

Vaccine Tourism, Federalism, Nationalism

*I. Glenn Cohen**

I INTRODUCTION

In early January 2021, the news stories started rolling out focused on so-called “vaccine tourism” to the sunny state of Florida. Non-Floridians were getting the coveted Pfizer and Moderna vaccines that were severely limited in supply. There were reports of a “celebrity lawyer from Argentina [who] got the vaccine while she was visiting Florida,” and an Argentine television personality whose mother was vaccinated in Miami.¹ Two “India travel agencies … reportedly market[ed] vaccine travel packages,” including roundtrip airfare and “a shot upon arrival” for two thousand dollars.² And, closer to home, a travel insurance broker in Canada reported that many of his clients who typically flew south for the winter but had decided to stay put were changing their minds once friends told them they could travel to Miami and get vaccinated, rather than waiting months or longer in Canada.³

Government officials in Florida were none too pleased. The mayor of Miami chafed, “[i]t’s sort of a slap in the face to this community that is desperately trying to get vaccinated.”⁴ Florida’s governor initially tried to distinguish different kinds of non-Floridians seeking vaccines:

[I]t is difficult to block non-residents from getting vaccinated because Florida attracts so many snowbirds.

“We’re a transient state,” DeSantis said Monday during a news conference in Miami. “You’ll have people that will be here and it’s not like they’re just on vacation for two weeks.”

* I thank Prue Brady for excellent research assistance with this chapter.

¹ Florida Officials Cracking Down on COVID-19 “Vaccine Tourism,” CBS (Jan. 21, 2021), www.cbsnews.com/news/florida-covid-vaccine-tourism/?ftag=CNM-oo-1oaab7e&linkId=109654223.

² Id.

³ Id.

⁴ Id.

Still, while it would be difficult to turn away snowbirds, tourists who are “flying by night” are a different matter, DeSantis said. “We’re discouraging people who come to Florida just to get a vaccine,” he said.⁵

By late January, the state sought to do more than “discourag[e] those from out of state or out of country from vaccination in Florida; amidst some confusion, the state sought to restrict vaccine access to “those who can prove state residency using a state driver’s license or other official documents, such as a deed, rental agreement or utility bill.”⁶

Was it right to do so? This chapter analyses the phenomenon of vaccine tourism and seeks to answer that question. Section I situates vaccine tourism in the larger phenomenon of medical tourism and describes what is undesirable about it. Section II seeks to answer the question of when a state should try to prevent international vaccine tourism head-on, arguing that states should adopt a communitarian conception of who qualifies that is tied to the purpose of the good in question. For vaccines, such a conception makes it appropriate for states to prohibit “tourists” from coming to a state such as Florida from abroad for the purpose of getting vaccinated. At the same time, this rationale does not justify excluding undocumented persons or even those who are not permanent residents but who have substantial ties to the community, such as part-time residents. Section III considers objections to the argument and briefly highlights some adjacent issues, such as whether interstate vaccine tourism is different from international vaccine tourism in the ethical analysis. Throughout this chapter, I use the state of Florida in the United States as my “home state” and the United States as my “home country” for ease of exposition, but I mean the arguments I offer to be more generally applicable. One editorial note as I review the proofs in April 2023: this chapter was written during the height of the COVID-19 pandemic. It reflects the facts on the ground as they then stood and captures my thinking while being “in the thick of it.” I have resisted the impulse to “Monday morning quarterback,” that is, to go back and change parts of it to reflect what actually transpired after I wrote it.

⁵ Jane Musgrave & John Pacenti, COVID-19 Vaccine Tourism? Florida Could Be Hot Spot as Governor Discourages Outsiders, USA Today (Jan. 12, 2021), www.usatoday.com/story/travel/news/2021/01/12/covid-vaccine-tourism-florida-discourages-outsiders-seeking-shot/6626445002/.

⁶ Megan Reeves & Allison Ross, Florida Limits Coronavirus Vaccines to Permanent, Seasonal Residents, Tampa Bay Times (Jan. 21, 2021), www.tampabay.com/news/health/2021/01/21/is-florida-vaccinating-non-residents-or-not-is-hard-to-get-an-answer/. For its part, the Centers for Disease Control and Prevention (CDC) COVID-19 Vaccine Task Force took different positions as supply changed. As it describes its position, “when there were limited supplies of COVID-19 vaccine available, [the] CDC allowed states to limit COVID-19 vaccination to residents and others temporarily living in the state to assure that all such individuals would have the opportunity for timely vaccination.” CDC, COVID-19 Vaccine Task Force Position on Citizenship and Residency, www.cdc.gov/vaccines/covid-19/citizenship-residency-position.html (last updated Oct. 21, 2021). By contrast, its later position was: “Now that COVID-19 vaccine supply availability has increased, there is no longer a public health rationale for excluding individuals who are not residents of a state or locality from being vaccinated in another state or locality. Therefore, residents and others who live in any state or locality should be allowed to get vaccinated in any state.” Id.

II WHAT IS WORRISOME ABOUT VACCINE TOURISM?

“Vaccine tourism” might be thought of as a subspecies of “medical tourism” or “medical travel.” As defined in my prior work, it involves patients traveling from one country (the home country) to another country (the destination country) for treatment.⁷ Vaccine tourism resembles most forms of medical tourism that involve “queue jumping,” such as a Canadian patient in need of a hip replacement traveling to a US state and paying for it out of pocket, rather than waiting for her turn on her home province’s wait list.⁸

Vaccine tourism shares three ethically worrisome aspects with that queue jumping example. First, there is a concern that only those who are sophisticated, able-bodied, and wealthy enough to travel can take advantage of this opportunity. In the case of COVID-19, there is no reason to think that the “vaccine tourism eligible” population matches the populations that we might be most inclined to prioritize for vaccination – those who are at higher risk by virtue of health status, community spread, or workplace exposure. There is an additional wrinkle in that there is considerable moral luck in the question of what the ordinary visa regime means for the ability of an individual of a particular country to travel to the United States or another country.

This complication is further highlighted in the early period of the COVID-19 pandemic given the additional extraordinary restrictions on travel between certain countries.

Second, depending on the availability of the COVID-19 vaccine in the destination country, non-citizens and non-residents who queue jump may displace (and thus delay) access for citizens and residents. Importantly, even when COVID-19 vaccine access at some point becomes plentiful in a country such as the United States, vaccine tourism may still foster a problematic displacement of priority: in this case, the doses that are taken by vaccine tourists are ones that might otherwise be donated to the hardest-hit countries, either directly or through programs such as the COVID-19 Vaccines Global Access Facility.⁹

Finally, as with other forms of medical tourism, there is a risk to the patient of being infected with COVID-19 as part of the travel process and a corresponding worry that that patient will infect others. The documented cases of multi-drug

⁷ I. Glenn Cohen, *Patients with Passports* (2014).

⁸ Id. This is in contrast to “circumvention tourism” involving travel for a service illegal in a patient’s home country (e.g., abortion, aid in dying) or travel for services illegal in both the patient’s home and destination country (e.g., travel to purchase a kidney for transplant). Id.

⁹ Of course, there is no guarantee that a country such as the United States will donate such “excess” doses. Many high-income countries, such as the United States and Canada, have made plans to stockpile more doses than they will use. If the choice is between a particular dose adding to a stockpile versus being used for a vaccine tourist, the latter seems less objectionable, even if less ethically good than the alternative of donation to a low-income country.

resistant bacterial infection spreading via medical travel serve as a precursor to some of what we face in COVID-19 air travel.¹⁰

All that said, in policy design one always wants to make sure that the cure is not worse than the disease. In thinking about how to discourage or prohibit vaccine tourism for any of the categories discussed in the following section, we want to make sure that the techniques employed do not end up shutting out vulnerable communities. In particular, one might be concerned that overly rigorous requirements for residency documentation might intimidate undocumented persons or those who already feel profiled by the state, preventing them from seeking out vaccination. This is a hard thing to measure, especially *ex ante*, but one should treat this as a background consideration in policy design related to administrability above and beyond questions of entitlement, to which I turn next.

III WHO IS ENTITLED TO A HOME COUNTRY'S VACCINE DOSES?

Given all this, is a state such as Florida (or a country as a whole) justified in adopting legal means to deny vaccine access to vaccine tourists?

My answer is a qualified yes. It is qualified because we need to be careful to distinguish a spectrum of potential vaccine tourists. As to international vaccine tourism, one might conceptualize a spectrum that includes:

Non-citizen/non-resident on a temporary stay: This would include, for example, an Argentine citizen/resident who travels to Florida for the purpose of getting vaccinated and leaves shortly thereafter.

Non-citizen/part-time resident: This would include, for example, the Canadian “snowbird” who travels to Florida under established immigration channels every year for part of the year and resides in that community.

Non-citizen/full-time resident: This category itself contains a spectrum of kinds of relationships with the United States. At one end are permanent aliens who have not (or not yet) applied for US citizenship: for example, a Brazilian citizen with a US green card residing in Florida. Somewhere in the middle of the spectrum is someone with an immigration status which allows them to live in the United States but explicitly does not permit them to transition to citizenship, a temporary status such as a Canadian citizen working in the United States on a TN visa. Then there are individuals who are undocumented workers, non-citizens who as a legal matter have no entitlement to work or live in the country but may have built long-standing ties (indeed, familial connections in some cases) in the country: for example, a Haitian worker in Florida without lawful citizenship or residency in the United States who works and lives with her family in the state.

Citizen/non-resident: This would include, for example, a US citizen who has lived in Bolivia for the last ten years and flies to Florida for a vaccination.

¹⁰ Cohen, *supra* note 7, at 48–50.

Citizen/resident: This would include, for example, a US citizen who resides in Florida.

Who in this spectrum has an entitlement to be vaccinated in the United States?

When laid out in this way, one can see three possible principles as to who should be entitled to vaccines distributed by a home country government (in this instance, I will continue to use the United States as my example).¹¹ First, *territoriality*: anyone who finds themselves in the United States territory, as a geographical matter, is entitled to a vaccine. Second, *citizenship*: anyone who is a citizen of the United States is entitled to a vaccine. Third, *communitarian*: anyone who is a member of the community in the relevant sense is entitled to a vaccine.

These principles could be individually sufficient (e.g., if citizenship is individually sufficient then both the citizen/resident and the citizen/non-resident are entitled to vaccination), or individually necessary (e.g., if citizenship is a necessary condition then all non-citizens must be excluded, even those who reside in the country). Multiple conditions could also be jointly sufficient or jointly necessary. To make things more complicated, while I have framed it as a matter of “entitlement” – an on/off switch – one could have a more nuanced account of priority setting where one who, for example, satisfies all three conditions has priority over someone who satisfies only a particular two, and so on.

All this shows how complex the picture of moral claims to vaccination is. I do not aim to offer a full theory in these few pages, but I do want to use this theorizing to explain why I think citizen/residents, non-citizen/full-time residents, and most (if not all) non-citizen/part-time residents, but not non-citizen/non-residents on a temporary stay, are entitled to vaccines supplied by the US government.

One way of putting this in terms of the theories developed so far is that I would reject a strong version of the territoriality principle in favor of a communitarian principle. Although it is not my focus, I also think there is a strong argument in favor of the citizenship principle, which would also justify vaccine access to US citizens living abroad, in addition to whomever the communitarian principle picks out as entitled to vaccine doses from the United States.

Before I delve into the communitarian approach, I want to raise one assumption of the argument I offer – that the United States is entitled to the doses it has purchased through advance purchase agreements, that these “belong” to the United States to distribute in a way that achieves its goals. While I think most people have assumed that this premise is true, it is not self-evidently true. One could, for example, think that all vaccine doses should be viewed as common global property and allocated by need or some other framework of distribution. For the purposes of this chapter, I am going to just assume that the United States has a claim over the doses it has purchased, if only because I think any other arrangement would be politically

¹¹ More accurately, perhaps three “intuitive” or “plausible” principles – one could certainly imagine many more.

impossible to imagine in our current moment. Readers who think this arrangement is unjust can take what follows as an argument operating in the sphere of “non-ideal justice,” or a second (or fifteenth!) best solution.¹²

*A Developing the Communitarian Approach Based
on the Nature of the Good*

The communitarian principle is that anyone who is a member of the community in the relevant sense is entitled to a vaccine. Now we have to unpack what it means to be a member of the community “in the relevant sense” for generating a claim to a US vaccine. Here it might be useful to start with an argument I offered in a 2014 article in which I analyzed a question somewhat similar to vaccine entitlement: Should non-resident/non-citizens (i.e., a French citizen who lives in Paris) be morally entitled to be waitlisted for US organs?¹³ One of the difficult parts of that argument required justifying why a non-citizen/non-resident was not entitled to be waitlisted but an undocumented person living in the United States did have such an entitlement. I justified that on a particular communitarian conception relating to reciprocity:

[T]he key reciprocity is *not* between organ donation and receiving ... but instead is between investment in the infrastructure of organ procurement and allocation and shared decision-making as organs *vel non*. It is this reciprocity that US citizen-residents share but that foreigners ordinarily lack, and thus this form of reciprocity justifies US citizen-residents’ priority, at least in the case of equally matched foreigners and US citizen-residents.

One interesting implication of this approach is that the strength of the argument varies with the amount that the home country’s citizen-residents (as against foreigners) have invested in or contributed to their country’s organ procurement and allocation system. Undocumented immigrants frequently pay into the US system through social security and other tax resources from which they do not draw, such that we can say that they in fact meet the investment prerequisites. Further, the OPTN [the Organ Procurement and Transplantation Network, the main organization setting policy for organ procurement and distribution in the U.S.] suggests that they frequently “pay in” more directly through organ donation. Second, the continued presence of undocumented aliens as residents in the United States, both with families and as part of communities, complicates our moral relation to them in a way that is not true in the case of true foreigner.¹⁴

But, as with most approaches to just distribution, our analysis of what is just must be closely tailored to the good in question. Human organs eligible for transplant,

¹² Example, John Rawls, *A Theory Of Justice* § 39, at 244–46 (1971).

¹³ I. Glenn Cohen, *Organs Without Borders? Allocating Transplant Organs, Foreigners, and the Importance of the Nation-State (?)*, 77 *Law Contemp. Probs.* 175 (2014).

¹⁴ Id. at 197–205.

say a kidney, are *not* collectively owned – most people do not think you have a rights claim to my kidney by virtue of being a fellow citizen or fellow resident of the same country.¹⁵ The kidney belongs to me, not the United States. That is the reason why the argument for a preference for US residents for organs procured in the United States requires a more roundabout argument about common investment in the system of procurement and distribution by members of the community.

In the case of vaccine doses that are in the possession of the US government, by contrast, these doses really do, in some sense, belong to the United States *qua* national government. They were purchased by the US government,¹⁶ purchases that were funded by US taxpayers. Those taxpayers include citizen/residents and many non-citizen/full-time residents. They do not include non-citizen/non-residents.¹⁷ Whether or not part-time residents qualify as taxpayers may depend on their immigration status, tax treaties between the United States and their country of citizenship, and the amount of time they spend in the United States.

¹⁵ But see Cécile Fabre, *Whose Body Is It Anyway?* 72–123 (2006) (offering some provocative arguments to the contrary).

¹⁶ What should we make of the fact that the vaccine doses were also the result of US investment in their development? It would be tempting to tether the argument to the multi-billion dollar investment by the United States in COVID-19 vaccine clinical trials, production scale-up, procurement, and delivery as part of Operation Warp Speed. But this might generate some unusual implications. First, while it would offer a hook for Moderna and Johnson & Johnson vaccines, Pfizer did not accept funding from the program. Example, Assistant Secretary for Public Affairs, Health & Hum. Servs., Fact Sheet: Explaining Operation Warp Speed (Jan. 21, 2021), www.hhs.gov/coronavirus/explaining-operation-warp-speed/index.html [<https://perma.cc/U5DF-FF9R>]. That would seem to suggest one set of entitlements and priorities for one vaccine but not the others. Second, it would seem to suggest that to determine if a particular non-US citizen/non-US resident had an entitlement claim to a particular vaccine, we would need to determine what investment his or her home country had made to its development such that we might draw distinctions between different home countries in terms of who could justifiably travel to the United States for vaccine tourism. Neither of these implications doom the argument, but they do make it less appealing.

One might also worry that the argument would generate obvious distributional effects between wealthier countries who invested in development and poorer ones who did not. But, of course, similar distributional effects follow from allowing the United States to prefer its own citizens for vaccinations because it was able to make advance purchasing agreements at prices that Liberia, for example, was not. Thus, this seems to me a strong argument against allowing claim rights for investment-to-innovate only if one was also prepared to make the stronger argument that the United States is not justified in prioritizing its citizen-residents for the doses it actually purchased. This relates back to the assumption I introduced earlier.

¹⁷ Indeed, undocumented immigrants frequently pay into the US tax system through Social Security and other tax resources from which they do not draw. Example, Henry Ordower, *Taxing Others in the Age of Trump: Foreigners (and the Politically Weak) as Tax Subjects*, 62 *St. Louis U. L.J.* 157, 171 (2017). Is it possible that there are some undocumented persons who do not pay taxes? Perhaps, though if we broaden the scope to include things such as sales tax, it becomes increasingly unlikely. Moreover, there are also citizens who do not pay taxes – lawfully or otherwise – but we do not, for example, restrict them from sending their children to public schools or other taxpayer-funded benefits. This seems no different. In any event, even if this communitarian principle was understood to exclude them, the second one I discuss will bring them back in.

There is a second communitarian pathway worth exploring. This goes more directly to the nature of the good and is, if anything, more straightforward. Why is vaccination sought? To protect oneself and to protect the community in one which lives – be it very small (one's family), larger (one's workplace), or larger still (everyone one encounters within a few feet indoors). If this is the “purpose of the good,” to sound somewhat Aristotelian, then the criterion for distribution should follow from it. Those who live in a particular community have a reciprocal relationship of a sort – the capacity to put others at risk of COVID-19 infection and the capacity to be put at risk by the COVID-19 infections of others. This remains just as true whether one is a citizen/resident or an undocumented person.

B *How to Treat Part-Time Residents?*

How does this criterion of distribution apply to the non-citizen/part-time resident? It seems to me that their entitlement claim scales up in proportion to their comparative risk of infecting or being infected by others in the community. Someone who lives in Florida for six months of the pandemic but then goes home is at substantial risk of being infected or infecting others in Florida during those six months. It would make sense from a public health/purpose of the good perspective to give them an entitlement to the vaccine during their period of Florida residency.

Now, perhaps one might agree that the part-time resident has an entitlement to the vaccine (or, to put this perhaps better, it would not be unjust to provide them a dose) but suggest that they ought to be of lower priority than the citizen/full-time resident, or even the non-citizen/full-time resident. To put this practically, a state such as Florida might roll out its vaccine in waves that put the part-time resident behind similarly situated full-time residents. One way of thinking about this is through a kind of “expected value” analysis tied to the purpose of the good. If the purpose of vaccinating Floridians is to prevent people in Florida from being infected or infecting others and allow the reopening in Florida, then vaccinating a four-month, part-time resident might generate a reduced advance toward that goal in contrast to vaccinating a full-time resident.¹⁸

As a back-of-the-envelope metric, that may sound plausible, but as we delve deeper into modeling this, I suspect it would show that things are actually considerably more complicated. For example, if we look back at the COVID-19 data, we would likely find that the difference in “expected value” for vaccinating the part-time versus the full-time resident depends on when in the various waves of the virus

¹⁸ If part of the goal of COVID-19 vaccination is to enable the return of the workforce, one might make a similar point that part-time residents are much less likely to be full-time workers in the state. Moreover, one might suggest that for full-time residents the benefit of the vaccination is carried forward for an indefinite time since residency in the state is for an indefinite time, whereas the part-time visitor may never come back. This might be used to develop more subtle forms of prioritization, but I suspect that adding the extra complexity may not be worth it.

we were discussing, where the part-time versus full-time residents lived (including where they fall on the social vulnerability index compared to full-time residents), their ages and health statuses, as compared to full-time residents, etc. I suspect we would find as much within-group variability amongst part-time residents as one would between part- and full-time residents, if not more. At the very least, as a matter of principled policy-setting, we ought to demand consistency. That is, if a state favored reduced priority for the part-time resident *for this reason*, then it should also apply the same reasoning *within* its full-time resident population and give more priority based on a similar expected value analysis. Perhaps we can characterize some of the decisions that states made regarding priority for the elderly and health care workers in this way.

At some point, though, I think we will reach a place familiar to the law of asking about what has been called “administrability” or “formal realizability” concerns, where the difficulty of administering a rule might matter as much as its fairness.¹⁹ That is, even if sub-rules that parse the part-time resident community would be more ethically justifiable, at some point the benefits are outweighed by the complexity of the undertaking and the game is no longer worth a candle. Perhaps this point is particularly salient in the COVID-19 vaccine context when we remember how huge an undertaking it was to begin rolling out the vaccine and the goal of doing so as quickly as possible.

Where has all this landed? I have argued that when a state such as Florida decides to whom it should make COVID-19 vaccines available, it certainly should make them available to full-time US citizens who are residents of Florida, as well as full-time non-citizen residents of Florida. I think there is a strong argument for also extending it to part-time residents of Florida so long as they substantially meet the communitarian principle for which I have argued: having the reciprocal capacity to put others at risk of COVID-19 infection and the capacity to be put at risk by the COVID-19 infections of others.²⁰

By the same token, a state such as Florida should reject providing the vaccine to those who visit for a temporary stay, the true vaccine tourists. Why? First, providing them vaccines incentivizes this kind of travel, which is problematic for all the reasons with which I began.

Second, non-citizen/non-residents who are temporary visitors have no strong claims on the communitarian or citizenship theories of entitlement I have sketched out; all they can offer is territoriality as a basis for their claim. But the nature of this good is such that mere temporary presence in the territory does not generate a strong claim to the good. To be fair, it is true that even on that temporary visit one might

¹⁹ Example, Duncan Kennedy, Form and Substance in Private Law Adjudication, 89 *Harv. L. Rev.* 1685, 1688 (1976); J. M. Balkin, The Crystalline Structure of Legal Thought, 39 *Rutgers L. Rev.* 1, 43 (1986).

²⁰ But, as I suggested earlier, it may be justifiable to give such individuals less priority in proportion to how much they are a part of the community in a relevant sense. This strikes me as a place where things are less clear.

put others at risk of infection or be put at risk of infection, but the surest way to guard against that risk is not to encourage travel for the purpose of getting vaccines. Further, while in some sense non-citizen/non-residents who are temporary visitors are extremely temporary members of the community, lines must be drawn and this one does not seem that hard as an exclusionary one.²¹

IV SOME OBJECTIONS AND LAST THOUGHTS

Having now set up the basic structure of the argument, I want to consider a few objections. The first objection is one I addressed earlier – that the starting assumption that any vaccine doses belong to a home country is problematic from a global justice perspective.

A second objection is that vaccine tourism plays an important role in bringing money back to hard-hit communities. That is, attracting vaccine tourists from abroad will fill hotel rooms, restaurants, and planes in a way that helps hard-hit communities. I have several responses. First, it is far from clear to me that the descriptive claim is correct: It may depend on how many places are offering doses to outsiders and how they compete. For example, many vaccine tourists might flock to flight hubs such as New York or Los Angeles, rather than Fairbanks, Alaska, such that the expected gain to the Fairbanks community never arises. Second, even if the gain were real, I think some might argue from the “purpose of the good” that this justification – bringing in money for hard-hit communities – is nevertheless not permissible. Vaccine doses are not, the argument goes, general purpose goods to make people’s lives go better but instead have a particular function – preventing infection – that guides their distribution. This can be connected to a bioethics literature on “indirect” versus “direct” benefits and “separate spheres”: Some argue that in decisions about allocation, the further away one gets from the purpose of the good in how it provides benefits, the less justified we are in counting that benefit in deciding allocation priority.²²

The easiest way to illustrate this would be to imagine another allocation scheme that the state of Alaska could adopt which might be even better at creating income to be given to the poorest people in the state: auctioning off doses to the highest

²¹ One might find an echo of this question in, of all places, the constitutional law of personal jurisdiction in US civil procedure. In *Burnham v. Superior Court*, 495 US 604 (1990), Justice Brennan and Justice Scalia famously dueled on whether mere presence in a state with service of process was enough as a basis for personal jurisdiction (Scalia’s view) versus the idea that even in such a brief visit, the individual had formed enough connection with the state to have purposefully availed himself enough of its protection, thereby justifying personal jurisdiction (Brennan’s view).

²² See, for example, Dan W. Brock, Separate Spheres and Indirect Benefits, Cost Effectiveness & Res. Allocation [pincite] (2003), <https://resource-allocation.biomedcentral.com/track/pdf/10.1186/1478-7547-1-4.pdf>; Frances M. Kamm, Morality, Mortality: Death and Whom to Save from It 107–15 (1993). For my own thoughts on this debate, see I. Glenn Cohen, Rationing Legal Services, 5 *J. L. Anal.* 221, 275–82 (2013).

bidders from outside the states. If that would be impermissible, the argument goes, why is deliberately attracting vaccine tourists to bring in money for hard-hit communities any better? When to count indirect benefits requires swimming in choppy philosophical waters, but the easiest lifesaver one can throw is to say whether it is all-things-considered *ethically* permissible. When the allocator (the US government) shares vaccine doses, surely enabling the state to make money is not the allocators' criteria for distribution – it distributes doses based on population size, not the degree to which a state is economically depressed. There may be other forms of allocation of federal funds that are meant for this latter problem, but vaccine doses are not such an allocation. It would be as though a friend lent you his or her car to take your mother to the hospital and you instead used it to make money off Uber rides. That would be impermissible because the car (or vaccine doses) was given for one purpose but you are using it for something very different. This is all the more so when, as with vaccine doses, there are multiple rival claimants, instead of a car that is merely sitting idle.

One final point before I close: Does the argument look different when we are discussing interstate medical tourism within a country (say travelers from New York to Florida) as opposed to people coming from abroad? A little. The communitarian arguments for excluding temporary visitors to the state persist in the interstate case, but are admittedly a bit weaker. Why weaker?

The New Yorker's tax dollars have gone to support the purchase of the vaccine doses just as much as the Floridian's, so that is not distinguishing. And while it is true that only the Floridian has the reciprocal relationship of putting others at risk and being put at risk of infection *in Florida*, we might go up a level of generality and say both have the same reciprocal relationship as to infection *in the United States* as a whole, which begs the question of why Florida and not the United States is the right level of analysis.

There is an answer but it is a little less satisfying – that is, that the United States decided to allocate doses to individual states initially based on population per capita above the age of eighteen.²³ It follows from that decision that any time New Yorkers take doses in Florida, that is one less dose of the share Florida was allocated for Floridians. At the extreme, imagine if the entire population of New York City were to arrive in Miami and claim doses. That would mean that New Yorkers had received more than they were entitled to and Floridians less. That would frustrate the logic of allocation the federal government settled on, as well as bring with it the risk of infection spread discussed earlier. It might also stymie attempts to key the reopening of a state to vaccination metrics. If that feels a little less satisfying as a reason, it is because the initial choice to distribute by state by population feels like

²³ Example, Lisa Simunaci, US Dep't of Def., Pro Rata Vaccine Distribution is Fair, Equitable (Dec. 11, 2020), www.defense.gov/News/News-Stories/Article/Article/2441698/pro-rata-vaccine-distribution-is-fair-equitable/.

more of an artifact of the need to quickly administer these vaccines rather than the result of a deeper moral reason connected to entitlement. One could have imagined rolling out the vaccine across the United States by population age, for example, irrespective of state.

This points to a bigger truth: The opportunity for interstate medical tourism is itself the result of vaccine federalism, or, more accurately, federalism in the way in which allocation criteria were set. Individual states got to decide whether and for how long to prioritize certain age bands, essential workers, and so on. Those differences inevitably provided incentives for interstate medical travel. This could have been avoided – the federal government could have done more to set uniform allocation policy (compare, for example, the allocation of organs to transplant where there are national rules rather than individual states setting their own policies). Perhaps in future planning, the decision to allocate doses to individual states initially based on population per capita above the age of eighteen is worth revisiting.