



A Passionate Voice for Compassionate Care

September 4, 2020

The Committee on Equitable Allocation of Vaccine for the Novel Coronavirus
National Academies of Sciences, Engineering, and Medicine
500 Fifth St. N.W.
Washington, D.C. 20001

RE: Discussion Draft of the Preliminary Framework for Equitable Allocation of COVID-19 Vaccine

Dear Committee members:

The Catholic Health Association of the United States (CHA), the national leadership organization of more than 2,200 Catholic health care systems, hospitals, long-term care facilities, sponsors, and related organizations, appreciates the opportunity to provide feedback on the *Discussion Draft of the Preliminary Framework for Equitable Allocation of COVID-19 Vaccine (2020)* developed by the National Academy of Medicine; National Academies of Sciences, Engineering, and Medicine Committee on Equitable Allocation of Vaccine for the Novel Coronavirus.

We believe that all people, barring exceptional circumstances, have a responsibility to be vaccinated when needed to protect vulnerable people and broader public health. This responsibility is rooted not only in protecting one's own health but more fundamentally in our obligation to protect through solidarity those who are most at risk or unable to be vaccinated. The development of an ethical framework for distributing vaccines is therefore critical so that individuals and families have equitable access to vaccines and are able to trust in their effectiveness.

We thank the Committee for its work to rapidly develop the draft framework for vaccine distribution and for providing an opportunity for comment. While we understand the framework is based on the data available at the time of its drafting, we appreciate that the framework was developed to allow adaptation by state, local, tribal and territorial authorities to meet local needs and conditions, to ensure that safety and effectiveness continues to guide our national response.

CHA has developed a [set of principles](#) that we believe provide a useful foundation for guiding efforts to effectively and justly develop and allocate a COVID-19 vaccine. These principles recognize that vaccine distribution decisions should be guided by the principles of *Primum non nocere* (do no harm), that all people have inherent dignity and worth, that local health care providers and community leaders be actively involved in vaccine distribution and that the

common good and distributive justice demands that limited vaccine resources be distributed in a way which benefits as many people as possible to save lives and for the welfare of society.

Proposed Foundational Principles

CHA welcomes the efforts by the committee to identify foundational principles for equitable allocation of vaccines. These principles not only help to shape the proposed priority setting and phased vaccine implementation but more fundamentally help ground the framework in values beyond mere utilitarian considerations.

We strongly support the framework's commitment to the "equal dignity, worth, and value" of every person in its discussion of the principle of "equal regard." This is consistent with CHA's principle that the vaccine process should respect the human dignity of all persons at all stages of life. Its inclusion helps ensure that vaccine priority setting at the local level continues to place the health and safety needs of individuals and their families above economic or other considerations.

Regarding the principle of "maximizing the benefit," we support the principle's overarching goal that vaccine distribution should be driven by the desire to "maximize the societal benefit by reducing morbidity and mortality caused by the transmission of novel coronavirus." Founding the principles in the goal of saving lives is consistent with the goal of medical treatment. We support rejecting hard line thresholds related to age or an individual's perceived "quality of life" or "quality life years" in establishing vaccine prioritization criteria. Instead, such priorities should be informed by the underlying clinical needs and likelihood of transmission and implemented together with the principle of "equal regard," to ensure that the efforts to maximum benefits are not done at the expense of human dignity and the common good.

We also support the inclusion of a principle related to the "mitigation of health inequities." This principle, together with principles for human dignity and maximizing benefits, helps ensure that the framework is responsive to the underlying structural, economic and social drivers of health inequity and systemic racism that have led to disparate health outcomes experienced by Black, Hispanic, Latino, Native American, Alaska Native and low-income populations during the COVID-19 pandemic. Socioeconomic factors such as higher rates of essential service work, inability to work from home, crowded living conditions, lack of access to personal protective equipment and higher rates of un-insurance and financial security have all contributed to higher rates of infection and death for these populations. Giving priority to individuals facing these social and economic realities not only serves to target limited vaccines to populations most in need but will also save lives and reduce transmission more broadly.

Finally, we support the need for "evidence-based" information in guiding vaccine prioritization. In this regard, we would support a framework which is adaptable and flexible to respond to new information and needs as greater information is learned on the impact of COVID-19 disease and the efficacy of potential vaccines. This is particularly critical at a time when vaccines are being developed at a historically fast pace and where clinical risk factors and vaccine dosage requirements remain in flux. By providing transparent data, we can promote greater transparency about the vaccine and safely and effectively distribute it.

Allocation Phases

CHA has called for vaccine allocation priorities based on populations identified as most at risk for suffering negative health outcomes from COVID-19 as well as front line health and essential service workers. The committee's proposed four-phase vaccine allocation strategy is consistent with that and provides a useful framework for guiding allocation decisions. We support the prioritization of high-risk workers in health care facilities, first responders, people with significant comorbidities and older adults in congregate or overcrowded settings. The COVID-19 pandemic has demonstrated that front line health care workers are critical for treating the disease and ensuring the ongoing responsiveness of our health care system. It has also demonstrated that older Americans living in congregate settings, such as nursing homes, assisted living facilities or congregate care programs are at a higher risk of severe negative health outcomes if they contract the disease. Prioritizing these groups will help save lives and ensure the viability of our health system.

Ensuring Equity in Implementation

We support the Committee's effort to identify the specific population groups at higher risk of being infected by or transmitting the disease because of their health, work or living conditions. The proposed framework provides helpful guidance in targeting particular population groups while at the same time providing sufficient flexibilities for local communities to identify emerging priority or need areas. We recommend that any further adaption of these targeted groups by local or federal health authorities should continue to follow the overarching goal of saving lives and reducing transmissions and should be done in a transparent manner to ensure broader community support.

We support the committee's effort to provide equity across all four phases of the allocation strategy and the inclusion in the framework of additional factors to ensure equitable implementation of a framework for vaccine allocation. The committee's use of the CDC's Social Vulnerability Index in developing the framework targets socioeconomic and health factors that, due to systemic racism, contribute to the more severe impact of COVID-19 in communities of color. We agree that sufficient quantities of vaccine should be provided to areas of high social vulnerability in a manner that ensures geographic and economic access, and that access by frail or disabled individuals must be ensured.

We particularly support the framework's assertion that all people, regardless of immigration status, should be included in each priority population group. Immigrants-- including undocumented immigrants-- working in health care, critical service industries or who are part of any other identified group should not be given less priority or excluded from the general priority population because of their immigration status. This includes immigrants, refugees and other asylum seekers held in immigration detention centers or other congregate settings. Similarly, we would encourage vaccine distribution protocols to include specific guidance on data protection and the assurance that vaccine distribution sites will be considered sensitive locations and protected from immigration enforcement actions. The COVID-19 disease knows no borders and all people must be free to get a vaccine to ensure population-wide immunity.

We agree that vaccines should be available to all individuals, whatever their economic or insurance status. Ensuring that all people have access to a vaccine, regardless of ability to pay, is not only a basic human right but is also critical for achieving community-wide immunity. The federal response to finance the development and distribution of a COVID-19 vaccine has been critical in providing the support necessary for expediting the research and production of COVID-19 vaccines. We would encourage this same federal financial commitment to covering the costs of administering vaccines to continue in the vaccination phase so that all people are able to receive a vaccine without co-pays, deductibles or other expenses that provide a barrier to receiving the vaccine. A federal financial commitment is also necessary so that the burden of paying for vaccination does not fall solely on health care providers and other private entities involved in delivering the vaccines.

Finally, we encourage the Committee to address in the final document the crucial role that public health, nonprofits, community leaders and other religious and social organizations can play in implementing the framework. Local governmental entities, health care providers, non-profit organizations, religious and community leaders must work in partnership to promote COVID-19 vaccine awareness, build trust and ensure equitable distribution of vaccines. Recent surveys demonstrate that nearly one third of Americans would be hesitant to get a COVID-19 vaccine. It is therefore critical that vaccine distribution plans are developed transparently and with the participation of local communities to ensure that plans are responsive to the specific local needs and are able to address misinformation or vaccine hesitancy. By respecting this subsidiarity and supporting it through solidarity, we can help to ensure that all people are treated equitably and display a uniformity of purpose and promise that the vaccine can be provided to the benefit of all.

As the entire human community awaits in hope of the dissemination of vaccines to address COVID-19, CHA thanks you for the important work you do and appreciates the opportunity to offer you our comments. If you have any questions about these comments, please do not hesitate to contact me or [Lisa Smith, vice president, advocacy and public policy at Lsmith@chausa.org](mailto:Lsmith@chausa.org).

Sincerely,

A handwritten signature in black ink that reads "Sr. Mary Haddad". The signature is written in a cursive, flowing style.

Sr. Mary Haddad, RSM
President and CEO