Experts Discuss COVID-19: Vaccine Allocation, Placebo Groups, and More

JAMA Live Highlights features comments from livestream interviews by JAMA Network Editor in Chief Howard Bauchner, MD. His discussions with experts in clinical care, public health, and health policy focus on critical issues related to the coronavirus disease 2019 (COVID-19) pandemic. Comments have been edited for clarity.

William H. Foege, MD, MPH
Emeritus distinguished professor of international health at Emory University, former chief of the US Centers for Disease Control and Prevention (CDC) Smallpox Eradication Program, and CDC director from 1977 to 1983.

On Prioritizing COVID-19 Vaccine Allocation: [Cochairing the National Academies of Sciences, Engineering, and Medicine committee] was an unbelievable experience. Often times we start with the science, then we address the ethics and the equity. This group started with ethics and equity and then asked what is an individual’s risk of getting the virus and what’s the risk of being sick, hospitalized, dying?

I think one of the big surprises in our report, since this is a disease that is hurting minorities more than others, is that people thought we would come out with minorities or the elderly as the first group to get the vaccine. With minorities, we do not say the problem is race. The problem is racism. And if you look at the individual risks of people who are minorities, then like the majorities, 3 are at the top of the list: heart failure, kidney failure, and a body mass index over 40.

So what if you aim at those things, and then you look at the social vulnerabilities? What does it mean to live with 3 generations in a house, the inability to work from home, every day having to face the virus, having problems with transportation, school children coming in and out? And so, we said let’s look at the risk factors and make those the decision point for getting vaccine rather than saying race. The virus doesn’t understand race, color; it does understand vulnerabilities.

On Contact Tracing: In May of 1974, at the peak of smallpox in India, one state alone was having 1500 new cases each day, which meant 1500 new investigations every day with contact tracing, which we did with no smartphones and no computers. And we were able to do contact tracing at a magnitude that you can’t imagine. Now, somehow in this country, we’re told we can’t do that. And here we have millions of tests being done that are useless because they come back so late that you can’t really use them for contact tracing.

On the Current Status of the CDC: It is a difficult time. We’ve learned many lessons over 75 years of disease control, and almost every lesson has been violated with this, the worst pandemic that we’ve seen in our lifetime. The first lesson is, know the truth; you can’t control an outbreak unless you know the truth about it. We’re in a position now that people are never sure what is the truth. They go to university experts rather than CDC to get their truth. This hurts me more than I can tell you. At CDC, the workers are still as dedicated as they’ve always been, and they’re working as hard. But there is now political interference that has made it difficult for them to do what they’ve done in the past.

Paul A. Offit, MD
Director of the Vaccine Education Center and professor of pediatrics in the Division of Infectious Diseases at Children’s Hospital of Philadelphia

On Vaccinating Placebo Groups After Authorization: Pfizer made an announcement. If they go through an Emergency Use Authorization, they’re going to vaccinate the placebo group. That obviously upset the FDA. Here’s the tension: On the one hand, you could understand how, for example, someone who’s over age 65, that now sees a vaccine that, let’s say, is 60% effective could say, “Look, I want that vaccine. It’s now approved at least through this mechanism; I want this vaccine.” On the other hand, if you now eliminate placebo groups going forward, you’re not going to learn about these other candidate vaccines in near the same manner. And let’s make the assumption, which I think is not a large assumption, that the first vaccine is not going to be necessarily the last, best vaccine—either with regard to safety or efficacy. How are you going to know that? If you have a vaccine initially that’s 50% effective, and then down the line...
there’s a vaccine that’s 80% to 90% effective, how are you going to learn that? And that is the history of vaccines. I mean, the first vaccine that comes out is invariably not the latest, best vaccine. So that’s what I think is worrying people.

On Vaccine Distribution to Non–Health Care Workers: It’s going to be a real challenge. Not just the shipping and storing at minus 70, which means making sure that the dry ice is constantly replenished—something we’ve never done in this country for a vaccine before. It also means identifying who those people are that are in that second wave, meaning other essential workers, people who are over 65, and people who have certain health problems.

How do you identify them? How do you make sure they come back roughly a month later [for boosters]? Some vaccines are 21 days later; another vaccine’s 29 days later. It’s going to be hard. And do you give this to large chain pharmacies? Or do you set it up the same way that we have set up testing centers? I don’t know. There’s going to be a learning curve associated with this. I’m sure there’s going to be a lot of stumbling. And looking back, we’ll see ways in which we could have done this a lot better.

On the Advantage of Vaccine Distribution Based on Nonracial Factors: This is the most important allocation of a medical resource that I can remember in my lifetime. We don’t want its implementation stalled or controversial as it winds its way up to the Supreme Court. What my coauthors and I in a JAMA Viewpoint tried to do is find a way to de facto give preference to racial minorities but based upon clear social and economic disadvantage. That was the way we were nudging the CDC’s Advisory Committee on Immunization Practices and the National Academies of Sciences, Engineering, and Medicine. They can accomplish the same goal but do it without feeding into the cultural controversies that are going on in our country today.

On the Impact of Distribution Guidelines: I think it will take the edge off of the raw power-based, money-based competition. But I can’t imagine that having considerable wealth, access to concierge or well-paid physicians, and also power, including political power, and celebrity or fame won’t push you closer to the top of the queue.

Michelle A. Williams, ScD
Dean of the faculty, Harvard T.H. Chan School of Public Health, Harvard University, Boston, Massachusetts

On Tools for Measuring Need: The CDC’s Social Vulnerability Index (SVI) was developed for us to be prepared to respond to natural disasters that would hit vulnerable communities. It is a good place to start, given the legal context that we have. But we will have to do the modeling in communities, in states, across this nation to really identify just how far and just how consistently it will capture the low-income Black and Brown and Native American populations that are vulnerable to this pandemic. The SVI is based on 15 different variables, and race is only 1 of them. The Area Deprivation Index integrates income, education, employment, and housing quality in deriving vulnerability. These variables are intertwined with race and ethnicity, and so you can get at the level of vulnerability without explicitly invoking race.

On Preventing Disparities: One of the most disheartening things at the outset of this pandemic was that access to testing really depended on whether you had resources or you were a celebrity. The people who needed testing the most were essentially an afterthought. I’m passionate about not repeating this inequity in access for the vaccine.

Andy Slavitt, MBA
Former acting administrator of the Centers for Medicare & Medicaid Services

On Progress Toward Ending the Pandemic: We’re doing pretty well at what I would call the hard sciences. We know how this thing spreads; we know how to avoid it. We still have holes in our knowledge around what makes people susceptible [and] how immunity works, and we’re completely flummoxed with what this thing does once it gets inside the human body. I don’t think it’s a big mystery at this point how to avoid more casualties, more losses, more suffering. The question of course is why aren’t we doing it?

Let me point to Africa, 1.3 billion people and to this point, about [48 000 deaths as of November 18]. What’s different about Africa and African nations is, one, they have experience in public health crises, more so than the private health care system. We’ve got a lot of investment in the private health care system, not so much in the public health system. Second, look around the world and shuffle countries into individual rights and freedoms and entrepreneurial vs communal and society oriented. We value a lot of the reasons why we’re in the first category, but the countries in the second category have done far better.

On the Notion That It’s Okay to Let Older People Die of COVID-19: The people we’re losing are losing an average of 10 years of their life. At some level in the abstract you can say, well, God, at least it’s not kids. But the truth is it could be kids. In some respects there is a societal question. What do we owe [older individuals]? You talk to people in the tribal reservation lands and they would tell you that the way you treat your elders is exactly who you are as a society. I don’t know that the moral argument works. I think what people are saying when they say [let the older people die] is, “I want to go back to my normal life. I don’t want to be inconvenienced.”

On Distribution of the First COVID-19 Vaccine Doses: I think one thing that the first 20 million [doses, distributed to health care workers and hospitals] accomplishes is it will send a signal to Americans that the people they trust—the medical professionals—find this vaccine to be safe.

Note: Source references are available through embedded hyperlinks in the article text online.

Editor’s Note: For more coronavirus livestream interviews visit JAMA’s COVID-19 Q&A page.