



September 4, 2020

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The AAMC (Association of American Medical Colleges) is pleased to provide comments related to the *Discussion Draft of the Preliminary Framework for Equitable Allocation of COVID-19 Vaccine*.

The AAMC is a not-for-profit association dedicated to transforming health care through medical education, patient care, medical research, and community collaborations. Its members are all 155 accredited U.S. and 17 accredited Canadian medical schools; more than 400 teaching hospitals and health systems, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools and teaching hospitals and their more than 179,000 full-time faculty members, 92,000 medical students, 115,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences.

We would like to congratulate the Committee on a thoughtful, thorough, and evidence-based report that recognizes that the implementation of the allocation strategy – as well as the ethical principles that undergird it – are as important as the framework itself. Given the significant health, social and economic injustices laid bare by the pandemic, we were particularly pleased to see the emphasis on mitigating inequities in vaccine access and the related foundational principles of fairness, equal regard, and transparency.

Community Engagement and Building Trust

As noted by the Committee, and as the report's review of the Ebola vaccine program makes clear, a mass vaccination program "will fail if there is widespread public mistrust". While the AAMC understands the Committee's decision not to consider mistrust or the related issue of political context in developing the framework, we respectfully disagree with the Committee's assertion "...that the equitable allocation framework that it recommends, if properly implemented and communicated, can secure public trust..." Sadly, the mistrust has run far too deep for far too long. Further, given the Committee's focus on "practical aspects of implementation" we worry about the practicality of a framework that does not explicitly place itself in our current context.

Therefore, regardless of the allocation plan ultimately recommended by the CDC's Advisory Committee on Immunization Practices (ACIP), the **AAMC strongly urges the Committee to include in its final report evidence-based strategies and resources that Federal, state and local public health and health care organizations can deploy now to engage communities, build trust, create partnerships and develop the bidirectional communication channels necessary to orient the vaccination effort toward success.**

Additional Clarity Needed Regarding "Population Group" Members

During the listening session we heard individuals representing diverse groups and interests question where they fit in the phased allocation strategy, particularly individuals at the intersection of groups that span Phases.

Indeed, as related to the Phase 1a category “High-Risk Workers in Health Care Facilities” the partial list of proposed, qualifying roles omits many public health workers (contact tracers, public health educators, etc.) and health care workers (community health workers, pharmacists who will administer vaccines, etc.) who arguably have 1a-levels of risk across the four allocation criteria but were not specifically called out.

One hazard of partial enumeration of groups comprising each Phase is that the “e.g.” indicates other groups are included, but not specified. However, as discussed in the report systems for allocation should be “consistently applied”. **The AAMC urges the Committee to more specifically define the groups/roles included in each Phase to provide the kind of clarity that would yield more consistent application of the allocation framework across states and communities.**

This also means that specific attention must be paid to intersectionality in instances where decisions might run counter to the framework’s foundational principles. For example, in light of the principles of fairness and equal regard, in what Phase are older adults living in jails, prisons or homeless shelters? Are they in 1b (“Older adults in congregate or overcrowded settings”) or 2 (“People in homeless shelters or group homes”; “Incarcerated/detained people and staff”)? Should some congregate settings take priority over others? Why?

The AAMC encourages the Committee to think through the ethical implications involved in these decisions, keeping in mind the foundational principles, and add those rationales – and group designations – to the final report in service of transparency.

What Data Are Needed to Ensure “Fidelity of the Allocation Process”?

The report notes that the “fidelity of the allocation process” requires “comprehensive, consistent data collection that includes the needed variables of race/ethnicity, age, gender, and social status.” It is well documented that roughly half of the US’s COVID-19 case data lack race/ethnicity information. Further, there are no standardized, validated “social status” data sets that could facilitate implementation of the framework in a data-driven, evidence-based way.

Since we believe such data are crucial to faithful implementation, **we encourage the Committee to enumerate the specific data fields and their potential sources in the final report.**

Federal Allocation of Vaccines to States: Population Size Versus Population Need

Despite the report’s acknowledgement that a requirement of the framework is that it be “adaptable to a variety of circumstances”, the Committee has endorsed a system of Federal vaccine allocation to states based on static population size as opposed to dynamic population need.

While acknowledging there is “obviously variation” by state/community in disease burden and population, the report asserts these differences are not large enough to warrant the deliberation required to allocate by need. This seems to run counter to the foundational principle of being “evidence based”. If, as suggested elsewhere in the report, relative need could be partially determined by indices such as the CDC’s Social Vulnerability Index (SVI), we do not see any significant risk of prolonged deliberation that would hamper timely, need-based allocation efforts. Further, the AAMC believes that

relative need is an important, fluctuating circumstance to which the allocation system must necessarily adapt.

We urge the Committee to either reconsider this strategy or to include in its final report evidence in support of and further justification for the original recommendation.

Finally, returning to the issue of trust, a tension exists that we strongly encourage the Committee to address head on in its final report.

On the one hand, it is an undeniable fact that racial and ethnic minority communities, due to decades and centuries of racism, bigotry, disinvestment and other mechanisms of injustice, have been disproportionately impacted by COVID-19. On the other hand, however, the report avers that a system for equitable allocation must be "...mindful of socially vulnerable populations without making allocation decisions based solely on sociodemographic factors." In short, while racial and ethnic minority groups are suffering disproportionately, the Committee chose not to give these communities explicit priority in the framework.

While many of the groups in the framework's early vaccination Phases – people with significant comorbid conditions, incarcerated individuals, essential workers unable to telework, etc. – are disproportionately comprised of members from racial and ethnic minority communities (due to many of the same mechanisms of injustice related to COVID health inequities), those correlations and overlaps do not adjust away the added burden of systemic racism on COVID-related risk. "Equal regard" in terms of vaccine allocation does not necessarily balance the inequity in disease exposure and severity experienced by communities of color.

As the report notes, during the pandemic states have developed lottery and allocation systems for scarce medications. Some of those plans rejected allocation based on race while others included it. The Committee made the decision not to explicitly account for race in the proposed allocation framework. To build trust, to be transparent, and to foster open dialogue **the AAMC strongly recommends that the National Academies' final report clearly articulate to the public, in a standalone section, why racial and ethnic minority communities are not considered a priority group in and of themselves.**

Again, we congratulate the Committee on a comprehensive and thoughtful draft report. The AAMC would be pleased to discuss these comments and/or the report with the Committee or the Academies. Please contact Philip M. Alberti, PhD, Senior Director Health Equity Research and Policy at palberti@aamc.org with any inquiries.

Sincerely,



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