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Committee on Equitable Allocation of Vaccine for the Novel Coronavirus
The National Academies of Science, Engineering, and Medicine
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Dear Dr. Foege and Dr. Gayle,

On behalf of the Cancer Support Community (CSC), an international nonprofit organization that provides support, education, and hope to cancer patients, survivors, and their loved ones, we appreciate the National Academies of Science, Engineering, and Medicine’s focus on this critical topic and we value the opportunity to submit this comment letter in regards to the Discussion Draft of the Preliminary Framework for Equitable Allocation of COVID-19 Vaccine (2020) (discussion draft).

As the largest provider of social and emotional support services for people impacted by cancer, and the largest nonprofit employer of psychosocial oncology professionals in the United States, CSC has a unique understanding of the cancer patient experience. We provide $50 million in free, personalized services each year to individuals and families affected by cancer nationwide and internationally. In addition to our direct services, our Research and Training Institute and Cancer Policy Institute are industry leaders in advancing the evidence base and promoting patient-centered public policies to ensure that the patient voice is at the center of the national dialogue.

The primary goal of the Preliminary Framework for Equitable Allocation of the COVID-19 Vaccine is to “maximize societal benefit by reducing morbidity and mortality caused by transmission of the novel coronavirus.” The committee lists the following foundational principles for equitable allocation of the COVID-19 vaccine:
1. **Maximization of Benefits:** “This principle encompasses the obligation to protect and promote the public’s health and its socioeconomic well-being in the short- and long-run. In the pandemic, it entails the obligation, as previously noted, to *maximize societal benefit by reducing morbidity and mortality caused by transmission of the novel coronavirus* (722-725).”

CSC recognizes the need for maximization of benefits and appreciates the committee’s focus on those individuals “(a) most at risk of infection and serious outcomes, (b) in roles considered to be essential for societal functioning, and (c) most at risk of transmitting the coronavirus to others.”

However, the discussion draft also states the following:

Current knowledge of the relative risks stemming from specific underlying risk actors is evolving quickly and will be better known by the time vaccines actually become available. This may allow decision makers to target those at greatest risk of serious morbidity and mortality more effectively than is possible today.

CSC would like to point out that there is already evidence that people impacted by cancer are more vulnerable to COVID-19. One study found that COVID-19 patients with cancer had higher risks in all severe outcomes, with those with hematologic (such as leukemia, lymphoma, and myeloma), lung, or metastatic cancer with the highest frequency of severe events (such as being admitted to intensive care units and needing mechanical ventilation) (Dai et al., 2020). Further, there is evidence that cancer screenings have plummeted during the pandemic, with one study (Mast & Munoz, 2020) showing screening for cancers of the cervix, colon, and breast down between 86% and 94% in March of 2020 alone. There are concerns that delayed or missed screenings will result in some cancer cases diagnosed later or with a poorer prognosis. National Cancer Institute (NCI) Director Norman Sharpless recently referenced the “steep drop in cancer diagnoses” and stated that “cancer is a complex set of diseases whose prognoses are influenced by the timing of diagnosis and intervention (2020). As we brace for this potential swell in the number of individuals diagnosed with cancer, we must also be aware of how COVID-19 will impact this group of people and what resources and services will be available to help them most successfully treat and attend to their cancer as well as mitigate their chances of contracting COVID-19.

In response to the significant potential impacts that COVID-19 has or will have on people impacted by cancer, we strongly recommend that cancer patients actively undergoing treatment, cancer survivors with compromised immune systems, and caregivers actively caring for these individuals be included in phase one of the vaccine allocation plan.

2. **Equal Regard:** “The government’s obligation to express equal regard to residents should both guide and constrain its allocation and distribution of goods, such as vaccines, and burdens, such as delays in the provision of vaccines. This fundamental obligation requires
3. that everyone be considered and treated as having equal dignity, worth, and value (750-753).”

CSC recognizes and supports the principle of equal regard. However, we also encourage the committee to understand and prioritize individuals at highest risk of infection and serious outcomes as outlined under “maximization of benefits” as well as individuals from communities that have both historically been underserved and those who have borne an unequal share of illness and death as a result of COVID-19 (such as racial and ethnic minority groups). When considering the possibility of vaccine rationing and the potential for practices such as random selection, it is critical to weight such a process to prioritize individuals who are at greater risk for infection, adverse outcomes, or death.

4. Mitigation of Health Inequities: “COVID-19 infections and deaths are strongly associated with race, ethnicity, occupation, and socioeconomic status. A significant higher burden is experienced by Black, Hispanic or Latinx, and American Indian and Alaska Native populations. Currently there is no evidence that this is biologically mediated, but rather the impact of systemic racism leading to higher rates of comorbidities that increase the severity of COVID-19 infection and the socioeconomic factors that increase the likelihood of acquiring the infection...(775-780).”

CSC strongly supports efforts to mitigate health inequities. As such, it is critical for the committee to view health inequities and health equality as separate and different. As stated by Winston-Salem State University (n.d.):

The terms equality and equity are often used interchangeably; however, they differ in important ways. Equality is typically defined as treating everyone the same and giving everyone access to the same opportunities. Meanwhile, equity refers to proportional representation (by race, class, gender, etc.) in those same opportunities. To achieve equity, policies and procedures may result in an unequal distribution of resources.

CSC encourages the committee to commit to seeking health equity versus health equality through a framework that prioritizes appropriate access through proportional representation based on risk and need.

5. Fairness: “The principal of fairness includes the obligation to develop allocation criteria based only on relevant-non-discriminatory characteristics, already noted under the principles of equal regard, to apply these criteria impartially, and to employ fair procedures in allocation and distribution. The principle of fairness here entails formulating criteria focused on individual, community, and social needs and risks, and vigilantly avoiding the sometimes conventional practices that create and sustain discrimination. (838-843).”

CSC supports the principle of fairness, however we wish to add additional insights to ensure that discrimination does not occur in vaccine allocation. Referenced in the discussion draft is July 2020 article in *Pediatrics* which categorizes five principles of
allocation drawn from different frameworks with specific relevance to COVID-19. While we agree that prioritization should be based on greatest urgent or acute need, we believe that allocation based on the likelihood of benefit to “those most likely to survive” is a slippery slope. Cancer is considered a disability under the Americans with Disabilities Act (ADA). Further, the Office for Civil Rights (OCR) at HHS issued a bulletin on March 28th of 2020 addressing the issue of triage programs for COVID-19 treatment during the pandemic. The bulletin reaffirms that “…persons with disabilities should not be denied medical care on the basis of stereotypes, assessments of quality of life, or judgments about a person’s relative “worth” based on the presence or absence of disabilities or age. Decisions by covered entities concerning whether an individual is a candidate for treatment should be based on an individualized assessment of the patient and his or her circumstances, based on the best available objective medical evidence.” We believe these principles should also apply to vaccine allocation.

6. **Evidence-Based:** “Vaccination phases—who receives the vaccine when—should be based on the best available evidence and models for identifying the populations most likely to become seriously ill or die without vaccination, for determining when slowing the pandemic is best accomplished with a focus on those most likely to spread the infection, and for estimating the added effect of vaccination on transmission in public and crowded settings (888-892).”

CSC strongly supports evidence-based approaches to accomplishing the goals listed in this section. As discussed under the principle of maximization of benefits, evidence regarding the increased risk for cancer patients and survivors must be taken into account. Further, we also agree with the committee that a vaccine is not a substitute for preventive policies including ample personal protective equipment for health care workers or other mitigation strategies.

7. **Transparency:** “The principle of transparency includes the obligation to communicate with the public openly, clearly, and straightforwardly about the vaccine allocation criteria and framework, as they are being developed and deployed. Central to this process is the clear articulation and explanation of the allocation criteria (899-902).”

CSC strongly endorses transparency in all actions surrounding vaccine decision-making and allocation. It is vital to do our best to understand the implications that these decisions may have on individuals and communities and communicate that information as clearly and quickly as possible. We also believe that there should be ample opportunity and time to review and comment on all vaccine allocation decisions as well as flexibility of the bodies making such decisions in order to evolve with time and new information.

Finally, while we recognize it is outside the scope of this committee to discuss affordability of the vaccine, it is vital to understand that there will be no access with affordability particularly among groups who may be most vulnerable to the potentially devastating impacts of COVID-19 infection.
In conclusion, we recognize the challenges inherent in the task of prioritizing allocation of a potentially lifesaving vaccine. We appreciate the opportunity to provide these comments and would be pleased to serve as a resource to your work. I can be reached at efranklin@cancersupportcommunity.org.

Sincerely,

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References


