CONSIDERING VACCINATION STATUS

Govind Persad*

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Note to Petrie-Flom Workshop Readers:

This is an early-stage draft on a highly current and developing issue—the appropriateness of policies that consider vaccination status. I have previously written on some related topics, and am applying some of my thinking in those contexts to this question. Please don’t be too bothered by the incomplete footnoting. Some questions I would very much appreciate thoughts on, particularly from students:

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Thanks to David Wasserman, Joe Millum, Paul Kelleher, Vardit Ravitsky, Keymanthri Moodley, Carla Saenz, and discussants at the National Academies of Science, Engineering and Medicine Workshop on COVID-19 Vaccine Credentials for discussion of some of these ideas. Thanks also to Jacob Buchheim for research assistance.
1) Are there relevant arguments I’m overlooking?
2) Are there topics that should be cut or relocated to other work?
3) How could the material in the current draft be reorganized for better clarity?
4) The draft is currently a little bit too long (~12,000 words) for most online law journals, but a bit too short (and not correctly timed?) for flagship law reviews. Which type of journal would be the better target, and how could revisions get it to the proper length?
5) Are there changes that would make the paper more clearly about “law” rather than “bioethics” or “health policy”?

I look forward to our discussion!

All the best,
Govind Persad
INTRODUCTION

Vaccination is one of the most powerful medical advances of the last 300 years. By reducing people’s susceptibility to disease, and in particular to communicable diseases, it has averted immense harm at the individual and population levels. Most recently, in the COVID-19 pandemic, vaccination has reduced death and hospitalization among vaccinated people by more than 90%, and averted hundreds of thousands of hospitalizations and deaths.¹ Yet, despite vaccination’s immense power to prevent harm, some people refuse to become vaccinated, even in the face of a pandemic, with about 14% committed to definitely refusing vaccination against COVID-19 and another 13% uncertain about their willingness to become vaccinated or only willing to do so if required.²

The power of vaccination, along with pockets of resistance to vaccination, has often led to laws and policies that consider vaccination status—that treat individuals who are vaccinated differently from people who are not. Vaccination status is almost invariably considered at the point of entrance into the school system,³ as well as by many higher education institutions. Even before the COVID-19 pandemic, vaccination against certain illnesses was a condition of employment in some settings, such as health care.⁴

The COVID-19 pandemic has heightened interest in policies that consider vaccination status. Many private businesses have begun considering vaccination status for potential employees or customers, with a recent survey suggesting that a

majority of large firms are considering such requirements.5 Universities have expanded their vaccination policies to include COVID-19 vaccinations.6 Some states and localities have made vaccination for government employees a condition of employment, or for certain businesses within their jurisdiction.7 The federal government has made nursing home funding conditional on vaccination,8 and appears poised to do so for military members as well.9 In addition to these participation-based policies, states, localities, and businesses have also offered a range of benefits to people who choose to be vaccinated.10 More recently, as hospitals become overwhelmed by unvaccinated patients, some have discussed the legitimacy of health insurers considering vaccination status11; medical professionals turning away patients who refuse vaccination;12 and hospitals considering vaccination status when making prioritization decisions under scarcity.13

At the same time, many have objected to policies considering vaccination status, on many different grounds. Most prominently, some jurisdictions have made vaccination status a legally protected category,14 or prohibited governmental entities, and sometimes even private businesses, from considering COVID-19 vaccination

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7 W.A.STE.DEPT. OF HEALTH, VACCINE MANDATE FREQUENTLY ASKED QUESTIONS (2021), https://www.governor.wa.gov/VaccineMandateFAQ.


status in different ways. The most common defense of these law is that they preserve individual freedom of choice. But these policies have also been criticized on other grounds and by other actors. Critics have claimed that policies considering vaccination status create and entrench social division between vaccinated and unvaccinated people.\textsuperscript{15} They have complained that such policies are overbroad and impose burdens disproportionate to benefits. They have claimed that these policies exacerbate preexisting inequality. And they have complained that they entrench unjust social structures and practices.

In this Essay, I consider whether and when policies should consider vaccination status. In Part I, I review several settings in which vaccination status has been considered. While my focus is on policies during the COVID-19 pandemic, most of these arguments are also relevant to pre-COVID-19 policies that considered vaccination status for other vaccines, and would remain relevant to considering vaccination status in future pandemics. In Part II, I consider potential normative justifications for, and arguments against, policies that consider vaccination status, focusing on four values: preventing harm, protecting the least advantaged, reciprocity, and equal concern. In Part III, I look at how legal responses to policies that consider vaccination status map onto these normative values. Rather than arguing that vaccination status should always or should never be considered, I conclude that the appropriateness of considering it is contextual, and depends on how well doing so serves the values discussed in Part II.

A note on terminology: the developing literature in this area uses a variety of terms to discuss vaccine-based policies, such as “vaccine credentials,” “vaccine passports,” “vaccine verification,” “vaccine mandates,” “vaccine requirements,” and so on. I prefer to focus on the question of considering vaccination status, for two reasons. First, the fundamental structure of the policies at issue is typically conditional: if someone is vaccinated, then they experience some policy outcome that an unvaccinated person does not. In some cases (being fired from a workplace), that outcome is more burdensome; in others (having to pay for a donut at Krispy Kreme rather than receiving one for free), it is less burdensome. Second, it is important not to confuse the question of whether it is appropriate to consider vaccine status with how, if at all, such a system of consideration should be implemented. The questions of credentialing and enforcement are important, but depend on the threshold issue of policy appropriateness.

I. WHERE IS VACCINATION STATUS CONSIDERED?

In this Part, I consider several contexts in which vaccination status has been, or might be, considered. There are several ways one might categorize these to avoid creating a disorganized “laundry list.” I will organize them in terms of what is made conditional on vaccination status, though alternative categorizations are possible.

The first type of context where vaccination status has been proposed for consideration is the receipt of financial or in-kind benefits and penalties. The second is participation in various activities or venues, including participation as a customer in market activities such as shopping or attending concerts and sports events, participation as a citizen in activities such as education and civic engagement, and participation as an employee or a contractor in business settings. The third set of contexts is the receipt of medical benefits or treatment. Most prominently, this includes recent debates over whether vaccination status should be considered when allocating scarce medical resources, as well as debates over whether physicians or other medical providers can exclude people who will not become vaccinated from medical practices.

Many examples lie at the intersection of two or more of these categories. For instance, the question of whether vaccination status should be considered in setting health insurance premiums overlaps all three, since health insurance is a financial benefit, is participation in an activity (being insured), and a condition on the receipt of medical benefits.

In addition to these three categories, two distinctions are also relevant: benefits versus penalties, and categorical rules versus multi-factor rules (Table 1).

<table>
<thead>
<tr>
<th></th>
<th>Financial</th>
<th>Participation</th>
<th>Health Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Categorical benefit</strong></td>
<td>Payment for vaccination</td>
<td>Only vaccinated people are hired</td>
<td>Only vaccinated people accepted as new patients</td>
</tr>
<tr>
<td><strong>Categorical penalty</strong></td>
<td>Fine for non-vaccination</td>
<td>Unvaccinated people are fired</td>
<td>Unvaccinated patients not seen</td>
</tr>
<tr>
<td><strong>Multi-factor benefit</strong></td>
<td>Payment for vaccination or exemption</td>
<td>Vaccinated students need not quarantine</td>
<td>Vaccination is a plus factor in scarce resource priority</td>
</tr>
<tr>
<td><strong>Multi-factor penalty</strong></td>
<td>Fine for non-exempt vaccination</td>
<td>Vaccinated students must pay their testing cost</td>
<td>Non-vaccination is a minus factor in scarce resource priority</td>
</tr>
</tbody>
</table>

Table 1: How Vaccination Status Might Be Considered
Many policies can be framed either in terms of appropriately rewarding people who have taken precautions, or appropriately requiring people who have not taken precautions to internalize the social harms that result of their choices. For instance, allowing normal insurance price increases but exempting people who are vaccinated would be a reward, whereas creating a higher insurance charge for unvaccinated people would be a penalty. Despite the two frames being different, the practical effects of the two policies may be identical. The same is true for using vaccination status as a tiebreaker for access to hospital beds under scarcity, which could be framed either as a plus factor for vaccinated people or a minus factor for unvaccinated people, even though the outcomes are identical.

Policies can also be implemented either categorically—excluding all unvaccinated people from an activity or benefit—or multi-factorially, using vaccination status as one determinant of how someone is treated. A policy could also apply only to segments of the population, rather than to everyone. For instance, because vaccine uptake has been lower among younger adults, a benefit program could be targeted to that group—as West Virginia did in promising savings bonds to people 16-35 who became vaccinated. Or, because older adults are at higher risk of needing hospitalization or intensive care after COVID-19 infection, health system burdens could be dramatically reduced by increasing uptake in older adults. A targeted benefit program for older adults could achieve this outcome, as could the use of vaccination status as a condition of receiving certain age-based benefits. Or, a universal vaccination requirement could be based on age, just as vaccine eligibility for COVID-19 vaccines was initially based on age. However, some might complain that excluding somebody from age-based benefits, particularly important benefits such as Medicare or Social Security, on the basis of vaccination status is an excessive abridgment of a fundamental right, or that using age as the basis for a vaccine policy is invidious age discrimination. Others might charge that the negative health consequences for people who elect to remain unvaccinated at the cost of their age-based benefits would outweigh the positive consequences of vaccination.

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A. Benefits and Penalties

After the wide availability of COVID-19 vaccines, several states and localities announced benefit programs for vaccine recipients, including eligibility for lotteries, scholarships, and payments.\(^{20}\) It remains unclear whether these programs increased COVID-19 vaccine uptake.\(^{21}\) In addition, the federal government and many businesses announced the availability of paid time off to be vaccinated and recover from side effects,\(^{22}\) and free transportation to vaccination sites. These programs follow prior precedent, where benefit programs have been used to encourage uptake of other vaccines.\(^{23}\) Many private businesses also announced giveaways or other perks for vaccine recipients.

In a few settings, financial penalties for unvaccinated people have also been used or floated during the COVID-19 pandemic. Typically, these exist in employment settings, and so could be considered conditions on participation (discussed next). However, some older vaccination laws—such as the law at issue in Jacobson v. Massachusetts—applied to the entire local population and were enforced via fines. More recently, a *Jacobson*-like approach was proposed in areas of New York City at risk of outbreaks.\(^{24}\)

B. Participation

Many businesses and other settings have begun to require COVID-19 vaccination as a condition of participation as a recipient of services or an employee. Settings where many people interact closely, such as universities and cruise lines, were early


adopters of these requirements: in the case of universities, these requirements built on consideration of other forms of vaccination, such as vaccination against measles or meningitis. Vaccination requirements as a condition of employment have also been adopted by many hospitals and other settings where health care is provided, again paralleling earlier requirements for other vaccines in these settings. Notably, the federal government recently made vaccination status a requirement for receipt of Medicare funds at nursing homes.

But many other businesses, including large employers, have started to do so as well, as have some sports and concert venues. Some consider vaccination status as a requirement for in-person participation, while others permit unvaccinated people to participate but require them to be tested more frequently or to mask when others need not. K-12 schools have begun to require vaccination for teachers, though not yet for eligible students. Some states have required them for government employees.

All of these cases where vaccination status is considered include exemptions or accommodations: people who cannot be vaccinated for medical reasons must always be accommodated, though they need not always be included on the same terms as those who can be vaccinated (for instance, in health care settings where workers who cannot be vaccinated may pose a direct threat to vulnerable patients), and people who cannot be vaccinated for religious reasons also must be accommodated in employment settings, and sometimes in other settings as well depending on state law. Some also include exemptions based on “philosophical” or “personal belief” factors.

Another possibility for differential participation, parallel to earlier practices for when smoking was widespread, would be to allow unvaccinated people to participate at certain times or in certain spaces, while other spaces remain reserved for vaccinated people. For instance, a grocery store could reserve certain times only for vaccinated people (just as they reserved certain shopping hours for older people and those with high-risk medical conditions before the availability of vaccines), while leaving others open to all. This approach, however, carries certain distinctive public health risks compared to exclusion from participation. It might lead to unvaccinated people clustering in the spaces in which they are allowed, and therefore could lead to increased spread among that group. For this reason, prior to the COVID-19 pandemic, some argued that these sorts of partial restrictions are inadvisable.

C. Access to Medicine

Recently, a few employers have proposed health insurance surcharges for

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28 Id.
unvaccinated employees. Health insurers have also restored copayments and coinsurance for COVID-19 treatment. Prior to the COVID-19 pandemic, certain medical practices—specifically pediatric practices—refused to see patients who were eligible for but refused vaccines. With rising cases again putting pressure on hospitals, debates over whether vaccination status should be a factor if medical resources become scarce have arisen, though no hospital has yet adopted such a policy.

II. WHY CONSIDER VACCINATION STATUS?

Despite the popularity of policies considering vaccination status in many settings, vaccination requirements have met a harsher reception not only among conservatives, but also among many progressive legal and ethical commentators. Several have criticized vaccine requirements as exacerbating disparities and failing to address inequity. Others have argued that vaccine requirements violate fundamental liberties or rights. The latter argument has also been taken up by more libertarian commentators as well.

In this Subpart, I engage with the arguments for and against considering vaccination status. I focus on three core substantive values discussed by the National Academies in their report on COVID-19 vaccine allocation, and by other commentators as well. The National Academies describes these values as “maximum benefit,” “equal concern,” and “mitigation of health inequities.” They also discussed but ultimately elected not to include a fourth substantive value, reciprocity. I describe these values slightly differently—as “harm prevention” (rather than “maximum benefit”), “protecting the disadvantaged” (rather than “mitigation of health inequities”), and “equal concern.” In addition, I discuss reciprocity: even if reciprocity is an inappropriate basis for vaccine allocation—though it appeared to play a role in arguments for prioritizing health workers and frontline workers—it seems more plausible as a basis for public health policies that respond to vaccination status.

These four values—preventing harm, protecting the disadvantaged, reciprocity, and equal concern—may have different relevance both absolutely, and compared to

31 Alexander, Kenneth, Tomas A. Lacy, Angela L. Myers, and John D. Lantos. “Should pediatric practices have policies to not care for children with vaccine-hesitant parents?.” Pediatrics 138, no. 4 (2016).
32; Wikler
33 https://www.nap.edu/read/25917/chapter/5#93
34 https://www.nap.edu/read/25917/chapter/5#93
one another, in different contexts. The relevance of context to the applicable values is a point emphasized in particular by some normative theorists, such as Michael Walzer.\textsuperscript{35} For instance, some argue that access to health care, construed however broadly or narrowly, should be based purely on forward-looking considerations of need, benefit, and urgency.\textsuperscript{36} In contrast, opportunities or goods other than healthcare are often distributed based on backward-looking considerations such as responsibility or ability to pay.

\textit{A. Preventing Harm}

The most common justification for considering vaccination status is to prevent harm. Considering vaccination status could prevent harm in at least three ways:

1. Policies that consider vaccination status as a basis for limits on participation in in-person activities could reduce the risk of unvaccinated people transmitting COVID-19 to one another, or to vaccinated people for whom vaccination is not completely protective against infection. This is particularly clear in settings such as nursing homes or cancer infusion centers where many participants may remain at heightened risk even if vaccinated.

2. Policies that consider vaccination status as a basis for participation could prevent unvaccinated people from becoming hospitalized, a particularly important consideration in areas where health systems are under strain, and also an important consideration for overall health care costs.

3. Policies that incentivize vaccination, whether by benefits or penalties, could both directly reduce spread and hospitalization and indirectly enable greater participation in various activities, including education, civic interaction, and employment, mitigating the indirect harms of the pandemic.

Of course, considering vaccination status could also cause harm—for instance, if people are injured by vaccines they are incentivized to take, or become unemployed because they are unwilling to become vaccinated. However, the net benefits of increased vaccination and of decreased infection and hospitalization plausibly exceed these harms. Vaccine injuries are far rarer than injuries from infection, and the absence of policies considering vaccination status may lead others to become unemployed due to illness or due to unwillingness to expose oneself to infection. With respect to the benefit of reducing hospitalizations, one compelling way of conceptualizing the appropriateness of considering vaccination status involves the

\textsuperscript{35} Spheres of Justice
\textsuperscript{36} Dan Wikler WaPo
duty to take reasonable precautions in order to avoid needing to be rescued.37

Some might make an “assumption of risk” argument: a given individual’s choice to remain unvaccinated simply reflects their choice to take the risk of contracting COVID-19. This assumption of risk argument is complicated, however, by several factors. First, children under 12 are not yet eligible for vaccination. Second, current vaccines are not perfectly protective, particularly for populations such as immune-compromised individuals, so people are at risk of contracting COVID-19 from others even after vaccination. Vaccination against COVID-19, as with many other diseases, appears to reduce but not eliminate the risk of infection and transmission. Third, people who are unvaccinated are very clearly at much higher risk of complications than people who are unvaccinated, and a major problem currently during the pandemic is that hospitals and health systems are being overwhelmed by COVID-19 patients.

Another set of worries about these policies argues that considering vaccination status provides the wrong kind of reason for people to get vaccinated.38 On this approach, people should get vaccinated because of their desire to protect themselves against COVID-19 infection, rather than in order to participate in work or activities, to receive financial benefits, or to improve their access to medical care. Decisions about matters of personal health, such as vaccination, should be driven by personal considerations rather than external considerations. The legal theorist Seana Shiffrin has previously made a parallel argument against policies that treat smokers differently from others.

The problem with this argument is twofold. First, it is typically appropriate to ask people to consider how their choices will affect others. It is not clear that merely because a choice also affects one’s own health, one is excused from having to consider how others will be affected as well. The approach of saying that all health-regarding choices should be insulated from external considerations seems too broad. One might try to cabin this more narrowly to medical choices that are more personal or intimate (such as procreative choices or end-of-life decisions), but it is not clear whether any such cabining is defensible. More importantly, it is unclear whether decisions about being vaccinated typically fall into this sort of intimate category where the public can reasonably be asked to bear the burden of individual choices. The most plausible case for asking the public to bear the burdens of individual choice is in situations where people have religious objections to vaccination, discussed later in Part III.

Second, even if we might ideally prefer for people to get vaccinated for the right reasons, the social harm caused by people remaining unvaccinated must also be factored in. Reasons-based concerns about vaccination may be overborne by the

37 Rulli and Wendler https://blogs.bmj.com/medical-ethics/2021/02/09/covid-19-the-duty-to-take-reasonable-precautions-against-infection/

value of containing the pandemic. All of this is compatible with the idea that the policies should try to give people reasons for what they are being required to do to do as a condition for various outcomes, and should also try to have vaccination be internalized as a social norm.

A different set of arguments criticizes vaccination requirements as a “band-aid” approach that fails to maximally prevent harm. These arguments often make the case that rather than considering vaccination status, governments or businesses should instead adopt other policies, such as mask requirements, widespread testing, contact tracing with paid isolation for cases, universal health care, paid leave, or paid closures of venues. These arguments sometimes cast policies that consider vaccination status as unacceptably individualist. Some also argue that it is inappropriate to consider vaccination status when the objective is to ease safer return to employment, education, or other activities, rather than to reduce cases or pursue disease eradication.

From a perspective of preventing harm, these arguments should be unpersuasive for several reasons. First, they likely rest on a false dilemma: considering vaccination status (or incentivizing vaccination) can coexist with other efforts to reduce the impact of the pandemic, and have done so in many settings. Second, if they rest on the idea that considering vaccination status blunts the political impetus for more radical reforms, that idea is both unproven and dangerously instrumentalizing: people who could be protected by the consideration of vaccination status should not be left exposed in order to strengthen the case for health care or employment reforms. Third, harms other than direct injury from COVID-19 matter. If considering vaccination status can enable education, employment, the receipt of medical care for other conditions, or other forms of human interaction, these are strong harm-prevention arguments in favor of considering vaccination. While enforced business, school, and venue closures, for instance, might—if perfectly implemented—have a better chance of reducing COVID-19 cases or deaths than policies that consider vaccination status, the collateral harms of these policies and of their enforcement would be far greater. Vaccination has the advantage that its ratio of burden to benefit is far lower than that of almost any other policy: other low-burden policies, such as masking, are not nearly as beneficial, while other policies that effectively prevent harm—like Australia’s hotel quarantines—involves far more burden compared to benefit.

B. Protecting the Least Advantaged

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40 Kofler/Baylis, Hastings Center
Beyond preventing overall harm, considering vaccination status may also protect individuals facing economic or place-based disadvantage, racism and other forms of bigotry, and medical vulnerability and/or ableism. This is because all of these sources of disadvantage are correlated with higher risk of direct harm from COVID-19: groups facing these disadvantages have suffered death more often, and earlier in life, from COVID-19. These groups have also suffered more indirect harm, in terms of unemployment, diminished education, and deaths from other causes such as overwhelmed hospital services or disruptions to other forms of support.

At the same time, some policies that consider vaccination status may present a risk of exacerbating some or all of these disadvantages. Poorer people are currently less likely to be vaccinated. Racial disparities in vaccination status differ by group, with Native Americans and Asian-Americans more likely than the average American to be vaccinated, African-Americans slightly less likely, and but comparably likely within the eligible population (that is, Hispanic Americans’ lower vaccination rates appear to be driven by age-based ineligibility). Older adults are more likely to be vaccinated, but we lack good data on whether people with medical conditions are likewise more likely.

Whether policies considering vaccination status actually exacerbate disadvantage is likely to depend on the nature of the policy. Policies that provide benefits, like West Virginia’s savings bonds program or recent offers of paid leave to federal employees, are very unlikely to exacerbate disadvantage. In contrast, the use of vaccination status as a condition for participation could exacerbate disadvantage, but assessing this issue is complex. For instance, while excluding unvaccinated people from workplaces or other venues risks disproportionately excluding poorer people, it may also protect those very people from infection, may encourage them to pursue vaccination (particularly if vaccinations are made available to those who are excluded), and—more importantly—may protect the majority of poorer people, who are vaccinated, against both direct harm due to post-vaccination infection and indirect harm due to closures of employment, education, and other settings.

Another important issue is the question of whether relative disadvantage is problematic. For instance, considering vaccination status may increase the freedoms of people who are vaccinated relative to the policy baseline, but leaves people who are not vaccinated in the same position they were previously. Or, it may increase the freedoms of people who are vaccinated as well as those who are unvaccinated, but increases the freedoms of vaccinated people more. Some may complain that a policy that has this effect expands disparities in outcomes. But it is not obvious we should be concerned about outcomes in which no one is worse off than they would have been in absolute terms without the policy (e.g. in an environment where spread was worse, or closures more widespread), or at least not obvious how concerned we

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41 Persad, Tailoring Public Health Policies, AJLM
should be about such outcomes.

Additionally, the importance of protecting the disadvantaged compared to other values is complex. Some may believe that if a proposal exacerbates disadvantage or further disadvantages some disadvantaged people or groups, then it is not acceptable, even if it better realizes other values (such as preventing harm, reciprocity, or equal concern) or mitigates disadvantage for others. (That is, they may regard not compounding preexisting disadvantage as a deontological constraint.) But even thinkers who are distinctively focused on prioritizing the disadvantaged, such as Rawls, focus on the effect of the overall policy environment rather than requiring each policy to maximally improve the situation of the least advantaged. (Rawls also regarded other values, such as basic liberties and fair equality of opportunity, as taking precedence over improving the material situation of the least advantaged.)

The “band-aid” argument has also been directed against the claim that considering vaccination status protects the least advantaged. These arguments make the case that considering vaccination status serves to enable or prop up an unjust status quo. The structure of these arguments typically claims that vaccination requirements will allow society to have people return to work, school, and other settings without addressing underlying injustices in those settings that expose people to differential risk or burden. Rather than vaccination requirements, these commentators argue, we should adopt other sorts of policies that presumably do better at addressing underlying injustice.

The problem with this argument is that no policy can reasonably be expected to address every form of injustice, and addressing some injustice is preferable to addressing none. Policies that mitigate harm can run parallel to policies that address other forms of injustice. For instance, there is no inconsistency between requiring vaccination and providing paid leave. Many countries outside the United States do both. There is similarly no inconsistency between considering vaccination status and having universal first-dollar healthcare, or requiring vaccination and adopting workplace regulations that better protect employees. In addition, it is inappropriate to expose people—especially the people who are likely to be most at risk from a spreading pandemic—to greater risk by blocking harm-mitigating policies in order to try to highlight the injustice of the pandemic. Even if the availability of vaccination does enable employers to have people return to work and undermines arguments for policies like paid shutdowns, refusing to protect people in order to accelerate a

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43 Mohapatra, Kofler/Baylis, Phelan (“immunity passports risk alleviating the duty on governments to adopt policies that protect economic, housing, and health rights across society by providing an apparent quick fix”). Cf. Arundhati Roy (“But unlike the flow of capital, this virus seeks proliferation, not profit, and has, therefore, inadvertently, to some extent, reversed the direction of the flow. It has mocked immigration controls, biometrics, digital surveillance and every other kind of data analytics, and struck hardest — thus far — in the richest, most powerful nations of the world, bringing the engine of capitalism to a juddering halt. Temporarily perhaps, but at least long enough for us to examine its parts, make an assessment and decide whether we want to help fix it, or look for a better engine.”)
revolution is not acceptable. Contrary to the claim that “nothing could be worse than a return to normality,” many things—including widespread death from a preventable disease—are worse than a “return to normal.”

It is also notable and relevant that consideration of vaccination status is widely accepted by many populations within the US, including populations that are socially disadvantaged. For instance, a majority of all racial groups support making vaccination a condition of employment for K-12 teachers, with Black Americans (58%) just as likely as White Americans, Asian Americans substantially more likely (86%), and Hispanic Americans only modestly less likely (52%). The largest divide is not by racial group, but by political affiliation. Many groups who suffer unfairness and discrimination under the status quo nevertheless prefer vaccination requirements to mitigate harm over a refusal to adopt vaccination requirements in the hope that some other, more sweeping policy will better address the problem.

A final, interesting argument might make the case that we should not ask people to change their bodies, via vaccination, to make those bodies less vulnerable to COVID-19 infection and hospitalization, if we could instead change social structures to make COVID-19 less prevalent. This argument recalls some ideas from theories of social construction and disability rights. But it also connects with larger themes regarding technology and its appropriate role in addressing social problems—for instance, similar arguments have been directed against the use of geoengineering or carbon capture to address climate change.

Whether there should be a presumption against asking individuals to change their bodies, and how strong any such presumption should be, are both interesting questions. For the first, some argue that there should be such a presumption, but others disagree that such a presumption exists, and instead argue that the appropriate response to a situation depends on the comparative social costs (including costs in terms of stigma). The challenge concerns (1) the relative costs of different options.

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44 https://www.ft.com/content/10d8f5e8-74eb-11ea-95fe-fcd274e920ca
45 https://apnorc.org/projects/support-for-mask-and-vaccine-mandates-in-schools/
46 Cf. A Aas, Sean, and David Wasserman. "Natural and social inequality: Disability and fair equality of opportunity." journal of moral philosophy 13, no. 5 (2016): 576-601., at 24 (“Although we have no categorical objection to medical correction or other healthcare interventions … we see no reason to presume that this is the correct response. Indeed it seems plausible that the blind and deaf people disadvantaged by new technologies were first and foremost entitled to adaptations in those technologies to make them accessible. Bodily modification is invasive; if disabled people want to be and can be accommodated without it, they should be.”)
47 https://eprints.lancs.ac.uk/id/eprint/82842/1/Markusson_et_al_Pol_econ_of_tech_fixes_Accepted_v_ersion.pdf
48 Anita Silvers, Formal Justice; See Samaha, Adam M. "What good is the social model of disability?." The University of Chicago Law Review 74, no. 4 (2007): 1251-1308., at 1269 (reviewing these examples)
49 Samaha, at 1278. See also Samaha, at 1305 (“So surely there are conditions under which an egalitarian will strongly prefer social reengineering over personalized services. Yet there is a fair
for addressing the pandemic, and (2) whether there should be any presumption against bodily change as an option for addressing a serious public health risk. This is particularly true when the bodily status in question, vulnerability to COVID-19, is not a socially meaningful identity category, unlike other physical differences such as hearing or mobility disabilities. Put another way, it is less plausible that there is any sort of “disability pride” involved in remaining vulnerable to COVID-19, even though vaccination involves an individual, bodily change rather than a change to the built or social environment.

C. Reciprocity

The prior two factors examined—preventing harm and protecting the disadvantaged—are forward-looking: they are about whether considering vaccination status will achieve or avert future outcomes. In contrast, arguments from reciprocity are backward-looking: in some cases, considering vaccination status might appear to appropriately recognize or reward past socially valuable conduct.

While the National Academies rejected reciprocity as an allocation criterion, and other bioethicists (including this author) have questioned it, reciprocity retains wide popularity and acceptance as a relevant criterion for decisionmaking. Many arguments for prioritizing frontline and medical workers appealed to reciprocity, and others have argued for its relevance elsewhere in pandemic response.50 Indeed, reciprocity may be more popular with the public than with theorists: most ordinary people believe that pay in employment should be based on backward-looking factors such as effort, sacrifice, and contribution, even though that is not the prevailing economic view.51

question as to exactly what these conditions are. It does not seem inherent within either anti-subordination or capabilities theories to systematically bias policy in favor of social change if there is a feasible alternative remedy directed at the victim of disadvantage. Of course, a capabilities proponent is not going to sacrifice the bodily integrity of impaired people and force them into corrective surgery, as long as they are exercising practical reason and not following discardable adaptive preferences. But what about closer cases? The answer is not apparent. . . . suppose that a medical service will alleviate the relevant disadvantage to the same degree as some type of environmental restructuring, but the cost of the latter vastly outruns the cost of the former. What now?”); see also Aas/Wasserman, at 24 (“whether a disabled person has a claim to medical modification rather than environmental accommodation will depend on cost and benefit considerations, e.g., whether providing medical treatment benefits the least well off more than other things we might do with the same resources”).


51 Kahneman, Daniel, Jack L. Knetsch, and Richard Thaler. "Fairness as a constraint on profit
Reciprocity-based arguments for considering vaccination status are often used to buttress harm prevention arguments, but can also stand separately. For instance, Tina Rulli and David Wendler’s argument that people have a duty to take reasonable measures to reduce the odds that they will require rescue justifies the duty on the basis of harm prevention, but also allows for differential treatment of those who violate their duty to take reasonable measures—a backward-looking argument.

The question underlying reciprocity arguments is a broader one in social policy: when it is fair to ask people to bear, or internalize, the cost of choices that impose social costs, or to reward or compensate people for the who make choices that generate social benefits. A uniform norm that people may never be asked to bear the costs of their choices avoids having to deal with finer distinctions. If the cost of all choices can be externalized onto the general public, then determinations of responsibility need not be made. But this view is out of step with public values and with the broader system.

A different and more common view is that people should not be asked to bear the costs of their health-regarding choices. But even here, we often regarded as legitimate to differentiate based on health choices, even though not legitimate to differentiate economically based on health status. So, for instance, many policies advocate or permit differentiating out-of-pocket costs depending on whether a patient chooses cheaper or more expensive approved interventions for the same condition. Some policies also permit other differentiation based on choice, such as higher charges for smokers. However, this policy does not exclude smokers from access to insurance, but only permits insurance to vary premiums to a bounded extent based on smoking.

There are other examples, however, where we do not allow differentiation based on health choices. For instance, many choices to procreate are discretionary, but health plans or insurance are no longer permitted to charge people more for procreative choices. Rather, we regard these choices as generating costs that society should bear.

Contrary to arguments that the smoking differentiation is entirely contrary to ideals underpinning insurance, such as solidarity, the fact that premium differentiation for smokers is regulated and limited suggests that policy endorses a sort of bounded solidarity. Some, perhaps even most, of the healthcare costs borne by smokers are subject to public sharing, but the solidarity expressed and the extent of sharing is not completely equal. This is similar to other policies that subsidize choices partially but not completely.

Should insurance be permitted to vary premiums based on vaccination status? The set of people who are unvaccinated combines two groups that are different with respect to reciprocity, and also tend to be different with respect to ameliorating seeking: Entitlements in the market." The American economic review (1986): 728-741.
disadvantage and preventing harm. These are people who are unvaccinated due to a lack of access, and people who are unvaccinated, despite having access, due to their beliefs or values. People who cannot access vaccines may not warrant the same reciprocity as people who have been vaccinated, because they have not been able to contribute to social good. But they also do not warrant the same backward-looking treatment as people who choose not to be vaccinated, because they are unable to contribute rather than unwilling to do so.

Permitting backward-looking considerations may prompt a further question, about the basis of people’s beliefs or values. People who are disadvantaged may often have understandable bases for refusing vaccination. But other disadvantaged people have decided to be vaccinated despite a history of discrimination and disadvantage. It may be appropriate to treat these two groups differently, even if both are more deserving of public support than individuals who have not suffered disadvantage and injustice. This suggests that a policy that considers vaccination status on reciprocity grounds may be more acceptable if it is combined with policies that address disadvantage more broadly. Such policies may both encourage vaccination and offset any disparate burdens imposed by policies that consider vaccination status. However, it would be legally difficult for a policy to treat people who are hesitant about vaccination due to a history of discrimination differently from people who are hesitant about vaccination for reasons unrelated to past discrimination. This is because courts generally only permit differentiation based on past recent discrimination by a governmental actor itself.

The optimal case for a policy considering vaccination status on reciprocity grounds would be a person who has access to vaccination, but has nevertheless rejected vaccination, and has rejected vaccination for reasons neither connected to past injustice nor grounded in a deep religious commitment. The podcaster Joe Rogan, who recently contracted COVID-19 after electing not to be vaccinated and advocating that people not be vaccinated, might be a good example.

How would it be fair to treat Joe Rogan? Other values still play a role: if it would still prevent harm to provide him with medical care, for instance, this factor may overwhelm reciprocity. But it is not clear that it would be unfair to consider reciprocity when it aligns with harm prevention—for instance, to allow a public insurer to charge Joe Rogan copayments for treatment that can go toward covering the costs of non-Covid-19 patient care that was delayed due to the pandemic. Most unvaccinated people, however, present a less clear case than Joe Rogan.

People who have dealt with lack of access might still appropriately be treated

53 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8009077/
56 https://www.washingtonpost.com/technology/2021/09/01/joe-rogan-covid/
differently, just as we sometimes appropriately treat differently people who are unable to do certain things not because of choice but because of societal barriers or physical differences. For instance, children who are ineligible for vaccination may still appropriately be excluded from certain spaces where vaccination is required, such as nursing homes, if the reason for the exclusion is not reciprocity but rather preventing harm. The same is true for people who have not been able to be vaccinated due to lack of access.

Last, it is worth noting that some arguments against considering vaccination status may weaken over time and depend on context. At the beginning of the year, or even earlier in the vaccine rollout, disparities in access were larger and unwillingness among minority populations was greater. At the current point, disparities in access have decreased and minority populations are increasingly catching up, especially once we look at the eligible population. In March, the average unvaccinated person was likely to be either in the “wait and see” group, or unvaccinated due to access barriers. Now, the average unvaccinated person is likely to be unvaccinated due to either incorrect factual beliefs or fundamental differences in values.

One way to further tease apart access limitations from vaccine rejection is to offer vaccination to people who are subject to a policy. This is already done for financial programs, but it could be done for venues as well. It could also even be done, for access to medical practices.

I close this Subpart with some brief thoughts on the case of whether reciprocity could be appropriately considered in the allocation of scarce medical resources. We often believe people who choose to protect others should be appropriately recognized. Medical scarcity is no exception: we often prioritize past organ donors or those who have committed to donate. We also sometimes treat people differently when they knowingly decline effective treatments—for instance, religious patients who refuse blood transfusion. The case for considering past choices seems strongest when those choices reflect commitments rather than access limits: for instance, in locations where most unvaccinated people fundamentally reject vaccination rather than being unvaccinated due to access issues, or where someone has explicitly been offered post-exposure prophylaxis in a situation of scarcity and declined it. (An even clearer case might be when someone has injured themselves by taking a dangerous or unapproved prophylactic, such as ivermectin, in an area where scarcity exists.)

Some, however, worry that considering past choices will further exacerbate disadvantage. Assessing this claim depends on empirical data and local context. While disparities in vaccination exist in many places, the existence and magnitude of disparities differs from place to place: for instance, in Mississippi, Black, Hispanic, and Asian people all have equal or higher vaccination rates compared to White people, whereas in Colorado this is not true. In some places, disadvantaged groups—

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like Native Americans in the United States—have higher vaccination rates than the general population, and even than more advantaged groups. In addition, given other predictors of risk such as age, the relevant metric is unlikely to be vaccination rates in the total population, but rather vaccination rates among populations at high risk of hospitalization. Most importantly, whether considering vaccination receipt or other past choices exacerbates disadvantage depends not only on who would experience less access, but who would gain. For instance, even if disadvantaged people were overrepresented among unvaccinated Covid-19 patients, they may be even more overrepresented among non-Covid-19 patients who need the same resources due to injuries, violence, or other acute or chronic conditions. Structural racism and inequality would make this outcome unsurprising. The same may be true for disparities of other kinds: people with a disability or high-risk medical condition may be at greater risk of poor health outcomes if unvaccinated Covid-19 patients are treated first.

Others may worry that considering past choices will covertly be used to effectuate invidious discrimination. But a policy that focuses specifically on certain easily identifiable choices, like vaccination or willingness to receive post-exposure prophylaxis, could instead be preferable in avoiding discrimination, by reducing the impetus to use race or class as proxies for assumptions about vaccination status. Empirical research could help clarify.

Ultimately, considering past choices in allocation may be more appropriate when unvaccinated patients are contacted for receipt of monoclonal antibodies and refuse them in an environment of known scarcity, or where unvaccinated people have refused vaccination in favor of unapproved drugs. They may also be more appropriate in states where vaccination rates are equal or higher among vulnerable people who are disadvantaged, and in localities where non-Covid-19 patients tend to be more disadvantaged. Considering whether someone has both declined vaccination and post-exposure prophylaxis as a tiebreaker factor under scarcity in a state where vaccination rates are equal or higher in minority populations—especially in a situation (say a hurricane) where some other factor has brought many non-Covid-19 patients who are disadvantaged and likely to benefit to the hospital—is different from a policy of barring all unvaccinated people from any care.

Some may fear a “slippery slope” where other factors are recognized as bases for allocation under scarcity. But, as discussed in Part III, few factors are as clearly understandable as personally and societally risky, and as assessable by an operationalizable rule, as refusing vaccination or prophylaxis in a pandemic. Other decisions where slippery slopes are feared often involve lack of intentional choice (e.g. addiction), a looser connection to the eventual harm (e.g. risky conduct), or difficulty of verifying the past choice.

Legally, so long as medical exemptions are honored, considering past conduct

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will not violate the Americans with Disabilities Act: refusing vaccination or prophylaxis is not itself a disability. With respect to religious motivations, courts have held that physicians may consider whether a patient refuses medical interventions like transfusions. Considering past conduct also is unlikely to violate federal anti-discrimination statutes pertaining to race, because the statutes typically focus on disparate impact, and it is not clear that the rules even would have disparate impact nor that any disparate impact would reach the level of legal unacceptability. The most likely basis for legal challenges, discussed in Part III, would instead be novel state laws that regard vaccination status as a legally protected class analogous to race or sex. In states that have adopted these laws, considering vaccination status directly—even to save more lives—might be ruled illegal.

D. Equal Concern

Last, we might evaluate whether considering vaccination status is consistent with equal concern for all. The same considerations that support concluding that considering vaccination status protects the disadvantaged also support concluding that it shows equal concern—even if it treats people differently, it helps mitigate differences in vulnerability to complications.

Equal concern is more often used as a basis to criticize policies that consider vaccination status, for instance on the basis that they divide society or are inconsistent with social solidarity. But equal concern does not require identical treatment, and treating people differently on the basis of relevant difference is not unequal concern. What is objectionable about invidious discrimination—for instance, racial segregation—is that it treats people differently on the basis of differences that are not relevant to the opportunity or good at issue, and does so in a way that exacerbates disadvantage and expresses unequal concern. In contrast, differential treatment of relevantly different people—for instance, requiring people who are smoking to stay in an area reserved for smokers, or separating the sick and well waiting rooms at a pediatrician’s office—treats people differently on the basis of relevant differences, in order to mitigate harm (harm which, in the COVID-19 pandemic, falls disproportionately on the disadvantaged). In doing so, it does not express unequal concern. Similarly, policies that consider vaccination status when it is relevant to the opportunity or good at issue do not express unequal concern.

One common normative mistake is to see society-level health policy decisions through the lens of the doctor-patient relationship and to argue that health policy cannot legitimately consider vaccination status because to do so would undermine the relationship between doctors and patients, which is supposed to be a relationship of loyalty rather than one that considers differences.\textsuperscript{59} That may be right in the case

\textsuperscript{59} Wikler, Washington Post
of bedside health decisions, but is not required in the case of social policy.

Many other arguments that considering vaccination status is inconsistent with equal concern would seem to also apply to vaccination itself. If considering vaccination status appears to be too individualistic and stopgap a solution compared to a broader overhaul of society to better realize equitable public health, the same should go for the investment of a large quantity of public funds in developing and distributing a vaccine. Even though vaccination is the most powerful intervention against communicable disease, it is also an innovation that, in the inevitable absence of universal vaccine uptake, generates new inequalities between those who are vaccinated and those who are not. Indeed, vaccination can plausibly be seen as a form of human enhancement. While vaccination also indirectly benefits the community, it does weaken the self-interested case for solidarity between people who are vaccinated and people who are not. Yet these facts come nowhere close to being a sufficient reason for rejecting investment in vaccination. Even if the availability of vaccination generates some inequality that would not otherwise exist, it mitigates even more harmful forms of inequality—such as inequality between the highly exposed and less exposed, or between the healthy and ill—and prevents a vast amount of harm. These same arguments also apply to considering vaccination status.

III. Vaccination Status in Practice

Legally, policies conditioning access on vaccination status might be either permitted, required, or prohibited. I will focus most of my attention on the question of whether they are permitted versus prohibited, but will also spend some time on the question of whether they are required in certain settings, as some have recently argued that mask mandates may legally be required.

The argument that vaccine requirements are permitted in business settings and in most other activities legally rests on a principle of business discretion, exemplified by the idea that businesses have a default right to decide whom to serve and whom to employ. So long as businesses do not discriminate on prohibited grounds, they can exclude people for any reason. The decision to exclude a customer or prospective employee who will not be vaccinated is no different from excluding someone who will not comply with a dress code or has not purchased a ticket to a concert or other venue. A similar argument applies to the case of financial benefits and burdens. Most actors distributing benefits or burdens are under no obligations to do so, so they enjoy

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62 https://www.washingtonpost.com/outlook/2021/05/04/vaccine-mandate-legal-schools-businesses/
broad latitude in deciding who should receive benefits and burdens.

This principle might be buttressed by the additional idea that businesses have an ethical, and potentially legal, duty to ensure the safety of people who are working or otherwise interacting in the space they are responsible for. Just as many have argued that businesses have a duty to require masks or provide other interventions that reduce the risk of COVID-19 spreading in spaces they control, a vaccination mandate may be not only permitted but might be seen as ethically praiseworthy because it aligns with this goal.

A. Potential Obstacles to Permission

1. Antidiscrimination Law

   In the employment setting, employers are obliged to accommodate religious exercise and religious practices of employees. However, if a practice imposes an undue hardship on an employer, it does not have to be accommodated. Similarly, employers are obliged to reasonably accommodate medical needs, including medical exemptions from vaccination, but similarly do not have to incur undue hardships. Parallel requirements apply, for medical needs, to governmental actors and to many businesses interacting with consumers. In many settings, these requirements also apply for religious needs, though they are weaker regarding the applicability of neutral laws to religious actors.

   Some have recently argued that considering vaccination status violates equal protection if previously infected people are required to be vaccinated. This argument is unpersuasive. First, many laws considering vaccination status aim to improve community protection, and if vaccinating someone with prior infection further improves protection, it serves that goal—just as licensing requirements are not lowered for someone driving a car with exceptional safety features, even if the car appears as safe driven by a poor driver as an older car would be when driven by a good driver. Second, proof of prior infection remains difficult to assess in the context of COVID-19. Third, for most other vaccination requirements, actors (such as schools) considering vaccination status are not required to provide an alternative option such as antibody titers. Fourth, and relatedly, remaining unvaccinated (when one does not have a religious or medical exemption) is not a fundamental right where strict scrutiny applies, particularly when the status is being considered by a private

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63 https://www.osha.gov/coronavirus/safework
actor.

In some states, vaccination status has been raised to the level of a protected class, which would interfere with many efforts to consider vaccination status. Though the normative case for this shift unpersuasive, it is worth engaging seriously. This is in part because the basis for when a group ought to be a protected class is often opaque. The classic origin for the concept of a protected class is Footnote Four of *Carolene Products*, which suggests that a protected class is one that is discrete and insular.67 Others have developed accounts that suggest that protected classes are groups that will struggle to protect themselves via the ordinary political process, or that are organized around an immutable characteristic.68

Interestingly, the fact that vaccination status have been established as a protected class by legislatures, rather than by courts interpreting some more fundamental idea of equal protection, suggests that unvaccinated people are not devoid of political power, since they have been able to obtain specific legislative protection. In fact, the groups that appear to be most likely to be unvaccinated by choice—as opposed to due to lack of access—are also groups that are able to exercise power in the political process disproportionate to their representation in society, including white, non-college educated and rural communities.69 However, legislators have also protected other classes that are not disproportionately powerful, such as gender and sexual minorities.

Another answer might be that unlike other identity-based statuses, vaccination status is easily changeable at low cost, and—unless backed by a religious exemption—is not an entrenched form of social meaning. Furthermore, the decision to be unvaccinated is more naturally seen as a form of conduct than a form of status. And that decision is also often based on demonstrably false empirical beliefs rather than on values.

At the same time, some arguments against consideration of vaccination status do bear a similarity to arguments for regarding other groups as protected classes. Most plausibly, perhaps, people who are unvaccinated are often underrepresented in politically empowered groups and also maybe akin to, although not identical to, “discrete and insular” groups that antidiscrimination law often protects. People who aren’t vaccinated are likelier to be less well educated and less well off economically then people who are vaccinated, although this may differ depending on whether we look at people who are waiting to see whether they would like to be vaccinated, versus people who are determined to remain unvaccinated. Individuals in the latter group are often better off in terms of education and are certainly less likely to be a member of a disadvantaged racial minority group.

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Another parallel is that unvaccinated people are often the object of public stigma or animus. However, the mere fact that a group is publicly stigmatized or subject to animus should not be sufficient to regard them as a protected class. This is because pure animus is distinct from animus grounded in defensible concerns about harm to others. When laws disadvantaging LGBT people were struck down as pure animus,\textsuperscript{70} it is because they were not grounded in a judgment about harm. In contrast, people who elect not to be vaccinated appear more akin to groups that face animus because they impose burdens on others, such as people who litter or environmentally pollute. These groups are also often socially stigmatized, but the fact of stigma would not be sufficient to determine that it is inappropriate to pass laws that require those who engage in this type of conduct to bear the cost of that conduct. A reasonable parallel here might be laws with respect to other health-affecting activities such as smoking. Smokers are often subject to various types of judgment and animus, but smokers are not typically a legally protected class.\textsuperscript{71}

2. Fundamental Rights

Considering vaccination status is different in contexts where doing so impinges on a fundamental right. The case of the existing K-12 vaccination mandates is a particularly interesting one for COVID-19 vaccination because it suggests that using vaccination as a condition for access to a fundamental right is nevertheless permissible. (While education is not a fundamental Federal right, it is a fundamental right in many states, and is regarded federally as more significant than many other rights.\textsuperscript{72}) So far, there has been little discussion of requiring COVID-19 vaccination for students returning to school, but it is difficult to see why such a requirement would be unacceptable for COVID-19 but acceptable for other diseases. This is particularly true both given that the emergency use authorization status of COVID-19 vaccines for people 12 to 15 does not appear to prevent a requirement, and one vaccine is already fully approved for people 16 and older.

Another concern appeals to the fit between the policy of a vaccination requirement and various public health goals. One set of arguments might argue that a vaccination requirement is overbroad because some people are little risk of causing harm to others by remaining unvaccinated. This argument has most prominently been raised in the context of people who have previously been infected by COVID-19. Evaluating this argument depends on how we think about individual interests in being vaccinated. If we think about the interest in accessing a specific opportunity while remaining unvaccinated as merely an ordinary interest, it is not clear why overbreadth is a decisive argument against considering vaccination status. Many policies are overbroad without thereby being infirm. The only way that such a policy would be

\textsuperscript{71} Gallagher v. City of Clayton, 699 F.3d 1013 (8th Cir. 2012).
\textsuperscript{72} Black, Derek W. "The Fundamental Right to Education." Notre Dame L. Rev. 94 (2018): 1059.
Infirm is if we went back to a sort of Lochneresque approach where governmental policies cannot be overbroad.

In contrast, if we regarded the individual interest in not being vaccinated, or in accessing a given space, as more of a fundamental right, then there is a more plausible argument that overbreadth is legally, and also ethically, problematic. If someone is already previously infected and unwilling to be vaccinated, it might be inappropriate to deny them access to an activity that is the object of a fundamental interest, such as travel or religious exercise. This argument of course depends on the extent to which prior infection actually confers protection against transmission or against contracting the disease. Vaccination does add to individual protection, so even if the marginal gain from vaccinating a previously infected person is lower, it may still be appropriate to require at least one dose of vaccine, just as it may be appropriate to require vaccination even for some people or at less risk of spreading or contracting COVID-19 if they remain entirely and vaccinated.

Furthermore, remaining unvaccinated does not necessarily fall under the right to refuse medical treatment discussed in cases like *Cruzan*. The goal of policies that consider vaccination status is not to paternalistically protect the vaccine recipient or question their judgment about what is medically best for them. Rather, it is to protect the public and reduce disease spread. Vaccination requirements, from *Jacobson v. Massachusetts* to newer cases, are grounded in this public health aim, as are other accepted requirements such as quarantine and even required treatment for tuberculosis.

A further question is whether any sort of differential participation constitutes unacceptable abridgment of a fundamental right. It would certainly seem inappropriate to prohibit people from becoming married, or from voting, on the basis of vaccination status. But it might be acceptable to limit access to certain ceremonies to celebrate a wedding on the basis of vaccination status. It is less clear whether it would be acceptable to limit access to in-person voting on the basis of vaccination status. Even though vaccination further lowers risk, if people could participate with increased safety by wearing masks and having the voting booths appropriately distanced, a vaccination requirement in such a setting may be an inappropriate condition on the exercise of a fundamental right.

3. Slippery Slopes

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73 Cf. Gostin, Cohen, and Shaw https://jamanetwork.com/journals/jama/fullarticle/2778526 (“The Court would likely subject government-run DHPs to high-level scrutiny if they prevented unvaccinated individuals from attending religious services or infringed other constitutionally protected rights.”)

74 https://www.nature.com/articles/d41586-021-01609-4

A major concern about considering vaccination status has been “slippery slope” fears—that considering vaccination status would lead to the consideration of other types of choice, or of unchosen forms of health status, in settings such as employment or health care provision.

Several limiting or differentiating principles that separate considering vaccination status from considering other choices or other health statuses are plausible. One simple principle is that choice can be differentiated from status, so someone who chooses not to be vaccinated is different from someone who may present health risks to others or costs to the health system because of factors they did not choose. It is typical that workplaces and other venues have to accommodate some of the cost to others of involuntary health differences, but do not have to accommodate the cost of choices.

Again, the parallel with smoking is relevant, in that smokers can be treated differently in many settings even though smoking may be seen as a health status. However, some may still worry about slippery slopes within the subset of choices, given that many health outcomes are attributable in part to choice. For instance, communicable diseases are often acquired through chosen activities, and other conditions that are costly, such as diabetes or heart disease, are correlated with choices about diet and activity. The difference between vaccination status and these other conditions that are correlated with choice, however, is that the choice to be vaccinated is a much less burdensome than the choice to change one’s diet, exercise patterns, or other obligations, and is much more clearly correlated with diminished risk. Even compared to smoking, vaccination is easier than quitting smoking: non-vaccination is not an addictive condition typically begun before the age of majority, whereas smoking is. Even if we grant that there is a spectrum rather than a hard limiting principle, being unvaccinated against COVID-19—or against other conditions—is clearly a choice, can be altered in many cases with little burden, and has a much clearer and tighter link to the socially harmful outcome than for these other choices or statuses.

Another difference is that being unvaccinated is not tied to a socially important or protected identity in the way that some other health choices may be. For instance, intentionally procreating does lead to health costs and other outcomes, but procreation is also regarded as a core and fundamental liberty. In contrast, the decision to be vaccinated or not is not core to individual identity. In cases where non-vaccination is core to individual identity, as when it falls under a religious exemption, then it does legally merit accommodation.

Even when vaccination status does merit accommodation, that does not entail that unvaccinated people must be treated identically to vaccinated ones. The accommodation must still be reasonable and not an undue hardship, and accommodation for people who are unvaccinated need be no more extensive than accommodation for people who have made other choices that impose potential social cost for other reasons, such as religious values. So for instants, it could be reasonable...
for a venue to require a person who is unvaccinated to remain outdoors, make only curbside purchases, participate remotely, wear a very high-quality mask, and or be subject to testing—all requirements that have been broadly imposed on the public during the pandemic in different settings, and would not obviously be unreasonable accommodations if unvaccinated people are to be included.

Another way of mitigating slippery-slope concerns is for policymakers to elucidate the goals and endpoints for policies that consider vaccination status, as some have recently emphasized for other types of policies such as mask requirements. Policies considering vaccination status are long-established in certain settings, most importantly education. But it is worth considering whether the point of policies considering vaccination status is to attempt to eradicate COVID-19, which is unlikely; to mitigate its effects on health systems, schools, and other essential services, a goal that is currently crucial but may become less important in future; to improve overall public health; or for some other reason. If eventually the burden of COVID-19 drops to the level of the burden of other conditions such as influenza, should vaccination status requirements continue under those conditions? Many of the same arguments still appear to apply, and might support some of the same policies—importantly, for instance, employers and businesses are permitted to offer incentives for flu vaccine uptake, or to require vaccination—but we might also wonder the extent to which the same policies remain justified in the light of changing health circumstances. One could argue that in the face of a less severe threat, considering vaccination status becomes less justified, although on the other hand it could also be argued that the pandemic has improved our understanding of what policies are implementable, and also that the combined impact of COVID-19 and the flu in future respiratory disease seasons supports vaccination requirements for both diseases.

4. Implementation Issues

Considering vaccination status may be evaluated differently in settings where vaccination is not widely accessible. The most likely context where this would happen in the United States is with respect to travel restrictions. Legally, there is no obvious problem with requiring vaccination to enter, despite unequal access, given that government enjoys broad discretion over entry. From an ethical rather than legal perspective, however, we might worry that considering vaccination status unfair or disproportionate burdens on people from poor countries where vaccination is not widely available. But this problem could be mitigated without removing the vaccination requirement. For instance, other requirements such as obtaining a visa also exist, particularly for poorer countries. People in countries where vaccination is not widely available could be provided with vaccines in-country, via embassies, as part of their visa application. Entry could then be provided only once vaccination had

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77 Kleindienst v. Mandel, 408 U.S. 753, 92 S. Ct. 2576, 33 L. Ed. 2d 683 (1972)
completed. Vaccination could also be provided with a single dose vaccine upon entry, combined with a follow-up quarantine.

A related policy context is what level of vaccination should suffice for vaccination requirements. The WHO has argued that for travel, all authorized vaccine should be regarded as equivalent. But it is doubtful that all authorized vaccines are equally effective, particularly against infection and transmission as opposed to severe disease. It would be more appropriate, and certainly legally acceptable, to vary the vaccination requirement depending on the risk present in a setting. While vaccines that are equivalently safe should not be used as a pretext for discrimination, as some European countries seem to have done by treating identical vaccines differently depending on their country of production, it is reasonable to require that vaccination meet a certain standard that not all WHO-authorized safe and effective vaccines may meet. Inactivated-virus vaccination, for instance, may be safe and much more effective than non-vaccination, while still being sufficiently less safe than vaccination with other technologies that it is appropriate to consider when deciding who may visit nursing home patients.

A different set of worries focuses on the reliability of determinations that someone has been vaccinated. This includes concerns about fraudulent documentation, concerns about whether to use attestation as opposed to some sort of chain-of-verification, and concerns about inaccuracy in any sort of verification approach. These concerns are important, but I will bracket them because they apply to any policy that makes benefits or access conditional on some factor, and are not unique to vaccination status. Similar concerns apply to policies that require educational credentials, licensing such as driver licensing, or that consider other factors such as income. An extensive literature is developing on how to approach some of these problems in the context of vaccination status, such as the question of whether to have a government-overseen vaccination card, and the merits of digital versus paper credentials. But it is important to differentiate the question of how to

78 https://www.who.int/news/item/01-07-2021-joint-covax-statement-on-the-equal-recognition-of-vaccines#:~:text=Any%20measure%20that%20only%20allows,in%20the%20distribution%20of%20COVID%2D2; see also https://jamanetwork.com/journals/jama/fullarticle/2778526 (“If DHPs were limited to only certain vaccine products, it would also exacerbate inequities based on access to particular vaccines.”).


80 Cf. Gostin, Cohen, and Shaw https://jamanetwork.com/journals/jama/fullarticle/2778526 (“Each vaccine could have variable effectiveness against currently circulating and future SARS-CoV-2 variants. Considerable variability in vaccine effectiveness in preventing symptomatic disease could affect the usefulness of DHPs.”)

technically implement policies that consider vaccination status, and how this implementation can avoid serious problems that are common to all cases of credential implementation, such as creep in what is stored, lack of access to the implementation for people who do not use smartphones, and issues of privacy or abuse. These issues are all distinct from the question of whether considering vaccination status is more fundamentally illegal or unjust, which is my focus here.

I similarly bracket, although with slightly more engagement, the question of whether considering vaccination status will lead to unjust enforcement. Again, the possibility of unjust and biased enforcement exists for all types of conditionality, as does the issue of enforcement costs. In some contexts, the cost of enforcement has been used as an argument against conditionality and in favor of unconditional policies, for instance for cash transfers or benefit programs. However, even “unconditional” programs almost always involve certain types of conditions, such as conditions on not receiving the benefit twice or not having the benefit available to people who are not residents of the country. The issue is more often about which eligibility criteria are appropriate for conditional programs, rather than there being a program that is truly unconditional. The relevant points I make elsewhere that I would repeat here is that any concern about unfair enforcement must also be applied to the proposed alternative to considering vaccination status, such as either unconditional participation in employment or other activities, participation made conditional on some other factor or factors (such as masking alone), or non-participation. All these other policies must either be enforced—sometimes much more extensively—or present a high risk of a spreading pandemic with inequitable outcomes. Any burdens from unfair enforcement must also be compared to the overall benefits of considering vaccination status for values such as benefit, equity, and reciprocity.

B. Potential Grounds for Requirement

In this Subpart, I turn from whether considering vaccination status is permissible to looking at whether doing so is required. Few so far have made this argument for vaccination, though analogous arguments have been made for masking, and would appear to apply for vaccination as well.

1. Antidiscrimination Law

Some have argued that disability law requires mask requirements in certain

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83 Persad, Tailoring Public Health Policies, AJLM
settings such as education.\textsuperscript{84} Given the clear, though imperfect, efficacy of vaccination against transmission,\textsuperscript{85} these arguments would seem to also support vaccination requirements in these settings, as a way of improving the safety of students at high risk.

However, the issue—for both mask and vaccination requirements—is complicated because disability law applies in different ways to employers and similar actors such as businesses and venues than it does to other discrete individuals. Employers are typically required to make accommodations at their own expense for employees or other participants with disabilities. In the COVID-19 context, for example, ventilation, outdoor participation, or permission to personally wear a mask might be such an accommodation. But these accommodations cannot typically require other employees or other participants to make personal choices that would promote the interests of people with disabilities. While it is difficult to find a perfectly analogous example, courts have typically been reluctant to require other employees or students to alter their diet or fashion choices to accommodate participants with food allergies or chemical sensitivities.\textsuperscript{86} Employers may encourage employees to make these changes, but cannot typically require them.

2. Fundamental Rights

Some have proposed the inventive argument that constitutional law requires consideration of vaccination status in cases where doing so enhances individual freedom to exercise fundamental rights.\textsuperscript{87} So, for instance, rather than universal restrictions on interstate travel, assembly, or speech, governments might be obligated to exempt people who are vaccinated because they no longer present the degree of risk that would justify those restrictions.

These arguments align with the public health law and ethics principle that restrictions must be the least restrictive alternative,\textsuperscript{88} and have substantial force in some settings. But their applicability is limited, particularly given the retreat from “lockdowns” that exclude everyone from being able to engage in activities that are constitutionally protected. The fundamental-rights argument establishes consideration of vaccination status as superior to blanket lockdowns, but does not

\textsuperscript{84} Dorfman/Raz Wash Post
\textsuperscript{85} https://www.cidrap.umn.edu/news-perspective/2021/08/study-ties-covid-vaccines-lower-transmission-rates
\textsuperscript{86} Buckles v. First Data Resources, Inc., 176 F.3d 1098 (8th Cir. 1999); Nevada v. Barr (DOJ), 2020 EEOPUB LEXIS 552 (EEOC 2020); cf. Turco v. Hoechst Celanese Corp. e
\textsuperscript{87} Cope, Kevin L., Ilya Somin, and Alexander Stremitzer. "Vaccine Passports as a Constitutional Right." George Mason Legal Studies Research Paper No. LS (2021): 21-11; Cope, Kevin, and Alexander Stremitzer. "Governments are constitutionally permitted to provide 'vaccine passports' - we think some may also be constitutionally obligated to do so." Journal of nuclear medicine: official publication, Society of Nuclear Medicine: jnumed-121.
\textsuperscript{88} Cf. Persad, AJLM
obviously demonstrate that consideration of vaccination status is legally superior to reopening access without consideration of vaccination status. Such wide-open access may be substantively unequal and may be less safe than access conditional on vaccination, but involves no legal restriction on access.

Furthermore, access to many constitutionally protected activities can be temporarily limited. Given the imperfect efficacy of any preventive measure against transmission, governments might be able to defend broad closures legally on the basis that it is crucial to prevent all transmission.

CONCLUSION

Policies considering vaccination status are already common, and likely to become more common-- as well as more debated. Rather than arguing that they are always or never permitted, I have tried to identify and propose a framework for their ethical and legal evaluation. So, for instance, it might be acceptable and appropriate to offer payment incentives for vaccination, or to exclude unvaccinated people from working in nursing homes, but not to exclude unvaccinated people from medical care or in-person voting. In general, the rule should be that consideration of vaccination status is more appropriate when it prevents more harm; when its overall effect is to ameliorate disadvantage; when it shows equal concern for people who are unvaccinated, and when it responds appropriately to considerations of reciprocity. In jurisdictions that do not recognize vaccination status as a protected class, the legal landscape around considering vaccination status tracks these values reasonably well.