

## Social Justice as a Necessary Guide to Public Health Disaster Response

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# SOCIAL JUSTICE AS A NECESSARY GUIDE TO PUBLIC HEALTH DISASTER RESPONSE

BY: STEPHEN S. HANSON\*+

The U.S. has no clear federal policy for how scarce medical resources are to be distributed, particularly in disasters or cases of similar urgency. This partly comes from being insulated from the impacts of many potential disasters by wealth and other factors but also comes from a historical unwillingness to make difficult medical ethical decisions based on questions of justice.<sup>1</sup> Distribution of solid organs for transplant is one of the few areas where we have carefully thought about just distribution, and it is almost entirely unique in having a carefully considered and complex distribution mechanism.<sup>2</sup> As such, discussions about appropriate distribution of scarce resources in something like disaster triage are in a much more basic stage than our discussions about, say, informed consent.<sup>3</sup>

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1. This will not be argued here, but consider that at the same time we had, *Canterbury v. Spence*, 464 F.2d 722, 789 (D.C. Cir. 1972), being decided in a way that helped us properly navigate goals of respecting patient autonomy and providing for patient's best interests, the U.S. also established the Medicare End-Stage Renal Disease benefit, which essentially decided not to ask questions of distribution of scarce resources but rather chose to provide access to that one resource sufficiently to make it not scarce and thus to make the question go away. See 42 U.S.C. § 1395rr(a) (explaining Medicare benefit is available for anyone diagnosed with end-stage renal disease). Had the decision been made by explicit choice to treat questions of distribution of resources by making them non-scarce, that would have been a justifiable decision that embraced rather than dodged the challenge of health resource distribution, but of course that path was not followed for other forms of treatment. For example, access to chemotherapy and the like remained rationed by ability to pay.

2. See 42 U.S.C. § 274(b)(2)(B) (2019) (codifying of the National Organ Transplantation Act which establishes the Organ Procurement and Transplantation Network to establish criteria for organ allocation); see also 42 C.F.R. § 121.8 (2019) (establishing allocation methods for organs).

3. As a minor but important point here, I want to distinguish between truly scarce resources and not truly scarce resources, and for one specific reason: The discussion about rationing of health care resources often means distribution of things such as access to primary health care and access to adequate health insurance, as raised in the Affordable Care Act. See 42 U.S.C. § 18022(b) (2018) (establishing requirements for essential health benefits that plans must provide). What these questions are primarily

A common decision in scarce resource distribution is to seek to produce the best results in a utilitarian fashion.<sup>4</sup> See, e.g., Alastair Browne, who concludes that in times of blood shortage:

[B]lood should be allocated to such patients solely on the basis of who has the best chance of maximum life extension, where this is calculated with the help of a point system by taking into account the probability of survival to discharge, comorbid conditions, and the age of the patient.<sup>5</sup>

Additionally, Philip Rosoff holds that in cases of drug shortages, “[t]he foremost criterion for giving one patient access to a scarce drug over another should be demonstrable evidence of a superior clinical therapeutic effect in the selected patient.”<sup>6</sup> In situations of military (or disaster) triage where the number of patients quickly overwhelm the routine medical assets available, patients with the greatest chance of survival with the least expenditure of time, equipment, supplies, and personnel are to be treated first.<sup>7</sup> Perhaps the more common viewpoint is to simply take for granted that the factors of saving the most lives and maximizing life-years are the only relevant factors to consider when distributing scarce resources, and proceed from there.<sup>8</sup>

Following this account, when resources are truly scarce, we should treat those most likely to live the longest, and avoid treatment of the sick and elderly. Nothing in this requires ignoring adequate palliative and comfort care for persons who would not receive the scarce resources, and several of these

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about is money, primarily in the distribution of insurance and affordable access to otherwise available care. Whatever else may be true, money is not a scarce resource in U.S. health care. See CTRS, FOR MEDICARE & MEDICAID SERVS., NATIONAL HEALTH EXPENDITURES 2018 HIGHLIGHTS (2018), <https://www.cms.gov/files/document/highlights.pdf> (explaining total U.S. health care expenditures reached \$3.6 trillion in 2018). It may be poorly allocated, spent in inefficient ways, or otherwise less than justly or wisely distributed, but in the country that spends the most per person on health care by far, money is not scarce. See *id.* (explaining that in 2018 health expenditures per person was greater than \$11,000). I mean really scarce resources, like solid organs, occasionally blood, short-term shortages of vaccines in some cases, and limited resources available in disasters like, e.g., Katrina and New Orleans. This may also eventually mean physician and nursing person-hours (if patterns do not change). It will not, in any foreseeable future not involving collapse of the health care system, include money.

4. Robert Baker & Martin Strosberg, *Triage and Equality: A Historical Reassessment of Utilitarian Analyses of Triage*, 2 KENNEDY INST. ETHICS J. 103, 104-05 (1992).

5. Alastair Browne, *Blood in a Time of Scarcity*, 22 CAMBRIDGE Q. OF HEALTHCARE ETHICS 159, 167, (2013).

6. Philip M. Rosoff, *Unpredictable Drug Shortages: An Ethical Framework for Short-Term Rationing in Hospitals*, THE AM. J. OF BIOETHICS 1, 3 (2012).

7. Thomas B. Repine et al., *The Dynamics and Ethics of Triage: Rationing Care in Hard Times*, 170 MIL. MED. 505, 505-06 (2005).

8. Samuel J. Kerstein & Greg Bognar, *Complete Lives in the Balance*, 10 AM. J. OF BIOETHICS 37, 37 (2010).

authors make that explicitly clear.<sup>9</sup> Some accounts also argue that we ought to treat clinicians because if cured or prophylactically vaccinated they can continue to provide care; the Centers for Disease Control and Prevention (hereinafter “CDC”) advocates this in regards to allocation of pandemic influenza vaccines.<sup>10</sup> There is a reason why this line of argument is commonly promoted – it makes practical and ethical sense on first glance. When posited against views that would prefer distribution for wealthy donors, those who can best game the system, or racist and classist distributions, this position appears obviously superior. Furthermore, on its face it appears neutral with regard to race, gender, wealth, and the like, as all that matters is whether and how much the recipient will benefit from the resource.<sup>11</sup> It may also seem preferable to other presumably inequity-blind methods of distribution such as lotteries or first-come first serve approaches, which might lead to extremely inefficient distributions.<sup>12</sup> When, for example, Philip Rosoff states that “[h]ence, a minimum criterion for fairness must be to treat people the same who are similarly situated—in this case, clinically situated,” this conclusion stated in this fashion seems basic and inarguable.<sup>13</sup>

The problem with this approach is that, contrary to the initial impression of inequality-blindness, it privileges the powerful, and unequally harms those who are least well off.<sup>14</sup> Naomi Zack notes that disaster magnifies social inequality: “In every civilian disaster thus far, the already disadvantaged have suffered most...”<sup>15</sup> In cases of natural disasters where evacuation is appropriate, this often occurs because the “poor are less physically mobile than those with more money.”<sup>16</sup> Both their access to vehicles, and familial or community ties to their neighborhood can keep less affluent persons from

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9. See Marianne Matzo et al., *Palliative Care Considerations in Mass Casualty Events with Scarce Resources*, 7 BIOSECURITY & BIOTERRORISM: BIODEFENSE STRATEGY PRAC & SCI. 199, 200 (2009) (explaining the need for palliative care in mass casualty events).

10. See CTRS FOR DISEASE CONTROL & PREVENTION, INTERIM UPDATED PLANNING GUIDANCE ON ALLOCATING AND TARGETING PANDEMIC INFLUENZA VACCINE DURING AN INFLUENZA PANDEMIC 2, 10 (2018), <https://www.cdc.gov/flu/pandemic-resources/national-strategy/planning-guidance/pandemic-severities-tier-1.html> (explaining CDC guidance of prioritizing front-line healthcare workers in the case of a limited vaccine supply during a pandemic influenza).

11. See Browne, *supra* note 5, at 167 (explaining that blood should be allocated based on who has the best chance of maximum life extension).

12. Govind Persad et al., *Principles for Allocation of Scarce Medical Interventions*, 373 LANCET 423, 423-24 (2009).

13. Rosoff, *supra* note 6, at 5.

14. See *Social Determinants of Health: Know What Affects Health*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/socialdeterminants/index.htm> (last updated Jan. 29, 2018) [hereinafter *Social Determinants of Health*] (explaining how poverty, unstable housing, low income, and living in unsafe neighborhoods can affect health).

15. NAOMI ZACK, *ETHICS FOR DISASTER* 106 (James P. Sterba ed., 2009).

16. *Id.* at 110.

evacuating in cases of danger.<sup>17</sup> In cases of disaster triage, the increased risk occurs because socially disadvantaged persons will already be less healthy.<sup>18</sup>

Multiple assessments of social determinants of health have made it very clear that persons who are poorer financially have poorer health, have fewer resources available to change health habits, die sooner, and have more comorbidities, than those who are wealthier.<sup>19</sup> In the U.S. the same is true of persons who are non-white, and those factors interact with each other.<sup>20</sup> For both socio-economic status and ethnicity in the U.S., being less well-off correlates with being less healthy.<sup>21</sup> One need not be a Rawlsian to argue that this issue must be considered in determining how to distribute scarce resources, especially if there are other alternatives with plausible moral justification; Philip Rosoff's above determination of the primary criterion for fair selection – similar clinical situation – ignores the crucial issue that the previously disadvantaged will generally not be the persons most likely to obtain the best results from a scarce resource.<sup>22</sup> Consequently, this fact that appeared to be basic and inarguable is also wrong: the minimum criteria for fairness must also include an assessment of inequality headed into the need for the scarce resource.<sup>23</sup>

I argue that ethical analysis of the possible policies for the allocation of scarce resources in cases of disaster or mass casualty incidents must take matters of justice into account. We must reject using methods that attempt to maximize results while ignoring prior inequalities related to ethnicity or socioeconomic status which are among the greatest social determinants of health.<sup>24</sup> If we focus on maximizing results, we will unjustly exacerbate the inequalities in society at a time of high stress when abuse of the power

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17. *Id.* at 110-13.

18. See *Social Determinants of Health*, *supra* note 14 (explaining how social disadvantages affect health).

19. See Christopher J. L. Murray et al., *Eight Americas: Investigating Mortality Disparities across Races, Counties, and Race-Counties in the United States*, 3 PLOS MED 1513, 1513 (2006) (explaining difference in life expectancy cannot be explained by race, income, or healthcare access alone); see also *Social Determinates of Health*, *supra* note 14 (explaining how poverty, unstable housing, low income, and living in unsafe neighborhoods can affect health).

20. Murray, *supra* note 19, at 1513.

21. Murray, *supra* note 19, at 1513; see also Christopher J. L. Murray et al., *Eight Americas: New Perspectives on US Health Disparities*, 29 AM. J. PREVENTIVE MED. 4, 4 (2005) (explaining disparities in mortality and health between race/ethnic groups and socio-economic status).

22. Elizabeth Lee Daugherty Biddison et al., *Too Many Patients...A Framework to Guide Statewide Allocation of Scarce Mechanical Ventilation During Disasters*, 155 CHEST 848, 850 (2019); Rosoff, *supra* note 6, at 3.

23. See Michael Joffe & Jenny Mindell, *Health Impact Assessment*, 62 OCCUPATIONAL & ENVTL. MED. 907, 910 (2005) (explaining health policies should assess impacts on existing inequalities).

24. Samantha Artiga & Elizabeth Hilton, *Beyond Health Care: The Role of Social Determinates of Health in Promoting Health and Health Equity*, KAISER FAMILY FOUND. 1, 2 (2018), <http://files.kff.org/attachment/issue-brief-beyond-health-care>.

structures in society will be likely to be more common.<sup>25</sup> This may also have implications for other distributions of scarce resources, such as allocation of solid organs for transplant.<sup>26</sup>

### I. ANALYSIS OF METHODS

Consider as a possibility the triage of patients in the what the CDC ranks as the mildest “moderate” pandemic influenza scenario, wherein 800,000 will require hospitalization and 160,000 will require ICU care, possibly with assisted ventilation.<sup>27</sup> Since in 2010 the U.S. was estimated to have about 62,188 ventilators in total, this would place a severe strain on the available resources even in a “moderate” scenario.<sup>28</sup> In such a case, the CDC predicts 48,000 deaths, although that number could be mitigated by public health actions.<sup>29</sup> These numbers may seem manageable, as the 2014-15 seasonal influenza required over 970,000 hospitalizations, which was largely accommodated by current resources.<sup>30</sup> The problem may be that, as pandemic influenzas in the past have peaked in short periods of time, the needs for resources will be concentrated into a short time period that could then overwhelm resources that could have been adequate if needed over a longer period.<sup>31</sup> Further, assuming conditions like the 1918 influenza pandemic could involve over 11 million hospitalizations, 3.5 million needing ICU care, and an expected 1.93 million deaths, which would certainly overwhelm any set of resources actually available.<sup>32</sup>

Assuming the moderate scenario, there would be 160,000 persons needing ICU care over a fairly short period of time in a country that has somewhere around 100,000 ICU beds, of which around 20% are neonatal beds, and about two-thirds are already occupied on a given day.<sup>33</sup> Some significant triaging

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25. See Biddison et al., *supra* note 22 at 850 (explaining how a system that looks towards prospects for long-term survival further disadvantages the poor and persons of color).

26. See generally 42 U.S.C. § 274 (2019) (establishing the framework for the National Organ Distribution).

27. U.S. DEP’T OF HEALTH AND HUMAN SERVS., PANDEMIC FLU PLAN: 2017 UPDATE 44 (2017), <https://www.cdc.gov/flu/pandemic-resources/pdf/pan-flu-report-2017v2.pdf>.

28. Lewis Rubinson et al., *Mechanical Ventilators in the US Acute Care Hospitals*, 4 DISASTER MED & PUB. HEALTH PREPAREDNESS 199, 203 (2010).

29. PANDEMIC FLU PLAN: 2017 UPDATE, *supra* note 27, at 44.

30. *Influenza (Flu): Summary of the 2014-2015 Influenza Season*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/flu/pastseasons/1415season.htm>, (last updated Feb. 11, 2019).

31. See Hiroshi Nakagawa & Takehide Onuma, *Experience of Triage During an A/H1N1 Influenza Pandemic in After-Hours Emergency Centers*, 55 JAPAN MED. ASSOC. J. 312, 317 (2012) (explaining the experience of after-hours emergency center centers during the peak of the 2009 H1N1 outbreak in Sendai).

32. PANDEMIC FLU PLAN: 2017 UPDATE, *supra* note 27, at 42-44.

33. *Critical Care Statistics*, SOC’Y OF CRITICAL CARE MED., <https://www.sccm.org/Communications/Critical-Care-Statistics>; see also PANDEMIC FLU PLAN: 2017

would be necessary, in even a moderate scenario, and even the best triage would seem to be unable to provide all needed treatments to all persons in need.<sup>34</sup>

A results-based approach to such a pandemic rations out the scarce medical resources in whatever way will produce the best result.<sup>35</sup> That result might be measured in lives saved, or an approach might use some methodology to more precisely measure the value of given results like seeking to save the most Quality-Adjusted Life Years (QALYs), but regardless of the details the doling out of health care is guided by the need to produce those results.<sup>36</sup> Consequently, persons who are most likely to benefit, and benefit the most, from a particular treatment are the ones who are most likely to be allocated that treatment.<sup>37</sup> This means that persons with other significant comorbidities, including persons with current pulmonary challenges that might be seen as likely to affect their success in recovery from ventilator distress, such as lifetime smoking habits or exposure to environmental air hazards, would be less likely to be allocated scarce ventilator or ICU support.<sup>38</sup>

However, the factors that would make one unlikely to be a candidate for producing the highest number of life-years are neither evenly nor fairly distributed across society.<sup>39</sup> Problematic comorbidities would be over-loaded in persons of lower socio-economic status and minority status.<sup>40</sup> We know that in the U.S. rates of smoking, diabetes, and overall poorer health are higher in persons of lower socio-economic status, Native Americans, and African Americans.<sup>41</sup> If these factors are used to distribute resources by utilitarian

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UPDATE, *supra* note 27, at 42-44 (explaining the number of persons requiring ICU hospitalization in the case of a pandemic influenza).

34. Michael D. Christian et al., *Development of a Triage Protocol for Critical Care During an Influenza Pandemic*, 175 CANADIAN MED. ASS'N. J. 1377, 1380 (2009).

35. *See id.* (explaining that a triage protocol seeks to maximize benefits for the largest number of people).

36. *See* Persad et al., *supra* note 12, at 424, 427 (explaining different approaches to scarce resource allocation).

37. *See* Tia Powell et al., *Allocation of Ventilators in a Public Health Disaster*, 2 DISASTER MED. & PUB. HEALTH PREPAREDNESS 20, 23 (2008) (explaining exclusion criteria for ventilator allocation focuses on those with high risk of mortality even with ventilator treatment).

38. *See* Matthew Sztajnkrzyer et al., *Unstable Ethical Plateaus and Disaster Triage*, 25 EMERGENCY MED. CLINICS OF N. AM. 749, 761 (2006) (explaining how one cannot choose one's position in life or underlying health which can be relevant in resource allocation); *see also* *Social Determinants of Health*, *supra* note 14 (explaining social determinants of health).

39. *See generally* Murray et al., *supra* note 19, at 1520 (showing how differences in mortality disparities are distributed across society).

40. *See* Biddison et al., *supra* note 22, at 850 (explaining that a system that looks to prospects for long-term survival will further disadvantage those who are already systematically disadvantaged).

41. Murray et al., *supra* note 19, at 1513; Denise B. Kandel et al., *Racial/Ethnic Differences in Cigarette Smoking Initiation and Progression to Daily Smoking: A Multilevel Analysis*, 94 AM. J. PUB. HEALTH 128, 132 (2004).

analyses – as they would under a results-based methodology – then that triage would prefer those who are already socially advantaged.<sup>42</sup>

This is an example of a challenge to universal programs that are designed to provide a universally valuable resource equally to all persons in society, but which fail to do so in actual practice.<sup>43</sup> For instance, john a. powell [sic – he intentionally does not capitalize his name] notes that the Interstate Highway act of 1956 is a good example of such a program.<sup>44</sup> Presumably this was conceived as a resource that would benefit everyone, as the mobility granted by interstates applied to all who drove, took buses, or enjoyed the results of interstate commerce.<sup>45</sup> But, interstates also displaced, surrounded, or damaged downtown neighborhoods while creating easy access to suburbs, enabling decades of white flight after *Brown v. Board of Education*, also in 1956.<sup>46</sup> The result of a system that, *ex ante*, might have seemed to provide universal benefit, ended up benefitting groups quite differently according to racial and socio-economic differences.<sup>47</sup>

If public policy is to be truly just, it must avoid the illusion of universally equally effective policies that in fact distribute benefits quite unequally, especially if those unequal distributions tend to disproportionately disadvantage those already less well-off.<sup>48</sup> In contrast, powell argues that we must target policies to treat different groups differently in order to produce a more universal effect – which he calls “targeted universalism” – so that the results are justly distributed.<sup>49</sup> This approach is necessary in order to keep scarce resource triage from greatly benefitting those who are already best-off.<sup>50</sup>

## II. CURRENT METHODS

To guide a discussion of what might be done to more justly distribute scarce resources this paper will examine three attempts to ameliorate the effect

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42. See Biddison et al., *supra* note 22, at 850 (explaining those already disadvantaged would be further burdened by an approach favoring long-term survival).

43. Biddison et al., *supra* note 22, at 850.

44. john a. powell [sic author intentionally does not capitalize his name], *Post-Racialism or Targeted Universalism?*, 86 DENV. U. L. REV. 785, 794 (2009).

45. See *id.* (explaining how programs universal on their face ultimately benefited whites more than non-whites); see also H. R. REP. NO. 2022 at 2–3 (1956) (explaining the need for highways for the overall economy as a whole and the need to meet current and future traffic demands).

46. powell, *supra* note 44, at 794; see also 394 U.S. 294, 298–300 (1955) (reiterating that racial discrimination in public schools is unconstitutional and granting enforcement authority to U.S. District Courts).

47. See powell *supra* note 44, at 298–300 (explaining disparities resulting through a program that appeared to provide a universal benefit).

48. powell, *supra* note 44, at 790.

49. powell, *supra* note 44, at 803.

50. powell, *supra* note 44, at 803.

of previous attempts to produce good results for persons already disadvantaged in society prior to the onset of the need for a scarce resource.

*a. UNOS and Organ Distribution*

Perhaps the most well developed system for distributing scarce resources in the U.S. is The United Network for Organ Sharing (UNOS) and the various entities that together make up the organ distribution system in the U.S., organized under the administrative system determined by the National Organ Transplant Act of 1984 and its later modifications.<sup>51</sup> That system establishes organs for transplant as a national resource and aims to use that resource to save the maximum number of lives and, in some cases, maximize the years of life saved.<sup>52</sup> Criteria for kidney allocation are the most complex, and consider a multitude of factors including (1) the quality of the donated kidney, (2) immune system compatibility, (3) distance, and (4) how long the recipient has been waiting for an organ.<sup>53</sup> Significant jumps in priority exist for persons for whom fewer organs will work well who match a particular organ, including pediatric patients, and for recipients who were previously living donors.<sup>54</sup> With the exception of waiting time, all of these factors are geared towards distributing the scarce organs to maximize successful transplants and improve survival rates attached to successful transplants.<sup>55</sup> Granting preference for prior donors is presumably meant to increase the number of donors by a number larger than the number of former donors now needing a transplant, and so creates more successful transplants.<sup>56</sup> In 2015, the U.S. Department of Health and Human Services added a rule aiming to match recipients with higher “Expected Post-transplant Survival,” in terms of years of life after transplant, to the highest quality kidneys donated in an effort to increase the number of life-years

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51. 42 U.S.C. § 274 (2019); 42 C.F.R. § 121 (2019).

52. Alexandra K. Glazier, *The Lung Lawsuit: A Case Study in Organ Allocation Policy and Administrative Law*, 14 J. HEALTH & BIOMEDICAL L. 139, 142–43 (2018).

53. See *How Organ Allocation Works*, ORGAN PROCUREMENT & TRANSPLANTATION NETWORK, <https://optn.transplant.hrsa.gov/learn/about-transplantation/how-organ-allocation-works/> (last visited Mar. 4, 2020) (explaining organ allocation priorities including factors involving justice and medical utility).

54. See ORGAN PROCUREMENT & TRANSPLANTATION NETWORK, POLICIES, 184–99 (2019) [https://optn.transplant.hrsa.gov/media/1200/optn\\_policies.pdf](https://optn.transplant.hrsa.gov/media/1200/optn_policies.pdf) (explaining policies of priority relating to liver and liver-intestine transplantation); see also *Pre-Implementation Notice: Liver and Intestinal Organ Distribution Based on Acuity Circles to be Implemented Feb. 4*, ORGAN PROCUREMENT & TRANSPLANTATION NETWORK (Jan. 20, 2020), <https://unos.org/news/pre-imp-notice-liver-intestinal-dist-acuity-circles-feb-4-2020/> (explaining changes prioritization based on factors such as distance, medical urgency, and pediatric status).

55. Glazier, *supra* note 52, at 142.

56. Mélanie Levy, *State Incentives to Promote Organ Donation Honoring the Principles of Reciprocity and Solidarity Inherent in the Gift Relationships*, 5 J. OF L. AND THE BIOSCIENCES 398, 413 (2018).

received per transplant.<sup>57</sup> Other organs have less complicated distribution systems, but are still organized under the aim of maximizing the results from donated organs.<sup>58</sup>

The focus on maximization of benefit is ameliorated somewhat by several modifiers in the selection procedure that are not strictly ends-based. Prior live organ donors are given strong preference, which is not accessible to all persons as not all are acceptable candidates for organ donation. Time, however, can flatten the inequalities that make some people more likely to be acceptable candidates.<sup>59</sup> Time spent on the list counts for points on the list, which can eventually move someone who is a marginally less likely candidate to maximize years of life ahead of a more likely candidate to do so.<sup>60</sup> This would appear to be an attempt to put some element of fairness into the system: any person, regardless of difficulty of matching a kidney, or likelihood of surviving long after receiving one, can make it to the top of the list and receive an organ. With lifespans of between five to ten years on dialysis reasonably possible, time on the list can become the dominant factor.<sup>61</sup> Even in this system that is heavily weighted towards producing the most life-years, using time in the system as a factor is a serious method of equalizing opportunity that flattens the benefit from other factors.<sup>62</sup>

Medicare's end-stage renal disease (ESRD) policy creates a serious difference between kidney allocation and other forms of medical resource distributions in the U.S. Through Medicare, every citizen in need has full funding for kidney dialysis.<sup>63</sup> One major form of inequality in the U.S. is access to affordable health care, and this is somewhat ameliorated in the case of kidney dialysis. Being on dialysis would bring a patient to the attention of clinicians that could have them placed on a list for a kidney. Two major factors, time and access, make distribution of kidneys more equitable, even though they

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57. *Board Approves Significant Revisions to Deceased Donor Kidney Allocation Policy*, ORGAN PROCUREMENT AND TRANSPLANTATION NETWORK (June 25, 2013), <https://optn.transplant.hrsa.gov/news/board-approves-significant-revisions-to-deceased-donor-kidney-allocation-policy/>.

58. *How Organ Allocation Works*, *supra* note 53.

59. Zhai Yun Tin, *What Happens When a Living Kidney Donor Needs a Transplant?*, KAISER HEALTH NEWS (Sept. 1, 2016), <https://khn.org/news/what-happens-when-a-living-kidney-donor-needs-a-transplant/>.

60. ORGAN PROCUREMENT & TRANSPLANTATION NETWORK, *supra* note 54, at 137-38.

61. *Dialysis*, NAT'L KIDNEY FOUND. (last visited Oct. 1, 2020), <https://www.kidney.org/atoz/content/dialysisinfo>.

62. ORGAN PROCUREMENT & TRANSPLANTATION NETWORK, *supra* note 54.

63. See 42 U.S.C. § 1395rr(a) (explaining Medicare benefit is available for anyone diagnosed with end-stage renal disease); see generally *Medicare Coverage of Kidney Dialysis & Kidney Transplant Services*, CENTERS FOR MEDICARE & MEDICAID SERVS., (last visited Nov. 2, 2020), <https://www.medicare.gov/Pubs/pdf/10128-medicare-coverage-esrd.pdf> (explaining the Medicare coverage benefits relating to ESRD).

are nominally distributed via a results-based analysis. While these factors do not directly preference persons who are less well off, they can ameliorate the features of utilitarian analyses that tend to harm their chances. This makes kidney distribution more comparable to disaster triage as the criteria for disaster triage distribution do not take insurance or other aspects of capacity to pay into account.

*b. International Decisions on Rights to Health Care*

There have been a few decisions in the courts of countries other than the U.S. that may be salient to this discussion, though they can only carry the guidance value of foreign court cases. These cases are in the context of the provision of health care to citizens in countries where there is a constitutional right to access to health care. Despite that not being the case in the U.S., they are relevant here in a discussion of emergency triage in the U.S. because of the assumption that all persons, or at least all citizens, in the U.S. have an equal right to access to emergency services.<sup>64</sup> The case most to the point of this discussion is the South African case of *Soobramoney v Minister of Health*.<sup>65</sup>

The Constitution of the Republic of South Africa guarantees the right to have access to health care services to everyone, and holds that the state must take reasonable measures, within its available resources, to ensure this right.<sup>66</sup> The 1997 *Soobramoney v Minister of Health* case tested the meaning of this in the context of limited resources.<sup>67</sup> Mr. Soobramoney was diabetic and also had ischemic heart disease and cerebro-vascular disease.<sup>68</sup> His kidneys failed in 1996 and his condition was diagnosed as irreversible.<sup>69</sup> He sought dialysis and was refused on the grounds that the facilities of the hospital were too limited to provide dialysis to all persons in need of it.<sup>70</sup> The hospital would automatically provide dialysis to patients with reversible acute kidney failure, and triaged patients with chronic kidney failure primarily to provide dialysis to those who were eligible for a kidney transplant.<sup>71</sup> Mr. Soobramoney's terminal comorbidities meant he was not eligible for a transplant, and so did not meet the criteria for chronic kidney dialysis.<sup>72</sup> The court eventually held that no violation of Mr. Soobramoney's rights under the Constitution had occurred, and that given the circumstances of limited availability it was permissible for the

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64. See generally Social Security Act § 1867, 42 U.S.C. § 1395dd (1988).

65. *Soobramoney v Minister of Health*, 1998 (1) SA 765 (CC) (S. Afr.).

66. S. AFR. CONST., 1996, Ch. 2, § 27.

67. *Soobramoney*, (1) SA at para. 1.

68. *Id.*

69. *Id.*

70. *Id.*

71. *Id.* at para. 3.

72. *Id.* at para. 4.

hospital to deny Mr. Soobramoney and similarly situated patients access to chronic kidney dialysis.<sup>73</sup>

*Soobramoney* appears as a decision that argues for a more utilitarian response to limited resources, albeit in a different context. Implementing this reasoning in the situation of disaster triage would suggest that aiming to produce the greatest number of years of life from the limited resources available is appropriate. Given that the health care system in South Africa at the time was only a few years removed from being a tremendously unequal system, and unequal largely along racial lines, and given that Mr. Soobramoney was requesting treatment from the state because he could no longer afford private care, it is likely that the inequality in his situation is similar to or greater than the inequality between persons in the U.S. needing care in a disaster.<sup>74</sup> So, insofar as there is a similarity here, the *Soobramoney* case argues for seeking the greatest number of years of life, regardless of prior inequality. If this is a guide for practice in the U.S., perhaps that it is the advice given when a system cannot provide for all.

However, two factors should modify this conclusion. First, the decision is described as “infamous” by equality advocates<sup>75</sup> and the decision made in the case is described as “tragic” and “agonising” by Justice Sachs in a concurring opinion.<sup>76</sup> This decision may describe a response to the state of both inequality and the health care system in South Africa in the years immediately following the fall of apartheid.<sup>77</sup> The appropriate response to this decision may be to recognize that major steps need to be taken to improve the systemic inequality in the country and its health care system and, consistent with the positive requirement that the government provide needed health care, such action must be taken.

This is suggested by the second modifying factor: that cases that followed *Soobramoney* have decided differently in comparable circumstances. The *Grootboom* case in 2000 held that a Constitutional right to adequate housing was violated by removing persons from ‘informal’ housing on private property without providing them with an adequate replacement.<sup>78</sup> In 2002 the Treatment Action Campaign succeeded in arguing that the government must provide drugs to HIV-positive pregnant women to help prevent transmission during birth.<sup>79</sup>

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73. *Id.* at para. 36.

74. Khetho Lomahoza, *Monitoring the Right to Health Care in South Africa: An Analysis of the Policy Gaps*, STUDIES IN POVERTY AND INEQUALITY INSTITUTE 5 (2013), [http://spii.org.za/wp-content/uploads/2018/02/Policy-brief-2\\_Monitoring-rights\\_Healthcare.pdf](http://spii.org.za/wp-content/uploads/2018/02/Policy-brief-2_Monitoring-rights_Healthcare.pdf).

75. *Id.*

76. *Soobramoney*, (1) SA at para. 57-59 (Sach, J. concurring).

77. *Apartheid*, Encyclopedia Britannica (Feb. 5, 2020), <http://www.britannica.com/topic/apartheid>.

78. *Government of the Republic of South Africa and Others v. Grootboom and Others*, 2000 (1) SA 46 (CC) at para. 99 (S. Afr.).

79. *Minister of Health v. Treatment Action Campaign*, 2002 (5) SA 721 (CC) at para. 136 (S. Afr.).

Both the right to adequate housing and the right to access to medical care are a part of the comprehensive Bill of Rights that comprises the second chapter of the Constitution, and both are a part of the overall mandate of the Constitution to protect human rights.<sup>80</sup> Based on these cases that followed *Soobramoney* it may be right to see *Soobramoney* as more of a call to action than a decision to serve as primary guidance.

*c. The Minnesota Pandemic Ethics Project*

In 2010, The Minnesota Pandemic Ethics Project produced two reports providing guidance for the development of a plan to both prepare for a pandemic and to guide resource distribution in the case that the need in a pandemic overwhelmed supply.<sup>81</sup> Their reports explicitly refers to the challenge of just distribution in the case of needing to ration resources, making public engagement in the process of devising the distribution plan, and issues of social justice specific points of importance in the plan.<sup>82</sup> As such, a close analysis of the results may show results applicable not only to Minnesota, but to other states or the U.S. as a whole as well.

The reports are a promising effort to produce public policy with an aim of bringing justice in distribution for the needs of those least well-off before a pandemic hits.<sup>83</sup> Fairness in distribution is a primary goal.<sup>84</sup> A policy designed according to these guidelines would promote three goals: (1) protecting the population's health, by reducing mortality and serious morbidity from disease and from damage to the public order; (2) protecting the public safety and civil order; and (3) striving for fairness and protecting against systematic unfairness.<sup>85</sup> The last point is to be accomplished by:

Reducing significant group differences in mortality and serious morbidity; Making reasonable efforts to remove barriers to access; Making reasonable efforts to reciprocate to groups accepting high risk in the service of others; Rejecting strategies that are discriminatory or exacerbate health disparities; and Using fair random processes for those similarly prioritized.<sup>86</sup>

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80. SOUTH AFRICAN HUMAN RIGHTS COMMISSION. ANNUAL REPORT FOR THE YEAR ENDING 31 MARCH 2019, 7, 13-14 (2019).

81. DEBRA A. DEBRUIN ET AL., IMPLEMENTING ETHICAL FRAMEWORKS FOR RATIONING SCARCE HEALTH RESOURCES IN MINNESOTA DURING SEVERE INFLUENZA PANDEMIC 6 (2010); DOROTHY E. VAWTER ET AL., FOR THE GOOD OF US ALL: ETHICALLY RATIONING HEALTH RESOURCES IN MINNESOTA IN A SEVERE INFLUENZA PANDEMIC (2010).

82. VAWTER et al., *supra* note 81; *see also* DEBRUIN et al., *supra* note 81, at 29, 30, 34.

83. DEBRUIN et al., *supra* note 81, at 34; *see also* VAWTER et al., *supra* note 81, at 17.

84. DEBRUIN et al., *supra* note 81, at 113; *see also* VAWTER et al., *supra* note 81, at 17.

85. VAWTER et al., *supra* note 81, at 18; *see also* DEBRUIN et al., *supra* note 81, at 63.

86. VAWTER et al., *supra* note 81, at 18.

As such, a policy designed on this structure would have at least the idea of targeted universalism and fairness built in.

However, what specific policies these three goals lead to will depend upon the relative weight given to each priority. As a simple example, in regard to the first goal, any distribution of life-saving resources that gets scarce resources to at least some members of the population that need them, no matter to whom, will reduce some mortality and serious morbidity. Therefore, if a policy were to focus on the latter two concerns, protecting public safety or striving for fairness, it could still meet the criterion of the first by producing some reduction in mortality and serious morbidity, even if a different distribution might produce a greater decrease. If, on the other hand, one were to seek to maximize the first goal of the reduction of mortality and serious morbidity, a different type of distribution would be necessary. The second of the two reports from the Minnesota Pandemic Ethics Project [hereafter, “For the Good of Us All”] recommends three clearly valuable aims for a pandemic response policy; the details of the policy will differ, perhaps dramatically, depending upon the value placed on each of the three goals.<sup>87</sup> For the Good of Us All indicates, however, that there is an obligation to use “fair random processes for those similarly prioritized,”<sup>88</sup> which is an excellent way to seek to make matters more fair for all involved. Yet, if prioritization places those more likely to survive if given the resource above those less likely to survive, this equalization technique will not reduce or remove the underlying problem of the least well-off being additionally burdened in a pandemic.

Initially, For the Good of Us All appears to support prioritizing the fairness of the distribution of treatments. It strongly recommends community engagement with the decision-making process as crucial to good disaster planning, so that communities who are least well off can have input into the plan that is developed.<sup>89</sup> It also recommends the easy and obvious exceptions to the principles of distribution such as deprioritizing persons who cannot benefit from the resource, persons who are going to die soon from a different comorbidity regardless, and persons who are already assumed to be immune due to prior vaccination or recovery from the illness – which would free up resources for those who are not in these categories.<sup>90</sup> Some specifics in For the Good of Us All also aim at protecting persons at heightened risk rather than those likely to produce best results.<sup>91</sup> For example, it recommends prioritizing pregnant women for antivirals as being at disproportionately high risk of

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87. VAWTER, *supra* note 81, at 18.

88. VAWTER, *supra* note 81, at 18.

89. VAWTER, *supra* note 81, at 18.

90. VAWTER, *supra* note 81, at 20, 29, 38.

91. VAWTER, *supra* note 81, at 10.

mortality, whether or not that would produce the greatest returns.<sup>92</sup> Of course, this policy would likely be met with general public approval, but For the Good of Us All also argues that other groups who face higher morbidity and mortality can be treated in this fashion: “For example, it may become evident during a pandemic that a particular demographic group or group with compounded social vulnerabilities may prove to be at exceptionally high risk of death.”<sup>93</sup> For the Good of Us All recommends prioritizing “those groups of the general public who are at the greatest risk of flu-related mortality or serious morbidity,”<sup>94</sup> which would provide resources to the worst off first. This is done with regard to influenza vaccinations in normal (non-pandemic) times of scarcity when, for example, the very old and very young are prioritized.<sup>95</sup> Because death rates from normal influenza are a U-shaped curve with the very young and the very old being at highest risk of death, this is consistent with a distribution that minimizes overall morbidity and mortality.<sup>96</sup> In other circumstances where that is not the case, as with distribution of mechanical ventilator support for extreme cases, the Report makes recommendations less obviously targeted at the least well-off.<sup>97</sup>

For ventilators, For the Good of Us All seems to prefer a more utilitarian approach: “This recommended ethical framework emphasizes clinical criteria. The clinical considerations help identify those most likely to benefit from access to a ventilator and reflect the panel’s commitment to reduce mortality and serious morbidity effectively and efficiently.”<sup>98</sup> This is motivated in part by the nature of the circumstance which necessitates a ventilator:

Ventilators are particularly time-critical resources. When someone develops breathing problems a decision needs to be made in short order whether a ventilator is available and who should receive it. There will be times that ventilators are extremely scarce and several people with similar likelihood of benefit will compete for access. Ventilators are given to people who are seriously ill from any number of causes. Therefore rationing decisions are less about which groups should receive ventilators before others and more narrowly focused on comparing the clinical likelihood of benefit of specific individual patients in a particular critical care unit.<sup>99</sup>

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92. VAWTER, *supra* note 81, at 28.

93. VAWTER, *supra* note 82, at 33.

94. VAWTER, *supra* note 81, at 19.

95. See CTRS FOR DISEASE CONTROL & PREVENTION, *supra* note 10 (explaining prioritization of infants and toddlers in the case of influenza vaccine scarcity).

96. *Influenza (Flu): People at High Risk for Flu Complications*, CENTERS FOR DISEASE CONTROL AND PREVENTION (Aug. 27, 2018), <https://www.cdc.gov/flu/highrisk/index.htm>.

97. See VAWTER, *supra* note 81.

98. VAWTER, *supra* note 81, at 55.

99. VAWTER, *supra* note 81, at 55 (emphasis omitted).

Specifically, they recommend prioritizing “patients who have a significantly greater likelihood of survival according to a standardized, evidence-based, clinical tool recommended by MDH.... [and] patients not likely to require more than short-term reasonable levels of critical care resources.”<sup>100</sup>

The Minnesota Pandemic Ethics Project is a tremendous step forward in development of disaster triage policies that can alleviate rather than exacerbate the underlying problems of injustice in distribution of universally valuable goods. Though the Project’s conclusions do not uniformly design policies that avoid increasing harm to the least-well-off in a disaster, it takes the problem extremely seriously and is an excellent guide for any future policy designs. It is vague, perhaps necessarily so, on how exactly to balance its three competing goals, but it has made good progress and allows for more.

### III. RECOMMENDATIONS FOR DISASTER TRIAGE

If we intend to justly distribute limited resources in the case of a disaster, then we must pay attention to making prior inequities less damning. Unfortunately, something like the ‘time on the list’ criterion used with kidney donors is not possible in a disaster. Devices like ‘first-come first served’ will also tend to harm rather than help the less well off, as expense, travel, childcare, time off work, and the like all benefit more well-off candidates for self-selecting treatment. Further, those who avoid getting care until it cannot be avoided will of course be in worse condition when they arrive. I can think of two types of options possible; one is clearly preferable but may not be feasible; the other is definitely possible but will not specifically benefit the least well off.

The first is to find a mechanism that will identify the least well off and grant them preference in treatment, at least to the point where their chance of obtaining care is not explicitly harmed by their poorer condition caused by inequality in society. The goal would be to make people’s chances of obtaining scarce resources equivalent to what they would have been if people did not have poorer health due to social inequality. Once those inequalities were effectively removed from the way people were treated by distribution methods, then a distribution that maximized benefit would be fairer. However, it is unclear what such an inequality rectifying mechanism might be. The Minnesota Pandemic Ethics Project may provide a starting point for seeking for such mechanisms, although it cannot fully provide such a tool at this point.

The second, less preferable option, would have to be some sort of randomization method that would grant all persons in reasonable need of scarce resources an equal chance at those resources. Though this random distribution would not allow for targeted distributions to maximize lives saved, it is the only

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100. VAWTER, *supra* note 81, at 53.

way, barring some discovery of a mechanism like that discussed above, not to make those unfairly made less-well-off by a system in which unearned social determinants of health determine one's health conditions also unjustly disadvantaged by scarce resource distribution. Drawing straws may not produce the maximized outcome in terms of years of life saved, but it is more just.