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COMMENTARY

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IMMUNITY PASSPORTS – UNWISE AND UNNECESSARY

by Bernhard Perchinig

Governments are considering 'immunity passports' to allow those with COVID-19 antibodies greater mobility and to provide employers with an increasing pool of people to fill public-facing jobs. This may seem tempting but would lead to mass discrimination in the labour market, and also provide perverse incentives to potential migrants to become infected. There are alternatives.

On 6 May, the Johns Hopkins University COVID-19 dashboard reported almost 3.8 million confirmed cases and over 258,000 deaths worldwide. Luckily, most of those infected recover after suffering mild symptoms as some 1.25 million persons have already. With the passing of time, the number of recoveries will reach millions.

Several states have suggested that immunity passports could allow those who have recovered from a COVID-19 infection free travel over the coming months of travel restrictions and closed borders. On 25 March, the World Health Organization strongly warned against the issuing of immunity passports due to the lack of reliable medical evidence that recovery from a COVID-19 infection definitely leads to long-lasting immunity.

Even if this were the case, many experts are warning immunity passports would have detrimental effects on labour markets, seriously infringe privacy rights in the field of health, and endanger the collective fight against the pandemic, both within states and internationally.

Perverse labour market signals

In most parts of the world, the state regulates the labour market (the EU's single market is a hybrid model of state and supranational regulation). Recruitment works via a series of signals that employers can trust and understand: national training certificates, employment history, reputation and recommendations, as well as basic information such as age or gender.

Legislation strictly limits access to and use of health data as a signal in recruitment. Employers cannot ask for genetic tests highlighting the likelihood of a potential employee developing cancer. Women cannot suffer discrimination on the grounds they might become pregnant during the term of employment. Highly developed economies generally work on the

assumption that education and performance should be the keys to professional positions, not physical traits.

The issue of immunity passports would seriously undermine this orthodoxy. Those who recover from an infection would become members of a preferred workforce presumed not at risk of re-infection from COVID-19, and therefore much more versatile and less likely to be absent from work due to prolonged illness. This cohort would eventually be likely to demand higher wages, a development that would not go unnoticed by other workers. Even though severe cases have also reported for patients younger than 30 or 40, the lethality of a COVID-19 infection in the age range below 40 is comparatively low. 'Corona-parties', where the young voluntarily seek infection, paradoxically to improve their life chances, would become a fact of life, undermining efforts to control the spread of the virus.

Internationally, the mass irregular movements of people in recent years amply demonstrate the willingness of millions of migrants to take risks in order to leave poor and unstable regions for the promise of a better life elsewhere. Given that the vast majority are under 40, many would see COVID-19 as a small price to ease their passage to Europe or other places. This could exponentially heighten the infection curve in the 'Global South' with very serious implications for fragile health infrastructures.

Risks of corruption and malpractice

No supranational regulatory body exists to coordinate the health systems in the 193 countries that are UN members. (The WHO works inter-governmentally, facilitating standard-setting through an open method of coordination.) Definitions, procedures and practices of issuing medical certificates differ from country to country. A variety of medical institutions issue health certificates, a privileged and apolitical process not normally under direct state control. Hence, the establishment of a universally recognised and trusted immunity passport would be extremely difficult.

Moreover, what about the risk of corruption in national medical systems? If immunity passports were introduced, some malpractice would be inevitable, for example where such documents were improperly issued in exchange for bribes. International disputes over authorities issuing a rising number of fake immunity certificates could undermine progress made to control the pandemic and re-introduced travel restrictions.

Even with strict rules in place to prevent such disputes, organised crime groups are likely to get involved. Forging passports and visas is big business in the criminal world. Faked immunity passports would be a hugely lucrative potential growth area.

While the security of travel documents has advanced in leaps and bounds over the past 20 years, most health certificates today are not more than a piece of paper with a rubber stamp. If immunity passports were to become quasi-travel documents, they would have to be forgery-proof like modern passports and searchable on a global biometric database comparable to the EU's Eurodac system for asylum fingerprints. Anyone familiar with such large-scale IT projects knows this would take years.

Smart mobility as a solution?

The intellectual rationale for issuing immunity passports is that borders are the 'skin' of the state, protecting inhabitants within from infection by contagious strangers. An immunity passport would therefore free the stranger from suspicion and allow entry. But this way of thinking does not really fit the actual pattern of the pandemic, which is one of regional and sectoral clustering. Regional hot spots have developed, for example in skiing resorts; or within specific institutions common to every country, namely care homes for the elderly in Italy, the UK and elsewhere. In all countries, there are places with a high caseload of infections and those where only very few people are infected.

Hence, a smarter answer to the problem of mobility during the pandemic would look at two elements. First, differentiated mobility based on the situation by region. Second, compulsory transnational contact tracing and rapid isolation of contacted persons in case of an infection, probably made possible by using mobile phone apps as a controlling mechanism. Those residing in an area with a low caseload and/or reproduction factor should have more mobility privileges compared to those originating in hotspot areas, under the condition that they use tracing apps. Mobility would depend on successful regional containment and cooperation rather than individual immunity. Admittedly, this would involve some discrimination against healthy persons in hot spot areas. This can be managed by allowing travel for those tested negatively in the last four days. Currently, Austria exempts those who take such a test from a 14-day quarantine they would otherwise be subject to upon entry. As a side effect, this strategy would foster public adherence to anti-COVID-19 measures in order to reach improved mobility status.

In the EU's free movement area, where practically all states have re-introduced internal border controls, this approach would require a regular regionalised evaluation of the situation

by the European Centre for Disease Prevention and Control, and enhanced cross-border cooperation between health authorities. Linking the fight against the pandemic with evidence-based criteria for regional mobility management, on a transnational basis, is infinitely preferable to the current uncoordinated efforts at member state level, based on traditional border control.

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