A fair allocation approach to the ethics of scarce resources in the context of a pandemic: The need to prioritize the worst-off in the Philippines

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Abstract
Using a fair allocation approach, this paper identifies and examines important concerns arising from the Philippines' COVID-19 response while focusing on difficulties encountered by various sectors in gaining fair access to needed societal resources. The effectiveness of different response measures is anchored on addressing inequities that have permeated Philippine society for a long time. Since most measures that are in place as part of the COVID-19 response are meant to be temporary, these are unable to resolve the inequities that have led to the magnitude of morbidity and mortality associated with the pandemic. These cannot improve the country's readiness to deal with pandemics and other emergencies in the future.

Transition to a new normal recognizes the possibility that other infectious diseases could come and endanger our health security. Our pandemic experiences are proving that having an egalitarian society will serve the interests not only of disadvantaged sectors but also of everybody else, including the privileged. Response measures should thus take the opportunity to promote equity by giving importance to the concerns of the underprivileged and vulnerable while giving preference to initiatives that can be sustained beyond the period of the current pandemic.

Keywords
bioethics, COVID-19, fair allocation, ethics, equity, scarce resources, new normal

1 | INTRODUCTION

The COVID-19 pandemic has caught a lot of people, governments and health agencies by surprise. Health authorities throughout the world have been aware for some time that contagious viruses could strike anytime and had prepared contingency measures before SARS-CoV-2 manifested its effects. But even the best prepared authorities have been stunned by the speed and ease with which the infections have been transmitted among individuals and across national boundaries.

In the Philippines, the consequences have been severe not only for vulnerable sectors but also for an entire population that previously had confidence in its ability to deal with pandemics and disasters. Located in Southeast Asia, the Philippines is an archipelago made up of more than 7,100 islands. The estimated population for the middle of 2020 is 110 million, which is expected to continue to increase slightly. Notwithstanding a downward trend in population growth and fertility rate, the country is still one of the most densely populated in Southeast Asia and even in the entire Asia-Pacific region. The downward trend in growth rate is attributed to an aging population, the diminishing birth rate and poor health care. The Philippines has a high tuberculosis prevalence and it is among the countries with a high probability of death from noncommunicable diseases. It has an average Human Development Index rating.1

1. Pletcher, H. (2020, May 21). Total Population of the Philippines 2024. Statista. Retrieved August 24, 2020, from https://www.statista.com/statistics/578726/total-population-of-philippines/
How dire is the situation in this country compared to the rest of the world? As of August 14, 2020, the Philippines was 22nd in the list of countries with the highest number of COVID-19 cases throughout the world and it had the highest number of cases among members of the Association of Southeast Asian Nations, even though its population is less than half that of second placed Indonesia. The Philippines also had the highest number of COVID-19 cases per million in the region, and the 14th highest number of active cases as well as the 32nd highest total number of deaths in the world. Additionally, the country had the highest number of deaths per million population among Southeast Asian countries as of August 14, 2020. In light of these statistics, it is quite frustrating that the Philippines could only manage to be ranked a lowly 128th in the number of tests done per million population. Perhaps this is partly due to the economic reality that the country’s Gross Domestic Product at Purchasing Power Parity (PPP) per capita in 2017 was only $8,361 – rated 115th worldwide and only 6th among Southeast Asian countries. The rankings using the above COVID-19 parameters have deteriorated even after the country was placed under the longest quarantine period in the world. The prolonged lockdown is understood to be the reason why Filipinos are experiencing a “recession for the first time since the 1997-98 Asian financial crisis”. Before the pandemic started to show its effects in the country in January 2020, the unemployment rate was recorded at 5.3 percent. It quickly rose to 17.7 percent in April 2020, meaning that there were 7.3 million Filipinos in the labor force who were out of a job – a record high for the country.

The impact of COVID-19 has been of such magnitude that social, cultural, economic, educational, political, and health institutions have been shaken. The steps taken to address this impact have forced the government to acquire loans since March this year amounting to US$ 6.8 billion, a figure that has worried economists and only 6th among Southeast Asian countries. The rankings using the above COVID-19 parameters have deteriorated even after the country was placed under the longest quarantine period in the world. The prolonged lockdown is understood to be the reason why Filipinos are experiencing a “recession for the first time since the 1997-98 Asian financial crisis”. Before the pandemic started to show its effects in the country in January 2020, the unemployment rate was recorded at 5.3 percent. It quickly rose to 17.7 percent in April 2020, meaning that there were 7.3 million Filipinos in the labor force who were out of a job – a record high for the country.

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This paper uses a fair allocation approach to identify and analyze ethical concerns arising in the context of the COVID-19 pandemic. Fair allocation is taken to refer to “arrangements that allow equal geographic, economic and cultural access to available services for all in equal need of care.” The arrangements can be systemic or politically driven; they can be the product of neglect or indifference. The approach shares the view that “all systematic differences in health between different socioeconomic groups within a country can be considered unfair and, therefore, classed as health inequities, [and these] . . . are directly or indirectly generated by social, economic and environmental factors and structurally influenced lifestyles.” While highlighting the existing access or lack of access in the context of very closely intertwined social and health indicators, this paper uses equity and equality interchangeably: “in the public health community the phrase social inequities in health carries the same connotation of health differences that are unfair and unjust.”

Hence, the paper’s fair allocation approach examines the COVID-19 related events and response measures on the basis of the principle that the pandemic experiences cannot be seen in isolation as strictly health phenomena: “Health equity cannot be concerned only with health, seen in isolation. Rather it must come to grips with the larger issue of fairness and justice in social arrangements, including economic allocations . . . Indeed, health equity as a consideration has an enormously wide reach and relevance.” This approach considers the impact of how health-related resources have been allocated or distributed and looks at the issues over a period that precedes the onset of the COVID-19 emergency and extends beyond the expected end of the current pandemic. What this avoids is a narrower view that looks at the COVID-19 emergency as a disease-focused phenomenon that started with the transmission of the virus to humans and will end when a medical solution is discovered in the form of a cure for the disease or the control of transmission. It is very important for a proper approach to “take into account how resource allocation and social arrangements link health with other features of states of affairs.”

The paper identifies important concerns as they arise in different areas, focusing mainly on the difficulties encountered by various sectors in accessing societal resources like education, housing,

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1. Efflein, J. (2020, August 14). COVID-19 Cases Worldwide as of August 14, 2020, by Country. Statista. Retrieved August 15, 2020, from https://www.statista.com/statistics/1043366/novel-coronavirus-2019-ncov-cases-worldwide-by-country/

2. Anonymous. (2020, August 17). Reported Cases and Deaths by Country, Territory, or Conveyance. Worldometer. Retrieved August 17, 2020, from https://www.worldometer.info/coronavirus/?utm_campaign=homeAdvegas1

3. De Best, R. (2020, August 5). COVID-19 Deaths Worldwide per One Million Population as of August 14, 2020, by Country. Statista. Retrieved August 15, 2020, from https://www.statista.com/statistics/1104709/coronavirus-deaths-worldwide-per-million-inhabitants/  

4. Anonymous. (2020, August 5). COVID-19 Deaths Worldwide per One Million Population as of August 14, 2020, by Country. Statista. Retrieved August 15, 2020, from https://www.statista.com/statistics/1104709/coronavirus-deaths-worldwide-per-million-inhabitants/  

5. Ibid.

6. Anonymous. (2020). Gross Domestic Product. Worldometer. Retrieved August 17, 2020, from https://www.worldometer.info/gdp/gdp-per-capita/

7. Castaneda, J. (2020, May 15). Why Duterte Won’t Lift World’s Longest Lockdown. Asia Times. Retrieved June 29, 2020, from https://asiatimes.com/2020/05/why-duerte-wont-lift-worlds-longest-lockdown/

8. Philippine Statistics Authority. (2020, August 7). Employment Situation in January 2020. Retrieved August 22, 2020, from https://psa.gov.ph/content/employment-situation-january-2020-0

9. Philippine Statistics Authority. (2020, June 5). Employment Situation in April 2020. Retrieved August 22, 2020, from https://psa.gov.ph/content/employment-situation-april-2020

10. Punongbayan, J.C. (2020, June 19). Last updated 2020, June 19. [Analysis] Duterte’s New COVID-19 Loans: Need we Worry? Retrieved June 29, 2020, from https://www.rappler.com/thought-leaders/264239-analysis-duerte-coronavirus-loans-need-we-worry

11. Whitehead, M., & Dahlgren, G. (2006). Concepts and Principles for Tackling Social Inequities in Health: Levelling up Part 1. Copenhagen: WHO Regional Office for Europe, 2006.

12. Ibid.

13. Ibid.

14. Sen, A. (2004). Why Health Equity? In S. Anand, F. Peter, & A. Sen (Eds.), Public Health, Ethics, and Equity, New York: Oxford University Press, pp. 21–34.

15. Ibid.
employment and fair wage, and economic aid. The difficulties often lie in terms of geographic, economic and cultural access. The resources referred to are not readily recognized by non-medical people as having a huge impact on health although they have long been accepted as social determinants of vulnerability to diseases. It is perhaps for this reason that the lack – or unfair allocation – of pertinent resources has been insufficiently addressed or pushed down the priority order in government decision-making. This paper examines an extensive inventory of reported experiences and explores their consequences and ethical implications as they arise from the inequities. It also investigates the interconnected and overlapping health, educational, and cultural fronts in the development of the pandemic and the impact that these have on existing social and economic inequities. By examining the way that pertinent resources are accessible to different stakeholders, a fair allocation approach highlights how closely the experiences of various socio-economic and political sectors are bound inextricably together. This is very useful because of the nature and character of the pandemic that we are going through. In the context of the COVID-19 pandemic we are forced to accept that the kind of life that each sector of the country’s population experiences is a function of the kind of life that every other sector is experiencing. During better times, we manage to live as if we have separate lives whose mutual and interdependent connections we can downplay or entirely overlook. This happens because the inter-connection is not easily perceived even when it is comprehensively present. Perhaps it is partly because we have been conditioned to accept the inequities as an inescapable part of reality in a resource-challenged country.

The pandemic has put the interconnectivity among various sectors under the spotlight through the impact of SARS-CoV-2. By infecting more than 23 million people of various demographics throughout the world, the virus has manifested its ability to penetrate barriers regardless of nationality, age, ethnic origin, or socio-economic circumstances. There is an undisputed real risk of acquiring infection regardless of who we are and what demographic category we belong to. Given the ease of transmission of the virus across the global population, no one can be left un-affected by the pandemic’s consequences. Even statistical outliers such as billionaires who can pass the time away in secluded vaca-tions have to be dependent on other people who maintain their yachts, produce and prepare their food, look after their psychosocial and medical needs, and provide such other services as they might require during their prolonged period of seclusion. The ability of these people to provide services can easily be affected by the pandemic. This paper proceeds by identifying specific inequities in the Philippines and beyond, exploring how these are being experienced in the context of the pandemic, and examining how problems are being addressed through specific measures in the evolving COVID-19 response. Each section focuses on an area of inequity and discusses the implications of measures being implemented not only for the short term but also for the post-pandemic period. The paper goes on to anticipate the ethical requirements for the post-pandemic new normal and to make broad recommendations for an ethical framework that ought to govern our transition to the new normal.

2 SCARCE RESOURCES IN THE CONTEXT OF A PANDEMIC

Ethical discussions regarding the allocation of scarce resources in emergency situations often refer to the distribution of ICU beds and critical care devices or drugs. In the context of the COVID-19 pandemic the fair allocation of ventilators has been in sharp focus. The discussions of triage criteria have been very important as health authorities scampers to deal with situations where demand could easily outstrip supply. Healthcare authorities want to be satisfied that their allocation of critical care resources meets the requirements of fairness and cost efficiency. At the bedside, physicians have to cope with the emotional burden associated with selecting whom to prioritize among human beings needing life-sustaining treatment. Physicians seek comfort in assurances that any decisions they make are consistent with guidance provided by peers and with societal values.

Faced with the scarcity of bedside resources, one has to remember that ethical issues regarding the allocation of scarce resources do not begin within hospital premises or in relation to the availability of medicines, devices, or hospital equipment. For example, in a country like the Philippines, there are many people who reside in places with under-equipped government hospitals that are often the last resort for needy patients requiring huge subsidized costs. On the other hand, there are private hospitals that are able to provide the best available facilities but have to charge full costs in order to sustain operations. The 2017 National Demographic and Health Survey of the Philippine Statistics Authority of 27,496 households showed that during the 30 days prior to the survey, 59% of the individuals who sought care first went to a public healthcare facility and 40% first consulted a private healthcare provider or facility; among those who were confined to a clinic or hospital in the 12 months prior to the survey, 55% were in a public facility.

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16Whitehead, & Dahlgren, op. cit. note 11.
17Wilkinson, R., & Marmot, M. (Eds.). (2003). Social Determinants of Health: the Solid Facts 2nd Ed. Copenhagen: WHO Regional Office for Europe. Retrieved August 15, 2020, from https://apps.who.int/iris/handle/10665/108082
18Cabral, E.I. (2016, April-June). The Philippine Health Agenda for 2016 to 2022. Philippine Journal of Internal Medicine. 5(2). Retrieved August 15, 2020, from https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=7&ved=2ahUKEwip6 N9vqFYAhUEyV0Kg-DHRQFjAbgQICChAE&url=https%3A%2F%2Fwww.pcp.org.ph%2Ffiles%2FPhil%2520Vo%2520Vo%2520In%2520The%2520Philippines%2520Health%2520Agenda%25202016_to%25202022.pdf&usg=AOvVaw2kRZMvXrsYxipAjRlzzcYS
19Anonymous. (2020, August 23). Reported Cases and Deaths by Country, Territory, or Conveyance. Worldometer. Retrieved August 23, 2020, from https://www.worldometers.info/coronavirus/
20Philippine Statistics Authority, & ICF. (2018). Philippines National Demographic and Health Survey 2017. Quezon City, Philippines, and Rockville, Maryland, USA: PSA and ICF. Retrieved July 27, 2020, from https://psa.gov.ph/sites/default/files/PHILIPPINE%20NATIONAL%20DEMOGRAPHIC%20AND%20HEALTH%20SURVEY%202017_new.pdf
This disparity in the provision of healthcare services violates the principle of equal access. This is one of the issues that the country’s Universal Health Care Law was intended to address. Signed by President Rodrigo Duterte on February 20, 2019,21 the law’s implementing rules and regulations were issued on October 20, 2019. However, on June 16, 2020, the Philippine Health Insurance Corporation (PhilHealth) suggested a delay in the law’s full implementation due to quarantine-related economic losses.22 While the system of universal healthcare is still being phased in, the dispensing of appropriate healthcare is inequitably distributed among various socio-economic sectors. Apart from purchasing power or the ability to pay for health-related needs, other factors affect access to much-needed health services including health literacy or the capacity to acquire and process pertinent information about one’s health condition and prognosis, and awareness of existing options and concomitant treatment costs. These are things that are not fairly distributed across individuals or demographic categories so that there are individuals or groups in the country who do not have the same capabilities as those who are socially or economically fortunate. The relevant factors have an impact not only on access to COVID-19 critical care facilities but also on a more general access to prevention and basic treatment.

If we begin to give thought to considerations of ethics and fairness only when we encounter shortages in the filling of prescriptions or the use of hospital facilities then we are likely to be acting merely to limit, or to make up for harm already inflicted on people because of their unmet healthcare needs. Our effort to respond justly to people’s emergency health care needs may be too late already at that point. But, using timely preventive measures, or simply well-directed dissemination of information, health problems that send people to emergency rooms can be avoided in the first place. These can even be addressed much earlier by attending to social determinants of health. There is nothing new about this observation, but the reiteration is timely because the emergency we are facing makes it easier to focus on basic principles of public healthcare. The effort to promote healthcare fairness, guided by the principle of prioritization of the worst off, has to be planned across various stages leading up to emergencies. Steps taken to promote fairness at the time of an emergency can easily be a merely remedial measure that ought to have been preempted by proper allocation initiatives way before the existence of an emergency. This paper discusses the fairness of allocation measures in relation to the dispensing of adequate information, the provision of isolation and quarantine facilities, the availability of healthcare services and providers, and the criteria for triage in the hospital setting.

3 | PROVIDING CARE AS A TWO-WAY PROCESS

It is important for this paper’s approach that healthcare is understood to be a two-way effort that involves people caring and people being cared for. This relationship between the “carer” and the “cared for” involves both parties thinking about the situation and making decisions together. The process stems from the autonomy of human beings or their right to self-determination. Patients in healthcare settings, as well as non-patients who are the intended beneficiaries of public health initiatives, simultaneously have the status of being cared for and being “carers.” They are carers in the sense of having to be decision-makers insofar as the care that they need and deserve is concerned. By virtue of their being carers, they need to have access to information that may initially be available only to those who are regarded as having the primary role as carers (healthcare professionals and authorities). This means that information understandable to carers also has to be rendered understandable to the cared for. This is important in the context of public health and health promotion where healthcare providers may need reminding that dispensing care and information is an effort that they jointly carry out with the recipients. The pandemic emergency does not necessarily clothe them with authority to perform their tasks with arrogance and disdain for the ignorance and lack of medical sophistication that they may occasionally encounter in the cared for.

This also means that the perspective of the cared for has to be understood – and respected – by the carer. In this way, the cared for is afforded an opportunity to exercise self-determination. Strictly speaking, the cared for does not shift perspectives. What happens is that the perspective of the cared for is taken into consideration by the healthcare provider because the process of caring, on this account, is being done by the carer on behalf of the cared for. The carer and the cared for are partners in the activity. The relationship between them is not hierarchical but complementary, as healthcare providers or researchers need to be reminded when seeking informed consent from patients or research subjects.

4 | INEQUITABLE ACCESS TO INFORMATION

As partners in decision-making, autonomous patients are entitled to full, accurate and understandable information. In addition to autonomy and equality, the prioritization of the worst off can be easily overlooked in individual consultations in resource-challenged environments, and this entitlement is all the more likely to be ignored in the public health context of a pandemic such as what we are going through during this period in history.

In a public healthcare setting, the carer-cared for dynamics between healthcare professional and patient are enlarged in scope. Respecting autonomy and equality while paying attention to the marginalized in decision-making are needed both with individuals in a clinic and within a community between officials and citizens.
In this section of the paper, the neglect of these principles, especially the prioritization of the worst off, in public healthcare decision-making is examined in relation to three problems within the Philippines in the context of the COVID-19 pandemic: paternalistic decision-making complicated by false information, failure to be mindful of literacy levels, and failure to account for language and other barriers. The first problem is paternalistic decision-making or deciding without consulting stakeholders. The Philippine government has needed to act swiftly to contain the spread of the disease. It has had to enforce quickly crafted rules that could not wait for extended rounds of consultations and confidence building. Quite understandably, the existence of a pandemic emergency compels decision-makers and government officials to act unequivocally and resolutely. However, emergencies also tend to trigger a highly paternalistic stance that can have the effect of reducing human beings to mere recipients of information. Failing to heed instructions for dealing with the pandemic, people may be shunted aside for being obstacles to the implementation of a necessary emergency response. Yet, firm and decisive action is not necessarily incompatible with a compassionate and lawful consideration for the rights of citizens regardless of their level of education and health literacy. Emergencies should inspire creativity in finding ways to implement laws and rules decisively without showing disrespect for fellow human beings who may not have the means or opportunity to understand the full import of new laws and rules. The arrogant display of power by authorities under these circumstances reflects a paternalistic stance that can deteriorate into a disregard for the interests of the cared for whom they need to protect in the first place.

These paternalistic regulations can pertain to decisions to lock down communities without prior consultation or information dissemination, sending patients home even if they have COVID-19 symptoms without giving prior information about the treatment protocol, etc. For example, 21 persons from an urban poor community in Quezon City were arrested for violating rules enforced during the enhanced community quarantine (ECQ) that took effect in Quezon City in April 2020. Those arrested explained that they were given false information about the distribution of goods to people who could not go out because of the lockdown. Disappointed that the relief goods did not reach them, they wandered off to an area where distribution of relief goods was supposed to be taking place. The Philippine National Police rejected their explanation so they were arrested. Desperately needing food and cash, and possibly exposed to SARS-Cov-2, they were hauled off to jail and told that they were lawbreakers who could not be set free unless they posted bail. In the aftermath they must have been more exposed to the infection that authorities should have protected them from. The fact that these people were misled into wandering off because of false information was bad enough. The real situation was made even worse because of the treatment that they got for actions motivated by desperation and ignorance. By acting decisively but with insufficient regard for individual sensitivities, authorities could be missing an important opportunity to process issues of fairness in the allocation of resources in the dispensing of full, accurate, and understandable information about the COVID-19 pandemic. Local media have reported situations reflecting a failure to appreciate pertinent information by people who have needed information the most but were probably not engaged in a meaningful conversation that considered their perspectives and vulnerabilities.

Paternalistic decision-making as illustrated here violates the equality between the carer and the cared for, in the carer (officers) failing to factor into decision-making the specific context of the cared for (those arrested). By not being sensitive to the situation of the economically deprived, the authorities failed to give due consideration to the interests of the worst off. In addition, the authorities may have failed to recognize their own deficiencies in disseminating accurate information in an effective and appropriate manner. Information dissemination that is sensitive to the target demographic is especially needed in the Philippines where educational challenges are present. It is in this area where the second decision-making problem comes in: the failure to account for literacy levels.

In a 2017 survey of people aged 16-64 by London-based research company Ipsos MORI conducted among 38 countries, the Philippines ranked the 3rd least accurate when it comes to answering various questions (including health-related data) but also the 3rd most confident with their answers. In this survey, respondents were given multiple choice factual questions about their country. Accuracy was measured by checking if the respondents’ answers were correct. Confidence was measured by asking the respondents how confident they were in the accuracy of their answers.

Additional insights about Filipinos’ level of literacy can be gained from the 2018 Programme for International Student Assessment (PISA) survey of 15-year-old students conducted by the Organisation for Economic Co-operation and Development (OECD). Among 79 countries, the Philippines ranked the lowest in reading and the 2nd lowest in both mathematics and science. The OECD notes that in the Philippines, students from the highest socio-economic quarter scored 88 points higher in reading compared to students from the lowest socio-economic quarter; 88 is close to the average of OECD countries’ difference in reading scores between each country’s highest and lowest socio-economic quarters, which is 89 points. Other insights about literacy can be gained from the Programme for International Student Assessment (PISA) results for 2018.

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25Ipsos. (2017). Perils of Perception 2017. Ipsos MORI. Retrieved May 21, 2020, from https://www.ipsos.com/sites/default/files/c1/news/documents/2018-02/ipsos-mori-perils-of-perception-2017-charts_0.pdf
26Schleicher, A. (2019). PISA 2018 Insights and Interpretations. OECD. Retrieved May 22, 2020, from https://www.oecd.org/pisa/pisa2018%20insights%20and%20interpretations%20final%20PD%20final%20PD%20final%20pdf.pdf
27OECD. (2019). Philippines Country Note Programme for International Student Assessment (PISA) Results from Pisa 2018. OECD. Retrieved May 22, 2020, from https://www.oecd.org/pisa/publications/PISA2018_CN_PHL.pdf
studies abroad have shown that lower income groups have a harder time comprehending health information.28,29 There is a direct relationship between socioeconomic status and the level of health literacy. This is a reason why a lot of Filipinos have failed to grasp the full significance of the existence of the COVID-19 pandemic and the importance of cooperating with measures to control and limit its spread.

The failure to account for stakeholders’ literacy levels violates the prioritization of the worst off. Understanding this specific context should result in the provision of more assistance to those in more need of health and educational services, not in the easy targeting for police apprehension.

Prioritization of the worst off should also apply to the removal of language barriers, the third decision-making problem addressed in this section. In the Philippines, Filipino is the national language, and both Filipino and English are the official languages. However, as many as 186 languages are spoken in the country.30 The OECD mentions in the 2018 PISA that: “Some 94% of 15-year-old students in the Philippines speak a language other than the test language (i.e. English) at home most of the time.”31 Notable efforts have been made by the University of the Philippines (UP) to translate English medical terms related to COVID-19 into the Filipino language. A UP professor, Eilene Antoinette Narvaez, has come up with a compendium of Filipino terms regarding COVID-19 and the university’s Department of Linguistics is connecting community translators with one another across the country.32 The UP College of Education has written a dictionary of COVID-19-related terms in both English and Filipino for children, and this dictionary contains links to videos of the Filipino sign language of the terms.33 Apart from the language or dialect that is being used, the level and the manner of discourse is also important. Viewed as a matter of fair allocation, the dissemination of information has to be seen in this context. Communication that is not carried out at the level of understanding pertinent to its divergent audiences or that is not cognizant of their specific information needs can only serve the interests of a select population and thereby contributes to inequity. This inequity arises especially because these divergent audiences are likely to be among the worst off financially and educationally, and deserve to be prioritized. In this country - as in many others - information infrastructures can be fully developed in affluent areas but not in others; access to interesting and high-quality information can be expensive; and training and equipment for the effective use of pertinent technology may not be equitably available.34 While the capability of new information and communication technology to level the playing field for all citizens has been much heralded, it may also have the reverse effect of exacerbating existing inequalities if access is not widely distributed and benefits are merely integrated into already existing socioeconomic structures.35

5 | TELEHEALTH AS A RESPONSE TO HEALTH INFORMATION INEQUITIES

In addition to translation initiatives, telehealth practice illustrates what can be done to address an otherwise crippling lack of access to vital health-related information.

Advocates of telehealth have been taking the opportunity to highlight how the practice can help address inequities in access to health information and to healthcare more broadly. Even before the onset of the COVID-19 pandemic, they were already promoting the use of digital means to address healthcare issues faced by vulnerable sectors. Telehealth has been demonstrated to help close the gaps in healthcare service delivery as a way of ensuring that national healthcare systems are responsive, efficient, and equitable in providing healthcare to all, especially the traditionally underserved and vulnerable populations. The World Health Organization (WHO) developed a National eHealth strategy framework in 2012 to guide countries in effectively integrating eHealth in their systems.36 The Philippine government was able to develop an eHealth strategic framework in 2013, but as early as 2008, the University of the Philippines (UP) National Telehealth Center (NTHC) was already practicing telemedicine.37

Recognizing the gaps in the healthcare system and the inequitable delivery of healthcare services, the UP NTHC provided telehealth services to aid physicians who were assigned to remote communities all over the Philippines upon being recruited to the

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28Tang, C., et al. (2019). Examining Income-Related Inequality in Health Literacy and Health-Information Seeking among Urban Population in China. BMC Public Health. 19, 221. Retrieved April 28, 2020, from https://bmcpublichealth.biomedcentral.com/article/10.1186/s12889-019-6538-2
29von Wagner, C., et al. (2007). Functional Health Literacy and Health-Promoting Behaviour In a National Sample of British Adults. Journal of Epidemiology & Community Health. 61(12), 1086-1090. Retrieved April 28, 2020, from https://jech.bmj.com/content/65/12/1086
30Eberhard, D.M., Simons, G.F., & Fennig, C.D. (Eds.). (2020). Philippines. Ethnologue: Languages of the World 23rd Ed. Retrieved July 7, 2020, from https://www.ethnologue.com/country/PH
31OECD, op. cit. note 27, p. 1.
32Anonymous. (2020, March 27). KapitDiliman! We’ve Got Your Back. UP Diliman Information Office. Retrieved April 28, 2020, from https://upd.edu.ph/kapitdiliman-we-got-your-back/?bclid=twAR3gFygw3xwgk9g2xIg3w/2w3yF7zjKGr0MuWCnl1hcvVqG9F3k4
33Anonymous. (2020, May 16). COVID-19 Dictionary for Filipino Children in Filipino and English (Full Version). University of the Philippines College of Education. Retrieved May 22, 2020, from https://educ.upd.edu.ph/covid-19-dictionary-for-filipino-children-in-filipino-and-english-full-version/
34Van Den Hoven, J., & Rookstoy, E. (2008). Distributive Justice and the Value of Information: a (Broadly) Rawlsian Approach. In J. Van den Hoven, & J. Weckert (Eds.), Information Technology and Moral Philosophy (Cambridge Studies in Philosophy and Public Policy, pp. 376-390). Cambridge: Cambridge University Press. https://doi.org/10.1017/CBO9780511498725.019
35Ibid.
36World Health Organization & International Telecommunication Union. (2012). National eHealth Strategy Toolkit Overview. World Health Organization. Retrieved May 16, 2020, from https://www.who.int/ehealth/publications/overview.pdf
37Patuco, I.D., & Tornero, A.S. (2016, December 31). Establishing the Legal Framework of Telehealth in the Philippines. Acta Medica Philippina. (50A, 237-246. Retrieved May 13, 2020, from https://actamedicaphilippina.upm.edu.ph/index.php/acta/article/view/763
Doctors to the Barrios Program (DTTB). Clinical specialists from the UP Philippine General Hospital (PGH) became the remote source of valuable knowledge to DTTB physicians as they provided healthcare services to their patients. This enabled the patients from far flung communities to access quality healthcare from specialists based at a tertiary hospital that was otherwise beyond their reach.

In various ways, the COVID-19 pandemic has turned the once underrated practice of telehealth into a widely explored alternative mode of practice. It is riding on the wave of the new normal in healthcare service delivery. Both the Department of Health (DOH) and the private sector have scrambled to utilize telehealth to provide consults and information to a nation hit hard by anxiety and uncertainty. One of the early users was the Lung Center of the Philippines COVID-19 Task Force. Through a social media platform, the Lung Center held teleconsultations and provided answers to COVID-19 related questions.38,39 The Philippine General Hospital established the “Bayanihan na” call center where consults were made through a hotline.40,41 The DOH, having no telehealth platform of its own, has collaborated with private providers to establish the DOH (Telehealth) hotline.42,43 Whereas only a few physicians practiced telehealth in the country at the beginning of the year, the COVID-19 pandemic has certainly accelerated the acceptance of telehealth as a means to improve healthcare. Aside from providing healthcare access to remote patients, the practice of telehealth has served to limit physical contact in order to reduce the risk of contracting COVID-19. Physicians who previously disliked the use of technology and preferred face to face consultations are now forced to “see” patients remotely. The tide has started to turn and this appears to have happened also in other countries.44 Multiple studies have shown how telemedicine has enhanced health service delivery.45,46,47

Even before launching the COVID-19 telemedicine hotline, the DOH already launched multiple telehealth initiatives: a non-COVID-19 clinical Helpdesk (through hotlines), email, and chat (including a DOH internet-based messaging app group that is open to lay people and another group for health care workers).48,49 Another heavily used platform is Facebook where infographic materials, videos, and press releases are done.50 The use of a digital platform in these ways is in line with what we expect post-COVID-19 society to be like. It is useful for people with COVID-19 symptoms as well as for those with non-COVID-19 health related issues.

A device called RxBox has become an important tool for the practice of telemedicine. The RxBox is a telemedicine device developed by the University of the Philippines Manila and supported by the DOH and the Department of Science and Technology. It captures medical signals through built-in medical sensors and has several capabilities such as functioning as a blood pressure and pulse rate monitor, pulse oximeter, and temperature sensor.51 Primarily used in isolated and disadvantaged communities nationwide, it is able to store data in an electronic medical record, and transmit this information via internet to a clinical specialist at regional government hospitals including PGH, the doctors from which can then offer expert advice. By facilitating teleconsultations within the National Telehealth Service Program, the RxBox can reduce the overall cost of healthcare by enabling healthcare workers to diagnose, monitor and treat patients within the rural healthcare facility, using medical sensors inside the box.52 As part of an initiative of the University of the Philippines and the Department of Science and Technology to respond to the pandemic, devices are being installed for...

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38Nonato, V., Crisostomo., S., & Calica, A. (2020, March 31). The Doctor Is Online: Physicians Offer Free Services to Decongest Hospitals. One News. Retrieved July 27, 2020, from https://www.onenews.ph/the-doctor-is-online-physicians-offer-free-services-to-decongest-hospitals
39Perez, R. (2020, April 7). DOH COVID-19 Hotline Now Provides Free Telemedicine Consultations. Smart Parenting. Retrieved July 27, 2020, from https://www.smartparenting.com.ph/life/news/doi-covid-19-hotline-telemedicine-a00041-20200407
40Dela Cruz, R.C. (2020, March 31). PGH Launches Covid-19 Hotline for Consultations, Donations. Philippine News Agency. Retrieved May 20, 2020, from https://www.pna.gov.ph/articles/1098332
41Romualdo, A.V.C.D.P. (2020, March 31). Bayanihan Na! UP-PGH Launches COVID-19 Ops Center. University of the Philippines Manila News. Retrieved May 20, 2020, from https://www.up.edu.ph/bayanihan-na-up-pgh-launches-covid-19-ops-center/
42Anonymous. (2020, April 7). DOH Boost Telemedicine Services for NCR Service to Expand to Other Regions Soon. Press Release. Department of Health. Retrieved May 16, 2020, from https://www.doh.gov.ph/doh-press-release/DOH-BOOST-TELEMEDICINE-SERVICES-FOR-NCR-SERVICE-TO-EXPAND-TO-OTHER-REGIONS-SOON
43CNN Philippines Staff. (2020, April 27). DOH Launches Telemedicine Consultation for Metro Manila Residents. CNN Philippines. Retrieved April 27, 2020, from https://cnnphilippines.com/news/2020/4/7/telemedicine-consultation-COVID.html https://www.pna.gov.ph/articles/1097975
44Galewitz, P. (2020, March 27). Telemedicine Surges, Fueled by Coronavirus Fears and Shift in Payment Rules. Kaiser Health News. Retrieved May 17, 2020, from https://khn.org/news/telemedicine-surges-fueled-by-coronavirus-fears-and-shift-in-payment-rules/
45Williams, O.E., et al. (2017). The Use of Telemedicine to Enhance Secondary Care: Some Lessons from the Front Line. Future Healthcare Journal. 4(2), 109-114. Retrieved May 20, 2020, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5650263/
46Bryant, B. (2018, December 11). Telemedicine Improves Healthcare through Innovative Service Delivery. National Association of Counties (NACO). Retrieved May 20, 2020, from https://www.naco.org/articles/telemedicine-improves-healthcare-through-innovative-service-delivery
47Siddique, N.K.A., et al. (2019). Telemedicine in Resource-Limited Setting: Narrative Synthesis of Evidence in Nepalese Context. Smart Homecare Technology and TeleHealth. Retrieved May 21, 2020, from https://www.dovepress.com/telemedicine-in-resource-limited-setting-narrative-synthesis-of-evidence-peer-reviewed-full-ext-article-SHTT
48Anonymous. (No date). National Telehealth Center. National Institutes of Health. Retrieved August 21, 2020, from http://nih.upm.edu.ph/institute/national-telehealth-center
49Anonymous. (2016-2020). PH COVID-19 Health Workers. Rakuten Viber. Retrieved August 21, 2020, from https://www.viber.com/en&fbclid=IwAR3YDl3lqYj5n8-UAgGZDfo5muohHkkCHVHYWV7GUGJ5U9/pxeFM3Pqpo
50Anonymous. (No date). Department of Health Philippines. Facebook. Retrieved August 21, 2020, from https://www.facebook.com/OfficialDOHgov/
51National Telehealth Center. (2014). RxBox: Advancing Community Healthcare 2014. Retrieved May 23, 2020, from https://telehealth.ph/project-rxbox
52Ibid.
at PGH. The RxBox is now being developed to have telemetry capability, which means being able to connect with a dashboard at the nurses’ station where vital signs can be read. The device therefore allows for remote monitoring that minimizes risks associated with the proximity of healthcare workers to patients with communicable diseases. The installation of 100 RxBox devices at PGH as a response to the COVID-19 pandemic will significantly improve access by people in remote locations to health care and information.53,54

Another initiative under the UP College of Medicine’s Surgical Innovation and Biotechnology Laboratory (SIBOL) in cooperation with UP Dilliman’s Electrical and Electronics Engineering Institute is a “telepresence” device, a computer programmed to automatically answer calls from authorized accounts using available teleconferencing and remote-control applications, minimizing contamination and allowing effortless access even by patients with no technological know-how.55 Like the RxBox, a “telepresence” device allows healthcare workers and patients to communicate with each other without need for face to face contact.56 This paper notes the use of telehealth care workers and patients to communicate with each other through multiple platforms that patients can easily connect with, and ultimately improving patient health outcomes.57

The current pandemic has hopefully provided an irreversible inertia for the DOH and other healthcare authorities and stakeholders to accelerate their preparedness and capability to respond to pandemics and disasters not only in the short term but also in the foreseeable future. This approach can be possible by focusing on removing barriers to inequitable access to healthcare communication and other healthcare resources, an important strategy in support of the prioritization of the worst off.

Paradoxically, the use of telehealth to address one kind of need highlights a problem of another kind. This has to do with healthcare being essentially an expression of closeness, of solidarity, and of removing physical and emotional barriers to well-being.58,59,60 Thus, we have seen how family members have bemoaned their inability to be close to their loved ones who are being administered critical (possibly end of life) care.61,62 Physical distancing appears to be antithetical to human beings’ emotional closeness.63,64 But this is another issue that is beyond the scope of this paper. The physical availability of health care workers is a related concern that the next section deals with.

6 | INEQUITABLE DISTRIBUTION OF HEALTHCARE WORKERS

The toll that the COVID-19 pandemic has taken on the country’s human resources for health (HRH) reminds us of the impact of the continuing migration of doctors, nurses, and other health care personnel to developed countries. Figures from the Professional Regulations Commission show that out of 84,783 licensed Filipino physicians, only 28,428 are actually practicing in the country.65 And while the country licensed an average of 26,000 nurses from 2012 to 2016, there were around 18,500 who moved abroad each year.56 There is an estimated shortage of 23,000 nurses nationwide and yet...
there are approximately 150,000 Filipino nurses working in the United States. According to Michael Obrigo and Danica Ortiz, researchers from the Philippine Institute of Development Studies, "less than 25 percent of cities and municipalities have HHR (human health resource) density above the 41 physicians, nurses and midwives per 10,000 population recommended by the WHO [in 2016]." According to 2017 statistics, among the 17 regions of the country, the number of doctors ranged from 10.6 to 0.9 (average of 3.9), the number of nurses ranged from 15.8 to 4.2 (average of 8.6), and the number of midwives ranged from 9.9 to 2.3 (average of 4.1) per 10,000 population.

To keep up with the continuing requirements for HRH, emergency hiring has been going on at a frenetic pace, sometimes to the extent of including interns who still lack the experience that would otherwise have been necessary. As part of COVID-19 measures, the DOH issued a call for volunteer doctors and nurses in three state hospitals. In response, almost 600 Filipino doctors and nurses volunteered regardless of experience and readiness to address the needs in stations for which they have not been thoroughly prepared. This has also been going on in other countries that are more economically endowed.

Here, we are made to wonder how this could be happening when, for many years, the Philippines has, in effect, accepted the responsibility of providing care to patients in other countries by encouraging the migration of its own healthcare professionals. This encouragement can be seen in the country creating bureaucratic institutions and promoting legislation to facilitate labor migration since the 1970s. The long-standing dilemma was highlighted again recently when public officials themselves debated a proposal to allow Filipino healthcare workers to leave for abroad in the midst of the pandemic.

Eventually, a decision was reached to allow the departure of those who already had legally binding contractual obligations but to temporarily prevent others from entering into new contracts to work abroad. More recently, the DOH authorized the recruitment of fresh medical graduates to work as depu-

The measures described in this section to address the lack of HRH in the context of the COVID-19 emergency are intended to be in place temporarily. Emergency healthcare staff are being recruited to work only during the period of the pandemic under contracts lasting only for 3 months. The ban on deployment of HRH to foreign countries will be lifted as soon as the pandemic subsides. Recruitment calls for foreign healthcare jobs have not slowed down, and processing of applications is ongoing. The conscription of pre-licensed fresh medical school graduates to work in emergency healthcare facilities will stop when the crisis ends. Hence, the measures cannot be expected to have an impact on the country’s capability to deal with the insufficiency or misdistribution of HRH that will plague the country beyond the period of the current pandemic. These measures fail to take into consideration the continuing nature of the issues that need to be addressed. They only help to cope with the exacerbation brought about by SARS-CoV-2. While it is important to deal with the exacerbation, it is even more important in the long run to maintain a level of readiness that can only be attained by ensuring a sound HRH profile within the country. As it is, we have a situation where because of poverty, a majority of Filipinos are forced to seek the services of government healthcare facilities that are served by only 4.5% of the country’s doctors, only about 1% of its nurses and about 23% of its midwives.
As the country maintains its position as an HRH supplier to much of the developed world, it must do more to improve healthcare access in rural areas as well as in urban yet under-served areas. While telehealth helps to mitigate problems arising from inequitable HRH distribution, there is a lot to do to improve the overall HRH profile and prepare the healthcare system for the impact of future pandemics or disasters. The systemic inequities, rooted as they are in the social determinants of health, are entrenched in the prevailing healthcare system; they perpetrate injustices against disadvantaged sectors of the population. These injustices violate the principle of the prioritization of the worst off.

Similar inequities need also to be addressed in the implementation of quarantine measures in the country.

7 | ALLOCATION OF SAFE ISOLATION OR QUARANTINE FACILITIES

The various levels of quarantine that continue to be enforced in different parts of the country are meant to isolate people who are infected and thereby minimize or control the spread of SARS-CoV-2. Obviously, isolation and quarantine should go hand in hand with testing. Otherwise one would not know who is capable of transmitting the infection and who should be isolated from whom. But testing has been scarce and inequitably distributed. The onset of testing in the country immediately showcased one source of inequity as government officials jumped the queue and had their swabs processed ahead of everybody else. Mostly asymptomatic government officials and their family members were tested even when healthcare institutions could not yet provide testing kits for many symptomatic and suspected patients. Meanwhile, a 34-year-old cardiologist fellow died from the virus, amidst reports that his COVID-19 test result came only after he died. Timely test results could significantly help in patient management, and possibly save lives. Of course, it is the rich who can more easily afford to pay for tests if they choose to. Power and wealth have been influential and if the situation is allowed to prevail we cannot hope to achieve the equitable allocation of healthcare resources that is a necessary condition for pandemic preparedness. Meanwhile, the insufficiency of testing kits is being manifested in the prevalence of online selling of kits unauthorized by the Food and Drug Administration.

Problematic and inequitable testing is worsened by problematic and inequitable isolation of the sick. This section of the paper discusses the Philippines’ quarantine problems in crowded residences and prisons.

In private residences, economically privileged people can readily provide the necessary spaces to separate their family members from one another and prevent the possible transmission of the offending virus. On the other hand, many of those who belong to the economically challenged segments do not have houses of their own. A large segment of the population has to rent living spaces in crowded locations. Those who cannot afford to pay rent end up as informal settlers in tiny spaces where isolation or self-quarantine is impossible. Out of 106.7 million Filipinos, 16.6% live below the poverty threshold while 5.2% cannot meet the basic food needs to stay healthy. Among families, 12.1 percent belong to the poor, which is equivalent to around 3 million families. Around 4.5 million Filipinos are either homeless or living in informal settlements. Of this number, about 3 million are living in Metro Manila. Within the Metropolitan Manila area, the city of Manila has been rated as the most densely populated city in the world with 66,000 people per square kilometer, 6 times as much as New York City’s 11,000. It is not difficult to see what this translates into at the community level.

In the 16,000 households in Baseco, a village in Manila, it is normal for a family of 10 to live in a 20 sqm make-shift hut. Due to hot weather, boredom, and hunger, people in the shanties wander around in their alleys not minding the threat of the virus. It is common to find "shacks no bigger than a flatbed truck [that] house large families whose members sleep side-by-side on wooden or cement floors." Obviously, "where people are packed like bees in a hive, there is no such thing as social distancing." For some people, finding space to live in is close to impossible, so they have to sleep on top of graves even before they die. It does not matter whether we are talking about normal times or pandemic emergencies. There are serious inequities to address, and if we continue to have an unfair distribution of dwelling places in our communities, we will have ready-made

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88 Magsino, D. (2020, March 13). FDA Warns Public Vs. Unregistered COVID-19 Test Kits in Philippines. GMA News Online. Retrieved July 2, 2020, from https://www.gmanetwork.com/news/news/nation/729568/fda-warns-public-vs-unregistered-covid-19-test-kits-in-philippines/story/

89 Mapa, C. (2019, December 6). Proportion of Poor Filipinos Was Estimated at 16.6 percent in 2018. Philippine Statistics Office. Retrieved April 27, 2020, from https://psa.gov.ph/poverty-press-releases/nid/144752

90 Chandran, R. (2018, June 7). Slum Dwellers in the Philippines Build Homes through Community Programs. The Christian Science Monitor. Retrieved May 18, 2020, from https://www.csmonitor.com/World/Asia-South-Central/2018/0607/Sam-dwellers-in-the-Philippines-build-homes-through-community-programs

91 United Nations Statistics Division. (2015). Demographic and Social Statistics. Demographic Yearbook 2015. Retrieved May 22, 2020, from https://unstats.un.org/unsd/demographic-social/products/dyb/dyb_2015.csh.html

92 Teneote, J., & Racelis, M. (2020, March 27). Coronavirus in Baseco: a Community Leader’s Assessment. Rappler. Retrieved April 27, 2020, from https://www.rappler.com/move-ph/256815-baseco-covid-19-coronavirus-baseco-community-leader-assessment

93 Coronel, S. (2020, March 24). Philippines: Covid-19 Will Devastate the Poor. The Interpreter. Retrieved May 17, 2020, from https://www.lowyinstitute.org/the-interpreter/philippines-covid-19-will-devastate-poor

94 Ibid.

95 Billing, L. (2020, March 21). Graveyard Living: Inside the ‘Cemetery Slums’ of Manila. The Guardian. Retrieved May 18, 2020, from https://www.theguardian.com/cities/2018/mar/21/cemetery-slums-life-manilas-graveyard-settlements-philippines
disasters for the next epidemic. We know that we need to allocate societal resources for housing fairly to avoid this. If we do not realize how inequities have aggravated our public healthcare situation in the context of the current pandemic, we will not learn our lesson ever.

In order to accommodate the rising number of persons needing isolation and quarantine facilities, the national government has coordinated with local governments and the private sector in converting hotels, sports facilities, school buildings, and churches into temporary quarantine sites. The facilities are meant to accommodate asymptomatic or mildly symptomatic patients who are either homeless or whose dwelling units do not have enough spaces to allow isolation. The temporary facilities may suffice for now, but certainly not for the near future. These facilities will be eventually returned to their original use; a more sustainable and long-term solution must be developed.

The problem with living spaces has somehow spilled over into the country’s prisons, a second area where chronic congestion issues are being magnified by the pandemic. Separated from the rest of the population, persons deprived of liberty (PDLs) could not be physically isolated from one another. One account describes how, in a jail dormitory, “518 men crowded into a space meant for 170” so that “inmates were cupped into each other, limbs draped over a neighbour’s waist or knee, feet tucked against someone else’s head, too tightly packed to toss and turn in the swirling heat.” This way of living inside prisons is unsurprising given that in November 2019, there were 215,000 PDLs in facilities that could only house 40,610. On April 17 of this year, The Bureau of Jail Management and Penology (BJMP) reported that the national congestion rate of the prison system was 534 percent. As of May 20 of this year, the Philippines had the second highest prison occupancy level in the world.

Given this state of the country’s penal system, how detrimental has the impact of COVID-19 been? In April of this year, one inmate from the New Bilibid Prison (NBP) died due to the SARS-CoV-2 virus as confirmed by the BJMP. Furthermore, 27 PDLs from the Correctional Institute for Women (CIW) had been infected.

As of May 1, as many as 332 PDLs in Cebu City Jail had tested positive for COVID-19. As of May 4, at least four inmates had died. As of May 25, the number of infected PDLs had risen to 517 in 10 different prisons. These statistics have worsened despite the measures that have been undertaken to combat the spread of the pandemic in jails, considering that on March 20, 2020, over 400 facilities were already locked down by the BJMP.

To separate the sick and at-risk PDLs from those who are not, the former have been quarantined in certain designated rooms within the correctional facilities to which they belong. Quarantine structures for PDLs have also been arranged around Metro Manila. In addition, quarantine facilities that can hold around 500 people have been set up by the International Committee of the Red Cross in certain prisons.

Despite these quarantine measures, problems still arise. A 61-year-old febrile PDL reported that he was transferred to a cell designed for two, but actually housed 11 people; still, his reaction was one of relief: “It’s better than sleeping on the stairs, piled up on top of one another.” While face masks are being provided to all PDLs, prisoners often do not wear them due to the scorching summer temperatures. Most recently, to address the problem of severely congested prisons, the Supreme Court of the Philippines ordered the release of around 10,000 prisoners.

The problems that are now being experienced in crowded residences and prisons are dramatic iterations of socio-economic inequities that have existed over a long period of time. Huge parts of the population do not have proper living spaces and do not actively pursue housing opportunities perhaps because, as a society, we have seen the disparity in housing conditions as a situation that has been entrenched by chance rather than as a matter of fair allocation over which we exercise control, and which we should
clamor for the government to make an urgent priority. The manifestations of these inequities have come to the fore recently are hurriedly being addressed now because of the impact that the lopsided housing situation has had on the ability of the country to cope with problems arising from the pandemic. The response measures are proving very costly and yet the infrastructure being built is only for temporary use. The same amount of money could perhaps have been used earlier on for durable facilities that would have reduced housing inequity and hence, the harm brought about by SARS-CoV-2. The experiences we have been going through constitute compelling evidence that the neglect cannot be allowed to continue. It is up to us to act on our responsibility and try to exercise control over the situation by putting pressure on authorities to promote the fair allocation of resources. Otherwise, the consequences can be even more costly in terms of economic development and the further loss of human lives.

It is about time we realized that the need for safe and healthy housing for all is a concern not only for the economically challenged but also for every other member of the community. In times of pandemic emergencies, anyone and everyone can be affected by the lack of safe and healthy housing suffered by disadvantaged sectors of society. When people get infected by a highly contagious virus and they have no safe isolation space to which they can withdraw, everybody else can be adversely affected as they radiate beyond their household. In a world of interconnected and interrelated human beings, anyone’s virus has the potential to infect everybody else.

8 | THE INTERRELATEDNESS OF HUMAN BEINGS AS HIGHLIGHTED BY COVID-19

The need for numerous safe isolation or quarantine facilities brings attention to how easily the SARS-CoV-2 virus can spread; one measure for this parameter is the basic reproduction number. The basic reproduction number is the basic reproduction number ($R_0$) of a disease indicates the number of people that an initially infected person will transmit the infection to assuming no one yet in the population is immune to the disease.113 On March 6, 2020, the WHO reported a reproductive number of 2 to 2.5.114 Another estimate put COVID-19’s $R_0$ at around 3.28 based on figures from different regions in China and overseas.115 To make sense of $R_0$, for instance the 3.28 figure, one person who has COVID-19 will infect around three people of COVID-19; total cases are now four. Each of these three newly infected will also infect three more, adding nine new cases to the previous total of four. Each of the nine new cases will infect three, and so on.

From these numbers, one can make sense of how COVID-19 is said to have exponential growth, seen internationally116 and in the Philippines.117 With exponential growth, as more people get infected, the faster will be the rate of new infections occurring. This growth rate is opposed to a linear growth rate where the rate of new infections occurring stays the same over time. From this picture, we can understand how quickly an entire population can be infected.

As a note of comparison, on March 3 of this year, the WHO announced COVID-19’s global mortality rate of 3.4%, more than 3 times higher than that reported for seasonal flu’s 1%.118 We have seen how quickly seasonal influenza can be passed on from one person to another and these reproductive numbers are up to more than 3 times higher than that for seasonal influenza’s 1.3.119 Although the reproduction numbers have gone down since the onset of the pandemic, the large number of people already affected, the capability of asymptomatic patients to transmit the infection, the lack of knowledge concerning other aspects of the disease, and the impact of the prolonged containment measures on social, psychological and economic issues have made it difficult to control further spread of the disease.

This ease with which the virus can spread has highlighted the interconnectedness and interdependence of people that SAR-CoV-2 has thrived on in its destructive effects. It is somewhat ironic that it has taken a tragedy like the COVID-19 pandemic to remind us, human beings, that we are all bound together by common conditions. While each of us can have different lifestyles with diverse socioeconomic backgrounds, the threat of the virus becomes clearer with more cases accruing. Even if the most economically secure among the population are able to isolate themselves in the comfort of palatial homes, their survival requires the promotion of the welfare of other people whom they need in their lives. For example, the rich need the farmers to be able to plant crops and every worker in the food chain to be able to function, so there can be products that can be bought in the market. Many of the rich probably took that for granted until they realized that they had to engage in panic buying in order to ensure their food supply when quarantine regulations took effect. Faced with the prospect of food becoming scarce, people had to accept that those workers needed fair access to health care.

113Liu, Y., et al. (2020). The Reproductive Number of COVID-19 Is Higher Compared to SARS Coronavirus. Journal of Travel Medicine. 27(2). Retrieved April 28, 2020, from https://academic.oup.com/jtm/article/27/2/taaa021/5735319
114World Health Organization. (2020, March 6). Coronavirus Disease 2019 (COVID-19) Situation Report - 46. World Health Organization. Retrieved April 28, 2020, from https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200306-strep-46-covid-19.pdf?sfvrsn=9eb904af_4
115Liu, Y., et al., op. cit. note 113.
because if they succumbed to the virus the food chain could break. As such, farmers, fisherfolk, food delivery workers, cashiers, grocery baggers, and customer care staff have been hailed as frontliners and heroes.120,121,122,123,124 Indeed, some people who have lived in near complete isolation have become infected even though they have been minimally exposed to such frontliners.125

As more people get infected, fewer and fewer safe spaces are left. This is a message that we get from the experiences in almost every community, but especially in high-density spaces such as crowded informal settlements, prisons, workplaces, public transport facilities, supermarkets, or even hospitals. Hence, we are not merely talking about interconnectedness of humans in an abstract sense that is more closely associated with philosophical discourse on concepts such as human dignity or the sanctity of human life in various contexts. We are referring to the physical interconnectedness that gives rise to concrete disease and deprivation that has affected more people with various kinds of social living conditions. We can easily take this for granted in the absence of a pandemic. But recent events have caused an alarming prevalence of the virus and its effects on society.

The interconnectedness of people of varying socio-economic standing as highlighted by the pandemic reinforces the view that inequality needs to be reduced and prioritization of the worst off must be observed in order to achieve the best outcomes. By giving more help to those who are more in need we move in the direction of achieving the best outcomes for more people.

The impact of interconnectedness and interdependence has been felt also in relation to the increased demand for hospital facilities.

9 | FAIR ACCESS TO HOSPITAL FACILITIES

In an archipelagic country composed of 17 regions across more than 7,000 islands, healthcare facilities are unevenly distributed. In 2018, around two thirds of hospital beds in the Philippines were in one area, the National Capital Region.126 The problem of physical location has been complicated by the suspension of public transportation during the quarantine. The quarantine period started in March 17, 2020.127 Since then, public transportation has not been fully restored. Various problems have ensued with largely ineffective government support for safe mass conveyances. A bone cancer patient with only one leg had to walk to her healthcare facility for her monthly check-up.128 A leukemia patient had to walk in excess of five kilometers to get his chemotherapy medication.129

As with other countries, the Philippines has a healthcare infrastructure that was not adequately prepared for the magnitude of this pandemic. Hospital facilities and opportunities for safe medical confinement are not well distributed. People have variable access to good quality facilities. Access is largely dependent on two factors: location and financial capability. Access in relation to location was taken up in an earlier section. This section focuses on financial capability as well as infrastructure and equipment availability. While universal healthcare funding is not fully in place, financial capability is a huge factor affecting access to hospital facilities.

A survey done in March 2020 showed that there were only 2,335 beds in all intensive care units (ICUs) in the Philippines, accounting for 3.1% of the total approved bed capacity of Levels 2 and 3 hospitals in the country.130 Therefore, there were not enough beds in ICUs to cater to the projected 8,800 to 19,800 critical COVID-19 cases if the number of additional cases did not go down.131 Earlier on, a number of private hospitals had announced that they were temporarily not accepting suspected or confirmed COVID-19 patients due to unavailable facilities and equipment.132

Philippine hospitals are classified into 3 levels. Level 2 and Level 3 hospitals, which have ICUs, can admit COVID-19 patients. There are 456 of these hospitals nationwide with a combined total number

120Dayrit, et al., op. cit., note 69.
121Medialdea, S.C. (2020, March 16). Community Quarantine over the Entire Luzon and Further Guidelines for the Management of the Coronavirus Disease 2019 (COVID-19) Situation. Office of the President of the Philippines Malacañang Memorandum from the Executive Secretary. Retrieved July 6, 2020, from https://www.officialgazette.gov.ph/downloads/2020/03mar/20200316-MEMORANDUM-FROM-ES-RRD.pdf
122CNN Philippines Staff. (2020, March 28). In Numbers: what Hospitals Need to Treat COVID-19 Patients. Rappler. Retrieved April 27, 2020, from https://www.rappler.com/hospital-capacity-to-deal-with-covid-19-case-surge-analysis-and-recommendations/
123UP COVID-19 Response Team. (2020, April 20). Estimating Local Healthcare Capacity to Deal with COVID-19 Case Surge: Analysis and Recommendations. University of the Philippines. Retrieved May 1, 2020, from https://www.up.edu.ph/estimating-local-healthcare-capacity-to-deal-with-covid-19-case-surge-analysis-and-recommendations/
124CNN Philippines Staff. (2020, March 28). Hospitals Close Doors to COVID-19 Patient after Reaching Capacity. CNN Philippines. Retrieved May 1, 2020, from https://cnnph ilippines.com/news/2020/3/23/st-lukes-coronavirus-patients.html?fbclid=IwAR0qitkJvLT6enPwE_3C32Uy9Cz+vePB81GoBKNc2Zc9j?-pAVAyV4dCI
of 67,119 beds, and 41% are in government owned hospitals while the remaining 59% are owned by private hospitals.133

As public hospitals become congested, some patients have been forced to consider confinement in private hospitals. But this is a privilege that very few could afford. One patient’s bill for a 16-day stay at a private hospital totaled PHP 3 million or around USD 59,000, which is about equivalent to a middle-class Filipino worker’s salary for 3 years.134 An estimate for a private hospital bill for a moderate COVID-19 case amounts to at least PHP 1 million or a little under USD 20,000.135 To address these financial concerns, the Philippine Health Insurance Corporation (PhilHealth) has come out with new policies for at least partial coverage of COVID-19 cases.136

The problem with PhilHealth is not everyone is able to use it. In 2018, 53.9 % of Current Health Expenditures came from household-out-of-pocket payment instead of medical insurance.137

Both public and private healthcare sectors have been overloaded to the point that inequities have often surfaced. Infected patients have been sent home to ease the burden on hospital facilities. For example, in Quezon City, reports of 3 COVID-19 positive patients being sent home were followed by reports of another 14 patients being sent home for the same reason of patient overload.138 Many more mildly symptomatic patients were subsequently refused admission, not being made aware earlier of the policy that only those who were likely to need ventilators were being admitted. Some of those who required admission could only be accommodated in tents set up on hospital grounds.

The stress on the healthcare system brought about by COVID-19 has reverberated in the management of other diseases. A 56-year-old man died from cardiac arrest in a tent outside a hospital after calls to more than 30 hospitals were met with rejection citing the lack of ventilators.139 A woman who needed an immediate operation to remove her placenta after giving birth died due to blood loss after being refused by six hospitals in Metro Manila because their hospital rooms were fully occupied by COVID-19 patients.140 Another patient died after spending 11 hours in a tent outside the Lung Center of the Philippines, prompting the Department of Health to remind hospitals that COVID-19 is not the only disease that has to be accommodated.141

The problems have been exacerbated by the lack of safety equipment for doctors. Public institutions like the Philippine General Hospital, the national university hospital, have had to call for donations of alcohol and masks.142 At one point, the National Centre for Mental Health was operating with 100 PPEs instead of its requirement of a minimum of 250 in a day.143

The situation in hospitals is further complicated by issues whose underlying roots are not so easy to explain. A person under investigation for having COVID-19 escaped from a private hospital where he or she was being observed.144 An overseas Filipino worker with COVID-19 symptoms also escaped from a hospital to probably go back to work abroad.145 Another patient who tested positive for the SARS-CoV-2 virus escaped by jumping from a hospital window after she was not given permission to go home.146 Expenses or space limitations are possible explanations but the exact reasons why these quarantined patients have tried to escape need to be probed further. Of course, the reasons may have to do with things that are not unique to hospitals. For instance, socio-economic conditions characterized by inequity and a lack of safety nets for the worst off may compel patients to ignore their health and avoid long hospitalizations so they can continue to try to make a living for themselves and their families.

As earlier noted, the fair allocation of critical care resources is a concern that arises way before the need to prioritize patients arises in the triage context within hospital premises. Many people affected – or suspected to be affected – by COVID-19 do not have full information about their options for consultation, treatment, or confinement. Access to the relevant services or facilities can easily be denied if pertinent information is not properly disseminated. People need to know about confinement options, contact procedures, costs, prerequisites for admission, etc., in order to gain fair access. Knowledge

133UP COVID-19 Response Team, op. cit. note 131.
134Garcia, M.A. (2020, April 15). COVID-19 Patient’s Hospital Bill Reaches P3M. GMA News Online. Retrieved April 27, 2020, from https://www.gmanetwork.com/news/news/nation/734202/covid-19-patient-s-hospital-bill-reaches-p3m/story/
135Punzalan, J. (2020, April 9). How Much to Be Treated for COVID-19 in a Metro Manila Private Hospital? for a Moderate Case, Prepare at Least P1M. PEP.ph. Retrieved April 27, 2020, from https://www.pep.ph/lifestyle/health-and-fitness/150720/covid-19-treatment-cost-a3830-20200409-frm
136Garcia, op. cit. note 134.
137Mapa, C.D.S. (2019, October 17). Total Health Expenditure Grew by 8.3 Percent in 2018. Philippines Statistics Authority. Retrieved April 27, 2020, from https://psa.gov.ph/nhpa-press-release/node/144466
138Chaves, C. (2020, March 22). Belmonte ‘Shocked’ 3 Patients who Tested Positive for COVID-19 in QC Sent Home. Manila Bulletin. Retrieved April 27, 2020, from https://news.mb.com.ph/2020/03/22/belmonte-shocked-3-patients-who-tested-positive-for-covid-19-in-qc-sent-home/
139Canyo, J. (2020, April 2). Her 56-Year Old Father Had a Heart Attack and No Hospital Would Take Him In. ANCX. Retrieved April 27, 2020, from https://news.abs-cbn.com/news/04/03/20/after-man-dies-in-tent-doh-reminds-hospitals-to-take-in-patients-ill-with-covid-19-other-illnesses
140Baticulan, R.E. (2020, March 20). Last updated 2020, March 20. Opinion: the Philippine Health Care System Was Never Ready for a Pandemic. CNN Philippines. Retrieved April 29, 2020, from https://cnnphilippines.com/life/culture/2020/3/20/healthcare-pandemic-opinion.html?fbclid=IwAR06Gf4Xpn3d7FEZ3JdCCVSl306Z7rYHt4D_iLg1DFaTClNM-4elwLxeU0
141Dancel, R. (2020, April 8). Last updated 2020, April 8. Struck down by COVID-19, Philippine Doctor Returns to Front Line to Rally Troops, The Straits Times. Retrieved April 29, 2020, from https://www.straitstimes.com/asia/se-asia/strike-down-by-covid-19-doctor-returns-to-frontline-to-rally-troops
142KBK. (2020, February 6). Person under Investigation for having COVID-19 in QC Sent Home. Manila Bulletin. Retrieved April 27, 2020, from https://news.mb.com.ph/2020/02/03/22/belmonte-shocked-3-patients-who-tested-positive-for-covid-19-in-qc-sent-home/
143Canoy, J. (2020, April 2). Her 56-Year Old Father Had a Heart Attack and No Hospital Would Take Him In. ANCX. Retrieved April 27, 2020, from https://news.abs-cbn.com/anx/culture/spotlight/04/02/20/her-56-year-old-father-had-a-heart-attack-and-no-hospital-would-take-him-in
144Cayabyab, M. (2020, April 26). Woman Dies after Being Refused by 6 Hospitals. Retrieved April 27, 2020, from https://www.philstar.com/nation/2020/04/26/2009815/woman-dies-after-being-refused-6-hospitals
about these factors helps one decide which treatment alternatives suit one’s financial capability. To be able to fully understand these factors, people need to be functionally literate and to have a minimum level of health literacy. As we address these issues during the pandemic, it should be clear to us that these are also long-standing concerns that have been waiting for durable solutions. Only durable solutions can help us maintain emergency readiness over the long term. In the meantime, during the COVID-19 pandemic, guaranteeing fair access is necessary. One way for authorities to do this is to uphold fair allocation principles in the various areas taken up so far, as well as in emergency critical care.

10 | FAIR ALLOCATION OF ICU AND CRITICAL CARE DEVICES: PRIORITIZATION OF PATIENTS

Resource allocation guidelines pertaining to in-hospital COVID-19 emergencies have the objective of fairly apportioning access to scarce critical care resources. In this specific context, what criteria ought to be applied? How can the interests of the worst off be protected? A survey undertaken before the current pandemic identified various criteria that have been offered for the allocation of critical care resources, including: “sickest first”, ‘waiting list’, ‘prognosis’, ‘behaviour’ (i.e., those who engage in risky behaviour should not be prioritized), ‘instrumental value’ (e.g., health care workers should be favoured during epidemics), ‘combination of criteria’ (i.e., a sequence of the ‘youngest first’, ‘prognosis’, and ‘lottery principles’), ‘reciprocity’ (i.e., those who provided services to the society in the past should be rewarded), ‘youngest first’, ‘lottery’, and ‘monetary contribution’. With specific reference to COVID-19, guidelines coming out of many countries have been offered, including those from the United States, Italy, France, and the Philippines. Considering that issues may arise in various contexts, it is helpful to be clear about the level of scarcity obtaining in a particular situation. The WHO Working Group on Ethics and COVID-19 distinguishes three levels of scarcity and their corresponding effects on the fair allocation of resources like ventilators: first, with little scarcity, first come, first served may be best for equality; second, with more scarcity, the prioritization of the worst off may be best; and third, “with even greater scarcity, a principle that aims to maximize benefit from the resource may be most justified.”

Of interest in this section is the scarcest level. In extreme situations where there are simply not enough resources to accommodate everyone in need, giving protection to the vulnerable could take a backseat as medical vulnerability, in the sense of having comorbidities, could be seen to indicate futility of critical care that includes ventilatory support. An early study showed that for COVID-19, the Case Fatality Rate (CFR) was elevated among those with preexisting comorbid conditions such as cardiovascular disease, diabetes, chronic respiratory disease, hypertension, and cancer. Another study of laboratory-confirmed cases of COVID-19 showed that “patients with any comorbidity yielded poorer clinical outcomes than those without” and “a greater number of comorbidities also correlated with poorer clinical outcomes.” Moreover, “persons with underlying chronic illnesses are more likely to contract the virus and become severely ill . . . [while those] with history of hypertension, obesity, chronic lung disease, diabetes, and cardiovascular disease have the worst prognosis and most often end up with deteriorating outcomes such as acute respiratory distress syndrome (ARDS) and pneumonia.”

A patient rendered vulnerable by comorbidities may be considered ineligible for the application of “intensive care treatments, in exceptional, resource limited circumstances.” Within Italy, COVID-19 deaths were mainly observed among older, male patients who were also suffering from multiple comorbidities. According to another study, “the existence of comorbidities increases the probability of dying from COVID-19 by 2.4 times compared to those who do not have pre-existing conditions.” In the United States, a study showed deaths were 12 times higher among patients with reported

145Krütli, P., et al. (2016) How to Fairly Allocate Scarce Medical Resources: Ethical Argumentation under Scrutiny by Health Professionals and Lay People. PLoS ONE. 11(7): e0159086. Retrieved March 23, 2020, from https://doi.org/10.1371/journal.pone.0159086

146Emanuel, E.J., et al. (2020, March 23). Fair Allocation of Scarce Medical Resources in the Time of Covid-19. The New England Journal of Medicine. Retrieved March 23, 2020, from https://www.nejm.org/doi/full/10.1056/NEJMsb2005114?query=featured_coronavirus

147Vergano, M., et al. (2020, March 16). Clinical Ethics Recommendations for the Allocation of Intensive Care Treatments, in Exceptional, Resource-Limited Circumstances. Italian Society of Anesthesia, Analgesia, Resuscitation, and Intensive Care (SIAARTI). Retrieved March 23, 2020, from http://www.siaarti.it/Assets/News/COVID19%20-%20documenti%20SIAARTI%20-%20COVID%20-%20Clinical%20Ethics%20Recommendations.pdf. opens in new tab.

150Azoulay, E., et al. (2020). Admission Decisions to Intensive Care Units in the Context of the Major COVID-19 Outbreak: Local Guidance from the COVID-19 Paris-Region Area. Critical Care. 24:1.

151Task Force Ethics Guidelines COVID-19 Philippines. (2020). Ethical Guidelines for Leaders in Health Care Institutions during the COVID-19 Pandemic. Philippine Journal of Internal Medicine. 58(1). Retrieved April 9, 2020, from https://www.pcp.org.ph/index.php/ojim/ojs/jim/1094-phil-journal-of-internal-medicine-vol-58-no-1.
underlying conditions compared with those without reported underlying conditions (19.5% versus 1.6%). Research findings such as these resulted in elderly patients being refused ventilatory support in Italy.\textsuperscript{162} The Independent reported that a doctor gave an account of medics being forced to ration care to patients in the wake of the COVID-19 outbreak such that elderly patients were being denied care based on their age and whether they had other conditions or not: “In Bologna, we are working with 80-years-old as our cut off, but between 65 and 80-years-old we still consider comorbidities.”\textsuperscript{161} There are similar accounts pertaining to Sweden’s Karolinska Institute.\textsuperscript{162,163}

Yet, the acceptance of advanced age in itself as an indicator of medical futility has to be conclusively established by evidence. Statistical findings of high mortality rates among patients belonging to the highest age groups can merely be reiterative of the high mortality rates among patients with comorbidities -- elderly patients have a higher likelihood of having more comorbidities. If we overlook this point, the elderly could be exposed to unfair allocation of resources based simply on their age rather than on their having comorbidities that leave them with poor chances of surviving with the use of critical care devices.\textsuperscript{164} As George Kuchel asserts, “having multiple chronic diseases and frailty is in many ways as or more important than chronological age” and “an 80-year-old who is otherwise healthy and not frail might be more resilient in fighting off infection than a 60-year-old with many chronic conditions.”\textsuperscript{165} In addition, recent studies have generated optimism about the success of measures to delay or minimize age-related immunological defects.\textsuperscript{166}

Admittedly, age serves as a useful indicator of the presence of comorbidities that the elderly are likely to have. However, the studies about chronological age and immunological developments cited above indicate that statistical correlation should not necessarily be taken to mean causal correlation. For this reason, age by itself should not be regarded as a valid basis for short-term triage decision-making. In the absence of validated empirical proof that a particular age level indicates the medical futility of applying scarce critical care resources, the vulnerability of patients that is associated with advanced age should instead signify a need for them to be given protection deserved by those who are worst off – the most vulnerable – among members of society.

Vulnerability can also give rise to injustice when a patient’s level of health literacy results in a failure accurately to communicate one’s medical history or the nature or intensity of symptoms being experienced. This exemplifies a failure in relation to the fair allocation of full and adequate information mentioned in an earlier section. For instance, a poor patient from a far-flung area with no prior knowledge about her condition may not mention relevant details in her history because she feels that these may not be important for a doctor’s diagnosis. When caregivers overlook this point and do not try hard enough to clarify to the patient what could be relevant, they could be compounding the effects of inequity in education, or dissemination of information. By their neglect, they allow the inequity to be manifested in the allocation of scarce lifesaving resources, especially in a triage situation. Where the dangers to a patient’s life may already be difficult to deal with, missing treatment opportunities just because of miscommunication is going to magnify the adverse impact of vulnerability. These examples of possible discrimination in a triage setting are most likely to affect those who belong to economically and educationally disadvantaged sectors of society because of their limited health literacy. Rather than being blamed on the disadvantaged themselves, a community’s level of health literacy should be presumed to be the result of a failure on the part of health authorities to convey pertinent information and make it understandable to the public.

Disadvantaged sectors are also more likely to be affected by disparities in the location of hospital facilities. In order to address the disproportionate access to critical care services by disadvantaged sectors, it would have been useful to have a monitoring, communication, and transport mechanism to facilitate their conveyance to pertinent facilities in case of need. Moreover, temporary measures established during this period have to make way for a more durable network for the just distribution of various levels of hospital care consistent with the concept of universal healthcare.

In light of the risk of the country’s emergency care infrastructure being overwhelmed by COVID-19, it may be tempting to invest huge sums of money on acquiring more critical care units and devices. However, a more sustainable response would be mindful of the unfair allocation of access to such resources. It would be more prudent to invest in a healthcare infrastructure that is anchored on equity and gives priority to the preventive aspects of healthcare that would give timely attention to the needs of
disadvantaged sectors and eventually ease the burden on more expensive tertiary care.

11 | THE NEW NORMAL

Everybody is hoping that solutions will soon emerge that can facilitate quick recovery and help individuals and families resume stable lives. Solutions being offered are expected to give rise to a new normal. Even when the government decides that the economic consequences are too much to bear for COVID-19 quarantine arrangements to continue, we cannot go back to the state of affairs that had to be suspended because of the emergency. We should now realize that we cannot just revive the suspended state.

Epidemiologists tell us that the COVID-19 pandemic will be with us far longer than we may have expected. While many studies on possible treatments or vaccines are being rushed, it has been observed that the progression of past influenza pandemics “was not substantially influenced by a vaccination campaign.” Even worse, we are reminded that “our record for developing an entirely new vaccine is at least four years — more time than the public or the economy can tolerate social-distancing orders.” We appear to be playing a waiting game where the cards are stacked against us.

According to studies, the pandemic is not likely to be under control until 55 to 70% of the population is immune, which has been estimated to be the threshold for acquiring herd immunity in the case of the current COVID-19 infection. If so, this outbreak may take 18 to 24 months. But there are even warnings that herd immunity may not work because of uncertainty concerning the duration of individual immunity to SARS-CoV-2 and the low seroconversion rates even in huge populations known to be COVID-19 hotspots. For instance, a study of 61,075 participants in Spain showed that only 5% developed antibodies. Seroconversion rates were all less than 4% for various subpopulations among 17,368 participants in China. These rates mean that a huge percentage of the population remains at risk for infection despite all the damage from the pandemic. Relying too much on the emergence of natural herd immunity will possibly just increase this damage.

In light of these considerations, there have been many predictions of what we are likely to see in a new normal -- wearing a face mask becoming routine, an occasional cough being regarded as a threat, workplaces feeling like hot zones, and public transit being personally dangerous. We can anticipate less travel, disruptions to consumer supply chains, social anxiety, heightened agoraphobia and, overall, greater mistrust in one another. As a corollary to physical distancing, digital interconnection is going to be intensified. We have seen this already in the accelerated shift to phone and internet banking.

In the move from dine-in to take-out and delivery modes of restaurant food consumption, in the spike of online shopping activities, and even in the accommodation of online religious worship, in the Philippines, religious services have been broadcast through social media while physical attendance in places of worship has been limited to a handful. A similar trend is going to be part of the new normal for many aspects of healthcare. We have seen how

167Kissler, S.M., et al. (2020). Projecting the Transmission Dynamics of SARS-CoV-2 through the Postpandemic Period. Science. Retrieved August 16, 2020, from 10.1126/science.abb5793
168Thompson, S.A. (2020). How Long Will a Vaccine Really Take? The New York Times. Retrieved May 16, 2020, from https://www.nytimes.com/interactive/2020/04/30/opinion/coronavirus-covid-vaccine.html
169Kwok, K.O., et al. (2020, March 21). Herd Immunity – Estimating the Level Required, to Halt the COVID-19 Epidemics in Affected Countries. Journal of Infection. 80(6). Retrieved May 10, 2020, from https://doi.org/10.1016/j.jinf.2020.03.027
170Thompson, S.A. (2020). How Long Will a Vaccine Really Take? The New York Times. Retrieved May 16, 2020, from https://www.nytimes.com/interactive/2020/04/30/opinion/coronavirus-covid-vaccine.html
171Kissler, S.M., et al. op. cit. note 169.
172Moore, et al., op. cit. note 167.
telehealth has taken on an increased role in the country. Telehealth can play a huge role in the new normal and we should make it happen.

Realistic estimates of how long it will take before we can have a vaccine, if possible at all, together with real concerns about the possibility that other infectious diseases (or global disasters) could come and endanger global health security, impress upon us that the radical changes in our way of life are going to persist even beyond the development of a COVID-19 vaccine. A new normal has begun to set in. The new normal is a sum total of the things that we can do as a departure from what we could do before the pandemic, the new things that we have to learn to do and the new ways in which we have to do these things, the political and cultural structures that are developing, and in general, the ways in which we will have to live our lives because of the challenges that have confronted us and are likely to continue to confront us. The new normal also refers to the period in which citizens are expected to become accustomed to the emerging state of things.

As we transition to the new normal and address the challenges that are coming our way, we have to remember that our ability to overcome the problems confronting us during the pandemic has been premised on the equitable sharing of resources. The efforts being exerted to contain the COVID-19 pandemic in the Philippines are being focused on addressing manifestations of underlying inequities – though that is perhaps happening more coincidentally than deliberately, and many efforts have been highly problematic and insufficient as pointed out in this paper. Because the insufficient efforts have been triggered by the existence of an emergency, most of the response measures are meant to be temporary. People on the brink of starvation have been receiving emergency food aid, and those with no financial savings have been receiving cash assistance. However, these efforts have neither been fully successful nor sustainable. Those who could not be isolated or quarantined have been evacuated, but these evacuation facilities are also temporary and the occupants are going to be reinstated in their cramped dwellings that cannot protect them from new transmissions or other communicable diseases in the future. If the inequities continue in the new normal, the normal is not going to be really new. The vulnerable are going to remain vulnerable and Philippine society will not be more prepared for the next pandemic.

Clearly, the lesson is that everyone, especially the most economically disadvantaged, need to have access to the resources that relate to their healthcare, inter alia, – adequate and accurate information so they can be properly advised about their healthcare needs; clean flowing water so they can wash their hands properly; and dwelling units that will give them the capability to be isolated from neighbours or from household members who can be infected. In support of these necessities, they will require employment opportunities that can yield fair wages or other opportunities to generate adequate income, and social and health insurance coverage that they can fall back on in times of need. Subject to certain logistical limitations, the Philippine government has seen the indispensability of temporarily providing the required resources to disadvantaged sectors. However, a lot more needs to be done. The distribution of resources has to proceed in a way that transcends the long-standing barriers associated with structural social inequities. Sustained fair allocation founded on equality, equity, and the prioritization of the worst off is indispensable. Sustainability is critical because, as has been pointed out, the problems that need to be addressed are chronic pre-pandemic inequities that are being magnified by the health emergency.

There is evidence that the need to improve the plight of the resource challenged has been partially acknowledged by the more economically advantaged sectors of Philippine society. Small and big business companies in the Philippines have made huge contributions to help provide for their emergency needs. The private sector has supported the national government, local government units, and the general population by providing wages to employees who could not work, monetary assistance, relaxed working conditions, emergency transportation, food products, ventilators, test kits, Personal Protective Equipment, and many other goods and services that can help everyone overcome the current crisis. Beyond this, these privileged sectors have to realize that what they have helped provide during the emergency is something that needs to be available in the long term and institutionalized for society to survive future pandemics and for their businesses to continue to thrive. Institutionalization requires arrangements that would provide realistic opportunities for disadvantaged sectors to acquire the goods and services that they need beyond the period of the current emergency.

As we transition to the new normal the most economically deprived should seize the opportunity to establish how important the improvement of their situation is in order for the current widespread problems to be properly addressed. While disadvantaged sectors continue to be dependent on others because of their vulnerability, society should seek to translate the realization that the health and security of the more privileged is dependent on the health and security of everybody else in society into sustainable measures to improve the conditions of the worst off and narrow the gaps between its most endowed and least endowed sectors.

In the new normal, there must be institutionalized safety nets that can be accessed when things go wrong. People should not have to beg and fight for places in dignity-sapping queues for the distribution of emergency social amelioration funds -- these should be available to

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184Beltran, M. (2020, May 12). The Philippines’ Pandemic Response: a Tragedy of Errors. The Diplomat. Retrieved July 7, 2020, from https://thediplomat.com/2020/05/the-philippines-pandemic-response-a-tragedy-of-errors/

185Esquerra, D.J. (2020, April 24). Palace: No More Cash Aid for Poor Families in Areas with Lifted ECQ. Inquirer.net. Retrieved July 5, 2020, from https://newinfo.inquirer.net/1264069/palace-no-more-cash-aid-for-poor-families-in-areas-with-lifted-ecq

186Geducko, A. (2020, May 30). Palace: No More Cash Aid this June. Manila Bulletin. Retrieved July 5, 2020, from https://mb.com.ph/2020/05/30/palace-no-more-cash-aid-this-june/

187Anonymous. (2020, March 23). Aid from Philippine Companies during Coronavirus Pandemic. Rappler. Retrieved April 27, 2020, from https://www.rappler.com/business/235591-aid-philippine-companies-coronavirus-pandemic
them as a matter of right. People should not have to be rushed to temporary isolation and quarantine places – prioritizing the concerns of the worst off is essential for the improvement of everybody’s health. To provide them with home spaces that will enable them to care for the sick while still protecting themselves also advances the health interests of everybody else in the country. This reality acquires an unprecedented level of concreteness in the context of a pandemic such as the one that we are currently experiencing. In the new normal, those who require medical attention should be protected by universal healthcare; we ought to realize that "those in the greatest need often have the poorest access to care – a striking example of unfairness." Very importantly, people should know all of these, what to do and where to go when they require services because, in the new normal, information will have to be dispensed efficiently and equitably regardless of the people’s level of understanding.

We see the entirety of the telehealth movement as a paradigm of how response measures ought to be characterized. It uses advanced technology to promote access by the underprivileged to the most important healthcare services. It listens to patients and gives them an opportunity to participate in their own care. What it is trying to do in the course of the current pandemic is something that is only a part of what it should aim to accomplish in the long term. Thus, it should be part of a sustained effort that can have a good chance to narrow the gap between the economically privileged and the economically challenged. It exists in sharp contrast with measures meant to address the lack of isolation spaces in many people’s dwellings. The isolation and quarantine facilities that have been set up are clearly temporary facilities that cannot be retained beyond the period of the emergency. The people currently using them will be going back to their informal settlements without any prospects of having their living conditions improved. Learning from these comparisons, we see the need to observe a number of criteria for evaluating COVID-19 response options consistent with the principles of equality, equity and the prioritization of the worst off:

1. Showing equal respect for all stakeholders by:
   a. involving them in consultations prior to the finalization of decisions and their implementation, consistent with what we have said about the relationship between the carer and the cared for
   b. upholding human rights, e.g. the right to health
   c. being mindful of the differences among individuals and groups that can render people more vulnerable to the impact of the pandemic
2. Promoting equity by giving priority to those who lack the means to cope with possibly traumatic impact on their own -- the underprivileged and vulnerable
3. Enhancing sustainability -- giving preference to measures that can be maintained beyond the period of the current pandemic in anticipation of future emergencies

4. Putting a premium on healthcare that tends to improve the conditions of the worst off

12 | CONCLUSION

Using a fair allocation approach, this paper has highlighted how closely the experiences of various socio-economic and political sectors are bound inextricably together. The various factors leading to the high rate of transmissibility of the SARS-CoV-2 virus, the high mortality rate, the need for isolation and quarantine, the indispensability of help coming from various types of frontline workers, and the need for large numbers of ICU facilities and healthcare workers have established very forcefully the interconnectivity and interdependence of all human beings regardless of sex, ethnic origin, age, economic class, or nationality. In the presence of the highly transmissible SARS-CoV-2, one person’s virus could literally be every person’s infection because of our physical interconnectivity, as discussed above. It is because of our interconnectedness and interdependence that, in a very real sense, every person is every other person’s keeper -- one cannot be safe if the other person is not safe.

We have observed that problematic experiences during the COVID-19 pandemic have arisen from systemic and persistent inequities. The interconnected and overlapping fronts that we have had to face in the course of the pandemic in the country are evidently related to the inequitable social and economic circumstances that existed way before the pandemic became a threat. The interconnection between the proper allocation of societal resources and the health status of society in general cannot be overlooked. The short-term efforts exerted to contain the pandemic have to be aimed at addressing the inequities. Having existed for a long time, these inequities deserve everyone’s attention not only during the pandemic but also when we emerge from it. This glaring reality may have been overlooked as authorities focus on the short term and see the measures as a requirement to tide us over until we can go back to normal. Thus, addressing the manifestations of the inequities has happened incidentally rather than deliberately, using stop-gap rather than long-term measures.

Yet, what we are going through now is not merely a fleeting disaster but an instantiation of chronic injustice characterized by inequities on many fronts. The totality of our experiences relating to the pandemic constitutes evidence that the inequitable access to essential goods and services needs to be overcome – not only for the sake of the underprivileged but also for the sake of everybody else regardless of economic, political, or social status. What is being asked of us is not merely to provide for people’s needs during an emergency but to manifest our realization that fellow Filipinos are countryfolk with whom we are interconnected and

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189Whitehead, & Dahlgren., op. cit. note 11.

189Kelly, M. (2020, May 14). An Appeal for Practical Social Justice in the COVID-19 Global Response in Low-Income and Middle-Income Countries. The Lancet Global Health. Retrieved May 20, 2020, from https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(20)30249-7/fulltext
interdependent “art bound by one fate, by the same joys and sorrows and by common aspirations and interests.” Apolinario Mabini, one of our nation’s heroes, wrote these words having in mind a war time context, and went on to say: “unite in a perfect solidarity of purpose and interest, in order to have force, not only to resist the common enemy but also to attain all the aims of human life.” A war is precisely what many of us think we are in the midst of today; the solidarity we seek can only find fulfilment in a new normal characterized by social, economic and political equity.

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