Ethics in Public Health
Rationing the Flu Vaccine

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Ethics in Public Health is a regular column within the *Journal of Public Health Management and Practice*. This column provides commentary and opinions on timely and important ethical issues in relation to public health practice. Readers of *JPHMP* are encouraged to contribute to this feature. Contact column editor: Robert S. Olick, JD, PhD, at olickr@upstate.edu. Submissions should be limited to 750 words. In addition, readers can pose questions to our column editor, and where feasible, these will be addressed in future columns.

In October 2004, the CDC announced that Chiron Corporation, chief supplier of inactivated influenza vaccine for the United States for the 2004–2005 flu season, would not be providing the 50 million vaccinations it had promised—half of the anticipated 90–100 million doses from all sources projected for the flu season. The resultant shortage set off a firestorm of concern. Well known to health care providers, but less so to the general public, flu is a major killer. Last year, flu-related illnesses caused more than 36,000 deaths and approximately 200,000 hospitalizations in the United States alone. The ethical challenge was how to decide who should receive this scarce life-saving preventive treatment. This column sketches one approach to addressing this dilemma that explains and justifies core features of the rationing scheme followed by the Centers for Disease Control and Prevention (CDC) and local public health officials. I also identify a number of related issues that emerged in the face of the vaccine shortage.

Seeking a Fair Distribution

The call to craft a policy for distribution of needed resources that cannot be provided to all due to limited supply, that is, to *ration* the flu vaccine, presented a classic problem of distributive justice. On one widely accepted account (the Aristotelian view), we should start from a premise of equality for all, and strive to treat like cases alike and different cases differently in proportion to their relevant differences. This formal principle of justice must be supplemented by a material principle that defines what differences between persons count as *morally relevant* to justify differential treatment. The CDC's Advisory Committee for Immunization Practices promptly determined risk for infection, risk for serious illness, and risk for spreading infection to be the overriding factors in identifying candidates for vaccination, issuing an interim list of priority groups: those 64 years or older, children 6–23 months, those with underlying chronic conditions between the ages of 2 and 63, pregnant women, nursing home and long-term-care patients, children aged 2–18 years on chronic aspirin therapy, household contacts of children under 6 months, and healthcare workers with patient contact under 65 years of age.[1] Inclusion of healthcare workers rests as well on the mandate to maintain the public health infrastructure.

Some questioned whether severely debilitated elderly nursing home patients should be included, others the propriety of excluding middle-aged immune-compromised but not chronically ill individuals, and some criticized lack of attention to the potential burdens on hospital emergency rooms. One recently published long-term study questions the benefits of flu shots for the elderly.[2] But overall the CDC approach has been received without significant controversy. As an ethical position two further core features are noteworthy. First, it rejects as irrelevant a number of factors that frequently enter rationing discussions elsewhere in health care, such as ability to pay, comparative social worth, queuing, and random selection. Second, it establishes no priorities among those categories of persons on the

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list. This task was left to state and county officials, some of whom struggled mightily with whether other criteria for rationing, such as those rejected by CDC, should be used to establish priorities among or within high-risk groups. At the local level, the principle of first-come, first-serve was frequently invoked for vaccination within particular risk groups, such as public clinics for the elderly; others invoked a lottery system. (See Billitier, this issue.) Some public health officials faced a different sort of (re)allocation question as we went deeper into the flu season: How to transfer delivered supply among providers, even across state lines, to adequately reach underserved high-risk groups and avoid wasting important resources.

Beyond Rationing

Several other ethical concerns emerged. The governor of Illinois and the mayor of New York City joined forces to procure additional vaccine from France and Germany. Who bears (or shares) responsibility for making the best efforts to procure vaccine in the face of a shortage? What should be done to increase vaccine production and supply to prevent future scarcity? Warnings of a shortage and (anticipation of) long lines led many who qualified to opt out of vaccination, contributing to a stockpiling in some areas, lowering of the age requirements (from 64 to 50), and the need for reallocation of supply. What lessons should we take from the public information campaign and the role of the media? Some drew lessons from existing preparedness plans for SARS, smallpox (see Phillips and Williamson, this issue), or bioterrorism. How closely do these plans and priorities fit the next flu season and beyond and anticipate the possibility of future scarcity?

An Ethics Advisory Panel

Also in Fall 2004, CDC announced the formation of a five-member ethics advisory panel composed of leading bioethics experts. The panel reportedly first set its sights on offering guidance for responding to this year's vaccine shortage, but its prospective agenda likely will have the greater impact. Among the issues reportedly on the panel's agenda are how to best allocate responsibility for rationing decisions between the CDC and local health departments; how to prevent future vaccine shortages (Congress and the World Health Organization have each begun looking at ways to increase vaccine production, such as changing market incentives for drug companies); and what principles should guide rationing decisions should a worldwide Asian avian flu pandemic or another new, more deadly influenza strain emerge.[3] The panel could also consider more discrete questions as whether certain critical professions (morticians?) ought to get priority in a pandemic, or what if we had to choose between the very young and the very old?[4]

Conclusion

The flu season turned out to be less serious than predicted. Remarkably, as winter progressed the pendulum swung from the hard choices of rationing to an easing of restrictions (lowering the healthy adult age to 50) to concerns that once-scarce doses could be wasted if not redistributed from one geographic area to another based on need. In light of concerns about a potential pandemic on the horizon, Health and Human Services has drafted a flu preparedness plan. The experience of this past flu season and the deliberations of the CDC's advisory panel will no doubt continue to shape the ethical dimensions of national, state, and local preparedness plans.

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