In the rush to roll out vaccines, commitment to social and racial justice must not fall by the wayside

Vaccines should be allocated in ways that reduce — rather than maintain, or worse, exacerbate — existing inequities across socioeconomic, racial, and ethnic groups.

By Harald Schmidt and Ruqaiijah Yearby Updated December 8, 2020, 3:05 a.m.

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In the coming days, planes and trucks will be loaded with the first batches of COVID-19 vaccines. Where they go matters as much for social and racial justice as it does for public health. There is a major risk that in the frantic pace of preparations for vaccine roll-out, equity will be considered only peripherally, as it has been throughout much of the COVID-19 pandemic.

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Initially, the vast majority of vaccine shipments will go to local health departments, hospitals, and other worksites of essential health care workers, followed by high-risk populations. The general population will likely be offered vaccines next spring. States and other administrative units face significantlogistical and practical challenges in deciding where to send box after box of vaccines in order to ensure proper storage, tracking, and administration. Planners also need to integrate an emerging consensus that vaccines should be allocated in ways that reduce — rather than maintain, or worse, exacerbate — existing inequities across socioeconomic, racial, and ethnic groups.

This matters, first, for deciding whether to send vaccines to states according to their population size alone or by some other measure. A few hypothetical examples of potential vaccine recipients can illustrate why. Let's call them Maria, Daniel, and Grace.

Suppose Maria is an hourly paid farmworker who lives in crowded quarters with other co-workers in rural New Mexico. According to the Centers for Disease Control and Prevention's Social Vulnerability Index, more than 3 in 10 peoplein the state are among the nation's most disadvantaged communities. Daniel lives in New Hampshire. He is currently unemployed, temporarily moved back in with his elderly mother, and also falls into the group of the nation's disadvantaged. Yet, because in New Hampshire this population group accounts for only a little over 1 in 10 of all people, if vaccines are distributed according to population alone, people like Daniel have a better chance than people like Maria in New Mexico to receive a safe and effective vaccine.

This is not fair. It maintains inequities where they could be reduced — yet allocating vaccines proportionate to population is the default model. By contrast, adjusting state allocations by their shares of disadvantaged groups (for whom a vaccine is far more important on economic, epidemiological,

and ethical grounds) would improve equity, and should be adopted urgently. Adopting the Social Vulnerability Index rather than population as a guideline — which the National Academies of Science, Engineering, and Medicine recommended in a recent report to address the disproportionate impact of COVID-19 on disadvantaged groups — provides policy makers a practical way of doing this.

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Within states, there are questions about whether they will make "special efforts ... to deliver vaccine to residents of high vulnerability areas," which the National Academies of Science, Engineering, and Medicine also recommended. To illustrate this, consider Grace, a furloughed single hospitality worker in Tennessee. The state's policy makers committed to reserve 10 percent of the vaccines the state receives as additional allotments for the most disadvantaged quarter of the population (measured on the Social Vulnerability Index). A little over 2 in 10 of the population fall into this category. For the worse-off in Tennessee, this is good news. Other states should therefore consider following Tennessee's example and commit to offering concrete additional amounts to their most disadvantaged populations.

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Even when policy makers have made reasonable efforts to prioritize vaccine availability to disadvantaged groups, it's unclear whether racial and ethnic groups most impacted by COVID-19 will take them. A recent poll suggests that while 59 perfect of white Americans would get vaccinated at the earliest opportunity, just 43 percent of Black respondents shared this view.

In the current context, it's critical to understand that vaccine hesitancy is not simply a matter of personal responsibility but has different reasons that require different responses. Particularly in Black communities, it can often reflect an entirely rational response to historical and ongoing experiences that have profoundly undermined trust. The failure of federal, state, and local governments to effectively address structural racism in employment, housing, and health care directly caused racial and ethnic disparities in COVID-19 infections and deaths. To overcome hesitancy, states should address structural racism as well as plan outreach and communication strategies in close partnersa littlip with community health centers, community organizations, community health workers, and faith leaders, and ensure that sufficient

numbers of dispensing sites are available in areas where, predominantly, more disadvantaged groups live.

To promote public health, to recognize the economic importance of employment for many who are worse-off, and to assist in ending systemic racism and the detrimental impact of the social determinants of health, it is imperative to (1) allocate vaccines to states by their share of disadvantaged populations rather than by population alone; (2) require states to document at the outset how they plan to deliver vaccine to their worse-off residents, including monitoring arrangements for disparate impact; and (3) plan outreach, communication, and dispensing locations in close partnership with the communities most impacted by COVID-19.

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