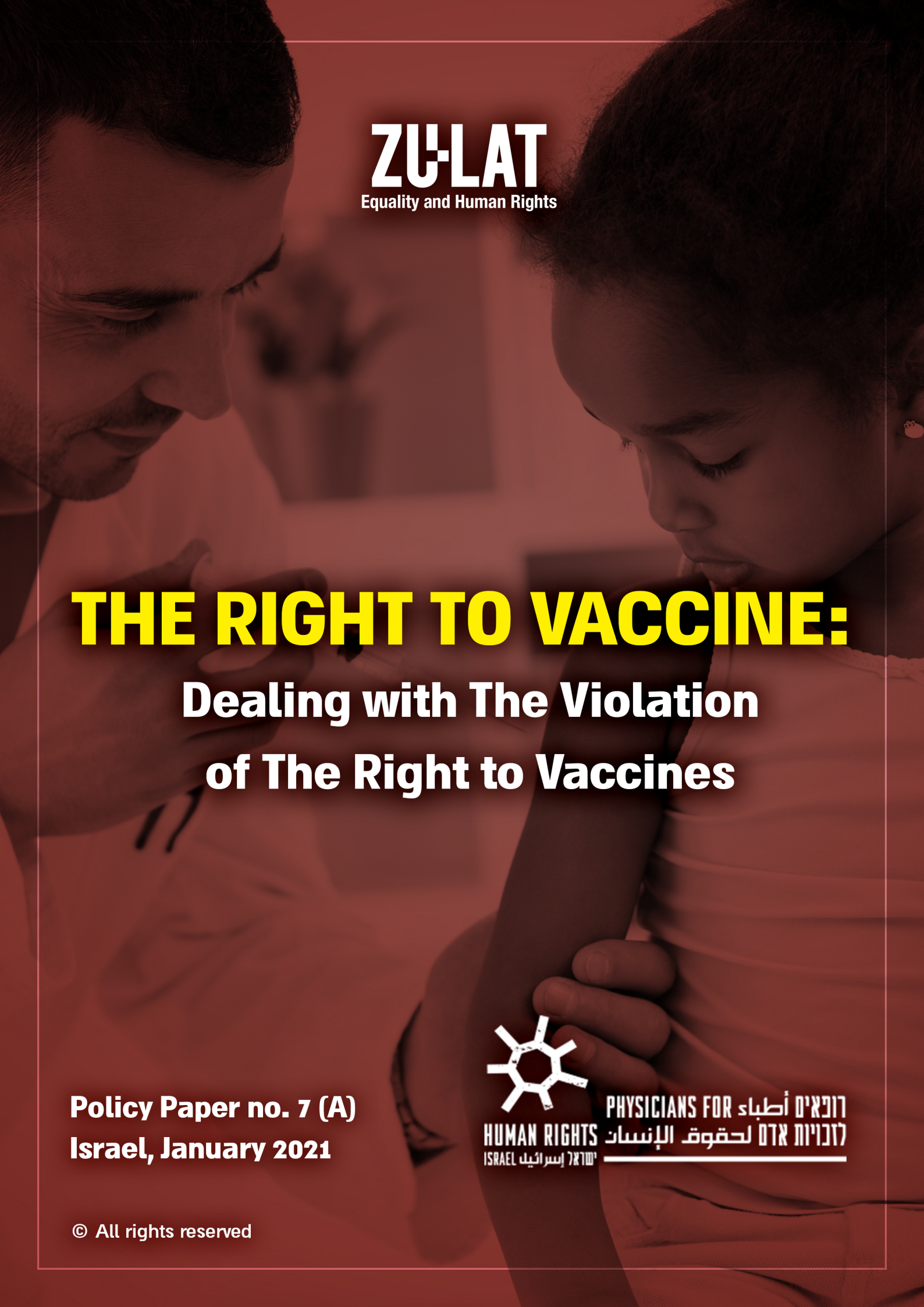

ZU-LAT
Equality and Human Rights

THE RIGHT TO VACCINE:

Dealing with The Violation of The Right to Vaccines

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HUMAN RIGHTS ISRAEL ישראל إسرائيل
PHYSICIANS FOR רופאים أطباء לזכויות אדם لحقوق الإنسان

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SUMMARY

This policy paper by the Zulat Institute, co-authored with Physicians for Human Rights, presents a series of demands to the Israeli Government concerning its corona vaccination policy and offers practical recommendations from the perspective of the human rights affected by this policy.

It addresses the government's actions, as well as their costs and implications, taking into account the constraints of confronting a new pandemic and finding wide-ranging solutions to an array of public policy factors within a short period of time.

The paper will present three main policy recommendations, including:

1. **Financing the vaccination campaign with dedicated funds, so as not to compromise the health system's budget.**
2. **Providing free vaccines to the entire population, including asylum seekers, migrant workers, and the Palestinian population in the occupied territories.**
3. **To the extent that the vaccine is shown to prevent infection, consideration may be given to stopping the employment of medical staff working with at-risk patients who refuse to be vaccinated and transferring them to other positions.**

More recommendations:

- Purchasing vaccines exclusively by the government to prevent people with means from "jumping the line."
- Ensuring an equitable supply of vaccines, without neglecting geographical/social peripheral regions.
- Ensuring accessibility to vaccination by outreaching to at-risk populations, including incapacitated and bed-ridden elderly people living in the community.

- Ensuring transparency in all decision-making processes.
- Ensuring decision-making by experts in diverse fields and representatives of all sectors of the population.
- Availing information to different population sectors (Arabs and others) and recruiting influencers in all communities.
- Portraying vaccination as a social responsibility that will lead to "herd immunity."
- Committing to participate in the efforts to promote fairness and justice on the international level as well.

These recommendations ensue from brainstorming by a team of multidisciplinary experts, who overviewed the development, purchase, and rollout of vaccines to the public; the decision-making processes, including the factors considered in the prioritization of the vaccination campaign; the question of informed consent, public compliance, and "vaccine hesitancy"; the responsibility of the medical staff and the compensation of vaccine victims, should any occur.

The coronavirus pandemic broke out in December 2019, first in China and later spread worldwide. Within a few months, the World Health Organization (WHO) declared it a global pandemic. Dozens of companies, research institutes, and countries began a race to find a vaccine. The vaccines recently approved by the US Food and Drug Administration (FDA) for emergency use in the United States and other countries represent a "game-changing" tool for dealing with the pandemic. However, the development of vaccines by private firms, the purchase of vaccines by countries around the world and their accessibility to the public, the prioritization of the vaccination, and "vaccine hesitancy" are all complex issues that require consideration of human rights aspects discussed in this policy paper.

For a long time, the development of vaccines by private manufacturers based on a competitive model prevented the presentation of transparent information to the public and decision-makers worldwide. Today, following the competitive model, vaccine prices

decided by the manufacturers do not allow all countries to afford these vaccines. The belated supply of vaccines to poor countries is unfair and leads to continued morbidity and mortality in those countries.

Moreover, the purchase and rollout of vaccines, as it is currently proceeding worldwide, does not conform to the universal right to health. Wealthy countries (including Israel) have ensured the supply of vaccines through "advanced-purchase agreements" with pharmaceutical companies, while poor countries have not. Continued morbidity in some countries, which will delay the attainment of "community immunity," raises a moral dilemma and will lead to enormous health damages and financial costs.

In the local level, given that "community immunity" (the term proposed instead of "herd immunity") is a public good that everybody is entitled to enjoy equally, only a centralized purchase of vaccines by the state with public funds will ensure universal accessibility. Transparent prioritization criteria that is based on the principle of equal concern and does not replicate existing patterns of inequality in Israeli society is essential.

In view of the possibility of "vaccine hesitancy" action is necessary to persuade hesitators to get vaccinated. "Vaccine hesitancy" could be reduced by addressing issues that bother the public in a respectful manner and by emphasizing the importance of the vaccine in providing communal and not just personal protection - in other words, as an act of responsibility toward fellow others.

Discussions on vaccination policy should be conducted in a transparent manner, with the participation of experts from different disciplines, and taking into account epidemiological, social, and ethical considerations.

POLICY RECOMMENDATIONS

Respect for human rights regarding the coronavirus vaccination policy requires the following steps, which we propose based on the analysis that will be presented below:

Vaccine Purchase and Rollout:

- Israel should join the WHO's "solidarity call to action."
- The government should be exclusively in charge of the purchase and supply of vaccines to prevent people with means from "jumping the line."
- Free vaccinations should be supplied to the entire population, including asylum seekers and migrant workers without visas.
- As long as the occupation continues, Israel should bear responsibility for providing vaccines to the Palestinian population in the territories.
- The vaccination campaign should be financed with dedicated funds (including the possibility of a special bond issue), without compromising the health system's budget. Moreover, given that the pandemic has brought to the fore the crucial need for a quality public health system on the one hand, and revealed the current slimness of the Israeli system after years of lack of investment on the other, steps should be taken to adjust the system's funding to the needs of the population.
- Vaccines should be provided by hospitals and HMOs in unified clinics.
- An equitable supply of vaccines should not neglect geographical and social peripheries.
- Ensuring high compliance rate requires an active referral from the family physician and "outreach" to at-risk populations.
- HMOs should continue monitoring the vaccine's side effects and share this information with other countries.

- Transparency and information sharing should be ensured with regard to the Israeli vaccine being developed at the Israel Institute for Biological Research (IIBR), which is underwritten by public funds.

Vaccine Prioritization

- Prioritize the population at risk of serious illness and their caregivers.
- Establish a logistical system for at-home vaccination of incapacitated and bed-ridden elderly people living in the community and their caregivers, similar to caregivers at long-term nursing facilities.
- Prioritize disadvantaged population groups due to socio-economic factors, including crowded housing conditions, cultural-linguistic minority groups (ultra-Orthodox, Arabs, Ethiopians), and impoverished populations that are more vulnerable than others to disease.
- Distribute vaccines among HMOs in accordance with the decisions on prioritization (taking into account, for example, the number of HMO members who are "at-risk population").
- Decision-making by an apolitical professional committee, composed of experts in a variety of fields and from diverse sections of the population.
- Conduct transparent discussions and publish their content in different languages in the mainstream and in social media.

Informed Consent and 'Vaccine Hesitancy'

- Fully disclose existing information about the vaccines and give the option to accept or refuse vaccination out of one's free will.

- Replace the term "herd immunity" used in the world of veterinary with the term "community immunity," which aspires to vaccinate a high percentage of the population.

- Actively monitor the issues that bother the public, including on social media, and provide a courteous response.

- Implement the strategies that led to the high compliance with the oral poliovirus vaccine (OPV) in 2013: deployment of Health Ministry representatives in the field; adapting the information campaign to different populations and sectors (for example, migrants who shun vaccination for fear of being deported); recruiting influencers in all communities; boosting the Health Ministry's hot line staff with Russian, Arabic, and Amharic speakers; producing radio broadcasts and pashkevils (street posters) for the ultra-Orthodox public.

- Provide information that avoids stigmatization, generalizations, and paternalism.

- Ensure transparency in all decision-making stages; explain the reasons behind decisions; ensure consistency and public participation; avoid conflicts of interest.

- Information to the public should be delivered by physicians or scientists with no political-party affiliation.

- If and when it is proven that the vaccine prevents transmission of the virus, emphasize the fact that the vaccine broadly protects the public at large and not just individuals. We propose to portray immunization as a manifestation of responsibility and solidarity.

- Counteract the phenomenon of "free riders" (anti-vaxxers who will benefit from the community immunity) by mulling positive incentives for vaccinees.

- When choosing positive incentives for vaccinees, ensure that these equally encourage the entire population to be vaccinated as well.

- If benefits are given to vaccinees, identical benefits should be given to people who cannot get vaccinated due to medical contraindications, as well as to those presenting positive serological tests or negative Covid-19 tests.

Medical Staff

- Provide comprehensive information to the medical staff and conduct persuasion efforts (dedicated conferences and individual contact with anti-vaxxers).

- If it is proven that the vaccine prevents transmission of the virus, consider stopping the employment of medical staff working with at-risk patients who refuse to be vaccinated and transferring them to other positions.

- Medical staff members opposed to the vaccine should note that their position differs from that accepted by the scientific community.

Compensation for Vaccine Victims

- Add the Covid-19 vaccine to the list of vaccines that qualify for compensation under the Vaccine Victims Insurance Law.

- Instruct the expert committee discussing lawsuits filed in accordance with this law to shift from adversarial to administrative hearings between plaintiffs and state representatives (similar to the hearings of National Insurance Institute committees).

- Instruct the expert committee discussing lawsuits filed in accordance with this law to base its decisions on circumstantial and not just scientific evidence.

- Israel must support compensation for vaccine victims in all countries under the COVAX (Covid-19 Vaccines Global Access Facility) initiative.

INTRODUCTION

The State of Israel, like the rest of the world, has been dealing with an unprecedented pandemic for almost a year. This pandemic has exacted a heavy health, economic, personal, and social price. Policymakers wisely decided to purchase large numbers of vaccines from leading pharma companies, but their former decisions on how to deal with the coronavirus have not been free of errors. These include succumbing to sectoral pressures, policies leading to feelings of discrimination and stigmatization, inconsistency, and decisions that made no sense.

The purpose of this report, which was written in December 2020, upon the approval of the first vaccines and their arrival in Israel, is to shed light on aspects of public policy that should be taken into account by decision-makers in the subsequent stages of managing the pandemic, chief among them the vaccination policy. A public policy that is implemented amid respect for human rights on the local, regional, and international level is a proper policy that contributes to building public trust, and should be strived for.

The report consists of the following chapters: Background on coronavirus vaccines; development, purchase, and public distribution of the vaccines; prioritization questions; public compliance with vaccination and confronting "vaccine hesitancy"; aspects of human and community rights. The report includes a list of practical recommendations for implementation by policymakers.

The team of experts, led by Dr. Shelly Kamin-Friedman, included (in alphabetical order): Dr. Hagai Boas, Prof. Nadav Davidovitch, Prof. Danny Filc, Prof. Khitam Muhsen, Dr. Carmel Shalev, and Ms. Hadas Ziv. The report is based on the knowledge of these experts, as well as on position papers, research, and press articles.

BACKGROUND

The coronavirus disease broke out in December 2019, first in China and later spread worldwide. The WHO initially defined it as an international public medical emergency, and later as a pandemic. As of mid-December 2020, some 73 million people had been infected with the virus worldwide and more than 1,640,000 had died in about 200 different countries. In Israel, as of this writing, more than 360,000 have been infected and over 3,000 people have died.

Afflicted by "pandemic fatigue," a year later the whole world had been longing for a vaccine, with the expectation that it would enable a return to normal life relatively soon, and reopening the economy, education, culture, and other parts of our lives of which we had been deprived in recent months in an unprecedented way.

All this led to a race to find a vaccine, in which dozens of companies, research institutions and different countries participated. The first company to reach the "finish line" was Pfizer, whose mRNA-based vaccine was approved for use in the United Kingdom (which began vaccinating its residents on 8 December 2020) and later received FDA approval. Moderna, which developed a vaccine based on a similar technology, also received FDA approval in December 2020, thus reinforcing capabilities to carry out a mass vaccination campaign.

The use of mRNA technology to produce vaccines is innovative, although mRNA vaccines for various indications have been tested in many clinical studies in the last decade. Unlike the well-known technology of using an attenuated or inactivated virus, mRNA molecules, which contain instructions for the production of one of the proteins in the virus, penetrate the vaccinated human cells and prompt the protein production. Upon being exposed to this protein, the immune system will provoke an immune memory response against it, which means that when exposed to the real virus, the vaccinated body will respond with antibodies.[1] The pandemic undoubtedly accelerated the testing due to a huge financial investment and close cooperation between scientists and regulatory authorities around the world.

[1] What is RNA Vaccine? *midaat.org.il*, viewed 20 December 2020 (Hebrew)

In addition to Pfizer and Moderna, over 200 companies and organizations worldwide are trying to produce a corona vaccine, with 46 of them already in the clinical trials phase (according to the WHO), including that of the IIBR, which began the human trials phase.

The news about various vaccines advancing in the clinical trial stage is great news. Never before in human history have vaccines been developed so rapidly, thanks to unprecedented collaborative efforts to tackle the global health emergency. The Pfizer and Moderna vaccines approved for use, along with the advanced stages of vaccine development by other companies, are a "game-changing" tool in confronting the pandemic.

However, the development of vaccines by private companies, the decisions of countries to purchase vaccines and their rollout to the public, the prioritization of the vaccination process, the subject of "vaccine hesitancy" both in the general public and among health workers – all raise complex questions.

This policy paper will address the issues that arise at the various stages of decision-making from the point of view of public policy and of universal and egalitarian human rights in the local, regional, and international context.

VACCINE DEVELOPMENT

In an operation dubbed "Operation Warp Speed", the US Administration partnered with private manufacturers to develop 300 million safe and effective vaccines by January 2021.[2] Other countries, such as Russia and China, have been working independently to develop vaccines for their own citizens, and so has Israel's IIBR. The development model is primarily a competitive one: pharma companies and countries are competing with each other to complete development in the shortest possible time.

The current crisis shows that where emergencies are concerned, the competitive model is problematic due to the need to maintain commercial confidentiality and could potentially cause health, social, and economic harm. Although at first glance the competitive model and for-profit structure of pharma corporations and biotech companies would appear to have led to innovation, it has for a long time kept transparent information from the public and from decision-makers worldwide.

The competition between companies has created duplication and inefficiency, and precluded joint clinical trials to compare vaccines to each other and to placebos in terms of safety, efficacy, benefit, cost, storage, delivery conditions, etc. More long-term research will be required in the field to ascertain which vaccines are the best in every respect.

The competitive model has led countries to negotiate individually with pharma companies, resulting in unequal access to vaccines by rich and poor countries. The latter, if they succeed to purchase vaccines, will receive them at a later stage and until then their citizens will continue to suffer from Covid-19 morbidity and mortality. In addition, the attainment of "community immunity," which means that the entire population is immune to infectious diseases if a sufficiently high percentage of persons are vaccinated, will be delayed globally.

Rand Corporation, one of the leading research institutes in the United States, published a report in October 2020 estimating that the lack of cooperation in development and

[2] Coronavirus: Operation Warp Speed, *US Department of Defense*

production may cause many countries to receive the vaccine belatedly.[3] The inefficiency of faster, wider, and fairer vaccine distribution on the international level may exact a huge global cost of over a trillion dollars due to the loss of human life, the cost of medical care, and the economic cost of dealing with a pandemic that primarily hurts the most vulnerable populations in any case. As long as countries have no recourse to vaccines and the virus continues to spread in their midst, the global efforts to stem the pandemic will fail and impede a return to normal life. As we see today in Israel and elsewhere, the level of morbidity is affected by "imports" from other countries. Closing skies and international borders cannot be sustained for long due to social and economic reasons. The Rand Corporation report has been cited broadly, including by the World Bank and various economic media outlets.[4]

In addition to the financial costs, we cannot ignore the moral dilemma involved in the fast delivery of vaccines to rich countries as opposed to the delayed supply to poor countries and the continued morbidity and mortality that ensues. One of the WHO's most important functions is to stop epidemic outbreaks, and as may be recalled, it led a successful global effort to supply vaccines against smallpox and other childhood diseases to the poorest countries, and is currently waging a campaign to eradicate polio. The current corona pandemic calls for a similar effort that is based on cooperation instead of competition in order to more effectively compare the various vaccines in terms of time and resources than under the competitive model and to ensure collaborative mass production for all countries and their citizens.

The concept of the right to health as part of human rights addresses equality between countries and not just within a country's own boundaries. The right to health is a universal human right that is being violated because of the huge gaps between rich and poor countries regarding the ability to acquire vaccines. In other words, inequality deeply hurts the fair distribution of vaccines to all citizens of the world. Thus, the collaborative development and production of vaccines for the benefit of all mankind and not for profit is a common global interest.

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[3] COVID-19 and the Cost of Vaccine Nationalism, Marco Hafner, Erez Yerushalmi, et al, *Rand Corporation*, 2020

[4] COVID-19 'Vaccine Nationalism' Could Cost the World Up to $1.2 Trillion a Year, *Rand Corporation*, 28 October 2020

VACCINE PURCHASE AND ROLLOUT

The universal right to health means that every man and woman has the right to receive quality and equal health services, and that every person has the right to social conditions that define and enable health, such as education, nutrition, quality water, fair and dignified income, and a healthy environment. As the Supreme Court held, "although the scope of the constitutional right to health has yet to be decided, there is no doubt that ensuring basic conditions of good health falls under the right to human dignity."[5]

Under the International Covenant on Social, Economic and Cultural Rights of 1966, the right to health is the right of every human being to enjoy the highest level of physical and mental health attainable (Article 12.1). It explicitly states that for the full realization of the right to health, countries must take the necessary steps to ensure the prevention, control, and supervision of infectious diseases (Article 12.2.c).

The purchase and rollout of vaccines, as it is conducted today globally, does not comply with the requirement of the universal right to health. As happened in the past with the avian flu vaccine, rich countries (including Israel) ensured the supply of vaccines through "advanced purchase agreements" (APAs). These are binding contracts, under which a government undertakes to purchase a considerable number of vaccines at a price mutually agreed with the manufacturer. For its part, the manufacturer undertakes to prioritize the supply of vaccines to those countries with which it has signed APAs.

The approach favoring a country's population due to APAs signed directly with pharma companies to keep its place in the "queue" for vaccines is called "Vaccine Nationalism." Given that experts estimate that the number of vaccines in the next two years will not be enough for the entire world population, and given the fact that only rich countries can sign APAs, this approach leads to very significant inequality between rich and poor countries

[5] Supreme Court Ruling 7245/10 Adalah vs. Ministry of Social Welfare, *adalah.org*, 2 July 2012 (Hebrew)

(at the moment, only the Russian and Chinese vaccines - Sputnik-5 and Sinopharm, respectively - will probably be substantially accessible to non-rich countries).[6]

To tackle inequality, WHO and GAVI-The Vaccine Alliance,[7] an international coalition that has been working since 2000 to make vaccines accessible to the world's poorest children, set up COVAX. This is a program that combines the capabilities of different countries to expand global supply of vaccines by signing centralized contracts with a variety of companies and ensuring a fair distribution of the purchased vaccines worldwide. For most countries, COVAX represents almost the only channel for the acquisition of a significant number of vaccines.

COVAX is an important public initiative, which attests to a sense of responsibility and solidarity. In addition, for those rich countries that have signed APAs with several companies simultaneously, the COVAX initiative constitutes an "insurance policy" in case the vaccines of some of the companies turn out to be insufficiently effective.

However, the patent regime that currently dominates the pharmaceutical and biotechnology industry under the World Trade Organization's TRIPS (Trade-Related Aspects of Intellectual Property Rights) agreement of 1995, gives corporations a monopoly on bio-products, protects information about the manufacturing process as a trade secret, and blocks the possibility of producing a cheaper generic product during the patented period. This regime aims to preserve the profits of private corporations, and not to guarantee the supply of a public product at cost. In the case of the corona vaccines, this patent regime raises yet another moral-ethical dilemma given that the vaccines were developed with public funds.

As part of COVAX, the WHO has been promoting a "solidarity call to action," urging governments around the world to promote the notion that "research products funded by public funds or donations be produced under a license that allows free access and use by others without restrictions." The document calls on companies holding intellectual property rights over knowledge relevant to the treatment of Covid-19 or vaccination to voluntarily waive these rights and transfer their knowledge to a common international body.

[6] Legal Agreements: Barriers and Enablers to Global Equitable COVID-19 Vaccine Access, Alexandra L. Phelan, Mark Eccleston-Turner, et al, *The Lancet*, 7 September 2020
[7] About Us, *GAVI-The Vaccine Alliance*

Unfortunately, only 40 countries have heeded the call to date, including only three rich countries (Netherlands, Norway, and Portugal). We believe that all countries are required to share knowledge and waive intellectual property rights, including the State of Israel with regard to the vaccine developed at the IIBR.

In early October 2020, in view of the health emergency and for the sake of global solidarity, India and South Africa approached the WTO with a proposal to apply certain provisions of TRIPS (such as Article 30) that allow for exceptions on patent rights and to temporarily suspend licenses in order to remove intellectual property restrictions pertaining to the corona vaccine to ensure that poor countries can also vaccinate their population.[8] This initiative encountered stubborn opposition from rich countries (US, Canada, EU) and pharma companies,[9] and at the time of writing the WTO has yet to pass a decision on the matter.

The opposition to restricting intellectual property rights and the fact that rich countries have joined COVAX but retained their APAs with different companies has led experts to estimate that while rich countries will vaccinate 20% of the population, other countries will be able to vaccinate only 3% of their population.[10]

Steps are needed to overcome the obstacles that the current patent regime pose to equality and fairness in providing vaccines to all humankind, either by the willingness of governments and pharma companies to voluntarily share knowledge or by an initiative similar to that of India and South Africa. As a step towards equality and fairness already at this stage, countries that have purchased vaccines in excess of the needs of their citizens could deposit their surplus vaccines in an international pool that would be donated to poor countries.

At the local level, it is important that vaccines be purchased by the state in an organized manner, financed by public funds, and be given free of charge to all Israeli citizens and anybody staying in Israel. This is the proper way to enable equal access to the entire

[8] Waiver From Certain Provisions of the TRIPS Agreement for the Prevention, Containment and Treatment of COVID-19, *World Trade Organization*, 2 October 2020
[9] South Africa and India Push for COVID-19 Patents Ban, Ann Danaiya Usher, *The Lancet*, 5 December 2020
[10] Legal Agreements: Barriers and Enablers to Global Equitable COVID-19 Vaccine Access, Alexandra L. Phelan, Mark Eccleston-Turner, et al, *The Lancet*, 7 September 2020

population, based on transparent prioritization criteria that do not replicate existent patterns of inequality in Israeli society and on the principle of equal concern for all.

A public model for the purchase of vaccines is also required in order to achieve "community immunity" to the corona virus, which is a public good that everyone is entitled to enjoy equally.

The fact that Israel has been negotiating simultaneously with a number of companies makes sense in this state of emergency. Just as important is the major effort of the clinical trials conducted by IIBR, especially in light of the fact that its vaccine will require much simpler refrigeration (at a temperature of 2-8 degrees Celsius) than those based on mRNA technology, and thus cost less than the vaccines purchased so far. IIBR's decision to enlist an international company to conduct the human trials in Phases 2-3 is the right decision, and such external assistance should similarly be sought in the future given the capabilities of experienced companies with mass production and quality control of products developed under constraints of time and knowledge.[11]

Alongside the purchase of vaccines and the development of an Israeli one, their rollout also requires special attention to ensure equal supply to social and geographical peripheries, especially in places where living conditions pose a unique logistical challenge due to lack of electricity and water infrastructure, such as the Bedouin community (particularly in the case of the Pfizer vaccine, which requires refrigeration at minus 70 degrees). Of course, it is also important to ensure the quality of storage and transportation of the vaccines, which pose a complex logistical challenge, further compounded by the fact that most vaccines require more than one dose.

Israel has an excellent community-based healthcare system (despite the tendency toward privatization and a chronic shortage of resources, budgets, and slots). The healthcare system plays and will continue to play a very important role in the vaccination process, as well as in the scientific monitoring of vaccines' benefits and side effects over time. Israel has the capability to collect and analyze data through the advanced computer systems at the disposal of HMOs and hospitals, as well as a skilled scientific community, and will thus

[11] In this context, it should be noted that the vaccine developed by Russia's Gamaleya Research Institute of Epidemiology and Microbiology should be purchased only for medical and non-political reasons, and definitely as a public purchase and not by private bodies

be able to share the accumulated knowledge with governments and scientific communities in other countries.

Vaccination by Israel's HMOs, which are among the most effective health organizations in the world, is preferable to vaccination by Home Front Command soldiers as this may be a deterrent (such an initiative was mentioned in the media).[12]

We call to consider the initial distribution of vaccines among the HMOs in a way that conforms to the prioritization model presented later on in this paper, whereby priority should be given to at-risk populations. We also call to setting up unified clinics to vaccinate members of all HMOs (as noted in the Knesset State Audit Committee's discussion of 14 December 2020); to making vaccination readily available through personal referrals from family doctors; and to outreaching to at-risk populations; and to vaccinating prison inmates.

HMOs are obliged to provide service to their members under the National Health Insurance Law, but there are also uninsured individuals in Israel that should be provided with vaccines, such as asylum seekers, migrant workers, and caregivers of elderly people living in the community.

In addition, many people from the Palestinian Authority (PA) work in Israel, and in general, Israel bears some responsibility for the situation of the Palestinians living under occupation. Having effectively controlled the area for over half a century and retained many powers that affect the PA's ability to take care of its people, both economically and health-wise, Israel has the obligation and responsibility to provide vaccines to the Palestinians, both logistically and financially. The obligation is both morally and in the interest of public health, as a protection against importing the virus into Israel in light of the daily traffic of PA people coming to work or do business in Israel and in order to attain the broadest community immunity.

Since the PA can purchase the vaccines only through the Israeli authorities and not independently, the Health Ministry must formulate criteria for the allocation of vaccines to the Palestinians based on the same parameters applied to Israel's residents (age, risk, etc.)

[12] Home Front Command: Assign Vaccination of the Population to the IDF, Shani Ashkenazi, *globes.co.il*, 6 December 2020 (Hebrew)

and work in cooperation with the PA. For the same reasons, it is also incumbent upon Israel to finance these vaccines, without waiting for assistance from the WHO. The Health Ministry's policy of allowing the PA to import only medicines registered in Israel that have undergone the required scientific and regulatory procedures must be adhered to. As long as the Palestinians are not free from Israel's occupation and control, the vaccines delivered to them must definitely be those approved by the Israeli health system. Furthermore, from a moral point of view, it is inconceivable that during such an acute pandemic Israel should deliver to the PA a vaccine that has not been approved for use on its own citizens.

VACCINE PRIORITIZATION

1. ETHICAL CONSIDERATIONS IN DETERMINING PRIORITIZATION

Since vaccine doses will arrive in Israel gradually until there is enough for everyone, the question arises of how to prioritize the vaccination process, of who will be the first in line and who will be last. Such prioritization criteria for the national distribution of the vaccine have already been set by the Health Ministry and are not in dispute. Israel has extensive professional experience in prioritizing new medical technologies as part of its annual update of the health insurance basket, and the criteria it has adopted for the corona vaccine are mostly accepted by the WHO and other countries. First in line are medical staff, caregivers in long-term facilities for the elderly, residents of such facilities, persons aged 65 and above, people with chronic diseases, essential services workers, and other at-risk populations. At the moment, the vaccine is not offered to children under the age of 16 (they were not included in vaccine manufacturers' trials) or to people who have in the past had an anaphylactic response to one of the constituents of the vaccine.

Ethically, it is indeed appropriate to first prevent serious illness and death and only then proceed to arrest the spread of the disease (assuming that the vaccine indeed prevents infection). Therefore, it is clear that priority must be given to the population at risk of serious illness and to the caregivers who come into contact with them.[13] Thus, for example, it is known that the source of the corona outbreaks among the elderly in long-term care facilities at the beginning of the pandemic was the nursing staff who had earlier become infected in the community.[14] Thought must also be given to elderly persons living in the community and confined to their homes and make the logistical arrangements to vaccinate them and their caregivers at home, similar to staff at nursing facilities.

Priority should also be given to socio-economically disadvantaged population groups living in overcrowded housing, including minority groups (ultra-Orthodox, Arabs, Ethiopians) and poorer populations that are more vulnerable to disease. Other groups that may be at high

[13] WMA Resolution Regarding the Medical Profession and Covid-19, *World Medical Association*, 10 November 2020

[14] The Human Rights of Older Persons in Times of Corona, Carmel Shalev, *Zulat Institute for Equality and Human Rights*, 25 October 2020

risk of exposure to the disease are essential services workers who come into contact with large crowds (such as drivers, cashiers in food stores, and teachers).

Having said that, the decisions on prioritization should also take into account such considerations as stigmatization and discrimination. For example, talk of high infection rates as a result of overcrowded housing in localities with a large ultra-Orthodox population may create a stigma, and even endanger other parts of the population who might erroneously conclude that they are not at risk.

Thought should also be given to the effect of prioritization decisions on the public's response to the vaccine. High resistance by a population group that has been given priority may stimulate "vaccine hesitancy" (see below), or vice versa: the call to vaccinate all people over the age of 60 who are at risk of serious illness due to their age could trigger a high compliance rate and have a positive impact on the responsiveness of the general public.

2. IDENTITY OF DECISION-MAKERS

The decisions on prioritization should be made by a committee of experts and not by ministers or politicians. The need for an expert committee is all the more necessary in light of media reports that the prime minister will head a ministerial committee that will oversee the vaccination and distribution of vaccines.[15]

In light of the intricate political situation in Israel – with a parity government whose management of the pandemic (such as its decision to put off implementation of the "traffic light" program) has often led to undesirable results, and the barrage of sectoral pressures (including non-transparent ones), it is important that the decisions on vaccine prioritization be made by experts, with political considerations that are legitimate in the broader sense only, pertaining to the balance of power in society.

As for the identity of the committee members, it is essential to appoint experts from diverse fields and from various population groups, including representatives of the public and not

[15] Netanyahu: 'We Will Get the Vaccine Like the Rest of the Countries, It'll Start in January', *Kan Israel Broadcast Corporation*, 12 November 2020 (Hebrew)

just professionals. The committee's deliberations should be conducted transparently and publicized so that the considerations are clear to all.

The vaccine operation is complex. It requires a great deal of knowledge and involves a variety of interests, economic and otherwise, and therefore there is great importance both to the composition of the expert committee and to the transparency of its deliberations.

INFORMED CONSENT TO VACCINATION

The Patient's Rights Law of 1996 stipulates in Chapter D, section 13 (a), that "medical treatment will not be given to a patient unless the latter has given their informed consent." This provision also applies to preventive medicine, including vaccines. The "informed consent" to medical treatment doctrine has two aspects under the law: the obligation to disclose to a patient "medical information that he reasonably needs to be able to decide whether to consent to the proposed treatment," and the patient's right to make a decision "by voluntary choice and independently." This right derives from the individual's constitutional right to autonomy to make decisions concerning the integrity of his body.

1. INFORMATION ON VACCINE RISKS

Caregivers are required to disclose information to the patient prior to medical treatment in a "reasonable manner". That is, the duty is not absolute and does not involve distant and rare risks constituting a "parade of horrors."[16] Where vaccines are concerned, revealing too much information about rare risks that may be discovered in the future might trigger inordinate worry and vaccine hesitancy. On the other hand, fully disclosing information may reinforce the trust in the health authorities and consequently promote high compliance with vaccination.[17] In light of the fact that the approved vaccines are new and have at this stage received emergency approval only, we believe that in this case it is justified to provide extensive information to people receiving the vaccine.

2. VACCINATION AS A VOLUNTARY ACTION

As noted, "informed consent" means that the patient has the right to make a decision on medical treatment "by voluntary choice and independently." Vaccination, as opposed to

[16] Supreme Court Ruling 1303/09 Margalit Kadosh vs. Bikur Holim Hospital, et al, *supremedecisions.court.gov.il*, 5 March 2012 (Hebrew)
[17] Informed Consent to Vaccination: Theoretical, Legal, and Empirical Insights, Dorit Rubinstein-Reiss, Nili Karako-Eyal, *American Journal of Law & Medicine*, 23 January 2019

requiring individuals to wear seat belts while driving or a helmet while riding a motorcycle, involves an invasive physical procedure that is sometimes accompanied by side effects, and in the absence of the individual's consent is perceived as an assault. Therefore, a person's freedom to choose vaccination should not be infringed upon by either threatening sanctions or promising a monetary reward.

Consent to the vaccine can be given orally or by gesture (outstretching the arm). In the case of incapacitated persons (for example, patients in geriatric or psychiatric institutions, who due to their medical, mental, or cognitive condition are unable to give informed consent), the consent of a guardian or proxy must be obtained. Leaving aside the legal requirement, vaccinating incapacitated people without an explicit consent stimulates hard feelings, and should therefore be avoided.

3. VACCINATION AS A SOCIAL RESPONSIBILITY

Alongside the individual's right to refuse vaccination is the social responsibility to get vaccinated. Since community immunity is a public good, individuals should be entitled to enjoy it only if they contribute their share (in fact, once community immunity is achieved, anti-vaxxers will enjoy it by default because they will be protected by those who took the vaccine). Moreover, anti-vaxxers may endanger the health of others: people who cannot be vaccinated (for example, children) or people who fail to develop immunity despite having been vaccinated. Vaccination is part of the "social contract" between the individual and society and is part of the individual's responsibility to act in solidarity.

Under which circumstances it is legitimate to violate the rights of the individual in order to protect the general public from infectious diseases remains a controversial question. According to one approach regarding public health,[18] the violation of an individual's rights (including the right to autonomy) is justified only in cases where the individual's actions cause harm to others. According to another approach,[19] the government has the responsibility and authority to vaccinate the population in order to prevent the spread of

[18] The Harm Principle: *On Liberty and the Subjection of Women*, John Stuart Mill, London: Penguin Books Limited, 2006

[19] Mandatory Vaccination: Understanding the Common Good in the Midst of the Global Polio Eradication Campaign, Lawrence O. Gostin, *Israel Journal of Health Policy Research*, 3 January 2018

infectious diseases, even at the cost of violating the individual's rights, not only in cases where the individual's behavior causes harm to others, but also when the interest of the community requires it. Recognition of the community's interest is consistent with the values of public health, which focuses on the health of the population rather than that of the individual. In our opinion, there is justification for government intervention to protect the community, and if this intervention proves to be effective and the attendant benefit to public health outweighs the harm to the individual - then such a step is essential.

VACCINE COMPLIANCE

1. VACCINE HESITANCY

Compliance with vaccines against Covid-19 may encounter difficulties due to "vaccine hesitancy". This phenomenon is in fact a series of attitudes towards vaccines, ranging from active demand for vaccines, through understandable fears about a new disease and a new vaccine, and an extreme minority's total opposition to vaccines in general.[20] The reasons for corona vaccine hesitancy in Israel can be divided into two categories:

General reasons headed by fears of a new vaccine whose long-term consequences are not yet known. Some of these concerns are fueled by the dissemination of fake news and conspiracy theories, which more significantly affect ideological anti-vaxxers.[21] A preliminary study conducted in Israel, before the pharma companies published their findings, showed that even among medical staff, questions about the risk posed by the new vaccine affected the decision to get vaccinated.[22] The lack of trust in the safety of the vaccine stems not only from the confusion and uncertainty about truth and falsehood, but also from the loss of trust in science and experts.

There are population groups in Israel of special social and cultural characteristics with a tendency toward vaccine hesitancy, such as some ultra-Orthodox sects that hesitate to vaccinate their children against a variety of childhood and seasonal diseases[23] [24], or sections of the Arab population that hesitate to get vaccinated against seasonal influenza. This is compounded by a decline in confidence in the political leadership due to the narrow

[20] Vaccine Hesitancy: Definition, Scope and Determinants, Noni E. MacDonald, *National Center for Biotechnology Information*, 14 August 2015
[21] The Effects of Anti-Vaccine Conspiracy Theories on Vaccination Intentions, Daniel Jolley, Karen M. Douglas, *journals.plos.org*, 20 February 2014
[22] Vaccine Hesitancy: The Next Challenge in the Fight Against Covid-19, Amiel A. Dror, Netanel Eisenbach, et al, *European Journal of Epidemiology*, 12 August 2020
[23] Risk Factors of Underutilization of Childhood Immunizations in Ultraorthodox Jewish Communities in Israel Despite High Access to Health Care Services, Khitam Muhsen, ReemAbed El-Hai, et al, *sciencedirect.com*, 9 March 2012
[24] The Behind-the-Scenes Activity of Parental Decision-Making Discourse Regarding Childhood Vaccination, Anat Gesser-Edelsburg, et al, *American Journal of Infection Control*, 1 March 2017

partisan considerations underlying the decision-making concerning the management of the pandemic to date.[25]

2. CONFRONTING CORONA VACCINE HESITANCY

As mentioned, high compliance with the corona vaccine is a public interest. On the one hand, the mortality rate from Covid-19 is several times higher than that of seasonal influenza[26] and infection can cause persistent illness, including in previously healthy young people (long-term Covid)[27], while on the other hand the vaccines approved by the FDA were found to be safe and effective in preventing disease.[28]

Aside from protecting the vaccinated individual from the virus, and assuming that the vaccine prevents infection (an issue yet to be resolved at this point), a high compliance with the vaccine is expected to lead to "community immunity," which means protecting the overall population against infectious disease once a high enough percentage of population have been vaccinated. According to current epidemiological information, community immunity will probably be attained if more than 60-70% of the population is vaccinated.

Community immunity will protect those who cannot be vaccinated at this point, such as children or people who have had an anaphylactic response to one of the constituents of the vaccine, and will help protect a minority of vaccinees who fail to develop immunity to the virus (vaccines have been shown to be 95% effective, which means that 5% run the risk of not being protected despite the vaccine).

Those people who cannot be vaccinated or fail to attain immunity, have the right to health to which we are all committed. Israel's public health system is based on such values as justice, equality, and mutual aid, as stated in the State Health Insurance Law. In a pandemic, the need for mutual commitment grows even stronger, as we are all connected

[25] Communicating About Vaccines in a Fact-Resistant World, Saad B. Omer, Avnika B. Amin, Rupali J. Limaye, *JAMA Pediatrics*, October 2017
[26] Estimates of the Severity of Coronavirus Disease 2019: A Model-Based Analysis, Robert Verity, Lucy C. Okell, et al, *The Lancet: Infectious Diseases*, 1 June 2020
[27] Long Covid: Let Patients Help Define Long-Lasting Covid Symptoms, *Nature*, 7 October 2020
[28] Safety and Efficacy of the BNT162b2 mRNA Covid-19 Vaccine, Fernando P. Polack, Stephen J. Thomas, et al, *The New England Journal of Medicine*, 10 December 2020

to each other, come into contact with each other, and may infect each other. The right to health is a social right that entails responsibility for others and concern for the weak, solidarity, collaboration, and universal social fairness. Of course, community immunity is in the public interest, since in addition to preventing disease it will enable us to reopen the economy, culture, and commerce, which are essential to the public's health and socio-economic resilience.[29]

For these reasons, immunization should be encouraged. However, fears that the state might impose compulsory vaccination as well as sanctions must be addressed. A basic principle in Israeli health law is that a person is not treated against his will, and senior health officials have emphasized this in the context of the new corona vaccines. Talking about compulsory vaccination creates unnecessary resistance. The Public Health Ordinance of 1940 stipulates that in cases where an infectious disease is contagious or is likely to turn into an epidemic, or when a contagious disease endangers public health, the health authorities are authorized to intervene and impose compulsory vaccination. However, in balancing the rights of the individual with the public interest, this authority must be exercised only if necessary and as a last resort, after examining alternatives that involve less severe infringement of individual rights. There is certainly no reason to talk about compulsory vaccination when the vaccine supply is slated to be phased out over months, as long as there are enough people willing to take the vaccine, and there seemingly is no widespread opposition.

3. PUBLIC INFORMATION AND TRUST

Trust is a basic condition for the public to comply with policymakers' decisions, in the area of public health in general and where vaccines are concerned in particular.[30] Information that promotes trust needs to address issues that are of concern to the public and not necessarily the scientific questions that experts believe should be elaborated upon and explained. Israelis are hesitant about getting vaccinated not because they lack knowledge,

[29] Policies and Strategies to Promote Social Equity in Health, Dahlgren, Göran & Margaret Whitehead, *Institute for Futures Studies*, September 1991

[30] Trust in Medical Organizations Predicts Pandemic (H1N1) 2009 Vaccination Behavior and Perceived Efficacy of Protection Measures in the Swiss Public, Ingrid Gilles, Adrian Bangerter, et al, *European Journal of Epidemiology*, 26 March 2011

but rather because they exercise self-determination and strive to make their own decisions based on dealing with considerable complexities. These complexities relate to vaccine efficacy versus the risk of illness, personal interest versus contribution to the community[31] and (in the context of Covid-19) the impact of vaccination on ending the global pandemic.

Similar to the campaign to promote compliance with the polio vaccine in 2013, Health Ministry officials need to monitor public discussions, including on social media, and provide matter of fact and respectful answers to the questions and issues cited in them.[32] For example, the anxiety about a new vaccine should be addressed in an information campaign that does not ignore the fear, and definitely does not dismiss it. Health officials need to address the fact that some issues remain unresolved at this stage, such as the question of whether vaccines prevent infection, the duration of immunity, and to what extent and at what speed the virus undergoes mutations.

Other crucial steps include participation of Health Ministry officials in the information efforts; adapting the information to different populations and sectors, such as labor migrants who avoid vaccination for fear of being deported; recruiting influencers from different communities; boosting the number of telephone operators at the Health Ministry's hot line with speakers of Russian, Arabic and Amharic; and producing radio broadcasts and printing pashkevilim (street posters) that are geared toward the ultra-Orthodox public. The information campaign should carefully avoid stigmatization, generalizations, and paternalism. In this context, we would like to commend the information effort waged since the start of the vaccination campaign, which has excelled in professionalism and has been free of narrow political considerations.

We would like to emphasize that apart from the information campaign, transparency at all stages of the decision-making process is also essential for building the public's trust in the vaccine. Transparency is required with regard to the purchase of vaccines from various companies (including the Russian vaccine), information about the benefits and risks of the

[31] Vaccine Hesitancy as Self-Determination: An Israeli Perspective, Baruch Velan, *Israel Journal of Health Policy Research*, 4 April 2016

[32] Challenges and Opportunities in the Israeli 2009 Pandemic Influenza Vaccination Program, Hagai Levine, Ran D. Balicer, et al, *Human Vaccines*, 1 October 2011

vaccine, the prioritization of vaccination, and the monitoring of the side effects in Israel and worldwide.

Transparency is also required regarding the development of the vaccine by the IIBR. We would like to point out that the IIBR operates as a government-affiliated unit, to which the provisions of the Freedom of Information Act do not apply, a fact creating ethical dilemmas not discussed in this document. However, the IIBR efforts to develop a vaccine that has nothing to do with a security threat should be transparent.

Moreover, since trust entails an emotional component and is built, among other things, by instilling the feeling that the vaccine recommendation is given by someone who acts for the common and individual good, [33] the identity of the person relaying the information is also important. A recommendation to get vaccinated by a person perceived as unreliable, driven by foreign interests or conflicts of interest, may even lead to a decrease in vaccine compliance.[34] Thus, the information should be delivered by doctors from different population sectors, or scientists with no political-party affiliation. The inclusion of such persons in the decision-making and mediation process will signal to the public that vaccination policy has been based on scientific and ethical reasons, has been balancing the power relations in society , and has examined various alternative to least infringe individuals' rights.[35]

4. IMMUNIZATION AS A COMMUNITY ACTION

Israel's is a family-based society.[36] In a society divided by religion, ethnic origin, and national affiliation, the concept of family has been shown to be a central value shared by most Israelis. A study on the OPV information campaign conducted in 2013 found that the Health Ministry encouraged immunization by addressing the value of family ("a single drop

[33] Law, Medicine, and Trust, Mark A. Hall, *Stanford Law Review*, November 2002
[34] The Role of Public Trust During Pandemics: Implications for Crisis Communication, Michael Siegrist, Alexandra Zingg, *European Psychologist*, 2014
[35] An Ethics Framework for Public Health and Avian Influenza Pandemic Preparedness, Nancy E. Kass, *Yale Journal of Biology and Medicine*, October 2005
[36] Familism, Postmodernity and the State: The Case of Israel, Sylvie Fogiel-Bijaoui, *Journal of Israeli History*, 4 June 2010

and the whole family is protected").[37] The ministry sought to emphasize that the live attenuated polio vaccine was not meant for the vaccinees (as they had already been vaccinated with the inactivated polio vaccine) but to protect at-risk populations. Another study found that pro-social motives played a key role in encouraging immunization in the 2013 campaign.[38]

Using the society-individual dichotomy is not effective on the informational level, as it creates an equation pitting the repressive dimension of society (represented by the state and its authorities) and the individual protecting himself, his freedoms, and his rights. The society-individual framing should be replaced with "community" as an intermediate component. We need to emphasize the interrelationship and interdependence between us, being part of humankind during a global pandemic emergency.

Accordingly, we propose to replace "herd immunity" (a utilitarian term originating in the veterinary world, suggesting that the herd must be protected in order to ensure that it remains healthy and continues to yield milk, meat, or any other benefit) with the term "community immunity." This term is more appropriate when referring to humans and populations, and its use is also recommended by the WHO.

In addition, vaccination strategy should be community-oriented (language, culture, community leaders). The vaccination should be presented as an act of responsibility toward the community at large and as a demonstration of solidarity: I will be vaccinated both for myself and for the community. Framing vaccination as an act that emphasizes responsibility toward others, mutual commitment, and a shared fate as human beings vulnerable to disease, may mitigate fear and anxiety given the fact that every act of solidarity contains a measure of heroism and sacrifice for the common good. The perception of immunization as a community act can beget a social norm whereby vaccination is the right health measure for both the individual and the general public.

[37] Between Individualism and Social Solidarity in Vaccination Policy: The Case of the 2013 OPV Campaign in Israel, Hagai Boas, Anat Rosenthal, Nadav Davidovitch, *Israel Journal of Health Policy Research*, 21 December 2016

[38] Prosocial Polio Vaccination in Israel, Chad R. Wells, Amir Huppert, et al, *Proceedings of the National Academy of Sciences*, 9 June 2020

5. POSITIVE INCENTIVES

Down the line, giving positive incentives to vaccines should be considered. Anti-vaxxers will be getting a "free ride" at the expense of vaccinees, and society is entitled to take proportionate steps to discourage such behavior. According to media reports, Israel's health authorities are mulling the idea of issuing a "green pass" to vaccinees, which will allow them to enter some of the public places that are currently closed to the general public. We support such an initiative, should it be needed because of low compliance with vaccination. However, we would like to present a number of reservations:

- Although positive incentives for vaccinees is an appropriate step, it should be implemented to the extent possible in a way that does not infringe on fundamental constitutional rights. According to the Supreme Court's judgement in the Adalah case, "the more the violation of autonomy affects aspects of personal expression and self-realization, the greater the tendency to view it as violating a constitutional right."[39] A distinction must be made between a vaccine requirement to enter public places for recreational and shopping purposes such as malls and banquet halls, which in our opinion does not constitute a constitutional violation of individual rights, as opposed to a vaccine requirement to enter synagogues or workplaces.

- A material connection must be established between the incentives to vaccinees and the prevention of infection, and therefore allowing only vaccinees to enter public places will be a legitimate step only if it reduces infection. At this point it is still unknown whether the vaccine prevents transmission or only protects the vaccinee from Covid morbidity. Continued follow-up of the vaccination process, extensive serological tests, and monitoring of infection rates will provide us clearer answers in the future.

- It should be noted that incentives that apply only to part of the population (such as requiring a vaccine to enter sporting events) are unequal and may not promote compliance among sections of the population who are not interested in such activities. The difference between people who are interested in sports and those who are not is irrelevant for the purpose of promoting vaccine compliance among

[39] Supreme Court Ruling 7245/10 Adalah vs. Ministry of Social Welfare, *adalah.org*, 2 July 2012 (Hebrew)

the general public, and therefore such a distinction, even if it does not amount to a violation of a constitutional right, is illegitimate. The chosen incentive should affect the entire population as equally as possible.

- People who would like to be vaccinated but cannot do so for medical reasons should receive the same privileges as those given to vaccinees. To this end, a vaccine "exemption" must be introduced in parallel with the promotion of the "green pass" idea.

- Should the argument arise that the incentives chosen to prevent "free riders" infringe on the rights of the individual, it is important to ensure that the infringement is proportionate. The test of proportionality calls for devising an effective and proportionate incentive that least infringes on rights. A way to ensure proportionality is to provide alternatives to vaccines (such as presenting a negative corona test or a positive serological test) entitling to the same benefits as those given to vaccinees.

RESPONSIBILITY OF THE MEDICAL STAFF

1. THE RESPONSIBILITY TO GET VACCINATED

The medical staff's compliance with the corona vaccine is essential in several respects: protecting personnel against contagion from patients to ensure they can continue to do their work, preventing the spread of the virus as they come in contact with patients, and the crucial impact of their response on the public's own confidence in the recommendation to get vaccinated.[40] However, leaving aside the responsibility aspect, however, medical personnel have the same right as other persons to refuse medical treatment, including vaccination.

To the extent that the vaccine is shown to prevent infection, consideration may be given to stopping the employment of medical staff working with at-risk patients who refuse to be vaccinated and transferring them to other positions. A precedent for this exists in the regulations stipulating that a polio vaccine is a prerequisite for working with infants up to the age of one year, while vaccination against measles, mumps, rubella, and chickenpox is a prerequisite for working with immunocompromised patients.

2. ATTITUDES TOWARD THE VACCINE

Medical staff are the most influential factor in people's decision to agree or refuse to be vaccinated. Their crucial influence stems from the fact that they are a key source of information, as well as from their acquaintance with the vaccine target population. It has been shown that patients will favor a recommendation given by the community medical staff rather than a recommendation given by policymakers.[41]

[40] The Role of Public Trust During Pandemics: Implications for Crisis Communication, Michael Siegrist, Alexandra Zingg, *European Psychologist*, 2014
[41] Ibid

The role of the medical staff is to provide information on the benefits and risks of the vaccine, as well as to correct misconceptions. To do this, they are required to be knowledgeable about the subject and to take the time to present the information to patients. We would like to emphasize that physicians are committed not only to treat patients, but also to promote governmental preventive medicine policies, such as to stop smoking, wearing seat belts in cars, or wearing a helmet while cycling.[42]

With regard to medical personnel voicing opposition to vaccines, a balance is required between freedom of expression and the huge importance attached to the opinion of an anti-vaxx doctors in light of the possible harm to public health.[43] Freedom of expression clearly is a fundamental right, and one must be very careful of a totalitarian approach in the name of public health that silences controversy and critical debate. Scientific criticism and free public discourse are essential for a healthy society.

After debating medical staff's opposition to the vaccine, the Israel Medical Association (IMA) decided that this was not an ethical offense. A physician who holds a view contravening what is accepted in the world of medicine should anchor his position in research and first present his claims to the medical community, the IMA affirmed. It also asserted that a physician who presents such views in the media should note the prevalent conventions in medicine at that time, should consider whether his views amount to intimidation or harm public health, and should act with professional responsibility.[44] Coronavirus vaccines have been approved for use on the basis of scientific evidence that they are effective and prevent serious illness with relatively mild side effects. Thus, health professionals who publicly oppose vaccines may endanger the public and are required to act responsibly.

[42] The Doctor as Promoter of Health: Healthy Lifestyle Counseling at the Clinical Meeting, Efrat Schreier, Nadav Davidovitch, Salman Zarka, IMA's journal *Harefua*, April 2009 (Hebrew)
[43] Freedom of Expression, Anti-Vaxx Doctors, and the Big Scam Called Homeopathy, Avinoam Reches, *Israel Association of Public Health Doctors*, 11 June 2019 (Hebrew)
[44] Home page of *Israeli Medical Association* (Hebrew)

COMPENSATION FOR VACCINE VICTIMS

Participants in the studies conducted by the vaccine manufacturers reported mild flu-like side effects shortly after vaccination, which are not different from the side effects of other vaccines (muscle ache, headache, fever, nausea) and pass after two days. Long-term side effects are not expected in the future (according to the manufacturers) and are unknown at this point. Long-term medical-scientific follow-up is needed in the rare cases where the vaccines cause significant harm.

Similar to other countries, Israel has a law stipulating compensation for vaccine victims without proof of "guilt." This social legislation was enacted in order to assist vaccine victims for reasons of fairness, which justify compensating a person injured while choosing to be vaccinated for the common good, as well as for reasons of solidarity, given that the burden of harm as a result of vaccination is not shared equally among all vaccinees. Also, legislators believed that ensuring compensation for vaccine victims would help stimulate high compliance with vaccination.[45]

However, from the day the law went into effect in 1989, no judgement has ever been rendered under it determining compensation for vaccine victims. The cases brought before the expert committee in charge of hearing claims filed under this law were rejected due to lack of evidence of a scientific causal link between the vaccine and the alleged injury. Furthermore, the hearings are a long, expensive, and adversarial process pitting plaintiffs against Health Ministry officials.[46] The law implementation is therefore inconsistent with its' objectives, which were to assist vaccine victims by easing their burden of proof and to hold a short and effective procedure. Moreover, hearing claims in an adversarial manner likely undermines public confidence in the state's willingness to compensate vaccine victims and contradicts the purpose of the law, which is to promote vaccine compliance.

[45] Draft of Vaccine Victims Insurance Law, *knesset.gov.il*, 1987 (Hebrew)
[46] Vaccine Victims Insurance Law 1989: Review of Law's Implementation vs. Objectives, Shelly Friedman (MHA thesis in Health Systems Management), *Ben-Gurion University of the Negev*, 2013 (Hebrew)

On 24 November 2020, the Health Ministry published a draft law amendment concerning insurance for vaccine victims, which proposes to include additional seven vaccines, including the corona vaccine, under the 1989 law. At the same time, according to media reports,[47] the APAs signed by Israel and other countries with corona vaccine manufacturers contain a "liability disclaimer" clause.

The planned addition of the corona vaccine to the list of vaccines qualifying for compensation under the law, especially in light of the "liability disclaimer" clause, is correct but thought must be given to changing the way in which claims are processed in order to better fulfill the law's goals.

Establishing a causal link based on circumstantial evidence and shifting to an administrative instead of an adversarial discussion may go a long way toward fulfilling the principles of fairness and solidarity that led to the enactment of the law in the first place, as well as to promote trust in the health authorities that is essential for stimulating a high vaccination compliance.

On the global level, manufacturers who profit from the sale of vaccines are supposedly liable for paying compensation in cases where the vaccines cause harm. In practice, however, they reportedly pressured countries to absolve them of this responsibility. The richer the country, the more likely it is to be able to bear such burden. However, poor countries' ability to purchase vaccines and undertake to compensate potential victims may be impaired by the corporations' abdication of responsibility. To prevent such a situation, the aforementioned COVAX could serve as a tool for the fair distribution of vaccines and for funding fair compensation to vaccine victims based on justice and mutual commitment toward the world's weak populations.[48]

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[47] Who's Responsible for Covid-19 Vaccine Damage? Not the Manufacturers, Meirav Arlosoroff, *themarker.com*, 16 November 2020; AstraZeneca To Be Exempt From Coronavirus Vaccine Liability Claims in Most Countries, Ludwig Burger, Pushkala Aripaka, *reuters.com*, 30 July 2020

[48] No-Fault Compensation for Vaccine Injury - The Other Side of Equitable Access to Covid-19 Vaccines, Sam Halabi, Andrew Heinrich, Saad B. Omer, *The New England Journal of Medicine*, 3 December 2020

CONCLUSION

This report by the Zulat Institute, in collaboration with Physicians for Human Rights, seeks to put on the agenda and provoke a public debate on issues pertaining to the interface between management of the corona pandemic and human rights.

The coronavirus pandemic, which is an unprecedented challenge the whole world has faced for almost a year for the first time ever, poses some new dilemmas and questions that require finding rapid medical solutions to prevent the spread of the disease, as well as more general ones. The latter are related to the right to health; to questions of equality in access to vaccines by different population groups in Israel and the territories, and between rich and poor countries; a person's right to his own bodily integrity, informed consent and the cost of "vaccine hesitancy," and more.

The main innovation in this report is that it offers a series of concrete policy tools to address the pandemic, as well as its health, social, economic, ethical, and moral implications. Among other things, policymakers are urged to see to the purchase of vaccines exclusively by the government in order to prevent people with means from "jumping the line"; to ensure the equal supply of vaccines to the entire population, including asylum seekers, migrant workers, and the Palestinian population in the Occupied Territories; to carry out the vaccination at HMO unified clinics, and to "outreach" to at-risk populations.

Should it be necessary to continue prioritizing the vaccines, we call on policymakers to give priority to the population at risk of serious illness (such as incapacitated and bed-ridden elderly people) and their caregivers, as well as to socioeconomically disadvantaged groups, such as people living in crowded housing conditions, cultural-linguistic minorities (ultra-Orthodox, Arabs, Ethiopians), and poor populations that are more vulnerable than others to disease. We recommend that the decisions on prioritization be made transparently, by a non-political professional committee composed of experts in various fields and representatives of various sectors of the population.

To deal with "vaccine hesitancy," we propose to encourage vaccine compliance by relating to issues that arise on social media, advocacy in different languages and in a manner

adapted to different populations and sectors, and to recruit influencers. The delivery of information to the public must be done on a large scale and transparently, by doctors or scientists with no political-party affiliation. If and when the vaccine is shown to prevent infection, we propose to present immunization as a display of responsibility and solidarity. If advocacy proves insufficient and the need arises for further action to promote compliance, a decision to make vaccination compulsory and impose sanctions should be avoided but giving positive incentives to vaccinees may be endorsed (as opposed to a denial of rights).

The proposed policy tools are consistent with the universal right to **health**, the right to **equality**, the values of **fairness and solidarity** – all of which underlie this report.

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In May 2020, we launched Zulat for Equality and Human Rights, a unique institute that combines research and analysis via social media networks and conventional media, and acts as a bridge between the political arena and civil society. Zulat's studies portray the political and public reality, but our work only begins there. As an activist think tank, we fight back by working to set an alternative agenda, change the public discourse, and advance policy and legislation to uphold democracy and human rights. We represent a broad perspective on human rights, that looks at universal rights, civil rights - private as well as collective, and social rights – as a whole. We believe all different types of rights depend and relay on one another.

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