Allocating Scarce Resources during Emergencies: Lessons from the Flu Vaccine Shortage

The recent shortage of flu vaccines provides an instructive opportunity for ethics committees to assess what lessons have been learned about allocating scarce resources. Imagine the typical scenario that played out across the country. St. Somewhere annually distributes 6,000 doses of flu vaccines to its employees and special patient populations. Because of an acute national shortage, St. Somewhere only received 800 doses at the beginning of the flu season and faced a difficult choice. The institution followed the Center for Disease Control’s (CDC) recommendation for flu vaccine distribution; however, the staff quickly realized that the CDC’s recommendations were not specific enough to resolve problems that arose at St. Somewhere. By CDC criteria, St. Somewhere needed 1,200 vaccines for direct care providers and another 500 for patients. What ethical criteria beyond the CDC guidelines, should St. Somewhere have used to decide who would be inoculated?

The early “rationing” challenge of the current flu season might seem like a fluke. However, prominent public health officials suggest that the vaccine shortage might be a national dry run for larger potential rationing dilemmas; for example, if the bird flu A(H5N1) strikes like the influenza of 1918. Currently, experts estimate there is a stockpile of 1 million doses of antiviral agents for the bird flu, yet 100 million doses would be needed in the event of the pandemic. Thus, St. Somewhere’s allocation difficulties, while minor compared to a pandemic, demonstrate that its ethics committee needs to devise a plan to distribute a limited resource. They should ask: What process and criteria need to be put in place now in anticipation of a national emergency?

When conversations about rationing begin, most involved typically focus on whether the criteria for distributing the limited resource are fair. However, such an approach overlooks an essential discussion about the process itself and about who should participate in the decision-making process. As the large scale attempts to allocate scarce health resources the process is as important as defensible criteria in finally gaining public legitimacy. In the preparatory phase of ethical decision making, it is critical to estimate the complexity and magnitude of the issue. Next the size of the community to be affected should be determined. Only after these things have been considered will it become apparent whether a formal process of decision making is required, and if so, who should participate. In the preparatory phase, when one considers who should participate in the process of decision making, it is important not to overlook those who will be affected and those who could contribute valuable information, even if they are not present for the discussion.

Allocation decisions whose outcomes will be controversial require a more formal structure, such as the use of an ethics committee or an ad hoc committee established for the specific issue. All this needs to be done in the open. If a decision with great complexity that affects a large population is made behind closed doors where the process is not open to public scrutiny and transparency, then it will likely result in public skepticism about the fairness of the plan and create lack of support for the final decision. Institutions would therefore be well served to establish or use an existing interdisciplinary group that can both consider the clinical facts and analyze the moral values.

Let’s apply this to St. Somewhere’s recent flu problem. First, the committee should have reflected on the scope of its authority: who was the ultimate decision maker about the allocation criteria? It should also have avoided public statements that did not accurately portray the scope of its authority, since as a result of doing so, it lost credibility. St. Somewhere’s ad hoc committee was properly authorized to make recommendations to its administrations who had the responsibility to implement its recommendations.

Second, the decision-making group needed to gather information. When the shortage first emerged there was public confusion about who was at greatest risk and who could forgo the vaccine without serious risk. In fact, the CDC gave equal priority to a wide range of patients such as children aged 6-23 months, adults aged 65 years and older, persons aged 2-64 years with chronic medical conditions, and residents of long-term care facilities. The CDC also recommended that those not at risk should forego or defer vaccinations and use preventive hygiene measures, such as more frequent hand washing during the flu season.

The fact gathering revealed that the CDC guidelines were not specific enough for St. Somewhere to
make choices among the priority populations it served. Consequently, the
decision-making group needed to further refine the allocation criteria and identify
other key commitments that might guide their decision. These moral commitments
could have come from St. Somewhere’s mission and core values statement—giving
preference to care for those who are poor and vulnerable. Or, St. Somewhere’s
rationing could have been informed by prior choices. For example, when the
hospital submitted its order, who did it originally intend to cover? If St.
Somewhere purchased the doses for patients with whom it had some unique therapeutic relationship, for example, patients who were at high risk and had traditionally depended on the hospital for
their vaccinations, then these prior commitments might have functioned as
criteria for allocation.

After the key commitments were identified, the decision-making group
should have prioritized the institution’s values. Since the hospital needed 1,700
vaccines, but only 800 were available, then a determination should have been made
how to divide the doses between direct caregivers and patients, and then further
subdivide doses according to subgroups of these two larger divisions. The hospital had
500 patients; however, as a consequence the allotment structure would have to deny
vaccinations to some members of a group recognized as priority by the CDC
including 150 pediatric patients (some of whom were under 24 months and with
chronic medical conditions), 25 adult hospice patients, 225 elderly residents in
long-term care, and 100 critical care patients. Although one option the ad hoc group considered was to evenly divide the
doses between caregivers and patients, this option ignored the fact that not all direct
care providers needed to be on the front line and could have safely forgone the
vaccine making more available to priority patients. A more workable option considered allocation based on severity of illness and
survivability. On this basis, the ad hoc group decided to give children at highest risk a
priority over dying patients in hospice, who, regardless of getting the vaccine, were
unlikely to survive their condition.

Attempting to establish a basis for allocating scarce resources revealed a harsh
truth to the ad hoc committee about the ethics of rationing, namely, it is difficult in advance
to identify criteria that will apply in all cases. The criteria are likely to change to match the
facts of the situation. For example, allocating extremely scarce anti-viral agents during a
bird flu outbreak might require giving the entire amount to healthcare professionals so
that a healthcare institution is able to provide care. Of course some proposed criteria might
always be unacceptable; for example, rationing limited resources based on power,
influence, control, and religion to name but a few.

Since allocating a scarce resource will depend on the particular circumstances,
it is vitally important to have in place a process that is marked by the following qualities:

- It is viewed as fair
- It allows for transparency for others to see how the decision was made
- It is shown to adjust its decision as new facts come to light
- It reflects that the interests of the institution have been served and not
  just the interests of a few.

Ethics Committees should explore the ethics of rationing, but they should not do
so in the confused atmosphere of a public health crisis similar to the recent flu vaccine
shortage. On the contrary, committees should have gained enough practical wisdom to
begin planning for the future today.