Vaccine Equity with Govind Persad

Christiane Wisehart, host and producer: I'm Christiane Wisehart. And this is Examining Ethics, brought to you by The Janet Prindle Institute for Ethics at DePauw University.

[music: Blue Dot Sessions, Partly Sage]

Christiane: Each day approximately 2 million people living in the United States receive their COVID-19 vaccines. Who gets vaccinated and when they get their doses is largely decided by each state's public health officials. And many states use age as the primary factor in determining who gets priority. My guest today, Dr. Govind Persad, is an expert in bioethics and health care law and argues that legislators should think through more equitable options for distributing vaccines.

Govind Persad: It makes sense to think, not just about personal medical risk, but also risk of being exposed and risk of transmitting COVID-19 to others. And so I think some of the states that have incorporated age alongside other factors, for instance, lowering your age cutoff for access in hard-hit neighborhoods or areas, I think that's a better approach than just using age as the only criterion or using it say alongside as opposed to combined with other criteria.

Christiane: Stay tuned for my interview with Dr. Govind Persad on today's episode of Examining Ethics.

Govind Persad: Emotions are really central to our own lived experiences. I think all of us are sort of emotional, uh, creatures. And so, understanding the emotions gives me understanding about myself and other people. But also, as somebody who is a democratic theorist, whose long thought about the value of democracy, the next question for me is like, how do we really realize a true and genuine form of democracy that's robust and long lasting? Um, and from people like King, Gandhi, all these people who were involved in organizing, you see a really strong emphasis on moral emotions as being part of the path to progress. So if you care about sort of moving past the problems we see, then we have to start really thinking about the role of the emotions play and how to cultivate the right sorts of emotions, in our fellow citizens, so that we can keep making progress in the right direction. So I think it really comes from a concern of moral progress and how do we get there.

Christiane: Stay tuned for my interview with Govind Persad on today's episode of Examining Ethics.

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Christiane: Many of us are currently facing questions about when to get our COVID-19 vaccine, or may have just completed the vaccination process. So with that in mind, I'm just going to cut to the chase and give you a fresh-from-my-closet-studio discussion with an expert in the ethics of

health care, Dr. Govind Persad. Before I start the interview, though, I quickly want to restate a statistic that Dr. Persad mentions. For some reason, the phone recording couldn't clearly capture what he was saying. A little bit into the discussion, he says that "There's higher risk for higher rates of death in Native American populations ages 30 to 39 compared to white populations ages 50 to 59." I also want to mention that we are not providing medical advice on this show, rather, we're just talking through, um, some policy suggestions. So keep both of those things in mind as I play this interview about vaccine equity with Dr. Govind Persad.

[interview begins]

Christiane: So we are having this discussion on March 17th, 2020, and I'm being really specific about the date here because the conversation around who should get a vaccine and when they should be able to get that vaccine is changing daily. With me today is Dr. Govind Persad, a professor and researcher at the Sturm College of Law at the University of Denver who works on issues of bioethics and healthcare. His recent research and writing centers on equity in vaccine distribution.

Dr. Persad, you have argued before that age should not be the main determinant of who gets priority in vaccine registration. And I thought that was really interesting because in the state where I live, Indiana, age is the main um, sort of filter for vaccine distribution. And I don't know, I thought that made sense because COVID kills elderly people at a higher rate. It doesn't seem like something you can mess around with aside from those women who dressed up in like wigs, uh, I think down in Florida. But what would you say to people like me who share that similar line of thinking?

Govind Persad: Age can be a legitimate factor among other factors in prioritizing who gets access to COVID-19 vaccines. And certainly one virtue of using it is that it is something that people have easy access to knowing what age they are. But a pitfall, I think of using solely age, basing it solely on age without considering other risk factors is both that's going to be less effective at saving lives, preventing complications, preventing the other arms of COVID-19 and then also less equitable.

So I think one example that really illustrates this is if you look at the CDC's data on death rates across different groups, it turns out that there were actually higher death rates in the CDC morbidity and mortality weekly report. There's higher risk for higher rates of death in Native American populations aged 30 to 39 compared to white populations aged 50 to 59, which is two decades older. Yet in Colorado where I live, we're not using age as the only factor, but everybody age 50 is going to be eligible I believe on Friday of this week. But there may be some folks who fall in fact into that higher risk group that I was talking about before, Native Americans aged 30 to 39, who don't have that same kind of access yet.

And so, I think it can be legitimate to think about age as one of the factors, but because age is only one of those predictive factors, it is both more equitable and better in terms of saving lives to try to incorporate other sources of risk. And that's especially true because people often focus on people's risk of dying if they get infected as the only thing that matters. But of course for a

transmissible condition like COVID-19, you also care about how likely somebody is to be exposed, how likely they are to spread infection if they are exposed. And infected. So I think it makes sense to think, not just about personal medical risk, but also risk of being exposed and risk of transmitting COVID-19 to others. And so I think some of the states that have incorporated age alongside other factors, for instance, lowering your age cutoff for access in hard-hit neighborhoods or areas, I think that's a better approach than just using age as the only criterion or using it say alongside as opposed to combined with other criteria.

Christiane: We just hit roughly the year anniversary for the pandemic in the United States. And I'm remembering back in March of 2020, a lot of people had this line about, well, COVID doesn't care if you're white, it doesn't care if you're black, it doesn't care what the color of your skin is, it's indiscriminate. And what I'm hearing you say is that that might actually not be true, right?

Govind Persad: So it's a little more complicated than that. It's not that the risk that someone faces is directly determined by their skin color or necessarily even by anything about biology. I'm not necessarily taking you to think that it does either. I think the best evidence that we have is that the reason why, for my stat about 30 to 39 year old Native Americans being at higher risk than 50, 59-year-old folks who are white or the other staff that kind of comes in that's sort of similar is if you look at the average age of death, this is again from a CDC study, it's about a decade earlier for folks who are minority patients than folks who are white. And that's not, I think because of anything about biology as best we can tell. That's because of the kinds of risks that I talked about before.

I think two of the most important ones are differential levels of exposure. So exposure, if you're in a frontline job, if you're working in a grocery store or working in a meat packing plant as opposed to being a work-from-home person like I am, or if you are exposed in crowded housing, because again many folks may live in housing that they have multi-generational, many people living in the same space, or just very much more crowded where you have many more people living in a single, fairly crowded housing complex. Where it's not possible necessarily to avoid somebody with COVID-19 in the hallways or in the next place over in contrast to living spread out in a single family setting or in more luxurious housing. That makes it easier both in terms of, as I said, housing, and then also the folks living in that nicer housing are often more likely to be in occupation that make it easier for them to protect themselves.

Some of my colleagues who work on this who are epidemiologists, public health folks, they say, it's not that it's sort of somebody's individual race or skin color that's the risk factor, it's the conditions that tend to be correlated with that having to do with occupation, having to do with housing and other factors. And then those you might say are often worse because of historical patterns of systemic racism and other forms of disadvantage. So, we have a lot of data on the US on these disparate impacts by race. I would suspect if you looked at disparate impacts by race plus economics, it would work even more stark.

You know, my family is South Asian. You look at the Asian American category, that category has not been hit to the same outsized degree as say, Native Americans. But if you drill down and look at subgroups, Filipino Americans in California have been hit very, very hard. And I think part

of the reason for that is if you look at the housing and economic circumstances they're in as opposed to some other subgroups in that same population of Asian-Americans, they're ones who are facing tougher economic circumstances who were exposed more at work, for instance. And so I think it's important to look at this interlocking set of factors. And again, that's why I think that approach of looking at say, lowering your age cutoff, or even eliminating the age cutoff for access of these hard hit areas, I think makes a lot of sense.

Christiane: What are some of the other considerations that legislators might think about when they're deciding who gets priority in terms of vaccinations?

Govind Persad: I think another area that it's worth the legislators starting to think more about, especially as you're getting more supply is trying to transition from having a passive system where you just set up a website and you wait for people to sign up, to doing more active outreach and bring the vaccine to people. And that I think is a matter, again, not just of equity, but also of saving more lives. So if you look at going back to age, even if you only focus among folks who are older Americans, so setting aside the points that I talked about earlier about risk at a given age being different depending on occupation, housing, other risk factors, the folks who are older who are more at risk are likely to be the ones who are going to have a harder time either signing up through these very complex online websites, or being able to travel a long distance to get vaccinated or wait outside for a long time in some of these states that did these overnight lines for vaccine.

So, the governor of Georgia yesterday, I think he put out an announcement saying, “There's not as many vaccines at Atlanta as there is demand. Well, you should drive to another area of Georgia where there are more vaccines.” Then it's interesting because that's sort of a way of almost unintentionally maybe, but you end up prioritizing people who are actually probably better able to protect themselves against COVID-19 and were healthier, those are going to be the folks who can drive for four hours to another site. So I think instead of focusing on that kind of passive approach of just make your website, have people sign up, being active in reaching out to people who were in your eligible groups, bring the vaccine to sites that are near where they live or near where they work, I think those are approaches that are going to be really important for policymakers to think more about.

Another advantage of the active priority approach as opposed to passive is that then you don't have to do... You know, people with, say, essential worker prioritization, they worry a lot about, "Oh, people will fake being a worker this and that." If you're bringing the vaccine to a meat packing plant and vaccinating on site, that gets rid of this need to do verification at the vaccination site. So if you can do that verification beforehand in terms of who you call or outreach to, that can be both more equitable and more effective to try to do it at the site.

Christiane: I like this idea of an active approach to vaccine distribution. So that makes me think that you probably wouldn't like something like a lottery system to try to make vaccine distribution more equitable because that still relies on the passive approach. Correct?

Govind Persad: I actually think a lottery approach is better than first-come, first-serve. Because even though a lottery isn't affirmatively and intentionally prioritizing people who are at higher risk. So it's not intentionally reaching out to people who are in zip codes that have been harder hit. It still at least avoids at least disparately screening them out the way first-come, first-serve does by favoring people who can click on websites faster, or who can wait in line longer. So I think the lottery is not great, but it's better than first-come, first-served.

So my colleagues at the university of Chicago, what they've done is that they actually just put all of their patients who receive care through their medical center in the South Side of Chicago in the lottery and they said, "Look, we'll randomize who we call to make them eligible for the vaccine." And when you call somebody, what they get is what's called a ticket where the person who's called can then schedule a signup at their convenience. And they follow up with people who didn't schedule for whatever reason to see why they're not interested in getting the vaccine.

But I think using that could have a major advantage over again, a first-come, first-serve. The first-come, first-serve tends to advantage people who are better at doing that navigation or who have family who can do it for them.

Christiane: So along the lines of this idea that the passive approach favors people who have access to and can use computers, who have the time to sit around and wait in line or set up, in a similar line, would it be, take me, for example, would it be morally acceptable for me individually to call my local hospital and say, "Hey, if you have some extras, put me on your wait list." Because I know a lot of people are doing that in a lot of states.

Govind Persad: I think that is fine, but it'd be better to do that along with something else. Overall I think that people are too invested in trying to guilt people over individual actions in the pandemic, and especially over doing individual actions that are allowed. So I think you shouldn't be necessarily trying to second guess your health system about whether you're eligible or not. So even if you agree with me that 30 to 39 year old Native Americans should be prioritized if they're at higher risk, that doesn't mean that I think that 50 year olds who sign up when they're allowed to in their state are doing something wrong. And I think that it is a mistake to deal with a systemic inequity by trying to make individuals feel guilty about making decisions within the system. It would be analogous to, I don't know, guilting people if they take their home mortgage deduction.

But I think that people who are troubled by the way the system is set up, call your hospital, ask them about that, but also say, if you believe this, "Hey, I've seen other hospital systems consider using a lottery for the wait list where they call their patients who've come in before." Or, "Hey, is there something that you as a hospital are doing to try to improve access or uptake for people in this zip code in our community where they're facing higher rates of COVID-19 cases and deaths." So I think that individual action is important, but it would be ideal if the individual action was about trying to improve policies and implementation as opposed to just individual people saying, "Oh, well, I'm not going to sign up or I'm not going to be on the waitlist because I feel guilty about being ahead of somebody else." I think it'd be better if folks could channel that guilt

into working for systemic improvements as opposed to just channeling it toward kind of guiltily waiting it out. {soft laughter}

So we're doing research for a paper now. And in doing it I found that the state of Michigan had considered sending more vaccines to areas that had had higher rates of COVID cases and deaths. And the legislature ended up saying, there was an amendment brought to say, "No, we can't do that. We have to do it just by population and ignoring that." And so that was an area where the legislature decided to override something that makes public health sense, saves more lives sense, and equity sense. And that's an area where if people had called their state legislator and said, "Hey, actually I think it's a good idea to send more doses to areas that have, are sort of more vulnerable on the CDC, social vulnerability index." It could've made a difference. I think there's real room for impact there.

Christiane: So is this a question that we're going to have to face again at some point? Is there a way that we can prepare now for thinking about future pandemics, future vaccine roll-outs?

Govind Persad: There are a lot of things that society could do to prepare more. And a lot of that is also things that are not within my specific expertise. I would say first, there's this phenomenon of the prevention paradox. Where people will spend a lot of money to try to solve a problem once they know the problem is happening, but they won't necessarily spend that money beforehand in terms of preparedness.

Let's say, adequately fund your public health agencies, which in the US at least, and I think in other places as well, in the US it's particularly bad in terms of them being defunded, but overall have not been funded in a way that's commensurate with their health impact. And in part that's because it's not always so obvious right away what the sort of payoff is. Say you never have a COVID pandemic, people say, "Gee, why are we spending all this money on the public health agency? It doesn't look like they're doing anything. There weren't any pandemics, what do we need them for?"

And so, and it'll be like, "Why would I ever fix the brakes on my car, they're always working?" And so I would say in terms of setting funding and research priorities, try to avoid that prevention paradox and be more cognizant of the social value of investing in a) pandemic preparedness, and also being able to have the resources in place to either prevent or respond to emerging pandemic diseases.

One thing that it's really interesting that I've talked about in some other work is, if you look at the incentives for pharmaceutical companies and for other actors, there's much less incentive to do something like developing a vaccine than there is to produce, say what people call "me-too", or "just as good" drugs for conditions where they can get a much more generous reimbursement. And I think people have talked about this, both for vaccines and for some other things like antibiotics where incentives are not very optimal because you're basically not sufficiently incentivizing development. Now we were very fortunate that we were able to get these COVID-19 vaccines efficaciously as quickly as we can. I think we need to build on that and think about how to have that kind of investment in preventatives for other kinds of conditions.

Imagine, COVID-19 is worse than the flu, but you have so many people who die of the flu every year. If you could get a flu vaccine that was more effective, or that applied across a variety of different flu strains, if you could get vaccines or other kinds of effective prophylaxis for conditions that you see maybe less than the US but are pandemic in the developing world like malaria, I think those are things that hopefully seeing the pandemic here will encourage or lead to greater investment in being ready as opposed to just being reactive.

It also makes sense of this just the way in which it's not just about health or biomedicine or doctors or hospitals. People have talked a lot about following the science, the importance of public health expertise, and it's certainly right that often that expertise has been not paid attention to, and it should have been. But some of the problems that we face aren't necessarily just about the health system. They're more kind of systemic problems in terms of economic inequalities, people not being able to be home from work if they get sick. Or not having adequate access to childcare. And so it's important to think about health and scientific expertise, but there are also issues that I think the pandemic has made clear that go beyond say just what people might call in ethics/bioethics or in policy/health policy, and go to more overall questions in social policy. And then thinking about where pandemic response has been most effective. There've been countries that are much poorer say than the US that were more effective at controlling COVID-19. It's not as though they had a better, I think, health system, but it might be that there were other aspects of their social policy response and more effective. And so I think it's important to think, not just about health policy, but about this broader question of policy reforms.

Christiane: Yeah. I love that answer because it's something that I've just been personally... I've just noticed over the summer and this winter is just how bright a light COVID has shined on, or has shone on inequity in our country.

Govind Persad: Yeah, absolutely. And I think it'd be really interesting to have people say in philosophy, who are in epistemology, think about this as a problem, not just for COVID-19, but for a lot of other things, these sort of challenges of identifying trusted sources of information. I think a lot of what's been a challenge in the US is, so many sources of misinformation or disinformation about effective things to do with the pandemic. And so I think that happens for COVID-19, but you also see it for people try to look for effective information about all kinds of things, not just about health but about finances, about other kinds of policies. And so I think that's something that, again, COVID-19 shines a bright light on that, but it also is an important issue I think, across a variety of different domains that's going to be really crucial in terms of being able to respond effectively to any sort of issue.

Christiane: Why do you care about this work?

Govind Persad: There are a lot of things that I care about, but where I think that my expertise as an ethicist or as a legal scholar isn't necessarily likely to have a ton of impact. Where having more impact in that area would be more about just doing something like, you know, giving money or calling my representative or whatnot. So this is an are where I think I found myself caring about it a lot because right now, for instance, I've been working on this piece about how

legally equity can be incorporated into vaccine distribution plans. And it actually ends up being a complex question because you can prioritize based on things like zip code, but in the US you can't necessarily prioritize based on individual people's race, even though some other countries have done that because their constitution is set up.

And that's an area where having this sort of legal and ethical background can have a really important impact in terms of helping people to choose and design policies that are going to be effective as saving lives, addressing inequities, while passing legal muster. So I think part of why... That's an answer, I guess, to why I find this an important area to be thinking about right now. I think in terms of earlier on back in 2009, I wrote something about allocating scarce medical resources, how I got interested in those questions then I think was that at that point I was a fellow at the NIH in bioethics. It was before I went to graduate school. And it was an area where it seemed interesting to me because it seemed like philosophical ethics could have a real impact on improving people's lives and making things fairer for folks in a tangible way. It's not the only area where these things can matter. There are a lot of other areas where it can matter too. But I think that's what got me interested in these issues initially.

[music: Blue Dot Sessions, Colrain]

Christiane: If you want to know more about Govind Persad's other work, and to find more information on vaccine equity, check out our show notes page at examiningethics.org.

The Prindle Institute for Ethics also produces a podcast called Getting Ethics to Work. You can find it at prindleinstitute.org/getethicstowork or wherever you find your podcasts.

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