Coronavirus, International Travel) Regulations (Northern Ireland) 2020.

1 THE HUMAN RIGHTS LAW FRAMEWORK

The framework provided by human rights law shapes the legislative response to the pandemic through both providing for positive obligations and limitations on the extent rights can be restricted. This includes the ECHR, directly applicable in the courts by virtue of the Human Rights Act 1998.

The positive obligations include binding duties under Article 2 ECHR (right to life) on public authorities to take all reasonable steps to save lives. The parameters of such obligations can be shaped by related international standards, including those in UN instruments on the right to health[8] and World Health Organization standards. Significant questions have arisen regarding the initial UK divergence from such standards in areas such as case finding, contact tracing and testing, along with preventing COVID-19 in care homes.[9]

The UK having surged to Europe's reported highest COVID-19 death toll points to countless thousands of additional avoidable deaths having consequently resulted from acts or omissions of public authorities. Such a context engages a broader set of procedural ECHR Article 2 duties to ensure there are prompt, effective investigations, independent of those responsible, into certain deaths. Domestically, the coronial inquest system can provide such a mechanism, whereby, for example, the contribution of acts or omissions of public authorities to the death of a frontline worker, including those resultant from government policy, could both be the triggering factor requiring an inquest and shape the parameters of the matters it examines. There is also the broader role of public inquiries ensuring 'lessons learned' lead to non-recurrence of failings. The present legislative basis is, however, not without its problems, with the controversial Inquiries Act 2005

8 Including Article 12 (right to highest attainable standard of health) and other provisions (including Article 7(b) on rights to safe and healthy working conditions) under the UN International Covenant on Economic, Social and Cultural Rights (ICESCR).

9 For further discussion, see: 'Editorial: Covid-19: why is the UK government ignoring WHO's advice?' 368 *British Medical Journal* (30 March 2020); and written evidence to the UK Parliament from Dr Oliver Lewis (Barrister at Doughty Street Chambers, London, and Professor of Law and Social Justice at the School of Law, University of Leeds) and Dr Andrew Kirby (Associate Professor in Microbiology, School of Medicine, University of Leeds, UK) 'The UK government's guidance on combating coronavirus in care homes is inconsistent with WHO standards' (COV0043).

permitting ministerial interference at numerous stages of a public inquiry.[10]

A broader set of positive obligations on the state party include those to ensure the socioeconomic well-being of the population during the emergency.[11]

The second limb of human rights obligations relates to the extent rights can be restricted in an emergency. In general, many rights protected by the ECHR are themselves qualified and can be restricted in accordance with their own limitation clauses. These provide for restrictions which are proportionate in pursuit of a legitimate aim including 'health' and the right to life of others. Many of the measures introduced to contain a pandemic will by their nature restrict rights such as rights to freedom of movement, freedom of assembly, and detention without trial (eg for purposes of testing, treatment or precautionary quarantining).

The general principles around these measures are that restrictions on such rights should: be proportionate, only used for the purpose of containing the pandemic and not unlawful collateral purposes;[12] be time-bound for only as long is as necessary; be applied in a non-discriminatory manner; and afford 'legal certainty'. The legal certainty requirements mean the rules need to be clear and the consequences for non-compliance foreseeable (particularly when they invoke criminal sanctions) to ensure citizens and law enforcement personnel alike can regulate their conduct.

More sweeping interference in rights at the time of an emergency will require a temporary derogation from human rights obligations. Under Article 15 of the ECHR a contracting state party can derogate from most ECHR rights for an emergency threatening the life of the nation to the extent strictly required by the exigencies of the

10 The Inquiries Act 2005 was rushed through Parliament to replace all other statutory basis for a public inquiry on the back of the (still outstanding) commitment by the UK to hold a public inquiry into the death of Pat Finucane. For commentary, see *The Apparatus of Impunity?* (CAJ/Queen's University Belfast 2015).

11 For analysis of many of the issues, see Juan Pablo Bohoslavsky, 'COVID-19: urgent appeal for a human rights response to the economic recession' (UN Independent Expert on the effects of foreign debt and other related international financial obligations of States on the full enjoyment of all human rights, particularly economic, social and cultural rights, Geneva, 15 April 2020).

12 An example of the misuse of emergency-type powers for collateral (ie different) purposes, includes the current concerns regarding the use of counter-terrorism questioning powers in ports in the CTA for routine immigration control purposes. See BrexitLawNI, *Policy Report: Brexit, Border Controls and Free Movement* (Queen's University Belfast 2018) 23–24. The collateral use of a statutory power can be unlawful under UK law. See, for example, *R (CC) v Commissioner of Police of the Metropolis and Another* [2012] 1 WLR 1913.

situation.[13] A number of such derogations were made in respect of NI during the 'Troubles'. This can include ECHR rights such as rights to liberty and free assembly but does not extend to forced labour, torture, or measures that impinge on the right to life. The Council of Europe is to be notified of derogations. It is only a sovereign government that can apply for a derogation and not a devolved administration, or any other public authority. The latter scenario was highlighted early in the pandemic when Mr Justice Hayden in the England and Wales Court of Protection, dealing with the transfer of a person from a care home in the context of COVID-19, thought he could invoke a derogation from the ECHR on his own.[14]

The UK has not derogated from the ECHR in the context of the pandemic, and therefore all restrictions must be in conformity with the limitation clauses to ECHR rights. Internationally, human rights protection during states of emergency has remained a topic of key concern. The UN Special Rapporteur (UNSR) on counter terrorism and human rights, Fionnuala Ní Aoláin, produced a detailed report on human rights protection and states of emergency in 2018.[15] In March 2020, UNSRs and other UN Human Rights Experts urged states not to use COVID-19 emergency measures to suppress human rights.[16]

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13 ECHR Article 15 derogation in time of emergency:
'1. In time of war or other public emergency threatening the life of the nation any High Contracting Party may take measures derogating from its obligations under this Convention to the extent strictly required by the exigencies of the situation, provided that such measures are not inconsistent with its other obligations under international law.
2. No derogation from Article 2, except in respect of deaths resulting from lawful acts of war, or from Articles 3, 4 (paragraph 1) and 7 shall be made under this provision.
3. Any High Contracting Party availing itself of this right of derogation shall keep the Secretary General of the Council of Europe fully informed of the measures which it has taken and the reasons therefore. It shall also inform the Secretary General of the Council of Europe when such measures have ceased to operate and the provisions of the Convention are again being fully executed.

14 *BP v Surrey County Council & Another* [2020] EWCOP 17 (25 March 2020) cited in Stevie Martin, 'A domestic court's attempt to derogate from the ECHR on behalf of the United Kingdom: the implications of Covid-19 on judicial decision-making in the United Kingdom' (*Blog of European Journal of International Law*, 9 April 2020).

15 UN Doc A/HRC/37/52 'Report of the Special Rapporteur on the promotion and protection of human rights and fundamental freedoms while countering terrorism on the human rights challenge of states of emergency in the context of countering terrorism' (UN General Assembly 1 March 2018).

16 Office of the UN High Commissioner for Human Rights, 'COVID-19: States should not abuse emergency measures to suppress human rights – UN experts' (Geneva, 16 March 2020).

2 COVID-19: PANDEMIC TO ST PATRICK'S DAY – THE FIRST MOVES TO LEGISLATE

In the UK the first emergency regulations were laid at Westminster on 10 February 2020 and only applied to England.[17] The regulations were made under the English equivalent of the PHANI 1967 and as such relied on public health legislation and not the Civil Contingencies Act.[18] The regulations gave health professionals, and (strangely) the Secretary of State, powers to detain persons suspected of having COVID-19 for screening, assessment and isolation (quarantine). The regulations also provide police officers with powers to enforce detention and detain persons who abscond from detention. The UK government stated at the time that it might formalise the regulations across the devolved administrations with the introduction of a Coronavirus Bill.[19]

It was March before these regulations were accompanied by others elsewhere on these islands. St Patrick's Day (17 March) was a particularly busy day. In Scotland, the Health Minister placed the National Health Service (NHS) on an emergency footing, citing powers under section 1 and section 78 of the NHS (Scotland) Act 1978.[20] In Wales, regulations (similar to those in England) were laid before the Welsh Assembly.[21] The Irish Cabinet also approved the Health (Preservation and Protection and other Emergency Measures in the Public Interest) Bill 2020. This Bill covered a number of social protection measures, extra powers to restrict public events and travel, and further powers for medical professionals to detain and isolate potentially infected persons.[22]

Substantive emergency legislation was not progressed in NI at this time. There were a number of ministerial statements from the Health Minister Robin Swann MLA.[23] This included announcing on Monday 2 March 2020 that PHANI 1967 had been amended to include COVID-19 under the list of notifiable (infectious) diseases. In addition, the NI health visitor regulations were amended to include 'Coronavirus

17 Health Protection (Coronavirus) Regulations 2020: see Department of Health and Social Care 'Secretary of State makes new regulations on coronavirus' (10 February 2020). For a critique see Jim Duffy, 'Corona-vires: has the Government exceeded its powers?' (*UK Human Rights Blog*, 13 February 2020).

18 Section 45R of the Public Health (Control of Disease) Act 1984 (chapter 22).

19 HL Deb 9 March 2020, vol 802, cols 426–7GC.

20 Scottish Government, 'Coronavirus (COVID-19): speech by Cabinet Secretary for Health and Sport' (17 March 2020).

21 Health Protection (Coronavirus) (Wales) Regulations 2020 SR 2020/308 (W 68).

22 Irish Government, 'Government approves legislation to support national response to COVID-19' (17 March 2020). The Bill passed through Dáil Éireann then the Seanad on 19 and 20 March 2020 respectively.

23 Department of Health, 'DoH ministerial announcements and statements 2020'.

Disease (COVID-19)' under the list of diseases for which no charges can be levied against any person for NHS treatment.[24] This means persons who are not 'ordinarily resident' in NI (and hence classed as 'visitors'), including migrants who find themselves in an irregular immigration situation (possibly due to loss of employment because of the pandemic) can avail themselves of free treatment for COVID-19.

Other 'positive action' measures have also been legislated for. The Communities Minister Deirdre Hargey MLA brought in a new Discretionary Support Grant for living expenses due to Coronavirus and pushed through legislation to limit evictions to prevent homelessness during the crisis – extending the notice to quit from one to three months.[25] There are still some gaps in social protection for migrants due to the Home Office 'no recourse to public funds' rules.

A week on from St Patrick's Day and the initiation of a *de facto* lockdown in NI (as for example, many schools had closed their doors), the NI Assembly debated and passed a Legislative Consent Motion to what would become the Coronavirus Act 2020.[26]

3 THE CORONAVIRUS ACT 2020

Rather than relying on the existing regulation-making powers in the Civil Contingencies Act the British government instead fast-tracked hefty new primary legislation: a move that has not gone without criticism.[27] What would become the 359-page Coronavirus Act was introduced into Westminster on 19 March 2020 and was law a week later. As set out in one critique by Professor Clive Walker and Dr Andrew Blick:

> Rather than turning to the laws already in place to handle crises like the pandemic, Parliament fast-tracked the Coronavirus Act 2020 ... with scant debate of its shabbily drafted contents over just seven days toward the end of March. Parliament then vanished into recess for four weeks. In addition, the government installed without any scrutiny in any form regulations under the [England] PHA [Public Health Act] 1984.[28]

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24 Provision of Health Services to Persons Not Ordinarily Resident (Amendment) Regulations (Northern Ireland) 2020 NISR 2020/25.

25 Private Tenancies (Coronavirus Modifications) Act (Northern Ireland) 2020 (chapter 2).

26 Northern Ireland Assembly (24 March 2020) Legislative Consent Motion: Coronavirus Bill.

27 Andrew Blick and Clive Walker, 'Why did government not use the Civil Contingencies Act?' *Law Society Gazette* (London, 2 April 2020).

28 Clive Walker and Andrew Blick, 'Coronavirus legislative responses in the UK: regression to panic and disdain of constitutionalism' (*Just Security*, 2 May 2020).

One particular area of concern highlighted by these authors relates to duties around coronial inquests, with concerns raised that 'death certification and coronial interventions are short-circuited by section 18 by enabling a doctor to certify the cause of death without the death being referred to a coroner'.[29]

As alluded to earlier, the coronial inquest system provides a key mechanism whereby the state can discharge its procedural duties under ECHR Article 2 to ensure there are prompt, effective investigations, independent of those responsible, into certain deaths.
Section 18(3) (with reference to Part 3 of schedule 13 of the Act) modifies NI death registration and coronial legislation. The Coroners Act (Northern Ireland) 1959 places duties on medical practitioners, registrars, undertakers, cohabitees, or persons in charge of a residence where a deceased person was residing to notify the coroner of certain deaths. Normally, this includes deaths from illness and natural causes if a medical practitioner has not seen and treated the deceased within 28 days of their death. The Coronavirus Act, however, removes this requirement, meaning deaths attributed to natural causes, where the deceased has not been seen by a doctor, no longer have to be notified to the coroner.[30]

This means, despite the duties under Article 2 ECHR, that deaths in which acts or omissions of public authorities are a factor (including through a failure to regulate private sector providers) may no longer need to be referred to the coroner for investigation. This would include removing the obligation to notify from the owners of care homes where a resident has died from suspected COVID-19 without seeing a doctor in which issues relating to their care and circumstances may have played a part.

By contrast, in Scotland on 13 May 2020 the Lord Advocate James Wolffe QC instructed that deaths in the following categories be reported to the procurator fiscal (the Scottish equivalent of a coroner):

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29 Ibid.

30 Section 7 of the Coroners Act (Northern Ireland) 1959 (chapter 15).
'7 [Words* in s. 7 omitted (temp.) (26.3.2020) by virtue of Coronavirus Act 2020 (c. 7), Sch. 13 para. 26]: Duty to give information to coroner: Every medical practitioner, registrar of deaths or funeral undertaker and every occupier of a house or mobile dwelling and every person in charge of any institution or premises in which a deceased person was residing, who has reason to believe that the deceased person died, either directly or indirectly, as a result of violence or misadventure or by unfair means, or as a result of negligence or misconduct or malpractice on the part of others, or from any cause other than natural illness or disease [*for which he had been seen and treated by a registered medical practitioner within twenty-eight days prior to his death], or in such circumstances as may require investigation (including death as the result of the administration of an anaesthetic), shall immediately notify the coroner within whose district the body of such deceased person is of the facts and circumstances relating to the death.

- all Covid-19 or presumed Covid-19 deaths where the deceased might have contracted the virus in the course of their employment or occupation.
- all Covid-19 or presumed Covid-19 deaths where the deceased was resident in a care home when the virus was contracted.[31]

The issue of inquests into deaths from COVID-19, particularly of frontline NHS staff, further became controversial following guidance issued in April by the Chief Coroner for England and Wales.[32] This guidance 'reminded' coroners that inquests were not the forum to address concerns 'about high-level government or public policy' and specifically told coroners not to look at provision of personal protective equipment (PPE) to NHS staff.[33] This led to the Committee on the Administration of Justice (CAJ) and other human rights organisations writing to the NI judiciary to raise concerns that such an approach was not compliant with ECHR Article 2 and seeking assurances that similar guidance would not be issued in NI. A prompt response was received from the Presiding Coroner, Mrs Justice Keegan, making clear 'there is no intention to issue guidance in this jurisdiction. Coroners in this jurisdiction will have discretion to investigate any death on a case-by-case basis, and will do so based on the individual merits of each case'.[34]

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31 Crown Office and Procurator Fiscal Office, 'Revised guidance on reporting of deaths during coronavirus outbreak' (15 May 2020).

32 Robert Booth, 'NHS staff coronavirus inquests told not to look at PPE shortages' *The Guardian* (London, 29 April 2020).

33 Chief Coroner HHJ Mark Lucraft QC, 'Guidance No 37 Covid-19 deaths and possible exposure in the workplace' (28 April 2020), paragraph 13.
'13. In the usual way, it is a matter of judgment for the individual coroner to decide on the scope of each investigation. The coroner must consider the question of scope in the context of providing evidence to answer the four statutory questions. Coroners are reminded that an inquest is not the right forum for addressing concerns about high-level government or public policy. The higher courts have repeatedly commented that a coroner's inquest is not usually the right forum for such issues of general policy to be resolved: see Scholes v SSHD [2006] HRLR 44 at [69]; R (Smith) v Oxfordshire Asst Deputy Coroner [2011] 1 AC 1 at [81]. In the latter case, Lord Phillips observed that an inquest could properly consider whether a soldier had died because a flak jacket had been pierced by a sniper's bullet, but would not "be a satisfactory tribunal for investigating whether more effective flak jackets could and should have been supplied by the Ministry of Defence." By the same reasoning, an inquest would not be a satisfactory means of deciding whether adequate general policies and arrangements were in place for provision of personal protective equipment (PPE) to healthcare workers in the country or a part of it.'

34 Correspondence from the Private Office of the Presiding Coroner to CAJ (4 May 2020).

The Coronavirus Act contains measures which are NI-specific.[35] These include (under section 51, schedule 21) powers for public health officers (but also police and immigration officers) to detain 'potentially infectious persons' for health screening and assessment; and under schedule 22 powers vested in the First Minister and Deputy First Minister to restrict events, gatherings and close premises. Significantly, the Coronavirus Act also makes major changes to the PHANI 1967, schedule 18, inserting temporarily a new Part 1A. This new part provides sweepingly broad regulation-making powers vested in the NI Department of Health. This includes powers in section 25B over international travel (medical examination, quarantining etc of passengers). Section 25C empowers regulations that place duties on medical professionals and requirements on matters such as keeping children off school, restrictions on events or gatherings and burials. Powers also extend to compelling medical examination or quarantining and the closure of premises.

Some safeguards are imposed on the regulation-making powers through sections 25D and 25E. Under section 25F the regulations may create new criminal offences. Under section 25P regulations are normally subject to prior Assembly scrutiny in draft followed by negative resolution, but an 'emergency procedure' under section 25Q enables passage without prior Assembly scrutiny when necessary 'for reasons of urgency'.

These regulation-making powers have become the basis of the main NI COVID-19 emergency regulations.

4 THE HEALTH PROTECTION (CORONAVIRUS, RESTRICTIONS) REGULATIONS (NORTHERN IRELAND) 2020

The Health Protection (Coronavirus, Restrictions) Regulations (Northern Ireland) 2020 (the NI COVID-19 Regulations) were made on 28 March 2020 by the Health Minister Robin Swann MLA using the PHANI 1967 powers augmented by the Coronavirus Act 2020. These regulations have to be reviewed every 21 days.

The first two regulations cover commencement, interpretation, the 'emergency period' and review process. Regulations 3 and 4 contain powers to close premises and businesses during the emergency. Notably, these powers are similar to those vested in the First Minister

35 The full range of powers and duties in the Coronavirus Act will not be set out in this commentary. The measures range from those to assist with the emergency registration provisions for medical and social work professionals to changing safeguards over surveillance powers.

and deputy First Minister in the Coronavirus Act (the latter of which were not then commenced, presumably given the duplication).

The two other substantive provisions in the original NI COVID-19 Regulations are regulation 5, which obliges persons not to leave home without reasonable excuse, and regulation 6, which restricts gatherings of more than two persons in a public place, with limited exceptions. Regulation 7 then covers enforcement powers, while regulation 8 deals with offences and penalties.[36] The following commentary will focus on regulations 5 and 6, given the human rights impact of these regulations on matters such as freedom of movement, freedom of assembly and rights to family life.

5 REGULATION 5: THE 'STAY AT HOME' DIRECTIVE

Regulation 5 stipulates you should not leave your home 'without reasonable excuse'. Around a dozen 'reasonable excuses' for leaving your normal place of residence were originally listed, but the list is not exhaustive. It includes leaving home to get food or medicine, for essential work, seeking medical assistance, to escape risk of harm (relevant to domestic abuse), to move children in shared care arrangements and so on.

Another permitted reason for leaving your home is 'to take exercise either alone or with other members of their household'. There was some initial contestation as to whether you could drive to a place to then take exercise. The regulations themselves do not provide further interpretation of the provision and in practice clarification was left to the PSNI as the enforcement body. There were, however, contradictory messages. The PSNI often follows National Police Chiefs' Council (NPCC) guidance. Media coverage clarified that NPCC guidance permitted driving a reasonable distance to do exercise.[37] On the same day this was publicised, the PSNI appeared to take a different line with a senior officer stating that 'anyone travelling from home for exercise *if they do not need to* is in breach of lockdown restrictions'.[38] *The Newsletter* reported that the PSNI in Carrickfergus went further by posting on Facebook 'Exercise begins and ends at your front door. By that I do not mean walking from your front door to your car to

36 Regulations 9–14 deal with fixed penalty notices for offences under the regulations and related enforcement procedures. Regulation 15 provides that the NI COVID-19 Regulations will expire within six months of coming into operation.

37 Jamie Grierson, 'Driving to take a walk is lawful during England lockdown, police told' *The Guardian* (London, 16 April 2020).

38 Julian O'Neill and Jayne McCormack, 'Coronavirus: travelling for exercise "breaching restrictions"' *BBC News NI* (Belfast, 16 April 2020) (emphasis added).

drive somewhere for exercise. This will not be tolerated …'.[39] In contradiction, the PSNI advice on its own website at the time was limited to 'encouraging' people not to drive to local beauty spots for their daily exercise. This was subsequently removed.[40]

The lack of legal certainty led to Executive discussion. On 24 April 2020 a statement was issued by the Executive Office (TEO) at the same time as an amendment was also made to the NI COVID-19 Regulations to allow persons to visit graveyards (subject to a duty on persons responsible for burial grounds to take all reasonable measures to ensure social distancing by the public). The TEO stated:

> The Executive has also agreed to amend the Regulations to clarify the circumstances in which a person can leave the house to exercise, including reasonable travel to exercise. For example, a drive to a safe space or facility would be permitted. However, taking a long drive to get to a beach, or resort where numbers of people may gather is unlikely to be regarded as reasonable, even for exercise.[41]

An amendment was then added stating that the regulations are still breached unless any 'associated travel' with exercise is reasonable.[42] It is, of course, only a breach of the regulations *per se,* rather than any associated guidance or advice (on matters such as social distancing), that triggers the use of enforcement powers.

By 23 April 2020 controversy over the use of PSNI enforcement powers led to a temporary direction that required the approval of a senior PSNI officer before a fine or community resolution notice (CNR) could be issued.[43] A few days later, on 28 April 2020, the Department of Health and PSNI issued a joint statement. This makes no reference to the 'drive for exercise' amendment and, rather than providing further guidance, only appears to add to the lack of legal certainty over the rules. The statement, which opens by curiously referring to the 'regulations on social distancing', instead emphasises officer discretion and states that individual answers for 'countless hypothetical scenarios' cannot be given.[44]

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39 Sam McBride 'The police's made-up coronavirus law ought to unsettle anyone who understands democracy' *The Newsletter* (Belfast, 18 April 2020).

40 PSNI, 'COVID-19 advice and information'.

41 The Executive Office, 'Executive approves opening of cemeteries on restricted basis' (24 April 2020).

42 Health Protection (Coronavirus, Restrictions) (Amendment) Regulations (Northern Ireland) 2020 NISR 2020/71, regulation 2(4)(b).

43 Rodney Edwards, 'PSNI chief tells officers to seek approval before issuing coronavirus fines' *Belfast Telegraph* (Belfast, 23 April 2020).

44 Department of Health, 'Joint statement by the Department of Health and the Police Service of Northern Ireland' (28 April 2020).

By 4 May 2020 385 fixed penalty notices and 655 CNRs had been issued. The temporary direction requiring senior officer approval was still in place at 7 May 2020. By this time the PSNI reported that the Police Ombudsman had only received 24 complaints that were COVID-19 related, all in the 'less serious' category.[45] Whilst the initial policing response was not widely contested as having been heavy handed, action taken against Black Lives Matter protestors on 6 June 2020, proved particularly controversial, in part due to the use of extended enforcement powers which had only been commenced the night before through the 'emergency procedure'.[46]

Whilst the application of the regulations to the anti-racism protests is further covered below in relation to restrictions on gatherings, regulation 5 is also engaged as protestors still require a 'reasonable excuse' to leave home. There is no explicit 'reasonable excuse' to leave your home to participate in a protest. However, given the list is non-exhaustive and protest activity engages fundamental human rights under the ECHR (to freedom of assembly and expression etc) it would appear disproportionate to interpret regulation 5 as not permitting a person to leave their home for *any* expressive activity (which would include a one-person protest).

The most common form of expressive free assembly from the initiation of the regulations was the weekly clap for NHS and other essential workers whereby individual households congregated to clap at 8pm each Thursday. Save for persons with front gardens, this technically, in standing on the pavement, involved leaving your residence. Presumably, however, this socially distanced activity was rightly read as constituting a 'reasonable excuse' to leave your home.

On 19 May 2020 an amendment to the regulations added further 'reasonable excuses' to the explicitly permitted reasons to leave your residence, two of which were to take part in 'outdoor activity' and 'outdoor gatherings'.[47] Both concepts can be interpreted as permitting persons to leave their home for *inter alia* protest activity although neither is defined. The 'outdoor gathering' provision was linked to a new regulation 6A, which permitted 'outdoor gatherings' of up to six persons who are not members of the same household (or any number of persons who are members of the same household).

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45 PSNI, 'Chief Constable's written report to Northern Ireland Policing Board, Thursday 7th May 2020 – COVID-19' (7 May 2020) paragraph 4(b)(f)(g).

46 Amnesty International UK and CAJ (n 6).

47 Health Protection (Coronavirus, Restrictions) (Amendment No 3) Regulations (Northern Ireland) 2020 NISR 2020.84, regulation 2(3).

6 REGULATIONS 6 AND 6A – RESTRICTIONS ON GATHERINGS

The original regulation 6 prohibited all gatherings *in a public place* subject to several limited exemptions.[48] This changed on 19 May 2020 when the restrictions became subject to regulation 6A on 'outdoor gatherings' of up to six persons. Regulation 6A is not qualified to a public place with the intention that it would also cover private spaces such as gardens.[49] The formulation of regulation 6A is, however, permissive, unlike regulation 6 which imposes a prohibition (but does not apply to private spaces, albeit persons from outside a household would still need a 'reasonable excuse' under regulation 5 to attend a gathering in a private space).

In the NI COVID-19 Regulations, there is no interpretation of the term 'gathering'. The equivalent provision in COVID-19 regulations in England defines gathering (from 1 June 2020) as 'when two or more people are present together in the same place in order to engage in any form of social interaction with each other, or to undertake any other activity with each other'.[50]

The application of the regulations to protests became particularly controversial from Saturday 6 June 2020 in relation to the policing operation over Black Lives Matter protests in Belfast and Derry-Londonderry. Despite efforts to ensure social distancing at the protest, around 70 fines or CNRs were issued to anti-racism protestors, mostly at the Derry protest, with PSNI officers expressly citing breaches of regulation 6A over 'gatherings' of more than six persons. Contrast was also drawn with a counter-protest to the anti-racism protests the following Saturday (13 June 2020, the 'protect our statues' protest) where no fines or CNRs were issued, although evidence was gathered.[51] Complaints from Black Lives Matter protestors led to the Police Ombudsman launching an investigation into PSNI consistency in enforcing the NI COVID-19 Regulations at large gatherings.[52]

48 These exemptions included where all persons were from same household; for essential work purposes; to attend a funeral (although regulation 5(g) usually restricts attendees to household members and close family); or when 'reasonably necessary' to provide care, emergency assistance, fulfil a legal obligation or move house. In addition to qualified exemptions subsequently being added for marriage ceremonies, drive-in entertainment/worship.

49 Minister Lyons, Northern Ireland Assembly Official Report (16 June 2020, 5.30pm) Health Protection (Coronavirus, Restrictions) (Amendment No 4) Regulations (Northern Ireland) 2020.

50 Health Protection (Coronavirus, Restrictions) (England) (Amendment) (No 3) Regulations 2020 SI 2020/558, regulation 2(7).

51 PSNI, 'Statement from Assistant Chief Constable Barbara Gray' (13 June 2020).

52 Police Ombudsman, 'Police Ombudsman to look at how police have enforced regulations on large public gatherings' (17 June 2020).

The enforcement action against anti-racism protestors prompted, among other matters, questions as to how 'gathering' was being interpreted, given that the protest organisers had gone to considerable efforts to ensure social distancing. This contrasted to a number of large social gatherings that had taken place prior to the Black Lives Matter protests and had not reportedly faced such enforcement action. Comparisons were even made between socially distanced protests and distanced queues for supermarkets, and in particular the IKEA Belfast store (the reopening of which had drawn considerable numbers).[53] Whilst an IKEA or supermarket queue would not lend itself to constitute a 'gathering' under the definition in English regulations, the lack of a definition in the NI COVID-19 Regulations leaves this contention more open.

A related question therefore concerns whether the anti-racism protests of 6 June 2020 should have been treated as one 'gathering' or as numerous separate 'gatherings' due to the express efforts of organisers to ensure the protests were socially distanced. A comparator can be drawn with those who participated in the expressive activity of the NHS clap on the pavement who were not considered to be one gathering. A further comparative example occurred several days after the anti-racism protests. Reportedly, around 100 people lined the streets of Ballymena to pay respects at a funeral but did so with social distancing in place, and without similar PSNI intervention.[54] At the time of writing, however, there is considerable political upheaval in relation to the provisions of regulations and the funeral of a senior republican in Belfast on Tuesday 30 June 2020, at a time when outdoor gatherings of up to 30 persons (with recommended social distancing) were permitted. This has again raised questions, among other matters, as to whether large numbers of people lining the route of a funeral are to be treated as one or numerous separate gatherings, or even as part of the funeral.[55]

There are therefore significant legal certainty issues with the definition and interpretation of 'outdoor gathering', including when gatherings are to be considered as one or numerous different gatherings. As well as the policing operation itself, a further point of concern in relation to the application of the regulations related to the extension of enforcement powers over regulation 6A on the eve of the protests. This is explored further below.

53 See *BBC News* (n 6) and 'Coronavirus: long queues form as Ikea in Belfast reopens' *BBC News NI* (Belfast, 1 June 2020).

54 'Funeral of Liam Neeson's mother Kitty held in Ballymena' *Belfast Telegraph* (Belfast, 9 June 2020).

55 See, for example, Northern Ireland Assembly Official Report (30 June 2020, 5.30pm) Health Protection (Coronavirus, Restrictions) (Amendment No 5) Regulations (Northern Ireland) 2020.

7 AMENDMENTS TO THE NI COVID-19 REGULATIONS, ALWAYS 'BY REASON OF URGENCY'?

The NI COVID-19 Regulations (of 28 March 2020) were first amended on 24 April 2020. By 30 June 2020, nine further amendment regulations had been made. All but the first amendment regulation have followed the NI Executive publishing (on 12 May 2020) its roadmap *Coronavirus: Executive Approach to Decision Making*, providing for a five-step process to move out of lockdown.[56]

Many amendments have therefore been to implement a gradual relaxation of restrictions. There have, however, also been 'technical' amendments, presumably to correct earlier oversights, gaps or drafting errors.[57]

The aforementioned regulation 6A permitting outdoor gatherings of up to six persons not from the same household was announced by the NI Executive on Monday 8 May 2020.[58] Accordingly and unsurprisingly, from Tuesday morning many persons went outdoors to meet family members and friends from outside their household for the first time since the lockdown. Technically, however, such gatherings during the daylight hours breached the regulations. The required amendment was not ultimately laid before the Assembly until 9am on Wednesday 20 May 2020 with it retrospectively coming into force on the Tuesday night at 11pm.[59] Whilst this issue many have passed largely unnoticed, it does highlight the risk of a brief gap between policy announcements and necessary legal changes.

Whilst from 19 May 2020 'outdoor gatherings' were permitted under regulation 6A, no consequential amendment was made to the regulations to extend the enforcement powers and offences for breaches of regulation 6A at the time. Amendment regulation No 4, of 21 May 2020, also did not make this change. The change was ultimately made by amendment regulation No 5 and proved controversial. The amendment was made and laid before the Assembly at 3pm and 5pm respectively on Friday 5 June 2020. Whilst other changes brought in by amendment No 5 did not come into force until 11pm on Sunday 7 June 2020, the provision that made regulation 6A an enforceable offence instead came into force at 11pm on the Friday itself – 5 June

56 The Executive Office, 'Executive publishes coronavirus recovery strategy' (12 May 2020).

57 See, for example, amendments made by the Health Protection (Coronavirus, Restrictions) (Amendment No 2) Regulations (Northern Ireland) 2020 NISR 2020/82, regulation 2(4)(a); 2(5)(a).

58 The Executive Office, 'Executive daily update: initiatives to deal with coronavirus' (18 May 2020).

59 Health Protection (Coronavirus, Restrictions) (Amendment No 3) Regulations (Northern Ireland) 2020 NISR 2020/84.

2020 . The significance of this was that the PSNI were then able to use the newly extended powers the following day at the Black Lives Matter protests.[60]

Among other matters, this brings into focus the use of the 'emergency procedure' to make amendments to the regulations. As set out above, the PHANI 1967 regulation-making powers have a standard procedure, under section 25P, requiring prior Assembly scrutiny, and an 'emergency procedure' under section 25Q whereby 'by reason of urgency, it is necessary to make the regulations without a draft being so laid and approved'. To date, however, *all* amendments to the NI COVID-19 Regulations have relied on the section 25Q emergency procedure. In human rights terms, amendments that actually ease restrictions will raise few issues, however, the difference with the amendment to regulation 6A was that it *extended* criminal offences. It is at best questionable whether this was necessary 'by reason of urgency' in advance of anti-racism protests, in a context whereby powers to enforce regulation 6A had not been available for several weeks since its introduction and other large gatherings had taken place.

One explanation for this was that the Department of Health intentionally fast-tracked the amendment and its commencement specifically to ensure the powers were available for the Black Lives Matter protests. Unless objective and reasonable justification for doing so can be provided, this would raise questions of differential and discriminatory treatment. An alternative explanation is that the timing of the amendment and its commencement were coincidental: the Department of Health was merely using the opportunity of a further amendment to make a technical fix to a previous drafting error. Whilst this account would not explain the accelerated commencement, it would also prompt questions as to whether the use of the section 25Q 'emergency procedure' was appropriate.

On 16 June 2020, the TEO Junior Minister Gordon Lyons MLA addressed the Assembly on the matter. The Minister stated the lack of enforcement powers over regulation 6A had been a 'drafting error' that was 'noticed and corrected on the same day' (ie 5 June 2020) by amendment regulation No 5. The Minister also stated that the PSNI had been 'unaware of the drafting error until it was drawn to their attention on the afternoon of the 5th June' but that he had been advised that the PSNI between 19 May and 5 June 2020 had not issued any fines (fixed penalty notices) for breaches of regulation 6A. The Minister added that the 'timing of the Black Lives Matter protest was purely coincidental,

60 Health Protection (Coronavirus, Restrictions) (Amendment No 5) Regulations (Northern Ireland) 2020 NISR 2020/96, regulation 1(3).

but the enforcement of the regulations is a matter for the PSNI'.[61] This draws further questions as to whether it was appropriate therefore to use the emergency procedure to extend criminal offences and related enforcement powers that the PSNI had apparently had no need for in the weeks from 19 May 2020 until the anti-racism protests.

On 11 June 2020 a further amendment regulation, No 6, amended the regulation 6A provision on 'outdoor gatherings' to increase the permitted number from six to 10 persons.[62] However, in a seemingly further drafting error, a consequential amendment was not made to the enforcement powers over regulation 6A meaning the PSNI were still empowered to disperse gatherings of seven or more (rather than 11 or more) persons.[63] This was ultimately rectified on 25 June 2020 by amendment regulation No 8.[64] Subsequently amendment regulation No 9 extended the numbers for gatherings under regulation 6 or 6A to 30 persons.[65]

8 LEGAL CERTAINTY AND PUBLICLY AVAILABLE INFORMATION ON THE NI COVID-19 REGULATIONS

A Department of Health website, with some short delays, has largely been the first place regulations are published, ahead of the statute law database.[66] This website initially provided no further information beyond links to the original NI COVID-19 Regulations and each amendment regulation. This finally changed on 5 June 2020 when accessible guidance was uploaded on the scope of the regulations.[67] A consolidated version of the regulations was also not uploaded until 12

61 Northern Ireland Assembly Official Report (16 June 2020, 5.30pm) Health Protection (Coronavirus, Restrictions) (Amendment No 4) Regulations (Northern Ireland) 2020.

62 Health Protection (Coronavirus, Restrictions) (Amendment No 6) Regulations (Northern Ireland) 2020 NISR 2020/103.

63 Health Protection (Coronavirus, Restrictions) (Amendment No 8) Regulations (Northern Ireland) 2020 NISR 2020/118, regulations 2(7) and 1(2).

64 Health Protection (Coronavirus, Restrictions) (Amendment No 9) Regulations (Northern Ireland) 2020 NISR 2020/121, regulations 2(3)(a) and 2(4).

65 See regulation 7(9A) of the NI COVID-19 Regulations (as amended up to Amendment No 6).

66 Department of Health, Health Protection (Coronavirus, Restrictions) (Northern Ireland) Regulations 2020 (first published 28 March 2020, version updated 30 June 2020). The Statute Law Database is found at Gov.uk.

67 Department of Health, 'Guidance on the restrictions in Northern Ireland and Public Health Advice' (5 June 2020 and subsequently updated 12 June 2020).

June 2020. Prior to this, readers would have needed to piece together the various amendment regulations themselves.[68]

During this time the PSNI COVID-19 information website deferred to this Department of Health website and was otherwise limited to setting out what were the penalties for infractions against the regulations.[69] The Public Health Agency public information website also made only passing reference to some provisions in the NI COVID-19 Regulations.[70] The NI Direct website also contained limited information.[71]

Whilst some remedy was eventually provided on 5 June 2020, prior to this for over two months following the initial commencement of the NI COVID-19 Regulations no guidance accessible to the public that accurately reflected the scope of far-reaching emergency law was readily available.

9 ENFORCEMENT POWERS

Regulation 7 relates to powers to enforce the NI COVID-19 Regulations. Regulation 7(1) ominously and with echoes of the vagueness and arbitrary nature of the Special Powers Acts originally provided that: 'A relevant person may take such action as is necessary to enforce any requirement imposed by regulation 3, 4 or 6'. This therefore covers regulations 3 and 4 (duties to close businesses and premises etc) and regulation 6 on public gatherings. (Enforcement over regulation 6A/6B was subsequently added.)

A 'relevant person' means a police officer or anyone else designated by the Department of Health for this purpose (to date on 15 May 2020 one designation order was also issued covering council officers).[72]

In relation to enforcement of the 'stay at home' rule, regulation 7(3) provides powers to direct a person to return to their residence, or remove them to same, when a relevant person 'considers' they have left their home without reasonable excuse. Save for the provision to 'direct a person to return' home being interpreted as permitting stopping that person, there are no stop and question powers or other provisions to

68 Health Protection (Coronavirus, Restrictions) Regulations (Northern Ireland) 2020 NISR 2020/55 (consolidated to include SR 2020/71, SR 2020/82, SR 2020/84, SR 2020/86, SR 2020/96 & SR 2020/103).

69 PSNI (n 40).

70 Public Health Agency, 'COVID-19: information for the public', namely 'only go outside for permitted shopping, health reasons, work or exercise. If you go out, stay 2 metres (6ft) away from other people at all times. Groups of 4–6 people who do not share a household can meet outdoors, maintaining social distancing'.

71 NI Direct, 'Coronavirus (COVID-19): staying at home and self-isolation'.

72 Department of Health, 'Designations under the Health Protection (Coronavirus, Restrictions) Regulations (Northern Ireland) 2020' (15 May 2020).

facilitate officers ascertaining (where not obvious) whether a person has a reasonable excuse for being outside their residence.

10 PASSENGER QUARANTINE: THE OTHER NI COVID-19 REGULATIONS

Two further and separate emergency regulations were made by the Department of Health on Friday 5 June 2020 using the modified PHANI 1967 powers.[73] These regulations were the statutory basis for a 14-day quarantine (through self-isolation) rule on incoming passengers as a preventative measure against imported cases of COVID-19 and came into force on Monday 8 June 2020 to coincide with similar regulations in England.

There was some prior, but limited, Assembly scrutiny of these regulations. In part due to the policy not being signed off despite such a system having been under discussion for some time.[74] The Irish government initiated its system on 24 April 2020.[75] The UK government confirmed its intention to take this measure as part of its COVID-19 recovery strategy in early May, with a subsequent ministerial statement setting out that devolved administrations would need to set out their own enforcement approaches.[76]

In common between Ireland and the UK are requirements on incoming passengers to fill in a COVID-19 passenger locator form, usually providing their details and address at which they will self-isolate for 14 days. The main difference is that the UK government draws its COVID-19 quarantine border around the whole CTA (the open border zone consisting of the UK, Ireland, Channel Islands and Isle of Man). The Irish government meanwhile (presumably in the

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73 The main provisions are found in the Health Protection (Coronavirus, International Travel) Regulations (Northern Ireland) 2020 NISR 2020/90. A second regulation made at the same time – the Health Protection (Coronavirus, Public Health Advice for Persons Travelling to Northern Ireland) Regulations (Northern Ireland) 2020 – *obliged* airlines/ferry companies on services directly to Northern Ireland from outside the Common Travel Area to provide information about the NI quarantine rules.

74 Committee for Health, Minutes of Proceedings and Minutes of Evidence (28 May 2020), item 6: 'SL1 The Health Protection (Coronavirus, International Travel) Regulations (Northern Ireland) 2020'.

75 This was then set up on a statutory basis from 28 May 2020 under the Health Act 1947 (Section 31a – Temporary Requirements) (COVID-19 Passenger Locator Form) Regulations 2020.

76 Home Office, 'Home Secretary announces new public health measures for all UK arrivals' (22 May 2020). For a broader narrative on the background see: CAJ, 'COVID 19, passenger quarantine and the Common Travel Area (CTA): how are requirements for 14 day self-isolation intended to work in the CTA?' (May 2020).

context of the very high number of COVID-19 cases in Great Britain) draws its boundary around the island of Ireland, exempting passengers that travel from NI, but not those who travel from the island of Britain.

The passenger quarantine regulations have been controversial with the airlines and airports. In response to criticism from Belfast International Airport that the quarantine rules were 'ill-timed, ill-thought through and illogical' and a 'crazy, crazy idea', the First Minister Arlene Foster reportedly told *Good Morning Ulster* that the quarantine measures were a 'reserved issue' that the UK government would review every three weeks.[77] The NI regulations were, however, made by the NI Department of Health and are subject to review by the NI Department of Health every three weeks.[78]

The NI COVID-19 Regulations are made by powers under the PHANI 1967 that make reference to international rather than domestic passengers and follow the UK government position of drawing the boundary around the CTA.[79] In practice, this means inbound passengers to NI from places like Germany and Greece, with low COVID-19 rates, are subject to the 14-day self-isolation rule, but passengers on flights and ferries from England, where rates are high, are not.

The NI regulations do have the air of having been overly copied and pasted from their English equivalents. This is notable in the almost identical schedule 2 on exemptions to the NI self-isolation regulations that, among other matters, cover Channel Tunnel train crews and maintenance workers.[80] Whilst this addition may be immaterial, more problematic are provisions that relate to incoming passengers entering NI over the land border. This is manifest in obligations for the UK passenger locator form to be provided 'on arrival' in NI and in the definition of 'transit passengers'.

The NI (and England) international passenger regulations close what had been termed the 'Dublin loophole' in the UK media. This referred to passengers returning to the UK re-routing their journey through Dublin airport to evade the UK quarantine requirements. This issue is addressed by applying the self-isolation rules to arrivals who have been outside the CTA in the preceding 14 days.[81] The NI regulations do not, however, close the 'Belfast loophole' whereby, for example, London-based employees of a company travelling to Dublin re-route

77 'Coronavirus: Quarantine "stake through the heart" of airport' *BBC News NI* (Belfast, 15 June 2020).

78 Health Protection (Coronavirus, International Travel) Regulations (Northern Ireland) 2020, SRNI 2020/90, regulation 11.

79 Specifically, temporarily inserted sections 25B and 25F(2).

80 Health Protection (Coronavirus, International Travel) Regulations (Northern Ireland) 2020, SRNI 2020/90, schedule 2, paragraph 12.

81 Ibid regulation 3(1)(b) and 4(1)(b).

their journey via a London–Belfast flight with onward bus travel to Dublin. This risks creating public health issues at NI transport hubs should it happen on a significant scale.

A more immediate question relates to passengers arriving in Dublin Airport who then travel to NI either as NI residents or in 'transit' to Donegal.

Whilst the PHANI 1967 powers provide for the implementation of international agreements, no arrangement was entered into with the Irish government for reciprocal use of data from the UK and Irish passenger locator forms respectively (a reciprocal arrangement is in place if the form is completed in England, Scotland or Wales).

By way of illustration, the process for an NI resident arriving from outside the CTA into Belfast International Airport is fairly simple. Their travel operator under law will have had to provide information on the self-isolation and form-filling requirements. The UK passenger locator form can be filled in online up to 48 hours before arrival, or in person at passport control on arrival at the airport where facilities will be available (the UK form is digital).

By contrast, it is not clear how an NI resident landing into Dublin Airport from outside the CTA can do this. They will fill in the Irish government's passenger locator form at passport control (ticking the exemption for onward travel to NI). However, the passenger is then required by law to provide the UK passenger locator form 'on their arrival' in NI. This provision does not appear to anticipate the common scenario whereby the passenger will be arriving in NI in a moving vehicle across the land border where there is no passport control. Nevertheless, this passenger will commit an offence for not providing the UK form 'on their arrival' (subject to a reasonable excuse defence).[82] Whilst the passenger can also provide the UK form up to 48 hours before arrival, it is not clear how the passenger will know this, or how passengers without a smartphone will fill it in.[83] Whilst NI law cannot place requirements in another jurisdiction, it is unclear why a reciprocal arrangement was not entered into to address this. Rather discussions were described as still 'ongoing' on matters such as information panels in each other's airports after the NI regulations had commenced.[84]

A further question faces passengers *transiting* through NI over land: for example, a resident of Donegal returning home having landed back

82 Ibid regulation 3(2) and 6(1)(a).

83 For further detail, see: CAJ, 'Passenger quarantine and the Common Travel Area: the Health Protection (Coronavirus, International Travel) Regulations (Northern Ireland) 2020' (CAJ Briefing Note No 2, June 2020).

84 Freya McClements, 'NI Executive seeks panels in ports and airports outlining quarantine rules' *Irish Times* (Dublin, 9 June 2020).

in Dublin Airport from outside the CTA. Unlike NI residents transiting home over land through the Republic, there is no exemption for such persons. This is as the definition of 'transit passenger' in the NI regulations (mirroring that of its English counterpart) is drafted to only cover passengers who do not enter the jurisdiction (ie those passing through an airport international transit lounge).[85] The passenger is therefore required to know about and fill in the UK passenger locator form online 'on arrival' at the land border (or 48 hours before). However, it is not clear if the form can be completed satisfactorily, as it has to include a UK address at which the passenger is to self-isolate.[86] Details required of any onward travel from the UK also do not appear to contemplate a journey by car.[87] In addition to duties and related offences as regards filling out the UK form, such passengers are not among the exemptions to the requirement to self-isolate in NI.[88] Whilst the self-isolation requirement can end on departure from NI, this does not in itself remove the requirement.[89] Similar issues also arise for Donegal residents who return home via an NI airport. In summary, the provisions contain significant ambiguities in relation to their application to the land border.

CONCLUSION

Whilst the NI COVID-19 Regulations may enjoy the novelty of being the only emergency legislation in Northern Ireland's existence that has garnered universal mainstream political support, they have not been without their problems.

The UK government, rather than relying on existing powers, rushed through the vast Coronavirus Act 2020. This amended existing Stormont-era public health legislation to vest wide regulation-making powers in the NI Department of Health. Health officials dealing with the broader pandemic have therefore been managing the NI COVID-19 Regulations, which include criminal offences and enforcement powers more familiar to justice officials.

Despite the duties under Article 2 ECHR to ensure prompt, effective investigations into certain deaths where acts or omissions of public

85 Health Protection (Coronavirus, International Travel) Regulations (Northern Ireland) 2020, SRNI 2020/ 90, schedule 2, paragraph 5(2)) provides: '"transit passenger" means a person who, on arrival in the United Kingdom, passes through to another country or territory without entering the United Kingdom"'.

86 Ibid schedule 1, paragraph 2(a)).

87 Ibid schedule 1, paragraph 2(J)).

88 Ibid. Exemptions (eg diplomats, cabin crew, transport workers) are set out in regulation 4(12)(d) and schedule 2.

89 Ibid regulation 4(7).

authorities might have played a role, the Coronavirus Act 2020 temporarily amends NI coronial legislation to limit duties to notify the coroner of deaths. Whilst the Presiding Coroner has confirmed there is no intention in NI to issue guidance similar to the controversial provisions in England and Wales (that told coroners not to look at matters such as PPE shortages), similar provisions to those in Scotland (where instructions have been issued that deaths of frontline workers and care home residents must be referred to the coroner) have not been taken forward to date in NI.

Despite the decree-like nature of emergency regulation-making powers, regularly shifting policy necessitating resultant legislative amendments has been characterised by some gaps, errors and confusion. It took over two months for any accurate and duly updated official guidance on the scope of COVID-19 regulations to appear on an official website and slightly longer for a consolidated version of the regulations (that by then had been amended six times) to be made available.

Whilst the initial urgency to implement lockdown is apparent and many subsequent measures have eased lockdown, an 'emergency procedure' has been used for each amendment without prior Assembly scrutiny. This included to controversially extend criminal offences over gatherings on the eve of Black Lives Matter protests. There remain inconsistencies and ambiguities as to how, for example, 'gathering' is interpreted in relation to protest activity. There are also questions as to why an amendment to deal with what had been described as a drafting error to extend enforcement powers over outdoor gatherings became so 'urgent' on the eve of anti-racism protests, when the PSNI had hitherto neither tried to use such a power nor even noticed they did not have it.

A further set of NI-based regulations enforces a 14-day passenger self-isolation rule for persons entering NI from outside the UK–Ireland CTA. In part due to possible over-replication of provisions designed for England and the lack of a reciprocal agreement with the Irish government there are significant problems with these provisions. This is particularly the case for persons landing in Dublin airport who re-enter, or transit through NI via land and may unwittingly be caught by criminal offences given the construction of the regulations does not adequately anticipate such a scenario.

Whilst the current trajectory is for the easing of regulations, it is more than possible any second wave of the virus will prompt reintroduction as has happened in other places. There are plenty of lessons learned to be addressed in the interim.

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Towards a Welsh health law: devolution, divergence and values

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ABSTRACT

COVID-19 and Brexit have given political impetus to re-examine Wales's place within the United Kingdom's devolution settlement. Health has been a key site for divergence in law and policy as between the administrations in Cardiff and London. In light of these contests, and the longer-running trends in devolution, this article considers whether a distinct 'Welsh' health law has now emerged. We examine the constitutional context and the range of sources for this new legal field. We argue that a set of values can be identified through an attentive reading of the legislative output of the Welsh Parliament, through reflection on the policy development of health in Wales, through the devolution process. While accepting that these are varied and heterogeneous, these values are as much an expression of universal ethical goals as they are of any delineable Welsh essence. No mere summation of positive law, these values allow one to define a distinctive realm of Welsh health law, have the potential to act as an interpretative lens for analysing law and policy flowing from Westminster, and could potentially act as a value structure for further Welsh legislation.

Keywords: devolution; divergence; values; Welsh jurisdiction; COVID-19; health law; healthcare; Coronavirus Act 2020; NHS; Brexit.

INTRODUCTION

The health landscape of Wales and the United Kingdom (UK) is changing. Pre-existing tensions and divisions over Brexit and wider constitutional issues of devolution and governance have been illuminated and exacerbated by COVID-19.[2] At the onset of the pandemic, the Welsh, Scottish and Northern Irish administrations and the UK Government, for England, committed to respond in a closely

1 Respectively Professor of Global Health Law, Lecturer in Law and ESRC Doctoral Researcher, School of Law and Politics, Cardiff University. We are indebted to Matt Watkins for detailed comments on earlier drafts. Thanks also to Abbie-Rose Hampton, Huw Pritchard and Charlie Sinden. The usual disclaimer applies. Research for this article was made possible by a Welsh Government Sêr Cymru award.

2 J Bradbury, 'Welsh devolution and the union: reform debates after Brexit' (2021) 92 Political Quarterly 125; G Evans 'Devolution and Covid-19: towards a "new normal" in the Territorial Constitution?' (2021) (1) Public Law 19-27.

coordinated fashion,[3] in line with the Sewel Convention and the Memorandum of Understanding. However, by May 2020 each began to develop policy independently.[4] Legal divergence has been matched by political dispute, with Cardiff and Edinburgh claiming they were ignored and outflanked, and Westminster complaining of deviation for its own sake.[5] The pandemic has undoubtedly made the existence of an increasingly distinct Welsh 'health space' visible to the wider public. It has also highlighted the contested and uneven nature of devolution, dramatising the defence of legislative autonomy in Wales and Scotland and resultant push-back by an actively pro-union UK Government.[6] These vectors traverse the adjustment to Britain's departure from the European Union (EU), with all three devolved administrations denying consent to the EU (Withdrawal Agreement) Act 2020. The destination of powers repatriated from Brussels, and the scope of the UK-wide internal market, are significant for the health competencies of devolved administrations.

Divergence in health law and policy across the UK is not a new phenomenon. It has been in train, steadily if often unremarked, since the implementation of devolution in 1998. In Wales, distinctive measures on organ donation, tobacco control and the structure of the health service, for example, have attracted the attention of scholars in law, ethics and health policy.[7] Such reviews have generally been discrete, however, focusing on a specific measure and contextualising it with reference to, say, English or Scottish equivalents. Less attention has been directed to the emerging ensemble of law and regulation as a whole. The contemporaneous challenges of COVID-19 and Brexit provide us with the occasion for just such an encompassing review.

We take up this challenge, inquiring into the nature and scope of health law in Wales and considering its prospects for further development. We first provide a brief chronology of Welsh devolution through the lens of health and contextualised by COVID-19. We subsequently outline sources of Welsh health law and explore emergent areas in which a distinct Welsh application and interpretation is visible, focusing on key initiatives like organ donation, tobacco control and the structure of NHS Wales. Welsh health law 'exists', we argue, not only as a distinctive corpus of legal rules and policies, but also

3 Coronavirus Act 2020.

4 'Covid: has devolution helped or hampered coronavirus response?' (*BBC News*, 28 October 2020).

5 W Hayward, *Lockdown Wales: How Covid-19 Tested Wales* (Seren 2020).

6 M Kettle, 'Johnson's last-minute bid to save the union can't undo years of neglect' *The Guardian* (London, 25 January 2021).

7 S Greer and D Rowland (eds), *Devolving Policy, Diverging Values? The Values of the United Kingdom's National Health Services* (Nuffield Trust 2007).

as a set of distinct challenges related to its constitutional frame and technical complexity, as well as the unique population health problems which it is deployed to address. Moreover, we will also suggest briefly that the distinctiveness of Welsh health law also rests on moral and political values which can be identified in current Welsh practice, in historical forms of health solidarity in Wales, and in the common British and European inheritance. Our conclusion draws out briefly some implications for health law scholarship in a devolved UK of the developments we have identified in the case of Wales.

HEALTH AND THE DEVOLUTION SETTLEMENT

Welsh legislative autonomy has evolved since 1998, from administrative to executive devolution, and from measures to primary law-making. Its pre-history can be traced to the start of the twentieth century. At that time, local authorities and the Welsh Board of Health were generally responsible for health, but there existed no distinct 'Welsh' decision-making level, *per se*. When the National Health Service (NHS) was established across the UK in 1948, newly nationalised voluntary and local authority hospitals were managed by regional boards, including one for Wales. The latter was directly accountable to the central government in London.[8] As the political founder of the Service, Aneurin Bevan, put it, 'when a bed-pan is dropped on a hospital floor, its noise should resound in the Palace of Westminster'.[9] No official Cabinet-level position representing Welsh interests existed until the creation of the Welsh Office and the position of Secretary of State for Wales in 1964, who was given responsibility for health in 1969.[10]

Policy determined in Westminster did not always reflect local needs, and the Welsh Office was devolved in administrative capacity only. Key reform initiatives like the Griffiths Report challenging the lack of NHS management structures (1983) and the 'internal market' among general practitioners and NHS hospitals (1991) were simply adopted and implemented in Wales as elsewhere. The advent of devolution came in 1998, following a (narrow) victory for the 'Yes' campaign in

8 P Michael, *Public Health in Wales (1800–2000): A Brief History* (Welsh Government 2008) 20.

9 Cited in P Nairne, 'Parliamentary control and accountability' in R Maxwell and N Weaver (eds), *Public Participation in Health: Towards a Clearer View* (The King's Fund 1984) 33–51.

10 D Miers and D Lambert, 'Law making in Wales: Wales legislation online' (2002) Public Law 663.

the 1997 referendum.[11] Devolution was seen by the Labour party, long dominant in Wales, as an opportunity to restore the non-market ethos of Bevan's NHS and to put 'clear red water' between it and the New Labour and Conservative Governments in London.[12] Under the keystone Government of Wales Act 1998 (GOWA 1998) health was deemed an area of conferred power through a process of executive, rather than legislative, devolution. This meant the newly created National Assembly for Wales could pass secondary legislation on health, but only after seeking the UK Parliament's approval on a case-by-case basis. Even then the doctrine of parliamentary sovereignty allowed (and still allows) Westminster to pass overriding legislation on exclusively devolved matters. Functions of the Secretary of State for Wales were transferred to the Assembly.[13] Tax powers were not included among these competencies.[14]

The Government of Wales Act 2006 (GOWA 2006) gave the Assembly primary law-making powers for the first time, allowing it to pass legislation ('Assembly Measures') on certain prescribed areas and establishing health as a non-reserved power. A 2011 referendum asked voters whether the Assembly should have direct legislative powers over 20 areas including health and education, as well as tax-raising powers: 63.5% voted yes on a relatively low turnout of 35.2%.[15] The Commission on Devolution in Wales 2012 recommended further expanding primary law-making and fiscal powers,[16] resulting in the Wales Act 2017. The Act extended Wales's fiscal powers, increasing the Welsh Government's borrowing limits and enabling it to set Welsh rates of income tax as well as moving Welsh devolution to a 'reserved powers' model, conceding legislative power to Cardiff in all but a series of enumerated areas.[17] This strengthening of devolution was reflected

11 The creation of a Welsh Assembly was approved by 50.3% in the 1997 referendum, representing a 50.1% turnout. N Duclos, 'The 1997 devolution referendums in Scotland and Wales' (2006) French Journal of British Studies 12.

12 D S Moon, 'Rhetoric and policy learning: on Rhodri Morgan's "clear red water" and "made in Wales" health policies' (2013) 28 Public Policy and Administration 306.

13 Transfer of Function Orders 1999; GOWA 1998, s 22(2), sch 2.

14 GOWA 1998, sch 2.

15 R Scully, 'Welsh referendum analysis: Wales "united in clear vote"' (*BBC News*, 4 March 2011).

16 Commission on Devolution in Wales, 'Empowerment and responsibility: devolving financial powers to Wales' (HM Treasury/Wales Office 2012); 'Empowerment and Responsibility: Legislative Powers to Strengthen Wales' (Office of the Secretary of State for Wales 2014).

17 Wales Act 2017, s 7A.

in the Assembly renaming itself Senedd Cymru (the Welsh Parliament) in 2020.[18]

It is clear from the foregoing that how we define health affects the scope of devolution. A narrower definition, focused on clinical medicine and orthodox public health interventions may concede more scope to the areas reserved to Westminster, limiting the action of Welsh authorities. Turning to the relevant legislation, schedule 2 of GOWA 1998 referred to '[h]ealth and health services'. This was preserved and elaborated on by GOWA 2006, which describes health as 'physical or mental health' and encompasses 'health and emotional well-being', 'social and economic well-being' and citizens' rights.[19] A similarly broad understanding of health is warranted by article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) which the UK has ratified.[20] General Comment 14 of the United Nations (UN) Committee on Economic Social and Cultural Rights defines the right broadly to include not only healthcare and standard disease control measures, but also underlying social and environmental determinants like housing and clean air. This inclusive approach is underwritten by the current popularity of 'Health in All Policies', acknowledging the influence that laws, actions and interventions outside the direct remit of the health sector have for the promotion of health.[21] Though not explicitly referenced in the legislation, GOWA 2006's definition of health and wellbeing is certainly consistent with such an approach.

It is important, however, to note that the scope of devolution in this area is not solely determined by definitions, but also by practice and policy. Reserved powers in ostensibly non-health areas may limit Cardiff's capacity to legislate for health. For example, prison policy is reserved to Westminster, but the Welsh Government manages prisoner healthcare.[22] As a result, there is no clean break, but a 'jagged edge' which causes difficulties in law and practice.[23] This unevenness is not simply a matter of definitions and overlapping competences. It is also a site of contestation between Cardiff and Westminster, as we explore in the next section with reference to the challenges of the recent coronavirus pandemic and the UK's exit from the EU.

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18 Senedd and Elections (Wales) Act 2020, s 2.

19 GOWA 2006, sch 5, matter 15.10 (a)–(f).

20 General Comment 14 of the Committee on Economic, Social and Cultural Rights.

21 E Ollila, 'Health in all policies: from rhetoric to action' (2011) 39 Scandinavian Journal of Public Health 11.

22 T Enggist et al (eds), *Prisons and Health* (WHO Regional Office for Europe 2014) 2.

23 R Jones and R W Jones, 'Justice at the jagged edge' (Wales Governance Centre 2019).

PULLING AWAY AND PUSHING BACK: COVID-19 AND BREXIT

COVID-19 has exposed the significance, and potential inadequacy, of current devolution arrangements.[24] In March 2020, Westminster passed the Coronavirus Act 2020, a collaborative effort which conferred new powers on devolved administrations.[25] A collective decision to institute a UK-wide lockdown was made on 23 March, though increasing divergence in timing and scope emerged over the following months.[26] The Government in Cardiff generally took a more cautious approach than its London counterpart, implementing a slower exit from the original lockdown in spring 2020 and a stricter 'firebreak' in Autumn 2020.[27] Most conspicuous in UK-wide media were restrictions on the movement of people into and out of Wales, which re-established a frontier with England that has not existed since mediaeval times.

Although civil service contacts, as between Cardiff, Belfast, Edinburgh and London, worked well throughout the crisis, intergovernmental relations were notably strained at the highest level.[28] UK Prime Minister Boris Johnson refrained from all communication with Mark Drakeford and Nicola Sturgeon, Welsh and Scottish First Ministers, in the key months between May and September 2020.[29] Rhetorical styles differed too, with Drakeford positioning himself, in Laura McAllister's words, as 'the political antithesis of Johnson'.[30] An early rise in popularity for the Welsh Labour Government was tempered by the UK Government's successful vaccine procurement strategy.[31] Labour's subsequent success in the Senedd elections of May 2021 has been attributed to the cautious approach to COVID-19 taken by Drakeford and former Health Minister Vaughan Gething, and to Wales's vaccine

24 Evans (n 2 above).

25 Coronavirus Act 2020, ss 11–13, ss 37–38, s 52, ss 87–88, s 90. For example, devolved ministers are empowered to temporarily close educational establishments.

26 Health Protection (Coronavirus) (Wales) Regulations 2020.

27 'National coronavirus firebreak to be introduced in Wales on Friday' (Welsh Government, 19 October 2020).

28 Hayward (n 5 above) ch 8.

29 Ibid.

30 L McAllister, 'Covid-19: how have our political leaders performed in the face of such a crisis?' (*Wales Online*, 4 July 2020).

31 'Covid-19: Wales has more confidence in Welsh Gov than England in UK Gov – study' (*Nation Cymru*, 21 June 2020); M Savage, 'Boris Johnson's poll lead over Labour boosted by Covid vaccine rollout' *The Guardian* (London, 27 February 2021).

roll-out programme which has been among the broadest and fastest in the world.[32]

Growing awareness of devolution and its applicability to health has, however, been accompanied by uncertainty as to which rules apply.[33] Much of the Welsh population get their news from London-based sources which often neglect to indicate that measures imposed by Westminster are specific to England only.[34] This potential for confusion threatens rule of law values concerning the 'knowability' of applicable criminal law and the capacity of citizens to hold governments to account. It also potentially jeopardises public health by undermining the even application of lockdown measures, which is essential to interrupting the spread of infection. This is not merely a matter of information and legal certainty, however. It also gestures to the current weakness of the Welsh public sphere and the absence of a robust civil society which can scrutinise and challenge Senedd Cymru and the Welsh Government.[35] This is not only an internal political weakness. The elision of Wales and England has also been reinforced by Westminster's increased deployment of the symbols and language of British identity and unity. Downing Street's COVID-19 briefings have been marked by the prominence of the UK flag and undifferentiated references to 'our nation', 'Britain' and 'our country'.[36]

This scene of contest and confusion has been exacerbated as a result of the UK's departure from the EU. If COVID-19 has promoted centrifugal tendencies between the devolved administrations and the UK Government, then by contrast the Internal Market Act 2020 may be the agent of recentralisation of power to Westminster. Passed to ensure the barrier-free movement of goods across the UK following the Brexit transition period, the Act mandates that the internal market be guided by principles of mutual recognition and non-discrimination. Legal and political scholars have identified the Act's troubling implications for pro-health policies under devolution.[37] Notably, no exception to these principles is permitted on public health grounds. Accordingly,

32 'Covid vaccination rollout: how is Wales leading the UK and the world?' (*BBC News*, 28 May 2021).

33 Hayward (n 5 above) ch 9.

34 'For Wales, see England? The UK media and devolution' (*IWA*, 25 September 2020).

35 R Rumdul, 'Critical friend or absent partner? Institutional and organisational barriers to the development of regional civil society' (2016) 23 European Urban and Regional Studies 848.

36 For a further example, see 'Eight-storey union flag planned for Cardiff UK-government building' (*BBC News*, 30 June 2021). h

37 N McEwen, 'The Internal Market Bill: implications for devolution' (*Centre for Constitutional Change*, 11 September 2020); T Lock et al, 'Rights and devolution after Brexit' (University of Edinburgh Working Paper 2018).

goods complying with English standards cannot be prevented from sale in Wales on the basis that Cardiff has legislated for a higher level of consumer protection. In other words, free trade is preserved within the UK by restricting the power of devolved governments to raise environmental and public health standards, as has been done in Wales regarding the single-use plastics and the pricing of alcohol.[38]

The administration in Wales refused to consent to the Act, invoking the process set out in Standing Order 29.[39] This restates the Sewel Convention, according to which the UK Government is obliged to obtain the consent of the devolved administrations in any case where it seeks to legislate in an area of non-reserved competence. Westminster ignored the Convention, passing the Act over the protests of the devolved governments. Consistent with its recentralising politics, it is effectively privileging the doctrine of parliamentary sovereignty over any more nuanced understanding of the contemporary UK constitution. In response, the Counsel General for Wales sought judicial review, arguing *inter alia* that the Act 'impliedly … repeal[s] areas of the Senedd's legislative competence' by preventing the imposition of legislative requirements on the sale of goods in Wales that are additional to requirements elsewhere in the internal market.[40] Labelling the Act 'a constitutional overhaul' which curtails protections once enjoyed as part of the EU, he predicted that the UK will cut standards and use the Act 'to force the devolveds to follow suit'.[41] On 19 April 2021, the High Court refused permission to continue the Counsel General's case, which it called 'premature', as neither party had exercised powers under the Act.[42] However, the Court of Appeal subsequently granted permission to appeal due to the 'important issues of principle going to the constitutional relationship between the Senedd and the Parliament of the UK' raised by the applicants.[43]

38 British Medical Association, 'Parliamentary briefing: UK Internal Market Bill, House of Commons Committee Stage' (September 2020). See further, T Sokol, 'Public health emergencies and export restrictions: solidarity and a common approach or disintegration of the internal market?' (2020) 57 Common Market Law Review 1819.

39 J Miles MS, *Legislative Consent Memorandum: United Kingdom Internal Market Bill* (25 September 2020) [84]; Scottish Government, *Legislative Consent Memorandum: United Kingdom Internal Market Bill* (September 2020) [117].

40 *R (on the application of The Counsel General for Wales) v The Secretary of State for Business, Energy and Industrial Strategy* [2021] EWHC 950 (Admin), Case No: CO/188/2021.

41 J Miles, 'Why Wales must resist the Westminster power-grab, and how to do it' (*Wales Governance Centre*, 21 January 2021); Miles (n 39 above).

42 *R v The Secretary of State for Business, Energy and Industrial Strategy* (n 40 above) [37] and [6].

43 M Antoniw MS, 'Written statement: legal challenge to the UK Internal Market Act 2020 – update' (29 June 2021).

Our discussion of health law in Wales in this section has emphasised variability over time. On the whole, competences have expanded, though the recent push-back from Westminster may see some recuperation of powers *de facto*, if not *de jure*. To a certain extent Wales currently takes a middle way between the separatist tendencies of Scottish and (Northern) Irish nationalists on the one hand, and the assertive centralisation of English conservatives on the other.[44] Though the outcome of this contest cannot be predicted, it is clear that the discrete arrangements of Wales, Scotland, Northern Ireland and England have already given rise to four separate health systems premised on divergence, as well as convergence, asymmetry as well as replication. They are tied together by the law of a sovereign Parliament whose authority can and at times does override theirs. To contextualise this internal unevenness, we now examine the disparate sources of health law in Wales.

SOURCES OF WELSH HEALTH LAW

Law in Wales generally manifests in four ways: legislation passed by the Senedd, laws of general UK-wide application passed at Westminster, European and international law, and the binding common law of England and Wales. As will be seen, these principles and rules cannot be ordered into a neat hierarchy without remainder. Rather, Welsh health law is better regarded in its complexity as a 'spaghetti bowl' of norms derived from multivarious, sometimes conflicting, sources.

Welsh legislation

Wales has its own health law framework, comprised of primary and secondary legislation enacted by Senedd Cymru. Primary legislation ('Acts of the Senedd') has the same legal force in Wales as Westminster laws.[45] Welsh health laws include the Social Services and Well-being (Wales) Act 2014 and the Public Health (Wales) Act 2017. The former imposes a duty to promote the wellbeing of those who need care and support, emphasising outcomes and partnerships in care; the latter requires public bodies to carry out health impact assessments and imposes a duty upon Welsh ministers to make regulations about the circumstances and ways in which they carry them out. As noted above, all health-related matters are devolved to Wales, except for those explicitly reserved to Westminster, including abortion and xenotransplantation.[46] Given its significance for criminal law, mental

44 M Kettle, 'Only a full devolution reset can stop the UK splintering apart' *The Guardian* (London, 30 June 2021).

45 Permitted by GOWA 2006, pt 4.

46 Wales Act 2017, sch 7A, s J1, s J2.

capacity continues to be governed by the UK-wide legislation, related regulations and Code of Practice. By contrast, while the Mental Health Act 1983 as amended in 2007 applies across England and Wales, mental health policy is almost wholly devolved.[47] Thus, while the conditions under which people can be lawfully detained or compelled into assessment are not devolved, care quality and the operation of Mental Health Review Tribunals are.[48]

The legislative process is initiated when a 'Public Bill' is introduced by the Welsh Government, a Member of the Senedd, or a Senedd Committee.[49] The Bill undergoes a four-stage process under Standing Order 26, including consideration of general principles by the Senedd in plenary and by its Health, Social Care and Sport Committee, line-by-line scrutiny, a discussion of proposed amendments, and a final vote. Secondary legislation is laid down by ministers as statutory instruments and regulations.[50] The latter may augment UK, as well as Welsh, legislation. The Welsh Government is now subject to a duty to codify discrete areas of legislation, including health. This will involve a consolidation and rational ordering, though not a substantive rewriting, of all applicable statutes, both Welsh and UK-wide.[51]

Welsh legislation is subject to limitation and challenge in several ways. As we have discussed, it may be repealed or abrogated by subsequent Westminster statutes, though this is subject to the Sewel Convention which requires Cardiff's consent as a political matter.[52] Equally, devolved legislation must be repealed if found to exceed legislative competence by the Supreme Court on referral by the UK Attorney General or the Counsel General for Wales,[53] as happened with the Recovery of Medical Costs for Asbestos Diseases (Wales) Bill 2013.[54] Finally, all new Welsh legislation must be pre-certified

47 With the exception of detaining restricted patients, mental health policy and services are fully devolved to Wales. See 'Commission on Justice in Wales: supplementary evidence from the Minister for Health and Social Services' (Welsh Government 2019) 3.

48 B Hannigan, 'Observations from a small country: mental health policy, services and nursing in Wales' (2021) Health, Economy, Policy and Law 1, 5.

49 'Guide to the legislative process' (Senedd Cymru, 28 May 2021).

50 Eg Coronavirus Act 2020 (Commencement No 1) (Wales) Regulations 2020.

51 Legislation (Wales) Act 2019, s 1.

52 Inserted into GOWA 2006, s 107(6), by Wales Act 2017, s 2.

53 This was the case with the Local Government Byelaws (Wales) Bill which the Supreme Court ultimately held was within the Senedd's competence: *Local Government Byelaws (Wales) Bill 2012 – Reference by the Attorney General for England and Wales* [2012] UKSC 53.

54 *Recovery of Medical Costs for Asbestos Diseases (Wales) Bill – Reference by the Counsel General for Wales* [2015] UKSC 3.

as compatible with the European Convention on Human Rights (ECHR)[55] and may be challenged under the Human Rights Act 1998 (HRA 1998) on the same basis as UK legislation.[56] Unlike the latter, however, Welsh laws can be struck down if they contravene Convention rights.[57] This additional check has been positively embraced by the Welsh Government, which opposed Westminster's 2016 proposal to withdraw from the ECHR and replace the HRA 1998 with a, 'British' Bill of Rights.[58]

Local authorities are empowered by Welsh legislation to plan, commission and provide frontline health services for their communities.[59] They also play an active role in addressing social determinants of health through functions relating to local transport, education and housing.[60] This is achieved through the passage of health-related byelaws (eg for the preservation of green spaces) and through policy development.[61] In particular the Well-being of Future Generations (Wales) Act (WBFGA) 2015 established public services boards (PSBs) within local authorities which have a statutory duty to carry out wellbeing assessments and formulate health and social care plans. The city of Cardiff PSB, for example, has acted to tackle air pollution by incentivising public transport use and cycling.[62]

UK legislation

The Westminster Parliament remains an important source of health legislation in Wales. Pre-1998 statutes have been carried over, though they are subject to amendment and repeal in areas of devolved competence such as health. Thus, the Children Act 1989 still applies

55 As with the Human Transplantation (Wales) Bill: Explanatory Memorandum incorporating the Regulatory Impact Assessment and Explanatory Notes (Welsh Government, 25 June 2013) [174]; Wales Office, Pre-Legislative Scrutiny of the Proposed National Assembly for Wales (Legislative Competence) (Health and Health Services) Order 2 (January 2011) [32].

56 GOWA 2006, ss 108A(1)–(2)(e).

57 T G Watkin, 'Human rights from the perspective of devolution in Wales' (British Academy Briefing 2016) 5.

58 House of Lords Select Committee, 'The UK, the EU and a British Bill of Rights, chapter 8: the impact of repealing the Human Rights Act in the devolved nations' (HRA0001) [159].

59 Local Government (Wales) Act 1994, sch 9, as amended by the Local Government (Wales) Measure 2011. See *Improving Health in Wales: A Plan for the NHS with its Partners* (National Assembly for Wales 2001) ch 4.

60 *Health in Wales: Chief Medical Officer's Report 2001/2002* (National Assembly for Wales 2002) 48.

61 Cardiff Council Environmental Scrutiny Committee, 'Report: cycling in Cardiff's parks' (March 2012) KF1, 6; Local Government Byelaws (Wales) Act 2012.

62 *Cardiff Well-being Plan 2018–2023: Annual Report 2019/20* (Cardiff Public Service Board 2020) 19.

subject to changes made by the Social Services and Well-being (Wales) Act 2014, which creates a statutory duty to assess the care and support needs of children and replaces the 'medical model' language of the UK Act, which determined need on specific bases of age and disability, with an 'impairment neutral' model, namely, 'people who need care and support'.[63] Post-1998 legislation of UK-wide application, such as the Health and Social Care Act 2012 and the Mental Capacity Act 2005, is a further source.[64] As noted above, the ongoing judicial review of the Internal Market Act 2020 will determine whether such legislation can be challenged for infringing on devolved competences. Should the application succeed, the Supreme Court would still only be able to advise on interpretation, as it cannot overturn an Act of the UK Parliament.[65] Under the Memorandum of Understanding between the constituent territories of the UK, consultations are to be held with the devolved governments on legislation that will apply across the UK, as was the case with the HRA 1998 and the Equality Act 2010, and on devolved matters and related policy fields regardless of whether they entail legislative change.[66] In addition, it is worth noting that the Welsh Affairs Committee at Westminster scrutinises Wales Office activity and UK proposals impacting Wales. In 2010 it inquired into the Senedd's legislative competence in relation to a change in organ donation rules discussed more fully in the next section.[67] Welsh Members of Parliament in the House of Commons can vote on health legislation regardless of its territorial scope of application.

European and international law

As the UK is no longer an EU member state, section 108(6) GOWA 2006, which required Acts of the Senedd to comply with EU law obligations, now has no legal effect.[68] New EU law has ceased to be binding in the UK following the Brexit transition period, but a snapshot of 'retained EU Law' as it applied on 31 December 2020 has been converted into domestic law.[69] Examples of this include UK Health and Safety (Consultation with Employees) Regulations 1996, which derived from the EU's Health and Safety Framework Directive

63 Social Services and Well-being (Wales) Act 2014, s 3. See L Clements, 'The Social Services & Well-being (Wales) Act 2014: an overview' (January 2021).

64 Westminster can also pass legislation for Wales only, like the Transport (Wales) Act 2006.

65 See the Counsel General's challenge of the Internal Market Act, discussed above.

66 Devolution Guidance Note 1 Common Working Arrangements [23]–[28].

67 House of Commons Select Committee, 'Organ donation (legislative competence)' (*Parliament.uk*, 4 April 2011).

68 EU Withdrawal Act 2020.

69 EU (Withdrawal) Act 2018, ss 2–4.

89/391/EEC, and the Control of Asbestos Regulations 2012 drawing on EU Directive 2009/148/EC.[70] British courts may have regard to decisions of the Court of Justice of the European Union (CJEU) so far as they are relevant or may aid in interpreting retained EU law in domestic cases, though they are not bound to do so.[71] However, the CJEU retains a time-limited jurisdiction in relation to the rights of EU citizens residing in the UK, which include rights to access healthcare and social security.[72] These are enforced through a preliminary reference procedure, by which UK courts seek guidance on the interpretation of citizens' rights in cases commencing within eight years of the transition period.[73]

International law relevant to health enters Welsh law in three ways. First, by direct incorporation into applicable UK law. Treaties may be domesticated in full, for example the ECHR through the HRA 1998, or in part, for example elements of the Convention on the Rights of Persons with Disabilities (CRPD) through section 6 Equality Act 2010.[74] Second, by direct incorporation through Senedd laws, for example the UN Convention on the Rights of the Child (CRC), article 24 of which confers the right to the highest attainable health standards, was integrated in Wales through the Rights of Children and Young Persons (Wales) Measure 2011. Third, by direct incorporation into Welsh law through secondary legislation, including the Equality Act (Wales) Regulations 2011. Additional to this are treaties ratified by the UK which it, and by extension the Welsh Government, is obliged to implement, even though their provisions are not part of domestic law, for example article 12 ICESCR which enshrines the right to the highest attainable standard of health for all. In addition, international law has proved an important source for Welsh policy and law-making in more indirect ways. For example, the Action on Disability Protocol embeds the CRC and optional protocols into Welsh law through a requirement being placed on specified bodies to have regard to the Convention when carrying out functions.[75]

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70 Health and Safety (Amendment) (EU Exit) Regulations 2018 (SI 2018/1370).

71 EU (Withdrawal) Act 2018, s 6.

72 Pt 2 of the European Withdrawal Agreement 2020. See T Hervey, N Miernik and J C Murphy, 'How is part two of the Withdrawal Agreement (citizens' rights) enforceable in the courts?' (*EU Law Analysis*, 28 May 2020).

73 European Withdrawal Agreement, art 158(1). Brought into UK law by the European Union (Withdrawal) Act 2018, s 7C, the UK legal effect will be the same as under the Treaty on the Functioning of the European Union, art 267.

74 The definition of 'disability' in the Equality Act 2010 overlaps with but is narrower than that in the CRPD.

75 Welsh Government, 'Action on disability: the right to independent living – framework and action plan' (2019) 7.

Professional and advisory bodies

Professional licensing and regulation of health workers in Wales remains a matter for UK-wide bodies, including the General Medical Council and the Nursing and Midwifery Council.[76] While not sources of law, statutory bodies like these and others help to shape and influence policy and governance by setting norms and standards for professional conduct. They enforce these standards through disciplinary powers, which are capable of review in the Court of Appeal and can result in practitioners being struck off the register.[77] Advisory bodies, professional associations and 'think tanks' operating at UK level, like the Nuffield Council on Bioethics, the Faculty of Public Health and the Nuffield Trust, provide expert input into policy and legislation affecting Wales, whether made in Cardiff or London. Thus, the Welsh Government pledged to invest an additional £295 million in NHS Wales in 2015–2016, after a Nuffield Trust report highlighted the threat to service provision resulting from Westminster's austerity policies.[78] This is complemented by the work of Wales-based bodies, whether official, such as the COVID-19 Moral and Ethical Guidance for Wales Advisory Group, which provides policymakers with COVID-related ethical advice, or civil society, such as Cymru Well Wales, a public and voluntary sector collective.[79] More indirectly, values and standards promoted by NHS Wales and Public Health Wales (PHW) may be taken up within the terms of employment contracts and, thus, be the focus of common law decisions on the quality of care or practices around the end of life, for example.

Common law and the 'Welsh jurisdiction'

Although legislation is increasingly important in health law generally,[80] case law remains central to areas such as consent, negligence and end-of-life decision-making, as well as to statutory interpretation.[81] In

76 Others include the General Dental Council, the General Chiropractic Council, the General Optical Council and the Hearing Aid Council.

77 See, for example, *General Medical Council v Bawa-Garba* [2018] EWHC 76.

78 A Roberts and A Chatsworth, 'A decade of austerity in Wales? The funding pressures facing the NHS in Wales to 2025/26' (Nuffield Trust 2014); 'Written statement – together for health' (Welsh Government, 25 March 2015). The report was commissioned by the Welsh Government.

79 PHW, ACE Aware Wales; Welsh Government, 'COVID-19 Moral and Ethical Guidance for Wales Advisory Group' (CMEAG-Wales).

80 M Brazier and J Miola, 'Bye-bye Bolam: a medical litigation revolution?' (2000) 8(1) Medical Law Review 85–114.

81 *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 583. See S W Chan and others, 'Montgomery and informed consent: where are we now?' (*British Medical Journal*, 12 May 2017). *R v Bournewood Community and Mental Health NHS Trust, ex parte L* [1998] UKHL 24; *HL v UK* [2004] ECHR 471.

our case, this remains the common law of England and Wales, which has been unified since 1535. The legal profession and judiciary are similarly fused across the two countries. In the present context it is worth noting, moreover, that legal commentators and the judiciary have treated law as being more or less one across all three jurisdictions, namely, Scotland, Northern Ireland, and England and Wales. Thus, leading Scots cases from *Hunter v Hanley*[82] to the recent *Montgomery v Lanarkshire Health Board*,[83] are treated as leading precedents for the whole UK.

This is starting to change, however. Whereas in 1999 Lord Bingham suggested that the prospect of a distinct Welsh common law was 'improbable', current and future trends render it more likely.[84] Thus, a distinct Wales court circuit has developed, alongside the practice of hearing Welsh cases in the Administrative Court in Wales[85] and the establishment of a Mental Health Review Tribunal for Wales, already mentioned.[86] All courts, common to England and Wales, or specific to the latter are faced with significant challenges in interpreting and applying applicable health law, given the complexity of sources. Where legislation from either Cardiff or London governs a field or an issue exclusively, its application will be unproblematic. But, as we have seen, this is rarely the case. Often it will be necessary to construe legislation of diverse origin together, as is the case with the Mental Health (Wales) Measure 2010 and the (UK) Mental Health Act 2007, for example. Moreover, the prior question of whether a field is exclusively governed by a specific law is always itself a matter of interpretation, as with more or less obvious examples of the 'jagged edge' between devolved and non-devolved responsibilities. These difficulties pose a significant impediment to the determination of the rights and responsibilities of health workers, patients and citizens, and thus to the effective delivery of care and public health more generally. Wales is alone in the UK in lacking a legal jurisdiction under which to determine these questions, and to allow the development of a coherent and intelligible body of law on the implementation of its devolved law-making powers in

82 *Hunter v Hanley* [1955] ScotCS CSIH_2.

83 *Montgomery v Lanarkshire Health Board* [2015] UKSC 1.

84 T Bingham, 'The common law: past, present and future' (1999) 25(1) Commonwealth Law Bulletin 18–30, 25.

85 R Evans, 'Devolution and the Administration of Justice' (Lord Callaghan Memorial Lecture 2010), cited in H Pritchard, 'Revisiting legal Wales' (2019) Edinburgh Law Review 23, 123–130, 126.

86 For a powerful critique of liberal approaches to health law and ethics, see Commission on Devolution in Wales, 'Empowerment and responsibility: devolving financial powers to Wales' (HM Treasury/Wales Office 2012).

health.[87] While this raises rule of law issues of general concern, it is worth recalling that health law raises especially significant matters of life and death, essential liberties, and meaning and value in individual lives. Realisation of these formal values is threatened by growth of heterogeneous norm-creation and interpretation without clear oversight by practitioners, academics and the judiciary.[88]

Such concerns have led to calls for the creation of a separate Welsh jurisdiction.[89] While initially reluctant, the Welsh Government added its support in a 2021 policy statement *Reforming the Union*.[90] Academic commentators concur on the basis that Wales already possesses two of the three widely accepted prerequisites for a separate legal jurisdiction, namely, a defined territory and a distinct body of law, though not yet a structure of courts and legal institutions.[91] More importantly, the complexity of law in Wales requires the development of legal sub-disciplines and a body of specialist practitioners that can only come about through a distinct jurisdiction. The creation of the Administrative Court for Wales points the way in this regard,[92] as does the appointment of Lord Lloyd Jones to the Supreme Court on the explicit basis that a judge with Welsh expertise was needed to interpret post-devolution law.[93]

LEGISLATING FOR HEALTH

Health law in Wales is increasingly distinctive from that in England and the rest of the UK, not only as regards its sources, but also in its content. This is significantly due to the activity of the legislator in Cardiff, seeking to maximise use of its limited, if expanding, devolved powers. Health is of particular political importance in this regard, given the close association of the Labour Party, long dominant in Wales,

87 E Llwyd, N Evans and A F Jones, 'Developing a Welsh legal jurisdiction' (Plaid Cymru 2010).

88 J Montgomery, 'Law and the demoralisation of medicine' (2005) 26 Legal Studies 185.

89 Commission on Justice in Wales, 'Report: justice in Wales for the people of Wales' (2019) 498–500.

90 Evidence submitted by the Welsh Government to the Commission on Devolution in Wales, Welsh Government Evidence Paper WG17658 (18 February 2013) 2. 'Reforming our Union: shared governance in the UK' (Welsh Government, June 2021).

91 J Williams, 'The emerging need for a Welsh jurisdiction' (2010) IWA Agenda 42, 38–40, 38.

92 *R (Bridges) v Chief Constable of South Wales Police* [2020] EWCA Civ 1058, heard in Wales, was the first UK case to consider the compliance of automated facial recognition technology with ECHR rights.

93 'First Welsh Supreme Court judge is appointed' (*BBC News*, 21 July 2017).

with the NHS.[94] Reform of healthcare delivery has, thus, been a key focus since devolution. Admittedly, prior to 1998, the Welsh Office had discretion regarding the organisation of the health service in Wales.[95] However, ultimate policymaking power remained at Westminster and the service was in truth no more than a 'bilingual' copy of its English counterpart, adopting market-oriented reforms under both Conservative administrations from 1979 to 1997.[96] These neo-liberal reforms were undone soon after devolution, in Wales as in Scotland.[97] Instead, Cardiff sought to integrate health and local government,[98] promoting participation and decentralisation by vesting the running of the NHS in 22 local health boards which were subject to a process of democratic health planning through reinvigorated Community Health Councils.[99] This innovation was subsequently curbed as a result of the 2003 Wanless Report, which highlighted the failure of Wales's reformed NHS to deliver improvements in the quality of care and access to it.[100] Since 2009, therefore, the recentralised Welsh NHS has been comprised of seven health boards and three NHS trusts, collectively responsible for providing primary and secondary care, along with public and mental health, accountable directly to the Welsh Government. Though abrogating the more thoroughly democratic orientation of the first phase of devolution, this recentralisation was subsequently seen as enabling Wales's relative success in implementing lockdowns and rolling out vaccine delivery during the COVID-19 pandemic.[101]

In public health, devolved Welsh administrations have sought to deal with the country's distinctive health burden, much of it a legacy of industrialisation and deindustrialisation in urban areas. High-profile

94 T Smith and E Babbington, 'Devolution: a map of divergence in the NHS' (2006) 1 British Medical Journal Health and Policy Review 9.

95 For example, the Health Authorities Act 1995 enabled the Welsh Secretary to vary, abolish or create health authorities. This power was used in 1996 to disband Wales's nine authorities and replace them with five. See Health (Wales) Act 2003.

96 S Greer, 'Devolution and health in the UK: policy and its lessons since 1998' (2016) 118 British Medical Bulletin 16.

97 Ibid 21–22.

98 S Greer, 'Four way bet: how devolution has led to four different models for the NHS' (The Constitution Unit 2004) 4.

99 'Improving health in Wales: structural change in the NHS in Wales' (National Assembly of Wales 2001). Community health councils will be replaced in 2023 by a single national Citizen Voice Body, shifting away from localism and towards (English) centralization: Health and Social Care (Quality and Engagement) (Wales) Act 2020, s 23, pt 4.

100 D Wanless, 'The review of health and social care in Wales' (Welsh Assembly Government 2003).

101 H Gye, 'Wales has triumphed on vaccine rollout because of small supply buffer and centralised NHS, First Minister says' (*i*, 15 June 2021).

initiatives have been directed at reducing tobacco use and increasing organ donation. Thus, smoking restrictions in all workplaces were introduced in 2005,[102] following earlier UK Labour Government White Papers.[103] The ban was extended to enclosed public spaces, as well as school grounds, hospital sites, public playgrounds and children's football matches, in an effort to reduce the harmful effects of second-hand smoke.[104] The sale of nicotine products (including e-cigarettes) to children under 18 has also been proscribed, though attempts to instate a general ban on smoking in cars and vaping failed to secure sufficient support among legislators.[105] These initiatives were intended to 'de-normalise smoking behaviour and reduce the chances of children and young people taking up smoking', a goal which the Welsh Government affirmed was underpinned by children's right to health *inter alia* enshrined under the UN CRC.[106] On the whole, a more openly interventionist and frankly paternalist public health strategy has prevailed, in the face of objections from libertarian commentators and campaigners who sought to defend the right to smoke in terms of individual autonomy, an argument which apparently has less traction in Labour-dominated Cardiff than at Conservative-led Westminster.[107]

The rhetorical privileging of collective over individual interests also marked the reform of post-mortem organ donation in Wales, Thus, where the UK-wide Human Tissue Act 2004 operated a system of express consent, evidenced by a person registering to be an organ donor, the Human Transplantation (Wales) Act 2013 enshrines the principle of deemed consent, under which all who die are assumed to have agreed to their organs being donated unless they object.[108] The Act imposes a duty on Welsh ministers to increase public knowledge about consent and is premised on claims that countries with 'opt-outs' have higher donation rates.[109] Indeed, Wales has the highest organ

102 Action on Smoking and Health, 'Advance media briefing: government consultation on smoking in workplaces' (17 June 2005).

103 *Smoking Kills* (Department of Health 1998); *Secondhand Smoke, Public Health* (Department of Health 2004).

104 Smoke-free Premises etc (Wales) Regulations 2007; Public Health (Wales) Act 2017; Smoke-free Premises and Vehicles (Wales) Regulations 2020.

105 Public Health (Wales) Act 2017, pt 1, s 1(3)(d); 'E-cigarette ban proposals defeated in Welsh Assembly' (*ITV News*, 16 March 2016).

106 Welsh Government, 'Smoke-free law: guidance on the chances from March 2021' (22 December 2020).

107 Eg smokers' lobby group Forest, see 'Wales starts public smoking ban' (*BBC News*, 2 April 2007).

108 Human Transplantation (Wales) Act 2013, ss 1–4.

109 A Abadie and S Gay, 'The impact of presumed consent legislation on cadaveric organ donation: a cross-country study' (2006) 25 Journal of Health Economics 599.

consent rate of all four of the UK's constituent territories, though there has been little overall change in the number of suitable donors or successful transplants.[110] Again, this public health measure was adopted in the face of pro-autonomy arguments, with the Welsh Government justifying its reforms on the basis that Wales is 'a nation known for altruism, generosity and thought for others'.[111] This sense of exceptionalism has dissipated somewhat since then given that similar opt-out systems have now been implemented in England and Scotland, respectively, and one is currently proposed for Northern Ireland.[112]

Our discussion of selected initiatives suggests the emergence of a substantive corpus of Welsh health law. We have also picked out some features and trends as regards the values that informed these developments. These varied over time and issue. Thus, while solidarity was consistently emphasised, values of participation rose and fell in influence. There has undeniably been an expressive element to this legislation, with health policy reform used to signal both the fact that Wales is now self-governing in this area and that it pursues more 'virtuous' policies. In sum, the embrace of collectivism in the absence of participation has privileged the central (now Welsh) state as the lead actor in health, rather than either private companies, local government, or citizens themselves. This stance came to wider public attention during the COVID-19 pandemic, as we discussed above, with First Minister Drakeford claiming his Government's aim had been to keep Welsh people 'safe'.[113]

In practice, as we have noted, these specific initiatives have met with only modest success. A history of inequality, poverty and marginalisation, in both urban and rural areas, means that much of the population continues to suffer from relatively poor underlying health. These enduring features were reckoned to be one cause of Wales's high COVID-19 death rate, and indeed government policy and decision-

110 J Parsons, 'Ensuring appropriate assessment of deemed consent in Wales' (2019) 45 Journal of Medical Ethics 210.

111 D J Dallimore et al, 'Media content analysis of the introduction of a "soft opt-out" system of organ donation in Wales 2015–17' (2019) 22 Health Expectations 485; *Proposals for Legislation on Organ and Tissue Donation* (Welsh Government White Paper WG13956, 2011) 1.

112 The Organ Donation (Deemed Consent) Act 2019, also known as Max and Keira's Law; Human Tissue (Authorisation) (Scotland) Act 2019; Northern Ireland Department of Health, 'Public consultation document on the introduction of a statutory opt-out system for organ donation for Northern Ireland' (11 December 2020).

113 Welsh Government, 'Written statement: keeping Wales safe from coronavirus' (Welsh Government, 22 September 2020).

making have not gone without criticism in this regard.[114] Viewed in terms of effectiveness, then, Welsh policy might be considered 'different', but not necessarily 'better' when compared with that in other parts of the UK.[115] Ironically perhaps, this adds a further justification for taking Welsh health law seriously as such. In ways not always allowed for by political speech writers, the concrete institutional and epidemiological problems which law and policy seeks to reshape are particular to Wales. If health law is to be more than simply an exercise in closed doctrinal reasoning, it needs to be developed and critiqued with reference to these practical effects and their specific national and sub-national contexts. Accepting that, in the next and penultimate section, we widen our review, considering features of historic and contemporary practice which indicate a discrete, though by no means unique, set of concerns and values for health law in Wales.

VALUES FOR A WELSH HEALTH LAW

Values matter to the descriptive study of policy and law. Political scientists, studying divergence and convergence as between the four UK health systems, recognise that 'different systems make different choices because policymakers differ in the meaning and priorities they assign to different values'.[116] Scholars of health law have been less willing to embrace value pluralism as an explanatory variable in their accounts. Developing in symbiosis with modern bioethics, health law has instead been described with reference to universally valid principles cast in fairly abstract terms. It is ideally timeless and placeless, with actual variation more likely to be attributed to day-to-day political tactics and constitutional struggles. Against this, however, one of us has argued elsewhere that health law in the decades following the Second World War was *British* in a significant sense: permeated by locally specific cultural forms and assumptions about the purpose of the welfare state and the NHS, and the nature of clinical practice, for

114 J Halliday, '"It's heartbreaking": inequality reaps high Covid toll in south Wales valleys' *The Guardian* (London, 8 February 2021); 'Covid-19: UK had one of Europe's highest excess death rates in under 65s last year' (*British Medical Journal*, 23 March 2021). See also Hayward (n 5 above).

115 E St.Denny, 'What does it mean for public policy to be "made in Wales"?' (*LSE BPP*, 19 October 2016).

116 S L Greer and D Rowland, 'Why discuss values in health? Why now?' in S L Greer and D Rowland (eds), *Devolving Policy, Diverging Values? The Values of the United Kingdom's National Health Services* (Nuffield Trust 2008) 13.

example.[117] In pointing towards *Welsh* values as an additional indicator of distinctiveness, we are not thereby elevating the merely provincial in place of the universal. Rather, we are drawing out the analytical implications of the relativisation of Anglo-Britain as the container and source of health law across the UK. Given this constitutionally, legislatively and (in part) jurisdictionally plural landscape, an adequate account of health law in the UK requires us to attend to the values immanent in the institutional histories and professional cultures of the devolved nations. That is, of course, an onerous and open-ended task well beyond the scope of the present article. What we offer here, in the case of Wales, is a very brief indication of some distinct values and their sources in law, practice and social history. Before doing so, it is important to clarify that we are not claiming that some Welsh essence expresses itself in health law. Even if such a quality could be defined, it would be unlikely to find a way through the admixture of applicable norms deriving from a variety of national, British and international sources. Moreover, as will be seen, the values themselves can also be traced to these diverse sources, and they are shared to varying degrees by many other countries.

Solidarity

Mutual concern and assistance have repeatedly been picked out as distinctive Welsh values, particularly by Labour leaders since devolution. Former First Minister Rhodri Morgan, for example, referred to solidarity as 'the powerful glue' of Welsh society.[118] This talk is no doubt strategic and performative, striving rhetorically to create a distinct polity within the terms of one party, and has properly been met with scepticism by some academic commentators.[119] Nonetheless, it does build on a tradition with historical warrant, albeit one which is more pluralistic than that evoked for party political advantage. Central to most accounts are the Welsh origins, not just of the founder of the NHS, Aneurin Bevan, but of its institutional form. As we have noted, prior to 1948, healthcare was provided across the

117 J Harrington, *Towards a Rhetoric of Medical Law* (Routledge 2017). The enduring importance of the NHS as a marker of Britishness is borne out in current debates about the terms of any future reunification of Ireland: see S Breen, 'Poll: NHS could be crucial in border poll with support for united Ireland and the Union running neck-and-neck' *Belfast Telegraph* (Belfast, 25 October 2020).

118 Rhodri Morgan, 'Clear red water' (speech to the National Centre for Public Policy Swansea, 11 December 2002)

119 Moon (n 12 above). See also, D Evans, K Smith and H Williams, 'Introduction: the Welsh way', in D Evans, K Smith and H Williams (eds), *The Welsh Way: Essays on Neoliberalism and Devolution* (Parthian 2021) 1–24.

UK through a patchwork of charitable, local authority and private facilities.[120] This largely restricted the best and most comprehensive care to the wealthy. The South Wales coalfield was a partial exception with its network of medical aid societies. Pooling the subscriptions of miners, societies employed general practitioners to deliver primary care for all, as documented in A J Cronin's bestselling 1937 novel *The Citadel*.[121] Alongside them, miners' institutes, hubs of community life in South Wales, catered to wider welfare needs by promoting sport and leisure activities.[122] For Cronin, this health infrastructure provided the blueprint for socialised medicine across the UK.[123] Bevan, who had himself chaired the Tredegar Workmen's Medical Aid Society, claimed that: 'all I am doing is extending to the entire population of Britain the benefits we had in Tredegar for a generation or more. We are going to "Tredegar-ize" you.'[124]

Solidarity was not limited to the coalfield or to groups traditionally seen as bearers of Welshness. Thus, nineteenth-century Irish immigrants, faced with sectarian hostility from the local population, established 'Hibernian societies' to provide mutual aid for healthcare and welfare more generally.[125] The 1980s saw a Wales-focused campaign to challenge prejudice and discrimination relating to the HIV/AIDS pandemic and to promote inclusive and rational public health strategies in response.[126] While wider alliances were not easily formed, they were able to build on the solidarity shown by the 'Lesbians and Gays Support the Miners' group in South Wales during the national strike of 1984.[127] Though women (and children) benefited from the medical aid societies, the latter were largely led and funded by men. There is nonetheless an important history of women's collective action for health down to the present day. Thus, in the nineteenth and early twentieth centuries, middle-class organisations, like the Ladies Samaritan Fund, raised and distributed funds for local hospitals and patients.[128] With a more overtly political focus, the suffrage movement from the 1890s onwards allied with Welsh nationalist and

120 Cf Michael (n 8 above) 3.

121 M Longley, 'Prudent progress in the Welsh NHS' (Nuffield Trust, 29 July 2015).

122 See, for example, Blackwood Miners' Institute, 'Our history'.

123 A J Cronin, *Adventures in Two Worlds* (Gollancz 1952) 140.

124 'NHS 70: Aneurin Bevan day celebrations in Tredegar' (*BBC News*, 1 July 2018).

125 P O'Leary (ed), *Irish Migrants in Modern Wales* (Liverpool University Press 2004) 44, 190, 207.

126 D Leeworthy, *A Little Gay History of Wales* (University of Wales Press 2019) 115ff.

127 Ibid xi.

128 K Bohata et al, *Disability in Industrial Britain: A Cultural and Literary History of Impairment in the Coal Industry, 1880–1948* (Manchester University Press 2020) 108.

socialist campaigns to promote social goals, including health.[129] Much more recently, Muslim women of South Asian heritage established and ran food delivery and support services in Cardiff and Swansea for communities disproportionately affected by the COVID-19 pandemic.[130] Mutual aid in these diverse forms has not been exclusive to Wales, of course.[131] We make no plea for exceptional virtue here. Rather, we do point to the framing of many of these initiatives in terms of specifically national traditions and note that this provides a discursive resource for argument about the development of health law in Wales.

Sustainability

Welsh historical experience also informs a concern with sustainability on the part of government and civil society. From the early nineteenth century, Wales was a major site of extraction (eg coal and slate mining) and primary processing (eg steel production) for the British economy. With ownership largely resting outside the country, this skewed development and created a massive burden of ill-health and environmental damage. Deindustrialisation since the 1960s, again imposed by external political and economic forces, has seen many of these difficulties persist and added new challenges (eg addiction and mental illness).[132] Over the same extended period, the Welsh language lost in prestige and numerical predominance, being marginalised by processes of British state-formation (eg in law and education) which privileged English.[133] Not surprisingly perhaps, devolved Wales has taken conservation and regeneration as key goals. An official commitment to achieve a bilingual society was matched by GOWA 1998, which imposed a duty on the Assembly (now Senedd) to promote sustainable development across all policies.[134]

The latter commitment has been given fuller legal form in the WBFGA 2015, which seeks to put the UN's Sustainable Development Goals at

129 U Masson, '"Hand in hand with the women, forward we will go": Welsh nationalism and feminism in the 1890s' (2003) 12 Women's History Review 357.

130 R Youle, 'The untold story of the Swansea Bangladeshi community and how it is reacting to the coronavirus pandemic' (*Wales Online*, 30 July 2020); E Ogbonna et al, 'First Minister's BAME COVID-19 Advisory Group report of the Socioeconomic Subgroup' (Welsh Government, 2020) 8.

131 See, for example, M Gorsky, 'Mutual aid and civil society: friendly societies in nineteenth-century Bristol' (1998) 25 Urban History 302.

132 C Jones, 'In what sense sustainable? Wales in future nature' in Evans et al (n 119 above) 91–104.

133 See G A Williams, *When Was Wales? A History of the Welsh* (Penguin 1984) 245–248.

134 See, respectively, Welsh Assembly Government, *Iaith Pawb: A National Action Plan for a Bilingual Wales* (WAG 2003); GOWA 1998, s 121.

the heart of public administration, as we have noted above. The Act's underpinning ethos of ensuring 'that the needs of the present are met without compromising the ability of future generations to meet their own needs'[135] can be read as a response to the instrumental depletion of Welsh lives and landscapes in the past. Its legal operationalisation of moral duties to coming generations is unique in the world.[136] A statutory duty is placed on public bodies to work collectively to achieve seven wellbeing goals, which include health and wellbeing, equality, and global responsibility. Citizens may seek judicial review of official decisions that fail to take account of these goals,[137] but it is the office of the Future Generations Commissioner which is central to overseeing the Act's implementation. Though the Commissioner cannot formally compel or prevent specific actions, she can issue recommendations to public bodies, including the Welsh Government, regarding their impact on sustainability.[138]

Widely acknowledged as a landmark initiative, the detail of the Act is not without its critics. In particular, as Haydn Davies has argued, it only imposes on authorities a relative duty 'to endeavour to achieve' its goals, not a duty to secure well-defined results.[139] As such it runs the risk of functioning merely as a means of signalling Welsh virtue, fine talk to compensate for Cardiff's still limited legislative capacity.[140] Against this, however, must be set recent developments, notably the success of the current Commissioner in objecting to the construction of the M4 relief road through environmentally significant wetlands near Newport in 2019.[141] More broadly, the Act has reinforced the more holistic approach to health, which includes, but also goes beyond clinical care and traditional public health, consistent with the promotion of equivalent 'One Health' approaches in Wales.[142]

Equality

The value of equality is implicit in the foregoing discussion of solidarity and sustainability. In both cases we observed historic and

135 WBFGA 2015, s 5.

136 See, further, R Jones, 'Governing the future and the search for spatial justice: Wales' Well-being of Future Generations Act' (2019) 197 Fennia 8.

137 WBFGA 2015, ss 3–5. See H Davies, 'The Well-being of Future Generations (Wales) Act 2015: duties or aspirations?' (2016) 18 Environmental Law Review 41.

138 WBFGA 2015, s 20.

139 Cf Davies (n 137 above) 47.

140 Evans et al, 'Introduction' (n 119 above) 9.

141 The Planning Inspectorate, 'M4 corridor around Newport (M4CAN) inspector's report on public local inquiries' (Welsh Government, 21 September 2018).

142 See, for example, Learned Society of Wales, 'One health Wales: the importance of People's Wellbeing and Planetary Health Western Mail Column' (21 June 2017).

contemporary trends extending the category of 'who counts', beyond the wealthy and beyond the present generation, respectively. Of course, the definition of equality, and of the duties that attend it, are contested among philosophers and practitioners. Against the thin conception of 'equality of opportunity' can be set the maximalist 'equality of outcome'.[143] Both differ from the now well-articulated understanding of 'equity' which directs that policymakers and legislators be guided by the different health needs of different groups in allocating resources.[144] Considerations of health equity are applicable both within Wales and across the UK. Thus, persistent disparities in life-expectancy and ill-health divide even neighbouring regions such as Cardiff and the former mining valleys. This is a challenge for the fair distribution of resources for health promotion as between regions internally. Equally, Wales as a whole has the highest percentage of the population over 70 and the highest rate of smoking in the UK, as well as the worst incidence of asthma in Europe.[145] In its turn, this casts a harsh light on the current funding settlement between Wales and the UK Treasury, based on the so-called Barnett formula, which is not calculated with reference to this greater health need.[146]

Further guidance, and a firmer normative basis for the value of equality, is provided by the international and domestic human rights materials which were considered above as sources of current Welsh health law. Thus, the principle of non-discrimination is enshrined in the ICESCR.[147] As the Committee responsible for that treaty made clear in its General Comment on the right to health, this is a non-derogable obligation of states (including the UK and through it the Welsh Government) – that is, it binds the authorities even in emergency situations, such as pandemics.[148] The principle is common to most human rights instruments, including the UN CRC, which, as we saw, is (in part) directly enforceable in Welsh law.[149] The Equality Act 2010 imposes a more detailed and enforceable equality duty on public bodies, including health boards and NHS trusts, to avoid and eliminate

143 K Saito, 'Social preferences under risk: equality of opportunity versus equality of outcome' (2013) 103(7) American Economic Review 3084–3101.

144 S Nesom, '5 things you should know about gender equality in Wales' (Wales Centre for Public Policy, 5 December 2018).

145 See Hayward (n 5 above) 75.

146 Wales Governance Centre, 'Barnett squeezed? Options for funding floor after tax devolution' (Wales Governance Centre, December 2016).

147 Committee on Economic, Social and Cultural Rights, General Comment No 3: The Nature of States Parties' Obligations (art 2, para 1 of the Covenant) (1990).

148 See further, S Sekalala and J Harrington, 'Communicable diseases, health security and human rights' in L Gostin and B Mason Meier, *Foundations of Global Health and Human Rights* (Oxford University Press 2020).

149 See preamble to Convention on the Rights of the Child 1989.

unlawful discrimination and safeguard the rights of people with a protected characteristic, for example race, gender, disability, sexual orientation.[150] Significantly, given the correlation between social deprivation and ill-health in Wales, discrimination based on economic status was not included among the protected grounds, however.[151]

Cardiff administrations have made high-profile commitments to equality, collaborating with the World Health Organization on assessment tools for measuring progress towards health equity for example.[152] Nonetheless, as in the case of sustainability, there is a risk that commitments remain 'short on detail, light on action', 'aspirational' rather than substantive, as has been argued of the high-profile *Advancing Gender Equality in Wales Plan* of 2020.[153] A more focused and critical approach was taken by Professor Emmanuel Ogbonna and colleagues, commissioned by the Welsh Government's BAME COVID-19 Advisory Group to report on the disparate impact of the pandemic in 2020.[154] The Ogbonna report identified structurally determined inequality in health provision and outcomes, as well as the disproportionate participation of minority staff in 'frontline' occupations, as key causes of this skewed outcome. Explicitly drawing on the MacPherson report into the murder of Stephen Lawrence,[155] it indicated that a lack of ethnic minority representation among NHS leaders and health decision-makers and a failure to engage with all service users and communities in Wales amounted to 'institutional racism'.[156] The report and the Welsh Government *Action Plan* based on it constitute a further important source of Welsh health values, foregrounding, as they do, active anti-racism over passive multiculturalism and attending carefully to the intersectional nature of discrimination in health, particularly as regards women of colour.[157]

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150 Equality Act 2010, s 149.

151 See B Hepple, *Equality: The Legal Framework* (Hart 2014) ch 1.

152 M Honeyman et al, *Digital Technology and Health Inequalities: A Scoping Review* (King's Fund and Public Health Wales 2020); 'New agreement between WHO/Europe and Welsh Government launched to accelerate action on health equity' (WHO, 5 November 2011).

153 Welsh Government, 'Advancing gender equality in Wales plan' (March 2020); M S Jones, 'Neo-liberal feminism in Wales' in Evans et al (n 119 above) 27–42, 32; A Parken, 'Putting equality at the heart of decision-making, Gender Equality Review (GER) Phase One: International Policy and Practice' (Wales Centre for Public Policy, July 2018) 9.

154 Ogbonna et al (n 130 above).

155 Sir W Macpherson of Cluny, *The Stephen Lawrence Inquiry: Report of an Inquiry by Sir William Macpherson of Cluny* (The Stationery Office 1999).

156 Ibid [1]–[5], 6.1.

157 Welsh Government, *An Anti-racist Wales: The Race Equality Action Plan for Wales* (2021).

The three values picked out here – solidarity, sustainability and equality – do not exhaust the field of course. The familiar canon of autonomy, beneficence, non-maleficence and justice will no doubt feature too in coming discussions of ethical practice and law-making in a devolved Wales.[158] Indeed, we can be confident that they already do, as a result of shared British institutions (eg the General Medical Council) and curricula (eg in law schools and medical schools). Nor have we specified these three values in anything like the detail required for philosophical argument or legal reasoning. That will be an important task. But, as we have suggested, it is one which is beyond the scope of this article. Rather, we have used the discussion to suggest Welsh distinctiveness, on the one hand, and the variety of sources, past, present, legal, cultural, which might inform a more systematic study of values, on the other. In this respect we draw support from the work of Alasdair MacIntyre on metaethics.[159] For him, the labour of identifying, arguing about and changing values is one of engagement with tradition. Careful study of context, attending to the particularities of time and place, is essential to identifying or reconstructing an ethic. Like MacIntyre, we see tradition as anything but fixed, essentialist or uncritical. Nonetheless, like him we argue that the elaboration of values must start from somewhere at some time. As such, we diverge from those more universalist views on the source of values, associated with liberal bioethics, which dominated the writing of British medical law from the 1980s onwards.[160]

CONCLUSION

'For Wales, see England.'[161] The notorious entry in the *Encyclopaedia Britannica* has echoed through the legal disciplines until recently. In our case, an unacknowledged Anglo-British frame set the terms of scholarship in health law. The commonplaces that sustained the field, ideas of medical progress and tragic scarcity of resources, the gentleman practitioner, the sovereign patient and so on, drew on

158 See T Beauchamp and J Childress, *Principles of Biomedical Ethics* (Oxford University Press 2009).

159 A MacIntyre, *Whose Justice? Which Rationality?* (Duckworth 1988) 349ff. For an insightful introduction, see D Solomon, 'MacIntyre and contemporary moral philosophy' in M C Murphy, *Alasdair MacIntyre* (Cambridge University Press 2003) 152–175.

160 J Montgomery, 'Law and the demoralisation of medicine' (2006) 26(2) Legal Studies 185–210.

161 *Encyclopaedia Britannica*, 9th edn (1889).

a wider elite culture, specific to the UK in the post-war decades.[162] As we have suggested, those commonplaces can no longer be taken for granted. Their rhetorical potency is waning, the frame broken by constitutional, institutional and cultural developments. Devolution has seen the creation of four health systems in the UK, each subject to the direction of different political masters and administrative cadres, who are themselves accountable to four different polities. Diverse political and professional traditions in health have been revived, as shown by the emphasis on public health and non-market forms of care delivery in Wales. In place of a single UK health law, then, we can observe the emergence of separate corpora of Welsh, Scottish, Northern Irish and English legislation. Each is necessarily subject to interpretation and application in a distinct body of case law, regardless of jurisdiction. Of course, all four retain a considerable family resemblance, due not least to the continuing UK-wide application of key statutes, but also to the shared past of a common NHS and even longer-standing public health practices. Indeed, as COVID-19 has demonstrated, common health threats, porous borders and population mobility mean that significant overlaps in policy and law will continue to be essential to effective health promotion. Nonetheless, convergence and coordination will be achieved increasingly from four separate starting points, rather than being imposed from the centre.

The challenge for health law scholars at this juncture, we would argue, is threefold. First, in embracing this newly apparent plurality, they need to pursue careful analysis, synthesis and criticism of each body of statutes and relevant case law in its own terms and in comparative perspective with reference to developments across the UK, but also internationally. This will be essential as an aid to interpretation, a spur to law reform and a guide to citizens, professionals and policymakers seeking clarity as to rights, duties, powers and liabilities. Second, scholars will need to attend to jurisdictional disputes and overlaps, to tangled hierarchies and heterogeneous sources of norms which may impede both health promotion and the rule of law. The presence of 'jagged edges' arising from uneven or incomplete allocation of powers is likely to be an enduring phenomenon. Moreover, grasping these struggles exceeds the capacity of purely doctrinal methods. Socio-legal and law and humanities approaches will be indispensable in grasping the implications of normative pluralism and contested territoriality for British health governance. Third, renewed attention to values, their content and their relation to legal developments, will be required in order to give coherence to extant materials, as well as enabling evaluation and reform. We have suggested that such values are best

162 See further, Harrington (n 117 above) ch 1.

identified through engagement with inherited practices and traditions, as well as contemporary legal and policy materials. This is always an active, critical and contingent process, one encapsulated for our context in the words of historian Gwyn A Williams: 'Wales is an artefact which the Welsh produce. If they want to. It requires an act of choice.'[163]

163 Williams (n 133 above) 304.

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Disability and COVID-19: improving legal and policy responses through grassroots disability ethics

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ABSTRACT

The emergency legal and policy responses to COVID-19 attempt to avoid discrimination against disabled people. But they do not address deeper ableist and disableist narratives and practices embedded in emergency health policy. Adopting a disability ethics approach to the guidelines that emerged during the COVID-19 pandemic shows that they rest on dubious ethical grounds. However, emergency legal and policy responses to COVID-19 can be improved by adopting an approach based on disability ethics principles that emerge from grassroots level.

Key words: disability; COVID-19; health policy; disableism; ableism; disability ethics.

INTRODUCTION

As national health systems across the world scrambled to address the strain that the COVID-19 pandemic was expected to place on their services, especially on intensive care units (ICUs), a myriad of guidelines emerged, aiming to help medical professionals to make difficult decisions about fair and equitable distribution of scarce healthcare resources. In the United Kingdom (UK), two such key instruments are the National Institute for Health and Care Excellence (NICE) rapid COVID-19 guidelines on critical care[2] and the British Medical Association (BMA) 'COVID-19: ethical issues' guidance.[3] Both guidelines state explicitly that direct discrimination against protected categories of patients, such as elderly patients and disabled patients, is illegal, unethical and should be avoided.

1 The support of the ESRC Health Governance After Brexit project, ES/S00730X/1, is gratefully acknowledged. In particular, Professor Tamara Hervey's generous help with the structure of this article is gratefully acknowledged and appreciated.

2 NICE, 'COVID-19 rapid guidelines: critical care in adults' (NICE, 20 March 2020).

3 BMA, 'COVID-19: ethical issues' (BMA, 7 September 2020).

Yet, because they permit 'proportionate means for achieving a legitimate aim' and recognise a commitment to saving as many lives as possible as a 'legitimate aim',[4] the guidelines have the effect of leaving space for *indirect* discrimination against disabled people. As a result, the ethical guidelines have not enjoyed universal acceptance, with the disability community in particular reacting with anger to what they perceived to be 'terrifying and discriminating' guidelines.[5] These concerns remained even after the NICE guidelines were amended, in response to the threat of judicial review,[6] to provide that direct discrimination on the basis of disability is inconsistent with the legal duty of equal treatment of all patients, and that medical professionals should conduct an individual assessment of disabled patients, rather than using a 'frailty assessment method'.[7]

The anger, distrust and fear of some in the disability community may seem unfounded and misplaced. After all, the legal principles of equality and non-discrimination apply irrespective of the COVID-19 pandemic, and disabled people can rely on those principles in this time as at all times. Protection from both direct and indirect discrimination is guaranteed by the provisions of the Equality Act 2010 and by the United Nations (UN) Convention on the Rights of People with Disabilities (UNCRPD) which the UK has ratified.[8] This article challenges this perspective. Using 'grassroots disability ethics' (GDE), this article shows how ethical guidelines like the NICE and BMA guidelines embed deeper problems than those that can be resolved by a liberal equality perspective, even including indirect discrimination. GDE is understood in this article as conceptualisations and formulations of an ethical approach to emergency triage and the distribution of limited resources during the pandemic that are produced by disabled people themselves and by their organisations. GDE principles are informed by lived experiences of disability and are positioned here within the broader concept of disability inclusivity in

4 Ibid 7.

5 John Ping, 'Coronavirus: anger over "terrifying and discriminating" intensive care guidelines' (*Disability News Service*, 26 March 2020).

6 The proposed judicial review, arguing that the 'frailty' assessment method in the guidelines was an unlawful limitation on the chances of a disabled person being admitted to an ICU, was brought on the grounds of unlawful discrimination in access to critical care, quoting arts 2, 3, 8 and 14 of the European Convention on Human Rights and ss 19 and 29 of the Equality Act 2010. See Local Government Lawyer, 'NICE amends Covid-19 critical care guideline after judicial review threat' (*LGL*, 1 April 2020).

7 NICE, 'NICE updates rapid COVID-19 guideline on critical care' (NICE, 25 March 2020).

8 Equality Act 2010, art 13 (direct discrimination) and art 19 (indirect discrimination). UNCRPD, art 5 (equality and non-discrimination).

health policy. GDE principles embody a human rights-based approach to public health and health services, on account of explicitly referring to the human rights of disabled people.[9] The article then demonstrates how the principles of GDE can be harnessed for better law- and policy-making. Thus, the article develops a rationale for both critiquing and improving current ethical guidelines.

The article proceeds as follows. After a brief discussion of the broader contexts, a conceptual framework for GDE is presented. Next, the detail of the guidelines is set out. While not formally law, guidelines like these have a quasi-legal status, in that, for instance, failure to adhere to them may result in disciplinary action or a tortious claim for damages should harm to a patient ensue. The main body of the article falls into two sections. First, it analyses the guidelines using the GDE framework, explaining their deficiencies from that perspective. Second, it shows how GDE principles may provide an alternative foundation for more inclusive healthcare decision-making, in the context not only of the UK's guidelines, but also similar guidelines elsewhere, and not only of COVID-19, but also of other health emergencies and situations of scarcity in healthcare resources.

CONTEXTS: THE COVID-19 PANDEMIC AND DISABILITY

Despite the popular opinion that COVID-19 is an equalising experience that affects everyone in the same way, 'we are not all equally in this together'.[10] Disabled people are disproportionately negatively affected by the global pandemic. At international level, a Global Monitoring Report, *Disability Rights during the Pandemic*, produced by a consortium of disability rights organisations, outlines the 'catastrophic' impact of the COVID-19 pandemic on persons with disabilities. The report describes the overwhelming failures of states to take sufficient measures when responding to the pandemic to protect the rights of persons with disabilities.[11] The UN and the World Health Organization (WHO) have warned that disabled people are more at risk of contracting the virus and that some of the practical measures to stop the spread of the virus may not be possible for disabled people

9 Amanda Roberts et al, 'Treat me right, treat me equal: using national policy and legislation to create positive changes in local health services for people with intellectual disabilities' (2012) 26 Journal of Applied Research in Intellectual Disabilities 14–25, 16.

10 Katherine Hall et al, 'Ethics and equity in the time of coronavirus' (2020) 12(2) Journal of Primary Health Care 102.

11 Ciara Brennan et al, Disability Rights during the Pandemic: A Global Report on Findings of the COVID-19 Disability Rights Monitor (Global Monitoring Disability Report, 27 October 2020).

to deploy.[12] In addition, experiences of disabled people during the pandemic suggest that discrimination in critical triage is not a worst-case scenario for disabled people around the world, but a lived reality for many.[13]

At European level, the European Union (EU) Agency for Fundamental Rights' report, *COVID-19 Pandemic in the EU*, argues that the challenges that disabled people continue to face in their everyday life could even amount to discrimination in the context of the pandemic.[14] For example, complex visiting guidelines or disproportionately implemented restrictions lead to greater stress and loneliness for disabled people.[15]

More broadly, the impact of the pandemic on disabled people, and the discrimination that stems from it, should be seen in the context of historical barriers to healthcare and social care that disabled people have faced and continue to face.[16] These barriers can be physical and social (such as inaccessible buildings and inaccessible transport), communications barriers (such as lack of assistive technology), or barriers emerging from stigma and discrimination at both individual and institutional level.[17] Research on inequalities in health and social care reveals that many disabled people are discriminated against in relation to healthcare and that, despite some improvements of law and policy in the area, more progress must be made to ensure equal access to health and social care.[18]

In the UK, the disability community has expressed grave concerns about the emergency legal and policy response to the pandemic and the way that it encroaches on established disability rights. The UK pandemic response has been described as not thought-through, not

12 UN News, 'Preventing discrimination against people with disabilities in COVID-19 response' (*UN News*, 19 March 2020) .

13 Brennan et al (n 11) 43.

14 EU Agency For Fundamental Rights, COVID-19 Pandemic in the EU: Bulletin 4 (Publications Office of the EU, July 2020).

15 Ibid.

16 Ruel Serrano, 'Working to remove barriers to health care for people with disabilities' (WHO, 10 December 2012).

17 UN, *Report on the World Situation 2018*, 'Persons with disabilities: breaking down barriers' (UN Publications, 22 July 2018) ch 5.

18 See Afia Ali et al, 'Discrimination and other barriers to accessing healthcare: perspectives of patients with mild and moderate intellectual disabilities' (2013) 8(8) PLOS One; Heather de Vries McClintock et al, 'Health experiences and perceptions among people with and without disabilities' (2016) 9 (1) Disability Health Journal 74; Michael Stilman et al, 'Healthcare utilization and associated barriers experienced by wheelchair users: a pilot study' (2017) 10(4) Disability and Health Journal 502; Dora Raymarker et al, 'Barriers to healthcare: instrument development and comparison between autistic adults and adults with or without other disabilities' (2017) 21(8) Autism 972.

proportionate and not protecting everyone.[19] The Coronavirus Act 2020,[20] the overarching legal response to the pandemic, is deeply problematic from a disability perspective, in particular because it removes the statutory duty on local authorities to provide social care services during the pandemic.[21] Writing in 2013, the prominent disability scholar and activist Mike Oliver can now be seen as prophetic about the way in which the Coronavirus Act 2020, as a response to COVID-19, has changed disability rights:

> Our differences are being used to slash our services as our needs are now being assessed as being moderate, substantial or critical and many local authorities are now only providing services to those whose needs are critical.[22]

These are the contexts in which guidelines for medical professional practice in the context of COVID-19 were developed.

GRASSROOTS DISABILITY ETHICS

The historic barriers to healthcare outlined above, as well as the challenges brought by the COVID-19 pandemic, have strengthened the call for a disability-inclusive approach to the ongoing public health crisis. GDE principles for an ethical distribution of limited resources fit within the broader concept of a disability-inclusive approach to health and health policy. A disability-inclusive approach is understood as 'mainstreaming disability in all plans and efforts', as well as 'adopting targeted measures' that meet specific requirements, since general responses to the pandemic might not respond effectively to the particular needs of disabled people.[23] Such an approach is inherently person-centred. It calls for the effective inclusion of disabled people as active participants in deciding how to meet their needs during the pandemic, alongside a core group of stakeholders, including family members and health professionals.[24] Disability inclusivity in emergency responses is facilitated by challenging the 'morally reprehensible' deprioritising of disabled people during the pandemic with a strong focus on their

19 John Pring, ' Coronavirus: grave concern over impact of emergency Bill on rights' (*Disability News Service*, 19 March 2020).

20 Coronavirus Act 2020.

21 Ivanka Antova, 'Disability and COVID-19 in England: emergency policy and legal responses' (2020) 28(4) Medical Law Review 804–816.

22 Mike Oliver, 'The social model of disability: 30 years on' (2013) 28(7) Disability and Society 1024, 1026.

23 UN, Policy Brief: A Disability-inclusive Response to COVID-19 (2020) 8.

24 S Senjam, 'A persons-centered approach for prevention of COVID-19 disease and its impacts on persons with disabilities' (2021) 8 Frontiers in Public Health 3.

human rights.[25] As the pandemic lays bare the disproportionately negative impact of COVID-19 on disabled people, disability scholars have renewed the pre-pandemic call for radical changes to be made to the way disability policy and health policy are made by means of mainstreaming disability lived experiences.[26]

The inclusion of disabled people's voices and lived experiences in 'both direct and indirect measures in the fight against COVID-19' is a legal requirement.[27] Article 4(3) of the UNCRPD requires states to 'closely consult and actively involve' disabled people and their representative organisations in the implementation of the Convention. In addition, article 33(3) requests states to ensure that disabled people participate fully in the monitoring of the implementation of the Convention. Disabled people and their organisations have been involved in the very creation of the UNCRPD through a 'unique' approach to treaty drafting that affords equal status to civil society members and state representatives, thus giving the UNCRPD an 'edge it would otherwise have lacked' had it not incorporated the lived experience of disability.[28] The effective inclusion of disability in the creation of international and domestic human rights standards and health protocols has been seen as a key step towards 'reshaping present exclusionary practices and structures' that underpin to a large extent the disproportionately negative impact of the COVID-19 pandemic on disabled people.[29]

There are real practical merits in ensuring the effective participation of disabled people in the drafting of emergency responses to the pandemic. The lived experience of disability can inform practices that mitigate some of the negative impact of the pandemic by ensuring that emergency measures are 'appropriately tailored' for disabled

25 Hannah Kuper, Lena Morgon Banks, Tess Bright, Calum Davey and Tom Shakespeare, 'Disability-inclusive COVID-19 response: what it is, why it is important and what we can learn from the United Kingdom's response' [version 1; peer review: 2 approved] (2020) 5:79 Wellcome Open Research 3.

26 Laufey Löve, Rannveig Traustadótti, Gerard Quinn and James Rice, 'The inclusion of the lived experience of disability in policymaking' (2017) 6–33 Laws 1–16, 2.

27 Elena S Rotarou, Dikaios Sakellariou, Emily J Kakoullis and Narelle Warren, 'Disabled people in the time of COVID-19: identifying needs, promoting inclusivity' 11:03007 (2021) Journal of Global Health, 3

28 Löve et al (n 26) 3.

29 Ieva Eskyte, Anna Lawson, Maria Orchard and Elizabeth Andrews, 'Out on the streets – crisis, opportunity and disabled people in the era of Covid-19: reflections from the UK' (2020) 14 European Journal of Disability Research 329–336, 334.

people.[30] There have been some attempts to do this in the UK during the pandemic. Examples include the provision of information about COVID-19 and social-distancing measures in British Sign Language and Easy Read formats for those with intellectual impairments;[31] or the development of guidance for carers of people with specific conditions, such as Alzheimer's.[32] The effective inclusion of disabled people's voices will also be important for stepping into the 'new normal' of a post-pandemic world where the less-known long-term effects of COVID-19 are studied and addressed.

Although GDE principles for the ethical and non-discriminatory response to the pandemic fit within the broader frameworks of disability inclusivity, person-centred and human rights-based approaches to health policy, GDE principles are understood in this article as potentially further reaching. GDE calls for the elevation of grassroots disability narratives to the main source, or foundation, of the emergency legal and policy responses. In this sense, a more appropriate conceptual framework to highlight the potential of GDE to achieve the 'reform in both the process and direction of policymaking' that the COVID-19 pandemic necessitates is the concept of co-production.[33]

Co-production, or 'the involvement of patients, service users, and members of the public in the design and delivery of healthcare' is an example of a grassroots disability activist narrative that has been gradually mainstreamed in policymaking.[34] Co-production goes beyond the call for effective inclusion of disabled people in health policy drafting and focuses on reversing the power disbalance within disability policy by placing disability lived experience as the leading expertise. A key element of GDE principles as co-production of emergency responses to COVID-19 (and to any future crisis) is the transformation of disabled people from passive recipients of legal and policy responses to active participants in 'collective organisational co-management and co-

30 Lieketseng Ned, Emma Louise McKinney, Vic McKinney and Leslie Swartz, 'COVID-19 pandemic and disability: essential considerations' (2020) 18(2) Social and Health Sciences 143.

31 MENCAP has produced an Easy Read summary of the government COVID-19 guidance from May 2021: The Coronavirus Rules from Monday 17th May.

32 The Alzheimer's Society has produced advice and guidance specifically for carers of people with dementia: 'Helping a person with dementia to keep safe and well during coronavirus'.

33 Peter Beresford, 'What are we clapping for? Sending people to die in social care: why the NHS did this and what needs to happen next?' in Peter Beresford et al (eds), *COVID-19 and Co-production in Health and Social Care Research, Policy, and Practice Volume 1: The Challenges and Necessity of Co-production* (Polity Press 2020) 94.

34 Nicola Gale, Patrick Brown and Manbinder Sidhu, 'Co-production in the epidemiological clinic: a decentred analysis of the tensions in community-based, client-facing risk work' (2018) 53 Social Policy Administration 203–218, 204.

governance of health'.[35] This is crucially important for challenging definitions of disability as individual physiological failure, as worthlessness or as a societal burden. GDE principles thus have the capacity to radically disrupt 'wider social and cultural processes that disempower and exclude' in favour of the sharing of decision-making with the community that empowers individuals and protects human rights.[36] During the pandemic, disabled people experience more than a higher risk of exposure to COVID-19, or lockdowns and social-distancing measures incompatible with their lives. Disabled people experience emergency responses to the pandemic that allow for indirect discrimination and inherently disempower and exclude them. The co-production of emergency legal and policy responses would allow for lived experience of disability to illuminate potentials for discrimination and produce truly effective protocols. Therefore, a GDE approach to the ethical guidelines that emerged during the pandemic is a key tool in both critiquing and improving legal and policy responses. The effectiveness of GDE in critiquing emergency guidelines is discussed next.

THE GUIDELINES

Both the NICE rapid COVID-19 guidelines on critical care[37] and the BMA's 'COVID-19: Ethical Issues' guidance[38] envisage difficult choices about prioritising patients having to be made by medical professionals only in a situation where the health system, or a particular hospital or ICU within it, is overwhelmed. In such a scenario, as the guidelines point out, however undesirable this might be, prioritisation of patients will become inevitable.

The BMA guidelines explicitly commit to each patient receiving the highest possible level of care during the pandemic. The BMA guidelines go on to balance two different, and competing, approaches to the distribution of limited resources. On the one hand, there is respect for the individual and the individual right to health. On the other hand, there is a utilitarian concern for the health of the population as a whole. If sufficient resources become unavailable, then utilitarianism must prevail, and the leading concern should be to minimise overall mortality and morbidity.

35 Andrew G H Thompson, 'Contextualising co-production and co-governance in the Scottish National Health Service' (2020) 5(1) Journal of Chinese Governance 48–67, 49.

36 Jane Booth, 'Empowering disadvantaged communities in the UK: missing the potential of co-production' (2019) 49 (2) Social Change 276–292, 282.

37 NICE (n 2).

38 BMA (n 3).

> Although doctors would find these decisions difficult, if there is radically reduced capacity to meet all serious health needs, it is both lawful and ethical for a doctor, following appropriate prioritisation policies, to refuse someone potentially life-saving treatment where someone else is expected to benefit more from the available treatment.[39]

The guidelines acknowledge that, whilst this situation would necessitate difficult and possibly distressing decisions, age and disability on their own may not be the only factors to be taken in consideration. Decisions should be based on 'evidence and reason'. However, in some cases, age and disability may feature as part of such an evidenced and reasoned decision-making process.

What medical professionals should prioritise in these very challenging circumstances is a higher survival probability, and a consideration of which patients would be expected to benefit more from critical care. The most urgent cases, the least complex cases, and patients expected to live the longest as a result of receiving critical care should be prioritised. Patients with co-morbidities that would impact on their capacity to benefit from treatment should not be prioritised. Patients who have 'sufficient background illness' or those who are frail should not be prioritised. Long-term health conditions are seen as a reason not to prioritise, while the key factor for prioritisation should be the capacity to benefit quickly from treatment.[40]

Although the guidelines recognise the key principle of reasonable adjustment as an important part of disabled people's equal access to health care, they envisage a scenario where this duty is affected by the pandemic. The guidelines' position is that reasonable adjustment should not 'trump' the utilitarian commitment to saving as many lives as possible. To this end, and only in this limited context, indirect discrimination, or unintentional discrimination against disabled patients because of their difference from other patients, would be ethical and lawful medical practice.

The NICE guidelines make similar arguments, but in a more broad-brush way. The NICE guidelines do not provide a detailed explanation of how decisions about whom to prioritise should be made in a situation where resources are insufficient. Instead, the NICE guidelines focus more heavily on the clinical factors that should be prioritised in decision-making.

The NICE guidelines state that, when making a decision about admitting a disabled patient to critical care, medical professionals should do two things. First, they should conduct an individual

39 Ibid 3.
40 Ibid.

assessment of frailty.[41] According to the NICE website, frailty is described as 'a loss of resilience that means people don't bounce back quickly after a physical or mental illness, an accident or other stressful event'.[42] This definition is based on a British Geriatrics Society model for recognising and assessing frailty.[43] Since the NICE guidelines are for admitting patients into ICUs, medical professionals would be able to make such assessments, and this suggests that the critical frailty score might still be used when deciding which patient should be prioritised in a situation of limited health resources.

The second thing medical professionals should do is follow the algorithm that the guidelines provide. According to the algorithm, if a patient is considered to be less frail, by using the individualised assessment described above, then admission into critical care is seen as appropriate. If the patient is deemed to be more frail, then a doctor must make an additional decision about admission to critical care as part of a holistic assessment. Although we have no detailed description of what a holistic assessment might mean, we can see from the guidelines that medical professionals should always consider co-morbidities, underlying health conditions, pathologies and severity of acute illness when deciding whom to prioritise.[44]

ANALYSIS

The guidelines do not suggest that disabled patients should automatically be excluded from receiving critical care, nor do they make an explicit argument that disabled lives do not matter. But, although they proclaim that discrimination against disabled people is not permitted, the BMA and NICE guidelines nonetheless embody and articulate a highly problematic approach when seen from the point of view of GDE. This is the case for five main overlapping reasons:

- the approach of the guidelines to the balance between utility and equality;
- the construction of disability as abnormality;
- disability as representing low quality of life or health;
- a concept of the 'ideal patient'; and

41 NICE (n 2) (my emphasis). Note that the algorithm states that 'any patient aged under 65, or patient of any age with stable long-term disabilities (for example, cerebral palsy), learning disabilities or autism: do an individualised assessment of frailty. Do not use CFS score.'

42 NICE, 'Improving care and support for people with frailty: how NICE can support local priorities'.

43 Jill Turner, 'Recognising frailty: good practice guide' (British Geriatrics Society, 11 June 2014).

44 NICE (n 2).

- the way the guidelines construct a disableist response to the COVID-19 pandemic from an ableist perspective.

Each is now discussed in turn.

The utility/equality balance

In the context of a global pandemic, or other health emergency, the necessity to prioritise limited resources inherently dictates that judgements about the value of lives will have to be made. To this end, the guidelines embody what has been described as an 'unstable compromise'[45] between competing ethical approaches, namely utilitarianism and egalitarianism. The scenario where the overall health of the population is seen as competing with the health of individuals is a fertile ground for negative conceptions of disability as a 'product of a damaged body or mind'[46] to underpin decisions about who should be saved and who should not be.

The guidelines state that utilitarian concerns override commitment to prioritising each patient, regardless of how their individual health might be perceived or valued. When developing an ethical reasoning or practice for distributing limited resources, the guidelines adopt an approach based on orienting activity toward a utilitarian good. In effect, this utilitarian good amounts to a devaluing of disabled lives, as less worthy of public investment.[47] Consistently with public health ethics, the utilitarian approach typically prioritises young and healthy people.[48] The BMA guidelines in particular make an explicit call for the overall morbidity and mortality being minimised, by allowing for disability to feature as a decision-making factor when choosing the patients in whom limited resources should be invested.

Such a utilitarian approach prioritises 'normal' and 'healthy' lives, and the overall health of a nation. A categorical exclusion, understood as a manifestation of the utilitarian principle of maximising population outcomes, would exclude patients with certain co-morbidities (for instance, severe cognitive impairment) as a priority for critical care.[49]

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45 Julian Savulescu, James Cameron and Dominic Wilkinson, 'Equality or utility? Ethics and law of rationing ventilators' (2020) 125(1) British Journal of Anaesthesia 10.

46 Dan Goodley and Katherine Runswick-Cole, 'The violence of disablism' (2011) 33(4) Sociology of Health and Illness 602, 603.

47 Shane Neilson, 'Why I won't see you on the barricades' (2020) 66 Canadian Family Physician 448, 450.

48 Jerome Singh and Keymanthri Moodley, 'Critical care triaging in the shadow of COVID-19: ethics considerations' (2020) 110(5) South African Medical Journal 355, 355.

49 Douglas White and Bernard Lo, 'A framework for rationing ventilators and critical care beds during the COVID-19 pandemic' (2020) 323(18) Journal of the American Medical Association 1773, 1773.

It would be more ethical to prioritise a non-disabled person because they would be understood as able to make a better contribution to the overall health of society, after recovery. But this population-focused utilitarian approach runs the risk of turning 'critical care into a life raft: the vulnerable are thrown overboard to keep the ship afloat'.[50]

An alternative, less restrictive, non-categorical utilitarian approach would focus on universal eligibility for critical care, but would see a prioritisation based on who would be 'most likely to benefit'. The people most likely to benefit are seen as those who would survive to hospital discharge if given the treatment. For example, it would be ethical to prioritise those with more years left to live, whether disabled or not. Or it would be ethical to prioritise younger patients, whether disabled or not, in order to give everyone an equal chance of going through all life stages (the life-cycle principle).[51] A GDE approach to the guidelines reveals that even this utilitarian approach runs the risk of perceiving disabled people as less likely to benefit from treatment because of how disability is understood, as opposed to an able-bodied or cognitively able 'norm'.

Disability as abnormality

When disability is seen as failure or abnormality, the life of a disabled patient is unlikely to be valued as much as a life that is considered 'normal' and a part of the health of a 'normal' society. Grassroots disability narratives have long challenged the portrayal of disability as abnormality and as an individual tragedy, rather than the end result of structural barriers and inequalities. From a GDE perspective, the COVID-19 ethical guidelines can be understood as a continuation of the long-standing discussion within disability studies about the prevalence of medical conceptions of disability, as opposed to conceptions of disability that aim to distance disability from biological determinism and functionalism (broadly speaking the social model of disability).

The medical model of disability, also referred to as the individual or 'personal tragedy' model of disability, is an early theory of disability that emerged from the medical profession, with the medical knowledge on the functions or performances of the body constructing disability

50 Andrew Peterson, Emily Largent and Jason Karlawish, 'Ethics of reallocating ventilators in the Covid-19 pandemic' (2020) 369 British Medical Journal 1, 1.

51 White and Lo (n 49).

as a failed performance or abnormally functioning body or mind.[52] Goodley describes what is understood here as a medical model as the dominance of functionalism as a social theory, which sees disability as the product of a damaged body or mind, thus 'functionalism underpins ableism: the social, cultural and political conditions of contemporary life that emphasise ability and denigrate disability'.[53] The medical model works through individualisation of disability.[54] The human body is seen as a 'universe' in itself and the 'problems' of this body are limited by the physical contours of the body, not to be equated with problems that a population or a group of people might experience collectively. Therefore, the medical model of disability is a highly divisive way of thinking: 'within the purview of the medical establishment, to keep it a personal matter and "treat" the condition and the person with the condition rather than "treating" the social processes and policies that constrict disabled people's lives'.[55] The COVID-19 pandemic presents significant challenges to disabled people that necessitate a deeper understanding of how disabled lives should be protected than the medical model affords.

By contrast, the social model of disability, which has become the normative analytical framework for disability studies, separates impairment from disability and places disability as the end result of the barriers that society creates.[56] The social model emerged as a framework to make sense of disability in 1976 in the work of the Union of the Physically Impaired Against Segregation (UPIAS), a group of disabled activists and socialists. Mike Oliver further elaborated the

52 Marno Retief and Rantoa Letšosa, 'Models of disability: a brief overview' (2018) 74(1) HTS Teologiese Studies/Theological Studies a4738, 3. See also Andrew J Hogan, 'Social and medical models of disability and mental health: evolution and renewal' (2019) 191(1) Canadian Medical Association Journal E16–E18; Jonathan M Levitt, 'Developing a model of disability that focuses on the actions of disabled people' (2017) 32(5) Disability and Society 735–747; and Stephen Bunbury, 'Unconscious bias and the medical model: how the social model may hold the key to transformative thinking about disability discrimination ' (2019) 19(1) International Journal of Discrimination and the Law 26–47.

53 Goodley and Runswick-Cole (n 46) 603.

54 Joel Michael Reynolds, '"I'd rather be dead than disabled" – the ableist conflation and the meanings of disability' (2017) 17(3) Review of Communication 149–163, 151.

55 Simi Linton, *Claiming Disability: Knowledges and Identity* (New York University Press 1998) 4.

56 Jonathan Levitt, 'Exploring how the social model of disability can be re-invigorated: in response to Mike Oliver' (2017) 32(4) Disability and Society 589.

social model in 1983[57] and 1990,[58] later describing it as nothing more than 'a tool to improve people's lives'.[59]

In the UK, the social model of disability has indeed been a highly effective tool for disability activism and emancipatory disability narratives (within which GDE can be placed), despite critiques of the social model and many of its limitations having been discussed at length.[60] Perhaps most importantly, critical disability studies scholars looking to go beyond the social model have argued that 'bodies are not simply born, but made'.[61] The strict separation of impairment from disability could leave the disabled body (or mind) open to theoretical interventions and definitions from a medical perspective alone, rendering disability a personal tragedy or failure, rather than an experience affecting many.[62] A GDE approach would instead prioritise disability-led, inclusive and human rights-centred definitions of disability, in line with the social model of disability.

The BMA and NICE guidelines can be seen as emergency responses that have inherited the medicalisation of disability, which dominates the medical profession. By relying heavily on utilitarian principles to justify indirect discrimination against disabled patients, the ethical guidelines in effect prioritise 'normality' when decisions about who should receive scarce healthcare resources are made. Thus, the guidelines reinforce the notion that 'abnormality' can and should be excluded if resources are limited. As such they are an embodiment of the medical model of disability that many disabled people see as undermining the validity of their existence.

The WHO requires states to 'ensure that decisions on the allocation of scarce resources (eg ventilators) are not based on pre-existing impairments, high support needs, quality of life assessments, or medical bias against people with disability'.[63] But guidelines like the BMA and NICE guidelines do not provide the necessary clarity[64] to medical professionals, especially where they lack knowledge and have

57 Mike Oliver, *Social Work with Disabled People* (Macmillan 1983).

58 Mike Oliver, *The Politics of Disablement* (Macmillan 1990).

59 Oliver (n 22) 1025.

60 Janine Owens, 'Exploring the critiques of the social model of disability: the transformative possibility of Arendt's notion of power' (2014) 37(3) Sociology of Health and Illness 385.

61 Elizabeth Donaldson, 'The corpus of the madwoman: toward a feminist disability studies theory of embodiment and mental illness' (2002) 14(3) Feminist Disability Studies 99, 112.

62 Ibid.

63 WHO, Disability Considerations during the COVID-19 Outbreak (WHO 2020).

64 Richard Huxtable, 'Bin it or pin it? Which professional ethical guidance on managing COVID-19 should I follow?' (2020) 21(1) BMC Medical Ethics 1, 9.

insufficient training in the needs and rights of disabled people.[65] In those circumstances, where medical professionals conduct the individual assessment required by the guidelines when deciding whom to prioritise for limited resources during the pandemic, such an assessment would involve an individual disabled person being evaluated and labelled through a process which separates that disabled person from mainstream society, education, work or social interaction. The separation arises because a disabled person is seen as deviating from an implicit dominant norm, and their difference is not valued.[66]

Disability as low quality of life or health

In a similar way, the guidelines embody the idea that disability is associated with a low quality of life, or health, when compared to an able 'norm'. Within the medical model, disability is understood as inherently negative, something to be endured, which should be cured or even eliminated, if possible.[67] A GDE perspective would offer an understanding of life with a disability as something that might be experienced, or even enjoyed, as a normal part of the life of an individual. When disabled people enter the medical field, they encounter difficulties or barriers because quotidian experiences for them (such as the use of feeding tubes or respirators) become indicators of an unacceptably low quality of life.[68] Including quality of life as a factor 'risks incorporating concerning value judgments that will systemically disadvantage people with disabilities and chronic health conditions and reduce the likelihood that they will receive medically indicated care'.[69] The perception of disability as an inevitable prognosis for bad quality of life post-critical care, or as a negative prognosis in terms of a fast recovery, allows for disabled patients to be deprioritised for access to a ventilator, even if they need it more than a non-disabled person presenting with the same disease.[70]

As the guidelines are applied by medical professionals, disabled people's impairments, or underlying health conditions that may be the reason for their disability, will be seen as a medically relevant ground for exclusion from prioritisation of resources. This is the case

65 Maya Sabatello et al, 'People with disabilities in COVID-19: fixing our priorities' (2020) 20(7) American Journal of Bioethics 187, 187.

66 Owens (n 60).

67 Fiona Campbell, *Contours of Ableism: The Production of Disability and Abledness* (Palgrave MacMillan 2009) 5.

68 Heidi Jenz, 'Ableism: the undiagnosed malady afflicting medicine' (2019) 191 Canadian Medical Association Journal E478, E479.

69 Ari Ne'eman, 'When it comes to rationing, disability rights law prohibits more than prejudice' (The Hastings Centre, 10 April 2020) 2 .

70 Gerard Goggin and Katie Ellis, 'Disability, communication, and life itself in the COVID-19 pandemic' (2020) 29(2) Health Sociology Review 168, 171.

even though disabled patients are seeking ICU admission because of COVID-19 and not because of a stable or a long-term health condition that they would otherwise manage. Disability, when understood only as reduced capacity to function 'normally', may be seen as inherent frailty, or as incapacity to be 'healthy' despite access to critical care.

The merit of applying a geriatric model of frailty assessment to disabled patients is highly questionable, since old age and disability may overlap in certain cases, but are certainly not the same thing. Frailty is assessed by various means, for example looking into the speed of walking, the strength of a grip, any increased challenges in getting out of bed or going to the toilet. For some disabled patients with particular health conditions or impairments these challenges may be an everyday reality, not necessarily a signal of increased frailty that may be seen as a reason not to be prioritised for critical care during a pandemic. Even the British Geriatrics Society model allows for the use of the critical frailty score, *only after* a comprehensive individual clinical assessment.

This concern about a frailty model lies at the heart of the successful challenge to the original NICE guidelines, which were amended precisely because they equated disability with frailty and frail patients were to be excluded from receiving critical care in favour of less frail, or non-disabled patients. The now amended NICE guidelines call on medical professionals to recognise the limitations of assessing disability as frailty and insist on an individualised assessment to be carried out instead. But it is precisely during this individualised assessment that the perception of disability as low quality life or health enters the decision-making process. Indirect discrimination against disabled people takes place when disabled lives and experiences are measured against an unattainable 'ideal' notion of health and humanity that distinguishes between disabled people and non-disabled people and leaves the former in a disadvantageous position. The ethical guidelines require attention to quality of life post-treatment. A GDE approach to the guidelines reveals that, where disabled lives are seen as lower quality and disabled people perceived as having a lower quality of health, the guidelines steer resourcing decisions in a way that discriminates against disabled people.

The 'ideal patient'

The NICE and BMA guidelines suggest that patients without underlying health conditions and co-morbidities, with a better ability to survive, with a better chance of benefiting from treatment and, perhaps most importantly, with less complexity to their health circumstances, would be *ideal* for prioritisation during the pandemic. In other words, the guidelines prioritise those who are seen as healthier already,

or those patients who are seen to be the closest to the unattainable health performance that constructs disability as lacking. From a GDE perspective, this is problematic. It articulates a normative notion of a rational, independent, autonomous subject, embedded in the notion of an ideal human patient. Such an 'ideal patient' is often evoked in policy making,[71] and COVID-19 guidelines are no exception. The guidelines lean heavily towards protecting this normative construction that leaves disabled patients, who inevitably challenge the hegemony of the 'ideal patient', in a disadvantageous position.

The pandemic constructed from an 'ableist' and 'disableist' perspective

Making this point more broadly, law and policy processes that construct human bodies according to an 'ideal' also contribute to ways that pandemic responses, like the BMA and NICE guidelines, embody and articulate an approach that is highly problematic from the point of view of GDE.

The ideal patient described above, the one who should be prioritised for limited health resources during a pandemic, is an example of defining disability as the opposite of ideal or normal. From a critical disability perspective, defining disability is about destabilising a definition of disability that relies on normative idealised understandings of how the human body or mind *should* perform. To build this destabilising narrative, critical disability scholars have developed the concepts of 'ableism' and 'disableism' as the two sides of the same coin, mutually supporting and promoting each other.[72] Goodley defines ableism as an ideal, not something to which anyone ever matches up. Disableism is the process of pressing normative ableism upon people: 'the oppressive practices of contemporary society that threaten to exclude, eradicate and neutralise those individuals, bodies, minds and community practices' that do not reach the unattainable ableist standard.[73] These practices occur across social contexts, including in the medical field. From this perspective, two entirely distinct categories exist: disabled or able,[74] the latter of which does not exist in absolute form, but as an imagined norm to which people can be compared. Ableist-normativity

71 Dan Goodley and Katherine Runswick-Cole, 'Becoming dishuman: thinking about the human through dis/ability' (2014) Discourse: Studies in the Cultural Politics of Education 2.

72 Dan Goodley, *Dis/ability Studies: Theorising Disablism and Ableism* (Routledge 2014) ix.

73 Ibid xi.

74 Campbell (n 67) 8.

is constantly produced and maintained through such comparisons,[75] ensuring that disableist discrimination takes place, by implicitly casting disabled people as comparatively 'less-than-human'.[76]

The COVID-19 ethical guidelines overtly favour those patients who are closer to the ableist normativity of the healthy individual, by marrying body performativity that challenges the notion of 'being healthy' with relevant medical factors that determine who should be prioritised for the limited health resources. The systemic nature of ableism and disableism is reproduced in the guidelines:

> Governmental policies, laws, and rules ... are designed for the benefits of the privileged group, people without impairment or disability. Ableism is constructed on the basis of hierarchy where people without disability are on the top.[77]

According to the guidelines, medical professionals should prioritise a higher survival probability, those expected to benefit more from treatment, the least complex cases, patients without co-morbidities or background illness, those most likely to recover, and those with capacity to recover quickly. These factors may seem perfectly relevant and objective to a medical professional, or to a lay person. The argument here is not that medical professionals would deliberately discriminate against disabled people. It is rather that medical professionals rely on an ableist definition of disability as a fixed or stable body or mind that simply does not perform as well as a non-disabled body or mind. In that context, the perception that medical intervention is less likely to 'fix' a disabled person's chances of recovery, even if critical care is administered, appears rational.

From a GDE perspective, however, when understood as incorporating the lived experience of the effects of processes of ableism/disableism, the guidelines fail to recognise or reflect the much more complex and fluid range of disability experiences. The medical profession is not exempt from producing ableist narratives and disableist practices under the disguise of medical knowledge or 'common sense'. '[A]bleism is that most insidious form of rhetoric that has become reified and so widely accepted as common sense that it denies its own rhetoricity—it "*goes without saying*".'[78]

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75 Fiona Campbell, 'Refusing able(ness): a preliminary conversation about ableism' (2008) 11(3) Media and Culture 1.

76 Laura Sanmiquel-Molinero and Joan Pujol-Tarrés, 'Putting emotions to work: the role of affective disablism and ableism in the constitution of the dis/abled subject' (2020) 33(4) Disability and Society 602, 605.

77 Heeson Jun, *Social Justice, Multicultural Counselling, and Practice: Beyond a Conventional Approach* (Springer International 2018) 246.

78 James Cherney, 'The rhetoric of ableism' (2011) 31(3) Disability Studies Quarterly.

Medical criteria that may be accepted as common sense, or, as the guidelines embody, the implicitly inevitable processes that doctors have to follow in the context of resource shortage, are not necessarily objective or value-free. Rather, they can be understood as an example of medical ableism exerting pressures during the pandemic that allow for disableism in the form of legal and ethical discrimination against disabled people to be justified within the guidelines. Critical care could be denied a disabled person, consistently with the guidelines, based on an ableist perception of the disabled person's quality of life or health applied during a triage process: a third party (medical professional) concludes that the disabled person's life has insufficient quality to be worth saving in comparison with non-disabled (or, rather, less disabled, as 'able' is an unattainable norm) others.[79] What may be considered as 'common sense' or medical objectivity, from a GDE perspective is revealed as smuggling in judgements on quality of life. These judgements are particularly pernicious when 'health' is nebulously defined as 'well-being', in effect a synonym for quality of life.[80]

Equally, consideration of long-term survival and short-term survival as a relevant factor is problematic from a grassroots disability perspective. Decisions, at least on allocation of treatment modalities and hospital beds, based on long-term or short-term survival have been seen as appropriate in the context of COVID-19.[81] But these have the effect of discriminating against disabled people, who regularly outlive the prognosis ascribed by medical professionals, often by decades. A disability does not automatically indicate a poor prognosis for short or longer-term survival.[82]

To summarise: from the point of view of GDE, the guidelines can be understood as constructing responses to the COVID-19 pandemic from an ableist perspective, which undervalues equal treatment of different bodies (or minds) in the name of a utilitarian approach to individual and societal health, 'well being' or quality of life that is constructed by reference to an 'ideal patient' who does not embody an 'abnormal' disability. Thus, the guidelines permit processes of decision-making that have the effect (even if not the intention) of discriminating against disabled people.

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79 Joseph Stramondo, 'COVID-19 triage and disability: what NOT to do' (*Bioethics Net*, 30 March 2020).

80 Anthony Gavin, 'The poverty of bioethics: disability, medical austerity, and traumatic care' (*Social Sciences and Humanities Open*, 4 June 2020).

81 Naomi Laventhal et al, 'The ethics of creating a resource allocation strategy during the COVID-19 pandemic' (2020) 146(1) Pediatrics 4.

82 Disability Rights Education Defense Fund (DREDF), 'Applying HHS' guidance for states and health care providers on avoiding disability-based discrimination in treatment rationing' (*Disability Rights Education and Defense Fund*, 3 April 2020).

AN ALTERNATIVE APPROACH: GDE

It is one thing to critique a law or policy from an external standpoint. It is quite another to offer an alternative approach. This article argues that GDE provides not only a standpoint for critique, as shown above, but also a basis for an alternative approach to healthcare decision-making in the context of COVID-19, and indeed in broader contexts, involving healthcare emergencies and/or scarcity of healthcare resources such as ICUs. GDE has potential to provoke positive change in three contexts: healthcare practice, healthcare policy and disability ethics more generally.

To illustrate this potential, let us first contrast the position of two doctors, from the UK and Canada, in terms of how they understand the decision-making required of them under ethical guidelines such as the BMA or NICE Guidelines.

Consider first the perspective of Dr Matt Morgan, a UK -based NHS doctor from Cardiff. Dr Morgan wrote an open letter from an ICU 'to those who are elderly, frail, vulnerable, or with serious underlying health conditions'.[83] In this remarkable letter, Dr Morgan reassures these people that they have not been forgotten. But observe the way in which the role of the medical professional is described during the pandemic:

> Our passion as an intensive care community is *fixing problems that can be fixed*. Yet we often meet patients like you who have problems that *cannot simply be fixed* … As difficult as this is, we will be honest. We will continue to use all of the treatments that may work and may get you back to being you again. We will use oxygen, fluid into your veins, antibiotics, all of the things that may work. But we won't use the things that won't work. We won't use machines that can cause harm. We won't press on your chest should your heart stop beating. Because these things won't work. They won't get you back to being you.[84]

To Dr Morgan, the point of doctors is to 'fix' patients. The challenge that disabled patients present is that they cannot be 'fixed'. In the context of a global pandemic and limited resources, this challenge becomes more acute. Not even powerful technology and advanced medication can fix the problem. The end strategy seems to be a nod towards 'do not resuscitate'.[85] Compassion, care, attention and understanding of disabled people is not denied here, quite the opposite. There is a nod to individual experience: 'you being you'. But there is a stronger sense of disableist inevitability in Dr Morgan's words that the responses to

83 Matt Morgan, 'Letter from ICU' (*The BMJ Opinion*, 12 March 2020).

84 Ibid (my emphasis).

85 John Pring, 'Coronavirus: activists' shock at intensive care doctor's resuscitation warning' (*Disability News Service*, 19 March 2020).

the pandemic will be impacting negatively on disabled people and a resignation or even acceptance that this cannot be changed, or 'fixed'.

Now, by contrast, consider the perspective, of Dr Shane Neilson, a Canadian doctor and scholar, and a father of a disabled son. In his opinion piece ('Why I won't see you at the barricades'), Dr Neilson discusses the 'vexed' relationship between the medical profession and disability, one that has historically disadvantaged and discriminated against disabled people. Dr Neilson responds to the call of duty to the profession to intensify work efforts during the pandemic and make difficult decisions on prioritising resources (to go to the barricades) with the following:

> In truth, I love to go to work, but not for you, not exactly; not for an abstract ideal; definitely not for emergency services vehicles sounding their klaxons in a fluid cordon around a building. I do it for me, because I like doing it, love it in fact. I do it because I like helping someone else; it makes me feel good. But the second my work becomes an activity oriented toward a utilitarian good, a recruited assent toward devaluing disabled lives, and a requirement I place myself at greater risk (and thereby my family, including my disabled son), I say no.[86]

Dr Neilson, in contrast to Dr Morgan, acknowledges the inherent unfairness of the necessity to prioritise resources for patients who can be 'fixed'. Dr Neilson does not accept the disableist inevitability of the medical profession having to make these decisions with a compassionate confidence in their ethical soundness. In fact, he calls for action and resistance: 'When disabled lives are explicitly protected by a discipline that historically has preferentially extinguished them – *that's* when I'll join you at the barricades.'[87]

GDE principles are principles for the ethical, fair and just distribution of limited resources that disabled people produce themselves based on their lived experience, and hoped-for futures,[88] and expertise in navigating through the complexities of ableism, disableism and different models of disability described above. Far from being passive recipients of ethically questionable emergency responses to the global pandemic, the disability community has been active in its resistance to the brutality of utilitarianism, to the reductionism inherent in bio-economic decision-making, and to the expressions of the value or worth of human lives these kinds of responses, including as embodied in the BMA and NICE guidelines, entail.[89]

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86 Neilson (n 47) 450.

87 Ibid 450.

88 Ibid 449.

89 Thomas Abrams and David Abbott, 'Disability, deadly discourse, and collectivity amid coronavirus (COVID-19)' (2020) 22(1) Scandinavian Journal of Disability Research 168.

Perhaps the most valuable contribution GDE can make to the evolving subject of ethics during the COVID-19 pandemic is in recognising the importance and prioritising the inclusion of lived experience in legal and policy responses to this pandemic, as well as future public health crises. Guidelines for provision of healthcare during COVID-19 must be developed in collaboration with disabled people's organisations and representatives from human rights bodies. Disability ethics based on lived experience can be a valuable tool for overcoming ideological divides and ethical disagreements, especially those which are framed as in-principle zero-sum decisions. The lived experience has a transformative power in ethical contexts. Instead of talking about abstract or theoretical concepts, to be solved by logical consistent argument, the conversation becomes about a set of concrete problems to be solved with practical reform informed by real people's experiences.[90] The medical profession has historically excluded disability voices, experiences and deconstructions of normative concepts like ableism. The COVID-19 pandemic requires bolder action to make sure these voices are included, not silenced.[91] Such bold action necessary to incorporate insights from disabled people's lived experience would require more effective inclusion policies and practices.

First, lived experience has the potential to inform healthcare practice and to help the medical profession to acknowledge, recognise and address the medical ableism that is often presented as scientific objectivity, but risks leaving both patients and practitioners exposed to the harsh consequences of decisions being based on questionable ethical grounds. COVID-19 presents an opportunity to provide all healthcare staff with rapid training on the rights of disabled people.[92] That training should embrace understandings of disability informed by lived experience and should distance itself from categories of 'normal' and 'abnormal' as abstract pathologies.[93] Understanding and awareness of disability ethics can help medical professionals, who have limited knowledge or appreciation of disability experience, when

90 Joseph Stramondo, 'Doing ethics from experience: pragmatic suggestions for a feminist disability advocate's response to prenatal diagnosis' (2011) 4(2) International Journal of Feminist Approaches to Bioethics 48, 71.

91 Emily Lund and Kara Ayers, 'Raising awareness of disabled lives and health care rationing during the COVID-19 pandemic' (2020) 12(S1) American Psychological Association S210, S211.

92 Richard Armitage and Laura Nellums, 'The COVID-19 response must be disability inclusive' (2020) 5(5) Lancet Public Health.

93 Shane Neilson, 'Ableism in the medical profession' (2020) 192(15) Canadian Medical Association Journal E411, E412.

making decisions about how disabled lives are to be valued in a triage situation,[94] on the basis of ethical guidelines.

Second, lived experience can also have a positive effect on health policymaking during the pandemic. For example, one of the policy responses to the pandemic in Northern Ireland has been the proposal to create a Mental Health Champion to represent the views and experiences of patients with a mental health disability and who can hold decision-makers accountable in terms of responding to the ever-changing pandemic landscape. In a statement following the announcement from the Northern Irish Department of Health, Disability Action Northern Ireland (DANI) urged (as a minimum) that criteria for appointment should include that the applicant has personal lived experience of mental ill health.[95]

GDE principles have the capacity to create alternatives to the ethical guidelines. For example, in a recent statement to the BMA following the publication of the BMA ethical guidelines, DANI produced the following guiding principles for ethical guidelines:

> We believe it is critically important healthcare professionals have guidance which includes and accurately reflects disabled people as citizens with fundamental rights (like all others) in the difficult times ahead.
>
> We also believe it is critical that we all have the medical equipment and resources needed.
>
> We call on the BMA to now reach out and meaningfully engage with Disabled People's Organisations. Participation is central to a rights-based approach to health.
>
> We are all in this together.[96]

On the basis of these kinds of principles, guidelines for healthcare decision-making in the context of pandemic-induced scarcity could be altered to express the following. As far as possible, decisions about allocation of scarce healthcare resources should be made in advance and actively include the public (most importantly disabled people themselves).[97] GDE calls for the co-production of guidelines where disability lived experience is an equal in value expertise upon which they

94 Satendra Singh, 'Disability ethics in the coronavirus crisis' (2020) 9(2) Journal of Family Medical Primary Care 167, 171.

95 Disability Action NI, 'Open letter to Minister Swann et al' (DANI, 23 April 2020).

96 Disability Action NI, 'Disability Action deeply concerned by recent BMA Guidance "COVID-19: ethical issues"' (DANI, 2 April 2020).

97 Lawrence Gostin, Eric Friedman and Sarah Wetter, 'Responding to Covid-19: how to navigate a public health emergency legally and ethically' (2020) 50(2) Hastings Center Report 8, 9.

are developed. Guidelines must be transparent and based on clearly explained rationales that are compatible with a person-centred and a human rights-based approach to health.[98] There must be a thorough, individualised review of each patient,[99] grounded in scientific evidence related to transmission of the virus, morbidity and mortality.[100] Such review must avoid explicit or implicit assumptions about the value or quality of life of a patient, based on aspects of their ability unrelated to COVID-19, so that the individual chance of a disabled person with COVID-19 to benefit from treatment is not influenced by how disabled lives are valued by society. Access to treatment decisions should not consider whether someone has a disability, or a proxy for a disability such as 'frailty'. Instead, they should focus on the patient's prospects of benefiting from treatment.[101] Where disabled people have existing health conditions or impairments that are unrelated to their chance of benefiting from treatment, those pre-existing conditions must not play any part in decision-making regarding a disabled person's equal right to access such treatment. ICU triage protocols should focus on identifying the patients who are most likely to die without a ventilator, but are the most likely to survive with one. They should do so using the best available clinical survivability scores, applied on an individual basis, not using broad categorical exclusions.[102] Going further, medical professionals should take decisions based not on an abstract 'norm' of able-bodied (or able of mind), but cognisant that every body (and mind) is different.

Third, and more ambitiously, GDE principles based on lived experience are also a vital part of the developing field of disability ethics. As such, GDE can have the function of transforming practice, through creative and emancipatory disruption of established ways of behaving, established ethical considerations and principles. In the same way in which disability disrupts and challenges ableist normativity, disability ethics can challenge the dubious theoretical grounds, or the uncomfortable compromise between competing ethical frameworks, by ushering in the power of lived experience.

98 Ibid 9.

99 DREDF (n 82).

100 Gostin et al (n 97) 9.

101 Michelle Mello et al, 'Respecting disability rights — toward improved crisis standards of care' (2020) 383 New England Journal of Medicine e26.

102 Mildred Solomon et al, 'Covid-19 crisis triage — optimizing health outcomes and disability rights' (2020) 383 New England Journal of Medicine e27.

CONCLUSION

Grassroots disability ethics principles are those for the ethical and fair distribution of resources and organisation of society that emerge from disabled people themselves. This article has shown that GDE can be used to help illuminate serious problems with COVID-19 guidelines, such as the NICE rapid COVID-19 guidelines on critical care[103] and the BMA 'COVID-19: ethical issues'.[104] Although these guidelines, like many others across the globe, do not overtly discriminate on grounds of disability, they do raise the possibility of indirect discrimination against disabled people, potentially involving the denial of life-saving treatment. More profoundly, the guidelines embody a disableist approach that non-discrimination law alone cannot address. This deeper problem lies with how disabled lives are understood, valued and consequently protected during the pandemic.

More broadly, and perhaps most poignantly, the NICE and BMA ethical guidelines, despite committing to avoiding direct discrimination, may be failing to achieve what they set out to do. The main purpose of both guidelines is to bring clarity and reassurance to both NHS staff who are tasked with making difficult decisions and to disabled patients who have to endure the consequences of these decisions. In their current form, the guidelines provide no such clarity. Instead, they encourage the formation of two opposing and incompatible 'camps': medical professionals versus disabled people, leaving very little space for sharing ideas, experiences and solidarity. Whilst more research is needed into the experiences with regard to the guidelines of both medical professionals and disabled patients during the pandemic, it is nonetheless safe to argue that GDE principles of including disability voices in the legal and policy responses to the COVID-19 pandemic would offer a stronger ethical foundation that brings clarity and reassurance to everyone.

Going further, GDE principles can be used as a foundation upon which to build a disability-inclusive and disability-led response not only to the current COVID-19 crisis, but to other contexts where healthcare resources become scarce. Disability-led narratives on what constitutes ethical, fair and just prioritisation of patients during the pandemic are missing from the guidelines. Yet, these disability-led narratives would offer the key improvement to the guidelines, as they would prevent the historic devaluation of disability to allow for indirect discrimination against disabled patients to be seen as an acceptable means to achieve a legitimate aim. Disability voices and experiences must be included in all policy and legal responses to the current pandemic, as well as

103 NICE (n 2).
104 BMA (n 3).

any future health crisis. Including disability voices and experiences in the construction of legal and policy responses to health crises has the potential to disrupt medicalised 'common sense' on disability in the health field and encourage the cross-pollination of practice with discussions from critical disability studies, disability rights and ethics.

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Patents, access to health and COVID-19 – the role of compulsory and government-use licensing in Ireland*

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ABSTRACT

As the race for effective vaccines and treatments for COVID-19 continues, attention must turn to how such health-technologies will be accessed globally once developed. Patents play a significant role in this context because they give the patent-holder the right to stop others using patented inventions. Patents are available on diagnostics, medicines and vaccines and could form significant access obstacles for COVID-19. Moreover, whilst many patent-holders may be willing to license health-technologies reasonably, others may not. Therefore, it is imperative that national governments ensure effective avenues exist to intervene with patent-holder discretion via compulsory licensing. This article focuses on the legal framework applicable in Ireland for such compulsory licensing interventions, interrogating the effectiveness of the current framework in alleviating access issues posed by patents for COVID-19. It demonstrates how the current framework could be reformed to make it more effective in tempering patent-holder control, where needed, whilst remaining in compliance with Ireland's international obligations.

Keywords: patents; COVID-19; compulsory licensing; government-use licence; service of the state; access to medicines.

INTRODUCTION

The race to secure effective vaccines and treatments for COVID-19 continues at pace.[1] However, as we get closer to finding effective vaccines and treatments for COVID-19, attention has turned to

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1 Ewen Callaway, 'The race for coronavirus vaccines' (2020) 580 Nature 576; Emiliano Rodríguez Mega, 'Latin American scientists join the coronavirus vaccine race: "No one's coming to rescue us"' (2020) 582 Nature 470; Ewan Callaway, 'The unequal scramble for coronavirus vaccines – by the numbers' (2020) 584 Nature 506.

how they will be accessed once developed, by whom first and on what terms.[2]

In this context, intellectual property rights and particularly patents play a significant but sometimes overlooked role.[3] A patent is an intellectual property right which allows the patent-holder to exclude others from using the invention under patent without the patent-holder's permission (licence). This in turn means that the patent-holder can dictate many aspects of how a patented invention is provided, including, at what price and to whom.[4] Where the patented invention is a health-related technology such as a vaccine, medicine or element(s) of a diagnostic, how patents are used has significant implications for healthcare because access to such technologies is often dependent on how patent-holders choose to license them. The stakes are heightened in the global pandemic context, where access to effective vaccines, medicines and diagnostics is key to saving lives and to controlling and limiting the spread of the virus. Moreover, alongside such implications for health, access to such Covid-19 health-technologies is also vital to alleviate the attendant devastation the pandemic continues to bring in terms of its effect on society and the economy more generally.[5]

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2 These include discussions in the vaccine context around COVAX a global initiative seeking to pool vaccine procurement for COVID-19 that is co-led by the Coalition for Epidemic Preparedness Innovations, Gavi, the Vaccine Alliance, and the WHO. See discussions: 'COVAX initiative: the COVID-19 vaccine Global Access Facility' (25 August 2020); WHO, '172 countries and multiple candidate vaccines engaged in COVID-19 vaccine Global Access Facility' (News Release, 24 August 2020). See also discussions of whether there will be enough supplies of the vaccine (once developed): Roxanne Khamsi, 'If a coronavirus vaccine arrives, can the world make enough?' (2020) 580 Nature 578.

3 Other forms of intellectual property rights may also be relevant to medical technologies, discussed in part one below. In the vaccine context, the vaccine production process may often be protected by trade secret protection, and access to such trade secret information and the know-how of vaccine production can prove additional obstacles for a generic company to recreate a vaccine. See Sarah Eve Crager, 'Improving global access to new vaccines: intellectual property, technology transfer, and regulatory pathways' (2014) 104(11) American Journal of Public Health e85–e91.

4 Aisling McMahon, 'Biotechnology, health and patents as private governance tools: the good, the bad and the potential for ugly?' (2020) 18(3) Intellectual Property Quarterly 161–179.

5 In Ireland, the GDP is expected to decrease by approximately 13% in 2020 due to economic disruptions caused by the COVID-19 crisis. See Kelly C De Bruin, Eoin Monaghan, Aykut Mert Yakut, 'The environmental and economic impacts of the COVID-19 crisis on the Irish economy: an application of the I3E model' (ESRI Research Series 106, July 2020); the UN predicts that 40–60 million people globally will be pushed into extreme poverty due to economic effects of COVID-19 crisis: UN Development Programme, *Brief 2: Putting the UN Framework for Socio-Economic Response to Covid-19 into Action: Insights* (June 2020).

Whilst many patent-holders have shown willingness to offer favourable licensing terms for COVID-19 health-related technologies,[6] there is no legal requirement for rights-holders to do so, and others in future may not. This in turn could limit access to and supply of patented health-technologies including vaccines, medicines and diagnostics for COVID-19.

Against this backdrop it is important to consider what avenues are available to national governments to intervene with how patent-holders license patented health-technologies for COVID-19 in cases where patent-holders refuse to license such technologies, or refuse to license them on reasonable terms. This article examines this issue, focusing specifically on the Irish jurisdiction as a case study and on the legal avenues for compulsory licensing and mechanisms for licensing for service of the state applicable in Ireland.[7]

Compulsory licensing allows states to authorise a third-party/government to use a patented technology without the patent-holder's consent. Whilst provisions for licensing for the service of the state (so-called 'government-use provisions'), where applicable within national laws, allow the government to license a patented technology (without the patent holder's consent) for use for service of that state. Both mechanisms, where authorised, facilitate a third party/the state using a patented invention without patent-holder consent where needed and could be used where public health requires it, for example, where necessary within the COVID-19 context.

Accordingly, the article argues that it is incumbent upon the Irish government, and other national governments, to re-evaluate the current operation of such licensing mechanisms to ensure these mechanisms are as effective as possible for use within the COVID-19 context should they be required. Indeed, other jurisdictions including Germany,[8] France[9] and Canada[10] have already taken steps to reform or tailor existing compulsory licensing frameworks to ensure effective avenues exists to temper patent-holder control where needed for COVID-19.[11] Moreover, a broader shift within the discourse is evident

6 See discussion in Aisling McMahon, 'Global equitable access to vaccines, medicines and diagnostics for Covid-19: The role of patents as private governance' (2020) Journal of Medical Ethics (forthcoming).

7 The article uses the term Ireland to describe laws applicable within the Republic of Ireland.

8 See discussion in Jennifer Enmon and Grant Shoebridge,'COVID-19 – patent rights in the time of a pandemic' (*Lexology*, 27 August 2020).

9 Ibid.

10 Ed Silverman, 'A Canadian bill would make it easier to issue compulsory licenses for Covid-19 products' (*Stat News*, 25 March 2020).

11 See general discussion of such moves in Adam Houldsworth, 'The key covid-19 compulsory licensing developments so far' (IAM, 7 April 2020).

around how compulsory licensing provisions are being discussed in the COVID-19 context: as where previously such provisions were viewed as exceptional measures sitting at the margins of patent law discourse, COVID-19 has brought such provisions under the spotlight as viable and necessary avenues for states to use to ameliorate access issues posed by patents on COVID-19 health-technologies. Yet, there is currently a dearth of literature on the operation of such provisions generally under Irish law[12] and, particularly, a notable gap on work assessing how such provisions might apply within the broader health context in Ireland, including for COVID-19.

This article fills this gap providing an overview of how these provisions operate in Ireland and offering the first comprehensive analysis of how such Irish provisions would likely apply if needed for COVID-19 including the shortcomings evident. In doing so, the article also puts forward novel reform proposals in relation to the Irish framework to make such licensing mechanisms more effective in alleviating potential access issues posed by patents on health-technologies for COVID-19 and within the health context more generally. Importantly, the article argues that current provisions within Irish law could in theory be interpreted as allowing the grant of compulsory licences or government-use licences in the COVID-19 context in *some circumstances*, but that shortcomings remain within the current framework. The amendments suggested to the domestic legal framework are aimed at increasing the effectiveness of the system, both in: 1) expanding/clarifying the scope for the use of such provisions for COVID-19; and 2) explicitly acknowledging within the legislation that such provisions can be used within the public health context thereby encouraging the use of such provisions where needed in Ireland.

Notably, alongside national laws, Ireland has obligations under EU law and international laws applicable in the compulsory licensing context. This article provides an overview of how these differing levels of obligations apply to Ireland's domestic framework, and the extent of

12 For a discussion of such mechanisms generally, see Robert Clark, Shane Smyth and Niamh Hall, *Intellectual Property Law in Ireland* (4th edn, Roundhall 2016) chapter 8, 'Voluntary and compulsory licenses'; European Patent Academy, 'Compulsory licensing in Europe: a country-by-country overview' (European Patent Office 2018), 61–63. For a brief discussion of the potential application of compulsory licenses for COVID-19 in Ireland, see Sophie Delaney, 'Compulsory licences on the horizon for drugs and equipment?' (*William Fry*, 27 March 2020); Donal M Kelly, 'COVID-19: the impact on IP law and practice in Ireland' (*IP Stars*, 5 May 2020); Samantha Silver and Lindsay MacLean, 'COVID-19: vaccine development and compulsory licensing' (*Kennedys Law*, 14 May 2020); Aisling McMahon, 'How patents will affect pandemic vaccines and treatments' (*RTE Brainstorm*, 3 July 2020).

reforms possible in this context, if Ireland is to remain compliant with such international legal obligations.[13]

Moreover, although the arguments focus on the Republic of Ireland, such arguments have broader significance given that the obligations imposed by the Agreement on Trade-Related Aspects of Intellectual Property Rights 1995 (TRIPS Agreement) apply in all World Trade Organization (WTO) contracting states including EU states and the EU in its own right, given that the EU is a signatory to the TRIPS Agreement.[14] The UK is also a signatory of the TRIPS Agreement and has participated in other WTO instruments, including the Amendment to the TRIPS Agreement in 2005,[15] by virtue of the EU's signing such agreements which bound all EU states (including the UK) at the time of signature. The UK has signalled its intent to remain party to such arrangements/agreements post-Brexit.[16] Accordingly, the WTO legal framework discussed in this article, which defines the parameters within which Ireland can reform its laws and remain compliant with its international law obligations, is applicable in all other WTO states including all EU states and the UK. Thus, this discussion is of broader relevance to any WTO state contemplating reform of its compulsory licensing laws in a manner which remains in compliance with WTO obligations. The obstacles posed by EU law to compulsory licensing use are also of relevance to all current EU states.

Furthermore, the legislative framework applicable in Ireland for compulsory licensing is broadly similar to the framework applicable within the UK under its Patents Act 1977, as amended, as many of the provisions applicable under Irish law were originally drawn from UK

13 Failing to comply with such international obligations under the Agreement on Trade Related Aspects of Intellectual Property Law (TRIPS Agreement) could render Ireland liable to the WTO dispute settlement mechanism and the possibility of trade sanctions for non-compliance. See general discussion on TRIPS Compliance in Edward Lee, 'Measuring TRIPS compliance and defiance: the WTO Compliance Scorecard' 18 (2011) Journal of Intellectual Property Law 401. Moreover, as the EU has signed the TRIPS Agreement, the Agreement has legal effects within the EU legal order, see Justine Pila and Paul Torremans, *European Intellectual Property Law* (Oxford University Press 2016) 35 and 61.

14 The EU signed the TRIPS Agreement on behalf of EU states as it was deemed to be within the competence of the EU: see Council Decision (of 22 December 1994) concerning the conclusion on behalf of the European Community, as regards matters within its competence, of the agreements reached in the Uruguay Round multilateral negotiations (1986–1994); OJ L 336 of 23/12/1994, page 1.

15 WT/L/641, Amendment of the TRIPS Agreement (8 December 2005).

16 The UK has indicated that during the Brexit transition period it will continue to be treated as a member state of the EU for the purpose of such instruments, and after this transition period the UK has confirmed its continued acceptance of such agreements/arrangements, see 'The United Kingdom's withdrawal from the European Union – Communication from the UK' WT/GC/206 para 2.6.

law.[17] Moreover, both jurisdictions have licensing for government/crown-use provisions – services of the state (in Ireland) and for the crown (under UK law)[18] – which are similar in nature. Hence, the analysis of the domestic framework applicable in Ireland for compulsory licensing and, particularly, licensing for services of the state resonates with the framework applicable in the UK context.[19]

The article is structured as follows: part one examines the potential impacts patents have on access to healthcare, providing a case for why effective compulsory licensing measures are needed at the national level to alleviate access issues posed by patents in the health context. Part two then examines the overarching international framework for compulsory licensing applicable in all WTO states including Ireland. This WTO framework sets down minimum criteria which present restrictions on uses of compulsory licences at a national level for COVID-19 which Ireland must continue to abide by in any reform of national laws in this area or face the possibility of WTO dispute settlement proceedings and potential trade sanctions. Following this, part three considers the domestic compulsory licensing framework applicable in Ireland, offering a critique of how the current framework would apply to the COVID-19 context, including the shortcomings evident. It then offers proposals for how this framework could be reformed to facilitate a more effective compulsory licensing system whilst remaining compliant with Ireland's international obligations. Part four examines licensing for service of the state provisions under Irish law, focusing on their potential to be used in the COVID-19 context, and reforms which would make this system more effective. Part five then outlines practical obstacles for the use of compulsory licences in Ireland posed by EU laws around data/marketing exclusivity and the EU's opt-out of the relevant WTO framework under Article 31*bis*. This section argues that such issues need to be addressed to ensure they do not cause undue barriers to compulsory licensing within EU states. Finally, part six concludes by arguing that compulsory licensing and government-use provisions are important tools within a state's broader arsenal of devices to alleviate access issues posed by patents on health-related technologies, including within the COVID-19 context. Accordingly, it is vital that national laws facilitate effective systems for such licensing interventions. The Irish state should address existing

17 Compulsory licensing is legislated for in the UK under sections 48, 48A and 48B of the Patents Act 1977 (as amended).

18 See section 55, 56 and 59 Patents Act 1977, as amended in the UK context.

19 It is, however, acknowledged that the two jurisdictions differ on some aspects, and this must be borne in mind in drawing any comparative lessons from the analysis for the UK context.

shortcomings as soon as possible lest such licensing measures be required for COVID-19.

1 PATENTS, ACCESS TO HEALTH AND COVID-19: THE NEED FOR EFFECTIVE NATIONAL COMPULSORY LICENSING MECHANISMS

Patents and patent-holder decisions on licensing can have a significant impact on access to health-technologies.[20] Once a technology is patented the patent-holder has the discretion to dictate how that invention is used and by whom for the duration of the patent (generally 20 years).[21] The patent-holder can refuse to license a technology to third-parties, which could effectively mean the patent-holder becomes the sole provider of that technology and, depending on their manufacturing capacity, this can have knock-on implications for the supply of that technology. This in turn can have significant adverse implications for health if the underlying patented technology is a medicine, vaccine, or diagnostic and if supply of such technologies is limited. These issues have been brought into the spotlight by COVID-19, particularly in light of recent debates around vaccine/medicine nationalism,[22] where some states have sought to negotiate agreements for preferential access of proposed vaccines or treatments for COVID-19 in their national states,[23] prioritising national interests over the interests/needs of other states. Such deals can have knock-on effects causing shortages of supplies of such vaccines, medicines or diagnostics available in other states.[24] Moreover, these types of deals are only likely to increase as we get closer to finding effective vaccines/treatments for COVID-19,

20 For a general discussion of the potential impacts of patents on access to and delivery of healthcare, which argues in favour of greater oversight of patent-holder's discretion in this context, see McMahon (n 4).

21 TRIPS Agreement, Article 33 which states that: 'The term of protection available shall not end before the expiration of a period of twenty years counted from the filing date.'

22 See discussion in McMahon (n 6).

23 Stephen Buranyi, '"Vaccine nationalism" stands in the way of an end to the Covid-19 crisis' *The Guardian* (London, 14 August 2020); Donato Paolo Mancini and Michael Peel , '"Vaccine nationalism" delays WHO's struggling Covax scheme' *Financial Times* (London, 2 September 2020).

24 Sarah Boseley, 'US secures world stock of key Covid-19 drug remdesivir' *The Guardian* (London, 30 June 2020); Barbara Mintzes and Ellen 't Hoen, 'The US has bought most of the world's remdesivir. Here's what it means for the rest of us' (*The Conversation*, 3 July 2020). Similar attempts to acquire preferential supplies at a national level are evident around proposed COVID-19 vaccines. See Duncan Matthews, 'Coronavirus: how countries aim to get the vaccine first by cutting opaque supply deal' (*The Conversation*, 27 July 2020).

with particularly acute effects on poorer nations and vulnerable populations.[25]

To alleviate these issues, states can try to *encourage* patent-holders to share intellectual property rights via voluntary licensing initiatives as part of a broader global solidarity approach to tackle COVID-19. Notable examples of such initiatives within the COVID-19 context include the Open COVID-19 pledge, and the World Health Organization's (WHO) COVID Technology Access Pool (CTAP).[26] It is undoubtedly important for states to endorse such initiatives,[27] and this article is not arguing that compulsory licensing offers a substitute to replace voluntary licensing initiatives. Rather, it argues that such voluntary mechanisms to encourage sharing of intellectual property should be strongly supported and endorsed by states, as state support for such voluntary licensing initiatives can form an important nudge to encourage patent-holders to participate in such initiatives, and the more national states do so, the greater the pressure placed on patent-holders to commit to voluntary licensing initiatives for COVID-19.

However, voluntary licensing models do not replace the need to have effective compulsory licensing mechanisms because voluntary licensing initiatives by their nature are subject to patent-holder opt-in, and, whilst many patent-holders may be willing to engage with these initiatives for COVID-19, they are not generally legally mandated to do so, and some patent-holders inevitably will not. Similarly, whilst many patent-holders may of their own accord be agreeable to license their COVID-19 technology on favourable terms, others may not. Accordingly, it is vital that states have an effective avenue to allow third parties or governments to use patented health-technologies without patent-holder consent where this is needed to alleviate access issues for COVID-19. Compulsory licensing and licensing for service of the state mechanisms provide such avenues, allowing states to intervene with a patent-holder's control over patented health-technologies where patent-holders refuse to license or provide such technologies

25 See also discussion on potential impacts on vulnerable populations in Ana Santos Rutschman, 'How "vaccine nationalism" could block vulnerable populations' access to COVID-19 vaccines' (*The Conversation*, 17 June 2020).

26 See COVID Pledge. For information on CTAP, see COVID-19 Technology Access Pool. An overview of both initiatives is provided in McMahon (n 6). See discussion of distinction between pools and pledges in: J L Contreras, M Eisen, A Ganz et al, 'Pledging intellectual property for COVID-19' (2020) 38 Nature Biotechnology 1146, 1147.

27 The benefits of voluntary licensing initiatives in such contexts, and the need for state support of these are discussed in detail in McMahon (n 6).

on reasonable terms.[28] Accordingly, where state support for voluntary licensing initiatives perform a useful 'carrot' function encouraging patent-holders to share intellectual property rights on reasonable terms, compulsory licensing is a vital 'stick' that states can use as a threat or as an mandatory measure where patent-holders do not offer reasonable terms and where public health requires access to patented technologies.[29] In effect, arguably, voluntary and compulsory licensing measures are complementary in nature and serve different functions in the access to medicines context.

Put simply, compulsory licensing measures are useful in such contexts because if a patent-holder refuses to license the patented technology on reasonable terms, depending on the national patent laws applicable, a compulsory licence could be applied for in that state which, if granted, would allow the government/third-party to produce that health-technology for supply within that state.[30] Alternatively, provisions allowing licences for service of the state where applicable (such as within Ireland) could be used to authorise the government to produce such technologies for that state. Such mechanisms, as noted, are useful negotiation tools, as the threat by the state of issuing a compulsory licence if reasonable licensing terms cannot be reached can be sufficient to encourage patent-holders to adopt more favourable licensing terms.[31] Hence, such licensing mechanisms provide a useful avenue to alleviate access issues where public health needs require these,[32] resetting the balance of control over how a patented technology is licensed away from patent-holders to states where needed. Accordingly, it is vital that existing national mechanisms

28 Such mechanisms could also be used in cases of vaccine/treatment nationalism to alleviate shortages of medicines which may arise elsewhere if patent-holders provide preferential supplies of patented vaccines, treatments, or diagnostics for particular states. See Mintzes and 't Hoen (n 24).

29 For a discussion of such measures as 'carrots and sticks' and the broader corporate responsibility context of patents, see Aisling McMahon and Edana Richardson, 'Patents, health and corporate responsibility' (Working Paper 2020) (on file with the author).

30 The issues may be more complex in the vaccine context as, alongside compulsory licences, other information on the process may be needed to allow a third party sufficient knowledge to produce the vaccine. Nonetheless, compulsory licences can help alleviate at least part of the issue posed in such contexts.

31 See discussion in Gorik Ooms and Johanna Hanefeld, 'Threat of compulsory licences could increase access to essential medicines' (2019) 365 British Medical Journal l2098.

32 See also discussion of role and use of such compulsory licensing flexibilities in Ellen 't Hoen, Jacquelyn D Veraldi, Brigit Toebes and Hans Hogerzeil, 'Medicine procurement and the use of flexibilities in the Agreement on Trade-Related Aspects of Intellectual Property Rights 2001–2016' (2018) 96 Bulletin of the World Health Organization 185–193.

for licensing without patent-holder authorisation are examined and reformed as necessary to ensure they are as effective as possible to meet public health needs.

It is acknowledged that compulsory licensing measures are conducted at the national level, and, where such licences are granted, they are predominantly aimed at alleviating issues in the national state. Thus, some may question whether using such mechanisms is akin to *vaccine/medicine nationalism* by another means. However, two points can be made to this potential critique: 1) Compulsory licences issued at the national level can give rise to a momentum for change which has global benefits, causing patent-holders to voluntarily license patented technologies for use elsewhere or to commit to not enforcing their intellectual property rights – we have already seen this in the COVID-19 context for the drug Kaletra, discussed below. 2) Arguably, the greater the number of states that use compulsory licences, the more normalised compulsory licensing becomes within the patent system for public health emergency contexts such as pandemics. This can make it easier for other states to use such mechanisms, and, relatedly, the greater number of states that threaten to use compulsory licensing within a particular context, the higher the likelihood of reputational damage to patent-holders who refuse to voluntarily license their patents on reasonable terms, which again can act as a strategy to encourage effective global change. Therefore, although such compulsory measures take place at the national level, they can have much broader, global or regional benefits.

Importantly, in making such arguments, the article is not suggesting that compulsory licensing or licensing for service of the state mechanisms are a panacea to address all access issues posed by intellectual property rights within the COVID-19 context. It is conceded that patents are not the only form of intellectual property rights relevant in the COVID-19 healthcare context, and particularly within the vaccine space, where trade-secret protection is also important.[33] In many cases, how a vaccine is produced may be protected by trade-secret protection and this knowledge may be necessary to create a generic version of a vaccine. This in turn differentiates vaccines from small-molecule medicines which are often easier to replicate by others without additional knowledge, e.g. of the manufacturing process, from

33 Trade secrets are defined by the World Intellectual Property Office as 'intellectual property rights on confidential information which may be sold or licensed'. See 'What is a trade secret?'. See also discussion in David S Levine, 'Covid-19 should spark a re-examination of trade secrets' stranglehold on information' (*Stat News*, 10 July 2020).

the patent-holder.[34] In the vaccine context or for biological (complex) medicines, having a compulsory licence over the patent will not necessarily *on its own* enable a third party to produce a similar version of that vaccine/medicine without the third party also having access to the information protected under the trade secret or additional know-how. This information may not be disclosed by the patent-holder, thereby requiring the third party to develop this knowledge to produce a generic vaccine – and this may be difficult and/or take considerable time. Nonetheless, this is not a reason to dismiss the role of compulsory licensing, as, even if it is more difficult to replicate a vaccine/medicine in such contexts, removing the patent obstacle will bring a third party closer to doing so. Furthermore, although outside the scope of this article, such issues arguably merely support the argument that, once a compulsory licence is issued on a patented invention, patent-holders should also disclose related information around the working of that invention, such as additional know-how and trade secret information.[35]

It is also acknowledged that alongside ensuring *effective* measures for compulsory licensing, there is a broader issue around states' willingness to use such compulsory licensing measures in the COVID-19 context and for public health more generally. Historically, higher-income states have been reluctant to use such compulsory licensing measures given the potential threat of backlash within the international community. Indeed, countries such as Thailand, Brazil and India faced backlash from the US and elsewhere, including threats of trade sanctions, for using such measures.[36] Some states, such as Ireland, with strong pharmaceutical industries may be particularly

34 Sara Eve Crager, 'Improving global access to new vaccines: intellectual property, technology transfer, and regulatory pathways' (2014) 104 American Journal of Public Health S414–S420. For a discussion on the difference between small molecule and biologic medicines and why manufacturing process information is information, see Generics and Biosimilars Initiative.

35 See discussion of possible avenues to obtain access to trade secret protected information under TRIPS in David S Levine, 'Covid-19 trade secrets and information access: an overview' (*Infojustice*, 10 July 2020). See also discussion in McMahon (n 6).

36 See C T Scopel and G C Chaves, 'Initiatives to challenge patent barriers and their relationship with the price of medicines procured by the Brazilian Unified National Health System' (2016) 32 Cad Saude Publica 121; S Tantivess, N Kessomboon and C Laongbua, 'Introducing government use of patents on essential medicines in Thailand, 2006–2007: policy analysis with key lessons learned and recommendations' (International Health Policy Program 2008); Z Siddiqiu, 'India defends right to issue drug "compulsory licenses"' (*Reuters*, 23 March 2016), as cited in E 't Hoen et al, 'Medicine procurement and the use of flexibilities in the Agreement on Trade-Related Aspects of Intellectual Property Rights, 2001–2016' (2018) 95 Bulletin of the World Health Organization 185, 189.

reluctant to use compulsory licensing measures, fearing industry backlash. However, it is in all our interests to eradicate the virus as soon as possible, from both a health and an economic industry perspective, and this can only be achieved by ensuring effective access to COVID-19 health-technologies.

Furthermore, arguably, COVID-19 is acting as a catalyst for change in this context, as a trend towards greater acceptability of the use, and need for, effective licensing interventions in the pandemic context is evident. For example, as noted, many countries have already amended laws to ensure effective avenues to obtain compulsory licences are available where needed for COVID-19.[37] Moreover, Israel issued the first compulsory licence for the pandemic on 18 March 2020, to allow it to import generic versions of AbbVie's Kaletra for COVID-19,[38] rather than receiving backlash/criticism, soon after Israel issued this compulsory licence, AbbVie committed to not enforcing its patents over Kaletra globally for COVID-19.[39] Given this backdrop, states, including Ireland, should be encouraged to evaluate existing systems and, arguably, will be more willing and empowered to introduce reforms and use compulsory licensing where needed for COVID-19.

Thus, in short, whilst compulsory licensing measures are not a panacea to solve all issues around access to health-technologies posed by intellectual property rights for COVID-19, they are a vital tool to alleviate access issues posed by patents. It is therefore imperative that states ensure such compulsory mechanisms are as effective as possible at a national level, so that they are open to states to use where needed to address one part of the broader access puzzle.

2 LICENSING WITHOUT PATENT-HOLDER'S AUTHORISATION: IRELAND'S INTERNATIONAL OBLIGATIONS

Turning then to the international framework within which licences without patent-holder's authorisation (such as compulsory licences and licences for service of the state) can be granted. At an international level, the minimum criteria for the grant of such licences are set out under Article 31 of the TRIPS Agreement. The TRIPS Agreement is applicable in all 164 WTO states globally, including Ireland. The EU is also a signatory of the TRIPS Agreement, which makes the TRIPS

37 Houldsworth (n 11); see discussion in Hilary Wong, 'The case for compulsory licensing during COVID-19' (2020) 10(1) Journal of Global Health 010358.

38 Houldsworth (n 11).

39 Phil Taylor, 'AbbVie won't enforce patents for COVID-19 drug candidate Kaletra' (*PharmaForum*, 25 March 2020).

Agreement 'binding upon the institutions of the Union and its Member States'.[40] Moreover, whilst the TRIPS Agreement does not have direct effect in EU member states by virtue of EU law,[41] nonetheless, when domestic courts are interpreting provisions of the TRIPS Agreement, they must do so 'as far as possible' 'in the light of the wording and the purpose' of the TRIPS provision, given the EU entered into the TRIPS Agreement on behalf of states.[42] Alongside the provisions within the TRIPS Agreement, all contracting parties of the TRIPS Agreement must also comply with the substantive provisions of the Paris Convention for the Protection of Industrial Property 1883, as amended (hereafter the Paris Convention) of which Article 5 relates to licensing without the rights-holder's authorisation.[43] Thus, the TRIPS Agreement and Paris Convention set out minimum standards for the use of compulsory licences within WTO states. Moreover, because the EU is a signatory of the TRIPS Agreement, there is an additional legal impetus arising from EU law for EU member states to abide by the provisions within TRIPS.

However, patent law is jurisdictional in nature and there is no global patent system *per se*. Instead, in practice, a compulsory licence is obtained at the national level, and the processes to apply for compulsory licences are governed by national laws separately in each state. Therefore, whilst every WTO member state must abide by relevant provisions within the TRIPS Agreement and the Paris Convention which set down *minimum* standards, they are free to impose *higher* standards than required under these international treaties within national laws for mechanisms for licensing without patent-holder's authorisation. Differences can therefore arise in the applicable rules around compulsory licensing in each national context. Accordingly, it is only by considering the requirements under the Paris Convention, the TRIPS Agreement and under national laws in the state concerned that a picture of how such licensing mechanisms operate in each national context, such as in Ireland, can be gleaned.

This section considers the international framework applicable for the grant of licences without patent-holder authorisation, focusing specifically on the minimum criteria set out under the Paris Convention, and under the TRIPS Agreement. It identifies the main shortcomings with this international law framework in terms of how

40 Article 216(2) Treaty on the Functioning of the EU, as discussed in Justine Pila and Paul Torremans, *European Intellectual Property Law* (Oxford University Press 2017) 69.

41 Pila and Torremans (n 40) 69.

42 Joined Cases C-300/98 and 392/92 *Parfums Christian Dior SA v TUK Consultancy BV* [2000] I-11307 [47] as discussed ibid.

43 Many WTO states, including Ireland, were already party to the Paris Convention upon the adoption of the TRIPS Agreement in 1995. The Paris Convention came into force in Ireland on 4 December 1925.

such international laws might impact the use of compulsory licensing mechanisms in Contracting States such as Ireland within the COVID-19 context. However, such restrictions are in many cases presented as offering a balance between patent-holders' right to intellectual property and broader public interests concerns.[44] Furthermore, changes to this international framework are likely to be a longer-term project given the complexity of achieving change of the TRIPS framework.[45] Within the COVID-19 context, therefore, it is more fruitful for the Irish government in the shorter term to ensure the legal framework in Ireland offers the most effective national framework for compulsory licensing possible, whilst remaining compliant with the current TRIPS framework. This national framework is discussed in part three below.

2.1 Compulsory licensing and the Paris Convention 1883

The Paris Convention was signed in 1883, however, the original Convention did not refer to compulsory licensing of patents. Compulsory licensing was discussed in the 1925 Revision Conference and subsequently provisions were included in the Paris Convention setting out minimum requirements for the grant of such licences.[46] In its current version, Article 5 of the Paris Convention states that contracting states of the Convention: '*shall* have the right to take legislative measures providing for the grant of compulsory licences to prevent the abuses which might result from the exercise of the exclusive rights conferred by the patent, for example, failure to work'.[47] This provision marks a recognition that contracting states are permitted to grant compulsory licences under the Convention. The Convention does not provide an exhaustive list of grounds under which a compulsory licence can be granted, merely providing 'failure to work' an invention as one example of a ground that a compulsory licence could be granted

44 On the right to intellectual property within the European Convention on Human Rights system, see Christophe Geiger and Elena Izyumenko, 'Intellectual property before the European Court of Human Rights' in Christophe Geiger, Craig A Nard and Xavier Seuba (eds), *Intellectual Property and the Judiciary* EIPIN series vol 4 (Edward Elgar 2018) 9–90. One could question the extent to which this balance incorporates other human rights concerns, such as the right to health. See, generally, discussion in Laurence R Helfer, 'Human rights and intellectual property: conflict or coexistence?' (2003) 5 Minnesota Intellectual Property Review 47; Philippe Cullet, 'Human rights and intellectual property protection in the TRIPS Era' (2007) 29(2) Human Rights Quarterly 403–430.

45 Frederick M Abbott, 'The future of the multilateral trading system in the context of TRIPS' (1997) 20 Hastings International and Comparative Law Review 661, 667.

46 Esther Van Zimmeren and Geertrui Van Overwalle, 'A paper tiger? Compulsory license regimes for public health in Europe' (2011) 42 International Review of Intellectual Property and Competition Law 1.

47 Article 5(A)(2) Paris Convention 1883, as amended.

for. However, it is permissible under the Paris Convention for states to adopt other grounds for compulsory licences beyond failure to work.[48] This provides considerable discretion to states in relation to the grounds which can be adopted at a national level for compulsory licensing.

Notably, the Paris Convention provides that a compulsory licence cannot be applied for:

> on the ground of failure to work or insufficient working *before the expiration of a period of four years from the date of filing of the patent application or three years from the date of the grant of the patent*, whichever period expires last; it shall be refused if the patentee justifies his inaction by legitimate reasons …[49] (emphasis added)

This provision means that national states are restricted in providing a compulsory licence *where it is granted on the ground of 'failure to work or insufficient working'* until a period of three years after grant or four years from the date of application has passed. However, this time restriction is not applicable beyond the circumstance of where a licence is granted for failure to work/insufficient working, i.e. it does not apply if compulsory licences are granted on other grounds. This point is returned to below in discussing the national requirements applicable under Irish law for the grant of a compulsory licence.

2.2 Compulsory licensing and the TRIPS Agreement

Alongside these provisions within the Paris Convention, there are seven main cumulative requirements for a compulsory licence under the TRIPS Agreement relevant to the healthcare context and to COVID-19.[50] Each of these criteria are considered here, alongside the implications of these criteria for the use of compulsory licensing for patented health-technologies for COVID-19.

Firstly, under the TRIPS Agreement, each authorisation of a compulsory licence must be considered 'on its individual merits'.[51] This implies that a state, for instance, cannot issue a blanket compulsory licence for an area of technology or specific issue such as issuing a compulsory licence for all 'COVID-19 related medicines'. Instead, each application for use of a patent without the patent-holder's permission must be considered individually for each individual medicine, vaccine etc. This requirement rules out the ability of any WTO state, including Ireland, using compulsory licences in a blanket manner to facilitate access to COVID-19 health-technologies.

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48 Van Zimmeren and Van Overwalle (n 46).

49 Article 5(A)(4) Paris Convention 1883, as amended.

50 For a full list of requirements: Article 31, TRIPS Agreement.

51 Article 31(a) TRIPS Agreement.

Secondly, a compulsory licence can only be granted if the proposed user of the licence had previously tried to obtain an authorisation for use of that technology from the patent-holder on reasonable commercial terms and conditions, and such efforts were unsuccessful within a 'reasonable period of time'.[52] A state can waive this requirement in 'the case of a national emergency or other circumstances of extreme urgency or in cases of public non-commercial use'. However, the rights-holder must be notified as soon as reasonably practicable in the context of a national emergency or situation of extreme urgency. Moreover, in the context of authorisation for public non-commercial use, the rights-holder 'shall be informed promptly'.[53]

The COVID-19 context could likely fall within the definition of a national emergency, particularly if a state of emergency was declared by the country where the compulsory licence was sought (although an official declaration of a state of emergency is not necessarily required for this waiver to apply).[54] Arguably, the fact that COVID-19 was declared a global pandemic by the WHO in March 2020,[55] and as this pandemic continues this may be sufficient to constitute a national emergency for the purposes of Article 31(b) TRIPS Agreement. This is supported by the fact that the text of the Doha Declaration on the TRIPS Agreement and Public Health, para 5(c) states that:[56]

> Each member has the right to determine what constitutes a national emergency or other circumstances of extreme urgency, it being understood that public health crises, including those relating to HIV/AIDS, tuberculosis, malaria and other *epidemics*, can represent a national emergency or other circumstances of extreme urgency [emphasis added].

Moreover, if there were a shortage of supplies of patented COVID-19 medicines, vaccines or diagnostics, this would arguably constitute a circumstance of extreme urgency given the likely threat to life such a shortage would pose within that state. In such circumstances, as in the case of a country seeking to provide COVID-19 medicines, vaccines or diagnostics to the public on a non-commercial basis, the requirement of having previously attempted to negotiate a licence with the patent-holder could be waived.

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52 Article 31(b) TRIPS Agreement.

53 Ibid.

54 For discussion of states of emergency in the COVID-19 context, see Alan Greene, 'State of emergency: how different countries are invoking extra powers to stop the coronavirus' (*The Conversation*, 30 March 2020).

55 'WHO Director-General's opening remarks at the media briefing on COVID-19' (11 March 2020).

56 See WTO, Ministerial Declaration of 14 November 2001, WTO Doc WT/MIN(01)/DEC/1, 41 ILM 746 (2002) (hereinafter Doha Declaration).

Third, the scope and the duration of the licence must be limited to the purpose for which it was authorised.[57] This implies that, after a crisis has been averted – or in the case of a compulsory licence granted in the COVID-19 context, after the global pandemic has been deemed to have ceased – then the compulsory licence would need to terminated (or within a reasonable period after this). This could be problematic within the health context because if a compulsory licence ceases it would likely reintroduce access issues, transferring control back to the patent-holder and thereby affecting who can supply such health-technologies thereafter. It could also lead to an increase in costs and limits on the supply of such patented medicines, vaccines or diagnostics. This could have particularly significant implications for developing countries that have less access to resources/funds to secure access to such products.

Fourth, the authorisation or licence must be non-exclusive, meaning that the compulsory licence does not stop the patent-holder from licensing others to use the technology.[58]

Fifth, any use under a compulsory licence is authorised 'predominantly for the supply of the domestic market' of the state where that use is authorised in.[59] This requirement will effect countries that have limited manufacturing capacity to make patented vaccines, medicines or diagnostics domestically even if a compulsory licence were granted. The implications of this requirement were previously evident in the AIDS crisis during the 1990s, and as a result the Doha Declaration was adopted,[60] and, subsequently, Article 31*bis* was introduced, which allows states to import patented inventions made under a compulsory licence elsewhere under certain circumstances.[61] However, shortcomings remain in relation to such provisions which have been well documented elsewhere.[62] Moreover, the EU has opted

57 Article 31 (c) TRIPS Agreement.

58 Article 31(d), TRIPS Agreement.

59 Article 31(f), TRIPS Agreement.

60 Paragraph 6 of which stated: '6. We recognize that WTO members with insufficient or no manufacturing capacities in the pharmaceutical sector could face difficulties in making effective use of compulsory licensing under the TRIPS Agreement. We instruct the Council for TRIPS to find an expeditious solution to this problem and to report to the General Council before the end of 2002.' Doha Declaration (n 56).

61 Article 31*Bis*, TRIPS Agreement, as amended. See Doha Declaration (n 56).

62 For a discussion, see Ellen 't Hoen, 'TRIPS, pharmaceutical patents and access to essential medicines: Seattle, Doha and beyond' (2002) 3(1) Chicago Journal of International Law; Duncan Matthews, 'WTO decision on implementation of paragraph 6 of the DOHA Declaration on the TRIPs Agreement and public health: a solution to the access to essential medicines problem?' (2004) 7 Journal of International Economic Law 73.

out of this procedure which means an EU state cannot be an eligible importing member, which could prove highly problematic in the COVID-19 context – this is a serious and unnecessary shortcoming for compulsory licensing use within EU states discussed in detail in part five below.

Sixth, under the TRIPS Agreement the patent-holder must be paid adequate remuneration in each case.[63] This provision may deter states/third parties from issuing compulsory licences, as there is uncertainty around how 'adequate remuneration' should be determined within states.[64] To facilitate better use of compulsory licensing, where public health demands it, further guidelines on how such remuneration should be determined would be useful,[65] alongside ensuring clarity on this at a national level – a point returned to below.

Seventh, the compulsory licence is liable to termination 'if and when the circumstances which led to it cease to exist and are unlikely to recur'.[66] Moreover, the 'competent authority shall have the authority to review, upon motivated request, the continued existence of these circumstances'.[67] Thus, the grant of such a licence can and indeed should be subject to periodic review to ascertain if the circumstances for grant still pertain. This implies that compulsory licensing provisions are time-limited in nature, and, for example, if COVID-19 was no longer considered a global pandemic or a national emergency (if this was the basis on which such a licence was granted), then that licence shall be liable to termination. Similarly, if a licence were granted in circumstances of urgency, once these circumstances dissipated then the licence would be liable to termination.

From the foregoing, it is thus evident that these culminative minimum WTO criteria present constraints on the use of compulsory licensing which may impede their effectiveness in alleviating access issues posed by patents for COVID-19.[68] Most notably, from the above, the provisions around the need for adequate remuneration for the rightsholder could deter applicants/states in using compulsory licensing, unless greater guidance is evident on how this would be

63 Article 31(h), TRIPS Agreement.

64 See discussion in Antony Taubman, 'Rethinking TRIPS: "adequate remuneration" for non-voluntary patent licensing' (2008) 11(4) Journal of International Economic Law 927–970.

65 WHO guidelines on this and proposals for how remuneration could be calculated are available at: James Love, *Remuneration Guidelines for Non-voluntary Use of a Patent on Medical Technologies* WHO/TCM/2005.1 (WHO 2005).

66 Article 31(g) TRIPS Agreement.

67 Article 31(g) TRIPS Agreement

68 See also Frederick M Abbott and Rudolf Van Puymbroeck, 'Compulsory licensing for public health: a guide and model documents for implementation of the Doha Declaration paragraph 6 decision' (2005) World Bank Working Paper 61.

determined. Furthermore, the need to grant a compulsory licence on a case-by-case basis for each patented invention means compulsory licensing does not offer a catch-all solution for addressing access issues on, for example, health-technologies for COVID-19. Nonetheless, taking a pragmatic view, it is likely to be difficult to successfully petition for any change of such TRIPS provisions, given that this would require a change of WTO law, which is fraught with difficulty given the need for multiple states' agreement, and, even if successful, any such change would likely take years to achieve. Furthermore, as noted, such conditions offer a balance to ensure interference with rights-holder's patent rights is not disproportionate. Thus, changing WTO law is not likely a feasible solution within the COVID-19 pandemic context, although addressing some of these shortcomings should not be abandoned in the longer term as doing so would facilitate states to offer a more effective system for compulsory licensing at the national level in future where public health requires such interventions.

Nonetheless, whilst WTO states including Ireland must abide by these international TRIPS and Paris Convention standards, national frameworks require consideration to ensure that compulsory licensing provisions are not going beyond the requirements set out within the TRIPS and Paris Convention, if the aim is to ensure compulsory licences offer effective mechanisms where needed to facilitate access to patented health-technologies. Changes to national laws are feasible within a shorter period of time, and, indeed, since COVID-19 many national states have already adopted legal measures to amend national laws on compulsory licensing to ensure such licences are easier to obtain if required in the COVID-19 context.[69] Ireland should follow suit, removing national obstacles to effective uses of compulsory licensing for COVID-19 and for public health more generally.

3 COMPULSORY LICENSING IN IRELAND AND COVID-19: AN APPRAISAL AND PROPOSAL FOR REFORM

This section offers an overview of the current applicable framework for compulsory licensing in Ireland, and the main shortcomings of this framework, focusing specifically on how compulsory licensing under the current framework could be used to alleviate access issues posed by patents for COVID-19 health-technologies. It then sets out reform proposals to offer a more effective system for compulsory licensing in Ireland.

Prior to delving into the analysis of such provisions, it is important to note two points. Firstly, compulsory licensing provisions operate in

69 Houldsworth (n 11).

Ireland alongside a government-use provision, allowing state use of a patented invention where needed for 'services of the State' (examined in part four below). These two avenues should be viewed as a package of complementary measures which operate together to permit interventions with patent-holder's control over patented inventions where needed to alleviate access issues arising.

Secondly, on first view, considered together, the texts of these legal provisions on compulsory licensing and licensing for service of the state in Ireland, although as will be seen they do not refer to public health or the public interest explicitly, nonetheless appear to offer scope for intervention with patent-holder discretion, particularly, because many of the provisions related to compulsory licensing and licences for 'service of the State' are drafted in a broad 'open-textured' manner.[70] Thus, one could argue, that because of the relatively expansive nature of some of these provisions (and particularly the service of the state provisions), they *could in theory* allow a broad interpretation, including for such provisions in their current form to be used, in some circumstances, to alleviate access issues in a pandemic context.

However, two issues arise in this context which support the need for reform. Firstly, Irish law contains instances where higher standards for compulsory licensing have been adopted than are needed to comply with minimum TRIPS standards. As will be seen, this limits the scope for use of such licences than could be possible in the COVID-19 context, and reforms are needed to address this.

Secondly, given the historical reluctance of states to issue compulsory licences, such expansive open-textured legislative provisions as they exist in the Irish context which fail to expressly refer to the use of these provisions in the health or pandemic context, and which require the Controller of Intellectual Property in Ireland or courts to interpret the measures as applying in the pandemic context, are problematic. This is because 'thought styles',[71] or interpretative communities,[72] whereby shared understandings or predispositions in favour of particular actions/interpretations may arise within such interpretative contexts. Within such contexts, the past actions within a decision-making framework can affect future decision-making, and such influences

70 Open-textured provisions are defined by Hart as 'statutes may be a mere legal shell and demand by their express terms to be filled out with the aid of moral principles'. See H L A Hart, *The Concept of Law* (Oxford University Press 1961) 199–200. See discussion in Aisling McMahon, 'Morality provisions in the European patent system: an institutional examination' (PhD Thesis, University of Edinburgh, 2016).

71 Mary Douglas, *How Institutions Think* (Syracuse University Press 1986).

72 Peter Drahos, 'Biotechnology patents, markets and morality' (1999) 21(9) European Intellectual Property Review 441–442.

can be particularly acute where decision-makers have considerable discretion over open-textured or expansive provisions.[73] In the institutional context, this is discussed in terms of 'path dependency' which implies that historical actions influence present acts,[74] or in simple terms that 'what happened at an earlier point in time will affect the possible outcomes of a sequence of events occurring at a later point in time'.[75] In essence, this implies that how a particular issue or provision (or an analogous issue) has been dealt with in the past by the institution will be influential, but not necessarily determinative, of present action(s).[76]

Accordingly, in situations where there has been a historical reluctance to interpret open-textured provisions in a manner which limits patent rights,[77] or where there has been historically limited use of such provisions to intervene with patent-holder discretion over licensing, this *status quo* of non-intervention and hence non-use/grant of compulsory licences is likely to be maintained unless change is encouraged by external action, such as by legislative reforms which specify that such provisions can be used in public health or pandemic contexts. In Ireland, there have been no compulsory licences issued to date in such contexts under section 70 of the Patents Act 1992 (as amended) (hereafter PA), and, similarly, the service of the state provision has received limited attention or use. Hence, leaving such provisions in their current form, without legislative intervention or guidance that expressly indicates the use of such provisions is possible within the public health and/or in a pandemic or epidemic context, is arguably likely to result in the *status quo* remaining and entrench a lack of willingness to use or interpret these provisions as applying in the public health context in Ireland.

For these reasons and for the specific reasons given below, legislative change is urgently needed to clarify the operation of these provisions in the public health context and to address specific shortcomings within the current framework.

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73 See generally McMahon (n 70).

74 See O Hathaway, 'Path dependence in the law: the course and pattern of legal change in a common law system' (2001) 86 Iowa Law Review 101.

75 W H Sewell Jr, 'Three temporalities: toward an eventful sociology' in T McDonald, (ed), *The Historic Turn in the Human Sciences* (University of Michigan Press 1996) 245, 262–263.

76 See McMahon (n 70); Aisling McMahon, 'Regulatory authorities and decision-making in health research: the institutional dimension' in Graeme Laurie et al (eds), *Cambridge Handbook of Health Research Regulation* (Cambridge University Press 2021).

77 See McMahon (n 70).

3.1 Compulsory licensing in Ireland

Section 70 of the PA[78] sets out the main criteria for the grant of a compulsory licence in Ireland. It provides that any person can apply for a compulsory licence to the Controller of Intellectual Property in Ireland,[79] (hereafter Controller) based on two main grounds namely:

1. on the basis of demand in the Irish state:
    a. 'a demand in the State for the subject matter of the patent is not being met or is not being met on reasonable terms';[80] or
    b. demand in the Irish state for the patented product is 'being met by importation other than from a member of the World Trade Organization';[81]
2. that the 'establishment or development of commercial or industrial activities in the State is unfairly prejudiced'.[82]

Of these grounds, the first ground is the ground most likely applicable in the COVID-19 context. However, the fact that grant of a compulsory licence in Ireland under this ground is premised on the demand for the invention in the state could pose an obstacle to the use of a compulsory licence, as assessing 'demand in a State' is a relatively subjective assessment. Under previous case-law, 'demand' in this context has been understood to mean public demand.[83] However, this would likely be construed as the actual demand at the price provided by the patent-holder not demand if the invention was provided at a lower price.[84] In the pandemic context, demand is likely to be high even if a vaccine, medicine or diagnostic is charged at high prices, given that access to this health-technology is required to meet a pressing health need. Thus, the need to show actual demand is not likely to be an obstacle. However, it is unclear what threshold is needed to show that demand is not being met under this ground. Arguably, unless a significant shortage of the patented invention were evident it may be difficult to justify a compulsory licence on this ground. Nonetheless, the lack of clarity around what is likely to constitute a failure to meet demand or failure to meet demand on 'reasonable terms' (or whether this could

78 This was amended by the Patent (Amendment) Act 2006; see also Patent Rules 1992, as amended, of which rule 50 applies in the context of compulsory licences.

79 The name of the Controller was changed from 'Controller of Patents Designs and Trade Marks' to the 'Controller of Intellectual Property' from December 2019, and this was amended in the Patents Act 1992, by virtue of section 42 of the Copyright and Other Intellectual Property Law Provisions Act 2019.

80 Section 70(1)(a)(i) PA.

81 Section 70(1)(a)(ii) PA.

82 Section 70 (1)(b) PA.

83 *Boult's Patent* (1909) 26 RPC 383 as cited in Clark et al (n 12) 201.

84 Ibid 201.

plausibly include a consideration of the price the invention is provided for) could deter applications or authorisations for compulsory licences in Ireland.

Alongside these two main grounds, a compulsory licence can also be obtained if a patent-protected invention (the second patent) cannot be used in a state without infringing upon rights from another patent (the first patent) – in such cases the patent-holder of the second patent can apply to the Controller for a licence under the 'first patent to the extent necessary for the exploitation of the invention concerned, provided that such invention involves an important technical advance of considerable economic significance in relation to the invention claimed in the first patent'.[85]

Overall, these grounds for compulsory licensing in Ireland are relatively restrictive in nature, even though, as noted above, the Paris Convention and the TRIPS Agreement provide considerable discretion to states in setting the grounds for compulsory licences. The restrictive nature of these grounds forms the first potential roadblock within Irish laws to providing an effective mechanism for compulsory licensing in the health context, and this is returned to in section 3.2 below.

Relatedly, section 70 PA, as amended, specifies that compulsory licences can only be granted three years after the publication of notice of the grant of a patent in Ireland.[86] This mirrors the criteria for the grant of compulsory licences in cases of 'failure to work or insufficient working' of a patent under the Paris Convention, discussed above. This condition of time within the Paris Convention allows the patent-holder sufficient time to show they are exploiting the patent and hence are not failing to work an invention.[87] However, in the Irish context, the reference to this time restriction covers all grounds for compulsory licensing and is not restricted to the context of 'failure to work' a patented invention, the context where this time-limit is specified as applying under the Paris Convention. This is an example of an additional restriction within Irish law beyond those which are required by the international legal framework applicable. To be compliant with international laws, it would be sufficient for Irish law to include this

85 Section 70(2) PA.

86 Section 70(1) PA states: 'At any time after the expiration of the period of three years, or such other period as may be prescribed, beginning on the date of the publication of notice of grant of a patent any person may apply to the Controller for a licence under the patent, or for an entry in the register to the effect that licences under the patent are to be available as of right …'.

87 Van Zimmeren and Van Overwalle (n 46) 17.

time restriction *only* in relation to a ground of grant of a compulsory licence based on failure to work an invention.[88]

This time restriction is potentially an obstacle to the use of compulsory licensing for COVID-19 related health-technologies, as it limits the state's ability to grant a compulsory licence for newly developed patented technology in Ireland. Generally, within the health-context, the regulatory approval process for new medicines or vaccines takes considerable time, often well beyond three years.[89] Thus, ordinarily having to wait until three years after patent grant to apply for a compulsory licence over a health-technology may not in practical terms pose a significant obstacle to accessing this technology. However, time is of the essence for COVID-19. There is a global effort to develop effective and safe medicines and vaccines for COVID-19 as soon as possible, yet this three-year requirement means that, even if there is such a medicine or vaccine, if it is under patent no compulsory licence can be applied for until three years post-grant. This obstacle should be removed as soon as possible outside the circumstances of where it is required under the Paris Convention (i.e. failure to work a patent). As having this time restriction for all grounds of compulsory licensing in Ireland unnecessarily ties the hands of the government for newly patented medicines/vaccines/diagnostics.

Turning then to the terms upon which the grant of a compulsory licence is made in Ireland, if the Controller is satisfied the grounds for a compulsory licence are met, according to section 70(3) PA the licence can be granted with the following main conditions:

- it would be a non-exclusive licence;
- it would be granted predominantly for the supply of the domestic market in Ireland;
- the licence granted can only be assigned with prior authorisation of the Controller and under specific conditions;
- the licence is granted subject to the payment to the patent-holder of 'adequate remuneration in the circumstances of the case, taking into account the economic value of the licence'. In this context, it is questionable how the adequacy of remuneration is to be determined, including how the 'economic value' of the licence

88 There was such a specific ground under Irish patent law, under section 70(2)(a) of the Patents Act 1992 which stated that: '(2) The grounds referred to in subsection (1) are the following: (a) that the invention which is the subject of the patent, being capable of being commercially worked in the state, is not being commercially worked therein or is not being so worked to the fullest extent that is reasonably practicable.' This was deleted by section 19, Patents Amendment Act 2006.

89 Stuart A Thompson, 'How long will a vaccine really take?' *New York Times* (New York, 30 April 2020).

is to be calculated, which could lead to uncertainty and potential challenge. Providing guidelines on this within Ireland would be useful to ensure this is not a roadblock to use of compulsory licensing if needed for COVID-19;
- the licence granted would be limited in terms of the scope and purpose for which it is granted.[90]

Many of these requirements merely reiterate the minimum requirements set out under the TRIPS Agreement considered above and are necessary to ensure Ireland's compliance with such international obligations.

In granting a compulsory licence under the Act, the Controller shall take account of the following matters:

a. the nature of the relevant invention, the time which has elapsed since the grant of the patent and the measures already taken by the proprietor or any licensee to make full use of the invention,
b. the ability of any person to whom a licence would be granted under the order to exploit the patent to the public advantage, and
c. the risks to be undertaken by that person in providing capital and exploiting the patent if the application is granted.[91]

These aspects imply a focus on the supply of the invention within the country by the patent-holder and suggest a need to allow the patent-holder time to develop sufficient supply of the invention. This condition likely relates to the narrow grounds currently in operation for compulsory licensing in Ireland. However, significantly, this section does not reference any public need or the public interest more generally, and, arguably, including a reference to demand to meet public need/interest would be preferable should compulsory licences be required for public health purposes.

Section 72 PA expressly provides that a Minister of the Irish government can apply for a compulsory licence under any of these above grounds set out under section 70 'after the expiration of the period of three years beginning on the date of the publication of notice of grant of a patent, or such other period as may be prescribed under section 70(1)' where section 70(1) provides that it can also be after 'such other period as may be prescribed'. Presumably, this caveat in section 70(1) allows the government to adopt legislative measures which would adopt an alternative period which could be used to reduce the time needed in circumstances outside of cases where compulsory licences are being used to address failure to work or failure to work the patent on sufficient basis.

Under section 72 PA, the minister can apply for the entry in the patent register to the effect that:

90 Section 70(3) PA.
91 Section 70(4) PA.

> ... licences under the patent are available as of right, or for the grant to any person specified in the application of a licence under the patent, and the Controller may, if satisfied that any of those grounds are established, make an order in accordance with the application.[92]

Thus, section 72 PA allows, for example, a health minister to apply for a compulsory licence for medicines/vaccines or other technology necessary in the COVID-19 context.

In terms of the practical application process for a compulsory licence, applicants apply to the Controller and provide a statement which sets out the facts of the application including 'evidence indicating that the applicant sought to obtain a licence' from the patent-holder but was unable to obtain such a licence on 'reasonable terms and within a reasonable time'.[93] The Controller '*may*, when so requested' (emphasis added) by the applicant dispense of this requirement for evidence if 'there exists a national emergency or other circumstances of extreme urgency' or 'in the case of an application for a licence for public non-commercial use' provided that the patent-holder has been 'informed as soon as reasonably practicable of the intention of the applicant to apply to the Controller for licence under patent'.[94] This mirrors provisions allowing for waiver of the requirement of attempting to negotiate access with the patent-holder in cases of emergency, urgency or public non-commercial use as set out in TRIPS.

3.2 Reform proposals

In short, based on the foregoing analysis, to facilitate greater effectiveness of the compulsory licensing mechanisms within Ireland for the COVID-19 context and for public health more generally, it is proposed that four main aspects of the current national framework be reconsidered, namely two legislative changes and two areas where further guidance on how legislative provisions are interpreted in practice would be useful

In the context of legislative reforms: firstly, it is vital that the requirement to wait for three years after the patent grant to apply for a compulsory licence is reconsidered. This requirement is only necessary under the Paris Convention in cases where a patent is applied for based on failure of the patent-holder to work the patent, or insufficient working of the patent.[95] However, the time restriction has been applied for all grounds of compulsory licensing applicable in Ireland under section 70 PA, thereby going beyond what is needed for Ireland to comply with international law, and this should be amended. This

92 Section 72(1) PA.
93 Section 73(1) PA.
94 Section 73(1A) PA.
95 Article 5(A)(4) Paris Convention.

could be achieved by amending section 70(1) of the Act. Alternatively, currently, section 70(1) PA provides that it is a three-year term 'or such other period as may be prescribed', implying this could be amended relatively easily by prescribing a shorter term by virtue of, for example, a statutory instrument. For the reasons given above, reducing this term is needed to ensure the Irish government's hands are not tied in using compulsory licensing for newly patented inventions. This time restriction should therefore be removed under Irish law for all grounds of compulsory licensing, other than in cases where the licence is granted on the basis of failure to work a patent or failure to work it sufficiently within Ireland. Thus, alongside amending section 70(1) to remove the time restriction, to ensure compliance with the Paris Convention, the Act could reintroduce a ground which expressly referred to the grant of a compulsory licence in the case of failure to work a patent or insufficient working of a patent[96] and should, in that context, include a provision which stated: 'in cases where a compulsory licence is granted on the basis of failure to work or insufficient working of a patent, such a licence shall only be granted 3 years after publication of notice of patent grant'.

Secondly, and relatedly, the grounds allowing for compulsory licences in Ireland could be expanded to include a broader catch-all ground relevant to the public interest/public health context. For example, a ground could be included which allowed for a compulsory licence where 'necessary for the public interest'. A non-exhaustive list should also be given within such an amendment, providing that it would apply, 'for example, in cases of national emergency, including, within a public health crisis (e.g. a pandemic), environmental emergency, or economic crisis'. As noted above, expressly referring to such measures as applicable in the public health context, including in a pandemic context, within the legislative framework would provide an explicit source referring to the use of such measures in the public health context, which could encourage greater willingness to use provisions where needed for COVID-19. Expanding the text to include examples such as use in an environmental emergency, economic crisis etc. would provide greater longevity for the proposed reform expressly confirming its use, where public interest required it, in other contexts. However, adopting

96 As noted above, a ground which expressly referred to failure to work an invention was evident in the Patents Act 1992 but was removed by the Patents Amendment Act 2006 in favour of a more generally worded ground related to demand in the state. Section 70(2)(a) Patents Act 1992 previously provided the following ground for a compulsory licence: 2(a) 'that the invention which is the subject of the patent, being capable of being commercially worked in the State, is not being commercially worked therein or is not being so worked to the fullest extent that is reasonably practicable'.

a broad provision of this kind may be opposed by industry, and an alternative would be to adopt a provision which allowed compulsory licensing where necessary for public health grounds, with a legislative provision specifying that an epidemic or pandemic context constitutes an example of public health grounds.[97] Or, alternatively, given that compulsory licensing and service of the state provisions operate as a package in Ireland, one solution would be to refer expressly to the public health context only under patents for 'service of the State' and not in the general compulsory licensing context. However, such an approach would unnecessarily confine the grounds within which licences could be granted for public health purposes, requiring service of the state provisions to be fulfilled, and this would fail to facilitate the use of compulsory licensing more broadly on this basis. It would also fail to facilitate third parties applying for compulsory licences on public health grounds, as licences for service of the state relate primarily to government use of such provisions.

Turning then to the need for further guidance: thirdly, certain aspects of the current grounds would benefit from further guidance, specifically under section 70(a) PA, guidance is needed on how 'demand' for the invention in the state will be assessed in practice, including what threshold is needed. Greater clarity is also needed around how whether an invention is being provided on 'reasonable' terms will be considered in practice, and how 'reasonableness' will be assessed.

Fourthly, and finally, guidelines should be issued within Ireland on how the requirement of adequate remuneration for a compulsory licence will be assessed in a particular context, ensuring any uncertainty in this context does not act as a deterrent to applicants in applying for compulsory licences or the approval of such licences. Whilst remuneration must be decided on a case-by-case basis in practice, having a statement on the overarching general principles applicable within Ireland on this, and raising awareness of the mechanisms used to determine this or general principles applicable, would arguably be useful to encourage greater recourse to such provisions, where needed.

The need for such legislative reforms and guidance around existing provisions under Irish law is compounded by the fact that the grant or applications for compulsory licences have historically been uncommon/non-existent in practice.[98] Thus, there is limited jurisprudence on compulsory licensing to draw on to give further clarity in the Irish context. Moreover, patent legislation in Ireland has been amended

97 Other countries have adopted such provisions in light of COVID-19. See, generally, Wong (n 37).

98 There are no official statistics on this in Ireland: see European Patent Academy, *Compulsory Licensing in Europe: A Country-by-Country Overview* (European Patent Office, 2018) 63.

several times since the Patent Act's adoption in 1992, including a relatively substantial amendment of the compulsory licensing provisions in 2006 to bring Ireland's laws in line with the TRIPS Agreement. Thus, any case law which does exist will likely be of limited use in determining the application of recently revised provisions. Moreover, whilst, the law in the UK is likely to be persuasive, given its similar wording to much of the current Irish patent legislation,[99] nonetheless, to introduce greater clarity in the area, further domestic guidance would be beneficial.

4 LICENSING FOR SERVICE OF THE STATE IN IRELAND: ACCESS TO HEALTH-TECHNOLOGIES AND COVID-19

Alongside the compulsory licensing provisions applicable under Irish law, section 77 PA provides for the right to use patented inventions in Ireland without the patent-holder's permission for 'service of the State' – this is effectively a government-use provision (akin to the crown-use within UK law).[100] This provision allows a government minister or person authorised by them powers to do any of the following acts without the consent of the patent-holder:

(a) where the invention is a product, make, use, import or stock the product or dispose of or sell or offer to dispose of or sell it to any person;

(b) where the invention is a process, use it or do in relation to any product obtained directly by means of the process anything mentioned in paragraph (a);

(c) supply or offer to supply to any person any of the means, relating to an essential element of that invention, for putting the invention into effect.[101]

This mechanism provides a relatively broad avenue within which use of a patented technology can be sought by the government without the patent-holder's consent and this could be useful within the COVID-19 context. Any of the above acts if conducted under this provision do not amount to patent infringement.[102]

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99 See discussion ibid.

100 For a discussion of the operation of crown-use in the context of COVID-19, see Karen Walsh, Andrea Wallace, Mathilde Pavis, Natalie Olszowy, James Griffin and Naomi Hawkins, 'Intellectual property rights and access in crisis' (Working Paper 2020) (on file with author). Other countries have similar crown or government-use provisions, for a list of such measures and their use in the COVID-19 context to date, see COVID-19 IP Policy Tracker. For a general discussion of these provisions under Irish law, see: Clark et al (n 12) [8.46]–[8.53] .

101 Section 77(1) PA.

102 Section 77(2) PA.

The use of the invention under this section for 'service of the State' is defined as 'a service financed out of moneys charged on or advanced out of the Central Fund or moneys provided by the Oireachtas or by a local authority for the purposes of the Local Government Act, 1941'.[103] Arguably, this would undoubtedly include Irish health services, given the public nature of such services in Ireland as provided by the Health Services Executive (HSE). In terms of renumeration, the TRIPS Agreement provides that a state can set out specific circumstances where it can use a patented invention without the patent-holder's consent, provided 'adequate' remuneration is paid to the rightsholder.[104] The PA provides that use of the invention under this section is subject to terms which may be agreed upon 'either before or after the use' with the approval of the Minister for Finance, by any government Minister and the applicant for the patent or the patent-holder.[105] Presumably, this also includes agreement on the terms of remuneration which could therefore be concluded before or after use under this section. In default of an agreement, or in the event of dispute, the matter would be settled under the Act by the appropriate court or by an arbitrator upon conditions they may direct.[106] However, a shortcoming within this process is if the terms of remuneration for the patent-holder were not concluded until after the use takes place, and, if there is uncertainty around the principles applicable for how remuneration is calculated, the government would not know how much it would likely cost to use this licensing mechanism, and this could potentially lead to a government's reluctance to use this provision, as high costs could arise.[107] Similar, to the compulsory licensing context, such issues would be alleviated to some extent by guidelines being provided at a national level around the overarching principles applicable for how remuneration would

103 Section 77(10) PA.

104 Article 31(h) TRIPS Agreement, as amended. See discussion in Clark et al (n 12) 8.48.

105 Section 77(3) PA.

106 Section 77(6) PA. Use of an invention for service of the state can be used without renumeration under the circumstances of section 77(4) PA which provides: '(4) Where an invention which is the subject of any patent or application for a patent has, before the date of filing, or, where priority is claimed, the priority date of the application, been duly recorded in a document by, or been tried by or on behalf of any Minister of the Government (such invention not having been communicated directly or indirectly by the applicant for or the proprietor of the relevant patent), any Minister of the Government or such of his officers, servants or agents as may be authorized in writing by him, may use the invention so recorded or tried for the service of the State free of any royalty or other payment to the applicant for or the proprietor of the patent, notwithstanding the existence of the application or patent …'

107 For a discussion of the analogous Crown use provision in the UK context, see Walsh et al (n 100).

likely be calculated or factors which would be considered within this process in Ireland. This could act as a useful toolkit in deciding adequate remuneration and would introduce greater clarity on these issues, thereby making it more likely that a government would use these provisions if needed.

Section 78(1) PA provides for additional extended provisions for uses of inventions for service of the state in exceptional circumstances, whereby the state can use patented inventions for any purposes where it appears necessary or expedient to a minister of the government for: 'a) maintenance of supplies and services essential to the life of the community; b) for securing a sufficiency of supplies and services essential to the well-being of the community ... f) for ensuring the public safety and the preservation of the State'. Although, the text of these provisions does not expressly refer to public health or the public interest, it is highly likely in theory that such provisions would be applicable within the COVID-19 context given the global pandemic we face, as it is likely that supplies of diagnostics, treatments or vaccines for COVID-19 would be viewed as supplies which were 'essential to the life of the community' and/or 'essential to the well-being of the community' and/or for 'the preservation of public safety in the State'. Thus, such grounds could potentially offer an effective avenue to gain access to such patented technology where necessary for COVID-19.[108]

However, the thresholds applicable under these circumstances would again benefit from further guidance. In particular, the use of these provisions (a) and (b) when applied to the COVID-19 context would likely rest on whether adequate supplies of a patented health-technology were available in the country. Yet, it is questionable how the notion of 'sufficiency of supplies' in this context would be interpreted. Greater legislative guidance on the threshold applicable would be useful in the event that this provision is needed for COVID-19 or within other health contexts in future.[109]

A further issue is that section 78(2) indicates the powers to use a patented invention for service of the state under the section 78(1) provision would only be invoked in exceptional circumstances. It states that: 'Where the Government are of the opinion that, owing to the *existence of exceptional circumstances*, it is desirable in the *interests of the community* that a power conferred by subsection 1 shall be available, they may by order declare that the power shall be available.'

108 Notably, in E*valve & Abbott v Edwards Lifesciences Limited* [2020] EWHC 513 (Pat), [77] where the similar UK mechanism of crown-use was raised: the court noted that an example of where this provision would be applicable was for the provision of life-saving generic medicines in the public interest in 'special cases, such as novel pandemic disease'. See discussion in Walsh et al (n 100).

109 See discussion in Kelly (n 21).

(emphasis added)[110] This current phrasing explicitly suggests use under section 78(1) grounds will only be in rare circumstances,[111] which may prove a considerable impediment to use of this mechanism as it suggests a very high threshold is needed if it is only to be used in 'exceptional circumstances'. It is proposed that legislative change is needed and the phrase the 'existence of exceptional circumstances' in this section be amended to indicate 'Where the Government are of the opinion that, it is *necessary in the interests of the community* that a power conferred by subsection 1 shall be available, they may by order declare that the power shall be available.' This should be accompanied within the legislation by a non-exhaustive list of examples of what *interests of the community* may include, with express reference to public health contexts, including a public health emergency such as a pandemic/epidemic etc.

Without adopting such changes, it is still likely that the global pandemic caused by COVID-19 would fall within exceptional circumstances suggested within section 78 PA, but expressly providing within legislation that a pandemic or epidemic comprises a circumstance where such licences if needed would fall within the interests of the community would arguably encourage greater clarity and, hopefully, result in greater state willingness to use such provisions where needed. Removing the term 'exceptional circumstances' would also potentially encourage greater recourse to this provision. Nonetheless, the elephant in the room may be the remuneration required if a licence were issued under this provision – and guidance on how this is determined is therefore vital.

5 EU OBSTACLES TO EFFECTIVE USE OF COMPULSORY LICENSING

Alongside these national reform proposals, it is also vital that some of the current obstacles stemming from EU law to the effective practical use of compulsory licensing in the health context within EU states are amended.[112] Most notable in this context are existing legal protections which pose difficulties for the registration of generic medicines (medicines which are similar/identical to the branded/patented version) that are produced under compulsory licences, namely data exclusivity protections and marketing exclusivity protections. Under

110 Section 78(2(a) PA.

111 See also discussion in Ann Henry, 'Coronavirus: patents rights and the public interest' (*Pinsent Masons, Out-Law*, 3 April 2020).

112 Ellen 't Hoen, 'European pharmaceutical legislation needs exceptions to data and market exclusivity to protect European patients from high drug prices' (*Medicines Law and Policy*, 21 May, 2018).

EU law, there is an eight-year data exclusivity protection which applies to all new medicines[113] – this effectively means that within this time period someone who, for example, produces a generic medicine under a compulsory licence would be unable to use the original clinical data conducted for the patented medicine's approval to support the application for generic approval. Having to conduct additional clinical studies would be both costly and time prohibitive for a generic producer and could effectively defeat the purpose of granting a compulsory licence as, in practice, although it could mean the licence to allow a third party to produce a generic version is granted, it would be difficult to gain approval for generics made under the compulsory licence. There is currently no explicit waiver on the data exclusivity protection where a medicine is subject to a compulsory licence.[114] This is a major regulatory stumbling block to the use of compulsory licensing in the EU for COVID-19 and other health contexts. Furthermore, marketing exclusivity applies, which means that a generic medicine cannot be marketed until 10 years after the original medicine obtained authorisation.[115] There is also no exception to this marketing exclusivity protection under EU law in cases of compulsory licensing. Such data and marketing exclusivity protections deterred Romania's use of a compulsory licence in 2016 for sofosbuvir to treat hepatitis C.[116] In order for compulsory licensing measures to be an effective avenue in EU countries for health-technologies, it is crucial that a waiver is introduced to such protections in this context.

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113 See Regulation (EC) No 726/2004 of the European Parliament and of the Council of 31 March 2004 laying down Community procedures for the authorisation and supervision of medicinal products for human and veterinary use and establishing a European Medicines Agency OJ L 136, 30.4.2004, Article 14(11) which states: 'Without prejudice to the law on the protection of industrial and commercial property, medicinal products for human use which have been authorised in accordance with the provisions of this Regulation shall benefit from an eight-year period of data protection and a ten-year period of marketing protection, in which connection the latter period shall be extended to a maximum of 11 years if, during the first eight years of those ten years, the marketing authorisation holder obtains an authorisation for one or more new therapeutic indications which, during the scientific evaluation prior to their authorisation, are held to bring a significant clinical benefit in comparison with existing therapies.'

114 See discussion in Houldsworth (n 11). See also, generally, discussion of data exclusivity and compulsory licensing in Phoebe Li and Pheh Hoon Lim, 'A precautionary approach to compulsory licencing of medicines: tempering data exclusivity as an obstacle to access' (2014) 3 Intellectual Property Quarterly 241.

115 Article 14(11) Regulation 726/2004.

116 E 't Hoen, P Boulet, B Baker, 'Data exclusivity exceptions and compulsory licensing to promote generic medicines in the European Union: a proposal for greater coherence in European pharmaceutical legislation' (2017) 10 Journal of Pharmaceutical Policy and Practice 19.

Finally, there are obstacles to Ireland to importing medicines manufactured under compulsory licence in another country where needed for COVID-19. As noted above, Article 31 of the TRIPS Agreement allows for compulsory licensing, but it requires that such licences are used *predominantly for the supply of the domestic market* within the state that the licence is granted within.[117] This can be highly problematic as, for example, in the developing-country context states may not have the domestic manufacturing capacity to produce generic versions of medicines under compulsory licence in the state. To address this, a wavier to this domestic production requirement for compulsory licensing was introduced by Article 31*bis*, which allows states to produce generic versions of health-technologies made under compulsory licence to be exported to states that require them but do not have the manufacturing capacity to produce these domestically, subject to certain requirements. This waiver was first introduced on a temporary basis on 30 August 2003; it was then approved as an amendment to the TRIPS Agreement in 2005, and finally ratified by the required number of WTO states, to enter into force in January 2017. This waiver is the only avenue by which states can import generic versions of patented medicines from another state where public health demands it, whilst remaining compliant with the TRIPS Agreement.

This provision is coming under the spotlight again in the COVID-19 context, for two reasons: 1) as has been seen already, COVID-19 can cause devastating health impacts within a region, and this in turn could impact domestic industries including pharmaceutical production. Thus, states that ordinarily have a strong pharmaceutical industry could find this halted by COVID-19 or other public health contexts, making it impossible to produce sufficient generics domestically even if a compulsory licence were granted. 2) States may lack domestic supplies of pharmaceutical ingredients necessary to make generic medicines for COVID-19, again rendering domestic manufacture of COVID-19 health-technologies under compulsory licence impossible.

Importantly, although historically this provision was most relevant to developing countries and least developed countries that lacked manufacturing capacity, it can be used by any WTO state that has notified the WTO that it is an eligible importing state, whereby 'it being understood that a Member may notify at any time that it will use the system in whole or in a limited way, for example only in the case of a national emergency or other circumstances of extreme urgency or in cases of public non-commercial use'.[118] However, the Annex to this provision also states that '*some Members will not use the system as importing*

117 Article 31(f) states that: 'any such use shall be authorized predominantly for the supply of the domestic market of the Member authorizing such use'.

118 Annex to the TRIPS Agreement, paragraph 1(b).

Members, and that some other Members have stated that, if they use the system, it would be in no more than situations of national emergency or other circumstances of extreme urgency' (emphasis added).

The EU is one such region that has voluntarily opted-out of the WTO framework, and therefore EU states are not eligible importing states, meaning the EU or member states cannot currently import generics made under compulsory licence elsewhere under Article 31*bis*.[119] Ireland has a strong pharmaceutical industry, and thus, ordinarily, this opt-out decision would be unlikely to pose an issue as there should be sufficient capacity/skills to produce generic medicines made under compulsory licence domestically. However, in the context of a global pandemic which can have devastating impacts on human health,[120] with further impacts on supply chains,[121] this could conceivably hinder any country's ability to continue pharmaceutical operations. Therefore, despite Ireland's ordinarily strong pharmaceutical manufacturing capabilities, it is highly plausible Ireland could need to utilise this measure for COVID-19 or future health crises. Thus, it is vital this opt-out decision for EU states is changed, as James Love has noted in this context, it is:

> ... totally irrational for any country, even a rich country, to keep its own hands tied to meet the COVID-19 needs of its population by voluntarily shutting itself off from patented ingredients, components, and essential medical products and supplies.[122]

There are calls for the EU to change this restriction, and the Irish government and other national EU Member State governments should support such calls to demand change on this as a matter of urgency.[123] The opt-out should either be revoked in its entirety if possible, or the EU should ensure a provision is included within this opt-out which allows such imports in cases of 'national emergency or other circumstances

119 'Implementation of paragraph 6 of the Doha Declaration on the TRIPS Agreement and public health General', Council Decision, Article 1(b), footnote 3; Article 31*bis*, Annex, Article 1(b), footnote 3.

120 At the time of writing, 4 September 2020, COVID-19 had resulted in over 873,000 deaths worldwide, with 26.5 million cases. See Worldometer.

121 See discussion in Anthony Lakavage, 'Covid-19 has exposed cracks in the global medicines supply chain. We need to fix them' (*Stat News*, 2 June 2020).

122 James Love, 'Open letter asking 37 WTO Members to declare themselves eligible to import medicines manufactured under compulsory licence in another country, under 31bis of TRIPS Agreement' (*Knowledge Ecology International*, 7 April 2020).

123 Ibid; see discussion in: Christopher Garrison, 'Never say never – why the high income countries that opted-out from the Art 31bis WTO TRIPS system must urgently reconsider their decision in the face of the COVID-19 pandemic' (*Medicines, Law and Policy*, 8 April 2020).

of extreme urgency',[124] so that importation of health-technologies made under compulsory licence elsewhere can be used where needed by EU states within the COVID-19 context and other health emergency situations.

CONCLUSION

Given the devastating global impacts of the COVID-19 pandemic on human life, society and the broader economy, it is vital that affordable global access to vaccines, diagnostics and treatments for COVID-19 are available once these are developed, as such access must be delivered without delay. However, as has been demonstrated, patents, depending on how patent-holders choose to use them, can prove significant obstacles to such access. Accordingly, it is vital that national governments have effective mechanisms in place to temper patent-holder control via compulsory licensing and government-use licences allowing states to intervene over patent-holder decision-making where needed. Such measures are also effective as negotiation tools for states, as often the threat of such licences will encourage patent-holders to offer access to patented health-technologies on more favourable terms.

Accordingly, the Irish government must re-evaluate the current framework for compulsory licensing and licensing for service of the state in Ireland to ensure the national legal framework applicable is as effective as possible, whilst remaining compliant with Ireland's international obligations. As demonstrated, shortcomings exist within the current framework in this context, and these should be addressed as soon as possible to offer a broader compulsory licensing system in Ireland which gives the state greater scope to intervene with patent-holder's licensing decisions. More specifically, the following changes are needed:

1. legislative change to amend the grounds for compulsory licensing offered under section 70 PA;
2. legislative change to remove the three-year time restriction outside of the context of compulsory licensing for insufficient working of a patent;
3. offering further guidance at a national level on what is meant within the current grounds in relation to 'demand' in the state; and
4. offering national guidance and raising awareness of how 'adequate' remuneration will be determined with reference to overarching principles applicable.

124 Ibid.

The article also proposes that the current provisions around licensing for service of the state are amended to incorporate:

1. legislative guidance making it clearer what threshold of supply or lack of supply is needed under section 78(a) and (b) PA;
2. legislative change removing the reference to 'exceptional circumstances' under section 78(2) and an express acknowledgment within the legislation that a pandemic/epidemic may constitute circumstances where licences for services of the state can be granted in the 'interests of the community' under this section; and
3. further guidance at a national level on the overarching principles used to determine adequate remuneration in such contexts.

Finally, obstacles to effective uses of such compulsory licensing mechanisms posed by EU data exclusivity and marketing exclusivity protections should be addressed as a matter of urgency, as these present significant practical impediments to using such licensing avenues for COVID-19 and for other public health crises. Ireland should petition the EU for a waiver to be provided within such protections where compulsory licences or licences for service of the state are issued. Ireland should also join calls for the removal of the EU's opt-out of the WTO framework allowing states to import medicines produced elsewhere under compulsory licensing.

In short, it is in all our interests, both in the health and economic sense, that COVID-19 is eradicated as soon as possible. It is also in all our interests that any obstacles to this eradication are addressed, and this includes obstacles created by patent rights. Compulsory licensing and licences for service of the state are an important tool to alleviate such access issues, which if left unchecked may significantly impede future access to supplies of medicines, vaccines and improved diagnostics for COVID-19. Allowing such potential patent obstructions to subsist without an effective avenue for remedy is contrary to all our interests, hence, using such licensing measures and adopting legislative provisions and national guidance to make the system for their use more effective within Ireland and other states is not only appropriate but wholly warranted.

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Proposals for copyright law and education during the COVID-19 pandemic*

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ABSTRACT

This article asks whether the catastrophic impact of the COVID-19 pandemic justifies new limitations or interventions in copyright law so that UK educational institutions can continue to serve the needs of their students. It describes the existing copyright landscape and suggests ways in which institutions can rely on exceptions in the Copyright, Designs and Patents Act 1988 (CDPA), including fair dealing and the exemption for lending by educational establishments. It then considers the viability of other solutions. It argues that issues caused by the pandemic would not enliven a public interest defence to copyright infringement (to the extent this still exists in UK law) but may be relevant to remedies. It also argues that compulsory licensing, while permissible under international copyright law, would not be a desirable intervention, but that legislative expansion to the existing exceptions, in order to encourage voluntary collective licensing, has a number of attractions. It concludes by observing that the pandemic highlights issues with the prevailing model for academic publishing and asks whether COVID may encourage universities to embrace in-house and open access publishing more swiftly and for an even greater body of material.

Keywords: copyright; fair dealing; public interest; open access; online learning; universities; education; COVID-19.

1 BACKGROUND

In this article, we discuss the relationship between copyright and education in light of the COVID-19 pandemic. Our focus is on higher education in the UK, although many of our ideas will be relevant to primary and secondary education, and to education in other countries. Our research question is simple: does the catastrophic impact of

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COVID justify state intervention so that educational institutions can continue to serve the needs of their students?

Although the COVID pandemic is often described as unprecedented, the copyright-related challenges it poses are not new but reflect longstanding questions about the goals and appropriate scope of copyright. Thus, we have for many years debated the sort of accommodations that should be made in copyright law to support education, given the high use of copyright works in teaching and learning but the problems in leaving every such use to one-on-one rights negotiation.[1] Different countries have embraced different solutions, including free exceptions, compulsory licences and state-sanctioned mechanisms to encourage voluntary blanket licensing. With growth in the use of digital technologies in education, it has been asked whether reform is necessary.[2] In the Directive on Copyright in the Digital Single Market (DSM Directive), for example, a mandatory exception for education was introduced in response to the concern that there is uncertainty regarding the application of existing exceptions and limitations to digital and online uses.[3]

The COVID pandemic has produced a more extreme and urgent version of the existing situation. It has necessitated two changes at educational institutions that are of particular relevance to this article: first, the closure of libraries, meaning that staff and students cannot

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1 See generally E Hudson, 'The *Georgia State* litigation: literal copying in education' (2019) 82 Modern Law Review 508. Copying by educational establishments and libraries was a significant focus of the Whitford Committee: see Committee to Consider the Law on Copyright and Designs, *Report on Copyright and Designs Law* (Cmnd 6732, 1977) (Whitford Report). Before that, the Gregory Committee also considered copying for students in its analysis of fair dealing: see Copyright Committee, Report of the Copyright Committee (Cmnd 8662, 1952). The Berne Convention for the Protection of Literary and Artistic Works (Berne Convention) has since its inception dealt with education in (what is now) Article 10(2): see S Ricketson and J Ginsburg, *International Copyright and Neighbouring Rights: The Berne Convention and Beyond*, volume I (2nd edn, Oxford University Press 2006), [13.44]–[13.45].

2 This expansion to the debate to consider digital technologies can be traced back a number of decades: see eg House of Representatives (Parliament of Australia), *Copyright Amendment (Digital Agenda) Bill 1999: Explanatory Memorandum* (1998–1999) 6 (goals of reform include to ensure that educational institutions, amongst others, 'have reasonable access to copyright material in the online environment'); K Crews, 'Distance education and copyright law: the limits and meaning of copyright policy' (2000) 27 Journal of College and University Law 15; J Secker, *Copyright and E-learning: A Guide for Practitioners* (Facet Publishing 2010) (a second edition was published in 2016, co-authored with C Morrison).

3 Directive (EU) 2019/790 of the European Parliament and of the Council of 17 April 2019 on copyright and related rights in the Digital Single Market and amending Directives 96/9/EC and 2001/29/EC, Recital 19. This exception is contained in Article 5.

access physical holdings and are entirely reliant on their library's virtual collection; and second, the need to move teaching and assessment online. As noted above, the copyright issues revealed by these changes are not new. However, the ramifications are more profound because certain in-person solutions are not available. To illustrate, for books not held in digital form, students cannot read the physical copy in the library.[4] Lecturers cannot play audio-visual content in class but exclude that content from any lecture recording.[5] In addition, with many universities planning to modify their teaching so that students can study remotely (and perhaps from outside the UK) for all or part of the 20/21 academic year, we need to plan for a lengthy period in which many of our students might never set foot in a library or a classroom, even if such spaces have reopened.[6]

Over the last few months, individuals from the UK education sector have articulated a number of concerns about the copyright impact of COVID.[7] One set of concerns revolve around pricing models for electronic content, for instance the huge discrepancies that can exist between buying the same book in hard copy and electronic form, and that publishers seem to be using price to encourage institutions to purchase aggregated access rather than individual items.[8] A second set

4 Reading a physical book in the library does not implicate any of the restricted rights of the copyright owner in sections 16–21 of the CDPA.

5 Playing a film in class may fall under the limitation in CDPA, section 34 which brings that act outside of the public performance right in section 19. However, if playing a film to students online implicates any of the restricted rights of the copyright owner, it will be the communication right in section 20, which is not caught by section 34. In Section 2 of this article, we discuss the legal analysis behind this statement and ask whether educators might instead turn to fair dealing for the purpose of illustration for instruction in section 32. But for now the point is that the copyright situation is clearer for in-classroom than for online use.

6 In saying this, we appreciate that many of our students will never visit a library even in normal conditions. Importantly, while for some this may reflect preferences regarding how to allocate their time (ie on pursuits beyond their academic studies), other students are highly reliant on online collections for other reasons, including disability, care responsibilities, work commitments and living arrangements.

7 See generally J Secker and C Morrison, 'Will the pandemic force universities to address the challenges of copyright?' (*Wonkhe*, Comment, 16 June 2020).

8 See eg A Vernon, 'During this crisis, publishers must allow greater access to their content', *Times Higher Education* (London, 24 March 2020); C McCluskey-Dean, 'Lobbying for fairer ebook access' (*Information in the Curriculum*, 12 May 2020). For pre-pandemic analysis of the pricing of e-books and digital content, see eg R Morais, J Bauer and L Borrell-Damián, *EUA Big Deals Survey Report: The First Mapping of Major Scientific Publishing Contracts in Europe* (European University Association April 2018); J Secker, E Gadd and C Morrison, *Understanding the Value of the CLA Licence to UK Higher Education* (Universities UK (UUK)/GuildHE CNAC July 2019).

of concerns relate to print items for which there is no digital version, such that institutions will need to digitise those items themselves if they require an electronic version. While many issues are logistical (for instance regarding staff access to the library and the resource-intensiveness of scanning), there are concerns that many copying requests will exceed the quantities permitted under the blanket licence with the Copyright Licensing Agency (CLA) and will not be caught by a free exception.[9] Third, there have been repeated questions about the use of audio-visual content given the complexity of rights in such material and the lack of a blanket licence (the nearest licence relating to broadcasts).[10] Finally, it has been asked whether copyright strategies that were devised for in-person classes can apply to equivalent teaching taking place online, including to students in other countries.

In this article we start in Section 2 by describing the prevailing copyright landscape. In presenting this material, one of our aims is to emphasise flexibilities in the existing system, especially under fair dealing. We then consider other possible accommodations, beginning in Section 3 with an expanded role for public interest arguments. We focus first on the public interest defence, which industry representatives have identified as a potential mechanism to give educational institutions greater scope to carry out unremunerated copying.[11] We identify a number of difficulties with this proposal, including that it would require a radical reconceptualisation of this (already controversial) defence. In contrast, there are more promising indications that public interest arguments might be relevant to remedies, notably injunctions. In Section 4, we consider licensing-based solutions. We start with compulsory licensing, which the UK government ruled out on the basis that it is 'likely to be incompatible with the international copyright

9 See CLA UUK/GuildHE Higher Education Licence (2019–2022), full terms and conditions. The CLA Licence covers copying from hard copy and digital sources and contains quantitative limits (typically 10 per cent or an article or chapter): clause 3.4. As discussed in Section 2.1, there have been temporary changes to the CLA Licence in response to COVID.

10 For discussion of the use of films and audiovisual works in online teaching, see E Hudson, 'Copyright guidance for using films in online teaching during the COVID-19 pandemic' (4 August 2020). The Educational Recording Agency (ERA) offers licences to schools and universities to use, for educational purposes, television and radio programmes of its members. However, this licence applies only to broadcasts and not audio-visual content more generally. Full terms and conditions.

11 Eg letter from D Prosser (Executive Director of Research Libraries UK) and other signatories to G Williamson (Secretary of State for Education) and O Dowden (Secretary of State for Digital, Culture, Media and Sport) dated 30 March 2020 (RLUK letter), requesting a 'statement from government' that section 171(3) 'can be used as a defence by public libraries, research organisations and educational establishments for as long as the current crisis lasts'.

framework'.[12] While we doubt this proposition as a matter of law, we accept that there are reasons why compulsory licensing is not a viable way forward at this time. That said, it is important that industry stakeholders reach negotiated solutions, and we suggest amendment of section 36 of the Copyright, Designs and Patents Act 1988 (CDPA) as one way to encourage this.

There are many issues that, for reasons of space and focus, we are unable to cover, including whether some publishers may be abusing a dominant position for the purposes of competition law.[13] That said, we include in Section 5 some brief remarks about whether COVID may provide further support for calls for the university sector to embrace open access not just for research but for teaching outputs such as textbooks.

2 THE PREVAILING COPYRIGHT ENVIRONMENT

As noted in Section 1, different countries have adopted different mechanisms to facilitate the use of copyright works in education. In the UK, the clear policy choice has been to encourage the roll-out of voluntary blanket licences and to enact exceptions which permit certain uses without remuneration.[14] We deal with licensing and exceptions in turn.

2.1. Licensing

Educational institutions have a number of different licensing options beyond one-on-one or transactional negotiation, including joining the blanket licences offered by collectives such as CLA and ERA, and executing licences with the producers of subscription databases and other digital products. One might also refer, here, to using resources distributed under Creative Commons licences.[15] Although reliant on the copyright system for their operation, Creative Commons licences remove many of the usual impediments to licensing by being applied prospectively by the creator rather than negotiated with the user. They are also unremunerated, reflecting the sharing and remix philosophy that sits behind the Creative Commons movement.

During the pandemic, copyright owners and collectives have implemented a number of initiatives to support education. For instance, some publishers have increased access to online textbook

12 Letter from A Solloway (Parliamentary Under-secretary of State – Minister for Science, Research and Innovation) to D Prosser dated 23 April 2020 (Solloway letter): see the RLUK letter and the Solloway letter each reproduced in full.

13 For a summary of how the relevant legal principles might apply to the exploitation of intellectual property rights, see L Bently, B Sherman, D Gangjee and P Johnson, *Intellectual Property Law* (5th edn, Oxford University Press 2018) 334–344.

14 Summarised in ibid 262–263.

15 See Creative Commons; and see summary in Bently et al (n 14) 309–312.

platforms.[16] In mid-April, the CLA Licence was temporarily revised to increase the quantitative copying limits for printed books, meaning that universities were able to copy up to 30 per cent or three chapters, although not where a digital edition is 'available through commercial channels'.[17] These revised terms expired on 30 June 2020. At the time of writing, university representatives have been lobbying for the extended terms to be reinstated,[18] and for educational establishments to be able to secure affordable access to electronic content.[19] This reflects the concern that publisher responses to COVID were one-off, time-limited accommodations to help universities at a time when urgent steps were required, given the imposition of lockdown measures by the UK government. But for many universities, the disruption to teaching in the 20/21 academic year will be even more significant. It is one thing to move a relatively small amount of teaching online and to cancel in-person exams. It is another to teach students remotely for an entire academic year, including to those outside the UK, and possibly against the backdrop of a dramatic fall in university income.

2.2 Exceptions

Exceptions and limitations directed specifically to education are contained in sections 32 to 36A of the CDPA. Other exceptions are also relevant, such as: fair dealing for the purpose of quotation, research or private study, criticism or review, and caricature, parody or pastiche;[20] the libraries and archives provisions;[21] and exceptions for users with a disability.[22] We elaborate on some of these exceptions, below, but

16 See items linked to in C Morrison and J Secker, 'Copyright, fair dealing and online teaching at a time of crisis' (*UK Copyright Literacy*, 18 March 2020).

17 See CLA Addendum amending CLA Higher Education Licence.

18 See letter from D Anderson-Evans (Chair, Copyright Negotiating and Advisory Committee, UUK) to J Bennett (Head of Rights and Licensing, CLA) dated 24 June 2020; M Reisz, 'Universities offered reprieve in pandemic book licensing battle' *Times Higher Education* (London, 11 July 2020). On 20 August 2020, CLA announced that there would be a further change to the terms of the CLA Licence in response to COVID-19. This change means that institutions may copy up to two chapters or 20 per cent of print books of participating publishers. These revised terms are effective to 31 July 2021. For full details, see CLA, 'Higher Education Licence terms amended until July 2021 to help sector deal with difficulties due to COVID-19'.

19 See also 'Jisc and Universities UK call for publishers to reduce their fees to maintain access to essential teaching and learning materials' (*Jisc News*, 17 June 2020).

20 CDPA, sections 30(1ZA), 29(1), 29(1C), 30(1) and 30A, respectively.

21 Especially CDPA, sections 41 (interlibrary supply) and 42A (copying requests for published works).

22 Especially CDPA, sections 31B and 31BA (accessible copies made by authorised bodies).

wish to preface this analysis by emphasising that there is much (often untapped) flexibility in these provisions.[23] While we are interested in assessing the merits of new interventions to respond to COVID, this is not to understate the power of existing provisions; and indeed we would urge the sector, especially when making representations to government and other stakeholders, not to concede too much by focusing on the limits and perceived uncertainty of current exceptions.[24]

As noted above, a number of fair dealing exceptions are relevant to education, but for the purposes of this article we focus on fair dealing for the purpose of illustration for instruction (section 32), which was introduced into the CDPA in 2014. This exception applies to all types of copyright work.[25] It can be used by those giving or receiving instruction or preparing for same[26] and is not limited to instruction taking place in educational institutions. The CDPA does not define 'illustration for instruction', and we see no reason to interpret this language narrowly. For instance, Recital 21 to the DSM Directive, discussing the new exception for the digital use of works for illustration for teaching, states that this provision 'should be understood as covering digital uses of works or other subject matter to support, enrich or complement the teaching, including learning activities'.[27] This can be contrasted with guidance issued in 2014 by the UK Intellectual Property Office which said that, to rely on section 32, 'the work must be used solely to illustrate a point',[28] and that the exception permitted 'minor uses'.[29]

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23 See generally E Hudson, *Drafting Copyright Exceptions: From the Law in Books to the Law in Action* (Cambridge University Press 2020). For analysis of section 32 and interpretations in the higher education sector, see C Morrison, *Illustration for Instruction and the UK Higher Education Sector: Perceptions of Risk and Sources of Authority* (MA Thesis, King's College London, 2018).

24 To illustrate, in the RLUK letter (n 11), concern was expressed that 'fair', in relation to education, is 'usually interpreted as, for example, a few lines of a poem, or a single book chapter'.

25 CDPA, section 32(1) (referring to 'a work', without limitation).

26 Ibid section 32(1)(b).

27 And note Recital 22, stating, *inter alia*, that the exception or limitation should cover uses of works in the classroom and other venues via digital means, 'as well as uses made at a distance through secure electronic environments, such as in the context of online courses or access to teaching material complementing a given course'. The UK government has indicated that it does not intend to implement the DSM Directive: answer to Copyright: EU Action: Written Question – 4371 by Chris Skidmore dated 21 January 2020. However, it may be that the UK ends up implementing all or part of the DSM Directive (for instance, by reference to a future trade deal with the EU); plus these sorts of indication may provide evidence of the prevailing culture and acquis that remains relevant to interpreting UK provisions.

28 Intellectual Property Office, *Exceptions to Copyright: Education and Teaching* (Intellectual Property Office October 2014) 3.

29 Ibid 4.

We believe these statements are unduly conservative and would frustrate the legislative goal of enhancing the use of digital technologies in education.[30] In this regard, we were pleased to read statements from the UK government in April 2020 that support a meaningful role for section 32 in online education, including that '[m]any materials used in presentations by teachers, including those which are streamed remotely to students, are likely to fall within [section 32]' and that '[i]t is likely that the courts will take a generous view of fair dealing during the present crisis, in particular where licences for the reasonable use of works are unavailable'.[31]

Applying this to teaching activities, we believe that section 32 can cover the inclusion of literary quotations, photographs and images on slides and in other learning materials distributed digitally to students, and the playing of musical and audio-visual works as part of online instruction. We believe that this can extend to entire works in some circumstances.[32] To give a straightforward example, consider teaching the case *Norowzian v Arks* to students studying intellectual property law.[33] In that case, Mr Norowzian alleged that copyright in his short film, *Joy* (approximately one minute in length), was infringed by a television advertisement for Guinness beer. We believe that playing both films in full is fair, so that students can properly understand the legal issues in the case and form their own view on the conclusion that there was no reproduction of a substantial part. Note that when giving this lecture in person the situation is more straightforward as section 34 would also apply. The effect of that provision is that the performance of a dramatic work and the showing of a film to students at an educational establishment, for the purposes of instruction, are not public performances for the purposes of infringement. But playing a film in an online class or making it available to students via the virtual learning environment (VLE) may implicate other rights,

30 Discussed in Hudson (n 23) 285.

31 Solloway letter (n 12).

32 It could be put against us that Recital 21 of the DSM Directive, which we cited earlier, states that '[i]n most cases, the concept of illustration would, therefore, imply the use only of parts or extracts of works'. But the Recital goes on immediately to say, 'which should not substitute for the purchase of materials primarily intended for the educational market'. This suggests the main issue is not quantity per se but market effect. Such a concept is not easy (as discussed in Hudson (n 1)), but we believe that for many copyright works used in teaching there is no economic interest that will be harmed by allowing that work to be viewed or watched by students, even in full – and especially where measures are taken to limit availability and re-use (eg by using lower-resolution images on slides, or by hosting content on password-protected VLEs to which only enrolled students have access).

33 *Norowzian v Arks Limited (No 1)* [1998] FSR 394; *Norowzian v Arks Limited (No 2)* [2000] FSR 363.

including reproduction and, arguably, communication to the public.[34] For section 34 to apply, we would need to construe its language to also cover these other rights. While Kitchin J was minded to do something similar in *Football Association Premier League v QC Leisure* in relation to section 72, that approach was permitted because of the wording and legislative backdrop of that exception.[35] Furthermore, Kitchin J referred to section 34 in the course of his reasoning, stating that 'in so far as [the communication right] also confers rights in respect of some of the activities falling within [the public performance right] … s. 34(2)

34 A claimant alleging infringement of the communication right in CDPA, section 20, would need to show that there was a communication, for instance through a file being made available or through content being transmitted to students. But even if this could be established, the university might seek to resist the proposition that any such communication was 'to the public', especially where the relevant film or extract was available only to students registered for that module via a password-protected VLE. For the communication right, the CJEU has stated repeatedly that the public 'refers to an indeterminate number of potential viewers and implies, moreover, a fairly large number of people': eg *GS Media BV v Sanoma Media Netherlands BV* (C-160/15) [2017] 1 CMLR 30 (Second Chamber), [36]. This emphasis on audience size can be contrasted, to a degree, with the approach to the public performance right in section 19, where factors such as the character of the audience have been significant: eg *Duck v Bates* (1884) 13 QBD 843. That said, in assessing whether a communication was to the public, courts have considered the cumulative effect of individual acts: eg *SGAE v Rafael Hoteles SL* (C-306/05) [2006] ECR I-11519 (Third Chamber), [38]; *Stichting Brein v Ziggo BV* (C-610/15) [2017] ECDR 19, [41]. Whether a university has infringed the communication right would therefore depend, *inter alia*, on whether the court assessed 'the public' by aggregating acts in different modules, over time and for different films. We should also emphasise that, even if a university succeeded on the section 20 point, it may still need to invoke an exception like section 32 in relation to the argument that it had infringed or authorised the infringement of the reproduction right.

35 *FAPL v QC Leisure* [2012] EWHC 108 (Ch), esp. [71]–[78]. That case related to the use by UK publicans of foreign decoder boxes to access the broadcast signal for football matches run by FAPL. On referral to the CJEU, it was held, *inter alia*, that the act of turning on the television in the pub, so that patrons could watch the football, was a communication to the public: *FAPL v QC Leisure* (Joined Cases C-403/08 and C-429/08) [2012] ECDR 8 (Grand Chamber). On return to the High Court, Kitchin J accepted that there was overlap between the (unharmonised) public performance right in section 19 and the (harmonised) communication to the public right in section 20. However, he also held that the publicans could have a defence under section 72. That provision stated that 'the showing … in public of a broadcast to an audience who have not paid for admission to the place where the broadcast is to be seen or heard does not infringe copyright' in the broadcast and any film included in it. (This reference to films was subsequently removed by the Copyright (Free Public Showing or Playing) (Amendment) Regulations 2016 (SI 2016/565).) Kitchin J was able to reach this conclusion because the words of section 72 were unambiguous: the showing or playing of the broadcast does not infringe *any* copyright in the broadcast or any film included in it, and therefore applied to the rights in sections 19 and 20.

cannot provide a defence'.[36] That is, Kitchin J saw section 34 as tied solely to public performance in a way that section 72 was not. However, as we have said, educators can instead turn to fair dealing in section 32 in relation to the use audio-visual content in online classes.[37]

The provision of digitised copies of readings might also fall within section 32, although the arguments are not quite as straightforward. For UK institutions, the need to explore fair dealing has been mitigated by the blanket licence offered by CLA.[38] In its usual form, that licence allows the copying of a chapter or article or up to 10 per cent of a published work. These limits have been temporarily lifted for the 20/21 academic year so that up to two chapters or 20 per cent of a print book may be copied.[39] But can UK universities digitise beyond the CLA limits by reference to fair dealing? We can envisage scenarios where the arguments for fair dealing are compelling, for instance where students need to read three chapters from a specialist title that is out of print. Here, one question is whether the required content can be selected by a lecturer but digitised by someone in the library. This is an issue because section 32 applies to dealings 'by a person giving or receiving instruction',[40] which could be interpreted to mean that a lecturer may not ask a librarian or teaching assistant to undertake the copying. We believe that section 32 ought not to be read in this way. First, it would suggest that the 'person' giving instruction cannot be

36 *FAPL v QC Leisure* [2012] EWHC 108 (Ch), [58].

37 Although we give the example of including two short films in a copyright lecture, we believe that section 32 could even extend to playing feature films, as explained in detail in Hudson (n 10). Consider the teaching activities in Film Studies. In normal times, such departments routinely screen films in person, under section 34, often using DVDs owned by the university. With the shift to online teaching, we believe that universities can allow students to watch entire feature films by reference to section 32. In developing a fair dealing policy for such practices, universities may benefit from ensuring that their activities mirror, as far as possible, the circumstances in which they screen films in person. This might include only granting access to students in that module, and via a password-protected platform such as the VLE; only allowing access for a limited period; not allowing students to download films; monitoring student usage; not using section 32 for filmmakers or studios with (known) strong preferences regarding rights; and including a copyright warning in addition to the sufficient acknowledgment required by section 32.

38 Compare equivalent institutions in the USA, where it is common for fair use to be relied upon (along with other strategies) for material included in electronic reserves and posted to VLEs: see Hudson (n 23) 194–205. This application of fair use to such practices was challenged in the *Georgia State* litigation. For the most recent judgment in this litigation, see *Cambridge University Press v Becker* (ND Georgia, 2 March 2020); and for a summary of the litigation, see Hudson (n 1).

39 See n 18 and surrounding text.

40 CDPA, section 32(1)(b).

a university or other establishment.[41] But for section 32 to function, it is necessary that it can be invoked by legal entities and not just individual members of staff. Second, section 32 does not contain the limits, found in section 29 (fair dealing for non-commercial research or private study), on copying by others.[42] Our interpretation also accords with university workflows and resourcing, for instance that librarians may have access to better copying equipment and be better placed to produce good quality scans.

But the big question is whether copying under section 32, as supplemented by the libraries and archives provisions, will get universities where they need to be in relation to required readings.[43] For many institutions, the issue is not copying smaller parts, as the CLA Licence provides a workable system for scanning articles, chapters and other extracts, plus VLEs can link to content in subscription databases. Instead, they are concerned about access to entire books where there is no digital version available on the market or that version is prohibitively expensive, subject to unduly restrictive licence terms, bundled with other (unwanted) content, etc.

To us, the most promising argument for unremunerated copying of entire works is a version of controlled digital lending (CDL), which has been implemented in the USA by reference to the first sale doctrine and

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41 This would also reflect the usual approach in the case law, in which judges often do not differentiate between the person sued (often a legal entity) and the person who performed the act of copying: see J McCutcheon and S Holloway, 'Whose fair dealing? Third-party reliance on the fair dealing exception for parody or satire' (2016) 27 Australian Intellectual Property Journal 54; Hudson (n 23) 288–289.

42 CDPA, section 29(3). Paragraph (a) relates to librarians and states that they may not do anything which is not permitted by CDPA, section 42A (request-based copying for published works), while paragraph (b) applies to all other third-party copyists and prevents them from participating in systematic copying. As noted by Bently et al, section 29(3) means that 'lecturers are unable to use the research or private study defence where they make multiple copies of a work for their students': Bently et al (n 13) 243. The existence of paragraph (3) suggests that agency arguments are otherwise available.

43 As indicated in n 42, there are library exemptions under which students may ask to be supplied with a 'reasonable proportion' of a published work for their own private study: CDPA, section 42A. An important caveat to this provision is that the person making the request must declare that, to the best of that person's knowledge, 'no other person with whom the person … studies has made, or intends to make, at or about the same time as the person's request, a request for substantially the same material for substantially the same purpose'. Thus, while section 42A may be relevant to a student writing a dissertation on a topic of their own devising, it would not apply to compulsory reading set by a lecturer (this contravening the exclusion on systematic copying, given the implicit assumption – which we acknowledge is sometimes wrong – that more than one student will wish to undertake the reading).

fair use.[44] The central idea of this strategy – which we emphasise is highly controversial[45] – is that libraries can digitise lawfully acquired hard copy titles and then loan digitised as well as physical versions. A strict 'owned to loaned' ratio must be maintained.[46] If a library owns, say, three copies of a book and it lends a digital version, it must withdraw one of the physical copies while the digital copy is on loan. The conditions of loan should approximate those for a physical title, for instance that each digital copy is loaned to a single user for a period analogous to the loan of a physical work.[47] Technological interventions are required to limit copying and redistribution by the borrower.

There are a number of issues with CDL. Perhaps the key issue is logistical rather than legal, namely the resources involved in scanning entire books and ensuring that the resulting files have the necessary digital rights management interventions applied. There are also questions about how CDL would apply to reference collections, bearing in mind that some university libraries do not maintain a

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44 For an overview CDL and its justification by reference to fair use, see D Hansen and K Courtney, 'A White Paper on controlled digital lending of library books' (Harvard Library Office for Scholarly Communication 2018). The authors trace the idea for CDL back to the 'pioneering article' by Michelle Wu: M Wu, 'Building a collaborative digital collection: a necessary evolution in libraries' (2011) 103 Law Library Journal 527.

45 One of the best-known practitioners of CDL is the Internet Archive (IA). The IA runs a large-scale digital preservation programme for books, historical documents and internet pages. It also runs an Open Library, in which members of the public may electronically borrow books that have been scanned by the IA. The IA's practices have long been criticised, but these objections intensified in 2020 following roll-out of a National Emergency Library: see eg A Albanese, 'Authors Guild, AAP Outraged by IA's "National Emergency Library"' *Publishers Weekly* (North Hollywood, 30 March 2020). The key change in the National Emergency Library, compared with the Open Library, was that titles could be borrowed by multiple users simultaneously. On 1 June 2020, a complaint was filed by four major publishers against the IA in relation to its Open Library and National Emergency Library: *Hachette Book Group, Inc v Internet Archive* (Case 1:20-cv-04160, SDNY, 1 June 2020). In this complaint, the plaintiffs described IA's activities as 'willful mass copyright infringement' (paragraph 2) and alleged that IA 'defends its willful mass infringement by asserting an invented theory called "Controlled Digital Lending" ("CDL")—the rules of which have been concocted from whole cloth and continue to get worse' (paragraph 8). The National Emergency Library closed on 16 June 2020. The Open Library remains in operation. For an overview, see A Romano, 'A lawsuit is threatening the Internet Archive – but it's not as dire as you may have heard' (*Vox*, 23 June 2020).

46 Hansen and Courtney (n 44) 2, quoting from the *Position Statement on Controlled Digital Lending by Libraries*.

47 Ibid 3, also quoting from the *Position Statement*.

circulating collection.[48] If a book may not be borrowed physically can it nevertheless be loaned digitally? In terms of the fair dealing analysis, there are limits in section 32 that are not found in the open-ended fair use exception of US law. The language of 'illustration for instruction' might seem inherently more confined than the illustrative purposes of 'teaching', 'scholarship' and 'research' in the US copyright statute.[49] One can also imagine fierce disagreement over the use of CDL for titles that are available commercially in digital form. One complaint seen repeatedly from universities is that prices for e-books are often many multiples of the hard copy version, even for single-user licences. But publishers would no doubt argue that there are good reasons for the price differential, and that CDL would involve such an obvious case of market substitution that no fair dealing analysis is tenable.[50]

It may be that, absent government intervention (discussed further in Section 4), a large-scale CDL scheme is unlikely to be rolled out in the UK any time soon. Nevertheless, the US experience with CDL may provide some useful ideas for UK institutions, for instance regarding the matters that might support CDL being a fair dealing,[51] and the sort of limits that might be placed on the accessibility and re-use of digital copies to buttress those arguments. We also observe that the legality of CDL in the UK may be bolstered by section 36A of the CDPA which states, without qualification, that 'copyright in a work is not infringed by the lending of copies of the work by an educational establishment'.

48 Eg the collection of the Bodleian Library at the University of Oxford.

49 Copyright Act of 1976 (US), section 107.

50 As seen in the complaint against IA (n 45), especially paragraphs 52 (the IA business model is 'parasitic and illegal'), 65 ('IA directly harms the Plaintiffs' print and ebook markets in all market segments by providing competing substitutes for numerous original works currently available in their catalog'), and 119–127 (setting out various types of market harm said to be caused by IA's practices).

51 See Hansen and Courtney (n 44) 16–32 (arguments that support fair use for CDL include: lack of profit by the defendant library or university; CDL facilitates research and learning; the defendant must have already purchased the content being digitised; for out-of-print books, there is no current market for the work; although entire works can be digitised (which can tend against fair use), this is offset by limits on loan duration, DRM to prevent re-use, etc; any market effect of CDL mirrors that of lending physical works, which is permitted by the first sale doctrine; and in many instances, there is no functioning digital market).

This could be a very important supplement to fair dealing.[52] For section 36A to be relevant to CDL, 'lending' must not be limited to physical copies. This proposition is supported by the definition of 'lent out' in the Public Lending Right Act 1979, which includes digital lending;[53] and section 40A of the CDPA, in relation to lending by public libraries, which likewise applies to the lending of e-books.[54] Such a definition was also accepted by the Court of Justice of the EU (CJEU) in *Vereniging Openbare Bibliotheken v Stichting Leenrecht*.[55] The VOB, the Netherlands Association of Public Libraries, sought a declaration that digital lending of e-books fell within an existing remunerated exception in the Dutch Copyright Act.[56] The case was referred to the CJEU in relation to various questions under the Rental

52 Just as the first sale doctrine is important for CDL in the USA: see ibid 11–16, where the authors argue that that CDL 'closely mimics the economic transaction that Congress has already provided for through the first sale doctrine under Section 109' (11), and that this favours fair use. We also note that, in future, CDPA, section 40B, could have work to do. That provision allows libraries and educational establishments, amongst others, to 'make available to the public by means of a dedicated terminal on its premises' a work or copy of a work that 'has been lawfully acquired by the institution'. If 'on its premises' is read literally (as the CJEU seemed to do in *Technische Universität Darmstadt v Eugen Ulmer KG* (C-117/13) [2014] ECDR 23 (Fourth Chamber)), this will not help with electronic lending to recipients located elsewhere, even if over a secure network which permits viewing but not downloading. But if 'premises' is read more broadly – or if section 40B were amended in a post-Brexit world – then that provision could also be useful for facilitating online access to staff and students.

53 Public Lending Right Act 1979, section 5(2), as amended by the Digital Economy Act 2017, section 31(1) ('"lent out" means made available to a member of the public for use away from library premises for a limited time (including by being communicated by means of electronic transmission to a place other than library premises) and "loan" and "borrowed" are to be read accordingly').

54 CDPA, section 40A(1A)(d) states that in subsection (1), lending 'is to be read in accordance with the definition of 'lent out' in section 5 of [the Public Lending Right Act 1979]'. Section 40A provides that certain acts carried out by a public library do not infringe copyright when carried out in relation to books within the public lending right scheme. It was revised in 2017 to state that this exclusion only applies to e-books where 'the book has been lawfully acquired by the library' and 'the lending is in compliance with any purchase or licensing terms to which the book is subject': section 40A(1ZA).

55 *Vereniging Openbare Bibliotheken v Stichting Leenrecht* (C-174/15) [2017] ECDR 3 (Third Chamber).

56 For a summary of events leading up to the test case brought by Vereniging Openbare Bibliotheken, see V Breemen, 'E-lending according to the ECJ: focus on functions and similar characteristics in *VOB v Stichting Leenrecht*' (2017) 39 European Intellectual Property Review 249.

and Lending Rights Directive.[57] The CJEU stated that, while the right of rental relates only to tangible objects, lending is a separate concept and could extend to digital copies.

It might be argued that section 36A of the CDPA is superfluous insofar as it relates to the lending right in section 18A, as that right only relates to lending 'through an establishment which is accessible to the public'.[58] The argument that university libraries are not (usually) publicly accessible is supported by the definition of library in section 43A(2) of the CDPA, where that term means '(a) a library which is publicly accessible, or (b) a library of an educational establishment'. This would not necessarily render section 36A redundant, as its language suggests that it applies to *other* restricted rights that might be implicated in the course of lending.[59] This might conceivably include digitising hard copy titles in order to lend them,[60] along with any acts of reproduction and communication in effecting the digital

57 Directive 2006/115/EC of the European Parliament and of the Council of 12 December 2006 on rental right and lending right and on certain rights related to copyright in the field of intellectual property (RLD).

58 CDPA, section 18A; see also RLD, Article 2(1) (definition of lending limited to acts 'made through establishments which are accessible to the public').

59 Section 36A states that 'copyright … is not being infringed by the lending', without limiting that copyright to any particular rights. For similar arguments, see the discussion of CDPA, section 72, as interpreted by Kitchin J in *FAPL* (n 35).

60 For analysis of the same question in relation to the dedicated terminals exception in Article 5(3)(n) of Directive 2001/29/EC of the European Parliament and of the Council of 22 May 2001 on the harmonisation of certain aspects of copyright and related rights in the information society (ISD) (in the UK, CDPA, section 40B), see *Technische Universität Darmstadt v Eugen Ulmer KG* (n 52), discussed in Hudson (n 23) 152–153. The CJEU accepted that Article 5(3)(n) 'would risk being rendered largely meaningless, or indeed ineffective, if those establishments did not have an ancillary right to digitise the works in question': [43]. The CJEU located this right in Article 5(2)(c), which permits member states to recognise an exception or limitation to the reproduction right 'in respect of specific acts of reproduction made by publicly accessible libraries, educational establishments or museums, or by archives, which are not for direct or indirect economic or commercial advantage'. Without a directly equivalent provision in the CDPA, it has been suggested that UK institutions could digitise pursuant to the preservation copying exception in section 42.

loan.[61] Even if we are wrong on this extended reach of section 36A, institutions could still point to other exceptions to undertake these acts, such as fair dealing in section 32.[62] Whichever route is taken, it is clear that the library would not be able to digitise or make available a copy from an unlawful source.[63]

We wish to make two final points in relation to fair dealing. First, section 32 contains two further requirements that we have not yet mentioned: that the dealing is for a non-commercial purpose and that it is accompanied by a sufficient acknowledgment (unless this would be impossible).[64] The non-commercial purpose limitation is addressed to the dealing, meaning that the status of the organisation or establishment

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61 Applying *Nederlands Uitgeversverbond v Tom Kabinet Internet BV* (C-263/18) [2020] ECDR 1 (Grand Chamber), it is not obvious to us that CDL would necessarily involve a communication to the public. In that case, Tom Kabinet ran an online reading club. Members of the club could access a virtual market where they could buy 'second-hand' e-books. The CJEU indicated that there was a communication as Tom Kabinet made the digital files available to anyone who was a member of the reading club: [65]. Furthermore, it was 'to the public' as anyone could join the club, and there were no technical measures that limited the accessibility of files. This allowed the conclusion that 'the number of persons who may have access, at the same time or in succession, to the same work via that platform is substantial': [69]. In contrast, under CDL, files are transmitted to or accessed by individual users on a strict owned-to-loaned basis. Similar to the discussion of the screening of films to students (see n 34 above), much will turn on whether a court will nevertheless aggregate individual acts of borrowing to say that communication was to a sufficiently large group of people to constitute the public.

62 Compare G Spedicato, 'Digital lending and public access to knowledge' in J Lai and A Dominicé (eds), *Intellectual Property and Access to Im/material Goods* (Edward Elgar 2016) 154. Spedicato observes that digital lending in Europe typically occurs by reference to licensing agreements, as a 'wide consensus has emerged in Europe on the view that digital lending should not come under any of the exceptions or limitations provided for by the EU copyright system'. Spedicato says that digital lending implicates the making available right (which we discuss in n 61 above), but that there is no exception or limitation in Article 5 of the ISD that mirrors Article 6 of the RLD (which allows member states to derogate from the public lending right through the creation of public lending rights schemes). Even if this analysis is correct for public libraries, we believe that university libraries running CDL can point to a number of exceptions and limitations to justify digital lending, including ISD Articles 5(2)(c) (for the digitisation aspect) and (3)(a) and DSM Directive Article 5(1). For UK universities, concerns about compliance with Article 5 may recede if and when the UK is no longer bound by EU copyright law.

63 Similar *Vereniging Openbare Bibliotheken v Stichting Leenrecht* (n 55), where the CJEU held that for a public lending exemption to apply as permitted by Article 6 of the Directive, the digital copy must not have been obtained from an 'unlawful source'. That conclusion was prompted by concerns about the circulation of pirated copies.

64 CDPA, section 32(1)(a), (c).

relying on section 32 is not determinative.[65] The need for a sufficient acknowledgment appears in a number of fair dealing provisions and is defined to mean identification of the work and its author.[66] This is not the same as a full-blown academic citation and can be satisfied by use of names, descriptions, logos etc.[67] Secondly, although this article has focused on section 32, university staff and students can rely on other fair dealing exceptions. We draw particular attention to fair dealing for the purpose of quotation, which was introduced into the CDPA 2014. This is a significant expansion to the fair dealing family and can apply to numerous acts by educators and students.[68]

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65 See Bently et al (n 13) 232–233, noting that an in-house education seminar might be non-commercial even if undertaken by a for-profit business and that not-for-profit entities may undertake commercial activities, such as selling academic books.

66 CDPA, section 178.

67 Eg in *Pro Sieben Media AG v Carlton UK Television Limited* [1999] FSR 610, 624–625, the requirement for a sufficient acknowledgment was satisfied by the appearance of a logo on a television programme.

68 CDPA, section 30(1ZA); for an overview, see Hudson (n 10) (focusing in particular on the use of films and audio-visual works in online teaching); Hudson (n 23) 276–284. In July 2019, the CJEU handed down three judgments that considered quotation: *Pelham GmbH v Hütter* (C-476/17) [2019] Bus LR 2159 (Grand Chamber); *Spiegel Online v Beck* (C-516/17) [2019] Bus LR 2787 (Grand Chamber); and *Funke Medien NRW GmbH v Germany* (C-469/17) (Grand Chamber, 29 July 2019). Following those cases, a number of matters are clear in relation to the quotation exception in EU copyright law: it can apply to any type of copyright work; it can apply to entire works; and it is not necessary for the quotation to be made in a work that is also protected by copyright. The CJEU also clarified that member states enjoy discretion in the operation of certain elements of the quotation exception, namely the purposes for which quotation can be applied, proportionality and fair practice. Although it has been argued that quotation is not limited to any particular purpose (only requiring that the defendant has *a* purpose), in *Pelham v Hütter* the CJEU identified the 'essential characteristics' of quotation as use of a work or extract 'for the purposes of illustrating an assertion, of defending an opinion or of allowing an intellectual comparison between that work and the assertions of that user': [71]. Although the CJEU suggested at [72] that music sampling might involve a quotation, the German Federal Court of Justice stated, on the return of the case, that none of quotation, parody or caricature apply to sampling. The court did, however, suggest that sampling might fall within pastiche: A Hui, '21 and illegal in all states? The German Pelham court confirms when sampling is illegal' (*The IPKat*, 5 May 2020). For analysis of the pastiche exception, including the argument that it applies to sampling (amongst numerous other uses such as mash-ups and fan fiction), see E Hudson, 'The pastiche exception in copyright law: a case of mashed-up drafting?' [2017] Intellectual Property Quarterly 346. For analysis of quotation, see T Aplin and L Bently, *Global Mandatory Fair Use: The Nature and Scope of the Right to Quote Copyright Works* (Cambridge University Press forthcoming 2020).

In conclusion, many practices of educators and students fall within existing exceptions, including in an online environment. We have also argued that educators could make further use of exceptions, for instance in the digitisation and supply of reading materials that fall outside of the CLA Licence. But we recognise that the challenges posed by COVID cannot be answered solely by the existing exceptions. Some of our suggestions would be novel for UK universities, for instance that CDL-style reasoning might inform reliance on sections 32 and 36A. We can imagine universities being selective in any digitisation of larger extracts or entire works, for reasons that include both the resource intensiveness of scanning and the need to undertake a legal assessment of each work. In addition, for universities teaching students located overseas, there is the issue that copyright law is territorial. That means that if, say, a UK university makes digitised readings available to students studying in Australia, the question of whether there is infringement in Australia will be judged by reference to Australian law.[69] Although in many instances there will be similar exceptions elsewhere,[70] and for many uses a very low risk of any complaint, this represents a limit for exceptions analysis. Taken together, these issues illustrate why licensing solutions may be even more attractive for some uses, for instance if licence arrangements permit universities to access born-digital content or scans made by other institutions, and if the licence extends to students located around the world. We return to licensing in Section 4. Before then, we consider in Section 3 another set of arguments in relation to copyright and COVID: whether educational establishments might be able to argue the public interest as a defence to copyright infringement or in the assessment of remedies. Might these arguments limit the need for licensing solutions?

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69 Liability will turn on the scope of rights and exceptions in the country in which the student is located. In the mandatory exception for education in the DSM Directive this is dealt with through a deeming provision that the use of works through secure electronic environments shall be taken to occur 'solely in the Member State where the educational establishment is established': DSM Directive, Article 5(3).

70 In Australia, there is no fair dealing exception for education, but there is fair dealing for research and study and an exception in section 200AB of the Copyright Act 1968 (Cth) for certain uses by cultural and educational institutions: for discussion of the latter, see Hudson (n 23) chapter 6. On 13 August 2020, the Australian government announced that it will make a series of reforms to the Copyright Act, including introducing a new fair dealing exception for non-commercial quotation and amending the existing education exceptions: Australian Government, Copyright access reforms (13 August 2020).

3 THE PUBLIC INTEREST

3.1 As a defence

As noted in the introduction, in its letter to the government, Research Libraries UK asked for confirmation that section 171(3) 'can be used as a defence by … educational establishments for as long as the current crisis lasts'.[71] Section 171(3) states that '[n]othing in this Part affects any rule of law preventing or restricting the enforcement of copyright, on grounds of public interest or otherwise'. An initial question is whether this provision permits the recognition of a public interest defence in addition to the exceptions and limitations set out in the statute. Although the Court of Appeal answered this question in the negative in *Hyde Park Residence v Yelland*,[72] it changed approach in *Ashdown v Telegraph Group Limited*.[73] The court reasoned that the entry into force of the Human Rights Act 1998 meant that there may be cases – albeit rare – where a public interest defence was needed to protect the freedom of expression of the defendant. It is open to question whether this defence remains available following the CJEU judgments in *Spiegel Online* and *Funke Medien*.[74] In those cases, it was held that the harmonisation of exceptions and limitations under Article 5 of the ISD is exhaustive, and that member states may not recognise any further derogation from the author's exclusive rights by reference to provisions of the Charter of Fundamental Rights of the European Union. As such, the suggestion that UK universities might, during the pandemic, invoke a public interest defence to copyright infringement could be met with the knockdown argument that the defence no longer exists.

We could stop there, but we believe it is nevertheless useful to explore the public interest defence, especially given the possibility that, at the end of this year, the UK will no longer be bound by EU copyright law. As Jonathan Griffiths has said, 'we know remarkably little' about the public interest defence in copyright,[75] and so an important debate remains to be had about its scope. Perhaps the only thing that is clear,

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71 RLUK letter (n 11).

72 [2001] Ch 143 (Aldous LJ with whom Stuart-Smith LJ agreed, Mance LJ dissenting). Although Aldous LJ rejected the proposition that there existed, in copyright, a public interest defence equivalent to that in the law of confidence, he accepted that there are limited circumstances where a court may refuse to enforce the copyright in a work because this would offend against the policy of the law. We return to this at n 81 below and surrounding text.

73 [2002] Ch 149.

74 Discussed above n 68, in relation to quotation.

75 J Griffiths, 'Pre-empting conflict – a re-examination of the public interest defence in United Kingdom (UK) copyright law' (2014) 34 Legal Studies 76, 77.

as Griffiths also notes, is that judges have shown little appetite to deny copyright claims on public interest grounds. In contrast, in other contexts, such as breach of confidence, misuse of private information and defamation, public interest jurisprudence is fairly mature. Given overlaps in the fact patterns that give rise to claims in copyright, breach of confidence and misuse of private information, a proper understanding of this latter group of claims is useful to determining its parameters in copyright.

Public interest defences are commonplace in civil law claims. They safeguard meritorious interferences with personal and/or property rights. As is commonly noted, the term 'public interest' lacks precise or fixed definition, although its core meaning can be sketched easily enough, as a wide range of commentators (one of us included) have observed.[76] Whereas some commentators have criticised this imprecision, an alternative response is that this fuzzy penumbra provides judges with the discretion to ensure justice is served when novel fact patterns emerge.

Importantly, what unites these exceptional interferences with rights is that there is an underlying public interest *in the information itself* which justifies that interference. For example, in *Lion Laboratories v Evans*,[77] it was in the public interest to know that the claimant's breathalyser equipment, which was used by the police, may be inaccurate and so lead to unfair prosecutions. The misuse of private information jurisprudence has seen this exception swell to encompass the right to criticise morally wrong behaviour, as where a newspaper exposed the adultery of a former England football team manager.[78] We can therefore interpret the public interest defence as a sort of public policy exception that denies rights claims where the rights of others have been unduly harmed. Of course, as with all discretionary powers, it is susceptible to misuse (intentional or otherwise), for it can allow judges to take their own moral view and call it 'the public interest'.[79]

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76 See eg E Barendt, *Freedom of Speech* (2nd edn, Oxford University Press 2005); H Fenwick and G Phillipson, *Media Freedom under the Human Rights Act* (Oxford University Press 2006); T Aplin, 'The development of the action for breach of confidence in a post-HRA era' [2007] Intellectual Property Quarterly 19; P Wragg, 'A freedom to criticise? Evaluating the public interest in celebrity gossip after Mosley and Terry' (2010) 2 Journal of Media Law 295; Griffiths (n 75).

77 [1985] QB 526.

78 *McClaren v Mirror Group Newspapers Limited* [2012] EWHC 2466; see also *Ferdinand v Mirror Group Newspapers Limited* [2011] EWHC 2454; *Terry v Persons Unknown* [2010] EWHC 119; and *Hutchinson v News Group Newspapers Limited* [2011] EWCA Civ 808.

79 For example, see criticisms of cases in P Wragg, 'The benefits of privacy-invading expression' (2013) 64 Northern Ireland Legal Quarterly 187.

It is understandable, in the current climate, that educators might argue that COVID presents such novel circumstances that it is in the public interest to limit or suspend rights in copyright content. It is also understandable why they would be attracted to that idea, since it is well established that the presence of a public interest tends to operate as a 'determinative factor'[80] in deciding claims. But although it may appear intuitive this application of the public interest defence strikes us as unsustainable and deeply implausible, as it would contravene the operative normative reasoning inherent in the defence.

Whereas the *definition* of the term is flexible, its function is fixed. It is the lens by which the courts scrutinise qualities in the contested material itself – be that copyrighted, defamatory, private or confidential information – and not the wider context of the litigation. In this way, the 'public interest' acts as a sort of tiebreaker where two rights claims are otherwise ostensibly equivalent. Across the range of common law and equitable causes of action – from claims in breach of confidence and misuse of private information to defamation, copyright and even data protection – the question of a public interest defence only arises if the defendant can establish a *prima facie* right to counteract the original rights claim. Consequently, it may be said that the public interest defence is parasitic upon an underlying rights-claim capable of providing some *prima facie* justification for the breach.

Most obviously, but not always, this countervailing right is freedom of expression under Article 10 of the European Convention on Human Rights. Alternatively, it may arise as the State's right to override personal or property rights so as to safeguard the public interest against breaches of national security or civil unrest or to protect (as in the case of COVID itself) the health and safety of citizens or their moral well-being. The State's interest, though, typically manifests in a negative form to deny the rights-claim. Indeed, we see this state interest in the limited public interest exclusion outlined by the Court of Appeal in *Hyde Park Residences Limited v Yelland*:

> [A] court would be entitled to refuse to enforce copyright if *the work is*: (i) immoral, scandalous or contrary to family life; (ii) injurious to public life, public health and safety or the administration of justice; (iii) incites or encourages others to act in a way referred to in (ii).[81]

In our paradigm, the university's claim does not fit the language of rights, whether relating to property, the person or the State. Although its conduct may support a noble, public-serving goal – such as access to education or information – its claim is too general and not rights-based. Universities are not saying, for example, that infringement of

80 *K v News Group Newspapers Limited* [2011] EWCA Civ 439, [23].
81 *Hyde Park Residences Limited v Yelland* (n 72) [66] (emphasis added).

copyright amounts to or is in pursuance of a free speech claim, as it was in, say, *Ashdown v Telegraph Group*.[82] Nor are they saying that there is something about the copyright material *specifically* that warrants either dissemination to a wider group or suppression of that information. The claim is not that there is something within the materials that the public ought to know; nor is there is any moral or legal wrong disclosed in that material that universities wish to criticise. In fact, the material itself is largely irrelevant. Instead, the public interest claim relates to the costs of obtaining and licensing that content. Thus, the institution's response to copyright infringement is, and can be no more than, a plea of poverty. They cannot afford the price of compliance.

Properly speaking, this is not a public interest defence at all. It is more like a necessity defence which resides not in the material itself but in the social, political and economic environment in which the university is operating. The institution is claiming that in order to provide a quality educational service it had to infringe copyright. It might even point to the actions of copyright owners, for instance in relation to pricing, as compounding this need.[83] We agree with the concern that there are copyright-related impediments to teaching during COVID and appreciate that many universities are facing very worrying economic forecasts. But acceptance that this enlivens a public interest defence would give that defence an entirely new function, and one that could be difficult to contain. Although the current pandemic may be seen as exceptional, it is not *sui generis*. If judges were to tolerate the suspension of rights in this context, why not others where there is major economic and social upheaval? Thus, to the extent there still exists in UK copyright law a public interest defence, there are many problems in applying it as a general safety valve during the pandemic.

3.2. In the assessment of remedies

While the socio-economic climate cannot sustain a public interest defence to copyright infringement, there are more promising arguments that such circumstances may have a bearing on the assessment of remedies. In a claim for infringement, the copyright owner will most likely seek a final injunction and damages for lost sales or licence fees. We deal with injunction and damages in turn.

Although the injunction is a discretionary equitable remedy and judges may therefore refuse an injunction and instead award damages in lieu,[84] in intellectual property law, a culture has arisen in which

82 *Ashdown v Telegraph Group* (n 73). Even in that case, the public interest defence was unsuccessful.

83 As noted earlier, we have not discussed the competition law concern about abuse of dominant position.

84 Now found in Senior Courts Act 1981, section 50.

injunctions are generally granted as if of right. As illustrated most graphically by *Chiron v Organon Teknika*, this has been the case even where there is a strong public interest in having continued access to the defendant's infringing product.[85] There are a number of justifications for this approach, including that each intellectual property regime has already been crafted to reflect public interest concerns; that refusing to order an injunction has the practical effect of sanctioning the defendant's wrongful conduct; and that there are significant difficulties in judges calculating damages in lieu (especially where the infringing conduct may occur for many years into the future).

There are also signs, however, that UK courts are becoming more receptive to public interest arguments. Although such arguments have been accepted from time to time,[86] this has been very controversial.[87] It is therefore significant that in *Coventry v Lawrence*, the Supreme Court, in discussing the jurisdiction to award damages in lieu, emphasised the discretionary nature of the injunction and the need to consider all the relevant facts, including the public interest.[88] In addition, it has been suggested that for intellectual property cases, the availability of an injunction must be considered in light of the Enforcement Directive, which in Article 3 says that remedies must be fair, equitable, effective, proportionate and dissuasive, amongst other things.[89] Both *Coventry* and Article 3 were considered by Birss J in *Evalve Inc v Edwards Lifesciences Limited*, handed down in March 2020.[90] In that case it was held that the defendant's device, used to treat

85 *Chiron Corporation v Organon Teknika Limited (No 10)* [1995] FSR 325. That case concerned the infringement of patents in relation to diagnostic tests for hepatitis. The defendants argued that the judge should award damages in lieu of an injunction, but these arguments were rejected. Although accepting that *Shelfer v City of London Electric Lighting Co* [1895] 1 Ch 287 did not describe exhaustively the circumstances in which such discretion could be exercised, and that the interests of the public might be relevant, Aldous J emphasised the various ways in which the patent monopoly is limited. Given these limitations, he concluded at 334 that 'it is a good working rule that an injunction will be granted to prevent continued infringement of a patent, even though that would have the effect of enforcing a monopoly, thereby restricting competition and maintaining prices. Something more should be established before the Court will depart from the good working rule suggested in the *Shelfer* case.'

86 Especially the (in)famous *Miller v Jackson* [1977] 1 QB 966, in which an injunction was declined on the basis that there was a public interest in playing cricket.

87 See eg J Heydon, M Leeming and P Turner, *Meagher, Gummow & Lehane's Equity: Doctrines and Remedies* (5th edn, LexisNexis Butterworths 2015) [21-095] (describing *Miller v Jackson* as a 'judicial aberration').

88 *Coventry v Lawrence* [2014] UKSC 13, especially [123]–[124].

89 See especially *HTC Corp v Nokia Corporation* [2013] EWHC 3778 (Pat).

90 *Evalve Inc v Edwards Lifesciences Limited* [2020] EWHC 513 (Pat).

mitral valve regurgitation, infringed patents held by the claimants.[91] The defendant sought to resist an injunction on the basis that, in essence, many doctors preferred the defendant's product to that of the claimants. Birss J observed that the 'previous reluctance' to refuse an injunction stemmed from *Shelfer's Case*, but that the Supreme Court had concluded, in *Coventry*, that 'a more flexible approach should be taken'.[92] That said, he also held that, when applying *Coventry* to patent infringement, it remained necessary to consider how the patent system already embodies the public interest, just as Aldous J had done in *Chiron v Organon Teknika*.[93] Where 'various public interests are engaged and pull in different directions, one should have in mind that the legislator is better equipped than the courts to examine these issues and draw the appropriate broad balance.'[94] On the facts, the public interest in freedom of clinical decision-making did not rise to the level that an injunction would be refused.[95] But drawing from the analysis of Birss J, one can imagine some compelling arguments that, during a pandemic, the public interest in education is such that access to learning materials must be maintained, and that an injunction should not be granted.

Of course, the refusal to grant an injunction does not mean that the educational establishment faces no consequences, as there is still the question of damages in lieu. In *Jaggard v Sawyer*, it was held that such damages should be calculated by reference to the price that would be accepted by a 'reasonable seller' rather than a 'ransom price'.[96] This raises the question of how the position of the reasonable seller is determined. This sort of evidentiary question is an issue for damages generally. For instance, it was said in *General Tire v Firestone* that, when quantifying damages by reference to a licence fee, the principles in the nineteenth-century case of *Penn v Jack* still apply, such that the rightsholder cannot 'ascribe any fancy sum which he says he might have charged'.[97] Instead, all that may be claimed is the 'going rate'.[98] This principle was applied in the successful strike-out application *Lilley v DMG Events Limited*, in which the litigant-in-person's copyright

91 That aspect handed down in [2020] EWHC 514 (Pat).

92 *Evalve Inc v Edwards Lifesciences Limited* (n 90) [46]–[47].

93 Discussed at n 85 above.

94 *Evalve Inc v Edwards Lifesciences Limited* (n 90) [73].

95 The reasoning here was that such a lack of choice was inherent in the patent system. This is not to say that there may not be circumstances where that choice needed to be maintained through the refusal to grant an injunction, but they would be limited.

96 *Jaggard v Sawyer* [1995] 1 WLR 269, 282.

97 *General Tire & Rubber Co v Firestone Tyre & Rubber Co* [1975] 1 WLR 819, 825, citing *Penn v Jack* (1867) LR 5 Eq 81, 113–114.

98 Ibid 825.

infringement claim amounted to, he alleged, £798,728,820.[99] Applying *Firestone*, the court found the claimant mistaken to assume 'the infringer had to take the [claimant] as he found him and, specifically, had to accept whatever rate of royalty which the [claimant] says he would have charged for a licence covering all the infringing acts'.[100]

But even if the claimant cannot pluck sums from thin air, to what extent, if at all, can the defendant push back against prices that it believes are excessive (as has been argued repeatedly in relation to the rates charged for licences for e-books and subscription databases)? And can defendants point to COVID to suggest that usual licence fees may need to be adjusted downwards? *Firestone* suggests that 'the circumstances in which the going rate was paid' are relevant.[101] Even if the publisher can produce evidence of a market at particular prices, it is obliged to show that the circumstances of those transactions is 'the same as or at least comparable with those in which the [rightsholder] and the infringer are assumed to strike their bargain'.[102] This might suggest that the existence of COVID could limit the relevance of pre-pandemic prices. That said, there are also limits to this analysis. For instance, it has been said that the *Firestone* assessment cannot amount to what the defendant '*could have afforded to pay*'.[103] In addition, *Firestone* should not be understood as a judicial discretion to award what is 'just and fair' in the circumstances. It is not an equitable measure but an opportunity for the parties to introduce extrinsic evidence of what the market will bear, should that amount be less than the publisher's expectation.

In sum, it is possible that public interest arguments could have some bearing on the outcome of any copyright litigation arising out of the pandemic. However, we believe that such arguments would be relevant for remedies – and, perhaps, the availability of a defence under fair dealing or another statutory exception – rather than crystallising as a standalone public interest defence.

99 *Lilley v DMG Events Limited* [2014] EWHC 610 (IPEC).

100 Ibid [52]. The court concluded the proper figure was the more modest sum of circa £83: [60]. This story has a fascinating sequel: Mr Lilley sought to have this decision set aside on the grounds of 'treason, fraud and perverting the course of justice': *Lilley v Euromoney Institutional Investor plc* [2014] EWHC 2364 (Ch), [3]. In subsequent, related litigation against three further publishers (on the same grounds), he accused the sitting judge, Birss J, of apparent bias and asked that he recuse himself. That application was denied, and his claim for £593m against the defendants dismissed. Despite being issued with an extended civil restraint order and being made bankrupt as a result of this litigation, he issued further proceedings in January 2017 against different defendants, this time for the lesser sum of £335m: *Lilley v FT Lmited* [2017] EWHC 1916 (Ch). He lost.

101 *Firestone* (n 97) 825.

102 Ibid.

103 *Irvine v Talksport Limited* [2003] EWCA Civ 423, [106] (emphasis in original).

4 OTHER OPTIONS

Thus far, we have described the licensing arrangements and exceptions that are most relevant to education, and concluded that the public interest defence – if it still exists in copyright law – does not map onto the particular issues raised by COVID. We have also observed that, while there are latent flexibilities in our existing statutory exceptions, there are ultimately limits to their reach, especially in relation to copying of lengthy extracts and entire works. In this final section, we consider measures that might be particularly relevant for this latter problem: compulsory licensing and the incentivisation of voluntary negotiation through amendment of section 36 of the CDPA.

In its letter to the UK government, Research Libraries UK identified compulsory licensing as a possible solution to challenges caused by COVID.[104] In its response, the government rejected this suggestion, stating that it would 'remove exclusive rights from right holders' and would likely be contrary to international copyright law.[105] Although the government did not spell out its reasoning, this statement would seem to reflect the proposition that compulsory licences are only possible under international copyright law where expressly countenanced in an international instrument.[106] Relevantly for this article, these instances are rare[107] and do not include education, except for developing countries.[108] This view of compulsory licensing also assumes that the greater does not include the lesser: that is, that permission for member states to introduce a free exception (under which copyright owners receive nothing) does not implicitly enable them to instead enact an exception that is subject to the payment of remuneration.[109]

104 RLUK letter (n 11).

105 Solloway letter (n 12).

106 See eg Bently et al (n 13) 315 (one reason there are few non-voluntary licences in the UK is that 'the international standards to which the United Kingdom has committed itself are generally incompatible with compulsory licensing'); see also N Caddick, G Davies and G Harbottle, *Copinger and Skone James on Copyright* (17th edn, Sweet & Maxwell online resource 2016–) [28–06].

107 Eg Berne Convention, Articles 11*bis*(2) (rebroadcasting), 13 (mechanical recording of musical works); Rome Convention, Article 12 (secondary uses of phonograms).

108 Appendix to the Berne Convention. For discussion, see N Ndiaye, 'The Berne Convention and developing countries' (1986) 11 Columbia-VLA Journal of Law and the Arts 47.

109 The Rome Convention provides what is arguably the strongest evidence of a demarcation between free and remunerated exceptions. In Article 15(2), Rome permits contracting states to enact 'the same kinds of limitations' for performances, phonograms and broadcasts as it does for copyright in literary and artistic works, but that 'compulsory licences' may only be granted 'to the extent to which they are compatible with this Convention'. Only one provision – Article 12 – refers expressly to the payment of equitable remuneration. Rome also countenances certain 'exceptions' in Article 15(1).

A number of counter-arguments can be made. First, even if we accept the latter argument, such that compulsory licensing for education cannot be justified by reference to Article 10(2) of Berne (as no mention is made of remuneration),[110] the UK could instead point to the three-step test in Article 9(2).[111] Sam Ricketson and Jane Ginsburg seem to treat this as given in *International Copyright and Neighbouring Rights*. They state, in relation to course packs, that '[s]uch usages are well developed forms of exploitation in many countries, subject to voluntary licensing arrangements or even compulsory licensing schemes that meet the requirements of article 9(2)'.[112] Second, many countries have compulsory licensing regimes outside the express examples in Berne and other international instruments, including for education.[113] With no objection having been made to these regimes, for instance under World Trade Organization dispute resolution processes, this state practice could be said to reflect consensus that compulsory licensing is compliant with international copyright law.[114] Finally, the position said to exist at the international level can be contrasted with EU copyright law, where a number of the permitted exceptions in Article 5 of the ISD are subject to the payment of fair compensation,[115] and the

110 Article 10(2) allows member states 'to permit the utilization, to the extent justified by the purpose, of literary or artistic works by way of illustration in publications, broadcasts or sound or visual recordings for teaching, provided such utilization is compatible with fair practice'. See P Goldstein and B Hugenholtz, *International Copyright: Principles, Law, and Practice* (3rd edn, Oxford University Press 2013) §11.1 (describing Article 10(2) as an 'uncompensated limitation').

111 Article 9(2) states: 'It shall be a matter for legislation in the countries of the Union to permit the reproduction of such works in certain special cases, provided that such reproduction does not conflict with a normal exploitation of the work and does not unreasonably prejudice the legitimate interests of the author.'

112 Ricketson and Ginsburg (n 1) [13.45]. In their discussion of the legislative history of Article 9(2), Ricketson and Ginsburg argue at [13.25] that the provision was 'envisaged' to cover free exceptions and compulsory licences and that this makes sense given its purpose and language; that Article 9(2) was intended to apply in a range of 'certain special cases'; and that states were not precluded from tying reliance on an exception to the payment of remuneration.

113 Eg Australian Copyright Act 1968 (Cth), Part IVA, Division 4; Singapore Copyright Act (chapter 63, revised edition 2006), section 52.

114 See Vienna Convention on the Law of Treaties, Article 31(3)(b) (subsequent practice can be used as an aid in treaty interpretation).

115 ISD, Articles 5(2)(a), (b) and (e). An entitlement to receive fair compensation is also found in the EU orphaned works exception: Directive 2012/28/EU of the European Parliament and of the Council of 25 October 2012 on certain permitted uses of orphan works, Article 6(5). In the UK, this amount is to be agreed between the parties or, if no such agreement can be reached, set by the Copyright Tribunal: CDPA, Schedule ZA1, paragraph 7(4). The mandatory exception for uses for the 'sole purpose of illustration for teaching' in the DSM Directive may be implemented as a remunerated exception: Article 5(4).

CJEU has pointed to remuneration in considering whether domestic exceptions are compliant with the three-step test as incorporated in Article 5(5).[116] As such, the UK government may be unduly cautious in suggesting that compulsory licensing for education would conflict with international copyright law.

There may nevertheless be philosophical and practical objections to compulsory licensing. The philosophical objection is that compulsory licences are antithetical to private property rights as they remove from individual copyright owners the ability to decide whether to licence rights and for how much.[117] This might be seen as problematic for a number of reasons: first, because it erodes the decision-making autonomy of owners; and second, because it is likely to lead to inefficient outcomes, on the basis that the state is poorly placed to set prices.[118] This latter concern will be particularly acute for those who favour neoliberal economic models, the central tenet of which is the supremacy of the market and limiting state interventions. One answer might be that, even if we normally prefer to leave the exploitation of copyright works to voluntary negotiation, a pandemic creates conditions where the usual reasons for market failure – holdout, fragmentation of rights, transaction costs, etc – are magnified and of far greater consequence. In universities, for example, access to physical library collections is likely to be limited for some time, making staff and students incredibly reliant on online and digitised content. Even if we ordinarily have an aversion to compulsory licensing, a pandemic may create an environment in which we cannot trust the market to support the required expansion of online collections, making state intervention essential.

But even if those arguments are compelling, there remains the question of whether it is realistic to expect the UK government to have the legislative bandwidth to develop a compulsory licensing regime from scratch, and whether the relevant copyright collectives would be able to implement that scheme in a timely manner. On the plus side, there are already workflows for reporting what has been copied and for the payment and distribution of fees. But before these could be adapted to any new scheme, the government would need to consider many important questions about the terms of the licence. One option

116 Eg *Technische Universität Darmstadt v Eugen Ulmer KG* (n 60) [48].

117 To use the economic language, this changes the copyright owner's entitlement from a property right to a liability rule: see G Calabresi and A Melamed, 'Property rules, liability rules, and inalienability: one view of the cathedral' (1972) 85 Harvard Law Review 1089. Similar objections have been made to the granting of damages in lieu of an injunction, as discussed above in Section 3.2.

118 Concerns about the deficiencies of state decision-making may be even stronger when the royalty is prescribed by statute (statutory licensing) rather than fixed by a tribunal, if a tribunal is better equipped than a legislative drafting team to respond to the views and evidence of relevant stakeholders.

might be for the government to develop a broad framework for the licence, on the basis that the precise details in relation to quantitative limits, pricing, reporting, and so forth would be agreed by the relevant parties or, if agreement could not be reached, set by the Copyright Tribunal. If it was attracted to this model, the government could use as a guide the simplified educational copying licence introduced in Australia to replace the schemes in Parts VA and VB.[119] But while this may speed up the legislative process at the government's end, it would risk generating a protracted commercial negotiation which in all likelihood would end up at the Tribunal.[120] To avoid such an outcome, the government could finalise many of the details itself, including how remuneration is calculated. But this would only magnify the concern, noted above, that states are not good at setting prices. That is, if the government will do a bad job at a compulsory licence at the best of times, it can hardly be expected to improve on its usual performance during pandemic conditions. Even for those whose views on state intervention are more charitable, one can imagine the concern that a hastily assembled scheme might be either useless to universities *or* damage the markets and income streams of authors and publishers.

We wonder, though, whether there is a government intervention that would incentivise rather than replace voluntary negotiation: reform of section 36 of the CDPA, perhaps for a limited period, so that it expressly allows educational establishments to copy lengthier extracts or even entire works (perhaps under CDL terms) *but not where licences are available that authorise those acts*.[121] To understand this suggestion,

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119 Introduced by the Copyright Amendment (Disability Access and Other Measures) Act 2017. For instance, section 113P(1) sets out the circumstances in which the copying or communicating of a work is non-infringing. These include that a 'remuneration notice' applies and is in force; the act is solely for the educational purposes of that or another educational institution; and that 'the amount of the work copied or communicated does not unreasonably prejudice the legitimate interests of the owner of the copyright'.

120 In Australia, the Copyright Agency Limited and Universities Australia were unable to reach agreement on the methodology for ascertaining the amount of equitable remuneration under a new licence covering the period 1 January 2019 to 31 December 2024. In late 2018, the Copyright Agency made an application to the Copyright Tribunal to determine this point. Interim orders were made by Perram J in May 2019: *Copyright Agency Limited v University of Adelaide (Interim Orders)* [2019] ACopyT 2. The matter continues.

121 See generally R Merges, 'Contracting into liability rules' (1996) 84 California Law Review 1293, arguing against the widespread use of compulsory licences, noting the efficiency of collective forms of administration and considering various ways to encourage such 'private liability rules' to emerge. For Merges, one way to encourage the latter is to 'modify property rule entitlements so as to increase slightly the risk that the [defendant] can escape entirely from the [claimant's] property right': at 1316.

it is necessary to step back a moment to understand the structure and goals of section 36. That provision allows educational establishments to copy and communicate, for the purposes of instruction, not more than 5 per cent of a work (not being a broadcast or artistic work). However, section 36 does not apply to the extent that a licence is available and the establishment is aware or ought to have been aware of that fact.[122] The idea is to simultaneously strengthen the hand of educational establishments at the negotiating table (as they know that they can copy certain amounts for free) and encourage copyright owners to offer licences that go beyond that which is covered by section 36.[123] Similar thinking underpinned the recommendation of the Whitford Committee in the 1970s in relation to photocopying by libraries, educational establishments, and so forth.[124] That committee saw blanket licensing as the best mechanism to deal with reprographic reproduction and recommended the removal of exceptions in the Copyright Act 1956. However, it also observed that users should not be asked to give up these exceptions 'without a guarantee that their needs will be met by blanket licensing schemes'.[125] The answer of the committee was that a time be set for such negotiations, after which, if licences were not in place, there would be a 'free-for-all' in which copies could be made without payment.[126] The Whitford Committee saw a number of benefits of this approach, including that the collectives administering the licences would have the flexibility to make different arrangements with different users.[127]

There are many different ways this general idea – of using an exception to incentivise licensing – could be operationalised, and articulation of a detailed plan is beyond the scope of this article. But, to provide a brief example, let us say that the aim is to encourage the expansion of collective licences for published print material so that lengthier extracts and entire works may be copied and made available to staff and students. We might start from the premise that, when it comes to facilitating digitisation, voluntary licensing – perhaps including a scheme for *licensed* digital lending – is the gold standard. There are a number of reasons for this. A licensing scheme can permit levels of

122 CDPA, section 36(6). It is important to bear in mind that the Copyright Tribunal has ultimate oversight of this process through its supervision of licensing schemes and bodies: see CDPA, chapter VII.

123 It has been questioned whether section 36 achieved this, at least in earlier iterations: R Burrell and A Coleman, *Copyright Exceptions: The Digital Impact* (Cambridge University Press 2005) 128–129.

124 Whitford Report (n 1).

125 Ibid [279].

126 Ibid.

127 Ibid [280].

access beyond those possible under CDL and could conceivably apply to a broader range of works. It avoids some of the uncertainties that are inherent in relying on exceptions, for instance in relation to the right to digitise and the legality of providing access to students located overseas. Depending on how the scheme was set up, universities may be able to access born-digital content or scans produced by other establishments (including, potentially, the British Library), rather than having to digitise everything themselves. Such digital content could include functionality to make it more user-friendly than a pdf of a book and could be accompanied by less aggressive digital rights management (DRM) overlays, to the extent licensed digital lending was permitted. Finally, there could be different approaches to pricing, ranging from transactional fees (whether based on pages, chapters or works) to a subscription-based 'all you can eat' model.

If the government agreed that such an expansion of collective licensing were desirable, it could consider a Whitford-esque approach in which it extends section 36 to cover a greater range of acts. At this point the government would need to think carefully about the details of this reform, as the goal would be to encourage a negotiated solution and not provide educational establishments with such an attractive exception that licensing becomes redundant.[128] But we can imagine that its response might comprise or include an exception that explicitly allowed educational establishments to adopt CDL. That exception would need to follow the key features of CDL, for instance in relation to the owned-to-loaned ratio and the inclusion of DRM to limit re-use by the borrower. It would permit educational establishments to copy entire works, although we can envisage a key area of debate being whether *any* published work held in physical form could be copied in full, or whether there would be different rules for titles that are also available commercially in digital form. Allowing such books to be digitised in full would raise complaints about market substitution. On the other hand, one might ask why universities should be asked to pay over and over again for the same content. If a university acquires, lawfully, a physical book and wishes to digitise that book and lend a soft copy under strict CDL terms, why should we protect the e-book market?

In suggesting the expansion of section 36, we do not mean to imply that this would be a straightforward or easy option for the UK government to operationalise. But we believe that the sort of consultation and review required for an exception would be of a much lower magnitude than that required for a fully fledged compulsory licensing system. Being unremunerated, there would be no need to set

128 Indeed, such an exception may be inconsistent with the three-step test as found in Article 5(5) of the ISD and various international treaties.

a price. The general idea would be to give universities greater comfort in embracing CDL than can be achieved from section 32 and 36A alone, but in the context where a collective licence and/or licensed digital lending scheme would be even better.

5 CONCLUSION

As stated in the introduction, the COVID-19 pandemic has not generated entirely new problems for educational institutions in relation to copyright but has magnified the effects of longstanding tensions and issues. We have made a number of suggestions for how universities may make better use of exceptions and have suggested that, if the government is minded to intervene, the best approach may be to encourage voluntary licensing. But, for universities and their representatives at the negotiating table right now, what can they do to ensure the economic realities of teaching during a pandemic figure in their discussions with rightsholders? As a matter of law, it is very important to hold the line in relation to exceptions, and we have also discussed whether public interest arguments might be relevant to remedies. But, beyond that, we see the negotiation as largely commercial in nature. Even before the pandemic, there were ongoing complaints that publishers were insisting on high, unrealistic prices for digital content. We would suggest that, before publishers get too strident in their insistence that everything should be left to private ordering and that this is just the way of things, they may want to reflect on one form of private ordering that universities might, following COVID, be even more minded to embrace. This crisis illustrates both the fragility of the university's position and their dependence upon the goodwill of publishers. It only heightens the urgency of considering new publishing models, given the preponderance of materials hawked about by publishers that emanate from the efforts of employees in the university sector. Is it not, then, time for the university sector to move even more aggressively towards open access and other in-house publishing models, so that we have greater control over our own destiny and can reap the benefits ourselves?

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The law of bare life

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ABSTRACT

2020 proved to be a remarkable year. Not the least remarkable was the realisation that, in a moment of perceived crisis, the instinctive response of the UK Government was to sweep away various so-called rights and liberties which might, in a calmer moment, have been presumed fundamental, and to rule by means of executive *fiat*. The purpose of this article is to interrogate both the premise and the consequence. Because, on closer inspection, there is nothing at all remarkable about how the Government reacted, for the same reason that there was little that was unprecedented about the experience of COVID-19. History is full of pandemics and epidemics, and government invariably acts in the same way. The first part of this article will revisit a particular theory of governance, again proved by history; that which brings together 'bio-politics' and the jurisprudence of the 'exception'. The second part of the article will then revisit a prescient moment in British history; another disease, another panicked government, another lockdown. In the third, we will reflect further on the experience of COVID-19 and wonder what might be surmised from our foray into the past.

Key words: Agamben; bio-politics; Schmitt; contagious diseases; COVID-19.

INTRODUCTION

As victory is proclaimed, however warily, in the 'war' against COVID-19, we are invited to reflect upon a very strange couple of years.[1] Of course, we could decline the invitation, as Dryden famously did of the 'great plague' of 1665. Preferring in his poem *Annus Mirabilis* to breeze over the buboes and focus on a series of naval victories over the Dutch. As for the 'Great' Fire of London, which followed very hot on the heels, an opportunity for the king to rebuild a city of 'more precious mould'.[2]

1 For a commentary on the deployment of militarised rhetoric to help regulate popular fears in moments of perceived crisis, see J Bourke, *Fear: A Cultural History* (Virago 2005) x–xi, and also 311.

2 J Dryden, '*Annus Mirabilis*' in K Walker (ed), *John Dryden: A Critical Edition of the Major Works* (Oxford University Press 1987) l.1169, at 69. There is brief allusion, at l.1066, to the 'spotted deaths' which preceded the fire, a divinely ordained punishment for the sin of regicide. Nothing more.

Samuel Johnson would later wonder at the tone, assuming that Dryden was just glad that things had not got worse.[3]

Less easy this time. A fascinated media, an enchanted populace, an economy laid waste, a death toll running to hundreds of thousands, and still climbing.[4] People will demand answers. A judicial inquiry into the handling of the COVID-19 crisis is scheduled for summer 2022. Whilst its ambit is still to be determined, it is reasonable to suppose that it will be mostly concerned with the evidence of assorted politicians and civil servants, along with myriad modellers, virologists and National Health Service (NHS) trust executives. All to tell their particular stories and, in many cases, make their excuses.[5] For which reason there will probably be a fair number of lawyers hovering in the background too.

There will be fewer historians and philosophers. Which is regrettable, because there are ways, other than the algorithmic, to model a crisis. There is human nature to be accounted, and there is the past. Both of which militate against the thought that we might be surprised by much of what has happened over the last year. If there is one thing which history tends to prove, time and again, it is the predictability of the allegedly unpredictable.[6] History is littered with pandemics

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3 At least not yet. By the time that *Annus Mirabilis* was rolling off the presses in early summer 1667, the Dutch had avenged the defeats of the previous year. Sailing up the Medway as far as Chatham, where the Royal Navy was in dock, having run out of money, and thus sailors, firing 13 warships and towing away the flagship *The Royal Charles*.

4 Precise numbers are difficult to discern. As to the overall economic cost, the Centre for Economics and Business Research estimated a drop in UK 'gross value added' of £251 billion for the year running from the first lockdown in March 2020. The official COVID-19 death-rate, as of May 2021, stands at 126,000. Though the figure remains highly contestable; for reasons to which we will return. No less elusive is the likely number of lives lost as a consequence of 'lockdown', which will be counted for years to come – damage to mental health, increased substance-abuse and alcoholism, cancelled elective surgery. NHS figures suggest 36,000 cancelled cancer operations alone over the 12 months from March 2020. For a sobering set of commentaries on the latter, see the special edition of the Journal of Public Health 42(4) published in December 2020, entitled 'The Collateral Damage of Covid-19'.

5 The evidence given to the Commons Science and Technology Select Committee by Prime Minister Johnson's former 'chief of staff', Dominic Cummings, on 26 May 2021, is suggestive. An opening apology followed by seven hours blaming everyone else.

6 See here, from the slightly different perspective, of anticipating financial crises, N Ferguson, *The Ascent of Money: A Financial History of the World* (Allen Lane 2008) 342–344.

and epidemics, from ancient times to modern.[7] In the second part of this article we will drop back a century-and-a-half to revisit one such moment; another disease, another panicked government, another overwrought lockdown.

In truth, we hardly need to go that far. In terms of debunking the myth of the unpredictable, a generation will do. COVID-19 is the third coronavirus to reach pandemic or epidemic proportions this century, to which can be added various other viral epidemics, most obviously influenza.[8] The chances of another was even gamed, to test our preparedness. Operation Cygnus, in 2016, concluded that the UK was ill-prepared to respond to a public health crisis of the kind which was, as many advised, 'inevitable'.[9] And so it proved. An early report from the National Audit Office, in May 2021, supposing that the often-frenetic response of Government through much of 2020 stemmed from a longer-term failure to build-in risk management 'resilience'. In the absence of which, Government was left 'firefighting' the crisis 'from day to day'.[10]

With consequences that were as predictable as the virus itself. Including the *de facto* suspension, by executive *fiat*, of various civil liberties and human rights which might, in a calmer moment, have been assumed to be 'fundamental'; from the right to protest, to the right to see family, to the right to sit on a park bench with a takeaway coffee. All very strange, dystopian indeed. But, again, no surprise. It is what government always does because it is never prepared, and it always panics. And then, in the absence of any planned mitigation, resorts to measures designed to reduce public life to its barest state. For however long it takes.

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7 See L Moote and D Moote, *The Great Plague* (Johns Hopkins University Press 2004) 5–10, 271–278, noting the prevalence of plagues through history. And also the tendency of each generation to assume, for reason of 'unprecedented' scale, that their plague was somehow 'greater' than any that had gone before.

8 After SARS and swine flu, in 2003 and 2009–2010 respectively.

9 Cygnus was gamed for a flu pandemic. On the inevitability of a viral pandemic in the 'near' future, see L Borysiewicz, 'Plagues and medicine' in J Heeney and S Fridemann (eds), *Plagues* (Cambridge University Press 2017) 85.

10 National Audit Office (NAO), 'Initial learning from the government's response to the Covid-19 pandemic', published 19 May 2021, at 32. Amongst the most significant consequences of the lack of planning, the NAO noted, were: a failure to identify those in greatest need of shielding; the consequence of mass disruption of schooling; absence of ready facilities to administer employment support; lack of mechanisms to provide emergency financial support for local authorities; the likelihood of fraud in loan administration and public procurement contracts; and tensions in the relationship between the NHS and social care services.

BIO-POLITICS AND BARE LIFE

Before we revisit our particular history, of lockdown in Victorian England, we might contemplate some of the philosophical implications of this 'bare' life. In order to do so we will need to situate it within the broader compass of what has become known as bio-politics. After which we will turn our closer attention to the jurisprudential corollary of life lived barely.

Bare life

The idea of 'bare life' is the focus of Giorgio Agamben's *Homo Sacer*, posited as the alternative to what might be variously termed the 'political', or even the 'good', life. A polarity which Agamben retrieves from classical Greece, but which finds a more modern articulation in the first volume of Michel Foucault's *History of Sexuality*. A concern with existence as simply that. There is an immediate resonance with Hobbes's idea of 'natural man', who contracts his way into a more secure political state. We will return to Hobbes shortly. As we will Agamben. For now, though, we should take a closer look at Foucault's variant. For which reason we must also, as a necessary preliminary, contemplate his theories of disciplinary power, and the relation of knowledge and power. The aligned 'techniques', as he termed them, of modern 'governmentality'.[11]

Something which has, of course, a facilitative and a constitutive dimension. In the final part of the first volume of the *History of Sexuality*, Foucault identified the seventeenth century as the moment when politics turned its attention to 'disciplining' the 'body as a machine'. After which it evolved into a closer interest in the 'mechanics of life' and 'biological processes'. A 'series of interventions and regulatory controls: a biopolitics of the population'.[12] The purpose of which was to control not just the quality of life, but the extent and the 'utility'.[13] Amongst the many things born during the 'classical period', by which Foucault means the Enlightenment, is the idea of 'public' health.[14]

Something else, is the prison. The subject of what is perhaps Foucault's most renowned piece of sociological history, *Discipline and Punish*. Looking for a definitive expression of modernity's aspiration to 'discipline' the 'body', Foucault alighted on Jeremy Bentham's

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11 M Foucault, *The History of Sexuality: Volume 1* (Penguin 1990) 141.

12 Ibid 139. For a comment on the significance of this moment in the evolution of Foucault's thinking and the development of 'bio-politics' as critique, see B Golder and P Fitzpatrick, *Foucault's Law* (Routledge 2009) 21.

13 Foucault (n 11 above) 144.

14 For the purpose, Foucault argues, of servicing emergent capitalism. See ibid 140.

'Panopticon'.[15] In its refined form a penitential model, though conceived to be of broader application across a range of public 'spaces'. Hannah Arendt famously extended the logic to the concentration camp.[16] Factories too, schools and monasteries, and, of course, hospitals.

It is no coincidence that Foucault came to the Panopticon whilst searching for the origins of an institution which was designed for the express purpose of regulating 'public health'; the mental 'hospital'. In the second part of this article, we are going to focus our attention more closely on the emergence of certain public health 'techniques' in the nineteenth century; designed more closely still to 'discipline' instances of sexual 'irregularity'. For present purposes, though, we might revisit what Foucault had to say about the 'bio-politics' of plague. Because it was here that he located the immediate stimulus for the development of these associated 'public' health 'techniques'.

Along with leprosy. The critical difference being that where lepers were cast out, plague victims were locked in the 'confused space of internment'.[17] Which, at once, made dealing with plague not just a medical issue, but a political and geographical one, necessitating, if it is to be effective, a common 'disciplinary' endeavour, scientific and juridical.[18] As he observed in *The Birth of the Clinic*, a 'medicine of epidemics could exist only if partnered by a police'.[19] And it had to be effective; the acid test of the 'disciplinary' state. Not just any 'public' health crisis; but the definitive crisis. Which that state, if it is to retain any credibility in terms of securing its citizenry, must be able to resolve. Whatever it takes.

There was, then, a common denominator between these different 'disciplinary' institutions. Each sought to internalise an 'other'. Whereas, in centuries past, they might be cast out, returned to their 'natural' status, literally an 'out-law', in modernity the plague-ridden are now retained within the disciplinary 'gaze' of the state.

15 M Foucault, *Discipline and Punish: The Birth of the Modern Prison* (Penguin 1977) 195–228.

16 The definitive statement is found in H Arendt, *The Origins of Totalitarianism* (Harcourt Brace Jovanovich 1973) and *Eichmann in Jerusalem: A Report on the Banality of Evil* (Penguin 2006). A further commentary, on point, is H Arendt, 'Social science techniques and the study of concentration camps' (1950) 12(1) Jewish Social Studies 49–64. For Agamben's intimation, see G Agamben, *Homo Sacer* (Stanford University Press 1998) 119–120, 166–168.

17 See Foucault (n 15 above) 232–2, and also *History of Madness* (Routledge 2009) 5–6.

18 Foucault (n 15 above) 172–173, 183–185. See S Elden, 'Plague, panopticon, police' (2003) 1(3) Surveillance and Society 240, 241–243; and also M Wagner, 'Defoe, Foucault and the politics of plague' (2017) 57 Studies in English Literature 501, 502–503.

19 M Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception* (Routledge 1973) 25.

[20] Returned to the condition of 'bare life', perhaps. But not cast-out, at least not in the prosaic sense. Agamben cites the original idea of *homo sacer* in 'archaic' Roman law; the 'sacred man' who 'may be killed and yet not sacrificed'.[21] Still within the ambit, but reduced to nothing.

The facilitative and constitutive dimensions of bio-political 'technology' are, of course, mutually sustaining. It is not just the body which is 'disciplined'. So too is the 'mind'.[22] The mentally ill 'cured', the criminal 're-formed'. Something which brings us to Foucault's writings on the relation of knowledge and power, and the idea of 'governmentality'.[23] The ways in which government permeates the subject.[24] There is, as Foucault argued at the outset of *Discipline and Punish*, 'no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations'.[25] Modern government is not simply a set of functioning institutions. It is far subtler, a series of interlinking and constantly mutating 'networks of power'.[26] Their movements oiled by discursive tensions which are themselves constantly mutating, with varying degrees of violence; the 'battle among discourses', for the privilege of telling the 'truth'.[27]

Plenty here for jurists to contemplate of course.[28] Not least the suggestion that the 'domain of law' should be 'viewed' henceforth 'not in terms of a legitimacy to be established, but in terms of methods of subjugation that it instigates'.[29] The very 'idea of justice in itself is an idea which in effect has been invented and put to work in different

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20 See Foucault (n 17 above) 439–442, discussing the like treatment of the mad and the criminal.

21 Agamben (n 16 above) 8, 71–78, 104–105.

22 See Elden (n 18 above) 248–249.

23 Again introduced at the close of the first volume of *Sexuality*, Foucault (n 11 above) 143–144.

24 See Golder and Fitzpatrick (n 12 above) 31, suggesting that 'governmentality' can be seen as a disciplinary precursor of 'bio-politics'.

25 Foucault (n 15 above) 27.

26 See M Foucault, 'Politics and the study of discourse' in G Burchell et al (eds), *The Foucault Effect: Studies in Governmentality* (Harvester 1991).

27 In A Sheridan, *Michel Foucault: The Will to Truth* (Tavistock 1980) 134. See also A Hunt and G Whickham, *Foucault and Law: Towards a Sociology of Law as Governance* (Pluto 1994) 11–14.

28 Even if Foucault seemed reluctant to describe a comprehensive legal philosophy. More a case of recovering 'fragmentary reflections on law', according to Golder and Fitzpatrick (n 12 above) 2–4, and also 17. For a comment on Foucault's resistance to prescriptive theory, see J Miller, *The Passion of Michel Foucault* (HarperCollins 1993) 200–202.

29 M Foucault, 'Two lectures' in C Gordon (ed), *Power/Knowledge: Selected Interviews and Other Writings 1972–1977* (Harvester 1980) 96.

societies' as the 'instrument' of particular interests.[30] To 'arrange things in such a way that, through a certain number of means, such and such ends may be achieved'. Law as a classical 'technology' of power.[31] Politics in the raw.

At this point we might return to Agamben, broadly accepting Foucault's 'genealogy'. First, the confirmation of 'bio-politics' as the grounding idea, and experience, of modernity; the 'growing inclusion of man's natural life in the mechanisms and calculations of power'.[32] Second, the confirmation of the broader sweep; of the dissonance in modernity between 'bare', and what he prefers to term 'good', life.[33] Here, though, Agamben stretches the thesis. So that 'bare life' is not simply reserved for the identifiable 'out-law'. But becomes definitive of politics more generally. A 'regression', as Foucault intimates, from the aspirations of Aristotelian political ethics.[34] A politics that 'knows no value ... other than life' itself.[35] Life lived at its barest, the ultimate Benthamite calculus, concerned not with what is 'right', still less the 'good' or the joyous. Merely with the 'health', the functionality, of the 'body'. The desire to live crushed by the 'sacredness of life', as Walter Benjamin would later put it.[36] In his *Rime of the Ancient Mariner,* Bentham's contemporary, Samuel Taylor Coleridge, termed it 'life-in-death' and represented it in the shape of a plague-ridden 'spectre-bark'.[37]

Here again we are brought back to the relation of knowledge and power, the ability to 'discipline' the political mind. Each society has its own composite 'regime of truth', fashioned by its discursive 'networks', purposed to enhance compliance.[38] And a corresponding, and elided, discursive regime of fear. The consequence of this is plain enough. It might be a fear of a warring neighbour, or some murderous terrorists,

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30 M Foucault, 'Debate with Chomsky' in P Rabinow, *The Foucault Reader* (Pantheon 1984) 6.

31 Foucault (n 26 above) 95. See Hunt and Whickham (n 27 above) 40–42.

32 Agamben (n 16 above) 119–120, approving the sentiment of Foucault in *Sexuality* (n 11 above) 145.

33 Agamben (n 16 above) 7–10.

34 Foucault (n 11 above) 145

35 Agamben (n 16 above) 10.

36 *Zur Kritik der Gewalt*, discussed in *Homo Sacer*, Agamben (n 16 above) 66.

37 In S Coleridge, *Complete Poetical Works* (Oxford University Press 1969), lines 193, 202, at 194–5. For a discussion of Coleridge's implicit critique of Benthamism and his use of the plague metaphor in the *Rime*, see D Lee, 'Yellow fever and the slave trade: Coleridge's *The Rime of the Ancient Mariner*' 65 (1998) English Literary History 675, 686–687; and I Ward, 'A painted ship and a painted ocean: *Gregson v Gilbert* revisited' in C Battisti and S Fiorato (eds), *Law and Humanities: Cultural Perspectives* (DeGruyter 2019) 243–244.

38 Foucault (n 29 above) 121.

or a nasty virus. But there will always be a fear of something, and we have to be afraid, terrified of the 'spectre'.[39] Otherwise there is no need for a state, at all. As Hobbes noted. It is why individuals are prepared to covenant their natural liberties to a 'sovereign', in return for the promise of security and a set of relatively constrained 'civil liberties'.[40] Which might, at any given moment, be suspended or abrogated, and which brings us to the idea of the 'state of exception'.

States of exception

Homo Sacer serves as a groundwork for an essay which Agamben published eight years later, *State of Exception*.[41] The title is intended to resonate with the writings of the controversial Nazi *kronjurist* Carl Schmitt. Schmitt first ventured a nascent theory of the 'exception' in his essay *On Dictatorship* in 1921. But it found fuller expression, the following year, in *Political Theology*. The opening line of which read 'Sovereign is he who decides on the exception.'[42] Schmitt thinks of it as a stress-test. When, in a moment of 'conflict', the relative strength of a sovereign-state is discovered. It does not, therefore, describe a moment of anarchy, a return to the Hobbesian 'state of nature'. Quite the opposite. 'There is no rule that is applicable to chaos.' It is, rather, a 'rule' designed to determine the stress. Which makes it an ultimate constitutional rule; the 'moment' indeed where a constitution 'proves' itself:

> The exception is that which cannot be subsumed; it defies general codification, but it simultaneously reveals a specifically juridical formal element: the decision in absolute purity. The exception appears in its absolute form when it is a question of creating a situation in which juridical rules can be valid.[43]

The power to make the determinative 'decision', to reshape 'juridical regulation' in the critical moment, thus defines sovereignty in 'absolute purity'.[44] An evident, and not coincidental, resonance with Foucault's idea of 'disciplinarity', and the incarceration of the 'out-laws'. Cast outside, but also kept within the 'framework of the juristic'.[45]

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39 See Bourke (n 1 above) 1, 24.

40 Agamben (n 16 above) 104–109. For a comment on this parallel, in the closer context of Foucault's writings on plague, see Wagner (n 18 above) 511.

41 G Agamben, *State of Exception* (Chicago University Press 2005). Originally published in Italy in 2003.

42 C Schmitt, *Political Theology* (MIT Press 1985) 5.

43 Ibid 16.

44 Schmitt quotes Kierkegaard: 'The exceptional will place everything in a much clearer light than the universal itself.' See Ibid 12–14, further discussed in Agamben (n 16 above) 16.

45 Schmitt (n 42 above) 13.

Agamben, interestingly, is reluctant to draw such bright lines. The 'state of exception is neither external nor internal to the juridical order'. For which reason the 'problem of defining it concerns precisely a threshold', where 'inside and outside do not exclude each other but rather blur with each other'.[46] The critical insinuation here being that the 'state of exception' cannot, *contra* Schmitt, be said to be securely embedded within the law. It is, in fact, a state of political 'force', the 'violence' of which is obfuscated.[47] Deliberately. Commonly by means of a sustaining, and suitably terrifying, rhetoric of 'necessity'.[48] How sharply we appreciate that this 'necessity' is a matter of impression will depend on how scared we are by the projected threat to our security. By the perception of '*tumultum*'; which is not just how scared we might be, but how scared government is that we are not as scared as we need to be.[49] The 'battle of discourses'.

There is a temptation to assign Schmitt's thesis, in turn, to history. Consonant with a peculiarly dark moment, to find a shocking realisation in the experience of Nazism.[50] A temptation both enhanced, and undercut, by his broader discussion of alternative theories of dictatorship. We noted before that Schmitt had advanced a preliminary version of his theory of the 'exception' in his earlier *On Dictatorship*. In which he suggested that there were two kinds of dictatorship; the 'commissarial' and the 'sovereign'. The first suspends the ordinary rule of law for the period of an identifiable crisis. The latter has a more permanent form; in effect making rule by executive 'decision' the norm.[51] As we search for resonances with the 'force' of law in 2020, the distinction necessarily intrigues.

Not least because, as Agamben argues, liberal democracies are not immune from dictatorial governance. There is, on the contrary, an 'inner solidarity between democracy and totalitarianism', which 'legitimates' necessary moments of 'violence'.[52] What we might know, more familiarly, as majoritarian tyranny. The tendency of 'democratic' politics to seek refuge, in moments of crisis, in the seeming security of 'absolute' executive governance. With the cultivated support of a

46 Agamben (n 41 above) 23.

47 Ibid 50–1, 53, 62.

48 Agamben (n 41 above) 24–26, 30.

49 Ibid 42–43.

50 For a commentary on Schmitt and Nazism, see J Bendersky, 'The expendable *Kronjurist*: Carl Schmitt and National Socialism 1933–36' (1979) 14 Journal of Contemporary History 309–328; and also G Schwab, 'Schmitt scholarship' (1980) 4 Canadian Journal of Political and Social Theory 149–155.

51 The distinction is discussed by Agamben in *Homo Sacer* (n 16 above) 38, and *State of Exception* (n 41 above) at 33–36. For further commentary, see G Schwab, *The Challenge of the Exception* (Greenwood 1979) 30–37.

52 Agamben (n 16 above) 10.

suitably terrified populace. A thesis which Schmitt advanced in a series of essays prophesying the failure of Weimar Germany; and the ease with which liberal democracy can mutate into 'sovereign' dictatorship. Most notably, perhaps, *The Crisis of Parliamentary Democracy*.[53] In which he argued that the Weimar 'crisis' was endemic, and could only be resolved by a fundamental rewriting of the Constitution.[54]

A good point, perhaps, for us to revisit a rather different moment, and a particular text, which fascinated Schmitt.[55] And fascinates Agamben.[56] The publication of Thomas Hobbes's *Leviathan* in 1650. A specific response to the establishment of the English Republic a year earlier, inaugurated with a spectacular 'act of violence', the execution of King Charles I. And a tacit re-constitution.[57] In autumn 1650, the new Republic imposed a fresh Oath of Engagement, demanding the fidelity of all citizens, in return for which, it would re-secure their civil rights. Hobbes wrote *Leviathan* to give a generation of distressed property-owning royalists the excuse they needed. Hardly the first usurpation in English history, Hobbes reminded his readers. Hardly the first re-constitution either, or the first time a new oath had been designed to supersede a former. The birth of legal positivism, delivered of a very chill pragmatism.

And suggesting another pathology. In which all states are constituted by recurring moments of violence and 'exception'. And another, more famous still, in which all citizens are hauled out of their original 'state of nature', and then contract away their liberties in return for the protection of a sovereign. Taking a longer glance back through the history of political thought, Agamben wonders, along with Foucault, if this was the moment when the philosophy of the 'good life' was

53 See C Schmitt, *The Crisis of Parliamentary Democracy* (MIT Press 1988) 14–17, arguing that the essence of democracy is identity rather than liberty; for which reason there is nothing incompatible between democracy and dictatorship.

54 Schmitt had in mind Article 48 of the Weimar constitution, which reserved the authority to determine a moment of 'exception' to the Reich President. A power which was immediately compromised by the need for parliamentary approval. A fatal weakness, he suggested, common to liberal democracies. Schmitt (n 42 above) 11. For further commentary on Schmitt and Article 48, see Schwab (n 51 above) 37–43.

55 Schmitt (n 42 above) 33. The idea that he might be thought the 'Hobbes of the twentieth century', as George Schwab has supposed, would accordingly have appealed. See Schwab, 'Introduction' to *Political Theology* (n 42 above) at xiv.

56 Agamben (n 16 above) 106–109, discussing the 'state of nature' as a 'state of exception'. A subject which Agamben has treated at greater length in a short essay on revolution entitled *Stasis: Civil War as a Political Paradigm* (Edinburgh University Press 2015), concluding, at 34–35, that the entire philosophy of *Leviathan* is that of disciplining the 'body'.

57 A formal reconstitution would only come in December 1653, with the enactment of the Protectoral Instrument of Government.

abrogated.[58] When the 'sovereign' state took over from God's divinely ordained 'lieutenant' as the guarantor of 'bare life'. Benjamin's thesis again. And Schmitt's. We might note the specific title of *Political Theology*. The 'theory' of the modern state as a secular 'theology', replete with an 'omnipotent' sovereign in place of an 'omnipotent' God.[59] Concerned with our well-being only insofar as it consolidates our obedience.

Something, again, for us to ponder, as we take the rather shorter glance back through the history of 2020. The threat is, of course, different. In 1650 it was fear of God which animated the 'exceptional' moment. What drove Schmitt's Germany towards Nazism was a fear of Jews.[60] For us, in summer 2020, it was fear of a virus; or, more particularly, the possibility that it might overwhelm our public health services. We are about to drop back a century-and-a-half to revisit another resonant moment, another disease and another panicked government. But before we do so, we might note the presence of a familiar visitor to our history. The person who awaits us, indeed, in the first pages of *State of Exception*.

There is no surprise in discovering that Agamben posits the alleged terrorist as the epitomic *homo sacer*, counter-terrorist 'law' as a classic example of 'exceptional' law. The inmates of the concentration camp established at Guantanamo Bay in early 2002 finding themselves in the much the same position as the inmates of Auschwitz and Buchenwald. Where 'bare life reaches its maximum indeterminacy'. The familiarly 'disquieting' presence placed outside the law, and within. It is difficult to imagine a more striking example of what Agamben terms the 'empty centre' of liberal legalism, the 'space of exception', where ideas of 'right' and the rule of law have no meaning.[61]

A metaphor which resonates very obviously with that deployed by Lord Steyn in his caustic denunciation of Guantanamo. A 'black hole', a place of such magnetic power that nothing can escape, and from which no one can be retrieved, an 'utterly indefensible' affront to the

58 Along with Leo Strauss too: see his *The Political Philosophy of Thomas Hobbes: Its Basis and its Genesis* (Chicago University Press 1963) xvi, 108, 129–130, 158–161. For Agamben's surmise (n 16 above), see 106–113.

59 Schmitt (n 42 above) 36.

60 The 'enemy', upon whom Schmitt, with a sad predictability, turned in 1935, coming out in support of the Nuremberg Laws. In his later writings, Schmitt dwelt at length on politics as the 'concrete' engagement of 'friend' and 'enemy'; again deriving inspiration from Hobbes. See C Frye, 'Carl Schmitt's concept of the political' (1966) 28 Journal of Politics 813–830; and also Schwab (n 51 above) 51–5, 134–138.

61 Agamben (n 16 above) 131, and (n 41 above) 3–4.

collected principles of due process, human rights and the rule of law.[62] Rhetoric echoed in courtrooms on both sides of the Atlantic. Justice Stevens, for example. In the case of *Boumediene v Bush*, confirming that the provisions of the US Constitution were precisely 'designed to survive, and remain in force in extraordinary times'.[63] Lord Hoffmann in the case of the 'Belmarsh detainees', suggesting that the 'real threat to the life of the nation' was the pretence that terrorism justified the suspension of basic civil liberties and human rights.[64]

In his seminal discussion of the 'rule of law', Lord Bingham likewise posited counter-terrorist 'law' as a defining example of executive over-reach. The sharpest representation of the 'encroachment by the state into what had been regarded as the private domain of the citizen'.[65] Reaching back into history for a couple of prescient cautions, Bingham alighted on John Selden and Thomas Jefferson. In the former case, speaking to Cicero's supposition that the priority of government must be the 'security' of its citizens. There was 'not any thing in the world more abused than this sentence'. It was Selden who drafted the Petition of Right in 1628, to counter the despotic aspiration of Charles I.[66] And Jefferson who re-drafted it a century-and-a-half later, to shape a nascent American Constitution.[67] He 'who would put security before liberty deserves neither'.[68] Thomas Jefferson was not inclined to live life barely.

LIFE IN BABYLON

Time now for our piece of historical modelling. In summer 1885, a series of articles appeared in the *Pall Mall Gazette* entitled *The Maiden Tribute to Modern Babylo*n. The author was an investigative journalist named William Thomas Stead. The *Maiden Tribute* was about the

62 J Steyn, 'Guantanamo Bay: the legal black hole' (2004) 53 International and Comparative Law Quarterly 1–15.

63 553 US 723 (2008). Quoted in T Bingham, *The Rule of Law* (Penguin 2010) 149.

64 *A v Secretary of State for the Home Department* [2004] UKHL 56, paras 36, 97, 222, 226. For commentary, see A Tomkins, 'Readings of *A v Secretary of State for the Home Department*' (2005) Public Law 259, 263–264; and T Poole, 'Harnessing the power of the past? Lord Hoffmann and the *Belmarsh Detainees Case*' (2005) 32 Journal of Law and Society 534–561.

65 Bingham (n 63 above) 157.

66 Selden was one of a number tasked by the House of Commons with drawing up a petition of 'grievances'. Foremost of which was the attempt to raise 'ship money' tax by prerogative, an emergency justified by the fact that there were a lot of 'pirates' about. As was usually the case.

67 For a discussion of Jefferson's influence on the drafting of the American Constitution, see L Kaplan, 'Jefferson and the Constitution: the view from Paris 1786–89' (1987) 11 Diplomatic History 321–335.

68 Bingham (n 63 above) 136.

'horrible realities' of child prostitution in the capital. Various accounts, including one in which Stead was able to 'purchase' a thirteen-year-old girl for just £5. A publishing sensation; ratcheted by Stead's assurance that his next scoop would be about 'Princes of the Blood'. Two days after the appearance of the first of Stead's articles, it was reported that 250,000 were gathered in Hyde Park demanding that the government do something. Josephine Butler sensed 'revolution'.[69] The Home Secretary wrote to Stead begging him to stop. W H Smith, presently Secretary of State for War, pulled the *Gazette* from his news-stands. Too little, far too late.[70]

Dr Acton's suspicions

There was nothing unusual in what Stead had done. Identify a 'scare' and work it; the gist of tabloid journalism.[71] And Victorian England was rarely without a workable 'scare'. Rarely without a rampant disease either; typhoid, tuberculosis, cholera, scarlet fever, whooping cough. Fortunately, it had lots of doctors and scientists. Some were brilliant. John Snow, who traced the cause of the 1854 cholera outbreak in London. William Budd who developed the theory of 'contagious' disease. Joseph Bazalgette, an engineer by training, who built the sewer network that would dramatically reduce the spread of cholera. Their brilliance has endured. That of others has not. Take, for example, William Acton. In his particular moment perhaps the most famous doctor in England, and the most dangerous. William Acton specialised in sexual diseases.[72] In so doing, engaging an area of medicine which fascinated his contemporaries, and sold a lot of books.

Long books, with very long titles. Such as *The Functions and Disorders of the Reproductive Organs in Childhood, Youth, Adult Age, and Advanced Life: Considered in their Physiological, Social, and Moral Relations*, published in 1862. The second last word is

69 Quoted in J Walkowitz, *Prostitution and Victorian Society: Women, Class, and the State* (Cambridge University Press 1980) 246.

70 Doubts as to the veracity of some of Stead's accounts would only later emerge. See S Robinson, *Muckraker: The Scandalous Life and Times of WT Stead* (Robson 2012) chs 6 and 7.

71 See here Bourke (n 1 above) xi, and 326–230, noting the prevalence of child-abuse 'scares' in modern journalism.

72 He had trained as a gynaecologist in Paris. It has been suggested that much of Acton's writing on prostitution and sexually transmitted diseases was derivative, taken from Duchatelet's *De la prostitution dans la ville de Paris*, published in 1836. For an overview of Acton's career, and reputation, see I Crozier, 'William Acton and the history of sexuality' (2000) 5 Journal of Victorian Culture 1–27. For a broader commentary on the coincidence of science and sexuality 'scares' in Victorian England, see E Rosenman, *Unauthorized Pleasures: Accounts of Victorian Erotic Experience* (Cornell University Press 2003) 28–32.

worth noting. In the main a treatise about masturbation; Acton's more particular fascination. But not his only one. Another, first published five years earlier, was *Prostitution Considered in its Moral, Social, and Sanitary Aspect, in London and Other Large Cities and Garrison Towns, with Proposals for the Control and Prevention of Attendant Evils*. We might spot the same word here, the fifth. A few other words too; garrison, control and evils. We will return to these shortly. In sum, William Acton viewed prostitution as a peculiarly dangerous form of sexual 'incontinence'. A 'revolting irregularity'.[73] Which needed to be regularised.

Hardly, in the moment, an unusual view. An 'erotic age of anxiety', it has been said; the anxiety being mostly discovered in the behaviour of women.[74] A land of 'falling angels', it was commonly surmised. None of whom fell quite so far as the prostitute or represented quite such a threat to political, and moral, order.[75] The 'darkest, the knottiest, and the saddest' of social problems, according to the social critic William Rathbone Greg.[76] Writing at the close of the century, Havelock Ellis would confirm that it was a 'remarkable fact that prostitutes exhibit the physical and psychic signs associated usually with criminality in more marked degree than even criminal women'.[77] Gladstone famously spent his evenings wandering the streets of London trying to retrieve 'falling' women. As did Dickens, who devoted much of his spare time to running a prostitute refuge in Shepherd's Bush.[78] Dickens assumed a less censorial perspective, even supposing that a prostitute might be reformed, by training her up in an alternative profession, and showing some kindness.

Acton was not so sure. And certainly not inclined to take any risks. Prostitution represented an existential threat to the health, physical and moral, of the nation. And its empire; something to which we will

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73 W Acton, *Prostitution Considered in its Moral, Social, and Sanitary Aspects* (John Churchill 1870) 449. The second edition essentially expands the first, incorporating additional 'observational' material. References are to this edition, unless otherwise stated.

74 See Rosenman (n 72 above) 7.

75 See M Wiener, *Reconstructing the Criminal: Culture, Law and Policy 1830–1914* (Cambridge University Press 1994) 16–17.

76 From his essay 'Prostitution', published in the Westminster Review in 1850. Quoted in I Ward, *Sex, Crime and Literature in Victorian England* (Hart 2014) 121.

77 H Ellis, *The Criminal* (Scribner 1890) 221. Quoted in Wiener (n 75 above) 239.

78 Urania Cottage, funded by his then friend Angela Burdett Coutts, the fabulously wealthy heir to the Coutts banking fortune. They would later fall out spectacularly, when it was discovered that Dickens had been conducting a decade-long affair with a young actress named Ellen Ternan. Coutts switched her philanthropic energies to the British Goat Society and the funding of various overseas bishoprics.

turn shortly. 'What', the doctor wondered, 'is a prostitute?' A question to which he already knew the answer:

> She is a woman who gives for money that which she ought to give only for love; who ministers to passion and lust alone, to the exclusion and extinction of all the higher qualities … She is a woman with half a woman gone, and that half containing all that elevates her nature, leaving her a mere instrument of impurity; degraded and fallen she extracts from the sin of others the means of living, corrupt and dependent on corruption, and therefore interested directly in the increase of immorality.[79]

We might note this word again, albeit in the negative key; immorality. Acton did not see himself as just another scientist, or indeed just another essayist. He was a guardian of the nation's morals, a sage, of the foreboding, and indeed forbidding, kind. A curator too, it has been supposed, of the composite 'mythologies' and misogynies of Victorian England.[80] Which convinced him that the real reason why women turn to prostitution has nothing to do with sex; being rarely 'troubled with sexual feeling of any kind'. And everything to do with venality. The 'natural instinct, the sinful nature' of women, 'idleness, vanity, and love of pleasure'.[81]

An insight gained from another of Dr Acton's interests, in literary criticism. Very evident in the first edition of *Prostitution Considered*.[82] Replete with long passages on the dangers of reading novelists who empathise with these 'instincts'. Such as Dickens, whose depiction of Nancy's death in Oliver Twist had apparently brought a young Queen Victoria to tears. Acton preferred the manlier reflections of Pope and Tennyson. Pope knew a 'harlot' when he saw one, incapable of 'one gen'rous Thought'.[83] Tennyson too:

> She like a new disease, unknown to men,
> Creeps, no precaution used, among the crowd,
> Makes wicked lightenings of her eyes, and saps
> The fealty of our friends, and stirs the pulse
> With devil's leaps, and poisons half the young.[84]

A pointed, and prescient, metaphor.

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79 Acton (n 73 above) 166.

80 M Spongberg, *Feminizing Venereal Disease: The Body of the Prostitute in Nineteenth-century Medical Discourse* (New York University Press 1997) 46.

81 Acton (n 73 above) 165.

82 See Walkowitz (n 69 above) 46.

83 A Pope, *To a Lady*, from *Moral Essays*. Quoted in S Claggett, 'Victorian prose and poetry: science as literature in William Acton's *Prostitution*' (2011) 33 Prose Studies 19, 28.

84 A Tennyson, *Idylls of the King*, 'Guinevere', lines 514–518, quoted in Acton (n 73 above) 166.

Less literature in the second edition of *Prostitution Considered*, less need. By now Acton had seen it all himself, days spent in the company of police officers checking out brothels and chatting with 'local government medical officers'. The 'fervent imagination' replaced by 'hard memory', a 'corroborative evidence' that was overwhelming.[85] And which left the doctor with just one compelling recommendation. Eschewing the possibility that prostitution might be eradicated by persuasion, Acton advised a strategy of surveillance and regulatory intervention.[86] In practical terms, targeted lockdowns, reinforced by criminal law. We might term it 'whack-a-mole'. He termed it 'recognition': 'Any scheme of legislation, having for its object the regulation of prostitution, must have as its starting point the recognition of it as a system.'[87]

Not always easy, especially with prostitutes of the asymptomatic variety; 'clandestine', as Acton termed them.[88] Still out, wandering the streets, when they were supposed to be inside, isolating. Which is why strategies of 'recognition' were so important; testing and tracing. To discover the most morally corrupted, the most sexually deviant and, for reasons of their dissimulation, the most dangerous and the most needing of regulation. The subject of the first volume of Foucault's *History of Sexuality*. The application of 'techniques' originally used in response to plague epidemics now repurposed to regulate sexuality.[89] Discursive as well as structural, for 'power's hold on sex' more generally 'is maintained through language, or rather through the act of discourse that creates, from the very fact that it is articulated, a rule of law'.[90] In its 'purest form', this power finds expression in legislative interventions intended to control sexual activity.[91]

Which is where Acton came in. Not because he was intrinsically brilliant, or indeed the converse. But because, as a 'man of science', he lent validity to the 'official fantasy'.[92] One of the emergent breed of 'doctor-judges' identified by Foucault. Working the illusion that they knew the 'truth', about sex and everything else that seemed to be going wrong. He certainly seemed to know lots about masturbating teenagers, and 'degraded' prostitutes. And numbers. Acton was also an

85 Not that overwhelming in truth. In terms of 'hard' evidence, just the testaments of a couple of police officers and some anecdotal conversation. See Acton (n 73 above) 71.

86 See S Marcus, *The Other Victorians: A Study of Sexuality and Pornography in Mid-nineteenth-century England* (Transaction 2009) 3–4.

87 Acton (n 73 above) vii–iii, 99.

88 Ibid 155–160.

89 Foucault (n 11 above) 3–8, 17.

90 Ibid 83.

91 Ibid 25, 33.

92 See Marcus (n 86 above) 1–2

early-day 'modeller'. Of the revisionist kind. Estimates for the number of prostitutes working in London, or anywhere else in England, at the time, were necessarily hazy. The Society for the Suppression of Vice suggested around 80,000 in the capital. A figure accepted by *The Lancet*. And by Acton. The lower limit, suggested by the Metropolitan Police, was nearer to 8,000. Which might have gained something in reassurance, but lost much in terms of titillation.

Another to prefer the upper limit was Bracebridge Hemyng. The young barrister, and later short-story writer, invited by Henry Mayhew to write an appendix on 'Prostitution' for the second edition of his *London Labour and the London Poor*, published in 1861. Hemyng knew how to paint a lurid picture, of East End streets teeming with child prostitutes, destined to contract a venereal disease within a 'week or two' of being pimped on the streets.[93] A prologue to Stead's *Tribute*. As to numbers, Hemyng went for the 80,000 option. At least. It is 'not improbable that it is below the reality rather than above it'. All his readers needed to know was that the 'magnitude' was truly 'frightful'.[94]

Hemyng was another of the new 'judges of normality', like Acton. For reason of their self-certified expertise, invited to assume a quasi-executive role in the 'discipline' of modern government.[95] Acton likened himself to the 'mysterious medicine man of yet wilder tribes', necessarily 'aloof from the life' of ordinary folk.[96] And thus best positioned to discipline them. Very much like Dr Hans Reiter, editor of a collection of essays entitled *State and Health*, published in 1942. Another expert in sexually transmitted diseases, chief medical officer for Mecklenberg-Schwerin, who spent most of the Second World War torturing inmates at Buchenwald concentration camp.[97] Reiter was quite sure that the greater responsibility of medicine was to serve the state, for the 'greater health of the people'. The epitome of the bio-politician it might be said. It is by Agamben. His workplace the 'fundamental biopolitical paradigm'.[98] The place where, to borrow again from Foucault, the 'strangers' are determined, and then

93 B Hemyng, 'Prostitution in London' in H Mayhew, *London Labour and the London Poor* (Penguin 1985) 475.

94 Ibid 476.

95 Foucault *Sexuality* (n 11 above) 57, and *Discipline* (n 15 above) 304. For commentary here, see Hunt and Whickham (n 27 above) 11–12, 50–1.

96 Quoted in Walkowitz (n 69 above) 85.

97 Captured by the Red Army, Reiter was tried at Nuremberg, where he confessed to various 'experiments' conducted in the camp. Interned briefly, and then released, his prospective value as an expert in germ-warfare outweighed other considerations. For a series of essays on Reiter's career and his subsequent trial, see volume 32(4) of Seminars in Arthritis and Rheumatism.

98 Agamben (n 16 above) 144–146, 182.

detached.[99] *Homo Sacer* closes here, in the concentration camp, life reduced to its very 'barest'.

Hans Reiter exists at the grimmer end of his professional spectrum. A little further along than William Acton; though not, perhaps, that much further.[100] Acton, like Reiter, was a man of the moment, who seized it. Taking advantage of a present sense of crisis to promote himself, and his prejudices. Shamelessly and dangerously, with tragic consequences.[101] We might conclude of doctors more generally, as Thomas Carlyle did of politicians. Some are indeed brilliant; others just seem, in the fleeting second, to be so. History writes them as charlatans. Carlyle had Disraeli in mind, the 'Hebrew conjuror'.[102] It is for each generation, in whatever passes for a democracy, to make its choice. And then, when it really comes to the crunch, amidst a pandemic perhaps, hope that it has chosen someone capable, rather than a clown. Or a shameless self-promoter, or a vicious sadist. We have, though, arrived at a dark place. Time for some fresh air. A trip to the seaside perhaps.

Sex and the navy

Not that fresh in truth. Or that light. The back lanes of Portsmouth docks. A risky place to be, the chances of a mugging ever-present, the still greater chances of picking up a nasty rash. There were laws in place to deal with both risks; none of which were much use. We will leave the muggings aside, and concentrate on the rashes. Which returns us to the 'evils' of prostitution. Such as it was, the common law of 'prostitution' limited itself to the crime of importuning for purposes, which might result in a fine of up to £2. Which hardly any prostitute could pay, and hardly any magistrate bothered to enforce. A negligence that attracted increasing condemnation as a particular concern started to grow in regard to the possible consequence of all the rashes.[103]

Which was to threaten the very foundations of empire. Venereal disease, gonorrhoea, syphilis; everyday hazards for anyone who consorted with prostitutes, as any of Acton's devoted readers would

99 Foucault (n 17 above) 206.

100 A man whose 'slipshod' research, along with his blind prejudice and overweening self-confidence, inflicted misery on thousands of women. See Spongberg (n 80 above) 50.

101 See Marcus (n 86 above) 2–8.

102 In his essay *Shooting Niagara and After?*, a bitter condemnation of the 1867 Reform Act. Quoted, and discussed, in S Heffer, *Moral Desperado: A Life of Thomas Carlyle* (Weidenfeld & Nicolson 1995) 358–60.

103 Harriet Martineau, for example, ascribing the seeming rise of prostitution to the 'negligence' of the police and magistracy. In her essay 'The Contagious Diseases Act as applied to garrison towns and naval stations', quoted in Ward (n 76 above) 125.

have known. But there was a particular 'at risk' category who needed extra protection. We might term it 'shielding'. Sailors. Of which, if it was to maintain its empire, the Royal Navy needed lots. Preferably healthy, not riddled with sexually transmitted diseases. Numbers, as ever, were hazy. But the evidence of assorted local magistrates, and harassed naval officers, was enough.[104] Certainly for William Acton. Who, fortunately, had a solution:

> Diseased prostitutes can no longer be permitted to infest the streets and spread contagion and death at their good pleasure. They cannot be kept off the streets except by being placed in confinement, and curing their diseases seems to be the necessary accompaniment of restraining their liberty.[105]

Against those who would prefer a more nuanced, even sensitive, strategy, Acton had this to say: 'A little tinkering here and there, may here and there produce some good.' It will not stop an epidemic. That will require 'regular machinery, carrying out some well-considered, universally accepted and definite scheme'.[106] A lockdown. No time for dithering either, still less sympathy. *Prostitution Considered* closed with another literary allusion. To the labours of Hercules; 'let loose upon the filthy stalls the cleansing waters'.[107] Or, more prosaically, some cleansing legislation.

Suitably alarmed, Parliament passed a first Contagious Diseases Act in 1864. To be followed by two more, in 1866 and 1869. The provisions of the 1864 Act permitted police, in 11 naval ports, to seize suspected prostitutes, so that they might be examined for evidence of a sexually transmittable disease. And then, if need be, and it usually was, to place them in 'lock-hospitals' for up to three months. Acton suggested longer, and wider. But it was a start. In 1866 the provisions were extended to a number of northern cities, where prostitution was anyway considered thoroughly undesirable. Along with all the drinking and the partying. The temperance movement was very supportive.

As was a Parliamentary Commission, established in 1868, to consider the efficacy of the existing measures. Not everyone was sure. The Chief Medical Officer, Sir John Simon, advised against radical 'extension', not least because they did not seem to be making much difference. Not though Dr Acton, whose opinions would be quoted more extensively than any other 'expert witness' in the resulting report; and far more than that of the Chief Medical Officer. Do nothing, Acton intimated, and the consequence would be apocalyptic. Lots of vicars agreed. A

104 See Walkowitz (n 69 above) 48–49, on the largely anecdotal evidence.

105 Acton (n 73 above) 240.

106 Ibid 267.

107 The allusion being to the cleansing of the Augean stables. Acton (n 73 above) 302.

third consolidating Act was duly passed in early 1869, widening the reach of provisions across the country to 18 'subject districts'.[108] We might term it 'tier-ing'.

The 1869 Act also extended the period during which a woman discovered to be infected might be interned, to nine months, and recommended an improvement in the quality of moral and religious instruction offered in the lock-hospitals. A holistic approach which earned Greg's strident approval. Not, he confirmed, the moment to listen to cavillers moaning on about civil liberties. The 'same rule of natural law which justifies the officer in shooting a plague-stricken sufferer who breaks through a *cordon sanitaire* justifies him in arresting and confining a syphilitic prostitute who, if not arrested, would spread infection all around her'.[109]

Some did though cavil. Florence Nightingale famously. Dissenting congregations too, Methodists, Quakers and Unitarians amongst the loudest. But most vociferous were early-day women's movements. The Ladies National Association produced a series of pamphlets replete with lurid accounts of forced vaginal examinations. Testaments to 'instrumental rape'.[110] Scattered insinuations too, including the idea that the greater cause of venereal disease in the Royal Navy was rampant homosexuality. And the very simple fact, already intimated by the Chief Medical Officer, that lockdown seemed to be making little difference anyway. The prostitutes still needed the money. The sailors still wanted the sex.

Acton dug in. Speaking to the Medical Officers of Health in 1869, he reiterated his belief that those women being swept off the streets 'we might almost call unsexed', very nearly un-human. The critical moment, noted by Foucault, the prelude to detachment and 'confinement'. When someone is adjudged to be a 'stranger', and reduced to the barest life.[111] As to the risk that the wrong women might be somehow caught up in the net; a 'remote possibility', trumpeted up by a 'shrieking sisterhood'.[112] A perception written into the second edition of *Prostitution Considered* which appeared the following year. The intimations of 'hard memory', all the evenings spent traipsing the streets of London with local constables, peering into the 'haunts of

108 For the extent of Acton's influence in the passage of all the Acts, the 1869 one in particular, see Walkowitz (n 69 above), suggesting, at 80, that Acton was the 'principal propagandist' for legislative intervention; and Claggett (n 83 above) 19–20.

109 Quoted in Walkowitz (n 69 above) 44–45.

110 See ibid 201–204.

111 See Foucault (n 17 above) 206.

112 Quoted in Walkowitz (n 69 above) 87.

prostitutes' and challenging 'painted' ladies.[113] Never had the stables been filthier, the need for the Contagious Diseases Acts greater. There would be no repeal, at least not for a while.

Another Commission, set up in 1871, did concede the case for ending compulsory vaginal inspections. But it would be another decade before anyone acted on it. The Acts would be eventually suspended in 1883. And then repealed, three years later. Attention had anyway drifted.[114] Courtesy of William Thomas Stead. The disease had not vanished, of course. Nor the prostitutes. But the empire was still intact, even if its sailors were not always. And Parliament had reconciled itself to what had been apparent to many for a long time. Speaking in Parliament, during the debates which led to the establishment of the 1871 Commission, the radical MP Jacob Bright had presented some alternative medical opinion. Most notably that of the Inspector-General of Army Hospitals, Frederic Skey. The 'public mind is alarmed, it has been coloured too highly'. William Acton, Bright concluded, was 'probably the most illogical man who ever put pen to paper'.[115]

Three years later came another report, entitled *An Exposure of the False Statistics of the Contagious Diseases Act*, written by an association of reformatory and refuge managers. It supposed that the 'regulationists' had systematically doctored the figures; pretending that the lockdown was doing far more good than was really the case.[116] Lies, damned lies, and statistics. A quote commonly associated with Mark Twain, who attributed it, in turn, to Disraeli.[117] The provenance might be uncertain, but the prescience is not.[118]

CONCLUSION: HISTORY REPEATING

'Those who cannot remember the past are condemned to repeat it.'[119] So, famously, said the philosopher, George Santayana. The moral might seem simple enough; that history is a resource which can prevent us from making the same mistakes. Except that, as Santayana intimated,

113 Acton (n 73 above) 22–26.

114 We might though note a further consequence of the repeal. Its success emboldened the National Association to enjoin a wider campaign, to end a still longer 'state of exception', that which denied women the vote. See Walkowitz (n 69 above) 1–6, and also 254–255, suggesting that the repeal campaign energised a 'revolt of the women' against 'state intervention'.

115 HL Deb 20 July 1870, cols 574–587.

116 See Walkowitz (n 69 above) 111.

117 M Twain, *Autobiography* (California University Press 2010) 1.228.

118 Hardly the first time, during a public health crisis, that figures might have been over, or indeed under, inflated. Published mortality bills during the 'great' plague of 1665 were almost certainly so. See here Moote and Moote (n 7 above) 81, 121.

119 G Santayana, *The Life of Reason: Reason in Common Sense* (Scribner 1905) 284.

what history really reveals is our propensity to keep repeating them. So what might we recollect from our brief journey back into the 'bare life' of mid-Victorian England?

We have already premised a couple of conclusions. First, be wary of those who would claim that a particular, and current, crisis is unprecedented. The fact-situation might be different, and the crisis genuine. But it is unlikely to be unprecedented. And the more urgently we are told that something is, and thus warrants the most dramatic of regulatory interventions, the more sceptical we should be. The more ready to interrogate what Agamben terms the 'empty centre' of the narrative.[120] Where, under the guise of the 'exceptional' moment, we will find, invariably, the 'force of law'. And hear, just as invariably, the rhetoric of 'violence', all the statistics, the blood-curdling imagery. The 'imaginary landscape' of 'fear'.[121] A related observation, vivid in our brief history of the contagious diseases scare, is to know your sage. The ghost of William Acton stalks every ministerial briefing.

Our second ready conclusion is a variant. Plagues are predictable, and so is the way that government will respond. This is not the place to debate the 'legality' of COVID-law.[122] It is, rather, to recognise the underlying pathology. Government in 2020 reacted in precisely the same way as government reacted in 1864. And, for that matter, during the 'great' plague which Dryden dodged.[123] It deployed a narrative of unprecedented crisis, declared a 'state of exception', and issued a series of executive orders, authorised, however vaguely, by statute, for the purpose of locking people down, or up. The fact that these powers were, on rare occasion, nodded through a cowed Parliament should not fool us. For the duration of the pandemic, as Lord Sumption has recently argued, the UK Government assumed 'coercive powers over its citizens on a scale never previously attempted', and did so, not only with a 'cavalier disregard' for the rule of law, but with 'minimal parliamentary involvement'.[124]

Sumption has been a consistent critic of 'COVID-law' and policy. A 'monument of collective hysteria and government folly'.[125] Further evidence that government, when placed under pressure, instinctively presumes to rule in disregard of the law. Reducing the UK, for much of 2020, to little more than a 'police state'; where elderly dog-walkers

120 Agamben (n 41 above) 86–88.

121 Foucault (n 17 above) 361.

122 For an interesting, if early, overview, see K Ewing, 'Covid-19: government by Decree' (2020) 31 Kings Law Journal 1–24. For a more recent one, see J Sumption, *Law in a Time of Crisis* (Profile 2021) 220–225.

123 Moote and Moote (n 7 above) 53–55, 116–117.

124 Sumption (n 122 above) 225, 228.

125 Ibid 218.

can be berated for having strayed too far from home; where sitting on a park-bench nibbling a hob-nob can result in a fixed-penalty fine; where young women holding a vigil for a murder victim can be violently dispersed by police 'snatch-squads'.[126] Hardly a testament to the health of the nation.

The conclusion is stark and unarguable. When COVID-19 arrived in the UK in spring 2020, Government responded by assuming the powers of a commissarial dictatorship. Whether or not the existential threat to the security of the nation was such as to legitimate the effective suspension of the 'rule of law' is a different question. Another for coming historians to ponder. But the bar, we might think, should be set high. Higher perhaps that the figure of 0.2; the percentage of the population in the UK whose deaths might be attributable, in part at least, to COVID-19.[127] The question of proportion; with which

126 For Sumption's commentary on life in a 'police state', see ibid 228–230. The elderly dog-walkers were discovered in the Peaks, miles from anyone, thanks to a police drone, and then 'shamed' on various media by the local, evidently bored, constabulary. Reports of careless bench-sitters are legion. The vigil in question was held in memory of Sarah Everard, at Clapham Common in March 2021. Shocking images of burly male police officers piling into slightly built young women, quietly stood, were beamed around the world within hours. Rather obviously resonant of similar images of police officers beating-up suffragettes a century ago. History will likely judge the events at Clapham Common similarly. There were so many more examples of variously idiotic and disturbing COVID-policing in the moment, but a special mention, perhaps, for the West Mercia Police, who felt obliged, in the midst of a very bleak mid-winter, to remind any prospective snow-ballers that their intended activity was not amongst those which fell under the hazy rubric of 'reasonable exercise'.

127 Taken as a raw percentage of the population. The sustainability of this figure is bound to remain a matter of contention for some time yet. Not least because we do not, and probably never will, know how many of those whose death certificates recorded a positive COVID-19 test actually died as a consequence of contracting the virus. The excess mortality rate, the most reliable statistic, suggests an overall increase, across the calendar year 2020, of around 7%; a rate that steadily reduced to 1% in the autumn, before rising again towards the end of the year. The consequential supposition, that a significant proportion of COVID 'deaths' were in fact attributable to mortality 'displacement', is argued in C Heneghan et al, 'Interpreting excess mortality in England: week ending 9 October 2020' (Centre for Evidence Based Medicine, 23 October 2020). And also J Aburto et al, 'Estimating the burden of the Covid-19 pandemic on mortality, life expectancy and lifespan inequality in England and Wales: a population-level analysis' (2021) 75(8) Journal of Epidemiology and Community Health, suggesting that a more credible figure for deaths caused as a direct consequence of contracting the virus during 2020 is closer to 63,000, which, if true, lowers the present bar further; from 0.2 to 0.1% of the population. On the difficulty of estimating COVID-19 related deaths, other than using 'excess mortality' figures, see T Beaney et al, 'Excess mortality: the gold standard on measuring the impact of COVID-19 worldwide?' (2020) 113 Journal of the Royal Society of Medicine 329–334.

Foucault closed his *History of Madness*. How, in an age of pretended reason, could 'so slim an eventuality come to hold such a power of revelatory dread'?[128]

And the question which Agamben has asked, repeatedly, in a series of provocative reflections on the particular experience of COVID-19. Suggestive certainly; the summer of 2020 as a moment of 'exception', during which the imperatives of 'bio-politics' swept away the pretences of liberal democracy. Schmitt's dark prophesy, of 'scientific thinking repressing the essentially juristic-ethical'.[129] In a first sense, simply abrogated. The familiar 'tendency', in a crisis, to 'use the state of exception as a normal paradigm of government'.[130] And in a second, overwhelmed. The irresistible 'force' of the 'great fear'. The 'situations of collective panic for which the epidemic provides once again the ideal pretext'. A paradigmatic 'object of anxiety'.[131] Not merely fear in the raw, but mutating cultures of shame and 'esteem' too; face-masks, vaccine 'passports', clapping for carers.[132] But rooted in fear, always. The reason why Parliament passed a series of Contagious Diseases Acts in the 1860s. And the reason why it has approved successive Coronavirus Acts in 2020. The 'force of law' cracking the veneer of legality.

Facilitated, of course, by our subscription to a particular philosophy of life which is 'bare'. Where all that matters is survival, at whatever cost. In a later 'clarification', Agamben wrote:

> The first thing the wave of panic that's paralyzed the country has clearly shown is that our society no longer believes in anything but naked life. It is evident that Italians are prepared to sacrifice practically everything – normal living conditions, social relations, work, even friendships and religious or political beliefs – to avoid the danger of falling ill. The naked life and the fear of losing it, is not something that brings men and women together, but something that blinds and separates them ... And what is a society with no other value than survival?[133]

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128 Foucault (n 17 above) 543.

129 Schmitt (n 42 above) 48.

130 G Agamben, 'The invention of an epidemic' (2020) published in (*Quodlibet,* 26 February 2020). Translated in 'Coronavirus and philosophers' (2020) in European Journal of Psychoanalysis.

131 M Peters and T Besley, 'Education, philosophy and viral politics' in M Peters and T Besley (eds), *Pandemic Education and Viral Politics* (Routledge 2020) 5.

132 In 1665 it was wearing toad-amulets, available at all reputable alchemists. In the 1870s it was the possession of 'certificates of health' stamped by a local magistrate. Prostitutes in possession of such certificates commonly charged extra and styled themselves 'Queen's women'. Something else that is predictable about a public health crisis is the emergence of new market-opportunities.

133 G Agamben, 'Clarifications' (2020) in 'Coronavirus and philosophers' (n 130 above).

As we begin to reflect on the experience of COVID-19, the instinctive reaction will be to blame someone; careless Chinese scientists, panicked government ministers, media fear-mongers, algorithm-obsessives. The likely cast for the coming judicial inquiry; in spirit, if not always in person. But there is a darker intimation in Agamben's 'clarification', which widens the net of complicity. To us.

First, because we refuse to accept the reality that life, lived at liberty, is full of 'uncontrollable risk'.[134] Second, because we are so 'sorely', and so easily, scared.[135] Third, because we are so eager to believe that the risk, and the fear, might be exorcised; in days past by a man of the cloth, these days by a member of the Scientific Advisory Group for Emergencies.[136] But it will never be so, for the reason that Franklin Roosevelt famously articulated. We cleave to fear, not just as a psychological, but as an emotional and cultural experience. There is 'nothing so much to be feared as fear itself'.[137] The 'war' against the virus, like the 'war against terrorism', or the war against syphilitic prostitutes, is simply the latest externalisation of an inner struggle which is definitive of the human condition. As Agamben puts it, 'The enemy isn't somewhere outside, its inside us.'[138]

Unsurprisingly, Agamben's critique has attracted plenty of attention, mostly hostile. Too 'far-fetched'. Too heartless. The complaint of a 'selfish' libertarian.[139] Liberal democracy has its place. But it must, when a crisis looms, step aside; for the greater interest. An argument which depends, of course, on accepting that liberal democracy is not, itself, the greater interest. Something to think about. As Lord Sumption again observes: 'So remarkable a departure from our liberal traditions surely calls for some consideration of its legal and constitutional basis.'[140] It says something that such a view might be

134 As Ulrich Beck termed it in his *Risk Society: Towards a New Modernity* (Sage 1992). Precisely the same conclusion ventured, in the closer COVID-context, by Lord Sumption (n 122 above) 233. We live in an 'age obsessed with escaping from risk'.

135 Bourke (n 1 above) 24, 56.

136 Ibid 369, commenting on the role which science has played in spinning the illusion that we can live without risk.

137 Ibid 184, 368–372.

138 Agamben (n 133 above).

139 See, for example, Sergio Benvenuto, concluding that 'lockdown' measures represent the 'lesser' of 'evils', in 'Welcome to seclusion' (*Antinomie*, 5 March 2020), translated in 'Coronavirus and philosophers' (n 130 above). For more balanced commentaries, see M Peters, 'Philosophy and pandemic in the postdigital era: Foucault, Agamben, Zizek' in Peters and Besley (n 131 above) 72–77; and also G Delanty, 'Six political philosophies in search of a virus: critical perspectives on the coronavirus pandemic' (LSE 'Europe in Question' Discussion Paper 156/2020) 6–8.

140 Sumption (n 122 above) 218–219.

considered somehow aberrant. Then again, as history time and again confirms, fear depresses thought. It is, as Agamben acknowledges, a 'bad counsellor'. Much the same was supposed in the wake of '9/11'. That to think about the causes of terrorism was to somehow sustain it; when precisely the converse is true.[141]

There may, or may not, be a rationale for 'COVID-law'. But there is no rationale for doing as Dryden might have us do. For this, put simply, is 'how freedom dies'.[142] Of course, to think against the grain requires courage. And, commonly, the assistance of time. The colder light of day, in which historians tend to write their histories. We can only surmise what they will say of the 'great plague' of 2020, or the 'great scare' as it may well, in time, be renamed. A 'hard case' undoubtedly, which tested a lot of things to their limit; health services, government, us. They may be kind; though probably not. In the meantime, we can suppose a couple more prospective conclusions. They will surely notice just how easily we were terrorised into embracing a 'state of exception'. And how readily we accepted a philosophy of life that was so 'bare'. Whether they will be much surprised is a different matter.

141 See here T Honderich, *After the Terror* (Edinburgh University Press 2002) 10–11, 59–61; and M Ignatieff, *Lesser Evil: Political Ethics in an Age of Terror* (Edinburgh University Press 2005) 167–168.

142 Sumption (n 122 above) 231.

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The COVID-19 pandemic and the challenge for innovation policy*

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The scramble to develop and deliver a vaccine for COVID-19 has led to calls for the establishment of a prize fund to incentivise scientists and pharmaceutical companies to invest in the endeavour.[1] The thrust of the argument will be familiar to anyone who has followed disputes over the limitations of the patent system in relation to pharmaceutical research: patents only work to create incentives if potential patent owners are able to fix prices at a level that will allow them to recoup the costs of their investment. The inability to charge such prices means that there is relatively little investment in drugs to treat conditions that blight the lives of millions in the global south or in last-line antibiotics that need to be prescribed in the smallest possible number of cases to preserve their efficacy. The market for a COVID-19 vaccine is, of course, vast and includes the world's wealthiest populations, but pharmaceutical companies know that there will be political pressure to keep prices low, with some countries already indicating that they will be willing to issue compulsory licences to force down the costs of any patented COVID-19 vaccine.[2]

We have argued elsewhere that policymakers are right to be experimenting with innovation prizes as a way of incentivising

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1 Daniel Hemel and Lisa Larrimore Ouellette, 'Want a corona virus vaccine, fast? Here's a solution' *Time Magazine* (New York, 4 March 2020); Chris Callaghan, 'Would a Longitude Prize speed production of a Covid-19 vaccine' *Times Higher Education* (28 March 2020); Alexander Tabarrok, 'Grand innovation prizes to address pandemics: a primer'; Tyler Cowan, '$1 million plus in emergent ventures prizes for coronavirus work'.

2 The Chilean Chamber of Deputies passed a unanimous resolution to this effect on 17 March 2020: English translation.

research.[3] Some areas of medical research would seem to be particularly well-suited to this form of policy intervention, although we need more evidence of the impact of prizes like Longitude 2014 (which seeks to incentivise the development of a point-of-care diagnostic test as a means of conserving antibiotics) before we can say this with certainty. We have significant reservations, however, about whether the establishment of an innovation prize is the right policy intervention for dealing with the challenges of getting a COVID-19 vaccine into general use. It has been reported that some 35 companies and academic institutions are working on a vaccine,[4] and a handful of candidates are now entering trials. There is, of course, no guarantee that any of the current efforts will bear fruit, since the development of a new vaccine is difficult and carries a high risk of failure. But it is far from clear that there are research teams currently sitting on the sidelines needing motivation to enter the fray. We need to be cautious of additional regulatory intervention in situations where the empirical evidence suggests that there are already adequate incentives to invest in a creative endeavour, a point that applies at least as strongly to the creation of prizes as it does to the extension of intellectual property rights. Scientists, engineers, research managers and funding bodies will step up when faced with a global health emergency. A handful of researchers may do so because they know that fame and quite possibly fortune will come to those who make the most noteworthy contributions to solving the current crisis. But few participants in the research push are likely to be motivated by dreams of a Nobel Prize or similar. The current crisis has revived our sense of community (panic-buying of toilet rolls notwithstanding), and people of all descriptions are bringing their expertise to bear on solving what problems they can. Engineers volunteering their time to work out how to repurpose industrial air separation units to produce medical grade oxygen or to find ways of printing plastic ventilator valves have done so without any expectation of recognition or reward.[5] Rarely has the construct of *homo economicus* seemed like a less safe guide for regulatory intervention.

None of this is to say that there are not likely to be significant barriers to the roll-out of a global immunisation programme. The winner of the race to produce a vaccine may well seek to patent it and, if so, there are

3 R Burrell and C Kelly, 'Public rewards and innovation policy: lessons from the eighteenth and early nineteenth centuries' (2014) 77 Modern Law Review 858.

4 Laura Spinney, 'When will a coronavirus vaccine be ready?' *The Guardian* (London, 5 April 2020).

5 The latter example is taken from a newspaper article on ingenuity and COVID-19: Oliver Wainwright, '10 Covid-busting designs: spraying drones, fever helmets and anti-virus snoods' *The Guardian* (London, 5 April 2020); the former is drawn from an anecdote relayed to one of the authors by someone who works in the petrochemical industry.

likely to be fierce arguments over pricing. Upscaling manufacture may be difficult, particularly if manufacturers are concerned about liability for producing a vaccine that has been put through an expedited set of approvals. Distributing vaccines is likely to be a significant problem in least developed and war-torn countries, and even in some developed countries anti-vaxer sentiment may delay herd immunity. These are not trivial problems, and some will demand a regulatory response. However, once a vaccine has been developed, manufacturing will be upscaled. Governments are, by their own description, on a war footing. We are in a world where the US government has already demonstrated its willingness to use emergency powers to force a private company to manufacture ventilators. Even if this move was largely a matter of political theatre,[6] it demonstrates that states will do what is necessary to ensure that a vaccine is produced as quickly as possible and in large quantities.[7]

To our minds, therefore, the current crisis does not demand an immediate innovation policy response. The challenge for innovation policy lies not in how it can get us from where we are to where we need to be. Rather, to play on an old joke, the question that needs to be asked is whether we should be starting from our current location. Hopefully, the terms of reference for public enquiries into our preparedness for the current pandemic will encompass missed research opportunities. In the meantime, it is important not to rush to judgement. Nevertheless, the early signs are that promising research opportunities *were* missed. In particular, scientists who had been working on a SARS vaccine have reported their frustration that funding dried up as the risks of SARS receded. If funding had been maintained and a successful SARS vaccine had been developed, we might be much closer to being able to produce a vaccine for COVID-19.[8]

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6 W J Hennigan, 'Inside Trump's coronavirus theatrics on war powers, ventilators and GM' *Time Magazine* (New York, 31 March 2020).

7 Access to specialised machinery and raw materials may well prove to be a problem, and lack of preparedness to upscale vaccine manufacture (which bodies like the World Health Organization have been warning about for years) may well produce delays and prolong the crisis. See Stanley Plotkin et al, 'The complexity and cost of vaccine manufacturing – an overview' (2017) 35(33) Vaccine 4064. The point we are making is simply that once nations like the USA are on a war footing these problems will eventually be overcome.

8 See, for example, the testimony of Professor Peter Hotez, Dean of the National School of Tropical Medicine, Baylor College of Medicine and co-Director of the Texas Children's Hospital Center for Vaccine Development, before the Congressional Committee on Science, Space and Technology, 5 March 2020.

We believe the challenge lies in moving towards a more 'proactive' innovation policy:[9] one that recognises that a patent-centric and market-focused innovation model may result in underinvestment in promising treatment opportunities until a crisis is upon us, at which point – if the crisis is of a sufficient magnitude – the market may in any event be forced to give way to the command and control imperatives of the state.

Prizes could have an important role to play in building a more proactive innovation system, but issues of prize design need to be taken seriously. Innovation ecosystems are invariably complex, and this is particularly true for medical research, where there are a vast array of actors and stakeholders. History can offer insights into how a system of prizes might operate. Attention soon falls on the eighteenth-century Longitude Prize whenever innovation prizes are being discussed: recent calls for the establishment of a COVID-19 vaccination prize have all referenced this historical precursor. However, in the UK at least, grand innovation prizes were unusual in the eighteenth and nineteenth centuries. Much more important was the system of *post hoc* rewards that complemented the still-developing patent system – and ameliorated some of its failures.[10] These were awarded by Parliament in response to petitions from inventors, with no *ex ante* guidance as to the categories of endeavour that might attract parliamentary approval. These rewards were used by the British state to endorse some of the most important discoveries of the period. Of most immediate relevance are the parliamentary payments to Edward Jenner, developer of the smallpox vaccine, who was awarded £10,000 in 1802 and a further £20,000 in 1807. In the parliamentary debates over Jenner's petitions it was accepted by all sides that Jenner 'could expect no reward from the method of patents, which were not applicable in the present case'.[11]

A generalised system of rewards comes with its own limitations, not least that (like the patent system) it does not provide a proactive steer as to the types of innovation that society is seeking to incentivise. It is, in any event, more or less impossible to imagine the re-creation of a generalised reward system given modern controls on the dispersal

9 As to the differences between proactive and reactive innovation policies, see also 'Scientists were close to a coronavirus vaccine years ago. Then the money dried up' *NBC News* (5 March 2020): reporting the comments of Dr Jason Schwartz, Yale School of Public Health.

10 On the existence of this system of rewards running parallel to patent protection see, Burrell and Kelly (n 3).

11 HC Deb 2 June 1802, page 596 per Mr Fuller MP. Jenner was committed to making his invention publicly available as soon as possible. Having tried, and failed, to find a willing patient for a public demonstration of vaccination in London, he self-published a guide to vaccination. See John Baron, *Life of Edward Jenner* (Henry Colburn 1827).

of public funds. The future must therefore lie in prizes, but here it is important to note that the distinction between prizes and rewards is one that needs to be handled with care. The more the subject of 'a prize' is described in broad terms, and the more there is discretion to adjust the size of the prize after the nature of the invention has been revealed, the closer a prize is to a reward. If the use of prizes is to be expanded, we need to be wary of schemes that close off promising lines of enquiry by defining 'success' narrowly. It may be that by defining very specific goals, prize competitions restrict the natural creativity of scientists and discourage exploration of tangential ways of tackling the underlying problem. We also need to be sceptical of the argument that highly prescriptive victory criteria can prevent arguments over whether a prize should be awarded. The original Longitude Prize was governed by a strict set of clearly articulated criteria and yet debate over whether Harrison was treated fairly continues to this day.[12]

The most interesting historical model – which combines the upfront steer provided by prizes with something of the expansive culture of a system of rewards – is the operation of the Board of Longitude in the period after the controversy over Harrison's timepiece had been resolved. Over time the Board's mandate was expanded to allow it to make payments in relation to a broad range of nautical inventions. The Board's very existence sent a signal as to the types of invention that were important, and the Board could give further guidance as to research priorities, but the attempt to prescribe narrow criteria for

12 Dava Sobel in her enormously influential book on the Longitude Prize famously argued that the eventual recipient of the prize, John Harrison, was poorly treated by England's scientific establishment: Dava Sobel, *Longitude: The True Story of a Lone Genius Who Solved the Greatest Scientific Problem of His Time* (Walker and Co 1995). There is, however, a case to be made that the Board of Longitude did not act entirely unreasonably in refusing to grant Harrison the full prize. On this account Harrison was an awkward character whose endeavours were supported for many years by the Board despite his seeming reluctance to disclose the nature of his invention. See Jim Bennett, 'The travels and trials of Mr Harrison's timekeeper' in Marie N Bourguet, Christian Licoppe and H Otto Sibum (eds), *Instruments, Travel and Science: Itineraries of Precision from the Seventeenth to the Twentieth Century* (Routledge 2002); Katy Barrett, 'Explaining themselves: the Barrington Papers, the Board of Longitude, and the fate of John Harrison' (2011) 65 Notes and Records of the Royal Society of London 145.

the award of a prize was largely abandoned.[13] A pandemic prize fund modelled along these lines might have a number of advantages beyond correcting for market failure. The financial and reputational incentives provided by prizes are important, but history shows that prizes and rewards have other functions. In the eighteenth century, the reward system was self-consciously used by Parliament to send a signal that society valued scientific endeavour, that accumulation of wealth was not the only criterion by which to judge an individual's contribution to society, and that there was something noble about 'giving an invention to the world with liberality',[14] as unfashionable as that may now sound. Closely related to these other functions is the possibility that a pandemic prize fund might also echo the Parliamentary processes of the past and further the process of rehabilitating the role of the expert in public life, a process that, thankfully, already seems to be underway.

It is not possible to predict future pandemics. That the Spanish flu pandemic occurred almost exactly a century ago is purely a matter of chance; there is no epidemiological equivalent to Kondratieff long-wave cycles. The next pandemic might hit in two years or two hundred years, and it might take any number of forms. There does, nevertheless, appear to be a consensus around some of the areas where future research will

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13 This is an oversimplification of a complex topic, but the gradual expansion of the Board's remit is clear. See e.g. Peter Johnson, 'The Board of Longitude 1714–1828' (1989) 99 Journal of the British Astronomical Association 63, 68: 'With the award of the main prize to Harrison ... the Board had fulfilled its role under the 1714 Act. However, it was kept in being under a new Act of 1774 which moved the emphasis away from longitude to navigation in general. The scope of the Board became much wider'; Sophie Waring, 'The Board of Longitude and the funding of scientific work: negotiating authority and expertise in the early nineteenth century' (2014) 16 Journal for Maritime Research 55, 58: 'In the nineteenth century, the remit of the Board of Longitude was considerably widened as the Admiralty attempted to extract useful technologies from the scientific community after the decisive, if limited, success of the marine chronometer... [this] ... left the precise nature of scientific expertise that the board should support, and how it was meant to advise the Admiralty, increasingly vague ...'. The flexible role of the Board in granting monetary awards meant that after 1800 the Board and Parliament presented alternative avenues by which inventors might seek recompense and recognition for their efforts. See Burrell and Kelly (n 3 above) 868. The Board had a number of ways of signalling its priorities, including by establishing sub-committees (although the history of these sub-committees is itself complex). We also acknowledge that the 1819 prize for discovering the north–west passage was run on the basis of precise navigational criteria, but this does not detract from the general thrust of the point being made here.

14 HC Deb 15 March 1802, page 203, per Admiral Berkeley: '[Jenner] had, with a generosity, liberality, and modesty, inseparable from true merit, communicated the result of his inquiries to the world. If he had pursued a contrary conduct, he would have realised a princely fortune.'

be crucial if we are to be in a better position to fend off the next crisis.[15] These include finding ways of predicting which animal pathogens are most likely to produce zoonotic diseases, tackling antimicrobial resistance (most immediately so that we can fight secondary bacterial infections during a viral pandemic, but in the longer term to guard against the renewed risk of bacterial pandemics), finding ways of accelerating the testing of vaccines without compromising patient safety, and developing new antivirals so that we have a greater range of therapies to test when confronted with a novel disease. These are some of the areas at which a new, flexible and open-ended pandemic prize fund might be targeted.

The establishment of a pandemic prize fund would, however, ideally form part of a comprehensive review of the benefits and costs of moving to a more proactive innovation policy. Such a review would not be a simple matter: the proactive/reactive distinction is a useful shorthand, but there are proactive elements of the current innovation policy landscape (as reflected in, for example, research council funding priorities). The patent system will remain important and thought needs to be given to how public funding of research, whether it comes in the form of grants or prizes, should bear on the rights of patent owners who have benefited from this funding. Some elements of the innovation policy landscape, such as R&D tax credits may, for better or worse, have an important role in international tax competition, irrespective of their impact on innovation outcomes. Thought also needs to be given to the time horizon in which innovation takes place. In the private sector there is the concern that the UK's model of corporate governance leads to a narrow and short-term focus on maximising share price at the expense of investment in technological advance. In the university sector difficult questions need to be asked about whether the REF-driven 'impact agenda' creates both a similar short-termism and a broader skewing effect (research bureaucrats across the land will soon be reappraising the work of those who not so long ago had been categorised as squandering opportunities to do 'impactful' research by wasting their time on novel corona viruses, disease transmission modelling, the history of pandemics and the optimal design of take-home examinations, to take just some of the more obvious examples).

Difficult questions and choices lie ahead, but if there is a positive to emerge from the current crisis it can only lie in forcing us to confront the need to do things differently. Critics have been arguing for years that the health innovation model is broken, but radical action has been ducked. There are, moreover, other areas where innovation is probably even more important. This is true for climate change mitigation

15 See also Bill Gates, 'Responding to Covid-19 – a once-in-a-century pandemic?' New England Journal of Medicine, 28 February 2020.

technologies, bearing in mind that under some models of the impact of climate change worrying about the deaths of 50–100 million of us in a pandemic will seem quaint. Perhaps the best thing that we can do now is to create an expectation that innovation policy, like many other things, needs to change. There must be no return to the *status quo ante*.

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Procurement and commissioning during COVID-19: reflections and (early) lessons*

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ABSTRACT

This commentary reflects on some common themes that are starting to emerge in the early analysis of the healthcare procurement and commissioning response to the COVID-19 pandemic. Although it largely results from the observation of the situation in the English NHS, the most salient issues are common to procurement in other EU healthcare systems, as well as more broadly across areas of the public sector that have strongly relied on the extremely urgent procurement exception in the aftermath of the first wave of the pandemic. Given the disfunction and abuse of 'unregulated procurement' in the context of COVID-19, the commentary reflects on the longer term need for suitable procurement rules to face impending challenges, such as Brexit and, more importantly, climate change.

Keywords: procurement; commissioning; healthcare; COVID-19; pandemic; extreme urgency; unregulated procurement; probity; integrity; conflicts of interest.

INTRODUCTION

A few months after the start of the COVID-19 pandemic, the impact of the extreme public health emergency on public governance mechanisms is still being acutely felt, both internationally and domestically. The long-term implications of this crisis are yet to take shape,[1] but there are already some indications of potentially significant

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† Professor of Economic Law and Member of the Centre for Health, Law, and Society at the University of Bristol Law School. This commentary results from active discussions in a webinar of the same title held at the University of Bristol Law School on 30 September 2020. I am indebted to the speakers and participants for very thought-provoking exchanges. A previous version of this commentary, including links to the presentations given by the speakers, was published in the University of Bristol Law School Research Blog on 5 October 2020. Comments welcome: a.sanchez-graells@bristol.ac.uk.

1 For high-level reflection, see REFORM, 'Building a resilient state: a collection of essays' (October 2020).

developments at EU level,[2] as well as evidence of the heightened risks for the UK's public health system post-Brexit.[3]

Healthcare procurement and commissioning have been at the very forefront of the initial reaction to the COVID-19 pandemic.[4] As discussed in an earlier contribution to this journal, where unforeseeable and extremely urgent circumstances not attributable to the contracting authority arise, public procurement rules get out of the way to free public buyers up to do all they can to get the required supplies and equipment.[5] The last few months have thus been, to put it simply, the longest period of (largely) unregulated procurement on record – and definitely the largest period since the inception of the EU public procurement rules.

The scattered evidence that continuously appears through the media,[6] as well as the more systematic reports that are starting to emerge,[7] show some evidence of positive adaptations to the immense challenges,[8] but also a clear disfunction of the (deactivated) mechanisms to ensure probity and integrity in procurement, and potential for abuse of extremely urgent 'unregulated procurement'.

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2 For discussion, see S Greer and A de Ruijter, 'EU health law and policy in and after the COVID-19 crisis' (2020) 30(4) European Journal of Public Health 623–624; T Clemens and H Brand, 'Will COVID-19 lead to a major change of the EU public health mandate? A renewed approach to EU's role is needed' (2020) 30(4) European Journal of Public Health 624–625; M Guy, 'Towards a European health union: what role for member states?' (2020) Journal of Risk Regulation, advanced access.

3 See e.g. N Fahy, T Hervey, M Dayan et al, 'Assessing the potential impact on health of the UK's future relationship agreement with the EU: analysis of the negotiating positions' (2020) Health Economics, Policy and Law, advanced access.

4 See e.g. Organisation for Economic Co-operation and Development, 'Stocktaking report on immediate public procurement and infrastructure responses to COVID-19' (updated 24 June 2020).

5 A Sanchez-Graells, 'Procurement in the time of COVID-19' (2020) 71(1) Northern Ireland Legal Quarterly 81–87.

6 For an early overview, see A Sanchez-Graells, '1 Billion problems in using extremely urgent public procurement to evade accountability?' (*howtocrackanut.com*, 17 May 2020).

7 See e.g. House of Commons Public Accounts Committee, 'Whole of government response to COVID-19', Thirteenth Report of Session 2019–2021 (23 July 2020) paras 15–17; or National Audit Office, 'Investigation into how government increased the number of ventilators available to the NHS in response to COVID-19' (30 September 2020). However, the more relevant reports are still work-in-progress. See e.g. National Audit Office, 'Supplying the NHS and adult social care sector with personal protective equipment (PPE)'; and National Audit Office, 'Government procurement during the COVID-19 pandemic'.

8 Confederation of British Industry, 'Public–private partnerships: lessons from COVID-19' (September 2020).

Against this background, on 30 September 2020, the Centre for Health, Law, and Society of the University of Bristol Law School had the honour of hosting an excellent panel of speakers for a webinar on 'Healthcare procurement and commissioning during COVID-19: reflections and (early) lessons'. The speakers provided short presentations on a host of very complementary issues surrounding the reaction of NHS procurement and commissioning to the COVID-19 challenges. The ensuing discussion brought to light a number of general themes that are, by and large, aligned with the worries that others and I had expressed at the outset of the pandemic, and a number of challenges that will shape the readjustment or reregulation of procurement and commissioning in the medium and long term.

The remainder of this commentary initially provides some brief notes on the most salient points made by the speakers in their presentations, which do not aim to be exhaustive. It then goes on to offer my own reflections and views on what lessons can be extracted from the procurement and commissioning reaction to the first wave of COVID-19, which do not necessarily represent those of the panel of speakers.

1 PRESENTATIONS BY THE PANEL[9]

Ms Neli Garbuzanova, Senior Procurement Manager (NHS) and Member of the European Commission Stakeholder Expert Group on Public Procurement, provided an 'Overview of the impact of COVID-19 on NHS procurement and commissioning'. Neli used a cycle-based analytical model of NHS procurement and commissioning,[10] highlighting the need for adjustments to the model in times of crisis but within certain limits. She presented the impact of COVID-19 at different stages of this cycle and stressed the various practical and governance challenges raised by the pandemic, as well as the main adaptations implemented during the first wave. Reflecting on potential governance shortcomings, Neli stressed the difficulties in enforcing rules on conflict of interest, as well as some of the new guidance on payment. She acknowledged the heterogeneous nature of pandemic 'needs', calling for a more targeted approach to commissioning and procurement with the lapse of time and increase of knowledge about the disease. Neli also offered interesting insights into future challenges

9 The speakers' slides are available via the earlier blog post at the University of Bristol Law School Research Blog.

10 See N Garbuzanova, 'A dynamic whole-cycle approach to public procurement: a practitioner's perspective on best-practice methodologies' (2019) 6(2) African Public Procurement Law Journal 88–133. This is coupled with a companion website.

derived from extreme urgency awards, including the need to modify 'rushed' contracts as the specific needs of a (potential) second wave become better understood. She also stressed the necessity for stronger collaboration at all levels, especially in times of crisis, which could build on some NHS national and local best practices.

Mr Rob Knott, Commercial Director, Digital (Guy's and St Thomas' NHS Foundation Trust) and former National Director of NHS Procurement, provided a very practical view of 'Procuring in times of COVID-19. Challenges at the frontline'. Rob provided an insiders' view on the tensions between centralised procurement and local pressures to ensure safety and continuity in frontline delivery of NHS services, as well as broader reflections on the challenges faced by the sudden and extreme change of circumstances that the pandemic brought. He made it clear that (further) digitalisation is very much needed in order to gain a better (almost) real-time view of operational needs and supply chain capacity to address them. He also emphasised how the pandemic stressed ongoing challenges in ensuring a proper functioning of centralised NHS procurement, and a more collaborative and integrated NHS provision. From a broader perspective, he also stressed that there will be an immediate need to pay more attention to issues such as embedding social value[11] and emerging new approaches to procurement to support longer-term economic goals post-COVID.

Dr Pedro Telles, Associate Professor, Law Department, Copenhagen Business School, discussed the 'Scope and limits to the use of the negotiated procedure for extreme urgency grounds', building on the views he had previously published in his personal blog.[12] Pedro stressed that the reaction to the pandemic has evidenced the scope for potential abuse of the direct award of contracts on the basis of the 'extreme urgency' exemption, not only or primarily in healthcare, but across very significant areas of public sector activity. He reflected on the governance problems that arise if contracting authorities take a bullish approach to relying on this exemption from the procurement rules, as the ordinary checks and balances are unable to facilitate timely remedies in case of abuse. He went back to the basics of the EU and UK regulation of extremely urgent procurement and stressed the need for robust justifications of the proportionality and necessity of the 'unregulated' procurement, as well as for the lack of imputability of the circumstances generating the extremely urgent need to the contracting authority. He stressed in particular the need for cumulative analysis of all requirements.

11 See Procurement Policy Note on Taking Account of Social Value in the Award of Central Government Contracts (PPN 06/20, September 2020).

12 TELLES.EU.

Dr Kirsi-Maria Halonen, Adjunct Professor, Faculty of Law, University of Lapland, and Member of the European Commission Stakeholder Expert Group on Public Procurement, presented her reflections on the 'Governance challenges in extremely urgent procurement: do we need new rules?'. She provided further evidence of the scope for abuse of direct awards of contracts (in particular for personal protective equipment (PPE)) exempted on the basis of extremely urgent need. Kirsi pointed at some rather extreme cases emerging from the Nordic experience, which have even required the application of criminal statutes. This triggered her reflection on whether the current approach is adequate, as far as the existence of extreme urgency is largely understood to justify the complete setting aside of all integrity and accountability requirements. Her answer was a resounding 'no', which led her to advocate for a new minimum regulation of extremely urgent procurement that sought to preserve the application of crucial elements of the existing procurement framework, such as the application of mandatory exclusion grounds, a tighter control and neutralisation of potential conflicts of interest and the introduction of additional guarantees, for instance, where there are any advanced payments.

Dr Mary Guy, Lecturer in Law, Lancaster University Law School, and Founder of the Health in Europe – Virtual Discussion Forum, built on her insightful 2019 modelling of the interaction between the NHS and private providers of healthcare in England,[13] to reflect on the 'Changing patterns of patient choice under COVID-19. What longer term implications?'. Mary explained how the immediate reaction to the pandemic significantly disrupted the different channels for the provision of both NHS and private healthcare, in particular as a result of two collective agreements aimed to bring private capacity under the NHS umbrella to both support the management of the crisis and to facilitate continuity in the provision of key services. Mary also reflected on the underpinning exclusion orders, which disapply competition law in the healthcare sector for the purposes of supporting that crisis and continuity-oriented collaboration between the NHS and private healthcare providers. She drew some interesting comparisons with similar approaches in other economic sectors (e.g. food retail

13 M Guy, 'Between "going private" and "NHS privatisation": patient choice, competition reforms and the relationship between the NHS and private healthcare in England' (2019) 39(3) Legal Studies 479–498.

distribution,[14] but also more generally[15]) and reflected on whether the situation in the healthcare sector is different and, as such, will perhaps lead to a longer-lasting differentiated treatment, raising questions about the long-standing relationship between the NHS and private healthcare.

2 SOME REFLECTIONS ON COMMON THEMES

There are a few common themes in the discussions surrounding the procurement and commissioning challenges that the COVID-19 pandemic brought. Some of these are hardly new issues, but the pervasiveness of the pandemic and the extreme economic burden of the procurement associated with it have perhaps brought a new sense of urgency in trying to find solutions (if there are any, or any practicable ones) to the integrity and efficiency challenges that extremely urgent procurement generates.

2.1 The limits of 'extreme urgency'

This is perhaps the obvious starting point. Extreme urgency is a sort of 'get away card' that sets aside procurement rules to free up public buyers to go to the market and get what is needed, when it is needed, (almost) no matter how.[16] There are important questions here, such as whether this is indeed the adequate approach, how long can this exemption apply for, or whether the exemption from 'standard' procurement rules should not imply the possibility of 'unregulated procurement', but rather the triggering of a lighter-touch regime that solely concentrated on key elements of probity and good commercial processes and practice. Ultimately, extremely urgent procurement and commissioning are still procurement and commissioning, in the sense that they have to be conducted through some process and by reference to some commercial practices. Therefore, there is no absence of regulation, but perhaps only informal regulation in that context.[17] The extent to which that should be formalised and constitute a special procurement regime will continue to trigger reflection and controversy.

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14 On which see O Odudu, 'Feeding the nation in times of crisis: The relaxation of competition law in the United Kingdom' (2020) 19(2) Competition Law Journal 68–78.

15 O Odudu, 'UK & COVID-19: an overview of the competition policy and leading cases' (24 September 2020) e-Competitions, Article No 96054.

16 For more details, see Sanchez-Graells (n 6).

17 To avoid opening a can of worms on the concept of regulation, perhaps it is best to make a distinction between (binding) legal rules and other forms of regulation, such as guidance or practice. However, this issue exceeds the scope of this comment.

Equally, there are challenges in establishing the cut-off point at which the exemption can no longer apply because either the needs that are being satisfied through the relevant direct awards are no longer extremely urgent (e.g. in relation to foreseeable but not immediate needs), or because the continued extreme urgency is attributable to a lack of institutional reaction to the situation (e.g. in terms of dedicating additional resources, or prioritising some activities over others).

2.2 Is the healthcare sector (procurement) special?

This is another point of contention, as in particular it seems more difficult to insist on compliance with formal rules for healthcare-related procurement and commissioning when public health goals – i.e. lives – are directly at stake than, for example, in relation to the award of consultancy contracts of dubious direct relevance to the official messaging about social-distancing measures. Rather than the need for a particularly lenient approach in the healthcare context, which can result in the unjustified syphoning-off of large amounts of public resources to the wrong providers or the acquisition of useless kit, it is perhaps better to think about it in terms of justification for the exemption. There is a sense that the excuse of the pandemic has been abused in some corners to simply engage in cronyism, if not worse. So, the issue is not so much whether something concerns a need for the direct provision of healthcare services, but whether there is a sufficiently close link between the intended provision of services and relevant public health goals. It is also worth stressing, as clearly emerged from the discussions in the webinar, that proper procurement has public health value or, seen from the other end, that bad procurement generates negative public health outcomes (e.g. every time supplies need to be discarded due to not being fit for purpose, with the ensuing operational risks and economic waste).

2.3 If not procurement rules, then what?

Another common theme concerns the possibility of keeping a wide procurement exemption as is (or, rather, as wide as it can be) and rely on other regulatory tools instead – such as other public law controls on the expenditure of public funds and, where adequate, criminal law. To my mind, the alternative this seems to present is a false one. Under their 'normal operation', procurement rules do not deactivate the rest of public and criminal law rules, but rather seek to diminish the need to rely on them. What this usually creates is a certain atrophy of those mechanisms, as the proper running of the procurement system tends to minimise the cases needing those types of interventions – and as those mechanisms can be captured by political interests and manipulate the system for purposes other than ensuring the probity

of public expenditure. This is exacerbated by the increasing reliance on the (judicialised) private enforcement of procurement rules, both as a mechanism to provide individual remedies and to uphold public interests, which seems to marginalise public oversight mechanisms to the uglier and uglier field of political football. From this perspective, it seems clear that taking all procurement rules out of the equation in the context of a major crisis can only put excessive pressure on a weakened set of accountability and responsibility mechanisms. This is not to say procurement rules should not be made more flexible in the face of extremely urgent needs, but rather to say that pinning all hopes of a proper and efficient expenditure of public funds on those other mechanisms may be wishful thinking. Once again, it seems that what is needed is more resource, including more resource for public oversight of compliance with the procurement and other rules in normal times, as well as in exceptional times.

2.4 The importance (and purpose) of the digital transformation

Another common theme in the discussions is that digital technologies can make a very important contribution to streamlining access to information and to facilitating an earlier intervention, in particular in supply-chain management and to adjust imbalances related to frontline operational needs. This concerns for example the need to have better and more readily accessible information about existing suppliers and about companies that seek to contract with the public sector for the first time in the context of an emergency – which will ring many a bell for those advocating for the creation of (centralised or interconnected) procurement registers – as well as a more granular and real-time view of stockpiles, goods in transit, and effective use of, for example, consumables. I find the thrust of this discussion very important because the main claim is not that the digital transformation should seek to replace current operational or decision-making mechanisms (although some tasks could clearly be automated), but rather seek to support decision-makers and those at the frontline by giving them relevant, accurate and timely information on which to base their decisions. Similarly, the digital transformation should not seek to enforce rigid (algorithmic) determinations of supplier responsiveness, for instance, but rather empower contracting authorities to better assess their risks and, where appropriate, to take corrective or palliative measures (such as e.g. economic guarantees). All of this leads me to think that the digital transformation is in reality one new wave of information-based transformation and that, put in this light, it presents different opportunities and challenges than if thought of as the 'robofication' or 'AI-fication' of procurement and, for example, healthcare services provision.

2.5 An opportunity to get rid of systemic regulatory anomalies?

Another common theme is that the reaction to the pandemic could serve as a catalyst to correct systemic regulatory anomalies – e.g. the existence of convoluted 'standard' procurement rules that the 'unregulated COVID-19 procurement experience' could show as redundant or ineffective.[18] I am sceptical about the possibility of implementing significant changes, for instance, in the regulation of healthcare procurement, but also more generally. The reasons for this are difficult to articulate concisely, but suffice it to say that the pandemic is not precisely backing up the claim that unregulated procurement is superior to ordinary procurement in all cases and, as repeatedly stressed, the general approach to procurement regulation seeks to prevent bad procurement, rather than enable good procurement. While good procurement needs to be possible within the existing regulatory framework (and I think it is, as long as the flexibility of the system is properly understood and used), it seems clear that unregulated procurement simply generates the very risks that can undermine a proper functioning of the procurement function. Therefore, I think that it would be wrong to class procurement rules (or some/most of them) as an anomaly that gets in the way of commercial approaches by the public sector, in order to advocate for a much 'freer' procurement regime post-COVID. As others have argued,[19] and very much in line with what Kirsi-Maria Halonen advocated in the webinar, the lessons seem to go very much in the opposite direction and to take us back to basics.

3 LOOKING (NOT THAT FAR) INTO THE FUTURE

Beyond the discussions in the context of the pandemic, some of the issues and central themes also relate to some challenges that lurk in the (not-too-distant) future. I am particularly worried about the following two.

18 The same is said of e.g. Brexit, as there is a clear appetite to rid (UK) procurers of the existing controls on their exercise of commercial discretion; see e.g. S Arrowsmith, 'Reimagining public procurement law after Brexit: seven core principles for reform and their practical implementation' Part I.

19 L Folliot Lalliot and C R Yukins, 'COVID-19: lessons learned in public procurement. Time for a new normal?' (2020) 3 Concurrences 46–58.

3.1 Are there many new lessons to be learned? How hard should we try to identify them?

One of the issues that will require a difficult decision is the extent to which the current massive wave of extremely urgent procurement should be subjected to post mortem analysis and to what purpose – especially as effective remedies will be nigh impossible to obtain and political responsibility does not seem to be the currency of the times. This concerns both public/political scrutiny and academic scrutiny. As a point of principle, no stone should be left unturned, on either front. However, this may not be a practical approach, or necessarily the preferable one, in particular concerning public oversight. Having already stretched public accountability institutions bogged down on the (myriad) details of COVID-related procurement and commissioning can detract from their ability to properly function post-COVID. This can be the case in the UK, for example, where the immediate future will bring the not smaller challenges of ensuring adequate governance, oversight and accountability of Brexit-related issues. In that regard, it can well be that a sort of 'amnesty' can be either formally declared or pragmatically adopted, so that regulators and other oversight bodies are not still looking at this crisis when the next one looms. Conversely, there seems to be a clear need for more (much more) academic research into the COVID-related practices and adaptations, both to draw the boundaries of any new 'light-touch regime' for (no longer unregulated) extremely urgent procurement and, perhaps more importantly, to reflect on how to maximise the opportunities brought forward by digitalisation from a governance perspective.

3.2 This is not the final crisis – what procurement rules for an ugly 'new normal'

The other thing that worries me, and much more, is that the pandemic is likely just a taster of the systemic distortions to come in our lifetime (not to mention the lifetime of our children and grandchildren). Given the institutional and social inertia against the adoption of truly radical sustainability-orientated procurement and consumption practices,[20] we can already foresee that dealing with the manifold implications of the climate emergency will at some point (rather soon) become the new (and from then on, permanent) extremely urgent need. At some point, extremely urgent will be the 'new normal' and that brings the question of what rules we need for that. From a dystopian perspective, it seems that unregulated procurement would only add corruption, maladministration and economic waste to the environmental meltdown

20 For a call to action, see e.g. S Schooner and M Speidel, '"Warming Up" to sustainable procurement' (2020) 60(10) Contract Management 32–41.

– perhaps even accelerating the mutually reinforcing decomposition of institutional and physical ecosystems. The only way to try and strike a more positive chord (and try to avoid that ugly future) seems to be to get cracking with seriously rethinking procurement to bring sustainability (both environmental and economic/institutional) at its core, and to also get serious in harnessing the potential for digital technologies to accelerate its uptake.[21] In the end, there are no hopes for a vaccine against climate change.

CONCLUSION

This commentary has offered some reflections on the emerging themes and early lessons that can be learned from the procurement and commissioning response to the COVID-19 pandemic. These point clearly towards the need for more academic work on understanding the specific details of this response, as well as a broader reconsideration of the adequate regulation of extremely urgent procurement. It could well be that not many regulatory reforms are required and that the main improvements to be had depend on the proper harnessing of the potential that digital technologies offer. This area of exploration is particularly crucial in the face of the bigger challenges posed by climate change. It deserves our attention and effort.

21 For some exploratory thoughts, see A Sanchez-Graells, 'Digital technologies, public procurement and sustainability: some exploratory thoughts' (2019) SSRN working paper.

Articles

Commentaries and Notes