Podcast Transcript:

Race and Regulation Podcast

Presented by the Penn Program on Regulation

Episode 8: Vaccination Equity by Design with Olatunde C. Johnson

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Music: Joy Ike's "The Fall Song"

Olatunde Johnson: Racial disparities in health care are pervasive. They are very well documented. We know all the reasons, or a lot of the reasons around these disparities. They are socioeconomic, they are about unequal insurance availability, they have a spatial dimension about the accessibility of health care facilities and providers. And then, there is also a role of explicit and implicit bias among care providers.

Cary Coglianese: That's Olatunde Johnson, an expert on antidiscrimination regulation, delivering a lecture organized by the Penn Program on Regulation at the University of Pennsylvania. I'm Cary Coglianese, the director of the Penn Program on Regulation and a professor at the University of Pennsylvania. Welcome to our podcast, *Race and Regulation*. In this series, we are talking about the most fundamental responsibility of every society: ensuring equal justice, and dignity and respect, to all people. Advancing racial justice calls for all of us to understand better the racial dimensions of regulatory systems and institutions.

We're glad you can join us as we hear from Olatunde Johnson, the Jerome B. Sherman Professor of Law at Columbia Law School, speaking about the inequities in access to COVID vaccines and the ways that regulatory mandates could have lessened these inequities.

Professor Johnson's remarks draw from research she conducted in collaboration with Kristen Underhill at Cornell Law School.

OJ: We were interested in the question of how to advance equity in the distribution of COVID vaccines. I spent most of the pandemic on my stoop in Harlem. I feel lucky to live in Harlem. I live right off Frederick Douglas Boulevard, which is kind of an example of this composite nation with all of its challenges. It's at the crossroads of race and class. It's taking on the challenges of

being an inclusive neighborhood. There are expensive brownstones next to Section 8 and public housing. There is lots of economic and racial diversity, but also a lot of inequality. And I could see very different effects of COVID-19 in my neighborhood, and certainly in the city beyond my neighborhood. Many of the people I knew, or that my kids knew, left the city. I was perfectly able to socially distance in the city. I didn't have to work in person, I didn't have to deliver anything. And as the data on the racial and economic impact came out in New York and throughout the country, we started to see this data on racial and ethnic disparity and on economic disparity and who was most affected.

CC: The data began to show that Black and Latino people, and Native Americans, were facing COVID hospitalization rates that were two to three times higher than those for white, non-Hispanic people. The COVID fatality rates were similarly twice as high.

OJ: There was also a spatial dimension to it and an occupational dimension. And also a neighborhood dimension that sometimes wasn't well captured by just looking at questions of racial disparity.

CC: In other words, the rates of COVID cases, hospitalizations, and deaths—and their disproportionate distribution—were not the same across all states. Even within states, patterns varied across different neighborhoods. Patterns of risk also varied across occupational categories as well, with service workers often receiving a disproportionate brunt of the disease. And within individual sectors, these disproportionate effects were observable. Among health care workers, for example, most of those who lost their lives to COVID were people of color.

OJ: I was curious then, when the vaccine rolled out, to see who would have access first, and about the administrative choices that would be made and whether they would reflect some of these spatial and occupational and racial differences. Essentially, what we saw were that Black, Latino, and Native American communities, in the initial stages, there were racial disparities overall in the uptake, or the receipt, of the vaccine, overall. And then, also, relative to the impact of COVID-19 in their communities, whether measured by the disease rate or death rates, and also within priority groups, and some of the hardest hit communities were Black, Latino, and Asian health care workers, and they had less early access to the vaccine.

CC: The disproportionate access to vaccines held true even taking into account many Black persons' understandable mistrust of the medical profession. Now, Professor Johnson and her coauthor, taking further their inquiry into the inequities, considered what is known as the inverse

equity hypothesis. This hypothesis posits an amplification effect from prevailing inequities in access to quality health care. As Professor Johnson explains:

OJ: Given the fact there are existing health care inequalities in access to health care resources, any time you have a new health technology, it tends to amplify that inequality, at least initially. So, researchers have studied innovations as varied as heart surgeries, immunizations, HIV treatments, hospital births, and have found this. So the idea is that early on in the diffusion of a new technology, such as the vaccine, wealthy people are early adopters. And then, as diffusion expands, demand and access by middle-income and poor people becomes greater. Some of these delays tend to persist even over time.

And so, we were interested in the fact that this was a theory that is known to public health researchers, and would it be anticipated? The idea is, vaccines and other innovations are going to aggravate inequality in very predictable ways. Racial disparities in health care are pervasive; they are very well documented. We know all the reasons or a lot of the reasons around these disparities. They are socioeconomic. They are about unequal insurance availability. They have a spatial dimension about the accessibility of health care facilities and providers. And then, there is also a role of explicit and implicit bias among care providers. Given these underlying disparities and the existence of justified medical mistrust, this inverse equity hypothesis would predict that there would be disparities in who had access to the vaccine.

CC: And did this prediction come to pass with the COVID vaccine?

OJ: In the early days of the vaccine, we definitely saw this to be true. So, despite the fact that individuals in communities of color were harder hit, they had less access to the vaccine. You could see this is as inevitable. But another approach that we think is fairer in terms of how health researchers and providers think about fairness, but also consistent with civil rights norms, would be to choose design mechanisms and guidance that really alleviate those disparities.

CC: In other words, could the rules surrounding the vaccine distribution be designed in ways that would combat the inverse equity hypothesis?

OJ: We saw that the CDC, in its initial guidelines, did make some key choices that likely made the vaccine more accessible on the basis of race and class. One was to make sure that the vaccine

was accessible to people who were uninsured. That was a design choice. That nobody had to pay for the vaccine upfront. So, being able to pay was not a barrier. Another, arguably, choice that decreased disparity that you could say was that it wasn't done through the primary care providers. That could cut both ways. That was at least an attempt to make access more widespread.

CC: But not all of the rules for the COVID vaccine's rollout worked to combat inverse equity in health care.

OJ: Other design choices contributed to disparity and really failed to mitigate disparity.

Many of us could see with our own eyes, even without having to consult detailed research documents, how some of the decisions that were made at the state and local level would generate different kinds of disparities. One was relying on opt-in and demand—that people had to present themselves. So, people who are most vulnerable sometimes are reluctant to do that for a range of reasons. The reliance on internet web-based scheduling was sort of a famous moment. There were lots of accounts of people trying to help other people schedule who didn't have access to the internet or couldn't use the technology. Mass vaccination sites—that we really see the benefits of that because it allowed you to schedule people quickly, but the downside was that they were often inaccessible by transit.

CC: What, then, might the CDC—the federal agency charged with coordinating public health regulations and responses—have done differently?

OJ: We see gaps in some of the decisions that were made by the federal regulatory agency. Their prioritization guidelines excluded certain high-risk categories, so they relied on broad categories of age and work status and medical risk for initial prioritization, which is important, but it also excluded some work categories that were very high risk, and a key thing such as delivery workers and service workers and other frontline workers, in the initial stages. It also excluded additional ways of measuring social health vulnerability that might have diminished racial and ethnic impact. For instance, the initial guidelines chose not to prioritize communities at high risk or who had suffered high rates of COVID-19 infection adverse consequences. This is not just a hindsight observation, this was a recommendation that was made at the time, and I don't know all the reasons behind the competing considerations, but that was an area that was chosen not to be put in as a priority category.

CC: In the future, what might be other suggested ways to mitigate these disparities?

OJ: Some of these suggestions that we make are things that we believe the CDC could have adopted at the time, or HHS—Health and Human Services. But they also have implications more broadly for the design of any kind of federal program. The first thing we emphasize is a broader use of equality directives. This is something that I have written about in other contexts, specifically around transit and housing.

So, in the context of COVID, affirmative guidance from HHS and the Department of Justice and the CDC might have directed states to avoid COVID-19 vaccine distribution mechanisms that exacerbate racial and ethnic inequities while also instructing them on how to improve access. So, this could include things like advising grant recipients to locate vaccination sites in communities most affected by the pandemic, decentralizing distribution, providing transportation, allowing walk-in or telephone scheduling as an alternative to internet registration, and partnering with community groups.

Music: Joy Ike's "Promised Land"

CC: One important step the CDC could have taken would have been to issue directives to states instructing them to look for ways to counteract inequities. Professor Johnson also recommends that the federal government require states and localities to develop their own equity plans, and she recommends the federal government specifically help states by creating what she calls "default equity plans."

OJ: We recommend affirmatively requiring grant recipients, such as public health authorities at the state and local level, to file an equity plan as a condition of receiving federal funds, and in the alternative, supplying them with an equity plan. We think this is a means of inducing states to attend to racial equity by having them file a plan that agencies that employ scientific experts and also equity experts can evaluate. As part of the CDC's response to racial disparities in COVID-19 burdens, the agency actually appointed a chief health equity officer and began collecting and reporting data on COVID-19 outcomes by race and ethnicity. And there was perhaps a missed opportunity to have that play more of a role in terms of interaction with state and local agencies. The agency didn't, however, require grant recipients to commit to specific equity-enhancing strategies as a condition of receiving vaccine supplies or other assistance from CDC or HHS.

For the vaccine distribution, we recommended default equity plans in part because of speed. Default equity is a starting point. States could then select the parts of the strategy that they wish to pursue or adopt the default plan wholesale. The creation of a default plan would save states time as they seek federal funds and ensure that states at least consider implementing strategies that are known to promote equity.

CC: Professor Johnson points out that these solutions—equity directives and equity planning—would be useful in addressing social inequities in areas beyond health care and vaccine distribution.

OJ: The equality directive model is something that there are versions of in housing, in education, and in transit. Environment and disaster relief are areas where it could be adopted more vigorously. Obviously, the environment has the model in that it has environmental impact statements but the racial equity piece and the idea of doing front-end assessments is not pervasive in the environmental area.

CC: No matter the context—whether in addressing environmental inequities or combatting inequities in vaccine distribution—the mandated planning model needs to ensure that those subjected to planning requirements do more than just go through the motions. As Professor Johnson puts it:

OJ: This always raises questions for people about is this real? Is this just paper enforcement? What kind of regulatory oversight and enforcement mechanisms are there?

CC: With adequate oversight and enforcement, these mandated planning requirements can make a difference. As Professor Johnson notes:

OJ: Some of the places that were driving a lot of infection, like in New York City, changed and adjusted practices quickly. There is still a vaccine disparity in New York City, but it definitely narrowed because they started to adopt things like partnering with community-based organizations, having drop-in, no-registration sites. So I think those things made a difference. I know that the data is kept separately for Native American populations, but they adopted really aggressive outreach practices from the start that I think made a big difference.

Music: Joy Ike's "Promised Land"

CC: Professor Johnson argues that these improvements can come about, even without using race itself as a specific criteria for governmental policy and administration. This is important because expressly relying on race could give rise to litigation and charges of reverse discrimination. Professor Johnson elaborates on the approach taken by New York state with respect to COVID.

OJ: It doesn't use race as a classification. It talks about areas of risk and mentions race. And so, it doesn't say there is some allocation or quota based on race. And I think often there are ways of attending to the disproportionate harm that certain communities face without explicitly using a racial classification. If you're going to not be able to be race-conscious, certainly do some GIS mapping and see who is being affected. And I think that, at least, should be more pervasive in how we think about regulation. The CDC has a social vulnerability index that is around a concentration of socioeconomic factors.

CC: Relying on a social vulnerability index can still target racial inequities. Using such an index, though, requires being able to adapt policies from location to location. This is sometimes a challenge, especially if local governments are preempted by uniform federal or state policies and prohibited from tailoring responses to meet variations in social vulnerabilities. Fortunately, in some states, such as New York, there was some recognition that COVID-related public health policies could and should vary based on local circumstances.

OJ: One of the areas that I think about a lot is the conflict between states and localities in a whole range of policies, like labor and guns and things like that, and when states preempt localities. There was conflict between New York City and New York state throughout the pandemic in terms of COVID policies. But much of the regulation was done at the state level. But they adopted a strategy that tailored policies and responses by region, and so that upstate didn't have to be subject to the same rules that we were downstate. It was data-driven, and it was transparent. I am not saying this is perfect. Nothing is perfect. But I thought as a model, it was very good. You knew your hospitalization rates, access to testing, death rates. Over seven days, we could all go on the dashboard and look at it and Albany or other parts of upstate New York, they didn't have to be subject to masking rules that New York City was subject to at the same time if they were having lower overall averages. So I think that's a good model for a policy—it's not about vaccines specifically, but about building trust and at a time where it's been a very polarizing kind of issue around the vaccine.

And then, New York City, also I think was very good at providing a lot of information and doubled down on some of the outreach efforts. I think what was really striking was the testing. Testing was very, very accessible in New York City.

CC: And by learning from places where vaccines and testing were made more accessible, public health officials across the United States can find better ways to reduce racial inequities when responding to future pandemics—or even when responding to many other types of problems. As Professor Johnson and her coauthor conclude in their study, "by using regulatory tools and system designs that build in equity from the start, we have a much better chance of mitigating" the effects of racial inequities across society.

Music: Joy Ike's "Walk"

CC: Thank you for listening to this episode of *Race and Regulation*. We hope you have learned more about the racial dimensions of vaccine policies and public health responses to COVID-19 throughout the United States.

This podcast has been adapted from a lecture delivered by Professor Olatunde Johnson in 2022. She spoke as part of the Penn Program on Regulation's lecture series on race and regulation, co-sponsored by the Office on Equity and Inclusion at the University of Pennsylvania Carey Law School.

I'm Cary Coglianese, the director of the Penn Program on Regulation. For more about our program and free public events, visit us at pennreg.org. You can also find other episodes in our *Race and Regulation* series wherever you get your podcasts. This podcast was produced by Patty McMahon, with help from Andy Coopersmith, our program's managing director. Our music is by Philadelphia-based artist Joy Ike.