Our Next Pandemic Ethics Challenge?
Allocating "Normal" Health Care Services

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Much discussion and public controversy about pandemic ethics has focused on triage strategies for ventilators and intensive care unit beds.[1] Attention now must turn to the ethical challenges of transitioning from "crisis" back to "normal" care.[2] Health systems have canceled patient care visits, postponed elective procedures, restructured clinics, reassigned staff members, and reallocated resources; and hospitals and clinics must decide whether, when, and how to undo these changes. Here, too, clinicians and administrators must determine whose care should be prioritized and whose must wait (perhaps weeks or months).

Dire shortages of health care resources demand hard choices about rationing. In crises, such choices are stark and visible. The sudden and dramatic shift in circumstances triggers a corresponding shift to crisis standards of care rooted in a scarcity-minded utilitarian value system. Since the need for rationing is obvious and unavoidable, such decisions are more explicit and deliberative than allocation decisions in times of plenty. In a crisis, clinicians opt to maximize short-term survival and save as many lives as possible. Likely survivors are then ranked using substantive criteria.[3] There is debate about which criteria should be used, but no debate about the need for choices.

By contrast, resource-allocation decisions are not explicit under normal conditions. Here, rationing undeniably occurs but in ways that are obscured, haphazard, and embedded within layers of bureaucratic control and structure. The default rationing scheme for normal American health care is first-come, first-served among those able to pay and navigate the system. Meanwhile, treatments are designed and delivered according to the administrative needs and interests of health care institutions. Thus, hospitals reduce staff and services on evenings, weekends, and holidays and prioritize hospital-based care over telemedicine and in-community care. These allocation decisions do not serve the interests of patients. Such patterns must change.

In the looming transition period following peak crisis, the backlog of clinical appointments and elective procedures will be immense. Demand for services will outstrip availability. At the same time, the system's normal problems will have intensified. Many patients will need more time with their doctors to catch up, while others will have lost their employer-based health care. Health care institutions will face these challenges with reduced operating budgets and workforces as a result of the prior limitation and restructuring of services.

The surge in demand will need to be managed as these same institutions are navigating the constantly changing landscape of testing and treatment options for patients with Covid-19. They must scrupulously reduce risks to the general population and to health care workers from additional outbreaks of SARS-CoV-2, and the risk of triggering new outbreaks will make it impossible to immediately reopen all clinics and services to what had been typical full operation. Capacity must be built back up safely and sustainably in ways that truly serve the greatest needs and interests of patients and communities.

Throughout this transition period, leaders will face the unenviable challenge of prioritizing among the competing needs and interests of millions of patients, clinicians, and staff members, as well as the fiscal health of their own institutions. Their decisions about who gets access when and how will benefit some but harm others. In that way, the decisions are analogous, on a macro scale, to microlevel triage decisions.

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Many problems that Covid-19 has brought into stark relief—limited access to health care, unjust impacts in marginalized communities, financial devastation in the face of illness—are anything but new.

As hospitals begin to welcome all patients back, they must retain the more deliberative, explicit, and transparent approach to allocation that they have used for developing crisis standards of care. After all, we are not really transitioning from crisis to normal care so much as from an intense, rapidly evolving crisis to a low-level, ongoing crisis with no foreseeable end point. Moreover, the only truly novel feature of this low-level crisis is the presence of Covid-19. Americans have endured an ongoing, low-level health care crisis for decades. Many problems that Covid-19 has brought into stark relief—limited access to health care, unjust impacts in marginalized communities, financial devastation in the face of illness—are anything but new.

The unprecedented challenge presented by the pandemic provides an unprecedented opportunity to rethink the institutional inertia and fundamental limiting assumptions of normal care that have long obscured and deflected ongoing problems in health care. Hospitals should seize this opportunity to build on the best of what works and experiment with new structures, modalities, services, and staffing models to better meet the needs of all stakeholders. The ethical values that underlie crisis standards of care have worked well in the pandemic crisis. They can—and should—guide decision-making during the low-level, ongoing crisis that will be part of the transition period ahead and, finally, spur an ethical response to the decades-long crisis as well.

The foundational ethical principle of crisis standards of care is fairness: a transparent decision-making process must prioritize allocation standards that are "recognized as fair" by all stakeholders.[4] The resulting allocation scheme is based on medical need, not on extraneous demographic and social factors. The ethical framework for crisis standards of care requires that the ethical norms of a duty to care and a duty to steward resources be balanced against one another, with conflicts resolved through fair and transparent processes.

Taking these ethical demands seriously requires important tangible shifts in our health care delivery system. Here are four changes we think should be made. First, fairness requires that institutions adopt a "safety-net" mentality, providing access and treatment to all regardless of ability to pay. Reimbursement mechanisms must respond to need rather than to wealth or insurance status. Hospitals should respond to financial shortfalls in solidarity by advocating for more resources, not by cutting services.

Second, the duty to steward resources demands continued expansion of telemedicine. This will preserve hospital resources to manage Covid-19 and the surge of demand for postponed services. Hospitals must ensure that further shifts to telemedicine do not disadvantage vulnerable populations, and they should prioritize face-to-face resources for patients who lack technological resources.

Third, the duty to steward resources and the duty to care both require investing more in community-based care, which increases access yet at lower cost. When hospital-based care is required, hospitals should proactively minimize logistical burdens for patients.

Fourth, the duty to care requires that hospitals and clinics be open and fully staffed on nights and weekends. Hospitals cannot pretend that care restricted to "normal business hours" will meet the vital needs of many patients. They must improve access for those with challenging work, travel, or personal limitations while protecting patients from the predictable harms of understaffing.

Justice is the ethical foundation of crisis standards of care. In the wake of this first wave of Covid-19, the key lesson Americans must appreciate is that justice must be the ethical foundation of *all* standards of care. Health care systems are always allocating resources. Ours has done so unfairly for a long time. We now have the power and opportunity to define and pursue a "new normal." We should do so guided by justice and the collective values and priorities that, as a nation, we have relied upon to respond to the largest public health emergency in our lifetimes.

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