Ethical Issues of the SARS-CoV-2 Outbreak in East-Central Europe and Beyond
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THE COVID PANDEMIC IN HUNGARY: LESSONS FROM A HUMAN RIGHTS PERSPECTIVE

Judit Sándor*

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The medical, epidemiological, virological, economic, and other consequences of the Covid-19 pandemic are still acutely felt a year and a half later. In this chapter, I will analyze the human rights aspects of this public health crisis and, in particular, those related to bioethics. However, I have not covered the assessment of the environmental impact of the Covid-19 pandemic, as this would call for a separate study. Pandemics have been experienced many times in human history, yet there are several unique characteristics of the current pandemic caused by the SARS-Cov-2 coronavirus. The evolution of the Covid-19 epidemic shows the most similarities with the Spanish flu epidemic between 1918 and 1919. The Spanish flu is estimated to have claimed the lives of more than 50 million people worldwide. Admittedly, there were no vaccines available at that time and, in any case, the war was claiming terrible casualties while intensive care was still in its infancy. In recent decades, the SARS, MERS and Ebola epidemics have also claimed many victims, but the current epidemic caused by the SARS-Cov-2 virus, now sweeping the globe in several waves, is in many ways unique.

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I. Restricting Freedoms to Combat the Pandemic

The Covid-19 pandemic has had a serious impact on virtually all human rights: privacy, freedom of speech, freedom of assembly and freedom to work. Restrictions on all these rights have been imposed to deal with medical emergencies worldwide.[1]

Even in the first phase of the pandemic, in April 2020, the WHO emphasized that the right to health and a global response must be given priority in combating the epidemic. Despite this, there have not been many examples of international cooperation regarding epidemiological measures.

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[1] Paolo Giordano, *How Contagion Works* (London: Weidenfeld and Nicolson, 2020).

With curfews imposed on several continents as a consequence of the worldwide spread of the coronavirus in 2020, the largest mass quarantine of the modern era has been created, as no global shutdown or lockdown of this scale has ever taken place before.[2] During the initial phase of the pandemic, most people put up with the unusual restrictions for quite a long time, even though they had enjoyed a wide range of liberties. They were ready to accept temporary restrictions on their rights for the benefit of an important shared interest: maintaining and protecting health, which suddenly overrode a number of other considerations.

However, as more and more new regulations were adopted, some tightening while others easing restrictions from one day to the next, even affecting rights unrelated to the epidemic, more and more questions were raised about the necessity of limiting human rights. How long and to what extent should individual rights be restricted, how could it be done in a lawful and proportionate manner, even in the context of such a serious epidemic?

II. The First Wave of the Pandemic in Hungary

After the first infection cases emerged in Hungary in March 2020, severe measures were imposed in our country, as well. Schools had to switch to online operation overnight, shops were open only on a limited basis, and even grocery stores introduced specific time slots available only for the elderly population. The first measure related to the epidemic was Government Decision 1012/2020 (I. 31.) on the establishment of a Competent Task Force. Subsequently, one of the most significant and controversial laws was adopted by the National Assembly on 30 March 2020, when it passed Act XII of 2020 on protection against the coronavirus, which gave the government the authority to extend the scope of the relevant decrees.

The management of healthcare institutions was turned over to the military; hospitals were ordered to focus on fighting the pandemic and reduce the provision of other healthcare services. There was no previous model for this radical change, which is likely to shape the relationship between health professionals and health authorities on the one hand, and between doctor and patient, society and healthcare on the other, for a long period of time. At the very beginning of the epidemic, both doctors and patients had to cope with a strange, hitherto unknown measure. Previously, prevention was one of the key elements of any health awareness campaign. In other words, the main advice was that everyone should see a doctor in time, have regular screening tests and see their doctor immediately if they noticed any abnormality. This ingrained message seemed to have suddenly gone with the wind in mid-March. It was replaced by a completely different slogan: "Everyone should stay at home and only contact a health care provider by phone in case of urgent need". Most general practitioners, specialist clinics and hospitals suddenly became inaccessible to large numbers of patients. This radically new message can only be changed by a huge awareness campaign and by making our hospitals safe

[2] Geoff Manaugh and Nicola Twilley, *Until Proven Safe: The History and Future of Quarantine* (Dublin: Picador, 2021).

again. Waiting lists increased by several months after the third wave of the epidemic subsided.[3]

Such a radical transformation of the doctor–patient relationship has also encouraged bioethical thinking to be innovative. On 14 April 2020, the Hungarian Medical Chamber (HMC) published a document entitled "Ethical Considerations for the Allocation of Medical Resources during the Covid-19 Pandemic". [4] This is a rather unique and, in many respects, forward-looking recommendation in the history of the Chamber. By publishing ethical considerations, the Chamber's main ambition was obviously to try to address, in an open manner, not only the strictly medical aspects of triage but also its philosophical and ethical perspectives, i.e. how scarce resources must be allocated during the epidemic. It is important to note that the HMC respects the concept of non-discrimination in this resolution, in that it emphasizes that no one should be disadvantaged simply because of their age or gender; that is, the authors of the document did not confine themselves to any single factor in their classification.

The HMC recommendation was made just after the massive and abrupt reduction in inpatient numbers before Easter 2020, and a month after many outpatient and inpatient facilities became inaccessible to a wide range of patients for an indefinitely long period. Even to those who have paid health insurance contributions throughout their lives, and who could rightly expect not to have to give up their health care in their old age, after a lifetime of hard work, and that this care would accompany them for the rest of their lives, were unable to access health care facilities and services.

Therefore, first of all, it is necessary to fight with all means to guarantee these rights in a justified way because the premature surrender of patients' rights may permanently distort the doctor-patient relationship.

The ethical dilemmas of turning ventilators on and off have been so far discussed in bioethics regarding patients with incurable and terminal conditions. For the past 30 years, ethical standards have been based on the need to respect the intent of the person most affected, the patient. As this was the basic bioethical situation known so far, and since access to ventilators also plays a role in the case of Covid-infected patients, the decisions on when and how and how long ventilators should be used may have been overly stressed, not only in Hungarian but also in the recommendations of Italian anesthesiologists. (Since then, many intensive care physicians have seriously questioned whether it is in any way appropriate to focus on the ventilator in cases of severe Covid infections.)[5]

Human rights issues are also raised in the work of healthcare staff. For example, how can healthcare workers' freedom of expression be protected when they come to an important conclusion about the epidemic, or when they discover the efficacy or even ineffectiveness of a therapy? According to what ethical principles do ethics committees evaluate Covid-19 protocols? How should they treat seriously ill, dying

[3] https://jogviszony.neak.gov.hu/varolista_pub/elojegyzesi-listak-hosszanak-lekerdezese/?ocsk=133,

[4] Hungarian Medical Chamber (2020) "Ethical Considerations for the Allocation of Medical Resources during the Covid-19 Pandemic". https://mok.hu/koronavirus/tajekoztatok/etikai-megfontolasok-az-orvosi-eroforrasok-elosztasahoz-covid-19-pandemia-idejen-magyarorszagon.

[5] https://www.statnews.com/2020/04/08/doctors-say-ventilators-overused-for-covid-19/.

people who cannot be visited by their relatives? There have been cases in Italy and the United States where nurses have given the opportunity for patients and their relatives to see each other on a smartphone. But psychological support is also needed to cope with the trauma of isolation. This is obviously the responsibility of psychiatrists and psychologists in the first place. The lack of care for relatives, the inability to say goodbye to the dying and the postponement of funerals cause traumatic experiences all over the world. We cannot hold the hands of dying patients, and pregnant women can't have their partners around while they are in labor. For many, assisted reproduction processes have had to be stopped, and millions are not going for screening examinations or rehabilitation.

III. The Second and Third Waves of the Epidemic

The second wave was characterized by the closure of Hungary's borders on 1st September 2020 and the introduction of a number of new measures. Special rules were established in relation to the state of emergency under Government Decree 478/2020 (XI. 3.) on the declaration of a state of emergency. The goal was to avert the consequences of the SARS-CoV-2 pandemic, which caused widespread illness and threatened the safety of life and property. Successive waves brought about different epidemiological measures[6] and each of the problems that emerged raised bioethical and human rights issues as well.[7]

While Central Europe came through the first wave of the pandemic relatively easily, these very countries suffered much greater losses in the second and third waves. As there was no data indicating that this was due to biological differences between populations, the high mortality rates can be attributed to the flaws in the post-socialist healthcare system. In the old socialist regime, healthcare was accessible to the population at the current standards of that time. However, this sector has weakened as a consequence of market dynamics following the fall of the regime, with many healthcare workers even leaving this sector due to low wages. For this very reason, society experienced an almost catastrophic disaster in that most healthcare services had become inaccessible. As a result, in the spring of 2020, many surgical procedures and medical interventions were canceled, or amputations were required instead of vascular surgery. Having control over one's body is also closely linked to personal rights and human dignity.

Altogether 140,900 Hungarian citizens died in 2020, which is a significant increase compared to the previous year. Statistics also reveal that September 2020 saw a real spike in death rates.

While the first wave of the epidemic was relatively mild in Hungary, the greatest problem in the spring of 2020 was the *ad hoc* evacuation of hospitals, rendering the Hungarian healthcare system almost inaccessible to the uninfected.

[6] Act CIX of 2020 dealt with protection against the second wave of the coronavirus pandemic, while Government Decision 2030/2020 (29.XII.) addressed support for the development of a national coronavirus vaccine.

[7] Judit Sándor, Health and Legal Policy in Hungary at the time of Covid-19 Pandemic, *Medicine and Law*, vol. 39, no. 2 (June 2020), 191–202.

III. Before the Fourth Wave

By mid-August 2021 in Hungary, more than 5.6 million people received anti-covid vaccines and the total number of doses administered reached 11.2 million. While before June Hungary was among the countries with highest vaccination rates in the world, many other European countries have accelerated their vaccination programs since then. As of August 15, 2021, Malta had the highest COVID-19 vaccination rate in Europe having administered 176.83 doses per 100 people in the country.[8]

The initial success in reaching a high vaccination rate in Hungary prompted the government to relax the public health measures. During the summer, wearing masks is not obligatory any longer, not even in shops and at public events, and although immunity and vaccination cards had been introduced already in the spring, showing these cards is no longer required to enter cinemas, theaters, restaurants, and other indoor facilities. In June, the Puskás Stadium in Budapest hosted Euro 2020 (European Soccer Championship) matches and the UEFA had allowed full capacity crowds of 68.000 people on each occasion.

At the end of the summer, in 2021, Hungary was the first country in Europe to allow the administration of a third vaccine, only four months after the second jab. People with low antibody levels may register for the third shot, especially those senior citizens above 65 who had received the Chinese Sinopharm vaccine, as tests showed that their antibody levels were not high enough to ensure protection against the coronavirus.

Hungary is lagging behind other EU countries in PCR testing. PCR testing is mandatory only before an invasive medical intervention, and even then, it has to be paid by the patient.

On July 13, 2021, twelve EU countries (Austria, Belgium, Denmark, France, Germany, Greece, Italy, Latvia, Luxembourg, Portugal, Slovakia and Spain) received approval for recovery and resilience funds, and on July 28, 2021, Croatia, Cyprus, Lithuania, and Slovenia also became eligible. The main aim of these funds is to boost economies and recover from the COVID-19 fallout. The European Commission has delayed approval of Hungary's recovery plan[9] partially because Hungary does not go far enough in combating corruption, and it potentially risks the timely arrival of billions of euros in funding. In July 2021, the European Commission's Rule of Law Report was published. It showed severe deficiencies in the rule of law in Hungary. This is especially worrying that Hungary may lose EU funds due to rule of law deficiencies.

The decision to withhold the approval of the Hungarian recovery and resilience plan[10] has been also motivated by the political controversy surrounding a new law

[8] www.euronews.com/travel/2021/09/14/which-eu-country-is-leading-the-covid-19-vaccination-race.

[9] The Recovery and Resilience Facility (RRF) is the largest component of Next Generation EU, the European Union's landmark recovery and structural transformation instrument. EU countries must submit recovery and resilience plans, which are assessed by the European Commission and approved by the Council.

[10] European Member States had to set out in their recovery and resilience plan the reforms and investments that they aim to implement by 2026. Once submitted, then the Commission assesses

passed by the country's parliament on pedophilia. The stated purpose of the law is to fight pedophilia and protect the children's wellbeing. The *Parliamentary Act No. LXXIX of 2021 on the fight against pedophile offenders and amending certain laws to protect children* was adopted in June. The contested law wanted to fix gender status at the moment of birth without the possibility to change. The new law includes a provision in the child protection system, by which the state protects the right of children to self-identity according to their gender of birth. Furthermore, in the adopted law homosexuality is regarded as harmful for children requiring minors to be protected from the "representations and popularization" of LGBTQ content in the media, and therefore children should be protected in the same way as in the case of pedophilia. As a result, the European Commission launched legal action against Hungary because of the violations of LGBTQ rights.

This indicates that the EU may start sanctioning the violation of rule-of-law by using a so-called "conditionality mechanism to freeze funds from its pandemic stimulus package before they have been disbursed. Hungary's government could potentially miss out on as much as 7.2 billion euros ($8.5 billion) of grants from the EU recovery plan compounding Hungary's many losses during the third wave of the pandemic.

Although the government communicated that "Brussels" attacked the country and that the European Union promotes gender reassignment surgeries among minors, the EU Rule of Law Report focuses instead on the violation of media freedoms, on narrowing the independence of the judiciary branch of power, and on the emergency measures irrelevant to the public health crisis of the pandemic.

IV. The Right to Health and Healthcare

By early summer 2021, 178 million people had been infected and 3,800,000 people had died as a result of the pandemic.[11] In absolute figures, the United States, India, Brazil, France, Turkey, Russia, England, Argentina and Italy were the biggest losers in this pandemic.[12] However, if we consider the figures in proportion to the population, with more than 30,000 Covid-related deaths, Hungary had also moved into the "vanguard" by the beginning of the summer.

The pandemic has affected all human rights, from respect for privacy to freedom of speech, from freedom of assembly to freedom of employment, but one of the most important fields where everyone has been affected simultaneously is the right to health.

It would be hard to find a more controversial or ambiguous human right than the "right to health." It derives primarily, though not exclusively, from Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), and requires governments to acknowledge "the right of everyone to the highest attainable

Member States' recovery and resilience plans within two months after submission and translates their content into legally binding acts.

[11] Since the submission of this chapter by the end of May 2022, 529 million people had been infected and 6,280,000 people had died as a result of the pandemic.

[12] Johns Hopkins University Coronavirus Resource Center, coronavirus.jhu.edu/map.html, last accessed on September 15, 2021.

standard of physical and mental health."[13] The pandemic situation has drawn our attention to the fact that the right to health has a fundamental role underpinning all other rights and it is instrumental in the exercise of other fundamental human rights, as well. If I have no access to basic and necessary healthcare, I cannot exercise my right to free speech or any other rights while I am ill, feverish or lacking medical care, and my right to freedom of assembly is also restricted in the event of an epidemic.[14]

The right to health has always been strongly influenced by the nature of government involvement, by a stronger or weaker form of welfare society, or its complete rejection, and by healthcare expenditure.[15] In the first wave of the Covid epidemic, the problem was not only related to the availability of Covid-related care and tests; a wide range of healthcare services also became simultaneously inaccessible.

In the field of healthcare, the greatest disruption has been the challenge to maintain treatment for conditions unrelated to the Covid pandemic. One thing that soon became clear was that our healthcare system was facing a serious ordeal. Fortunately, Hungary was only minimally affected by the spring wave of the epidemic but, despite this, the healthcare system is being almost completely reorganized, with most healthcare services becoming inaccessible. During the epidemic, it became obvious that while equipment purchases can be implemented relatively quickly, it is however impossible to remedy infrastructure deficiencies, train healthcare staff or increase capacity in a suddenly unfolding crisis.

The right to health has been seen by many as a mere exaggeration of the human rights optimism emerging after World War II. In recent years, neo-liberal economic approaches have given the market a dominant role in this area, and in many cases, they have also intended to build health care on pure market foundations.

Apart from the many tragic ramifications of the Covid-19 epidemic, the prime lesson to be drawn is that the right to health is an integral part of the catalogue of fundamental rights, and that without health, or where health is permanently threatened, people cannot exercise their fundamental freedoms. Moreover, the right to health is also closely linked to the right to life, and therefore any sudden, drastic restriction of the right to health may have a negative impact on the right to life, as well.

Although the provision of healthcare services undoubtedly requires substantial budgetary resources, this pandemic has shown that health care must have priority over many other state-subsidized activities. During the epidemic, human lives were reduced to mere figures, reported daily. In the third wave, by early summer 2021, the epidemic had already claimed the lives of nearly 30,000 of our fellow citizens, representing one of the worst mortality rates per capita in the world. The epidemic has not only isolated people physically, socially but also emotionally, and to date there

[13] Jennifer Prah Ruger, Toward a Theory of a Right to Health: Capability and Incompletely Theorized Agreements, *Yale Journal of Law and Humanities*, vol. 18, no. 2 (January 2006): 3.

[14] Judit Sándor, Rebalancing Human Rights at the Time of Covid-19 Pandemic, *Pravni zapisi*, vol. 11, no. 2 (2020): 385–412.

[15] Máté Julesz, *Az egészséghez való jog* [The Right to Health] (Budapest: Medicina, 2020), p.105.

has been no collective mourning, apart from a few individual initiatives. All this is a conscious evasion of what is undoubtedly a trauma that is hard to handle.[16]

Since the primary responsibility for dealing with the epidemic lies with our healthcare system, at what stage it is confronted with such a serious epidemic is not irrelevant. The main lesson of the epidemic so far is that, when planning healthcare resources, it is always worth planning for a little more in anticipation of just such an unanticipated event. The epidemic also showed that, in spite of the existence of private health care, many elements of the epidemic typically require community-based care. Even those who thought they could afford higher levels of care and therefore could opt out of the community perspective, are dependent on public health measures to eliminate the pandemic.

The Hungarian Government did everything to avoid facing moral questions raised by the pandemic. One method for keeping this cold-minded approach was applying military rhetoric in government communication that would not allow any expression of empathy, any mechanism of deliberation involving the negotiation of expert recommendations, or any debate or critical remark on handling the pandemic. Just like in times of war, measures were announced on a weekly basis and had to be followed without any reflection for the sake of public safety. In the media the Chief Medical Officer, police officers on her side, declared the actual policy. General measures that represented a turning point in handling the pandemic were always announced by the Prime Minister.

Besides the militarization of pandemic control that required discipline from everyone, the other official way the government dealt with the pandemic was based on pure rational, economic calculations. Not showing any compassion towards the victims and their families, the daily report of the government only listed the age and the underlying disease of the victims, reducing human beings into numbers.

After the second wave, economic arguments against lockdowns became more frequent. The government faced the choice between safeguarding public health and fostering economic recovery and stability. A large segment of the population also wanted to return to their normal lives without limitations. Although Sandel's analysis of the moral limits of the market does not deal with healthcare, the issue can be approached not only from a human rights perspective but also from a moral angle.

Prolonged limitations on the right to health not only endanger the right to life and healthcare, but also seriously impact human dignity. Many people who suffered pain and uncertainty due to delayed or unavailable diagnosis felt that their dignity was not respected. Individual needs were erased as the major focus was on containing the spread of infections. Those who were hospitalized and died at the hospital could not see their relatives before their deaths. Because of the serious workload imposed on the health care workers they were often not able to communicate with the victims' relatives in time.

[16] Judit Sándor, Az eutanázia kontextusai [Contexts for Euthanasia], Litera, June 29, 2021, available online at litera.hu/irodalom/publicisztika/sandor-judit-az-eutanazia-kontextusai-szeljegyzetek.html, last accessed on September 15, 2021.

Intensive care units have become total black boxes, especially because the media could not enter, and the Hungarian public saw COVID departments and intensive care units only from the foreign press.

Article 3 of the Oviedo Convention lays down the principle of equitable access to health care. According to this article, "Parties, taking into account health needs and available resources, shall take appropriate measures with a view to providing, within their jurisdiction, equitable access to health care of appropriate quality." The Bioethics Committee of the Council of Europe also highlights the importance of this passage in the implementation of the vaccination procedures that are just starting. The interpretation of equity in the context of the epidemic is not clear. Although there are different possible principles of classification, the question is how applicable the classification principles used during disasters are in the event of a prolonged epidemic. Thus, while for a shorter period of time it is easy to give up treatment in favour of the epidemiological care of others without endangering one's health or life, in the longer term this is a disproportionate burden. There are some interventions that, if not performed, will result in a permanent deterioration of one's quality of life. Although not incompatible with life, the outlook for and quality of life will be permanently impacted if vascular surgery is not performed because of the epidemic and an otherwise salvageable leg must be amputated instead.

V. Vaccination Order and Certification

As soon as vaccines against coronavirus became available, new questions emerged that had also not yet been resolved. For example, who should have priority in the order of vaccination, and based on their age, occupation or illness?

The CDBI document[17] also deals with the vaccination of people in vulnerable situations, so the vaccination of people with physical and mental disabilities, minorities, homeless people, refugees, asylum seekers and even migrants should also be provided. This is not only dictated for humanitarian reasons, it is also necessary for the protection of society at large, as vaccination is also in the interest of society as a whole.

The choice of being vaccinated or not was so far clear in the Hungarian public health law. There are compulsory vaccinations listed and voluntary ones. During the COVID pandemic, however, a new category has emerged, as in the case of the various COVID-19 vaccines, it was voluntary and not compulsory, but people without vaccination faced several restrictions in their daily lives. As to the choice between various types of anti-covid vaccination, the decision should be based on medical aspects and discussed with the patient. After all, it is the patient who bears the consequences of the decision. Since this type of vaccination is voluntary, and the patient is protecting both themselves and the community by deciding to have the vaccine, then the patient cannot be circumvented in any way. The health aspects of the vaccine provided to the patients must be transparent and providing it must not be based on coercion. In 2021 in Hungary, there was strong political pressure in favor

[17] Covid-19 and Vaccines Ensuring Equitable Access to Vaccination during the Current and Future Pandemics rm.coe.int/dh-bio-statement-vaccines-e/1680a12785, downloaded on 17 June 2021.

of the so-called Eastern vaccines, Sinopharm and Sputnik-V. Minister for Foreign Affairs often appeared in the airport receiving help from Russia and China while the help from the European Union was not mediatized.

From a legal and ethical perspective, patient rights in relation to voluntary vaccines against Covid are highly individual. The first fundamental difference compared to mandatory vaccination is that the patient voluntarily decides to take the Covid vaccine. This also implies, for example, that they have fewer rights in terms of government compensation than in the case of mandatory vaccinations. This is because, in the case of mandatory vaccination, if a person subject to the vaccination requirement suffers serious impairment to their health, disability or death as a result of the vaccination, the government will compensate them or their dependents. At the same time, the voluntary nature and the enhanced risks and responsibility placed on the individual also imply that they should be able to decide, in consultation with their general practitioner and taking their health considerations into account, to receive the most appropriate vaccine for their age group. Of course, the picture is nuanced by the fact that this voluntary vaccine is free of charge, so the person being vaccinated does not pay the does not pay the direct monetary costs themselves. In addition, many different vaccines are available based on a variety of principles, and there are health and age-specific criteria to differentiate between vaccines. When the pandemic was raging, the priority was to get as many people as possible vaccinated as early as possible. However, everyone was also free to consider whether to choose an early vaccine, whatever it was, or whether to wait for the vaccine that best suited their condition, perhaps later. Nevertheless, we can only determine the differences once we know enough about the vaccines. In any event, the administration of a voluntary vaccine must not be based on extortion, deception or even on the basis of consent obtained through pressure, because then it is no longer voluntary but coercive. Uncertainty over vaccines was also fueled by lack of information. A medical consultation hotline could have been established, or the online registration system made more interactive, allowing feedback to the patient on their expected date of vaccination and the choice of vaccines. This is because a great deal of stress is caused by people who, being unsure whether their registration was successful because they do not receive any information, would call their general practitioner, who becomes overwhelmed and unable to answer these questions, every day.

As vaccines became available to an increasing number of people, the idea of giving special rights to those holding vaccination certificates was developed. It raises important questions as to what the consequences might be of unilaterally restoring rights in the case of voluntary vaccination, as long as vaccination is not available to everyone.

In March 2021, the Council of Europe published a document on the human rights aspects of vaccination certificates.[18] The document also addresses the protection of sensitive data on vaccine certificates. The issues of privacy and data security have always been at the core of epidemic management.

[18] Council of Europe (2021) Protection of Human Rights and the "Vaccine Pass", rm.coe.int/protection-of-human-rights-and-the-vaccine-pass/1680a1fac4.

The European Court of Human Rights issued a ruling on mandatory vaccinations in April 2021. Although the vaccine involved in the case is not related to the Covid-19 pandemic, the court's reasoning may provide guidance in other vaccine-related disputes. In the *Vavricka* case[19], the parents objected to the fact that their child could enroll in a Czech day-care center only after mandatory vaccination. According to the applicant, mandatory vaccination would be contrary to the right to privacy. However, the Court did not agree with this argument. "The obligation to vaccinate and the exclusion of [unvaccinated persons] was based on a law approved by parliament, and this legitimizes mandatory vaccination." The obligation to vaccinate undoubtedly interferes with autonomous decision-making, but it is justified by the protection of (the rights) of others and public health. According to the Court, this restriction is necessary and proportionate to the objective to be achieved, namely, the protection of public health. Based on the Court's arguments, it follows that, once vaccines against Covid-19 are proven safe to use, public health interests may justify making them mandatory.

As soon as vaccines against coronavirus became available, new questions emerged that had also not yet been resolved. For example, who should have priority in the order of vaccination, and based on their age, occupation or illness?

By October 15, 2021, the Hungarian Constitutional Court had received about 823 petitions related to the regulation granting benefits to the so-called covid protection certificate. The Council of the Constitutional Court accepted the joint constitutional complaints and opened a substantive investigation. In its decision published on 19 October 2021, the Constitutional Court ruled that the provisions challenged with the petition were not unconstitutional.

The mandatory vaccination of COVID-19 for healthcare workers were subject of several constitutional complaints. By October 15, 2021, about 250 petitions had been received in the field. In its decision published on December 3, 2021, the Constitutional Court found that the impugned provisions were not unconstitutional.

VI. Reconciliation of Autonomy and Community Aspects

One of the most important 20th-century achievements of bioethics and human rights is the recognition of autonomy in health interventions. Informed consent based on autonomy lays the ethical foundation for medical care. We are used to this, and perhaps the most difficult aspect during the epidemic was the temporary surrender of autonomy because of community interests regarding the epidemic. People were not allowed to choose their medical treatment; they were often deprived of access to medical care and had to endure many restrictive measures. In the same time, as Paolo Giordano put it, "[the] epidemic encourages us to think of ourselves as belonging to a collective. … In the contagion we become, again, a community."[20]

[19] *Vavřička and Others v. the Czech Republic*, ECtHR, Applications no. 47621/13 and 5 others, judgment of April 8, 2021.

[20] Paolo Giordano, *How Contagion Works, Science, Awareness and Community in Times of Global Crises* (London: Weidenfeld & Nicolson, 2020).

The Charter of Fundamental Rights expresses caution in Article 35, stating that "Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all the Union's policies and activities." However, it was the epidemic that showed the need for cooperation in a pandemic. While in the first wave, the most severely affected countries themselves tried to find a solution individually, in the second and third waves of the epidemic, European countries decided on a common procurement of vaccines.

From the point of view of healthcare workers, inconsistent and sudden actions, withdrawal, and reorganization of treatments are issues that deeply affect their own professional integrity and also cause unpredictable traumas. Not only have many health workers and doctors around the world died from the infection, but we know of suicide cases[21] and mental breakdowns that can apparently persist even after the epidemic has subsided. A wider ethical approach also takes into account the psychological support that health workers exposed to increased mental-physical strain receive, including more frequently available rest periods.

Only if all these steps are taken together, they can alleviate the psychological stresses generated during the health care carved in military form, so that a physician-patient relationship which is ideal for healing, yet honest and humane, can develop after the pandemic has subsided. By curbing the epidemic, we hope that we will soon find ourselves once again in the health conditions of the 21st century, and that we will once again be able to report on the positive health effects of the latest technologies.

Health is closely associated with the concept of human dignity. Wiktor Osiatyński also refers to the fact that the right to health is as closely associated with human dignity as the first-generation rights in the human rights catalogue.[22] The rigid separation of the different generational rights is based only on a taxonomic, structural distinction rather than a justifiable, principled one. At the same time, the right to health obviously does not mean a legal assurance or guarantee of health, since health has many genetic, environmental and other factors, but no one can be excluded from the conditions for maintaining and preserving their health.[23]

VII. Data Protection, Surveillance, Epidemic Management

The pandemic management has also seriously affected the rights to privacy and data protection. Five days after the declaration of the state of emergency on March 11, 2020, Government Decree 46/2020 (III.16) stipulated that the Minister in charge of innovation and technology is entitled to access and manage any personal details in the possession of state and municipal bodies, business organizations and even private

[21] Bryn Nelson and David B. Kaminsky, COVID-19's Crushing Mental Health Toll on Health Care Workers, *Cancer Cytopathology*, vol. 128, no. 9 (September 2020), 597–598. Available at acsjournals.onlinelibrary.wiley.com/doi/epdf/10.1002/cncy.22347, last accessed on September 15, 2021.

[22] Wiktor Osiatyński, *Human Rights and Their Limits* (Cambridge: Cambridge University Press, 2009), 129.

[23] Thérèse Murphy, *Health and Human Rights* (Oxford: Hart, 2013), 42–43.

individuals. The same authorization was granted to the so-called Operational Corps by Government Decree 83/2020 (IV.3.) with regard to personal data processed in the Electronic Health Service Space. The Government Decree 179/2020 (V.4) suspended the right of the person concerned to be informed in advance before the start of data processing, and increased the time limit for the release of data of public interest from fifteen days to two periods of forty-five days, i.e. ninety 90 days. Registration for vaccinations was also based on a central registration system run by the government. Later on, an immunity certificate confirming vaccination against the disease, which also included the passport number and the personal identity card number was adopted. Centralization of data management can be also observed elsewhere due to the epidemic, as well as the implementation of regulatory monitoring and epidemiological surveillance through a digital application for cell phones. After the third wave has abated, checking passengers according to various criteria, taking their temperature, testing them and accepting their immunity certificates in whole or in part also means that surveillance has been normalized. It is important to see the difference between monitoring and health care. While these regulatory epidemiological measures aim to curb an epidemic, they do not amount to the provision of health care. No matter how perfect the application, or even if it is downloaded voluntarily, monitoring alone does not result in health care. A technocentric view may complement it, but in no way replaces health care.

Even before the Covid pandemic, the widespread use of artificial intelligence, robotics, and information technology, capable of being used for surveillance, urged the rapid inclusion in human rights law. Without it, this model seeks to build up complete surveillance: to map the movements and contacts of the individual. During the pandemic, these tools are useful, and this digital monitoring is in many ways more convenient. However, there are fears that the resulting convenient governance will persist through the management of data, and that certain rights, such as travel and freedom of movement, will become the privilege of a privileged class.

Numerous countries have introduced applications for contact tracking and reporting. Apart from containing useful information, such as test sites near a person's home, they also indicate contact with an infected person. In France, the StopCovid application, developed by INRIA (National Research Institute for Digital Science and Technology), was released on June 2, 2020. On May 29, 2020, a decree (Decree No. 2020-650 of 29 May 2020 on data processing, known as "StopCovid") was issued, which lays down the final legal framework for implementing the application.[24]

In China, the social credit system that was already in use[25] has rendered monitoring individuals an integral part of everyday life. When personal data are collected and used for public safety purposes, the consent of the persons concerned is not required. The publication on COVID-19 monitoring mechanisms issued by

[24] https://www.gouvernement.fr/info-coronavirus/tousanticovid, last accessed on September 15, 2021.

[25] Katja Drinhausen and Vincent Brussee, China's Social Credit System in 2021: From Fragmentation towards Integration, *MERICS China Monitor*, March 3, 2021, available at merics.org/en/report/chinas-social-credit-system-2021-fragmentation-towards-integration download date, last accessed on September 15, 2021.

the Chinese Cybersecurity Directorate stipulates that organizations authorized by the National Health Committee are entitled to collect this data without a permit.[26]

Tracking for epidemiological reasons must not be more extensive than justified, nor may it be self-serving, threatening, or withholding data or sharing it for other purposes. Tracking that complies with human rights standards must be aimed at combating the epidemic, providing access to care and should in no way be a substitute for health care.

VIII. What could be the Human Rights Implications of the Pandemic?

Digitized management of the pandemic, with tracking, can become permanent if citizens become used to making their data available. Another possible scenario leads to improving health care, rebuilding elements of the welfare state based on lessons learned from the epidemic. Reallocating budgetary resources to health, for example from prestige projects, or through expressing solidarity in the taxation system. Increased recognition of the work of healthcare staff, especially nurses and specialist nurses, and adequate financial recognition of their work is also an important element of preparedness for epidemics. But this model does not mean abolishing freedoms or limiting privacy and liberty. After curbing the epidemic, making up for missed interventions, accelerating interventions on waiting lists and mental health care will increase demand for health care for years to come.

The current slow-down[27] of the Covid pandemic in Europe is not only a time for relief, but also calls for important and urgent social changes. This global human catastrophe has drawn attention to the vulnerability of human dignity and health, and of humans in general. It is not enough to cover ethics in a formal way, as there is a need for more serious environmental, veterinary and food monitoring, more social control of virological laboratories, and closer international cooperation and solidarity during a pandemic. Many people have already emphasized the need for a new social contract[28], but after this pandemic we simply cannot continue where we left off. Updating the catalogue of human rights and ensuring that second generation human rights, in particular the right to health, are duly recognized and that appropriate conditions for their enjoyment are provided are absolutely necessary.

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[27] During the summer of 2021.

[28] Minouche Shafik, *What We Owe Each Other: A New Social Contract* (London: The Bodley Head, 2021), 71–93.

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