Received: 12 November 2020 | Revised: 4 December 2020 | Accepted: 4 December 2020

DOI: 10.1111/ajt.16458

EDITORIAL

AJT

Leveling-up versus leveling-down to address health disparities in transplantation

Racial inequity in access to kidney transplantation continues to be an area of focus. Rightly so, as deceased donor organs represent a scarce resource and disparities in access require attention. In this month's *AJT*, Reese et al provide insights into the disparate allocation of preemptive deceased donor kidneys, show why Blacks have lower rates of preemptive transplants, and propose interventions that are targeted at reducing this disparity.[1] One important aspect of this work is the focus on listing criteria that currently requires only a single test of eGFR ≤ 20 ml/min/1.73 m^2. Here, the authors have struck on a fundamental issue which has been the cornerstone of waitlist eligibility yet is flawed in its lack of incorporating greater measures of medical urgency.

Health disparities are "directly or indirectly generated by social, economic, and environmental factors and structurally influenced lifestyles".[2] Underlying determinants contributing to inequities are influenced by several factors, but importantly these are modifiable. Consistent with the interventions proposed by Reese et al, such as easing waitlisting processes, strategies that "level-up" access to underserved populations to equalize opportunity currently afforded to those with the greatest access to health care are preferred.[2] However, if these interventions fail, the authors suggest removing preemptive waitlist time altogether which would directly result in lower preemptive transplant rates.[1] Strategies that "level-down" existing benefits should be taken with caution as they reduce optimal care and welfare of the overall system. Leveling-down objections are considered only if no alternative solutions are available (including direct financial and other supports to increase access to groups currently deprived). In accordance with long established ethical principles governing organ allocation: equality (justice), utility, and respect for persons, here too, a pluralistic egalitarian approach requires balancing principles of equality (eliminating disparities) and welfare (doing the most good overall).[3]

The ethical framework to support the authors viewpoint posits that "first come-first served" privileges individuals with greater access to health care and worsens disparities within underserved groups.[4] However, this argument should be taken in context of first come-first served versus random allocation as it was originally described.[4] A process of random allocation would likely reduce disparities in access by ensuring organs are allocated independent of social determinants, but its adoption is challenged by the fact it may reduce utility and removes patient need as a driver. Prior to implementing extreme measures that would eliminate preemptive wait time, a firmer ethical rationale is necessary for policy change.

For too long the transplant community has failed to address observed racial disparities in access to the waitlist, preemptive transplantation, and living donor transplant. Although race is a critical factor, other social determinants including gender and socioeconomic status are also likely to contribute to most observed disparities.[5] Reese et al take a comprehensive look at racial disparities from the perspective of access to the waitlist and inequities in preemptive transplantation. Importantly, they emphasize that the transplant community should be more introspective and proactive to address disparities during the routine management of their patients, particularly when racial disparities are so well established.

KEYWORDS

editorial/personal viewpoint, ethics, ethics and public policy, kidney disease, kidney transplantation/nephrology, organ procurement and allocation, social sciences

DISCLOSURE

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

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