THE HASTINGS CENTER

BIOETHICS FORUM ESSAY

Prioritizing the 1a: Ethically Allocating Scarce Covid Vaccines to Health Care Workers

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Beginning this week, guarded vehicles loaded with geo-tracked and temperature-monitored doses of the first Covid-19 vaccine authorized in the United States are fanning out to hospitals across the country. The doses will be delivered into the arms of the country's weary health care workers, who for the last 10 months have been on the front lines of delivering crisis care to patients sickened and killed. In vaccine prioritization protocols produced by the Centers for Disease Control and Prevention and the National Academies of Sciences, Engineering, and Medicine, as well as by individual states, these are the individuals who, along with nursing home residents, make up phase "1a" – those who are first in line to be offered the initial limited doses of vaccine. While much attention has been paid to who should come next, less is known

about how hospitals are allocating vaccine doses among their staff. For many medical centers, the first shipments will only be enough to vaccinate a fraction of their workers. Who goes first within the “1a” category, and how are such decisions made? Below, we outline some of the ethical considerations that should inform the allocation of scarce Covid-19 vaccines to those at the head of the line.

What is the broader goal of vaccination?

At the individual level, the goal of vaccination against Covid-19 is to protect the recipient from severe disease. (While it is possible that vaccination may also protect the individual from becoming infected with and/or transmitting the SARS-CoV-2 virus, we don’t yet know that from existing data.) Health care institutions, however, must be guided by broader aspirations. Medical centers in areas that are not facing a surge in cases may have the luxury of viewing vaccination primarily as a benefit to their workers. Systems that conceive of vaccination in this way may choose to prioritize those who, due to age or underlying conditions, are most at risk for hospitalization or death from Covid-19. Or they may choose to recognize and affirm the sacrifices made by workers who take the most risk and prioritize those who work in high-exposure areas, including Covid-designated units. But for hospitals stretched thin by rapidly escalating infection rates and mandatory quarantine due to exposure, conceiving of vaccination primarily as a benefit to be distributed to the worthiest or neediest employees may be inappropriate. In these more urgent contexts, administrators must allocate vaccine doses with an eye toward preserving the hospital’s ability to continue to deliver life-saving care. Realizing this goal would require weighing and balancing multiple considerations, including health care workers’ risk of becoming infected, their risk of transmitting the virus to immunosuppressed patients and other staff, and the effects that their absence might have on the provision of care.

Do those at the bedside get priority?

There is widespread agreement in frameworks for national guidance that health care workers should be among the first to be offered vaccination against Covid-19. These frameworks endorse a broad definition of “health care worker” that goes beyond clinical care providers such as physicians and nurses to include support staff such as technicians and environmental services workers. All of these candidates for vaccine priority may work in hospitals areas where risk of exposure to Covid-19 is highest. Allocation protocols that see vaccination as a benefit to be distributed to the most needy or worthy workers should acknowledge this shared risk by including support staff within the 1a tier and vaccinating them alongside physicians and nurses.

In some cases, however, limited vaccine availability and dire conditions that threaten hospitals’ abilities to provide care may force institutions to distinguish between direct care providers and support staff. It is likely that in many such cases, direct care providers will receive first priority, but this is not certain. That is because the question, “What allocation scheme will ensure that this hospital can continue to function?”, is an

empirical one. The infection of an environmental services worker or patient transporter who moves from unit to unit and interacts with many patients and staff members may be as devastating to the hospital as the infection of an attending physician in an ICU. When the good of the community does require hospitals to prioritize direct care providers, however, this should remind us of the greater precarity faced by support staff, who are typically lower paid and more easily replaced than clinicians. Of additional consideration, these individuals may have higher risks outside of the hospital, such as closer living quarters or second jobs where social distancing may not be possible.

What does it mean to be most at risk?

Health care centers wishing to prioritize workers who are most at risk must carefully define what this means, as different definitions imply different prioritizations. Prioritization of workers *at greatest risk for severe illness or death* would place older health care workers and those with certain underlying conditions at the front of the line. Prioritization of workers *at greatest risk of infection* would mean that the first doses would go to those with the highest likelihood of exposure – for example, providers who work in critical care units, emergency departments, and urgent care.

What about staff who decline to be vaccinated?

The rapidity of Covid-19 vaccine development is unprecedented in vaccine history, and its degree of politicization has been extraordinary. The vaccines currently being delivered to the health care work force employ a novel mRNA technology never before used in a licensed vaccine. All of these factors have fostered significant Covid-19 vaccine hesitancy among the public, including members of the health care workforce. This hesitancy extends beyond typically vaccine-hesitant groups to include people who generally embrace vaccination, but express skepticism about Covid-19 vaccines. Vaccine hesitancy among health care workers poses at least two ethical questions: 1) Should workers who initially decline lose their priority status for future vaccination opportunities? and 2) Should Covid-19 vaccination be mandated for health care workers? Guaranteeing health care workers who initially decline vaccination that they will retain their priority should they opt for vaccination in the future may inhibit the ability of hospitals to respond to new challenges that might arise in this fast-moving pandemic. Health care centers may need to reorder internal prioritization for subsequent vaccination waves in order to respond to where staffing needs are greatest. Regardless, these individuals will retain their 1a priority as health care workers. Many health care centers require vaccination against flu, but hospitals are unlikely to consider making Covid-19 vaccination mandatory for staff under an emergency use authorization. When and if these vaccines receive full FDA approval, however, hospitals and other health care providers will be forced to answer this question. Mandating vaccination is a significant infringement on individual liberty, but one that is generally considered justified based on the low risk to the individual and the substantial benefits to the public, especially vulnerable populations.

Should the prioritization tiers be made public?

Allocation frameworks published by the CDC and National Academies are, by their nature, public documents intended for public consumption and guidance. Frameworks for application within medical centers are not public unless the institutions choose to make them so. If publicized, they may expose the institution to objections from staff or give rise to resentment in employees feeling devalued by their inclusion in lower-priority groups. But such concerns must be weighed against the ethical imperative of transparency. And in a social and political climate plagued by misinformation, conspiracy theorizing, and understandable anxiety, we hope that hospitals will eschew secrecy and communicate with the kind of candor that characterizes public discourse at its best.

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