Due to an astounding confluence of human ingenuity and transnational cooperation, millions of health care workers will receive an initial dose of a vaccine for the novel coronavirus by the end of 2020. It’s a hopeful end to a traumatic year, especially for those who have been on the front lines of a global pandemic.

But over the past week, my health professional colleagues receiving with relief their first vaccine dose have turned to ask the same question: "when and how can my parents be vaccinated?"

Unfortunately, the answer to this question seems to be the same as the answer to all too many questions in health care: it depends on where you live.

Even the initial images of vaccination display differences across jurisdictions in how policy makers will allocate scarce vaccine resources. In the United Kingdom, where the first dose of the Pfizer-BioNTech vaccine outside of a trial was given, persons living in a “care home for older adults and their carers” were prioritized first, before “all those 80 years of age and over and front line health and social care workers.” In the United States, an African American nurse from hard-hit New York was the first face of the vaccine rollout that prioritized frontline health care workers concurrent with older adults in residential facilities. As a practical matter of rapid dissemination, initial doses of the Pfizer-BioNTech vaccine were shipped to hospitals with ultralow temperature storage so that they could vaccinate their workforces. Administration to long-term care facility residents and staff is following quickly behind in the United States through a partnership with pharmacies.

The initial images concord with areas developing allocation priorities and deployment plans through different policy-making processes and with different priorities. The United States, not surprisingly, has a web of processes for national vaccine prioritization—yet states have the final say. The National Academies of Science, Engineering, and Medicine (NASEM)—a private organization—created an initial set of recommendations with expert input, including from ethicists. The Centers for Disease Control and Prevention’s Advisory Committee on Immunization Practices (ACIP) has made preliminary recommendations for prioritization as the vaccine approval process progressed. Most states are following the ACIP guidance, at least for the initial phases, but some are not. Notably, some are prioritizing those with high-risk conditions above those in older age groups, some are further segmenting within the initial priority groups, and some are treating special populations, like the incarcerated or the homeless, differently.

Similarly, European countries announced plans that vary with respect to how they are treating different age groups, residents of long-term care facilities, and those with comorbidities. The UK has plans to roll out the vaccine by sharply defined age groups, while other countries are working out approaches that target those with medical vulnerabilities. And in China, where virus transmission is low, those accepting risk during the pandemic, such as diplomats and vaccine makers, received the first doses; people in important industries, those interacting with imported goods, and overseas travelers might be prioritized next.

Another area of congruence, though not consensus, around the world, is how to allocate vaccines in ways that increase equity. The NASEM explicitly called its work a “Framework for Equitable Allocation” and recommended the use of a social vulnerability index to guide prioritization within each phase and population group. The World Health Organization similarly supported mitigating health inequities. Yet in the United States, there is concern that an explicit consideration...
of race could be overturned by the courts.\textsuperscript{3} It may be that dissemination strategies, as much as explicit criteria, will determine whether vaccine receipt is equitable.\textsuperscript{4}

Of course, one thing we’ve learned from this pandemic is that to fight it, we have to adapt to changing scientific knowledge and information about human behavior. Discussions of age criteria have been conducted in the absence of real knowledge about how well mRNA vaccines work in older adults. There is still uncertainty about whether vaccinated people can still transmit the virus; if this was known for certain, we might prioritize essential workers or younger people to break chains of transmission faster.\textsuperscript{5} Likewise, we need to be cognizant that marginalized groups disproportionately affected by the virus might be more hesitant to be vaccinated.\textsuperscript{6} Innovative strategies, informed by social science, to increase vaccine acceptance are needed.\textsuperscript{7} In other words, all of us in the health policy sphere will need to continue drawing on the wells of flexibility and perseverance we’ve tapped in 2020 into 2021 and beyond if we hope to help defeat this pandemic.

\section*{ARTICLE INFORMATION}
\textbf{Correction:} This article was corrected on January 7, 2021, to fix a sentence in which “incarcerated” had been incorrectly written as “incarnated.”

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