Covid-19 Vaccinations and Mandates: Protective or Punitive? A Catholic Ethical Perspective

Staff of the Nathaniel Centre for Bioethics

The statistics for the Covid-19 pandemic (2019 –)

Estimated deaths (as of 20 November 2021):

- **5.45 million** reported deaths – official tally of deaths specific to Covid-19.
  The official tally of deaths from Covid-19 is likely to be an undercount and is treated as the minimum estimation, given that it is unlikely that all global deaths will have been officially recognised, reported and recorded as such. Reported deaths are defined as "the number of deaths officially reported as due to Covid-19."
  (https://covid19.healthdata.org/global?view=cumulative-deaths&tab=trend)
- **8.5 to 17.5 million** estimated total deaths, defined as "the estimated number of deaths attributable to Covid-19, including unreported deaths". (https://covid19.healthdata.org/global?view=cumulative-deaths&tab=trend)

Comparison between Covid-19 and estimated figures for other worldwide outbreaks of disease:

- 1918 to 1920, influenza pandemic ('Spanish flu') – 17 to 100 million people died (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7314216/)
- 1957 to 1958, influenza A virus subtype H2N2 – 1 to 4 million people died (https://www.who.int/influenza/preparedness/pandemic/GIP_PandemicInfluenzaRiskManagementInterimGuidance_Jun2013.pdf?ua=1)
- 1968 to 1970, influenza A virus subtype H3N2 – 1 to 4 million people died (https://www.who.int/influenza/preparedness/pandemic/GIP_PandemicInfluenzaRiskManagementInterimGuidance_Jun2013.pdf?ua=1)
- 1977 to 1979, influenza A virus subtype H1N1 – 700,000 people died (https://link.springer.com/article/10.1007/s00430-009-0118-5)
- 1981 to present, HIV/AIDS - 27.2 to 47.8 million people have died (as of 2020) (https://www.unaids.org/en/resources/fact-sheet)
- 2013 to 2016, Ebola – 11,323 people died (https://apps.who.int/gho/data/view.ebola-sitrep.ebola-summary-latest?lang=en)

Introduction

In recent weeks, New Zealand has moved away from its strategy of 'elimination' of the Covid-19 virus to a new approach which will enable us to live with the highly transmissible delta variant of the virus. This shift, which involves a gradual easing of the lockdown restrictions that we have previously utilised to stop the spread of the disease, relies heavily on achieving high levels of vaccination rates amongst the population to (i) reduce the transmission of the virus and (ii) lessen the severity of its effects for those who will become infected.

As New Zealand epidemiologist Professor Jackson of the University of Auckland recently noted: "Every national and international health authority has always accepted the only possible sustainable way to deal with Covid is through the development of immunity. Since the introduction of safe and effective vaccines, every health authority has recommended **high levels of vaccination as the only safe and acceptable way to achieve high levels of immunity**."[1]

Our country is now moving towards a target of 90% of the eligible population (12 years or over) being fully vaccinated. Even when or if that target is reached, approximately 25% of our population (approximately 1.2 million people) will not have the protection offered by vaccines. The projected risks of deaths and an over-burdened health system if we do not reach this target raise difficult questions about **the extent to which it is justifiable to enforce cooperation – that is, making vaccination either mandatory or compulsory for certain groups or all.**

The purpose of vaccination – protecting individual and community health

The purpose of a vaccine is multifaceted and includes the following:

- prevent us from becoming infected with a disease
- prevent serious illness if we do become infected with a disease
- reduce the mortality rate caused by a disease
- in a pandemic, ease the strain on healthcare workers and healthcare systems by reducing the number of people becoming severely ill from a disease
- in a pandemic, reduce the 'knock on' mortality rate from other illnesses and health conditions due to the overloading of the healthcare system because of the pandemic disease
- prevent symptomatic and asymptomatic transmission of a disease from those who have it to those who do not have it
- provide ongoing immunity for the future
- through high levels of community vaccination, provide a protective shield around people who are unable to be vaccinated

Catholic bioethics: faith and reason

A Catholic bioethical approach is characterised by its emphasis on faith and reason. As Pope St John Paul II has written: "Faith and reason are like two wings on which the human spirit rises to the contemplation of the truth." Pope Benedict made the same point when, speaking to a general audience on Wednesday 16 June 2010, he remarked: "Faith consolidates, integrates and illumines the heritage of truth that human reason acquires. The trust with which St Thomas endows these two instruments of knowledge, faith and reason may be traced back to the conviction that both stem from the one source of all truth, the divine *Logos*."

A Catholic ethical perspective thus draws on its own faith tradition as well as the contribution of science and research.

Reframing the discussion about vaccine mandates

The introduction of mandatory vaccinations for workers on the frontline of Covid-19 MIQ management in New Zealand occurred relatively early on to mitigate the risks for them as individuals, for their families and for their communities. However, vaccine mandates are not a new concept. Those working with persons who are addicted to alcohol or drugs, for example, have long been required to be vaccinated against hepatitis B. In addition, we have long accepted the need to be vaccinated to travel to certain parts of the world.

New Zealanders have, over the past 20 months, accepted severe restrictions to their personal liberties for the sake of protecting each other from the Covid-19 pandemic – for the sake of the common good and in order to protect the most vulnerable. Because those who are double vaccinated against Covid-19 now present a much-reduced risk of transmitting the virus, there is no longer an argument for maintaining the highest level of restrictions for this group. Indeed, it is arguably unjust to continue to apply the same lockdown restrictions across both groups of people – vaccinated and unvaccinated. Conversely, the principle for the preferential option for the poor means that we can continue to justify implementing restrictions to the liberties of those not vaccinated and who are at the greatest risk of spreading the Covid-19 virus.

In which case, and only because of the significant public health risks that still exist, a government policy of 'returning' previously proscribed liberties to the vaccinated is wrongly described as a 'reward' for that group. Equally, the maintenance of restrictions for the unvaccinated is wrongly described as a form of 'punishment' for those who are unvaccinated. Philosophically and ethically speaking, this is a justifiable expression of treating unequals unequally – a justifiable case of 'discrimination' (see above).

As a society, we should never uncritically accept the imposition of such restrictions by our political leaders. However, having regard to the current situation, we bishops believe that, on balance, the introduction of vaccine mandates for certain sectors, as well as the use of vaccine passes, are warranted for now.

At the same time, Andrew Hamilton (SJ), while supportive of the move to make full vaccination a condition for greater social participation, and while describing it as "an expression of decency and fraternity undertaken out of responsibility for others", notes that vaccination passes are worryingly promoted by some as "certificates of merit that divide the worthy from the worthless" rather than an act of benevolence to people who are vulnerable: "The risk inherent in such promotion is that it will create a further gap between the well off and the poor, between those to whom society has been kind and the alienated, between the able in mind and body and those with disabilities, between those in their own homes or in institutions, and between those in majority and those in minority groups."[2]

Commenting on the imposition of vaccine mandates, the traffic light system and the introduction of the "My Vaccine Pass", the Catholic Bishops of Aotearoa recently noted in their pastoral letter:

> As a society, we should never uncritically accept the imposition of such restrictions by our political leaders. However, having regard to the current situation, we bishops believe that, on balance, the introduction of vaccine mandates for certain sectors, as well as the use of vaccine passes, are warranted for now. At the same time, remaining always mindful of state overreach, and anticipating that restrictions we may consider to be warranted now may not be warranted in the future, we urge that the mandates and requirements for vaccine passes be continually reviewed. In other words, our support of these measures is contingent on, and only justified by, the emergency situation as it exists at this point in time.[3]

Reason: The research and statistics supporting Covid-19 vaccines

1. A French study (10 October 2021) of over 22 million people compared 11.3 million vaccinated over-50's with the same number of unvaccinated from the same age group between 27 December and 20 July 2021 and found "a reduction in the risk of hospitalisation superior to 90%" from the 14th day after the second dose and a similar reduction in the number of deaths from Covid-19. (https://www.theguardian.com/world/2021/oct/11/french-study-vaccines-cut-covid-deaths)
2. A Centers for Disease Control and Prevention article (published September 17, 2021) records the death rate of unvaccinated people as being 16.6 times higher than that of the vaccinated. (https://www.cdc.gov/mmwr/volumes/70/wr/mm7037e1.htm?s_cid=mm7037e1_w)
3. Epidemiologist Professor Rod Jackson (University of Auckland) writes in an article published on October 4: "Vaccinated people are about 75 percent less likely than unvaccinated people to develop a Covid-19 infection if exposed, and over 90 percent less likely to develop severe disease. (https://www.rnz.co.nz/news/on-the-inside/452878/nz-needs-a-more-urgent-vaccination-plan-with-nearly-80-percent-now-single-dosed-the-majority-will-support-it)
4. In the current Auckland-Hamilton outbreak, of a total of 6532 cases, the fully vaccinated make up only 693 or 10.6%. More importantly, the fully vaccinated total only 18 people out of 365 or 4.9% of hospitalised cases, meaning that vaccinations are currently providing a more than 95% protection from the most serious health consequences. (https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-data-and-statistics/covid-19-case-demographics – accessed 19 November 2021)
5. Vaccine effectiveness against Covid-19 hospitalisations can drop over time. A recent Centers for Disease Control and Prevention study on the comparative effectiveness of various vaccines in preventing hospitalisations reported that, after 120 days, protection remains at 92% for the Moderna mRNA double dose, while the Pfizer mRNA double dose had declined but still offered 77% protection compared with unvaccinated people. Awareness of these differences is being used to guide policy recommendations regarding the need for booster shots. (https://www.cdc.gov/mmwr/volumes/70/wr/mm7038e1.htm?s_cid=mm7038e1_w)
6. A recent study based in Israel has found that people who received a third dose of the Pfizer–BioNTech vaccine were almost 20 times less likely to get seriously ill from Covid-19, and 10 times less likely to be infected, than were people who had received their second and last dose at least 5 months before. (https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)02249-2/fulltext)
7. Much of the fourth wave of surging infections overseas is being driven by transmission in children. In addition, the fourth wave also "follows the relaxation of Covid restrictions like masks, density limits, testing and tracing as well as a failure to address safe indoor air." C. Raina MacIntye, Professor of Global Biosecurity. "Will Australia follow Europe into a fourth Covid wave? Boosters, vaccinating kids, ventilation and masks may help us avoid it." *The Conversation*, 23 November 2021

Faith: The principles of Catholic Social Teaching informing a Catholic response

Catholic social teaching applies Gospel values such as love, peace, justice, compassion, reconciliation, service and community to modern social problems. The issues relating to vaccines directly engage at least four of the principles of Catholic Social Teachings:

- **the common good** – working to establish the conditions which allow people, as groups and individuals, to flourish in truth and justice
- **preferential option for the poor** – prioritising those who are most vulnerable
- **solidarity** – recognising others as fellow human beings and creating relationships of interdependence between individuals and peoples that tend towards genuine ethical-social solidarity
- **the dignity of the human person** – including a right to healthcare and freedom and protection from all things which threaten a person's flourishing

In reflecting on the concept of justice, it is worth recalling one of its most fundamental tenets – the idea, attributed to Aristotle, that "equals should be treated equally and unequals unequally". As one commentator notes: "In its contemporary form, this principle is sometimes expressed as follows: 'Individuals should be treated the same, unless they differ in ways that are relevant to the situation in which they are involved'."

In other words, a commitment to justice does not rule out treating people differently according to certain justifiable criteria. **The question to be considered is the extent to which this might apply when considering the rights and liberties of people who are vaccinated against Covid-19 and the rights and liberties of those who are not vaccinated.**

Making vaccinations mandatory for certain roles or activities does not remove people's rights to act according to their conscience although, clearly, the existence of such mandates mean that some individuals pay a significant personal cost for their beliefs – in the short-term if not the long term.

Reframing the discussion about Māori and Pacific communities

Hamilton also notes that "For society to turn its back in scorn or condemnation on people who are vulnerable would be callous." Why? Because the people demonstrated to be most at risk live "in areas with limited government services, reliant on poorly paid and unprotected work ... [and are] more likely to be afraid of vaccination and less trusting of government advice. For these reasons they are also less likely to be double vaccinated."

As Professor Rod Jackson has recently pointed out, "We're going to see pockets – certainly households, but I think communities – where you might be lucky to get 50 per cent vaccinated. I'm really concerned that we're going to see some major outbreaks that are going to overwhelm local and indeed national health services."

Sadly, we are seeing scorn and condemnation of the unvaccinated emerging in certain commentaries about the low vaccination rates. By way of example, some have resorted to racist reporting, branding Māori, and especially rangatahi, "as slow and selfish", responsible for "holding back the rest of the country". However, as Dr Vini Olsen-Reeder (Ngā Pōtiki a Tamapahore, Ngāti Pūkenga, Ngāi Te Rangi, Te Arawa), observes:

> The truth is, we've been held back by a rollout that ignored the basic statistics. Māori are a young population. Our median age is around 26. For Pacific, it's around 24. (This compares to the Pākehā median age of 41, and the national medium of 37.) That means half of us are under those ages. So, when it comes to vaccination, the great bulk of us — more than 90 percent of Māori, including me — sit in Group 4, which was everyone aged 12 and over. [This] means we've only been eligible for vaccination since September 1. [At the time of writing] that's only 53 days ago. The vaccination rollout started in February; Group 3 started back in May. So, of course, Māori are playing catch-up.[4]

Olsen-Reeder also notes that Māori and Pacifica are more vulnerable, with an at least 50 per cent higher risk of dying from Covid than Pākehā.[5] In the latest outbreak, of 2492 cases, 770 people are Māori and 1047 are our Pacific whanaunga.[6] Modelling by research centre Te Pūnaha Matatini has determined that Māori are 2.5 times more likely to be hospitalised with Covid-19 than non-Māori, after controlling for age and pre-existing conditions, while Pacific people are three times more likely to end up in hospital. In addition, and of great concern, is the fact that Māori are more likely to have pre-existing conditions, like diabetes and asthma, that put them at greater risk if they contract Covid-19.

A commitment to the principle of the preferential option of the poor demands that the figure of 90%+ vaccination rates amongst eligible citizens (12 years plus) which is being spoken of as a robust threshold for removing lockdown restrictions for the general population (vaccinated and unvaccinated), needs to be achieved across all ethnicities rather than calculated against the population as a whole. As Professor Rod Jackson has recently pointed out, "We're going to see pockets – certainly households, but I think communities – where you might be lucky to get 50 per cent vaccinated. I'm really concerned that we're going to see some major outbreaks that are going to overwhelm local and indeed national health services."[7]

Vaccines and breakthrough infections

It is possible to be infected with Covid-19 after being vaccinated. When this occurs, it is called a 'breakthrough infection', a well-recognised phenomenon in epidemiology.

The fact that there are rising rates of Covid-19 infection amongst vaccinated persons has now been linked to the waning effectiveness of vaccines to prevent transmission, something that is increasingly being addressed by the introduction of a third 'booster' shot. However, although it is possible to catch Covid-19 after having been vaccinated, research shows that the Pfizer/BioNTech vaccine remains effective in minimising how sick people will become if they do get a breakthrough infection and in preventing death from the virus.[8] As recently reported in the Lancet, "vaccination (compared with no vaccination) was associated with reduced odds of hospitalisation or having more than five symptoms in the first week of illness following the first or second dose,"[9] with persons not fully vaccinated having >10 times higher Covid-19 mortality risk.[10]

In addition to this, "a vaccinated person is less likely to get Covid in the first instance, is less contagious [if they do get Covid], and is contagious for a shorter time, resulting in significantly less spread of the virus through a highly vaccinated community. This, combined with the well-known ability of vaccines to keep people out of hospital and ICU, makes them the most important part of the health response in the near future."[11,12] While some studies are now showing that there are no differences in peak viral loads between vaccinated and unvaccinated individuals, vaccinated people clear the virus faster[13] with lower levels of virus overall. Having less time with very high levels of virus present means vaccinated people have less opportunity to spread the virus overall.

It is also to be expected that, as vaccination rates rise, there will be far fewer non-vaccinated people in the community which means, comparatively speaking, that more of the community cases will be 'breakthrough'. Eventually, if the vaccination numbers rise enough, a point is reached where there will be more cases of vaccinated people with Covid-19 than unvaccinated but, crucially, less severe sickness overall, lower mortality rates and, where there are outbreaks, less strain on the healthcare system and healthcare workers.

Knowing that the vaccinated can still become infected by Covid-19 emphasises the importance of minimising the potential for the virus to spread through all of the means at our disposal – masks, social distancing and testing and isolating whenever we show any symptoms.

Conclusion

In the current context, the vaccine mandates may be regarded as a legitimate imposition for the sake of protecting those most vulnerable and for upholding the common good. A commitment to justice does not rule out treating unequals unequally. In the words of the New Zealand Bishops: "As a society, we should never uncritically accept the imposition of such restrictions by our political leaders. However, having regard to the current situation, we bishops believe that, on balance, the introduction of vaccine mandates for certain sectors, as well as the use of vaccine certificates, are warranted for now."[14]

Despite waning effectiveness against protection from infection, the Pfizer vaccine remains highly effective against severe sickness, hospital admissions and death. Pope Francis has stated that receiving the Covid-19 vaccine is not only morally acceptable but constitutes a moral obligation to protect one's own health and for safeguarding the common good.[15]

Endnotes

1 See https://www.nzherald.co.nz/nz/the-conversation-nz-needs-a-more-urgent-vaccination-plan-with-nearly-80-now-single-dosed-the-majority-will-support-it/JTJTGHW3PX3LK6LFRJRM6SRDVE/
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5 See https://journal.nzma.org.nz/journal-articles/estimated-inequities-in-covid-19-infection-fatality-rates-by-ethnicity-for-aotearoa-new-zealand
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7 See https://www.stuff.co.nz/national/health/coronavirus/300454659/covid-19-target-for-90-vaccination-not-anywhere-near-enough--epidemiologist
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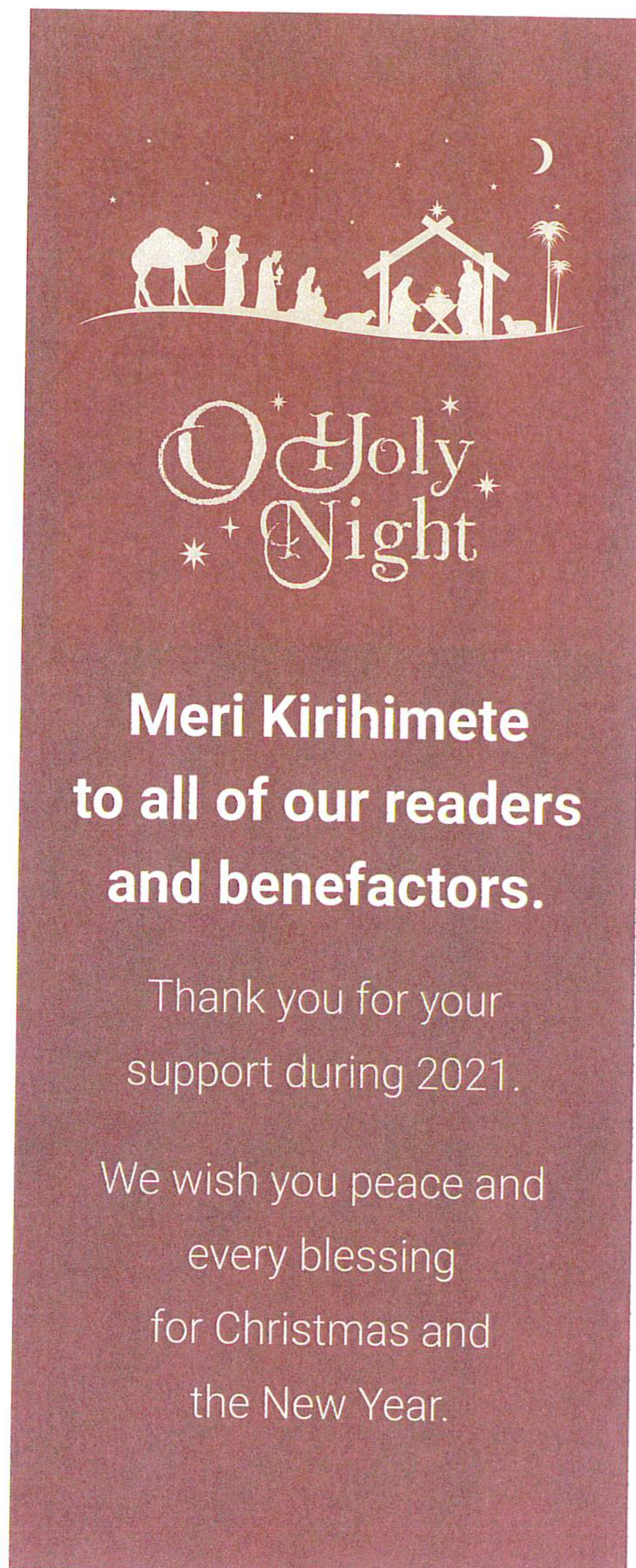
10 See https://www.cdc.gov/mmwr/volumes/70/wr/mm7037e1.htm?s_cid=mm7037e1_w
11 See https://theconversation.com/no-vaccinated-people-are-not-just-as-infectious-as-unvaccinated-people-if-they-get-covid-171302
12 See https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)02183-8/fulltext
13 See https://www.medrxiv.org/content/10.1101/2021.07.28.21261295v1
14 See https://www.catholic.org.nz/assets/Uploads/Bishops-Pastoral-Letter-Covid-19-vaccinations-extended.pdf
15 https://www.ncronline.org/news/vatican/pope-francis-suggests-people-have-moral-obligation-take-coronavirus-vaccine



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1 Congregation for the Doctrine of the Faith (2020). *Letter "Samaritanus Bonus" of the Congregation for the Doctrine of the Faith on the care of persons in the critical and terminal phases of life.*
2 McCabe, M & Kleinsman J. "Ethics for the times of the pandemic alongside the care professionals", *The Nathaniel Report*, Issue 64, August 2021.
3 Timothy Radcliffe, 'Coming Home from Emmaus,' *The Tablet*, 17 April 2021: 12-13.