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Opinion

Four Ways to Fix the Vaccine Rollout

The situation is already devolving into chaos. We need new ideas.

Illustrations by David Vanadia

Make It a Lottery

By Robert M. Wachter and Ashish K. Jha

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Target Hot Spots

By Shan Soe-Lin and Robert Hecht

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Over the next few months, we will face agonizing decisions about which groups to vaccinate to stop the spread of Covid-19 as quickly as possible.

The first phase is fairly straightforward. We must vaccinate the 15 million high risk health care workers, the two million older people living in nursing homes or other conjugate settings and the oldest of the 1.5 million prisoners in federal and state institutions. Then people in their 80s, given the rates of severe illness and death in this cohort.

But things get more complicated in the second phase, which will start in late January or early February, assuming that we can accelerate the sclerotic pace of the rollout.

We disagree with the federal and state panels that are trying to select people for this phase based on occupation and vaccinate those who are most essential and on the front lines and thus at greatest risk of infection, such as Uber drivers, public utility crews and grocery store workers.

At the moment, the coronavirus is spreading so pervasively that we are all at significant risk of being infected. Those who do not work on the front lines are at most one or two degrees away from someone who does. And trying to vaccinate groups of workers in small and dispersed workplaces or verify their eligibility at clinics and pharmacies is going to be a logistical nightmare.

Instead, we should prioritize towns and neighborhoods where the incidence of new infections is highest.

This will be the most effective way to cut the number of new cases — and thus additional deaths. And it will be the best way to get the economy open again, saving us hundreds of billions of dollars and millions of jobs.

Most states now have solid data on the numbers of new infections that are occurring community by community. We could quickly and easily select the communities with the most new coronavirus cases per capita over the previous two weeks. We should also focus on places with a minimum absolute number of newly infected people, to gain critical mass and avoid having the scarce vaccines dispersed across small populations.

Take our home state of Massachusetts. We would start with hot spots where daily new infections were at least 150 per 100,000 people in the past 14 days, and where there have been at least 1,000 infections during the same period. On that basis, the towns of Lawrence, Lynn, Lowell, Methuen, Revere and Saugus and some Boston neighborhoods would be first to be vaccinated, followed by Chelsea, Everett, Fall River and New Bedford.

The goal would be to saturate these hot spots, so within a week, 60 to 70 percent of the eligible population would be vaccinated, enough to reach herd immunity. For the first set of Massachusetts towns, this would require about 300,000 vaccinations. This strategy would eliminate the need to screen individuals based on age or occupation; just simple proof of residence, such as a driver's license or utility bill, would be required.

Some may object that the hot spots are places where people refused to mask or observe social distancing — why should we reward them by moving them to the front of the line? But most of these places are hot spots because they are home to low-wage workers on the front lines who live in dense multigenerational housing and thus are unable to avoid being heavily exposed to the coronavirus.

Many are also communities of color that have suffered more from Covid-19, with residents who have been forced to take extra risks in order to bring home paychecks to support their families. They have experienced the highest rates of hospitalization and death.

It won't be easy. It will require the full participation of health centers, mobile vaccination teams, and pharmacies in these hot spots, plus leadership from local officials and community

organizations to motivate everyone to get their shots. And even after vaccination, people must continue with masks and social distancing.

The hot spot approach would do away with the ugly and unproductive debates in which groups of workers and their unions and employer groups are positioning themselves to get to the front of the queue. It would focus the efforts of state officials on a small number of locations, making it easier to implement. And as trust builds in these communities, mass vaccination will likely snowball and lead more rapidly to the high levels of coverage that we need.

Targeting hot spots will bring down new infections fastest for all of us, saving jobs and lives.

Don't Pressure the Vaccine-Hesitant

By Peter Doshi and Jennifer Block

Dr. Doshi, an associate professor of pharmaceutical health services research at the University of Maryland School of Pharmacy, leads the Restoring Invisible and Abandoned Trials Initiative. Ms. Block (@writingblock) is the author of "Everything Below the Waist: Why Health Care Needs a Feminist Revolution."

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Write Better Algorithms

By Ravi B. Parikh and Amol S. Navathe

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Covid-19 Vaccines ›

Words to Know About Vaccines

Confused by the all technical terms used to describe how vaccines work and are investigated? Let us help:

- **Adverse event:** A health problem that crops up in volunteers in a clinical trial of a vaccine or a drug. An adverse event isn't always caused by the treatment tested in the trial.
- **Antibody:** A protein produced by the immune system that can attach to a pathogen such as the coronavirus and stop it from infecting cells.
- **Approval, licensure and emergency use authorization:** Drugs, vaccines and

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