

**LETTER TO THE EDITOR****Transplant programs during COVID-19: Unintended consequences for health inequality**

To the Editor:

Transplant programs are being scaled back as healthcare systems worldwide respond to COVID-19. Most centers are now taking only superurgent and urgent cases, if at all. Management of donor organs is also affected. Contingency protocols may prioritize distance over equitable sharing principles. Live and deceased donation is either being selectively paused or operating under stringent criteria based on local capacity. This will inevitably lead to variable patient experience.

Healthcare rationing is understandably being driven by concerns of limited workforce, patient safety (intensive care unit capacity, ability to segregate critical care), and paucity of data on the disease in transplant recipients. Although pragmatic, the disproportionate resource allocation to COVID-19 will have unintended consequences for those already carrying the burden of health inequality. While these effects may be unavoidable, decision makers need to be cognizant of disparity and actively try to mitigate impact. We are particularly concerned about patients from areas of high social deprivation and of minority ethnic status.

Strategies that geographically localize donor and recipient pairing are sensible when trying to reduce risk of infection. However, rates of donation are higher in areas of low social deprivation.<sup>1</sup> In countries such as the United Kingdom and the United States, social deprivation is linked to minority ethnic status.<sup>2</sup> Because minority ethnic patients already wait longer for a donor organ,<sup>3</sup> we are exaggerating issues of poor access to life-saving treatment. For transplanted patients, the same factors are associated with higher risk of infection, graft failure, and mortality.<sup>4</sup> Data also suggest that the pandemic is not a “leveler.” Due to systemic issues in society, adults from low-income households and of minority ethnic status are less able to socially distance and self-isolate<sup>5</sup> and have higher rates of transmission and mortality. The net result is that those already disadvantaged in the transplant cycle, whether or not they receive an organ during this time, remain at risk of the worst health outcomes.

Three actions are suggested. First, patient education is essential and must be culturally tailored to ensure that safety messages are transparent to all. Information repositories will be effective here to rapidly share resources, particularly for migrant and immigrant populations. Second, integration with voluntary workforce can bolster

capacity for practical aid that meaningfully promotes self-management (ie, self-isolation, adherence with medication). Third, we must continue to creatively upscale services so that patients can access essential advice and care when they need it. Well-coordinated emergency and community workforce initiatives could conserve resilience in transplant teams.

This is an unprecedented time. We need to remember that risk, access and outcomes are not equal outside of or within a pandemic. Difficult decisions are being made, with potential to further disadvantage marginalized patients. The transplant community and transplant societies must come together to share knowledge, experience, and resources in an attempt to avoid the widening of stubborn health inequalities. They exist at every stage of the transplant process. At a time when everyone is “looking” for COVID-19, we need to look for solutions that safeguard outcomes, with diversity and equity central to our efforts.

**KEYWORDS**

allied health/nursing, ethics and public policy, patient characteristics, patient safety, quality of care/care delivery, social sciences

**DISCLOSURE**

The authors of this manuscript have no conflicts of interest to disclose as described by the *American Journal of Transplantation*.

**DATA AVAILABILITY STATEMENT**

Data sharing is not applicable to this article as no new data were created or analyzed in this study.

Shivani Sharma<sup>1</sup>   
Christopher Lawrence<sup>2</sup>   
Francesco Giovino<sup>3</sup>

<sup>1</sup>*School of Life and Medical Sciences, University of Hertfordshire, Hatfield, UK*

<sup>2</sup>*Spire Healthcare, London, UK*

<sup>3</sup>*Fondazione Policlinico Universitario Agostino Gemelli IRCCS, Rome, Italy*

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**Correspondence**

Shivani Sharma

Email: s.3.sharma@herts.ac.uk

**ORCID**Shivani Sharma  <https://orcid.org/0000-0002-7682-2858>Christopher Lawrence  <https://orcid.org/0000-0002-8159-0879>Francesco Giovinazzo  <https://orcid.org/0000-0002-3392-9292>**REFERENCES**

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