# Pandemic resource allocation needs to address health inequity

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If some regions become hot spots and hospitals reach maximum capacity during the COVID-19 pandemic, hospitals have plans for how to decide who gets critical care resources, such as a bed in the intensive care unit or a respirator. Many hospitals recommend distributing resources to the healthiest patients who are most likely to survive. However, Johns Hopkins Medicine physicians and bioethicists say that using this kind of selection method preferentially chooses people who are white or affluent over patients who are Black, Latino or from the inner city.

In a commentary published June 22 in *The Lancet*, the Johns Hopkins team provides recommendations for how hospitals can provide equitable care during pandemic resource allocation, such as by requiring regular bias training and creating periodic checkpoints to assess inequities in the system.

"Prejudice, institutional racism and redlining over generations has led to drastic health inequities in Baltimore and many other cities around the country, making these populations of people inherently sicker," says Panagis Galiatsatos, M.D., M.H.S., assistant professor of medicine at the Johns Hopkins University School of Medicine. "We wanted to make sure that we developed a plan that ensures that resources are fairly distributed and that we weren't contributing to existing inequalities. And we want to be able to share these guidelines to other hospitals so they can also be prepared to make humane decisions for their patient communities."

The American College of Chest Physicians and the Society of Critical Care Medicine recommend using the sequential organ failure assessment (SOFA) to determine which patients are the healthiest and should get resources, based on factors such as whether the patient has health issues such as heart failure or diabetes. However, the aforementioned organization's physicians say this model hasn't been effectively evaluated for the COVID-19 pandemic. They also say that although the method works on entire populations, it hasn't been tested on individual disadvantaged groups. And, because the criteria disproportionally affect minority groups and the poor, the researchers say, the proposed system need adjusting.

The first thing the team recommends is to have unconscious-bias training for the people in critical care medicine making the decisions about who gets resources.

Next, the team says hospitals need to periodically assess their survival numbers by income, race and other socioeconomic factors. Then, they must have an outside committee that includes community members to assess where there are weaknesses in the system and develop strategies to address these deficiencies. For example, some populations might need more time with a specific resource than affluent, white patients because people in the group may otherwise be more likely to die.

Galiatsatos is available to discuss how current resource allocation methods cast aside vulnerable populations. He can also talk about the methods his team suggests to address the inequities.

**More information:** Panagis Galiatsatos et al, Health equity and distributive justice considerations in critical care resource allocation, *The Lancet Respiratory Medicine* (2020). DOI: 10.1016/S2213-2600(20)30277-0

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