EDITORIALS & OPINIONS

The Bulletin
AN INDEPENDENT NEWSPAPER

Heidi Wright — Publisher
Gerry O'Brien — Editor
Richard Coe — Editorial Page Editor

Join the race to get people vaccinated

It's a race to get more COVID-19 vaccines in more people's arms. The winner will be all of us.

Vaccines won't be the sole savior, but getting more people vaccinated should enable Oregon to get more back to normal.

Among the caregivers at St. Charles Health System 72% were vaccinated for COVID-19 as of Monday. That's 3,058 who are fully vaccinated. Another 49 have their first shot.

More would be better. We'll take it. Mosaic Medical Clinic has managed to get more than 90% of its primary care providers vaccinated out of a total of 31. Let's see the rest of Central Oregon match that. Heck, let's beat it.

Getting to herd immunity, where enough people are immune to the virus to stop it from spreading, won't be easy. It may require more than a 70% vaccination rate for the community. And this is a race we don't want to lose.

There's always going to be some vaccine hesitancy. There's hesitancy among some caregivers at St. Charles. There are going to be people who will never be vaccinated. There are people who should not be.

There are some things you can do to encourage more people to get vaccinated. Talk about your plans to get vaccinated. Post about it on social media. That helps make it the thing to do.

If you have concerns, talk to your doctor. They know you, your medical history and they know about the vaccines. The Oregon Health Authority has a detailed list of questions and answers about the vaccines here: tinyurl.com/OHAfaq The Centers for Disease Control and Prevention has a good website here: tinyurl.com/CDCcovidfaq.

In Deschutes County you can pre-register for a vaccination even if you are not yet eligible. Go to centraloregoncovidvaccine.com to sign up. Please sign up. Do it for yourself, your family, your friends and the rest of us.

Oregon must do more to protect residents in long-term care facilities

More than half of Oregon's COVID-19 deaths occurred in long-term care facilities. It was more than 1,100 people as of late February.

Even if you take the pandemic out of it, long-term care facilities in Oregon had 50 times as many flu outbreaks as hospitals in the last five years.

People who are in long-term care are at high risk from communicable diseases and Oregon needs to do more about it. The Oregon Secretary of State's Office went looking for answers and released a report this month.

To be clear, long-term care includes nursing, assisted living, residential care, memory care communities and adult foster care. If you want the details about the advisory report's analysis of the background of the problems, the report is available online.

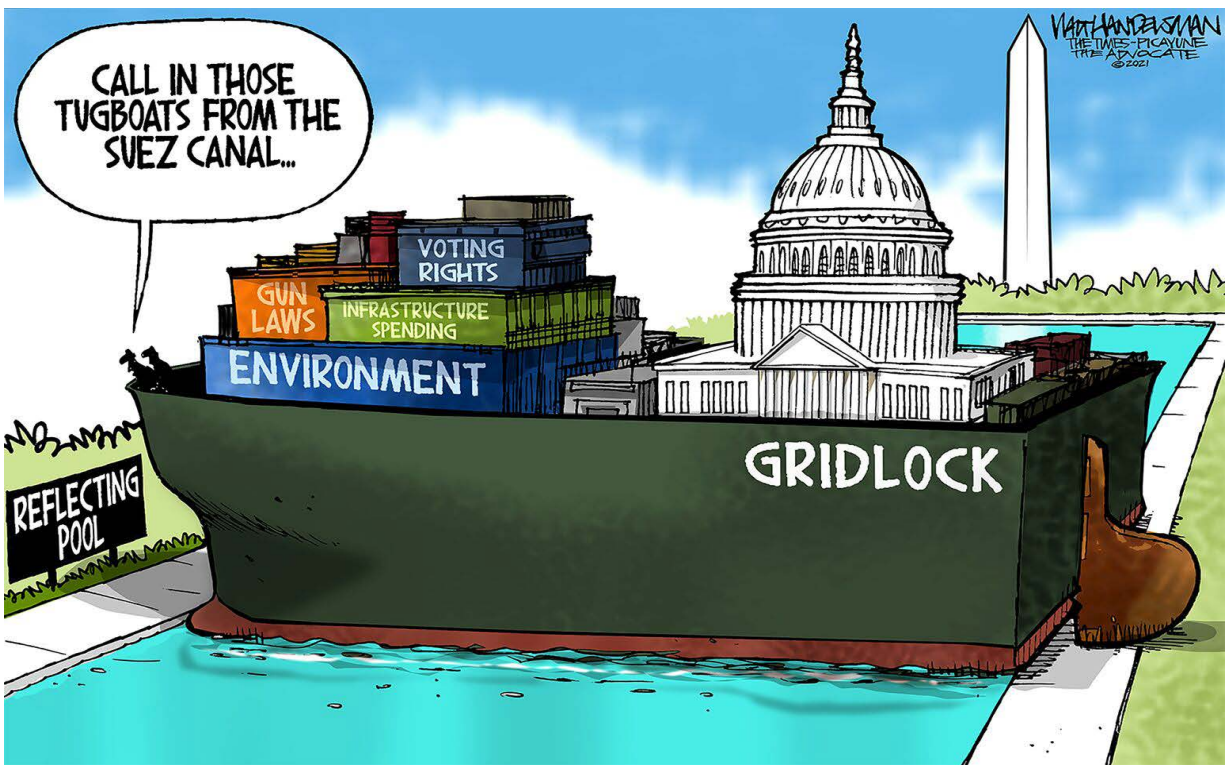
We want to focus on what the Oregon Department of Human Services, the Oregon Health Authority and the Legislature need to do. The report recommended a host of changes. There are basically three components:

- Public reporting. Requiring long-term care facilities to publicly report the number and percentages of residents and staff who have received COVID-19 vaccinations. That will, at least, create public pressure to ensure the residents are protected.
- More monitoring visits by the state. Looking into if the state needs more people to monitor and investigate the performance of long-term care facilities.
- Better tracking. Tracking performance infection control, vaccinations and emergency preparedness at the facilities.

There are costs, of course. There may also be pushback against some of these suggestions. Public reporting of vaccination rates and staff could be resisted. When that change was first implemented for schools in Oregon, there were concerns. But the greater public transparency has led to important improvements in understanding. For instance, although statewide vaccination rates are high for schools — around 90% — there is considerable variation within individual schools.

What are Oregon legislators going to do to ensure residents of long-term care are better protected? It's not something the state can afford to continue to get wrong.

Editorials reflect the views of The Bulletin's editorial board, Publisher Heidi Wright, Editor Gerry O'Brien and Editorial Page Editor Richard Coe. They are written by Richard Coe.



GUEST COLUMN

Consumers need more reasonable drug prices

BY JOAN MORGAN AND MIKE NIELSEN


Morgan


Nielsen

When it comes to prescription drugs, there are some fundamental truths we can't deny: There's no price someone wouldn't pay for medications that would extend his or her life or the lives of loved ones, AND there's no limit to how far pharmaceutical companies will go to deny responsibility for skyrocketing medications costs.

As you read this, Big Pharma is hitting back against any effort to regulate the industry. The companies are using their unlimited funds — gained from their out-of-control pricing — to run advertisements and testify in Salem in hopes of killing legislation that might harm their highly profitable bottom lines.

As consumers, we've personally experienced the ever-increasing costs of prescription drugs. For instance, Mavyret — a curative treatment for hepatitis C — costs $13,200 for 84 pills. So $13,200 divided by 30 days – which is roughly $440/day, or 3 pills daily at $157/pill. Then there's Gilotrif (or Afatinib) — a life-saving cancer drug. It costs $11,000 a month in Oregon for a 30-day supply. This same drug — which costs $82 a month in the Netherlands — was "only" $4,000 a month in 2018. That's a 175% increase in two years.

The truth is, not all of us have the privilege of wealth or outside assistance to afford drugs. Instead, Oregon's most vulnerable populations have to make dire sacrifices — deciding between paying housing costs, buying food and other essentials, or getting their medications. There is no doubt that this way of living is detrimental to the health, safety and quality of life of all Oregonians.

There is a solution. The Oregon Legislature is considering a package of bills that would work together to lower the cost of prescription drugs: SB 763, SB 764, and SB 844.

SB 763 would lift the veil on drug sale practices — requiring pharmaceutical representatives to register with the state in order to market their products. This would work to rein in prescription drug costs by making closed door meetings and financial transactions transparent to Oregon consumers.

SB 764 would prohibit a practice known as "pay-for-delay" — in which big pharmaceutical companies often pay generic drug manufacturers to delay distribution of medications at a substantially lower cost. By passing this bill, Oregon will ensure that less expensive medications become available sooner. It will give our state the power to take action against pharmaceutical companies that fail to comply.

Most importantly, SB 844 would establish an Oregon Prescription Drug Affordability Board that would identify prescription drug products that create affordability challenges; set an upper payment limit for excessively priced drugs; and penalize emergency price gouging.

The pharmaceutical industry will tell you that these are all radical ideas, but our state already performs similar scrutiny on health insurance rate increases – saving Oregon consumers hundreds of millions of dollars in unjustified premium increases over the last decade. We believe it's time for drug prices to get the same level of scrutiny. For far too long, pharmaceutical companies have played an aggressive game of "Not Us" when it comes to drug pricing, even though the vast majority of drug prices start with the price they set. We cannot let them continue to exploit the lack of regulation on their industry — padding their profits and forcing those who need prescriptions to accept unaffordable price increases or suffer without those drugs.

The Oregon Legislature should do the right thing for Oregonians and pass SB 763, SB 764, and SB 844.

Joan Morgan is a health care worker and caregiver for her father, who has late-stage lung cancer, and her mother, who has Parkinson's. She lives in Happy Valley. Mike Nielsen is a Vietnam veteran and lives in Bend. He spent a year working to secure funds for medication for his wife, Jacki, who was diagnosed with hepatitis C. Their submission is part of an effort by the Oregon Coalition for Affordable Prescriptions, affordablerxnow.org.

Letters policy: We welcome your letters. Letters should be limited to one issue, contain no more than 250 words and include the writer's signature, phone number and address for verification. We edit letters for brevity, grammar, taste and legal reasons. We reject poetry, personal attacks, form letters, letters submitted elsewhere and those appropriate for other sections of The Bulletin. Writers are limited to one letter or guest column every 30 days. Email: letters@bendbulletin.com

States must ensure COVID-19 vaccine distribution is done equitably

BY HARALD SCHMIDT, LAWRENCE GOSTIN AND MICHELLE WILLIAMS
Special to The Washington Post

President Joe Biden's announcement that all U.S. adults will be eligible for coronavirus vaccines by May 1 is, in many ways, good news. But opening the gates does not mean that the debate about equitable and fair allocation is over. Far from it.

To ensure equitable allocation and mitigate the pandemic's disproportionate impact on disadvantaged communities, three things are central: prioritizing more vulnerable communities; conveying that doing so is good for both public health and equity; and making clear that equity is not the enemy of efficiency. These steps will matter as much once we open up vaccine eligibility to the general population as they do now.

State policies on who gets the vaccine have been the subject of much controversy over the past few months. Kitchen tables across the country have featured a recurrent question: "When is it my turn?"

By May 1, these questions will end. At least 50 million people who were not included in any of the previous priority groups will qualify. But they will be competing for doses against those who were eligible for vaccines earlier, and who, for one reason or another, remained unvaccinated. This includes people who wanted a vaccine but weren't able to get one, as well as those with reservations about the injection. Surveys suggest this group includes at least 30% of those in all priority groups, or about 70 million people.

In other words, at least 100 million people will likely still not be vaccinated on May 1. Getting shots into those arms will take time, and although we will no longer have priority groups based on age or profession, it is imperative to still prioritize those for whom vaccines matter the most.

For many who have not yet been vaccinated, waiting another month or longer will be an inconvenience that can be handled safely. But others will continue to be at greater risk of the virus and may no longer be able to withstand the pandemic's economic impact. We also know that because of structural racism, that latter group will include much larger shares of people of color, who not only lag behind in vaccination coverage but also have suffered far higher rates of unemployment, infections and deaths, as well as structurally curtailed economic opportunities.

Data bear out that the worse-off people are, the more dramatic the consequences of COVID-19. A recent study using the Social Vulnerability Index — a measure developed by the Centers of Disease Control and Prevention that compiles a bunch of factors (such as income, quality of housing and education) into a single score for a region's overall vulnerability — found that an increase of 0.1 point in the SVI score was associated with a 14.3% increase in COVID-19 incidence and a 13.7% increase in mortality rate.

Such disadvantage indices can and should be used to guide allocations within and across states. Encouragingly, in a review we conducted with colleagues in November, we found that 19 states used an index such as the SVI. By late January, this number had increased to 29, allowing state planners to identify where to place vaccination sites; to tailor communication and outreach strategies so that they are responsive to the specific communities; and to monitor and adjust allocations as needed to make sure disadvantaged groups are not left out.

Such data prove that promoting equity and protecting public health are flip sides of the same coin: Meaningful herd immunity is not achieved by simply vaccinating the largest number of people, but by vaccinating more of those people who are most likely to get and spread the infection. The increasing uptake by states is promising, and hopefully will become universal.

It also demonstrates the false dichotomy that equity comes at the expense of efficiency. For example, adjusting allocation quotas in a spreadsheet so that disadvantaged areas receive larger amounts of vaccine doses can be done in an instant. All it takes is intentionality and attention to details.

It is understandable that most people take a first-person approach to the pandemic. But the pandemic is not just about us as individuals; rather, it is about all of us as an interconnected collective.

Twenty-eight states have already expanded their eligibility to all adults, or will do so before the second week of April. Yet 17 of these states are below average in terms of the population share that has received vaccines. And in general, vaccination rates are lower in counties that have been hit harder by COVID-19 and have higher poverty rates or larger shares of Black and Hispanic populations. We all stand to benefit if those states and regional health departments use data to ensure, at minimum, that vaccination rates among the nation's most vulnerable are not lower than among the more privileged groups — both for public health reasons and for social justice.

Harald Schmidt is an assistant professor of medical ethics and health policy at the University of Pennsylvania. Lawrence Gostin is a professor and director of the O'Neill Institute for National and Global Health Law at Georgetown University Law Center. Michelle Williams is dean of the Harvard T.H. Chan School of Public Health.