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ENSURING NON-DISCRIMINATION IN THE CONTEXT OF COVID-19 TRIAGE PROTOCOLS

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First, I want to express how very honored I am to be here today and to express my sincere thanks to the Conference Organizers and Sponsors, Members of the International Law Commission and fellow panelists here today.

As other panelists have expressed, international law has a critical role to play in adopting and facilitating the implementation of norms to prevent and react effectively to pandemics.¹

Today I would like to focus particularly on the role international law has to play in ensuring that the real or perceived limitations of States' health care resources are not allocated on the basis of discrimination.

What I am referring to is health care rationing, a term used to denote triage strategies such as 'Do Not Resuscitate' orders and other

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1. See *Pandemics and International Law*, YOUTUBE (Nov. 18, 2020), <https://youtu.be/t-wcYGfv3-w>.

protocols that determine who gets prioritized in care.² We know that rationing will likely occur and is already occurring. As of today, there are 55,936,901 active cases of COVID-19 and 1,343,116 deaths attributable to the virus.³ There are a finite number of ventilators, hospital beds, care providers, nurses, and doctors to serve the rising number of persons in need of vital medical care who contract COVID-19.⁴ Necessarily, States and governments are developing protocols for rationing care and plans for how they will make decisions as to who will be prioritized and afforded care and treatment.

The protocols informing health care rationing are raising grave concerns for groups who, in practice, are deprioritized and not provided equitable care. These concerns are not theoretical. Guidance within numerous States' and governments' triage plans show that younger persons and persons perceived as healthier will be prioritized over those with less physical ability or cognition, and overall worse general health.⁵ The United States Centers for Disease Control and Prevention (CDC) has proposed a rationing protocol based on age, disability, health conditions and body size—which it has labeled a

2. See generally Bo Chen & Donna Maria McNamara, *Disability Discrimination, Medical Rationing and COVID-19*, 12 ASIAN BIOETHICS REV. 511 (2020), <https://doi.org/10.1007/s41649-020-00147-x> (using a human rights lens to analyze the number of 'Do Not Resuscitate' orders imposed on people with disabilities).

3. WHO Coronavirus Disease (COVID-19) Dashboard, WORLD HEALTH ORG. <https://covid19.who.int/> (last visited Nov. 17, 2020) (maintaining an up-to-date record of COVID-19 cases and deaths around the world).

4. Abigail Beall, *The Heart-Wrenching Choice of Who Lives and Dies*, BBC (Aug. 28, 2020), <https://www.bbc.com/future/article/20200428-coronavirus-how-doctors-choose-who-lives-and-dies> (reporting on the difficult ethical decisions doctors must face in deciding who should receive treatment in times of resource scarcity).

5. See, e.g., *Re: Complaint of Disability Rights Washington, Self Advocates in Leadership, The Arc of the United States, and Ivanova Smith Against the Washington State Department of Health (WA DOH), the Northwest Healthcare Response Network (NHRN) and the University of Washington Medical Center (UWMC)*, DISABILITY RTS. WASH. (Mar. 23, 2020), http://thearc.org/wp-content/uploads/2020/03/OCR-Complaint_3-23-20.pdf (mentioning the state-run University of Washington Medical Center's policy as an example).

“comorbidity.”⁶ New York’s 2015 guidelines on ventilator use⁷ acknowledge the inequity of considering age as a relevant factor but nonetheless dictate that children under the age of eighteen will be given priority over adults in cases where there would be equal benefit from ventilator use.⁸ Italy, one of the countries hit worst by the pandemic, mentions the word “age” twice in their triaging guidelines, both in the context of factoring age into triaging decisions.⁹ Switzerland adopted guidelines during COVID-19 that, during cases of resource limitations, automatically exclude patients above eighty-five from ventilator access and exclude those over seventy-five who have certain comorbidities.¹⁰ In South Africa, a score-based protocol has been put into place, scoring patients to predict their potential mortality.¹¹ Age is used as a “tie breaker,” with older patients being

6. Katrina N. Jirik, *Disability and Rationing of Care amid COVID-19*, HARV. L. PETRIE-FLOM CTR. (Apr. 13, 2020), <https://blog.petrieflom.law.harvard.edu/2020/04/13/disability-and-rationing-of-care-amid-covid-19> (discussing the rationing protocol and referring to it as “updated eugenic[s]”).

7. *Ventilator Allocation Guidelines*, N.Y. DEP’T OF HEALTH (Nov. 2015), https://nysba.org/app/uploads/2020/05/2015-ventilator_guidelines-NYS-Task-Force-Life-and-Law.pdf.

8. Chiara Caraccio, Robert S. White, & Rohan Jotwani, *No Protocol and No Liability: A Call for COVID Crisis Guidelines that Protect Vulnerable Populations*, 9 J. COMP. EFFECTIVENESS RES. 829, 832 (July 24, 2020), <https://doi.org/10.2217/cer-2020-0090>.

9. Matteo Cesari & Marco Proietti, *COVID-19 in Italy: Ageism and Decision Making in a Pandemic*, 21 J. POST-ACUTE LONG-TERM CARE MED. 576, 576 (Apr. 1, 2020), <https://doi.org/10.1016/j.jamda.2020.03.025> (quoting the two “critical paragraphs” in which the word “age” appears).

10. Patricia Barnes, *Sentencing Older COVID-19 Patient’s to Death by Triage*, FORBES (July 2, 2020, 6:14 PM), <https://www.forbes.com/sites/patriciagbarnes/2020/07/03/sentencing-older-covid-19-patients-to-death-by-triage/?sh=5937d629276b> (acknowledging that Switzerland’s approach might “result in a younger candidate with a lower chance of survival receiving priority over older patients for treatment”).

11. N. Erasmus, *Age Discrimination in Critical Care Triage in South Africa: The Law and the Allocation of Scarce Health Resources in the COVID-19 Pandemic*, 110 S. AFR. MED. J. 1172, 1172 (2020), <http://www.samj.org.za/index.php/samj/article/view/13139/9613> (commenting that this score-based approach disproportionately discriminates against older adults, individuals who are cognitively and physically impaired, and individuals with disabilities).

deprioritized, even if they have the same score as someone younger.¹²

Evidence for discriminatory triage protocols can also be found in a recent survey on ventilator triage protocols in the United States led by the Association of Bioethics Program Directors (ABPD) which found that 38.5% of hospital protocols designate persons in need of greater clinical attention and resource use of lower priority.¹³ It further found that only 26.9% of hospital policies specified that triage decisions should not be based on disability.¹⁴ Similarly, organizations of persons with disabilities have raised serious concerns¹⁵ about the discriminatory impacts of triage protocols that use criteria that could result in denial or removal of care of persons with disabilities, resulting in the discriminatory denial of the rights to health—and life. To provide just one example, triaging patients based on assumptions for long-term survival may disadvantage persons with disabilities, not only by preventing them access to lifesaving resources, but also because it may deny them the right to have an individual assessment by healthcare workers, instead subjecting them to decisions about their care based on stereotypes.¹⁶

12. *Id.*

13. Caraccio, White, & Jotwani, *supra* note 8, at 829 (citing Arnand H. Matheny Antommara et al., *Ventilator Triage Policies During the COVID-19 Pandemic at U.S. Hospitals Associated with Members of the Association of Bioethics Program Directors*, ANN. INTERN. MED. 1, 4 (2020)).

14. *Id.*

15. Stephanie Collins & Jane Buchanan, *US Disability Groups Push for Equality in Covid-19 Response*, HUM. RTS. WATCH (Apr. 22, 2020, 5:07 PM), <https://www.hrw.org/news/2020/04/22/us-disability-groups-push-equality-covid-19-response#> (providing examples of human rights groups in the United States that have been challenging discriminatory state policies on emergency care).

16. Elizabeth Pendo, *COVID-19 and Disability-Based Discrimination in Health Care*, AM. BAR ASSOC. (May 22, 2020), <https://www.americanbar.org/groups/diversity/disabilityrights/resources/covid19-disability-discrimination/> (examples of discriminatory decision-making include “categorical exclusions based on disability; explicit or implicit quality-of-life assessments; assumptions regarding long-term survival that disadvantage people with disabilities; failure to incorporate reasonable modifications in receiving treatment, including allowing for a longer time on a ventilator; provisions authorizing reallocation of ventilators from chronic ventilator users to other patients; assumptions or concerns about the ability of people with intellectual and developmental disorders to comply with post-treatment protocols; and overall failure to require an individual assessment of each patient to avoid decisions based on diagnoses and stereotypes”).

Concern over discriminatory health care rationing is also being articulated at the universal level. The U.N. Independent Expert on the enjoyment of all human rights by older persons reports that arguments have been put forward questioning the worth of saving older people's lives where medical resources such as ventilators in intensive care units are limited.¹⁷ Accordingly, the Independent Expert has emphasized that “[t]riage protocols must be developed and followed to ensure such decisions are made on the basis of medical needs, the best scientific evidence available and not on non-medical criteria such as age or disability.”¹⁸

There is also compelling evidence that any triage policy which includes the presence of comorbidities may very likely discriminate against racial minorities.¹⁹ Both African American and Hispanic patients are more likely to suffer kidney failure, congestive heart failure, and chronic liver disease than their white counterparts.²⁰ Yet, according to the ABPD study, 95% of ventilator triage protocols utilize an assessment of organ failure in making initial determinations about resource allocation.²¹ Such an approach creates policies that funnel resources away from minority populations and place them at higher risk for COVID-19-related complications or death. Data from the United States' CDC provides further evidence for this concern, finding that non-white individuals are between 1.1 to 3.7 times more likely to be hospitalized for COVID-19, and 1.0 to 2.4 times more

17. Rosa Kornfeld-Mattee, “Unacceptable” – UN Expert Urges Better Protection of Older Persons Facing the Highest Risk of the COVID-19 Pandemic, U.N. OFF. HIGH COMM’R FOR HUM. RTS. (Mar. 27, 2020), <https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=25748>.

18. *Id.*

19. See *We Must “Revitalize Our Forces for Racial Equality and Justice,” Says COVID-19 Panel*, U.N. OFF. HIGH COMM’R FOR HUM. RTS. (Mar. 2, 2021), <https://www.ohchr.org/EN/NewsEvents/Pages/Racial-discrimination-COVID.aspx> (discussing racial and ethnicity-based discrimination in the context of COVID-19); cf. Alexander F. C. Hulsbergen et al., *Ethical Triage During the COVID-19 Pandemic: a Toolkit for Neurosurgical Resource Allocation*, 162 ACTA NEUROCHIRURGICA 1485, 1488 (2020), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7220806/> (cautioning that even if certain societal groups have a lower “healthy” life expectancy, this stratification should not be used for making triage decisions).

20. Caraccio, White, & Jotwani, *supra* note 8, at 832.

21. *Id.*

likely to die from COVID-19.²²

Triage or health care rationing on a discriminatory basis is also evident in the context of detention. In the United States, one in five prisoners has had COVID,²³ and there have been over 275,000 cases within U.S. prisons as a whole.²⁴ Immigration detention centers are also hotspots for COVID-19 transmission, with some immigrants voluntarily choosing deportation in order to avoid the risk of disease.²⁵ This manifestation of discriminatory health care rationing is perhaps less studied in that it appears this population is fully omitted from health care triage plans.²⁶ Like other infectious diseases, COVID-19 poses a higher risk to populations in places of detention, such as prisons, jails, and immigration detention centers, where the virus can spread rapidly and access to personal protective equipment (PPE) is extremely limited and access to health care already poor.²⁷ A recent

22. *Risk for COVID-19 Infection, Hospitalization, and Death by Race/Ethnicity*, CTRS. FOR DISEASE CONTROL AND PREVENTION, <https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html> (last visited Feb. 18, 2021)

23. Beth Schwartzapfel, Katie Park, & Andrew Demillo, *1 in 5 Prisoners in the U.S. Has Had COVID-19*, MARSHALL PROJECT (Dec. 18, 2020, 6:00 AM), <https://www.themarshallproject.org/2020/12/18/1-in-5-prisoners-in-the-u-s-has-had-covid-19>.

24. Madeleine Carlisle & Josiah Bates, *With Over 275,000 Infections and 1,700 Deaths, COVID-19 Has Devastated the U.S. Prison and Jail Population*, TIME (Dec. 28, 2020, 2:52 PM), <https://time.com/5924211/coronavirus-outbreaks-prisons-jails-vaccines>.

25. Hannah Dreier, *To Stay or to Go?*, WASH. POST (Dec. 26, 2020), <https://www.washingtonpost.com/nation/2020/12/26/immigration-detention-covid-deportation/?arc404=true> (noting that some immigrants must choose between endangering their lives in U.S. detention centers or returning to the countries they fled from and facing dangers there).

26. *See generally Systemic Indifference: Dangerous & Substandard Medical Care in US Immigration Detention*, HUM. RTS. WATCH (May 8, 2017), <https://www.hrw.org/report/2017/05/08/systemic-indifference/dangerous-substandard-medical-care-us-immigration-detention> (“serious lapses in health care . . . have led to severe suffering and at times the preventable or premature death of individuals held in immigration detention facilities in the United States”).

27. *See* Schwartzapfel, Park, & Demillo, *supra* note 23 (attributing the rapidity of the spread to prisoners’ inability to socially distance); *see also* Emily Widra & Dylan Hayre, *Failing Grades: State’s Responses to COVID-19 in Jails & Prisons*, PRISON POL’Y INITIATIVE (June 25, 2020), https://www.prisonpolicy.org/reports/failing_grades.html (noting that in prisons and jails, “social distancing is impossible, sanitation is poor, and medical resources are

report from the Associated Press and Marshall Project shows that approximately 20% of all inmates in U.S. state and federal prisons have been infected—a rate more than four times the general population.²⁸ Further, a nationwide review of state plans for administering vaccines in prisons shows that the majority prioritized vaccinating prison staff over incarcerated people.²⁹ Similarly, according to a recent Federal Bureau of Prisons press release, the federal prison system plans to vaccinate prison employees but has no immediate plans to inoculate prisoners.³⁰ The deprioritization of prisoner’s right to health and safety is, according to advocates, being driven by public antipathy towards people convicted of crimes rather than evidence-based data on the particular vulnerabilities of persons in places of detention.³¹ And, where states are prioritizing prisoners, there has been ample pushback.³² After the state of Colorado published its vaccine distribution plan that appeared to place incarcerated persons in line for the vaccine before seniors, there was a public outcry, after which the state’s governor stated multiple times that those in prison should not and would not be vaccinated prior to the general public.³³ The public’s reaction to Colorado’s vaccine distribution plan

extremely limited”).

28. Schwartzapfel, Park, & Demillo, *supra* note 23.

29. *But see* David Montgomery, *Prioritizing Prisoners for Vaccines Stirs Controversy*, PEW (Jan. 5, 2021), <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2021/01/05/prioritizing-prisoners-for-vaccines-stirs-controversy> (explaining that Connecticut, Delaware, Maryland, Massachusetts, Nebraska, New Mexico and Pennsylvania have designated inmates as top priority “Phase One” recipients for vaccines, according to the Prison Policy Initiative’s December survey published in January 2021).

30. *Id.*

31. *See id.* (noting that in spite of the rapidity in which COVID-19 spreads through prison populations, some Colorado residents were outraged by a draft version of the state’s vaccine distribution plan which put incarcerated individuals ahead of non-incarcerated seniors and residents with certain health maladies).

32. *But see States Across the U.S. Are Taking Different Approaches Towards Vaccinating Inmates*, NAT’L PUB. RADIO (Feb. 22, 2021), <https://www.npr.org/2021/02/22/970278576/states-across-the-u-s-are-taking-different-approaches-toward-vaccinating-inmates> (acknowledging that the Colorado Governor’s decision *not* to prioritize inmates for the vaccine has also been met with scrutiny).

33. Alex Burness, *Gov. Polis Says Colorado Prisoners Shouldn’t Get COVID-19 Vaccine Before Free People*, DENVER POST (Dec. 1, 2020), <https://www.denverpost.com/2020/12/01/polis-covid-vaccine-prison-jail-colorado>.

reflects long-standing societal discrimination against detained individuals that is playing out through inequitable vaccine distribution protocols.

These are just a few examples of groups that appear deprioritized in health rationing protocols on a discriminatory basis, including age, dubious “quality of life” arguments based on ableness, and devaluing persons within places of detention.³⁴ The question of health care rationing is always difficult, but the “answers” cannot be rooted in discriminatory beliefs which equate some lives as more valuable than others.³⁵ Further, as I will discuss more fully, the triage priorities articulated in these examples are illegal under international law because they prioritize the enjoyment of some people’s right to health—and possibly to life—on a discriminatory basis. Any plan that discriminates on the basis of age, ability, or level of health violates the legal rights of people and is unlawful.³⁶

Thankfully, international law provides extensive guidance to States on ensuring non-discrimination that can be applied to the context of COVID-19 triage protocols and related resource rationing.

The rights to equality and non-discrimination are the foundations of international human rights law. Most broadly, these principles are enshrined in Article 1 of the Universal Declaration of Human Rights, which proclaims that all human beings are “born free and equal in dignity and rights.”³⁷ Article 2 further provides that everyone is

34. See G.A. Res. 217 (III) A, Universal Declaration of Human Rights, art. 2, U.N. Doc. 217 A(III) (Dec. 10, 1948) [hereinafter UDHR] (providing that “[e]veryone is entitled to all the rights and freedoms set forth in this Declaration without distinction of any kind . . .”).

35. *Id.* arts. 2, 25 (prohibiting the application of codified rights in a discriminatory manner and providing that “[e]veryone has the right to a standard of living adequate for the health and well-being of himself and of his family . . .”).

36. See International Convention on Civil and Political Rights, art. 26, 999 U.N.T.S. 171 (1976) [hereinafter ICCPR] (providing that “the law shall prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.”); *Equality and Non-discrimination*, <https://www.un.org/ruleoflaw/thematic-areas/human-rights/equality-and-non-discrimination/> (last visited Apr. 20, 2021 (noting how the principles of equality and non-discrimination are part of the foundations of the rule of law).

37. UDHR, *supra* note 34, art. 1.

entitled to human rights and freedoms “without distinction of any kind.”³⁸ The Declaration also recognizes the right to conditions “adequate for the health and well-being” of all.³⁹

Under the International Covenant on Economic, Social and Cultural Rights (ICESCR), ratified by 160 States, everyone has the right to “the highest attainable standard of physical and mental health.”⁴⁰ To ensure this right, State parties to the ICESCR are obligated to take effective steps for the “prevention, treatment and control of epidemic, endemic, occupational and other diseases.”⁴¹ The United Nations Committee on Economic, Social and Cultural Rights, which monitors state compliance with the ICESCR, has clarified in General Comment No. 14 that the right to health includes that, in relevant part, services are: available in sufficient quantity; accessible to everyone without discrimination, and affordable for all, including marginalized groups.⁴² Accordingly, triage protocols that deny medical care based on stereotypes, assessments of quality of life, or judgments about a person’s perceived chance of survival based on the presence or absence of disabilities or age are not just incompatible with the obligation to prevent discrimination but are actively promoting discriminatory protocols and policies.⁴³

Similarly, the 167 State parties to the International Covenant on Civil and Political Rights (ICCPR) have undertaken to guarantee the rights within the Covenant without discrimination, even during national emergencies.⁴⁴ The ICCPR strictly prohibits measures by States in the context of emergencies that discriminate solely on the ground of race, color, sex, language, religion or social origin.⁴⁵ The Siracusa Principles issued by the United Nations Economic and Social Council in 1984, and general comments of the United Nations Human

38. *Id.* art. 2.

39. *Id.* art. 25.

40. International Covenant on Economic, Social and Cultural Rights art. 12, 993 U.N.T.S. 3 [hereinafter ICESCR].

41. *Id.* art. 12(c).

42. Economic and Social Council, *General Comment No. 14: The Right to the Highest Attainable Standard of Health (art. 12)*, U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000) [hereinafter ICESCR General Comment 14].

43. *See generally id.*

44. ICCPR, *supra* note 36, art. 2.

45. ICCPR, *supra* note 36, art. 4.

Rights Committee on states of emergency similarly require governments to consider the disproportionate impact on specific populations or marginalized groups when implementing measures related to public health and emergencies.⁴⁶ Further, the Siracusa Principles require that any State measures be based on scientific evidence, neither arbitrary or discriminatory in application, and respectful of human dignity.⁴⁷ These are two very pointed examples of how paramount non-discrimination is in international law. It is preserved in the ICCPR and underscored by U.N. commentary, remaining in effect throughout national emergencies, including COVID-19.⁴⁸ Accordingly, States are obligated, without exception, to ensure that health care triage protocols and other measures related to the management of COVID-19 do not violate the principle of non-discrimination.⁴⁹

A number of international legal instruments also create relevant obligations for States to ensure equal treatment of persons deprived of liberty. The ICCPR specifically provides that “all persons deprived of their liberty should be treated with humanity and with respect for the inherent dignity of the human person.”⁵⁰ The “right to the highest attainable standard of physical and mental health” provided by the ICESCR extends to all persons, whether they are deprived of liberty or not.⁵¹ More specific rules regulating the treatment and well-being of persons in place of detention were developed in 1955 through the

46. See Economic and Social Council, *Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights*, U.N. Doc. E/CN.4/1985/4, ¶¶ 39-70 (Sept. 28, 1984) [hereinafter *Siracusa Principles*] (setting forth the permissible derogations from rights guaranteed in the ICCPR during periods of public emergency while setting limits and stipulating some rights that are non-derogable).

47. *Id.*

48. ICCPR, *supra* note 36, art. 2; *Siracusa Principles*, *supra* note 46, ¶¶ 39-70.

49. See Chen & McNamara, *supra* note 2, at 512, 517 (arguing that medical rationing should be solely based on medical necessity and must not negatively take into account individual identities or experiences such as disability or age); *COVID-19 does not discriminate; nor should our response*, UNITED NATIONS HUM. RTS. OFF. HIGH COMM’R, <https://www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=25730&LangID=E> (last visited Apr. 13, 2021) (contending that pandemic mitigation measures should not be applied in a discriminatory manner).

50. ICCPR, *supra* note 36, art. 10(1).

51. ICESCR, *supra* note 40, art. 12.

United Nations Standard Minimum Rules for the Protection of Prisoners (SMR).⁵² The SMR establishes standards and principles governing health care and treatment of persons in custody.⁵³ Subsequently, the United Nations adopted the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment and the Basic Principles for the Treatment of Prisoners.⁵⁴ These instruments should be consulted by States to better manage COVID-19 infections and protocols for ensuring the safety of persons in places of detention. By consulting these instruments during the creation and revisions of protocols for COVID-19 management, States can ensure that persons in places of detention are equally considered and protected during the pandemic.

Along with the instruments described above, the International Convention on the Elimination of All Forms of Racial Discrimination 1965 (ICERD),⁵⁵ the United Nations Convention on the Rights of Persons with Disabilities 2008 (CRPD),⁵⁶ and the United Nations Independent Expert on the enjoyment of all human rights by older persons further require their States parties to ensure non-discrimination.⁵⁷ These, along with numerous legal instruments interpreting the obligations enshrined in these Conventions, create a clear obligation for States to ensure all persons are afforded full and equal enjoyment of the right to health.

With respect to codified law on pandemics specifically, Article 42 of the International Health Regulations of 2005, which pertains to the

52. G.A. Res. 70/175, *United Nations Standard Minimum Rules for the Protection of Prisoners*, U.N. Doc. A/RES/70/175 (Aug. 30, 1955).

53. *Id.* at Rules 1, 24 (providing that “[n]o prisoner shall be subjected to degrading treatment” and that “[p]risoners should enjoy the same standards of health that are available in the community . . .”).

54. G.A. Res. 43/173, *Body of Principles for the Protection of All Persons under Any form of Detention or Imprisonment*, U.N. Doc. A/RES/43/173 (Dec. 9, 1988).

55. International Convention on the Elimination of All Forms of Racial Discrimination, 660 U.N.T.S. 195 [hereinafter ICERD].

56. G.A. Res. 61/106, *Convention on the Rights of Persons with Disabilities*, U.N. Doc. A/RES/61/106 (Jan. 24, 2007).

57. UNITED NATIONS INDEPENDENT EXPERT ON THE ENJOYMENT OF ALL HUMAN RIGHTS BY OLDER PERSONS FURTHER REQUIRE THEIR STATES PARTIES TO ENSURE NON-DISCRIMINATION, <https://www.ohchr.org/en/issues/olderpersons/ic/pages/icolderpersons.aspx> (last visited Feb. 18, 2021).

implementation of health measures, requires that measures taken pursuant to the regulations shall be applied in a transparent and non-discriminatory manner.⁵⁸ This specific codification in the context of pandemics, along with the well-settled principle of non-discrimination of international law, makes it unequivocally clear that there can be no denial of the right to health based on discrimination, even in a pandemic where States face resource scarcity.⁵⁹

At a bare minimum, these obligations require that States tailor their rationing protocols to ensure that the allocation of medical care and resources is not distributed in a discriminatory manner.⁶⁰ To achieve this, transparency and full disclosure of the means and rationale informing States' rationing plans is essential. Likewise, States' rationing plans should be informed by international law and in recognition of the obligations to ensure non-discrimination and equal enjoyment of the right to health. In some circumstances, non-discrimination could be achieved by utilizing blind decisions on resource allocation and prioritization of care to ensure just treatment. "Blinded" decision-making can eliminate the possibility of implicit bias playing a role in triage decisions.⁶¹ Other scenarios may call for a different approach where equity is an issue, namely where certain groups are disproportionately affected and therefore require identity to be a factor in triage decisions. In these situations, triage criteria that seek to maximize saved lives without factoring inequalities in the right

58. International Health Regulations, 2509 U.N.T.S. 79 (2005) [hereinafter 2005 IHR].

59. ICCPR, *supra* note 36, art. 2; see *Human Rights Dimension of COVID-19 Response*, HUM. RTS. WATCH (Mar. 19, 2020, 12:01 AM), <https://www.hrw.org/news/2020/03/19/human-rights-dimensions-covid-19-response> (noting that although the scale and severity of COVID-19 justify restrictions on certain rights, careful attention must be made to ensure non-discrimination, the protection of human rights, and respect for human dignity).

60. ICCPR, *supra* note 3636, art. 2; LIST OF NON-DEROGABLE RIGHTS AND FREEDOMS UNDER ARTICLE 4 OF THE ICCPR, <https://www.legislationline.org/documents/id/7775> (last visited Apr. 20, 2021).

61. Caraccio, White & Jotwani, *supra* note 8; see generally Melinda Fouts, *Overcome Biases and Blind Spots In Decision Making*, FORBES (Oct. 9, 2018), <https://www.forbes.com/sites/forbescoachescouncil/2018/10/09/overcome-biases-and-blind-spots-in-decision-making/?sh=2a44c840196a> (explaining "blind decision making").

to health and life may further exacerbate vulnerable groups.⁶² In determining how to balance these considerations to ensure the right to health is enjoyed equally, States and governments will need to rely on the legal instruments which govern the right to health in international law, along with input from physicians and experts with diverse backgrounds, who are able to ensure that the policies put in place to deal with resource scarcity are made with equity and non-discrimination at the forefront.⁶³ These policies must be detailed and specific, ensuring healthcare workers know how to implement them correctly in times of uncertainty.⁶⁴

When there is a health care resource shortage—whether equipment, providers or both—the question cannot be “Who should be given the best chance to live?” It must, in accordance with law, be “How can we allocate our resources to ensure everyone has an equal chance at treatment and survival?” To achieve this, States must conceptualize and implement triage protocols anchored in legal, ethical, and procedural principles which afford equal concern and equal recognition of each person’s dignity, worth and value. No person’s right to health should be prioritized over another’s.

62. Susanne Jöbges et al., *Recommendations on COVID-19 triage: international comparison and ethical analysis*, 34 *BIOETHICS* 948 (2020), <https://onlinelibrary.wiley.com/doi/10.1111/bioe.12805>.

63. Caraccio, White & Jotwani, *supra* note 8.

64. *Id.*; Nancy E. Kass, *An Ethics Framework for Public Health*, 91 *AM. J. PUB. HEALTH* 1776 (2001), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1446875>.

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