

Canadian Pandemic Influenza Plan for the Health Sector 2006

Relevant Clauses

Section Two: Background

6.0 Ethics and Pandemic Planning

The debates in public health ethics have not centred around the need to protect and promote the public's health, but rather on the means by which to do this. Specifically, one of the greatest debates in pandemic planning has been around the issue of resource allocation. For example, given that 30 million doses of a pandemic vaccine cannot be made available to everyone at the same time, who will get what by when? The ethical principle that has guided these discussions is distributive justice. Distributive justice implies the distribution of resources in a fair and equitable manner based on need. This principle underlies the recommendation that health care workers form a priority group for the vaccine. However, how the distribution is done is important. Discussions on resource allocation that address the hard realities of limited resources bring into focus a seminal ethical principle adopted by public health ethics: respect for the inherent dignity of all persons.³ This means that although some people may not be eligible for a vaccine initially, they need to be informed and cared for in a way that is respectful and maintains their dignity. This principle will need to inform the allocation of all scarce resources during a pandemic.

Annex D: Preparing for the Pandemic Vaccine Response

3.3 Prioritization

Although enough vaccine will be made to immunize all Canadians, the new pandemic vaccine will still become available in batches, necessitating decisions regarding how these doses will be distributed across Canada and whether to prioritize certain subgroups of the population ahead of others. As indicated earlier, the degree to which prioritization is needed will be linked to the vaccine production and administration rate.

At this time there is no policy decision regarding distribution of the first doses of vaccine across Canada. While a per capita approach seems to be the most equitable approach and should be used for planning purposes, there are other factors that may influence this decision at the time. For example, if the vaccine becomes available as first wave activity appears to be subsiding in some provinces but escalating in others, perhaps the first doses should be sent to the area where activity is escalating in an effort to mitigate the impact of the first wave in those locations. Alternatively, the provinces with subsiding activity might be in the best position to deliver mass immunization programs, as human resources could be shifted away from patient care, given the declining number of new cases, and into vaccine administration. Mathematical modeling and feedback from pandemic planning exercises may provide some insight with respect to this issue, but there are other factors that will also need to be considered. Final allocation decisions, therefore, may not be made until the pandemic is under way and the vaccine becomes available.

In order to assist with preparations for implementation of a priority-based strategy at the local level, the Pandemic Vaccine Working Group of PIC developed priority groups (i.e. subgroups of the entire population) for planning purposes, which were published as a numbered list in Annex D, both with the 2004 and the 2006 edition of the CPIP. This document is now replacing that

version of Annex D.

The subgroups of the population identified in the previous version of Annex D have been retained, as each group has commonalities, such as a role in contributing to the pandemic planning goals and potential access strategies, which make the groupings logical from a planning perspective. These existing subgroups of the Canadian population can be classified into occupation-based groups, high-risk groups and healthy adults and children (i.e. those not a part of the occupational groups identified). Table 4 lists the working definition for each of the subgroups and gives examples of who might be included in each group. The subgroups are intended to be mutually exclusive but, together, to cover the entire Canadian population. Most of these definitions can also be found in the Glossary for the Plan. **The groups are presented in alphabetical order: this table does not represent a priority list.**

Table 4. Population subgroups

Population Subgroup (NOT in priority order)	Definition (for the purposes of this process)	Examples of who would make up the group and how they might be accessed
Health care workers	Persons who work in settings where essential health care is provided	Nurses, physicians, laboratory workers, pharmacists, emergency medical services • Might be accessed through workplace-based clinics
Healthy adults	All individuals, 18 years of age and over, who do not have a medical condition or fit into an age category that would qualify them for inclusion in the high-risk group and who do not fall into one of the other occupation-based groups <i>(Note: if adults 65 years and over are considered to be at "high risk of poor outcome", as they are on a seasonal bases, then they would not be included in this group)</i>	• Might be accessed through community-based clinics
Healthy children	All individuals, 2-17 years of age, who do not have a medical condition that would qualify them for inclusion in the high-risk group	• Might be accessed through school or community-based clinics
High risk (of poor outcome)	Those groups in which epidemiological evidence indicates that there is an increased risk of poor outcome due to the disease	This would have to be determined according to the epidemiology of the pandemic** • Might be accessed through dedicated clinics at locations convenient for the particular groups (e.g. nursing homes for residents)
Key health decision makers*	Persons whose decision-making authority is necessary for implementing and maintaining the health sector response to pandemic influenza	Medical officers of health, hospital Chief Executive Officers and Chiefs of Staff, Ministers of Health • Might be accessed through workplace-based clinics

Population Subgroup (NOT in priority order)	Definition (for the purposes of this process)	Examples of who would make up the group and how they might be accessed
Key societal decision makers*	Persons whose decision-making authority will be necessary at the time of the pandemic to minimize societal disruption	Mayors, police chiefs, fire chiefs, judges, other government ministers • Might be accessed through workplace-based clinics
Public health responders*	Persons who are essential to the implementation and maintenance of the public health response to pandemic influenza and who would not be expected to come within 1 meter of a known influenza case in their work setting	Public health nurses not involved in patient care, other public health staff, public health administrators • Might be accessed through workplace-based clinics
Pandemic societal responders*	Persons who are trained or primarily involved in the provision of an essential service that, if not sustained at a minimal level, would threaten public health, safety or security	Police officers, firefighters, corrections officers, utility workers, mortuary staff • Might be accessed through workplace-based clinics
<p>* These definitions were developed to facilitate pandemic planning regarding the identification of specific groups that may be targeted as part of specific public health interventions and therefore may not be well recognized outside of the public health sector. Also note that where the third column in the table includes occupational groups, this has been provided as an example and is not intended to be inclusive <i>or</i> to convey that the entire occupational group would meet the criteria for inclusion in this defined population subgroup for immunization.</p> <p>** For planning purposes the high-risk groups for annual influenza (as identified by the National Advisory Committee on Immunization) have been used:</p> <ul style="list-style-type: none"> • Adults and children with selected chronic health conditions if significant enough to require regular medical follow-up or hospital care. These high-risk conditions include the following: <ul style="list-style-type: none"> • cardiac or pulmonary disorders (including bronchopulmonary dysplasia, cystic fibrosis and asthma), diabetes mellitus and other metabolic diseases, cancer, immunodeficiency, immunosuppression (due to underlying disease and/or therapy), renal disease, anemia or hemoglobinopathy, conditions that compromise the management of respiratory secretions and are associated with an increased risk of aspiration, children and adolescents with conditions treated for long periods with acetylsalicylic acid. • People of any age who are residents of nursing homes and other chronic care facilities. • People ≥ 65 years of age • Healthy children aged 6 to 23 months • Pregnant women 		

Determining the order in which these subgroups of the population would receive vaccine is a much more difficult task and one that experts concur must take into consideration several factors, many of which will not be known until the pandemic occurs. The following are examples of these factors and considerations:

- **Impact on pandemic goals** (i.e. minimizing serious illness, overall deaths and societal disruption): minimizing serious illness and overall deaths would suggest giving high-risk groups and health care workers priority over others. However minimizing societal disruption may favor prioritization of the critical infrastructure occupational groups and perhaps healthy adults.
- **Operational considerations** (e.g. size of the group, ease of identification and accessibility): depending on the amount of vaccine available it may be easiest to prioritize smaller groups that can be easily located and identified, for example, health

- care workers, or to immunize everyone in a remote community at once.
- **Severity/epidemiology of the pandemic:** a severe pandemic may result in public pressure to immunize children first. Similarly if the pandemic virus is similar to one that has circulated previously (e.g. H2N2) it may make sense to prioritize the age groups that would not be expected to have been exposed to a similar virus previously.
- **Difference in vaccine effectiveness between groups** (e.g. if vaccine effectiveness is significantly lower in the elderly and immunocompromised): this may favour prioritizing the “healthy” over some of the high-risk groups.
- **Timing of vaccine availability** (e.g. end of first wave, inter-wave period, start of second wave): availability between waves may favour prioritization of the occupational groups in preparation for the next wave or those in high transmission settings like school-age children, in an effort to flatten the epidemic curve of the second wave. Vaccine availability at the start of a second wave may lead to prioritizing those at high risk, especially if a significant proportion of the other groups are expected to have developed immunity during the first wave.
- **Public opinion and risk perception as a consideration** (e.g. perceived severity of the pandemic and risks of the vaccine): the public may want children to be immunized first if the pandemic is severe. Alternatively, if the pandemic is perceived as relatively mild and the vaccine is highly reactogenic, the public may wish to delay immunizing children until more is known about the long-term effects of the new vaccine.

Conceptualizing how all these variables might interact in order to present a menu of priority lists for each possible contingency is not an efficient use of time or resources. There are simply too many potential combinations of factors and considerations, and many of these (e.g. public opinion) may not be “static” over the course of the pandemic. Such lists would run the risk of derailing planning efforts: with focus on the order of the population subgroups, many planners would be forced to spend time justifying the lists instead of working on how the specific groups of people would be identified and accessed should it be necessary to prioritize them as part of the pandemic vaccine program.

It is envisioned that at the time of the pandemic the Pandemic Vaccine Working Group would make recommendations regarding whether prioritization of the vaccine supply is necessary and, if necessary, the order in which the subgroups of the population would be immunized and whether any subgroups should be targeted at the same time. The Pandemic Vaccine Working Group of PIC is dedicated to developing a prioritization decision-making strategy or tool that would encompass the factors and considerations listed previously. This strategy/tool would be made publicly available for educational purposes, but ultimately it is expected to be used by the Working Group to make recommendations regarding prioritization to PIC and subsequently to the Public Health Network Council. The national policy decision regarding the order in which the population subgroups should be immunized across Canada would likely be made by Ministers of Health on the advice of the Chief Medical Officers of Health and the Public Health Network Council, with the strong recommendation that the order decided on would be consistently applied across Canada.

Annex G: Clinical Care Guidelines and Tools

1.2 Ethics of clinical care during public health emergencies

On the bases of the six ethical principles outlined in the CPIP, health care planners and clinicians will want to consider the need for the following:

- **Ensure equity and distributive justice.** Decisions taken during an influenza pandemic must be fair, especially as they relate to allocation of limited resources during an emergency. This principle applies to policy development by health care planners and policy implementation by clinicians. Respect the inherent dignity of all persons. As noted, resources will be limited. This principle refers to the importance of how resource allocation is carried out. Although some people may not be eligible for all interventions, they need to be informed and cared for in a way that is respectful and maintains their dignity.
- **Work with transparency and accountability.** In particular, health care planners have an obligation to educate clinicians and the public in terms of decisions taken and the process used to arrive at these decisions. Clinicians have an obligation to educate their patients about the decisions taken and the process used to arrive at these decisions.

Appendix I: Pandemic Primer for Front-Line Health Care Professionals

5. The Five Best Practices for Health Care Professionals to Consider When Preparing for Pandemic Influenza

Best Practice #4 – Ethics-based decision making

Third, studies of Canadian values explored in the context of pandemic planning have identified the **importance of being practical, fair and equitable**. The public realizes that it won't be "business as usual" during a pandemic, and there will be a scarcity of resources. Work has already begun on rationing the use of respirators in intensive care units according to principles such as, "those who are most likely to recover will have priority". Doctors will be expected to do their best in making these difficult choices during a pandemic and will need to work hard to ensure that the choices they make are fair, humane and for the larger good.

Source: Public Health Agency of Canada (2006). Canadian Pandemic Influenza Plan for the Health Sector. Available from <http://www.phac-aspc.gc.ca/cpip-pclcpi/>