POINTS OF VIEW

# Vaccinating Health Care Employees — Do They All Deserve Early Access?

When Covid-19 vaccines came to the U.S. market, many doses were distributed to health care organizations, not just because they had the freezer capacity to handle the fragile products but also because most allocation guidelines gave priority to high-risk health care workers. Such workers were seen as deserving priority because of the risks they incur, the important role they play in caring for people infected with Covid-19, and their risk of transmitting the virus.[1]

Early on, many health care organizations discovered they had more vaccine than they had high-risk employees willing to be vaccinated. Some responded by vaccinating low-risk employees, such as part-time outpatient clinicians, noninterventional radiologists, and even nonclinician researchers working in non-Covid labs.[2]

I believe that in vaccinating low-risk employees, the leaders of these organizations violated their duty to promote public health. Furthermore, they contributed to an unfortunate narrative: that powerful people in health care are willing to serve their own interests ahead of society's.

From the outset, U.S. vaccine distribution was dysfunctional. States were given vaccines with little federal guidance on how to allocate them and few resources for distributing them efficiently. States, in turn, allocated doses to large health care organizations, typically with guidelines about whom to vaccinate. In North Carolina, for example, organizations were told that Phase 1a of vaccination was reserved for "healthcare workers caring for and working directly with patients with Covid-19."[3]

This allocation criterion left organizations with the challenge of defining high-risk employees. There is no simple way to delineate the border between high-risk and lower-risk employees. Because it is hard to know what level of exposure qualifies as high risk, any cutoff will create resistance among powerful people who wonder why they are not being given priority. If it makes sense to vaccinate interventional radiologists, for example, then it becomes difficult to exclude noninterventional radiologists, if for no other reason than fear of dissension among the ranks.

The border between black and white is often gray, but that doesn't justify ignoring the border altogether. Yet some health care organizations acted as if the difficulty of drawing a sharp line between high- and low-risk workers justified treating all employees as high-risk. These actions delayed the provision of vaccine to actual high-risk populations. In North Carolina, Phase 1b of the state's vaccination efforts was delayed when large health care organizations began vaccinating low-risk employees, thereby forcing essential workers and people 75 or older to wait longer to be vaccinated. The organizations behaved as if vaccines were theirs to distribute, rather than recognizing them as scarce public goods.

Some ethicists argue that not only was it proper to vaccinate low-risk employees, but it was also morally laudable for those employees to receive the vaccine. These commentators contend that if a low-risk employee refused a vaccine, it would simply "move horizontally to another similarly low priority employee."[4] This view misunderstands the specifics of vaccine allocation. First, it wrongly considers only the next person who would receive a vaccine, should a low-risk employee decline a vaccination, when clearly shortening the waiting line also helps the high-risk people who are further down the list.

Second, this view mistakenly supposes that the organizations in question had no choice but to vaccinate all their employees because not doing so would risk wasting vaccines. That presupposition ignores the ease with which these organizations could have shifted from vaccinating their low-risk employees to vaccinating high-risk patients who are in their care. In fact, it is hard to imagine any organizations better positioned to improve vaccine allocation than America's leading health care providers. Health care organizations

were entrusted with scarce vaccines; health care leaders were expected to behave nobly.

Trust in the medical profession is already declining, in part owing to concerns about the commodification of medical practice, with many people working in health care enriching themselves even as a growing number of Americans struggle to pay their medical bills.[5] Now, in the face of the worst pandemic in a century, some leading American medical centers vaccinated their own low-risk employees even as millions of vulnerable, high-risk Americans remained in harm's way, waiting patiently in line.

The country deserved better.

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