DAILY NEWS

The vaccine prioritization mistake: Why are we doling out doses by health status?

Josh Bloom and Dr. Jeffrey A. Singer

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It is no exaggeration to compare the COVID vaccine rollout to a Keystone Cops movie. When people spend hours frantically trying to find a website to register for vaccination while unused vials of it are discarded by day's end, it doesn't take a Sherlock Holmes to detect that something is wrong with the system. Part of the problem rests with efforts to prioritize vaccinations based upon individuals' health status.

Although it may intuitively — and perhaps ethically — make medical sense to inoculate people who are most likely to become seriously ill if infected, the nearly impossible logistics of doing so will almost certainly cause more damage than it will prevent. One need look no further than the CDC's "People With Certain Medical Conditions" publication to see one reason why such a protocol is a bad idea.

Medically speaking, some of the CDC classifications are perplexing. For example, people who smoke are classified along with those with 11 other conditions as being "at increased risk of severe illness from the virus that causes COVID-19." Yet severe asthma, cystic fibrosis and high blood pressure are relegated to "second place" — "conditions [that] might be at an increased risk for severe illness from the virus that causes COVID-19."

Regardless of the data CDC used to establish this pecking order, deciding to put smokers ahead of severe asthmatics or people with high blood pressure does not pass the common-sense test.

If the medical side of this prioritization plan is bad, the logistics of implementing it are far worse. Adding this layer on top of an already dysfunctional system will, no doubt, further hamper the goal of vaccinating as many people as possible.

How can health status be factored into a system so broken that people spend hours online trying to schedule their vaccination only to find that appointments *may* become available in three months provided there *is* a supply of vaccine while in other places, leftover doses are thrown away?

Even with an adequate supply, it will be impossible to apply CDC criteria. Will the workers who are vaccinating thousands of people really be able to check to see whether a 55-year old man who wants the vaccine actually has any of the conditions listed by the CDC? People who desperately want the vaccine fill out the screening forms using the "honor system."

And many of the criteria are subjective. How high is high blood pressure? Is someone with a BMI of 31 (highest risk) distinguishable from someone with a BMI of 29 (lower risk)? Will there be someone present with a scale to measure height and weight and calculate the number? Of course not.

How can someone prove that they truly belong in a group that will be given higher priority? Will a letter from a doctor suffice? Who will read and interpret that letter?

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Application of the CDC guidance invites line-jumping. People will exaggerate (or simply make up) the severity of their asthma, heart disease, obesity or chronic lung disease, and there will be no way to challenge these claims. It is impossible.

Requiring documentation for people to receive the vaccine before their age group qualifies can only serve to amplify the disparity in vaccination between those who are already being medically underserved. People who are poor, live in underserved communities, are disabled or already have substandard medical care will be less likely to even know about conditions that will put them at high risk, let alone be able to call their long-time primary care physician for documentation of their condition. And people in this group are *more* likely to have these conditions.

In a perfect world where an ample supply of vaccine is available and some — any — kind of coherent policy is in place, it might be sensible to provide vaccines to those who have specific medical needs that would get them to the front of the line. But we have nothing of the sort. Aggravating the situation is the inefficiency and inflexibility inherent in any centrally planned system of distribution.

Central planning suffers from a lack of local knowledge along with an inability to rapidly adjust to changes in supply and demand. Fortunately, our federal system allows for 51 different possible plans instead of just one. This reduces potential harm from a one-size-fits-all approach and allows the various states to learn from one another's experiences. Experience should by now have taught us that simpler is better.

Right now, the best thing we can do is use simple determinants like age, job/career and residence in an assisted living facility or nursing home to push people to the head of the line. Anything more will only make a dysfunctional system even worse.

Bloom is senior vice president and director of chemical and pharmaceutical science at the American Council on Science and Health; Singer practices general surgery in Phoenix and is a senior fellow at the Cato Institute.