New Zealand Medical Association
Te Hauora mō ngā Iwi Katoa

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Ethical Framework for Resource Allocation in Times of Scarcity

Dear Nic

Thank you for inviting the New Zealand Medical Association (NZMA) to provide feedback on the above consultation. The NZMA is New Zealand's largest medical organisation, with more than 5,000 members from all areas of medicine. The NZMA aims to provide leadership of the medical profession, and to promote professional unity and values, and the health of all New Zealanders. We recognise the principles of te Tiriti o Waitangi and the special obligations to Māori, particularly to ensure equity and active protection. Current disparities in health outcomes between Māori and non-Māori are unacceptable. The NZMA is committed to advocating for policies in health and the social and wider determinants of health that urgently address these disparities and contribute to equity of health outcomes. Our submission has been informed by feedback from our Board, Advisory Councils and members. We also attach an appendix containing supplementary feedback by a public health physician on our Specialist Advisory Council that elaborates on some of the points in our submission by providing detailed responses and supporting references to the consultation questions.

1. We note that the ethical framework has been developed to help clinicians, nurses, hospital administrators and public health policy makers optimise distribution and prioritisation of vital resources in times of scarcity, and that the document is best used to identify important ethical principles, highlight ethical tensions and support robust decision making; it is not a set of rules. The NZMA strongly supports the development of a shared ethical framework to help decisions about resource allocation and prioritisation, particularly for the COVID-19 pandemic. Having an agreed foundational framework for decision making will help by:

- ensuring different and sometimes competing foundational ethical principles are considered, and any tensions between them identified
- providing greater structure for debating complex questions
- facilitating more transparent arguments and reasoning, including delineating the role of evidence from the role of values in the arguments presented.

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Scope and Context

2. We believe the document needs to more clearly identify and define its focus and scope. In particular, the document needs to be clear about whether it is about all prioritisation decisions or about prioritisation decisions during a pandemic. If its scope is limited to the latter (as seems to be the case), it is necessary to make the case for why the potentially hyperacute and extreme scarcity that could have been (or could still be) generated by a rampant upsurge in COVID-19 generates the need for rationing principles beyond the day-to-day rationing that happens routinely within our health services. They are on the same continuum, and scarcity is ubiquitous.

3. It would be useful for the document to identify some of the ways which decision making during a pandemic differs from that during other times. These could include the time pressures during a pandemic (information is changing all the time and decisions need to be made quickly) and the fact that widespread consultation is not possible because of these time pressures. Having wide agreement is also essential during a pandemic, hence the importance of trust in leaders and content specialists and the value of kotahitanga (unity), central to the concept of the "team of 5 million."

4. The unique challenges of a pandemic situation notwithstanding, we contend that the NEAC document would benefit from cataloguing the approaches to prioritisation and rationing that are already used in the health system. As the document stands, there is an impression that the principles outlined are made in a vacuum in a health sector not already dealing with scarcity. We suggest that principles of prioritisation/rationing that are currently in use could be identified and assessed for how they might or might not be fit for purpose for managing the surge in disease burden associated with a pandemic. In this regard, it would be useful to reference other health sector and public policy prioritisation/rationing frameworks in New Zealand and perhaps elsewhere.[1] Of particular note and of direct relevance to the example of vaccines given in the document are PHARMAC's rationing processes[2] and decision-making frameworks including its Factors for Consideration.[3]

5. We suggest the title of the document needs to be amended/expanded so that it is clear the document applies to resource allocation in a pandemic situation and is not intended as a generic guide to resource allocation in times of scarcity as it currently reads.

Harm minimisation

6. While the framework captures most of the ethical tensions, we believe the principle of minimising harm is worth adding to the list of foundational ethical principles. It is conceptually distinct from the principles "getting the most out of resources" and "achieving equity." The concept of harm avoidance has particular relevance for vaccines where it is important to find the right balance between having reliable evidence of safety and the potential for benefit. Harm avoidance also has relevance for ICU care given the possibility of complications arising from such care leading to permanent disabilities or other forms of harm. Even PPE use can have

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[1] Marckmann G, et al. Putting public health ethics into practice: a systematic framework. Front Public Health. 2015;3:23. Available from www.frontiersin.org/articles/10.3389/fpubh.2015.00023/full; Marsh K, et al. Prioritizing investments in public health: a multi-criteria decision analysis. J Public Health (Oxf). 2013;35(3):460-6. Available from https://academic.oup.com/jpubhealth/article/35/3/460/1567336

[2] Grocott R. Applying Programme Budgeting Marginal Analysis in the Health Sector: 12 Years of Experience. Expert Rev Pharmacoecon Outcomes Res. 2009 Apr;9(2):181-7. Available from https://www.tandfonline.com/doi/full/10.1586/erp.09.2

[3] Available from https://www.pharmac.govt.nz/medicines/how-medicines-are-funded/factors-for-consideration/supporting-information/

unintended negative consequences and so should take into account the principle of minimising harm. For example, during the Ebola epidemic, full coverall suits were found to increase risk due to contamination during the doffing (suit removal) process.

Probability and impact to support risk management

7. Decision making around resource allocation in the setting of COVID-19 is closely associated with risk management. It may be helpful to develop this idea further in the framework and to introduce concepts of probability and impact to supplement the principles already provided. Some risks may have low probability but high impact. Such risks can be particularly difficult to manage, and it can therefore be helpful to define the nature of the risks being considered. While judgements about probability are science based or at least evidence informed, judgements about impact involve a combination of evidence and science (what could happen?) as well as values (how much does it matter?).

Access to appropriate scientific and technical advice

8. Informed decision making, particularly around management of infectious disease risk, requires an in-depth technical understanding and knowledge of the available scientific evidence which can then be used to inform cultural and personal value judgements about the 'best' resource allocation. We suggest that this dimension needs to be borne in mind when considering the te Tiriti principles' application to resource allocation. We support the statement "Māori are key decision makers in the…response to pandemics or public health emergencies" (table 2) but believe that access to expert scientific advice is a necessary requirement for informed Māori self-determination, particularly in the context of a novel infectious disease where the evidence base is rapidly evolving and therefore particularly challenging to navigate. Access to appropriate technical expertise as well as appropriate representation is also vitally important for the decision-making groups that are being proposed.

Overarching framework

9. The control of infectious disease epidemics requires a collective response. In an interconnected society, one person or group's risk management decisions have flow on effects for the risk experienced by others. With respect to the pandemic response, te Tiriti concepts of coordination, co-design and partnership are of key importance. These need to occur within a common overarching framework aiming to minimise overall clinical impact as well as inequities for Māori and other vulnerable groups.

Prioritising the people most in need

10. There is a view that the principle of "prioritising the people most in need" is quite vague and therefore difficult to differentiate conceptually from the "getting the most out of resources" and "achieving equity" principles. This principle could be made more useful by defining it more clearly and explaining how it differs from the other principles listed. The accompanying bullet points in table 1 appear to conflate "prioritising the people most in need" with the other principles. For example, the third bullet point states: "One option is to give priority to individuals or groups in greatest need in order to restore them to an appropriate health threshold". Yet if this option is chosen, the principle becomes redundant because it falls under the "achieving equity" principle. While this principle seems to be relevant when considering ICU care, it essentially falls under the principle of "getting the most out of resources" due to excluding those who need ICU care but are unlikely to benefit due to having minimal chance of survival. As such, we suggest

removing this principle unless it can be clearly differentiated in a way that makes it useful as a practical aid to decision making.

Prioritising PPE and vaccines for healthcare workers

11. We believe that it would be useful for the document to identify an additional argument for prioritising PPE and vaccines for healthcare workers—namely, the risk that healthcare workers themselves may become vectors of disease to vulnerable patient groups, particularly in the hospital setting (eg, young cancer patients who are immunocompromised due to chemotherapy). Thus, vaccinating healthcare workers arguably has wider population health benefits and possibly equity benefits (based on the assumption that disadvantaged groups are more likely to be exposed to healthcare workers should they become infected). With respect to PPE, we suggest that it would also be useful for the document to identify, as a separate ethical responsibility, the duty of care and employer obligation to provide safe workplaces under the Health and Safety at Work Act 2015.

Distinguishing between ethical values that inform how decisions are made and what decisions are made.

12. We note that this document builds on the work of *Getting Through Together*.[4] One of the strengths of this earlier resource is that it distinguishes between ethical values that inform how we make decisions and ethical values to inform what decisions are made. This is important because the way we make decisions is arguably as important as the decisions that we make. While many of the ethical values on how we make decisions are included in the narrative of the current document, we suggest it would be useful to tabulate these in the same way as in *Getting Through Together*.

Social worth

13. We note that the document refers to the concept of social worth in the example on PPE, stating that: "Social worth is not typically an acceptable criterion for distributing health care resources and should be invoked only if absolutely necessary and justified in limited circumstances." We do not believe social worth is an acceptable principle. However, we do see value in the utilitarian principle, whereby certain peoples' skills are of critical importance for society as a whole, and we believe it reasonable for the document to identify this.

Quality-adjusted life year (QALY) measure

14. We believe the document incorrectly dismisses the use of QALYs. For example, on page 14, it states: "Screening measures, including the quality-adjusted life year (QALY) measure, must be avoided as they are inherently biased against people with disabilities". And in table 3 on page 18, it states: "Need to ensure that disability status and age are not used as proxies for capacity to benefit and that QALY assessments are excluded." It is important to note that QALYs themselves are simply a metric (like age, weight or cardiovascular risk score). The issue is not the QALY metric per se but how they are used. In dismissing the use of QALYs, the document conflates a potentially useful value-free metric with how that metric is then used for allocating resources. QALYs can both disadvantage and advantage certain groups depending on how they are used. By way of explanation, QALYs incorporate both quality of life and longevity/loss of life potential– which relates to age. As such, depending on how they are used, then can either discriminate positively or negatively against people with poorer baseline quality of life such as people with

[4] Available from https://neac.health.govt.nz/publications-and-resources/neac-publications/getting-through-together-ethical-values-pandemic

disabilities. If used in a Utilitarian frame, maximising total health years gained regardless from whom (as QALY gains), then people with disabilities and co-morbidities will be disadvantaged. But if used in a Rawlsian frame to identify people worst off to begin with, QALYs (lost to begin with), then the same people are advantaged. We suggest NEAC reflect this in the document by amending its wording on QALYs. We refer to our appendix for further discussion of QALYs and how they are used.

Establishment of decision-making group(s)

15. The proposal that a "decision-making group be established in appropriate health services institutions at both the national and local level, as necessary" is problematic. There are practical challenges associated with establishing decision-making groups at the local level. Decisions are made by the people with authority to make decisions, who are then responsible for the outcome of their decisions. There is usually a chain of delegated authority and accountability provisions. In the examples in the document, the decision makers currently are the directors of ICUs (in allocating ICU beds and ventilators), the Director General of Health and the CEOs of DHBs (in distributing the Government's stock of PPE), and PHARMAC (in deciding who will receive a vaccine).

16. Concerns have been raised that regional variability arising from the establishment of local decision-making groups could result in postcode healthcare whereby a person's location determines the healthcare they receive during a pandemic. To mitigate against this, we suggest that it would be useful to provide national direction or support for Clinical Ethics Advisory Groups at each DHB. Such groups could support decision makers in allocating resources in an equitable way during a pandemic. We also suggest that it would be useful for the document to reference the New Zealand Influenza Pandemic Plan which had ethical considerations at the top of their list of key issues.[5] With respect to decisions relating to traditional public health interventions, we also draw attention to the Public Health Association's Te Ture Whakaruruhau Code of Ethical Principles.[6]

Wider scope

17. Although perhaps outside the scope of NEAC and this document, it may be worthwhile alluding to the trade-offs that occur between disease control during a pandemic (especially in the face of uncertainty) and health losses associated with disease control activities. For example, while lockdown successfully interrupted the chain of transmission of COVID-19 and averted a deluge of hospitalisations, the economic consequences of the lockdown include increased unemployment with associated adverse consequences for mental health and well-being.

Other matters

18. We assume that feedback on the specific Māori aspects of this paper has been sought from the National Māori Pandemic Group Te Rōpū Whakakaupapa Urutā.[7]

19. On page 11, with respect to the allocation of resources, the document appears to confuse public health with publicly funded health services and infection control. This needs to be clarified further as PPE is not public health or a public health resource. PPE is really a concern in an

[5] Available from https://www.health.govt.nz/system/files/documents/publications/influenza-pandemic-plan-framework-action-2nd-edn-aug17.pdf
[6] Available from https://www.pha.org.nz/page-18201
[7] https://www.uruta.maori.nz/

infectious disease outbreak or pandemic and is not necessarily relevant in resource scarcity in other contexts.

20. We believe that the Ministry of Health should be required to publish data around who is accessing different parts of the pandemic service and outcomes (eg, COVID-19 testing, hospitalisation, mortality) and who is not getting the services (eg, who is sent home without treatment if hospitals are at capacity). These data should be reported by ethnicity, age, DHB of domicile, gender, etc.

21. In paragraph 1 on page 4, we suggest that lower socioeconomic groups be added to the list of factors that make people more vulnerable during the COVID-19 pandemic.

22. On page 13, there is a statement that NEAC agrees that there are no ethically defensible groups to prioritise an infected patient over any patient who is not infected (University of Sydney 2020). We seek clarification on whether this view has taken into account the greater public good arising from the treatment of patients with COVID-19. If treating a patient with COVID-19 prevents spread of the virus to potentially thousands of others, then there is a view that these patients should be prioritised over non-infected patients.

23. In paragraph 2 on page 14, there is a statement: "It is important that all organisations inform the public about any changes to standards of care before such changes are introduced" (University of Sydney). It has been pointed out that this has certainly not been done to date. For example, some cardiac patients have been discharged earlier or been changed from coronary artery bypass grafting (CABG) to percutaneous coronary intervention to prevent some patients going to ICU after CABG surgery and preserve beds for possible COVID-19 patients.

24. In paragraph 2 on page 15, we suggest that "older patients" be added to the list of groups that are disadvantaged such that the sentence reads: "Current approaches for guidelines for access to ventilators and ICU beds use comorbid conditions, future life expectancy and health and public safety workers' status as the key determinants for prioritisation – all of which disadvantage lower socioeconomic status, Māori, Pacific peoples, older patients and people with disability".

25. On page 25, in the second paragraph under the heading 'All people are equally deserving of care', there is a typo in the first sentence. This should be "regardless <u>of</u> their immigration status' not "regardless if their immigration status".

26. While the document uses the examples of ICU allocation, PPE allocation and vaccine allocation, there are a number of other situations during a pandemic that present ethical challenges that it may be useful for the document to consider. These include attendance at funerals and tangihanga and being able to visit dying whānau in rest homes.

Consultation process and next steps

27. It is concerning that the document appears to already be published in its final form. We would have appreciated the opportunity to provide feedback at an earlier stage on a draft version of the document. We would welcome clarification of the next steps including whether the document will be revised to address the issues that have been raised during consultation.

We hope our feedback is helpful.

Yours sincerely

Dr Kate Baddock
NZMA Chair