



Considering Race and Ethnicity in Covid Risk Assessments — Legal Concerns and Possible Solutions

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Most new treatments and preventive interventions for Covid-19 have initially been in short supply, which has necessitated strategic allocation of these resources among the people

who could benefit from them. The basic framework that the Centers for Disease Control and Prevention (CDC) and other government agencies have recommended for allocating scarce resources is based on a 2020 National Academies of Sciences, Engineering, and Medicine report on allocating Covid-19 vaccines, which advised consideration of risks to individual people and society and mitigation of health inequities.

Risk factors for SARS-CoV-2 infection and severe illness include being Black, Indigenous, or Latinx. Explicitly including race or ethnicity as a factor in government allocation of resources, however, raises serious legal issues under the U.S. Constitution's Equal Pro-

tection Clause and federal antidiscrimination statutes. Although this issue has not been subject to substantial litigation in health care contexts, court decisions in education and other contexts limit the government's ability to prioritize members of particular racial or ethnic groups in resource allocation. Recent litigation challenging the consideration of race and ethnicity in the allocation of scarce Covid-19 antibody treatments in New York highlights these issues.

It is well documented that Black, Indigenous, and Latinx people have been at high risk for poor outcomes during the Covid-19 pandemic. For example, Black people have been hospitalized at

2.3 times the rate and died at 1.7 times the rate of non-Hispanic White people, and Hispanic or Latinx people have been hospitalized at 2.2 times the rate and died at 1.8 times the rate of non-Hispanic White people.¹ Moreover, Black, Indigenous, and Latinx people have died from Covid-19 at younger ages than White people, on average.

Many structural factors contribute to higher Covid-related risks in these populations than among White people. These factors include lower socioeconomic status and poorer living conditions, on average; more limited access to preventive interventions and treatment; and increased viral exposure among frontline, essential, and critical-infrastructure workers, who are disproportionately members of historically marginalized groups. An additional factor may be the long-term effect of stress caused by discrimination. Al-

though race and ethnicity are social constructs rather than biologic characteristics, screening for economic, social, or medical factors independently does not fully capture Black, Indigenous, and Latinx people's increased risks.

The federal government and state governments have recognized being a member of a historically marginalized racial or ethnic group as an independent risk factor for Covid-19 throughout the pandemic. One of the CDC's stated reasons for initially prioritizing essential frontline workers for vaccination over older or sicker people was that these workers tended to be members of racial or ethnic groups that were at heightened risk for Covid-19. Guidance from the Food and Drug Administration on the allocation of the monoclonal antibody sotrovimab mentions consideration of race and ethnicity. The CDC's general Covid-19 guidance also identified being "from certain racial and ethnic minority groups" as a factor associated with a higher likelihood of becoming severely ill from Covid-19.

Government rationing of scarce resources based on race or ethnicity, however, is legally problematic. The Equal Protection Clause and Title VI of the Civil Rights Act prohibit discrimination by the government based on race or ethnicity, except in very limited circumstances.² Laws or policies that treat people differently on the basis of racial or ethnic classifications are generally subject to "strict scrutiny" by courts, which means that they must be narrowly drawn and represent the least restrictive means of achieving a compelling government interest.

They seldom survive legal challenge.

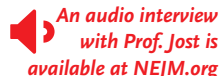
In response to the omicron surge in December 2021, the New York State and New York City health departments issued guidance on the use of Covid-19 drug treatments and other therapies that were then in limited supply. Oral antiviral treatments were to be authorized for patients over a certain age and weight who tested positive for SARS-CoV-2, had mild-to-moderate Covid-19 symptoms, and had "a medical condition or other factors that increase their risk for severe illness." As the state guidance further specified, "Non-white race or Hispanic/Latino ethnicity should be considered a risk factor, as longstanding systemic health and social inequities have contributed to an increased risk of severe illness and death from COVID-19."³ The city guidance included similar language. The health departments also recommended a prioritization schedule for Covid-19 antibody treatments, grouping patients into five categories according to age, vaccination status, and various risk factors, including race and ethnicity.

Three lawsuits were filed in federal courts asking that this guidance be immediately blocked. Two of the lawsuits, *Jacobson v. Bassett* and *Roberts v. Bassett*, claimed that it discriminated against White people by categorizing them as lower priority for treatment. A third, *Foundation Against Intolerance & Racism v. City of New York*, was filed by an organization that says its mission is to protect members of all racial and ethnic groups and claimed that the guidance discriminated not only against White

people but also against members of other racial and ethnic groups by labeling them as more prone to disease and therefore contributing to stigma and by subjecting them to experimental treatments.⁴

Concern that members of marginalized groups might be used as "guinea pigs" for experimental treatment has a historical basis, most famously in the Tuskegee syphilis experiments. Some medical and public health experts have argued that prioritization for new interventions that is based solely on skin color could contribute to mistrust or be stigmatizing.⁵ New York's guidance, however, clearly links the consideration of race and ethnicity to structural factors, not biology. The only amicus brief filed in these cases thus far was cosigned by the National Medical Association, which represents African American physicians, and strongly supported the guidance.

Two of the lawsuits have been dismissed. The courts did not use strict scrutiny to assess the merits of the guidance, but rather ruled that the plaintiffs had not shown that the guidance had injured them: the state and city had not required favorable treatment of Black, Indigenous, and Latinx people, they had merely provided science-based information to health care professionals, who themselves made clinical treatment decisions. The courts also held that the White plaintiffs had not explained how the guidance affected them personally, since they had not had Covid-19 or needed treatment, and the antiviral treatments were no longer in scarce supply. The plaintiffs in these cases have appealed



to the U.S. Court of Appeals for the Second Circuit. The judge in the case claiming discrimination against both White people and members of other racial and ethnic groups has put it on hold awaiting the decisions in the appeals of the other two cases.

The issue of discrimination in the allocation of Covid-19 interventions has been raised in other contexts, as well. The attorney general of Arizona asked the Department of Health and Human Services to revoke any guidance recommending consideration of race or ethnicity as risk factors for Covid-19 and to adopt a rule prohibiting the use of criteria based on race or ethnicity in the allocation of medical resources, unless an explanation is offered as to why the guidance would survive strict scrutiny. Utah and Minnesota reportedly recommend-

ed consideration of race and ethnicity in the rationing of scarce Covid-19 treatments but reversed course under the threat of legal action.

The question of how data about racial and ethnic disparities in the risk of severe Covid-19 should be translated into prevention and treatment policy is likely to persist. Although Covid-19 treatments and preventive interventions aren't currently in short supply, there may be renewed shortages if Congress continues to hold up funding for federal Covid-19 programs. The New York court decisions may offer a way forward. So long as governments merely provide factual scientific information, leaving health care professionals with the freedom, and the responsibility, to make clinical decisions for their patients, guidance may be safer from legal challenge than policies that explicitly ration interventions would be.

Disclosure forms provided by the author are available at NEJM.org.

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Understanding Covid Vaccine Efficacy over Time — Bridging a Gap Between Public Health and Health Care

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Imagine if we could track, for each patient seen at a health care facility, which Covid-19 vaccine they had received when and what their clinical evaluation revealed. We could then have near-real-time insights into the efficacy of vaccines, how that efficacy changes over time, how new viral strains alter it, and which viral and host features (including underlying medical conditions) lead to breakthrough infections in

immunized people. Such tracking would require robust linkage among clinical outcomes (including details of clinical interventions and laboratory studies), data on the specific vaccine administered and the date of administration, and information about the status of the pandemic in the relevant geographic area.

This effort is not an act of futuristic visioning. Tightly integrated population-based health care

organizations in countries such as Israel have directly informed public health policies such as recommendations for a third, boosting vaccination, at the scale of several million people.¹ Unfortunately, these successes accentuate the relative failures in linking public health and health care elsewhere. In most high-income countries, vaccinations are recorded in electronic databases — registries — for public health purposes.