

How should health resource allocation be applied during the COVID-19 pandemic in South Africa?

To the Editor: The rapid spread of COVID-19 infection has overwhelmed the best-resourced healthcare systems. How then should South Africa (SA), with its limited healthcare resources, manage the COVID pandemic without denying care to deserving non-COVID patients?

The focus of SA politicians and healthcare planners has been to 'save lives' by redirecting material and human resources to prevent and treat COVID. Both private and public hospitals have stopped elective imaging, procedures and surgery. Patients who could be discharged were, and wards were cleared to cope with the predicted surge in COVID-infected patients. Clinical specialists from all areas of practice have been called to the frontline to assist with screening of patients. In Europe and the USA, where most COVID patients have received treatment irrespective of age and comorbidities, hospitals have run out of ventilators and ICU personnel, despite being far better resourced than SA. If we experience the same overwhelming burden of patients requiring hospitalisation, we will not have enough tests, beds, ventilators or health professionals to cope.

Six weeks after lockdown was imposed, the numbers of COVID infections and COVID-related hospital admissions and deaths are rising in a predicted, exponential fashion. Before our hospitals become overwhelmed with COVID patients, it is opportune to take a step back and evaluate whether we are using our healthcare resources appropriately.

The authors have witnessed how the intense focus on COVID has created a backlog of patients with non-COVID diseases who are not able to access care. Many cancer diagnoses and hence treatments have been delayed, as have joint replacements and cataract surgery. Patients with diabetes, asthma and other chronic illnesses have missed appointments. Many are unable to access medications.

SA health professionals are familiar with prioritising care within severe resource restraints. We cannot offer dialysis to everyone with kidney failure,^[1] cannot admit all our head injury patients to intensive care,^[2] and cannot prescribe expensive drugs to every deserving patient. For healthcare managers, the redistribution of tasks among health workforce teams is also nothing new, with SA having implemented task-shifting strategies to rapidly expand HIV management programmes.

Whereas the COVID pandemic necessitates the implementation of unusual measures as a result of the highly infectious nature of SARS-CoV-2 (the initial lockdown was called for to plan for these), we must

now ensure that the care of non-COVID patients is not compromised as a result of the undue prioritisation of COVID patients. As for other diseases, principles of healthcare rationing must apply, with COVID patients competing for the same limited resources as non-COVID patients. For example, with the average ventilation and ICU time of COVID patients exceeding that of many non-COVID patients with potentially better outcomes, the latter should not be denied care at the expense of the former. For us not to neglect deserving patients with highly treatable conditions, hospitals may have to ring-fence wards, ICUs, theatres and human resources, as well as imaging and pathology services, to take care of non-COVID diseases during the COVID pandemic.

In conclusion, we need to avoid all our hospitals and doctors becoming 'COVID hospitals' and 'COVID doctors' to the exclusion of appropriately managing other diseases, perhaps with better prognoses. This requires careful and considered allocation of scarce resources by priority setting across disciplines, regardless of COVID status. It also requires quick upscaling of human resources and facility capacity, and process optimisation that can assist with the performance of more basic and routine tasks in an efficient and cost-effective manner.

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