

# WHO GOES FIRST?

Making Hard Decisions in an Unequal World

The 2020-2021 Atkins Center for Ethics High School Essay Competition

Sponsored by the UPMC Magee-Womens Hospital

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— *the* —

# ATKINS CENTER FOR ETHICS

The Atkins Center for Ethics at Carlow University is committed to bringing ethical reflection to bear on important social issues through teaching, community engagement, and scholarship. Furthermore, it is designed to raise awareness about the importance, complexity, and consequences of incorporating ethics in all that we do throughout our lives and careers.

The Atkins Center was founded with a generous endowment by Michele Atkins, a Carlow alum (1982) and former chair of the Carlow University board of trustees, and her husband Pat Atkins. In their words, “Pat and I are committed to raising the level of awareness of ethical issues for this region and for the country. The examination of issues involving what is right, fair, just, legal and moral is becoming increasingly critical to the future of our world.”

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# ESSAY PROMPT

While the coming months may see the development of a COVID-19 vaccine, mass production could take many more months. In these circumstances governments, businesses, and hospitals must make tough decisions: who goes first? Who should get vaccinated or receive needed supplies first?

What rationale can be used to make such decisions and what factors are ethically relevant? COVID-19 disproportionately affects people 60 and older as well as those with preexisting medical conditions. Should age or prior health be relevant factors? It likewise disproportionately affects minorities and the economically disadvantaged, exacerbating long-standing structural and societal factors, such as unequal access to healthcare, safe working conditions, and more. Are race, gender, citizenship, or economic status therefore relevant? Should those designated necessary workers — including healthcare workers and emergency responders, but also gas station attendants, fast food workers, and grocery store clerks — be given early access? Since few individuals cleanly fit into any one of these, what should be done when real individuals cannot be neatly classified into exclusive camps or categories?

In light of these layered complexities, how would you distribute a vaccine? What triage policies would you implement and how would you personally justify those policies ethically?

## Judges:

Michael Balmert, PhD  
Kate Garfinkel, JD  
Frances Kelley, PhD  
Mary Onufer, PhD  
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The Atkins Center for Ethics would like to extend a special thank you to the **UPMC Magee-Womens Hospital**, for their generous support and sponsorship of this contest.

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# PROPOSED VACCINE DISTRIBUTION SYSTEM

## First Place Essay

**Geina Shaker**

Greater Latrobe High School (Class of 2022)

Since the first confirmed case of the novel coronavirus, 2019-nCoV, in the United States on January 20, 2020, cases have rapidly risen to over 20 million by January 2021 (Holshue et al.). Many medical companies, such as Moderna and Pfizer, have worked on developing a vaccine for Covid-19, and as many have reached the final stages and will soon begin mass production, the challenge of distributing a limited number of vaccines must be addressed. There are four main stages of a potential vaccine distribution system in which certain demographics should be prioritized: healthcare workers, essential workers, the elderly, and adolescents.

The first and most important stage covers healthcare personnel, which includes those who work in medical settings and are at risk of exposure to infectious patients or materials. According to the CDC, this would protect the individuals whose key services are critical in maintaining a society's public health and also ensure that healthcare personnel do not infect patients in medical facilities who are likely to be at high risk for severe Covid-19 illness ("The Importance"). While it seems apparent for medical workers to have priority, the decision of which groups to vaccinate in the following stages is not as undisputed.

The second stage of the Covid-19 vaccine should be distributed to those who are essential to the functioning of society, 75+ year olds, and high risk individuals whose medical conditions make Covid-19 life-threatening. At this stage, those who are essential to societal functioning consist of frontline workers, such as first responders, educators, corrections workers, and public transport workers, whose necessary services put them at risk due to their high rates of interaction with people (Dooling 10). This would not only protect them from the people they are exposed to, but it will also protect the citizens they serve. In order to prevent serious or fatal cases of Covid-19, the vaccine must also be distributed to high risk individuals. High risk individuals include those who live in long-term care facilities or have conditions such as cancer, chronic kidney disease, COPD, Down Syndrome, heart problems, diabetes, or are in an immunocompromised state ("People with"). Age is also a factor in making someone high risk, as the risk increases with age.

The demographic of 75+ year olds makes up about 6.01% (2010) of the population (Howden and Meyer) but 60.3% of Covid-19 related deaths ("Demographic Trends"). These disproportionately high death rates make it imperative that a method of protection is available for the most vulnerable generation. Some argue vaccines should be distributed to groups with higher case rates rather than death rates. This would include adults ages 18 to 64, who make up 75% of cases ("Demographic Trends"). However, this group makes up about 60% of the population, a much greater proportion of the United States, meaning it would take a substantial amount of time to completely vaccinate this demographic, leaving more time for the high risk elderly to have

extreme, and potentially lethal, cases (“United States”). Also, many 18 to 64 year olds are at high risk of exposure due to their work. Adults under the age of 50 comprise 66.1% of frontline and essential workers, and these workers are prioritized in stages 1, 2, and 3 of this proposed vaccine distribution (Rho et al.). Vaccinating essential workers and those with underlying medical conditions would help to diminish the high infection rates of the 18 to 65 year olds who are at the highest risk of exposure before the vaccine is more widely available to the younger population. For these reasons, vaccinating the elderly before 18 to 64 year olds is sound.

The prioritization of frontline essential workers and high risk individuals also accounts for the disproportionate rates of Covid-19 cases and deaths in Hispanics, Latinos, and African Americans. These disparities are due to “underlying conditions that affect health including socioeconomic status, access to health care, and exposure to the virus related to occupation” (“COVID-19 Hospitalization”). Hispanics, Latinos, and African Americans are overrepresented in essential jobs that do not have options to work from home, such as food service, construction, home health care, and nursing homes, putting them at higher risk of exposure (Williams et al. 1506). African Americans are also more likely to have “higher rates of underlying conditions like diabetes, high blood pressure, obesity and chronic lung disease,” which can lead to severe cases of Covid-19. According to the CDC, African Americans are 3.7 times more likely to be hospitalized and 2.8 times more likely to die of Covid-19 compared to white or non-Hispanic persons, and Hispanics or Latinos are 4.1 times more likely to be hospitalized and 2.8 times more likely to die of Covid-19 compared to white or non-Hispanic persons (“COVID-19 Hospitalization”). This stage aligns with the goals of the distribution of the vaccine, which includes the “preservation of societal functioning” by protecting frontline workers and the “prevention of morbidity and mortality” by protecting the elderly and those with high risk medical conditions (Dooling 4).

The third stage of vaccine distribution is similar to stage two, but it includes essential workers who are at a moderate risk of exposure to Covid-19 and 50 to 75 year olds. Essential workers in this stage would include jobs such as public safety and construction workers and those in the energy and legal industries (Dooling 10). The age group containing 50 to 75 years olds accounts for 26.07% of the population (“United States”) and makes up 35.2% of deaths (“Demographic Trends”). The prioritization in this stage is supported by the same principles as in stage two, and the same reasoning applies.

The fourth stage of vaccine distribution should include all 5 to 17 year olds. Studies have shown the many negative effects that quarantine, online school, and a lack of social interaction can have on children and adolescents. The distribution of a vaccine to this age group would facilitate the transition of many schools back to a 5-day-a-week brick and mortar setting. Although this age group comprises only 8.8% of cases, this demographic has been greatly impacted by Covid-19-related quarantines (“Demographic Trends”). One study comparing post-traumatic stress symptoms between quarantined and non-quarantined children found that children in quarantine had four times higher mean stress scores (Brooks et al.). The many implications of quarantine, such as boredom, financial stress, fear of infection, lack of personal

space, and more screen time due to home confinement can all have damaging effects on young people's mental health (Francisco et al.). Another study found that most students prefer in-person classes due to the struggles of online school, such as a "lack of motivation, understanding of the material, decrease in communication levels between the students and their instructors and their feeling of isolation caused by online classes" (Alawamleh et al.). The importance of the mental health and education of America's youngest generation and future leaders is what gives 5 to 17 year olds the priority over all other demographics not included in this distribution structure.

A triage system that prioritizes those at risk of acute or fatal cases of Covid-19 and those whose necessary work puts them at risk of exposure is the most ideal, despite its limitations. The distribution of the vaccine to adolescents is also vital in preventing the long lasting mental and social effects of quarantine. Any proposed vaccine distribution plan should aim to preserve life and normal societal functioning.

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# COVID-19 VACCINE DISTRIBUTION

## Second Place Essay

Isaac Krom

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There are three ethical principles that should govern Covid-19 vaccine allocation. The first principle, maximizing individual benefits, is exemplified by vaccinating people at a high risk of covid complications (Day; Dooling; Park; Persad). The second principle, prioritizing a return to societal normalcy, can be achieved by vaccinating in such a way that benefits society as a whole (Day; Dooling). The third principle is maintaining a positive public image and can be achieved by fighting the spread of misinformation and, more importantly, ensuring there is no inequality in vaccine allocation (Abramowitz; Dooling; Gupta and Ramu 155; Persad). The best allocation plan balances these three principles and can be achieved by prioritizing based on location once the high-risk populations have been vaccinated.

With the spread of the virus during 2020, hospitals became overwhelmed by the number of Covid-19 patients (Day). Data published by the CDC in January 2021 shows that approximately 45 percent of Covid-19 hospitalizations are people 65 years of age or older (CDC). This demographic also accounts for over 75 percent of all Covid-19 deaths (Kistler). Most of those hospitalized outside of that age category have underlying health conditions such as asthma, diabetes, or hypertension. This group also contributes to a large portion of covid deaths (CDC). By prioritizing these two groups when distributing vaccinations, the principles of maximizing individual benefits (by reducing morbidity) and returning to societal normalcy (by alleviating overwhelmed hospitals) are utilized (Dooling). In addition to this, healthcare workers should be able to receive the vaccine during the first stage, as they have the biggest exposure risk and are needed for hospitals to remain open. This would prevent an outbreak from infecting those most needed to fight it (Abramowitz; Park; Dooling).

Kathleen Dooling first presented the logic behind first vaccinating these high-risk populations in an Advisory Committee on Immunization Practices meeting about vaccine distribution. This plan, which was published and is being followed by the CDC, goes on to set up a chart of “essential” workers (in order of priority) along with a parallel chart of vulnerable populations (in order of vulnerability). For example, at the same time that all people over the age of 75 are vaccinated, the CDC would vaccinate “frontline essential workers,” including but not limited to teachers, grocery store workers, first responders, and correction workers. This plan continues to lay out priority levels in this structure until everyone is vaccinated (Dooling).

One of the problems with the CDC’s plan lies in the fact that vaccines, while efficient in terms of preventing complications and building individual immunity, are ineffective in preventing viral transmission (Reddy; Russel; John Hopkins University). While the vaccines protect those who receive them, they do not necessarily help those who haven’t received them, as they can still

contract the virus from a vaccinated person. Because the CDC is trying to vaccinate all over the U.S. at the same time, the people deemed least “essential” will still have to remain locked down until they receive the vaccine themselves. This creates a situation in which no one can return to social normalcy safely until everyone is vaccinated.

Furthermore, this plan is based on a principle of equitable distribution, whereas once public image is taken into account it may be better to base distribution on equality over equitability, which is closer to “fairness.” Simply put, in order for any allocation plan to be effective, the public needs to accept it (Abramowitz; Dooling; Gupta and Ramu 155; Persad). As Alice Park, a health writer for TIME, states that public trust “has been eroded by confusing and conflicting messages in recent months.” These conflicting messages, which can be credited partially to the small amount of knowledge pertaining to Covid-19, have led to many people not trusting the new vaccines, as they think that the vaccines have been rushed and that protocols have been overlooked (Persad; Gupta and Ramu 153). While the vaccines have certainly been manufactured at an above-average pace, they still had to pass the same tests that any vaccine does in order to gain the trust and approval of organizations such as the CDC, the World Health Organization, and the Food and Drug Administration. This information needs to be clearly articulated to the public (Abramowitz; Day). Additionally, because public trust is already on edge, the allocation plan cannot risk inciting any social opposition or it may risk falling apart due to insufficient participation (Abramowitz). By constructing a pyramid of how different occupations are “essential” to societal functioning, the CDC is, to some extent, discriminating based on occupation. Furthermore, due to the higher prevalence of unstable working conditions in racial minorities, this plan could disproportionately vaccinate based on race, which could very easily be misconstrued to the public as some form of racism (Bureau of Labor Statistics).

In order to stay out of a negative light, which could bring risks of unacceptance by the public, a vaccine allocation plan would need to be completely equal past the initial stage of vaccinating high risk populations and healthcare workers. The only way to do this completely is to wait until there are enough vaccines for everyone, or all consenting people, to be vaccinated (Abramowitz). This, however, would sacrifice the principles of prioritizing a return to societal normalcy and maximizing individual benefits by waiting until the last minute to vaccinate the non high risk public. Because the three principles cannot each be fully prioritized without sacrificing the other two, some aspect of equality will need to be sacrificed in order to maintain the balance among the principles (Dooling). The solution may lie in prioritizing location rather than occupation for second stage vaccination.

Simply put, there is a much higher population density in cities than there is in the countryside. For example, New York City has over 25,000 people per square mile, whereas Ithaca, another city in New York, has only around 5,500 (World Population Review). In places with higher population density, people interact with a larger group, and it is harder to remain socially distant. Additionally, with less space, total lockdowns happen more often in cities (WPR). It would

therefore be logical to vaccinate the major cities before less densely populated areas, whether those be smaller cities, towns, or countrysides.

Furthermore, the Covid-19 virus has been shown to disproportionately affect racial minorities, namely African Americans and Hispanics. This is believed to be due to a higher amount of comorbidities in these groups, along with socioeconomic circumstances leading to overcrowded housing within these groups (Abramowitz). These minorities are often clustered in cities, so vaccinating the cities would also help alleviate this issue (Rubenstein 88-92; Harshbarger and Perry).

By prioritizing more densely populated areas and determining second stage vaccine allocation based on location rather than occupation, the unavoidable inequality resulting from limited vaccine supplies can be shifted from individual (person to person) to locational, thus prioritizing people equally, no matter their race or occupation. This will prevent seemingly underrepresented peoples, or their advocates, from resisting the planned allocation.

Additionally, by vaccinating entire areas at one time, parts of America will be able to return to a societal norm, rather than everyone waiting to return at the same time. The last places to be vaccinated, however, will still reach societal norms at the same time as a plan that waits until there is a large enough supply for everyone. Alongside the first stage, in which high risk populations and healthcare workers are vaccinated, this plan factors in all three ethical principles necessary for proper vaccine allocation.

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# UNTITLED

## Third Place Essay

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As the distribution of the COVID-19 vaccine has begun, the question of what factors should be considered rages on. In the United States, the first pick is high-risk healthcare workers. The administration to healthcare workers who tend to those with COVID is an easy choice due to the rate of exposure. The harder decision is who should get the vaccine next. Vaccination is meant to save lives, so distribution should be about reducing the maximum number of fatalities. A plethora of factors should play into who receives the vaccine first. Age, race, financial status, profession, and population density all affect exposure and fatality rate and must be considered.

The most agreed upon factor is age, as COVID-19's fatality rate disproportionately affects elderly people ("Older Adults and COVID-19"). Race is much more controversial, but it has a sensible basis in statistics. People of color, such as African Americans and Hispanics face a higher death rate than white people. In New York City, Hispanics had a 50% higher likelihood to die from COVID-19 compared to whites, while black Americans were twice as likely as whites to die from COVID (Seervai). Not only that, but other racial minorities such as Native Americans have a higher risk of hospitalization and death (Seervai). Newly settled refugees also encounter many factors that increase COVID fatality rate, such as economic instability ("Newly Resettled Refugee Populations").

Part of what makes COVID-19 so lethal to ethnic minorities is the fact that it affects lower income households much worse than other households. Housing density also exacerbates these systemic issues, with higher population density in lower income neighborhoods leading to more exposures. I would argue that those in lower financial sectors should have priority in COVID vaccination. Not only does COVID kill more lower-income Americans than it does wealthy Americans, but poorer Americans also have more of an urgency to get back to their professions (Finch and Hernández Finch). Well-off families can withstand the time away from work, or even being laid off from their jobs, but disadvantaged families need a steady source of income to survive. Furthermore, it would give lower class Americans first pick at many industries opening back up, giving them priority in choosing the best jobs for themselves and their families. Distributing vaccines to working class families first will save more lives than if economics were not considered, and it would help ease financial inequality. Lower-income jobs usually come without substantial healthcare plans and are more likely to require in-person work, like retail and service industries (Finch and Hernández Finch). Lower-income households also face a harder time getting access to quality internet connection and the technology needed to work from home (Tanguay and Lachapelle). The lack of paid sick days encourages lower-income workers to show up even if they are sick, potentially with COVID.

But what about those who have even less control over their situations? Prisoners are unable to socially distance themselves from others, despite the high incidence rate of COVID in prisons. A controversial argument, but prisoners should have right of way given the rate of exposure. “One in five federal and state prisoners in the United States has tested positive for the coronavirus, a rate more than four times as high as the general population. In some states, more than half of prisoners have been infected, according to data collected by The Marshall Project and The Associated Press” (Schwartzapfel, Beth, et al.) Many Americans have scoffed at the idea that those who have committed crimes should be prioritized over law-abiding citizens. But triage plans are based in statistics. If prisoners are facing significantly higher rates of infection than the average population, they should receive vaccines alongside those who face exposure most often.

While who should have priority is important, it is also vital to note those who should be last to receive the vaccine. Wealthy, young, and white Americans are in the lowest risk groups thanks to the factors listed above. Those whose work can easily be done from home like office workers should be considered low priority unless they are immuno-suppressed. The less contact a person has with strangers, the less likely they are to contract COVID. Using this simple logic, the more often one must leave the house, for work or running errands, the higher priority they should be in triage plans.

COVID-19 has taken lives and jobs away from some of the most disadvantaged groups in America. Racial and economic disparities have always existed, but the COVID pandemic has worsened it to a devastating degree. Triage plans should be built around lessening those damages. Prisoners face unjust death sentences with the spread of COVID being heightened by cramped quarters and little health protections. Vaccines are a lifeline to many communities so triage plans must be taken seriously with an unbiased mind. It is the responsibility of all Americans to limit their potential exposures, but not all are fortunate enough to have the option of staying home. Those who have little choice in their high-risk situations should be first to receive the vaccine.

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